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Testimony

Before the Subcommittee on Domestic  
Policy, Committee on Oversight and  
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Representatives

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**MEDICAID**

State and Federal Actions  
Have Been Taken to  
Improve Children's Access  
to Dental Services, but More  
Can Be Done

Statement of Katherine M. Iritani  
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Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today as you examine federal and state efforts to improve access to dental services by children in Medicaid (a joint federal and state program that provides health care coverage, including dental care, for low-income children). Dental disease remains a significant problem for children in Medicaid. Although dental services are a mandatory benefit for the 30 million children served by Medicaid,<sup>1</sup> these children often experience elevated levels of dental problems and have difficulty finding dentists to treat them. In testimony before your Subcommittee last September, we reported that children in Medicaid were almost twice as likely to have untreated cavities as children with private insurance and that the percentage of children in Medicaid who received any dental care was far below the Department of Health and Human Service's (HHS) target for low-income children.<sup>2</sup> Concerns about low-income children's poor oral health, inadequate access to dental services, low payment rates for dental services, and insufficient federal and state efforts to address oral health access problems are long-standing. During subcommittee hearings in May 2007 and February 2008, you raised concerns about the effectiveness of federal oversight of state Medicaid dental services by the Centers for Medicare & Medicaid Services (CMS), the agency that oversees Medicaid at the federal level.

My remarks today are based on our report, released at this hearing, *Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain*.<sup>3</sup> This report was prepared at the request of the subcommittee and examined (1) state strategies to monitor and improve access to dental care for children in Medicaid and (2) CMS actions since 2007 to improve oversight of Medicaid dental services for children. To identify state strategies to monitor and improve children's access to Medicaid dental services, we conducted a Web-based survey of state Medicaid directors in all 50 states and the

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<sup>1</sup>Low-income children eligible under a state Medicaid plan generally are entitled to coverage of screening, diagnostic, and treatment services—including dental services—under Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit.

<sup>2</sup>GAO, *Medicaid: Extent of Dental Disease in Children Has Not Decreased*, [GAO-08-1176T](#) (Washington, D.C.: Sept. 23, 2008).

<sup>3</sup>GAO, *Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain*, [GAO-09-723](#) (Washington, D.C.: Sept. 30, 2009).

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District of Columbia (we refer to the District of Columbia as a state in this report)—all 51 responded to our survey. The survey included questions on the methods states have used for promoting and monitoring dental utilization, statewide goals for the delivery of dental services, and the federal support provided to states for the provision of Medicaid dental services. We also reviewed contracts between state Medicaid programs and nine large managed care organizations (MCO) to identify certain dental provisions concerning network adequacy and access standards.<sup>4</sup> To examine CMS’s oversight of state Medicaid dental services for children, we interviewed CMS officials, dental associations, and key stakeholders; reviewed federal laws, regulations, and CMS guidance; and analyzed data used by CMS to monitor provision of Medicaid dental services. Our work was performed in accordance with generally accepted government auditing standards.

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## State Medicaid Programs Reported They Employ Multiple Strategies to Monitor and Improve Access to Medicaid Dental Services, but Problems Persist

All 51 states responding to our survey reported that they monitor the provision of dental care to Medicaid-enrolled children—often using three or more methods. Common methods included collecting utilization data, conducting surveys of oral health, and monitoring dental claims.<sup>5</sup> States also reported using various measures to assess children’s access to Medicaid dental services, including the percentage of children who had a dental visit in the previous year, the percentage of children who had not visited a dentist in the last 3 years, and the percentage of dentists in the state who treat children in Medicaid. Forty-two states also reported that they have set at least one statewide dental utilization goal related to the provision of children’s dental care in Medicaid. Commonly reported goals include the percentage of children receiving any dental care in a given period exceeding a certain threshold, the ratio of participating dental providers to Medicaid children exceeding a certain threshold, and the percentage of children who report difficulty finding dental care fall below a certain threshold.

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<sup>4</sup>We obtained a non-generalizable sample of contracts from MCOs that covered dental services and that served the most Medicaid beneficiaries in nine states, including five states whose dental programs had been reviewed by CMS in 2008.

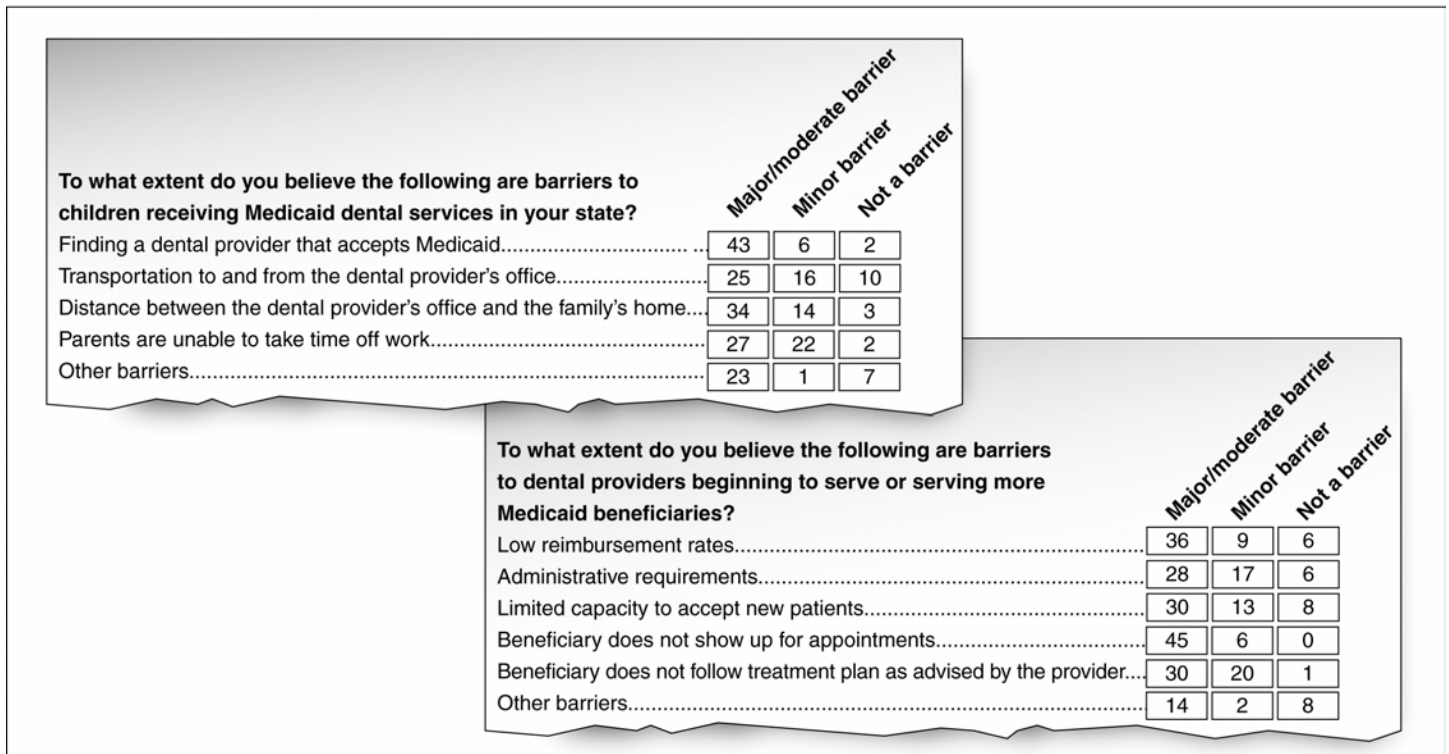
<sup>5</sup>States are required to report annually to CMS on the provision of EPSDT services, including dental services. The annual EPSDT participation report, Form CMS-416, is the agency’s primary tool for gathering data on the provision of dental services to children in state Medicaid programs.

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States' oversight of MCO provider networks varied. All 21 states that provide Medicaid dental services through MCOs reported that they set measurable access standards for MCOs, but more than half also reported that MCOs in their state do not meet any, or only meet some, of the state's dental access standards. Common MCO access standards include maximum waiting times for appointments, maximum travel time or distance to the dentist's office, and minimum provider-to-patient ratios. Twelve of the 21 states reported that they routinely verify that MCO providers accept new Medicaid patients. Two states did not report taking any action to verify MCO provider networks. Although 17 states reported that they used incentives or penalties to encourage the MCOs to meet or exceed state standards, potential incentives or penalties did not always produce the desired result. For example, one state reported MCOs had not met any of the established standards even though MCOs could be paid a bonus if they met some or all of the standards. Similarly, other states reported that only some standards were being met, despite potential financial penalties for MCOs that did not meet all of the state's standards. Our review of nine MCO contracts illustrates variations in the standards that states established for MCOs concerning network adequacy and access measures. For example, some, but not all, contracts specified a maximum number of Medicaid enrollees per dental provider—one contract specified a county-level maximum of 486 enrollees per dental provider, while other contracts did not specify such a maximum.

Nearly all states reported that they had undertaken initiatives to improve children's access to Medicaid dental services, but persistent barriers remain. For example, states reported simplifying claims processing, increasing reimbursement rates, recruiting providers, and educating beneficiaries. Although some states reported limited success, Medicaid dental utilization rates remain low. CMS data show that the national average Medicaid dental utilization rate for children had improved from 27 percent in 2000 to 35 percent in 2007—but in 2007, only 1 state reported a dental utilization rate above 50 percent and 12 states remained below 30 percent. Forty-eight states reported that the principal barriers that contributed to the low use of dental services by Medicaid beneficiaries in 2000—including low provider participation rates, administrative burdens, and insufficient funding—were impeding their current efforts. States also reported that access rates could be affected by barriers faced by children seeking dental services, such as finding a provider that accepts Medicaid, and barriers faced by providers serving Medicaid beneficiaries, such as beneficiaries not showing up for appointments (see fig. 1).

**Figure 1: Barriers to Children Seeking Medicaid Dental Services and Barriers to Dental Providers Serving Medicaid Beneficiaries, as Reported by State Medicaid Programs**



Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009).

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## CMS Has Taken Action to Improve Federal Oversight of State Medicaid Dental Services for Children, but Gaps Remain

Responding to concerns expressed by your subcommittee about CMS oversight of state Medicaid dental services, CMS has taken a number of actions since May 2007 to strengthen its oversight of Medicaid dental services for children, but gaps remain in the agency's efforts. CMS actions include the following:<sup>6</sup>

- **Focused dental reviews in 17 states identified significant concerns, but CMS did not plan additional reviews.**<sup>7</sup> Between October 2007 and May 2008, CMS conducted a series of focused dental reviews in 17 states.<sup>8</sup> CMS identified concerns in all 17 states it reviewed, including multiple findings in some states, and made recommendations to all states. In 11 states, CMS reported concerns that the states were not adhering to federal law or regulations. CMS also identified several promising practices to improve the delivery of oral health services, which it highlighted in its summary report.<sup>9</sup> Although CMS reviews identified shortcomings in state practices and identified needed improvements, CMS did not have plans at the time of our review to conduct focused dental reviews in additional states. CMS 416 data from 2006 showed that 24 of the 34 states that CMS did not review reported dental utilization rates between 31 and 40 percent of eligible children having received any dental service in the prior year—well below HHS's Healthy People 2010 goal of having 66 percent of low-

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<sup>6</sup>See [GAO-09-723](#) for additional information on the actions taken by CMS to improve its oversight of Medicaid dental services.

<sup>7</sup>CMS focused reviews were designed to examine state efforts to improve children's dental utilization rates, assess state compliance with federal Medicaid statutes and regulations, and identify promising or notable state practices to improve the delivery of oral health services.

<sup>8</sup>Fifteen of the 17 states reviewed had reported dental utilization rates below 30 percent in fiscal year 2006: Arkansas, California, Delaware, District of Columbia, Florida, Louisiana, Michigan, Missouri, Montana, Nevada, New Jersey, New York, North Dakota, Pennsylvania, and Wisconsin. In addition, Maryland was reviewed in October 2007 and Georgia was reviewed in May 2008 at the request of the subcommittee.

<sup>9</sup>CMS, *2008 National Dental Summary*, (January 2009) and *Final Report on Maryland's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program With a Focus on Dental Services for Children* (Feb. 5, 2008).

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income children under age 19 receive a preventive dental service.<sup>10</sup> In addition, CMS did not require corrective action in states found to have inadequate MCO networks. CMS's focused dental reviews identified eight states that provided dental services through managed care that did not ensure that MCO provider networks were adequate to afford access to covered dental services. CMS made recommendations to strengthen MCO provider networks in all eight states; however, CMS did not require these states to take corrective action—rather, agency officials indicated they would follow up with states on the status of CMS's recommendations.

- **CMS established an Oral Health Technical Advisory Group and published a dental policy document, but states reported additional guidance was needed.** In conjunction with the National Association of State Medicaid Directors, CMS established an Oral Health Technical Advisory Group to address issues related to oral health services. Advisory group projects include examining the effects of recent legislation on oral health programs, considering improvements to the CMS 416 annual reports, and improving materials used to inform beneficiaries of their Medicaid dental benefits. In addition, CMS posted a 16-page document on Medicaid dental policy issues on its Web site in September 2008. This document covered a variety of questions from states on topics including periodicity schedules, dental referral requirements, covered services, and patient cost sharing.<sup>11</sup> Although CMS has taken action to provide some guidance to states, states report that additional guidance from CMS is needed. In response to our survey, nearly all states reported that additional CMS guidance could help them improve delivery of Medicaid dental services. States cited a need for additional information in several areas, including information on billing policies, establishing appropriate dental fee schedules, improving documentation and coding practices, and information on quality and preventive initiatives.

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<sup>10</sup>Recognizing the importance of good oral health, HHS in 1990 established oral health goals as part of its Healthy People 2000 initiative; and in 2000 updated these oral health goals for 2010. These include goals related to oral health in children, for example, reducing the proportion of children with untreated tooth decay. Another goal relates to the Medicaid population: to increase the proportion of low-income children and adolescents under the age of 19 who receive any preventive dental service each year to 66 percent in 2010. See U.S. Department of Health and Human Services, Public Health Service, *Progress Review: Oral Health* (Feb. 7, 2008).

<sup>11</sup>HHS, Centers for Medicare & Medicaid Services, *Policy Issues in the Delivery of Dental Services to Medicaid Children and Their Families* (Sept. 22, 2008); <http://www.cms.hhs.gov/medicaiddentalcoverage/> (accessed Oct. 6, 2008).

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- **CMS has taken steps to improve communications with states and stakeholders, including sharing promising state dental practices, but states reported further collaboration was needed.** From 2007 through 2009, CMS held several meetings and conference calls with state dental representatives, provider associations, and other stakeholders to discuss issues concerning Medicaid dental services for children. Groups involved in CMS partnership activities included American Academy of Pediatric Dentistry, the American Association of Public Health Dentistry, the Association of State and Territorial Dental Directors, and the American Dental Association. CMS also posted “promising practices”—described by CMS as successful state programs that reflect innovative approaches to meeting common problems—on its Web site. As of May 2009, CMS had posted promising dental practices from Delaware, South Carolina, Tennessee, and Virginia. Although CMS has taken action to involve stakeholders and share promising dental practices, 37 states responding to our survey indicated a need for more information on other states’ efforts to improve dental utilization. Eleven states reported that they were unaware of the promising practices posted on CMS’s Web site and 26 states responding to our survey reported that their states had best practices that could be shared with other states, such as providing mobile dental vans, training and reimbursing physicians to do oral screens and apply fluoride varnish, and establishing a dental home for children.

In conclusion, states and CMS have made concerted efforts to improve access to dental services for children in Medicaid. However, information on the oral health of and receipt of dental services by Medicaid children show that more needs to be done. Although many states have reported moderate increases in access to Medicaid dental services, states responding to our survey reported that low provider and beneficiary participation, and administrative burdens—many of the same factors that contributed to the low use of dental services in 2000—still present barriers to access today. CMS’s reviews of states’ efforts have identified deficiencies in several state Medicaid programs, but CMS has not required corrective actions by states or planned additional dental reviews. In our report, we are making four recommendations to CMS to strengthen the agency’s monitoring of state Medicaid dental services for children and help states improve children’s access to Medicaid dental services. Our recommendations include developing a plan to review dental services for Medicaid children in all states with low utilization rates, ensuring that states found to have inadequate MCO dental provider networks take action to strengthen these networks, working with stakeholders to develop needed guidance on topics of concern to states, and identifying ways to improve sharing of promising practices among states.



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In commenting on a draft of our report being released today, CMS generally concurred with all four recommendations and described several initiatives planned or under way that would strengthen its oversight of state Medicaid dental services for children. CMS indicated that the agency was developing additional guidance and technical assistance to states on the provision of EPSDT services, with a particular focus on access to dental services. CMS also reported that its efforts to implement the Children's Health Insurance Program Reauthorization Act of 2009 would include a number of activities related to dental services, such as a new quality measure program and new reporting requirements.

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Mr. Chairman, this concludes my prepared remarks. I would be pleased to answer any questions you or other members of the subcommittee may have.

For further information regarding this statement, please contact Katherine Iritani at (202) 512-7114 or at [iritanik@gao.gov](mailto:iritanik@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Kim Yamane, Assistant Director; Sarah Burton; Mollie Hertel; Sarah Marshall; Terry Saiki; and Teresa Tam also make key contributions to this statement.

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# Related GAO Products

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*Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain.* [GAO-09-723](#). Washington, D.C.: September 30, 2009.

*Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay.* [GAO-08-1121](#). Washington, D.C.: September 23, 2008.

*Medicaid: Extent of Dental Disease in Children Has Not Decreased.* [GAO-08-1176T](#). Washington, D.C.: September 23, 2008.

*Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services.* [GAO-07-826T](#). Washington, D.C.: May 2, 2007.

*Medicaid Managed Care: Access and Quality Requirements Specific to Low-Income and Other Special Needs Enrollees.* [GAO-05-44R](#). Washington, D.C.: December 8, 2004.

*Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care.* [GAO-03-222](#). Washington, D.C.: January 14, 2003.

*Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services.* [GAO-01-749](#). Washington, D.C.: July 13, 2001.

*Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations.* [GAO/HEHS-00-149](#). Washington, D.C.: September 11, 2000.

*Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations.* [GAO/HEHS-00-72](#). Washington, D.C.: April 12, 2000.

*Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort.* [GAO/HEHS-97-86](#). Washington, D.C.: May 16, 1997.

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