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Testimony
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DOMESTIC POLICY SUBCOMMITTEE
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"Necessary Reform to Pediatric Dental Care under Medicaid"

As Founding Director of the Children's Dental Health Project (CDHP) and Director of the Maternal and Child Health Bureau's *National Oral Health Policy Center at CDHP*, I am pleased to respond to the Subcommittee's request for testimony on policy recommendations to improve the oral health of children in Medicaid. This testimony is supported by federal studies and by analyses conducted at Columbia University where I serve as Professor of Dental Medicine and Health Policy & Management.

The Subcommittee's finding that only a minority of Medicaid-enrolled children in Maryland obtain dental care, that many children go years without care, and that the majority of care is provided by a small subset of dentists typifies the situation nationally.

<u>Medicaid reaches only one-third of child beneficiaries nationally</u>
The Agency for Health Care Research and Quality reports that nationally 58% of children with private dental coverage obtain care in a year while only 34% of children in Medicaid and SCHIP do so. The Center for Medicare and Medicaid Services' data similarly show that by 2006 only 33% of Medicaid-enrolled children obtained a dental visit – up from 22% seven years earlier. Much of this increase may be attributed to Medicaid expansions that resulted from SCHIP enactment in 1997 while some may be attributed to state-level program reform. By 2006, the latest year for which CMS data are available, reported utilization across states ranged as high as 44% and as low as 19%.

<u>Disease trends are outstripping capacity</u>
Program performance fails profoundly to keep pace with the growing dental disease burden in the beneficiary population. CDC reports that early childhood tooth decay is trending upward, affecting more than one-quarter (28%) of US 2-5 year olds and impacting a higher percentage of poor and low-income children. Coupled with demographic trends, the volume of disease and associated treatment needs are increasingly outstripping program capacity. (States report that an increasing percentage of children are born under Medicaid and Census reports that more children were born last year than at the peak of the baby boom),.

<u>State dental Medicaid reforms improve but do not correct shortcomings</u>
States often have little incentive to address shortcomings in their dental Medicaid performance because of limited federal oversight and lack of sanctions for poor performance, the relatively small size of the dental program within Medicaid (about 5% of Medicaid expenditures), the lack of provider demand or beneficiary voice, and the small staffs serving this component of the multifaceted Medicaid program.

A small number of states, however, including DE, IN, MI, SC, TN, and VA, have made notable dental Medicaid program improvements. Even these efforts typically yield levels of care far lower than provided to privately-insured children (DE 29%; IN 41%; MI 37%; SC 43%, TN 36%, VA 32%). This may be attributed in part to lack of care-seeking behavior by beneficiaries but is more likely due to the lack of available providers.

Dentist participation in Medicaid is low and insufficient

With few exceptions, less than half of dentists enroll as providers. Even in the states recognized for their major reforms - reforms that have included market-based fee increases - fewer than half of dentists are enrolled in all but SC (40% in DE, 37% in IN, 37% in MI, 27% in TN, 25% in VA). Among dentists who enroll as Medicaid providers, often with the encouragement of their state dental associations, only a small percentage actively provide significant levels of care as earlier reported by the Subcommittee.

Attendees at a recent dental association symposium on Medicaid noted, as did the Subcommittee, that many self-identified Medicaid dentists are such "virtual providers" who enroll but do not provide services under the program. Among barriers conjectured by attendees were "fear of practice being overrun by Medicaid patients," feeling among older dentists they have previously served Medicaid populations and that it is now the responsibility of younger practitioners, discomfort caring for young children, and misinformation about the population.

Dentists often note that their business model does not readily accommodate discounted public insurance plans and some state payment rates are indeed too low to allow for all but marginal volume of services to beneficiaries. However, among some of the dental practices that successfully serve large numbers of child beneficiaries are those affiliated with multi-state Medicaid-specific management companies. These practices typically locate in impoverished areas along public transportation routes where physical access is assured and organize their schedules in ways that best accommodate the most socially disadvantaged of the beneficiary population.

Higher payment rates are necessary but not sufficient to improve performance

It is widely appreciated that paying providers at adequate rates is a necessary but not sufficient condition for improving dental access for Medicaid-enrolled children. In addition to reforming payment rates to levels that reflect market conditions, successful reforms also actively and continuously engage state dental associations as partners, streamline administration, and provide facilitation services to both beneficiaries and dentists.

A group of 30 dental Medicaid experts were recently polled by Columbia University researchers on factors required to improve Medicaid dental programs. The six categories of action recommended were (1) developing an adequate provider network, both numerically and geographically; (2) providing adequate funding; (3) ensuring supportive program administration; (4) fostering a political, professional, and advocacy climate that encourages change; (5) delivering comprehensive beneficiary assistance; and (6) addressing program design issues including continuous eligibility, single point of administration, and accountable contracting with vendors.

Not all fee changes lead to utilization improvements.

A Columbia University study of dental Medicaid performance over the years 1999-2006 identified 41 states that reported fee increases but only 25 of these also showed an increase in utilization, likely because the others' increases were insufficient. However, even among the 25 states whose fee increases are associated with utilization increases,

only 13 states reached utilization levels of 33% or more. *Improved* levels of care ranged from 19% to 43%. No state experienced improvements in utilization if they did not also raise fees. The ongoing study will further analyze the relationship between program reforms, including fee changes, and attainment of utilization rates that exceed the national average. Notable were some states, particularly those that are rural or frontier, in which utilization rates exceed the national average despite low fees. Conjectured is that in such states the professional culture, role of dentists in their communities, lower dentists' operating costs, personal relationships, and/or larger proportion of children in Medicaid lead to more equitable care across income strata.

Managed care risk-contracting contributes to the problem of low utilization
States frequently contract with managed care vendors to develop networks, manage claims, and administer their dental Medicaid programs. When states put those contractors at financial risk without establishing rigorous performance accountability standards and allowing compensation for unanticipated increases in utilization, they establish a powerfully perverse incentive for underutilization. The greater the utilization, the greater the risk that vendors will not only lose profit but will expend more dollars than they take in as premiums.

This constraining condition can be eliminated by rewarding rather than punishing vendors for improved utilization. State Medicaid contracting could be better modeled on federal contracting for its Military dependent dental program in which the vendor is financially incentivized for increased utilization and encouraged to promote oral health and dental care among beneficiaries.

Disease management is critical to improved health at lower costs
In the big picture, however, disease burden will overwhelm any and all efforts to repair children's cavities because the sheer volume of cavities in need of fillings swamps the capacity of the public and private dental delivery systems. Improved health outcomes at reduced costs can only be accomplished through a fundamental shift in the nation's approach to dental caries management in children.

Cavities result from an infectious, transmissible disease process that is typically established in children's mouths before age two and that plays out over a lifetime. "Dental caries" is overwhelmingly a dietary disease that results from high frequency ingestion of simple carbohydrates and can be well suppressed through the use of fluorides.

Each child has a unique level of risk for this disease and would benefit from appropriately tailored preventive and management strategies. The one-size-fits-all semiannual cleaning and fluoride approach to cavity prevention commonly practiced today starts too late for meaningful prevention and misses opportunities for *bona fide* disease management through individualized care plans like those used to manage asthma and diabetes in children. Needed are family-centered behavioral interventions coupled with pharmacologic interventions that are instituted early in affected children's lives, coupled with public education about caries as a manageable disease.

Findings of over 40 years of laboratory and applied research by the National Institute for Dental and Craniofacial Research awaits implementation in the form of refined clinical protocols that can be demonstrated to delay disease onset and reduce population-level disease burden. Implementing such practices, however, will require changes in provider education, public awareness, financing arrangements, and practice staffing and organization.

Policy recommendations

Among specific public policies that arise from these observations are the following.

1. To address Medicaid-provider shortages:
    a. Authorize and support programs that identify and address root-causes of private provider willingness to care for children in Medicaid including programs that correct stigma, improve provider education, and incentivize dentists. Markedly increased funding for the HRSA *Grants to States to Support Oral Health Workforce Activities* program in more than 18 states.
    b. Address workforce shortcomings by considering opportunities for advanced US training of dentists educated outside of North America and for "midlevel" providers, and by engaging outreach workers and peer-counselors in locales and programs where at-risk children live, learn, and play. Through these personnel, further integrate oral health into WIC, Head Start, early intervention, and early education programs.
    c. Incentivize dentists to serve in the public delivery systems through expanded scholarship and loan programs.

2. To address state Medicaid dental program performance
    a. Direct CMS to intensify oversight of state programs, issue clarifying guidance, promote and disseminate best practices, provide or contract for technical assistance to states, and prohibit those risk-based contracting practices that results in incentives for underutilization.
    b. Authorize and fund grants to states to engage technical support for development of dental Medicaid program infrastructure including personnel, processes, provider relations, and enhanced contracting.
    c. Fully fund the CDC dental public health infrastructure and implementation grant program beyond 12 states so that all states develop the public health capacity to partner effectively with, and provide expertise to, state dental Medicaid programs.
    d. Establish an outcomes and cost-effectiveness demonstration program of Medicaid early childhood disease management interventions.

3. To address the growing disease burden and improve health outcomes at lower costs:
    a. Authorize and adequately support research on clinical practice transformation and education of dental and medical professionals to expand their engagement in non-surgical pediatric caries management.

b. Create at CDC a national public awareness and education program on caries understanding and prevention.
c. Establish federal support for state Medicaid program demonstrations on early intervention, individualized care plans, and disease management.
d. Create programmatic incentives to address the overwhelming lack of dental care provided to pregnant women both to improve their oral health and to reduce risk for disease transmission to the next generation.

Retain past Congressional legislative successes

Congress can significantly improve children's oral health and dental care by ensuring that all of the dental provisions that it adopted in passing the vetoed Child Health Insurance Reauthorization Act are retained in future legislation. These include ensuring dental services as part of well baby-well child care; requiring uniform state reporting on program performance; informing parents at their children's birth about risks for early childhood caries and its prevention; promoting development of quality measures for children's oral healthcare; facilitating public-private contracting, and investigating the roles for mid-levels of various types in improving oral health and healthcare.

Conclusion

Among health conditions afflicting America's children, including autism, asthma, diabetes, and tooth decay, tooth decay remains the single most common condition and is consequential to millions of children's lives because of the pain and infection that it produces. But among these conditions, tooth decay is uniquely preventable and, once established, readily manageable. The way out of so much current suffering is early and effective prevention and disease management coupled with ready access to reparative surgical care for children whose mouths are already damaged.