

**WRITTEN  
TESTIMONY  
OF  
James J. Crall, DDS, ScD**

**Domestic Policy Subcommittee  
Oversight and Government Reform Committee  
Tuesday, September 23, 2008  
2154 Rayburn HOB  
10:00 a.m.**

***“Necessary Reforms to Pediatric Dental Care under Medicaid”***

I, James J. Crall, D.D.S., Sc.D., hereby submit the following as written testimony pursuant to the Subcommittee’s request for my views on policy reforms that have been proven to improve access to, and utilization of, pediatric dental care in Medicaid. This testimony concerns the hearing to be held on Tuesday, September 23, 2008 at 10:00 a.m. in Room 2154 of the Rayburn House Office Building. My comments largely focus on (1) the impact of Medicaid reimbursement rate increases on dentists’ participation and children’s utilization of dental services in Medicaid and (2) the benefits of no-risk contractual arrangements that separate or ‘carve out’ Medicaid dental benefits from global Medicaid managed care arrangements. I sincerely appreciate the opportunity to participate in this hearing.

**1. Impact of Medicaid Reimbursement Rate Increases**

**a. Impact on Dentists’ Participation in Medicaid**

Access to an ongoing source of dental care is a critical component for maintaining good oral health in children. Access to a ‘dental home’ or regular source of dental care is especially important for children who are at elevated risk for tooth decay (dental caries), predominantly children in low-income families and children with special health care needs, who generally are covered by Medicaid. National surveys showing an increase in tooth decay in young children (what we now refer to as Early Childhood Caries or ECC) combined with the already large and growing numbers of children on Medicaid (nearly 30 million or 1-in-3 American children) underscore the need for engaging substantial numbers of dentists as Medicaid providers across the U.S. However, chronically low reimbursement to dentists for services rendered has been acknowledged by several private and governmental reports to be a major, if not the greatest, barrier to dentists’ participation in Medicaid.

Relationship between Reimbursement and Access to Dental Services for Children in Medicaid

Access to dental services for children covered by Medicaid is a significant and chronic problem. Studies conducted by the U.S. Department of Health and Human Services<sup>1</sup> report that (a) relatively

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<sup>1</sup> Office of the Inspector General (OIG), U.S. Department of Health and Human Services. Children’s Dental Services Under Medicaid: Access and Utilization. San Francisco, CA: U. S. Department of Health and Human Services, 1996.

few children covered by Medicaid receive recommended dental services and (b) inadequate reimbursement is the most significant reason why dentists do not participate in Medicaid. Reports issued by the U.S. General Accounting Office<sup>2,3</sup> (GAO) to Congress in 2000 noted that Medicaid payment rates often were well below dentists' prevailing fees and that "as expected, payment rates that are closer to dentists' full charges appear to result in some improvement in service use."

The GAO's April 2000 Report to Congress compared a sample of dentists' fees in the private sector to Medicaid fees for the same services, and projected the proportion of dentists who might accept the Medicaid fees. The study indicated that the level of Medicaid dental reimbursement in 1999, nationally and in most States, was about equal to or less than the 10<sup>th</sup> percentile of respective fees – i.e., at least 90 percent of dentists charged more, and usually substantially more, than the Medicaid fee. A subsequent assessment conducted in 2004 by myself and Dr. Don Schneider (former Chief Dental Officer at CMS) found that in 41 states, the majority of Medicaid dental reimbursement rates for common children's dental procedures remained below the 10<sup>th</sup> percentile and frequently were below even the 1<sup>st</sup> percentile of dentists' fees – meaning that the Medicaid rates were lower (and often substantially lower) than the fees charged by any dentist in the respective states.

Impact of Efforts by Some States to Establish Market-based Medicaid Reimbursement Rates

Beginning in the late 1990s, following a series of Oral Health Policy Academies organized by the National Governors Association, several states moved to increase Medicaid reimbursement levels to considerably higher levels consistent with the market-based approach advanced during the NGA Policy Academies. As shown in the table below, subsequent evaluations suggest that (similar to findings by the GAO) Medicaid payments that approximate prevailing private sector market fees do contribute to increased participation by dentists in Medicaid.

STATE	Market Benchmarks for Adjustments to Medicaid Rates	Changes in Dentists' Medicaid Participation	Intervals After Rate Increases (months)
Alabama	100% of Blue Cross rates	+39% +117%	24 44
Delaware	85% of each dentist's submitted charges	1 private dentist to 130 (of 378 licensed dentists)	48
Georgia	75th percentile of dentists' fees	+546% +825%	27 48
Indiana	75th percentile of dentists' fees	+58%	54
Michigan Healthy Kids Dental	100% of Delta Dental Premier (16 counties)	+300%	12
South Carolina	75th percentile of dentists' fees	+73% +88%	36 42
Tennessee	75th percentile of dentists' fees	+81%	20

<sup>2</sup> General Accounting Office (GAO). Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations; U.S. General Accounting Office, Report to Congressional Requesters. HEHS-00-72, April 2000.

<sup>3</sup> General Accounting Office. Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations; U.S. General Accounting Office, Report to Congressional Requesters. HEHS-00-149, September 2000.

Other states, including Virginia, Texas and Connecticut also have taken steps to raise their Medicaid dental reimbursement rates to what are considered reasonable market-based rates. Unfortunately, as in the case of Connecticut and Texas, these changes often follow years of protracted litigation in federal courts. The table below provides a comparison of Texas Medicaid payment rates for selected procedures and fees charged by dentists within the State of Texas and within the West South Central (WSC) Region comprised of AR, LA, OK & TX. Details of the data elements are provided below.

TX Medicaid Payment Rates for Selected Procedures			Comparisons with Dentists' Claims for Insured Patients in the ADA West South Central (WSC) Region and in the State of Texas			
CDT4 Procedure Code	Procedure Description	TX Medicaid Payment Rate	WSC Region 50th Percentile	TX State 50th Percentile	TX State 75th Percentile	State Percentile Corresponding to TX Medicaid Payment Rate
<b>Diagnostic</b>						
D0120	Periodic Oral Exam	\$14.72	\$27.00	\$28.00	\$32.00	< 1st
D0150	Comprehensive Oral Exam	\$18.02	\$40.00	\$40.00	\$49.00	< 1st
D0210	Complete X-rays, with Bitewings	\$36.04	\$67.00	\$65.00	\$81.00	2nd
D0272	Bitewing X-rays - 2 Films	\$11.93	\$25.00	\$25.00	\$29.00	< 1st
D0330	Panoramic X-ray Film	\$32.54	\$65.00	\$65.00	\$75.00	1st
<b>Preventive</b>						
D1120	Prophylaxis (cleaning)	\$18.75	\$40.00	\$42.00	\$47.00	< 1st
D1203	Topical Fluoride (excluding cleaning)	\$7.50	\$19.00	\$19.00	\$22.00	< 1st
D1351	Dental Sealant	\$18.55	\$33.00	\$35.00	\$39.00	< 1st
<b>Restorative</b>						
D2150	Amalgam, 2 Surfaces, Permanent Tooth	\$43.73	\$68.00	\$91.00	\$107.50	< 1st
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	\$52.57	\$110.00	\$119.00	\$135.00	< 1st
D2751	Crown, Porcelain Fused to Base Metal	\$264.00	\$650.00	\$660.00	\$725.00	< 1st
D2930	Prefabricated Steel Crown, Primary Tooth	\$78.03	\$152.00	\$146.00	\$175.00	< 1st
<b>Endodontics</b>						
D3220	Removal of Tooth Pulp	\$43.98	\$93.00	\$95.00	\$118.00	< 1st
D3310	Anterior Endodontic Therapy	\$177.99	\$420.00	\$426.00	\$509.00	3rd
<b>Oral Surgery</b>						
D7140	Extraction, Single Tooth	\$33.52	\$75.00	\$79.00	\$92.00	1st

The first two columns in the above table list procedure codes and descriptors for 15 procedures commonly used to assess Medicaid reimbursement rates for EPSDT services. The third column shows TX Medicaid payment rates in 2004 (which were largely unchanged during the previous decade and remained unchanged until a federal court settlement in September, 2007). The next two columns show the median or 50<sup>th</sup> percentile charges for these services by dentists in the four West South Central states and in TX; while the second column from the right shows charges representing the 75<sup>th</sup> percentile of fees charged by dentists in TX. The far-right column shows the percentile equivalents for the TX Medicaid rates (i.e., the percent of dentists who charge the same or lower amounts than Medicaid paid).

As an example, the table indicates that for a periodic oral examination (D0120), the WSC regional and TX 50<sup>th</sup> percentiles of dentists' charges were \$27 and \$28, respectively. In 2004, the Texas Medicaid program paid \$14.72 for that procedure, an amount that no dentist in TX would see as equal to or greater than their current charges (i.e., < 1<sup>st</sup> percentile). That is to say, 100% of TX dentists would see the Medicaid payment rate as less than their usual charges, and a majority would see it as substantially less than their usual charges. The same can be said for 10 of the other selected procedures -- i.e., the respective Texas Medicaid payment amounts were less than the usual charges reported for any dentist in Texas, and below the cost of providing the procedure for the majority of Texas dentists. From an economic perspective, these payment levels which are substantially below the prevailing charges of the vast majority of TX dentists, and typical of Medicaid rates in many if not most other states, would not be expected to provide adequate incentives for dentists to participate in Medicaid.

In September, 2007, following a settlement in the federal court case of *Frew vs. Hawkins*, Texas EPSDT dental Medicaid reimbursement rates for 35 common procedures were raised by 100% (effectively to the 50<sup>th</sup> percentile of Texas dentists' fees). This action followed more than a decade of essentially stagnant dental Medicaid rates in the face of steady modest increases in the cost of dental care (~ 4.5% annually). Significant increases also were provided for approximately 20 additional relatively common dental procedures. Information recently obtained from individuals involved in the *Frew* case indicates that following the Medicaid reimbursement rate increases, the State has issued approximately 500 new Texas Medicaid dental provider numbers.<sup>4</sup>

Information obtained from these (and other) states which have implemented dental Medicaid reimbursement increases that brought their Medicaid payment rates into the range of what are considered to be 'reasonable market-based rates' have had a clearly positive impact on the number of dentists who provide dental services for children enrolled in Medicaid. Material regarding reimbursement rates and financing of dental services in Medicaid was included in the original version of the *Guide to Children's Dental Care in Medicaid* (the *Guide*) that was submitted by the American Academy of Pediatric Dentistry (AAPD) to the Centers for Medicare and Medicaid Services (CMS), but was redacted by CMS.

The entire section of the document that AAPD submitted to HCFA (CMS) on Program Financing and Payments (Section C in the submitted table of contents) was deleted from the published version of the *Guide*. Topics addressed within this section are delineated below.

C. Program Financing and Payments

1. Funding Levels for Public Dental Programs for Children
2. Actuarial Estimates of Necessary Funding Levels for Publicly-Financed Children's Dental Benefits Programs
  - a. American Academy of Pediatrics Analysis
  - b. Reforming States Group Analysis
3. Historic Funding Levels in Public Pediatric Dental Care Programs
4. Reimbursement for Dental Services
  - a. U.S. General Accounting Office Study
  - b. Comparisons of Medicaid Reimbursement Rates for Pediatric Dental Services to Prevailing Market Rates

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<sup>4</sup> In Texas a dentist may have more than one provider number (e.g., for dentists who practice in multiple locations).

- c. Global versus Selective Reimbursement Rate Adjustments
  - d. Periodic Reimbursement Rate Adjustments
5. General Financing Considerations for Medicaid/EPSDT Dental Program Improvements

Additional information was provided in the *Guide* on comparisons of Medicaid dental expenditures vs. expenditure levels for the general population of U.S. children, along with summaries of relevant actuarial studies that had been conducted on behalf of the American Academy of Pediatrics and the Milbank Memorial Fund. These analyses showed that roughly \$14-\$17 per enrolled beneficiary (often referred to as PMPM or per-member-per-month) would be necessary to pay for dental services for children enrolled in Medicaid at market rates comparable to those used by commercial dental benefit plans for employer-sponsored groups. Typical benefits administration rates would raise those levels to \$17-\$20 PMPM for administering a Medicaid dental benefits program -- i.e., if states were to contract with dental benefits managers to administer the benefits. A subsequent actuarial analysis commissioned by the American Academy of Pediatric Dentistry in 2004 generally affirmed those findings. The actuarial information was included in the *Guide* to provide general benchmarks that state Medicaid programs could use to assess their current allocation levels for dental benefits for children enrolled in Medicaid. Available information suggests that many states allocate only a small fraction of the financial resources suggested by these actuarial studies (e.g., on the order of \$5-\$7 PMPM).

**b. Impact of Medicaid Reimbursement Rate Increases on Children's Use of Dental Services**

Perhaps more directly to the point, the table below shows data from CMS 416 annual reports illustrating significant increases in utilization of dental services by children covered by Medicaid in five states following significant reimbursement rate increases. The increased use of dental services also constitutes a significant positive impact of Medicaid dental reimbursement rate increases.

	FY1998	FY2001	2001 vs. 1998	FY2003	2003 vs. 1998	FY2006	2006 vs. 1998
	CMS 416	CMS 416	CMS 416	CMS 416	CMS 416	CMS 416	CMS 416
	% with	% with	% with	% with	% with	% with	% with
	Dental Visits	Dental Visits	Dental Visits	Dental Visits	Dental Visits	Dental Visits	Dental Visits
AL	41,659	105,522	253%	151,581	364%	188,475	452%
DE	8,428	15,430	183%	18,269	217%	24,973	296%
IN	47,730	160,627	337%	212,909	446%	251,647	527%
SC	96,590	88,523	92%	245,297	254%	229,447	238%
TN	148,028	141,140	95%	249,252	168%	295,413	200%

The rate increases which have been implemented in these and a handful of other States were not done in isolation, and generally were part of a broader combination of actions designed to address issues which have been identified as chronic barriers to dentist participation and access to dental care in Medicaid.<sup>5</sup> Although addressing these other issues is viewed as an important element of comprehensive dental Medicaid program reform, increasing Medicaid rates to reasonable market-based levels is critical to obtaining adequate levels of dentists' participation in Medicaid.

<sup>5</sup> See series of briefs prepared by J. Crall and D. Schneider for the American Dental Association (available on the Medicaid and SCHIP Dental Association's website at <http://www.medicaidental.org/pubs/index.html> ).

## **2. Advantages of No-risk Contractual Arrangements that Separate or 'Carve Out' Medicaid Dental Benefits from Global Medicaid Managed Care Arrangements**

In addition to the essential step of raising Medicaid dental reimbursement rates to reasonable market-based levels, many States also have taken steps to implement no-risk, administrative services only (ASO) contracts that separate or 'carve out' dental Medicaid benefits from global Medicaid managed care arrangements. Examples include Michigan's Healthy Kids Dental Program and Medicaid dental programs in Connecticut, Maryland, Tennessee and Virginia. Such arrangements eliminate the need for subcontracting between global Medicaid managed care organizations (which often are not in the business of providing dental benefits) and dental benefits managers. This change not only helps to simplify program administration and reduce confusion among dentists and Medicaid beneficiaries alike, the no-risk aspect also helps to eliminate the inherent incentive in risk-based contractual arrangements for managed care organizations and/or dental benefits managers to reduce payments to dentists in order to enhance the intermediaries' profits.

In addition to simplifying the administration of Medicaid dental benefits, these arrangements allow States to retain greater control in establishing reimbursement rates while affording reasonable profits for dental benefits managers. Additional advantages of the 'single-vendor' approach from the dentists' perspective include more streamlined enrollment procedures (because dentists do not need to fill out multiple enrollment forms and undergo credentialing by multiple dental benefits management organizations) and less confusion about program policies governing allowable services and billing processes which often results from having multiple dental benefits intermediaries involved within the same State (often within the same geographic region within a State). Moreover, contracting with a single dental Medicaid intermediary (single vendor) simplifies the contracting process, improves the ease of program monitoring, and has the potential for better contract enforcement on the part of the State Medicaid program.

### **Summary and Conclusions**

In summary, several States have taken significant steps to increase dentists' participation and access to dental services in their Medicaid EPSDT programs over the past decade. Successful efforts generally have involved the necessary step of raising Medicaid dental reimbursement rates to reasonable market-based levels combined with additional steps to make Medicaid dental program administration more 'dentist friendly'. Streamlining provider enrollment and implementation of no-risk contractual arrangements that separate or 'carve out' Medicaid dental benefits contracting from global Medicaid managed care arrangements have been prominent parts of these strategies. In my opinion, promoting the adoption of these strategies by other States would help to substantially improve children's access to dental care in Medicaid.

Thank you for the opportunity to participate in this hearing.

James J. Crall, DDS, ScD.