ORAL HEALTH FOR UNDERSERVED CHILDREN IN MARYLAND

TESTIMONY BY

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To

The Subcommittee on Domestic Policy
Committee on Oversight and Government Reform

Chairman Kucinich, Congressman Issa and members of the Subcommittee on Domestic Policy, thank you for inviting me here today to discuss the issues of oral health care for poor children, especially the situation in Maryland. I would like to give you my perspective on how in one of the richest states in the country, Medicaid can fail some of our most vulnerable children, as evidenced by the recent tragic death of a child due to a dental infection. Furthermore, I would like to suggest improvements in reporting, oversight, and policy that will make Medicaid oral health care in Maryland, and perhaps many other states more functional and effective.

In 1997 access to oral health care services for Maryland's poor children was the worst in the country. At that time, only 19% of children in the Maryland's Medicaid program had at least one dental visit each year and only 7% received restorative (treatment) services. There has been incremental progress made, primarily through the enactment of Maryland State legislation championed by key legislators and promoted by oral health advocates and organized dentistry in the State. This includes legislation that mandated utilization targets and reporting, loan assistance repayment programs for dentists who agree to treat Medicaid children, programs to facilitate foreign-trained dentists to serve as Pediatric Dental Fellows who treat Medicaid children, and budget bill language that increased 11 selected dental restorative (treatment) fees.

However, much more progress is needed in Maryland to properly address oral health care services for poor children. It is estimated that 50% of children covered by Medicaid in Maryland have cavities with only a small portion of these children receiving necessary restorative care. Consequently, many children still suffer from pain and infection from oral conditions, adversely affecting learning and behavior. Parents and health care workers continue to struggle to find dental providers to get the needed reparative services for these children.

The Maryland Legislature in 1998 required Maryland's Department of Health and Mental Hygiene (DHMH) to submit annual reports on "Dental Care Access" to the Maryland General Assembly. The October 2006 report covers topics such as: (1) Number of participating dentists; (2) Community clinic dental providers; and (3) Number of children and adults receiving dental services. Additionally, quality of Managed Care Organizations (MCO) services is measured by several DHMH reports: Consumer Assessment of Healthcare Providers and Systems-2006, Hedis-2006, External Quality Review Organization Report-2005 and Value-Based Purchasing

Activities Report-2005. Below is my analysis of some of the access to oral health care issues in Maryland, compared to these reports:

Providers

The DHMH October 2006 report to the Maryland General Assembly lists 918 unduplicated Medicaid providers as of July 2006 which is up from that reported in July 2005 by nearly 600 providers. The report ascribes the increase to "an information systems data clean-up. A footnote also states that, "Some dentists may not be accepting new referrals and many dentists limit the number of new referrals that they accept". Further, the number of dental Medicaid providers on DHMH's web site is 1,483 which includes 88 Washington, D.C. providers. A cursory glance of the provider lists on the web site shows numerous duplicate dentists, dentists who no longer practice, dentists who have moved, and deceased dentists. I was surprised that I was listed as a dental provider in Western Maryland, even though I only practice in Baltimore.

A more realistic calculation of the actual providers may be generated from direct calling of those dentists on the provider list to ask the question, "Will you take a new Medicaid patient", or by contacting county oral health officers for their knowledge of those dentists that will take a new Medicaid patient. Using this method the following information was obtained from 748 of the listed 918 unduplicated providers, derived from 19 of the 23 counties and Baltimore City located in Maryland:

County *	**# willing to take a new Medicaid patient**	**Unduplicated providers on DHMH list**
Charles	0	13
Calvert	1	10
Frederick	4	32
Prince George's	46	235
Allegany	2	23
St Mary's	9	21
Wicomico	10	20
Caroline	4	9
Cecil	1	7
Kent	1	4
Queeen Anne's	4	8
Wicomico	9	25
Worcester	2	8
Howard	10	62
Somerset	2	11
Talbot	1	4
Dorchester	1	8
Carroll	6	25
Baltimore County	57	223
Totals	170	748

*19 of 23 counties and Baltimore City that are located in Maryland

This shows that there is perhaps only one fifth of the actual number of listed Medicaid providers who will see a new patient. The discrepancy regarding the listed providers and those who are willing to take a child enrolled in Medicaid as a new patient is incredibly frustrating to patients and health care workers who seek care for these children.

The October 2006 DHMH report also lists Community Clinic Dental Providers. The numbers of public health clinics in Maryland is critical because it is believed that they provide the vast majority of oral health services. The report correctly states that there are only 12 of the 24 local health departments in Maryland that offer oral health services. However, there may only be nine, not 13 Federally Qualified Health Centers (FQHCs), with oral health services, with one of these sites having only a part-time dentist.

Number of Children in Medicaid, Dental Services Rendered and Children/Enrollee Ratio

The DHMH 2006 report lists the number of children receiving dental services, counting only those children ages 4-20, who have been enrolled for at least 320 days. However, the April 2005 report of the National Oral Health Policy Center mandates that States use Form 416, which requires counting total eligible children.

The table below compares for 2005 the number of children enrolled in Medicaid and the percent receiving any dental service as reported by Maryland's DHMH and as reported on CMS's Form 416. Additionally, the last column shows the ratio of dental providers to enrollee for 2006 as reported by DHMH, i.e., 1 dentist for every 439 children. Yet, if one uses the total eligible children (Form 416) per the number of providers (those willing to accept a new patient), the ratio would be far less, at about 1 dentist for every 2,500 children, exceeding the ratio of 1:2,000 as required by Maryland law.

Method of Counting Children	Total # of Enrollees	% Receiving Any Service	Children/Enrollee ratio
Children Ages 4-20 Enrolled over 320 days	227,572	45.8%	1:434
Total Eligible Children (Form 416)	501,807	30.7% `	~1:2,500

Furthermore, DHMH continues to emphasize "percent receiving (any) service" as an indicator of access to care. A better indicator may be whether a child is receiving any restorative (treatment) service. In Maryland in 2005 only 15.8% of Medicaid children received a treatment service, as reported by DHMH. However, if the total of eligible children was used as derived from

Form 416, the number of children receiving restorative dental services would be 13.0%, ranking Maryland eight from the bottom of the 35 states reporting this information in 2005.

Quality Measures of Oral Health Care in Maryland Medicaid

In 2001 DHMH conducted town meetings to assess issues regarding the Medicaid system. Although these meetings concerned the total health care system, reports from those who attended these meeting indicated that most of the discussions focused on lack of access to oral health care. In the one session that I attended, the only issue that was discussed was the problem of access to oral health care. However, of the four quality reports published by DHMH in 2005-2006, only 1 of the 118 pages of reports addresses a dental issues. For instance the Consumer Assessment of Healthcare Providers and Systems-2006 survey has no consumer questions specific to oral health care or dentistry.

It is difficult to appreciate why these reports does not include oral health care, since access to oral health has been a continuing concern in Maryland for so many years. In any case, surveys may not be the best way to understand the problems of quality of oral health care in Maryland Medicaid. Perhaps a better approach would be to use regional focus groups to elicit much more specific information regarding parents' and health care workers' satisfaction with oral health services in Medicaid. Such focus groups would be a good follow up to the earlier town meetings.

Reimbursement Rates for Dental Procedures

Although the reimbursement rates for 12 selected restorative procedures were increased in 2003, most of the rates for procedures still are far below what a dentist would accept. The American Dental Association Survey of March 2004 ranks Maryland as 39 out of 50 states regarding reimbursement rates for diagnostic and preventive procedures. Incredibly, this report is lists Maryland as the worst state in the country for reimbursement rates for restorative procedures.

An illustration of the problem is the current reimbursement rate for dental sealants. Maryland Medicaid pays $9 per sealant, whereas the 50th percentile for dentists' fees in Maryland for a sealant is $40. In addition, Medicaid restricts this procedure to only a few teeth and will not pay for sealants on any primary tooth or any permanent premolar.

It is unreasonable to expect a high number of dentists to participate in Medicaid when the rates do not cover overhead costs and do not equal an acceptable discount rate, at perhaps 20-25%, for dentist participation. Furthermore, paperwork, red tape issues, and "no-shows" are frequently cited by dentists as reasons for not participating in Medicaid.

Summary

Oral health care for children in Maryland Medicaid continues to be inadequate despite some successful State legislative efforts championed by some key legislators with support from advocacy groups. Part of this inadequacy may be the result of reporting efforts that mask the severity of the access issues. Inaccurate reporting not only frustrates parents and health care workers seeking care for children, but the understatement of the problems adversely affects decisions of policy makers. The net result is that oral health care in Maryland Medicaid needs closer scrutiny and much more improvement as children with untreated dental problems suffer from pain, infection and morbidity and have related behavioral and learning problems.

How to Solve Dental Access Issues

- Recognize that oral health is critical to the overall general health of our children.
- State Medicaid managed care programs need more oversight and accountability. Uninterested third parties should evaluate the performance of oral health programs that serve Medicaid enrollees.
- State Medicaid programs need to be encouraged to work with oral health advocate to strengthen and improve programs and services.
- State Medicaid programs need to publish accurate data that it is helpful to case managers and patients who are seeking care, as well as to program administrators and policy makers.
- Reimbursement rates for dental procedures need to be adjusted to be consistent with commercial PPO schedules.
- Better case management and ease of paperwork is needed to increase dental provider networks.
- A public health infrastructure is needed to provide a geographically distributed backbone of oral health services. Maryland, similar to other states, needs the necessary resources to expand its oral health safety net system.