Statement on the Rural Dental Care Problem in PA

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The previous panels have summarized the major challenges we face in increasing access to dental care in the Commonwealth of Pennsylvania. Hence, I will not repeat the economic factors, the high debt facing the new dentists, lifestyle issues, among others, but I would like to address a major reason for lack of engagement of dentists in the Medicaid program, and it is not only about money. As the Dean of a large clinic serving close to 30,000 patients enrolled in Medicaid each year, I have wondered several times why we have designed and operated a program to discourage participation.

The current financing model depends on the transfer of funds from the state to managed care organizations and these organizations such as UPMC, Jefferson Health, Keystone, Amerihealth, among others, either operate the program or hire another company to manage the daily processing of preauthorization and claims and not to mention the cumbersome process of credentialling the providers. The system thrives on bureaucracy, and checks and balance to scrutinize the dentists. For example, when a patient who needs urgent root canal therapy seeks care at Temple Dental, we can provide urgent care, but we need to apply for a special approval called Benefit Limits Exception and Preauthorization. The process will take weeks if not months to be completed and given the number of patients and the managed care organizations we work with, the human resources required to manage submitting preauthorization can be enormous. And, when we submit them, the likely outcome is rejection. After the rejection of a preauthorization or BLE we can provide the necessary care if the patient can pay for the service (low fees). We could have provided the care at Medicaid rates from the beginning of the first visit, but we cannot because a rejection is required before we can charge patients. This is one example of how the bureaucracy works. Another example is the credentialing process. We need to submit forms to each individual company to have our providers credentialed and when we have 140 providers and work with multiple plans, the administrative burden and cost can be high.

I always ask why the system is designed this way, but I cannot find an answer other than the goals is to delay care and conserve on expenses by the Managed Care Organizations. The majority of the fees of procedures covered by Medical Assistance have not increased for a long time, years. And even when there is an increase in fees by the Department of Human Services that may not translate into increased fees for the providers. The MCOs may not increase the fees at all or delay the increase for several months.

The solutions to the access to dental care in rural areas must be multi-pronged and start

with redesigning the financial model to reduce the bureaucratic burden and increase the transfer of funds from taxpayers to the providers. The other recommendation could include:

- Loan repayment or forgiveness programs tied to rural service.
- Expanded training pathways with rural externships or residencies where students live for an extended period in rural areas.
- Grants and financial support to establish rural practices.
- Defining the scope of practice of the oral health team to ensure continuity of community models with clinical care.
- Funding for teledentistry infrastructure and use of technology to diagnose, advise, and educate.