STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

DEC 0 1 2010

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

The Honorable Edward J. Kasemeyer
Acting Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg
Annapolis, MD 21401-1991

RE: Health-General Article, § 13-2504(b), HB 70 (Ch. 656 of the Acts of 2009) and 2009 Joint Chairmen's Report (p. 82) – 2010 Annual Oral Health Legislative Report

Dear Governor O'Malley, President Miller, Speaker Busch, Chairman Kasemeyer and Chairman Conway:

Pursuant to Health-General Article, § 13-2504(b), the Maryland Medicaid Program and the Office of Oral Health within the Department of Health and Mental Hygiene (the Department) submit this comprehensive oral health legislative report.

This consolidated oral health report addresses the following initiatives: 1) Dental Care Access under HealthChoice (as originally required by SB 590 from 1998) as well as the Office of Oral Health's efforts to improve access; 2) the Oral Health Safety Net Program (as originally required by SB 181/HB 30 from 2007); and 3) the Oral Cancer Initiative (as originally required by SB 791/HB 1184 from 2000). More specifically, the report discusses:

- Maryland Medicaid HealthChoice availability and accessibility of dentists;
- Medicaid managed care and dental managed care organization utilization outcomes, and allocation and use of related dental funds;
- The results of the Oral Health Safety Net Program administered by the Office of Oral Health;
- The findings and recommendations of the Office of Oral Health's Oral Cancer Initiative; and
- Other related oral health issues.

In addition, the 2009 Joint Chairmen's Report (on pg. 82) requested that without adding an official reporting requirement, the report also be distributed to the budget committees.

The Department is pleased to share this report, detailing the work that has been completed to improve dental care for Marylanders. If you have any questions regarding this report, please do not hesitate to contact Ms. Wynee Hawk, Director of Governmental Affairs, at (410) 767-6481.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: Wynee Hawk, R.N., J.D.
Frances B. Phillips, R.N., M.H.A.
John Folkemer, M.S.W., M.P.A.
Russell W. Moy, M.D., M.P.H.
Harry Goodman, D.M.D., M.P.H.
Ms. Sarah Albert, MSAR #7890

MARYLAND'S 2010 ANNUAL ORAL HEALTH LEGISLATIVE REPORT

Martin O'Malley	Anthony G. Brown	John M. Colmers
Governor	Lt. Governor	Secretary

I. Introduction

During the 2009 session of the Maryland General Assembly, HB 70 (Health-General Article §13-2504, Annotated Code of Maryland) was enacted in part to require the Department of Health and Mental Hygiene (the Department) to submit one comprehensive legislative report each year on Maryland's oral health efforts and accomplishments. The report focuses on three major areas: (1) Dental care access; (2) the Oral Health Safety Net Program; and (3) the Oral Cancer Initiative. Previously, the Department had been statutorily required to report on these oral health issues by submitting three separate legislative reports. More specifically, the new statute requires the consolidated oral health report to address the following areas:

(1) Dental care access under Maryland's Medical Assistance Program including:

(A) The availability and accessibility of dentists throughout the State participating in the Maryland Medical Assistance Program;

(B) The outcomes that managed care organizations and dental managed care organizations under the Maryland Medical Assistance Program achieve concerning the utilization targets required by the five-year Oral Health Care Plan, including:

(i) Loss ratios that the managed care organizations and dental managed care organizations experience for providing dental services; and

(ii) Corrective action by managed care organizations and dental managed care organizations to achieve the utilization targets; and

(C) The allocation and use of funds authorized for dental services under the Maryland Medical Assistance Program.

(2) The results of the Oral Health Safety Net Program administered by the Office of Oral Health; and

(3) Findings and recommendations of the Office of Oral Health's Oral Cancer Initiative.

II. Maryland's Oral Health Accomplishments

Part 1. Dental Care Access under HealthChoice and DentaQuest As Originally Required by SB 590 (Ch. 113 of the Acts of 1998), as Amended by HB 70 (Ch. 656 of the Acts of 2009)

Background

The Maryland Department of Health and Mental Hygiene's (the Department) Medical Assistance (Medicaid) program delivered oral health services to approximately 265,000 children and adult enrollees during 2009; 50,000 more than in 2008. Maryland has made major program changes and has seen a significant increase in dental utilization over the last few years. But like many other states, Maryland continues to confront barriers to providing comprehensive oral health services to Medicaid enrollees. Barriers include low provider participation due to, among other things, low reimbursement rates, missed appointments, and a lack of awareness among enrollees about the benefits of basic oral health care. As Medicaid's population continues to increase each year, these barriers remain significant impediments to increasing access to dental services.

In June 2007, the Secretary of the Department convened the Dental Action Committee (DAC), a broad-based group of stakeholders, in an effort to increase children's access to oral health services. The DAC also worked to identify ways to increase the amount of oral health services utilized by eligible Medicaid enrollees. The DAC focused its efforts and recommendations on four topic areas: (1) Medicaid reimbursement and alternative models; (2) provider participation, capacity, and scope of practice; (3) public health strategies; and, (4) oral health education and outreach. The DAC reviewed dental reports and data to develop a comprehensive series of recommendations, building on past dental initiatives, lessons learned, and best practices from other states. The DAC submitted a comprehensive report to the Secretary on September 11, 2007 (http://www.fha.state.md.us/pdf/oralhealth/DAC_Final_Report.pdf).

In June 2009, the DAC formally transitioned from being a committee based in the Department focused on increasing access to dental care for underserved Maryland children to becoming an independent, sustainable Statewide oral health coalition whose mission is to improve the oral health of all Marylanders. As an independent stakeholder coalition with an expanded mission, the DAC underwent a name change and is now called the Maryland Dental Action Coalition (MDAC). By March 2010, the MDAC received funding from a private foundation (the DentaQuest Foundation), secured an office and hired an executive director. Both Medicaid and the Office of Oral Health are non-voting members of the MDAC. Due to the major program changes the Department has made to the dental program, the Centers for Medicare and Medicaid Services has recommended Maryland's process and approach to other states struggling with poor dental outcomes.

Senate Bill 590

SB 590 (Ch. 113 of the Acts of 1998) took effect on October 1 of that year. It established the Office of Oral Health within Public Health's Family Health Administration and requires that the Medicaid program offer oral health services to pregnant women enrolled in Medicaid managed care organizations (MCOs). It established a five-year Oral Health Care Plan that set utilization targets for MCOs. The base for these targets is the rate of service use of children under age 21 in 1997, which was 19.9%.[1] The first year of the five-year plan was calendar year (CY) 2000. The utilization target for that year was 30%, with annual increases of 10%. The utilization target for the end of the five-year plan (CY 2004) was 70%.

Part I of this report provides an overview of CY 2009 Medicaid dental results under the HealthChoice program and the dental Administrative Services Organization (ASO), DentaQuest, as well as the DAC's recommendations and the resulting implementation efforts of the Department. It also addresses Medicaid-related dental access issues identified in SB 590 as follows: (1) the availability and accessibility of dentists throughout the State that participate in the Maryland Medical Assistance program; (2) the outcomes achieved by MCOs and dental managed care organizations in reaching the utilization targets; and (3) the allocation and use of dental funding. This section of the report further includes the Office of Oral Health's efforts that specifically address increasing access to oral health care.

Implementing Change to Increase Utilization of Dental Services

The DAC's September 11, 2007 recommendations called for establishing a dental home for all Medicaid children. In short, it advocates for connecting eligible children with a dentist to provide comprehensive dental services on a regular basis. To accomplish this goal, the DAC recommended several changes to the Medicaid program. To streamline the Medicaid process for providers and recipients, the DAC recommended a single statewide dental vendor, an ASO. The DAC further recommended increasing dental reimbursement rates to the 50th percentile of the American Dental Association's (ADA) South Atlantic region charges for all dental codes. The DAC's report also includes suggestions to enhance education, outreach, dental public health infrastructure, provider participation, and provider scope of practice.

The Office of Oral Health received a five-year state dental infrastructure grant from the Centers for Disease Control and Prevention (CDC) in August 2008 that includes a requirement to develop a 5-year state Oral Health Care Plan. This plan is currently in development and is expected to be completed by January 2011 in coordination with the MDAC. The Office of Oral Health expects that by 2015 Maryland will distinguish itself as a national leader in access to oral health services. By that time, it is expected that a

[1] The rate of 19.9% is based on enrollment in the same MCO for at least 320 days. According to the HCFA-416 report, the utilization rate for 1997 was 14%. This rate was calculated based on services provided to children with any period of Medicaid eligibility and does not take into account a minimum enrollment period. It also includes children of all ages.

majority of Maryland residents will have a dental home accessible to them, and residents from each jurisdiction will have access to an oral health safety net clinic.

The Department has implemented many of the DAC (now MDAC) recommendations, as shown below:

1. The Department awarded a contract to Doral Dental Services of Maryland (now renamed DentaQuest) to serve as the single statewide dental vendor. The Department worked closely with DentaQuest to transition dental services from the MCOs, and DentaQuest began managing dental services and paying claims July 1, 2009. During the transition, members were notified of the new dental benefits administrator and additional dental providers were recruited to participate in the program. The new Medicaid dental program has been named 'Maryland Healthy Smiles.' The transition to the ASO is now complete, and DentaQuest has attracted almost 200 new providers and has been successful in increasing utilization.
2. The Governor's FY 2009 budget included $7 million in general funds ($14 million total funds) to increase targeted dental rates to the ADA 50th percentile for the South Atlantic region starting in July 2008 (see Attachment 1 for a list of dental codes and rates). This rate increase has attracted many new dental providers to the Maryland Healthy Smiles program. A second round of rate increases continues to be delayed due to budget constraints.
3. To provide for greater access to dental services for young children, beginning July 1, 2009, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical providers (pediatricians, family physicians, and nurse practitioners) may receive Medicaid reimbursement for providing fluoride varnish treatment to children age 9 – 36 months through the Maryland Mouths Matter: Fluoride Varnish and Oral Health Assessment Program for EPSDT Medical Providers. Certified medical providers who successfully complete an Office of Oral Health training program for oral health assessments and fluoride varnish application are eligible for this Medicaid reimbursement. As of June 30, 2010, 553 providers have completed the training program, and 319 of these EPSDT medical providers have enrolled with DentaQuest as fluoride varnish providers which has improved utilization for children aged 0 – 3. While final utilization for FY 2010 is not yet available, over 12,000 fluoride varnish treatments have been provided to children aged 9 – 36 months since the start of this program.
4. The DAC recommended legislation in 2007 to improve and expand the oral health safety net by strengthening the role of dental hygienists. During the 2008 session, the General Assembly unanimously passed legislation that facilitates the role of dental hygienists working for public health programs. The legislation, sponsored by Del. Veronica Turner in the House of Delegates (HB 1280) and by Sen. Thomas M. Middleton in the Senate (SB 818), took effect October 1, 2008. The law now allows dental hygienists who work for public health programs to provide services within their scope of practice; a dentist does not have to be on the premises or see the patient before the dental

hygienist's services are rendered. Dental hygienists working for public health agencies now are able to more efficiently and expeditiously provide services within the scope of their practice in offsite settings (e.g., schools and Head Start centers). As a result of this law change, health department dental programs have begun recruiting and enlisting public health dental hygienists and additional school-based health centers are beginning to employ dental hygienists to provide preventive services.

5. The Governor's FY 2011 budget includes $1.5 million to continue support for new or expanded dental public health services, especially targeting jurisdictions without public health clinics. With this funding, residents in every county in Maryland now have access to a public health safety net dental clinical program that is located in and/or serves their jurisdiction (see Table 3). In 2007, only half of the State's jurisdictions had such programs. Also, the Robert T. Freeman Dental Society Foundation Deamonte Driver Dental Van Project began operations in March 2009 and has been providing care to students from Prince George's County and Montgomery County public schools. As of June 30, 2010, 1,314 children were seen of which 180 needed immediate or urgent care and were referred to neighborhood "Dentists in Action" and other area dental clinics. "Dentists in Action" is a new community dental network developed by the van project in which enlisted local Medicaid dental providers offer complex dental treatment for children unable to be treated directly on the van. (see Part 2 – Oral Health Safety Net Program).

6. General dentists have received training in didactic and clinical pediatric dentistry so that they may competently treat young children. As of June 30, 2010, over 300 general dentists received this training through various courses sponsored by the Office of Oral Health as well as a multi-week course developed and presented by the University of Maryland Dental School. Another course sponsored by the Office of Oral Health and presented by the University of Maryland Dental School conducted in mid-September provided training to 85 public health general dentists and their staff.

7. Based on recommendations from a DAC subcommittee to develop a marketing campaign aimed at the public, the Office of Oral Health – with the support of Maryland Sens. Barbara Mikulski and Ben Cardin – received $1.2 million in federal funding on August 2, 2010 to develop a Statewide Oral Health Literacy Campaign for the public. The purpose of the Oral Health Literacy Campaign is to better inform parents and caregivers of low-income families about the importance of oral health. These groups would then be better able to care for their families' oral health by incorporating sound and evidence-based preventive measures, including appropriate use of fluoride, oral hygiene and dietary practices as well as appropriate dental service utilization. This campaign also aims to enable families to better navigate the oral health care delivery system and to offer certain tools to health care providers to enable them to better communicate important oral health care messages and actions to their patients. The Department has already been partnering with the University of Maryland College Park School of Public

Health on a grant project funded from a private non-profit foundation to develop evidence-based messages for the Oral Health Literacy Campaign.

8. A subcommittee of the MDAC continues to work on a plan to develop a program whereby dental screenings are incorporated with vision and hearing screenings for public school children. The MDAC has had to revise its plans and timeline for this program because of the economic climate in Maryland and is still contemplating whether to submit legislation to establish the program. It has developed a Proof of Concept paper which it hopes will provide direction and guidance for eventual enactment of this program by FY 2012.

For additional information concerning the Oral Health Safety Net Program, please see Part 2 of this report.

Availability and Accessibility of Dentists

HealthChoice and DentaQuest

HealthChoice is the current service delivery system for most children and non-elderly adults enrolled in Medicaid and the Maryland Children's Health Program (MCHP). Dental care was a covered benefit provided by the MCOs until the implementation of the Maryland Healthy Smiles dental ASO on July 1, 2009. This report analyzes the MCO utilization and funding of dental services for January 1, 2009 – June 30, 2009 and DentaQuest utilization and funding for July 1, 2009 – December 31, 2009. HealthChoice MCOs were required to offer comprehensive oral health services including preventive care to children through 20 years of age and to pregnant women.[2] While adult dental services are not a required benefit and are not funded by the Department, all seven HealthChoice MCOs offered basic oral health services to adults during the first half of CY 2009. The dental benefits offered to adults typically included cleanings, fillings, and extractions. Since the ASO implementation, two MCOs have stopped providing this optional service to adults and one MCO no longer covers extractions.

MCOs were required to develop and maintain an adequate network of dentists who could deliver the full scope of oral health services for children and pregnant women. HealthChoice regulations (COMAR 10.09.66.05 and 10.09.66.06) specified the capacity and geographic standards for dental networks. They required that the dentist to enrollee ratio be no higher than 1:2,000 for each MCO. In addition, each MCO ensured that enrollees had access to a dentist within a 30-minute or 10-mile radius for urban areas and a 30-minute or 30-mile radius for rural areas. Through the toll-free HealthChoice Enrollee Action Line, DHMH monitored access issues via enrollee complaints.

As of July 2008, there were approximately 743 dentists enrolled as providers in the HealthChoice program (listed in the HealthChoice provider directories). The number of dentists listed as providers decreased compared to 2007 mainly due to the

[2] Children are only covered up to age 19 under MCHP.

Department's request for MCOs to update their provider directories in January 2008 (Table 1). The 2008 count is a point in time count of providers, and was increased by the end of 2008 due to several provider outreach activities. The overall statewide ratio of dentists (listed in HealthChoice provider directories) to HealthChoice enrollees under age 21 was 1:679 in July 2008, within the required 1:2,000 ratio. After the July 1, 2008 rate increases and the Secretary's challenge to dentists to participate with Medicaid, approximately 65 additional dentists joined the HealthChoice program.

DentaQuest has been actively enrolling new dentists in the Maryland Healthy Smiles program since the July 1, 2009 implementation of the ASO. Providers can now participate with Medicaid through a single point of contact, rather than contracting with seven separate MCOs. DentaQuest handles credentialing, billing, and any other provider issues, which streamlines the process for providers. Through these efforts, DentaQuest has increased the number of participating dental providers and as of June 30, 2010, there are 939 providers enrolled, resulting in a dentist to enrollee ratio of approximately 1:575. DentaQuest is required to have a dentist to enrollee ratio of 1:1,000 after the first year of the program, 1:750 after year two, and 1:500 after year three. As the number of participating providers continues to increase, the Maryland Healthy Smiles program will eventually assign each child to a dental home. The Department has received positive feedback from providers who have worked with DentaQuest.

Table 1: Dentists Participating in HealthChoice and DentaQuest

	Dentists Listed in HealthChoice Provider Directories[2]		**DentaQuest Providers[2]**	
	July 2007	**July 2008**	**August 2009**	**June 30, 2010**
Baltimore Metro	497	401	242	344
Montgomery/ PG Counties	356	278	208	296
S. Maryland	40	28	29	39
W. Maryland	57	43	65	97
E. Shore	50	40	43	53
MD Bordering States	n/a	n/a	62	110
Fluoride Varnish Providers	**n/a**	**n/a**	**225**	**319**
Unduplicated Total[3]	**964**	**743**	**649[4]**	**939**

[1] Baltimore Metro includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Western Maryland includes Allegany, Garrett, Washington, and Frederick Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

[2] Some dentists may not be accepting new referrals and many dentists limit the number of new referrals that they accept. These numbers only reflect the availability of practitioners.

[3] The unduplicated total is different than the total in each geographic region because it is possible for a dentist to have multiple sites. Also, clinics with multiple dentists may only be counted once. Fluoride varnish providers are not included in the total.

[4] The transition between the MCOs and DentaQuest resulted in the loss of several providers at the start of implementation in July 2009.

According to the Maryland State Board of Dental Examiners, as of August 2010, there were a total of 4,120 dentists licensed and actively practicing in Maryland, or about 40 more dental providers than in 2008. The table below shows how many pediatric and general dentists were practicing in the State as of August 2010, and indicates how many dentists are participating with DentaQuest, as of June 30, 2010. In the two far right columns of Table 2, the number of dentists billing includes two "dummy" provider numbers that could be used by MCOs when submitting copies of their claims data to the Department if a dentist did not have a Medicaid provider number. These two provider numbers rendered a significant number of dental services, as multiple dental providers used these two "dummy" numbers. Furthermore, clinics with multiple dentists are only counted once. The total of these two columns, therefore, significantly undercounts the actual number of providers.

Table 2: Active Dentists and Dentists Participating with DentaQuest/HealthChoice

REGION[1]	Total Active Dentists (August 2010)	Active General Dentists	Active Pediatric Dentists	Dentists Enrolled with DentaQuest as of June 2010 (% of Total Active Dentists)**	Dentists who Billed One or More Services in CY 2009 (% of Total Active Dentists)*	Dentists who Billed $10,000+ in CY 2009 (% of Total Active Dentists)*
Baltimore Metro	1,826	1,463	54	344 (18.8%)	362 (19.8%)	201 (11.0%)
Montgomery/ Prince George's	1,663	1,316	52	296 (17.8%)	288 (17.3%)	176 (10.6%)
S. Maryland	136	114	2	39 (28.7%)	35 (25.7%)	20 (14.7%)
W. Maryland	277	215	8	97 (35.0%)	81 (29.2%)	49 (17.7%)
E. Shore	218	172	9	53 (24.3%)	68 (31.2%)	28 (12.8%)
Other				110	59 (N/A)	23 (N/A)
TOTAL	**4,120**	**3,280**	**135**	**939 (22.8%)**	**846 (20.5%)**	**479 (11.6%)**

* These columns include claims submitted with two "dummy" provider numbers which rendered a significant number of dental services, as multiple dental providers used these two "dummy" numbers. Further, clinics with multiple dentists are only counted once. The total of these two columns, therefore, significantly undercounts the actual number of providers.

** The number of providers billing one or more services may be higher than the number currently participating with DentaQuest in some regions because of system differences. The availability of updated provider information in the DentaQuest file is not immediately available to the systems used to run this data.

[1] Baltimore Metro includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Western Maryland includes Allegany, Garrett, Washington, and Frederick Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

In 2008, less than 19% of Maryland licensed active dentists were participating with Medicaid. As of June 30, 2010, almost 23% of Maryland dentists are now enrolled with Medicaid. A total of 846 dentists billed one or more Medicaid services and 479 dentists billed $10,000 or more to the Medicaid program in 2009. This represents 20.5% and 11.6% respectively, of the total active, licensed dentists in the State. The number of dentists billing at least one Medicaid service has steadily increased over the last three

years, from 671 dentists in 2007 to 778 dentists in 2008 to 846 dentists in 2009. The number of dentists billing more than $10,000 to Medicaid increased from 364 in 2007 to 479 in 2008 and remained the same in 2009. Pediatric dentists are rare in the State and continue to account for only 3% of the total number of active dentists in Maryland (Table 2).

Within Maryland, several areas have been designated as Dental Health Professional Shortage Areas (HPSAs). Regions designated as HPSAs are portions of the Eastern Shore, Western Maryland, Southern Maryland and Baltimore City (Attachment 2). Residents living in all regions of the State now have access to low-cost dental services available through community programs sponsored by Federally Qualified Health Centers (FQHCs), local health departments, academia, and other private, non-profit health organizations (e.g., community hospitals). Table 3 provides an overview of available local health department and community providers as of July 2010. It is important to note that these community clinic providers offer varying levels of dental services and not all accept Medicaid. As of July 2010, 15 Maryland jurisdictions are served directly by local health department or school-based clinical dental programs. This includes two new counties (Kent and Queen Anne's) which had been identified in the past as having no dental public health services. Further, the Worcester County Local Health Department is planning on opening its onsite clinical dental program by October 2010. The St. Mary's County Local Health Department does not directly administer a clinical dental program but acts as a conduit for low-income patients to be served by the majority of private dental practitioners in the county. The Howard County Local Health Department subcontracts with an FQHC, Chase Brexton Health Services, for its clinical dental service program. In addition, four jurisdictions on the Eastern Shore without a local health department dental program are served by two FQHCs – Choptank Community Health Systems (Caroline, Talbot and Dorchester) and Three Lower Counties (Somerset). Beginning in FY 2010, Calvert and Cecil Counties now provide clinical dental services to low-income patients through a non-profit community hospital and academic center, respectively. Jurisdictions that are or will be served by both a local health department and other community dental clinical program include: Baltimore City, Anne Arundel, Baltimore, Carroll, Charles, Kent, Montgomery, Prince George's, Queen Anne's, Washington, Wicomico, and Worcester Counties.

Table 3: Community Clinic Dental Providers[1]

County	Local Health Department Clinic	Community Health Centers	Dental School/Other
Allegany	On Site	None	Allegany Health Right (contracts with private dental providers)
Anne Arundel	[3] On Site	Stanton Center	
Baltimore City	[3] On Site	So. Baltimore, Total Health, Chase Brexton, Parkwest, People's Comm., BMS, Healthcare for the Homeless	University of Maryland Dental School
Baltimore County	[2, 3] On Site	Chase Brexton	
Calvert	None	None	Calvert Memorial Hospital
Caroline	None	Choptank (2 sites)	
Carroll	On Site	None	[4]Access Carroll
Cecil	None	None	University of Maryland Dental School
Charles	On Site	Nanjemoy	[4] Health Partners
Dorchester	None	Choptank	
Frederick	On Site	None	
Garrett	On Site	None	
Harford	On Site	None	
Howard	Subcontract - Chase Brexton FQHC	[5] Chase Brexton	
Kent	School-based program in partnership with Queen Anne's County LHD	Served by Choptank	Served by University of Maryland Dental School (Cecil County)
Montgomery	[2,3] On Site	Community Clinics, Inc. (CCI)	
Pr. George's	[3] On Site	Greater Baden	
Queen Anne's	School-based program in partnership with Kent County LHD	Served by Choptank	
Somerset	None	Three Lower Counties	
St. Mary's	Serves as an intermediary between Maryland Medicaid Program and private dental providers	None	Does not directly provide services but is the main entry point for Medicaid patients and makes arrangements with private providers for care.
Talbot	None	Served by Choptank	
Washington	On Site	Walnut Street	
Wicomico	On Site	Served by Three Lower Counties FQHC	
Worcester	In Development – September 2010	Served by Three Lower Counties FQHC	

1 Community clinic providers may also be counted in HealthChoice or DentaQuest provider directories (in Table 1) if they contracted with MCOs or accept Maryland Healthy Smiles.
2 Does not currently treat Medicaid enrollees.
3 Multiple sites.
4 New Maryland Community Health Resources Grant Program.
5 Partnership of Howard County Health Department and Chase Brexton.

HealthChoice and DentaQuest Dental Utilization Rates

Children

Dental care is a mandated health benefit for children through age 20 under EPSDT requirements.[3] Utilization of dental services has been low for a number of years, but has increased significantly in recent years. Prior to implementation of the HealthChoice managed care program in 1997, 14% of all children enrolled in Medicaid for any period of time received at least one dental service. This number was below the national average of 21%.[4] As previously noted, the General Assembly passed SB 590 to establish targets for utilization of dental services by children enrolled in HealthChoice to reach 70% within five years, beginning with 30% in Year 1. For performance measurement and comparison, CY 2000 was established as Year 1 of the five-year Oral Health Care Plan developed by the Department. The Department worked with many stakeholders to assess the Medicaid program's progress in expanding access to dental services for children.

MCO Plan and DentaQuest Performance

In an effort to assess the performance of individual HealthChoice MCOs and now DentaQuest, the Department uses a measure closely modeled on the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) measure for Medicaid children's dental services utilization. The counted number of individuals is based on two criteria: 1) an age range from 4 through 21 years; and 2) enrollment of at least 320 days. The Department modified its age range to reflect 4 through 20 years because the Maryland Medicaid program only requires dental coverage through age 20. Since the inception of the HealthChoice program, the percentage of children receiving dental services increased from 19.9% in 1997 to 59.0% in 2009 (Table 4). As a comparison, the HEDIS 2009 (CY 2008) national average for Medicaid was 44.2%.[5] Through the efforts of the Department, HealthChoice utilization in 1999 was ten percentage points below the national average, and as of 2008, utilization is more than ten percentage points above the national HEDIS average. Attachment 3 shows utilization data by age and region.

[3] Children are only covered up to age 19 under MCHP.
[4] Academy of Pediatrics State Medicaid Report for Federal FY 1996 - Analysis of HCFA National Data for Medicaid Children's Dental Services Utilization.
[5] National Committee for Quality Assurance.

Table 4: Number of Children Receiving Dental Services
Children ages 4-20, Enrolled for at least 320 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service	HEDIS National Medicaid Average**
FY 1997	88,638	17,637	19.9%	
CY 1999	122,756	31,742	25.9%	36.41 %
CY 2000	132,399	38,056	28.7%	40.34 %
CY 2001*	142,988	48,066	33.6%	37.4 %
CY 2002	194,351	67,029	34.5%	39 %
CY 2003	203,826	88,110	43.2%	39.4 %
CY 2004	213,234	93,154	43.7%	42.7 %
CY 2005	227,572	104,188	45.8%	41 %
CY 2006	223,936	103,561	46.2%	42.5 %
CY 2007	216,885	111,791	51.5%	43.5 %
CY 2008	243,076	135,403	55.7%	44.2%
CY 2009	254,811	150,275	59.0%	N/A

*Starting with data for CY 2001, DHMH revised its methodology to include children enrolled in the same MCO for at least 320 days, consistent with HEDIS methodology. Prior to CY 2001, these data included individuals enrolled in any MCO for at least 320 days.
**Mean for the Annual Dental Visit (ADV) measure, *total* age category (ages 2-21 years of age), as of HEDIS 2006. The 2-3 year age cohort was added as of HEDIS 2006.

Beginning in the 2006 dental report, the Department also reported utilization rates of children with any period of enrollment. Utilization rates are lower when analyzed for any period of enrollment because the population in the analysis includes children who: 1) are in the MCO for only a short period of time due to turnover in eligibility or enrollment; and 2) are new to the MCO, and the MCO has not yet had a chance to link the child to care. MCOs have less opportunity to manage the care of these populations. Of the 540,179 children enrolled in HealthChoice for any period of time during CY 2009, 43.8% of these children received one or more dental service, as compared to 36.7% in CY 2008. The utilization rates of children with any period of enrollment have significantly increased over the five year period in all age groups. The large increase in utilization for children age 0 – 3 is likely due to allowing EPSDT physicians to apply fluoride varnish beginning July 1, 2009 (Table 5).

Table 5: Percentage of Children Enrolled in HealthChoice who had at Least One Dental Encounter by Age Group, Enrolled for Any Period					
Age Group	**CY 2005**	**CY 2006**	**CY 2007**	**CY 2008**	**CY 2009**
0-3*	7.8%	7.9%	10.0%	12.3%	18.6%
4-5	37.7%	37.2%	42.4%	47.7%	56.0%
6-9	42.5%	42.3%	47.6%	53.1%	60.7%
10-14	39.4%	39.5%	44.2%	48.8%	56.4%
15-18	32.4%	32.3%	35.8%	39.5%	46.0%
19-20	19.0%	18.4%	20.1%	23.4%	30.1%
Total	**29.6%**	**29.3%**	**32.9%**	**36.7%**	**43.8%**

*Most newborns and infants are not expected to use dental services. As a result, the dental service rate for the 0-3 age group should be interpreted with caution.

Type of Dental Services

In response to the concern that while access to dental care has increased, the level of restorative services or treatment may not be adequate, the Department has examined the type of dental services that children in HealthChoice receive. As indicated above, the findings of the analysis indicate that access to any dental service, including restorative services, has increased from 19.9% in FY 1997 to 59.0% in CY 2009 (Table 4). Access to restorative services increased from 6.6% of all children in FY 1997 to 21.8% in CY 2009 (Table 6). This increase in utilization is due in part to raising the fees for twelve restorative dental procedure codes in 2004 and more recently due to increased outreach efforts.

Table 6: Percentage of Children Receiving Dental Services by Type of Service Children ages 4-20, Enrolled for at least 320 days			
Year	**Diagnostic**	**Preventive**	**Restorative**
FY 1997	19.6%	18.1%	6.6%
CY 2000	27.3%	24.6%	9.3%
CY 2001	31.7%	29.1%	10.8%
CY 2002	31.7%	29.1%	10.3%
CY 2003	40.8%	37.9%	13.6%
CY 2004	41.0%	38.0%	13.8%
CY 2005	42.7%	39.7%	15.8%
CY 2006	43.7%	40.5%	16.4%
CY 2007	48.6%	45.2%	19.3%
CY 2008	53.1%	50.1%	21.3%
CY 2009	55.5%	52.3%	21.8%

As noted above, utilization rates are lower when analyzed for any period of enrollment versus a period of continuous enrollment because the MCO or ASO has had less opportunity to manage the care of these populations. For those children enrolled for any period, 42.7% received a preventive or diagnostic visit in 2009, as compared to 35.5% in 2008 (Table 7). Of those receiving a preventive or diagnostic visit, 33.2%

received a follow-up restorative visit. The CY 2009 rates indicate a steady increase over the previous five years.

Table 7: Preventive/Diagnostic Visits followed by a Restorative Visit by HealthChoice Children Enrolled for Any Period (Age 0-20)

Year	Total Enrollees	Preventive / Diagnostic Visit	Preventive / Diagnostic Visit followed by Restorative Visit
CY 2005	483,304	136,183 (28.2%)	36,001 (26.4%)
CY 2006	491,646	137,826 (28.0%)	36,675 (26.6%)
CY 2007	493,375	155,939 (31.6%)	44,491 (28.5%)
CY 2008	505,339	179,268 (35.5%)	53,294 (29.7%)
CY 2009	540,173	230,442 (42.7%)	76,608 (33.2%)

Although there has been a modest utilization increase in restorative visits since the implementation of the restorative fee increase in 2004, barriers to receiving restorative care remain. Children not receiving needed restorative care may ultimately seek care in an emergency room. In CY 2009, 2,412 children with any period of enrollment visited the emergency room with a dental diagnosis, not including accidents, injury or poison, which is slightly more than in CYs 2005 – 2008, but still less than 1% of the total population (Table 8).

Table 8: Emergency Room Visits with a Dental Diagnosis by HealthChoice Children Enrolled for Any Period (Age 0-20)*

Year	Total Enrollees	Enrollees who had an ER visit with a Dental Diagnosis	Number of Encounters for ER Visits with a Dental Diagnosis
CY 2005	483,304	1,685	1,872
CY 2006	491,646	1,809	2,117
CY 2007	493,375	2,005	2,283
CY 2008	505,339	2,175	2,596
CY 2009	540,179	2,412	2,927

*For this measure, a dental diagnosis is included regardless of whether the diagnosis appeared in the primary or secondary field. Dental services provided in the ER exclude accidents, injury and poison.

Pregnant Women

Prior to the implementation of HealthChoice in 1997, adult dental care was not covered under Medicaid. SB 590 (1998) required that HealthChoice cover dental services for all pregnant women. The percentage of pregnant women 21 and over enrolled for at least 90 days receiving dental services was 28.7% in CY 2009 (Table 9). The percentage of pregnant women 14 and over enrolled for any period receiving a dental

service in 2009 was 26.9%, as compared to only 20.5% in 2008 (Table 10). There is no comparable HEDIS measure for dental services for pregnant women.

Table 9: Percentage of Pregnant Women 21+ Receiving Dental Services Enrolled for at least 90 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 1999*	17,914	2,474	13.8%
CY 2006	26,848	4,224	15.7%
CY 2007	25,643	4,923	19.2%
CY 2008	26,744	6,060	22.7%
CY 2009	30,035	8,620	28.7%

Table 10: Percentage of Pregnant Women 14+ Receiving Dental Services Enrolled for Any Period

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 2006	46,375	6,946	15.0%
CY 2007	45,852	7,889	17.2%
CY 2008	46,180	9,469	20.5%
CY 2009	48,001	12,933	26.9%

In Tables 9 and 10, pregnant women were identified using the following methods: (1) enrollment in Medical Care Program coverage group P02 or P11 in the CY MMIS eligibility files, (2) pregnancy diagnoses codes, (3) kick payments for live births in the CY capitation rate dataset, and (4) payment for an individual in a Sixth Omnibus Budget Reconciliation Act (SOBRA) rate cell for pregnant women. This is a change in methodology from previous reports to include more pregnant women enrolled in traditional Medicaid coverage groups, which was a necessary change due to changes in enrollment after the Parent Expansion (July 2008).
*In 1999, we did not use pregnancy diagnoses to identify pregnant women.

Adults

Apart from those dental services covered for pregnant women, adult dental services are not included in MCO capitation rates and therefore are not required to be covered under HealthChoice. In CY 2008, all seven MCOs provided a limited adult dental benefit and spent approximately $8.86 million for these services. In the second half of CY 2009, two MCOs dropped their adult dental benefit completely, and a third MCO no longer covers extractions. Despite these limitations, the MCOs spent $12.3 million on adult dental services in CY 2009. An analysis shows that 14.4% of adults enrolled for at least 90 days received at least one dental service in CY 2009.

Table 11: Percentage of Non-pregnant Adults 21+ Receiving Dental Services Enrolled for at least 90 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 1999	111,753	16,139	14.4%
CY 2000	114,223	16,986	14.9%
CY 2001	111,694	16,795	15.0%
CY 2002	117,885	16,800	14.3%
CY 2003	116,880	21,288	18.2%
CY 2004	115,441	12,457	10.8%
CY 2005	116,266	11,093	9.5%
CY 2006	114,844	11,747	10.2%
CY 2007	138,212	18,290	13.2%
CY 2008	125,386	23,587	18.8%
CY 2009	177,474	26,063	14.7%

Strategies to Improve Access to Dental Care

The Department monitored the number and percentage of oral health services provided by HealthChoice MCOs on a biannual basis using encounter data. The Department reviewed MCOs' outreach plans and held MCOs accountable for not meeting established dental utilization targets through the use of Value Based Purchasing (VBP) incentives and sanctions. In CY 2008, the VBP target for an MCO to receive an incentive payment was 50% utilization for children, while an MCO with utilization of less than 47% was sanctioned. The Department has taken additional steps to collaborate with MCOs to improve access to dental care. In July 2007, the Department sent a dental transmittal letter to health care providers to clarify policies and to inform providers of the benefits available to children. The letter provided information about covered services and clarifies that the Department requires an oral health assessment by a physician or nurse practitioner as part of periodic well child care.

In 2008, the Department issued a request for proposal (RFP) for an administrative services organization to administer dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management program through fee-for-service Medicaid. The RFP included requirements for provider network development and expansion such as increasingly stringent provider to recipient ratios, established appointment time frames, and travel time and distance limitations. Recipient outreach requirements included welcome calls within ten days of enrollment, assignment to a primary care dentist by the third year of the contract, pre-appointment reminder calls, and missed appointment follow-up calls. By the end of the year, a vendor had been selected and a contract was awarded for an April 1, 2009 effective date.

In July, 2009, DentaQuest began functioning as the Department's administrative services organization for all dental services for children, pregnant women, and Rare and

Expensive Case Management program adults. DentaQuest is responsible for all functions related to the delivery of dental services including provider network development and maintenance, claims processing, utilization review, authorization of services, outreach and education, and complaint resolution. During the first contract year, utilization rates and provider networks have increased. Also in July, 2009, the Department began training and reimbursing primary care providers for the application of fluoride varnish for children up to 3 years of age. By June 30, 2010, over 9,400 children had received fluoride varnish from their primary care provider.

Funding

Dental funding for children and pregnant women has increased in recent years, from approximately $12 million in CY 2000 to $137.6 million for CY 2010 (Attachment 4). This growth in funding reflects increases in the Medical Assistance fee schedule for selected codes that were raised to the 50th percentile of the South Atlantic ADA charges for dental services. It also reflects increased utilization due to improved outreach activities and additional providers participating with the Medicaid program.

In past years, HealthChoice and Medicaid dental funding has been developed as follows:

- For CY 2004, the Department allowed sufficient funding for 40% utilization. The rates were based on actual MCO expenditures for dental services in 2001, with an allowance for assumed utilization growth and inflation. This is consistent with the methodology used for setting rates for other MCO services.

- For CY 2005 and CY 2006, the Department used a similar methodology as for CY 2004. The rates were based on actual expenditures trended forward and accounting for the increased fees for the 12 restorative procedure codes.

- In CY 2005, the MCOs received $33 million in dental capitation payments, but using a fee-for-service reimbursement rate estimate, the MCOs spent approximately $37 million for children and pregnant women, and an additional $2.3 million for adult dental services.

- In CY 2006, the MCOs received $35.1 million in dental capitation payments for children and pregnant women, but reported spending $46.6 million, including $4.28 million on adult dental services.

- In CY 2007, MCOs received $42.5 million in dental capitation payments for children and pregnant women in response to increased utilization in CY 2006. The MCOs reported spending $53.8 million, including $5.36 million on adult dental services.

- In CY 2008, MCOs received $55.4 million in dental capitation payments for children and pregnant women due to increased utilization. The MCOs reported spending $71.4 million, including $8.86 million on adult dental services.

- In CY 2009, MCOs were responsible for providing dental services for children and pregnant women for the first half of the year. Capitation rates for dental services for the first half of CY 2009 totaled $39.6 million. Beginning July 1, 2009, DentaQuest began paying dental claims on a fee-for-service basis. The total dental expenses for the second half of 2009 totaled $43.2 million. An additional $12.3 million was spent by the MCOs for adult dental in CY 2009.

- In CY 2010, the Department estimates total DentaQuest dental expenses to be $137.6 million. The MCOs will continue to incur adult dental expenditures, but will not be reimbursed for these services.

Conclusion

Utilization of dental services by children has increased significantly since the implementation of HealthChoice in 1997 from 19.9% to 59.0% in 2009. In 1999, utilization for children was ten percentage points below the national HEDIS average, and by 2008, utilization has increased to ten percentage points above the national HEDIS average. However, many children still are not receiving needed dental services and additional improvements are needed. The Dental Action Committee addressed barriers to dental care access by making key recommendations to increase reimbursement for Medicaid dental services and to institute a single dental administrative service organization (ASO). The reforms recommended by the Dental Action Committee have been supported and, to a great degree, instituted by the Department to effectively address the barriers to dental care access previously experienced in the State. Dental provider rates were increased in 2008, and the Department is committed to a second round of rate increases once the budget situation improves.

In conjunction with DentaQuest, the Department has reformed and rebranded the Medicaid dental program, which has attracted almost 200 additional participating dentists, who eventually will serve as dental homes for Medicaid enrolled patients. DentaQuest continues outreach to providers, and now that provider networks are more robust, DentaQuest will begin more aggressively outreaching to ensure children are receiving dental care. Beginning July 1, 2009, Medicaid began to allow EPSDT trained providers to apply fluoride varnish treatments to children age 9 – 36 months. This program, adapted from a successful North Carolina program, allows young children with limited access to a dentist to receive dental care. The utilization rate of children age 0 – 3 has already experienced an increase in CY 2009 due in part to this initiative.

The Department continues to work with the Maryland State Dental Association, University of Maryland Dental School, and others on various branding and marketing efforts to promote the new Medicaid dental program to dentists. The Maryland State Dental Association conducted its third “Access to Care Day” in September 2010 as part

of their annual organizational meeting with approximately 150 dentists and staff in attendance. As in past "Access to Care Day" events, representatives from DentaQuest were present at the meeting to enlist new dentists into the program. This day is part of the dental association's efforts to partner with the Department in recruiting new dentists into the program. Free continuing education credits and training in pediatric dentistry are provided to dentists who attend this session. These annual programs have given dentists the opportunity to openly discuss the Maryland Healthy Smiles Program with DentaQuest representatives, Departmental staff, and members of the newly organized Maryland Dental Action Coalition (MDAC). With efforts such as those described in this report, the Department is committed to continuing to improve upon successes, and to work with the MDAC on recommended strategies to make access to dental care and a dental home a reality for all Maryland children.

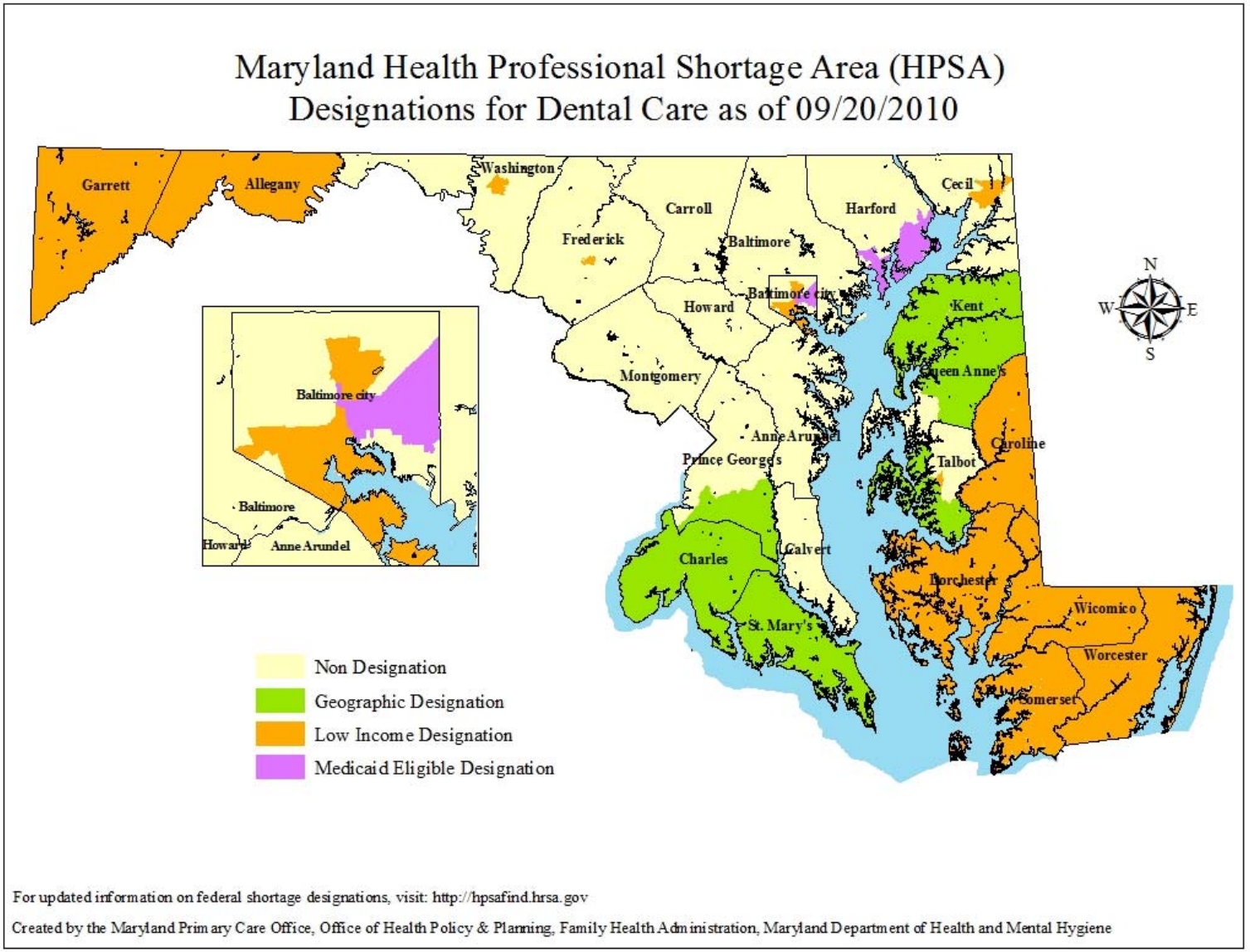
ATTACHMENT 1

Dental Procedures Targeted for Fee Increase in FY 2009

Proc Code	Description	MD (FY08)	DC	PA	VA	MD (FY09)	Benchmark (ADA/ NDAS)
		State Medicaid Fees					
D0120	Periodic Oral Examination	$15.00	$35.00	$20.00	$20.15	$29.08	$35.00
D0140	Oral Evaluation-Limited-Problem Focused	$24.00	$50.00	N/A	$24.83	$43.20	$52.00
D0145	Oral Evaluation, Patient < 3 Years Old	$20.00	$0.00	N/A	$20.15	$40.00	$40.00
D0150	Comprehensive Oral Evaluation	$25.00	$77.50	$20.00	$31.31	$51.50	$62.00
D1110	Prophylaxis Adult 14 years and Over	$36.00	$77.50	$36.00	$47.19	$58.15	$70.00
D1120	Prophylaxis Child Up to Age 14	$24.00	$47.00	$30.00	$33.52	$42.37	$51.00
D1203	Topical Application of Fluoride, child (Exclude Prophylaxis)	$14.00	$29.00	$18.00	$20.79	$21.60	$26.00
D1204	Topical Application of Fluoride, adult (Exclude Prophylaxis)	$14.00	$26.00	N/A	$20.79	$23.26	$28.00
D1206	Topical Fluoride Varnish	$20.00	$0.00	$18.00	$20.79	$24.92	$30.00
D1351	Topical Application of Sealant per Tooth	$9.00	$38.00	$25.00	$32.28	$33.23	$40.00
D7140	Extraction Erupted Tooth or Exposed Root	$42.00	$110.00	$60.00	$69.00	$103.01	$124.00
D9248	Non-Intravenous Conscious Sedation	$0.00	$0.00	$184.00	$110.00	$186.91	$225.00

On average, fees for the 12 target procedures increased by about 94 percent in FY 2009. The last column shows the median (ADA's 50th percentile) of fees charged by dentists in 2007 in the South Atlantic region. The median (50th percentile) of charges in South Atlantic region means that 50 percent of dentists in this region charge this amount or less. It is important to note, however, that the South Atlantic median is based on the charges by dentists for the services performed, which do not equate to the payments received as reimbursement from insurance companies, public agencies, or private pay patients.

ATTACHMENT 2



ATTACHMENT 3

Dental Utilization Rates, CY 2000 -CY 2009
Enrollment ≥ 320 days in an MCO, age 4-20

Criteria	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009
Age										
4-5	29.3%	33.3%	33.7%	42.8%	43.6%	45.9%	46.2%	52.5%	57.0%	60.9%
6-9	31.6%	37.2%	38.2%	48.0%	48.7%	51.1%	51.6%	57.6%	62.5%	65.6%
10-14	29.2%	34.1%	35.5%	44.0%	44.8%	46.9%	47.5%	53.2%	57.2%	60.7%
15-18	24.7%	29.4%	29.9%	38.0%	37.6%	39.7%	40.2%	44.3%	47.6%	51.2%
19-20	17.8%	19.7%	20.8%	26.8%	26.8%	27.7%	26.9%	28.4%	33.2%	37.5%
All 4-20	**28.7%**	**33.6%**	**34.5%**	**43.2%**	**43.7%**	**45.8%**	**46.2%**	**51.5%**	**55.7%**	**59.0%**
Region*										
Baltimore City	25.1%	27.4%	27.8%	35.6%	35.8%	38.1%	38.8%	45.9%	51.8%	56.6%
Baltimore Suburbs	32.5%	35.4%	37.7%	46.1%	46.1%	47.0%	47.1%	51.4%	54.8%	56.7%
Washington Suburbs	30.4%	35.9%	39.6%	47.8%	46.4%	50.2%	49.5%	54.8%	58.8%	62.1%
Western Maryland	38.2%	46.0%	42.85	51.0%	56.1%	56.4%	55.7%	59.3%	61.9%	64.1%
Southern Maryland	26.5%	29.3%	31.8%	39.6%	39.5%	40.0%	43.3%	46.7%	52.2%	56.1%
Eastern Shore	26.4%	32.6%	31.3%	44.4%	48.2%	49.2%	51.8%	55.7%	55.7%	59.4%

*Baltimore Suburbs includes Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Washington Suburbs includes Prince George's and Montgomery Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Western Maryland includes Allegany, Garrett, Washington, and Frederick Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

ATTACHMENT 4

MCO Funding and Expenditures for Dental Services, FY 1997 – CY 2009 Utilization of Dental Services in HealthChoice, FY 1997-CY 2009				
Year	**Amount Paid in MCO Capitation Rates for Dental**	**Amounts Spent by MCOs for Dental (Source: HFMR) (Includes adult dental)**	**Utilization Rate for General Access (Children 4-20 Years with 320 Days of Enrollment)**	**Utilization Rate for Restorative (Children 4-20 Years with 320 Days of Enrollment)**
FY 1997	N/A	$2.7 M*	19.9%	6.6%
CY 2000	$12.3 M (est.)	$17 M (est.)	28.7%	9.3%
CY 2001	$27.1 M	$23.6 M	33.6%	10.8%
CY 2002	$40.3 M	$28.9 M	34.5%	10.3%
CY 2003	$33 M	$32.5 M	43.2%	13.6%
CY 2004	$28 M	$36.7 M	43.7%	13.8%
CY 2005	$33 M	$42.0 M	45.8%	15.8%
CY 2006	$35.1 M	$46.6 M	46.2%	16.4%
CY 2007	$42.5 M	$53.8 M	51.5%	19.3%
CY 2008	$55.4 M	$71.4 M	55.7%	21.3%
CY 2009**	$82.8 M	$39.3 M	59.0%	21.8%
CY 2010***	$137.6 M	Not available	Not available	Not available

* In FY 1997, the Department spent $2.7 M on dental services under its fee-for-service program.
****** In CY 2009, MCO capitation rates included dental services from January 1, 2009 – June 30, 2009, totaling $39.6 million. Under the new Maryland Healthy Smiles program, dental expenses totaled $43.2 million for the period July 1, 2009 – December 31, 2009.
*** Beginning in FY 2010, Maryland Healthy Smiles is not paid a capitation rate, but is reimbursed FFS and paid an administrative fee.

Part 2. Oral Health Safety Net Program
As Required by SB 181/HB 30 from the 2007 Legislative Session

Background/History

Lack of access to oral health services is both serious and complex in scope, requiring multiple strategies. To remedy this situation, HB 30/SB 181 (Ch. 528/527 of the Acts of 2007) established the Oral Health Safety Net Program with the Department's Office of Oral Health. The purpose of the Program is to: (1) support collaborative and innovative ways to expand the oral health capacity for low-income, disabled, and Medicaid populations by awarding community-based oral health grants to local health departments, FQHCs, and entities providing dental services within State facilities; (2) contract with a licensed dentist to provide public health expertise for the State; and (3) provide continuing education courses for providers that offer oral health treatment to underserved populations.

Further, SB 63 was introduced as Departmental legislation during the 2009 legislative session and passed unanimously (Ch. 352 of the Acts of 2009). This legislation repealed the September 30, 2011 sunset provision for the Oral Health Safety Net Program, thereby providing the Program with a permanent statutory framework.

Current Status

Since creation of the Oral Health Safety Net Program, the Office of Oral Health has embarked on enhancing the oral health safety net through new and creative strategies to increase access to oral health services for low-income, uninsured individuals, and Medicaid recipients. These strategies include providing new or expanded dental services in publicly-funded federal, State or local programs, developing public and private partnerships, expanding school-linked dental initiatives that include dental mobile vans, transportation innovations, case management, and leasing and contractual agreements with private dental offices, among other strategies. The Office of Oral Health is administered by a licensed dentist who provides dental expertise to the Office of Oral Health on oral health issues such as protocol evaluation, provider recruitment, and continuing education courses for providers that offer oral health treatment to underserved populations.

A. Carrying out Major Oral Health Recommendations of DAC

As discussed in Part 1 of this report, the Department convened the DAC to develop strategies to expand Maryland's oral health services to low-income individuals. A major DAC recommendation was to maintain and enhance the dental public health infrastructure through the Department's Office of Oral Health by ensuring that residents in each local jurisdiction have access to a local health department dental clinic and/or other community oral health safety net clinic. Such an effort would require the provision of funding to fulfill the requirements outlined in the Oral Health Safety Net statute.

In light of the DAC's recommendation to the Secretary of the Department that the dental public health infrastructure needed strengthening, the Governor's FY 2010 budget for the Department's Family Health Administration included $1.5 million to increase clinical dental treatment and preventive services for low-income Maryland children, especially those who are Medicaid-eligible or uninsured, and to support many of the requirements listed in the 2007 Oral Health Safety Net legislation. While these oral health safety net grant funds are being used Statewide, grants are also being used to provide new dental services in jurisdictions previously identified as not being served by a public health dental clinical program (Worcester, Kent, Queen Anne's, St. Mary's, and Calvert Counties).

One of the current Office of Oral Health operational grants projects, a new Worcester County Health Department dental clinic, was first initiated as the result of a capital infrastructure grant program issued in 2008 in partnership with the Office of Capital Planning, Budgeting and Engineering Services to acquire, design, construct, renovate, convert, and equip a dental program facility. In FY 2010, the Office of Oral Health continued to provide operational funds for two other local health department clinical dental programs in Harford and Charles Counties that it had provided capital infrastructure funding support in the past.

In addition to these local health department projects, FQHC capital infrastructure projects also have been funded by the Office of Capital Planning, Budgeting and Engineering Services as well as by the Maryland Community Health Resources Commission and the federal Health Resources and Services Administration (HRSA). High-need dental public health geographic areas on Maryland's Eastern Shore and in southern Maryland have greatly benefitted from these grant programs. See Table 3 for a full listing of state public health dental programs.

The Office of Oral Health in FY 2010 also continued to fund new and established dental programs to address immediate service needs and to increase service capacity of dental practitioners. These grants have helped to provide continued support for: 1) new clinical programs funded since 2009; 2) established clinical programs to expand oral health services; and 3) school-based oral health services.

B. Addressing Immediate Service Needs

Support for New Clinical Programs Funded Since 2009: The following three projects, selected through a competitive request for proposals, currently or will provide and/or facilitate comprehensive clinical dental services for the public and establish dental homes in communities to ensure the consistent availability of dental services in four counties, which have no dental public health infrastructure. The three-year programs address the unique needs of local populations and provide evidence-based and appropriate educational, diagnostic, preventive, restorative and emergency care.

- Calvert County: Since its inception in September 2009, Calvert Memorial Hospital's project has provided direct services to Medicaid and other low-income children in Calvert County. This project has recruited two dental teams consisting of a dentist, dental hygienist, and dental assistant who have provided oral health services including preventive, restorative, and basic oral surgeries. These teams have performed these dental care services in two local private dental offices through prior arrangements with the office dentist owners for easy access to individuals who live in the respective communities.
- Kent/Queen Anne's Counties: Having begun operations in Fall 2009, the Kent and Queen Anne's County Local Health Departments' project has endeavored to increase access to comprehensive oral health services and enhance dental capacity for low-income children. The project hired a dentist to oversee local mobile dental teams and establish transportation to regional dental homes through the purchase and operation of a wheelchair-accessible van. Patients requiring intensive oral health treatment have been linked with community dentists or dental programs to ensure dental homes.
- Worcester County: Originally scheduled to open in April 2010, this project had to delay its opening to October 2010 because of capital infrastructure construction delays. Once it opens, the Worcester County Local Health Department program will focus on creating quality, comprehensive, and sustainable oral health education, prevention, and treatment services for Medicaid and low-income, uninsured children in Worcester County. The project will enhance regional efforts for screening and primary prevention in the community, including at schools and Head Start programs. Project support will be needed for continued development of the operational infrastructure necessary to run the clinic.

Note: While St. Mary's County was initially identified as a jurisdiction in need of dental public health clinical services, a unique program has been administered at the St. Mary's County Local Health Department for many years whereby the health department acts as an intermediary between Medicaid and local dental providers. This arrangement has led to their enlisting the majority of dentists practicing in this jurisdiction to participate in Medicaid and in serving as an entry point to these dentists for Medicaid patients. Due to the long-term effectiveness of this program, it was determined that support for this program of the type given to the other "in-need" counties was not needed.

Support to Established Clinical Dental Programs to Expand Oral Health Services: The following counties either initiated or expanded education, screening, and clinical oral services (prevention and treatment) to improve access to oral health care:

- Baltimore City: Helping Up Mission (HUM), in partnership with the University of Maryland Dental School, provides dental services to HUM homeless residents, to increase their potential for employment.
- Caroline, Dorchester, and Talbot County: Choptank Community Health Systems, Inc. funds the salary of a dentist to provide services in a hospital operating room at Dorchester General Hospital for children with high dental treatment needs.

- Carroll County: Carroll County Local Health Department funds a dentist to provide support for pediatric dental services for Medicaid and other low-income Carroll County children.
- Charles County: Charles County Local Health Department initiated provision of adult dental services for low-income Charles County adults and seniors by supporting a dentist.
- Howard County: Howard County Local Health Department initiated provision of pediatric dental services for Medicaid and other low-income Howard County children by supporting a dentist at Chase Brexton Health Services, an FQHC which has been contracted to provide the care.
- Prince George's County: Prince George's County Local Health Department initiated provision of pediatric dental services for Medicaid and other low-income Prince George's County children by supporting a dentist.
- Worcester County: Worcester County Local Health Department, in conjunction with funding for addressing immediate service needs, will provide support for preventive dental services for Medicaid and other low-income Worcester County children through an expansion of the fluoride varnish program, education of medical providers about fluoride varnish, and provision of oral health services for children.

Continued Support for New and Established School-based Oral Health Services

New and established school-based funding initiatives from the Office of Oral Health are ongoing, including a school dental sealant demonstration project that was completed in Spring 2010 and continued support for the Deamonte Driver Dental Van Project which began operation in March 2009. School based sites provide a critically needed venue to provide children with preventive oral health services, education, oral screening, and access to a dental home. The Office of Oral Health is supporting the following four school-based oral health models:

- Deamonte Driver Mobile Dental Van Project: As previously noted, the Prince George's County Local Health Department partnered with the Robert T. Freeman Dental Society Foundation to deliver school-based oral health care services and provided a dental home in Prince George's County and surrounding areas where there are no available dental services, using a mobile dental van. In addition, this project has enrolled new dental providers in the community who have agreed to become Medicaid dental providers and provide complex dental treatment for children unable to be treated directly on the van. The dental van, called the *Deamonte Driver Dental Van Project*, is providing diagnostic, preventive, and simple restorative dental services to low-income students in one Montgomery County School (Foundation School) and in eight schools in Prince George's County including the Foundation School where Deamonte Driver, the 12-year old Prince George's County child who died from a dental infection, attended school. As of June 30, 2010 during the 2009-2010 school year, 1,314 children were seen of which 180 needed immediate or urgent care and were referred to neighborhood "Dentists in

Action" and other area dental clinics. This program also has helped recruit and enroll 291 new dentists into Maryland Medicaid to provide treatment for children referred from the van project.

- School-based Dental Sealant Demonstration Project: The Maryland Department of Health and Mental Hygiene's Office of Oral Health received a grant award from the Centers for Disease control and Prevention (CDC) that was entitled *State-Based Oral Disease Prevention Program*. The grant was built upon the existing efforts of the Office of Oral Health to plan, implement and evaluate population-based oral disease prevention and promotion programs. As part of this grant, the Office of Oral Health developed a school-based dental sealant demonstration project which was designed to demonstrate the logistics and cost-effectiveness of school-based dental sealant services. The Office of Oral Health partnered in this effort with the University of Maryland Dental School, which had expertise and experience in statewide dental assessment, surveillance and prevention activities. The statewide demonstration program was conducted at ten elementary schools that were selected according to sampling needs. Dental screenings and sealants, when indicated, were provided to third graders in public school elementary schools from 2009 to 2010. The dental sealant demonstration project will contribute to future Office of Oral Health policies and programs supporting statewide oral disease prevention and community-based public health prevention services for prioritized populations.

- School-based Dental Prevention Services: Grants were awarded to Baltimore City, Baltimore County, Caroline, Cecil, Garrett, Somerset, and St. Mary's Counties for expansion of critically needed preventive dental sealant programs and fluoride application programs. Programs target children in Title I schools (i.e., schools that typically have 40% or more of its students that come from low-income families) to provide preventive dental sealant and fluoride application services to prevent the onset of dental decay in these high-risk, low-income students.

- School-Based Oral Health Access Programs: Local health departments in Kent and Queen Anne's counties have developed school-based dental access points and assessment/prevention services. The project includes school-wide oral health education to Medicaid-enrolled and uninsured students on location at 11 schools in Kent and Queen Anne's Counties using a mobile dental team comprised of a dental hygienist and dental assistant. Selected patients are receiving an oral health assessment, cleaning, and sealant treatment. Patients with further dental needs are being linked to an existing dental home such as the University of Maryland Dental School clinic in Perryville, MD (Cecil County) or the Choptank Community Health Systems, Inc. clinical program in Goldsboro, MD (Caroline County), with case management provided to coordinate care.

C. Expanding the Oral Health Infrastructure through Other Programs

Maryland Community Health Resources Commission Dental Grant Awards

The Maryland Community Health Resources Commission (MCHRC) continues its commitment to creating new and expanding existing access to dental care for low-income, under- and uninsured Maryland residents. Since March 2008, the Commission has awarded 17 dental services grants totaling $4.4M including three new dental grants in 2010.

The established MCHRC dental grant projects (14), which were awarded to local health departments, FQHCs and private, non-profit foundations and hospitals throughout the State, have collectively served approximately 27,556 low-income children and adults resulting in 58,750 visits.

The three new FY 11 MCHRC dental grants are projected to serve (based on data reported by the grantees) a total of 6,800 Marylanders. These three FY 11 MCHRC dental grants were awarded to:

1. **Choptank Community Health System,** an FQHC centrally located in Caroline County, was awarded a two-year grant ($270,000) to provide access to dental services in nearby Kent County, a Medically Underserved Area (MUA). The program will support a dental partnership with the Chester Hospital and will support Choptank's efforts to secure additional federal funding to support the establishment of a dental center in Kent County. Choptank has used prior MCHRC grant funds to leverage additional federal resources, and the MCHRC will be working with the Department to facilitate these efforts.

2. **Health Partners,** a non-profit 501(c)(3) charitable organization in Charles County, was awarded a two-year grant ($120,000) to expand its dental capacity at its free clinic (which is currently staffed by dental volunteers) and expand its existing school-based dental program. Health Partners has indicated that the MCHRC dental grant will enable the organization to double its dental capacity, will enable Health Partners to hire a part-time dental hygienist, and will enable its volunteer dentists to focus on restorative dental care at the facility.

3. **Access Carroll,** a non-profit organization in Carroll County, was awarded a two-year grant ($300,000) to help support the staffing needs of a new dental facility. Access Carroll will use MCHRC funds to help cover the salaries of the dental staff hired for the facilities, and is currently pursuing capital and other operating support for the new facility.

Pediatric Dental Fellows

The Pediatric Dental Fellows Program has placed trained dentists into the community (local health departments and FQHCs/community health centers) to provide comprehensive oral health services to Medicaid recipients. These dental fellows are specially trained to provide care to children under five years of age. Some of the dental fellows also provided operating room care. Ongoing recruitment difficulties, however, continues to reduce if not threatens to eliminate the number of pediatric dental fellows in the future. In FY 2010, there was one dental fellow practicing in Baltimore City. However, five dental fellows who have successfully completed the program continue to provide dental care services to Medicaid patients in the locales where they were originally assigned – in this case, in Baltimore City and Carroll, Charles, Frederick and Washington counties.

Eastern Shore Oral Health Outreach Program/Lower Eastern Shore Dental Education Program

These programs are an outgrowth of the *Oral Health Demonstration Project: Maryland State Children's Health Insurance Program* conducted by the University of Maryland, Baltimore College of Dental Surgery from January 1999 through June 2001 in two regions in Maryland. The Eastern Shore Oral Health Outreach Program (ESOHOP) and the Lower Eastern Shore Dental Education Program (LESDEP) expand the success of the earlier demonstration project to all Maryland Eastern Shore counties. One of the goals of ESOHOP and LESDEP is to provide case management services, education, Head Start oral health screenings, and fluoride rinse programs for children on the Eastern Shore.

Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP)

The purpose of the MDC-LARP is to increase access to oral health care services by increasing the number of dentists who provide services for Medicaid recipients. In CY 2009, a total of 13 dentists participated in the program; three of these dentists completed their three-year service obligation in December 2009. The service obligation requires that the dentists must participate in MDC-LARP for the full three years and during that period 30% of their base patient population must be Medicaid patients. In January 2010, five new MDC-LARP dentists started the program and will continue through December 2012. During 2009, MDC-LARP dentists treated 13,017 non-duplicated patients and had 32,542 dental visits by Medicaid recipients. Since the inception of the program in 2001, MDC-LARP dentists have seen 54,717 non-duplicated patients through 136,792 patient visits.

Part 3. Oral Cancer Initiative
As Required by SB 791 and HB 1184 from the 2000 Legislative Session

SB 791/HB1184 (Ch. 307/308) were enacted during the 2000 legislative session established the Department's Oral Cancer Initiative (Health – General Article, §§18-801—802, Annotated Code of Maryland). This statute requires the Department to develop and implement programs to train health care providers on screening and referring patients with oral cancer and to provide education on oral cancer prevention for high-risk, underserved populations. This legislation required that the Office of Oral Health develop activities and strategies to prevent and detect oral cancer in the State, with a specific emphasis on targeting the needs of high-risk, underserved populations. The major components of this initiative have encompassed: 1) oral cancer education for the public; 2) education and training for dental and non-dental health care providers; 3) screening and referral, if needed; and 4) conducting an evaluation of the program.

The Oral Cancer Mortality Prevention Initiative (the Initiative) directed by the Office of Oral Health, enables counties to provide an education and awareness campaign to the public and to address the oral cancer screening training needs among health care providers. Since funds were made available for the Initiative in 2000, 15,254 people have been screened for oral cancer, 1,889 individuals have been referred to smoking cessation services, and 3,671 health care providers have received oral cancer prevention and early detection education through Office of Oral Health grants to local health departments throughout Maryland.

Additional Office of Oral Health efforts resulting from the Initiative include the development and distribution of a toolkit to assist local jurisdictions in promoting and facilitating oral cancer prevention activities; the creation of educational materials for low-literacy populations, and the annual observance of Oral Cancer Awareness Week in Maryland.

During this same time period, the Maryland General Assembly created the Cigarette Restitution Fund Program (CRFP) (2000), providing funds for cancer prevention, education, screening and treatment for the seven targeted cancers, which includes oral cancer. Some local jurisdictions have opted to provide oral cancer screening and/or education to residents. To date, 5,535 individuals have been screened for oral cancer, and 6,596 health care providers have received oral cancer prevention and early detection education through CRFP grants. One jurisdiction, Garrett County, continues to use CRFP funding to provide oral cancer activities. In cooperation with the Office of Oral Health, the CRFP develops and maintains the Oral Cancer Minimal Clinical Elements for screening, diagnosis, treatment, follow up, and care coordination to provide guidance for public health programs that screen for oral cancer. In addition, CRFP cancer research funds provided to Johns Hopkins University and the University of Maryland have been used to conduct oral cancer research.

As a result of these cumulative efforts, thousands of Maryland residents have been screened for oral cancer and considerably more, including dental and medical care

practitioners, have received oral cancer prevention messages, information and strategies. Still many others have been referred to smoking cessation programs. Plans to evaluate the success of these programs are scheduled for the future and include upcoming surveys of the public.

Background/History

Maryland has significantly decreased its mortality rate for oral cancer. According to the CDC in their most recent reporting period (2001-2005), Maryland ranks 25th among all states compared to 8th as reported for 1997-2001, and now has a slightly lower rate than the U.S. average. Contributing to this improved oral cancer mortality rate has been the annual average decline in the oral cancer mortality rate for African-American males since 2000, which is now lower than the U.S. average. Oral cancer mortality has also declined for white women.

The annual age-adjusted incidence rate for oral cancers remains significantly higher in Maryland than the national average having increased slightly from 1999-2003 because of a 3.2% annual increase in rates among white men. (Source: SEER (Surveillance Epidemiological End Results), National Cancer Institute). However, a slight decrease in oral cancer incidence was seen over this same period for African-American men and women. Over 47% of oral cancer cases were diagnosed at a regional rather than local stage (meaning after the cancer had spread to adjacent areas and tissues, possibly including lymph nodes), which contributes to a low survival rate since oral cancer has a far better prognosis when found locally and early.

Progress in Maryland residents receiving an annual oral cancer examination has been continuously made since the initial survey in 1996. In the 2008 Maryland Cancer Survey, 40% of Marylanders age 40 and over reported that they had received an oral cancer examination in the past year and 50% of adults ages 40 and over reported that they received an oral cancer examination at least once in their lifetime. Despite this progress, there remains considerable room for improvement with respect to the proportion of Marylanders who receive oral cancer examinations. Only 73% of Marylanders ages 40 and over reported that they had a dental visit of any type in the past year. Additional progress in this area is especially needed for African-Americans in Maryland because only 23% of those ages 40 and over reported having an oral cancer examination in the past year. Nevertheless, these oral cancer examination rates surpass the goal of Healthy People 2010 target of 20%.

Current Status

In July 2009, the Department awarded grant money to local health departments to implement oral cancer prevention initiatives. County initiatives include providing oral cancer education and oral cancer screenings for the public and education and training of health care providers on the proper way to conduct an oral cancer exam.

In FY 2010, 60 health care providers received education about oral cancer exams and tobacco cessation counseling for patients. Community-based education programs reached approximately 860 individuals with 65 individuals referred to smoking-cessation programs.

Approximately 604 individuals were screened for oral cancer. Of the individuals screened, 12 had suspicious lesions and four were referred to a surgeon for biopsy. Three cases of oral cancer were detected and these individuals were provided case management to ensure they received appropriate treatment. More than 230 of screened adults were referred to local tobacco cessation programs.

The 10th annual Maryland Oral Cancer Awareness Week (OCAW) was held April 12-18, 2010. The Office of Oral Health provided updated information to county coordinators, including prevention materials, scripts for public service announcements, and articles for local newspapers. During this week, Office of Oral Health had a display in the lobby of 201 W. Preston St., where the Office shared information on oral cancer and how to quit smoking. The Office of Oral Health continues to partner with the Quitline on all events related to oral cancer and tobacco use. Free incentives were distributed to promote the programs.

The Office of Oral Health was a sponsor for the Baltimore Oral Cancer Walk at Druid Park in Baltimore on April 24, 2010. As a sponsor, the Office of Oral Health had a display board at the event and distributed oral cancer brochures to participants. Chapstick, oral cancer awareness ribbons, and Office of Oral Health pens were also distributed. Information about the walk can be found at: http://www.baltimoreoralcancerwalk.com.

This year, OCAW packets were sent to every Local Health Department Tobacco Prevention Coordinator, Cancer Prevention Coordinator and Oral Health Program Coordinator that included extra health education materials. Further, dentists in the Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP) also received the OCAW packet. Items contained in the OCAW packets included: a) three color posters – 12" x 15"; b) 25 brochures from the National Institute of Dental and Craniofacial Research (NIDCR), entitled 'Detecting Oral Cancer – A Guide for Health Care Professionals' (opens up to a large poster showing how to conduct an oral cancer exam and what suspicious oral lesions look like); c) 25 brochures also from NIDCR, entitled 'Are You at Risk for Oral Cancer?' and 'What African-American Men Need to Know;' d) 50 brochures of the new Office of Oral Health oral cancer brochure; e) 50 brochures on the Maryland Tobacco Quitline; and f) additional oral health-related items such as a press release, two radio PSA scripts, a proclamation, two editorials, and a listing of Internet resources.

Other activities during OCAW included the Office of Oral Health and the Maryland Tobacco Quitline partnering to support the link between cessation programs and the reduction of oral cancer. This partnership began with OCAW and remains strong

over time. Brochures for the Office of Oral Health and the Maryland Tobacco Quitline are distributed together.

Conclusion

The Office of Oral Health will continue local health department funding to implement the oral cancer prevention program. Furthermore, the Office will work with local health departments to identify model programs and best practices. The 11th annual Maryland Oral Cancer Awareness week will be held May 8-14, 2011.

Looking Forward into the Future

Recent efforts by the Department and its partners resulted in Maryland becoming one of only six states in the country to receive an "A" grade from the Pew Charitable Trust in its report "The Cost of Delay: State Dental Policies Fail One in Five Children." In addition to Medicaid's many efforts to successfully expand Maryland's oral health capacity for low-income and vulnerable populations, the work outlined in this report continues to be a priority for the Office of Oral Health. Following the recommendations of the DAC and working with dedicated State partners, the Office envisions continued growth and support of the Oral Health Safety Net Program, the various projects which have stemmed from it and the Oral Cancer Initiative. Expansion of service providers, education and outreach, as well as funding support to Maryland's oral health programs will be continually addressed.