



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

October 9, 2008

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

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

**RE: SB 590 (Ch. 113 of the Acts of 1998) – Annual Report on Access
to Dental Services in the HealthChoice Program**

Dear President Miller and Speaker Busch:

Enclosed please find the Department of Health and Mental Hygiene's ninth annual report to the General Assembly on dental care access in the HealthChoice program. This report is required by SB 590 (Ch. 113 of the Acts of 1998).

If you have questions or need more information, please do not hesitate to contact Anne Hubbard, Director of Governmental Affairs, at (410) 767-6481.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: John Folkemer
Susan Tucker
Tricia Roddy
Anne Hubbard
Sarah Albert, MSAR# 95

**Annual Report to the General Assembly
As Required by SB 590 from the 1998 Legislative Session
Dental Care Access under HealthChoice
October 2008**

Background

The Maryland Department of Health and Mental Hygiene's (DHMH) Medical Assistance (Medicaid) program delivered oral health services to approximately 186,000 children and adult enrollees during 2007. Despite significant improvement under HealthChoice, the amount of oral health services utilized by enrollees of the Medicaid managed care program remains unacceptably low. Like many other states, Maryland continues to face numerous barriers to providing comprehensive oral health services to Medicaid enrollees. Barriers include low provider participation due, among other things, to low reimbursement rates, missed appointments, and a lack of awareness among enrollees about the benefits of basic oral health care. As Medicaid's population continues to increase each year, these barriers remain as significant impediments to increased access to dental services.

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

Senate Bill 590

Senate Bill 590 was passed during the 1998 legislative session and became effective October 1998. It establishes the Office of Oral Health within Public Health's Family Health Administration and requires that the Medicaid program offer oral health services to pregnant women enrolled in Medicaid managed care organizations (MCOs). It established a five-year oral health care plan that set utilization targets for MCOs. The base for these targets is the rate of service use of children under age 21 in 1997, which was 19.9%¹. The first year of the five-year

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

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

Senate Bill 590 also requires that DHMH submit an annual report addressing:

1. The availability and accessibility of dentists throughout the State that participate in the Maryland Medical Assistance program;
2. The outcomes achieved by MCOs and dental managed care organizations in reaching the utilization targets; and,
3. The allocation and use of dental funding.

This report provides an overview of the DAC's recommendations and the resulting implementation efforts of the Department. It also addresses the issues identified in Senate Bill 590. Finally, this report details the Office of Oral Health's efforts to increase access to oral health care and the Department's current five-year oral health plan.

Action Plan for Increasing Utilization of Dental Services

In CY 2003, in compliance with Senate Bill 590, the Department developed a five-year oral health plan with the Oral Health Advisory Committee, i.e., CY 2004 to 2008 (Attachment 2). This oral health plan outlines issues facing Maryland and proposes strategies and potential partners to address these issues. The four pillars included in the plan are: (1) Improving Access to Oral Health Services and Improving Dental Public Health Capacity; (2) Oral Health Policy Analysis and Development - Local and State Level; (3) Oral Health Education for Patients, Dentists and Others; and, (4) Establishing Linkages and Ensuring Coordination on Oral Health. The goal of this plan is to ensure that Maryland's children receive dental care. The current plan will expire this year, and the Office of Oral Health will create a new five-year plan for CYs 2009 to 2013.

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

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

1. The Department issued a Request for Proposals (RFP) in July 2008 for a single statewide dental vendor, an administrative services organization (ASO), and plans to

- award a contract by March 2009. The anticipated start date is July 2009. Bid applications were received September 2008, and are currently under review.
2. The Governor's FY 2009 budget includes \$7 million in general funds (\$14 million total funds) to increase targeted dental rates to the ADA 50th percentile for the South Atlantic region starting in July 2008 (see Attachment 1 for a list of dental codes and rates).
 3. The Governor's FY 2009 budget includes \$2.1 million for new or expanded dental public health services, which includes school health initiatives such as a dental mobile van. In July 2008, the Office of Oral Health issued two RFPs totaling \$1 million, one for dental services and the other for capital infrastructure. Over \$4 million in grant application requests were received. In August 2008, the Office of Oral Health awarded a capital grant award to the Worcester County Health Department and three operational grant awards to Kent and Queen Anne's County Health Departments, Worcester County Health Department, and Calvert Memorial Hospital. All awardees are located in jurisdictions identified by the Maryland General Assembly as areas in need of dental services.
 4. During the 2008 Session, the General Assembly passed legislation expanding the role of dental hygienists (HB 1280 / SB 818). This legislation enables dental hygienists working for public health agencies to more efficiently and expeditiously provide services within the scope of their practice in offsite settings (e.g., schools and Head Start centers). The legislation makes clear that a dentist does not have to be on the premises or see the patient before services are rendered.
 5. General dentists have received training in didactic and clinical pediatric dentistry so that they may competently treat young children. In April 2008, over 150 general dentists received this training through a multi-week course developed and presented by the University of Maryland Dental School.
 6. A subcommittee of the DAC is working to develop a program whereby dental screenings are incorporated with vision and hearing screenings for public school children. The target date for legislation and eventual enactment of this program is 2010.
 7. A subcommittee of the DAC is working to develop a marketing campaign aimed at both the public and health care professionals. The Department is currently seeking federal funding for this initiative.

Availability and Accessibility of Dentists

HealthChoice

HealthChoice is the current service delivery system for most children and non-elderly adults enrolled in Medicaid and the Maryland Children's Health Program (MCHP). HealthChoice MCOs are required to offer comprehensive oral health services including preventive care to children through 20 years of age and to pregnant women. While adult dental services are not a required benefit and are not funded by the Department, all seven HealthChoice MCOs offer basic oral health services to adults. The dental benefits offered to adults typically include cleanings, fillings, and extractions.

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

As of July 2008, there were approximately 743 dentists enrolled as providers in the HealthChoice program (listed in the HealthChoice provider directories). The number of dentists listed as providers decreased mainly due to the Department’s request for MCOs to update their provider directories in January 2008. The 2008 count more accurately represents the active number of participating dentists as compared to last year (Table 1). The overall statewide ratio of dentists (listed in HealthChoice provider directories) to HealthChoice enrollees under age 21 was 1:562 in June 2008, 1:410 in June 2007, and 1:439 in June 2006.

Table 1: Dentists Participating in HealthChoice

Region¹	Dentists Listed in HealthChoice Provider Directories²		
	July 2006	July 2007	July 2008
Baltimore Metro	453	497	401
Montgomery/ PG Counties	360	356	278
S. Maryland	39	40	28
W. Maryland	55	57	43
E. Shore	45	50	40
Unduplicated Total³	918	964	743

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

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

³ The unduplicated total is different than the total in each geographic region because it is possible for a dentist to have multiple sites.

According to the Maryland State Board of Dental Examiners, as of July 2007, there are a total of 4,033 dentists licensed and actively practicing in Maryland. The table below shows how many pediatric and general dentists are practicing in the State as of July 2007, and indicates how many dentists participate with HealthChoice, as of July 2008. In the two far right columns in Table 2 below, the number of dentists billing includes two "dummy" provider numbers that can be used by MCOs when submitting copies of their claims data to the Department if a dentist does not have a Medicaid provider number. These two provider numbers rendered a significant number of dental services, as multiple dental providers used these two “dummy” numbers. Further, clinics with multiple dentists are only counted once. The total of these two columns, therefore, undercounts the total number of providers.

Table 2: Active Dentists and Dentists Participating in HealthChoice

REGION¹	Total Active Dentists	Active General Dentists	Active Pediatric Dentists	Dentists Listed in HealthChoice Directory² as of July 2008 (% of Total Active Dentists)	Dentists Billing One or More Services to HealthChoice in CY 2007 (% of Total Active Dentists)	Dentists Billing \$10,000+ to HealthChoice in CY 2007 (% of Total Active Dentists)
Baltimore Metro	1,780	1,403	56	401 (22.5%)	268 (15.1%)	163 (9.2%)
Montgomery/Prince George's	1,619	1,294	47	278 (17.2%)	220 (13.6%)	125 (7.7%)
S. Maryland	158	129	5	28 (17.7%)	25 (15.8%)	13 (8.2%)
W. Maryland	262	207	6	43 (16.4%)	40 (15.3%)	27 (10.3%)
E. Shore	214	173	4	40 (18.7%)	47 (22.0%)	27 (12.6%)
Other					71 (N/A)	9 (N/A)
TOTAL	4,033	3,206	118	743 (18.4%)	671 (16.6%)	364 (9.0%)

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

² Includes Dentists listed in the HealthChoice directory as of July 2008. The total is different than the total in each geographic region because it is possible for a dentist to have multiple sites.

A total of 671 dentists billed one or more service to HealthChoice and approximately 364 dentists billed \$10,000 or more to the HealthChoice program in 2007. This represents 16.6% and 9.0% respectively, of the total active, licensed dentists in the State. Within Maryland, several areas have been designated as a Dental Health Professional Shortage Areas (HSPA). Regions designated as HPSAs are portions of the Eastern Shore, Western Maryland, Southern Maryland and Baltimore City (Attachment 3). Pediatric dentists are rare in the State and account for only 3% of the total number of active dentists in Maryland (Table 2).

Based on a recommendation by the DAC, the Department issued a Request for Proposals for a single statewide dental vendor, an ASO, to increase the dental provider network and improve overall access to dental services. Providers will be able to participate with Medicaid through a single point of contact. The ASO will handle credentialing, billing, and any other provider issues, which will streamline the process for providers. Unlike the HealthChoice MCOs, the ASO will be paid on a fee-for-service basis rather than on a capitated basis. Vendor proposals were submitted in September 2008, and the Department intends to award the contract by March 2009. The new ASO is scheduled to begin operating July 2009.

In certain regions, dental services are also provided through community clinics, which are known as Federally Qualified Health Centers (FQHC), and/or the local health departments. Table 3 provides an overview of available local health department and community providers as of July 2008. It is important to note that most but not all of these community clinic providers have contracts with MCOs, and they offer varying levels of oral health services. All community health centers listed may not currently provide full dental services. As of July 2007, 13 local

health departments were providing dental services, and there were 15 FQHC HRSA-approved sites in Maryland.

Table 3: Community Clinic Dental Providers¹

County	Local Health Department Clinic	Community Health Centers	Dental School/Other
Allegany	On Site	None	
Anne Arundel	³ On Site	Stanton Center	
Baltimore City	³ On Site	So. Baltimore, Total Health, Chase Brexton, Parkwest, People's Comm., BMS, Healthcare for the Homeless	University of Maryland Dental School
Baltimore County	^{2,3} On Site	Chase Brexton	
Calvert	None	None	In Development – Calvert Memorial Hospital
Caroline	None	Choptank	
Carroll	On Site	None	
Cecil	None	None	In Development – University of Maryland Dental School
Charles	On Site	Nanjemoy	
Dorchester	None	Choptank	
Frederick	On Site	None	
Garrett	On Site	None	
Harford	On Site	None	
Howard	⁴ On-Site (thru 12/08)	⁴ Chase Brexton (as of 1/09)	
Kent	In Development	In Development – Choptank	
Montgomery	^{2,3} On Site	None	
Pr. George's	³ On Site	Greater Baden	
Queen Anne's	In Development	None	
Somerset	None	Three Lower Counties	
St. Mary's	None	None	
Talbot	None	Choptank	
Washington	On Site	Walnut Street	
Wicomico	On Site	None	
Worcester	In Development	None	

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

HealthChoice Dental Utilization Rates

Children

Dental care is a mandated health benefit for children through age 20 under EPSDT requirements. However, utilization of dental services has been low for a number of years. Prior

to implementation of the HealthChoice managed care program in 1997, 14% of all children enrolled in Medicaid for any period of time received at least one dental service. This number was below the national average of 21%.² The General Assembly passed Senate Bill 590, establishing targets for utilization of dental services by children enrolled in HealthChoice to reach 70% within five years, beginning with 30% in Year 1. For performance measurement and comparison, CY 2000 was established as Year 1 of the five-year oral health plan developed by the Department. The Department worked with the Oral Health Advisory Committee and the MCOs to assess the HealthChoice program's progress in expanding access to dental services for children.

MCO Plan Performance

In an effort to assess the performance of individual HealthChoice MCOs, the Department uses a measure closely modeled on the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) measure for Medicaid children's dental services utilization. The counted number of individuals is based on two criteria: 1) an age range from 4 through 21 years and 2) enrollment of 320 days. The Department modified its ages to reflect 4 through 20 years because the Maryland Medicaid program only requires dental coverage through age 20. Since the inception of HealthChoice, the percent of children receiving dental services increased from 19.9% in 1997 to 51.5% in 2007, a steady increase over the past decade (Table 4 below). As a comparison, the HEDIS national average for Medicaid was 42.5% in CY 2007.³ Attachment 4 shows utilization data by age and region.

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

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
FY 1997	88,638	17,637	19.9%
CY 1999	122,756	31,742	25.9%
CY 2000	132,399	38,056	28.7%
CY 2001*	142,988	48,066	33.6%
CY 2002	194,351	67,029	34.5%
CY 2003	203,826	88,110	43.2%
CY 2004	213,234	93,154	43.7%
CY 2005	227,572	104,188	45.8%
CY 2006	223,936	103,561	46.2%
CY 2007	216,885	111,791	51.5%

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

² Academy of Pediatrics State Medicaid Report for Federal FY 1996 - Analysis of HCFA National Data for Medicaid Children's Dental Services Utilization.

³ National Committee for Quality Assurance.

Beginning last year, the Department also reported utilization rates of children with any period of enrollment. Utilization rates are lower when analyzed for any period of enrollment. This is because the population in the analysis includes children who 1) are in the MCO for only a short period of time due to turnover in eligibility or enrollment, and 2) are new to the MCO, and the MCO has not yet had a chance to link the child to care. MCOs have less opportunity to manage the care of these populations. Of the 493,375 children enrolled in HealthChoice for any period of time during CY 2007, 32.9% of these children received one or more dental service, which is slightly higher than the percentage of children receiving a dental service in CY 2006 (Table 5).

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

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

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

Type of Dental Services

In response to the concern that while access to dental care may have increased, the level of restorative services or treatment may not be adequate, the Department began to more fully examine the types of dental services that children in HealthChoice receive. Beginning February 2002, in collaboration with the University of Maryland Baltimore Dental School, the Department examined children's access to different types of services, including diagnostic, preventive and restorative. Diagnostic services include evaluation services and oral exams; preventive care includes cleanings, sealants, x-rays, and fluoride treatments; and restorative care includes fillings and crowns.

The findings of the analysis indicate that access to any dental service, as well as access to restorative services, has significantly improved since 1997. Access to any dental service increased from 19.9% in FY 1997 to 51.5% in CY 2007 (Table 4) and access to restorative services increased from 6.6% of all children receiving a restorative service in FY 1997 to 19.3% in CY 2007 (Table 6). This increase in utilization is due in part to raising the fees for twelve restorative dental procedure codes in 2004 (Attachment 5).

**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%

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

As noted above, utilization rates are lower when analyzed for any period of enrollment versus a period of continuous enrollment. This is because MCOs have less opportunity to manage the care of these populations. For those children enrolled for any period, 31.6% received a preventive or diagnostic visit in 2007 (Table 7). Of those receiving a preventive or diagnostic visit, 28.5% received a follow-up restorative visit. The CY 2007 rates are slightly better than the rates in CY 2006 and CY 2005.

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

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

Although there has been a modest utilization increase in restorative visits since the implementation of the 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 2007, 2,005 children with any period of enrollment visited the emergency room with a dental diagnosis, not including accidents, injury or poison, which is slightly higher than in CY 2006 and CY 2005 (Table 8).

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

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

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

Pregnant Women

Prior to the implementation of HealthChoice in 1997, adult dental care was not covered under Medicaid. Senate Bill 590 required that HealthChoice cover dental services for all pregnant women. The proportion of pregnant women 21 and over enrolled for at least 90 days receiving dental services was 18.0% in CY 2007 (Table 9). The percentage of pregnant women 14 and over enrolled for any period receiving a dental service in 2007 was 15.7% (Table 10). There is no comparable HEDIS measure for dental services for pregnant women.

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

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

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

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

Adults

Apart from those dental services covered for pregnant women, adult dental services are not included in the MCO capitation rates and therefore, are not required to be covered under HealthChoice. In CY 2006, all seven MCOs provided a limited adult dental benefit and spent approximately \$4.3 million for these services, which is not included in the capitation rate paid by the State to the MCOs. An analysis shows that 13.2% of adults enrolled for at least 90 days received at least one dental service in CY 2007, with an estimated cost of \$5 million. As of September 2008, all seven MCOs continue to provide an adult dental benefit. This additional dental benefit provided by the MCOs will likely not be provided by the MCOs once the State carves dental services out of the HealthChoice MCO service package and provides dental services through a statewide ASO vendor.

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

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

Strategies to Improve Access to Dental Care

The Department monitors the number and percentage of oral health services provided by HealthChoice MCOs on a biannual basis using encounter data. DHMH holds MCOs accountable for not meeting established dental utilization targets through the use of sanctions. The Department has taken additional steps to collaborate with MCOs to improve access to dental care. Beginning in 2007, the Department requires MCOs to inform the Department of the number of dental appointments they are scheduling for their members weekly. The Department has also provides each MCO with a list of children who have been without a dental service for a significant period of time and requires the MCOs to actively seek dental appointments and report progress to the Department.

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

MCOs' outreach plans present the MCOs' strategies for meeting yearly utilization targets and for assuring adequate accessibility to providers. The Department reviews each MCO's outreach plan. Based on the MCO's progress and their outreach plan, Departmental staff may suggest additional outreach strategies or practices that have been known to be successful for other MCOs. Examples of enrollee outreach strategies include:

- Mailings to members about dental care, e.g., postcards, letters, or newsletters.
- Developing incentive programs designed to induce members to seek oral health care, including offering gift certificates for completed dental appointments and providing members with dental supplies.
- Providing dental education awareness programs in schools in collaboration with sealant and/or follow-up initiatives.
- Developing programs that combine intense case management and outreach, for example, encouraging local health departments to work with dentists to ensure access.

Funding

HealthChoice dental funding for children and pregnant women has increased in recent years, from approximately \$12 million in CY 2000 to \$48.6 million for CY 2008 (Attachment 6). This increase reflects increases in the Medical Assistance fee schedule for selected codes to be raised to 50th percentile of the South Atlantic ADA charges for dental services. It also anticipates increased utilization due to improved outreach activities.

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

- For CY 2004, the Department allowed sufficient funding for 40% utilization. The rates were based on actual MCO expenditures for dental services in 2001, with an allowance for assumed utilization growth and inflation. This is consistent with the methodology used for setting rates for other MCO services.
- For CY 2005 and CY 2006, the Department used a similar methodology as for CY 2004. The rates were based on actual expenditures trended forward and accounting for the increased fees for the twelve restorative procedure codes.
- In CY 2005, the MCOs received \$33 million in dental capitation payments, but using a fee-for-service reimbursement rate estimate, the MCOs spent approximately \$37 million for children and pregnant women, and an additional \$2.3 million for adult dental services.
- In CY 2006, the MCOs received \$35.1 million in dental capitation payments for children and pregnant women, but reported spending \$46.6 million, including adult dental services.
- In CY 2007, MCOs received \$42.5 million in dental capitation payments for children and pregnant women in response to increased utilization in CY 2006. The MCOs reported spending \$53.8 million, including adult dental services.

- In CY 2008, MCOs will receive \$48.6 million in dental capitation payments for children and pregnant women due to increased utilization. In CY 2009, MCOs will be responsible for dental services for children and pregnant women and receive capitation payments for the first half of the year, and beginning in July 2009, the statewide dental ASO will pay dental claims on a fee-for-service basis.

Statewide Dental Initiatives

Public Health Infrastructure

The Dental Action Committee (DAC) made several recommendations to the Secretary of DHMH concerning strengthening the dental public health infrastructure. The 2008 Maryland General Assembly approved the Governor's FY 2009 budget, which included \$2.1 million to support many of the requirements listed in the 2007 Oral Health Safety Net legislation, which strives to improve the dental public health infrastructure in Maryland.

The Office of Oral Health released two RFPs in July 2008 totaling \$1 million. The requests were for grant proposals for: 1) new or expanded dental operational services (\$500,000) and; 2) new or expanded dental capital infrastructure projects (\$500,000). These grant funds were targeted to jurisdictions identified by the Maryland General Assembly as in need of dental services and currently not served by a public health dental clinical program (Worcester, Kent, Queen Anne's, St. Mary's, and Calvert Counties). In response to the dental capital infrastructure RFP, the Office of Oral Health and Office of Capital Planning, Budgeting and Engineering Services received four grant proposals totaling approximately \$1 million in grant requests. In response to the operational dental services program, the Office of Oral Health received 14 grant proposals that totaled over \$3 million in grant requests. This level of demand demonstrates the need for increased funding for these oral health grant programs. The recipient of the dental capital infrastructure grant was the Worcester County Health Department, and the recipients of the dental operational grants were the Worcester County Health Department, Calvert Memorial Hospital, and a partnership of the Kent and Queen Anne's County Health Departments.

The Office of Oral Health also issued grants to Choptank Community Health Systems, the Helping Up Mission in Baltimore City, and the local health departments in Howard, Carroll, Prince George's, Charles, and Harford Counties. The grants to the Charles and Harford County Health Departments helped to establish public health dental clinics in their respective jurisdictions for the first time. The Office of Oral Health is currently working with the Prince George's County Health Department to award a dental mobile van grant to a local non-profit dental community organization.

In addition to supporting clinical dental treatment services, the Office of Oral Health also administers preventive and education grant programs to twenty local health departments that provide a variety of oral health services including clinical services, sealants, fluoride, case management, and oral health education. In FY 2008, over 10,000 children and adults received clinical dental care in a local health department dental clinic. In addition, approximately 2,500 children received dental sealants through school based sealant programs; 9,900 children

participated in a school-based fluoride rinse, tablet or varnish program; and over 15,000 children were educated on good oral health habits.

Finally, to improve and expand dental public health resources, the DAC recommended a change in legislation that would create a new public health dental hygienist category in Maryland. The legislation, which was sponsored by Delegate Turner in the House of Delegates (HB 1280) and by Senator Middleton in the Senate (SB 818), was passed unanimously during the 2008 Maryland General Assembly session. The legislation enables dental hygienists working for public health agencies to provide services within the scope of their practice in offsite settings (e.g., schools and Head Start centers) without the patient being seen by a dentist beforehand or a without a dentist directly on the premises.

Maryland Community Health Resources Commission Dental Grant Awards

The MCHRC released a request for proposals for dental projects on July 27, 2007. The proposals were to ensure and demonstrate access to comprehensive dental care, including preventive, diagnostic, emergency, and restorative care, with special consideration to applications that emphasize providing dental services to low-income families and children. Grant awards could be used to expand existing services or to create new sources of dental care.

The following dental awards, totaling \$1,509,004, were made in January 2008:

Choptank Community Health System (an FQHC) expansion	\$300,000
Allegany County Health Department expansion	\$200,000
Baltimore City Health Department expansion	\$70,750
Carroll County Health Department expansion	\$29,030
Garrett County Health Department expansion	\$173,660
Harford County Health Department new dental clinic	\$435,564
Wicomico County Health Department expansion	\$300,000

In their first round of grants, awarded in January 2007, the Maryland Community Health Resources Commission awarded the REACH Dental Program of the Anne Arundel County Department of Health a three-year, \$450,000 grant. The project, entitled *The REACH Dental Program*, established a dental program to provide preventive and restorative oral health services to individuals enrolled in the REACH Program. The Anne Arundel County Department of Health opened a dental clinic in its dental facilities in Glen Burnie during evenings and on Saturdays. Referrals to discounted specialty dental services are provided to individuals needing more extensive care. The MCHRC also awarded Chase Brexton Health Services, Inc. a two-year, \$200,000 grant for emergency department linkage to primary medical and dental care. This referral service will link patients who present to Northwest Hospital Center and Howard County General Hospital emergency departments with non-urgent medical and dental conditions and who have no provider-of-record to services at one of the Chase Brexton sites.

A number of public health dental initiatives that involve local health departments and other community resources have shown promise in increasing access to oral health care for HealthChoice recipients. The HealthChoice program partners with the Office of Oral Health, which oversees these initiatives. These initiatives include the following.

Pediatric Dental Fellows

This program places trained dentists into the community (local health departments and Federally Qualified Health Centers/Community Health Centers) to provide comprehensive oral health services to Medicaid recipients. These dentists are specially trained to provide care to children under five years of age. In FY 2008, there were six (6) dental fellows practicing in Baltimore City, and Caroline, Carroll, Dorchester, Frederick, Howard, and Washington counties. Some of these dental fellows also provide operating room care. However, ongoing recruitment difficulties may reduce the number of pediatric dental fellows in the future.

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

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

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

The purpose of the MDC-LARP is to increase access to oral health care services by increasing the number of dentists who provide services for Medicaid recipients. In CY 2007, a total of eleven dentists participated in the program; three of these dentists completed their obligation in December 2007. In January 2008, five new MDC-LARP dentists started the program and will continue through December 2010. During 2007, MDC-LARP dentists provided 19,361, appointments for Medicaid recipients.

Conclusion

While utilization of dental services by children has increased significantly since the implementation of HealthChoice in 1997 from 19.9% to 51.5% in 2007, many enrollees are not receiving needed dental services and Maryland must improve access. One challenge to improving utilization is that dental reimbursement rates had not been sufficient to attract enough dentists to care for the large number of Medicaid and MCHP children in Maryland. As important as it is to increase rates, the Department believes and agrees with the Dental Action Committee (DAC) that reimbursement rates are not the sole problem and increasing rates alone will not assure that all vulnerable children and pregnant women get needed preventive dental care and treatment services. Another significant barrier to improving access to Medicaid dental services is that the HealthChoice dental program itself, with multiple contracted MCOs subcontracting to multiple dental vendors, presented a complex dental health care delivery system to health care providers and the public alike. Finally, dentists reported that perceived bureaucratic issues such as dissimilar MCO policies, erratic customer service, cumbersome

paperwork and time-consuming credentialing processes provided additional disincentives for dentists to participate in the Medicaid program.

The Dental Action Committee addressed these barriers to dental care access by making key recommendations to increase reimbursement for Medicaid dental services and to institute a single dental administrative service organization (ASO) that will be carved out of the HealthChoice MCO service package. The Department is currently implementing both of these recommendations. The first phase of a dental rate increase went into effect on July 1, 2008 and the single ASO dental program is on track to be implemented in July 2009. The Department believes that the increased rates and more simplified Medicaid dental program will attract more dentists to join and become dental homes for Medicaid enrolled patients. The Department also is working with the Maryland State Dental Association, University of Maryland Dental School, the Public Justice Center and others on various branding and marketing efforts to promote the new Medicaid dental program to dentists. Already, the Maryland State Dental Association is planning an unprecedented "Access to Care Day" in 2008 as part of their annual organizational meeting. Representatives from dental vendors currently serving the Medicaid dental program will be present at the meeting to enlist new dentists into the program. With efforts such as those described in this report, the Department is committed to continuing to work with the DAC on recommended strategies to make access to dental care and a dental home a reality for all Maryland children.

ATTACHMENT 1

Dental Procedures Targeted for Fee Increase in FY 2009

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

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

ATTACHMENT 2

The 5-Year (2004-2008) Oral Health Plan for the Maryland Department of Health & Mental Hygiene Facilitated by the Office of Oral Health

Mission

The mission of the Office of Oral Health, within the Department of Health and Mental Hygiene, is to improve the oral health status of Maryland residents through a variety of public oral health initiatives and interventions, characterized by a focus on health promotion and disease prevention. The Office of Oral Health develops and supports statewide cost-effective preventive and educational programs and policies that demonstrate and define the role of oral health as part of overall health. The Office of Oral Health partners with other State agencies, local health departments, schools, community agencies, and private providers in developing policies, programs and activities.

Dental Public Health Goals

Dental public health addresses disparities in oral health and dental care by:

- Assessing, analyzing, and evaluating the prevalence, distribution, and severity of conditions;
- Implementing or replicating successful community-based preventive programs (e.g., fluoridation and school sealant programs);
- Promoting oral health public education;
- Building coalitions that can encourage reforms and improve oral health; and
- Addressing the need for the development of community-based ‘safety net’ care delivery systems.

Problem – Kids

The 2000-2001 *Survey of the Oral Health Status of Maryland School Children* found:

- 42% of all children (K, 3rd, 9th, 10th grade) had untreated decay.
- 53% of children in kindergarten and 3rd grade had untreated decay in their primary teeth.
- The Eastern Shore had the highest percentage of untreated dental decay (54%) followed by the Central Baltimore region (48%). The Southern Region had the lowest percentage of untreated dental decay (14%)

The 2000 *Survey of Oral Health Status of Maryland’s Head Start Children* found:

- Approximately 55% of the Head Start children surveyed had decayed or filled tooth surfaces.
- The majority of caries experience among these Head Start Children was represented by untreated decay (96%).
- Of those children with decay, almost 17% had complained of pain to a parent or guardian.

Problem – Oral Cancer in Maryland

- The oral cancer mortality rate in Maryland is among the highest (8th) in the United States and ranks sixth for African-American males.
- Maryland’s oral cancer death rate is 15 percent higher than the national rate and the number of new cancer cases in Maryland also is higher than the national average.
- Conservative cost estimates regarding the average inpatient and outpatient treatment for a survivor of oral cancer at the University of Maryland Medical System is roughly \$100,000 per case.
- *2002 Survey of Maryland Adults’ Knowledge of Oral Cancer* found:
 - 42% of Marylanders report having an oral cancer exam.
 - 77% of those who had an oral cancer exam had it conducted by a dentist.

Problem – Capacity

- Lack of dental providers in rural areas.
- Lack of public health clinics to serve the uninsured and underinsured.
- Lack of dental providers accepting Medical Assistance.

Priority Areas

Over the next five years the Office of Oral Health will focus its resources in the following areas:

- I. Improving Access to Oral Health Services and Improving Dental Public Health Capacity
- II. Oral Health Policy Analysis and Development - Local and State Level
- III. Oral Health Education for Patients, Providers and Others
- IV. Establishing Linkages and Ensuring Coordination on Oral Health

Priority One

Improving Access to Oral Health Services and Improving Dental Public Health Capacity

Why: Oral diseases are not self-limiting and increase in severity with time. As a result, medical, nutritional, psychological, educational, social, esthetic, and speech difficulties can originate from preventable oral disease and injury. Adverse oral health conditions have been shown to affect aspects of daily living such as quality of life, economic productivity, and work or school performance and attendance including readiness to learn. Future contributions to society and the workplace also may be affected by the poor self-esteem, physical well being, and quality of life generated by oral health problems.

How:

- Address the three (3) components of dental public health: assessment, policy, and assurance.
- Assess the clinical dental public health programs that currently exist to determine why a certain population is targeted, what services are provided, what gaps exist, if there are overlaps to other programs, what programs work well and what is efficient.
- Identify and evaluate models that provide direct care to low-income populations such as the University of Maryland Baltimore College of Dental Surgery’s Dental Fellows Program and the Maryland Dent-Care Loan Assistance Repayment program to determine what resources are necessary to expand them and what the value of expanding them is.
- Develop guidelines to define a dental public health clinic and specify what services must be provided to be designated as a dental public health clinic.
- Increase the number of dentists and dental hygienists practicing in Maryland who serve low-income and other vulnerable populations.
- Increase the number, quality, and capacity of dental care safety net clinics in FQHCs and in other clinics, including local health departments.
- Build a network of dental professionals that have the skills to treat children, individuals with special health care needs (children and adults), adults and the elderly.
- Increase the number of Dental Health Professional Shortage Area Designations.
- Develop a standardized oral health case management process that can be easily duplicated.
- Develop a data driven evaluation of dental public health to determine effectiveness and to help define success.
- Seek funding for new initiatives.

Potential Partners: Maryland Department of Health and Mental Hygiene – Family Health Administration, Maryland Dental Society, Maryland State Dental Association, University of Maryland Baltimore College of Dental Surgery, Maryland Dental Hygienists Association, Judy Centers, Maryland Higher Education Commission, Maryland Dental Society, Academy of General Dentistry, Local Health Departments, FQHCs/MQHCs, Chronic Hospitals, Area Health Education Centers, University of Maryland Statewide Health Network, Maryland State Department of Education, Maryland Medicaid, Maryland Department of Aging, Governor’s Office of Children, Youth and Families, Social Services – Caseworkers

Priority Area II
Oral Health Policy Analysis and Development - Local and State Level

Why: Good oral health is more than clinical services. The development of clear and relevant policy ensures the efficient and appropriate use of funding to address oral health issues for all Marylanders.

How:

- Advise the Department of Health and Mental Hygiene on oral health issues that affect specific target populations.
- Create and maintain an oral health surveillance system for use by policy makers and program planners.
- Disseminate scientifically proven policies and oral health interventions that prevent oral diseases to the public, healthcare providers, legislators, and others interested in oral health.
- Provide technical assistance to communities seeking to implement community water fluoridation or fluoride rinse, tablet or varnish programs.
- Assess, evaluate and disseminate information about successful local oral health programs so that they can be replicated in other communities.
- Integrate oral health promotion in existing programs, both inter and intra agency, that engage individuals at high-risk for oral diseases.
- Collaborate with State partners to develop policy to increase oral health services.
- Conduct an annual review of Behavioral Risk Factor Surveillance Survey (BRFSS) to determine functionality
- Conduct a study to determine the financial benefit gained from dental public health activities and use these results to guide policy decisions.
- Seek funding for new initiatives.

Potential Partners: Maryland Department of Health and Mental Hygiene – Family Health Administration, Maryland Dental Society, Maryland State Dental Association, University of Maryland Baltimore College of Dental Surgery, Maryland Dental Hygienists Association, Academy of General Dentistry, Local Health Departments, Maryland Medicaid, Local Government, Administration on Aging.

Priority Area III
Oral Health Education for Patients, Providers and Others

Why: Since dental disease occurs frequently and treatment is more expensive than prevention, educating patients and providers on proven intervention strategies has both health and economic benefits for children and adults. Educating the public on good oral hygiene and nutrition behaviors, community water fluoridation, tobacco cessation programs, and examinations for oral cancers can result in improved oral health for all individuals.

How:

- Develop a comprehensive statewide oral health education and awareness program for children and adults.
- Strengthen and expand the Maryland Oral Cancer Prevention, Education and Training Initiative.
- Provide prenatal oral health education to all pregnant women.
- Provide Anticipatory Guidance/Risk Assessment tools to non-dental professionals.
- Develop and evaluate a comprehensive oral health school health curriculum for all grades, including Head Start.
- Provide training to organizations working with children and families.
- Link oral health messages to routine medical appointments for children and adults such as immunizations and physicals.
- Develop a speakers bureau to educate non-dental professionals about oral health
- Develop, implement, and evaluate oral health education programs for at risk groups including but not limited to the elderly, individuals with special health care needs, medically challenged, HIV/AIDS, African American men, adults, homeless, and the undocumented.
- Seek funding for new initiatives.

Potential Partners: Maryland Dental Hygienist Association, Maryland State Dental Association, University of Maryland Baltimore College of Dental Surgery, Maryland Higher Education Commission, Office of Primary Care and Rural Health, Maryland Dental Society, Academy of General Dentistry, Local Health Departments, FQHCs/MQHCs, Area Health Education Centers, University of Maryland Statewide Health Network, Maryland State Department of Education, Maryland Medicaid, Med Chi, Nurses, Nurse Practitioners, Physicians, Physician Assistants, Maryland Department of Human Resources, Head Start, Office of the Maryland WIC Program, Governor’s Office of Children, Youth, Families, Obstetricians/Gynecologists, faith based organizations

Priority Area IV
Establishing Linkages and Ensuring Coordination of Oral Health

Why: The creation of strong and diverse partnerships ensures that oral health messages will be introduced and incorporated into a wide variety of pre-existing programs designed to reach those individuals most at risk.

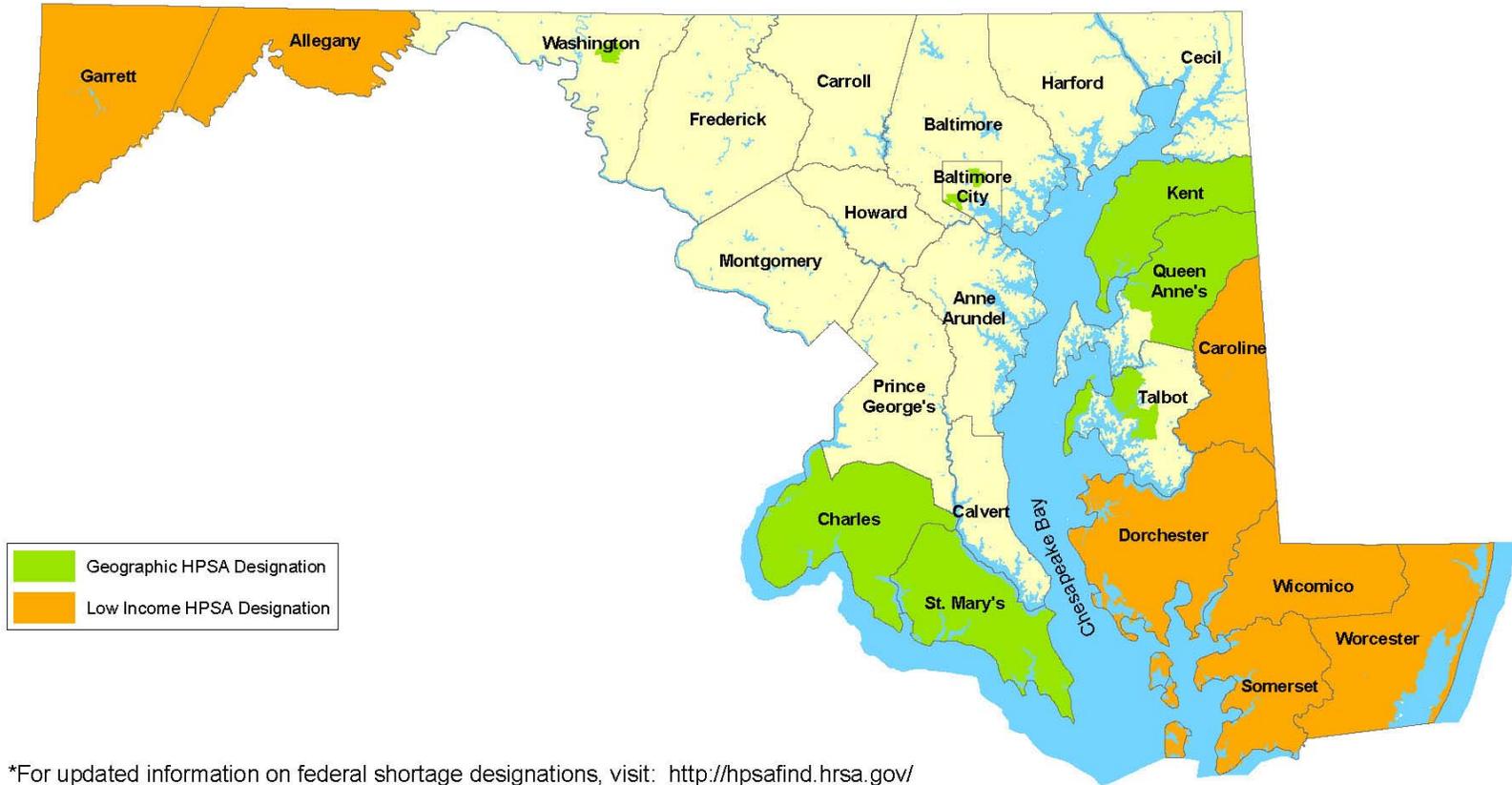
How:

- Identify and actively pursue additional funding sources to support oral health activities and programs.
- Establish and maintain working relationships with key partners in the dental community both within DHMH and outside of DHMH.
- Serve as a coordinator for distributing information to advocates via newsletter, email, and website.
- Provide guidance to the Oral Health Advisory Committee.
- Develop and strengthen state and local coalition building.
- Recruit and retain qualified Office of Oral Health staff for program support.
- Work to incorporate non-dental groups in the promotion of oral health.
- Establish partnerships with private industry and corporations.
- Seek funding for new initiatives.

Potential Partners: Maryland Dental Hygienist Association, Maryland State Dental Association, University of Maryland Baltimore College of Dental Surgery, Maryland Dental Society, Academy of General Dentistry, Local Health Departments, FQHCs/MQHCs, Area Health Education Centers, University of Maryland Statewide Health Network, Maryland State Department of Education, Maryland Medicaid, Med Chi, Nurses, Nurse Practitioners, Physicians, Physician Assistants, Maryland Department of Human Resources, Head Start, Office of the Maryland WIC Program, Governor’s Office of Children, Youth, Families, Obstetricians/Gynecologists, funding organizations, faith based organizations

ATTACHMENT 3

Maryland Health Professional Shortage Area (HPSA) Designations for Dental Care as of 4/10/2008*



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

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



ATTACHMENT 4

Dental Utilization Rates, CY 2000 -CY 2007
Enrollment \geq 320 days in an MCO, age 4-20

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

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

ATTACHMENT 5

**Dental Restorative Fee Increase
Effective March 1, 2004**

CDT-4 Procedure Code	Description	Previous Fees – Based on Fee-for- Service, 2001	Fees - 50th Percentile of ADA 2004 Rates for South Atlantic Region
D2140	Amalgam-1surf	\$37	\$70
D2150	Amalgam-2surf	\$45	\$88
D2160	Amalgam-3surf	\$52	\$104
D2330	Resin-1surf, ant	\$39	\$84
D2331	Resin-2surf, ant	\$48	\$102
D2332	Resin-3surf, ant	\$56	\$125
D2335	Resin-4surf, incisal angle	\$66	\$151
D2391	Resin-1 surf, post	\$39	\$93
D2392	Resin-2 surf, post	\$48	\$120
D2393	Resin-3 surf, post	\$56	\$150
D2930	Prefab SSC-primary	\$75	\$154
D2931	Prefab SSC-permanent	\$75	\$180

ATTACHMENT 6

MCO Funding and Expenditures for Dental Services, FY 1997 – CY 2008				
Utilization of Dental Services in HealthChoice, FY 1997-CY 2007				
Year	Amount Paid in MCO Capitation Rates for Dental	Amounts Spent by MCOs for Dental (Source: HFMR) (Includes adult dental)	Utilization Rate for General Access (Children 4-20 Years with 320 Days of Enrollment)	Utilization Rate for Restorative (Children 4-20 Years with 320 Days of Enrollment)
FY 1997	N/A	\$2.7 M*	19.9%	6.6%
CY 2000	\$12.3 M (estimate)	\$17 M (estimate)	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	\$48.6 M	Not Available	Not Available	Not Available

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