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☞ Details: Public Hearing: Audit Letter Report (April 2008), Dental Services for Medical Assistance Recipients, Department of Health and Family Services

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2007-08
(session year)

Joint
(Assembly, Senate or Joint)

Committee on Audit...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

Testimony of

Dr. Allen Finkelstein
Chief Dental Officer

AmeriChoice
A UnitedHealth Group Company

For the
Joint Legislative Audit Committee
Regarding the State Auditors
The Dental Service for Medical Assistance Recipients Report

June 10, 2008

Introduction

Thank you to the distinguished members of the Committee for the opportunity to testify today about the important role of dental care for Medicaid-eligible children and adults. I am Dr. Allen Finkelstein, and I am Chief Dental Officer of AmeriChoice, which is UnitedHealth Group's business unit exclusively committed to serving beneficiaries of Medicaid and the State Children's Health Insurance Program (SCHIP).

I am also here today as a practicing dentist of more that 39 years. Like any health care professional, my role is to take care of people, and I committed to provide those dental services to our members in the State of Wisconsin.

At UnitedHealth Care/AmeriChoice, we remain fully committed to working with parents, communities and the government to ensure that timely dental care is not just *available* to our most vulnerable children and adults but that it also is *delivered* to them.

- Dental care is critical to overall well-being and should be on a par with other aspects of health.
- A person's health must be viewed holistically, and health care must be approached in an integrated way.
- Patients should always come first and be cared for personally as individuals.
- Medicaid beneficiaries face challenges in accessing adequate health care. It takes flexibility and a willingness to try new and innovative approaches to make health care work better for them and for the providers who treat them.
- And, finally, to understand your patients, you need to stay in close touch. I am grateful that AmeriChoice recognizes the value in this connection to members by enabling me to continue to see patients and work one-on-one with providers and communities across the country.

Today, UnitedHealth Care/AmeriChoice serves more that 1.6 million members in health plans through Medicaid and SCHIPs in 13 states. Our participation in the Medicaid program is fundamental to our parent Company's core mission: to support the health and well-being of individuals, families, and communities.

Driving Increased Utilization of Available Services, Fostering Holistic Care

There are two significant issues that affect the provision of dental care to Medicaid beneficiaries and the uninsured-access and utilization. Much of the recent public debate has centered on access to providers. We must remember a child may have access to a network of willing dentists, but nothing meaningful happens until the child sits in the dentist's chair.

From our experience, the most pressing challenges in increasing utilization is educating families about the importance of dental care, engaging providers and parents in a proactive and holistic approach to children's health, and encouraging the use of the wide range of dental services and benefits available. Driving increased utilization by the most vulnerable families will require a strong shared commitment and collaboration from all involved,

namely government agencies, school, community organizations, parents, insurance companies and the health care community. We all need to be in this together.

The Importance of Preventive Dental Care

Tooth decay is America's most prevalent chronic childhood disease, more widespread than asthma and diabetes. Of the 4 million children born each year, more that a half of them will have cavities by the time they reach second grade, according to the Children's Dental Health Project. For lower income populations, the situation is more severe. In the 2000 "Oral Health in America Report," U.S. Surgeon General David Satcher called dental and oral disease a "silent epidemic," disproportionately affecting poor children. Children in poverty are more likely to experience dental decay and cavities, and those children without dental insurance are three times more likely to have dental needs than children with either public or private insurance. An estimated 20 million children in the United States do not have dental insurance.

This is particularly unfortunate, because dental disease is largely preventable and treatable. Preventive treatment is cost effective and can ensure against more expensive ailments and unnecessary disease. Proper care and education must start early, and reinforcement must come from all areas of a child's life, including dentists, medical doctors, parents, and schools. Since pediatricians and other child health professionals are far more likely than dentists to encounter parents and children with Medicaid, it is essential that doctors reinforce, educate and give priority to dental care and oral hygiene. Care of the teeth needs to be linked with care of the rest of the body.

Barriers to Delivering Dental Care to Children with Medicaid

There are many barriers contributing to this silent epidemic, including a lack of adequate education and understanding about the detrimental effects of poor oral health. More needs to be done to educate the public and those in the medical field to put an end to the epidemic.

Socio-economic factors: In many cases, families with lower incomes have needs that compete with and take priority over adequate dental care. Dental hygiene often takes a back seat to basic daily survival needs such as food, shelter and child care. These issues often are compounded by language and cultural barriers and the complexities inherent in administering a multi-faceted program such as Medicaid.

Dental care not prioritized: Common misconceptions and out-of-date beliefs about dental health are rampant. Many parents and community leaders do not understand the importance of dental health and its connection to more serious health issues. For instance, many parents think taking care of baby teeth is not integral to overall dental hygiene, and as a result, the dental health of a toddler growing into a child is compromised. Once again, this is where pediatricians, insurers, school systems and government agencies can be of enormous assistance.

If parents are not educated about the importance of oral health, or if they have more pressing life needs, dental services will not make it to the top of their list.

Other important factors also contribute to low utilization and dental care delivery problems, including difficulty in communicating with members and the declining number of dentists generally.

Communication hurdles: Health plans report challenges in communications with Medicaid beneficiaries. Many people on Medicaid have transient living situations and frequently lack telephone service impending regular communication with beneficiaries. Our Wisconsin Health Plan has experienced a high rate of returned mail.

Another significant issue health plans experience is lack of understanding about the reasons children or whole families are dropped from state Medicaid rolls. As the health insurer, we receive a data feed from the state that tells us who has dropped off of Medicaid, but we rarely know why. It could be the result of a rise in income that leaves a family no longer eligible for Medicaid, or it could be that a homeless family has moved from one shelter to another and did not receive the paperwork for renewing eligibility. Even if the paperwork arrives safely, more basic concerns may take precedence over navigating the administrative process. Current Medicaid rules prevent us from contacting a family once they are dropped from Medicaid and from our program.

Dental Provider Participation: Integral to this discussion are the issues related to the providers themselves.

The United States is experiencing a shortage of dentists and people entering the dental field, and some dental schools have been closing. Twenty percent of current dentists are expected to retire in the next ten years, and there are an insufficient number of replacements in the pipeline. Moreover, the number of people electing to go into pediatric dentistry as a specialty has diminished. It would take a significant and immediate increase in dental school enrollments to reverse the overall trend. Support and incentives for dental providers to treat children with lower incomes are also insufficient. Many dentists find it too difficult to treat Medicaid children and adults because of the high percentage of missed appointments

To serve the needs of Medicaid beneficiaries effectively, we must also address the needs of the providers who care for them including adequate reimbursement.

Policies and Legislation

Medicaid does work. It has been extremely valuable to children and their families across the country. However, the Wisconsin legislature can play a pivotal role in improving Medicaid, making it more accessible to providers and easier for the most vulnerable people in our country to use. Currently, states are required to inform Medicaid beneficiaries of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program which provides dentist

referrals, regular screenings, and general dental care maintenance and restoration. All 25 million Medicaid beneficiaries under the age of 21 are eligible for EPSDT. However, less than one in four children with Medicaid receive these services. We believe Medicaid could help us as the health plan administrators to increase utilization, so that children and their families receive adequate preventive care for a lifetime of healthy teeth and gums.

We suggest these areas where public policy changes could make the most impact:

- Elimination of separate licensing requirements for Medicaid dentists in the state of Wisconsin.
- Institution of dental screening requirements prior to the beginning of each school year, as is current practice with child immunizations and well-child checkups. Sixty years ago when I was about to enter kindergarten, my parents were required to bring me in for a dental exam. But today, 25 percent of poor children start kindergarten without ever having seen a dentist, and in most cases there is no requirement that they do so.
- Training and education programs to help prepare minority high school and college students for a career in dentistry and grants to train pediatricians and dentists in the field of pediatric dentistry.
- Increasing the fees for Medicaid and CHIP dentists to be competitive with other states. (see addendum attached)
- Training Primary Care Physicians to dental screen, apply fluoride varnish and make early referrals to dentists for preventive and restorative care. The American Academy of Pediatrics has stated that by age one a child should have a dental home.

In Closing, we applaud the efforts of this joint legislative committee in your approach to dental care for the underserved. We are committed to working with our providers, and all the participants to address current and future challenges. We are determined to do all we can individually and collaboratively to fulfill the promise of attaining quality dental care for the people of Wisconsin.

Reimbursement Rates for Selected Procedure
As of March 2008

	Dental Sealants	Comp Exam	Cleanings	Panorex	Extractions
Illinois	$36.00	$21.05	$41.00	$22.60	$39.12
Iowa	20.58	23.67	24.70	46.31	51.46
Michigan	15.12	18.90	19.53	17.56	44.47
Minnesota	17.30	25.50	18.34	46.75	44.70
Wisconsin*	16.99	20.96	21.60	40.05	41.81
New York*	43.00	29.00	58.00	40.00	60.00
New Jersey*	41.00	110.00	50.00	85.00	121.00
Arizona*	24.00	32.00	48.00	45.00	60.00

*Fee for Service Rates (AmeriChoice Service States)


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Testimony of Dr. William K. Lobb, Dean of the Marquette University School of Dentistry
Before the Joint Legislative Audit Committee
June 10, 2008

Good Afternoon, Co-Chair Sullivan, Co-Chair Jeskewitz and distinguished members of this Committee. I am Dr. William Lobb, Dean of the Marquette University School of Dentistry, and I am honored to appear before you today. Our Director of State Relations, Ms. Mary Czech-Mrochinski, accompanies me today. I also bring greetings from our University President, Fr. Robert Wild.

The Marquette University School of Dentistry (MUSOD), founded in1894, has been the major provider of dentists for the State of Wisconsin for more than a century. MUSOD has had a partnership with the State of Wisconsin for over 30 years. We currently have two clinical grant agreements with the Department of Health and Family Services (DHFS): one grant for $2.8 million annually to support our clinical operations, and another grant for $60,500 annually for a pediatric dentistry program. In addition, we have a contract with the Higher Educational Aids Board (HEAB) to provide dental education under the Dental Capitation Contract which provides an in-state tuition subsidy for up to 160 Wisconsin residents per year. We have a partnership with the State of Wisconsin and we believe the State of Wisconsin receives an impressive return on investment on less than $4.3 million annual spending for these services.

As you may know, in 2002 we transitioned into a new facility. The School also revised its whole dental curriculum, a feat never before undertaken by any other dental school. Marquette's School of Dentistry is now similar to the medical model where students engage in dental rounds. Students are in the dental clinic beginning in their first year of education rather than merely their third and fourth years. The school was designed so that our students would engage in outreach around the State of Wisconsin and expose our students to a variety of clinical settings and patient populations. Every dental school in the country and many schools internationally have visited our school to study our curriculum and facility. I invite you to visit the school and see our operations first hand.

Department of Health and Family Services Grant for Clinical Services

The Department of Health and Family Services (DHFS) provides $2.8 million annually to MUSOD to support the provision of dental services by the School of Dentistry. However the total value of the services provided by MUSOD is approximately $10 million. During the last fiscal year (July 1, 2006- June 30, 2007), MUSOD treated 19,311 patients with clinical services provided in the following areas: our Main Clinic on campus, the Tri-County Dental Clinic in Appleton, the Chippewa Valley Technical College and the Ministry Dental Center in Stevens Point. More recently we opened our new Parkway Clinic on Milwaukee's South Side and we are currently building out another new clinic on Milwaukee's North Side which will be open this fall. These two clinics were needed to fill the void in services created by the City of Milwaukee's decision to close both the Isaac Coggs Community Health Center (Milwaukee) and Matthew Keenan Clinic at the Johnston Community Health Clinic (Milwaukee). We are planning additional partnerships. In addition, MUSOD provides dental services to inmates who reside in the Pre-Release Correctional Centers in Milwaukee County. Fifteen MUSOD students

Wisconsin, increased the number of Wisconsin residents eligible for this "in-state" tuition subsidy from up to 100 to a maximum of 160 (an average of 40 per class, or the equivalent of half the class); this was phased in over a four-year period. This contract does not directly benefit MUSOD.

For the 2008-09 in-coming class the School received over 3,000 applicants, the vast majority of whom are from out-of-state. Approximately 215 Wisconsin residents applied for admission to MUSOD for the fall of 2008. The School could fill the entire class, 80 slots per year, with out-of-state residents. However, we have a partnership with the State of Wisconsin and the Capitation Contract is intended to ensure that Wisconsin has an adequate supply of dentists. In fact, we believe and the Governor's Task Force on Oral Health Care concurred, that it would be in the best interest of the State to increase the number of Wisconsin residents eligible for Dental Capitation Contract. According to our internal data, over 70 percent of Wisconsin dentists graduated from Marquette's School of Dentistry.

Marquette University School of Dentistry is proud of the work we have been able to accomplish through a strengthened and ongoing partnership with the State of Wisconsin. We look forward to continuing to build upon this strong base to serve Wisconsin's oral health care needs for the 21st Century. Thank you. I would be happy to answer any questions at this time.


FORWARD

Children's Health Alliance of Wisconsin

WISCONSIN ORAL HEALTH COALITION
Children's Health Alliance of Wisconsin

Testimony to The Joint Legislative Audit Committee

Given by Matt Crespin, RDH, BS, CDHC
Oral Health Project Manager
Children's Health Alliance of Wisconsin

June 10, 2008

Good afternoon Senator Sullivan, Representative Jaskewitz and members of the Joint Legislative Audit Committee. My name is Matt Crespin oral health project manager for Children's Health Alliance of Wisconsin. The Alliance serves as voice for children's health and works on bringing diverse partners together to increase access to quality care for children. The Alliance leads and manages the Wisconsin Oral Health Coalition made of up over 130 individuals and organizations working to increase access to oral health care for Wisconsin children.

First I'd like to thank the committee for requesting the audit. The findings are not a surprise to many of us. It has confirmed what many people believed to be the case.

The findings of the recent audit of dental services for Medicaid (MA) recipients in the four counties where dental services are provided through an HMO have confirmed the Coalitions beliefs. The coalition is concerned with the following:

- The disparity of investment among HMO's in dental services varying from 73-110 percent.
- The rising number of enrollees and the decreasing number of providers. Wisconsin has done an admirable job of increasing those eligible for services but we have not provided sufficient access to care.
- The cost to provide care using the HMO system is more expensive than using a fee-for-service system. This raises questions on how HMO's are being held accountable and what motivates their service delivery.

We are counting on your committee and colleagues in the legislature to use these findings for swift change.

The Coalition is supportive of any and all creative ideas that are meaningful and equate to true access. The Wisconsin Dental Association has consistently called for increased reimbursement, which the Coalition supports, but it has often been dismissed as self serving. This audit confirms the Coalitions belief that reimbursement plays a significant role in access, in addition to critical strategies for prevention and education.

The Coalition also supports increasing the capacity of community health centers providing dental care because the resources provided have resulted in a significant increase in dental access. However, the community health centers and other free dental care can not be relied upon to meet the dental needs of the MA population.

The Coalition would like to see funding to implement some or all of the recommendations from the Governors Task Force to Improve Oral Health. Additional funding for prevention efforts such as school-based dental sealant programs is also needed, as current funding can not meet the need.

The Coalition supported the administrative rule allowing registered dental hygienists to become Medicaid providers. This has increased access to preventive services for the MA population, but does not address the gap in treatment services.

Wisconsin has a history of providing for the basic needs of people. I hope we can agree that dental care is a basic health need. We've learned that it affects our children's ability to perform well in school. It affects young adult's ability to have self confidence and obtain employment. While all health care is expensive, dollars for dental care is limited to 1% of the entire MA budget. Again we are counting on you and your colleagues to take the findings of this audit seriously, work with the Department of Health and Family Services and provide leadership in ensuring dental care to our children and families in need.

If you have further questions please contact:

Matt Crespin
Oral Health Project Manager
Children's Health Alliance of Wisconsin

Karen Ordinans
Executive Director
Children's Health Alliance of Wisconsin


FORWARD

TESTIMONY PRESENTED AT
JOINT LEGISILATIVE AUDIT COMMITTEE HEARING

Tuesday, June 10, 2008, 1:00 PM

Milwaukee Innercity Congregations Allied for Hope Representative

My name is Bernice Popelka, and I'm here today as a representative of Milwaukee Innercity Congregations Allied for Hope known as MICAH. We are congregations of many different faith traditions, known for our effective work on social justice issues. MICAH and eight other organizations throughout Wisconsin are united under WISDOM, the state organization.

We of MICAH and WISDOM are all concerned about the health needs of Wisconsin's public school children, and that includes dental health. The stark reality is, for example, 64% of Milwaukee Public School children have significant untreated dental problems. You and I know untreated dental pain inevitably impacts a child's ability to concentrate on school work and learning.

MICAH and WISDOM continue efforts for a school-based model for children in low-income schools so they may have comprehensive health care. The one place we know our children will be, is in the schools. We believe a school-based program, in alliance with local dentists, is the way to provide comprehensive care at a lower cost and with a much lower rate of "no shows." A program that is more streamlined with a reliable process of patient referral.

We have reviewed the Legislative Audit Bureau report and strongly agree that the four counties...Milwaukee, Racine, Waukesha, and Kenosha...need to be switched from HMO services to a fee-for-service program. Today's scarce monetary resources must not be squandered, depriving our children...our future generation...of needed health care. We also feel that instituted programs should provide for increased reimbursement rates to dentists so that more dentists can afford to serve under a fee-for-service program.

Thank you for your concerns on this most important service to the citizens of Wisconsin.

Bernice Popelka
414-228-4689

Left before testifying


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WISCONSIN LEGISLATURE
P.O. BOX 8952 • MADISON, WI 53708

June 10, 2008

Senator Jim Sullivan
Co-Chairperson
Joint Legislative Audit Committee
State Capitol, Room 15 South
Madison, WI 53708

Representative Sue Jeskewitz
Co-Chairperson
Joint Legislative Audit Committee
State Capitol, Room 314 North
Madison, WI 53708

Dear Sen. Sullivan and Rep. Jeskewitz:

We would like to thank you for holding a public hearing on the April 2008 Audit Letter Report: Dental Services for Medical Assistance Recipients. As founding members of the La Crosse Area Dental Advocacy Coalition, we have been working in collaboration with state and local agencies, the Wisconsin Dental Association, and countless area dental health professionals to raise awareness of the need for comprehensive changes to the way that dental care services are delivered to MA patients.

The lack of access to dental care represents one of the most pressing health care problems facing low-income families and individuals. Dental decay is the number one chronic disease of childhood, especially among low-income children who are often unable to see a dentist on a regular basis. If left untreated, dental decay and other oral health problems often lead to more complicated problems later in life.

In the ongoing debate over health care reform, the dental health component is often overlooked. Recent studies have shown a linkage between good dental hygiene and the overall health of an individual, and by treating children and educating them at an early age about the importance of dental care, we can help to prevent serious complications down the road. However, the lack of adequate reimbursement for dental care services provided to MA patients under the HMO model has become an increasingly problematic obstacle for health providers. We strongly encourage the legislature to make the increase of dental reimbursement rates a top priority in the ongoing health care discussions.

This audit confirms our concerns regarding the issues facing our current dental service delivery system and the failure of our state to meet the oral health needs of Wisconsin's low-income children and families. While the issue of dental care and MA reimbursement rates were discussed as part of the 2008-2009 budget negotiations, a comprehensive solution to this problem has yet to be reached.

It is our sincere hope that this audit will help to highlight the need for reform and prompt the development of alternative dental service delivery models. We would like to thank you for your consideration of these issues, and ask for your support in moving forward with us toward a solution to our dental health crisis.

Sincerely,

Jennifer Shilling
State Representative
95th Assembly District

Dan Kapanke
State Senator
32nd Senate District

CC: Joint Legislative Audit Committee members


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Children's Community Health Plan™

A member of Children's Hospital and Health System.

MS 6280, PO Box 1997
Milwaukee, WI 53201-1997
Phone toll-free: (800) 482-8010
www.childrenschp.com

TO: Senator Sullivan and Representative Jeskewitz, Co-Chairs
Members of the Joint Legislative Audit Committee
FROM: Mark Rakowski, Children's Community Health Plan and Children's Hospital & Health System
DATE: June 16, 2008
RE: Written Testimony for Dental Audit Hearing

As the Director of Managed Care for Children's Hospital's & Health System and the Executive Director of Children's Community Health Plan, I have the unique distinction of representing Children's Community Health Plan, one of the HMOs in Southeastern Wisconsin that arranges and pays for dental services to its members, and also Children's Hospital Dental Clinics, one of the largest providers of dental care to Medicaid recipients in Wisconsin.

Children's Community Health Plan is supportive of any changes in the delivery model for dental services if it will increase access to dental care for Medicaid recipients. However, we are concerned that a carve-out of these benefits or a return to the fee-for-service model that is in place in 68 counties in the state will not achieve this result unless a significant increase in funding is also done and that this increase finds its way to community providers. The Healthy Kids Dental Program implemented in the state of Michigan is an example of what can happen when dental reimbursement is increased.

I do not wish to repeat testimony you heard at the June 10, 2008 public hearing so I will be brief with respect to our specific response to the Audit:

In regard to the Legislative Audit Bureau Report, we disagree with:

- the finding that the fee for service system in place in 68 counties provides higher access rates than the managed care model achieves in 4 counties in SE Wisconsin. The HMOs are providing a level of service and coordination that fee-for-service does not have, including:
  - dedicated member advocates,
  - arrangement of transportation for members in need in Milwaukee County,
  - direct contact with individuals who have not received dental care, both by mail and by phone,

- follow-up with all individuals that have accessed an emergency room for dental care, and

- a dedicated administrator at SEDA that works directly with dental offices to arrange for care in urgent and emergent situations.

- By their very nature, these value-added services can only increase the percentage of individuals accessing dental services, which does not occur in the current fee-for-service model. The fact that there are slightly higher access rates in the 68 fee-for-service counties than in the 4 HMO counties is a reflection of the differences in the demographics of these populations, of the varying concentration of dentists in these communities, and of the differences in payer mix facing dentists in these communities.

- As far as reimbursement is concerned, Children's Community Health Plan recognizes the low fee-for-service rates that are the basis of the HMO cap rates, and has consciously made a decision to fund dental care at amounts in excess of what we are receiving from the state of Wisconsin. As noted in Table 6 of the LAB report, Children's Community Health Plan is HMO E which has paid a premium of 10.3% over and above what we received in capitation. (During its testimony on June 10, United Healthcare incorrectly claimed that it was HMO E). All of the value-added services noted above are paid for in addition to what is being paid to Southeast Dental. Children's Community Health Plan has recently agreed to contribute $82,000 to the Racine Community Health Center to allow them to equip two additional dental operatories, which will improve dental access for all residents in Racine County.

- The finding that the cost per Medicaid recipient is higher under managed care than under fee for service. The managed care cost of $270 is based on the amount paid by the state to the HMOs which is inclusive of administrative costs. The amount paid under fee-for-service reflects only the payments made to dentists for services provided. While the overall percentage paid to HMOs for admin is 15%, the admin costs related to coordinating and paying for dental care may very easily be 25%. Taking this into account, the managed care cost is, in fact, slightly lower than fee-for-service.

To summarize, the managed care model can work for dental services. It fails only to the same extent fee-for-service fails because of the inadequate reimbursement for dental services in Medicaid. With improved reimbursement and increased participation of dentists, managed care can provide better coordination of dental and medical care that will increase access.

Thank you. If you have any questions, I would be very willing to meet with you in person.


FORWARD

Good Afternoon:

My name is Renee Ramirez and I am the executive director of the new Waukesha County Community Dental Clinic, located in downtown Waukesha. I am here to today to ask that you support a reform to help solve the oral health crisis that low income families are facing as a result of not having adequate access t dental care.

The current system of HMO provided service in our region has led to an enormous gap in care for poor children and families. In Waukesha County, we have seen a disturbing number of these kids with massive decay. For too long, dental care has been a luxury that's been out of reach for many families. Waukesha County children whose parents might not be able to afford dental care or have access to it, now have a place to call their dental home.

Four years ago, under a planning grant from the Healthier Wisconsin Partnership Program, the Waukesha County Dental Coalition was formed to study this issue and propose a solution. We established partnerships with many community agencies, dentists, schools, and others. Our assessment found that one in four children enrolled in Waukesha County Head Start programs and one in five third grade students in the Oconomowoc and Waukesha schools had untreated dental decay, and adults were turning to the emergency rooms at hospitals with pain and infection because they had virtually no place to turn for service, because while they have Medicaid, only two dentists in Waukesha County who offer dental care to patients with BadgerCare insurance, and then only on a limited basis.

The Waukesha County Dental Coalition proposed a dental health clinic to address this access problem, to provide basic services, education, prevention and community outreach to these individuals. This new community dental clinic is now known as the Waukesha County Community Dental Clinic, Inc.; a not for profit clinic. It is a six chair dental clinic, with a full time dental staff, with hopes to enlist volunteer dentists, assistants, and hygienists in the very near future to serve the underserved in Waukesha County.

Our phone is "ringing off the hook" with calls from patients who have Medicaid/Badgercare. These patients are coming in with actual excitement about having a tooth removed. The reason, they are finally able to find relief from the pain. Last week a middle aged woman came to the clinic with 4 teeth severely decayed and with an infection traveling into her jaw. She had been suffering with a tooth ache for six months ago, but couldn't get an appointment to see a dentist in Waukesha County. She lacks transportation outside Waukesha County, which inhibits her from seeing a provider in Milwaukee County. What was just a single tooth ache six months ago has turned into a situation where a serious infection is traveling into the bone, requiring antibiotics, and subsequently 4 permanent teeth needed to be extracted. Had this woman had early intervention, she would most likely be in a different situation today.

Let me share a few stories from the Waukesha County Community Dental Clinic from just the last week. Yesterday, a mother of three children with BadgerCare accompanied her children to the dental clinic. She was thrilled to know that she would finally have a place to take her children for their dental health needs. She told me that she had incurred more than $1000 in dental expenses last year because, even though her children had state dental insurance. She wasn't able to find a dentist in Waukesha County to treat her children. She had waited more than a year and was tired of waiting; she knew that her children's dental health was important, so she found a dentist who would allow her to pay back her balance in installments.

Just this morning, a woman called with an emergency. She woke up with severe swelling to her mouth and called the designated HMO providers in Waukesha County. No one was able to see her. She was desperate to find relief and learned about our clinic through a social service agency. We were able to see her and provide appropriate treatment.

Finally, the most disturbing for us is to see teenagers who haven't been able to have normal hygiene and dental care for years. They are coming with severe decay and with low self esteem. When our dentist asks the young adults why there is so much decay, they say that they brush but can't find a dentist in Waukesha County to clean their teeth.

These stories are just a few of the many more similar situations we see every day.

The clinic's mission is to provide dental care to children and adults in need. However, our clinical advisory committee understands that this clinic can't possible address the needs of all, so they have limited the services provided to adults. We are only treating emergent and urgent needs and providing comprehensive dental care to children. While the

Waukesha County Community Dental Clinic is providing care to many, it isn't the only solution to this dental access problem.

The Waukesha County Community Dental Clinic is providing services to patients with BadgerCare with the HOM component. It has been very easy to process the claims and the reimbursement process is very efficient through South East Dental Associates. Working with the State of Wisconsin in order to provide dental care for individuals with "straight" Title 19, however, is a bit more complicated; the pre-authorization process is difficult and the delay in receiving reimbursements, I believe, inhibits dentists from participating in providing dental care to these individuals. Additionally, whether working with the State of Wisconsin or with SEDA, reimbursement rates are low and don't even cover half of the cost of providing services. I know, that as the executive director, I will have to ask volunteers to provide dental care and raise funds through grants and private donations to help cover these deficits created by the low rates of reimbursements. From the perspective of the community dental clinic, I welcome higher reimbursement rates, not only to help me cover the costs of running the Waukesha County Community Dental Clinic, but also in order to encourage more dentists to join my clinic in providing services to these patients with BadgerCare insurance.

As only the third provider of dental care to BadgerCare patients in Waukesha County, the Waukesha County Community Dental Clinic is only a partial solution. I believe reform is a timely and worthy step to take, so ultimately all those in need can be appropriately served.

Thank you.


FORWARD

WISCONSIN STATE LEGISLATURE

Joint Legislative Audit Committee

Committee Co-Chairs:
State Senator Jim Sullivan
State Representative Suzanne Jeskewitz

August 8, 2008

Ms. Karen Timberlake, Secretary
Department of Health Services
1 West Wilson Street, Room 650
Madison, Wisconsin 53703

Dear Ms. Timberlake:

Thank you for the testimony you offered before the Joint Legislative Audit Committee at its public hearing on June 10, 2008, concerning the Legislative Audit Bureau's recent letter report on *Dental Services for Medical Assistance Recipients*. We appreciated receiving the information you shared.

We remain particularly concerned about the delivery of dental services to Medical Assistance recipients in Milwaukee, Racine, Kenosha, and Waukesha counties. In your testimony you agreed with the Audit Bureau's recommendation to develop one or more alternative delivery models, and you indicated you are in the process of doing so. We ask that, as soon as is practical, you provide us with the status of your work and information regarding your next steps and specific strategies in determining an alternative delivery model. Should this detailed information not be available for our review before October 1, 2008, please write us to convey the anticipated timeline for its completion.

Please also know that a number of those who testified after you at the hearing expressed concern that they had not been invited to participate in the development of the Department's alternative delivery models. If that is the case, we would encourage you to gather input from a variety of stakeholders as you work to finalize plans and next steps. Given the particular challenges that were described in testimony at our Committee hearing, we believe this input is essential in developing a solution to the problem of access to dental services.

We look forward to hearing from you in the weeks ahead. Please contact us with any questions.

Sincerely,

Senator Jim Sullivan, Co-chair
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

cc: Ms. Rana Altenburg, Marquette University
Ms. Mara Brooks, Wisconsin Dental Association

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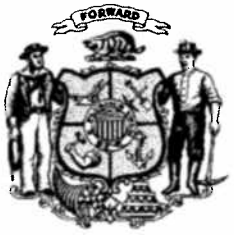
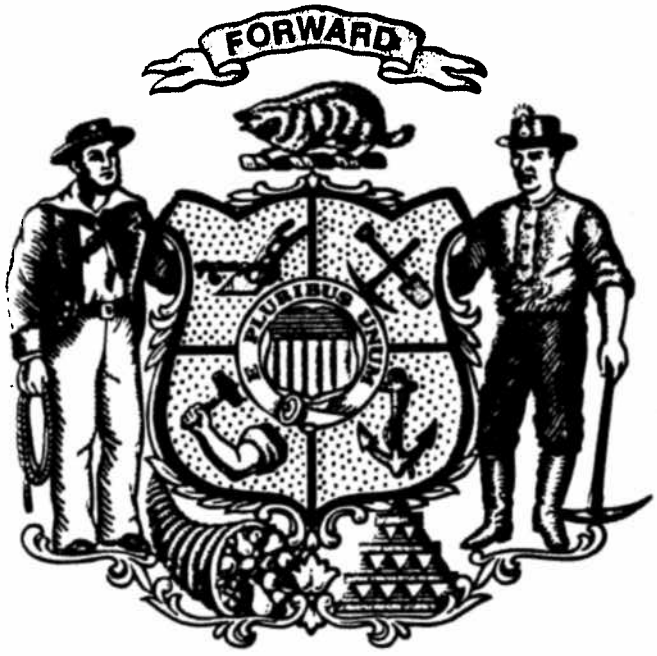
WISCONSIN STATE LEGISLATURE


FORWARD

	FQHCs (Official Name)[1]	Headquarter City		Associated Dental Clinic	Dental Clinic City
1	Beloit Area Community Health Center	Beloit	1	Beloit Community Health Clinic On-site Dental Clinic	Beloit
2	Scenic Bluffs Community Health Centers	Cashton	2	Scenic Bluffs Community Health Centers On-site Dental Clinic	Cashton
3	N.E.W. Community Clinic	Green Bay	3	N.E.W. Dental and Health Clinic at the Northeast Technical College	Green Bay
4	Kenosha Community Health Center, Inc.	Kenosha	4	Kenosha Community Health Clinic On-site Dental Clinic	Kenosha
5	Northern Health Centers	Lakewood	5	Nicolet Medical and Dental Center	Lakewood
6	Access Community Health Centers, Inc.	Madison	6	William T. Evjue Clinic On-Site Dental Program	Madison
7	Family Health Center of Marshfield, Inc.	Marshfield	7	Chippewa Pediatric Dentistry Clinic	Chippewa Falls
			8	Ladysmith Dental Clinic	Ladysmith
			9	Owen Dental Center	Owen
8	Fox Cities Community Health Center/Centro De Salud - Tsev Kuaj Mob	Menasha	10	Tri-County Community Dental Clinic (Contracted)	Appleton
9	Sixteenth Street Community Health Center	Milwaukee	11	Adult & Pediatric Medicine Behavioral Health/Dental Care Social Services Site	Milwaukee
10	Westside Healthcare Association, Inc.	Milwaukee	12	Lisbon Ave Health Clinic On-site Dental Program	Milwaukee
11	Milwaukee Health Services, Inc.	Milwaukee	13	Isaac Coggs Health Connection On-site Dental Clinic	Milwaukee
12	Health Care for the Homeless of Milwaukee	Milwaukee	14	Madre Angela Dental Clinic (Contracted)	Milwaukee
13	North Woods Community Health Centers	Minong			
14	Lake Superior Community Health Center	Superior	15	Lake Superior Community Health Clinic On-site Dental Program	Superior
15	Bridge Community Health Clinic	Wausau	16	Bridge Community Health Center On-site Dental Program	Wausau
16	Family Health/La Clinica	Wautoma	17	Family Health La Clinica On-site Dental Program	Wautoma
	[1]Wisconsin Primary Health Care Association Organizational Membership Directory				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A Dental Scandal

Poor children often can't find anyone to check their teeth.

By Josh Goodman

The death of Deamonte Driver shocked the country. Deamonte, a 12-year-old from suburban Prince George's County, Maryland, died in February 2007 when bacteria from an abscessed tooth spread to his brain, leading to a fatal infection that basic dental care could easily have prevented.

There were national headlines and even a congressional investigation. Health care specialists were asked what could have gone wrong for a child to die from a seemingly innocuous condition.

But almost as disturbing as Deamonte's death was a second disclosure that emerged from the controversy. The death wasn't exactly a freak occurrence. "I don't think there was anything unusual in Maryland that wasn't happening nationwide," says Harry Goodman, the state's director of oral health. "We were probably right in the middle for access to care for Medicaid children."

Goodman isn't being unduly defensive. Advocates, dentists and state government officials all agree that the nation's system for providing dental care to the poor is broken. Medicaid beneficiaries commonly go without basic dental services, leading them to develop painful conditions that are costly to treat. Once in a while, these conditions are fatal.

For at least a decade, states have been aware of the problem. Several are now seeing some success from reforms aimed at improving dental care for the poor. But they're also running into major challenges, including turf battles among the oral health professions and shortages of dentists and money. A less tangible but equally worrisome obstacle is a mindset, shared by citizens and policy makers alike, that treats dental care as more of a luxury than a necessity.

AP IMAGES

Searching for Care

At the heart of the Medicaid dental dilemma is a paradox. Under federal rules, every state Medicaid program offers dental coverage to poor children. Yet only about one-third of those children see a dentist in any given year. The problem is this: Just because kids need to see dentists doesn't mean dentists have to see Medicaid patients. This was the situation Deamonte Driver's mother faced. She was on Medicaid and searched in vain for weeks for a dentist who would see her children.

Nationally, only a fraction of licensed dentists regularly accept Medicaid patients. There's a reason for that: States pay dentists as little as half of what they make from private patients. It isn't just a matter of avarice. In some cases, the reimbursement rates

aren't enough to cover costs, meaning dentists lose money on every new Medicaid patient they see.

Dentists don't shy away from Medicaid solely because of the reimbursement rates. They also cite Byzantine processes for filing claims, which can cause payments to be delayed for months. Frank McLaughlin, executive director of the Maryland Dental Association, says many dentists in his state prefer to see poor patients for free rather than deal with Medicaid. The hassles of seeking the state's paltry payments, he says, often aren't worth the effort.

All of this is significant because, beyond Medicaid, there is virtually no dental care safety net for the poor. "If you don't have regular health insurance, but something happens, you can always show up at an emergency room," notes Shelly Gehshan, of the National Academy for State Health Policy. "If you have an abscessed tooth and show up in an emergency room, all they're going to be able to do is give you painkillers and tell you to call a dentist." The result is what the U.S. Surgeon General termed in a 2000 report a "silent epidemic" of oral health disease for poor children—rotting teeth and gum diseases that cause pain, hamper job prospects and ultimately lead to more serious conditions.

The situation is even worse for adults on Medicaid. Only eight states offer full dental benefits for that population. Some provide no dental benefits at all.

Michigan's Plan

Long before Deamonte Driver's death, states had begun looking for solutions to these problems. The most basic is to raise reimbursement rates. Gehshan recently co-authored a report that looked at five states—Alabama, Michigan, Tennessee, South Carolina and Virginia—that have increased reimbursements in the past decade. In every case, more dentists started accepting Medicaid patients and more children began receiving dental care.

That still leaves the administrative problems. In this regard, Michigan has come up with an interesting experiment. Starting eight years ago, in a limited number of counties, it outsourced its Medicaid dental coverage to Delta Dental, the largest oral health insurer in the state, and matched Delta Dental's standard reimbursement rates. This means dentists can follow the same familiar reimbursement procedures they use for other patients. It also means that every dentist in the target counties who accepts Delta Dental thereby accepts Medicaid. "We were purchasing their network," says Christine Farrell, of the Michigan Department of Community Health, "and taking away the stigma of Medicaid."

This is, of course, a costly solution. Michigan has to pay fees to Delta Dental, offer the higher reimbursement rates and pay for the additional care now that more kids are seeing a dentist. Those costs have led some states to try a different approach.

Nothing to Smile About

Medicaid children receiving dental services, 2004

30% Received any dental services

22% Received preventive dental services

16% Received dental treatment

Sources: Centers for Medicare & Medicaid Services and National Academy for State Health Policy

If dentists who will see Medicaid patients are in short supply, the thinking goes, why not allow caregivers other than dentists to provide basic oral examinations?

That's what North Carolina has been trying for several years through a program that targets very young children. While many youngsters on Medicaid don't see dentists, they do visit pediatricians. So North Carolina pays to train pediatric doctors and nurses in the basics of oral health. Medicaid pays them when they conduct oral screenings, apply fluoride or counsel parents on good dental practice. North Carolina's model is spreading. Eighteen Medicaid programs now reimburse primary care providers for some dental health services.

For its part, Maryland is trying multifaceted solutions. This year, the legislature approved a reform package that will boost reimbursements by $42 million over three years, create a single dental vendor for the Medicaid program and expand dental health clinics. Dental hygienists will be empowered to do more work in schools and clinics without a dentist's supervision.

Maryland's approach could be a template for what a comprehensive approach to dental access might look like. The question is whether other states will follow the template. If history is any guide, many won't.

Questions of Attitude

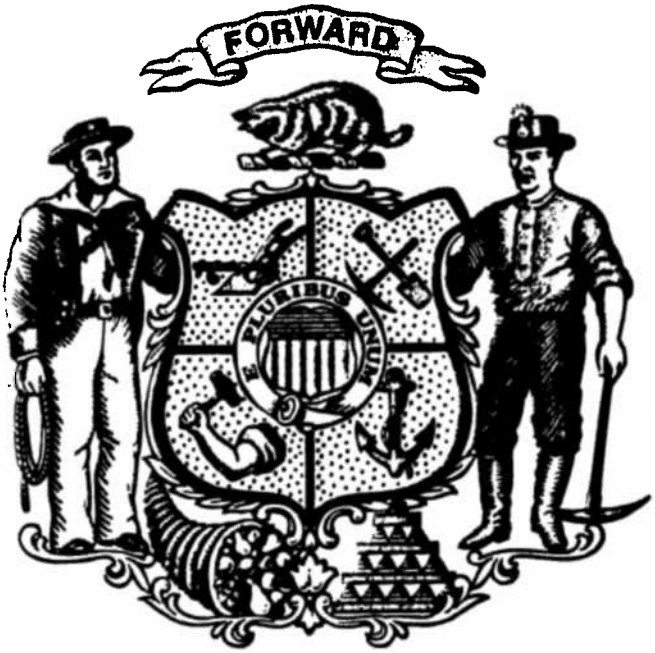
In some places, one reason is simply a fatalistic attitude toward the problem. Ken Rich, Kentucky's Medicaid dental director, says some people simply assume they will have all of their teeth pulled at a fairly young age, like their parents and grandparents before them.

But, in a sense, Medicaid recipients who neglect their teeth are simply taking cues from elected officials and other policy makers who don't make dental care a priority, either. When state budgets become tight—as they are right now—oral health is often one of the first budget items to get cut. California Governor Arnold Schwarzenegger has proposed cutting dental benefits for 3 million adults on Medicaid. Last year, Colorado dropped dental care for pregnant women on Medicaid. Planned expansions of dental coverage in Nevada and Ohio have been delayed.

Nowhere is this dynamic more obvious than in Michigan. Even though statistics show that the kids being served by Delta Dental have more access to care, the state hasn't expanded the program to many of Michigan's population centers. "It's a cost issue," says Christine Farrell. The state also reduced reimbursement rates for Delta Dental in 2006, resulting in a drop in the number of dentists participating.

All of this is a tremendous source of frustration to dentists, who think policy makers view oral health care as an optional service rather than a necessity, even though dental problems can lead to nutritional problems, heart disease and strokes. "The people who make decisions, who control the money and control public policy, don't have dental problems," says Paul Casamassimo, former president of the American Academy of Pediatric Dentistry. "The idea of a child dying of tooth decay is something they never would have dreamed of." Of course, since Deamonte Driver's death, fewer people need to be reminded of that possibility.

Josh Goodman can be reached at jgoodman@governing.com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Editorial: Junking the status quo

A state audit shows that the HMO model of delivering dental care to Medicaid patients in the four-county Milwaukee area isn't working and needs to be replaced.

From the Journal Sentinel

Posted: April 21, 2008

A new state audit confirms what some lawmakers and the Wisconsin Dental Association have been saying for years - a vast majority of lower-income children, especially in the Milwaukee metropolitan area, are not receiving proper dental care.

The fault doesn't lie with dentists but with the state's inadequate dental reimbursement rate for Medicaid patients, one of the lowest in the nation. In Milwaukee, Waukesha, Racine and Kenosha counties, where Medicaid dental care is delivered primarily by HMOs, the problem of access is even worse than in other areas of the state, which rely on traditional fee for service. And even more perplexing and disturbing, the costs are higher than in the state's 68 other counties.

Clearly, the system of delivering dental care in this area needs to be changed. The Legislative Audit Bureau came to the same conclusion. It recommended that the Department of Health and Family Services develop alternative ways of delivering dental care to Medicaid patients in southeastern Wisconsin before the current HMO contracts expire in December 2009.

Based on the audit, that recommendation is easily justified.

For instance, auditors found that the HMOs in the four-county Milwaukee area consistently failed to provide an adequate number of dentists and timely access to care. They also found that the rate of dental utilization by children was about 3% less in the four-county area than in other parts of the state and that the average procedure cost here was $270, compared with $211 under the fee-for-service system elsewhere in the state.

Because there are inherent differences between managed care and fee for service, the two systems can't be directly compared, HMO officials say. The population density and demographic characteristics of Medicaid patients in this area also are significantly different, they argue. Those explanations have some validity but not nearly enough to justify retaining the status quo.

State Rep. Sue Jeskewitz (R-Menomonee Falls), co-chair of the Legislature's Audit Committee, told us Monday she was especially troubled by the HMO administrative costs.

The committee will hold a hearing next month. When it does, it also must look at increasing the Medicaid dental reimbursement rate.

From the April 22, 2008 editions of the Milwaukee Journal Sentinel
Have an opinion on this story? Write a letter to the editor.


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Kate 4/22/08

? circumstance were treatment is mandatory

- in ER's

- EMPTLA

? Bill recently encouraging retired DDS

4/07 Rep

AB263

- [redacted] . . . .

? Donated dental

- WDA has data

- not huge prog. in Kate's

? 3M in service

1200

4/98 - 12/06

473 members participate

3. Which TC have Dental Clinics

- MATC Madison -
  MATC Milw
  NETC
  Western
  CVTC
  Lakeshore

2. listing of