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 – Joshua M. Sharfstein, M.D., Secretary

OCT 18 2012

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

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

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

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

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

RE: 2012 Annual Oral Health Legislative Report as Required by Health-General Article, Sections 13-2504(b) and 13-2506 and HB 70 (Ch. 656 of the Acts of 2009)

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

Pursuant to Health-General Article, §13-2504(b), the Maryland Medicaid Program and the Office of Oral Health within the Department of Health and Mental Hygiene (the Department) submit this comprehensive oral health legislative report to the Governor and the General Assembly. In addition, the 2009 Joint Chairmen's Report (on pg. 82) requested that without adding an official reporting requirement, the report also be distributed to the budget committees.

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

- Maryland Medicaid availability and accessibility of dentists;
- Medicaid dental administrative services organization (ASO) 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;

- The activities of the Office of Oral Health's Oral Health Literacy Campaign funded by a grant from the Centers for Disease Control and Prevention;

- The results of the Statewide follow-up survey concerning the oral health status of school children in Maryland as required by Health-General Article, §13-2506; and

- Other related oral health issues.

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

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

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MARYLAND'S 2012 ANNUAL ORAL HEALTH LEGISLATIVE REPORT

Health-General Article, §13-2504(b)

Martin O'Malley	Anthony G. Brown	Joshua M. Sharfstein, M.D.
Governor	Lt. Governor	Secretary

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Executive Summary

In 2010 and 2011, the Pew Center on the States named Maryland a national leader in improving dental care access for low-income Marylanders, especially those who are Medicaid-eligible or uninsured. As the only state to meet seven of the eight dental policy benchmarks, the Pew Center ranked Maryland first in the nation for oral health.[1] The Centers for Medicare and Medicaid Services (CMS) also has recognized Maryland's improved oral health service delivery by requesting Maryland share its story at its national quality conference in August 2011, including its story and achievements in its best practices guide for States and their Governors through the Medicaid State Technical Assistance Team (MSTAT) process, and inviting Maryland to present in the inaugural CMS Learning Lab: Improving Oral Health Through Access web seminar series. Maryland's current oral health achievements are a direct result of the state's progress in implementing the 2007 Dental Action Committee's (DAC) comprehensive recommendations for increasing access to oral health services through changes to the Maryland Medical Assistance Program (Medicaid) and expansion of the public health dental infrastructure.

Guided by the DAC's recommended strategies, the Medicaid program has made major programmatic changes that have contributed to a significant increase in dental utilization in recent years. Maryland continues to improve its dental program by successfully confronting complex and multi-faceted barriers to providing comprehensive oral health services to Medicaid enrollees, such as low provider participation. Low provider participation results from multiple factors including, but not limited to, low reimbursement rates, missed appointments, and a lack of awareness among enrollees about the benefits of basic oral health care.

The DAC recommended that the Department of Health and Mental Hygiene (the Department) initiate a single statewide dental administrative services organization (ASO). In July 2009, DentaQuest (formerly named Doral Dental) began functioning as the Department's ASO for all dental services for children, pregnant women, and adults in the Rare and Expensive Case Management (REM) Program. DentaQuest is responsible for all functions related to the delivery of dental services, including provider network development and maintenance, claims processing, utilization review, authorization of services, outreach and education, and complaint resolution. Calendar year (CY) 2011 is the second full calendar year that DentaQuest has coordinated dental services for Medicaid. The Department spent $152.7 M for CY 2011, nearly $100 M more than dental expenditures in CY 2008 (see Attachment 4). Utilization rates have increased and provider networks have expanded since DentaQuest rebranded Medicaid dental services as the Maryland Healthy Smiles Program:

- As of August 2012, 1,616 dentists have enrolled in DentaQuest to provide care, up from 649 in August 2009.

[1] http://www.pewstates.org/uploadedFiles/PCS_Assets/2011/The_State_of_Childrens_Dental_health.pdf

- Approximately 368,000 children and adults in Medicaid received dental care in 2011, 82,000 more than in 2010.
- Maryland continues to perform significantly above the national Health Employer Data Information Set (HEDIS™) average for children's dental services utilization at 66.4 percent, more than eighteen percentage points higher than the 2010 HEDIS™ average of 47.8 percent.
- Over a six-year period, less than one percent of children enrolled in Medicaid sought treatment for a dental diagnosis in the emergency room.
- The percentage of pregnant women 14 years and over enrolled for any period receiving a dental service in 2011 was 28.4 percent, as compared to 26.6 percent in 2010.
- DentaQuest is making progress toward its goal to assign all children to a dental home, as well as its efforts to implement more aggressive outreach to link Medicaid populations to care.

Additionally, the DAC recommended enhancement of the dental public health infrastructure by ensuring that each local jurisdiction has a local health department or community dental clinic. The Governor made it a priority to include $1.5 M in the FY 2013 budget to continue support for community-based oral health grants through the Oral Health Safety Net Program established in 2007, which expands the oral health capacity for low-income, disabled, and Medicaid populations. Building on prior successes, this additional funding now provides Marylanders in every county access to a public health dental clinic that is located within or serves their jurisdiction. Other dental public health achievement highlights include:

- In 2010, $1.2 M in federal funding was secured to develop a statewide Oral Health Literacy Campaign. The campaign, titled "Healthy Teeth, Healthy Kids" was unveiled in March 2012 and extended through July 2012. Efforts are underway to evaluate and extend this campaign.
- During the 2011-2012 school year, the Deamonte Driver Mobile Dental Van Project provided diagnostic and preventive services for 1,185 Prince George's County children, of which 147 received clinic referrals for immediate restorative care or urgent care.
- A statewide school-based dental sealant demonstration project was completed in 2010, in which third graders in 10 elementary schools received dental screenings and any needed sealants. As a result of this demonstration, the Office of Oral Health issued its first Request for Applications (RFA) in FY 2013 for local health departments to develop statewide school-based and/or school-linked dental sealant programs for their own jurisdictions. Eight local health departments received grants under this RFA in July 2012. In addition, school-based oral health access programs were established in 11 schools beginning in FY 2010 in Kent and Queen Anne's Counties using a mobile dental team.
- In January 2012, five new dentists started the Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP) and will continue through

December 2013. During CY 2011, MDC-LARP dentists treated 15,628 unduplicated patients and billed 39,071 dental visits for Medicaid patients.

- The Kaiser Foundation awarded a $200,000 grant to the Maryland Dental Action Coalition in partnership with the Office of Oral Health in order to fund a pilot dental screening program to link to an established school-based dental clinic in Prince George's County. This pilot program began operations in October 2011, and the partnership will issue an interim report on its progress in the fall of CY 2012.
- The Maryland Community Health Resources Commission (MCHRC) continues to expand oral health capacity for vulnerable populations. Since 2008, the MCHRC has awarded 20 dental grants totaling $4.6 M, which collectively provided services to more than 35,000 low-income children and adults and resulted in nearly 83,000 visits.

The DAC also recommended providing training to dental and medical providers in oral health risk assessments. In July 2009, the Department began training and reimbursing primary care providers for the application of fluoride varnish for children up to three years of age. By June 2012, 385 unique Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) certified providers administered over 58,000 fluoride varnish treatments. As of September 2012, approximately 584 dentists had received training in pediatric dentistry through various state-sponsored courses.

The Oral Cancer Initiative requires that the Department implement programs to train health care providers on screening and referring patients with oral cancer, and provide education on oral cancer prevention for high-risk, underserved populations. Through the combination of the Initiative's funds with Cigarette Restitution Fund Program (CRFP) funds, thousands of Maryland residents have been screened for oral cancer or referred to smoking cessation programs, and a large number of practitioners have received oral cancer prevention messages, information, and strategies.

Maryland continues to make progress in the percentage of residents receiving annual oral cancer examinations. In FY 2012, 6,735 individuals were screened for oral cancer, and 13,281 individuals along with 395 healthcare providers received education on oral cancer through the Initiative. In addition, the Department participates in awareness-building activities, and in the last year took part in Maryland Oral Cancer Awareness Week (OCAW), sponsored the second Baltimore Oral Cancer Walk, and collaborated with the Maryland Tobacco Quitline to support the link between cessation programs and the reduction of oral cancer.

The Department greatly appreciates the strong commitment to transforming Maryland's oral health capacity demonstrated by the Governor and the Maryland General Assembly. With ongoing funding and support, the Department and its many dedicated partners will continue working together to successfully address the oral health needs of all Marylanders, with a special emphasis on vulnerable populations.

I. Introduction

Pursuant to Health-General Article, §13-2504(b), the Maryland Medical Assistance Program (Medicaid) and the Office of Oral Health within the Department of Health and Mental Hygiene (the Department) are required to submit a comprehensive oral health report that addresses the following areas:

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

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

(B) The outcomes that managed care organizations and dental managed care organizations under the Maryland Medical Assistance Program achieve concerning the utilization targets required by the five-year Oral Health Care Plan, including: (i) loss ratios that the managed care organizations and dental managed care organizations experience for providing dental services, and (ii) corrective action by managed care organizations and dental managed care organizations to achieve the utilization targets; and

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

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

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

(4) A one-time reporting of the results of the statewide follow-up survey concerning the oral health status of school children in Maryland as required by Health-General Article, §13-2506.

Part 1 of this report addresses the Department's progress in implementing the 2007 Dental Action Committee (DAC) recommendations for improving access to oral health services in Maryland. This section includes information on the availability of dentists participating in the Maryland Healthy Smiles Program, access to care for Medicaid populations under administrative services organization (ASO) DentaQuest, and services offered by local health departments to low-income residents in dental Health Professional Shortage Areas (HPSAs).

Part 2 describes in further detail the Oral Health Safety Net Program administered by the Department's Office of Oral Health. This section discusses collaborations between

the Department and other stakeholders to strengthen access to comprehensive dental care for low-income, disabled, and Medicaid populations through clinical dental programs, school-based oral health services, and other initiatives throughout the state. This section also provides a status update on the Department's follow-up survey concerning the oral health status of school children in the state.

Part 3 focuses on progress made by the Office of Oral Health's Oral Cancer Mortality Prevention Initiative. This section documents the initiatives implemented to increase public and professional awareness of the importance of oral cancer screening, the impact of outreach combined with broadening training efforts for dentists to conduct oral cancer screenings, and progress in detecting and treating oral cancer in Maryland residents since the initiative began in 2000.

II. Maryland's Oral Health Accomplishments

Part 1. Medicaid Dental Care Access

Background

The Department's Medicaid program delivered oral health services to approximately 368,000 children and adult enrollees during 2011; 82,000 more than in 2010. Maryland has made major program changes and has seen a significant increase in dental utilization over the last few years, which contributed greatly to Maryland being recognized as an oral health leader by the Pew Center on the States[2] and by CMS. Despite these successes, Maryland continues to improve its dental program by confronting barriers to providing comprehensive oral health services to Medicaid enrollees. Barriers include low provider participation due to, among other things, low reimbursement rates, missed appointments, and a lack of awareness among enrollees about the benefits of basic oral health care. As Medicaid's population continues to increase each year, these barriers remain significant impediments to increasing access to dental services.

In June 2007, the Secretary of the Department convened the Dental Action Committee (DAC), a broad-based group of stakeholders, in an effort to increase children's access to oral health services. The DAC 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.[3] The DAC's report called for establishing a dental home for all Medicaid-covered children. To accomplish this goal, the DAC recommended several changes to the Medicaid program for connecting eligible children with a dentist to provide comprehensive dental services on a regular

[2] http://www.pewstates.org/uploadedFiles/PCS_Assets/2011/The_State_of_Childrens_Dental_health.pdf
[3] http://fha.dhmh.maryland.gov/oralhealth/docs1/DAC_report.pdf

basis. The DAC also included suggestions to enhance education, outreach, dental public health infrastructure, provider participation, and provider scope of practice.

In June 2009, the DAC formally transitioned from being a Department-based committee focused on increasing dental access for underserved Maryland children to becoming an independent, sustainable statewide oral health coalition (now called the Maryland Dental Action Coalition (MDAC)), whose mission is to improve the oral health of all Marylanders. By March 2010, the MDAC received funding from a private foundation (the DentaQuest Foundation), secured an office, and hired an executive director. Upon establishing formal governance, enlisting new partners, and electing officers, the MDAC has evolved into an effective statewide advocacy organization for oral health issues, and has partnered with the Department in taking positions on important oral health legislation. The MDAC also worked with many partners, including the Department (Medicaid and the Office of Oral Health), to develop and launch a State Oral Health Plan in May 2011, and highlighted the plan at an Oral Health Summit that the MDAC co-sponsored in October 2011. Proceedings of the Oral Health Summit were published in a special issue of the Journal of Public Health Dentistry in the spring of 2012.

Sustainability is a core issue for the MDAC. After achieving 501(c)(3) status in May 2012, it has secured a Kaiser Foundation grant to develop a pilot program for a school dental screening and case management program, the last unfunded DAC recommendation. MDAC also received a competitive 1-year planning grant from the DentaQuest Foundation to develop a state oral health alliance, called the Maryland Oral Health Learning Alliance (MOHLA), and it has recently submitted an operational grant proposal to DentaQuest to fund years two and three of the MOHLA. Further, the coalition has entered into a strategic alliance with the Office of Oral Health to support the successful oral health literacy social marketing/media campaign entitled “Healthy Teeth, Healthy Kids.” MDAC was at the center of a highly successful public launch of the campaign in March 2012 that featured Lieutenant Governor Anthony Brown, Senator Ben Cardin, and Congressman Elijah Cummings.

Senate Bill 590

Senate Bill 590 (1998) established the Office of Oral Health within the Department’s Family Health Administration (now the Prevention and Health Promotion 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 21 years of age in 1997, which was 19.9 percent.[4]

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

Part 1 of this report provides an overview of CY 2011 Medicaid dental results under the dental ASO DentaQuest, as well as the Department's progress in implementing the DAC recommendations. It also addresses Medicaid-related dental access issues identified in SB 590 (1998) as follows: (1) the availability and accessibility of dentists throughout the State that participate in the Maryland Healthy Smiles Program; (2) the outcomes achieved by DentaQuest in reaching the utilization targets; and (3) the allocation and use of dental funding. This section of the report further includes the Office of Oral Health's efforts that specifically address increasing access to oral health care.

Implementing Change to Increase Utilization of Dental Services

The Office of Oral Health received a five-year state dental infrastructure grant from the Centers for Disease Control and Prevention (CDC) in August 2008 that includes a requirement to develop a five-year State Oral Health Plan. The State Plan was developed by the MDAC in coordination with many partners that included the Office of Oral Health, and was unveiled at a press conference featuring Congressman Elijah Cummings and Secretary Joshua Sharfstein in May 2011. The central theme of the State Plan is to develop strategies and policies aimed at ensuring that a majority of all Maryland residents will have a dental home accessible to them. The momentum for the drive to implement such change began with the DAC report targeting the utilization of dental services for children.

The Department has made progress in implementing many of the DAC (now MDAC) recommendations as follows:

DAC Recommendation 1: Initiate a Statewide single vendor dental Administrative Services Organization (ASO).

Action Taken: The Department awarded a contract to DentaQuest to serve as the single statewide dental vendor. DentaQuest began managing dental services and paying claims in July 2009, and the new Medicaid dental program has been named "Maryland Healthy Smiles". DentaQuest has attracted over 900 new dental providers since the start of the program and has been successful in increasing utilization.

DAC Recommendation 2: Increase dental reimbursement rates to the 50th percentile of the American Dental Association's (ADA) South Atlantic region charges, indexed to inflation, for all dental codes.

Action Taken: The Governor's FY 2009 budget included $7 M in general funds ($14 M total funds) to increase targeted dental reimbursement rates to the MDAC's recommended level effective in July 2008 (see Attachment 1 for a list of dental codes and rates). While this rate increase has been effective in attracting new dental providers to the Maryland Healthy Smiles Program, a second round of rate increases continues to be delayed due to budget constraints.

DAC Recommendation 3: 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)).

Action Taken: The Governor's FY 2013 budget includes $1.5 M to continue support for new or expanded dental public health services, especially targeting jurisdictions without public health clinics. With this funding, residents in every county in Maryland now have access to a public health safety net dental clinical program that is located in and/or serves their jurisdiction (see Table 3). In 2007, only half of the state's jurisdictions had such programs.

DAC Recommendation 4: Establish a public health level dental hygienist to provide screenings, prophylaxis, fluoride varnish, sealants, and x-rays in public health settings.

Action Taken: During the 2008 session, the Maryland General Assembly unanimously passed legislation that facilitates the role of dental hygienists working for public health programs. Now these dental professionals are able to more efficiently and expeditiously provide services within the scope of their practice in offsite settings (e.g., schools and Head Start centers), and as a result, health department dental programs have begun recruiting and enlisting public health dental hygienists and additional school-based health centers are beginning to employ dental hygienists to provide preventive services.

DAC Recommendation 5: 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.

Action Taken: In 2010, with the support of Senators Mikulski and Cardin, the Office of Oral Health secured $1.2 million in federal funds to develop a statewide Oral Health Literacy Social Marketing and Media Campaign for the public. The purpose of the Oral Health Literacy Campaign was to inform parents and caregivers of low-income families about the importance of oral health for their children, how to prevent cavities, and how to access the oral health care delivery system.

Prior to the development of the campaign, the University of Maryland School of Public Health conducted research through a telephone survey of 803 adults and four focus groups. Results showed that this audience had limited knowledge about how to prevent tooth decay in children, and the least understanding of oral health care importance were among those with lower levels of education, those without dental insurance, and those enrolled in Medicaid.

In March 2011, the Office of Oral Health contracted with social marketing firm PRR, Inc. to plan, develop, and conduct the campaign. The Office of Oral Health also formed a strategic alliance with the MDAC to brand and to monitor the campaign's implementation. A strong infrastructure was created to advise and guide the development

and implementation of the campaign. This infrastructure consisted of a work group, an advisory committee and a strategic network of partners comprised of more than 160 individuals representing the dental and medical professions, as well as a variety of social service, community and public health organizations. Together, these individuals helped craft the campaign messages, identify influencers, discover barriers, highlight benefits, develop tactics, and identify potential partners. They also pledged to support the campaign.

The Oral Health Literacy Campaign "Healthy Teeth, Healthy Kids" launched March 23, 2012 at The Dr. Samuel D. Harris National Museum of Dentistry. Speakers at the launch included Maryland Lieutenant Governor Anthony Brown; U.S. Senator Ben Cardin, D-Md.; U.S. Representative Elijah Cummings, D-Md.; and Dr. Harry Goodman, Director, Office of Oral Health, Maryland Department of Health and Mental Hygiene. Volunteer dental professionals provided free dental screenings to preschoolers attending the launch, and attendees received free oral health educational materials.

After the launch, the "Healthy Teeth, Healthy Kids" campaign ran from late March through mid-July 2012, and used traditional media, social media, and other effective communication tools to reach its audience. The campaign included nine weeks of radio, television, and transit advertising; a direct mailing of 120,000 brochures to women on Medicaid with children ages 0 – 3; and the distribution of 80,000 oral health kits to at-risk mothers with children ages 0 – 6 through WIC, Head Start, and local health departments. The campaign also included ongoing involvement of more than 120 partner organizations that spread the campaign's message by distributing brochures and working one-on-one with mothers of young children. Partner organizations are placing posters in clinics and medical offices, banners or articles on their website and in newsletters, linking to the campaign websites at www.healthyteethhealthykids.org, "liking" the campaign Facebook page, and posting comments or video to the Facebook page (located at www.facebook.com/HealthyTeethHealthyKids). Currently, a post-campaign survey is being conducted to help determine the success of the campaign in reaching and influencing the behavior of its target audience.

DAC Recommendation 6: Incorporate dental screenings with vision and hearing screenings for public school children or require dental exams prior to school entry.

Action Taken: An MDAC Subcommittee continues to work on a plan to develop a program whereby dental screenings are incorporated with vision and hearing screenings for public school children. The dental screening program is envisioned to have a care coordination/case management plan in place for children identified to be at high risk for dental disease. The MDAC had been challenged to find the support to conduct this program because of the economic climate in Maryland. However, upon developing a Proof of Concept paper which specified steps needed for eventual enactment of a program, the MDAC, in coordination with the Department and other partners, successfully secured $200,000 in grant funding from the Kaiser Foundation in June 2011. The grant is funding a pilot school dental screening program linked to an established school-based dental clinic in Prince George's County. The pilot program began

operations in October 2011, and the partnership will issue an interim report on its progress by the end of CY 2012.

DAC Recommendation 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.

Action Taken: General dentists have received training in didactic and clinical pediatric dentistry so that they may competently treat young children. As of September 30, 2012, approximately 584 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 School of Dentistry (referred to in past reports as the Baltimore College of Dental Surgery). This includes a course sponsored by the Office of Oral Health and presented by the University of Maryland School of Dentistry conducted in September 2012 that provided training to 104 public health general dentists and their staff (for additional information concerning the Oral Health Safety Net Program, please see Part 2 of this report).

To provide for greater access to dental services for young children, beginning in July 2009, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical providers (pediatricians, family physicians, and nurse practitioners) certified by the Office of Oral Health became eligible to receive Medicaid reimbursement for providing fluoride varnish treatments to children ages 9–36 months through Maryland Mouths Matter: Fluoride Varnish and Oral Health Assessment Program. As of June 2012, 686 providers had completed the training program, and 385 of these EPSDT medical providers have enrolled with DentaQuest as fluoride varnish providers. The program overall has improved utilization for children ages 0 – 3. Approximately 58,770 fluoride varnish treatments have been provided to children ages 9 – 36 months since the start of this program in July 2009 to June 2012.

Availability and Accessibility of Dentists in Medicaid

Background: HealthChoice MCOs and Dentist Enrollment

HealthChoice is the current health service delivery system for most children and non-elderly adults enrolled in Medicaid and the Maryland Children's Health Program (MCHP). Until the implementation of the Maryland Healthy Smiles dental ASO on July 1, 2009, dental care was a covered benefit provided by the HealthChoice MCOs. HealthChoice MCOs were required to offer comprehensive oral health services including preventive care to children through 20 years of age and to pregnant women.[5] While adult dental services are not a required benefit and are not funded by the Department, all seven HealthChoice MCOs offer basic oral health services to adults. HealthChoice adult dental benefits typically include cleanings, fillings, and extractions (see Table 11 for more information on HealthChoice adult dental benefits).

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

HealthChoice MCOs were also required to develop and maintain an adequate network of dentists who could deliver the full scope of oral health services for children and pregnant women. HealthChoice regulations 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, the Department monitored access issues via enrollee complaints.

As of July 2008, there were approximately 743 dentists enrolled as providers in the HealthChoice program. The 2008 count was a point-in-time count of providers, and it increased by the end of 2008 due to several provider outreach activities. The overall statewide ratio of dentists[6] to HealthChoice enrollees under age 21 years was 1:679 in July 2008. Shortly after the July 1, 2008 rate increases and the Secretary's challenge to dentists to participate with Medicaid, approximately 65 additional dentists joined the HealthChoice Program.

Current Dentist Enrollment: Maryland Healthy Smiles Program

DentaQuest has been actively enrolling new dentists in the Maryland Healthy Smiles Program since its July 1, 2009 implementation. DentaQuest is required to have a dentist-to-child enrollee ratio of 1:1,000 after the first year of the program, 1:750 after year two, and 1:500 after year three. Through DentaQuest, providers can now participate with Medicaid via a single point of contact, rather than contracting with seven separate MCOs. DentaQuest handles credentialing, billing, and any other provider issues, which streamlines the process for providers. As a result, DentaQuest has increased the number of participating dental providers. As of August 31, 2012, there were 1,616 providers enrolled, resulting in a dentist-to-child enrollee ratio of approximately 1:389. As the number of participating providers continues to increase, the Maryland Healthy Smiles Program has begun assigning each child to a dental home in CY 2012. The Department has received positive feedback from providers who have worked with DentaQuest.

Table 1: Dentists Participating in DentaQuest[2]

Regions[1]	**DentaQuest**			
	August 2009	**July 2010**	**August 2011**	**August 2012**
Baltimore Metro	242	344	410	765
Montgomery/Prince George's Counties	208	296	365	695
Southern Maryland	29	39	51	90
Western Maryland	65	97	128	222
Eastern Shore	43	53	84	168
MD Bordering States	62	110	152	281
Unduplicated Total[3]	**649[4]**	**939**	**1,190**	**1,616**

[6] Only dentists listed in HealthChoice provider directories were counted.

[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, Frederick, Garrett, and Washington Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.
[2] Some dentists may not be accepting new referrals and many dentists limit the number of new referrals that they accept. These numbers only reflect the availability of practitioners.
[3] The unduplicated total is different than the total in each geographic region because it is possible for a dentist to have multiple sites. Also, clinics with multiple dentists may only be counted once. Fluoride varnish providers are not included in these calculations.
[4] The transition between the HealthChoice MCOs and DentaQuest resulted in the loss of several providers at the start of implementation in July 2009.

According to the Maryland State Board of Dental Examiners, as of August 2012, a total of 4,131 dentists actively practice in the State of Maryland. Table 2 indicates as of August 2012 how many pediatric and general dentists were practicing in Maryland and how many dentists are participating with DentaQuest. For the last two columns, because providers who practice in multiple locations may have different provider numbers for each practice affiliation, records were manually unduplicated by provider name. Dentists working for group practices or clinics were impossible to identify; therefore, the number of unique providers may undercount significantly the total number of dentists providing dental services to Medicaid enrollees.

Table 2: Active Dentists and Dentists Participating with DentaQuest

REGION[1]	Total Active Dentists (August 2012)	Active General Dentists	Active Pediatric Dentists	Dentists Enrolled with DentaQuest as of August 2012 (Percentage of Total Active Dentists)	Dentists Who Billed One or More Services in CY 2011 (Percentage of Total Active Dentists)	Dentists Who Billed $10,000+ in CY 2011 (Percentage of Total Active Dentists)
Baltimore Metro	1,835	1,496	58	765 (41.7%)	450 (24.5%)	355 (19.3%)
Montgomery/ Prince George's	1,667	1,334	52	695 (41.7%)	413 (24.8%)	310 (18.6%)
Southern Maryland	154	130	3	90 (58.4%)	49 (31.8%)	38 (24.7%)
Western Maryland	288	227	10	222 (77.1%)	119 (41.3%)	94 (32.6%)
Eastern Shore	217	174	9	168 (77.4%)	72 (33.2%)	60 (27.6%)
Other				281	122 (N/A)	46 (N/A)
TOTAL	**4,161**	**3,361**	**132**	**1,616 (38.8%)[2]**	**1,155 (27.8%)**	**881 (21.2%)**

[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, Frederick, Garrett, and Washington Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

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

In 2008, less than 19 percent of Maryland licensed active dentists were participating with Medicaid. As of August 2012, 38.8 percent of Maryland dentists were enrolled with Medicaid (see Table 2). In 2011, 1,155 dentists billed one or more Medicaid services, and 881 dentists billed $10,000 or more to the Medicaid program. This represents 27.8 percent and 21.2 percent respectively, of the total active, licensed dentists in the state. The number of dentists billing at least one Medicaid service has steadily increased over the last three years, from 846 dentists in 2009 to 1,057 dentists in 2010 to 1,155 dentists in 2011. The number of dentists billing more than $10,000 to Medicaid also increased from 479 in 2009, to 765 in 2010, to 881 in 2011. Pediatric dentists remain a minority in the state, accounting for approximately 3.2 percent of the total number of active dentists in Maryland.

Addressing Dental Health Professional Shortage Areas (HPSAs)

Within Maryland, several areas have been designated as dental HPSAs. Regions designated as Dental HPSAs are portions of the Eastern Shore, Western Maryland, Southern Maryland, and Baltimore City (see Attachment 2). Residents living in all regions of the state now have access to low-cost dental services available through community programs sponsored by Federally Qualified Health Centers (FQHCs), local health departments, academia, and other private, non-profit health organizations (e.g., community hospitals).

As of September 2012, there were 16 Maryland jurisdictions served directly by local health departments on-site or school-based clinical dental programs. This includes Kent and Queen Anne's counties, which had been identified in the past as having no dental public health services, as well as the Worcester County Local Health Department, which began operating its onsite clinical dental program in October 2010. The St. Mary's County Health Department does not directly administer a clinical dental program but acts as a conduit to link low-income patients with private dental practitioners who are available to provide dental services to this population within the county. The Howard County Health Department subcontracts with an FQHC, Chase Brexton Health Services, for its clinical dental service program. In addition, four jurisdictions on the Eastern Shore without a local health department dental program are served by two FQHCs – Choptank Community Health Systems (Caroline, Talbot, and Dorchester) and Three Lower Counties (Somerset). Beginning in FY 2010, Calvert and Cecil Counties now provide clinical dental services to low-income patients through a non-profit community hospital and academic center, respectively. Jurisdictions that are served by both a local health department and other community dental clinical program include: Baltimore City, Anne Arundel, Baltimore, Carroll, Charles, Kent, Montgomery, Prince George's, Queen Anne's, Washington, Wicomico, and Worcester Counties.

Table 3 provides an overview of available local health department and community providers as of September 2012. It is important to note that these community clinic providers offer varying levels of dental services and not all of them accept Medicaid.

Table 3: Community Clinic Dental Providers[1]

County	Local Health Department Clinic	Community Health Centers	Dental School/Other
Allegany	On Site	None	Allegany Health Right (contracts with private dental providers), Allegany County Community College (Dental Hygiene Program)
Anne Arundel	[2,3] On Site (2 sites)	Stanton Center	
Baltimore City	[2,3] On Site (2 sites)	South Baltimore, Total Health, Chase Brexton, Parkwest, People's Community, BMS, Healthcare for the Homeless	University of Maryland School of Dentistry, Kernan Hospital, Baltimore City Community College (Dental Hygiene Program)
Baltimore County	[2] On Site (2 sites)	Chase Brexton	Community College of Baltimore County (Dental Hygiene Program)
Calvert	None	None	Calvert Memorial Hospital
Caroline	None	Choptank (2 sites)	
Carroll	On Site	None	[4]Access Carroll
Cecil	None	None	University of Maryland School of Dentistry
Charles	On Site	Nanjemoy	[4] Health Partners
Dorchester	None	Choptank	
Frederick	On Site	None	
Garrett	On Site	None	
Harford	On Site	None	
Howard	Subcontract - Chase Brexton FQHC	[5] Chase Brexton	
Kent	School-based program in partnership with Queen Anne's County LHD	Served by Choptank	Served by University of Maryland School of Dentistry (Cecil County)
Montgomery	[2,6] On Site (5 sites)	Community Clinics, Inc. (CCI)	
Prince George's	[2] On Site (2 sites)	Greater Baden	
Queen Anne's	School-based program in partnership with Kent County LHD	Served by Choptank	
Somerset	None	Three Lower Counties	
St. Mary's	Serves as an intermediary between Maryland Medicaid Program and private dental providers	None	Does not directly provide services but is the main entry point for Medicaid patients and makes arrangements with private providers for care.
Talbot	None	Served by Choptank	
Washington	On Site	Walnut Street	
Wicomico	On Site	Served by Three Lower Counties FQHC	
Worcester	On Site	Served by Three Lower Counties FQHC	

1 Community clinic providers may also be counted in DentaQuest provider directories (see Table 1 above) if they accept Maryland Healthy Smiles.
2 Multiple sites.
3 Began treating Medicaid enrollees in FY 2013.
4 Maryland Community Health Resources Commission Grant Program funded in FY 2010.
5 Partnership between Howard County Health Department and Chase Brexton.
6 Does not currently treat Medicaid enrollees.

Maryland Healthy Smiles Program Dental Utilization Rates

Children and Dental Utilization

Under EPSDT requirements, dental care is a mandated health benefit for children under age 20 years.[7] Utilization of dental services was historically low, but has increased significantly in recent years. Prior to implementation of the HealthChoice managed care program in 1997, only 14 percent 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 percent.[8]

To assess the performance of HealthChoice and DentaQuest, the Department uses a measure closely modeled on the National Committee for Quality Assurance (NCQA) HEDIS™ measure for Medicaid children's dental services utilization. The counted number of individuals is based on two criteria: an age range from four through 21 years, and enrollment of at least 320 days. The Department modified its age range to reflect four through 20 years because the Maryland Medicaid program only requires dental coverage through age 20 years.

At the inception of the HealthChoice program in 1997, the percentage of children receiving dental services was 19.9 percent. In 1999, HealthChoice utilization increased dramatically to 25.9 percent; however, performance was still ten percentage points below the HEDIS™ national Medicaid average. After the Dental Action Committee made its 2007 recommendations, access for children enrolled in HealthChoice increased from 51.5 percent in CY 2007 to 59.0 percent in CY 2009, performing nearly 14 percentage points above the 2009 HEDIS™ national Medicaid average (see Table 4).

Since the transition from HealthChoice to DentaQuest in July 2009, Maryland has continued to perform above the national average for providing dental services to children (see Table 4). In CY 2011, the percentage of all children in Medicaid receiving a dental service was 66.4 percent. As a comparison, the HEDIS™ 2011 (CY 2010) national average for Medicaid was 47.8 percent.[9] For more detailed analysis, Attachment 3 shows child dental utilization data by age and region.

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

Table 4: Number of Children Receiving Dental Services
Children Ages 4-20, Enrolled for at Least 320 Days in Medicaid**

Year	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service	HEDIS™ National Medicaid Average*
CY 2005	267,633	117,473	43.9%	41.0%
CY 2006	267,376	117,532	44.0%	42.5%
CY 2007	263,742	130,112	49.3%	43.5%
CY 2008	278,063	149,673	53.8%	44.2%
CY 2009	304,907	184,563	60.5%	45.7%
CY 2010	335,214	214,265	63.9%	47.8%
CY 2011	363,465	241,149	66.4%	N/A

*Mean for the Annual Dental Visit (ADV) measure, *total* age category (ages 2-21 years), as of HEDIS™ 2006. The 2-3 year age cohort was added as of HEDIS™ 2006.
** To track DentaQuest's progress as the sole dental services administrator for children enrolled in the Medicaid program, the Department's methodology for CY 2010 and future calendar years analyzes all children enrolled in Medicaid managed care and FFS programs, instead of children's managed care enrollment alone (e.g., CY 2005 – CY 2009).

In recent years, the Department began reporting utilization rates of children with any period of enrollment. Utilization rates are lower when analyzed for any period of enrollment because the population includes children who were in a HealthChoice MCO or Medicaid for only a short period. Children may have had turnover in eligibility or enrollment, or may have been new to the HealthChoice MCO or Medicaid, and therefore there was insufficient time to link the child to care. MCOs and ASOs have less opportunity to manage the care of these populations. Of the 628,889 children enrolled in Medicaid for any period during CY 2011, 49.8 percent of these children received one or more dental service, as compared to 46.8 percent in CY 2010. The utilization rates of children with any period of enrollment have significantly increased over the five-year period for all age groups. The steady and significant increase in utilization for children ages 0 – 3 years is likely due to the change that took effect July 1, 2009, which allowed EPSDT certified pediatric physicians to apply fluoride varnish (see Table 5).

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

Age Group	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
0-3*	7.9%	10.0%	12.3%	18.6%	22.5%	25.0%
4-5	37.2%	42.4%	47.7%	56.0%	59.8%	62.9%
6-9	42.3%	47.6%	53.1%	60.7%	63.6%	66.2%
10-14	39.5%	44.2%	48.8%	56.4%	58.7%	61.1%
15-18	32.3%	35.8%	39.5%	46.0%	48.2%	50.9%
19-20	18.4%	20.1%	23.4%	30.1%	30.3%	33.2%
Total	**29.3%**	**32.9%**	**36.7%**	**43.8%**	**46.8%**	**49.8%**

* Most newborns and infants are not expected to use dental services. As a result, the dental service rate for the 0-3 age group should be interpreted with caution.
** To track DentaQuest's progress as the sole dental services administrator for children enrolled in the Medicaid program, the Department's methodology for CY 2010 and future calendar years analyzes all children enrolled in Medicaid managed care and FFS programs, instead of children's managed care enrollment alone (e.g., CY 2006 – CY 2009).

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 receive. As indicated above, access to any dental service, including restorative services, has increased from 19.9 percent in FY 1997 to 66.4 percent in CY 2011 (see Table 4). Access to restorative services increased from 6.6 percent of all children in FY 1997 to 25.1 percent in CY 2011 (see Table 6). This overall increase in utilization is due in part to raising the fees for twelve dental restorative codes in 2004, raising the fees for twelve dental diagnostic and preventive procedure codes in 2008, and increasing outreach efforts to Medicaid recipients and providers.

Table 6: Percentage of Children Receiving Dental Services by Type of Service Children ages 4-20, Enrolled for at Least 320 Days in Medicaid*

Year	Diagnostic	Preventive	Restorative
FY 1997	19.6%	18.1%	6.6%
CY 2000	27.3%	24.6%	9.3%
CY 2001	31.7%	29.1%	10.8%
CY 2002	31.7%	29.1%	10.3%
CY 2003	40.8%	37.9%	13.6%
CY 2004	41.0%	38.0%	13.8%
CY 2005	42.7%	39.7%	15.8%
CY 2006	43.7%	40.5%	16.4%
CY 2007	48.6%	45.2%	19.3%
CY 2008	53.1%	50.1%	21.3%
CY 2009	55.5%	52.3%	21.8%
CY 2010	61.9%	58.2%	25.0%
CY 2011	64.5%	60.8%	25.1%

* To track DentaQuest's progress as the sole dental services administrator for children enrolled in the Medicaid program, the Department's methodology for CY 2010 and future calendar years analyzes all children enrolled in Medicaid managed care and FFS programs, instead of children's managed care enrollment alone (e.g., FY 1997 – CY 2009).

As noted above, utilization rates are lower when analyzed for any period of enrollment versus a period of continuous enrollment because the MCO or ASO has had less opportunity to manage the care of these populations. For those children enrolled in Medicaid for any period, 48.9 percent received a preventive or diagnostic visit in 2011, as compared to 45.8 percent in 2010 (see Table 7). Of those receiving a preventive or diagnostic visit, 32.6 percent received a follow-up restorative visit.

Table 7: Preventive/Diagnostic Visits Followed by a Restorative Visit by Children Enrolled for Any Period in Medicaid* (Ages 0-20), CY 2005 – CY 2011

Year	Total Enrollees	Preventive / Diagnostic Visit	Preventive / Diagnostic Visit followed by Restorative Visit
CY 2005	483,304	136,183 (28.2%)	36,001 (26.4%)
CY 2006	491,646	137,826 (28.0%)	36,675 (26.6%)
CY 2007	493,375	155,939 (31.6%)	44,491 (28.5%)
CY 2008	505,339	179,268 (35.5%)	53,294 (29.7%)
CY 2009	540,173	230,442 (42.7%)	76,608 (33.2%)
CY 2010	602,761	276,178 (45.8%)	94,517 (34.2%)
CY 2011	628,889	307,214 (48.9%)	100,256 (32.6%)

* To track DentaQuest's progress as the sole dental services administrator for children enrolled in the Medicaid program, the Department's methodology for CY 2010 and future calendar years analyzes all children enrolled in Medicaid managed care and FFS programs, instead of children's managed care enrollment alone (e.g., CY 2005 – CY 2009).

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 2011, 2,860 children with any period of enrollment in HealthChoice visited the emergency room with a dental diagnosis, not including accidents, injury or poison, which is a slight increase compared to CYs 2005 – 2009. However, the percentage of children with emergency room visits relative to the total Medicaid population eligible for dental services remains at less than 1 percent (see Table 8).

Table 8: Emergency Room Visits with a Dental Diagnosis* by Children Enrolled for Any Period in Medicaid (Ages 0-20), CY 2005 - 2011**

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 (0.35%)	1,872
CY 2006	491,646	1,809 (0.36%)	2,117
CY 2007	493,375	2,005 (0.41%)	2,283
CY 2008	505,339	2,175 (0.43%)	2,596
CY 2009	540,179	2,412 (0.45%)	2,927
CY 2010	602,761	2,609 (0.43%)	3,068
CY 2011	628,889	2,860 (0.45%)	5,682

* For this measure, a dental diagnosis is included regardless of whether the diagnosis appeared in the primary or secondary field. Dental services provided in the ER exclude accidents, injury and poison.
** To track DentaQuest's progress as the sole dental services administrator for children enrolled in the Medicaid program, the Department's methodology for CY 2010 and future calendar years analyzes all children enrolled in Medicaid managed care and FFS programs, instead of children's managed care enrollment alone (e.g., CY 2005 – CY 2009).

Pregnant Women and Dental Utilization

Prior to the implementation of HealthChoice in 1997, Medicaid did not cover adult dental care. SB 590 (1998) required that HealthChoice cover dental services for all pregnant women. In July 2009, DentaQuest took over administration of dental services for pregnant women. DentaQuest identifies pregnant women by eligibility coverage groups and by using dental claims data to identify if a patient is pregnant at the time of treatment.

The percentage of pregnant women 21 years and over enrolled for at least 90 days receiving dental services was 28.0 percent in CY 2011 (see Table 9). The percentage of pregnant women 14 years and over enrolled for any period receiving a dental service in 2011 was 28.4 percent, as compared to 26.6 percent in 2010 (see 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 in Medicaid for at Least 90 Days

Year	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service
CY 2006	34,480	4,395	12.7%
CY 2007	35,444	5,072	14.3%
CY 2008	36,458	6,272	17.2%
CY 2009	37,206	8,871	23.8%
CY 2010	40,206	10,060	25.0%
CY 2011	30,882	8,653	28.0%

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

Year	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service
CY 2006	47,339	6,620	14.0%
CY 2007	48,437	7,447	15.4%
CY 2008	49,299	9,022	18.3%
CY 2009	49,551	12,369	25.0%
CY 2010	51,957	13,812	26.6%
CY 2011	38,164	10,857	28.4%

* In Tables 9 and 10 for CY 2011, pregnant women were identified using the following methods: (1) enrollment in Medical Care Program coverage group P02 or P11 in the CY MMIS eligibility files, (2) kick payments for live births in the CY capitation rate dataset, (3) payment for an individual in a Sixth Omnibus Budget Reconciliation Act (SOBRA) rate cell for pregnant women, and (4) delivery CPT codes. This is a modification in methodology from CY 2006 through CY 2010 because it excludes pregnancy diagnoses codes. Pregnant women enrolled in an X02 coverage group were excluded from this analysis because they are not eligible for the dental benefit.

HealthChoice Dental Utilization Rates

Non-Pregnant Adults and Dental Utilization

Apart from dental services covered for pregnant women and adults in the Rare and Expensive Case Management (REM) Program, adult dental services are not included in MCO or ASO capitation rates and therefore are not required to be covered under HealthChoice or DentaQuest. In CY 2008, all seven HealthChoice MCOs provided a limited adult dental benefit and spent approximately $8.86 M for these services. After transitioning to DentaQuest, the MCOs spent $12.3 M on adult dental services in CY 2009, $6.5 M in CY 2010, and $11.4 M in CY 2011.

As of September 2012, all seven HealthChoice MCOs provide limited dental services to non-pregnant adults (see Table 11). In CY 2011, 22.7 percent of non-pregnant

adults enrolled in a HealthChoice MCO for at least 90 days received at least one dental service in CY 2011, up from 14.9 percent in CY 2010 (see Table 12).

Table 11: HealthChoice Dental Benefits for Non-Pregnant Adults as of September 2012

MCO	Dental Benefits Offered
AMERIGROUP Community Care	Exam and cleaning 2 times a year (every 6 months), limited x-rays, and 20% discount on non-covered dental services
Diamond Plan (Coventry)	Exam and cleaning 1 time per year, x-rays, unlimited fillings, medically necessary extractions, general anesthesia during dental procedures when medically necessary
Jai Medical Systems	Exam and cleaning 2 times a year (every 6 months); unlimited x-rays, fillings, and extractions
Maryland Physicians Care	Effective August 1, 2012: Exam and cleaning 2 times a year (every 6 months; $5 copay per visit); limited x-rays, limited fillings for cavities, simple extractions and medically necessary emergent extractions (80% co-insurance applies)
MedStar Family Choice	Effective August 1, 2012: Exam and cleaning every 6 months, x-rays, and fillings
Priority Partners	Exam and cleaning 2 times a year (every 6 months), limited x-rays, and emergency extractions
UnitedHealthcare	Annual exam and cleaning, x-rays, and surgical extractions

Table 12: Percentage of Non-Pregnant Adults 21+ Receiving Dental Services, Enrolled in HealthChoice for at Least 90 Days

Year	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service
CY 1999	111,753	16,139	14.4%
CY 2000	114,223	16,986	14.9%
CY 2001	111,694	16,795	15.0%
CY 2002	117,885	16,800	14.3%
CY 2003	116,880	21,288	18.2%
CY 2004	115,441	12,457	10.8%
CY 2005	116,266	11,093	9.5%
CY 2006	114,844	11,747	10.2%
CY 2007	138,212	18,290	13.2%
CY 2008	125,386	23,587	18.8%
CY 2009	177,474	26,063	14.7%
CY 2010	195,577	29,106	14.9%
CY 2011	223,582	50,675	22.7%

Strategies to Improve Access to Dental Care

Prior to 2009, 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 with Value Based Purchasing (VBP) incentives and sanctions. In CY 2008, the VBP target for an MCO to receive an incentive payment was 50 percent utilization for children, with sanctions given to an MCO with utilization of less than 47 percent.

Following the DAC recommendation to institute a single ASO to administer Medicaid dental benefits, the Department selected DentaQuest to function as the Department's ASO for all dental services for children, pregnant women, and REM Program adults. Since its start in July 2009, DentaQuest has been responsible for all functions related to the delivery of dental services including provider network development and maintenance, claims processing, utilization review, authorization of services, outreach and education, and complaint resolution. During the first contract year, utilization rates and provider networks increased. Also in July 2009, the Department began training and reimbursing primary care providers for the application of fluoride varnish for children up to three years of age. Consequently, utilization for children under the age of three has increased, and by June 2012, 385 unique EPSDT certified providers administered over 58,000 fluoride varnish treatments. Currently, DentaQuest is working on its goal to assign all child recipients to a dental home, which began in CY 2012.

Funding

Medicaid dental funding for children and pregnant women has increased in recent years, from approximately $12 M in CY 2000 to $152.7 M for CY 2011 (see Attachment 4). This growth in funding reflects increases in the Medicaid fee schedule for selected codes to the 50th percentile of the ADA's South Atlantic region charges for dental services. It also reflects increased utilization due to improved outreach activities and additional providers participating with the Medicaid program.

The following details the history of Medicaid dental funding:

- For CY 2004, the Department allowed sufficient funding for 40 percent 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 M in dental capitation payments, but using a fee-for-service reimbursement rate estimate, the MCOs spent approximately

$37 M for children and pregnant women, and an additional $2.3 M for adult dental services.

- In CY 2006, the MCOs received $35.1 M in dental capitation payments for children and pregnant women, but reported spending $46.6 M, including $4.28 M on adult dental services.
- In CY 2007, MCOs received $42.5 M in dental capitation payments for children and pregnant women in response to increased utilization in CY 2006. The MCOs reported spending $53.8 M, including $5.36 M on adult dental services.
- In CY 2008, MCOs received $55.4 M in dental capitation payments for children and pregnant women due to increased utilization. The MCOs reported spending $71.4 M, including $8.86 M 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 M. Beginning July 1, 2009, DentaQuest began paying dental claims on a fee-for-service basis. The total dental expenses for the second half of 2009 totaled $43.2 M, for a total of $82.8 M spent in CY 2009. An additional $12.3 M was spent by the MCOs for adult dental in CY 2009.
- In CY 2010, DentaQuest dental expenses totaled $137.6 M for children and pregnant women. HealthChoice adult dental expenditures totaled $6.5 M, for which MCOs did not receive reimbursement.
- In CY 2011, DentaQuest dental expenses totaled $152.7 M for children and pregnant women. HealthChoice adult dental expenditures totaled $11.4 M, for which MCOs did not receive reimbursement.

Conclusion

Utilization of dental services by children has increased significantly from the implementation of HealthChoice; from 19.9 percent in 1997 to 66.4 percent in 2011. In 1999, utilization for children was ten percentage points below the national HEDIS™ average, and by 2011, utilization has increased to more than eighteen percentage points above the most recent national HEDIS™ average. However, many children still are not receiving needed dental services and the program still needs additional improvements. The DAC addressed barriers to dental care access by making key recommendations to increase reimbursement for Medicaid dental services and to institute a single dental ASO. The Department supports and, to a great degree, has effectively instituted the reforms recommended by the DAC to address the barriers to dental care access previously experienced in the state. Dental provider rates increased in 2008, and the Department is committed to a second round of rate increases once the budget situation improves.

In conjunction with DentaQuest, the Department has reformed and rebranded the Medicaid dental program. The Maryland Healthy Smiles Program has attracted over 900 additional participating dentists since its start in 2009, and these providers are serving as dental homes for Medicaid-enrolled patients. DentaQuest continues its outreach to providers, and now that networks are more robust, DentaQuest will begin more aggressive outreach 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 ages 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. As of June 2012, DentaQuest has trained 686 fluoride varnish providers in Maryland. The utilization rate of children ages 0 – 3 years has experienced a steady increase from CY 2009 through CY 2011, due in part to this initiative.

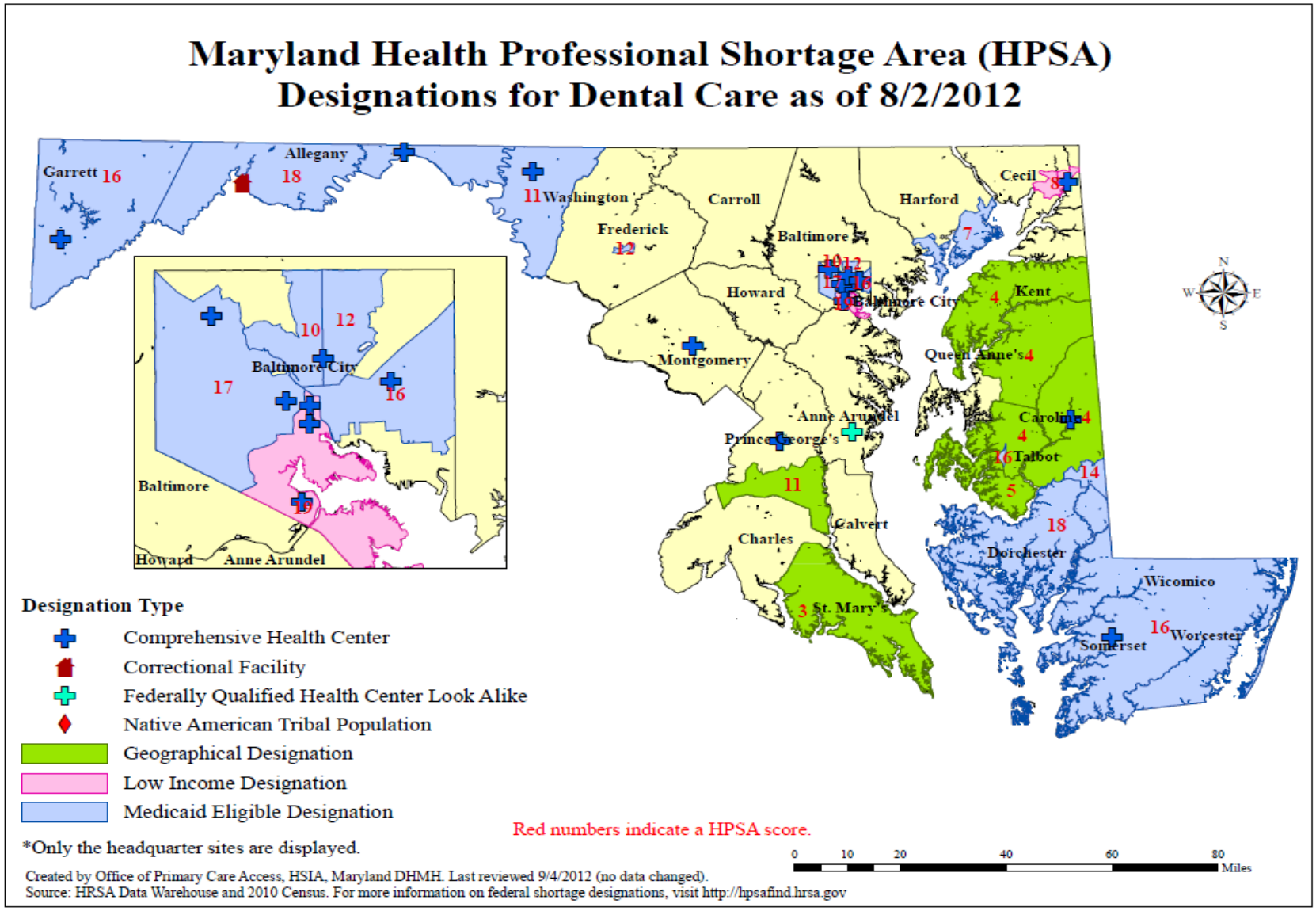
The Department continues to work with the Maryland State Dental Association (MSDA), University of Maryland School of Dentistry, and others on various branding and marketing efforts to promote the new Medicaid dental program to dentists. The MSDA conducted its fifth "Access to Care Day" on September 20, 2012 as part of their annual organizational meeting with over 165 dentists and staff in attendance. As in past "Access to Care Day" events, representatives from DentaQuest were present at the meeting to enlist new dentists into the program. In addition, Dr. Harry Goodman, the Department's Office of Oral Health Director, gave a presentation on the progress of the reforms the state has instituted in response to the DAC's recommendations. This day is part of the dental association's efforts to partner with the Department in recruiting new dentists into the Maryland Healthy Smiles Program. Dentists and dental hygienists who attend the session receive free continuing education credits and training in pediatric dentistry. These annual programs have given dentists and their staff the opportunity to discuss the Maryland Healthy Smiles Program and other state oral health issues with DentaQuest representatives, Departmental staff, and members of the newly organized MDAC. With efforts such as those described in this report, the Department is committed to continuing to improve upon successes, and to working with the MDAC on recommended strategies to make access to dental care and a dental home a reality for all Maryland children.

Attachment 1: Dental Procedures Targeted for FY 2009 Fee Increases

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 targeted diagnostic and preventive 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 the 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: Map of Maryland Health Professional Shortage Areas (HPSAs)



Attachment 3: Medicaid Dental Utilization Rates, CY 2000 – CY 2011

Enrollment in Medicaid ≥ 320 Days*, Ages 4-20

Criteria	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Age												
4-5	29.3%	33.3%	33.7%	42.8%	43.6%	45.9%	46.2%	52.5%	57.0%	60.9%	67.8%	70.8%
6-9	31.6%	37.2%	38.2%	48.0%	48.7%	51.1%	51.6%	57.6%	62.5%	65.6%	71.5%	73.8%
10-14	29.2%	34.1%	35.5%	44.0%	44.8%	46.9%	47.5%	53.2%	57.2%	60.7%	66.4%	68.5%
15-18	24.7%	29.4%	29.9%	38.0%	37.6%	39.7%	40.2%	44.3%	47.6%	51.2%	55.9%	58.5%
19-20	17.8%	19.7%	20.8%	26.8%	26.8%	27.7%	26.9%	28.4%	33.2%	37.5%	38.6%	41.2%
All 4-20	**28.7%**	**33.6%**	**34.5%**	**43.2%**	**43.7%**	**45.8%**	**46.2%**	**51.5%**	**55.7%**	**59.0%**	**63.9%**	**66.4%**
Region**												
Baltimore City	25.1%	27.4%	27.8%	35.6%	35.8%	38.1%	38.8%	45.9%	51.8%	56.6%	62.4%	64.4%
Baltimore Suburbs	32.5%	35.4%	37.7%	46.1%	46.1%	47.0%	47.1%	51.4%	54.8%	56.7%	61.7%	63.6%
Washington Suburbs	30.4%	35.9%	39.6%	47.8%	46.4%	50.2%	49.5%	54.8%	58.8%	62.1%	65.8%	70.4%
Western Maryland	38.2%	46.0%	42.8%	51.0%	56.1%	56.4%	55.7%	59.3%	61.9%	64.1%	56.9%	69.6%
Southern Maryland	26.5%	29.3%	31.8%	39.6%	39.5%	40.0%	43.3%	46.7%	52.2%	56.1%	66.6%	57.5%
Eastern Shore	26.4%	32.6%	31.3%	44.4%	48.2%	49.2%	51.8%	55.7%	55.7%	59.4%	69.6%	67.9%
All Regions	**28.7%**	**33.6%**	**34.5%**	**43.2%**	**43.7%**	**45.8%**	**46.2%**	**51.5%**	**55.7%**	**59.0%**	**63.9%**	**66.4%**

* To track DentaQuest's progress as the sole dental services administrator for children enrolled in the Medicaid program, the Department's methodology for CY 2010 and future calendar years analyzes all children enrolled in Medicaid managed care and FFS programs, instead of children's managed care enrollment alone (e.g., CY 2000 – CY 2009).

** 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, Frederick, Garrett, and Washington Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

Attachment 4: Medicaid Dental Funding, Expenditures, and Utilization Rates, FY 1997 – CY 2011

MCO and DentaQuest Funding and Expenditures for Dental Services, FY 1997 – CY 2011 Utilization of Dental Services in HealthChoice and DentaQuest, FY 1997 - CY 2011				
Year	**Amount Paid in MCO Capitation Rates or DentaQuest for Dental**	**Amounts Spent by MCOs for Dental[±] (Includes Adult Dental)**	**Utilization Rate for General Access (Children 4-20 Years with 320 Days of Enrollment)**	**Utilization Rate for Restorative (Children 4-20 Years with 320 Days of Enrollment)**
FY 1997	N/A	$2.7 M*	19.9%	6.6%
CY 2000	$12.3 M (est.)	$17 M (est.)	28.7%	9.3%
CY 2001	$27.1 M	$23.6 M	33.6%	10.8%
CY 2002	$40.3 M	$28.9 M	34.5%	10.3%
CY 2003	$33 M	$32.5 M	43.2%	13.6%
CY 2004	$28 M	$36.7 M	43.7%	13.8%
CY 2005	$33 M	$42.0 M	45.8%	15.8%
CY 2006	$35.1 M	$46.6 M	46.2%	16.4%
CY 2007	$42.5 M	$53.8 M	51.5%	19.3%
CY 2008	$55.4 M	$71.4 M	55.7%	21.3%
CY 2009**	$82.8 M	$39.3 M	59.0%	21.8%
CY 2010***	$137.6 M	$6.5 M	63.9%[†]	25.0%[†]
CY 2011	$152.7 M	$11.4 M	66.4%	25.1%

* In FY 1997, the Department spent $2.7 M on dental services under its FFS program.
****** In CY 2009, the total spent by the Department on dental services was $82.8 M. This included $39.6 M in MCO capitation rates for dental services from January 1, 2009 – June 30, 2009 and $43.2 M for dental services under the new Maryland Healthy Smiles Program for the period July 1, 2009 – December 31, 2009.
*** Beginning in FY 2010, Maryland Healthy Smiles is reimbursed FFS and paid an administrative fee. The $6.5 M in CY 2010 and $11.4 M in CY 2011 spent by MCOs account for adult dental services only and is not reimbursed by the state.
[†] To track DentaQuest's progress as the sole dental services administrator for children enrolled in the Medicaid program, the Department's methodology for CY 2010 and future calendar years analyzes all children enrolled in Medicaid managed care and FFS programs, instead of children's managed care enrollment alone (e.g., FY 1997 – CY 2009).
[±] Source: HFMR.

Part 2. Oral Health Safety Net Program

Background

Lack of access to oral health services is both serious and complex in scope, requiring multiple strategies. To remedy this situation, SB 181/HB 30 (2007) established the Oral Health Safety Net Program within the Department's Office of Oral Health. The purpose of the Program is: to 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; to contract with a licensed dentist to provide public health expertise for the state; and to provide continuing education courses to providers that offer oral health treatment to underserved populations.

Current Status

Since the creation of the Oral Health Safety Net Program, and as stipulated in the legislation, the Department has recruited a licensed public health dentist who provides dental expertise to the Office of Oral Health on policy development, legislation, surveillance, protocol evaluation, provider recruitment, and continuing education courses for providers that offer oral health treatment to underserved populations. This legislation has also enabled the Office of Oral Health to seek out new and creative strategies to enhance the oral health safety net, and to increase access to oral health services for low-income and 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, leasing and contractual agreements with private dental offices, as well as other strategies.

Comprehensive Oral Health Report

Health-General Article, §13-2506 requires that "the Department shall conduct a statewide follow-up survey on or before June 1, 2011, concerning the oral health status of school children in the State." To fulfill this requirement, the Office of Oral Health began planning its next update to the statewide oral health survey of Maryland elementary school children (kindergarten and 3rd grade), which it conducts every five years. In June 2010, the Office of Oral Health entered into a Memorandum of Understanding with the University of Maryland School of Dentistry to conduct the statewide needs assessment in late September 2011, coinciding with the beginning of the school year. The purpose of this needs assessment was to update oral health status trends in this population since the last oral health needs assessment, *The 2005-2006 Oral Health Survey of Maryland School Children*, and to recommend, develop, and/or revise statewide programmatic priorities and strategies in the overall oral health care delivery system based on the findings. Great progress on the development of this oral health needs assessment has been made since last year.

In June 2011, the study design was finalized and the necessary commitments to conduct the survey were secured from the majority of county school superintendents as well as from the Maryland State Superintendent of Schools. The University of Maryland School of Dentistry researchers randomly selected 60 schools in 19 counties so as to create a sample representative of Maryland's statewide population. Beginning in August 2011, data collection schedules were established with sample schools. Public schools were eligible for selection in all school districts except Montgomery County, which refused to participate. Because of the lack of participation of Montgomery County schools in the survey, the final sample included 50 elementary schools (of the target 60) from 17 school districts (of the target 19). However, the 50-school sample size was still representative of all regions of the state and met the sample size requirement established by the Centers for Disease Control and Prevention.

Dentists began performing dental examinations in the schools in late September 2011. This data collection phase ended in June 2012. Data collection consisted of two components: an open-mouth dental examination of each participating child at the school, and a health questionnaire that was completed by the child's parents or guardians at home at the same time that they completed an active consent form. The dental examination component of the survey collected oral health status information, including the number of teeth, the level and treatment of active and previous oral disease, and the presence of any dental sealants. The health questionnaire component allowed for the collection of information about the child, including age, gender, dental insurance status, history of dental visits, history of toothaches, and other related descriptive characteristics.

With all school visits completed, the next stage is to analyze the data. The analysis team is currently in the process of linking the oral health status and health questionnaire data. The team anticipates completing preliminary analyses and summary reports by December of 2012. Final reports will be available by the spring of 2013. It is estimated that the final data set will consist of approximately 1,500 children.

The following types of analyses are planned and will be highlighted in the final report:

1. Prevalence of lifetime dental caries experience (stratified by grade, geographic region, dental insurance status, and eligibility for free/reduced school meals);
2. Prevalence of current decay (active disease) (stratified by grade, geographic region, dental insurance status, and eligibility for free/reduced school meals);
3. Prevalence of toothache pain (stratified by grade, geographic region, dental insurance status, and eligibility for free/reduced school meals);
4. Having a usual source of dental care (stratified by grade, geographic region, dental insurance status, and eligibility for free/reduced school meals);
5. Dental visit rates (stratified by grade, geographic region, dental insurance status, and eligibility for free/reduced school meals);
6. Prevalence of dental sealants (stratified by grade, geographic region, dental insurance status, and eligibility for free/reduced school meals); and
7. Treatment needs (stratified by grade, geographic region, dental insurance status, and eligibility for free/reduced school meals).

Carrying out Major Oral Health Recommendations of DAC

As discussed in Part 1 of this report, the Department convened the DAC to develop strategies to expand Maryland's oral health services to low-income individuals. The DAC recommended maintaining and enhancing 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. In order for this to occur, the Oral Health Safety Net statute would require funding to fulfill the requirements outlined.

In light of the DAC's recommendation to the Secretary that the dental public health infrastructure needed strengthening, the Governor's FY 2013 budget for the Department's Family Health Administration (now the Prevention and Health Promotion Administration) included $1.5 M to bolster clinical dental treatment and preventive services for low-income Maryland children, especially those who are Medicaid-eligible or uninsured, and to support many of the requirements listed in the 2007 Oral Health Safety Net legislation. While these Oral Health Safety Net grant funds are being used statewide, these funds were specifically targeted to provide dental services in jurisdictions previously identified as not being served by a public health dental clinical program (Calvert, Kent, Queen Anne's, St. Mary's, and Worcester Counties).

The Office of Oral Health, in coordination with the Office of Capital Planning, Budgeting, and Engineering Services, has issued capital infrastructure grants to Harford, Charles, and Worcester Counties over the past decade to acquire, design, construct, renovate, convert, and equip dental program facilities. The Worcester County Health Department began operating its dental clinic in April 2011, after receiving a capital infrastructure grant in 2008. This health department dental program provided dental services for 3,057 low-income county children and adults during CY 2012 through its onsite clinical and school-based/linked programs. In FY 2012, the Office of Oral Health provided operational funds to these three local health department clinical dental programs, as well as to other jurisdictions throughout Maryland.

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

In FY 2012, the Office of Oral Health continued to fund new and established dental programs to address immediate service needs, and to increase the service capacity of dental practitioners. Since 2009, these grants have provided continued support for both new and established clinical programs to expand oral health services and school-based oral health services.

Addressing Immediate Service Needs

Support for New Clinical Programs Funded Since 2009

The following projects, selected through a competitive RFP, currently provide and/or facilitate comprehensive clinical dental services for the public, and establish dental homes within communities to ensure the consistent availability of dental services in four counties which previously had no dental public health infrastructure. These three-year projects address the unique needs of local populations, and provide evidence-based and appropriate educational, diagnostic, preventive, restorative, and emergency care.

- Calvert County: Since its inception in September 2009, Calvert Memorial Hospital's project has provided direct services to Medicaid and other low-income children in Calvert County. This project has recruited two dental teams, each consisting of a dentist, dental hygienist, and dental assistant who provide preventive and restorative oral health services as well as basic oral surgeries. In order to provide easy access to these services for individuals who live in the community, the dental teams have negotiated an arrangement with two local private dental offices to perform dental care services in their facilities.

- Kent/Queen Anne's Counties: Having begun operations in fall 2009, the Kent and Queen Anne's County Local Health Departments' project aims to increase access to comprehensive oral health services and to enhance dental capacity for low-income children. The project hired a dentist to oversee local mobile dental teams and establish transportation for patients to regional dental homes through the purchase and operation of a wheelchair-accessible van. The project links patients requiring intensive oral health treatment with community dentists or dental programs to ensure patients have dental homes.

- Worcester County: Since its creation in April 2011, the Worcester County Local Health Department program has provided comprehensive oral health education, prevention, and treatment services for Medicaid and low-income, uninsured children in the county. The project enhances regional efforts for screening and primary prevention in the community, including schools and Head Start programs. The Office of Oral Health plans to maintain funding for the dental project until it is able to become self-sustaining through the receipt of sufficient Medicaid and other insurance revenues.

Note: While St. Mary's County was identified initially as a jurisdiction in need of dental public health clinical services, a unique program has been administered for many years at the St. Mary's County Health Department whereby the local health department acts as an intermediary between Medicaid and local dental providers. This arrangement has led to enlisting the majority of dentists practicing in this jurisdiction to be Medicaid providers, and the local health department serving as an entry point to dental care for Medicaid patients. Due to the long-term success of this program, it was determined unnecessary to provide financial support for this program similar to the type given to other "in-need" counties.

Support to Established Clinical Dental Programs to Expand Oral Health Services

The following counties receive funds annually from the Office of Oral Health to expand education, screening, and clinical oral health services (prevention and treatment) to improve access to oral health care:

- Baltimore City: Helping Up Mission (HUM), in partnership with the University of Maryland School of Dentistry, provides dental services to HUM homeless residents to improve their systemic and oral health, enhance their self-esteem and quality of life, and increase prospects for employment.
- Caroline, Dorchester, and Talbot Counties: 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 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 Health Department initiated provision of adult dental services for low-income Charles County adults and seniors by supporting the cost of a dentist.
- Harford County: Harford County Health Department expanded the space for its dental clinical program in April 2012 and increased the number of dental chairs from three to six. This expansion was due to its success in providing access for low-income county residents. The health department now can accommodate more patients.
- Howard County: Howard County Health Department began providing pediatric dental services for Medicaid and other low-income Howard County children by contracting with FQHC Chase Brexton Health Services and supporting a dentist there.
- Prince George's County: Prince George's County Health Department initiated provision of pediatric dental services for Medicaid and other low-income Prince George's County children by supporting a dentist. The Prince George's County Health Department will administer and operate the Deamonte Driver Dental Van Project (DDDP) which targets low-income school children beginning in FY 2013.
- Worcester County: Worcester County Health Department provides both restorative and preventive dental services for Medicaid and other low-income Worcester County children through an expansion of the fluoride varnish program provided by dental and medical professionals and provision of clinical and school-based/linked oral health services for children and adults.

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

New and established school-based funding initiatives from the Office of Oral Health are ongoing. School-based sites are critical venues for providing children with preventive oral health services, education, oral screening, and access to a dental home. The Office of Oral Health is supporting the following five school-based oral health models:

- Deamonte Driver Mobile Dental Van Project: The Prince George's County Local Health Department receives funding for this program to deliver school-based oral health care services and provide a dental home for children in Prince George's County and surrounding areas where there are no available dental services. This project has also helped enroll additional Medicaid dental providers in the community who are willing to provide complex dental treatment for children unable to be treated on the van. The dental van provides diagnostic, preventive, and simple restorative dental services to low-income students in one Montgomery County School and in 20 Prince George's County schools. The Prince George's County Foundation School is one of these sites, and is where Deamonte Driver, the 12-year old Prince George's County child who died from a dental infection, attended school. During the 2011-2012 school year, the Deamonte Driver Mobile Dental Van Project saw 1,185 children, of which 147 needed immediate or urgent care and were referred to neighborhood dental clinics. The Van has scheduled visits to twenty schools during the 2012-2013 school year, and the DDDP will also work collaboratively with the Colgate Bright Smiles/Bright Future Mobile Dental Unit to provide services to five Title I schools, which typically have 35 percent or more of their population enrolled in free and reduced meal programs.

- School-Based Dental Sealant Services: In 2008, the Department's Office of Oral Health received a five year grant award for a *State-Based Oral Disease Prevention Program* from the CDC. This grant builds upon the existing efforts of the Office of Oral Health to plan, implement, and evaluate population-based oral disease prevention and promotion programs. As part of this grant, the Office of Oral Health developed a school-based dental sealant demonstration project to examine the logistics and cost-effectiveness of school-based dental sealant services. The Office of Oral Health partnered with the University of Maryland School of Dentistry, which has expertise and experience in statewide dental assessment, surveillance, and prevention activities. The statewide demonstration program was conducted at 10 elementary schools that were selected according to sampling needs. Dental screenings and sealants, when indicated, were provided to third graders in public elementary schools from 2009-2010.

- CDC funds also allowed for the successful recruitment of a School-Based Dental Sealant Coordinator in March 2011. The Office of Oral Health's dental sealant demonstration project has served as a guide for the development of new and existing policies and programs that support statewide oral disease prevention and community-based public health prevention services. As a result, the Office of Oral Health for the

first time issued a RFA in FY 2013 for local health departments to develop statewide school-based and/or school-linked dental sealant programs for their own jurisdictions. Eight local health departments were awarded grants for the first time under this RFA in July 2012. Local health departments receiving these grants are: Allegany, Baltimore, Charles, Howard, Kent, Prince George's, Somerset, and Wicomico Counties.

- The Office of Oral Health developed a dental sealant manual to assist local health departments in the implementation of school-based or school-linked dental sealant programs. The new statewide school-based/linked dental sealant project also is supporting a website - Mighty Tooth (http://mightytooth.com/) – developed by the dental sealant demonstration project. The statewide dental sealant program places a special emphasis on vulnerable populations, specifically school children in Title I schools. Title I schools are an appropriate venue to provide preventive dental sealant and other prevention services such as topical fluoride modalities to inhibit the onset of dental decay in these high-risk, low-income students.

  The Office of Oral Health recently received a HRSA grant award ($500,000/year each for 3 years) for a large but competitive state oral health program workforce to further support this and other efforts.

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

Expanding the Oral Health Infrastructure through Other Programs

Maryland Community Health Resources Commission Dental Grant Awards

The MCHRC continues its commitment to creating new and expanding existing capacity for dental care to serve low-income, underinsured and uninsured Maryland residents. Since March 2008, the Commission has awarded 20 dental services grants totaling $4.6 million. The MCHRC dental grant projects, which were awarded to local health departments, FQHCs, and private, non-profit foundations and hospitals throughout the state, have collectively served more than 35,000 low-income children and adults, resulting in nearly 83,000 visits.

The MCHRC seeks to support programs that will be sustainable after its initial grant funds have been expended. MCHRC dental grantees leveraged their grant resources to secure more than $2.9 million in additional federal, local, private, and other resources to maintain programs in their underserved communities. As in recent years, the MCHRC included expanding access to dental services for children in its FY 2012 RFP, and awarded three new dental grant awards this past fiscal year. These three new grants are summarized below, as are additional recent grants awarded by the MCHRC:

- **Walnut Street Community Health Center (new)**, an FQHC located in Hagerstown, was awarded a two-year grant ($98,000) to support a mobile dental program that will provide dental sealants and cleanings in several Title 1 schools in Washington County. The mobile dental unit has two separate areas for patients to be treated, each with a dental chair. In addition to the mobile dental program, Walnut Street provides a pediatric dental program in its offices in downtown Hagerstown. The mobile dental program has provided dental services to nearly 150 patients in its first year.

- **Bel Alton Community Development Corporation (new)**, a non-profit organization in southern Maryland, was awarded a two-year grant ($250,000) to support a school-based dental outreach program and dental clinic for underserved communities in southern Maryland. Grant funds awarded by the MCHRC enabled Bel Alton to hire a dentist and outreach case managers. Children found to be in need of dental services or a "dental home" will be referred to Bel Alton's dental clinic, part of its community center. In addition to MCHRC grant funds, Bel Alton has leveraged federal capital resources to help pay for the costs of dental equipment. In its first year of the grant, Bel Alton targeted three Title 1 elementary schools in Charles County, and reported providing dental services to more than 150 students at these schools.

- **The Baltimore City Health Department (new),** was awarded a two-year grant ($58,428) to help integrate oral health education and screening into the immunization services program operated by the City Health Department. The project aims to reach 2,800 children and supports several key focus areas in the 2011-2015 Maryland Oral Health Plan, and the target group of the grant program coincides with the target audience selected for the Maryland Oral Health Literacy Campaign.

- **Choptank Community Health System**, an FQHC centrally located in Caroline County, was awarded a two-year grant ($270,000) in FY 2011 to provide access to dental services in nearby Kent County, a Medically Underserved Area (MUA). The grant supports a partnership with the Chester River Hospital Center to provide pediatric dental surgery services and has served 98 underserved children on the Eastern Shore with complex dental needs.

- **Health Partners**, a non-profit 501(c)(3) charitable organization in Charles County, was awarded a two-year grant ($120,000) in FY 2011 to expand its dental capacity at its free clinic (which is currently staffed by dental volunteers) and expand its existing school-based dental program. Since receipt of the MCHRC grant, Health Partners has reported serving more than 1,000 adults and children, far exceeding initial grant projections.

- **Access Carroll**, a non-profit organization in Carroll County, was awarded a two-year grant ($225,000) in FY 2011 to support a new dental facility that will be integrated with Access Carroll's current medical services. The grant enabled Access Carroll in its first year of the grant to provide access to emergency dental services, including extraction and repair of teeth for uninsured, underinsured, and low-income residents of Carroll County, while the new dental suite is being renovated. The grant has provided dental services to more than 100 uninsured patients in the first year of the program, and the number of patients served will expand with the opening of the new dental facility this year.

Pediatric Dental Fellows

The Pediatric Dental Fellows Program, which is administered by the University of Maryland School of Dentistry in partnership with the Office of Oral Health, has been in existence for over a decade. The goal of the Program is to place trained pediatric dentists in the community (local health departments, and FQHCs and community health centers) to provide comprehensive oral health services to Medicaid recipients. These dental fellows, most of whom were foreign dental graduates who have successfully completed U.S. pediatric dental residency programs, receive a Maryland dental license through this program. They are specially trained to provide care to children less than five years of age; some are also able to provide operating room care. Ongoing recruitment and U.S. visa difficulties, however, have caused a dramatic reduction the number of pediatric dental fellows able to be placed in the future. Currently, there are no pediatric dental fellows available to be placed. Despite the current situation, it is important to note that two pediatric dental fellows who successfully completed the program continue to provide dental care services to Medicaid patients in FQHCs in Montgomery and Washington Counties. One of the fellows is the dental director of his respective clinical dental program. Other fellows have established successful private dental practices and continue to treat Medicaid patients.

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 School of Dentistry from January 1999 through June 2001 in two regions in Maryland. The Eastern Shore Oral Health Outreach Program and the Lower Eastern Shore Dental Education Program expand the success of the earlier demonstration project to all Maryland Eastern Shore counties. One of the goals of these programs is to provide case management services, education, Head Start oral health screenings, and fluoride rinse programs for children on the Eastern Shore. This program is currently working on a data collection tool to enable it to better identify children at risk for oral disease and to coordinate their care through the Medicaid dental administrator with local private and public oral health care resources.

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

The purpose of the MDC-LARP is to improve access to oral health care services by increasing the number of dentists who provide services for Medicaid recipients. In CY 2011, a total of 15 dentists participated in the program; five of these dentists completed their three-year service obligation in December 2011. The service obligation requires that the dentists must participate in MDC-LARP for the full three years and during that period, 30 percent of their base patient population must be Medicaid patients. In January 2012, five new MDC-LARP dentists started the program and they will continue through December 2014. During CY 2011, MDC-LARP dentists treated 15,628 non-duplicated patients and had 39,071 dental visits by Medicaid recipients. Since the inception of the program in 2001, MDC-LARP dentists have seen 84,445 non-duplicated patients through 211,112 patient visits

Part 3. Oral Cancer Initiative

Background

Senate Bill 791 and House Bill 1184 (2000) established the Department's Oral Cancer Initiative (Health-General Article, §18-801—802). This statute requires that the Department develop and implement programs to train health care providers on screening and referring patients with oral cancer, and provide education on oral cancer prevention for high-risk, underserved populations. This legislation requires that the Office of Oral Health develop activities and strategies to prevent and detect oral cancer in the state, with a specific emphasis on high-risk, underserved populations. The major components of this initiative are oral cancer education for the public, education and training for dental and non-dental health care providers, screening and referral, if needed, and an evaluation of the program.

The Oral Cancer Mortality Prevention Initiative (the Initiative), directed by the Office of Oral Health, enables counties to provide an education and awareness campaign to the public and to address oral cancer screening training needs among health care providers. Since funds were made available for the Initiative in 2000, 26,721 people have been screened for oral cancer and 4,485 health care providers have received oral cancer prevention and early detection education through Office of Oral Health grants to local health departments throughout Maryland.

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

During this same period, the Maryland General Assembly created the Cigarette Restitution Fund Program (CRFP) (2000), which provides funds for cancer prevention, education, screening, and treatment for seven targeted cancers, including oral cancer. Some local jurisdictions have opted to provide oral cancer screening and/or education to residents. To date, 9,374 oral screening exams have been performed and 12,481 health care providers have received oral cancer prevention and early detection education through CRFP grants. Two jurisdictions, Baltimore City and Garrett County, continue to use CRFP funding for oral cancer screening

activities. In cooperation with the Office of Oral Health, the CRFP develops and maintains the Oral Cancer Minimal Clinical Elements for screening, diagnosis, treatment, follow up, and care coordination to provide guidance for public health programs that screen for oral cancer. In addition, Johns Hopkins University and the University of Maryland use CRFP cancer research funds to conduct oral cancer research.

As a result of these cumulative efforts, thousands of Maryland residents have been screened for oral cancer. More individuals, including dental and medical care practitioners, have received oral cancer prevention messages, information, and strategies. More individuals also have been referred to smoking cessation programs. Plans to evaluate the success of these programs are scheduled for the future, and include upcoming public surveys.

Oral cancer mortality rates have decreased from 2005 to 2009. According to data from the CDC's most recent reporting period (2005-2009), Maryland ranks 16th among all states compared to 8th as reported for 1997-2001, and now has a rate similar to the national average. Over the 5-year period from 2005 to 2009, oral cancer mortality rates decreased at a rate of 3.2 percent per year for blacks and 3.3 percent per year for whites.

The incidence of oral cancer in Maryland increased at a rate of 3.9 percent per year from 2005 to 2009.[10] From 2005 to 2009, oral cancer incidence rates in Maryland decreased at a rate of 1.0 percent per year for blacks, and increased 5.6 percent per year for whites. The 2009 age-adjusted incidence rate for oral cancer is statistically significantly lower in Maryland than the national average.[11] In 2009, over 47 percent 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. Oral cancer has a far better prognosis when found locally and early.

The rate of Maryland residents receiving annual oral cancer examinations since the initial survey in 1996 continues to increase. In 2010, 37.8 percent of persons in Maryland 40 years of age and older reported they had an oral cancer exam in the past year, and 45.6 percent of adults ages 40 and over reported that they received an oral cancer examination at least once in their lifetime. Despite this progress, there remains considerable room for improvement with respect to the proportion of Marylanders who receive oral cancer examinations. Only 74.5 percent of Marylanders ages 40 and over reported that they had a dental visit of any type in the past year. Some progress in this area has been made for black non-Hispanics in Maryland with 23 percent of those ages 40 and over reporting having an oral cancer examination in the past year, an increase from 20.3 percent in 2002. Because of this progress, some of the oral cancer examination rates surpass the Maryland 2015 target of 48 percent.[12]

Current Status

In July 2011, the Department awarded grants to local health departments to implement oral cancer prevention initiatives. County initiatives include providing oral cancer education, oral

[10] Maryland Cancer Registry.
[11] U.S. Surveillance Epidemiological End Results (SEER).
[12] See Maryland Behavioral Risk Factor Surveillance System (BRFSS), 2010.

cancer screenings for the public, and education and training of health care providers on the correct method for conducting an oral cancer exam.

In FY 2012, 6,735 individuals received oral cancer screenings. Of those screened, 22 were referred to a surgeon for biopsy. There were also 13,281 individuals educated on oral cancer, and 395 healthcare providers who received education on oral cancer.

In April 2012, the Department observed Maryland Oral Cancer Awareness Month. The initiative has been extended to a month-long observance from a week-long annual observance in previous years. 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 the month, the Office of Oral Health had a display in the lobby of 201 West Preston Street building where the Office shared information on oral cancer and how to quit smoking. The Office of Oral Health continues to partner with the Tobacco Quitline on all events related to oral cancer and tobacco use. Free incentives were distributed to promote both programs. Brochures for the Office of Oral Health and the Maryland Tobacco Quitline are distributed together.

The Office of Oral Health helped to sponsor the 4th Baltimore Oral Cancer Run/Walk at Druid Hill Park in Baltimore on April 14, 2012. As a sponsor, the Office of Oral Health had a display board at the event and distributed oral cancer brochures to participants, along with lip balm, oral cancer awareness ribbons, and Office of Oral Health pens. For more information about the event, visit: http://donate.oralcancer.org/index.cfm?fuseaction=donorDrive.eventDetails&eventID=526.

This year, all materials for Oral Cancer Awareness Month were made available online in an effort to "go green." Every local health department's Tobacco Prevention Coordinator, Cancer Prevention Coordinator, and Oral Health Program Coordinator, along with dentists in the MDC-LARP, received an email notification about the available materials. Items online included a color poster; a brochure from the Office of Oral Health on oral cancer; and additional oral health-related items, such as a press release, audio and print PSAs, a proclamation, editorial, a bulletin board for local use, listing of internet resources, and information on the 5K Oral Cancer Run/Walk.

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. Finally, the Department established a new Managing for Results (MFR) target: "By calendar year 2013, reduce the oral and pharyngeal cancer mortality rate in Maryland to a rate of no more than 2.3 per 100,000 persons" with the aim of continuing to decrease the burden of oral cancer in Maryland.

Conclusion and Future Initiatives

Maryland is recognized as a national leader in access to oral health services. Because of the many accomplishments in oral health care in Maryland resulting from the implementation of the DAC recommendations, CMS has recommended Maryland's dental strategies as a model for

other states struggling with poor oral health outcomes at conferences, in web seminars, and by including Maryland in its best practices recommendations for other states and their governors. Further, Maryland received its second consecutive "A" grade in May 2011 from the Pew Center on the States in its follow-up report entitled *The Cost of Delay: State Dental Policies Fail One in Five Children.*[13] As the only state in the country to pass seven of the eight metrics in this report, the Pew Center ranked Maryland first in the nation for oral health. Maryland also has been recognized by the federal Department of Health and Human Services (DHHS) as a success story and representative of a momentous federal occasion recognizing oral health for the first time as a Leading Health Indicator in August 2012. Maryland's oral health efforts were featured in a national webinar on August 20, 2012 with Deputy DHHS Secretary Howard Koh, and Rear Admiral William Bailey, Assistant Surgeon General and Chief Dental Officer, U.S. Public Health Service.

The work outlined in this report continues to be a priority for both Medicaid and the Office of Oral Health as they work together to expand oral health access for Maryland's low-income and vulnerable populations. Medicaid and the Office of Oral Health will continue to follow the DAC recommendations, and to work with dedicated state partners through the MDAC. In turn, both Departmental offices envision continued growth and support of the Maryland Healthy Smiles Program, the Oral Health Safety Net Program (including local health department and FQHC clinical dental programs), and the various projects which have stemmed from both offices, so long as there is sufficient funding. The Department will continue to increase the number of dental service providers, expand education and outreach, and promote oral health literacy for the public, as well as provide funding support for the Oral Cancer Initiative.

[13] http://www.pewtrusts.org/uploadedFiles/Cost_of_Delay_web.pdf