Greater Hartford Legal Aid, Inc.

Testimony of Jamey Bell
before the Human Services Committee
re
SB 3 AN ACT CONCERNING INCREASED ACCESS TO HEALTH CARE THROUGH THE HUSKY PROGRAM,
SB 1425 AN ACT CONCERNING MANAGED CARE ORGANIZATIONS CONTRACTING WITH THE DEPARTMENT OF SOCIAL SERVICES,
HB 7322 AN ACT CONCERNING MEDICAID MANAGED CARE REFORM,
&
HB 7375 AN ACT CONCERNING HEALTH CARE ACCESS AND EXPANSION OF THE HUSKY PROGRAM
March 15, 2007

Good afternoon Senator Harris, Representative Villano, and members of the Human Services Committee. Thank you for this opportunity to testify about SB 3, SB 1425, HB 7322 and HB 7375. 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 support for the provisions in these bills concerning increasing eligibility for Medicaid, piloting Primary Care Case Management (PCCM) and increasing Medicaid provider reimbursement rates. Making more CT residents eligible for Medicaid expands the federal funds available to us for health care. Instituting PCCM, at least on a trial basis, will enable the state to test alternatives to the badly broken Medicaid managed care program, which has clearly demonstrated serious problems with access to care, improper denials of care and delayed payments to providers. Finally, it is not open to dispute that significant increases in Medicaid provider reimbursements are necessary to increase access to services, and prevent further erosion of the program and harm to recipients. (Attached to my testimony as Attachment #1 is legal services' position on all the pending health care-related proposals.) Together these changes will begin to address some of the serious problems in the Medicaid program, and at the same time utilize the state's health care dollars more effectively, humanely and efficiently.

My testimony concentrates on two specific 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, and will begin to remedy the crisis in children's access to oral health care under the Medicaid program which has existed for well over a decade;

2. Dental care reimbursement rates must be raised so significantly because they have not been increased since 1993, and at that point the more substantial increases were to preventive care procedures vs. treatment procedures, resulting in not only a very large overall disparity between Medicaid and market fees, but also the enormous specific disparity for treatment related codes.

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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-296,000 member class of HUSKY A Medicaid recipients for violations of federal law as a result of this scarcity. Claims on behalf of the **206,000 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 #2).)

Thus fee increases in the Medicaid dental program must be significant enough to at least cover providers' costs and expand capacity (attract new providers or induce existing providers to serve more HUSKY kids). Other states' experiences and recent surveys of providers **in Connecticut** has shown that targeting rates at the 70th percentile of dentists' charges will expand capacity for these nearly 200,000 children. Of particular note 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 #3)

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 SB 3 and HBs 7322 and 7375 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, this large increase is necessary not because dental providers are just looking for their "piece of the pie", but because Medicaid dental fees are disproportionately abysmal. They were last increased in 1993 (for children's codes only) (adults' fees remain untouched since 1989) and at that time the fee schedule was weighted toward prevention, i.e. the prevention-related procedures were raised greater relative amounts. Of course this action made sense—well-functioning health care systems should encourage and favor disease prevention. But in this context, where no fee adjustments over time were built in, the *result* is simply that the disparities are now **greater** between Medicaid treatment fees and market-rate treatment fees than between Medicaid prevention fees and market-rate prevention fees. This explains why, when examining the results of increasing existing fees to the 70th percentile, the increases are so much higher for the treatment-related codes compared to prevention-related codes.

The disparity, and the 14 years of stagnation in the fee schedule, has also resulted in a huge "pent-up demand" for treatment. Because of this lengthy unmet need for treatment, the costs of meeting the dental care needs of children on Medicaid will be large in the first few years after increased access is achieved. However, once the treatment backlog is met, and the health care system is able once again to focus on *prevention* of this wholly preventable disease, costs will go down, because prevention in this context is vastly cheaper than treatment. At that point the goal of seeing more and more children can be met at the lower preventive cost level, rather than where we are now-- seeing too few children at too high a cost (in expensive emergency and operating rooms).

Thank you for your attention.

PLEASE SUPPORT INCREASED ELIGIBILITY AND ACCESS TO MEDICAID, HUSKY & SAGA

1 Improve Access to Health Care for Medicaid, HUSKY & SAGA Participants by

- Raising rates paid to the SAGA providers, including the rates of providers under the behavioral health carve-out.
- Raising Medicaid provider rates, including HUSKY provider rates, to at least 100% of Medicare rates (except for those providers receiving cost-based reimbursements).
- Raising dental rates to 70th percentile of dentists' fees.

2 Increase Eligibility for Medicaid; Maximize Federal Support for Health Care for Connecticut Residents by

- Increasing HUSKY parent coverage to 185% of the federal poverty level.
- Providing coverage for pregnant women with incomes up to 300% of the federal poverty level.
- Covering people who are elderly and/or disabled with incomes up to 185% of the federal poverty level.

***NOW* is the time to expand coverage for Medicaid, HUSKY and SAGA and increase provider rates. Such reforms:**

- Help to ensure real access to comprehensive health care for our poorest children, their parents, the elderly and disabled;
- Are important and sensible components of universal health care and maximize federal funds;
- Will provide essential health insurance for our most vulnerable residents; and,
- Prevent the cost shifting that endangers the fiscal health of our health care facilities and increases costs for our business community and their employees.

Supporting organizations: Advocacy Unlimited, AIDS LIFE Campaign, Center for Children's Advocacy, CT AIDS Resource Coalition, CT Association for Human Services, CT Association of Area Agencies on Aging, CT Association of Nonprofits, CT Children's Medical Center, CT Community Providers Association, CT Conference of the United Church of Christ, CT Hospital Association, CT Legal Services, CT Oral Health Initiative, CT Primary Care Association, CT State Medical Society, CT Voices for Children, CT Women's Consortium, Greater Hartford Legal Aid, Legal Assistance Resource Center of CT, National Alliance on Mental Illness of CT, National Association of Social Workers/ CT, National Council of Jewish Women, New Haven Legal Assistance Association, Planned Parenthood of CT

Bell Attachment #1

Bell Attachment #1

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

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Bell Attachment # 2

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.

For more information, contact

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Bill Attachment # 2

third in a series
February 2007

b

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.[2] In fact, dental decay is the single most common chronic childhood disease — five times more common than asthma.[2]

Connecticut Health Foundation

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.[3]

Bell Attachment # 3

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 raised[1]), 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 $8[4] for children on HUSKY A — only about one-third of the $22[5] 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 Services[1]

	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**

**Fees of two orthodontic procedures (8080 and 8670) 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.*

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[4,6,7]	100% of Blue Cross rates[4,6,7]	1,912[7,8]	308 to 456[7]	48%
Delaware 1998[4]	85% of dentists normal submitted charges[4]	302[8,9]	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]	75th 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[8]	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]	75th percentile[4,15]	1,561[8]	619 to 886[4]	43%
Tennessee 2002[4,15]	75th percentile[4,16]	2,861[8]	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 Fees[1]

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.

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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