

Statement of the American Dental Association  
to the  
Subcommittee on Domestic Policy  
Committee on Oversight and Government Reform  
U.S. House of Representatives

On

One Year Later: Medicaid's Response to Systemic Problems Revealed by  
the Death of Deamonte Driver

February 14, 2008

Chairman Kucinich and members of the subcommittee, the American Dental Association (ADA) appreciates the opportunity to provide a statement for the record for today's hearing, "One year later: Medicaid's Response to Systemic Problems Revealed by the Death of Deamonte Driver." The ADA is a professional association representing 155,000 practicing dentists across the country committed to the public's oral health, ethics, science and professional advancement. The ADA thanks the subcommittee for holding this hearing to follow up on efforts undertaken over the last year by the Centers for Medicare and Medicaid Services (CMS) to address the oral health needs of low-income, underserved children. The hearing is timely as we have come upon the one-year anniversary of the tragic death of 12-year-old Deamonte Driver, a boy from neighboring Prince George's County, Maryland, who died from a brain infection related to untreated dental disease.

Last year, the subcommittee examined CMS oversight of the dental program for Medicaid eligible children during a hearing held on May 2. This hearing brought the issue of dental access under Medicaid to the forefront. The subcommittee questioned CMS on its role in assuring that eligible children are receiving dental services under state Medicaid programs. During the hearing, subcommittee members learned that critical information relating to provider reimbursement and managed care oversight had been eliminated from the 2004 Guide to Children's Dental Care in Medicaid, that CMS did not assess any penalties against managed care organizations that contracted with state Medicaid agencies but failed to provide dental services, and that CMS had not made children's access to dental care an enforcement priority. The ADA is aware that a

follow-up request was sent to CMS asking for additional information and for details on the “Value-Driven Health Care” initiative referenced in CMS’s response. The ADA is hopeful that today’s hearing will shed additional light on what is being done by CMS to address access barriers faced by low-income children seeking dental services and how to move forward from this point. The Association offers several suggestions in this statement.

## **Oral Health**

Today, it is commonly understood that oral health is essential to overall health and widely recognized that advances made in both preventing, treating and understanding oral disease have been substantial. However, poor oral health remains a problem for many in America. Unfortunately, many children face barriers to accessing dental care that cannot be solved overnight and have very real consequences. Former U.S. Surgeon General David Satcher noted in his report, *Oral Health in America*, that dental caries (tooth decay) is the most common chronic childhood disease.<sup>1</sup> It is five times more common than asthma, and low-income children are affected twice as frequently by dental caries as children that live in higher income families. The 2000 report shows that nearly 80 percent of the tooth decay occurs in approximately 25 percent of the children, children from the lowest income families. An April, 2000, General Accounting Office study<sup>2</sup> found that dental disease is a chronic problem among low-income and vulnerable populations and that barriers, other than access to insurance coverage, exist that limit the ability of these populations access to services.

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<sup>1</sup> Department of Health and Human Services (US). Surgeon General’s report on oral health, 2000. Available from: URL: <http://www.surgeongeneral.gov/library/oralhealth/>

<sup>2</sup> GAO/HEHS-00-72: Dental Disease Is a Chronic Problem Among Low-Income Populations, April 2000.

The consequences of poor oral health can, as Deamonte's tragic death shows, extend beyond the mouth. It is well documented that poor oral health can lead to oral infections that affect systemic health and new evidence continues to emerge supporting this understanding. For example, oral bacteria have been associated with bacterial pneumonia in bed- or chair-bound patients and may also be passed from mother to child resulting in a higher prevalence of caries in these children. Although it is not clear if treating an oral disease will improve specific health problems, we do know that oral health is an integral component of an individual's overall health.

### **Current Reporting Requirements and Recent Activities**

Under current federal requirements, state Medicaid agencies must submit data through CMS's Form 416 on an annual basis. States must provide information on: (1) the number of children provided child health screening services, (2) the number of children referred for corrective treatment, (3) the number of children receiving dental services, and (4) the state's results in attaining goals set for the state under section 1905 (r) of the Social Security Act.

The Form 416 information concerning the Medicaid program is useful but not adequate and data on the SCHIP program is not required, so more should and can be done. During the SCHIP reauthorization debate in 2007, the ADA supported provisions that would have implemented data reporting requirements for the program. Specifically, the provisions would have required states to report the following on an annual basis: the number of enrolled children by age group; the number of enrolled targeted low-income

children who receive any preventive or restorative care under the plan by age group; and the number of enrolled targeted low-income children who receive a protective sealant on at least one permanent molar tooth by age group including age 8.

The ADA is aware that CMS is currently examining 15 dental Medicaid programs with the lowest utilization based on Form 416 submissions. This is a positive step towards addressing dental access for children enrolled in Medicaid and demonstrating that CMS is serious about obtaining the information necessary to develop needed long-term policy changes.

While more complete data collection is very important, it is not adequate to ensure better quality care is delivered to Medicaid and SCHIP children. In addition to data on dental visits and services provided, the ADA believes there should also be a means of assessing dental Medicaid and SCHIP program effectiveness through a quality assurance process that measures oral health status. Providing an understandable assessment of oral health in a user-friendly manner will shed light on where additional resources need to be engaged. This approach reflects the current thinking on health care – which is that the emphasis should be on wellness and prevention of disease and not on disease and treatment.

### **Access Barriers**

Many barriers exist in trying to provide oral health care services to low-income children in this country. To address these barriers we need a multi-pronged approach that ensures greater Medicaid and SCHIP participation by private practice dentists which, along with

continued support of federally qualified health centers, creates a patient-centered environment where care, prevention and education are all addressed.

There are certainly challenges to meeting this goal. A September 2000 GAO study found geographical and economical barriers -- as well as inadequate patient understanding of the need to access dental care -- as impediments to access. GAO determined that federal programs such as health centers, the National Health Service Corps and the Indian Health Service have limited ability to meet the dental needs of the poor and noted that incremental improvements have been shown in states that increase reimbursement rates closer to market rates charged by dentists. Other challenges such as transportation and work schedules may limit a parent's ability to bring a child to a dental appointment. Additionally, there are a number of parents with a child enrolled in Medicaid or SCHIP that are unaware of the dental services available under their state programs. The Association has a number of suggestions for addressing these barriers discussed below.

### **Working to Address the Access Problem**

A special charitable event hosted by the ADA has been a very effective means of spotlighting the needs of the underserved populations. For the last six years the ADA has held an annual event where low-income, underserved children can receive free dental care. The ADA's sixth Give Kids a Smile (GKAS) event was held on February 1, 2008. More than 45,139 dental team members registered to participate, including 11,823 dentists. Nationwide, 1,796 programs were held and registered participants treated some 458,758 children. While the annual GKAS programs provide beneficial services to low-income

children, the ADA recognizes that charity care is certainly not a substitute for fixing the existing problems in Medicaid and SCHIP.

The ADA supports federal legislation that targets the shortcomings of the current Medicaid and SCHIP dental programs. Most notable, legislation has been introduced by Representative Elijah Cummings that would provide funding for two pilot programs to address pediatric dental needs for low-income children. One pilot program would provide grants to federally qualified health centers to improve pediatric dental services. The second would address dental workforce needs by providing grants to dental schools and qualified hospitals to increase the pursuit of pediatric dentistry. The legislation, H.R. 2371 – Deamonte’s Law – was introduced in 2007 and is strongly endorsed by the ADA.

The ADA also believes that to truly improve access to dental services within Medicaid and SCHIP we must bring a great many more private practicing dentists into the programs. Over 90 percent of all practicing dentists are in the private sector and while safety-net facilities that target underserved populations are important they do not employ large numbers of dentists. In fact, in fiscal year 2006, health centers that receive section 330 funding employed approximately 1,911 (FTE) dentists<sup>3</sup>, which is less than 2 percent of all practicing dentists in the United States. The ADA believes passage of the “Essential Oral Health Care Act of 2007”, H.R. 2472, is very important to address the goal of bringing more private practitioners into the Medicaid and SCHIP programs as the bill would significantly increase federal matching funds for states that improve their plans by increasing dental fees, eliminating administrative barriers and other factors.

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<sup>3</sup> DHHS, HRSA, BPHC, 2006 Uniform Data System.

Several states have already significantly improved their dental Medicaid programs by using the approach called for in H.R. 2472. The Healthy Kids Dental program in Michigan and the South Carolina Dental Medicaid program are two examples that have been cited by CMS as successful programs. Healthy Kids provides Medicaid beneficiaries with the same Delta Dental private sector coverage that is widely accepted by most dentists in the state. The program is available in 59 counties around the state and serves more than 200,000 Medicaid beneficiaries. Seventy-five percent of the dentists in the affected counties participate and parents are overwhelmingly satisfied with the program. Dental visits for children enrolled in Healthy Kids are 50 percent higher compared to children in the traditional program in the remaining portion of the state. In South Carolina, the state Medicaid program increased dental reimbursements to merely the 75<sup>th</sup> percentile of private sector reimbursements and eliminated existing administrative barriers for dentists such as prior authorization requirements and claims processing. According to information available from CMS, participation increased from 619 dentists in 1999 to 1,197 in 2006 and the number of enrolled children that received dental services increased from 26.1 percent in 1999 to 38.5 percent in 2005. In both Michigan and South Carolina the state dental societies were actively engaged in outreach and promotion of the changes to their Medicaid dental programs.

## **Conclusion**

Access to dental services continues to be problematic for low-income populations. In order to truly address this problem, practitioners, payers, parents and policymakers need

to come together and make the system work for the most vulnerable among us.

Fundamental changes to the Medicaid program are long overdue to ensure that low-income children have the same access to oral health care services that many Americans enjoy. We know that it can be done. Michigan and South Carolina are two examples of states that have been effective in increasing utilization of dental services under Medicaid and increasing participation in the program by private practicing dentists. Additionally, enacting Deamonte's Law to increase opportunities for the pursuit of pediatric dentistry and services available in federally qualified health centers is an effective means of targeting resources to the underserved population.

More and better data of dental services needs to be collected and there should be a means of assessing dental Medicaid and SCHIP program effectiveness through a quality assurance process that measures oral health status in a user-friendly manner. Increasing education efforts to ensure that (1) parents are aware of the important role oral health plays in overall health and (2) the dental benefits available to enrolled children is very important. Support for CMS's efforts to monitor dental service utilization to ensure access for all children enrolled in the program is also essential. Tackling the problem of access is no small task and will take time to address. Moving forward with legislative efforts that target access and vigilantly monitoring utilization will move us forward to ensuring low-income children have the same access to dental service as most Americans do today.

