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Domestic Policy Subcommittee
Oversight and Government Reform Committee

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2154 Rayburn HOB

My name is Dr. Fredrick Clark. I have been a dental practitioner in Temple Hills, MD in Prince George's County for seventeen years. I am also a Dental Child Care Advocate. I have in the past served on the State of Maryland Oral Health Advisory Committee and also a past member of the Headstart Advisory Board. I have treated children in Medicaid plans throughout my entire dental career. I am here today because a child from my county lost his life because he could not receive dental treatment in a timely manner. I am here to provide my personal perspective on problems related to access to care for children in the Medicaid program and those who are uninsured and barriers that may exists in Prince George's County. I feel that one of the primary barriers to access is lack of adequate participation by private dental offices in the Medicaid program. Prince George's County has approximately 45-50,000 child Medicaid participants. Some 200 dental offices are listed as providers according to the Prince George's County Health Department. But when these offices were contacted to check on their participation, only 25% of those offices would see child Medicaid patients. With this disproportionate ratio of patients to providers, it is virtually impossible for a parent to find a dentist to treat their child's

dental concerns. Why does this disparity exist? There are many reasons, some of the reasons cited were:

- Low reimbursement rates for dental services
- Inability to receive timely payment for services
- Inadequate network of specialists in which to refer difficult cases
- Poor communication between Dental Providers and MCO's
- Interference with the Doctor-Patient relationship
- Difficulty in the credentialing process
- High broken appointment rate among Medicaid patients

For years Dentists have had difficulty in participating in the Medicaid programs even before the plans were taken over by MCO's. Some of the same complaints existed for years resulting in refusal by many offices to participate in Medicaid. HMO's and MCO's have created a new landscape in which the medical field has had to adapt but the changes have not been favorable to the Doctors. The way Managed Care Plans are structured inherently create an antagonistic relationship within the medical and dental communities due to fee setting, low co-payments by patients, non-negotiation with the providers of care to improve payments and low capitation rates. The combination of Managed Care Plans and Medicaid makes for an unpalatable mixture that most Doctors have refused to have any part of.

At the treatment level, ground zero, there is a constant inundation of calls of patients attempting to acquire appointments, parents report of calls to numerous offices and the inability to receive appointments. There are reports of children in pain, children with abscesses, when children can be seen there may be 3, 4 or 5 children in a single family, all of whom may have a number of cavities. Sometimes they can be treated if the child is manageable, if not the search begins for a pediatric dentist which is almost impossible find. A search through the local yellow pages revealed that there were only four listings for pediatric dentists in a county which has 800,000 residents and 50,000 child Medicaid recipients. I have served the Medicaid population in spite of problems of low compensation and in some instances refusal to be paid. I grew up in South Central Los Angeles as a poor child and I feel a commitment to treat these children, who I know that if I were not there, there may be no one to serve them. The patients who pay for services allow me to treat some of the patients who have little or nothing. Pro bono care is a part of the norm in our community. This also occurs in treatment of adults who are indigent.

Enrollment in the MCO entails filling out a long document of almost 20 pages and credentials must be sent, the waiting period for the in-house credentialing to be completed may take months. Also an office inspection must take place to insure that the Doctors office meets numerous specified requirements (cleanliness, sterilization procedures, OSHA Guidelines, Records keeping, etc).

Dental Medicaid dollars ultimately are allocated to insure that poor children are able to receive desperately needed health services. The MCO’s role in this process is to create

the network of providers and set up a compensation structure that insures that the process works. My primary concern is that Medicaid dollars should go to Medicaid treatment and as little as is necessary to administrative cost. This program was not set up for someone to profit off the backs of children. I do not begrudge a for profit business making a profit but this program was designed to help children and should be run as a non-profit organization with open books so that the bottom line of the business is not the primary concern. I am in no position to say if the MCO's have anything to hide but obviously the fees are still too low to encourage private dental office participation in Medicaid.

Many factors could be put in place to make the system more responsive, such as:

- Involving dental organizations to participate in the fee setting process, this would insure the compensation structure necessary to encourage participation by the private dental sector.
- Create an efficient safety net program that insures that a parent knows where to take a child in case of pain or distress.
- Create an effective referral network of specialists to treat difficult or emergency cases which may be outside the scope of care of the general dentist.
- Encourage government to increase funding to the National Health Service Corp to train and place more pediatric dentists in areas of need or shortage.
- Create effective patient education information on dentistry and engaged in media campaigns to educate the public about dental diseases and preventive care, by use of Public Service Announcements via television and radio ads.

- Look to alternative programs to administer Medicaid services, encourage best practice models, and fund county health clinics to hire dentists and dental hygienists.
- Each State needs a Chief Dental Officer to coordinate the Public Health Dental needs of the State.