# 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 50$^{th}$ 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 25$^{th}$ percentile of the American Dental Association's South Atlantic charges and many are below the 10$^{th}$ 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 25$^{th}$, 50$^{th}$, and 75$^{th}$ percentiles of the American Dental Association's (ADA) South Atlantic region charges, the DAC settled on an across the board rate increase to the 50$^{th}$ 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 50$^{th}$ 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 50$^{th}$ 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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- 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 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**

**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 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**

**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 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:**
- ★ – 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

# 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

# Dental Action Committee

**AGENDA**
**June 12, 2007**
**4:00 – 6:00 p.m.**

| | |
|---|---|
| 4:00 – 4:15 | Welcome, Introductions<br>*Kelly Sage, Tricia Roddy* |
| 4:15 – 4:30 | Committee Charge<br>*Secretary Colmers* |
| 4:30 – 4:40 | Introduction of Committee Chair and Vice-Chair and Review of Committee Ground Rules<br>*Jane Casper* |
| 4:40 – 4:45 | Review of Meeting Schedule and Topics<br>*Kelly Sage* |
| 4:45 – 6:00 | Future Meeting Agenda Development and General Discussion<br>*Jane Casper, Kelly Sage, Tricia Roddy* |
| 6:00 | Adjournment |

# Dental Action Committee
# June 12, 2007
## Minutes

**Secretary's Statement**

Secretary John Colmers informed the committee that the Dental Action Committee has been convened following tragic events in February that have reinforced the consequences of failing to provide preventive care and adequate dental access.

The Secretary stated it will take the input of all stakeholders: dental providers, health programs, parents, care givers, Medicaid agencies, managed care programs, pediatricians and state and federal policy makers to address the issues. The committee is charged with developing and recommending concrete actions that can be taken, immediately as well as in the future. The Secretary encouraged the committee to think outside the box and be creative but realistic and recommend targets and goals that have a likelihood of being achieved.

The Department's first priority is to address dental access. The Department is currently hiring a State Dental Director. The types of recommendations the Secretary is looking for are to be as specific as possible. The Secretary suggests:

- A public education campaign that educates to engage families in improving oral hygiene at home and in seeking preventive dental services.
- Strategies that encourage dental providers to participate in the Medicaid program and develop dental homes.
- Strategies to develop appropriate reimbursement rates for dentists.
- Strategies to allow other health professionals to provide preventive services in underserved areas including consideration of other dental health professionals.
- Strategies to encourage dental schools to train more pediatric dentists.
- Strategies to improve access at Federally Qualified Health Centers and school based health centers for dental care.
- Strategies to further engage pediatric providers in patient education.

The Secretary instructed the committee to submit their recommendations by September 2007 which is appropriate as it relates to budget considerations and the creation of the FY 09 budget.

The Department is taking steps to address the issues independent of the committee's work. The Department is currently involved in improving and monitoring of dental services within the Medicaid program. Some of the projects that have already been completed include:

- A transmittal letter has been sent out to all dental providers describing what dental services are covered under Medicaid.
- A letter has been sent to the managed care organizations (MCOs) requesting a complete review of their dental provider lists including information on which

dental providers have active contracts and which ones are open to new patients. While this review is being completed, MCOs have been instructed to directly link patients to dentists rather than give patients a list of providers.

- A letter was sent out to MCOs with the names of children the Department has who have no encounter data record of having received dental services. The letter requires a corrective plan of action and requires the MCO to report back on progress on a monthly basis.
- A letter has been developed to send to parents encouraging good oral hygiene and to use other regular dental services. This letter will be reviewed at the second meeting of this committee to obtain committee input.
- The Department, through the Office of Oral Health, is working to strengthen the dental public health infrastructure. This is being accomplished by funding to local health departments (LHDs) for clinical dental programs, school sealant programs, fluoride programs and oral health education.
- Seed money to the Charles and Harford County LHDs to establish much needed oral health clinics.
- Partnering with the Maryland Health Resources Commission to explore ways to support funding of the Oral Safety Net bill that was passed by the legislature this last year. It had a fiscal note of $2 million.
- Implement strategies outlined in the evaluation of the dental public health infrastructure report that was released in December 2006.

The Secretary is passionate about changing the status quo and wants to see tangible progress being made to increase the number of children who have access to dental services.

**Meeting Agenda Review**

Committee members reviewed the committee ground rules, future meeting dates and meeting agendas. Committee members outlined the following topics for the remaining four meetings:

June 26: Education & Outreach

- Report from DHMH on current activities in education especially as addressed in 5-year plan
- Review MCO ed and outreach efforts – what is happening, what is required, what is effective what are minimum standards
    - Best practices
    - And what is required to be reported
- Non-traditional methods of outreach – best practices nationally, not necessarily Oral Health (OH)
- Review Medicaid Letter to parents
- Review health proficiency standards as they pertain to OH in K-12
- Review Strategies to parents with CSHN (children w/special needs)
- Reviewed. In early head start & in HS (National Maternal & Child Oral Health Resource Center)
- Review social marketing campaigns

- Review best practices from other states: Smile Alabama, Heal Huntsville, RI, VA, MI, TN, WA

July 10: Public Health Strategies

- Strategies to increase public dental health providers: review state pay scales
- Review strategies to increase operating room time for public health
- Strategies to support SB181
- Review DHPSA designations and shortage areas
- Review best practices in case management programs
- Review public health progress towards 5 year plan
- Review current partnerships, coordination and communication between public health and HealthChoice
- Review best practices assisting HS to receive exams and treatment needs and review HS OH data
- Review models for alternative forms of public health care delivery
- Strategies to link dental license renewal to providing care in public health clinics: strategies to encourage public participation through dental board
- Models to include dental exams upon school entry
- Review recommendations from evaluation of dental public infrastructure report
- Presentation of current dental funding: OOH

July 24: Reimbursement & Model of Care

- Review strategies to expedite, streamline, standardize, and computerize credentialing
- Review costs to increase rates & review private insurance reimbursements vs. Medicaid
- Review Medicaid case management strategies
- Review Medicaid models from other states (Doral as SME)
- Strategies to increase reimbursement rates for CSHN
- Review electronic claims/forms submission
- Review EVS: Other models to verify enrollment
- Subject matter experts to discuss strategies
- Review claim rejection policies
- Review provider hotline policies
- Medicaid will provide analysis of alternative models
- Review coverage as pertains to foster children
- Review other models of payment to providers (i.e. bundling, etc.)
- Presentation of current dental funding – MA
- Review Milbank Report
- Review other pilot programs in the State: Choptank and St. Mary's

Aug 7: Provider Participation, Capacity, and Scope of Practice

- Education and Outreach efforts to pediatricians and done by OBs, family physicians, and pediatricians

- Review strategies to educate dentists about young children
- Strategies to incorporate education w/FL varnish
- Review strategies to not over burden those already providing care
- Review tax incentives to encourage participation
- Review strategies to expand specialty network
- Strategies to retain current providers
- Review provider hotline and MA customer services
- Review dental hygienists and assistants' scope of practice; review:
    - Dental public health hygienist
    - ADA Endorsements on:
        - Community dental health coordinator
        - Oral preventive assistant
    - Advanced dental hygiene practitioner
- Review MA data for providers who bill over $10k annually
- Review strategies to incentivize general dental providers to see young children (0-5 years) and to practice in underserved areas
- Review current pediatric resident and family practice residents exposure to oral health
- Strategies to include oral health with rest of body in medicine
- Strategies to involve mid-level medical practitioner in OH delivery
- Required commercial dental providers to also see a percentage of MA patients

Committee staff will develop an e-mail list of interested parties so individuals who are not serving on the committee can receive committee minutes and materials.

# Dental Action Committee

**AGENDA**
**June 26, 2007**
**4:00 – 6:00 p.m.**

| | |
|---|---|
| 4:00 – 4:10 | Welcome, Updates, Review of Minutes from June 12 Meeting<br>*Jane Casper, Chair* |
| 4:10 – 4:40 | Review of Education and Outreach Materials Best Practices/Social Marketing Concepts<br>*Kelly Sage* |
| 4:40 – 4:55 | Review of MCO Education and Outreach Efforts<br>*Kathleen Loughran, Amerigroup*<br>*Jai Seunarine, Jai*<br>*Lesley Wallace, Helix* |
| 4:55 – 5:00 | Review and Discussion of Medicaid Letter to Parents<br>Susan Tucker |
| 5:00 – 5:30 | Public Testimony |
| 5:30 – 6:00 | Committee Discussion and Formation of Education and Outreach Subcommittee<br>*Jane Casper* |
| 6:00 | Adjournment |

# Dental Action Committee
# June 26, 2007
## Minutes

**Committee Members in Attendance:**

Carol Antoniewicz (Medicaid Matters! Maryland), Donna Behrens (Maryland Assembly of School Based Health Centers), Winifred Booker (Maryland Dental Society), Jane Casper (dental public health hygienist), Leigh Cobb (Advocates for Children and Youth), Harry Goodman (Head Start Region III Consultant), Elyse Markwitz (Priority Partners), Garner Morgan (Maryland State Dental Association), Laurie Norris (Public Justice Center), Elizabeth Ruff (Carroll County Health Department), Donald Shell (Prince George's County Health Department), Mark Sniegocki (Doral Dental), Leslie Stevens (Maryland Oral Health Association), Duane Taylor (for Miguel McInnis, Mid-Atlantic Association of Community Health Centers), Norman Tinanoff (University of Maryland Dental School), Anthony Valdes (United Healthcare), Grace Williams (Maryland Medicaid Advisory Committee), Grace Zaczek (Maryland Community Health Resources Commission), Linda Zang (Maryland State Department of Education, Head Start Collaboration Office)

**Department of Health and Mental Hygiene Attendees:**

John Folkemer (DHMH, Deputy Secretary for Health Care Financing), Tricia Roddy (DHMH, Office of Planning Development and Financing), Kelly Sage (DHMH, Office of Oral Health), Susan Tucker (DHMH, Office of Health Services)

Due to time constraints, the Committee Chair, Jane Casper, has organized subcommittees for each of the topic areas that will be examined by the Committee. The chair of each subcommittee will be chosen by the subcommittee members. Each subcommittee will develop recommendations that will be presented at the August 21, 2007 meeting of the Dental Action Committee.

Today's topic is Education and Outreach and subcommittee members will meet after today's discussion. The members of the Education and Outreach Subcommittee are:

Ms. Linda Zang
A representative from the Maryland Dental Hygienists Association
Ms. Leslie Stevens
Ms. Leigh Cobb
Ms. Elyse Markwitz
Dr. Norman Tinanoff
Mr. Miguel McInnis

**5-Year Oral Health Plan**

Kelly Sage reviewed and discussed the Department's progress in the Priority Area III of the 5-Year Oral Health Plan.

- The Office of Oral Health in partnership with the Head Start Collaboration Office developed a series of oral health awareness lesson plans for use in Head Start programs.
- The Office of Oral Health in partnership with the Office of the Maryland WIC Program developed a series of oral health awareness lesson plans for use in WIC clinics targeted towards mothers of young children.
- The Office of Oral Health sponsors an annual Oran Cancer Awareness Week to heighten awareness about oral cancer for both the general public and for healthcare providers.
- The Office of Oral Health provides funding to local health departments to train healthcare providers about oral cancer, specifically on how to perform an exam for oral cancer, on the Eastern Shore and in Western Maryland. Additionally, seven counties also provide education to the public as part of oral cancer screening programs.
- The Office of Oral Health disseminated the American Academy of Pediatrics oral health anticipatory guidance training to local health departments.
- The Office of Oral Health developed and distributed the Maryland Oral Health Resource Binder for local health departments. This binder provided the tools for local health departments to deliver consistent oral health messages across the state.
- The Office of Oral Health in partnership with Morgan State University hosted three conferences to bring awareness of oral health for young children to people outside the field of oral health including Head Start staff, WIC staff, and advocates for children and parents.
- University of Maryland Dental School in partnership with the Office of Oral Health provides continuing education for local health department dental staff, community clinic dental staff, pediatric dental fellows, and pediatric clerks yearly on the topic of Advanced Pediatric Dentistry.

**Local Health Departments**

Kelly Sage also provided a broad overview of the types of strategies local health departments (LHDs) are using in their education and outreach programs. What they do varies from county to county and includes:

- Provide classroom education for children K-12 as well as Head Start (Tooth Fairy Program).
- School Sealant Programs.
- Educational presentations and one-on-one sessions with parents and care givers in Head Start and early Head Start.
- Work with youth who are in drug and alcohol classes to provide oral health education around the use of tobacco.
- Provide educational resources to teachers, community groups, dental hygiene programs and local dental societies.
- Conduct presentations in coordination with hospitals expectant parent classes.
- Sponsor television and radio public service announcements at the local level.

- Provide education and outreach at health fairs, presentations to recreation and parks groups.
- Presentations to teens about oral cancer, tobacco and oral piercings.
- Provide health care provider education seminars on oral cancer.
- Distribute infant care bags given by visiting nurses.
- Oral health orientation to school nurses.

There has been no broad based evaluation of the above strategies; however, local health departments share best practices, problems and successes. All local health departments that receive finances from the Office of Oral Health must do oral health education as a part of their other programs and an education component has to be written into their grant.

**Social Marketing Campaign**

Kelly Sage provided a brief overview of social marketing. Social Marketing is marketing that gets people to change their behaviors. This type of marketing presents the benefits of a behavior change so they outweigh the cost of engaging in the behavior. Social marketing identifies who your targeted audience is, what message are you trying to get out and how to motivate them. Social marketing is expensive because there is a lot of background research involved to reach the target population.

The committee was given information on the state of Arizona who has a new campaign to reduce tooth decay in children birth to 3 years old as well as other programs across the country like the I Am Moving I Am Learning campaign.

**MCO Outreach and Education Programs**

The Committee was given a review of MCO education and outreach efforts. Several MCOs (Jai, Amerigroup, and Helix) shared examples of their outreach materials. Although each MCO is different, they all have dental programs that employ similar strategies that include:

- Mailers and wellness letters sent to members
- Follow up telephone calls if no response from the letter
- Home visits (Jai)
- Referrals to the local health departments for demographic information
- Schedule dental appointments at well child visits
- Provide transportation for dental appointments
- Develop collaborative partnerships with dental providers, local health departments, dental schools and Head Start Programs.
- Encouraging providers to extend hours during the week and provide hours on Saturday
- Develop incentive programs that provide gift cards, give-aways, etc. to maintain oral hygiene
- Include dental information in the MCO newsletter
- Conduct dental fairs as part of the school curriculum during the school year

- Contract with dental providers that primarily serves Medicaid recipients and the underserved who maximize the amount of services provided during each visit
- Hire bilingual staff appropriate for the clientele served in that area
- Hire a community outreach staff person
- Develop letters and programs designed specifically for pregnant women and new mothers
- Work with medical disease management programs
- Partner with grass roots organizations.
- Implement an outreach initiative for children who have not had a dental appointment within the last year for ages 4-20 years old
- Health newsletters and magazines
- Position posters in pediatrician offices and specialty providers offices

Some of the challenges in MCOs providing dental care include:

- Access – lack of dental and specialty dental providers. Difficulty getting an appointment in a timely fashion.
- Difficult to get parents to buy into the importance of oral care and to prioritize dental care with all of the other challenges they may be facing. Many parents are fearful of dentists
- Health disparities in the African American community
- Significant no-show rates
- Difficulty contacting members, even with LHD referrals
- Home visits, although effective, are labor intensive
- Not all models of service delivery work in all areas of the state (urban vs. rural)

MCOs say the most successful strategies are their partnerships with dental providers and home visits. Committee members stated the dental side and the medical side within any MCO must communicate. The people who are missing the most in education are the physicians.

The committee was given the draft of a letter the Department is developing to be sent out to parents and care givers regarding the importance of oral hygiene, dental health and dental care. The Department will forward the letter to all committee members for comment and feedback to Susan Tucker, Executive Director, Office of Health Services at tuckers@dhmh.state.md.us on content and what the mailing cycle should be. Translations for the letter will be discussed.

**Public Testimony**

Ms. Barbara Brocato from the Maryland Dental Hygienists' Association wanted to highlight for the committee awards that other states have received from the American Dental Hygienists Association for their outreach and prevention. There have been programs in New York, Oregon and Idaho where dental hygienists worked with Head Start and other community groups to do oral screenings, sealants and varnishes that were very successful.

Mr. Dwayne Taylor representing Miguel McInnis from the Mid-Atlantic Association of Community Health Centers spoke about the many Federally Qualified Health Centers (FQHCs) across the state, many of which have school-based programs within those health centers. Some health centers have dental clinics. The Association wants to make sure that the information that comes out of this subcommittee is provided to their outreach workers who are out in the community every day.

**Committee Discussion**

The Medicaid population has changed over the years and now includes more working poor families.

- We must start to encourage providers while they are still in medical and dental school because current providers are not willing to participate in the Medicaid Program
- Have a holiday for health care by employers
- Teach parents to talk to their children about oral care
- Make it easier to get a dental appointment
- Policy makers should pose as a recipient and try to make a dental appointment
- There are dental lesson plans on the Office of Oral Health website
- MCOs to establish relationships with pediatric dental students to enhance capacity
- Parents don't have the same dental benefits as their children so the parents are not committed to oral health and dental care
- Scholarships for dental students who commit to working in the Medicaid Program after dental school (tabled until August 7)
- Sponsor a mobile dental unit to go from school to school (tabled to August 7)
- Put a dental chair on the Well Mobile. Take that mobile unit to rural areas. (tabled to August 7)
- Start talking about dental care and oral health in the medical home
- Local health departments are a great resource
- Develop an relationships with local hospitals in order to secure operating room time for children with severe need (tabled until August 7)

**Charge to the Subcommittee**

The Outreach and Education Subcommittee is charged with developing a series of recommendations given the information shared at this meeting. Develop a unified message to 1) increase health literacy, 2) stress prevention of oral disease and 3) develop strategies that give recipients a buy-in to prevent disease.

Mr. John Folkemer, Deputy Secretary, Health Care Finance was introduced to the committee. Mr. Folkemer stated all states are struggling with lack of dental care and shared that he was impressed with the positive approach this committee was taking to the issues and problems.

Next meeting is July 10, 2007 and the topic area will be Public Health Strategies.

# Dental Action Committee

**AGENDA**
**July 10, 2007**
**4:00 – 6:00 p.m.**

| | |
|---|---|
| 4:00 | Welcome, Updates, Review of Minutes from June 26 Meeting<br>*Jane Casper, Chair* |
| 4:05 | Public Health's Role in Increasing Access to Oral Health<br>*Michelle Gourdine, MD, Deputy Secretary for Public Health Services* |
| 4:10 | Overview of Office of Oral Health Programs<br>*Kelly Sage, DHMH, Office of Oral Health* |
| 4:15 | Maryland Community Health Resources Commission<br>*Grace Zaczek* |
| 4:25 | Local Dental Public Health Strategies<br>*Leslie Stevens, Maryland Oral Health Association/Allegany County Health Department*<br>*John Strube, Choptank Community Health System*<br>*Patricia Bell-McDuffie, Baltimore City Health Department*<br>*Jane Casper, Howard County Health Department*<br>*Harry Goodman, Pediatric Dental Fellows Program, University of Maryland Dental School* |
| 4:50 | Overview of Dental Health Professional Shortage Areas (HPSA) in Maryland<br>*Elizabeth Vaidya, DHMH, Office of Health Policy and Planning* |
| 5:00 | Public Testimony |
| 5:30 | Committee Discussion<br>*Jane Casper, Harry Goodman* |
| 6:00 | Adjournment |

# Dental Action Committee
# July 10, 2007
## Minutes

**Committee Members in Attendance:**

Carol Antoniewicz (Medicaid Matters! Maryland), Debbi Badawi (Maryland Academy of Pediatrics), Donna Behrens (Maryland Assembly of School Based Health Centers), Winifred Booker (Maryland Dental Society), Yvonne Bronner (Morgan State University), Carol Caiazzo (Maryland State Dental Hygienists' Association), Jane Casper (dental public health hygienist), Leigh Cobb (Advocates for Children and Youth), Harry Goodman (Head Start Region III Consultant), Hakan Koymen (Maryland Academy of Pediatric Dentistry), Elyse Markwitz (Priority Partners), Miguel McInnis (Mid-Atlantic Association of Community Health Centers), Garner Morgan (Maryland State Dental Association), Elizabeth Ruff (Carroll County Health Department), Donald Shell (Prince George's County Health Department), Mark Sniegocki (Doral Dental), Leslie Stevens (Maryland Oral Health Association), Norman Tinanoff (University of Maryland Dental School), Anthony Valdes (United Healthcare), Grace Williams (Maryland Medicaid Advisory Committee), Grace Zaczek (Maryland Community Health Resources Commission), Linda Zang (Maryland State Department of Education, Head Start Collaboration Office)

**Department of Health and Mental Hygiene Attendees:**

Michell Gourdine (Deputy Secretary for Public Health Services), Tricia Roddy (DHMH, Office of Planning Development and Financing), Kelly Sage (DHMH, Office of Oral Health), Susan Tucker (DHMH, Office of Health Services)

The Committee Chair, Jane Casper announced the members of the Public Health Subcommittee:

Harry Goodman, D.D.S.
Elizabeth Ruff
Donald Shell
Leslie Stevens
Grace Zaczek
Miguel McInnis

**Remarks from the Deputy Secretary**

Michelle Gourdine, M.D., Deputy Secretary for Public Health Services gave opening remarks and encouragement. Dr. Gourdine highlighted some of the things the committee should keep in mind as it moves forward with its charge:

- Local Health Departments (LHDs) play a significant role in delivering oral health services for children.

- 50% of the 24 jurisdictions provide oral health services and two more that are in the process of opening dental clinics. The areas of the state that have the greatest need are Southern Maryland and the Eastern Shore.
- We have a great relationship with the University of Maryland (U of MD) and the Department supports the Pediatric Dental Fellows Program and the U of MD Dental School.
- Partnerships are important in our goal of increasing access.
- We have seen an expansion in the number of FQHCs that have oral health programs. There are also community clinics that offer oral health programs throughout the state.

We want to build on these successes that we already have and be able to get recommendations from the committee on how to do that. Resources are limited and the Department is looking for creative options on how to expand these important services.

**Overview of the Office of Oral Health (OOH) Programs**

Kelly Sage provided an overview of the Office of Oral Health programs:

- Gives grants to local health departments (LHDs). For fiscal year (FY) 2008, twenty LHDs have been awarded grants for oral health services like clinical services, sealants, dental services, fluoride varnishes and oral cancer programs for screening and provider education.
- The U of MD conducts surveys and the data analysis of Maryland school children. They are currently working on data collected during the 2005-2006 school year.
- Support the Pediatric Dental Fellows Program
- Will be repeating the Head Start Oral Health Survey that looks at rates of untreated decay.
- Fund two programs at the Holly Center in Salisbury, Maryland 1) the Urgent Dental Clinic that provides dental services to head start children. This facility can provide some sedation services and 2) The Adult Dental Clinic that serves adult mentally disabled adults on the Eastern Shore. They also see adults from other parts of the state.
- Provide a grant to the Maryland Foundation of Dentistry for the Handicapped, a program for low income disabled adults. Dentists in the community donate their time and services.

Office of Oral Health funding provides many services. FY 2006 accomplishments include:

- Almost 7,000 children and 843 adults with dental visits through LHDs.
- Over 3,000 children received a sealant through school sealant programs.
- Almost 10,000 children were provided fluoride rinse in school based programs
- 200 children received oral health case management through LHD programs.
- Approximately 1,300 head start children had oral health screenings.
- 300 health care providers had education about oral cancer.

- 2700 adults had screening for oral cancer and one case of oral cancer was detected and the individual received appropriate treatment.
- 600 adults were referred to a smoking cessation programs in 2006 through LHD programs.
- The OOH administers the Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP). The program is a partnership between DHMH and the Maryland Higher Education Commissions which allows 5 dentists each year to receive education loan repayment for their dental or undergraduate loans of up to $99,000 over a 3 year commitment to the program if they agree to see at least 30% Medicaid in their practice. They can practice anywhere in the state. We do give priority to those practicing in Southern MD, Western MD and the Eastern Shore. We also have many loan repayment dentists in the Baltimore area, Prince George's and Montgomery Counties. This is the seventh year the program has been in operation. We currently have 7 dentists in the program and 5 dentists are selected each year. For CY 2006, loan repayment dentists provided over 16,000 appointments for Medicaid children. Some of the loan repayment dentists work with LHDs.

Currently there are 12 LHDs that have dental clinics with 2 more coming on board this year in Charles and Harford Counties. One of the goals of the OOH is to support LHDs who want to provide dental that don't currently provide it. The OOH would like to evaluate the current salaries of dentists in the Maryland State salary system. There is a big discrepancy between what the state system pays and what private practice pays. The LHDs have a difficult time attracting dental personnel. The OOH is looking to increase the amount of repayment in the MDC-LARP program. The OOH has been without dental expertise since January 2002 and would like to hire a dentist who will serve as the lead clinical expert on dental public health for DHMH and develop policy that improve dental health outcomes.

**Overview of the Maryland Community Health Resources Commission**

Grace Zaczek presented information regarding the Maryland Community Health Resources Commission. The Maryland Community Health Resources Commission (MCHRC) is an 11-member Commission, authorized by House bill 627 in the 2005 Maryland legislative session. The Commission's mission is to develop and implement strategies which improve availability and accessibility of comprehensive, community-based health care. The MCHRCs focus is on low-income, underinsured and uninsured Maryland residents, particularly families with incomes up to 200% Federal poverty level (FPL).

The Commission has a broad charge to expand access to care in many different areas: primary care, mental health, substance abuse treatment, dental care, school-based health care and specialty care if funds are available in the future. The Commission will expand access to care through a group of safety net providers or "Community Health Resources." The Commission has approximately $6 million per year for operating grants to assist community resources in improving access to care for the low-income, the under- and the uninsured.

To address the dental issue, the Commission has put together a request for proposals with a total of $2 million worth of awards for new clinics and expansions of existing sites. They will be for one or two years depending on the rates of expansion or new sites. Likely recipients are LHDs, FQHCs, FQHC look-alikes and other community clinics.

The MCHRC will conduct a mandated dental services study to address dental access and reimbursement issues for geographic areas statewide, all age groups, ethnic and racial minorities and low-income, under- and uninsured individuals. To conduct the dental study the Commission will consult with communitiy health resources that provide dental services, MCOs, U of MD Dental School and dental services providers. Additionally, the Commission has $1.7 million annually for health information technology projects to develop, support and monitor a unified data information system among community health resources, specialty providers, hospitals and other health care service providers.

The Commission has established regulations which identify the types of community health resources eligible for grants to expand access to community-based care. The Commission has established regulation to provide emergency funding to address rare, one-time, unanticipated situations which if unfunded, would seriously impact care in an eligible community health resource. In January 2007, the MCHRC awarded $22 million of need in response to 50 applications. The Commission awarded $4.6 million in operating grants to 12 community health resources statewide to address:

- Diverting non-urgent care from hospital emergency departments to community providers.
- Primary care.
- Mental health services.
- Substance abuse treatment.
- Dental services

The 12 grants range form $100,000 to $500,000 for one to three years with emphasis on direct services and strategies for sustaining those direct services after the grants have ended. The grantee will provide the Commission with data to demonstrate improved access to care as a result of the project activities.

The Commission has an emphasis on sustainability and how the grantee will sustain activities after the grant is finished. One of the components of the grant application is how the grantee anticipates obtaining future funding to continue the activity.

**Local Dental Public Health Programs**

Maryland Oral Health Association (Leslie Stevens) – The mission of the Maryland Oral Health Association (MOHA) is to promote and improve the health and well being of Maryland residents through State and local oral health programs. The Association gets updates from OOH and the Maryland State Board of Dental examiners. The Association sponsors a Dental CE, hosts speakers and holds troubleshooting sessions. During

meetings the Association highlights various programs discuss problems and issues and propose legislation. Reoccurring concern are the need for competitive salaries, low reimbursement rates, credentialing and dental program funding.

The Allegany County Health Department Dental Program (Leslie Stevens) – Provides clinical services to MA/MCO children through 18 years old. The clinic had 2,935 dental visits and 1,153 individual visits for children this year. Currently the clinic is fully staffed. The dental clinic treats any child it screens and is identified as needing immediate or urgent care. The program runs adolescent clinics for youth placed in Boy's Camps and has an adult extraction clinic one day a month. School programs include fluoride mouth rinse, school-based dental sealant, first-grade screening and Head Start screenings. Educational programs include expectant parent classes at the local hospital, Head Start classrooms, WIC, Jackson Unit-youth housed in drug and alcohol unit, health fairs and dental educational resources available for community use. Concerns for the program include recruitment, staffing, credentialing, MCO contact, low rates, lack of adult dental care, broken appointments and demand on the program.

Choptank Community Health System, Inc. (John Strube)– A private, non-profit community health center network, provides access to quality health care through the delivery of comprehensive medical, dental and behavioral health care services in Caroline, Dorchester and Talbot Counties. The first dental center was started in 2001 and the first school-based program was started the same year. School-based dental care is now being provided in all three counties. Since July 2006, the program has served 24,000 individuals for 83,000 visits, a third of that being dental. Part of the programs success is the willingness, ability and desire to collaborate with community resources. The collaboration with the U. of MD has allowed the program to provide services without making the trip across the bay. Challenges the program faces include capacity, funding, integration of information services and our medical technology, integration of medical and dental records.

Howard County Oral Health Program (Jane Casper)– Opened in 2000 and started with volunteer dentists and the dental clinic opened in 2002. There is a need for dental services in this wealthy county because there are pockets of impoverished areas in the county and many new immigrants from Central America, Vietnam, Korea, Africa and Eastern Europe. Funding is obtained through grants. Education is given at Head Start centers, day care centers, Pre- and elementary schools, senior centers, community health fairs, LHD prenatal clinics, Teens as Parents Program, Parents with Partners Program. The clinic has a pediatric fellow from the U of MD dental school and a general dentist. The program does oral cancer screenings, smoking cessation programs, oral screenings at elementary schools. The clinic serves as a site for internship for community service for dental hygiene students from the U of MD and CCBC. Translation services are provided as well as transportation. The challenges include the expense for transportation, funding for equipment, hiring personnel and resistance from the Board of Education to implement a sealant program.

**Pediatric Dental Fellows Program**

Harry Goodman provided an overview of the Pediatric Dental Fellowship Program. The University of Maryland Dental School places trained pediatric dentists in public health settings to provide services specifically to Medicaid children. The program has been a successful tool in recruiting dentists to work in public health. These Pediatric Dental Fellows are able to provide hospital-based oral health services for those children with severe dental disease.

**Health Professional Shortage Areas (HPSA)**

Elizabeth Vaidya from the DHMH Office of Health Policy and Planning (FHA) provided an overview of Dental HPSAs in Maryland. Information and handouts about Dental HPSAs were provided to Committee members.

**Public Testimony**

No Public Testimony

**Committee Discussion**

- Maryland needs to make dental screenings mandatory. You can triage the cases and catch the children who have greatest need.
- Credentialing problems differ by MCO.
- Look at the Vaccines for Children model to look at funding and providers
- Look at what other states are doing.
- Do a presentation at the school superintendents meetings regarding dental sealants and fluoride mouth rinse.
- Develop a speakers bureau
- Look at hearing screening and flu mist models regarding the removal of children from class.
- Pediatricians can advocate for school screenings.
- Incorporate fluoride varnish with school screenings
- Expand who can do oral screenings.

# Dental Action Committee

**AGENDA**
**July 24, 2007**
**4:00 – 7:00 p.m.**

| | |
|---|---|
| 4:00 | Welcome, Updates, Review of Minutes from June 26 Meeting<br>*Jane Casper, Chair* |
| 4:05 | Medicaid Overview<br>*Tricia Roddy, DHMH, Office of Planning* |
| 4:15 | Medicaid Reimbursement Rate Information and Fiscal Impact<br>*Susan Tucker, DHMH, Office of Health Services* |
| 4:25 | Review of the Milbank Memorial Foundation Report "Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need, Getting Value for State Payments"<br>*Laurie Norris, Public Justice Center* |
| 4:30 | MCOs Present Administrative Procedures |
| 4:45 | State Models<br>*Robert Lynn, Doral Dental, USA* |
| 5:05 | Discussion of Advantages and Disadvantages of Alternate Models<br>*Tricia Roddy, Susan Tucker* |
| 5:15 | Public Testimony |
| 5:35 | Committee Discussion<br>*Jane Casper, Harry Goodman* |
| 6:00 | Review of Education and Outreach to Parents and Caregivers Subcommittee Recommendations<br>*Ilise Marrazzo, DHMH, Office of Oral Health* |
| 7:00 | Adjournment |

# Dental Action Committee
## July 24, 2007
### Minutes

**Committee Members in Attendance:**

Carol Antoniewicz (Medicaid Matters! Maryland), Debbi Badawi (Maryland Academy of Pediatrics), Donna Behrens (Maryland Assembly of School Based Health Centers), Winifred Booker (Maryland Dental Society), Yvonne Bronner (Morgan State University), Carol Caiazzo (Maryland State Dental Hygienists' Association), Jane Casper (dental public health hygienist), Leigh Cobb (Advocates for Children and Youth), Harry Goodman (Head Start Region III Consultant), Leslie Grant (National Dental Association), Hakan Koymen (Maryland Academy of Pediatric Dentistry), Elyse Markwitz (Priority Partners), Miguel McInnis (Mid-Atlantic Association of Community Health Centers), Garner Morgan (Maryland State Dental Association), Laurie Norris (Public Justice Center), Elizabeth Ruff (Carroll County Health Department), Donald Shell (Prince George's County Health Department), Mark Sniegocki (Doral Dental), Leslie Stevens (Maryland Oral Health Association), Norman Tinanoff (University of Maryland Dental School), Anthony Valdes (United Healthcare), Grace Williams (Maryland Medicaid Advisory Committee)

**Department of Health and Mental Hygiene Attendees:**

John Folkemer (Deputy Secretary for Health Care Financing), Tricia Roddy (DHMH, Office of Planning Development and Financing), Kelly Sage (DHMH, Office of Oral Health), Susan Tucker (DHMH, Office of Health Services)

The Committee Chair, Jane Casper announced the members of the Medicaid Reimbursement Rates and Alternate Models Subcommittee:
Laurie Norris
Elyse Markwitz
Norman Tinanoff
Anthony Valdes
Grace Williams
Leslie Grant
Garner Morgan
Mark Sniegocki
Katheleen Loughran
The Subcommittee agreed to meet after the full DAC meeting at 7:00

The Committee reviewed the July 10, 2007 minutes and accepted the minutes with one change. The Vaccines for Children 'Model' should be changed to 'Program'.

**Medicaid Overview**

Tricia Roddy provided an overview of the data that was sent to Committee members prior to the meeting (see handout). Ms. Roddy discussed the following points:

- The data provided was based on HEDIS information, which requires recipients to be enrolled for 320 days and includes children up to 20 years of age.
- The Committee was interested in know the number of children aged 0-3 who received dental services (slide 4).
- Foster care children receive more dental services than the general Medicaid population, and this is true for all medical services.
- REM children receive less dental services than the general Medicaid population.
- 75% of all dental services provided are preventative and diagnostic.
- About 13-14% of pregnant women receive dental services.

**Medicaid Reimbursement Information and Fiscal Impact**

Susan Tucker provided an overview of Medicaid reimbursement rates (see handouts).

- This showed that Maryland's reimbursement is low in comparison to other South Atlantic states in diagnostic and preventative dental services.
- Maryland's restorative codes have gone up; Maryland has targeted certain codes.
- Maryland is lower than the 25$^{th}$ % of charges of South Atlantic dentists.
    - This means 25% of dentists charge less and 75% charge more. We do not know what the dentists get paid, only what they charge.
- Maryland's restorative rate increases have resulted in some utilization increase, but not an increase in Medicaid provider participation.
- Ms. Tucker then discussed the fiscal impact of raising reimbursement rates (see handouts).
- The total state amount would be ½ of the amount shown; the other ½ would come from a federal match.
- We need to do more than just raise rates to make an impact on dental; we need to develop a complete package.
- Some of our restorative fees were increased to 50% of charges a few years ago.

**Review of the Milbank Memorial Foundation Report**

Laurie Norris provided a review of the Milbank Report on "Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need, Getting Value for State Payments". She discussed the following points:

- This report attempted to create a model that delivered care, provided oversight, and achieved value.
- The report suggested assigning each child a level of need.
- The report discussed Dental Delivery Systems in terms of delivery and oversight: there were 4 levels of Dental treatment mapped out in report: preventative care, restorative care, advanced care, catastrophic care.
- The report suggested a blended model of capitated payments for those children with the fewest dental needs and a fee for service model for children with the most dental needs.
    - In 1999 dollars, the report estimated the capitation payment would be $17 per member per month.
- The Committee was not aware of any other state attempting to use a blended model.

**MCOs Present Administrative Procedures**

Mark Sniegocki of Doral Dental discussed Doral's administrative procedures. Mr. Sniegocki discussed Doral's claims and pre-authorization processes, services provided to providers, and the credentialing process.

- Doral works for 5 MCOs.
- Doral does almost 100% government programs.
- 64% of Doral's claims are done electronically
- Question about which codes need preauthorization? How does this compare nationally?
- Doral does credentialing for all 5 MCOs, including a site visit
    - Suggestion by the Committee to have a single entity do credentialing
    - The Committee inquired whether this credentialing different than processes used for private insurance.

Linda Dean of United HealthCare discussed United HealthCare's credentialing process.

- Credentialing turnaround is 78 days average, they are trying to improve this
- Presented a fast track suggestion
    - This would cost $50 – United administrative fee
- Committee asked why the graduation information was collected – this seems duplicative of state licensing
- California shares site visit information, is this something we can consider in Maryland?

Dr. Kilberg of UnitedHealth Care discussed Untied HealthCare's pre-authorization processes.

- Takes about 2 days if it goes to the right address
- They are denied based on medical necessity, often for a lack of info (x-ray)
- Are not denied if performed on an emergency basis
    - Prior authorization for a toothache – if the only thing to be done is a root canal, this should be perform, and a narrative should be written on the claim form, indicating the emergency
- Committee would like a copy of provider manuals

**State Models**

Mr. Robert Lynn of Doral Dental presented information regarding alternative state Medicaid models. Mr. Lynn addressed several states' ability to maintain adequate dental coverage despite cuts in Federal and State funding levels. Mr. Lynn described the various dental carve-out programs across the country. He shared that states that have moved to dental carve-out scenarios have been able to increase their utilization rates.

**Discussion of the Advantages and Disadvantages of Alternate Models**

Susan Tucker and Tricia Roddy discussed the pros and cons of various dental Medicaid models, including the current MCO model, single payor options (both at risk and not at risk models), and the traditional fee-for-service model. A chart detailing this comparison was distributed to Committee members.

**Public Testimony**

No public testimony.

**Committee Discussion**

The Committee's discussion was as follows:

- Licensing / credentialing – would like a clearinghouse / streamlined process
- PMPM costs in the S. Atlantic region – each state could decide to give us this information or not
    - Medicaid pays a PMPM as a bundled capitation payment with medical, administration, and all other services, including dental determined by considering the past utilization and trending these numbers forward
        - Therefore, the PMPM for dental is lower because access to dental services (approximately 50%) is built into the equation
        - What is the incentive to increase utilization?
            - Pay for performance was not funded for quality incentives
    - MCOs are paying dental for adults – the state does not pay for adult dental, except in the REM program

**Review of Education and Outreach to Parents and Caregivers Subcommittee**

Ilise Marrazzo facilitated the discussion of the Education and Outreach Subcommittee recommendations. The Committee decided to keep the subcommittee's recommendations and make the following additions:

- Convene a focus group to look at involving pediatricians in the delivery of oral health education and services such as Fluoride varnish
- Cross-train dental and medical students
- Create a social marketing campaign that includes the development of a streamlined oral health message that can be used across disciplines
- Utilize school health services, school based health centers, and local health departments as tools to educate children in all schools
- Focus education efforts and delivery on population groups most at risk for oral disease (immigrant families, children with special health care needs)
- Include nutrition education as part of oral health messages
- 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
- Office of Oral Health should partner with school based health centers and school health services to create a prevention message for schools
- Review existing educational videos for use in medical and dental offices
- Partner with train the parent programs (ex. Parents as Teachers) to provide oral health education to parents/caregivers

The meeting concluded at 7:20 p.m.

# Dental Action Committee

**AGENDA**
**August 7, 2007**
**4:00 – 7:00 p.m.**

| | |
|---|---|
| 4:00 | Welcome, Updates, Review of Minutes from July 24 Meeting<br>*Jane Casper, Chair* |
| 4:05 | EPSDT Provider Education<br>*Marti Grant, DHMH, Maryland Medical Programs* |
| 4:15 | Risk Assessment/Anticipatory Guidance Training for Medical Providers<br>*Ilise Marrazzo, DHMH, Office of Oral Health* |
| 4:25 | Review of Medicaid Provider Data<br>*Susan Tucker, DHMH, Office of Health Services* |
| 4:35 | Current Provider Recruitment Strategies<br>*Mark Sniegocki, Doral*<br>*Linda Dean, United HealthCare* |
| 4:45 | Dental Hygienists Scope of Practice in Other States<br>*Jane Casper* |
| 4:55 | Provider Incentives Panel<br>*Maryland State Dental Association, National Dental Association, Maryland Dental Society, Maryland Academy of Pediatric Dentistry (panelists to be determined)* |
| 5:05 | Public Testimony |
| 5:35 | Committee Discussion<br>*Jane Casper, Harry Goodman* |
| 6:00 | Review of Public Health Subcommittee Recommendations<br>*Jane Casper, Harry Goodman* |
| 7:00 | Adjournment |

# Dental Action Committee
# August 7, 2007
## Minutes

**Committee Members in Attendance:**

Carol Antoniewicz (Medicaid Matters! Maryland), Debbi Badawi (Maryland Academy of Pediatrics), Winifred Booker (Maryland Dental Society), Carol Caiazzo (Maryland State Dental Hygienists' Association), Jane Casper (dental public health hygienist), Leigh Cobb (Advocates for Children and Youth), Harry Goodman (Head Start Region III Consultant), Hakan Koymen (Maryland Academy of Pediatric Dentistry), Elyse Markwitz (Priority Partners), Miguel McInnis (Mid-Atlantic Association of Community Health Centers), Garner Morgan (Maryland State Dental Association), Laurie Norris (Public Justice Center), Elizabeth Ruff (Carroll County Health Department), Donald Shell (Prince George's County Health Department), Mark Sniegocki (Doral Dental), Leslie Stevens (Maryland Oral Health Association), Norman Tinanoff (University of Maryland Dental School), Anthony Valdes (United Healthcare), Grace Williams (Maryland Medicaid Advisory Committee), Grace Zaczek (Maryalnd Community Health Resources Commission)

**Department of Health and Mental Hygiene Attendees:**

Ilise Marrazzo (DHMH, Office of Oral Health), Susan Tucker (DHMH, Office of Health Services), Paula Hollinger (DHMH, Health Workforce)

The Committee Chair, Jane Casper announced the members of the Provider Participation, Capacity, and Scope of Practice Subcommittee:
Leslie Grant
Garner Morgan
Debbie Badawi
Carol Caiazzo
Hakan Koymen
Donna Behrens
Elyse Markwitz
Jane Casper
Leigh Cobb

The Committee reviewed the July 24 minutes and approved the minutes as written.

**EPSDT Provider Education**

Marti Grant provided an overview of the EPSDT program requirements for providers and provider education regarding oral assessments. These materials were sent to Committee members prior to the meeting (see handout). The following was discussed:

- An orientation is given to new primary care providers (PCPs) who are serving the Medicaid population when visiting their practice. Each provider is given a packet of information for their reference.
- During the oral exam, providers are asked to document any identified problems or indicate the mouth is within normal limits.

- Quality monitoring of all oral assessment components is conducted and a score is assessed.
- The Healthy Kids Manual is on the Department's website
- Of the 2,000 records that have been reviewed this year, 95% show that PCPs are completing an oral assessment as part of the physical and 75% of records that would require a dental referral, ages 2 and above, did have a dental visit.
- Committee expressed concern with PCPs not given specific training on oral health. It is difficult for PCPs to assess the condition of a tooth and children should automatically be referred to a dentist.
- Residents and dental providers should be encouraged to see children at age one.
- Dr. Goodman will be teaching 100 PCPs per year about oral health examinations.

**Risk Assessment/Anticipatory Guidance Training for Medical Providers**

Ilise Marrazzo gave the Committee information on two tools that can be used as a model for training providers (see handouts). The American Academy of Pediatrics (AAP) has developed a training program for pediatricians and other providers who interact with children. It is an online program that goes over oral health risk assessment, what the provider should be looking for and the importance of a dental home.

The Center for Maternal and Child Oral Health has an entire area on their website dedicated to special care which allows dentists and their staff to go through 6 modules on how to interact with children with special health care needs.

The Department needs to develop a relationship with the AAP in Maryland to have pediatric dentists and dental hygienists do hands on training with other providers.

The AAP of Maryland just submitted an application for a planning grant to do a pilot project to train pediatricians on the Eastern Shore on oral health exams.

**Review of Medicaid Provider Data**

Susan Tucker reviewed data from the analysis of dental service utilization by selected groups of beneficiaries enrolled in the MCHP and Medicaid programs requested by the Committee (see handout). Data provided to the Committee at the meeting addressed the following issues:

- The number of children in the 0-3 age group broken down by each individual age.
- The number of people who got a preventive or diagnostic visit that may have led to a restorative visit in the same year.
- The number of dental services provided in the emergency room (excluding accidents, injury and poison).
- The number of providers who billed at least one dental encounter by county (active dentists).
- Data indicates that children age 0-3 don't get much dental care and are particularly underserved.
- You have to keep in mind that this data is from what dentists provide on their forms.
- Directories are not accurate in identifying active dental providers.

**Current Provider Recruitment Stategies**

Mark Sniegocki and Marcel of Doral gave the Committee an overview of their recruitment efforts in Maryland. Doral conducts recruitment on behalf of five of the managed care organizations (MCOs): Amerigroup, Coventry Diamond Plan, Priority Partners, Maryland Physicians Care and Helix Family Choice. Key components of their network development strategies include:

- Contacting providers and potential providers every six months.
- Contact is done by mail, phone and face-to-face by appointment.
- Conduct provider orientation sessions to introduce and educate providers to Doral and the program.
- Take Five Initiative – brochure sent to providers that asks them to take five patients into their practice and give the program a try (provider does need to contracted and credentialed).
- Offer help to the provider's office with administrative work.
- Ask dentists to give back to the community by participating in the program.
- The average annual provider turnover is 13-14 %.

Philip Hahn of United HealthCare gave the Committee an overview of their recruitment strategies (see handout). Key components of their recruitment efforts include:

- Use of the internet.
- Target each section of the state on a quarterly basis. Targets are constantly under review.
- Comprehensive packets are given to potential providers.
- Try to appeal to the community service aspect of participating in the project.
- Face-to-face visits.
- Attend conferences.
- Assist providers with the Medicaid application.
- Recruiters have extensive knowledge in Medicaid.
- Negotiate services that are "outside of the box."
- Give providers quick fact sheets on how the plan works and who to call for help.

**Committee Discussion**

The Committee discussion was as follows:

- Maryland needs to encourage young dentists at the dental school level that Medicaid is not a bad thing. We have to court young dentists and young practitioners.
- Need to develop a support system.
- Need to develop a reward system for long-term participation.
- Maryland structure is concentrated and young new dentists can't open a practice and have to join a group. You must adapt to the structure in this state, pinpoint those who want to provide services and support them.
- Look at recruitment practices to see if there are cultural barriers to recruiting providers. Plans must be educated regarding these barriers.
- Ask dentists to provide pro bono hours to replace CEUs.
- FQHCs get federal funds that could be tapped into.
- Support the existing infrastructure so it continues.
- State to provide plans with a listing of new dentists.
- Speakers should come and talk to 4th year dental students.

- The arena in which we treat children is different. Must make the patient want to be there. Use a different mode of delivery from what is used in general dentist's office.
- Develop regional treatment centers.
- It was proposed years ago that before a provider license would be granted, they would have to participate in Medicaid.
- The Committee should have an evaluation that tracks whether or not the Committee made a difference. This subject has not been addressed by any subcommittee.

**Dental Hygienists Scope of Practice in Other States**

Carol Caiazzo gave the Committee some examples from other states and suggestions on how to expand dental hygienists scope of practice.

- Do away with the waiver required to practice in a public health setting or multiple waivers to practice in more than one setting. The waiver allows a dental hygienist to practice without a licensed dentist present.
- Increase access by expanding the duties of dental hygienists.
- Pennsylvania – the dentists and hygienists collaborated and put in a bill for hygienists to perform 3600 hours of practice under a licensed dentist and then be able to practice dental hygiene without a dentist. They are called public health dental hygienists. They can do assessments, cleanings, fluoride treatments and sealants.
- North Carolina, Georgia and Massachusetts also have public health dental hygienists in various settings.
- New Mexico has a collaborative practice program where a certified dental hygienist can provide dental hygiene services in a cooperative working relationship with dentists. By removing supervision requirements hygienists can work in a variety of settings.
- Allow dental hygienists to become Medicaid providers. This is being done in 12 different states.
- Expand the duties of the dental hygienist to allow them to go into the schools and public health settings and do assessments and screenings.
- In a public health setting, the dental hygienist should be able to supervise a dental assistant.
- Expand the duties of certified dental assistants in a public health setting to allow them to perform services like polish teeth and do cleanings.
- The state needs to recognize all levels of professionals in dental public health clinics.
- Maryland has three specifications of public health hygienists: Hired with no experience, hired with two years experience and public health hygienists.
- Don't have hygienists bill as a provider, if they work in a facility bill as the facility which avoids credentialing and processing with the MCOs.
- There has been a manpower study done by the ADA who is looking to standardize the testing for the certification of dental assistants.
- Committee to look at report from the ADA that deals with public health issues.

**Public Testimony**

Al Bedell from the Alliance for Integrated Health Care made a recommendation to recruit dentists on a volunteer basis all over the state to establish a "Dentists Day" to see MCHP

and underprivileged children all over the state pro bono. This would be a grass roots effort where children would be x-rayed, examined and treated for what was needed. Each dentist will treat five children. This will be done in collaboration with the school systems and all school systems will participate. Use school buses to get children to their appointments. We must develop an incentive to get dentists to participate.

**Review of Public Health Strategies Subcommittee Recommendations**

Dr. Harry Goodman facilitated the discussion of the Public Health Strategies Subcommittee recommendations (see handout). The Committee decided to accept the subcommittee's recommendations with the following additions and exceptions:

- Look at resource allocation. Determine where the children at the greatest risk are and make sure resources are used effectively.
- Support the existing infrastructure on an on-going basis.
- Look at Dental Board barriers and issues regarding foreign graduates (to be considered by the Scope of Practice Subcommittee).
- The Dental Society will be opposed to recommendation #9 which proposes Medicaid reimbursement for pediatricians to provide dental screenings, education and fluoride varnish.
- Need help in attracting dentists to provide follow-up and specialty care.
- Empower general practice dentists.
- Use Oral Safety Net bill funds to develop the creation of a speaker's bureau.
- Obtain technical support from the Department with costing out subcommittee recommendations to help prioritize the final list of recommendations.
- Cost out a "well functioning" Office of Oral Health.
- Committee agreed that they should develop 6 overarching recommendations that have the greatest impact. Developing a strong Office of Oral Health should be an overarching recommendation.

August 21, 2007 is the last meeting unless the Committee feels it needs another meeting which will be held on August 28, 2007. At the next meeting the following subcommittees will give their reports: Medicaid Reimbursement Rates and Alternative Models of Care and Provider Participation, Provider Capacity and Scope of Practice. The Committee will review the draft of final recommendations (please submit all recommendations to Ms. Sage prior to the meeting).

The meeting adjourned at 6:45 p.m.

# Dental Action Committee

**AGENDA**
**August 21, 2007**
**4:00 – 6:00 p.m.**

| | |
|---|---|
| 4:00 | Welcome, Updates, Review of Minutes from August 7 Meeting<br>*Jane Casper, Chair* |
| 4:05 | Medicaid Rates and Alternate Models Subcommittee Recommendation Review<br>*Laurie Norris* |
| 4:35 | Provider Participation, Capacity, and Scope of Practice Subcommittee Recommendation Review<br>*Leigh Cobb* |
| 5:05 | Approval of Education and Outreach and Public Health Strategies Recommendations and Main Themes<br>*Jane Casper, Harry Goodman* |
| 6:00 | Adjournment |

# Dental Action Committee
# August 21, 2007
## Minutes

**Committee Members in Attendance:**

Carol Antoniewicz (Medicaid Matters! Maryland), Debbi Badawi (Maryland Academy of Pediatrics), Donna Behrens (Maryland Assembly of School Based Health Centers), Winifred Booker (Maryland Dental Society), Yvonne Bronner (Morgan State University), Carol Caiazzo (Maryland State Dental Hygienists' Association), Jane Casper (dental public health hygienist), Leigh Cobb (Advocates for Children and Youth), Harry Goodman (Head Start Region III Consultant), Leslie Grant (National Dental Association), Hakan Koymen (Maryland Academy of Pediatric Dentistry), Elyse Markwitz (Priority Partners), Miguel McInnis (Mid-Atlantic Association of Community Health Centers), Garner Morgan (Maryland State Dental Association), Laurie Norris (Public Justice Center), Elizabeth Ruff (Carroll County Health Department), Donald Shell (Prince George's County Health Department), Mark Sniegocki (Doral Dental), Leslie Stevens (Maryland Oral Health Association), Norman Tinanoff (University of Maryland Dental School), Anthony Valdes (United Healthcare), Grace Williams (Maryland Medicaid Advisory Committee), Grace Zaczek (Maryland Community Health Resources Commission), Linda Zang (Maryland State Department of Education)

**Department of Health and Mental Hygiene Attendees:**

John Folkemer (Deputy Secretary for Health Care Financing), Tricia Roddy (DHMH, Office of Planning Development and Financing), Kelly Sage (DHMH, Office of Oral Health), Susan Tucker (DHMH, Office of Health Services), Paula Hollinger (DHMH, Health Workforce)

The Committee Chair, Jane Casper, opened the meeting by reviewing the agenda. The Committee reviewed the August 7 minutes and approved the minutes as written. Mr. Miguel McInnis asked for time on the agenda to discuss three issues of importance to the Committee: diversity, budgetary concerns, and the recommendation main themes. The Chair added Mr. McInnis to the agenda following the discussion of the two subcommittee recommendation reports. Dr. Leslie Grant announced that California is moving towards mandatory school screenings. In addition, Dr. Grant notified the Committee that she has *Smile Alabama* materials available to those who are interested.

**Medicaid Rates and Alternate Models Subcommittee Recommendation Review**

Ms. Laurie Norris reviewed the recommendations from the Medicaid Rates and Alternate Models Subcommittee (handout). The subcommittee was unable to reach consensus regarding the issue of a delivery model (single vendor ASO vs. retaining current structure with modifications). Ms. Norris invited subcommittee members to share their thoughts with the Committee regarding the delivery model.

Mr. Mark Sniegocki, speaking on behalf of Doral and not its clients, is supportive of the exploration of a single vendor concept in Maryland (handout). He advised the Committee to consider the experiences of other states in moving toward this model.

Additionally, Mr. Sniegocki also shared that the District of Columbia was moving to a single vendor.

Ms. Kathleen Loughran, oh behalf of Amerigroup, distributed a handout detailing recommendations developed by Amerigroup. Ms. Loughran recommended that the Committee and DHMH study the changes to the program made recently in a year and then revisit the single vendor concept at that time if it is decided that the changes were not effective.

Dr. Norman Tinanoff stated that an important component of overhauling the system is the increase in rates as recommended by the subcommittee. Dr. Tinanoff stressed the need for rates to be indexed so that when rates increase in the region, Medicaid reimbursement rates also increase. Some discussion ensued among the larger group that perhaps the rate increase should be targeted towards preventive, restorative, and few additional codes in order to keep costs down. Additionally there was discussion regarding targeting higher rates to services provided to children between 0-3 years.

Ms. Elyse Markwitz, on behalf of Priority Partners, stated that Priority Partners is supportive of a single vendor system and that they are willing to share their expertise as needed. Additionally, she stated that Priority Partners is willing to work to minimize pre-authorizations and Ms. Markwitz requested if the State could reinforce the use of the ADA Claim Form.

Committee Vice Chair, Dr. Harry Goodman, called a vote regarding whether the Committee was comfortable taking a vote today regarding the delivery model. Those in favor of voting on a delivery model = 19, those not in favor of voting = 5. Those in favor of recommending a single vendor ASO = 21, those not in favor = 0, those abstaining = 3. The recommendation regarding the delivery model was announced as the single vendor ASO system.

**Provider Participation, Capacity, and Scope of Practice Subcommittee Recommendation Review**

Ms. Leigh Cobb reviewed the recommendations from the Provider Participation, Capacity, and Scope of Practice Subcommittee (handout). The full Committee discussed the recommendations. The Committee members discussed the following issues:

- The Maryland State Dental Association will not support the recommendation that primary care providers apply fluoride varnish.
- Better linkages need to be established between medical offices and dental offices (stronger relationships and referral networks).
- Dental Assistants are not currently licensed by the state, so expanding their scope of practice appears unwise.
- Establish cross-training between medical and dental students.

**Addition of Diversity, Budgetary Concerns of Recommendations, and Public Health Strategies Recommendation Concerns**

Mr. McInnis distributed a handout with a recommendation on diversity that he would like to see added to the Committee report. There was agreement that this recommendation should be added to the report under Public Health Strategies. Mr. McInnis also stated this concern that the Committee has not seen any cost figures for the recommendations

and that the Committee would not be able to prioritize their recommendations without this information. Ms. Kelly Sage and Ms. Susan Tucker stated that DHMH will be working during the upcoming week to provide costs for the recommendations. Things that have a quantifiable cost will have dollar amounts; however, many of the recommendations will be difficult to cost out. DHMH will use a cost rating system to identify recommendations as either low, medium, or high cost.

Mr. McInnis noted the lack of a recommendation in Public Health Strategies that encourages DHMH and other organizations to seek and leverage Federal funds to assist FQHCs in expanding so that more dental services can be provided. Dr. Goodman stated that he was in agreement and that a recommendation would be added to Public Health Strategies to address this.

**Education and Outreach Recommendations Review**

Ms. Casper led the review of the Education and Outreach Recommendations. The Committee decided to eliminate recommendation EO-11 since is it also included under Provider Participation, Capacity and Scope of Practice. The addition of "other safety net providers" will be included under EO-23.03. Ms. Casper called a vote to approve the recommendations with the suggested changes. Those in favor of the recommendations with the changes = 24, those opposed = 0, those abstaining = 0.

**Public Health Strategies Recommendation Review**

Ms. Casper let the review of the Public Health Strategies Recommendations. The Committee eliminated recommendations PHS-09 and PHS-13 due to the fact that they are also included under Provider Participation, Capacity and Scope of Practice. The following recommendations were added:

- The recommendation regarding diversity as submitted by Miguel McInnis.
- The Dental Action Committee should continue to meet to assist DHMH in implementing the recommendations and in evaluating DHMH's progress.
- Provide funding so that every jurisdiction has a FQHC, community health center, or other safety net provider able to provide dental services.
- Mandatory oral exams prior to school entry (equal to the requirement for health physicals).
- Federal funds should be sought by FQHCs and the Office of Oral Health to support oral health programs and to leverage additional funds.
- The Office of Oral Health should develop an oral health disease burden document for the state.

In addition, changes to existing recommendations were made and these will be included in the final draft of the recommendations. Ms. Casper called a vote to approve the recommendations with the suggested changes. Those in favor of the recommendations with the changes = 24, those opposed = 0, those abstaining = 0.

**Next Committee Meeting Information**

The Dental Action Committee will meet next Tuesday, August 28 from 4-6 in the L-1 conference room.

Meeting adjourned at 6:15 p.m.

# Dental Action Committee

**AGENDA**
**August 28, 2007**
**4:00 – 6:00 p.m.**

| | |
|---|---|
| 4:00 | Welcome, Updates, Review of Minutes from August 21 Meeting<br>*Jane Casper, Chair* |
| 4:05 | Review Final Report Timeline<br>*Harry Goodman, Vice Chair* |
| 4:15 | Medicaid Rates and Alternate Models Recommendation Review and Vote<br>*Jane Casper and Harry Goodman* |
| 4:30 | Provider Participation, Capacity, and Scope of Practice Recommendation Review and Vote<br>*Jane Casper and Harry Goodman* |
| 4:45 | Review of Main Recommendation Points<br>*Jane Casper and Harry Goodman* |
| 5:05 | Review of Prioritized Recommendation List<br>*Jane Casper and Harry Goodman* |
| 5:25 | Review of Draft Report<br>*Jane Casper and Harry Goodman* |
| 6:00 | Adjournment |

# Dental Action Committee
# August 28, 2007
## Minutes

**Committee Members in Attendance:**

Carol Antoniewicz (Medicaid Matters! Maryland), Debbi Badawi (Maryland Academy of Pediatrics), Donna Behrens (Maryland Assembly of School Based Health Centers), Winifred Booker (Maryland Dental Society), Carol Caiazzo (Maryland State Dental Hygienists' Association), Jane Casper (dental public health hygienist), Leigh Cobb (Advocates for Children and Youth), Harry Goodman (Head Start Region III Consultant), Leslie Grant (National Dental Association), Hakan Koymen (Maryland Academy of Pediatric Dentistry), Elyse Markwitz (Priority Partners), Miguel McInnis (Mid-Atlantic Association of Community Health Centers), Garner Morgan (Maryland State Dental Association), Laurie Norris (Public Justice Center), Elizabeth Ruff (Carroll County Health Department), Donald Shell (Prince George's County Health Department), Mark Sniegocki (Doral Dental), Leslie Stevens (Maryland Oral Health Association), Norman Tinanoff (University of Maryland Dental School), Anthony Valdes (United Healthcare), Grace Williams (Maryland Medicaid Advisory Committee), Grace Zaczek (Maryland Community Health Resources Commission), Linda Zang (Maryland State Department of Education)

**Department of Health and Mental Hygiene Attendees:**

Sharon Bloom (DHMH, Office of the Secretary), Lori Demeter (DHMH, Center for Preventive Health Services), Amanda Rosecrans (DHMH), Tricia Roddy (DHMH, Office of Planning Development and Financing), Kelly Sage (DHMH, Office of Oral Health), Susan Tucker (DHMH, Office of Health Services), Paula Hollinger (DHMH, Health Workforce)

The Committee Chair, Jane Casper, opened the meeting by reviewing the agenda and noting that Provider Particpation, Capacity, and Scope of Practice recommendations would be heard before Medicaid Rates and Alternate Models recommendations. The Committee reviewed the August 21 minutes and approved the minutes as written.

**Review Final Report Timeline**

Vice Chair, Harry Goodman, reviewed the timeline for submitting the final report to the Secretary and highlighted that Committee members would have two opportunities to offer feedback and comments on the draft report:

- September 5: the Chairs will submit to members a draft report for their review. Members will need to submit comments to the chairs by no latter than September 7.
- On September 9, the Chairs will submit to members a revised draft report for their review. Members will need to submit comments to the chairs by no later than September 10.
- On September 11, the Chairs will submit the final draft report to the Secretary and will e-mail Committee members a copy of the final draft report.

**Provider Particpation, Capacity, and Scope of Practice Recommendation Review and Vote**

In reviewing the Provider Participation, Capacity, and Scope of Practice subcommittee recommendations, the Committee adopted the following changes: For PPCSP-01: Delete: "increase scope of practice" and replace with "change supervision requirements" (adopted by unanimous consent).

For recommendation PPCSP-02, the Committee addressed the recommendation sentence-by-sentence. After some discussion, the Committee left the first sentence unchanged (adopted: 18 in favor; 4 oppose; 0 abstain). In the second sentence, the Committee deleted "age 2" and replaced with "age 1" (adopted by unanimous consent). In the third sentence, after some discussion regarding allowing personal care physicians (PCPs) to bill Medicaid, the Committee decided to recommend allowing PCPs to bill Medicaid (adopted: 19 in favor; 2 oppose; 0 abstain). Finally, the Committee considered deleting the fourth sentence but instead decided to leave it to the chairs to wordsmith sentences two and four (adopted: 19 in favor; 0 oppose).

In recommendation PPCSP-03, the Committee deleted "age 12" and replaced it with "age 5." The DAC also inserted "and toothbrush prophylaxis" after "coronal polishing" and deleted "varnish" (all actions adopted by unanimous consent).

The Committee debated the benefits of allowing taxes as incentives to dentists in considering recommendation PPCSP-05. Some Committee members felt strongly that taxes were strong incentives while others argued rates were key. A motion to delete the recommendation was defeated (a first vote: 9 in favor of deleting; 9 oppose. Due to not all members were in the room, the decision to revote was adopted by unanimous consent. The second vote: 9 in favor of deleting; 12 oppose). The Committee also decided to delete "HealthChoice" and replace with "Medicaid" and delete "as an alternative to increasing reimbursement rates" (adopted by unanimous consent).

Following the discussion, the Committee adopted the Provider Participation, Capacity, and Scope of Practice recommendations as amended to reflect these modifications (adopted: 19 in favor; 1 oppose; 1 abstain).

**Medicaid Rates and Alternate Models Subcommittee Recommendation Review**

In reviewing the Medicaid Rates and Alternate Models subcommittee recommendations, the Committee adopted the following changes: For RM-01.1: insert "annual indexing of" after "Index the". Delete "increase in step with" and replace it with "50$^{th}$ percentile of". Finally, delete "charges" and replace with "fee schedule" (all actions adopted by unanimous consent).

In reviewing recommendation RM-01.02, discussion moved in favor of deleting it from the recommendation list. With no opposition, the recommendation was deleted (motion to delete adopted by unanimous consent).

For recommendation RM-04, the Committee moved to strike the recommendation and replace with "Implement a dental home for every Medicaid child by 2011" (adopted by unanimous consent).

Finally, the Committee voted to adopt the Medicaid Rates and Alternate Models recommendations as amended to reflect these modifications (adopted: 23 in favor; 0 oppose; 0 abstain).

**Review of Main Recommendation Points**

During the review of the Dental Action Committee Main Recommendation Points, the Committee discussed making main recommendation PHS-R1 stronger and more specific. The Committee deleted "the recommendations set forth in the Dental Public Health Infrastructure Report," as it felt this clause vague, and left it with the Chairs to rework the language of the recommendation to strengthen it. The Committee also reviewed PHS-R2, and deleted "in certain grades" (adopted by unanimous consent).

For recommendation PPCSP-R2, the Committee discussed which medical professionals ought to be covered by that recommendation; and in so doing, the DAC deleted "pediatricians, physicians, physician assistants and nurse practitioners" and replaced it with "dental and medical providers". It also inserted "about oral health care" after "parents/caregivers". Finally, the DAC deleted "apply fluoride varnish to children at risk for oral disease" and replaced it with "assist families in establishing a dental home" (each of these actions adopted by unanimous consent).

Finally, the Committee adopted all Dental Action Committee Main Recommendations as amended to reflect these modifications (adopted: 21 in favor; 0 opposed; 1 abstain).

**Review of Prioritized Recommendation List**

Vice Chair Harry Goodman explained the priority rankings and explained the difficulty with reviewing them as a whole. As a result, he asked if there were any priorites assigned that the Committee disagreed with. In response to this, the Committee increased the priority assignment of recommendation PHS-11 from low to medium priority. Additionally, recommendation PHS-15 was increased from medium priority to high priority. (Cost for recommendation PHS-03 was changed to $8 million per request of the Committee.) The Vice Chair also invited feedback from Committee members during the drafting process to comment on any other changes to priority members felt necessary.

**Review of Draft Report**

Committee members were give a copy of a draft report to indicate the direction the Chairs were going with the drafting process. The Committee urged the Chairs to make the language of the report inspirational. Committee member, Carol Antoniewicz, submitted a memo to the Chairs regarding the style and tenor of the report. The Committee also identified that finding a dental home for every Maryland child as the central theme of the report. Members also agreed to submit letters of support for the report to the Chairs to be included as an appendix to the report.

**Adjournment**

The meeting adjourned at 5:55 p.m.

Dental Action Committee
Recommendations from the
Reimbursement Rates and Delivery Models Sub-Committee
August 21, 2007

1. **Rates** –
    a. raise dental reimbursement rates to the 50th percentile of ADA South Atlantic (SA) charges, for all codes
    b. index the reimbursement rates to increase in step with the ADA SA charges
    c. consider using funds generated by HB1 (2004) to fund the rate increase
2. **New procedure codes** –
    a. add and fund new dental procedure codes for
        i. behavior management
        ii. treating very young children
        iii. treating children with special needs
        iv. treating foster children
3. **Delivery model** – Unresolved. We discussed the following two models, but could not reach consensus on a recommendation.
    a. change to a statewide single vendor dental provider, ASO (administrative services only)
        i. specifics to be designed by an ongoing task force or committee, to include
            1. a competitive bidding process
            2. a catchy new name
            3. strong oversight by DHMH
            4. a simplified administrative interface for dentists
                a. one credentialing system
                b. minimized prior authorization
                c. expedited claims processing
            5. simplified navigation for parents
    b. retain the current MCO and dental sub-contract structure but try to modify it to be more "friendly" to dentists, for example by
        i. Creating a credentialing clearinghouse
        ii. Reducing the requirements for prior authorization
4. **Dental home** –
    a. Phase in the dental home concept, in year 2 or year 3, after more dentists have been recruited to participate.

Public Health Subcommittee Report
August 7, 2007

Public health goal: Assist families in establishing a dental home in partnership with local health departments, other safety net providers, and private providers

Public health strategies:

1) Fund the Oral Health Safety Net bill (HB 30; SB 181)
2) Provide funding so that every local health department has a clinical dental program
3) 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
4) Ensure that every local health department with a clinical dental program provides dental care services to Medicaid-enrolled patients
5) Enact the recommendations of the Dental Public Health Infrastructure Report not addressed in the above public health strategies:
    a. The Office of Oral Health should develop a white paper describing disease burden and disseminate it to appropriate stakeholders
    b. Office of Oral Health further develop a state oral disease surveillance program
    c. Office of Oral Health should develop an evidence-based Oral Health Plan
    d. Office of Oral Health should establish and sustain a statewisde oral health coalition
    e. Office of Oral Health should promote oral health through a multi-faceted oral health communications program
    f. DHMH should partner with the University of Maryland Dental School, the Mid-Atlantic Association of Community Health Centers, Area Health Education Centers, community colleges, and the Maryland Oral Health Association to develop ongoing dental educational programs in underserved areas
    g. 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
    h. The Office of Oral Health should build evaluation capacity
6) Mandate that a dental screening performed in conjunction with vision and hearing screenings in public schools
7) Increase the salary scale for State and County dentists, dental hygienists, and dental assistants to be competitive with private sector salaries (for example the state pay scale should correspond with the $50^{th}$ - $75^{th}$ percentile for the private sector for all the dental classifications)
8) 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.
9) Medicaid reimbursement for pediatricians (replication of the ABCD program) to provide dental screenings, education and fluoride varnish in their offices; establish separate reimbursement code for dental screening (triage) which would be in addition to a dental examination.

    a. Help develop and promote caries management protocols with the University of Maryland Dental School for high risk children

10) 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
11) 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
12) Expand the full-time staff in the Office of Oral Health in order to assist in enacting the Dental Action Committee recommendations
13) Review the state classification specifications for dental assistants and hygienists in partnership with the Maryland Oral Health Association and the Dental Board
14) Increase the cooperation between Public Health and Medicaid at DHMH
15) Continue to support community water fluoridation efforts
16) Provide more portable equipment for use in schools and other centers
17) Office of Oral Health should develop a definition of a dental home for the state utilizing existing definitions and tailoring to Maryland's needs
18) Fund and expand school-based dental programs with enough salary support to suitably recruit dental professionals
19) Partner with Maryland Assembly of School Based Health Centers to support additional SBHC with dental facilities
20) Create a speaker's bureau utilizing dental public health experts to be available to communities and organizations
21) Continue to support programs such as the Pediatric Dental Fellowship Program
22) Facilitate more successful applications by local entities for Dental Health Professional Shortage Areas (HPSAs)
23) Assist local health departments to test residents' well water for naturally occurring fluoride

24) Require new community water systems to provide fluoridated water

# Education and Out Reach Sub-Committee

Members – Carol Antoniewicz, Leigh Cobb, Elyse Markwitz, Miguel McInnis, Leslie Stevens, H. Duane Taylor, Norman Tinanoff, Linda Zang

The subcommittee would like to offer the following preliminary list of recommendations in order to get feedback from the larger committee. We realize that these suggestions will require further study to determine the impact of each idea, as well as the feasibility and associated costs. A concern raised by committee members is that educational efforts may increase demand for services while the capacity to provide services remains poor. Additionally, this subcommittee will gladly work with DHMH to further refine and investigate specific recommendations which they have interest in implementing.

Recommendations for Education and Out Reach are in the following domains – Physicians, Dentists, Dental Students, Public and Private Schools, DHMH and MCOs.

**Physicians**

- Physicians and their assistants are critical to oral health and outreach. They need to be educated about oral health care (early childhood caries, connection between pregnancy outcomes and oral health, etc.) the oral examination, the referral process, and fluoride varnish treatment procedures; as well as given the ability to bill Medicaid for these services. Attending oral health education courses should be a pre-requisite to billing for oral health services.
- The concept proposed by Dr. Sharfstein that topical fluoride treatments are incorporated into the immunization record has great merit.

**Dentists**

- 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.

**Dental Students**

- 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.
- Develop more course material related to public health and cultural sensitivity.
- Better prepare general dental students for treating children.

**Public and Private Schools**

- 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.
- 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.

**DHMH**

- 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.
- DHMH needs to be better educated or have better oversight regarding credentialing issues, rejected claims, customer relations, as well as communicating with Medicaid providers.
- DHMH should construct a List Serve, or other Web tools, to foster communication with the dental community.
- DHMH should examine and develop where needed, new initiatives to serve hard to reach population.

- DHMH should increase the support of the Office of Oral Health to enable:
    - This office to produce targeted, unified messages for health departments, public and private schools, MCOs, physicians, dentists, parents, WIC and Head Start.
    - 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.
    - This office should partner with County health departments and Federally Qualified Health Centers for local outreach.

**MCOs**

- 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 and commendable. If DHMH requires these services to increase, it must be recognized that there are additional associated costs.
- 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.
- 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.

**DRAFT**

**Scope of Practice /Provider Participation /Provider Incentives Subcommittee**

**Scope of Practice**

**1)** Increase the scope of practice for dental hygienists with a minimum of two years experience who work in a public health setting to allow them to:

a. provide screenings, prophylaxis, fluoride varnish, sealants
b. provide supervision to dental assistants

2) 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. These practitioners should also be educated regarding the need to help families find a dental home by age 2. 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. Pediatricians, family physicians, PCPs and others who serve the Medicaid/MCHP population should also receive specific instructions on how to help families find and maintain a dental home through the Medicaid Dental Network.

3) 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 12.

a. This would include coronal polishing and fluoride varnish applications;
b. Would occur only under the direct supervision of a licensed dentist;
c. The scope of practice for dental assistants should be regulated by the State.

**Provider Incentives/Provider Participation**

1) The State should fund increased reimbursements for dentists who treat:
   a. very young children
   b. children with special needs
   c. children with complex treatment needs

2) Use tax incentives both to encourage dentists to participate in Health/Choice and also to reward those who continue to participate in a significant way, as an alternative to increasing reimbursement rates.
   a. Allow a portion of Medicaid reimbursements to be put in an IRA type account or the state employees deferred compensation plan;
   b. Provide income tax credits/tax deductions for Medicaid reimbursements for providers who see significant numbers of Medicaid patients over time;
   c. Incentives should be graduated in order to reflect the number of children or families treated

d. Tax incentives/credits should go to individual practitioners, not the clinic for which a practitioner works.

3) Expand the loan repayment program

4) Offer a student loan program beginning in the 2nd year of dental school for those willing to provide dental services in a designated shortage area upon graduation
   a. Offer a similar 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 a designated shortage area upon graduation.
   b. This program is not intended to compete with or negatively impact Maryland's Pediatric Dental Fellows Program.

5) Establish a liaison between dental offices and Medicaid to streamline process issues

6) Promote recognition of Medicaid providers (newsletter, media, etc.)

7) The dental societies (AAPD/MSDA/MDS/MAGD) will collaborate to train general dentists in treatment of young children and children with special needs. Developing CE courses will be part of this collaboration.

CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT

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**Memorandum**

To: Tricia Roddy, DHMH
Alycia Steinberg, DHMH
From: David Idala, CHPDM
CC: Ann Volpel, CHPDM
Mike Nolin, CHPDM
Date: July 19, 2007
Re: Dental Action Committee Data Request

At the request of the Dental Action Committee (DAC), the Center for Health Program Development and Management (Center) has completed an analysis of dental service utilization by selected groups of beneficiaries enrolled in the Maryland Children's Health Program (MCHP) and Maryland's Medical Assistance Program (Medicaid), with any period of enrollment, for:

- Baseline patient utilization
- Provider participation
- Safety net clinics
- Dental care expenses

Children, Age 0-20[1], Enrolled in HealthChoice

Tables 1 (a) and 1 (b) show the number of children, by age group, enrolled in the HealthChoice program in calendar year (CY) 2005 and CY 2006, respectively. These tables also present:

- The number of children by age[2] group with at least one dental encounter during the calendar year
- The percentage of children by age group who had at least one dental encounter during the respective calendar years

[Insert Tables 1 (a) and 1 (b)]

Tables 2 (a) and 2 (b) show the number of children by county enrolled in the HealthChoice program in CY 2005 and CY 2006, respectively. These tables also display:

[1] 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.
[2] Age is calculated as of December 31 of the respective years.

- The number of children by county with at least one dental encounter during the calendar year
- The percentage of children by county who had at least one dental encounter during the calendar year

[Insert Tables 2 (a) and 2 (b)]

Tables 3 (a) and 3 (b) show the number of children, ages 0-20, enrolled in the HealthChoice program in CY 2005 and CY 2006, respectively, by managed care organization (MCO). These tables also present:

- The number of children by MCO with at least one dental encounter during the calendar year
- The percentage of children by MCO who had at least one dental encounter during the calendar year

[Insert Tables 3 (a) and 3 (b)]

Tables 4 (a) and 4 (b) represent the type and number of dental services received by children enrolled in the HealthChoice program in CY 2005 and CY 2006, respectively.

[Insert Table 4 (a) and 4 (b)]

Pregnant Women Enrolled in HealthChoice

Tables 5 (a) and 5 (b) show the number of pregnant women[3], by county, enrolled in the HealthChoice program in CY 2005 and CY 2006, respectively. Also shown are:

- The number of pregnant women by county with at least one dental encounter during the calendar year
- The percentage of pregnant women, by county who had at least one dental encounter during the calendar year

[Insert Tables 5 (a) and 5 (b)]

Tables 6 (a) and 6 (b) show the number of pregnant women enrolled in a HealthChoice MCO in CY 2005 and CY 2006, respectively, and also present:

- The number of pregnant women by MCO with at least one dental encounter
- The percentage of pregnant women by MCO who had at least one dental encounter

[Insert Tables 6 (a) and 6 (b)]

[3] Pregnant women were defined as any woman, age 14 and above, who had a delivery, or was in a SOBRA coverage group or SOBRA rate cell at any time during the calendar year.

Tables 7 (a) and 7 (b) show the type and number of dental services received by pregnant women enrolled in the HealthChoice program in CY 2005 and CY 2006, respectively.

[Insert Tables 7 (a) and 7 (b)]

Children Enrolled in Foster Care

Tables 8 (a) and 8 (b) show the number of foster care[4] children, ages 0-20, enrolled in Medicaid or MCHP in CY 2005 and CY 2006, respectively, by age group. These tables also present:

- The number of foster care children by age group with at least one dental encounter[5] during the calendar year
- The percentage of foster care children by age group who had at least one dental encounter during the calendar year

[Insert Tables 8 (a) and 8 (b)]

Tables 9 (a) and 9 (b) show the number of foster care children enrolled in Medicaid or MCHP in CY 2005 and CY 2006, respectively, by county. These tables also indicate:

- The number of foster care children by county with at least one dental encounter during the calendar year
- The percentage of foster care children by county who had at least one dental encounter during the calendar year

[Insert Tables 9 (a) and 9 (b)]

Tables 10 (a) and 10 (b) display the number and type of dental services received by foster care children enrolled in Medicaid or MCHP in CY 2005 and CY 2006, respectively.

[Insert Tables 10 (a) and 10 (b)]

Tables 11 (a) and 11 (b) display dental expenditures[6] for foster care children enrolled in Medicaid or MCHP by county in CY 2005 and CY 2006, respectively.

[Insert Tables 11 (a) and 11 (b)]

[4] The foster care cohort excludes children in subsidized adoption.
[5] The analysis includes all dental encounters for the foster care cohort, regardless of whether the encounter took place while the beneficiary was in a foster care coverage group or not. The data indicate that about 300 dental encounters took place while these beneficiaries were not enrolled in foster care coverage groups.
[6] For services provided in the HealthChoice program and reported through encounter data, we applied the Medicaid FFS fee schedule to estimate reimbursement levels, as actual reimbursement data is not available on encounter data. For procedures that are reimbursed "by report," we applied average reimbursement levels which where provided by the Department; otherwise, no fee was applied. Overall, the percentage of services where no fee was available was 3 percent. As a result of this constraint with the fee schedule, the HealthChoice expenditures in this report underestimate the actual dollars billed by HealthChoice dental providers.

Rare and Expensive Case Management (REM)

Tables 12 (a) and 12 (b) show the number of REM children, ages 0-20, enrolled in Medicaid or MCHP in CY 2005 and CY 2006, respectively, by age group. These tables also present:

- The number of REM children with at least one dental claim by age group during the calendar year
- The percentage of REM children who had at least one dental claim by age group during the calendar year[7]

[Insert Tables 12 (a) and 12 (b)]

Tables 13 (a) and 13 (b) show the number of REM children, by county, enrolled in Medicaid or MCHP in CY 2005 and CY 2006, respectively. These tables also show:

- The number of REM children by county with at least one dental claim during the calendar year
- The percentage of REM children by county who had at least one dental claim during the calendar year

[Insert Tables 13 (a) and 13 (b)]

Tables 14 (a) and 14 (b) represent the type and number of dental services received by REM children enrolled in Medicaid or MCHP in CY 2005 and CY 2006, respectively.

[Insert Tables 14 (a) and 14 (b)]

Tables 15 (a) and 15 (b) display dental expenditures[8] for REM children enrolled in Medicaid or MCHP by county in CY 2005 and CY 2006, respectively.

[Insert Tables 15 (a) and 15 (b)]

Safety Net Clinics

Table 16 (a) and 16 (b) show visits, by county, for dental services provided by safety net clinics[9] in CY 2005 and CY 2006, respectively.

[Insert Tables 16 (a) and 16 (b)]

[7] The analysis includes all dental encounters for REM beneficiaries during the calendar year. There were only six encounters by the REM cohort that occurred while the beneficiaries were not enrolled in the REM program.
[8] We used the actual pay field from the dental fee-for-service claims to calculate the expenditure associated with the use of dental services by the REM cohort.
[9] We only included services that could definitely be linked to a safety net clinic; we may not have captured services that were billed under an individual provider's name.

Dentists who Billed at Least $10,000 to HealthChoice

Table 17 displays the number of dentists, by county, who billed[6] at least $10,000 to HealthChoice in CY 2006.

[Insert Table 17]

## Children, Age 0-20, Enrolled in HealthChoice

Table 1(a). Percentage of Children Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by Age Group (CY 2005)

| Age Group | Number of Eligible Beneficiaries | Number of Beneficiaries with at Least One Dental Encounter | Percent of Beneficiaries with at Least One Dental Encounter |
|---|---|---|---|
| 0-3 | 124,358 | 9,759 | 7.8% |
| 4-5 | 54,297 | 20,487 | 37.7% |
| 6-9 | 93,728 | 39,808 | 42.5% |
| 10-14 | 109,822 | 43,308 | 39.4% |
| 15-18 | 78,913 | 25,532 | 32.4% |
| 19-20 | 22,186 | 4,220 | 19.0% |
| Total | 483,304 | 143,114 | 29.6% |

Table 1(b). Percentage of Children Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by Age Group (CY 2006)

| Age Group | Number of Eligible Beneficiaries | Number of Beneficiaries with at Least One Dental Encounter | Percent of Beneficiaries with at Least One Dental Encounter |
|---|---|---|---|
| 0-3 | 128,599 | 10,109 | 7.9% |
| 4-5 | 54,058 | 20,096 | 37.2% |
| 6-9 | 96,235 | 40,743 | 42.3% |
| 10-14 | 107,233 | 42,340 | 39.5% |
| 15-18 | 82,028 | 26,458 | 32.3% |
| 19-20 | 23,493 | 4,318 | 18.4% |
| Total | 491,646 | 144,064 | 29.3% |

Table 2 (a). Percentage of Children Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by County (CY 2005)

| County | Number of Eligible Beneficiaries | Number of Beneficiaries with at Least One Dental Encounter | Percent of Beneficiaries with at Least One Dental Encounter |
|---|---|---|---|
| Allegany | 7,650 | 3,244 | 42.4% |
| Anne Arundel | 27,518 | 6,726 | 24.4% |
| Baltimore County | 58,392 | 18,661 | 32.0% |
| Calvert | 5,264 | 1,409 | 26.8% |
| Caroline | 4,614 | 1,941 | 42.1% |
| Carroll | 6,973 | 1,948 | 27.9% |
| Cecil | 9,356 | 2,078 | 22.2% |
| Charles | 9,865 | 1,924 | 19.5% |
| Dorchester | 4,638 | 1,615 | 34.8% |
| Frederick | 12,003 | 3,669 | 30.6% |
| Garrett | 3,883 | 2,144 | 55.2% |
| Harford | 15,435 | 4,403 | 28.5% |
| Howard | 11,880 | 3,802 | 32.0% |
| Kent | 1,873 | 652 | 34.8% |
| Montgomery | 53,947 | 19,532 | 36.2% |
| Prince George's | 83,244 | 21,966 | 26.4% |
| Queen Anne's | 3,041 | 1,020 | 33.5% |
| St. Mary's | 7,411 | 2,297 | 31.0% |
| Somerset | 3,182 | 997 | 31.3% |
| Talbot | 2,908 | 1,115 | 38.3% |
| Washington | 13,594 | 3,918 | 28.8% |
| Wicomico | 12,250 | 4,219 | 34.4% |
| Worcester | 4,432 | 1,416 | 31.9% |
| Baltimore City | 119,345 | 32,280 | 27.0% |
| Out of State | 606 | 138 | 22.8% |
| Total | 483,304 | 143,114 | 29.6% |

Table 2 (b). Percentage of Children Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by County (CY 2006)

| County | Number of Eligible Beneficiaries | Number of Beneficiaries with at Least One Dental Encounter | Percent of Beneficiaries with at Least One Dental Encounter |
|---|---|---|---|
| Allegany | 7,645 | 3,252 | 42.5% |
| Anne Arundel | 27,870 | 6,967 | 25.0% |
| Baltimore County | 59,270 | 18,349 | 31.0% |
| Calvert | 5,302 | 1,586 | 29.9% |
| Caroline | 4,765 | 2,081 | 43.7% |
| Carroll | 6,938 | 1,991 | 28.7% |
| Cecil | 9,532 | 1,977 | 20.7% |
| Charles | 9,903 | 1,978 | 20.0% |
| Dorchester | 4,735 | 1,774 | 37.5% |
| Frederick | 12,380 | 3,792 | 30.6% |
| Garrett | 3,908 | 2,234 | 57.2% |
| Harford | 15,376 | 4,506 | 29.3% |
| Howard | 12,067 | 3,580 | 29.7% |
| Kent | 1,900 | 647 | 34.1% |
| Montgomery | 56,397 | 19,735 | 35.0% |
| Prince George's | 84,814 | 21,587 | 25.5% |
| Queen Anne's | 3,087 | 1,086 | 35.2% |
| St. Mary's | 7,564 | 2,296 | 30.4% |
| Somerset | 3,190 | 1099 | 34.5% |
| Talbot | 2,914 | 1,192 | 40.9% |
| Washington | 13,991 | 3,676 | 26.3% |
| Wicomico | 12,505 | 4,535 | 36.3% |
| Worcester | 4,407 | 1,427 | 32.4% |
| Baltimore City | 120,672 | 32,627 | 27.0% |
| Out of State | 514 | 90 | 17.5% |
| Total | 491,646 | 144,064 | 29.3% |

Table 3(a). Percentage of Children Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by MCO (CY 2005)

| MCO | Number of Eligible Beneficiaries | Number of Beneficiaries with at Least One Dental Encounter | Percent of Beneficiaries with at Least One Dental Encounter |
|---|---|---|---|
| MPC | 83,600 | 25,426 | 30.4% |
| Coventry | 4,123 | 576 | 14.0% |
| Americaid | 140,831 | 40,275 | 28.6% |
| JAI | 5,545 | 1,346 | 24.3% |
| United | 111,827 | 30,805 | 27.5% |
| Helix | 21,212 | 6,644 | 31.3% |
| Priority | 116,166 | 38,042 | 32.7% |
| Total | 483,304 | 143,114 | 29.6% |

Table 3(b). Percentage of Children Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by MCO (CY 2006)

| MCO | Number of Eligible Beneficiaries | Number of Beneficiaries with at Least One Dental Encounter | Percent of Beneficiaries with at Least One Dental Encounter |
|---|---|---|---|
| MPC | 81,475 | 25,639 | 31.5% |
| Coventry | 5,537 | 855 | 15.4% |
| Americaid | 151,370 | 38,328 | 25.3% |
| JAI | 5,639 | 1,652 | 29.3% |
| United | 109,152 | 31,514 | 28.9% |
| Helix | 22,005 | 7,246 | 32.9% |
| Priority | 116,468 | 38,830 | 33.3% |
| Total | 491,646 | 144,064 | 29.3% |

Table 4(a). Number of Dental Services by Children Enrolled in HealthChoice (with any period of enrollment) (CY 2005)

| Procedure Code | Count |
|---|---|
| Diagnostic (D0100 - D0999) | 315,466 |
| Preventive (D1000 - D1999) | 340,938 |
| Restorative (D2000 - D2999) | 131,195 |
| Endodontics (D3000 - D3999) | 13,527 |
| Periodontics (D4000 - D4999) | 2,108 |
| Prosthodontics - Removable (D5000 - D5999) | 88 |
| Implant Services (D6000 - D6199) | 0 |
| Prosthodontics - Fixed (D6200 - D6999) | 2 |
| Oral and Maxillofacial Surgery (D7000 - D7999) | 27,837 |
| Orthodontics and Dentofacial Orthopedics (D8000 - D8999) | 17,433 |
| Adjunctive General Services (D9000 - D9999) | 23,780 |
| Total | 872,374 |

Table 4(b). Number of Services by Children (0-20) in HealthChoice (with any period of enrollment) (CY 2006)

| Procedure Code | Count |
|---|---|
| Diagnostic (D0100 - D0999) | 330,939 |
| Preventive (D1000 - D1999) | 340,046 |
| Restorative (D2000 - D2999) | 137,445 |
| Endodontics (D3000 - D3999) | 14,173 |
| Periodontics (D4000 - D4999) | 1,968 |
| Prosthodontics - Removable (D5000 - D5999) | 60 |
| Implant Services (D6000 - D6199) | 2 |
| Prosthodontics - Fixed (D6200 - D6999) | 15 |
| Oral and Maxillofacial Surgery (D7000 - D7999) | 28,193 |
| Orthodontics and Dentofacial Orthopedics (D8000 - D8999) | 18,693 |
| Adjunctive General Services (D9000 - D9999) | 25,358 |
| Total | 896,892 |

## Pregnant Women Enrolled in HealthChoice

Table 5(a). Percentage of Pregnant Women Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by County (CY 2005)

| County | Number of Eligible Beneficiaries | Number with Dental Encounter | Percent with Dental Encounter |
|---|---|---|---|
| Allegany | 781 | 107 | 13.7% |
| Anne Arundel | 2,345 | 241 | 10.3% |
| Baltimore County | 4,980 | 801 | 16.1% |
| Calvert | 555 | 63 | 11.4% |
| Caroline | 406 | 68 | 16.7% |
| Carroll | 680 | 63 | 9.3% |
| Cecil | 876 | 99 | 11.3% |
| Charles | 1,021 | 70 | 6.9% |
| Dorchester | 364 | 79 | 21.7% |
| Frederick | 1,055 | 112 | 10.6% |
| Garrett | 338 | 89 | 26.3% |
| Harford | 1,430 | 212 | 14.8% |
| Howard | 883 | 126 | 14.3% |
| Kent | 172 | 25 | 14.5% |
| Montgomery | 3,104 | 446 | 14.4% |
| Prince George's | 5,606 | 615 | 11.0% |
| Queen Anne's | 265 | 33 | 12.5% |
| St. Mary's | 824 | 135 | 16.4% |
| Somerset | 254 | 48 | 18.9% |
| Talbot | 235 | 28 | 11.9% |
| Washington | 1,305 | 183 | 14.0% |
| Wicomico | 1,150 | 196 | 17.0% |
| Worcester | 391 | 59 | 15.1% |
| Baltimore City | 8,482 | 1,102 | 13.0% |
| Out of State | 57 | 10 | 17.5% |
| Total | 37,559 | 5,010 | 13.3% |

Table 5(b). Percentage of Pregnant Women Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by County (CY 2006)

| County | Number of Eligible Beneficiaries | Number with Dental Encounter | Percent with Dental Encounter |
|---|---|---|---|
| Allegany | 767 | 123 | 16.0% |
| Anne Arundel | 2,470 | 296 | 12.0% |
| Baltimore County | 5,062 | 822 | 16.2% |
| Calvert | 574 | 31 | 5.4% |
| Caroline | 423 | 67 | 15.8% |
| Carroll | 700 | 65 | 9.3% |
| Cecil | 977 | 92 | 9.4% |
| Charles | 1,086 | 94 | 8.7% |
| Dorchester | 404 | 80 | 19.8% |
| Frederick | 1,080 | 117 | 10.8% |
| Garrett | 383 | 122 | 31.9% |
| Harford | 1,487 | 222 | 14.9% |
| Howard | 843 | 122 | 14.5% |
| Kent | 164 | 18 | 11.0% |
| Montgomery | 3,254 | 454 | 14.0% |
| Prince George's | 5,723 | 623 | 10.9% |
| Queen Anne's | 274 | 39 | 14.2% |
| St. Mary's | 896 | 183 | 20.4% |
| Somerset | 268 | 51 | 19.0% |
| Talbot | 231 | 37 | 16.0% |
| Washington | 1,407 | 167 | 11.9% |
| Wicomico | 1,199 | 240 | 20.0% |
| Worcester | 389 | 72 | 18.5% |
| Baltimore City | 8,772 | 1,127 | 12.8% |
| Out of State | 35 | 4 | 11.4% |
| Total | 38,868 | 5,268 | 13.6% |

Table 6(a). Percentage of Pregnant Women Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by MCO (CY 2005)

| MCO | Number of Eligible Beneficiaries | Number with Dental Encounter | Percent with Dental Encounter |
|---|---|---|---|
| Maryland Physicians Care | 7,809 | 959 | 12.3% |
| Coventry | 578 | 69 | 11.9% |
| Americaid | 10,253 | 1,589 | 15.5% |
| JAI Medical Systems | 446 | 54 | 12.1% |
| United Healthcare | 8,602 | 834 | 9.7% |
| Helix | 1,888 | 395 | 20.9% |
| Priority Partners | 7983 | 1,110 | 13.9% |
| Total | 37,559 | 5,010 | 13.3% |

Table 6(b). Percentage of Pregnant Women Enrolled in HealthChoice (with any period of enrollment) who had at Least One Dental Encounter by MCO (CY 2006)

| MCO | Number of Eligible Beneficiaries | Number with Dental Encounter | Percent with Dental Encounter |
|---|---|---|---|
| Maryland Physicians Care | 7,290 | 986 | 13.5% |
| Coventry | 787 | 103 | 13.1% |
| Americaid | 12,525 | 1,655 | 13.2% |
| JAI Medical Systems | 472 | 49 | 10.4% |
| United Healthcare | 8,060 | 926 | 11.5% |
| Helix | 1,837 | 353 | 19.2% |
| Priority Partners | 7,897 | 1,196 | 15.1% |
| Total | 38,868 | 5,268 | 13.6% |

Table 7(a). Number of Services by Pregnant Women Enrolled in HealthChoice (with any period of enrollment) (CY 2005)

| Procedure Code | # of Services |
|---|---|
| Diagnostic (D0100 - D0999) | 10,038 |
| Preventive (D1000 - D1999) | 4,066 |
| Restorative (D2000 - D2999) | 6,723 |
| Endodontics (D3000 - D3999) | 1,181 |
| Periodontics (D4000 - D4999) | 354 |
| Prosthodontics - Removable (D5000 - D5999) | 33 |
| Oral and Maxillofacial Surgery (D7000 - D7999) | 2,209 |
| Orthodontics and Dentofacial Orthopedics (D8000 - D8999) | 131 |
| Adjunctive General Services (D9000 - D9999) | 908 |
| Total | 25,643 |

Table 7(b). Number of Services by Pregnant Women Enrolled in HealthChoice (with any period of enrollment) (CY 2006)

| Procedure Code | # of Services |
|---|---|
| Diagnostic (D0100 - D0999) | 11,745 |
| Preventive (D1000 - D1999) | 4,337 |
| Restorative (D2000 - D2999) | 8,410 |
| Endodontics (D3000 - D3999) | 1,402 |
| Periodontics (D4000 - D4999) | 429 |
| Prosthodontics - Removable (D5000 - D5999) | 33 |
| Oral and Maxillofacial Surgery (D7000 - D7999) | 2,147 |
| Orthodontics and Dentofacial Orthopedics (D8000 - D8999) | 88 |
| Adjunctive General Services (D9000 - D9999) | 1,021 |
| Total | 29,612 |

## Children Enrolled in Foster Care

Table 8(a). Percentage of Children in Foster Care (with any period of enrollment) who had at Least One Dental Encounter by Age Group (CY 2005)

| Age Group | Count | Number with Dental Encounter During CY 2005 | Percent with Dental Encounter During CY 2005 |
|---|---|---|---|
| 0-3 | 2,190 | 201 | 9.2% |
| 4-5 | 958 | 407 | 42.5% |
| 6-9 | 1,876 | 948 | 50.5% |
| 10-14 | 3,395 | 1,843 | 54.3% |
| 15-18 | 4,079 | 2,037 | 49.9% |
| 19-20 | 1,300 | 435 | 33.5% |
| Total | 13,798 | 5,871 | 42.5% |

Table 8(b). Percentage of Children in Foster Care (with any period of enrollment) who had at Least One Dental Encounter by Age Group (CY 2006)

| Age Group | Count | Number with Dental Encounter During CY 2006 | Percent with Dental Encounter During CY 2006 |
|---|---|---|---|
| 0-3 | 2,169 | 194 | 8.9% |
| 4-5 | 965 | 407 | 42.2% |
| 6-9 | 1,991 | 1,005 | 50.5% |
| 10-14 | 3,291 | 1,728 | 52.5% |
| 15-18 | 4,128 | 2,005 | 48.6% |
| 19-20 | 1,271 | 418 | 32.9% |
| Total | 13,815 | 5,757 | 41.7% |

Table 9(a). Percentage of Children in Foster Care (with any period of enrollment) who had at Least One Dental Encounter by County (CY 2005)

| County | Count | Number with Dental Encounter During CY 2005 | Percent with Dental Encounter During CY 2005 |
|---|---|---|---|
| Allegany | 172 | 83 | 48.3% |
| Anne Arundel | 421 | 160 | 38.0% |
| Baltimore County | 1,247 | 558 | 44.7% |
| Calvert | 88 | 45 | 51.1% |
| Caroline | 72 | 39 | 54.2% |
| Carroll | 122 | 46 | 37.7% |
| Cecil | 137 | 31 | 22.6% |
| Charles | 217 | 66 | 30.4% |
| Dorchester | 60 | 29 | 48.3% |
| Frederick | 322 | 149 | 46.3% |
| Garrett | 86 | 60 | 69.8% |
| Harford | 291 | 115 | 39.5% |
| Howard | 190 | 74 | 38.9% |
| Kent | 23 | 15 | 65.2% |
| Montgomery | 888 | 343 | 38.6% |
| Prince George's | 1,549 | 413 | 26.7% |
| Queen Anne's | 38 | 15 | 39.5% |
| St. Mary's | 137 | 59 | 43.1% |
| Somerset | 81 | 42 | 51.9% |
| Talbot | 55 | 27 | 49.1% |
| Washington | 356 | 148 | 41.6% |
| Wicomico | 184 | 79 | 42.9% |
| Worcester | 50 | 27 | 54.0% |
| Baltimore City | 6,987 | 3,247 | 46.5% |
| Out of State | 25 | 1 | 4.0% |
| Total | 13,798 | 5,871 | 42.5% |

Table 9(b). Percentage of Children in Foster Care (with any period of enrollment) who had at Least One Dental Encounter by County (CY 2006)

| County | Count | Number with Dental Encounter During CY 2006 | Percent with Dental Encounter During CY 2006 |
|---|---|---|---|
| Allegany | 175 | 107 | 61.1% |
| Anne Arundel | 488 | 160 | 32.8% |
| Baltimore County | 1,259 | 538 | 42.7% |
| Calvert | 90 | 49 | 54.4% |
| Caroline | 80 | 40 | 50.0% |
| Carroll | 110 | 44 | 40.0% |
| Cecil | 178 | 43 | 24.2% |
| Charles | 226 | 68 | 30.1% |
| Dorchester | 90 | 35 | 38.9% |
| Frederick | 286 | 130 | 45.5% |
| Garrett | 84 | 55 | 65.5% |
| Harford | 526 | 164 | 31.2% |
| Howard | 191 | 65 | 34.0% |
| Kent | 37 | 17 | 45.9% |
| Montgomery | 784 | 293 | 37.4% |
| Prince George's | 1,572 | 425 | 27.0% |
| Queen Anne's | 57 | 22 | 38.6% |
| St. Mary's | 134 | 47 | 35.1% |
| Somerset | 95 | 51 | 53.7% |
| Talbot | 77 | 37 | 48.1% |
| Washington | 358 | 159 | 44.4% |
| Wicomico | 286 | 140 | 49.0% |
| Worcester | 94 | 41 | 43.6% |
| Baltimore City | 6,516 | 3,025 | 46.4% |
| Out of State | 22 | 2 | 9.1% |
| Total | 13,815 | 5,757 | 41.7% |

Table 10(a). Number of Services by Foster Care Recipients (with any period of enrollment) - CY 2005

| Procedure Code | Count |
|---|---|
| Diagnostic (D0100 - D0999) | 14,982 |
| Preventive (D1000 - D1999) | 15,742 |
| Restorative (D2000 - D2999) | 6,085 |
| Endodontics (D3000 - D3999) | 481 |
| Periodontics (D4000 - D4999) | 193 |
| Prosthodontics - Removable (D5000 - D5999) | 5 |
| Oral and Maxillofacial Surgery (D7000 - D7999) | 966 |
| Orthodontics and Dentofacial Orthopedics (D8000 - D8999) | 643 |
| Adjunctive General Services (D9000 - D9999) | 702 |
| Total | 39,799 |

Table 10(b). Number of Services by Foster Care Recipients (with any period of enrollment) - CY 2006

| Procedure Code | Count |
|---|---|
| Diagnostic (D0100 - D0999) | 14,812 |
| Preventive (D1000 - D1999) | 14,696 |
| Restorative (D2000 - D2999) | 5,775 |
| Endodontics (D3000 - D3999) | 532 |
| Periodontics (D4000 - D4999) | 189 |
| Prosthodontics - Removable (D5000 - D5999) | 6 |
| Oral and Maxillofacial Surgery (D7000 - D7999) | 1,017 |
| Orthodontics and Dentofacial Orthopedics (D8000 - D8999) | 560 |
| Adjunctive General Services (D9000 - D9999) | 758 |
| Total | 38,345 |

Table 11(a) Estimated Dental Expenditure for Children in Foster Care (with any period of enrollment) by County (CY 2005)

| **County** | **Pay** |
|---|---|
| Allegany | $23,564.60 |
| Anne Arundel | $46,969.83 |
| Baltimore County | $146,277.21 |
| Calvert | $10,842.40 |
| Caroline | $7,092.24 |
| Carroll | $12,047.96 |
| Cecil | $7,610.08 |
| Charles | $14,140.43 |
| Dorchester | $5,111.04 |
| Frederick | $39,202.88 |
| Garrett | $17,106.04 |
| Harford | $33,705.84 |
| Howard | $20,665.37 |
| Kent | $4,801.48 |
| Montgomery | $91,866.01 |
| Prince George's | $95,324.07 |
| Queen Anne's | $4,453.88 |
| St. Mary's | $20,366.91 |
| Somerset | $8,255.24 |
| Talbot | $7,953.08 |
| Washington | $34,050.44 |
| Wicomico | $15,864.59 |
| Worcester | $6,468.64 |
| Baltimore City | $676,798.85 |
| Out of State | $217.72 |
| Total | $1,350,756.83 |

Table 11(b) Estimated Dental Expenditure for Children in Foster Care (with any period of enrollment) by County (CY 2006)

| County | Pay |
|---|---|
| Allegany | $21,684.60 |
| Anne Arundel | $48,325.71 |
| Baltimore County | $144,836.49 |
| Calvert | $10,655.56 |
| Caroline | $8,968.48 |
| Carroll | $8,177.60 |
| Cecil | $11,381.88 |
| Charles | $13,731.38 |
| Dorchester | $6,102.20 |
| Frederick | $28,008.07 |
| Garrett | $18,011.96 |
| Harford | $44,216.44 |
| Howard | $15,861.90 |
| Kent | $3,627.84 |
| Montgomery | $89,402.29 |
| Prince George's | $112,554.13 |
| Queen Anne's | $3,335.76 |
| St. Mary's | $12,740.04 |
| Somerset | $11,248.00 |
| Talbot | $7,362.48 |
| Washington | $35,424.20 |
| Wicomico | $35,326.98 |
| Worcester | $9,225.92 |
| Baltimore City | $618,833.91 |
| Out of State | $150.72 |
| Total | $1,319,194.54 |

## REM

Table 12(a). Percentage of Children in REM (with any period of enrollment) who had at Least One Dental Claim by Age Group (CY 2005)

| Age Group | Count | Number with Dental Claims During CY 2005 | Percent with Dental Claims During CY 2005 |
|---|---|---|---|
| 0-3 | 662 | 45 | 6.8% |
| 4-5 | 342 | 63 | 18.4% |
| 6-9 | 699 | 215 | 30.8% |
| 10-14 | 783 | 229 | 29.2% |
| 15-18 | 506 | 164 | 32.4% |
| 19-20 | 233 | 52 | 22.3% |
| Total | 3,225 | 768 | 23.8% |

Table 12(b). Percentage of Children in REM (with any period of enrollment) who had at Least One Dental Claim by Age Group (CY 2006)

| Age Group | Count | Number with Dental Claims During CY 2006 | Percent with Dental Claims During CY 2006 |
|---|---|---|---|
| 0-3 | 612 | 44 | 7.2% |
| 4-5 | 342 | 59 | 17.3% |
| 6-9 | 704 | 202 | 28.7% |
| 10-14 | 789 | 256 | 32.4% |
| 15 - 18 | 559 | 143 | 25.6% |
| 19 - 20 | 238 | 52 | 21.8% |
| Total | 3,244 | 756 | 23.3% |

Table 13(a). Percentage of Children Enrolled in REM (with any period of enrollment) who had at Least One Dental Claim by County (CY 2005)

| County | Count | Number with Dental Claims During CY 2005 | Percent with Dental Claims During CY 2005 |
|---|---|---|---|
| Allegany | 55 | 9 | 16.4% |
| Anne Arundel | 206 | 52 | 25.2% |
| Baltimore County | 411 | 108 | 26.3% |
| Calvert | 25 | 5 | 20.0% |
| Caroline | 40 | 12 | 30.0% |
| Carroll | 41 | 7 | 17.1% |
| Cecil | 44 | 0 | 0.0% |
| Charles | 52 | 5 | 9.6% |
| Dorchester | 30 | 13 | 43.3% |
| Frederick | 66 | 6 | 9.1% |
| Garrett | 16 | 2 | 12.5% |
| Harford | 73 | 13 | 17.8% |
| Howard | 55 | 11 | 20.0% |
| Kent | 8 | 2 | 25.0% |
| Montgomery | 298 | 65 | 21.8% |
| Prince George's | 476 | 95 | 20.0% |
| Queen Anne's | 19 | 4 | 21.1% |
| St. Mary's | 23 | 3 | 13.0% |
| Somerset | 23 | 10 | 43.5% |
| Talbot | 18 | 9 | 50.0% |
| Washington | 79 | 15 | 19.0% |
| Wicomico | 82 | 36 | 43.9% |
| Worcester | 27 | 8 | 29.6% |
| Baltimore City | 1,051 | 277 | 26.4% |
| Out of State | 7 | 1 | 14.3% |
| Total | 3,225 | 768 | 23.8% |

Table 13(b). Percentage of Children Enrolled in REM (with any period of enrollment) who had at Least One Dental Claim by County (CY 2006)

| County | Count | Number with Dental Claims During CY 2006 | Percent with Dental Claims During CY 2006 |
|---|---|---|---|
| Allegany | 58 | 10 | 17.2% |
| Anne Arundel | 206 | 46 | 22.3% |
| Baltimore County | 416 | 97 | 23.3% |
| Calvert | 29 | 5 | 17.2% |
| Caroline | 37 | 12 | 32.4% |
| Carroll | 48 | 6 | 12.5% |
| Cecil | 49 | 2 | 4.1% |
| Charles | 51 | 8 | 15.7% |
| Dorchester | 32 | 10 | 31.3% |
| Frederick | 73 | 3 | 4.1% |
| Garrett | 15 | 2 | 13.3% |
| Harford | 79 | 18 | 22.8% |
| Howard | 49 | 10 | 20.4% |
| Kent | 7 | 1 | 14.3% |
| Montgomery | 300 | 78 | 26.0% |
| Prince George's | 496 | 96 | 19.4% |
| Queen Anne's | 14 | 1 | 7.1% |
| St. Mary's | 24 | 5 | 20.8% |
| Somerset | 21 | 6 | 28.6% |
| Talbot | 17 | 7 | 41.2% |
| Washington | 72 | 16 | 22.2% |
| Wicomico | 78 | 34 | 43.6% |
| Worcester | 27 | 7 | 25.9% |
| Baltimore City | 1,039 | 275 | 26.5% |
| Out of State | 7 | 1 | 14.3% |
| Total | 3,244 | 756 | 23.3% |

Table 14(a). Number of Services by REM Recipients (with any period of enrollment) (CY 2005)

| Procedure Code | Count |
|---|---|
| Diagnostic (D0100 - D0999) | 1,378 |
| Preventive (D1000 - D1999) | 1,728 |
| Restorative (D2000 - D2999) | 812 |
| Endodontics (D3000 - D3999) | 41 |
| Periodontics (D4000 - D4999) | 3 |
| Oral and Maxillofacial Surgery (D7000 - D7999) | 277 |
| Orthodontics and Dentofacial Orthopedics (D8000 - D8999) | 68 |
| Adjunctive General Services (D9000 - D9999) | 128 |
| Total | 4,435 |

Table 14(b). Number of Services by REM Recipients (with any period of enrollment) (CY 2006)

| Procedure Code | Count |
|---|---|
| Diagnostic (D0100 - D0999) | 1,460 |
| Preventive (D1000 - D1999) | 1,809 |
| Restorative (D2000 - D2999) | 662 |
| Endodontics (D3000 - D3999) | 44 |
| Periodontics (D4000 - D4999) | 8 |
| Oral and Maxillofacial Surgery (D7000 - D7999) | 225 |
| Orthodontics and Dentofacial Orthopedics (D8000 - D8999) | 20 |
| Adjunctive General Services (D9000 - D9999) | 123 |
| Total | 4,351 |

Table 15(a). FFS Dental Expenditure for Children in REM (with any period of enrollment) by County (CY 2005)

| County | Pay |
|---|---|
| Allegany | $3,783.54 |
| Anne Arundel | $17,301.76 |
| Baltimore County | $32,587.16 |
| Calvert | $1,533.50 |
| Caroline | $2,388.88 |
| Carroll | $1,508.92 |
| Cecil | $0.00 |
| Charles | $579.86 |
| Dorchester | $3,588.48 |
| Frederick | $645.28 |
| Garrett | $248.00 |
| Harford | $5,046.66 |
| Howard | $3,921.24 |
| Kent | $1,196.00 |
| Montgomery | $13,713.62 |
| Prince George's | $15,227.18 |
| Queen Anne's | $508.00 |
| St. Mary's | $2,106.00 |
| Somerset | $3,489.56 |
| Talbot | $2,241.70 |
| Washington | $7,946.22 |
| Wicomico | $8,103.64 |
| Worcester | $854.72 |
| Baltimore City | $67,049.86 |
| Out of State | $90.00 |
| Total | $195,659.78 |

Table 15(b). FFS Dental Expenditure for Children in REM (with any period of enrollment) by County (CY 2006)

| County | Pay |
|---|---|
| Allegany | $3,992.34 |
| Anne Arundel | $12,224.40 |
| Baltimore County | $30,386.18 |
| Calvert | $882.02 |
| Caroline | $2,873.95 |
| Carroll | $1,379.00 |
| Cecil | $325.00 |
| Charles | $998.74 |
| Dorchester | $2,027.65 |
| Frederick | $671.20 |
| Garrett | $614.00 |
| Harford | $3,840.76 |
| Howard | $1,459.08 |
| Kent | $172.00 |
| Montgomery | $14,711.48 |
| Prince George's | $15,951.33 |
| Queen Anne's | $121.00 |
| St. Mary's | $1,001.51 |
| Somerset | $2,489.80 |
| Talbot | $1,929.68 |
| Washington | $3,585.64 |
| Wicomico | $7,392.84 |
| Worcester | $2,319.62 |
| Baltimore City | $63,079.35 |
| Out of State | $140.00 |
| Total | $174,568.57 |

Safety Net Clinics

Table 16(a). Visits by Safety Net Clinics by County (CY 2005)

| County | Number of FFS Dental Claims | FFS Payments | Number of Dental Encounters |
|---|---|---|---|
| Baltimore City | 2,523 | $124,592.52 | 19,248 |
| Caroline | 200 | $20,444.00 | 14,318 |
| Charles | 14 | $2,403.80 | 0 |
| Prince George's | 59 | $10,123.40 | 1,380 |
| Somerset | 100 | $13,039.90 | 9,686 |
| Washington | 46 | $5,710.30 | 7,133 |
| Wicomico | 585 | $16,986.00 | 0 |
| Total | 3,527 | $193,299.92 | 51,765 |

Table 16(b). Visits by Safety Net Clinics by County (CY 2006)

| County | Number of FFS Dental Claims | FFS Payments | Number of Dental Encounters |
|---|---|---|---|
| Baltimore City | 2,415 | $121,288.97 | 19,791 |
| Caroline | 188 | $23,069.48 | 17,494 |
| Charles | 1 | $176.51 | 36 |
| Prince George's | 43 | $7,589.93 | 1,313 |
| Somerset | 76 | $11,033.68 | 10,079 |
| Washington | 59 | $7,529.20 | 10,552 |
| Wicomico | 391 | $9,600.00 | 0 |
| Total | 3,173 | $180,287.77 | 59,265 |

Dentists who Billed at least $10,000 to HealthChoice

Table 17. Number of Dentists who Billed at least $10,000 to HealthChoice by County (FY 2006)**

| County | Number of Dentists |
|---|---|
| Allegany | 9 |
| Anne Arundel | 21 |
| Baltimore County | 54 |
| Calvert | 4 |
| Caroline | 2 |
| Carroll | 7 |
| Cecil | 1 |
| Charles | 1 |
| Dorchester | 0 |
| Frederick | 8 |
| Garrett | 5 |
| Harford | 6 |
| Howard | 10 |
| Kent | 1 |
| Montgomery | 65 |
| Prince George's | 52 |
| Queen Anne's | 5 |
| Somerset | 2 |
| St. Mary's | 9 |
| Talbot | 5 |
| Washington | 6 |
| Wicomico | 7 |
| Worcester | 2 |
| Baltimore City | 63 |
| Washington, D.C. | 4 |
| Unknown | 1 |
| Total | 350 |

**931 dental providers provided at least one service in CY05

**HealthChoice MCO Dental Revenues and Expenditures**
**For CY 2005**

| MCO | Revenues | Expenditures For Children | Expenditures For Preg. Women |
|---|---|---|---|
| All MCOs | $31,783,434 | $36,567,162 | $1,394,632 |

**ANNUAL EPSDT PARTICIPATION REPORT - CMS 416 - FY 2005**
**BEST PRACTICES STATES**

| | Eligible for EPSDT | Receiving Any Dental Services | Preventative Dental Services | Dental Treatment Services | % Receiving Services |
|---|---|---|---|---|---|
| **Alabama** | 501,776 | 180,089 | 160,873 | 98,061 | **35.89%** |
| **Maryland** | 501,807 | 154,394 | 127,237 | 65,329 | **30.77%** |
| **Michigan** | 1,054,836 | 317,483 | 307,301 | 143,947 | **30.10%** |
| **Rhode Island** | 113,744 | 41,282 | 33,774 | 18,808 | **36.29%** |
| **Tennessee** | 786,347 | 294,039 | 255,020 | 153,033 | **37.39%** |
| **Vermont** | 73,799 | 36,294 | 32,540 | 16,303 | **49.18%** |
| **Virginia** | 526,762 | 128,218 | 109,489 | 57,584 | **24.34%** |
| **Washington** | 634,517 | 265,934 | 242,803 | 136,164 | **41.91%** |
| | | | | | |
| **National** | 17,700,542 | 5,728,186 | 4,877,785 | 2,879,401 | **32.36%** |

**SOUTH ATLANTIC STATES**

| | Eligible for EPSDT | Receiving Any Dental Services | Preventative Dental Services | Dental Treatment Services | % Receiving Services |
|---|---|---|---|---|---|
| **Maryland** | 501,807 | 154,394 | 127,237 | 65,329 | **30.77%** |
| **Delaware** | 83,422 | 22,895 | 19,906 | 11,568 | **27.44%** |
| **D.C.** | 91,734 | 26,846 | 22,516 | 19,613 | **29.27%** |
| **Georgia** | Not Available | | | | |
| **North Carolina** | 891,305 | 332,696 | 293,227 | 160,793 | **37.33%** |
| **Pennsylvania** | 1,069,806 | 292,828 | 240,877 | 129,417 | **27.37%** |
| **South Carolina** | 536,780 | 227,489 | 229,076 | 127,260 | **42.38%** |
| **Virginia** | 526,762 | 128,218 | 109,489 | 57,584 | **24.34%** |
| **West Virginia** | Not Available | | | | |
| | | | | | |
| **National** | 17,700,542 | 5,728,186 | 4,877,785 | 2,879,401 | **32.36%** |

***Eligibles for EPSDT includes ages 0-21 and eligible for any length of time.**

| Dental Procedure | Dental Procedure Code | Maryland | Alabama | Michigan | Rhode Island | Tennessee | Vermont | Virginia | Washington |
|---|---|---|---|---|---|---|---|---|---|
| **Diagnostic** | | | | | | | | | |
| Periodic Oral Exam | **D0120** | $15.00 | $18.00 | $14.89 | $10.00 | $24.00 | $18.00 | $20.15 | $22.44 |
| Initial Oral Exam | **D0150** | $20.00 | $22.00 | $18.90 | $20.00 | $35.00 | $32.00 | $31.31 | $34.68 |
| X-rays - complete | **D0210** | $57.00 | $60.00 | $40.95 | $40.00 | $75.00 | $56.00 | $71.91 | $45.90 |
| Panoramic X-rays | **D0330** | $15.00 | $49.00 | $17.56 | $32.00 | $60.00 | $48.00 | $53.99 | $43.86 |
| | | | | | | | | | |
| **Preventative** | | | | | | | | | |
| Prophylaxis | **D1120** | $24.00 | $28.00 | $19.53 | $22.00 | $35.00 | $29.00 | $33.52 | $23.69 |
| Fluoride treatment | **D1203** | $14.00 | $15.00 | $13.23 | $18.00 | $20.00 | $15.00 | $20.79 | $13.66 |
| Sealant | **D1351** | $9.00 | $26.00 | $15.12 | $18.00 | $28.00 | $28.00 | $32.28 | $22.66 |
| | | | | | | | | | |
| **Restorative** | | | | | | | | | |
| Amalgam | **D2150** | $88.00 | $60.00 | $48.41 | $37.00 | $76.00 | $67.00 | $75.53 | $63.88 |
| Resin x2 | **D2331** | $102.00 | $72.00 | $60.48 | $44.00 | $90.00 | $79.00 | $89.18 | $66.97 |
| Crown | **D2751** | $375.00 | $427.00 | $293.23 | $450.00 | $544.00 | $420.00 | $500.00 | $357.04 |
| | | | | | | | | | |
| **Endodontics** | | | | | | | | | |
| Removal/Pulpotomy | **D3220** | $60.00 | $49.00 | $66.15 | $59.00 | $95.00 | $75.00 | $83.19 | $45.33 |
| Endodontics | **D3310** | $230.00 | $365.00 | $239.40 | $175.00 | $355.00 | $284.00 | $347.90 | $255.03 |
| Extraction | **D7140** | $42.00 | $53.00 | $44.47 | $39.00 | $68.00 | $82.00 | $69.00 | $59.43 |

# Current Dental Payment Rates by South Atlantic States

| Dental Procedure | Code | State Medicaid Programs | | | | | | | | | MD State Employee Benefits | 25% ADA S. Atlantic Charges | 50% ADA S. Atlantic Charges | 75% ADA S. Atlantic Charges |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | MD | DE | DC | GA | NC | PA | SC | VA | WV | | | | |
| **Diagnostic** | | | | | | | | | | | | | | |
| Periodic Oral Exam | D0120 | $15 | 85% of charges | $35 | $22.77 | $27 | $20 | $22 | $20 | $20 | $23 | $28 | $33 | $39 |
| Initial Oral Exam | D0150 | $20 | | $78 | $39.33 | $45 | $20 | $30 | $31 | $30 | $39 | $45 | $55 | $65 |
| X-Rays, complete | D0210 | $57 | | $91 | $72.45 | $75 | $45 | N/A | $71 | $62 | $63 | $85 | $93 | $105 |
| Panoramic X-Rays | D0330 | $42 | | $80. | $56.92 | $58 | $37 | $55 | $54 | $55 | $69 | $74 | $80 | $90 |
| **Preventive** | | | | | | | | | | | | | | |
| Prophylaxis | D1120 | $24 | 85% of charges | $47 | $32.08 | $25 | $22 | $31 | $34 | $30 | $39 | $44 | $48 | $55 |
| Fluoride Treatment | D1203 | $14 | | $29 | $17.59 | $15 | $17 | $17 | $21 | $15 | $22 | $20 | $24 | $28 |
| Sealant | D1351 | $9 | | $38 | $27.94 | $30 | $25 | $27 | $32 | $24 | $27 | $32 | $36 | $42 |
| **Restorative** | | | | | | | | | | | | | | |
| Amalgam | D2150 | $88 | 85% of charges | $115 | $69.34 | $79 | $50 | $75 | $76 | $72 | $73 | $97 | $111 | $130 |
| Resin X 2 | D2331 | $102 | | $135 | $91.08 | $77 | $55 | $88 | $89 | $85 | $96 | $117 | $135 | $156 |
| Crown | D2751 | $375 | | $177 | N/A | N/A | $300 | N/A | $500 | $510 | $660 | $675 | $750 | $828 |
| **Endodontics** | | | | | | | | | | | | | | |
| Removal/Pulpotomy | D3220 | $60 | 85% of charges | $134 | $90 | $78 | $50 | $87 | $83 | $42 | $99 | $115 | $140 | $175 |
| Endodontics | D3310 | $230 | | $498 | $380 | $263 | $180 | $367 | $348 | $168 | $373 | $476 | $525 | $620 |
| Extraction | D7140 | $42 | | $110 | $64 | $58 | $45 | $620 | $69 | $44 | $63 | $93 | $110 | $132 |

**BUDGET ESTIMATE FOR INCREASED DENTAL FEES**
**For Calendar Year 2008 (Total Funds)**

## Preliminary Estimates

| | No change to existing Dental Fees | Increase Fees to 25th Percentile ADA South Atlantic | Increase Fees to 50th Percentile ADA South Atlantic | Increase Fees to 75th Percentile ADA South Atlantic |
|---|---|---|---|---|
| I. 2005 HealthChoice Dental Base (Eligible Population Only) | $ 37,961,794 | $ 37,961,794 | $ 37,961,794 | $ 37,961,794 |
| II. Adjustment to base due to fee increase | $ - | $ 13,317,550 | $ 22,092,057 | $ 32,140,337 |
| III. Adjusted 2005 HealthChoice Dental Base (unit cost) | $ 37,961,794 | $ 51,279,344 | $ 60,053,851 | $ 70,102,131 |
| IV. Adjustment to base due to additional Utilization associated with fee increase | 1.000 | 1.0715 | 1.1097 | 1.1534 |
| V. Adjusted 2005 HealthChoice Dental Base (Increased fees and increased utilization) | $ 37,961,794 | $ 54,945,817 | $ 66,641,758 | $ 80,855,798 |
| VI. Total Additional Costs in 05 associated with fee increase | $ - | $ 16,984,023 | $ 28,679,964 | $ 42,894,004 |
| VII. Unadjusted Preliminary Trend 2005/2008 (Est.) (Mercer 6/19 annual midpoint 5.5% 36 mo.) | 1.174 | 1.174 | 1.174 | 1.174 |
| VIII. Estimated Additional 2007/2008 Trend associated with Outreach of services for identified non-utilizers | 1.089 | 1.089 | 1.089 | 1.089 |
| IX. Change in enrollment 2005/2008 | 1.047 | 1.047 | 1.047 | 1.047 |
| X. Projected CY 2008 Costs | $ 50,832,349 | $ 73,574,630 | $ 89,235,959 | $ 108,269,122 |
| XI. Total Additional Costs in 08 associated with fee increase | $ - | $ 22,742,281 | $ 38,403,610 | $ 57,436,774 |

# Dental Delivery Options for Children and Pregnant Women Enrolled in HealthChoice

| | Continue current at-risk MCO program | Carve out dental from MCO – but contract with dental benefit Provider to manage services for State (at-risk) | Carve out dental from MCO – but contract with dental benefit provider to manage services for State (no-risk) | Carve out dental from MCOs – and revert to fee-for-service system |
|---|---|---|---|---|
| Advantages of each option | | | | |
| Dental benefits would not be interrupted for current HealthChoice enrollees | **X** | | | |
| Ability to coordinate with child's medical home | **X** | | | |
| MCOs provide basic oral health services to adults without additional funding | **X** | | | |
| Provides dental outreach for children and pregnant women | **X** | **X** | **X** | **Limited** |
| Flexibility to increase provider fees in underserved areas | **X** | **X** | | |
| Flexibility to provide incentives for recipients (such as gift cards) | **X** | **X** | | |
| Recruits and enrolls dental providers | **X** | **X** | **X** | **Limited** |
| Provides customer service activities | **X** | **X** | **X** | **Limited** |
| Level of administrative burden for DHMH | **Least Burdensome** | **Extra Contracting/ Monitoring** | **Extra Contracting/ Monitoring** | **Most Burdensome** |
| Can develop dental home – if dentist provider pool is expanded | **X** | **X** | **X** | |
| Streamlines administrative burden for dental providers – only one entity (contracting, credentialing, claims, prior authorization, etc.) | | **X** | **X** | **X** |
| Better able to match enrollees to participating dentists | | **X** | **X** | |

| | Continue current at-risk MCO program | Carve out dental from MCO – but contract with dental benefit Provider to manage services for State (at-risk) | Carve out dental from MCO – but contract with dental benefit provider to manage services for State (no-risk) | Carve out dental from MCOs – and revert to fee-for-service system |
|---|---|---|---|---|
| Disadvantages of each option | | | | |
| Would not be able to continue to provide basic dental services for adults without additional funding | | **X** | **X** | **X** |
| May result in tighter prior authorization | **X** | **X** | | |
| Would need to increase DHMH staff to provide same level of customer service, outreach and case management, provider relations, utilization review, etc | | | | **X** |
| Least adequate provider network | | | | **X** |
| More administratively burdensome for providers | **X** | | | |

# Supply of Dental Providers

| REGION[1] | Total Active Dentists | Active General Dentists | Active Pediatric Dentists | Dentists Listed in HealthChoice Directory[2] (% of Total Active Dentists) | Dentists Billing One or More Services to HealthChoice (% of Total Active Dentists) | Dentists Billing $10,000+ to HealthChoice (% of Total Active Dentists) |
|---|---|---|---|---|---|---|
| **Baltimore Metro** | 1,780 | 1,403 | 56 | 453 (25.4%) | 308 (17.3%) | 161 (9.0%) |
| **Montgomery/ Prince George's** | 1,619 | 1,294 | 47 | 360 (22.2%) | 216 (13.3%) | 117 (7.2%) |
| **S. Maryland** | 158 | 129 | 5 | 39 (24.7%) | 28 (17.7%) | 14 (8.9%) |
| **W. Maryland** | 262 | 207 | 6 | 55 (21.0%) | 41 (15.6%) | 28 (10.7%) |
| **E. Shore** | 214 | 173 | 4 | 45 (21.0%) | 43 (20.1%) | 25 (11.7%) |
| **Other** | | | | | 25 (N/A) | 5 (N/A) |
| TOTAL | 4,033 | 3,206 | 118 | 918 (22.8%) | 661[3] (16.4%) | 350[4] (8.7%) |

[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] Includes Dentists listed in the HealthChoice directory as of July 2006. The total is different than the total in each geographic region because it is possible for a dentist to have multiple sites.

[3] Includes two "dummy" provider numbers that can be used by MCOs when the dentist does not have a Medicaid provider number. These two provider numbers rendered a significant number of dental services. Multiple dental providers use these two dummy numbers. Therefore the total of 661 undercounts the total number of providers. Clinics with multiple dentists are counted only once.

[4] Clinics with multiple dentists are counted only once.

## Dental Procedure Codes that require Preauthoriztion

| Procedure Code | Procedure Description | Doral | DBP | JAI | FEE FOR SERVICE |
|---|---|---|---|---|---|
| D0340 | cephalometric film | YES | | | |
| D2721 | crown-resin based with predominantly base metal | YES | | | YES |
| D2752 | crown-porcelain fused to noble metal | YES | | | |
| D2750 | crown - porcelain fused to high noble metal | YES | YES | | |
| D2751 | crown - porcelain fused to predominantly base metal | YES | YES | | YES |
| D2752 | crown - porcelain fused to noble metal | YES | YES | | |
| D2780 | crown, 3/4 cast high noble metal | | YES | | |
| D2781 | crown, 3/4 cast predominately base metal | | YES | | |
| D2782 | crown, 3/4 cast noble metal | | YES | | |
| D2783 | crown, 3/4 porcelain/ceramic | | YES | | |
| D2790 | crown - full cast high noble metal | YES | YES | | |
| D2791 | crown - full cast predominantly base metal | YES | YES | | YES |
| D2792 | crown - full cast noble metal | YES | YES | | |
| D2950 | core buildup, including any pins | YES | YES | | |
| D2951 | pin retention - per tooth, in addition to restoration | YES | YES | | |
| D2952 | cast post and core in addition to crown | YES | YES | | |
| D2954 | prefabricated post and core in addition to crown | YES | YES | | |
| D2955 | post removal (not in conjuction with endodontic therapy) | YES | | | |
| D2961 | labial veneer (resin laminate) - LAB | | | | YES |
| D2962 | labial veneer (porcelain laminate) - LAB | | | | YES |
| D2980 | crown repair-by report | YES | | | |
| D3230 | pulpal therapy - anterior-primary tooth | | | | YES |
| D3240 | pulpal therapy - posterior-primary tooth | | | | YES |
| D3310 | root canal therapy - anterior (excluding final restoration) | YES | YES | | YES |
| D3320 | root canal therapy - bicuspid (excluding final restoration) | YES | YES | | YES |
| D3330 | root canal therapy - molar (excluding final restoration) | YES | YES | | YES |
| D3346 | retreatment of previous root canal theraphy- anterior | YES | YES | | YES |
| D3347 | retreatment of previous root canal theraphy- bicuspid | YES | YES | | YES |
| D3348 | retreatment of previous root canal theraphy- molar | YES | YES | | YES |
| D3410 | apicoectomy/periadicular surgery-anterior | YES | | | YES |
| D3421 | apicoectomy/periadicular surgery-bicuspid (first root) | YES | | | YES |
| D3425 | apicoectomy/periadicular surgery-molar (first root) | YES | | | YES |
| D3426 | apicoectomy/periaducular surgery (each additional root) | YES | | | YES |
| D3430 | retrograde filling - per root | YES | | | YES |
| D3450 | root amputation per root | | | | YES |
| D3470 | intentional reimplantation (including necessary splinting) | YES | | | |
| D4210 | gingivectomy/gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant | YES | | | YES |
| D4211 | gingivectomy/gingivoplasty- one to three contiguous teeth or bounded teeth spaces per quadrant | YES | | | YES |
| D4230 | anatomical crown exposure- four or more contiguous teeth per quadrant | | YES | | |

## Dental Procedure Codes that require Preauthoriztion

| Procedure Code | Procedure Description | Doral | DBP | JAI | FEE FOR SERVICE |
|---|---|---|---|---|---|
| D4231 | anatomical crown exposure- one to three teeth per quadrant | | YES | | |
| D4240 | gingival flap w/ root planing - four or more contiguous teeth or bounded teeth spaces per quadrant | YES | | | YES |
| D4241 | gingival flap w/ root planing - one to three contiguous teeth or bounded teeth spaces per quadrant | YES | | | |
| D4249 | clinical crown lengthening - hard tissue | YES | YES | | |
| D4260 | osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant | YES | YES | | YES |
| D4261 | osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant | YES | YES | | |
| D4263 | bone replacement graft- first site in quadrant | YES | YES | | |
| D4265 | biologic materials to aid in soft and osseous tissue regeneration | | YES | | |
| D4271 | free soft tissue graft procedure (including donor site surgery) | YES | YES | | |
| D4273 | subepithelial connective tissue graft procedures, per tooth | YES | YES | | |
| D4275 | soft tissue allograft | | YES | | |
| D4320 | provisional splinting - intracoronal | YES | | | |
| D4321 | provisional splinting - iextracoronal | YES | | | |
| D4341 | periodontal scaling and root planing-four or more teeth per quadrant | YES | | | YES |
| D4342 | periodontal scaling and root planing-one to three teeth per quadrant | YES | | | |
| D4276 | combined connective tissue and double pedicle graft, per tooth | | YES | | |
| D5110 | complete denture - maxillary | YES | | | YES |
| D5120 | complete denture - mandibular | YES | | | YES |
| D5211 | maxillary partial denture - resin base (including any conventional claps, rests and teeth) | YES | | | YES |
| D5212 | mandibular partial denture - resin base (including any conventional claps, rests and teeth) | YES | | | YES |
| D5630 | repair or replace broken clasp | | | | YES |
| D5650 | add tooth to existing partial denture | | | | YES |
| D5660 | add clasp to existing partial denture | | | | YES |
| D5710 | rebase complete maxillary denture | YES | | | |
| D5711 | rebase complete mandibular denture | YES | | | |
| D5720 | rebase maxillary partial denture | YES | | | |
| D5721 | rebase mandibular partial denture | YES | | | |
| D5860 | overdenture-complete, by report | YES | | | |
| D5861 | overdenture-partial, by report | YES | | | |
| D5862 | precision attachment, by report | YES | | | |
| D5986 | fluoride gel carrier | YES | | | |
| D6240 | pontic- porcelain fused to high noble metal | | YES | | |
| D6740 | crown- porcelain or ceramin | | YES | | |
| D6781 | crown- 3/4 cast predominantly base metal | | YES | | |

## Dental Procedure Codes that require Preauthoriztion

| Procedure Code | Procedure Description | Doral | DBP | JAI | FEE FOR SERVICE |
|---|---|---|---|---|---|
| D6782 | crown- 3/4 cast noble metal | | YES | | |
| D6783 | crown- 3/4 porcelain or ceramic | | YES | | |
| D6970 | cast post and core in addition to fixed partial denture retainer | | YES | | |
| D6972 | prefabricated post and core in addition to fixed partial denture retainer | | YES | | |
| D6973 | core build up for retainer, including any pins | | YES | | |
| D7140 | extraction, erupted tooth or exposed root (elevation and/or forceps re | YES | YES | | |
| D7210 | surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | YES | YES | | |
| D7220 | removal of impacted tooth - soft tissue | YES | YES | | |
| D7230 | removal of impacted tooth - partially bony | YES | YES | | |
| D7240 | removal of impacted tooth - completely bony | YES | YES | | |
| D7250 | surgical removal of residual tooth roots (cutting procedure) | YES | YES | | |
| D7260 | oroantral fistula closure | YES | | | |
| D7270 | tooth reimplantation and/or stabilization or accidentally evulsed or displaced tooth | YES | | | |
| D7272 | tooth transplantation (includes reimplantation from one site to another and splintin and/or stabilization | YES | | | |
| D7280 | surgical access of unerupted tooth | YES | | | |
| D7282 | mobilization of erupted or malpositioned tooth to aid eruption | | YES | | |
| D7285 | biopsy of oral tissue-hard (bone, tooth) | YES | | | |
| D7286 | biopsy of oral tissue-soft | YES | | | |
| D7290 | surgical repositioning of teeth | YES | YES | | |
| D7291 | transseptal fibertomy/supra crestal fibertomy, by report | YES | | | |
| D7310 | alveoloplasty in conjunction with extractions - per quadrant | YES | YES | | |
| D7320 | alveoloplasty not in conjunction with extractions - per quadrant | YES | YES | | |
| D7340 | vestibuloplasty- ridge extension (secondary epithelzation) | YES | | | |
| D7350 | vestibuloplasty-ridge extention (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue | YES | | | |
| D7410 | excision of benign lesion up to 1.25 cm | YES | | | |
| D7412 | excision of benign lesion, complicated | | YES | | |
| D7440 | excision of malignant tumor-lesion diameter up to 1.25 cm | YES | | | |
| D7450 | removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm | YES | | | |
| D7460 | removal of benign nonodontogenic cyst or tumor - lesion diameter of 1.25 cm | YES | | | |
| D7471 | removal of lateral exostosis -(maxilla or manible) | YES | | | |

## Dental Procedure Codes that require Preauthoriztion

| Procedure Code | Procedure Description | Doral | DBP | JAI | FEE FOR SERVICE |
|---|---|---|---|---|---|
| D7472 | removal of torus palatinus | YES | YES | | |
| D7473 | removal of torus mandibularis | YES | YES | | |
| D7485 | surgical reduction of osseous tuberosity | | YES | | |
| D7840 | condylectomy | | | | YES |
| D7850 | surgical disectomy, with/without implant | | | | YES |
| D7860 | arthrotomy | | | | YES |
| D7865 | arthroplasty | | | | YES |
| D7870 | arthrocentesis | | | | YES |
| D7872 | arthroscopy:diagnosis w/without biopsy | | | | YES |
| D7960 | frenulectomy (frenectomy or frenotomy) - separate procedure | YES | YES | | |
| D7970 | excision of hyperplastic tissue - per arch | YES | YES | | |
| D7971 | excision of pericoronal gingiva | YES | YES | | |
| D7972 | surgical reduction of fibrous tuberosity | | YES | | |
| D7982 | sialodochoplasty | | | | YES |
| D8010 | limited orthodontic treatment of the primary dentition | | YES | | |
| D8020 | limited orthodontic treatment of the transitional dentition | | YES | | |
| D8030 | limited orthodontic treatment of the adolescent dentition | | YES | | |
| D8070 | comprehensive orthodontic treatment of the transitional dentition | | YES | | |
| D8080 | comprehensive orthodontic treatment of the adolescent dentition | YES | YES | YES | |
| D8210 | removable appliance therapy | | YES | | |
| D8220 | fixed appliance therapy | | YES | | |
| D8660 | pre-orthodontic treatment visit | YES | YES | YES | YES |
| D8665 | orthodontic records | | YES | | |
| D8670 | periodic orthodontic treatment visit (as part of contract) | YES | YES | YES | YES |
| D8680 | orthodontic retention (removal of appliances, construction and placement of retainer(s)) | | YES | | YES |
| D8999 | unspecified orthodontic procedure, by report | YES | | | |
| D9220 | deep sedation/general anesthesia - first 30 minutes | YES | YES | | |
| D9221 | deep sedation/general anesthesia - each additional 15 minutes | YES | YES | | |
| D9310 | consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment) | | YES | | |
| D9410 | house/extended care facility call | | YES | | |
| D9420 | hospital call | | YES | | |
| D9910 | application of desensitizing medicament | YES | YES | | |
| D9940 | occlusal guard, by report | YES | YES | | |

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

May 16, 2007

Dear :

The Department of Health and Mental Hygiene has been working to increase access to oral health services for many years. While we have come a long way, slightly less than half of the children eligible to receive a dental service actually receive these services. We can do better and are committed to do so with your help.

I have directed my staff to organize a Dental Action Committee to make recommendations to the Department regarding strategies to: 1) engage families to improve oral hygiene at home and seek early preventive care, 2) expand the dental public health infrastructure in the State, 3) encourage the dental provider community to participate in Medicaid, 4) explore the creation of new dental workforce positions to provide services to the underserved, and 5) increase the number of pediatric dentists trained in the State. The Committee will meet during the Summer to discuss these issues. A final set of recommendations will be submitted to me by mid-September.

I invite you to participate as a member of the Dental Action Committee. Your expertise and input are crucial to the development of a comprehensive series of recommendations to help guide the Department to increase access to oral health services in Maryland. Attached you will find the schedule of meetings. The first meeting is scheduled for Tuesday, June 12, 2007 from 4:00 p.m. to 6:00 p.m. at the Department of Health and Mental Hygiene in Baltimore. Please respond to Ms. Kelly Sage, Chief, Office of Oral Health, at 410-767-7899 regarding your ability to attend these meetings.

Maryland is at an important crossroad in expanding oral health services to its most vulnerable residents. I hope you will thoughtfully consider participating as a member of the Dental Action Committee. I look forward to working with you and the other members of the Committee to address the oral health issues facing our State.

Sincerely,

John M. Colmers
Secretary

cc: Michelle A. Gourdine, M.D.
Russell W. Moy, M.D., M.P.H.
Ms. Susan Tucker
Ms. Tricia Roddy
Ms. Kelly Sage

# Dental Action Committee
# Meeting Dates

Location: Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201
Conference Room: L-2 (Lobby Level)

Time: 4:00 p.m. to 6:00 p.m.

Contact: Kelly Sage: 410-767-7899

| Date | Topic/Lead |
|---|---|
| Tuesday, June 12 | Introduction and charge<br>(Lead: Medicaid/Public Health |
| Tuesday, June 26 | Education and outreach, with special focus on reaching parents<br>(Lead: Medicaid/Public Health) |
| Tuesday, July 10 | Public health strategies<br>(Lead: Public Health) |
| Tuesday, July 24 | Medicaid reimbursement rates and models of care<br>(Lead: Medicaid) |
| Tuesday, August 7 | Provider participation, capacity, and scope of practice<br>(Lead: Medicaid/Public Health) |
| Tuesday, August 21 | Wrap-up<br>(Lead: Medicaid/Public Health) |

# Dental Action Committee

Committee Members

**Chair** – Jane Casper, RDH, public health dental hygienist
**Vice-Chair** – Harold Goodman, DMD, MPH, University of Maryland Dental School

**Members**
Carol Antoniewicz – Medicaid Matters! Maryland
Debbie Badawi – Maryland Chapter of the American Academy of Pediatrics
Donna Behrens – Maryland Assembly of School Based Health Centers
Winifred Booker – Maryland Dental Society
Yvonne Bronner – Morgan State University
Carol Caiazzo – Maryland Dental Hygienists' Association
Leigh Cobb – Advocates for Children and Youth
Leslie Grant – National Dental Association
Hakan Koymen – Maryland Academy of Pediatric Dentistry
Tonia Lewis – Parent's Place of Maryland
Elyse Markwitz – Priority Partners
Miguel McInnis – Mid-Atlantic Association of Community Health Centers
Garner Morgan – Maryland State Dental Association
Laurie Norris – Public Justice Center
Elizabeth Ruff – Carroll County Health Department
Donald Shell – Prince George's County Health Dept./MD Association of County Health Officers
Mark Sniegocki – Doral Dental
Leslie Stevens – Maryland Oral Health Association
Norman Tinanoff – University of Maryland Dental School
Anthony Valdes – United Health Care
Grace Williams – Maryland Medicaid Advisory Committee
Grace Zaczek – Maryland Community Health Resources Commission
Linda Zang – Maryland State Department of Education, Head Start Collaboration Office

ELIJAH E. CUMMINGS
7TH DISTRICT, MARYLAND

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SUBCOMMITTEE ON READINESS

SENIOR WHIP

# Congress of the United States
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www.house.gov/cummings

July 24, 2007

The Honorable Martin O'Malley
Governor
State of Maryland
100 State Circle
Annapolis, Maryland 21401-1925

Dear Governor O'Malley:

I was horrified, as I am sure you were, to learn that a 12-year-old Maryland boy died on February 25 when a tooth infection spread to his brain. Forty dollars worth of dental care could have saved Deamonte Driver, but he was poor and homeless and he did not have access to a dentist. In response, I have aggressively pursued a federal agenda to address the issue of inadequate access to dental care through the introduction of *Deamonte's Law* (H.R. 2371) and a hearing and investigation of the House Oversight and Government Reform Committee. Maryland is not the only state that is experiencing difficulty in obtaining dental care for its Medicaid-eligible children—this is indeed a nationwide problem. 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. We have the potential to implement reforms in Maryland that could make it a model for other states, and I look forward to working with you to achieve this end.

Unfortunately, dental decay remains the single most prevalent chronic disease of U.S. children and it is on the rise. Recent data from the Centers for Disease Control and Prevention show a 15 percent increase in dental caries among preschool aged children between 1999-2004. But unlike many childhood diseases, dental caries, the disease that causes cavities, is preventable. Dental caries is established in children by the age of two and the decay is progressive if not treated. In fact, 80 percent of all tooth decay is found in 25 percent of children. Minority, low-income, and geographically isolated children suffer disproportionately from dental caries primarily due to lack of access to early and continuous care. Nearly all of this disease can be prevented by starting care early in a child's life.

It was startling for me to learn that in 1997, Maryland had the worst access to oral health care services for poor children in the country. At that time, only 19 percent of children in Maryland's Medicaid program had at least one dental visit each year and only seven percent received treatment services. Although incremental progress has been made, it is estimated that still 50 percent of children covered by Maryland's Medicaid program have cavities with only a small

portion of these children receiving necessary restorative care. It is time for Maryland to comprehensively address the oral health needs of our state's children.

I am extremely encouraged by your timely establishment of the Maryland Dental Action Committee, and I welcome the opportunity to discuss its work with you. Over the past several months, I have been meeting with national dental organizations, government officials and other stakeholders to identify solutions to address inadequate access to dental care. There is no single step we can take to fix this problem; it requires coordination and participation at all levels of government, and from industry and the community at large. In my study of this issue, I have become aware of several steps that the State of Maryland can take that I am eager to share with you. Please consider the following:

- **Eliminate the middle man by refusing to subcontract.** By doing business directly with dental managed care organizations, rather than subcontracting, unnecessary costs and paperwork would be eliminated. This practice has been incredibly successful in states like Virginia, where the provider network was increased by approximately 30 percent and utilization rose as a result by 58 to 78 percent.

- **Manipulate reimbursement rates to target desired services.** If you determine that the state will raise reimbursement rates for dentists participating in Medicaid, consider targeting the increased rates to services like early care and prevention, which we know yield a large return on investment. In Rhode Island, this approach has been particularly successful in increasing care for children under 6 years old.

- **Invest in a stronger dental workforce.** Because Deamonte Driver was a child and his dental disease was so far advanced, a dentist would have needed special training to meet his needs. The University of Maryland Dental School has suggested that we invest in continuing education to train general practice dentists in pediatric dentistry, to boost the dental workforce for children like Deamonte. The legislation that I have introduced would set up a federal grant program to achieve this; however, it is an initiative that could easily be implemented at the state level now.

- **Strengthen the dental safety net.** One of the issues that repeatedly came up in our Congressional hearing in May was the idea of establishing a "dental home" for every child. If children have a dentist who they see on a regular basis, they are more likely to get the care they need early and often. We can begin to set this standard by investing in the institutions that we currently rely on to provide a health safety net, Community Health Centers. Again, my legislation would address this issue at the federal level, but the State could implement it as well.

- **Educate parents on the importance of dental health and the services available to their child.** Parents must be informed of the need to address their child's dental health needs. Few adults are aware of the fact that dental health is an essential component of overall health and we can help prevent dental disease by informing them. I have recommended an initiative at the federal level to inform new mothers around the time of birth of their child's dental health needs, and a similar policy could be adopted in

Maryland. Furthermore, an education campaign for parents would make great strides in spreading the word about the importance of dental health.

- **Examine innovative solutions and replicate their models.** I was very interested to meet recently with Michael Lindley, CEO of Forba, LLC, a company that manages a national chain of "Small Smiles" facilities that make a profit by providing dental care to Medicaid-eligible children. We have heard time and again that dentists cannot afford to accept Medicaid patients, yet here is a company that serves communities across the country and thrives solely by treating this population. The company takes a high volume of patients, recognizing that approximately half of them will miss appointments; it has several dental chairs in one office; and it trains dentists in pediatrics. Mr. Lindley indicated that the State of Maryland could better facilitate its work by speeding up the credentialing process, instituting electronic payments, limiting prior authorization, and easing the administrative burden. I highly recommend that you consult with Small Smiles and similar organizations to determine what the State can do better.

Again, I look forward to working with you to coordinate efforts at the state and federal levels to improve children's access to dental care. I am available to discuss this issue further with you at any time. Please feel free to contact Ms. Danielle Grote in my office at (202) 225-4741 with any questions or for additional information.

Sincerely,

Elijah E. Cummings
Member of Congress

cc: John Colmers, Secretary, Maryland Department of Health and Mental Hygiene

Advocates FOR CHILDREN & YOUTH

*Voices for Maryland's Children*

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

September 5, 2007

**Re: Support for the Dental Action Committee Recommendations**

Dear Secretary Colmers:

Thank you for your leadership in beginning to address the lack of dental access for children on Medicaid and MCHP. The formation of the Dental Action Committee (DAC) and subsequent hard work of the DHMH staff and Committee members over the summer are strong indicators that all parties are willing and able to work together to address this "silent epidemic". We look forward to working with you and your staff to implement the recommendations of the DAC.

As you review the DAC's recommendations, I urge that you also consider the following points:

- **Reform strategies must be targeted to focus resources on both the "front end" and the "back end."** The best way to save money and improve oral health in the medium- to long-term is to build an effective preventive oral care delivery system capable of reaching and treating all at-risk very young (ages 1 to 6) children. While we are doing that, however, we must protect the health and well-being of many thousands of older children (ages 6 to 21) by providing restorative treatment to those who need it.

- **We must build the capacity to measure our progress.** Although outcome measures were not specifically addressed by the DAC, a number of the recommendations will facilitate better collection of data. As we improve our data collection system, it is imperative that we develop the capacity to disaggregate data based on race and ethnicity. As we move forward, it is also essential that we set benchmarks and develop a plan for measuring progress and outcomes.

- **We must carefully consider all of our actions and efforts with an eye toward eliminating racial and ethnic disparities in oral health outcomes, and achieving cultural competency in providing oral health education and treatment.** Racial and ethnic disparities in access to care cannot be tolerated.

- **We must not be intimidated by the price tag for moving forward; the costs to children of doing nothing or partially fixing the system are too high.**

- **As we work to improve the system for children and pregnant women enrolled in MA, we must be mindful of adults and others without access to oral health care.** Improving the public health infrastructure and developing a clear message about the importance of oral health are important first steps for improving oral health care for everyone.

- **Visible leadership from you is going to be critical to the success of these efforts.** We urge you to embrace the task of reaching out to Maryland's dentists, sharing your vision with them, and inspiring them to join wholeheartedly in achieving better oral health for low-income children. In addition, such conversations can lead to relationships that will provide useful feedback during the implementation of reform efforts.

Thank you for the opportunity to serve on the DAC, I look forward to continuing to work in partnership with DHMH toward our mutual goal of making Maryland a leader on children's oral health. Your commitment and leadership have already begun to make a difference.

Sincerely,

Leigh Stevenson Cobb
Health Policy Director

# CARROLL COUNTY HEALTH DEPARTMENT

LARRY L. LEITCH, M.A., M.P.A.
HEALTH OFFICER, CARROLL COUNTY

ELIZABETH M. RUFF, M.D.
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September 7, 2007

John M. Colmers, Secretary
Department of Health & Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

Dear Secretary Colmers:

Participating on the Dental Action Committee has been a wonderful experience, giving me hope that action will finally be taken to enable the most vulnerable children in our State to receive the dental treatment they need. For the past 37 years, while working as a pediatrician in Maryland, first at University of Maryland Hospital and then at Carroll County Health Department, I have seen first hand the dire consequences of lack of dental care: 3 year olds with "nursing bottle caries", 7 year olds going to school with abscessed teeth, and teenagers who have had multiple permanent teeth removed.

In Carroll County Health Department, we were finally able to open a Pediatric Dental Clinic in 2001: this clinic now provides services to approximately 1,100 MA children each year. However, there are still close to 2,000 MA children who never see a dentist. Currently, almost no private dentists see MA children, largely because of the extremely low rate of reimbursement, which does not even cover their costs. Each time the Health Department clinic opens the waiting list (which is only 2 to 3 times a year), we can only accept the first 100 people who call, and usually there are 400 to 500 phone calls in the first 3 to 4 days.

The recommendations of the committee, if implemented, should go a long way towards correcting the problems. We realize that the price tag will be high, but the cost of doing nothing will be higher. You encouraged us to be open to change, and I believe these recommendations reflect that. Preventive services are as important as restorative care, and this can be addressed in a variety of settings, by a variety of health care providers. Disparities in oral health outcomes must be eliminated in this, the wealthiest state in the nation. Increasing the reimbursement rate is essential if we wish to demonstrate to private providers that we value their services.

Thank you for your leadership and commitment in convening this committee and expressing such interest in the problem of access to dental care for our children. I look forward to continuing to work with DHMH in the hope that Maryland will be a leader in health care for children.

Sincerely,

Elizabeth M. Ruff, M.D.
Deputy Health Officer
Carroll County

September 6, 2007

John Colmers, Secretary
Department of Health and Mental Hygiene
201 Preston Street
Baltimore, Maryland

Dear Secretary Colmers:

We at Doral deeply appreciate the opportunity to work with the Dental Action Committee to suggest enhancements to the current program. It has been a very gratifying experience to work with this group of caring professionals towards the worthy goal of increasing dental access for children.

By way of perspective, Doral Dental USA has been a subcontractor to Medicaid MCO's within the state of Maryland for the last eight years. Currently we administer adult and child dental benefits for Amerigroup, Coventry Diamond Plan, Helix Family Choice, Maryland Physicians Care and Priority Partners. Nationally, Doral administers dental benefits for nearly 10 million government sponsored program members in 19 states. The recommendations submitted by this committee equal or exceed the best practices I have encountered in other states.

We at Doral do not presume to speak on behalf of our clients in your state, but as a company that has been heavily involved in Maryland for the past nine years, Doral heartily endorses the contents of this combined report and urges the department to strongly consider enacting these recommendations.

Sincerely,

Mark A. Sniegocki
Regional Executive Director
Eastern Region
Doral Dental USA

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Administration for Children and Families, Region III

Suite 864
150 S. Independence Mall West
Philadelphia, PA 19106-3499

September 3, 2007

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

Dear Secretary Colmers:

As the Federal Region III Head Start Oral Health Consultant with responsibility for a 6-state region including Maryland, I wish to thank you for your vision and interest in oral health and commissioning the Dental Action Committee (DAC) to address oral health needs in Maryland. This letter gives my full support for the recommendations being forwarded to you by the (DAC). As the Vice-Chair of the DAC, I firmly believe that these recommendations which entail improvements in the Medicaid program, dental public health infrastructure, scope of practice for health care providers and unified dental health educational messaging to disparate populations will go far in meeting our shared vision of a dental home for all Maryland children.

As you well know, Head Start children from Maryland and the contiguous states which comprise Federal Region III experience high oral health needs and yet limited access to dentists' services. I am aware that Maryland has made great strides in recent years to improve access to care but the problem obviously still exists. A study conducted in 2000 by the University of Maryland Dental School that was funded by your Department found that over half of Maryland Head Start children had tooth decay with many of them in pain.

While the death of 12- year old Deamonte Driver was certainly a tragedy especially because it was so avoidable, countless more children suffer daily from pain, infection and pathology associated with oral diseases. I believe that implementation of the recommendations of the Dental Action Committee through your leadership will signal a new day in Maryland where there can be enhanced access to oral health care services and reduced unmet dental treatment needs among our most vulnerable populations. As the Region III Head Start Oral Health Consultant, I am fully committed to working with the Department of Health and Mental Hygiene and other partners in Maryland to fulfill the promise of the DAC recommendations now being forwarded to you.

Again, I wish to thank you for your attentive and genuine interest in the oral health needs of poor Maryland children and allowing me the opportunity to be a part of the Dental Action Committee. It is critical that the recommendations of this Committee be implemented in order to improve the somatic, social and psychological health of Head Start children and their peers throughout Maryland.

Sincerely,

Dr. Harold S. Goodman
Head Start Oral Health Consultant
Region III

August 29, 2007

Dear Secretary Colmers,

The Maryland Chapter of the American Academy of Pediatrics fully supports the recommendations of the Dental Action Committee as outlined in their report. Specifically, pediatricians in the state support education efforts for pediatricians and general dentists regarding oral health care for children. Families generally see their pediatrician or family physician several times when a child is young, making this primary care provider a natural entry point into dental care. Therefore establishing linkages between primary care and dental offices and providing cross training for dentists and physicians will directly benefit the children we serve, particularly those who are uninsured or who receive Medicaid. Given the limited resources and access to care of this population, serious consideration should be given to having physicians begin preventive fluoride varnish for very young children who do not have a dentist.

The Chapter also recognizes the importance of providing oral health screening in schools, with a model already being in place for hearing and vision screening in the schools. Similarly an expansion of public health dental services, including emergency services, is essential in order to eliminate the significant disparity between need for dental services and available providers.

Finally, given that the underlying issue with regard to inadequate dental care in the state is the paucity of dental providers accepting Medicaid patients, the reimbursement rates must be increased in order to allow more dentists to be able to provide services to this population.

Thank you very much for your time and attention to this crucial health care issue affecting Maryland's children.

Sincerely,

Debbie Badawi
AAP Fellow

Chesapeake
PediatricDental
group

3. September. 2007

Dear Secretary Colmers:

Being one of the few Pediatric Dentists in the State of Maryland who actually treats Medicaid/Healthchoice children, I have a unique insight into the practice of dentistry with low-income children. My role on the Dental Action Committee (DAC) has been one that gives many of the members an "inside" look into a private practice that also services Medicaid children. I came from a system in the State of North Carolina where most dental practitioners saw Medicaid in one form or another. So, when I moved to Maryland, and found that there was such an adversity to seeing children from low-income families, I made it my goal to try to change my residents and peers perceptions of Medicaid and its stereotypes.

I believe the recommendations that the DAC has provided will help to bridge the gap in the number of practitioners that take Medicaid and the number of patients that are waiting to be seen. I think there are several factors that are important in order to change the minds and attitudes of practitioners in this state:

- **Reimbursement rates must increase** in order to attract enough dentists and specialists to participate with Medicaid. This is just an undeniable fact and is the most common reason why practitioners will not see Medicaid.
- **Simplify the current system** by using a single company to provide coverage. Practitioners view the system as too confusing, which makes dentist not want to get involved with several different insurance groups.
- **Concentrate our services** by targeting those children from 0-3 years of age, and those kids with significant dental problems. This is the population where we will make the most difference.
- **Help educate more general dentists** during their training in dental school. We should graduate dentist that feel comfortable in treating many kids, and especially seeing kids early. There is no reason for any dentist in this state to turn away a child because they do not feel comfortable seeing patients under the age of 3, 4, 5, or 6. This is the time when we should be concentrating on these children and promoting prevention.

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Chesapeake
PediatricDental
group

I strongly believe in the goals of the DAC, and I truly believe that we will make a difference. However, there are many stereotypes and biases that we will need to overcome, and we as pediatric dentists should be leading the charge. I do not believe that by putting the burden on physicians to apply fluoride varnish, hygienists to act as primary care providers, and allowing large corporations to open dental clinics which only view patients as profits or losses, and not as individual children is the answer. The answer lies within our dentists and specialists, who have been trained to treat dental disease, we just need to open their eyes and show them that treating these children should not be a chore, but should be an obligation. An obligation that will not only prevent another Deamonte Driver from every happening again, but also helping children who are in pain get the treatment they need and deserve.

I know that I tend to preach as I talk about this topic, many members of the committee will attest to that. But, when I became a Pediatric Dentist, my goal was to treat those children that had disease. The ones who were the less fortunate, did not have the best homes or family lives, and always seemed to get the short end of the stick when it came to healthcare. These are not the only children that I see, but I have been able to create a practice that can balance patients from all walks of life. This is the mentality that we have to instill in our students in dental school, the new dentists that graduate and start dental practices, and our specialists whose expertise is most often required with these children.

As, I said before, we have a long road, but by taking this matter seriously, and with your hard work and perseverance, we will be able to create a system that works for everyone and helps all the children in our State.

Always feel free to contact me anytime with any questions or concerns.

Sincerely,

Hakan O. Koymen, DDS, MS
Pediatric Dentist

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September 7, 2007

John Colmers, Secretary of Health
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore Maryland 21205

Dear Secretary Colmers:

I am writing to offer our very strong support for the recommendations offered to you in the final report of the Dental Action Committee. We were pleased to see such strong recommendations. These recommendations if implemented will go a long way to improving the oral health care for children on Medicaid in Maryland. The Maryland Assembly on School-Based Health Care was honored to have served on this important committee and we applaud your strong commitment to improving oral health care for children.

We at the Maryland Assembly on School-Based Health Care are committed to increasing access to health care. The loss of Demonte Driver was a tragedy and speaks strongly to why health care is not just about having insurance. What good was Medicaid coverage to this family when they could not find anyone to take care of him! We hope as you consider the many great recommendations before you and that you remember that the majority of our children on Medicaid have trouble accessing the health care system as it is today. We cannot rest until all children have access to quality health care!

The Maryland Assembly on School-Based Health Care looks forward to our continued role as a resource and a voice for school health services and school-based health centers throughout Maryland. We hope to continue to serve on the Dental Action Committee and be a part of designing a responsive and accessible dental health care system for our most vulnerable children.

Sincerely

Donna Behrens

Donna Behrens, R.N.,M.P.H., B.S.N.
Executive Director
Maryland Assembly on School-Based Health Care

# MARYLAND DENTAL HYGIENISTS' ASSOCIATION

September 6, 2007

John Colmers, Secretary
Department of Health and Mental Hygiene
201 Preston Street
Baltimore, Maryland

Dear Secretary Colmers,

It has been an honor for the Maryland Dental Hygienists' Association to serve on your Dental Action Committee. This committee is comprised of a diverse group of individuals that came together for a common cause. That cause was to provide dental care to Medicaid children in Maryland. Our focus never wavered; our decisions were based on finding the best way to serve this population. We looked at many different ways as to how this could be accomplished. The Committee deliberated on Medicaid fees and reimbursement, Providers, incentives, facilities and much more. It found solutions to the problems at hand. We know that the problem will not be solved over night but we now have a plan that we feel will work.

I look forward to this Committee meeting in the future to implement our recommendations and continue to improve on this problem. The Medicaid children of Maryland will have a dental home, receive necessary treatment, preventive information and be able to attend school free of dental pain.

Sincerely,

Carol Caiazzo RDH
Liaison
Maryland Dental Hygienists' Association

# Maryland Dental Society

**A Component Chapter of the National Dental Association**

**P.O. Box 13572**
**Baltimore, Maryland 21203-3572**


05 September 2007

Secretary John M. Colmers
Maryland Department of Health & Mental Hygiene
210 West Preston Street
Baltimore, Maryland 21201

Dear Secretary Colmers:

The Maryland Dental Society greatly respects your vision to convene the Dental Action Committee (DAC). In the week following one of the most nationally publicized deaths from oral disease in Maryland history, you responded immediately to the concerns of dentists and to the oral health care crisis facing the dental profession and the State of Maryland.

Per the mandate enlisted to the DAC, the efforts to gain meaningful answers and institute systemic changes that will demonstrate measurable results and produce improved oral health care for all Marylanders are outlined in our report, *Access to Dental Services for Medicaid Children in Maryland.* I am humbled by the opportunity to represent the Maryland Dental Society and to share with you the magnitude of the commitment and dedication that is required and that is common among our members, who are more often than not, Medical Assistance providers.

The horrifying impact of untreated tooth decay, dysfunction, poor appearance and low self-esteem has overwhelmed children, parents and professionals in our state. I appreciate the opportunity as a pediatric dentist to also be another voice for our most vulnerable citizens.

I am confident that in your willingness to assemble the DAC, search for a creative and energetic state dental director with public health and or equivalent credentials and promote meaningful incentives for provider participation in the Medical Assistance Program, the continuous cycle of oral disease that clearly impacts Maryland commerce will begin to improve.

It is gratifying for the Maryland Dental Society to have your fortitudinous leadership to navigate the Department of Health & Mental Hygiene. I look forward to being involved with the promise and success of the recommendations provided to you by the DAC this summer.

Sincerely,

Winifred J. Booker

Winifred J. Booker, DDS
Immediate Past President

xc: Kenny Hooper, DDS, President, Maryland Dental Society
Joshua M. Sharfstein, MD, Commissioner, Baltimore City Health Department


**Maryland Oral Health Association**

*Helping to create a healthy Maryland through community oral health programs*

P.O. Box 1745 • Cumberland, Maryland 21501

August 31, 2007

John M. Colmers, Secretary
Maryland Department of Health and Mental Hygiene
201 W. Preston Street, 5th floor
Baltimore, MD 21202

Dear Mr. Colmers;

The Maryland Oral Health Association (MOHA) supports the Dental Action Committee's recommendations. The mission of the Association is to promote and improve the health and well being of Maryland residents through state and local oral health programs. The Association's members are representatives from public oral health programs. The Committee's main points and recommendations address possible solutions to improve access to care for children in the State of Maryland.

The concerns of the Association have been: to provide more support for the Office of Oral Health; enhancing the Dental Public Health infrastructure so capacity can be increased in existing and new public health dental clinics; improve the salary scale for dental professionals to address recruitment concerns in the State of Maryland system; the need to increase rates to assure that dental public health clinics can continue to provide services and to have a unified oral health message across Maryland.

Thank you for your consideration and great concern with improving the oral health of Maryland's children.

Sincerely,

Leslie Stevens, RDH, BS
President, Maryland Oral Health Assoc.
P. O. Box 1745
Cumberland, MD 21502

db

MARYLAND STATE DEPARTMENT OF EDUCATION
Achievement Matters Most

**Nancy S. Grasmick**
**State Superintendent of Schools**

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

Dear Secretary Comers,

It was a pleasure serving on the Dental Action Committee with informed and expert colleagues in the oral health arena. As Coordinator of Maryland's State Collaboration Project, I bring a Head Start perspective to the work of the committee. Over 12,000 of Maryland's poorest children are enrolled in Early Head Start and Head Start programs and receive educational and comprehensive services, including health and oral health services.

A shortage of pediatric dentists and general dentists willing to treat the birth to five-year old children enrolled in Early Head Start and Head Start has led to only 70% of children needing dental treatment receiving it. Some of these children's dental problems are severe and affect the child's ability to learn and participate.

The recommendations developed by the Dental Action Committee are basic to our children's well-being and future. I urge you to accept the recommendations and begin the steps necessary for implementation. In my role as the Head Start State Collaboration Coordinator, I will assist in sharing information and act as a liaison with the Head Start community.

Sincerely,

Linda Zang

Linda Zang, Director
Head Start State Collaboration Project

Medicaid
Medicaid Matters! Maryland
Matters

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September 5, 2007

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

Re: Dental Action Committee Recommendations

Thank you for the opportunity to serve on the Dental Action Committee (DAC) and for your commitment to taking action to increase access to dental care for Maryland's children. We commend your staff for their responsiveness in assisting the DAC. Their expertise and hard work has been very valuable.

In addition to supporting the Committee's recommendations, it seems important to articulate the "spirit" of the changes we believe will accomplish the goal of excellent oral health for children on Medicaid. To wit,

- We feel a **sense of urgency:** not only has a child died but we have been aware of poor access for years. A giant leap forward is needed, a noticeable change. The well-being of over 400,000 children is at stake today. Maryland is a wealthy state; we can take care of our children.

- We cannot state strongly enough our belief in the **need for leadership from highest levels of DHMH** to build relationships with dentists, influence changes within school systems, primary care physicians, etc. We especially hope that you and John Folkemer will have direct contact with leaders of all the dental organizations to let them know DHMH is willing to partner with them to make substantive changes for the benefit of children.

- Some solutions will be costly, yet **be aware of the cost of NOT acting** – school days lost; pain, suffering, DEATH; more expensive restorative care; inappropriate use of the Emergency Room. Some solutions may have a modest price tag but require **willingness to "do things differently"** – school screenings, coordination between primary care physicians and dentists.

- Focus resources on **"front-end" and "back-end" needs.** A) Dental care for very young children and reducing early childhood caries must become a higher priority. With the proper support, local health departments and primary care physicians can make sure parents know that baby teeth are important. B) Expedite access to dental

care for older children with urgent needs. Until current access problems are resolved, Medicaid should provide case management for children who present to the ER with oral health needs.

- Review ALL elements with an eye toward **eliminating racial and ethnic health disparities**. Some recommendations could see early implementation as pilot programs in areas with higher risk/need. Involve Dr. Hussein (Office of Minority Health) and groups representing minority health professionals, e.g National Dental Association.

- **Data collection and analysis** will be crucial to see if changes are having an impact.

- We pledge our willingness to **communicate with key legislators** as needed.

Although they are beyond the committee's focus, as an advocacy group for people enrolled in Medicaid, we need to mention two additional issues:

- Access to dental care for adults: We have appreciated the MCOs which elect to provide [limited] dental services even though that is not part of their capitated payment. We strongly support use of the single dental vendor model which has shown dramatic improvements in children's access in other states and we hope that MCOs will continue to offer adult dental benefits. We also urge DHMH to restore the dental benefit for adults under Medicaid. With mounting evidence of the interplay of oral health and heart disease, low birth weight infants, etc. adult dental should be part of the Medicaid benefits package.
- Shifting Medicaid toward a more "patient-centered" program. To quote New York governor Elliot Spitzer, *"Our agenda is based on a single premise: patients, not institutions, must be at the center of our health care system. That means that every decision, every initiative and every investment we make must be designed to suit the needs of patients first. The result will be a high-quality health care system at a price we can all afford."* Whether it is an adult who is discouraged by the lengthy Medicaid application or a parent who has trouble locating a dentist, we've seen how barriers result in poorer outcomes and higher health costs. Medicaid Matters because people matter. Let's make the system work for them.

Again, thank you for your leadership and commitment to life-saving healthcare for Maryland's children. We look forward to continuing the work to improve dental outcomes children.

Sincerely,

Coordinator
info@medicaidmattersmd.org

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

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September 7, 2007

Jane Casper, RDH, MA-Chair
Harry Goodman, DMD, MPH -Vice Chair
Dental Action Committee
Department of Health and Mental Hygiene
201 W Preston St.
Baltimore, MD 21201

Dear Jane and Harry,

It has been a pleasure working with you on the Dental Action Committee. I believe that the recommendations developed by the Committee reflect a comprehensive approach to expanding dental access to underserved children and families in Maryland. The Federally Qualified Health Centers (FQHC's) strongly support the Committee's recommendations to expand the public health dental safety net. As you know, a majority of the established FQHC's offer dental services to their patients across the state. Last year, the FQHC's provided over 51, 351 patient encounters in 2006 to over 23,540 patients. Many of the health centers have planned or will plan to expand over the next several years but are in need of financial support from the state in order to do so.

We believe that state investment in the public health dental safety net is a wise investment that will yield dividends in the form of increased access, reduced cost and leveraged federal funding. Since 2002, HRSA has provided over $45 million in oral health grants to support oral health access for underserved families. In a recent speech at the National Association of Community Health Centers in Dallas, Dr. Duke, HRSA Administrator, reconfirmed her commitment to providing funding for oral health access to FQHC's. Therefore, we believe that state support directed to FQHC's for oral health expansion would enable Maryland FQHC's to be successful in leveraging the HRSA dollars.

Again, I thank you for the opportunity to voice our concerns and look forward to the implementation of the proposed recommendations.

Sincerely,

Miguel McInnis, MPH
Chief Executive Officer
Mid-Atlantic Association of Community Health Centers

CC: MACHC Board Members
Pamela Metz Kasemyer
Kelly Sage

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DENTAL
ASSOCIATION

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September 3, 2007

John M. Colmers, Secretary
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201



Dear Secretary Colmers:

Thank you for promptly taking the initiative to establish the Maryland Dental Action Committee. It is most encouraging to those of us in the dental community that early on in your administration you have determined that there is a dire lack of consistency of care and access in provision of oral health services to underserved populations in our state.

Your vision in forming a diverse coalition of stakeholders in dental service delivery provided the DAC with a variety of points of view and issues of concern. You will be pleased to know that these committed volunteers worked tirelessly to come to a consensus that would best serve the dental needs of Maryland's most vulnerable little citizens.

The attached report of recommendations incorporates the charge that you delivered to us at our preliminary meeting on June 12, 2007. We have included educational components for caregivers, strategies to encourage increased provider participation, possible mechanisms for utilization of mid-level and ancillary health providers and incorporation of school based programs. Indeed, the overwhelming and collective desire of the DAC is to assist in "strengthening the dental public health infrastructure" in Maryland.

The recommendations of the DAC are congruent with the overall vision and mission of The National Dental Association to "…elevate the global oral health concerns of underserved communities… ". Earlier this year, in the aftermath of the tragic dentally related deaths of Deamonte Driver and Alexander Callender, the NDA established the following legislative priorities:

A Dental Director in Every State
Dental Care for all Americans
Increase Funding to Expand Pediatric Dental Residencies
Meaningful Incentives for Dental Medicaid Providers
Dental Examinations Prior to School Entry
Increased Funding to Educate Native, Hispanic and African American Dentists

Thank you again, Secretary Colmers for your attention to the oral health needs of the residents of Maryland. I am most appreciative that you have allowed me the opportunity to serve on the Dental Action Committee.

It is my hope that no other child will be unable to concentrate in school, have a sleepless night or die because of dental pain, infection or lack of access to care.

Sincerely,

Leslie E. Grant, DDS, MSPA
Immediate Past President
Legislative Chair

Cc: Governor Martin O'Malley
Senator Benjamin Cardin
Congressman Elijah Cummings
Commissioner Joshua Sharfstein

**The Parents' Place of Maryland**
**A Resource Center for Families**

September 4, 2007

John Colmers, Secretary
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Secretary Colmers:

The Parents' Place of Maryland (PPMD) is writing in support of the work of the Department of Health and Mental Hygiene's Dental Action Committee (DAC). Parents' Place of Maryland, a non-profit dedicated to supporting families of children with special healthcare needs (CSHCN), was represented on the committee by Grace Williams, Health Coordinator. Ms. Williams is a member of our staff and participates on the Maryland Medicaid Advisory Committee. She represented both interests during the DAC process.

The Parents' Place of Maryland, established in 1991, is the Maternal Child Health Bureau funded Family-to-Family Health Information Center, a resource and information center for families of children with special healthcare needs. We provide information and resources to over 3500 families in Maryland each year. About 40% of our calls are from families on Maryland Medical Assistance. Access to providers, including oral health providers, is consistently one of the top three reasons families contact us. A survey of over 250 families conducted by PPMD with the DHMH Office of Genetics and Children with Special Healthcare Needs revealed similar data.

The Dental Action Committee has identified four main strategies to increase access to oral health services for Maryland children. The recommendations made for each of the four main areas will have a significant impact on access for Maryland children, including those with special healthcare needs.

PPMD is committed to the DAC, its report and the recommendations. We will continue our efforts to support this work and Maryland families. We look forward to working in partnership with you on this important issue.

Sincerely,

Josie Thomas
Executive Director

PRIORITY PARTNERS
A MANAGED CARE ORGANIZATION FROM JOHNS HOPKINS AND THE MARYLAND COMMUNITY HEALTH SYSTEM

September 5, 2007

The Honorable John M. Colmers
Secretary, Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201

Dear Secretary Colmers:

Priority Partners is pleased to write a letter of support for the Dental Action Committee (DAC) Proposal. Priority Partners is concerned with the difficulties that have been experienced with accessing dental care and we are very supportive of the recommendations submitted by the DAC that are intended to:

- Increase participation of dentists to increase access to care
- Implement education initiatives to assist with reducing the number of children needing extensive dental services
- Strengthen the oral health safety net
- Strengthen the oral health delivery system

Priority Partners is dedicated to the mission of increasing access to dental care to its members. We look forward to working collaboratively with the Department of Health and Mental Hygiene to accomplish the goals set forth by the Department and the Dental Action Committee.

Sincerely,

Robert R. Neall
Chief Executive Officer

Public Justice Center

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

September 3, 2007

**Re: Support for the Dental Action Committee Recommendations**

Dear Secretary Colmers:

Thank you for your strong leadership in the first days of your administration to begin to address the lack of dental access for children on Medicaid and MCHP. The death of Deamonte Driver called for no less. Your early action to form a broad-based Dental Action Committee (DAC) gives me encouragement that you will take immediate steps to adopt and implement its recommendations.

Serving on the DAC has been an intense, challenging and rewarding experience. Your staff has done a commendable job in supporting the work of the DAC. And the members of the DAC, in my estimation, have done a commendable job in responding to your request that we make it our summer's work to determine how best to improve dental access for Maryland's children on Medicaid. The attendance at meetings has been close to 100% every time, there has been standing room only in the observer's section, and our sub-committee work has been engaged and committed. This is clearly an issue that has grabbed and held everyone's attention, and that continues to cry out for solutions.

In considering the DAC's recommendations, I urge you to also consider the following points, as well as Congressman Elijah E. Cummings' suggestions to Governor O'Malley in his letter dated July 24, 2007:[1]

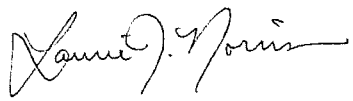
- **Visible leadership from you is going to be critical to the success of these efforts.** We urge you to embrace the task of reaching out to Maryland's dentists, sharing your vision with them, and inspiring them to join wholeheartedly in achieving better oral health for low-income children. In addition, such conversations could lead to relationships that might provide useful feedback during the implementation of reform efforts.
- **We must build the capacity to measure our progress.** One item you will not see included in the DAC recommendations is a strategy for setting goals and measuring progress toward those goals. This task was not included on the DAC agenda and was not assigned to any sub-committee, possibly because some DHMH staff feel leery of going down this path. Based on past results we know that performance measures can drive performance. Setting clear new measures that challenge us to do better is critical to our success. I suggest that the DAC be given the task, during its follow-up meetings, of developing a recommended plan for measuring progress and outcomes.

[1] See attached.

- Though some of the recommendations carry a large price tag, **we must not lose sight of the high cost of doing nothing or not enough:** missed school days leading to diminished learning; pain, suffering, and even death; the lack of preventive care causing the need for much more expensive restorative care; and expensive, avoidable use of the emergency room.[2]
- **Reform strategies must be targeted to focus resources on both the "front end" and the "back end."** The best way to save money and improve oral health in the medium- to long-term is to build an effective preventive oral care delivery system capable of reaching and treating all at-risk very young (ages 1 to 6) children. At the same time, however, we must be sure to also provide needed restorative treatment to the many thousands of older (ages 6 to 21) children who need it.
- **We must carefully consider all of our actions and efforts with an eye toward eliminating racial and ethnic disparities in oral health outcomes, and achieving cultural competency in providing oral health education and treatment.** This includes examining how the licensing, credentialing and discipline processes may have an unintentionally adverse and disparate impact on minority dentists, how oral health education messages may fail to reach minority parents, and how office practices may intimidate or otherwise discourage minority patients. See Recommendation PHS-27.
- The DAC's recommendations are just the beginning; changes to Medicaid/HealthChoice and the public health infrastructure are not the only avenues toward achieving better oral health for children. **DHMH can leverage more resources to help increase access to dental care by calling on DAC members and other interested parties** (especially organized dentistry, dental hygienists, pediatricians, obstetricians, and community clinics, as well as local health departments, dental and medical schools, public schools, social service providers and advocates) **to form collaborative partnerships** in service of additional creative approaches outside the Medicaid/HealthChoice and public health arenas.

I thank you for the opportunity to serve on the DAC, and look forward to continuing to work in partnership with DHMH toward our mutual goal of making Maryland a leader on children's oral health. Your commitment and leadership have already begun to make a difference.

Sincerely,



Laurie J. Norris
Staff Attorney

Enclosure: Letter dated July 24, 2007 from Congressman Elijah E. Cummings to Governor Martin O'Malley

[2] In Cecil County, there are reportedly approximately 200 children who continually cycle through the emergency room seeking treatment for dental pain, but who never get seen by a dentist to treat the underlying cause.

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September 7, 2007

John Colmers, Secretary
Department of Health and Mental Hygiene
201 Preston Street
Baltimore, Maryland 21201

RE: Dental Action Committee Recommendations

Dear Secretary Colmers:

Thank you for the opportunity to serve on the Dental Action Committee. UnitedHealthcare-Medicaid ("UHC") applauds your leadership on this issue and looks forward to working with you as this initiative moves forward. As you are aware, UHC is a strong proponent of increasing dental access for all Marylanders and provides for dental benefits for both children and adults that participate in the HealthChoice and Primary Adult Care programs.

The Dental Action Committee has made seven recommendations. UHC is supportive of six of the seven recommendations. The recommendation that initiates a statewide single vendor dental administrative services (ASO) provider for Maryland is one UHC cannot support. UHC believes that separating dental from medical care management creates additional barriers for members accessing quality dental and medical services. Using a single vendor ASO to manage approximately 300,000 children in the Maryland HealthChoice program will:

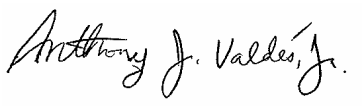
- Create care coordination barriers with the managed care organizations (MCOs).
    - Comprehensive health care is critical to successful member outcomes. Dental care must be coordinated with medical care to achieve these outcomes. Oral health should not be isolated from the rest of the body, instead it should be a part of comprehensive health care.
    - Early recognition of childhood disease, special needs members and hospital care for members can not be accomplished without case management by MCO medical staff.
    - Dental and medical communities have linked periodontal disease to pre-term and low births, diabetes, cardiovascular disease, COPD (respiratory), obesity and more. Dental vendors do not have programs that address these issues nor do they have access to

medical records that provide the complete picture of an individual's true health care.

- Place the responsibility of navigating the confusing administrative hurdles of coordinating medical, dental, and pharmaceutical care and referrals on the member.
- Create an additional barrier to ensuring Maryland can measure overall health outcomes and quality for each child. MCOs are uniquely situated to manage and meet all quality standards and facilitate the proper and accurate data associated with reporting.
- Increase overall costs to the State. Currently MCOs are not paid for dental case management and outreach to members. MCOs are able provide these services by spreading the costs of these services across the cumulative rate MCOs are paid. An ASO does not have this flexibility and additional costs will be incurred by the State to ensure care management, coordination and outreach are being accomplished.
- Eliminate dental benefits for approximately 150,000 adults who now have dental benefits through MCO sponsored adult dental programs.

We have an opportunity to improve upon a system that with the 6 recommendations from DAC will create a firm foundation for success. It is time to seize this opportunity by increasing access to and the quality of dental services in Maryland through the proven system of comprehensive managed health care. Dental care is part of the overall health care of the individual, family, and community. As written in the Dental Action Committee's report to you: The first ever 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." Initiating a single ASO dental vendor is separating oral health and general health.

Sincerely,



Anthony J. Valdés
Chief Executive Officer
UnitedHealthcare – Maryland Medicaid

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September 7, 2007

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

Dear Secretary Colmers,

We thank you for your vision and leadership regarding Maryland's oral health access issues. The University of Maryland Dental School fully supports the findings and recommendations of the Committee. We look forward to continue our collaboration with the Department of Health and Mental Hygiene (DHMH) and other stakeholders to make Maryland a model state in assuring access to oral health care for all Marylanders.

As a result of the Committee's work, we have gained a better appreciation for how we can integrate the activities of the Dental School with those of DHMH to enable comprehensive solutions to this long standing problem. Access to oral health care, including expanded education and prevention, must be available to all throughout the State. Accordingly, we are committed to the solutions to oral health access for Maryland citizens by:

- Expanding our dental student and dental hygiene class size to enable greater number of oral health providers for Maryland's poor citizens.
- Enhancing training of our dental and dental hygiene students in issues of clinical care for the underserved.
- Providing dental hygiene education programs in areas that are too distant for daily commuting.
- Offering oral health education to Maryland's Family Practitioners, Pediatricians and other health care providers.
- Providing mini-Pediatric Dentistry residencies to Maryland's general dentists for training in the specialized care and treatment of young children.
- Working with local health department and FQHC dental safety net clinics to expand dental capacity by providing Pediatric Dental Fellows, as well as additional rotations for dental and dental hygiene students in these sites.

- Increasing the Dental School's capacity to provide care for the poor citizens of Maryland, both at our main facility, as well as strategic placement of satellite clinics in areas of need.

- Continuing to be the provider of last resort for poor adults and children who cannot access oral health care in the community.

It is clear that for our commitments to succeed and to fully address the recommendations of the Dental Action Committee, it is necessary for the State to find the resources to fund the Oral Health Safety Net Bill (SB 181/HB30, 2007) and to increase Medicaid dental reimbursement rates. Only with the dedication and will of committed individuals, as well as necessary financial resources can we establish a dental home for all Maryland's Medicaid children and become the national model for oral health care.

We would be delighted to meet with you to discuss the many ways we can continue to partner in this effort.

Best regards,

Norman Tinanoff, DDS, MS
Professor and Chair

Cc
Dr. Christian Stohler, Dean
Dr. David Ramsay, President
Dr. Harold Goodman, Vice Chair, DAC
Ms. Jane Casper, Chair, DAC