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

NOV 14 2011

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: 2011 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 results of the Statewide follow-up survey concerning the oral health status of schoolchildren 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

cc: Marie Grant, J.D.
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MARYLAND'S 2011 ANNUAL ORAL HEALTH LEGISLATIVE REPORT

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

Executive Summary

In 2010 and 2011, the Pew Center on the States named Maryland as 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] 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 (Medicaid) Program 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 influenced 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 is a result of low reimbursement rates, missed appointments, a lack of awareness among enrollees about the benefits of basic oral health care, as well as other factors.

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 Rare and Expensive Case Management (REM) program adults. DentaQuest is responsible for all functions related to the delivery of dental services, including provider network development and maintenance, claims processing, utilization review, authorization of services, outreach and education, and complaint resolution. Calendar Year (CY) 2010 is the first full year that DentaQuest has coordinated dental services for Medicaid. The Department spent $136 M for CY 2010.

Utilization rates have increased and provider networks have expanded since DentaQuest rebranded Medicaid dental services as the Maryland Healthy Smiles Program:

- As of August 2011, 1,190 dentists have enrolled in DentaQuest to provide care, up from 649 in August 2009.
- Approximately 286,000 children and adults received dental care in 2010, 21,000 more than in 2009.
- Maryland continues to perform significantly above the national Health Employer Data Information Set (HEDIS) average for children's dental services utilization at 63.9 percent, eighteen percentage points higher than the 2009 HEDIS average of 45.7 percent.

[1] http://www.pewcenteronthestates.or7g/uploadedFiles/The_State_of_Children%27s_Dental_Health.pdf

- Over a five-year period, less than one percent of children enrolled in Medicaid sought treatment for a dental diagnosis in the emergency room because of improved dental care access.
- The percentage of pregnant women 14 years and over enrolled for any period receiving a dental service in 2010 was 26.6 percent, as compared to 25.0 percent in 2009.
- DentaQuest plans to assign all children to a dental home during CY 2012, as well as implement more aggressive outreach to link Medicaid populations to care.

Another major DAC recommendation was to enhance the dental public health infrastructure by ensuring that each local jurisdiction has a local health department or community dental clinic. The Governor's FY 2012 budget includes $1.5 M to continue support for community-based oral health grants to expand the oral health capacity for low-income, disabled, and Medicaid populations through the Oral Health Safety Net Program established in 2007. 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 for the public that is anticipated to be unveiled in February 2012.
- During the 2010-2011 school year, the Deamonte Driver Mobile Dental Van Project saw 2,993 children, of which 367 needed immediate or urgent care and received clinic referrals.
- A Statewide School-based Dental Sealant Demonstration Project was conducted at 10 elementary schools where dental screenings and any needed sealants were provided to third graders in 2009-2010. In addition, school-based dental prevention services grants were awarded to seven jurisdictions for expansion of critically needed preventive dental sealant and fluoride application programs, and school-based oral health access programs were established in 11 schools in Kent and Queen Anne's Counties using a mobile dental team.
- In January 2011, five new Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP) dentists started the program and will continue through December 2013. During CY 2010, MDC-LARP dentists have treated 14,100 non-duplicated patients and had 35,249 dental visits by Medicaid patients.
- A $200,000 Kaiser Foundation grant to the Maryland Dental Action Coalition in partnership with the Office of Oral Health will enable a pilot dental screening program to be established in October of 2011 in Prince George's County that will incorporate dental screenings with vision and hearing screenings for public school children.
- The Maryland Community Health Resources Commission (MCHRC) continues to expand the oral health capacity for vulnerable populations, and since 2008 has awarded 17 dental grants totaling $4.4 M which have

collectively provided services to approximately 33,250 low-income children and adults, resulting in 76,159 visits.

The DAC also recommended providing training to dental and medical providers in oral health risk assessments and in assisting families in establishing a dental home for all children. 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 August 31, 2011, 347 unique Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) certified providers administered over 38,000 fluoride varnish treatments. As of June 2011, over 400 dentists had received training in pediatric dentistry through various State-sponsored courses. Another course sponsored by the Office of Oral Health and presented by the University of Maryland School of Dentistry provided training to 80 public health general dentists and their staff in August 2011.

The Oral Cancer Initiative 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. Through the combination of these 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 2011, there were 4,732 individuals screened for oral cancer, 2,464 individuals educated on oral cancer, and 419 healthcare providers received education on oral cancer. 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 the Governor and Maryland General Assembly have demonstrated to transforming Maryland's oral health capacity. With ongoing funding and support, the Department and its many dedicated partners will continue to work 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 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 (MCOs) 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 schoolchildren 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 Medical Assistance (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 Statewide follow-up survey concerning the oral health status of schoolchildren in the State.

Part 3 focuses on progress made by the Office of Oral Health's Oral Cancer Mortality Prevention Initiative. This section documents 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 Medical Assistance (Medicaid) program delivered oral health services to approximately 286,000 children and adult enrollees during 2010; 21,000 more than in 2009. 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 States.[2] 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 basis. The DAC also included suggestions to enhance education, outreach, dental public health infrastructure, provider participation, and provider scope of practice.

[2] http://www.pewcenteronthestates.org/uploadedFiles/The_State_of_Children%27s_Dental_Health.pdf
[3] http://www.fha.state.md.us/pdf/oralhealth/DAC_Final_Report.pdf

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 its many partners, including the Department (Medicaid and Office of Oral Health), to develop a State Oral Health Plan which was highlighted at an Oral Health Summit that MDAC sponsored in October 2011. Sustainability is a core issue for the MDAC and, along with plans to become a 501(c)(3) organization at the end of calendar year (CY) 2011, 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.

Senate Bill 590

Senate Bill 590 (1998) established the Office of Oral Health within the Department's Family Health Administration, and requires that the Medicaid program offer oral health services to pregnant women enrolled in Medicaid managed care organizations (MCOs). It established a five-year Oral Health Care Plan that set utilization targets for MCOs. The base for these targets is the rate of service use of children under age 21 years in 1997, which was 19.9 percent.[4]

Part 1 of this report provides an overview of CY 2010 Medicaid dental results under the dental Administrative Services Organization (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

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

Oral Health, and 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 Doral Dental Services of Maryland (now renamed 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 400 new 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 2012 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, the support of Senators Barbara Mikulski and Ben Cardin helped the Office of Oral Health to secure $1.2 M in federal funding to develop a Statewide Oral Health Literacy Campaign for the public. The purpose of the Oral Health Literacy Campaign is to better inform parents and caregivers of low-income families through various traditional, social media, and other effective communication tools about the importance of oral health, and to enable families to better navigate the oral health care delivery system. In March 2011, the Department contracted with PRR, Inc., a social marketing firm, to plan, develop, and conduct the campaign in close coordination with the Office of Oral Health. An advisory committee and strategic planning council, representing numerous community partners and stakeholders, have been convened to garner input and support for the Oral Health Literacy Campaign. The Department is also working with the University of Maryland, College Park School of Public Health on a grant project funded from a private non-profit foundation to develop messages to incorporate into the campaign. The advisory committee recommends that the campaign be unveiled to the public in February 2012, in coordination with Children's Dental Health Month.

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 funds will be used to pilot a school dental screening program that will be linked to an established school-based dental clinic in Prince George's County. The pilot program will begin operations in October 2011.

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 June 30, 2011, over 400 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). Another course sponsored by the Office of Oral Health and presented by the University of Maryland School of Dentistry conducted in August 2011 provided training to 80 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, 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 treatment to children 9 – 36 months of age through the Maryland Mouths Matter: Fluoride Varnish and Oral Health Assessment Program. As of August 31, 2011, there were 630 providers who completed the training program, and 347 of these EPSDT medical providers have enrolled with DentaQuest as fluoride varnish providers; this has improved utilization for children ages 0 – 3 years. Since the start of the program in July 2009 through July 2011, the program provided 34,533 fluoride varnish treatments to children ages 9 – 36 months.

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, six of the seven HealthChoice MCOs offer basic oral health services to adults. Adult dental benefits typically include cleanings, fillings, and extractions (see Table 11 for more information on HealthChoice adult dental benefits).

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

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

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 (listed in the HealthChoice provider directories; see Table 1). The 2008 count was a point in time count of providers, and increased by the end of 2008 due to several provider outreach activities. The overall Statewide ratio of dentists (listed in HealthChoice provider directories) to HealthChoice enrollees under age 21 years was 1:679 in July 2008, within the required 1:2,000 ratio. 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 (formerly Doral Dental) has been actively enrolling new dentists in the Maryland Healthy Smiles Program since the July 1, 2009 implementation of the ASO. This report includes the first yearlong assessment of DentaQuest's progress and analyzes the dental utilization and funding for CY 2010.

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. Through these efforts, DentaQuest has increased the number of participating dental providers and as of August 31, 2011, there are 1,190 providers enrolled, resulting in a dentist-to-child enrollee ratio of approximately 1:506. 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. As the number of participating providers continues to increase, the Maryland Healthy Smiles Program plans to assign each child to a dental home; this will occur during CY 2012. The Department has received positive feedback from providers who have worked with DentaQuest.

Table 1: Dentists Participating in DentaQuest[2]

Regions[1]	**HealthChoice**	**DentaQuest**		
	July 2008	**August 2009**	**July 2010**	**August 2011**
Baltimore Metro	401	242	344	410
Montgomery/ PG Counties	278	208	296	365
S. Maryland	28	29	39	51
W. Maryland	43	65	97	128
E. Shore	40	43	53	84
MD Bordering States	n/a	62	110	152
Unduplicated Total[3]	**743**	**649[4]**	**939**	**1,190**

[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 September 2011, there were a total of 4,162 dentists licensed and actively practicing in the State of Maryland, or 42 more dental providers than in 2009. Table 2 indicates as of September 2011 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 (September 2011)	Active General Dentists	Active Pediatric Dentists	Dentists Enrolled with DentaQuest as of August 2011 (Percentage of Total Active Dentists)**	Dentists Who Billed One or More Services in CY 2010 (Percentage of Total Active Dentists)	Dentists Who Billed $10,000+ in CY 2010 (Percentage of Total Active Dentists)
Baltimore Metro	1,838	1,477	64	410 (22.3%)	437 (23.8%)	317 (17.2%)
Montgomery/ Prince George's	1,669	1,319	56	365 (21.9%)	356 (21.3%)	274 (16.4%)
S. Maryland	140	120	2	51 (36.4%)	47 (33.6%)	26 (18.6%)
W. Maryland	292	229	10	128 (43.8%)	101 (34.6%)	75 (25.7%)
E. Shore	223	177	9	84 (37.2%)	69 (30.9%)	52 (23.3%)
Other				152	111 (N/A)	31 (N/A)
TOTAL	**4,162**	**3,322**	**141**	**1,190 (28.6%)**	**1,057 (25.4%)***	**765 (18.4%)***

* 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.
** The number of providers billing one or more services may be higher than the number currently participating with DentaQuest in some regions because of system differences. The availability of updated provider information in the DentaQuest file is not immediately available to the systems used to run this data.
[1] Baltimore Metro includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Western Maryland

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

In 2008, less than 19 percent of Maryland licensed active dentists were participating with Medicaid. As of August 2011, almost 29 percent of Maryland dentists were enrolled with Medicaid. A total of 1,057 dentists billed one or more Medicaid services and 765 dentists billed $10,000 or more to the Medicaid program in 2010. This represents 25.4 percent and 18.4 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 778 dentists in 2008 to 846 dentists in 2009 to 1,057 dentists in 2010. The number of dentists billing more than $10,000 to Medicaid increased from 479 in 2008 and 2009 to 765 in 2010. Pediatric dentists are rare in the State, accounting for only 3 percent of the total number of active dentists in Maryland (Table 2).

Addressing Dental Health Professional Shortage Areas (HPSAs)

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

As of September 2011, there were 16 Maryland jurisdictions served directly by local health department or school-based clinical dental programs. This includes two new counties (Kent and Queen Anne's) which had been identified in the past as having no dental public health services, 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 Local 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 Local Health Department subcontracts with an FQHC, Chase Brexton Health Services, for its clinical dental service program. In addition, four jurisdictions on the Eastern Shore without a local health department dental program are served by two FQHCs – Choptank Community Health Systems (Caroline, Talbot, and Dorchester) and Three Lower Counties (Somerset). Beginning in FY 2010, Calvert and Cecil Counties now provide clinical dental services to low-income patients through a non-profit community hospital and academic center, respectively. Jurisdictions that are 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 2011. 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	[3] On Site (2 sites)	Stanton Center	
Baltimore City	[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, 3] 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	[2,3] On Site (5 sites)	Community Clinics, Inc. (CCI)	
Prince George's	[3] 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 Does not currently treat Medicaid enrollees.
3 Multiple sites.
4 Maryland Community Health Resources Grant Program funded in FY 2010.
5 Partnership between Howard County Health Department and Chase Brexton.

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.[6] 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.[7]

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 (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 (Table 4a). In CY 2010, the percentage of all children in Medicaid receiving a dental service was 63.9 percent. As a comparison, the HEDIS 2010 (CY 2009) national average for Medicaid was 45.7 percent.[8] For a more detailed analysis, Attachment 3 shows child utilization data by age and region.

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

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

Year	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service	HEDIS National Medicaid Average**
FY 1997	88,638	17,637	19.9%	
CY 1999	122,756	31,742	25.9%	36.4%
CY 2000	132,399	38,056	28.7%	40.3%
CY 2001*	142,988	48,066	33.6%	37.4%
CY 2002	194,351	67,029	34.5%	39.0%
CY 2003	203,826	88,110	43.2%	39.4%
CY 2004	213,234	93,154	43.7%	42.7%
CY 2005	227,572	104,188	45.8%	41.0%
CY 2006	223,936	103,561	46.2%	42.5%
CY 2007	216,885	111,791	51.5%	43.5%
CY 2008	243,076	135,403	55.7%	44.2%
CY 2009	254,811	150,275	59.0%	45.7%

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

After the transition from HealthChoice MCO administration to DentaQuest in 2009, the Department changed its methodology for measuring the number of children receiving dental services. Since all children in Medicaid enroll in DentaQuest regardless of whether they are enrolled in a HealthChoice MCO or receive medical care under the Fee-For-Service (FFS) program, the new methodology (Table 4a) accounts for all children in the Medicaid program. For comparison purposes, the methodology includes children ages 4-20 years and those enrolled in Medicaid for at least 320 days for CYs 2005 - 2010.

Table 4a: 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%	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.

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 in the analysis includes children who were in a HealthChoice MCO or Medicaid for only a short period of time. Children may have had turnover in eligibility or enrollment or may have been new to the HealthChoice MCO or Medicaid and therefore there was not enough time to link the child to care. MCOs and ASOs have less opportunity to manage the care of these populations. Of the 602,761 children enrolled in Medicaid for any period of time during CY 2010, 46.8 percent of these children received one or more dental service, as compared to 43.8 percent in CY 2009. 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 (Table 5).

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

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

* 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 will analyze 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, the findings of the analysis indicate that access to any dental service, including restorative services, has increased from 19.9 percent in FY 1997 to 63.9 percent in CY 2010 (Table 4a). Access to restorative services increased from 6.6 percent of all children in FY 1997 to 25.0 percent in CY 2010 (Table 6). This increase in utilization is due in part to raising the fees for twelve restorative dental procedure codes (Attachment 1), and more recently, due to increased outreach efforts.

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

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

* 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 will analyze 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, 45.8 percent received a preventive or diagnostic visit in 2010, as compared to 42.7 percent of those enrolled in HealthChoice for any period in 2009 (Table 7). Of those receiving a preventive or diagnostic visit, 34.2 percent received a follow-up restorative visit.

Table 7: Preventive/Diagnostic Visits Followed by a Restorative Visit by Children Enrolled for Any Period (Ages 0-20), CY 2005 – CY 2010

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%)

* 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 will analyze 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 2010, 2,609 children with any period of enrollment in HealthChoice visited the emergency room with a dental diagnosis, not including accidents, injury or poison, which appears slightly more than in CYs 2005 – 2009; but the percentage of children relative to enrollees has decreased and is still less than 1 percent of the total Medicaid population (Table 8).

Table 8: Emergency Room Visits with a Dental Diagnosis by Children Enrolled for Any Period (Ages 0-20)*, CY 2005 - 2010

Year	Total Enrollees	Enrollees who had an ER Visit with a Dental Diagnosis	Number of Encounters for ER Visits with a Dental Diagnosis
CY 2005	483,304	1,685	1,872
CY 2006	491,646	1,809	2,117
CY 2007	493,375	2,005	2,283
CY 2008	505,339	2,175	2,596
CY 2009	540,179	2,412	2,927
CY 2010**	602,761	2,609	3,068

* 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 will analyze 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, adult dental care was not covered under Medicaid. 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 dentist 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 25.0 percent in CY 2010 (Table 9). The percentage of pregnant women 14 years and over enrolled for any period receiving a dental service in 2010 was 26.6 percent, as compared to 25.0 percent in 2009 (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%

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%

* In Tables 9 and 10, pregnant women were identified using the following methods: (1) enrollment in Medical Care Program coverage group P02 or P11 in the CY MMIS eligibility files, (2) pregnancy diagnoses codes, (3) kick payments for live births in the CY capitation rate dataset, (4) payment for an individual in a Sixth Omnibus Budget Reconciliation Act (SOBRA) rate cell for pregnant women, and (5) delivery CPT codes. This is a modification in methodology from previous reports to include more pregnant women enrolled in traditional Medicaid coverage groups, which was a necessary change due to variances in enrollment after the Parent Expansion (July 2008). Pregnant women who were 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 REM adults, 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, and $6.5 M on adult dental services in CY 2010.

As of July 2011, six of the seven HealthChoice MCOs provide limited dental services to non-pregnant adults (Table 11). An analysis shows that 14.9 percent of non-pregnant adults enrolled in a HealthChoice MCO for at least 90 days received at least one dental service in CY 2010 (Table 12).

Table 11: HealthChoice Dental Benefits for Non-Pregnant Adults as of July 2011	
MCO	**Dental Benefits Offered**
AMERIGROUP Community Care	Exam and cleaning 2 times a year (every 6 months), limited x-rays, 20% discount on non-covered dental services
Coventry	Exam and cleaning 2 times a year, unlimited fillings, unlimited simple and surgical extractions
Jai Medical Systems	Exam and cleaning 2 times a year (every 6 months); unlimited x-rays, fillings, and extractions
Maryland Physicians Care	Exam and cleaning 2 times a year (every 6 months); x-rays, unlimited fillings, and simple extractions
MedStar Family Choice	No adult dental benefits
Priority Partners	Exam and cleaning 2 times a year (every 6 months), limited x-rays and emergency extractions
UnitedHealthcare	Exam and cleaning 2 times a year, x-rays, and 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%

Strategies to Improve Access to Dental Care

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

providers of the benefits available to children. The letter provided information about covered services and clarified that the Department requires an oral health assessment by a physician or nurse practitioner as part of periodic well-child care.

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

In July 2009, DentaQuest began functioning as the Department's ASO for all dental services for children, pregnant women, and Rare and Expensive Case Management program adults. DentaQuest is responsible for all functions related to the delivery of dental services including provider network development and maintenance, claims processing, utilization review, authorization of services, outreach and education, and complaint resolution. During the first contract year, utilization rates and provider networks have increased. Also in July 2009, the Department began training and reimbursing primary care providers for the application of fluoride varnish for children up to three years of age. By August 31, 2011, 347 unique EPSDT certified providers administered over 38,000 fluoride varnish treatments. DentaQuest plans to assign all children to a dental home by CY 2012.

Funding

Dental funding for children and pregnant women has increased in recent years, from approximately $12 M in CY 2000 to $137.6 M for CY 2010 (Attachment 4). This growth in funding reflects increases in the Medicaid fee schedule for selected codes that were raised 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.

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

- 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.

Conclusion

Utilization of dental services by children has increased significantly from the implementation of HealthChoice; from 19.9 percent in 1997 to 63.9 percent in 2010. In 1999, utilization for children was ten percentage points below the national HEDIS average, and by 2010, utilization has increased to more than fifteen percentage points above the national HEDIS average. However, many children still are not receiving needed dental services and additional improvements are needed. 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 reforms recommended by the DAC have been supported and, to a great degree, instituted by the Department to effectively address the barriers to dental care access previously experienced in the State. Dental provider rates were increased in 2008, and the Department is committed to a second round of rate increases once the budget situation improves.

In conjunction with DentaQuest, the Department has reformed and rebranded the Medicaid dental program. The Maryland Healthy Smiles Program has attracted over 400

additional participating dentists since its start in 2009, and these providers will soon serve 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 August 2011, DentaQuest has enrolled 347 fluoride varnish providers in Maryland. The utilization rate of children ages 0 – 3 years has experienced a steady increase in CY 2009 and CY 2010 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 fourth "Access to Care Day" on September 22, 2011 as part of their annual organizational meeting with over 150 dentists and staff in attendance. As in past "Access to Care Day" events, representatives from DentaQuest were present at the meeting to enlist new dentists into the program. In addition, Dr. Laura Herrera, the Department's Chief Medical Officer, 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. Free continuing education credits and training in pediatric dentistry are provided to dentists and dental hygienists who attend this session. These annual programs have given dentists and their staff the opportunity to openly 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 work with the MDAC on recommended strategies to make access to dental care and a dental home a reality for all Maryland children.

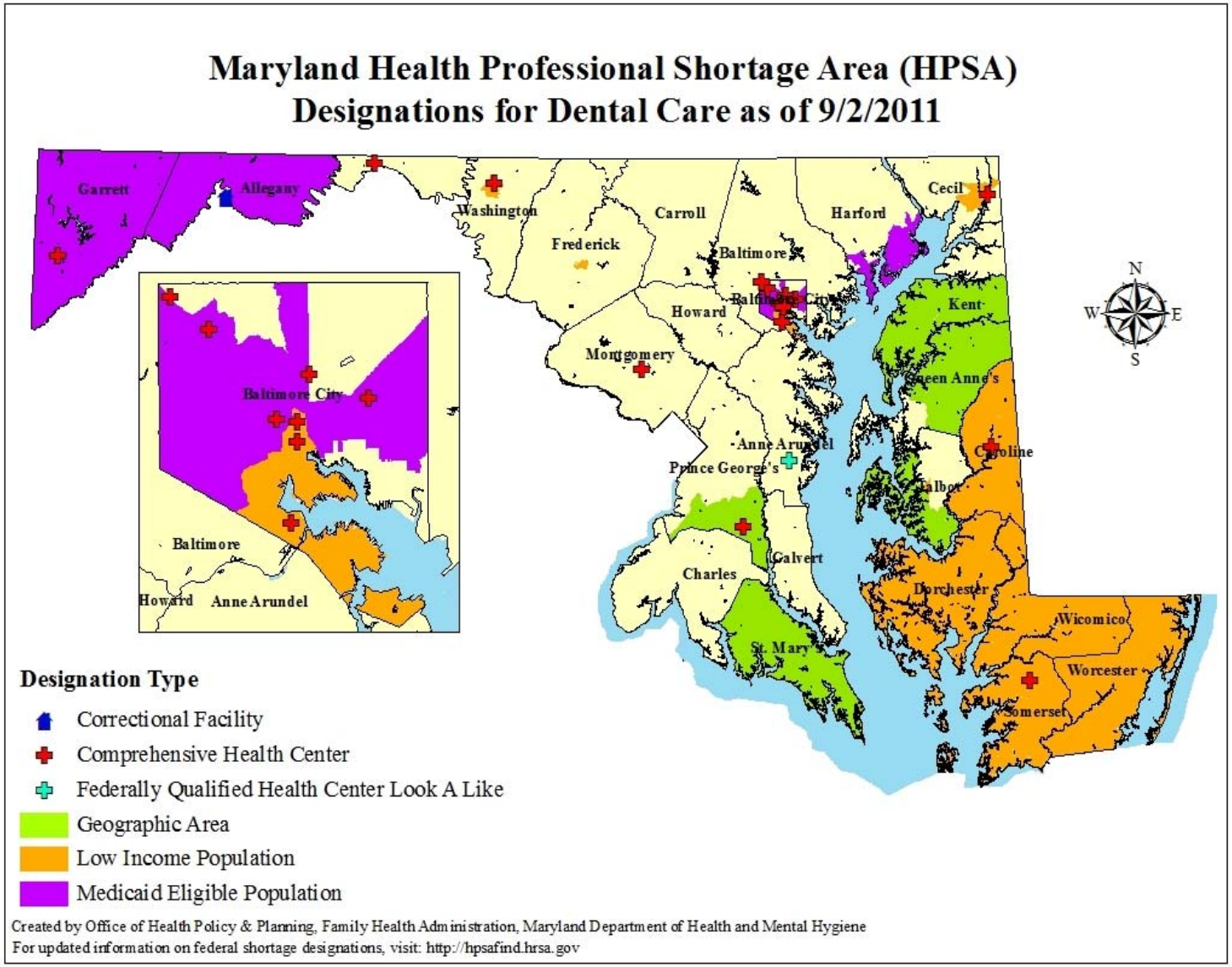
ATTACHMENT 1

Dental Procedures Targeted for Fee Increase in FY 2009

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

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

ATTACHMENT 2



ATTACHMENT 3

Dental Utilization Rates, CY 2000 - CY 2010
Enrollment ≥ 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*
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%
6-9	31.6%	37.2%	38.2%	48.0%	48.7%	51.1%	51.6%	57.6%	62.5%	65.6%	71.5%
10-14	29.2%	34.1%	35.5%	44.0%	44.8%	46.9%	47.5%	53.2%	57.2%	60.7%	66.4%
15-18	24.7%	29.4%	29.9%	38.0%	37.6%	39.7%	40.2%	44.3%	47.6%	51.2%	55.9%
19-20	17.8%	19.7%	20.8%	26.8%	26.8%	27.7%	26.9%	28.4%	33.2%	37.5%	38.6%
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%**
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%
Baltimore Suburbs	32.5%	35.4%	37.7%	46.1%	46.1%	47.0%	47.1%	51.4%	54.8%	56.7%	61.7%
Washington Suburbs	30.4%	35.9%	39.6%	47.8%	46.4%	50.2%	49.5%	54.8%	58.8%	62.1%	65.8%
Western Maryland	38.2%	46.0%	42.8%	51.0%	56.1%	56.4%	55.7%	59.3%	61.9%	64.1%	56.9%
Southern Maryland	26.5%	29.3%	31.8%	39.6%	39.5%	40.0%	43.3%	46.7%	52.2%	56.1%	66.6%
Eastern Shore	26.4%	32.6%	31.3%	44.4%	48.2%	49.2%	51.8%	55.7%	55.7%	59.4%	69.6%
All Regions	**28.7%**	**33.6%**	**34.5%**	**43.2%**	**43.7%**	**45.8%**	**46.2%**	**51.5%**	**55.7%**	**59.0%**	**63.9%**

* 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 will analyze 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

MCO and DentaQuest Funding and Expenditures for Dental Services, FY 1997 – CY 2010
Utilization of Dental Services in HealthChoice and DentaQuest, FY 1997-CY 2010

Year	Amount Paid in MCO Capitation Rates or DentaQuest for Dental	Amounts Spent by MCOs for Dental (Source: HFMR) (Includes Adult Dental)	Utilization Rate for General Access (Children 4-20 Years with 320 Days of Enrollment)	Utilization Rate for Restorative (Children 4-20 Years with 320 Days of Enrollment)
FY 1997	N/A	$2.7 M*	19.9%	6.6%
CY 2000	$12.3 M (est.)	$17 M (est.)	28.7%	9.3%
CY 2001	$27.1 M	$23.6 M	33.6%	10.8%
CY 2002	$40.3 M	$28.9 M	34.5%	10.3%
CY 2003	$33 M	$32.5 M	43.2%	13.6%
CY 2004	$28 M	$36.7 M	43.7%	13.8%
CY 2005	$33 M	$42.0 M	45.8%	15.8%
CY 2006	$35.1 M	$46.6 M	46.2%	16.4%
CY 2007	$42.5 M	$53.8 M	51.5%	19.3%
CY 2008	$55.4 M	$71.4 M	55.7%	21.3%
CY 2009**	$82.8 M	$39.3 M	59.0%	21.8%
CY 2010***	$137.6 M	$6.5 M	63.9%†	34.3%†

* 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. MCO capitation rates included dental services from January 1, 2009 – June 30, 2009, totaling $39.6 M. Under the new Maryland Healthy Smiles Program, dental expenses totaled $43.2 M 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 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 will analyze all children enrolled in Medicaid managed care and FFS programs, instead of children's managed care enrollment alone (e.g., FY 1997 – CY 2009).

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, HB 30/SB 181 (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 also has 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 is 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.

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. Dentists began performing dental examinations in the schools in late September 2011, and will continue through June 2012 when the academic year ends. This assessment consists of two components: an open-mouth dental examination of each participating child at the school, and a health questionnaire to be completed by the child's parents or guardians at home at the same time that they complete an active consent form. In the dental examination component of the survey, oral health status information will be collected, 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 will enable 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. When all school visits have been completed, the data will be analyzed, and a report of the study's results disseminated to stakeholders and made available on the Office of Oral Health's website. It is anticipated that the entire project, including study preparation and planning, data collection, analysis, and report generation, will be completed in mid-2013.

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. An overarching DAC recommendation was to maintain and enhance the dental public health infrastructure through the Department's Office of Oral Health by ensuring that residents in each local jurisdiction have access to a local health department dental clinic and/or other community oral health safety net clinic. In order for this to occur, funding to fulfill the requirements outlined in the Oral Health Safety Net statute would need to be provided.

In light of the DAC's recommendation to the Secretary of the Department that the dental public health infrastructure needed strengthening, the Governor's FY 2011 budget for the Department's Family Health 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, other funds continue to be used to provide new 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).

One of the current Office of Oral Health operational grants projects, a new Worcester County Health Department dental clinic, was initiated as a result of a capital infrastructure grant program issued in 2008 in partnership with the Office of Capital Planning, Budgeting and Engineering Services to acquire, design, construct, renovate,

convert, and equip a dental program facility. The Worcester County Health Department dental clinic opened in April 2011 and began providing clinical dental services for low-income county residents. In FY 2011, the Office of Oral Health continued to provide operational funds for local health department clinical dental programs in Harford and Charles Counties, both of which it had supported with capital infrastructure funding in the past.

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

In FY 2011, 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 three 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 programs address the unique needs of local populations, and provide evidence-based and appropriate educational, diagnostic, preventive, restorative, and emergency care.

- Calvert County: Since its inception in September 2009, Calvert Memorial Hospital's project has provided direct services to Medicaid and other low-income children in Calvert County. This project has recruited two dental teams, 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 individuals who live in these communities, the dental teams perform dental care services in two local private dental offices through prior arrangements with the office owners.

- 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. Patients requiring intensive oral health treatment have been linked with community dentists or dental programs to ensure dental homes.

- Worcester County: The opening of this project was postponed from April 2010 to April 2011 because of capital infrastructure construction delays. Now open, the Worcester County Local Health Department program provides 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 at schools and Head Start programs. The Office of Oral Health will need 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 initially identified 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 Local Health Department whereby the health department acts as an intermediary between Medicaid and local dental providers. This arrangement has led to their enlisting the majority of dentists practicing in this jurisdiction to be Medicaid providers, and in serving as an entry point to these dentists for Medicaid patients. Due to the long-term success of this program, it was determined that financial support for this program of the type given to other "in-need" counties was not necessary.

Support to Established Clinical Dental Programs to Expand Oral Health Services

The following counties receive funds annually 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 Local Health Department funds a dentist to provide support for pediatric dental services for Medicaid and other low-income Carroll County children.
- Charles County: Charles County Local Health Department initiated provision of adult dental services for low-income Charles County adults and seniors by supporting the cost of a dentist.
- Howard County: Howard County Local Health Department began providing pediatric dental services for Medicaid and other low-income Howard County

- Prince George's County: Prince George's County Local Health Department initiated provision of pediatric dental services for Medicaid and other low-income Prince George's County children by supporting a dentist.
- Worcester County: Worcester County Local Health Department, in conjunction with funding for addressing immediate service needs, provides support for preventive dental services for Medicaid and other low-income Worcester County children through an expansion of the fluoride varnish program, education of medical providers about fluoride varnish, and provision of oral health services for children.

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

New and established school-based funding initiatives from the Office of Oral Health are ongoing. 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 four school-based oral health models:

- Deamonte Driver Mobile Dental Van Project: The Prince George's County Local Health Department partnered with the Robert T. Freeman Dental Society Foundation to use a mobile dental van 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 to 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, called the *Deamonte Driver Dental Van Project,* provides diagnostic, preventive, and simple restorative dental services to low-income students in one Montgomery County School, and in 19 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 2010-2011 school year, 2,993 children were seen, of which 367 needed immediate or urgent care and were referred to neighborhood dental clinics.
- School-based Dental Sealant Demonstration Project: 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. In addition, CDC funds allowed for the recruitment of a School-Based Dental Sealant Coordinator as of 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. This demonstration project places a special emphasis on dental sealants for vulnerable populations.

- School-Based Dental Prevention Services: Grants were awarded to Baltimore, Caroline, Cecil, Garrett, Somerset, and St. Mary's Counties, and Baltimore City for expansion of critically needed preventive dental sealant and fluoride application programs. Initiatives target children in Title I schools (i.e., schools that typically have 40 percent or more of their population enrolled in free and reduced meal programs to provide preventive dental sealant and fluoride application services to inhibit the onset of dental decay in these high-risk, low-income students).

- School-Based Oral Health Access Programs: Local Health Departments in Kent and Queen Anne's Counties have developed school-based dental access points and assessment/prevention services. The project includes school-wide oral health education to Medicaid-enrolled and uninsured students on location at 11 schools in Kent and Queen Anne's Counties using a mobile dental team comprised of a dental hygienist and dental assistant. Selected patients 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 Maryland Community Health Resources Commission (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 MCHRC has awarded 17 dental services grants totaling $4.4 M. 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 approximately 33,250 low-income children and adults, resulting in 76,159 visits.

The MCHRC seeks to support and prioritizes programs that will be sustainable after MCHRC grant funds have been expended. MCHRC dental grantees have leveraged their grant resources to secure more than $2.9 M in additional federal, local, private, and other resources to maintain programs in their underserved communities.

The MCHRC has included expanding access to dental services for children in its FY 2012 RFPs, and grant awards are anticipated to be announced by December 2011. The following is an update on the most recent MCHRC dental grants made in FY 2011.

- **Choptank Community Health System,** an FQHC centrally located in Caroline County, was awarded a two-year grant ($270,000) to provide access to dental services in nearby Kent County, a Medically Underserved Area (MUA). The grant supports a partnership with the Chester River Hospital Center to provide pediatric dental surgery services, and has served 60 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) to expand its dental capacity at its free clinic (which is currently staffed by dental volunteers), and expand its existing school-based dental program. In the program's first six months, Health Partners far exceeded its projected number of patients, serving 327 adults and children, which is triple its expected patient volume, and has indicated that its transportable dental unit is developing a replicable model of identifying high-risk children in public schools.

- **Access Carroll**, a non-profit organization in Carroll County, was awarded a two-year grant ($300,000) to create a new dental facility that will be integrated with Access Carroll's current medical services. Additionally, Access Carroll is helping to support 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 50 uninsured patients in the first year of the program.

Pediatric Dental Fellows

The Pediatric Dental Fellows Program has placed trained dentists in the community (local health departments, FQHCs, and community health centers) to provide comprehensive oral health services to Medicaid recipients. These dental fellows are specially trained to provide care to children under five years of age. Some of the dental fellows also provide operating room care. Ongoing recruitment difficulties, however, threaten to eliminate the number of pediatric dental fellows able to be placed in the future. Despite these challenges, there are still plans to place one pediatric dental fellow at the Choptank Community Health Systems, Inc. dental program in Caroline County sometime in CY 2011. In addition, three pediatric dental fellows who have successfully completed the program continue to provide dental care services to Medicaid patients in

FQHCs in Montgomery, Somerset, and Washington Counties. One of the fellows is the dental director of his respective clinical dental program.

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.

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 2010, a total of 15 dentists participated in the program; five of these dentists completed their three-year service obligation in December 2010. 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 2011, five new MDC-LARP dentists started the program and will continue through December 2013. During CY 2010, MDC-LARP dentists treated 14,100 non-duplicated patients and had 35,249 dental visits by Medicaid recipients. Since the inception of the program in 2001, MDC-LARP dentists have seen 68,816 non-duplicated patients through 172,041 patient visits.

Part 3. Oral Cancer Initiative

Background

Senate Bill 791 and House Bill 1184 enacted during the 2000 legislative session 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 targeting the needs of 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 the oral cancer screening training needs among health care providers. Since 2000 when funds were made available for the Initiative, 19,986 people have been screened for oral cancer, and 4,090 health care providers have received oral cancer prevention and early detection education through Office of Oral Health grants to local health departments across the State.

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

During this same time period, the Maryland General Assembly created the Cigarette Restitution Fund Program (CRFP) (2000), providing funds for cancer prevention, education, screening, and treatment for the seven targeted cancers, which include oral cancer. Some local jurisdictions have opted to provide oral cancer screening and/or education to residents. To date, 6,833 individuals have been screened for oral cancer, and 11,513 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 to provide 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, CRFP cancer research funds provided to Johns Hopkins University and the University of Maryland have been used to conduct oral cancer research.

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

Oral Cancer – Incidence and Mortality Rates

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

The annual age-adjusted incidence rate for oral cancers remains significantly higher in Maryland than the national average; it increased slightly from 1999-2003 because of a 3.2 percent annual increase in rates among white men (Surveillance

Epidemiological End Results (SEER)), National Cancer Institute). However, a slight decrease in oral cancer incidence was seen during this same period for African-American men and women. 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.

Progress continues in improving the rate of Maryland residents receiving annual oral cancer examinations since the initial survey in 1996. In the 2008 Maryland Cancer Survey, 40 percent of Marylanders 40 years and over reported that they had received an oral cancer examination in the past year, and 50 percent of adults age 40 years and over reported that they received an oral cancer examination at least once in their lifetime. Despite this progress, there remains considerable room for improvement with respect to the proportion of Marylanders who receive oral cancer examinations. Only 73 percent of Marylanders age 40 years and over reported that they had a dental visit of any type in the past year[9]. Additional progress in this area is especially needed for African-Americans in Maryland, because only 23 percent of those age 40 years and over reported having an oral cancer examination in the past year. Nevertheless, these oral cancer examination rates surpass the goal of the Healthy People 2010 target of 20 percent[10].

Current Status

In July 2010, the Department awarded grant money to local health departments to implement oral cancer prevention initiatives. County initiatives include providing oral cancer education and oral cancer screenings for the public and education and training of health care providers on the correct method for conducting an oral cancer exam.

In FY 2011, there were 4,732 individuals screened for oral cancer. Of those screened, 20 were referred to a surgeon for biopsy. There were also 2,464 individuals educated on oral cancer, and 419 healthcare providers who received education on oral cancer.

The 11th annual Maryland Oral Cancer Awareness Week (OCAW) was held April 11-15, 2011. The Office of Oral Health provided updated information to county coordinators, including prevention materials, scripts for public service announcements, and articles for local newspapers. During this week, the Office of Oral Health had a display in the lobby of Department headquarters at 201 West Preston Street 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.

The Office of Oral Health was a sponsor of the 2nd Baltimore Oral Cancer Walk at Druid Hill Park in Baltimore on April 9, 2011. As a sponsor, the Office of Oral Health had a display board at the event and distributed oral cancer brochures to participants. Lip

[9] 2008 Maryland Cancer Survey, Maryland Department of Health and Mental Hygiene.
[10] Healthy People 2010, accessed July 27, 2009

balm, oral cancer awareness ribbons, and Office of Oral Health pens were also distributed. Information about the walk can be found at: http://www.baltimoreoralcancerwalk.com/

This year, Oral Cancer Awareness Week packets that included extra health education materials were sent to every Local Health Department Tobacco Prevention Coordinator, Cancer Prevention Coordinator, and Oral Health Program Coordinator. Further, dentists in the MDC-LARP also received the OCAW packet. Items contained in the OCAW packets included: oral cancer awareness ribbons; a color poster; brochures from the Office of Oral Health on oral cancer, from the Maryland Tobacco Quitline, and from the National Institute of Dental and Craniofacial Research (NIDCR) entitled 'What African-American Men Need to Know;' a brochure from the NIDCR, entitled 'Detecting Oral Cancer - A Guide for Health Care Professionals,' which opens up to a large poster showing how to conduct an oral cancer exam and what suspicious oral lesions look like; and additional oral health-related items such as a press release, two radio public service announcement (PSA) scripts, a proclamation, two editorials, a bulletin board for local-use, and a listing of internet resources.

In addition, the Office of Oral Health and the Maryland Tobacco Quitline partnered to support the link between cessation programs and the reduction of oral cancer during Oral Cancer Awareness Week. This partnership began with the awareness week but remains strong over time. Brochures for the Office of Oral Health and the Maryland Tobacco Quitline are now distributed together.

Conclusion and Future Initiatives

The Office of Oral Health will continue local health department funding to implement the oral cancer prevention program. Furthermore, the Office will work with local health departments to identify model programs and best practices. The 12th annual Maryland Oral Cancer Awareness Week will be held April 22-28, 2012.

Maryland has been 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, the Centers for Medicare and Medicaid Services (CMS) has recommended Maryland's dental strategies as a model for other states struggling with poor oral health outcomes. 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." 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.

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 newly formulated 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. Expansion of dental service providers, education and outreach, and oral health literacy for the public as well as funding support for the Oral Cancer Initiative will be continually addressed.