



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

OCT 13 2009

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

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

The Honorable Ulysses Currie
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

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

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

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

Dear Governor O'Malley, President Miller, Speaker Busch and Chairmen Currie and Conway:

Pursuant to Health General Article § 13-2504(b), HB 70-Chapter 656 of the Acts of 2009 (Section 1), and the 2009 Joint Chairmen's Report on page 82, the Maryland Medicaid Program and the Office of Oral Health within the Department of Health and Mental Hygiene (the Department) submit this comprehensive oral health legislative report. HB 70 requires that the statutorily-required oral health reports that the Department had historically submitted to the Governor and General Assembly as three separate reports now be consolidated into one annual report.

The consolidated report addresses the following oral health initiatives: 1) Dental Care Access under HealthChoice (as originally required by SB 590 from 1998, as amended by HB 70 from 2009) as well as the Office of Oral Health's efforts to improve access; 2) the Oral Health Safety Net Program (as originally required by SB 181/HB 30 from 2007, as amended by HB 70 from 2009); and 3) the Oral Cancer Initiative (as required by SB 791/HB 1184 from 2000). In addition, the 2009 Joint Chairmen's Report (on p. 82) requested that without adding an official reporting requirement, the report also be distributed to the budget committees.

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



The Honorable Martin O'Malley
The Honorable Thomas V. Mike Miller, Jr.
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The Department is pleased to submit this report, which details the work that has been completed to improve dental care for Marylanders. If you have any questions regarding this report, please do not hesitate to contact Anne Hubbard, Director of Governmental Affairs, at (410) 767-6481.

Sincerely,



John M. Colmers
Secretary

Enclosure

cc: John Folkemer, M.S.W., M.P.A.
Frances B. Phillips, R.N., M.H.A.
Russell W. Moy, M.D., M.P.H.
Harry Goodman, D.M.D., M.P.H.
Anne Hubbard, M.B.A.
Sarah Albert, MSAR # 7980

MARYLAND'S 2009 ANNUAL ORAL HEALTH LEGISLATIVE REPORT

Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

John M. Colmers
Secretary

I. Introduction

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

- (1) Dental care access under Maryland's Medical Assistance Program including:
 - (A) The availability and accessibility of dentists throughout the State participating in the Maryland Medical Assistance Program;
 - (B) The outcomes that managed care organizations and dental managed care organizations under the Maryland Medical Assistance Program achieve concerning the utilization targets required by the five-year Oral Health Care Plan, including:
 - (i) Loss ratios that the managed care organizations and dental managed care organizations experience for providing dental services; and
 - (ii) Corrective action by managed care organizations and dental managed care organizations to achieve the utilization targets; and
 - (C) The allocation and use of funds authorized for dental services under the Maryland Medical Assistance Program.
- (2) The results of the Oral Health Safety Net Program administered by the Office of Oral Health; and
- (3) Findings and recommendations of the Office of Oral Health's Oral Cancer Initiative.

II. Maryland's Oral Health Accomplishments

Part 1. Dental Care Access under HealthChoice

As Originally Required by SB 590 (Ch. 113 of the Acts of 1998), as Amended by HB 70 (Ch. 656 of the Acts of 2009)

Background

The Maryland Department of Health and Mental Hygiene's (the Department) Medical Assistance (Medicaid) program delivered oral health services to approximately 213,000 children and adult enrollees during 2008. Despite significant improvement under HealthChoice, Maryland, like many other states, continues to face numerous barriers to providing comprehensive oral health services to Medicaid enrollees. Barriers include low provider participation due, among other things, to low reimbursement rates, missed appointments, and a lack of awareness among enrollees about the benefits of basic oral health care. As Medicaid's population continues to increase each year, these barriers remain as significant impediments to increased access to dental services.

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

Senate Bill 590

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

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

(CY) 2000. The utilization target for that year was 30%, with annual increases of 10%. The utilization target for the end of the five-year plan (CY 2004) was 70%.

This section of the report provides an overview of CY 2008 Medicaid dental results, as well as the DAC's recommendations and the resulting implementation efforts of the Department. It also addresses the Medicaid-related dental access issues identified in SB 590: (1) the availability and accessibility of dentists throughout the State that participate in the Maryland Medical Assistance program; (2) the outcomes achieved by MCOs and dental managed care organizations in reaching the utilization targets; and (3) the allocation and use of dental funding. This section of the report further includes the Office of Oral Health's efforts that specifically address increasing access to oral health care.

Action Plan for Increasing Utilization of Dental Services

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

The Office of Oral Health received a five-year Centers for Disease Control and Prevention (CDC) state dental infrastructure grant that includes a requirement to develop a 5-year state Oral Health Care Plan. This plan is currently in development and will be completed in coordination with the Dental Action Committee. The Office of Oral Health expects that by 2015 Maryland will distinguish itself as a national leader in access to oral health services. By that time, it is expected that a majority of Maryland residents will have a dental home accessible to them, and residents from each jurisdiction will have access to an oral health safety net clinic.

Progress has been made by the Department on many of the DAC's recommendations, as shown below:

1. The Department awarded a contract to Doral Dental to serve as the single statewide dental vendor. The Department worked closely with Doral to transition dental services from the MCOs and Doral began managing dental services and paying claims July 1, 2009. During the transition, members were notified of the new dental benefits administrator and additional dental providers were recruited to participate in the program. The new Medicaid dental program has been named 'Maryland Healthy Smiles.'
2. The Governor's FY 2009 budget included \$7 million in general funds (\$14 million total funds) to increase targeted dental rates to the ADA 50th percentile for the South Atlantic region starting in July 2008 (see Attachment 1 for a list of dental codes and

- rates). This rate increase has attracted many new dental providers to the Maryland Healthy Smiles program. A second round of rate increases has been delayed due to budget constraints.
3. To provide for greater access to dental services for young children, beginning July 1, 2009, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical providers (pediatricians, family physicians, and nurse practitioners) may receive Medicaid reimbursement for providing fluoride varnish treatment to children age 9 – 36 months through the Maryland Mouths Matter: Fluoride Varnish and Oral Health Assessment Program for EPSDT Medical Providers. Certified medical providers who successfully complete an Office of Oral Health training program for oral health assessments and fluoride varnish application are eligible for this Medicaid reimbursement. As of August 2009, approximately 400 EPSDT medical providers have successfully completed the Office of Oral Health training program.
 4. The DAC recommended legislation to improve and expand the oral health safety net by strengthening the role of dental hygienists. During the 2008 session, the General Assembly unanimously passed legislation that facilitates the role of dental hygienists working for public health programs. The legislation, sponsored by Delegate Veronica Turner in the House of Delegates (HB 1280) and by Senator Middleton in the Senate (SB 818), took effect October 1, 2008. The legislation requires dental hygienists who work for public health programs to provide service within their scope of practice, a dentist does not have to be on the premises or see the patient before services are rendered. The legislation requires dental hygienists who work for public health programs to provide service within their scope of practice, a dentist does not have to be on the premises or see the patient before services are rendered. This legislation has enabled dental hygienists working for public health agencies to more efficiently and expeditiously provide services within the scope of their practice in offsite settings (e.g., schools and Head Start centers). As a result of this legislation, health department dental programs have begun recruiting and enlisting public health dental hygienists and additional School-based Health Centers are making plans to employ dental hygienists to provide preventive services.
 5. The Governor's FY 2010 budget includes \$1.5 million to continue support for new or expanded dental public health services, especially targeting jurisdictions without public health clinics. With this funding, every county in Maryland now has, or will have within the next year, a public health safety net dental clinical program (see Table 3). In 2007, only half of the State's jurisdictions had such programs. Also, the Robert T. Freeman Dental Society Foundation Deamonte Driver Dental Van Project began operations in March 2009 and by June 2009 had provided care to over 700 students from Prince George's County public schools. It has helped recruit and enroll new dentists into Maryland Medicaid to provide treatment for children referred from the van (see Part 2 – Oral Health Safety Net Program).
 6. General dentists have received training in didactic and clinical pediatric dentistry so that they may competently treat young children. As of August 2009, over 250 general dentists received this training through various courses sponsored by the Office of Oral Health as well as a multi-week course developed and presented by the University of Maryland Dental School.

7. A subcommittee of the DAC is working to develop a marketing campaign aimed at the public. Currently, a \$1.2 million fiscal appropriation has been approved for this statewide campaign by Congress' Labor, Health and Human Services and Education Appropriations Subcommittee and is now awaiting full committee approval. Furthermore, the Department is partnering with the University of Maryland at College Park School of Public Health on a grant proposal for submission to a private non-profit foundation for funding for this program.
8. A subcommittee of the DAC is working to develop a program whereby dental screenings are incorporated with vision and hearing screenings for public school children. The target date for enactment of this program is 2011.

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

Availability and Accessibility of Dentists

HealthChoice

HealthChoice is the current service delivery system for most children and non-elderly adults enrolled in Medicaid and the Maryland Children's Health Program (MCHP). Dental care was a covered benefit under the HealthChoice program until the implementation of the Maryland Healthy Smiles dental ASO on July 1, 2009. This report analyzes the MCO utilization and funding of dental services during CY 2008. HealthChoice MCOs were required to offer comprehensive oral health services including preventive care to children through 20 years of age and to pregnant women.² While adult dental services are not a required benefit and are not funded by the Department, all seven HealthChoice MCOs offered basic oral health services to adults in CY 2008. The dental benefits offered to adults typically include cleanings, fillings, and extractions. Since the ASO implementation, one MCO has stopped providing this optional service to adults.

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

As of July 2008, there were approximately 743 dentists enrolled as providers in the HealthChoice program (listed in the HealthChoice provider directories). The number of dentists listed as providers decreased as compared to 2007 mainly due to the Department's request for MCOs to update their provider directories in January 2008 (Table 1). The 2008 count is a point in time count of providers, and was increased by the end of 2008 due to several provider outreach activities. The overall statewide ratio of dentists (listed in HealthChoice provider

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

directories) to HealthChoice enrollees under age 21 was 1:679 in July 2008, within the required 1:2,000 ratio. After the rate increases and the Secretary’s challenge to dentists to participate with Medicaid, approximately 65 additional dentists joined the program. Doral has since increased the number of dental providers participating with Maryland Healthy Smiles and as of August 24, 2009, there are 874 providers enrolled, a dentist to enrollee ratio of approximately 1:577. Doral is required to have a dentist to enrollee ratio of 1:1,000 after the first year of the program, 1:750 after year two, and 1:500 after year three.

Table 1: Dentists Participating in HealthChoice and Doral

	Dentists Listed in HealthChoice Provider Directories²			Doral Providers²
	July 2006	July 2007	July 2008	July 2009
Baltimore Metro	453	497	401	295
Montgomery/ PG Counties	360	356	278	358
S. Maryland	39	40	28	34
W. Maryland	55	57	43	67
E. Shore	45	50	40	67
Unduplicated Total³	918	964	743	821⁴

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

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

³ The unduplicated total is different than the total in each geographic region because it is possible for a dentist to have multiple sites. Also, clinics with multiple dentists may only be counted once.

⁴ Doral’s total number of providers is as of July 1, 2009. As of August 24, 2009, 874 dental providers are enrolled with Doral.

According to the Maryland State Board of Dental Examiners, as of July 2008, there were a total of 4,082 dentists licensed and actively practicing in Maryland, or about 50 more dental providers than in 2007. The table below shows how many pediatric and general dentists were practicing in the State as of July 2008, and indicates how many dentists participated with HealthChoice, as of July 2008. In the two far right columns of Table 2, the number of dentists billing includes two "dummy" provider numbers that could be used by MCOs when submitting copies of their claims data to the Department if a dentist did not have a Medicaid provider number. These two provider numbers rendered a significant number of dental services, as multiple dental providers used these two “dummy” numbers. Furthermore, clinics with multiple dentists are only counted once. The total of these two columns, therefore, significantly undercounts the actual number of providers.

Table 2: Active Dentists and Dentists Participating in HealthChoice

REGION¹	Total Active Dentists	Active General Dentists	Active Pediatric Dentists	Dentists Listed in HealthChoice Directory² as of July 2008 (% of Total Active Dentists)	Dentists Billing One or More Services to HealthChoice in CY 2008 (% of Total Active Dentists)*	Dentists Billing \$10,000+ to HealthChoice in CY 2008 (% of Total Active Dentists)*
Baltimore Metro	1,823	1,471	61	401 (22.0%)	350 (19.2%)	210 (11.5%)
Montgomery/Prince George's	1,635	1,294	48	278 (17.0%)	288 (17.6%)	175 (10.7%)
S. Maryland	142	119	3	28 (19.7%)	35 (24.6%)	19 (13.4%)
W. Maryland	267	207	7	43 (16.1%)	85 (31.8%)	55 (20.6%)
E. Shore	215	168	8	40 (18.6%)	73 (34.0%)	41 (19.1%)
Other					10 (N/A)	5 (N/A)
TOTAL	4,082	3,259	127	743 (18.2%)	778 (19.1%)	479 (11.7%)

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

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 2008. The total is different than the total in each geographic region because it is possible for a dentist to have multiple sites.

A total of 778 dentists billed one or more services to HealthChoice and 479 dentists billed \$10,000 or more to the HealthChoice program in 2008. This represents 19.1% and 11.7% respectively, of the total active, licensed dentists in the State. The number of dentists billing at least one Medicaid service increased from 671 in 2007 to 778 in 2008. The number of dentists billing more than \$10,000 to Medicaid increased from 364 in 2007 to 479 in 2008. Pediatric dentists are rare in the State and continue to account for only 3% of the total number of active dentists in Maryland (Table 2).

After the FY 2008 rate increase, approximately 65 dentists joined the program. The Department's single statewide ASO dental vendor, Doral, has continued to increase the dental provider network and hopes to improve overall access to dental services, eventually creating a dental home for all Medicaid children. The total number of providers participating with the Medicaid program through Doral is 874 as of August 24, 2009, and provider enrollment efforts are continuing. Providers can now participate with Medicaid through a single point of contact, rather than contracting with seven separate MCOs. Doral handles credentialing, billing, and any other provider issues, which streamlines the process for providers.

Within Maryland, several areas have been designated as Dental Health Professional Shortage Areas (HPSAs). Regions designated as HPSAs are portions of the Eastern Shore, Western Maryland, Southern Maryland and Baltimore City (Attachment 2). Low cost dental services are now or will be available in all regions of the State through community programs sponsored by Federally Qualified Health Centers (FQHCs), local health departments, academia, and other private, non-profit health organizations (e.g., community hospitals). Table 3 provides an overview of available local health department and community providers as of July 2009. It is important to note that these community clinic providers offer varying levels of dental services and not all accept Medicaid. As of July 2009, 13 Maryland jurisdictions are served directly by local health department clinical dental programs with 3 more counties (Kent, Queen Anne's, and Worcester) to be served by a local health department dental clinical program in beginning in FY 2010. The St. Mary's County Local Health Department does not directly administer a clinical dental program but acts as a conduit for low-income patients to be served by the majority of private dental practitioners in the county. The Howard County Local Health Department subcontracts with an FQHC, Chase Brexton Health Services, for its clinical dental service program. In addition, four jurisdictions on the Eastern Shore without a local health department dental program are served by two FQHCs – Choptank Community Health Systems (Caroline, Talbot and Dorchester) and Three Lower Counties (Somerset). Calvert and Cecil Counties will be providing clinical dental services to low-income patients beginning in FY 2010 through a non-profit community hospital and academic center, respectively. Jurisdictions that are or will be served by both a local health department and other community dental clinical program include: Baltimore City, Anne Arundel, Baltimore, Charles, Kent, Prince George's, Queen Anne's, Washington, Wicomico, and Worcester Counties.

Table 3: Community Clinic Dental Providers¹

County	Local Health Department Clinic	Community Health Centers	Dental School/Other
Allegany	On Site	None	
Anne Arundel	³ On Site	Stanton Center	
Baltimore City	³ On Site	So. Baltimore, Total Health, Chase Brexton, Parkwest, People's Comm., BMS, Healthcare for the Homeless	University of Maryland Dental School
Baltimore County	^{2,3} On Site	Chase Brexton	
Calvert	None	None	In Development – Calvert Memorial Hospital – September 2009
Caroline	None	Choptank	
Carroll	On Site	None	
Cecil	None	None	In Development – University of Maryland Dental School – Fall 2009
Charles	On Site	Nanjemoy	
Dorchester	None	Choptank	
Frederick	On Site	None	
Garrett	On Site	None	
Harford	On Site	None	
Howard	Subcontract - Chase Brexton FQHC	⁴ Chase Brexton	
Kent	In Development – FY 2010	Choptank	
Montgomery	^{2,3} On Site	None	
Pr. George's	³ On Site	Greater Baden	
Queen Anne's	In Development – FY 2010	Choptank	
Somerset	None	Three Lower Counties	
St. Mary's	Serves as an intermediary between Maryland Medicaid Program and private dental providers	None	Does not directly provide services but is the main entry point for Medicaid patients and makes arrangements with private providers for care.
Talbot	None	Choptank	
Washington	On Site	Walnut Street	
Wicomico	On Site	Served by Three Lower Counties FQHC	
Worcester	In Development – FY 2010	Served by Three Lower Counties FQHC	

- 1 Community clinic providers may also be counted in HealthChoice provider directories (in Table 1 above) if they contract with MCOs
- 2 Does not currently treat Medicaid enrollees
- 3 Multiple sites
- 4 Partnership of Howard County Health Department and Chase Brexton

HealthChoice Dental Utilization Rates

Children

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

MCO Plan Performance

In an effort to assess the performance of individual HealthChoice MCOs, the Department uses a measure closely modeled on the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) measure for Medicaid children's dental services utilization. The counted number of individuals is based on two criteria: 1) an age range from 4 through 21 years; and 2) enrollment of at least 320 days. The Department modified its age range to reflect 4 through 20 years because the Maryland Medicaid program only requires dental coverage through age 20. Since the inception of HealthChoice, the percentage of children receiving dental services increased from 19.9% in 1997 to 55.7% in 2008, a 180% increase (Table 4). As a comparison, the HEDIS 2008 (CY 2007) national average for Medicaid was 43.5%.⁵ Attachment 3 shows utilization data by age and region.

³ Children are only covered up to age 19 under MCHP.

⁴ Academy of Pediatrics State Medicaid Report for Federal FY 1996 - Analysis of HCFA National Data for Medicaid Children's Dental Services Utilization.

⁵ National Committee for Quality Assurance.

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

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

*Starting with data for CY 2001, DHMH revised its methodology to include children enrolled in the same MCO for at least 320 days, consistent with HEDIS methodology. Prior to CY 2001, these data included individuals enrolled in any MCO for at least 320 days.

**Mean for the Annual Dental Visit (ADV) measure, *total* age category (ages 2-21 years of age), as of HEDIS 2006. The 2-3 year age cohort was added as of HEDIS 2006.

Beginning in the 2006 dental report, the Department also reported utilization rates of children with any period of enrollment. Utilization rates are lower when analyzed for any period of enrollment because the population in the analysis includes children who: 1) are in the MCO for only a short period of time due to turnover in eligibility or enrollment; and 2) are new to the MCO, and the MCO has not yet had a chance to link the child to care. MCOs have less opportunity to manage the care of these populations. Of the 505,339 children enrolled in HealthChoice for any period of time during CY 2008, 36.7% of these children received one or more dental service. The utilization rates of children with any period of enrollment have steadily increased over the four year period in all age groups (Table 5).

Table 5: Percentage of Children Enrolled in HealthChoice who had at Least One Dental Encounter by Age Group, Enrolled for Any Period

Age Group	CY 2005	CY 2006	CY 2007	CY 2008
0-3*	7.8%	7.9%	10.0%	12.3%
4-5	37.7%	37.2%	42.4%	47.7%
6-9	42.5%	42.3%	47.6%	53.1%
10-14	39.4%	39.5%	44.2%	48.8%
15-18	32.4%	32.3%	35.8%	39.5%
19-20	19.0%	18.4%	20.1%	23.4%
Total	29.6%	29.3%	32.9%	36.7%

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

Type of Dental Services

In response to the concern that while access to dental care has increased, the level of restorative services or treatment may not be adequate, the Department has examined the type of dental services that children in HealthChoice receive. As indicated above, the findings of the analysis indicate that access to any dental service, including restorative services, has increased from 19.9% in FY 1997 to 55.7% in CY 2008 (Table 4). Access to restorative services increased from 6.6% of all children in FY 1997 to 21.3% in CY 2008 (Table 6), a 223% increase. This increase in utilization is due in part to raising the fees for twelve restorative dental procedure codes in 2004 and more recently due to increased outreach efforts.

**Table 6: Percentage of Children Receiving Dental Services by Type of Service
Children ages 4-20, Enrolled for at least 320 days**

Year	Diagnostic	Preventive	Restorative
FY 1997	19.6%	18.1%	6.6%
CY 2000	27.3%	24.6%	9.3%
CY 2001	31.7%	29.1%	10.8%
CY 2002	31.7%	29.1%	10.3%
CY 2003	40.8%	37.9%	13.6%
CY 2004	41.0%	38.0%	13.8%
CY 2005	42.7%	39.7%	15.8%
CY 2006	43.7%	40.5%	16.4%
CY 2007	48.6%	45.2%	19.3%
CY 2008	53.1%	50.1%	21.3%

During the 2004 legislative session, the General Assembly passed HB 1134, which required dentists participating in HealthChoice to notify MCOs when enrolled children are in need of dental therapeutic/restorative treatment that the dentist is unable to provide. MCOs were required to provide families with a list of participating dentists who provide the needed therapeutic/restorative treatment and assist the family in arranging an appointment for the needed care if necessary. MCOs' compliance with this requirement was monitored on an ongoing basis as part of the Department's review of MCOs' annual enhanced dental services plans. The Department will begin to monitor Doral's compliance with this requirement.

As noted above, utilization rates are lower when analyzed for any period of enrollment versus a period of continuous enrollment because MCOs have had less opportunity to manage the care of these populations. For those children enrolled for any period, 35.5% received a preventive or diagnostic visit in 2008 (Table 7). Of those receiving a preventive or diagnostic visit, 29.7% received a follow-up restorative visit. The CY 2008 rates indicate a steady increase over the previous four years.

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

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

Although there has been a modest utilization increase in restorative visits since the implementation of the restorative fee increase in 2004, barriers to receiving restorative care remain. Children not receiving needed restorative care may ultimately seek care in an emergency room. In CY 2008, 2,175 children with any period of enrollment visited the emergency room with a dental diagnosis, not including accidents, injury or poison, which is slightly more than in CYs 2005 - 2007 (Table 8).

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

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

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

Pregnant Women

Prior to the implementation of HealthChoice in 1997, adult dental care was not covered under Medicaid. SB 590 (1998) required that HealthChoice cover dental services for all pregnant women. The proportion of pregnant women 21 and over enrolled for at least 90 days receiving dental services was 20.6% in CY 2008 (Table 9). The percentage of pregnant women 14 and over enrolled for any period receiving a dental service in 2008 was 18.8% (Table 10). There is no comparable HEDIS measure for dental services for pregnant women.

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

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 1999	17,914	2,474	13.8%
CY 2000	18,514	2,843	15.4%
CY 2001	19,644	3,109	15.8%
CY 2002	21,112	3,063	14.5%
CY 2003	21,819	4,140	19.0%
CY 2004	21,412	3,102	14.5%
CY 2005	23,088	3,354	14.5%
CY 2006	20,756	3,187	15.4%
CY 2007	19,968	3,603	18.0%
CY 2008	20,749	4,280	20.6%

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

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 2005	37,559	5,010	13.3%
CY 2006	38,868	5,268	13.6%
CY 2007	38,718	6,078	15.7%
CY 2008	37,454	7,047	18.8%

Adults

Apart from those dental services covered for pregnant women, adult dental services are not included in the MCO capitation rates and therefore are not required to be covered under HealthChoice. In CY 2008, all seven MCOs provided a limited adult dental benefit and spent approximately \$8.86 million for these services. By comparison, in CY 2007, MCOs spent approximately \$5.36 million on adult dental services. An analysis shows that 18.8% of adults enrolled for at least 90 days received at least one dental service in CY 2008. As of September 2009, six of the seven MCOs continue to provide an adult dental benefit.

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

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

Strategies to Improve Access to Dental Care

The Department monitored the number and percentage of oral health services provided by HealthChoice MCOs on a biannual basis using encounter data. The Department reviewed MCOs' outreach plans and held MCOs accountable for not meeting established dental utilization targets through the use of Value Based Purchasing incentives and sanctions. The Department has taken additional steps to collaborate with MCOs to improve access to dental care. Beginning in 2007, the Department required that MCOs inform the Department of the number of dental appointments they are scheduling for their members weekly. The Department also provided each MCO with a list of children who have been without a dental service for a significant period of time and required the MCOs to actively attempt to schedule dental appointments and report progress to the Department.

In July 2007, the Department sent a dental transmittal letter to health care providers to clarify policies and to inform providers of the benefits available to children. The letter provides information about covered services and clarifies that the Department requires an oral health assessment by a physician or nurse practitioner as part of periodic well child care. To more easily link children to dental care, an MCO dental provider enrollment contact list was also included in the transmittal.

In 2008, the Department continued working with the Dental Action Committee to implement its primary recommendation to remove dental benefits from the managed care organizations' responsibility. To this end, the Department issued a request for proposal (RFP) for an administrative services organization to administer dental benefits for children, pregnant women, and adults in the Rare and Expensive Case Management program through fee-for-service Medicaid. The RFP included requirements for provider network development and expansion such as increasingly stringent provider to recipient ratios, established appointment time frames, and travel time and distance limitations. Recipient outreach requirements included welcome calls within ten days of enrollment, assignment to a primary care dentist by the third year of the contract, pre-appointment reminder calls, and missed appointment follow-up calls.

By the end of the year, a vendor had been selected and a contract was awarded for an April 1, 2009 effective date.

Funding

HealthChoice dental funding for children and pregnant women has increased in recent years, from approximately \$12 million in CY 2000 to \$81.5 million for CY 2009 (Attachment 4). This growth in funding reflects increases in the Medical Assistance fee schedule for selected codes that were raised to the 50th percentile of the South Atlantic ADA charges for dental services. It also anticipates continued increased utilization due to improved outreach activities and additional providers participating with the Medicaid program.

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

- For CY 2004, the Department allowed sufficient funding for 40% utilization. The rates were based on actual MCO expenditures for dental services in 2001, with an allowance for assumed utilization growth and inflation. This is consistent with the methodology used for setting rates for other MCO services.
- For CY 2005 and CY 2006, the Department used a similar methodology as for CY 2004. The rates were based on actual expenditures trended forward and accounting for the increased fees for the 12 restorative procedure codes.
- In CY 2005, the MCOs received \$33 million in dental capitation payments, but using a fee-for-service reimbursement rate estimate, the MCOs spent approximately \$37 million for children and pregnant women, and an additional \$2.3 million for adult dental services.
- In CY 2006, the MCOs received \$35.1 million in dental capitation payments for children and pregnant women, but reported spending \$46.6 million, including \$4.28 million on adult dental services.
- In CY 2007, MCOs received \$42.5 million in dental capitation payments for children and pregnant women in response to increased utilization in CY 2006. The MCOs reported spending \$53.8 million, including \$5.36 million on adult dental services.
- In CY 2008, MCOs received \$55.4 million in dental capitation payments for children and pregnant women due to increased utilization. The MCOs reported spending \$71.4 million, including \$8.86 million on adult dental services.
- In CY 2009, MCOs were responsible for providing dental services for children and pregnant women for the first half of the year. Capitation rates for dental services for the first half of CY 2009 totaled \$39.6 million. Beginning July 1, 2009, Doral began paying dental claims on a fee-for-service basis. The Department expects the total dental expenses for the second half of the year to total \$41.9 million.

Conclusion

While utilization of dental services by children has increased significantly since the implementation of HealthChoice in 1997 from 19.9% to 55.7% in 2008, many children still are not receiving needed dental services. The Dental Action Committee addressed barriers to dental care access by making key recommendations to increase reimbursement for Medicaid dental services and to institute a single dental administrative service organization (ASO). The reforms recommended by the Dental Action Committee have been supported and, to a great degree, instituted by the Department to effectively address the barriers to dental care access previously experienced in the State. Dental provider rates were increased in 2008, and the Department is committed to a second round of rate increases once the budget situation improves.

In conjunction with Doral, the Department has reformed and rebranded the Medicaid dental program, which has attracted more participating dentists and who eventually will serve as dental homes for Medicaid enrolled patients. Already, over 100 new dentists have enrolled to participate in the Maryland Healthy Smiles Medicaid dental program. Doral continues to outreach to providers, and once provider networks are more robust, Doral will begin aggressively outreaching to ensure children are receiving dental care. Beginning July 1, 2009, Medicaid began to allow EPSDT trained providers to apply fluoride varnish treatments to children age 9 – 36 months. This program, adapted from a successful North Carolina program, allows young children with limited access to a dentist to receive dental care.

The Department is also working with the Maryland State Dental Association, University of Maryland Dental School, the Public Justice Center and others on various branding and marketing efforts to promote the new Medicaid dental program to dentists. “Access to Care Day” occurred on September 24, 2009 as part of the Maryland State Dental Associations' annual organizational meeting in Ocean City, MD. This day is part of the dental association's efforts to partner with the Department in recruiting new dentists into the program. Dentists had the opportunity to openly discuss the Maryland Healthy Smiles Dental Program with Doral representatives, Departmental staff, and members of the DAC. Free continuing education credits and training in pediatric dentistry were provided to the dentists who attended this session. With efforts such as those described in this report, the Department is committed to continuing to work with the DAC on recommended strategies to make access to dental care and a dental home a reality for all Maryland children.

ATTACHMENT 1

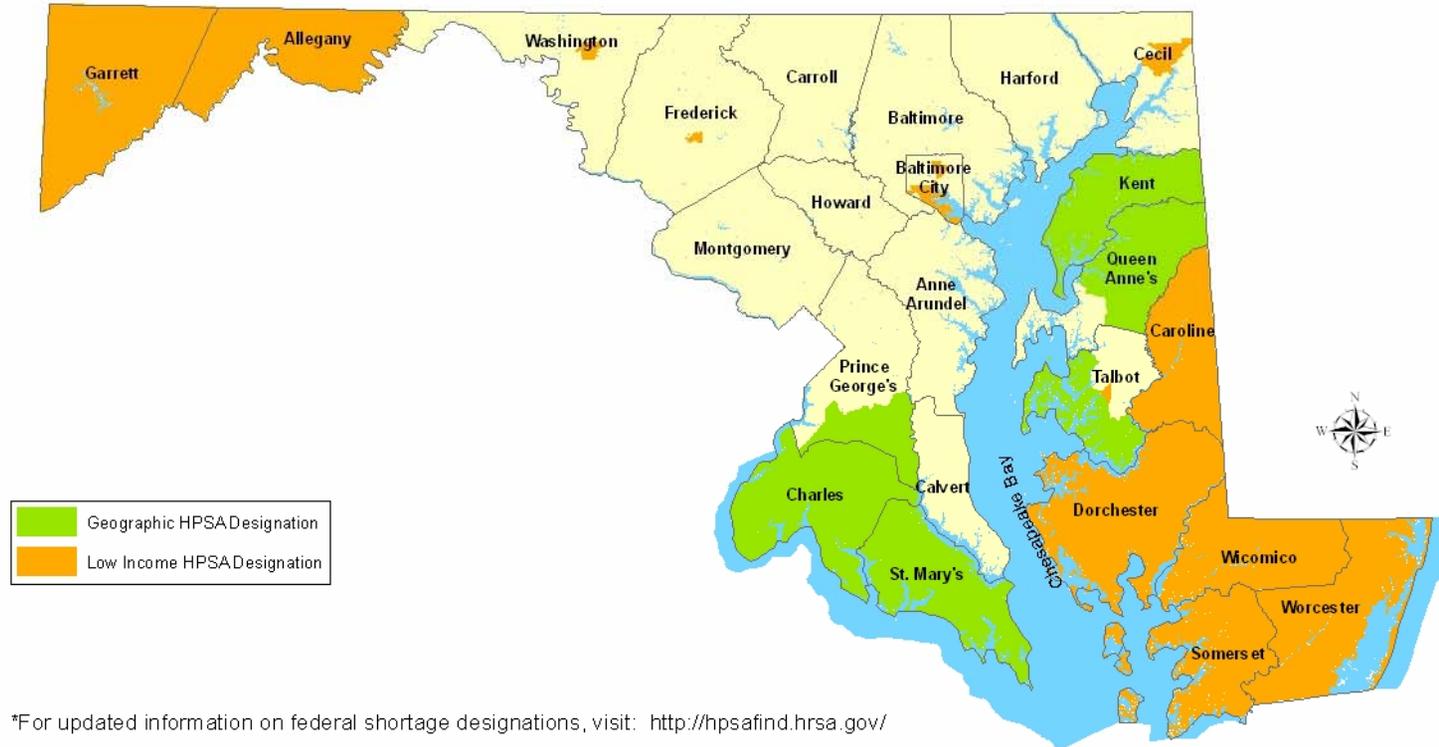
Dental Procedures Targeted for Fee Increase in FY 2009

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

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

ATTACHMENT 2

Maryland Health Professional Shortage Area (HPSA)
Designations for Dental Care as of 7/29/2009*



*For updated information on federal shortage designations, visit: <http://hpsafind.hrsa.gov/>

Prepared by the Office of Health Policy and Planning, Family Health Administration, Maryland Department of Health and Mental Hygiene

ATTACHMENT 3

Dental Utilization Rates, CY 2000 -CY 2008
Enrollment \geq 320 days in an MCO, age 4-20

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

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

ATTACHMENT 4

MCO Funding and Expenditures for Dental Services, FY 1997 – CY 2009				
Utilization of Dental Services in HealthChoice, FY 1997-CY 2008				
Year	Amount Paid in MCO Capitation Rates for Dental	Amounts Spent by MCOs for Dental (Source: HFMR) (Includes adult dental)	Utilization Rate for General Access (Children 4-20 Years with 320 Days of Enrollment)	Utilization Rate for Restorative (Children 4-20 Years with 320 Days of Enrollment)
FY 1997	N/A	\$2.7 M*	19.9%	6.6%
CY 2000	\$12.3 M (est.)	\$17 M (est.)	28.7%	9.3%
CY 2001	\$27.1 M	\$23.6 M	33.6%	10.8%
CY 2002	\$40.3 M	\$28.9 M	34.5%	10.3%
CY 2003	\$33 M	\$32.5 M	43.2%	13.6%
CY 2004	\$28 M	\$36.7 M	43.7%	13.8%
CY 2005	\$33 M	\$42.0 M	45.8%	15.8%
CY 2006	\$35.1 M	\$46.6 M	46.2%	16.4%
CY 2007	\$42.5 M	\$53.8 M	51.5%	19.3%
CY 2008	\$55.4 M	\$71.4 M	55.7%	21.3%
CY 2009**	\$39.6 M	Not available	Not available	Not available

* In FY 1997, the Department spent \$2.7 M on dental services under its fee for service program.

** In CY 2009, MCO capitation rates included dental services from January 1, 2009 – June 30, 2009. Under the new Maryland Healthy Smiles program, the Department estimates dental expenses to total \$41.9 million for the period July 1, 2009 – December 31, 2009.

Part 2. Oral Health Safety Net Program As Originally Required by SB 181/HB 30 (Ch. 527 and 528 of the Acts of 2007), as Amended by HB 70 (Ch. 656 of the Acts of 2009)

Background/History

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

The Department developed a legislative proposal as the result of the 2008 Joint Chairmen's Report directing the Department to draft legislation for consideration in the 2009 legislative session that would formally establish the Oral Health Safety Net Program within the Department. To that end, SB 63 was introduced as Departmental legislation during the 2009 session of the Maryland General Assembly and passed unanimously. This legislation repealed the September 30, 2011 sunset provision for the Oral Health Safety Net Program, thereby providing the Program with a permanent statutory framework.

Current Status

Since creation of the Oral Health Safety Net Program, the Office of Oral Health has embarked on enhancing the oral health safety net through new and creative strategies to increase access to oral health services for low-income, uninsured individuals, and Medicaid recipients. These strategies include providing new or expanded dental services in publicly-funded federal, State or local programs, developing public and private partnerships, expanding school-linked dental initiatives that include dental mobile vans, transportation innovations, case management, and leasing and contractual agreements with private dental offices, among other strategies. The Office of Oral Health also hired a licensed dentist in November 2007 who provides dental expertise to the Office of Oral Health on oral health issues such as protocol evaluation, provider recruitment, and continuing education courses for providers that offer oral health treatment to underserved populations. The Office had been without dental expertise since 2002.

A. Carrying out Major Oral Health Recommendations of the Dental Action Committee

As discussed in Part 1 of this report, the Department convened the Dental Action Committee (DAC) to develop strategies to expand Maryland's oral health services to low-income individuals. A major DAC recommendation was to maintain and enhance the dental public health infrastructure through the Department's Office of Oral Health by ensuring that residents in each local jurisdiction have access to a local health department dental clinic and/or other

community oral health safety net clinic. Such an effort would require the provision of funding to fulfill the requirements outlined in the Oral Health Safety Net statute.

In light of the DAC's recommendation to the Secretary of the Department that the dental public health infrastructure needed strengthening, the Governor's FY 2009 budget for the Department's Family Health Administration included \$2 million to increase clinical dental treatment and preventive services for low-income Maryland children, especially those who are Medicaid-eligible or uninsured. While these oral health safety net grant funds are intended to be used Statewide, they are specifically targeted for jurisdictions currently not served by a public health dental clinical program (Worcester, Kent, Queen Anne's, St. Mary's, and Calvert Counties), and for purposes other than those specified in HB 30/SB 181 (2007). Further, the 2009 Maryland General Assembly approved the Governor's FY 2010 budget, which maintained \$1.5 million in the Department's budget to support many of the requirements listed in the 2007 Oral Health Safety Net legislation.

Also in 2008, the General Assembly directed that \$500,000 be set aside out of the Governor's FY 2009 \$2 million budget for the Department and be placed in a capital infrastructure grant program to acquire, design, construct, renovate, convert, and equip dental program facilities (oral health safety net clinics). The Office of Oral Health eventually issued Request for Proposals (RFPs) for the oral health capital infrastructure projects (\$500,000) in collaboration with the Department's Office of Capital Planning, Budgeting and Engineering Services. The recipient of the oral health capital infrastructure grant was the only targeted jurisdiction to apply for the capital infrastructure grant, the Worcester County Health Department, which received \$500,000. However, one of the other applicants for the oral health capital infrastructure grant, Healthcare for the Homeless, which is an FQHC, was awarded full funding for its oral health project by the Office of Capital Planning, Budgeting and Engineering Services out of funding sources reserved for FQHCs. In addition, another FQHC, Park West Medical Center, also received an oral health capital infrastructure grant to renovate and expand its current facility in northwest Baltimore City.

In FY 2008, the Office of Oral Health had helped fund and initiate two new local health department clinical dental programs for low-income children in Harford and Charles Counties. For the first time, these two jurisdictions were able to offer a full realm of dental clinical services at a public health clinic targeting Medicaid-enrolled and other low-income children residing in their respective counties. During FY 2009, following an assessment of the dental public health infrastructure, the Office of Oral Health established programs to generate new oral health services and to increase service capacity of dental practitioners. The Office utilized a two-pronged approach that: (1) addresses immediate service needs; and (2) establishes dental clinics where there are none.

B. Addressing Immediate Service Needs

Establishing Access to Care: The following three projects, selected through a competitive request for proposals, will provide and/or facilitate comprehensive clinical dental services for the public and will establish dental homes in communities to ensure the consistent availability of dental services in four counties, which have no dental public health

infrastructure. The three-year programs address the unique needs of local populations and provide evidenced-based and appropriate educational, diagnostic, preventive, restorative and emergency care.

- Calvert County: Scheduled to begin in September 2009, Calvert Memorial Hospital's project targets services to Medicaid and other low-income children in Calvert County and coordinates care for improved oral health. This project is recruiting two traveling dental teams consisting of a dentist, dental hygienist, and dental assistant who will provide oral health services including preventive, restorative, and basic oral surgeries. These teams will perform dental care utilizing existing dental offices for easy access to individuals who live in the respective communities.
- Kent/Queen Anne's Counties: Scheduled to begin operations in fall 2009, the Kent and Queen Anne's County Local Health Departments' project will increase access to comprehensive oral health services and enhance dental capacity for low-income children. The project includes hiring a dentist to oversee local mobile dental teams and establishing transportation to regional dental homes through the purchase and operation of a wheelchair-accessible van. Patients requiring intensive oral health treatment will be linked with community dentists or dental programs to ensure dental homes.
- Worcester County: Scheduled to begin in April 2010, the Worcester County Local Health Department program will focus on creating quality, comprehensive, and sustainable oral health education, prevention, and treatment services for Medicaid and low-income, uninsured children in Worcester County. The project will enhance regional efforts for screening and primary prevention in the community, including at schools and Head Start programs, and provide oral health services at the Health Department until completion of a new dental clinic facility, another Office of Oral Health project described below. Additionally, the project will support development of the operational infrastructure necessary to run the clinic.

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

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

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

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

School-based Oral Health Services

New school-based initiatives are currently underway or being planned including a school dental sealant demonstration project to take place beginning in the Spring 2010 and support for the Deamonte Driver Dental Van Project which began operation in March 2009. School-based sites provide a critically needed venue to provide children with preventive oral health services, education, oral screening, and access to a dental home. The Office of Oral Health is supporting three school-based oral health programs.

1. Deamonte Driver Dental Van Project: As previously noted, the Prince George's County Local Health Department partnered with the Robert T. Freeman Dental Society Foundation to deliver school-based oral health care services and provided a dental home in Prince George's County and surrounding areas where there are no available dental services, using a mobile dental van. In addition, this project has assisted dental providers become Medicaid dental providers and has provided complex dental treatment for children unable to be treated directly on the van. The dental van, called the *Deamonte Driver Dental Van Project*, is providing diagnostic, preventive, and simple restorative dental services to low-income students in one Montgomery County School (Foundation School) and in eight schools in Prince George's County including the Foundation School where Deamonte Driver, the 12-year old Prince George's County child who died from a dental infection, attended school. Beginning in March 2009, this highly acclaimed project has provided the aforementioned dental services to approximately 700 children with many more planned to be seen in the 2009-2010 school year.
2. School-Based Dental Prevention Services: Baltimore City, Baltimore County, Caroline, Cecil, Garrett, Somerset, and St. Mary's Counties have been identified for expansion of critically needed preventive dental sealant programs and fluoride application programs.

Programs target children in Title I schools (i.e., schools that typically have 40% or more of its students that come from low-income families) to provide preventive dental sealant and fluoride application services to prevent the onset of dental decay in these high-risk, low-income students.

3. **School-Based Oral Health Access Programs: Kent and Queen Anne's County Local Health Departments** are developing school-based dental access points and assessment/prevention services. The project includes school-wide oral health education to Medicaid-enrolled and uninsured students on location at 11 schools in Kent and Queen Anne's Counties using a mobile dental team comprised of a dental hygienist and dental assistant. Selected patients will receive an oral health assessment, cleaning, and sealant treatment. Patients with further dental needs will be linked to an existing dental home such as the University of Maryland Dental School Clinic in Cecil County or Choptank Community Health Systems, Inc., with case management provided to coordinate care.

C. Expanding the Oral Health Infrastructure through Other Programs

Maryland Community Health Resources Commission Dental Grant Awards

The Maryland Community Health Resources Commission (MCHRC) continues its commitment to creating new and expanding existing access to dental care for low-income, under- and uninsured Maryland residents. In March 2008, the Commission awarded four dental services grants totaling \$968,924:

1. **Allegany Health Right, Inc. (\$82,350): Improving Access to Dental Care for Marylanders.** This project coordinates emergency dental care and establishes a dental home for uninsured adults with services from community dentists who provide care at discounted rates.
2. **Family Health Centers of Baltimore (FHCB) (\$300,000): FHCB South Baltimore Dental Clinic.** FHCB will expand pediatric dental services with an additional dentist, add evening and weekend dental services, and work with local schools to insure that children receive dental screenings and referrals for dental care.
3. **Kernan Hospital (\$287,410): Kernan Dental Services Expansion Project:** This project will expand existing services and establish a dental home for all patients, including special needs patients who have almost no access to dental care in traditional settings.
4. **Prince George's County Health Department (\$299,164): Improving Access to Dental Care in Prince George's County.** The Prince George's County Health Department will add a dentist to expand oral health services for low-income and uninsured children and adults in Prince George's County.

In March 2009, the MCHRC made two oral health services awards totaling \$800,000 and one School-based Health Center award totaling \$224,100:

1. **Catholic Charities, Spanish Catholic Center (\$300,000): Expanding Oral Health Access.** This project will expand existing dental services for low-income, uninsured adults and children in Montgomery County.

2. Chase Brexton Health Services, Inc. (\$500,000): Improving Access to Dental Care for Uninsured and Underinsured Howard County Residents. This project will create new comprehensive dental services for children and adults at Chase Brexton's Howard County site. This FQHC will work with the Howard County Health Department and the Howard County Public Schools to operate a dental education and screening/fluoride and sealant/ referral program for Pre-K through 2nd grade students in the county's Title I schools.
3. Montgomery County Department of Health and Human Services (\$224,100): Implementing Dental Varnish and Asthma Prevention Program.

Pediatric Dental Fellows

This program places trained dentists into the community (local health departments and FQHCs/Community Health Centers) to provide comprehensive oral health services to Medicaid recipients. These dentists are specially trained to provide care to children under five years of age. In FY 2009, there were four dental fellows practicing in Baltimore City, Carroll, Charles and Frederick Counties. Some of these dental fellows also provided operating room care. However, ongoing recruitment difficulties will continue to reduce if not eliminate the number of pediatric dental fellows in the future.

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

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

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

The purpose of the MDC-LARP is to increase access to oral health care services by increasing the number of dentists who provide services for Medicaid recipients. In CY 2008, a total of 11 dentists participated in the program; three of these dentists completed their three-year service obligation in December 2008. The service obligation requires that the dentists must participate in MDC-LARP for the full three years and during that period 30% of their base patient population must be Medicaid patients. In January 2009, five new MDC-LARP dentists started the program and will continue through December 2011. During 2008, MDC-LARP dentists treated 7,758 non-duplicated patients and had 19,395 dental visits by Medicaid recipients. Since the inception of the program in 2001, MDC-LARP dentists have seen 41,700 non-duplicated patients through 104,250 patient visits.

D. Conclusion

The Department recognizes the continued need for expanding the oral health safety net in Maryland as demonstrated by the overwhelming response to the grants offered by the Office of Oral Health. The Department agrees that the Oral Health Safety Net Program enhances and expands the oral health infrastructure in Maryland to better serve low-income and disabled children and adults.

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

SB 791 and HB 1184 enacted during the 2000 legislative session established the Department's Oral Cancer Initiative (Health-General Article, §§18-801—802, Annotated Code of Maryland). This statute requires that the Department develop and implement programs to train health care providers on screening and referring patients with oral cancer and to provide education on oral cancer prevention for high-risk, underserved populations.

The oral cancer mortality prevention initiative, directed by the Office of Oral Health, enables counties to provide an education and awareness campaign to the public and to address the oral cancer screening training needs among health care providers. Of the six counties that received oral cancer mortality prevention initiative funding in FY 2009 from the Office of Oral Health, three are also using Cigarette Restitution Fund (CRF) funding to provide oral cancer services. In these three counties, the funding from the Office of Oral Health has been used for public and provider education whereas CRF funding was used by one county to conduct oral cancer screening, perform biopsies, and assist in treatment when necessary and by two counties to conduct public and provider education.

Background/History

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

The annual age-adjusted incidence rate for oral cancers remains significantly higher in Maryland than the national average having increased slightly from 1999-2003 because of a 3.2% annual increase in rates among white men (according to Surveillance Epidemiological End Results from the National Cancer Institute). However, a slight decrease in oral cancer incidence was seen over this same period for African-American men and women. Over 47% of oral cancer cases were diagnosed at a regional rather than local stage (meaning after the cancer had spread to adjacent areas and tissues, possibly including lymph nodes), which contributes to a low survival rate since oral cancer has a far better prognosis when found locally and early. While the 2006 Maryland Cancer Survey found that 37% of persons 40 years of age and older in Maryland reported they had an oral cancer exam in the past year, surpassing the Healthy People 2010 target of 20%, too many high-risk Maryland adults still lack access to critically important annual oral health screening and diagnostic services.

Current Status

In July 2008, the Department awarded grant money to local health departments to implement oral cancer prevention initiatives. County initiatives include providing oral cancer education and oral cancer screenings for the public and education and training of health care providers on the proper way to conduct an oral cancer exam.

In FY 2009, 72 health care providers received education about oral cancer exams and tobacco cessation counseling for patients. Approximately 819 individuals were screened for oral cancer. Of the individuals screened, 11 people had suspicious lesions and four people were referred to a surgeon for biopsy. Three cases of oral cancer were detected and these individuals were provided case management to ensure they received appropriate treatment. More than 345 adults were referred to local tobacco cessation programs.

The ninth annual Maryland Oral Cancer Awareness Week (OCAW) was held June 21 – 27, 2008. The Office of Oral Health provided updated information to county coordinators including prevention materials, scripts for public service announcements, and articles for local newspapers. During this week, the Quitline and the Office of Oral Health had a table in the lobby of 201 West Preston Street sharing information on oral cancer and how to quit smoking. Free incentives were distributed to promote the programs.

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

Other activities during FY 2009 included the Office of Oral Health and the Maryland Tobacco Quitline partnering to support the link between cessation programs and the reduction of oral cancer. This partnership began with OCAW but remains constant throughout the year. Brochures for the Office of Oral Health and the Maryland Tobacco Quitline are distributed together. In addition, the Office of Oral Health created a new oral cancer brochure that made its debut for OCAW.

Conclusion

The Office of Oral Health will continue local health department funding to implement the oral cancer prevention program. Furthermore, the Office will work with local health departments to identify model programs and best practices. The tenth annual Maryland Oral Cancer Awareness week will be held April 12-18, 2010.

Looking Forward into the Future

In addition to Medicaid's many efforts to successfully expand Maryland's oral health capacity for low-income and vulnerable populations, the work outlined in this report continues to be a priority for the Office of Oral Health. Following the recommendations of the DAC and working with dedicated State partners, the Office envisions continued growth and support of the Oral Health Safety Net Program, the various projects which have stemmed from it and the Oral Cancer Initiative. Expansion of service providers, education and outreach, as well as funding support to Maryland's oral health programs will be continually addressed.