DENTAL ACTION COMMITTEE

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September 11, 2007

John M. Colmers, Secretary
Department of Health and Mental Hygiene
201 W. Preston St., Suite 500
Baltimore, MD 21201

Dear Secretary Colmers:

In response to your request in May, the Dental Action Committee was formed and charged with making recommendations to you on increasing access to dental care for underserved children in Maryland. In fulfilling our charge, please find the enclosed recommendations for your consideration entitled "Access to Dental Services for Medicaid Children in Maryland: Report of the Dental Action Committee."

As oral health advocates, we are honored to have had the opportunity to work with an exceptionally caring, and passionate group of professionals enabling us to propose improvements to our State's oral health care delivery system. We also are grateful for your efforts in successfully securing a Dentist position for the Office of Oral Health; we understand that recruitment is underway for this critically needed individual.

We strongly believe that following the enclosed Dental Action Committee recommendations will result in Maryland becoming a model for the entire country in increasing access to oral health for all children, and ensuring that every child in Maryland, regardless of race, ethnicity or economic status, will have a dental home. Once you have received and have had the opportunity to review the Dental Action Committee Report, we would like to request the opportunity to schedule a meeting with you in October to discuss the Dental Action Committee report, and subsequent steps necessary to achieve our shared goals.

On behalf of the Dental Action Committee, we would like to thank you for the opportunity to address oral health access issues confronting Maryland and making it possible for our children to achieve overall health.

Sincerely,

Jane Casper

Jane Casper, RDH, MA, Chair
Dental Action Committee

Harold S. Goodman

Harold S. Goodman, DMD, MPH, Vice-Chair
Dental Action Committee

"A dental home for all Maryland children"

Access to Dental Services for Medicaid Children in Maryland

Report of the
Dental Action Committee

For John Colmers, Secretary
Department of Health and Mental Hygiene

September 11, 2007

Jane Casper, RDH, MA, Chair
Harold S. Goodman, DMD, MPH, Vice Chair

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EXECUTIVE SUMMARY

The **Dental Action Committee** was formed by Department of Health and Mental Hygiene Secretary, John Colmers, in June 2007 in response to continuing concerns regarding access to oral health care services. Awareness of this chronic access issue was heightened when a Prince George's County child, who had been enrolled in Medicaid, died from a dental infection which spread to his brain. The Dental Action Committee (hereafter "DAC" or "Committee") was charged with developing a series of recommendations in the following priority areas: (1) Medicaid reimbursements and alternate models; (2) public health strategies; (3) oral health education and outreach to parents and caregivers; and (4) provider participation, capacity, and scope of practice. After a careful review of data and best practices, the DAC developed seven principle recommendations for the Secretary to act upon. These seven principle recommendations are coupled with a more detailed list of recommendations for the Secretary's consideration in Appendix A. Additionally, the DAC recognized that significant racial and ethnic disparities exist in the receipt of oral health services to children. The well-being of Maryland's children requires that any comprehensive plan to increase access to oral health services address these disparities. It is the intent of these recommendations to establish Maryland as a national model of oral health care for low-income children.

Vision

Establish a dental home for all Medicaid children in Maryland where comprehensive dental services are available on a regular basis.

Main Recommendation Points

The Dental Action Committee recommends the following seven (7) points for immediate action by the Department of Health and Mental Hygiene:

FIRST: Initiate a statewide single vendor dental Administrative Services Only (ASO) provider for Maryland.

SECOND: Increase dental reimbursement rates to the 50th percentile of the American Dental Association's South Atlantic region charges, indexed to inflation, for all dental codes.

THIRD: Maintain and enhance the dental public health infrastructure through the Office of Oral Health by ensuring that each local jurisdiction has a local health department dental clinic and a community oral health safety net clinic and by providing funding to fulfill the requirements outlined in the Oral Health Safety Net legislation (SB 181/HB 30 2007).

FOURTH: Establish a public health level dental hygienist to provide screenings, prophylaxis, fluoride varnish, sealants, and x-rays in public health settings.

FIFTH: Develop a unified and culturally and linguistically appropriate oral health message for use throughout the state to educate parents and caregivers of young children about oral health and the prevention of oral disease.

SIXTH: Incorporate dental screenings with vision and hearing screenings for public school children or require dental exams prior to school entry.

SEVENTH: Provide training to dental and medical providers to provide oral health risk assessments, educate parents/caregivers about oral health, and to assist families in establishing a dental home for all children.

PURPOSE STATEMENT: DENTAL ACTION COMMITTEE

Background

It is unfathomable and unacceptable that a child died in Maryland, the wealthiest state in the nation, as a result of an infection originating from dental decay. The first U.S Surgeon General's Report on Oral Health in America stated that "oral health and general health should not be interpreted as separate entities." All too common thinking that oral health is distinct from overall health has led to decades of inaction on oral health issues in this state. Dental decay is the most prevalent chronic childhood disease in the United States, but, unlike many childhood diseases, dental disease is completely preventable.

Sadly, the most vulnerable members of society, our poor and minority children, are the most at risk. Secretary of Health and Human Services Secretary, Donna Shalala, remarked that "inequities and disparities [exist] that affect those least able to muster the resources to achieve optimal oral health." Poor children are among the last ones to see a dentist, the last ones to have preventive dental care and the last ones to have necessary restorative treatment. As a result of their dental status, these children are in pain, are malnourished, suffer from poor self-esteem, miss inordinate amounts of school time, and as a result have a reduced capacity to learn and succeed academically.

Ten years ago, Maryland had the dubious distinction of being among the worst in the nation with regard to access to Medicaid oral health care services. Having been aware for many years of this difficulty concerning access, Maryland was confident that the situation for low-income children would improve under Maryland's Medicaid managed care system, HealthChoice, which was implemented in 1998. Improvements in access were indeed achieved under HealthChoice particularly in the area of oral health screenings. Twice as many children achieved access to oral health care as compared with the experience prior to the advent of HealthChoice and more children also accessed oral health services through expansions of the Maryland Children's Health Program (MCHP). Children receiving restorative services also increased proportionately although still below the level of documented oral health need for this population.

However, despite these efforts by the MCOs to access and reach more children, more improvements are clearly needed. Insufficient progress has been made in achieving necessary preventive and treatment services for this at-risk population. Provider participation remains quite low and very young children rarely see dental providers under the HealthChoice system. Most significantly, the program has not been able to offer dental homes for these low-income children.

Due to the low dental provider participation in the HealthChoice Program, children and adults with advanced dental problems or with medical complications are frequently referred for services at distant locations (up to three hours away) or simply unable to access treatment. The local health departments, Federally Qualified Health Centers (FQHCs), and Managed Care Organizations (MCOs) under the HealthChoice Program continue to have difficulty finding dental providers to serve the Medicaid population, particularly practitioners in the community who have the training and skills to treat very young children ages 0-5.

Most private dental providers continue to find it undesirable to participate in the HealthChoice Program. Only about half of Maryland's local health departments and only 10 out of the 16 FQHC's provide dental services. Many of the FQHC's are desperately in need of funding in order to expand and meet the increasing number of Health Choice enrollees. Many of those clinics only offer examinations, preventative, restorative (fillings) and rehabilitative care. Specialized care oftentimes requires referrals to dentists at the University of Maryland Dental School or to pediatric fellows sponsored by the Dental School where long waiting times often exist. Some of the largest local health department clinical dental programs do *not* contract with MCOs to serve Medicaid-enrolled children and pregnant women. Some local health departments provide urgent dental care (such as extractions) for those who cannot afford private dental services, but *not* to Medicaid-enrollees. Even those local health departments that do provide dental care to Medicaid enrollees cannot keep up with the demand, for example only opening the phone lines for appointments twice each year. Most FQHC's provide comprehensive dental services to Medicaid-enrollees, but these worthwhile programs only exist in limited areas of the State. For instance, on the Eastern Shore, nine (9) counties are served by only two (2) FQHCs and only one FQHC serves Western Maryland.

In sum, our oral health care support structure for low-income, special needs, and other underserved at-risk Marylanders lacks adequate dental provider capacity and oversight. Despite the requirements of EPSDT, we fail to assure that Medicaid-enrolled children access needed dental treatment services. We also fail to provide sufficient dental care for low-income children and adults not covered by Medicaid, who require urgent or other dental treatment services. The need for more providers, more dental treatment services, more specialized care, and more targeted case management add to the complexity of designing a system that will cost effectively meet the extensive oral health care needs of disadvantaged, underserved people throughout Maryland.

Specifically, in Maryland:

- **Access to oral health services for Medicaid children is severely limited with only 3 in 10 children aged 0-20 years enrolled in Medicaid receiving a dental service in a given year.**
- **Children under age three and children with special health care needs face even greater difficulties accessing oral health services. For instance, a Dental School survey found that nearly 55% of Head Start children had caries experience and over 95% of children with caries experience had untreated decay.**
- **Most of Maryland's Medicaid reimbursement rates to dentists are below the 25th percentile of the American Dental Association's South Atlantic charges and many are below the 10th percentile.**
- **Only 12 of 24 Maryland jurisdictions have local health departments with clinical dental services available on site. Of these, only 9 local health departments provide dental care to children and others enrolled in Medicaid.**
- **Only 19% of dentists provide dental services to Medicaid children and only 7% of dentists billed more than $10,000 to HealthChoice in 2006 (with the most severe shortages occurring in rural counties). With so few dentists providing these services, families have limited choices for dental care.**
- **Oral disease is not self-limiting and can result in serious consequences, including death, as evidenced in the tragic case of Deamonte Driver in Prince George's County.**
- **Effective measures for preventing and treating oral disease exist, yet are under utilized in the Medicaid population in Maryland.**
- **Maryland's oral health safety net infrastructure of local health departments, Federally Qualified Health Centers, community clinics, and other providers is inadequate to provide the services to all of the children in need.**
- **Oral health literacy in Maryland is low among at-risk populations and current methods of promoting oral health are not sufficient.**
- **Physicians and other medical personnel provide services to Maryland Medicaid children on a regular basis, but are not trained to provide appropriate risk assessments, anticipatory guidance, or appropriate oral health referrals to children in need.**

Unfortunately, it is the death of 12 year old Deamonte Driver that has finally brought significant attention to the oral health crisis in Maryland. Action, not finger pointing, will solve this crisis. However, lack of adequate dental care for Maryland's children is multi-faceted. There is low oral health literacy among the public because of inconsistent and sometimes culturally incompetent oral health messaging, the Medicaid system remains cumbersome and underfunded, the dental public health infrastructure is poorly funded and inadequate, and the state lacks a dental provider work force that is adequately trained and willing to treat low-income children. Deamonte Driver was failed by a public oral health care delivery system that limited, if not hindered, his access not only to "back-end" treatment services but *also* to "front-end" services such as diagnostic and preventive oral health care. The failure on both ends of this paradigm is a tragedy for this child and his family; cost-effective preventive care could have averted the costly treatment services which came too late. The rudiments of preventing dental disease are well known and evidence-based. Over 15 years ago, a Baltimore Sun editorial decrying access to dental care in Maryland remarked that "prevention is the strategic centerpiece of modern dentistry."

It is time to fix these problems and to ensure that a tragedy like Deamonte's will never again occur in the State of Maryland. It is most gratifying that Secretary Colmers took the immediate step in response to this situation to seek and receive approval to recruit and eventually appoint a dentist with public health experience and credentials for the Department. But the need to act goes considerably further than this critically needed first step and has been recognized by state and federal leaders alike. Congressman Elijah E. Cummings, in a July 24, 2007 letter (see Appendix E) addressed to Governor Martin O'Malley, remarked that "it is unfortunate that Maryland had to be the site for this terrible tragedy; however, from this incident comes great potential for our State to establish itself as a leader in this cause." Congressman Cummings continued that he is "extremely encouraged by your timely establishment of the Maryland Dental Action Committee and I welcome the opportunity to discuss its work with you."

The recommendations of the DAC will require an infusion of funds and resources at a time when the State is experiencing a severe budget deficit. However, the DAC firmly believes that there is an even greater cost in *not* acting. In the short term, children and their families will continue to use hospital emergency rooms as an inadequate and inefficient source of their dental care at a significantly higher cost to the State. In the short term, children with rampant and severe dental disease that might have been prevented through routine access to care will continue to require treatment in hospital operating rooms at a very high expense to the State. But the more long-term costs in terms of pain, lost school days, self-esteem, success in school and quality of life – and yes, even preventable death – has an inestimable cost to society in terms of diminished general, social, and psychological health. After years of inordinate talking about doing something and implementing "band-aid" approaches, *now* is the time to think and do things differently on a major scale.

The Dental Action Committee

The Dental Action Committee ("DAC" or "Committee") met seven times from June 12 – August 28, 2007. The purpose of the Committee, as a cross section of the dental community and related organizations, was to submit a set of recommendations to the Secretary of the Department of Health and Mental Hygiene that was, in their expert judgment, the best way to increase access to oral health services for Maryland's most vulnerable population. The membership of the DAC

was comprised of a broad-based group of stakeholders concerned about children's access to oral health services, with representatives from the following organizations:

- Advocates for Children and Youth;
- Carroll County Health Department;
- Doral Dental, USA;
- Head Start;
- Maryland Academy of Pediatrics;
- Maryland Academy of Pediatric Dentistry;
- Maryland Assembly on School Based Health Care;
- Maryland Association of County Health Officers;
- Maryland Community Health Resources Commission;
- Maryland Dental Hygienists' Association;
- Maryland Dental Society;
- Maryland Medicaid Advisory Committee;
- Maryland Oral Health Association;
- Maryland State Dental Association;
- Maryland State Department of Education;
- Medicaid Matters! Maryland;
- Mid-Atlantic Association of Community Health Centers;
- Morgan State University;
- National Dental Association;
- Parent's Place of Maryland;
- Priority Partners;
- Public Justice Center;
- United Healthcare; and
- University of Maryland Dental School.

TOPIC AREA SUMMARIES

In order to effectively address and fulfill its charge, the Dental Action Committee identified four strategic areas on which to focus its investigation and discussion. These included strategies in: finance, public health, education, and scope of practice. Specifically, the DAC sought to identify:

- **Financing** changes necessary to increase private dental participation and simplify the patient navigation process;
- **Public Health** initiatives necessary to strengthen the oral health safety net;
- **Education** initiatives needed to help children, parents and others understand the need for preventive dental care and how to do effective home care in order to reduce the number of children who will need extensive dental services in the future;
- **Scope of Practice** changes needed to strengthen the oral health delivery system.

The Dental Action Committee then formed four subcommittees, with each subcommittee responsible for providing oversight on its designated strategy and for researching and developing recommendations.

Each of the subcommittees drafted recommendations that were submitted to the full DAC for discussion. What follows is a summary of the discussions which occurred among the full DAC pertaining to each of the four sets of recommendations submitted by the subcommittees prior to being voted on. The recommendations in the four areas that were adopted by the DAC appear in Appendix A.

1) Medicaid Rates and Alternate Models

On July 24, background information was presented to the DAC on Medicaid rates and alternate models; the Medicaid Rates and Alternate Models subcommittee provided its recommendations to the full Committee on August 21 (see Appendix C). The DAC was nearly unanimous (1 dissenting vote) in recommending a single dental Administrative Services Only (ASO) provider. The DAC voted for a single dental ASO vendor for numerous and compelling reasons. The underlying reasoning behind the DAC recommendation for a single dental ASO vendor includes:

(1) Simplification of the current delivery system for the public in terms of access to dentist panels, social marketing, case management, enrollment, and eligibility, and simplification for dental providers in terms of billing, credentialing and prior authorization;

(2) Demonstrate to the dental community and others that the state is willing and able to address legitimate concerns in a straightforward comprehensive manner;

(3) More transparency with greater knowledge about how money is spent and who is being held responsible for assuring access to services; the simplification of the system will allow more accountability and easier oversight by DHMH;

(4) Decrease costs because dealing with administrative costs and profits of only one entity rather than multiple MCO and dental vendors; and

(5) Increases the State's ability to negotiate contract terms through issuance of a new Request for Proposal (RFP) in which the Department and many dental stakeholders can together determine the elements of a contractor bid that meets the oral health needs of Medicaid-enrolled children and adults.

The major concerns expressed by some on the DAC regarding a single vendor entailed the potential for increased costs due to separate medical and dental case management which also reduces the potential for a medical and dental connection; increased risk because of a single dental vendor, the long time it will take to develop an RFP and the potential loss of the current Medicaid adult program for adults. While the DAC acknowledged that there are risks involved, it noted that MCOs currently report that they lose money on the dental program because they are forced to subsidize the current program. This can result in a change in dental vendors and/or even the MCO itself causing confusion for the public and practitioners alike. The DAC did not appear concerned over the time it will take for the development and issuance of an RFP because it recognized the importance of this process to achieving the goal of a single vendor ASO provider, and because dental services would continue to be provided within the current system until the new system is in place.

As for losing adult dental benefits, it is true that all seven MCOs do offer this coverage although not required to do so by the Department. However, the MCOs have been inconsistent over the years in offering this benefit and information about such coverage remains confusing to both the public and providers alike. Member handbooks for the MCOs that can be currently accessed through the DHMH Medicaid website still show some of the MCOs either not offering the adult dental benefit or only offering "medically necessary" adult dental services. The DAC believes that transition to a single ASO dental vendor will simplify this system. The Committee believes that issuing an RFP to transition to a single dental ASO vendor provides an opportunity to request that medically necessary and emergency, pain relief dental services for Medicaid-enrolled adults (such as are currently covered under Medicaid FFS) be included in the services administered by the single dental vendor. The Committee also believes that it would be best not to lose the limited additional adult dental coverage currently available through the MCOs, and would like to see the Department request funding to continue those services through the single dental ASO vendor. The DAC believes that the provision of such services not only appropriately addresses the needs of this population but also provides a meaningful, targeted and cost-effective approach to keeping adults out of hospital emergency rooms and securing significant cost-savings to the State.

The other main topic of discussion was the need to significantly increase dental reimbursement rates. After comparing Maryland's reimbursement rates to other states' and the 25th, 50th, and 75th percentiles of the American Dental Association's (ADA) South Atlantic region charges, the DAC settled on an across the board rate increase to the 50th percentile of the ADA's South Atlantic region charges. The DAC noted the importance of indexing ***to inflation*** the reimbursement rates to ensure that the rates continue to match the 50th percentile of the ADA's South Atlantic region charges. The DAC importantly recognized that rate increases alone will not increase access to oral health services and that significant change in Medicaid processes must be undertaken in order to increase dentist participation. Other recommendations centered on establishing new Medicaid dental procedure codes and increased reimbursement rates targeted to

dentists providing care to young children, to children with behavioral management needs, and to children with other special needs. The DAC formulated and the following main recommendation points on August 28:

> *Initiate a statewide single vendor dental Administrative Services Only provider for Maryland.* (**RM-R1**)
>
> *Increase dental reimbursement rates to the 50th percentile of the American Dental Association's South Atlantic region charges for all dental codes.* (**RM-R2**)

2) Public Health Strategies

On July 10, background information on Maryland's public health infrastructure was presented to the Dental Action Committee; the subcommittee reported its findings and provided its recommendations for public health strategies to increase children's access to oral health services on July 24 (see Appendix C). Since Secretary Colmers had already sought and received approval to recruit a public health dentist for the Department, Committee discussion centered on other key topics, the first being the importance of increasing access to dental care for underserved children by funding SB181/HB 30 (2007), the Oral Health Safety Net Act. The DAC agreed that ensuring a dental clinic in every local jurisdiction by establishing a dental clinic in each local health department and creating or expanding dental clinics within safety net providers such as FQHC's was essential to increasing children's access to dental services. Another key point discussed by the Committee was the ability to identify children with decay at a young age. The DAC felt strongly that this would be best accomplished by insuring that children receive dental screenings along with their school-based vision and hearing screenings and/or that a dental exam be required prior to school entry, The DAC acknowledged the crucial role a strong Office of Oral Health plays in expanding the dental public health infrastructure in Maryland. In addition, it was noted that public health is essential to assisting children to have a dental home. Even with significant increases in private dentists serving Medicaid children, public health system will continue to play a large role in ensuring access to care for families. The DAC synthesized these big issues into the following two main recommendation points that were approved by the DAC on August 21:

> *The Department should maintain and enhance the dental public health infrastructure by ensuring that each local jurisdiction has a local health department dental clinic and a community oral health safety net clinic and by providing funding to fulfill the requirements outlined in the Oral Health Safety Net legislation (SB 181/HB 30 2007).* (**PHS-R1**)
>
> *Incorporate dental screenings with vision and hearing screenings for public school children and/or require dental exams prior to school.* (**PHS-R2**)

3) Education and Outreach for Parents and Caregivers

On June 26, the DAC received information and heard testimony on education and outreach models for parents and caregivers; the Education and Outreach subcommittee reported its findings and provided recommendations to the DAC in the area of education and outreach on July 24 (see Appendix C). At this meeting, many recommendations for education and outreach

for parents and caregivers as well as healthcare providers were discussed but, overall, the Committee discussion centered on the development of a unified oral health message for use by healthcare providers, local health departments, safety net providers, and other child and family support programs. The DAC discussed creating messages for multiple audiences, including parents and caregivers of all children, healthcare providers, and dental and medical students. However, the main discussion centered on the development of an educational campaign directed to parents and caregivers of young children in an effort to prevent and detect the onset of early dental disease. The DAC identified a theme that synthesized the discussion regarding education and outreach for parents and caregivers. The result was the following main recommendation point approved by the DAC on August 21, 2007**:**

> *The Department should develop a unified and culturally and linguistically appropriate oral health message for use throughout the state to educate parents and caregivers of young children about oral health and the prevention of oral disease.* (**EO-R1**)

4) Provider Participation, Capacity, and Scope of Practice

On August 7, the DAC received background information and heard testimony on provider participation, capacity and scope of practice; the subcommittee reported its findings and made its recommendations to the Committee on August 21 (see Appendix C). The DAC discussion regarding this topic focused on creative ways of increasing the number of providers willing to treat Medicaid children. Of high priority was changing the supervision requirements for dental hygienists working in public health settings to allow them to perform screenings, prophylaxis, fluoride varnish, sealants and x-rays without supervision of a dentist. Additionally, the DAC discussed utilizing the medical community to provide early identification of dental disease and educate parents and caregivers about oral health. More significantly, the DAC voted to train pediatricians to apply fluoride varnish and to be able to bill Medicaid for this service. The majority vote to allow this important provision followed a very spirited discussion pitting most of the Committee against the represented dental professional organizations. The dental professionals on the DAC expressed concern that if non-dental professionals were to apply fluoride varnish, the parents would feel that their child's dental needs had been met and that further dental care would be not be necessary. The fear was that this may result in parents not seeking a dental home for their children. In acknowledging the significance of this point, the majority of the Committee believed that part of any training program for pediatricians and other non-dental professionals must include information that would enable these practitioners to not only stress to parents the importance of oral health and related prevention and treatment strategies but also the value of a dental home. While the vote was not unanimous, the majority of the Committee still strongly believed that this measure was critical in ensuring that young children be assessed at the appropriate early interval and that their parents receive the necessary information and guidance to reduce the long-term risk and the associated high costs of oral disease. The DAC also investigated the role that tax incentives and/or credits could play in increasing provider participation. The DAC suggested that measures such as the Maryland Dent-Care Loan Assistance Repayment Program and similar programs be expanded to encourage more dental providers to treat Medicaid children. The DAC approved the following two main recommendation points on August 28:

Allow public health dental hygienists to provide screenings, prophylaxis, fluoride varnish, sealants, and x-rays in public health settings. (**PPCSP-R1**)

Provide training to dental and medical providers to provide oral health risk assessments, educate parents/caregivers about oral health, and to assist families in establishing a dental home for all children. (**PPCSP-R2**)

The DAC and its subcommittee developed additional recommendations, which are included in Appendix A. The full list of recommendations accounts for the priority, costs, and timeframe needed to implement each recommendation. The recommendations correspond with the main recommendation points detailed above.

EVALUATION AND OVERSIGHT

The Dental Action Committee further recommends that it continue to convene quarterly to assist the Department in implementing the recommendations and to provide an evaluation of the Department's progress towards establishing a dental home for every low-income child in Maryland.

Of great importance to the Dental Action Committee is a commitment by the Department to thoroughly address the racial and ethnic disparities that exist in access to oral health care. The DAC recommends that the Department, in conjunction with the DAC, convene an oral health disparities workgroup to assist the Department in developing specific strategies designed to increase access to oral health services for minority populations in Maryland. In addition, the Department should utilize this workgroup to develop strategies to attract more minorities to the dental profession.

The DAC also strongly recommends that the Department use the restructuring anticipated in this report as an opportunity to improve its data collection system. It is absolutely imperative that the state and/or the dental vendor have the ability to disaggregate data based on age, race, ethnicity and county of residence. Good data is essential to addressing racial and ethnic disparities and for developing realistic outcome and progress measures.

The Dental Action Committee looks forward to continuing to meet and work with the Department as the State implements the recommendations outlined in the Report. Members of the DAC would be pleased to serve on a separate committee as part of the process of developing an RFP for a single ASO vendor, should the Secretary adopt that recommendation. The Committee will continue to help monitor public health access for Medicaid children and will help develop new recommendations/initiatives in response to a changing environment, including recommendations concerning what performance and outcome measures should be used to evaluate our progress toward achieving better access to dental care and better oral health status for Maryland's poor and low-income children.

Finally, the DAC recommends that the Dental Action Committee produce an annual report detailing its findings and the progress made in ensuring that appropriate access to dental health care is provided for Maryland's children.

CONCLUSION

Former U.S. Surgeon General, Dr. David Satcher, stated in the Surgeon General's Report on Oral Health in America that "it [is] abundantly clear that there are profound and consequential disparities in the oral health of our citizens." He remarked further that "to improve quality of life and eliminate health disparities demands the understanding, compassion, and will of the American people…more needs to be done if we are to make further improvements in America's oral health."

With the enactment of the recommendations in this Report, Maryland has the opportunity to become the model for Dr. Satcher's vision. But the time to act is *now*; every day that we fail to make significant and effective changes to the oral health care delivery system, more children and adults continue to suffer from the pain, infection and pathology associated with oral diseases. And yes, others may die as well.

As tragic as it was for Deamonte Driver to die from a dental infection, it would be an even greater tragedy for our State not to learn from and act upon his untimely death. Leonardo da Vinci once said that "our life is made by the death of others." May the lives of Maryland's children be forever improved by the actions taken in response to the death of this unfortunate child.

Appendix A:

Recommendations of the Dental Action Committee: In Detail

Dental Action Committee Recommendation 1

"Initiate a statewide single vendor dental Administrative Services Only (ASO) provider for Maryland."

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
1	Initiate a statewide single vendor dental Administrative Services Only (ASO) provider for Maryland.	RM-R1				
1.01	Change to a statewide single vendor dental ASO (Administrative Services Only) provider.	RM-03	★★★	$ $ $		1 1 1
1.02	Specifics of the RFP should be designed by an ongoing task force or committee to include: a competitive bidding process, a catchy new name, strong oversight by DHMH, simplified administrative interface for dentists (one credentialing system, minimized prior authorizations, expedited claims processing), and simplified navigation for parents.	RM-03.01	★★★	AC		1 1
1.03	Establish an ombudsman for dental offices interacting with Medicaid in an effort to streamline processes.	PPCSP-08	★★★	$		1
1.04	DHMH should take all necessary steps to extend oral health coverage for new mothers for a year after birth. This will improve the oral health status of the new mother, give an opportunity to educate the parents about oral health for their children, and allow the new mothers to bring their children in for a dental visit before the first birth day.	EO-18	★★★	$ $		1 1 1
1.05	Implement a dental home for every Medicaid child by 2011.	RM-04	★★	n/a		1 1 1

Recommendation Legend

Costs:
- $ - Up to $500,000 in costs
- $ $ - Up to $5 million in costs
- $ $ $ - Over $5 million in costs
- AC – Administrative/Staffing costs
- Undet – Undetermined as of this time
- * – Ongoing costs associated

Priority:
- ★ – least important priority
- ★★★ – most important priority

Timeframe:
- 1 – up to one year to implement
- 1 1 – up to three years to implement
- 1 1 1 – up to five years to implement

Dental Action Committee Recommendation 2

"Increase dental reimbursement rates to the 50th percentile of the ADA's South Atlantic charges for all codes."

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
2	Increase dental reimbursement rates to the 50th percentile of the ADA's South Atlantic charges for all codes.	RM-R2				
2.01	Raise dental reimbursement rates to the 50th percentile of the American Dental Association's (ADA) South Atlantic region charges, for all codes.	RM-01	★★★	$ $ $	$40 million	1 1
2.02	Annually index the reimbursement rates to the 50th percentile of the ADA South Atlantic region charges.	RM-01.01	★★★	$ $ $ *		1 1
2.03	Promote recognition of Medicaid providers (newsletter, media, etc.).	PPCSP-09	★★★	AC		1
2.04	DHMH needs to be better educated or have better oversight regarding credentialing issues, rejected claims, customer relations, as well as communicating with Medicaid providers.	EO-19	★★★	AC		1
2.05	Add and fund new dental procedure codes for behavior management, young children, children with special needs, and foster children.	RM-02	★★	$ $		1 1
	Alt. The state should fund increased reimbursements for dentists who treat: very young children, children with special needs, and children with complex treatment needs.	PPCSP-04	★★	$ $		1 1

Recommendation Legend

Costs:
- $ - Up to $500,000 in costs
- $ $ - Up to $5 million in costs
- $ $ $ - Over $5 million in costs
- AC – Administrative/Staffing costs
- Undet – Undetermined as of this time
- * – Ongoing costs associated

Priority:
- ★ – least important priority
- ★★★ – most important priority

Timeframe:
- 1 – up to one year to implement
- 1 1 – up to three years to implement
- 1 1 1 – up to five years to implement

Dental Action Committee Recommendation 3

"The Department should maintain and enhance the dental public health infrastructure through the Office of Oral Health by ensuring that each local jurisdiction has a local health department dental clinic and a community oral health safety net clinic and by providing funding to fulfill the requirements outlined in the Oral Health Safety Net legislation (SB 181/HB 30 2007)."

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
3	The Department should maintain and enhance the dental public health infrastructure through the Office of Oral Health by ensuring that each local jurisdiction has a local health department dental clinic and a community oral health safety net clinic and by providing funding to fulfill the requirements outlined in the Oral Health Safety Net legislation (SB 181/HB 30 2007).	PHS-R1	★★★	$ $ $		1 1 1
3.01	Fund the Oral Health Safety Net bill (HB 30; SB 181).	PHS-01	★★★	$ $ $	$6 million	1
	Alt. DHMH should examine and develop where needed, new initiatives to serve hard to reach population.	EO-21	★★★	Undet		1
3.02	Provide funding so that every local health department has a clinical dental program and provides emergency dental services.	PHS-02	★★★	$ $ $	$8.4 million	1 1 1
3.03	Provide funding so that every jurisdiction has clinical dental services provided by a FQHC, community health center, or other safety net provider.	PHS-03	★★★	$ $ $	$9.5 million	1 1 1
3.04	Establish, recruit and hire a full-time dentist trained and experienced in public health (preferably with an MPH) for the Office of Oral Health/DHMH.	PHS-04	★★★	$ *	$95,000 to $150,000	1
3.05	Ensure that every local health department with a clinical dental program provides dental care services to Medicaid-enrolled patients	PHS-05	★★★	$		1 1 1
3.06	Office of Oral Health should sustain a statewide oral health coalition	PHS-06.04	★★★	$		1
3.07	Increase the salary scale for State and County dentists, dental hygienists, and dental assistants to be competitive with private sector salaries	PHS-08	★★★	$ $	$644,000	1 1
	Alt. Review the state classification specifications for dental assistants and hygienists in partnership with the Maryland Oral Health Association and the Dental Board	PHS-14	★★★	AC		1 1
3.08	Incorporate fluoride varnish programs and other preventive strategies in every local health department and partner for its use with agencies such as Head Start, Judy Centers, etc.	PHS-09	★★★	$		1 1
3.09	Help develop and promote caries management protocols with the University of Maryland Dental School for high risk children.	PHS-10	★★★	$		1 1
3.10	Increase the amount of loan repayment assistance provided to dentists in the Maryland Dent-Care Loan Assistance Repayment Program and also the number of dentists able to participate in the program.	PHS-12	★★★	$ $ *	$547,000	1 1
	Expand the loan repayment program (MDC-LARP).	PPCSP-06	★★★	$ $	$547,000	1 1

(Recommendation 3 continued on next page)

Dental Action Committee Recommendation 3 – Continued

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
3	The Department should maintain and enhance the dental public health infrastructure through the Office of Oral Health by ensuring that each local jurisdiction has a local health department dental clinic and a community oral health safety net clinic and by providing funding to fulfill the requirements outlined in the Oral Health Safety Net legislation (SB 181/HB 30 2007).	PHS-R1	★★★	$ $ $		1 1 1
3.11	Expand the full-time staff in the Office of Oral health in order to assist in enacting the Dental Action Committee recommendations.	PHS-13	★★★	$ *	$65,000	1
3.12	Increase the cooperation between Public Health and Medicaid at DHMH	PHS-15	★★★	AC		1
3.13	Expand the full-time staff in the Office of Oral health in order to assist in enacting the Dental Action Committee recommendations.	PHS-16	★★★	$		1
3.14	Fund and expand school-based dental programs with enough salary support to suitably recruit dental professionals	PHS-19	★★★	$ $		1 1 1
	Alt. School based health centers in conjunction with local health departments should be funded to provide oral health screenings and fluoride varnish treatment to underserved children and to educate all children about the importance or oral health. These procedures should be a required part of the immunization record submitted by parents to the schools.	EO-16	★★★	$		1 1
	Alt. Utilize school health services, school based health centers, and local health departments as tools to educate children in all schools.	EO-04	★★★	$		1 1
	Alt. Partner with Maryland Assembly of School Based Health Centers to support additional SBHC with dental facilities.	PHS-20	★★★	AC		1
	Alt. Office of Oral Health should partner with school based health centers and school health services to create a prevention message for schools.	EO-08	★★★	AC		1 1
	Alt. School based health centers should partner with the Maryland State Department of Education and the Office of Oral Health to include grade appropriate oral health messages into the health curriculum.	EO-17	★★★	AC		1 1 1
	Alt. MCO's should use School-Based Health Centers and other school based services to educate and provide outreach to Medicaid families about dental coverage, scheduling and follow up for oral health needs.	EO-25	★★★	$		1 1
3.15	Federal funds should be sought by FQHCs and the Office of Oral Health to support oral health programs and to leverage additional funds.	PHS-28	★★★	AC		1 1
3.16	Offer a student loan repayment program beginning in the 2nd year of dental school for those willing to provide dental services in designated shortage areas upon graduation.	PPCSP-07	★★★	$		1 1

(Recommendation 3 continued on next page)

Dental Action Committee Recommendation 3 – Continued

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
3	The Department should maintain and enhance the dental public health infrastructure through the Office of Oral Health by ensuring that each local jurisdiction has a local health department dental clinic and a community oral health safety net clinic and by providing funding to fulfill the requirements outlined in the Oral Health Safety Net legislation (SB 181/HB 30 2007).	PHS-R1	★★★	$ $ $		1 1 1
3.17	Continue to support programs such as the Pediatric Dental Fellowship Program	PHS-22	★★	$	$45,000	1
3.18	Enact the recommendations of the Dental Public Health Infrastructure Report not otherwise addressed in the above public health strategies	PHS-06	★★	$		1 1 1
3.19	Office of Oral Health further develop a state oral disease surveillance program	PHS-06.02	★★	$		1 1 1
3.20	Office of Oral Health should develop an evidence-based Oral Health Plan	PHS-06.03	★★	$		1 1
3.21	The Office of Oral Health should build evaluation capacity for the purposes of better evaluating public health programs.	PHS-06.08	★★	$		1 1
3.22	Provide funding for case management strategies for underserved populations/high risk children in an effort to combine dental and medical case management services provided by MCOs	PHS-11	★	$ $ $		1 1 1
3.23	Provide more portable equipment for use in schools and other centers	PHS-17	★	$		1 1
3.24	Facilitate more successful applications by local entities for Dental Health Professional Shortage Areas (HPSAs)	PHS-23	★	AC		1
3.25	Assist local health departments to test residents' well water for naturally occurring fluoride	PHS-24	★	$		1 1
3.26	Require new community water systems to provide fluoridated water	PHS-25	★	AC		1 1 1
3.27	The Office of Oral Health should develop a white paper describing disease burden and disseminate it to appropriate stakeholders	PHS-06.01	★	AC		1 1
3.28	Offer a program to foreign trained dentists who enroll in the dental school to complete their U.S. training and licensure and who are willing to provide dental services in designated shortage areas upon graduation (not to impact the existing Pediatric Dental Fellows Program).	PPCSP-07.01	★	$		1 1

Recommendation Legend

Costs:
- $ - Up to $500,000 in costs
- $ $ - Up to $5 million in costs
- $ $ $ - Over $5 million in costs
- AC – Administrative/Staffing costs
- Undet – Undetermined as of this time
- * – Ongoing costs associated

Priority:
- ★ – least important priority
- ★★★ – most important priority

Timeframe:
- 1 – up to one year to implement
- 1 1 – up to three years to implement
- 1 1 1 – up to five years to implement

Dental Action Committee Recommendation 4

"Establish a public health level dental hygienist to provide screenings, prophylaxis, fluoride varnish, sealants, and x-rays in public health settings."

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
4	Establish a public health level dental hygienist to provide screenings, prophylaxis, fluoride varnish, sealants, and x-rays in public health settings.	PPCSP-R1				
4.01	Change supervision requirements for dental hygienists with a minimum of two years experience who work in public health settings to allow them to: provide screenings, prophylaxis, fluoride varnish, sealants, and x-rays; and to provide supervision to dental assistants.	PPCSP-01	★★★	AC		1

Recommendation Legend

Costs:
- $ - Up to $500,000 in costs
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Priority:
- ★ – least important priority
- ★★★ – most important priority

Timeframe:
- 1 – up to one year to implement
- 1 1 – up to three years to implement
- 1 1 1 – up to five years to implement

Dental Action Committee Recommendation 5

"The Department should develop a unified and culturally and linguistically appropriate oral health message for use throughout the state to educate parents and caregivers of young children about oral health and the prevention of oral disease."

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
5	The Department should develop a unified and culturally and linguistically appropriate oral health message for use throughout the state to educate parents and caregivers of young children about oral health and the prevention of oral disease.	EO-R1				
5.01	Create a social marketing campaign that includes the development of a streamlined oral health message that can be used across disciplines.	EO-03	★★★	$	$350,000	1 1
	Alt. Office of Oral Health should promote oral health through a multi-faceted oral health communications program.	PHS-06.05	★★★	$		1 1
	Alt. DHMH should partner with the University of Maryland Dental School, the Mid-Atlantic Association of Community Health Centers, Area Health Education Centers, community colleges, the Maryland Oral Health Association, community health centers and other safety net providers that provide dental services, and the Maryland Children's Oral Health Institute to develop ongoing dental educational programs in underserved areas.	PHS-06.06	★★★	$		1 1
	Alt. Focus education efforts and delivery on population groups most at risk for oral disease (immigrant families, children with special health care needs).	EO-05	★★★	$		1
	Alt. Include nutrition education as part of oral health messages.	EO-06	★★★	$		1
	Alt. Educate parents/caregivers about their responsibility in preventing oral disease and in ensuring access to oral health services as well as to address issues of dental phobia among caregivers.	EO-07	★★★	$		1 1
	Alt. Review existing educational videos for use in medical and dental offices.	EO-09	★★★	AC		1
	Alt. It is suggested that the MCOs develop a dental information packet, perhaps for in their news letter or other communication tools that includes information contained in the Access to Dental Care Early Head Start and Head Start Guide for Parents and the accompanying guide for staff, as well as portions of the draft letter that DHMH has circulated to the Committee. The development of this packet should be coordinated with the Office of Oral Health.	EO-24	★★★	$		?
	Alt. Partner with "train the parent" programs (e.g., Parents as Teachers) to provide oral health education to parents/caregivers.	EO-10	★★★	$		1 1

(Recommendation 5 continued on next page)

Dental Action Committee Recommendation 5 – Continued

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
5	The Department should develop a unified and culturally and linguistically appropriate oral health message for use throughout the state to educate parents and caregivers of young children about oral health and the prevention of oral disease.	EO-R1				
5.02	DHMH should construct a List Serve, or other Web tools, to foster communication with the dental community.	EO-20	★★★	$	$5,000	1
5.03	DHMH should increase the support of the Office of Oral Health to enable:	EO-22	★★★	$		?
	5.03.01. This office to produce targeted, unified messages for health departments, public and private schools, MCOs, physicians, dentists, parents, WIC and Head Start.	EO-22.01	★★★	$		1 1 1
	5.03.02. This office to be a clearing house for oral health education material and lesson plans produced by other organizations, such as MCO, local health departments so that this messaging also is unified, culturally sensitive and linguistically appropriate.	EO-22.02	★★★	$		1 1
5.04	The MCOs outreach and education programs regarding incentives, phone calls to members that have children that have not seen a dentists, home visits and the current screening programs are commendable. If DHMH requires these services to increase, it must be recognized that there are additional associated costs.	EO-23	★★★	$ $		1 1
5.05	Office of Oral Health should develop a definition of a dental home for the state utilizing existing definitions and tailoring to Maryland's needs.	PHS-18	★★	AC		1
5.06	This office should partner with County health departments and Federally Qualified Health Centers for local outreach.	EO-22.03	★★	$		1
5.07	Create a speaker's bureau utilizing dental public health experts to be available to communities and organizations	PHS-21	★	AC		1

Recommendation Legend

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Priority:
- ★ – least important priority
- ★★★ – most important priority

Timeframe:
- 1 – up to one year to implement
- 1 1 – up to three years to implement
- 1 1 1 – up to five years to implement

Dental Action Committee Recommendation 6

"Incorporate dental screenings with vision and hearing screenings for public school children and/or require dental exams prior to school entry."

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
6	Incorporate dental screenings with vision and/or hearing screenings for public school children or require dental exams prior to school entry.	PHS-R2				
6.01	Require that a dental screening be performed in conjunction with vision and hearing screenings in public schools and/or that a dental exam be required prior to school entry (similar to health physicals). Children would not be excluded from school for failure to meet the requirement.	PHS-07	★★★	AC		1

Recommendation Legend

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Priority:
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- ★★★ – most important priority

Timeframe:
- 1 – up to one year to implement
- 1 1 – up to three years to implement
- 1 1 1 – up to five years to implement

Dental Action Committee Recommendation 7

"Provide training to dental and medical providers to provide oral health risk assessment, educate parents/caregivers about oral health, and to assist families in establishing a dental home for all children."

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
7	Provide training to dental and medical providers to provide oral health risk assessments, educate parents/caregivers about oral health, and to assist families in establishing a dental home for all children.	PPCSP-R2				
7.01	Assist the Academy of Pediatrics and the Academy of Pediatric Dentistry in establishing a relationship by creating a liaison between the two organizations with the purpose of facilitating communication and joint training opportunities.	EO-01	★★★	$		1 1
7.02	Cross-train dental and medical students	EO-02	★★★	$		1 1 1
7.03	Offer free continuing education for dentists as an incentive to participate in Medicaid. Target programs involving young children, pregnant women and children with special needs. Such programs could use traditional lecture formats, as well as web casts.	EO-12	★★★	$		1 1
	DHMH should develop continuing education programs, summits and forums that engage dental providers in issues of cultural competency, community oral health, care of special populations	PHS-06.07	★★★	$		1 1
7.04	Better prepare general dental students for treating children.	EO-15	★★★	Undet		1 1
7.05	Pediatricians, family physicians, PCPs and their auxiliaries should be encouraged to receive training on oral health risk factors, dental emergencies, oral health screenings, and the application of fluoride varnish. Physicians working in public health clinics and physicians serving high risk underserved children, who have received the training referenced above, should be able to bill Medicaid for these procedures when they are performed on eligible preschool children. These practitioners should also be educated regarding the need to for a dental home by age 1 and receive specific instruction on how to assist families in finding and maintaining a dental home through the Medicaid Dental Network.	PPCSP-02	★★★	$		1 1 1

(Recommendation 7 continued on next page)

Dental Action Committee Recommendation 7 – Continued

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
7	Provide training to dental and medical providers to provide oral health risk assessments, educate parents/caregivers about oral health, and to assist families in establishing a dental home for all children.	PPCSP-R2				
7.06	Increase dental student's service learning experiences from three to five weeks. This will increase capacity as well as encourage students to work in the community.	EO-13	★★	Undet		1 1
7.07	Develop more course material related to public health and cultural sensitivity.	EO-14	★★	Undet		1 1
7.08	Investigate including topical fluoride treatments into the immunization record (models such as Baltimore City's pilot program).	EO-11	★★	AC		1 1 1
7.09	Increase the scope of practice of dental assistants, certified by the National DANB examination, to allow them to perform certain expanded functions—for which they have received appropriate training, in a dental office on pediatric patients up to age 5. This would include coronal polishing and toothbrush prophylaxis and fluoride applications; would occur only under the direct supervision of a licensed dentist; and the scope of practice for dental assistants should be regulated by the State.	PPCSP-03	★	AC		1 1
7.10	The dental societies (AAPD/MSDA/MDS/MAGD) should collaborate to train general dentists in treating young children and children with special needs.	PPCSP-10	★	$		1 1

Recommendation Legend

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Priority:
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Timeframe:
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Other Dental Action Committee Recommendations

No.	Dental Action Committee Recommendation	Cross Reference	Priority	Overall Cost Estimate	Known Cost	Timeframe
8.01	The Dental Action Committee should continue to meet to assist DHMH in implementing the Committee's recommendations and to evaluate DHMH's progress in increasing access to oral health services for children.	PHS-26	★★★	AC		1
8.02	Use tax incentives both to encourage dentists to participate in Medicaid and also to reward those who continue to participate in a significant way.	PPCSP-05	★★★	Undet		1 1 1
	8.02.01. Provide income tax credits/tax deductions for Medicaid reimbursements for providers who see significant numbers of Medicaid patients over time.	PPCSP-05.02	★★★	Undet		1 1 1
	8.02.02. Tax incentives/credits should go to individual practitioners, not the clinic for which a practitioner works.	PPCSP-05.04	★★★	Undet		1 1 1
	8.02.03. Allow a portion of Medicaid reimbursements to be put in an IRA type account or the state employees deferred compensation plan.	PPCSP-05.01	★★	Undet		1 1 1
	8.02.04. Incentives should be graduated in order to reflect the number of children or families treated.	PPCSP-05.03	★	Undet		1 1 1
8.03	The Department should consider diversity throughout all its oral health initiatives. Strategies to reduce disparities in oral health should address both patients and dental professionals.	PHS-27	★★★	$		1

Recommendation Legend

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Priority:
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Timeframe:
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- 1 1 1 – up to five years to implement