

Greater Hartford Legal Aid, Inc.

**Testimony of Jamey Bell
before the Public Health Committee
re**

HB 7069 AN ACT CONCERNING ACCESS TO ORAL HEALTH CARE

March 5, 2007

Good afternoon Senator Handley, Representative Sayers, Senator Roraback, Representative Carson, and members of the Public Health Committee. Thank you for this opportunity to testify about HB 7069. My name is Jamey Bell, and I have worked as a legal aid lawyer for almost 25 years, representing low-income health care consumers, primarily children, for the last 13 years. On the basis of this experience I urge you support this bill which will remedy the crisis in access to oral health care under the Medicaid program which has existed for well over a decade. Passage of this bill will begin to undo serious harm to children on Medicaid, and at the same time utilize the state's health care dollars more effectively, humanely and efficiently.

My testimony makes two basic points:

1. Raising dental care reimbursement rates to the 70th percentile of providers' charges is necessary to, and will, attract providers willing to meet the needs of children on Medicaid and HUSKY;
2. DSS should be required to report sufficient information to truly measure whether the increase in expenditures is leading to increased access to and utilization of care.

First, for the past 15 years, less than 30% of Connecticut's children on Medicaid have seen a dentist even once a year, though the American Academy of Pediatrics recommends children get check-ups and cleanings every six months. The results are lost school days, costly emergency room care, *preventable* poor health, pain and impaired childhoods for the most vulnerable children in our state. Access to Medicaid dental providers-- both in the safety net (community, school-based and hospital clinics) as well as private practice-- is limited in large part because rates paid under the managed care program are often too low to cover overhead costs.

In 2000 legal services lawyers filed suit against DSS on behalf of a now-295,000 member class of HUSKY A Medicaid recipients for violations of federal law as a result of this scarcity. Claims on behalf of the **195,000 children** in the class, for the denial of dental services guaranteed under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions of the Medicaid Act, are being readied for trial. (Legal claims made on behalf of adults in the class were dismissed on technical grounds about enforceability of the law by individuals, not on the grounds that the state is not violating the law.) **Attached to my testimony is an Update on the litigation (Attachment #1).**

Of particular note, however, is that *other than DSS and the Governor's Office of Policy and Management, everyone* concerned with remedying this extremely serious problem **agrees that raising reimbursement rates so that providers who want to can afford to participate is the**



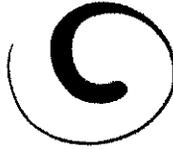
one absolutely necessary foundational step. In this instance, “everyone” includes not just dentists, but also all other knowledgeable and interested groups who have no stake in the matter other than their commitment to children’s health: school-based health centers, community health centers, dental hygienists and assistants, the CT Oral Health Initiative, the CT Health Foundation, the University of CT School of Dental Medicine, oral public health experts retained by the children’s lawyers in the litigation, and CT Appleseed. Also attached to my testimony is the most recent Oral Health Policy Brief by the CT Health Foundation, the third in a series, entitled “HUSKY A Dental Care: Avoiding the Repercussions of Poor Dental Care for Children on Medicaid”, which includes charts showing the vast gulf between current Medicaid fees and CT’s commercial fees, and the results of fee increases in nine other states. (Attachment #2)

It is **not sufficient** to focus expenditures only on the safety net (public clinics, hospitals, and schools), although that impulse is logical and understandable. As a legal services lawyer my whole career, I am the safety net’s biggest fan—it is the health care salvation of my clients. But oral health care access is in too big a crisis right now—one much too long neglected—to wait for the safety net infrastructure development necessary to meet the huge unmet need that exists. As the CT Health Foundation’s brief points out, only 1/3 of the dental care currently being provided is provided in the safety net; 2/3 of the care is provided by the very few private providers who are still participating. Further, the safety net providers are working as hard as they can, yet their costs have also risen steadily since the last increase in fees in 1993, and they are in danger of sinking. A legislative oral health champion who also works in the safety net trenches has told me for years now that her school-based health clinic cuts paper towels in half in order to stretch their dollars as far as possible. The **significant** across-the-board dental fee increases in HB 7069 will begin to alleviate this crisis **immediately**, and will have the effect of “raising all boats”, both safety net and private sector—and we all know that children on Medicaid need all the life rafts they can get!

Second, it is critically important that the significant influx of public funds called for in this bill be spent **as intended** and be spent **well**. An extremely good beginning is included in subsections (b) and (g), which require reporting by DSS on the increase in the number of providers registered to provide dental services under Medicaid and HUSKY. But I respectfully point out that these requirements may not be enough to give you, as stewards of this program, and us as advocates for these children, the information we really need. Under this language, it would arguably be sufficient for DSS to provide you, after 3 years of this large increase in funding, with a one-sentence report noting that the number of providers has increased by “x” number. A manageable way to get the crucial information we will all need would be to change the first sentence of subsections (b) and (g) to state:

The Commissioner of Social Services shall evaluate whether the fee schedule established pursuant to subsection (a) [(e)] of this section results in improved access to oral health care for enrollees under the age of nineteen, as measured by the increase in the number of providers registered to provide dental services under Medicaid [HUSKY Plan], the increase in services provided to enrollees under the age of nineteen and the increase in the amount of enrollees receiving services.

Thank you for your attention.



Greater Hartford Legal Aid, Inc.

**UPDATE RE CARR V. WILSON-COKER,
MEDICAID DENTAL CARE LITIGATION
February 2007**

The Facts: Due to a dramatic scarcity of Medicaid dental providers, for the past 15 years, **less than 30% of Connecticut's children on Medicaid have seen a dentist even once a year**, although under Medicaid law they are entitled to check-ups twice a year. Even fewer adults on Medicaid can find dental care. The results are lost school days, lost employment opportunities, costly emergency room care, *preventable* poor health, and pain.

The Litigation: Legal services advocates sued DSS in federal court in 2000, for its failure to pay providers enough to attract enough of them to meet the dental care needs of families on Medicaid. (DSS has not raised its dental services fee schedule for children since 1993, and has not raised the adult dental fee schedule since 1989.) The court certified the case as a class action in March 2001; the class now numbers over 295,000 people, **205,000 of them children**. In January 2006 the judge issued rulings confirming that the children's lawyers have a right to enforce the laws related to the children's class in court, and clearing the way for these claims to proceed to trial. (The court issued judgment for DSS on the adults' claims, on a technical legal argument that the law does not allow suits by individuals to enforce it; the court **did not** find that DSS had not violated the law.)

Attempts to Settle the Case: After the 2006 session in which legislators set aside substantial funds to raise reimbursement rates, lawyers for the children spent the summer working with experts and in September 2006 made a comprehensive settlement proposal to DSS, which mirrored the legislature's intention to set rates at the 70th percentile of providers' charges, improved EPSDT outreach and support, and imposed strict reporting, monitoring and outcome requirements on providers and DSS. After a 3 and 1/2 month delay, DSS in January 2007 proposed a settlement "concept" focusing not on reimbursement rates but on enhancing the safety net, which included no reporting, monitoring or outcome measures, and no reference to any proven performance record in any state regarding demonstrable improvements in access to dental care for children or adults. Lawyers for the children responded with their desire to meet as soon as possible to continue settlement discussions, and requested substantial details regarding DSS' proposal. Lawyers for the children in Carr v. Wilson-Coker have never refused a settlement offer in the case, and remain anxious to resolve these serious dental care access problems with solutions that are evidence-based, proven effective, supported by the provider and public health community, and which provide accountability for the expenditure of the state's funds.

HOW TO SOLVE THE PROBLEM: DSS must effectively enable children and their parents to locate and get to willing Medicaid dental care providers. And it must pay providers fairly for their services—instead of continuing to exploit the seriously stretched public health/safety net



providers and the few remaining private providers. The children's lawyers remain committed to the settlement process and look forward to hearing from DSS regarding the next settlement conference date.

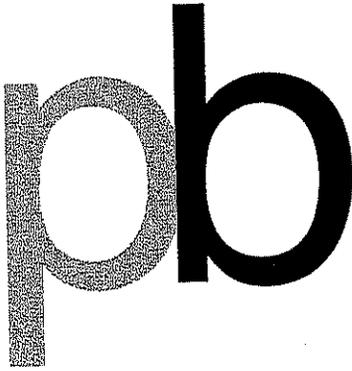
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policy brief

HUSKY A DENTAL CARE: AVOIDING THE REPERCUSSIONS OF POOR DENTAL CARE FOR CHILDREN ON MEDICAID

SUMMARY FINDINGS

- Because current Medicaid fees to providers are too low, the majority of children on HUSKY A in Connecticut do not have access to dental care.
- The state currently pays approximately one-third the amount per child for HUSKY A dental coverage than it does for coverage of state employees and their children.
- Raising Medicaid reimbursement rates to the 70th percentile has resulted in increased access to dental care in other states.

Oral Health Services for Children on HUSKY A

Approximately one-quarter of all children in Connecticut are enrolled in Medicaid, also known as HUSKY A. Among these approximately 250,000 enrollees, two-thirds receive no dental services at all.¹ This dental utilization rate is the lowest among the New England states and is less than half that of privately insured children nationally.²

The repercussions of this neglect are significant. Acute dental problems cause three days of lost school per 100 children.³ In fact, dental decay is the single most common chronic childhood disease — five times more common than asthma.³



BARRIERS TO RECEIVING DENTAL SERVICES

Private Provider Participation Is Limited Due to Low Reimbursement Rates

Children on HUSKY A cannot access dental care because of the small number of private dentists participating in the program, due to low dental reimbursement fees. Less than 15 percent of all Connecticut providers participate.¹

Dental fees for HUSKY A enrollees were set in 1993, at the 80th percentile of prevailing fees then. But they have not been adjusted since. As such, Connecticut's HUSKY A fees are now in the lower 1st to 7th percentiles of dental fees in the New England states.¹

Limited Dental Safety Net

Meanwhile, Connecticut's dental safety net system — made up of dental clinics owned and operated by public and volunteer organizations — is not sufficiently robust to satisfy the need. The safety net provides only about one-third of the dental care that HUSKY A children receive, while Connecticut's private dentists participating in the Medicaid program provide two-thirds of the care.⁸

Connecticut's HUSKY A fees are now in the lower 1st to 7th percentiles of dental fees in the New England states.

Bill Attach. mt # ?



POTENTIAL SOLUTIONS

Increasing access to dental care for children on HUSKY A requires a multi-pronged approach. One solution with demonstrated success: raising reimbursement fees to an adequate level, so more dentists can participate. This will expand services for children in need by maximizing the efficiencies of the private sector, as well as utilizing the unique skills and reach of safety net providers.

Specifically, if Connecticut raises the reimbursement level to the 70th percentile (provided that orthodontic fees are not raised¹), the cost would total \$21 million in the first year, which would be eligible for a 50 percent federal match. It will also be necessary to improve and simplify administration of the program for providers, to ensure efficient and easy participation.

PUTTING CHANGES IN CONTEXT

It is important to evaluate these proposed changes in light of the current environment. Connecticut now pays a per-member-per-month cost of \$8⁴ for children on HUSKY A — only about one-third of the \$22⁵ per-member-per-month cost for state employees and their children. It is not surprising, therefore, that only 33 percent of the state's HUSKY A recipients can locate and visit a dentist in a year, compared to 75 percent of state employees.

By raising HUSKY dental reimbursement rates to the 70th percentile (Table 1), the per-member-per-month cost for Medicaid recipients will have to be raised to \$15 — a cost that is still considerably lower than the state employees plan.

Table 1

Current and Projected Costs of HUSKY A Children's Dental Services for All Services and Modified Services¹

	Total Program Cost: All Fees Except Orthodontics Raised*	
	Current Utilization (33%)	Projected Rates (50%)
Number of Children Receiving Services	88,876	133,974
Current HUSKY A Fees	\$16,360,526	\$24,639,346
2005 NDAS Fees at 70th Percentile	\$37,092,983	\$55,862,926

¹Fees of two orthodontic procedures (B060 and B670) maintained at 2004 HUSKY A levels. Analysis based on data from the Connecticut Department of Social Services, analyzed by Connecticut Voices for Children for CHF, and data from the National Dental Advisory Service.

Raising reimbursement to an adequate level will expand services for children by maximizing the efficiencies of the private sector as well as utilizing the unique skills and reach of safety net providers.

RAISING MEDICAID REIMBURSEMENT - THE EXPERIENCE OF OTHER STATES

By comparison, nine other states have increased Medicaid reimbursement to the 75th percentile or a comparable market-based rate. Because of the change, all of these states have shown substantial increases in private provider participation (Table 2), and dental access has improved significantly.

Table 2

Increase in Provider Rates Among States That Have Increased Fees to Market Rates

State Year of Change	New Rates	Approx. # Dentists in State	Numerical Increase in Participating Providers*	% Increase in Participating Providers
Alabama 2000 ^{6,7}	100% of Blue Cross rates ^{6,7}	1,912 ⁸	308 to 456 ⁷	48%
Delaware 1998 ⁴	85% of dentists normal submitted charges ⁴	302 ⁹	1 to 108 ⁹	> 1000%
Georgia 2000 ⁴	75% to 85% of UCR ⁴	4,000 ⁴	259 to 1,355 ⁴	423%
Indiana 1998 ^{4,10}	75 th percentile ^{4,10}	3,583 ¹⁰	770 to 1,096 ¹⁰	42%
Michigan (Select Counties) 2000 ¹⁰	100% of Delta Dental Premier Rates ¹⁰	N/A	115 to 351 ¹⁰	205%
Nebraska 1998 ⁴	85% of UCR ⁴	1,077 ⁴	798 to 964 ¹² 231 to 387 ^{**12}	21% 68% ^{**}
North Carolina 2003 ¹³	73% of University Faculty rates ¹³	3,500 ¹³	644 to 855 ^{**14}	33% ^{**}
South Carolina 2000 ^{4,15}	75 th percentile ^{4,15}	1,561 ⁴	619 to 886 ⁴	43%
Tennessee 2002 ^{4,16}	75 th percentile ^{4,16}	2,861 ⁴	380 to 700 ¹⁶	84%

*Change reported after a period of 2-3 years from the rate increase except for Delaware which was 5 years.

**Providers billing greater than \$10,000 per annum.

UCR = Usual and Customary Rates

Table 3

Comparison of Current Connecticut Medicaid Fees and Proposed New Fees¹

DESCRIPTION	CURRENT HUSKY A FEES	2005 NDAS FEES AT 70TH PERCENTILE
Initial exam	\$24	\$65
Cleaning	\$22	\$52
Sealant	\$18	\$42
Amalgam - 2 surface	\$38	\$126
Stainless steel crown	\$85	\$207
Extraction single tooth	\$33	\$122

Source: Connecticut Department of Social Services and National Dental Advisory Service.

It is not surprising, therefore, that only 33 percent of the state's HUSKY A recipients can locate and visit a dentist in a year, compared to 75 percent of state employees.



CONCLUSION

One-quarter of Connecticut's children have no routine access to dental care and, as a result, a large proportion have significant untreated dental disease.

By raising Medicaid reimbursement rates for dentists to the 70th percentile, the state will significantly increase the number of private practitioners participating in the program, safety net providers can expand their reach, and access to care for children on HUSKY will improve.

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