STATEMENT OF

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ON

ACCESS TO DENTAL SERVICES FOR MEDICAID RECIPIENTS

BEFORE THE

HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON DOMESTIC POLICY

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Good afternoon Chairman Kucinich, Ranking Member Jordan and members of the Subcommittee. Thank you for the opportunity to speak with you today about the initiative the Centers for Medicare & Medicaid Services (CMS) has taken with regard to access to dental care for children served by the Medicaid program. Mr. Chairman, we appreciate your ongoing concern and hard work to improve dental access for children receiving Medicaid benefits. CMS is committed to ensuring access to quality health care for all Medicaid beneficiaries, and access to dental services is a key part of this agenda.

Background

As you know, Medicaid is a shared partnership between the Federal Government and the States with estimated total State and Federal expenditures of $419 billion[1] in Calendar Year 2010. The Federal Government provides financial matching payments to the States, conditioned on each State designing and running its own program consistent with the Federal statute. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to meet the needs of their beneficiaries within their unique political, budgetary, and economic environments. As a result, there is considerable variation among the States in eligibility, services, and reimbursement rates to providers and health plans. States enroll providers, set reimbursement rates, and negotiate managed care contracts.

[1] 2009 National Health Expenditures Data (Table 3)

CMS has a key role to play in this unique Federal-State partnership. One of CMS's primary goals is to assure the program integrity of the Medicaid program. Program integrity is often used to refer to fiscal management of the program and fiscal management is certainly a central component of our mission. But program integrity also means ensuring that eligible individuals have ongoing and consistent access to the care that the Medicaid program guarantees them. Due in no small part to your efforts to improve access to dental services for children enrolled in Medicaid, Mr. Chairman, CMS has taken a number of important steps to improve oral health care for children. CMS is committed to continuing these efforts, and we are also taking additional steps to improve access to dental services for children in Medicaid. There can be little question that there is a significant and troubling gap between what Federal Medicaid law promises children in terms of oral health care, and what children actually receive. Working closely with States over the next few years, we intend to narrow that gap.

In my role as Director of the Center for Medicaid and State Operations (CMSO), I have made improving access to mandatory critical dental benefits one of my top priorities, not only because of the tragic events in years past, but because it is the right thing to do and furthermore, it is what the Medicaid program requires. The research has clearly established the inextricable link between oral health and overall health and we are taking several steps to acknowledge and formalize that link through policymaking, collaborative activities and oversight.

CMS Response to Improving Oral Health

As noted earlier, States, the District of Columbia, and the Territories administer 56 unique Medicaid programs with policy guidance and oversight from CMS. CMS is committed to working with the States to improve oral health care and access to that care through interventions focused in three strategic areas: improving access to dental services, with an emphasis on prevention; ensuring that reimbursement aligns with desired outcomes; and focusing attention on the quality of the dental services provided. We are approaching these interventions through different avenues including policymaking and data collection, collaboration with States and other partners to share experiences and best practices, and oversight. Because each State and each State's Medicaid program is unique and targeted to the population served, and because the problems we face are not the same in Atlanta as they are in Columbus, Orange County or upstate

New York, there is no one single activity that can be implemented to assure improvement. Improvement requires a persistent, robust and dynamic process that involves the Federal government, the States, the oral health provider community as well as other health providers, parents, and other key stakeholders.

1. Policy and Data Improvements

CHIPRA Dental Benefits

CMS is currently in the process of implementing the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).[2] CHIPRA was signed by President Obama on February 4, 2009 and ensures that States can strengthen their existing Medicaid and the Children's Health Insurance Program (CHIP) programs and provide coverage to additional low-income, uninsured children and pregnant women. CHIPRA also included a number of key provisions that firmly plant oral health within the scope of key benefits for both CHIP and Medicaid.

Medically necessary dental services for children have always been covered for Medicaid-enrolled children through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements and CHIP children who are enrolled in Medicaid-expansion CHIP programs. The enactment of CHIPRA provides the opportunity to reach more children and provide them with necessary dental services by requiring that States operating separate CHIP programs provide coverage of dental services.[3] Dental care was previously an optional benefit for separate CHIP programs, although all States had elected to cover some level of dental benefits.

The CHIPRA dental requirements became effective October 1, 2009, and require all States to provide comprehensive dental benefits to children enrolled in CHIP. Each State's dental benefit must cover "dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions." States may achieve this standard using one of two options: 1) Adopting one of the dental benchmark benefit packages

[2] Public Law 111-3
[3] Public Law 111-3. Section 501.

specified in CHIPRA such as a State employee benefits package or 2) Developing a State-defined CHIP dental benefit that meets the new Federal standards.

In addition, for the first time, States with separate CHIP programs have the option to supplement children's private health insurance with a dental coverage plan financed through CHIP. This is a new provision in CHIPRA that recognizes that while many children in the CHIP income range may have insurance for medical care, they lack dental coverage. Prior to CHIPRA, States were not permitted to provide this supplemental coverage because children had to be uninsured to enroll in CHIP. We anticipate that this new supplemental coverage will help assure that many more children have access to comprehensive benefits that include coverage for oral health services.

CMS Oral Health Technical Advisory Group

To assure consistent State input in our policymaking related to oral health care, CMS developed an Oral Health Technical Advisory Group (OTAG). The first meeting was held in July 2008 and the OTAG continues to meet on a regular basis, generally every four to six weeks. The OTAG includes a State Medicaid Director who serves as the Chair, seven State Medicaid and/or Dental representatives, and two State CHIP Directors. The OTAG works closely with CMS staff on technical policy issues related to the operation of the Medicaid program. The OTAG has advised CMS on many dental-related issues, including the development of a "Questions and Answer" policy document that addresses the most recurring Medicaid dental issues. This document is available on the Medicaid Dental Coverage Web site available at http://www.cms.hhs.gov/MedicaidDentalCoverage/.

National EPSDT Workgroup

Our policymaking, guidance and training agenda will be further guided by two new initiatives that are being launched to augment CMSO's focus on oral health: an EPSDT listening session and a National EPSDT Workgroup.

As a first step to developing the EPSDT workgroup, CMS has scheduled a "listening session" to take place on October 16, 2009 to hear input from stakeholders on their experiences and

recommendations for improving the implementation of EPSDT services, including dental services. We have invited a broad audience of interested individuals and organizations to participate in this listening session to provide CMS with initial input to help us focus on areas that would be of most use to States, providers and other organizations. We are considering replicating this listening session on the regional level.

CMS will use the feedback gathered from the listening session to convene a national EPSDT workgroup, with participation from other Federal agencies, States, oral and medical health providers, consumer groups, advocacy organizations and researchers. The direction of this effort will be informed by the listening session, but in general we believe that individuals participating in this group will be able to assist CMS by helping us to prioritize and design projects such as improved data collection and appropriate periodicity schedules. Some of the tasks that may emerge from the workgroup will include updating the State Medicaid manual and issuing updated policy guidance through regulation, and the provision of training and support to State Medicaid and CHIP programs.

Improved Data Collection

CMS is committed to capturing more accurate dental information from States in order to analyze and monitor progress in the provision of dental services. We are working to ensure the accurate submission of dental services data on the CMS-416 form which provides basic information on participation in the Medicaid program. Specifically, the form provides CMS with information on the number of children provided child health screening services, the number of children referred for corrective treatment, the number of children receiving dental services, and the State's results in attaining goals set for the State under section 1905(r) of the Social Security Act. The information is used to assess the effectiveness of State EPSDT programs.

CMS is working to improve data collection on the CMS-416 by adding two new lines of data to capture improved information on all types of State providers delivering dental or oral health services to children. CMS is aware that many States are utilizing new provider types or expanding the scope of practice for existing dental providers. In order to address these changes in service providers, CMS sought input from the OTAG to determine how we could capture those services provided to Medicaid eligible children from the non-dentist providers. With

OTAG input and concurrence, we designed modifications to the CMS-416 to include reporting on the number of children who receive an oral health service from a non-dentist as well as the total number of children receiving any dental or oral health service.

After development of the new form, CHIPRA added new requirements to the data collected on the CMS-416 Form. Specifically, beginning April 1, 2011, CHIPRA requires CMS to report data on the number of children in the age grouping that includes age 8 (6-9 year olds) who have received a protective sealant on at least one permanent molar tooth. The first permanent molars generally erupt between ages 6 and 9, and it is recommended the molars be sealed reasonably soon after eruption to protect the pit and fissure surfaces of the teeth. Sealants reduce the risk of pit and fissure caries in susceptible teeth and are cost-effective when maintained. In addition, we will be collecting data to separately determine the number of children that are receiving dental services under a CHIP-funded Medicaid expansion plan. Because CHIPRA required changes to the CMS-416, CMS felt it would be confusing and burdensome to require States to change to a new version of the form in two consecutive years. In addition, we are now considering a broader set of revisions to the form to improve data collection regarding EPSDT services for children. Therefore, CMS did not issue a new form in 2009; States will use the current form to report their 2010 data and CMS will consider the inclusion of the previously approved dental data when we make the CHIPRA-mandated changes to the form. We intend to have the revised CMS-416 to States in Spring/Summer 2010.

2. Outreach, Collaboration and Sharing of Best Practices

Dental access problems are not simple to solve but many States are making headway by experimenting with different types of approaches. As described briefly below, CMS has several initiatives underway to identify, evaluate and share information about promising practices such as streamlined administrative processes, use of mobile dental services, and collaborations with Head Start or other public health programs. A "promising practice" represents a State approach to meeting a challenge related to Medicaid or CHIP program operations, clinical practice, or functional level that serves to enhance quality of care and/or life and may be of interest to other

States. The CMS Promising Practices[4] Web page contains a list of promising practices that have been vetted for publication as well as information on the process for submitting a promising practice for consideration.

National Medicaid Dental Town Hall Forum

On April 6, 2009, CMS held a National Medicaid Dental Town Hall Forum in Baltimore, Maryland. The overall intent of the Forum was to bring together interested parties to present their views, concerns and recommendations related to oral health issues. In addition, it provided a venue for participants to furnish feedback on various oral health issues and to discuss best practices and innovative delivery modes for dental care. The Forum was held in conjunction with the National Association of State Medicaid Directors (NASMD), representing our State Medicaid partners, and the American Dental Association (ADA), representing our provider partners. CMS asked three State Medicaid dental programs that have made significant progress in their programs through various innovations or partnerships to make presentations. In particular, Virginia highlighted the successful partnership it developed between its State Medicaid program and the State's Dental Association. Other partnerships that were presented included those between State Medicaid programs and dentists, and successful support provided by the Maryland State legislature. Arizona demonstrated that a managed care model can be a successful option for some States.

CMS received significant comments and input from the forum participants. Over 115 individuals registered to attend the Forum in person, and 250 individuals participated via a webcast of the Forum. Many participant comments focused on the three areas that CMS had highlighted for discussion: payment opportunities (including increased reimbursement), delivery of dental services through managed care organizations, and education and communication of information to dental providers and Medicaid beneficiaries. Additional subjects that were raised as public comments included how the absence of adult dental coverage in a State's Medicaid program negatively impacts the provision of dental services to children; dental workforce challenges, in particular, the need for pediatric dentists and dentists with specialized training in treating those with special needs; and the need for stronger links to family practitioners and

[4] http://www.cms.hhs.gov/PromisingPractices/

pediatricians. CMS received very positive feedback about the Forum and intends to use the information received in our future work on dental and EPSDT services.

Quality Measures

CMS is also currently engaged with the Agency for Healthcare Research and Quality (AHRQ) in developing recommendations to the Secretary for quality measures for children. CHIPRA requires that the Secretary develop a set of core quality measures for Medicaid and CHIP by January 2010, and by 2011 for all pediatric care. Reporting under these measures is voluntary for the States. The objective is to develop and adopt measures that can guide programmatic decisions and contribute to our knowledge of what is and what is not working for our nation's children. The initial core set of child health quality measures must include "dental care, conditions requiring the restoration of teeth, relief of pain and maintenance of dental health." AHRQ convened a meeting of the National Advisory Council Subcommittee on Quality Measures, of which CMS is an *ex-officio* member, which recommended three dental quality measures for consideration to be included in a comprehensive, initial core set of quality measures for voluntary State reporting starting in 2011. Once these measures are adopted, we will work closely with States to promote reporting on these measures and to create opportunities for States to identify and share best practices that enhance children's access to quality dental care.

Additionally, both CHIPRA and the American Recovery and Reinvestment Act of 2009 (the Recovery Act) provide State Medicaid programs multiple opportunities to adopt, implement or upgrade health information technology (HIT) to implement electronic health records. This transition to more advanced technology offers new and potentially groundbreaking opportunities to improve quality as well as data collection in health care service delivery.

Insure Kids Now!

On August 4, 2009, CMS and the Health Resources and Services Administration (HRSA) launched a dental page on the Insure Kids Now![5] Web site to make information on dental providers and benefits readily available as required by CHIPRA. The site provides a current list of all Medicaid and CHIP dentists and providers within each State and a description of the

[5] http://www.insurekidsnow.gov/

Medicaid and CHIP dental services that are covered in each State. These new requirements were intended to make it easier for families to identify dental providers in their area that accept Medicaid and CHIP patients. To date, there have been over 43,000 hits on the Insure Kids Now! Web site. Further improvements to the site are planned, but in the short time since the new portion of the Web site launched, CMS has received several notes of positive feedback and also requests from dental providers across the country asking for information on how they can become a Medicaid or CHIP provider.

Working with Providers

Building upon CMS' previous work with the dental professional community, the American Dental Association has agreed to take the lead for the Dental Quality Alliance (DQA). One goal of the DQA will be to bring about consensus in the area of evidence-based performance indicators that can be used to measure improvements in access and quality consistently throughout the country. DQA has set December 4, 2009 for the first meeting of the Steering Committee for this Alliance. The Steering Committee will establish rules, parameters for membership, and the agenda for the DQA. It is expected that the DQA will include members from all oral health organizations involved in dental care delivery. CMS has been offered a seat on the DQA Steering Committee and will continue to provide leadership in this endeavor. One goal of the Alliance will be to bring about consensus in the area of evidence-based performance indicators that can be used to measure improvements in access and quality consistently throughout the country.

Oral Health Education for Parents of Newborns

On the prevention side, CMS is beginning its work with various partners both in and outside government to meet the CHIPRA requirement for dental education for parents of newborns. Specifically, CHIPRA required that the Secretary develop and implement a program to deliver oral health educational materials to inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within their newborn's first year. This initiative provides us with a terrific opportunity to form new partnerships with the goal of educating parents of the need to perform oral hygiene on babies as soon as the first tooth erupts.

Opportunities for Improved Access

As States work through access to dental care challenges, some are developing local solutions, in keeping with State licensing requirements and scope of practice limits, to engage dental hygienists, pediatricians and others to assure that families learn about the importance of oral health and have access to needed care, regardless of whether they live in an urban or rural community or on an Indian reservation.

Our colleagues at HRSA also provide critical support for oral health through workforce development activities as well as facilitating direct patient care. HRSA operates several oral health workforce programs that support students, residents and practitioners. For example, in 2008, HRSA awarded $10 million to support 259 general and pediatric dentistry residents. There are also 424 dentists and dental hygienists participating in the National Health Service Corps providing over 1 million patient visits per year and placing oral health providers in underserved communities. In addition, HRSA supports direct patient care through Federally Qualified Health Centers (FQHCs) and other community health centers which are largely financed with Medicaid funds. In 2008, health centers employed 2,299 dentists, 892 dental hygienists, and 4,329 other dental staff.

3. Oversight

We expect that improved guidance and data, training, and providing new opportunities to share best practices will help move the Medicaid and CHIP programs forward in terms of assuring appropriate access to dental services for children. At the same time, oversight and review of State practices and access problems remains a top priority for CMS.

Focused Dental Reviews

Mr. Chairman, as you know, in 2008, CMS completed 16 State dental reviews[6] targeting States with low dental utilization for children receiving Medicaid. The purpose of the reviews was to determine what efforts each State had planned or implemented to address the issue of dental

[6] States reviewed: Arkansas, California, Delaware, Florida, Georgia, Louisiana, Michigan, Missouri, Montana, Nevada, New Jersey, New York, North Dakota, Pennsylvania, Wisconsin and the District of Columbia.

underutilization for children in that State, and to make recommendations on additional steps the State should take to increase these utilization rates. Specifically, the CMS review team interviewed State officials, contractors, managed care organizations, as well as a sample of providers, and conducted extensive document reviews in the areas of outreach, periodicity, access, diagnosis and treatment services, support services, and coordination of care. Additionally, CMS reviewed information collected from families of children enrolled in Medicaid. Based on these interviews and the State dental reviews, in January 2009 CMS released the 2008 National Dental Summary of the findings from these individual State reviews.

Some of the more concerning findings include: States not meeting the requirement for timely dental access standards or lack of monitoring provider networks for adequacy; States not following the required dental periodicity schedule requirements; and one State was identified as limiting access to medically necessary EPSDT services. The 2008 National Dental Summary report includes several recommendations for State action. Specifically the report recommends that States should: track which children have not received services and take steps to ensure access to dental care; consider innovative approaches to delivering dental services; and consider working with leaders in the dental community and in the provider community more broadly to develop incentives and encouragement for expanding provider enrollment in Medicaid.

As a follow-up to these reviews, CMS is re-engaging each of the 16 States to determine the current status on dental utilization improvement efforts. While these subsequent dental reviews are ongoing, a few promising practices have already emerged. Selected counties in one State have increased access to dental services through use of County Health Department run mobile dental vans in schools. A multi-site FQHC in one State reported success by cultivating an atmosphere of mutual respect to encourage compliance with dental appointments, which ultimately increased access. One State reported a 90 percent compliance rate for their Head Start population. Several States reduced administrative burdens for providers by reducing prior authorization requirements and developing more user-friendly administrative processes. We plan to continue to work with States to review the actions they are taking to improve access to oral health care for their Medicaid-eligible children and to identify where further improvements are warranted.

Periodicity Schedule Review

In addition to the 16 State-focused dental reviews in 2008, CMS collected information on the availability of dental periodicity schedules from all 50 States and the District of Columbia. All but three States reported having some type of periodicity schedule, although it appeared that not all were in compliance with Federal requirements. For example, some of the schedules provide a timeframe for when a primary care physician should refer the child for a service, but did not specifically address how often the actual dental service should occur. Additionally, CMS found that several of the periodicity schedules were not easily accessible by providers and beneficiaries.

In response, the CMS Regional Offices contacted every State and outlined the expectations for an oral health periodicity schedule that is separate and distinct from the general health screening schedule. We noted that the schedule should be developed in consultation with recognized dental organizations involved in children's dental health care. All states now have dental periodicity schedules. CMS will continue working with States to assure that their periodicity schedules meet CMS requirements.

Issues Noted by the Government Accountability Office (GAO)

The GAO has stated that CMS should develop a plan to review dental services for Medicaid children in all States with low utilization rates. CMS concurs and recognizes the need to continue the State review process and to increase our focus on improving access to dental services for children enrolled in Medicaid to ensure that children receive the full scope of services available under the EPSDT benefit. To this end, CMS has undertaken a number of activities related to improving access to dental services for all eligible children as described above.

In an effort to identify areas where States have been successful in providing comprehensive oral health care to Medicaid beneficiaries, CMS is scheduling site visits with States that have high dental utilization data, based on reports from the 2008 CMS-416 data. This aligns with GAO's comments that CMS perform additional dental reviews to further examine oral health access across the States. In addition to the targeted dental reviews, CMS is discussing many ways to

include dental services within the context of larger EPSDT program reviews. We have also just received a request from one State to perform an on-site dental review of their Medicaid program.

The GAO has also mentioned that CMS should ensure that States found to have inadequate dental provider networks within their managed care organizations (MCOs) take action to strengthen those networks. CMS agrees that States must ensure that MCOs offer an adequate network of providers for Medicaid beneficiaries to choose from, both dental and otherwise. There are requirements for States to ensure, through their contracts with managed care entities, that each entity "Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract."[7] We believe this language includes oral health providers. Regulations further require States to obtain supporting documentation of the adequacy of a managed care entity's provider networks. CMS cannot approve contracts without these requirements being met. However, once a network is verified for purposes of contract approval, changes in networks can occur. In some instances, previously open panels of physicians or dentists may become filled to capacity, providers may drop out of a network, or other challenges may occur which can create an issue with ongoing provider availability. As one means of addressing this issue, CMS is working with States to implement the CHIPRA requirement that all States post a listing of participating Medicaid and CHIP dental providers on the Insure Kids Now! Web site as noted above.

The GAO has also indicated that CMS should work with stakeholders to develop guidance on topics of concern to States and identify ways to improve the exchange of promising practices among States. CMS understands the value added by stakeholders and we are actively engaged with a range of partners that share our goal of making the Medicaid program the most effective program it can be. These outreach efforts are evidenced by the OTAG, CMS's recent Town Hall meeting, listening sessions and ongoing workgroups that are in early phases. As stated earlier, CMS is committed to working with our partners to continue improving access to dental services for children. CMS is also dedicated to the effort of sharing promising practices among States and other stakeholders.

[7] 42 CFR 438.206(b)(1)

Conclusion

In conclusion, States and CMS continue to make strides in improving access to oral health care for children enrolled in Medicaid and CHIP, but much more must be done. The downturn in the economy threatens some of the gains that have been made and has the potential to stall future progress in the absence of continued, focused, and proactive efforts to improve access to dental services for all Medicaid and CHIP-eligible children. The opportunities provided by CHIPRA and the Recovery Act, and the interest among many States, provider organizations, children's advocates, philanthropies as well as the attention that you give this issue, Mr. Chairman, give us reason to be hopeful and excited about the potential opportunities for improving oral health care for children. Thank you again for the opportunity to speak with you today.