



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

October 23, 2013

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: 2013 Annual Oral Health Legislative Report as Required by Health-General Article Sections 13-2504(b) and HB 70 (Ch. 656 of the Acts of 2009)

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

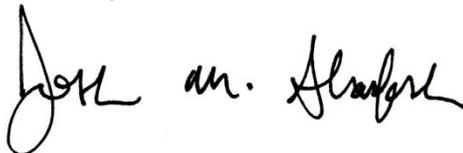
Pursuant to Health-General Article, §13-2504(b), the Maryland Medicaid Program and the Office of Oral Health within the Department of Health and Mental Hygiene (the Department) submit this comprehensive oral health legislative report to the Governor and the General Assembly. In addition, the 2009 Joint 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 (Ch. 113 of the Acts of 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(Ch. 527 of the Acts of 2007)/HB 30 (Ch. 528 of the Acts of 2007)); and 3) the Oral Cancer Initiative (as originally required by SB 791 (Ch. 307 of the Acts of 2000) and HB 1184 (Ch. 308 of the Acts of 2000)). More specifically, the report discusses:

- Maryland Medicaid availability and accessibility of dentists;
- Medicaid dental administrative services organization (ASO) utilization outcomes, and allocation and use of related dental funds;
- The results of the Oral Health Safety Net Program administered by the Office of Oral Health;
- The findings and recommendations of the Office of Oral Health's Oral Cancer Initiative;
- The activities of the Office of Oral Health's Oral Health Literacy Campaign funded by a grant from the Centers for Disease Control and Prevention;
- A status update on the Statewide follow-up survey concerning the oral health status of school children in Maryland; 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,

A handwritten signature in black ink that reads "Josh M. Sharfstein". The signature is written in a cursive, flowing style.

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Marie Grant, J.D.
Laura Herrera, M.D., M.P.H.
Patrick Dooley, M.A.
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MARYLAND'S 2013 ANNUAL ORAL HEALTH LEGISLATIVE REPORT

Health-General Article, §13-2504(b)

Martin O'Malley
Governor

Anthony G. Brown
Lieutenant Governor

Joshua M. Sharfstein, M.D.
Secretary

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Executive Summary

Maryland has been recognized as a national leader in oral health as a direct result of the state's progress in implementing the 2007 Dental Action Committee's (DAC) comprehensive recommendations for increasing access to oral health services through changes to the Maryland Medical Assistance Program (Medicaid), and expansion of the public health dental infrastructure. Since 2010 the Pew Center on the States, which issues annual oral health report cards for the states, has bestowed high grades on Maryland for its efforts to improve 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 access policy benchmarks, the Pew Center ranked Maryland first in the nation for oral health in 2011.¹ When Pew revised its report card parameters and performance measures in 2012 to emphasize prevention rather than access, Maryland's "B" grade made the state one of only thirteen to receive a grade higher than a "C."²

The Centers for Medicare and Medicaid Services (CMS) have also recognized Maryland's improved oral health service delivery by inviting Maryland to share its story at the agency's 2011 national quality conference, and to participate in the inaugural CMS Learning Lab: *Improving Oral Health through Access* webinar series. CMS has included Maryland's story and achievements in its best practices guide for states and their Governors through the Medicaid State Technical Assistance Team (MSTAT) process. Additionally, Maryland's oral health achievements were highlighted at a recent U.S. Department of Health and Human Services (HHS) webinar, which for the first time recognized oral health as a Healthy People 2020 Leading Health Indicator. The webinar was led by HHS Assistant Secretary Howard Koh and Rear Admiral William Bailey, Assistant Surgeon General and Chief Dental Officer of the U.S. Public Health Service.³

Guided by the DAC's recommended strategies in 2007, the Medicaid program has implemented major programmatic changes that have since contributed to a significant increase in dental utilization. Maryland continues to improve its dental program by successfully confronting complex and multi-faceted barriers to providing comprehensive oral health services to Medicaid enrollees, such as low provider participation. Low provider participation results from multiple factors including, but not limited to, low reimbursement rates, missed appointments, and a lack of awareness among enrollees about the benefits of basic oral health care.

The DAC recommended that the Department of Health and Mental Hygiene (the Department) initiate a single statewide dental administrative services organization (ASO). In July 2009, DentaQuest (formerly named Doral Dental) began functioning as the Department's ASO for all dental services for children, pregnant women, and adults in the Rare and Expensive Case Management (REM) Program. DentaQuest is responsible for all functions related to the delivery of dental services, including provider network development and maintenance, claims processing, utilization review, authorization of

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

² http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Pew_dental_sealants_report.pdf

³ http://www.healthypeople.gov/2020/learn/LHI_OH_082012_Transcript.pdf

services, outreach and education, and complaint resolution. Calendar year (CY) 2012 is the third full calendar year that DentaQuest has coordinated dental services for Medicaid. The Department spent \$150.5 M for dental expenditures in CY 2012, \$95 M more than in CY 2008 (see Attachment 4). Utilization rates have increased and provider networks have expanded since DentaQuest rebranded Medicaid dental services as the Maryland Healthy Smiles Program. Highlights include:

- As of August 2013, 1,244 dentists have enrolled with DentaQuest to provide care, up from 649 in August 2009.
- Approximately 391,000 children and adults in Medicaid received dental care in 2012, 24,000 more than in 2011.
- Maryland continues to perform significantly above the national Health Employer Data Information Set (HEDIS™) average for children's dental services utilization at 67.8 percent, more than 22 percentage points higher than the 2011 HEDIS™ average of 45.4 percent.
- Over a seven-year period, less than one percent of children enrolled in Medicaid sought treatment for a dental diagnosis in the emergency room.
- The percentage of pregnant women 14 years and over enrolled for any period receiving a dental service in 2012 was 30.7 percent.
- As of September 2013, DentaQuest has successfully implemented dental home structures in four Maryland counties, and is working to implement the dental home program statewide during fall 2013.

Additionally, the DAC recommended enhancement of the dental public health infrastructure by ensuring that each local jurisdiction has a local health department or community dental clinic. The Governor made it a priority to include \$1.5 M in the FY 2014 budget to the Department's Office of Oral Health (OOH), which continues support for community-based oral health grants through the Oral Health Safety Net Program established in 2007. This program aims to expand the dental public health capacity for low-income, disabled, and Medicaid populations. Building on prior successes, this additional funding now provides Marylanders in every county access to a public health dental clinic that is either located within or serves their jurisdiction. Other dental public health achievement highlights include:

- In 2010, \$1.2 M in federal funding was secured to develop a statewide Oral Health Literacy Campaign. The campaign, titled "Healthy Teeth, Healthy Kids," was unveiled in March 2012, and remains in place through federal grants awarded to the OOH. Efforts are underway to evaluate and extend this campaign.
- During the first three quarters of the 2012-2013 school year (as of June 30, 2013), the Deamonte Driver Mobile Dental Van Project provided diagnostic and preventive services for 1,391 Prince George's County children, of which 55 received clinic referrals for immediate restorative care or urgent care.

- School dental sealants, along with community water fluoridation, are two evidence-based oral disease prevention services highly recommended by many federal agencies.
 - In 2010, a statewide school-based dental sealant demonstration project was completed. Third graders in 10 elementary schools received dental screenings and sealants.
 - In 2012 the OOH received a 3-year (\$500,000/year) Health Resources and Services Administration (HRSA) *State Oral Health Workforce* grant to support direct school-based or school-linked dental sealant services. This award will be used to fund grants over this three-year time span beginning in FY 2013. The OOH is issuing a Request for Applications (RFA) during each of these three years exclusively for local health departments to develop statewide school-based or school-linked dental sealant programs for their own jurisdictions.

Eleven local health departments received OOH grant awards to implement school dental sealant programs in FY 2013. FY 2013 results for these programs as of June 30, 2013 are: 7,115 children screened, 3,254 referred for further treatment, 22,779 received oral health education, and 2,194 received dental sealants. The school dental sealants grant program has been well-received, and will be expanded to offer 12 grant awards to local health departments in FY 2014.

- Using a mobile dental team, school-based oral health access programs have been operating in 11 schools in Kent and Queen Anne's Counties since FY 2010.
- The Kaiser Foundation awarded a \$200,000 grant to the Maryland Dental Action Coalition (DAC) in partnership with the OOH to fund a pilot dental screening program linking to an established school-based dental clinic in Prince George's County. The program began operations in October 2011, was evaluated by the OOH during FY 2013, and a report on its progress will be issued by the end of CY 2013.
- In January 2013, five new dentists started the Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP). These dentists will work with the program through December 2015. During CY 2012, MDC-LARP dentists treated 12,946 unduplicated patients, and billed 32,365 dental visits for Medicaid patients.
- The Maryland Community Health Resources Commission (MCHRC) continues to expand oral health capacity for vulnerable populations. Since 2008, the MCHRC has awarded 20 dental grants totaling \$4.6 M, which

collectively provided services to more than 35,000 low-income children and adults, resulting in nearly 84,000 dental visits over the life of the program, 1,000 of which occurred in FY 2013.

The DAC also recommended providing training in oral health risk assessments to dental and medical providers. In July 2009, the Department began training OOH and reimbursing Medicaid primary care providers for the application of fluoride varnish for children up to three years of age. By June 2013, 441 unique Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) certified providers had administered over 84,685 fluoride varnish treatments. As of September 2013, approximately 882 dentists had received training in pediatric dentistry through various state-sponsored courses. Two separate pediatric dentistry courses will be offered for public health and private sector Medicaid general dental practitioners in fall 2013. This is possible through a partnership of MDAC, the OOH, and the University of Maryland School of Dentistry.

The Oral Cancer Prevention Initiative, mandated by Senate Bill 791 (Ch. 307 of the Acts of 2000), requires that the Department implement programs to train health care providers on screening and referring patients with oral cancer, and provide education on oral cancer prevention for high-risk, underserved populations. Through the combination of the Initiative's funds with Cigarette Restitution Fund Program (CRFP) funds, thousands of Maryland residents have been screened for oral cancer or referred to smoking cessation programs, and a large number of practitioners have received oral cancer prevention messages, information, and strategies.

Maryland continues to make progress in the percentage of residents receiving annual oral cancer examinations. As of June 30, 2013, FY 2013 totals include 6,753 individuals screened for oral cancer, and 21,411 individuals and 380 healthcare providers having received education on oral cancer through the Initiative. In addition, the Department's OOH participates in awareness-building activities, and in the last year took part in several Maryland Oral Cancer Awareness Month (OCAM) activities, sponsored the fifth Annual Baltimore Oral Cancer Walk/Run for Awareness, 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 demonstrated by the Governor and General Assembly to transforming Maryland's capacity to provide oral health services. With ongoing funding and support, the Department and its many dedicated partners will continue working together to 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 Department is required to report each year on:

- (1) The results of the Oral Health Safety Net Program;
- (2) Findings and recommendations for the Oral Health Program and any other oral health programs established under Title 18, Subtitle 8 of this article, including the Oral Cancer Initiative;
- (3) The availability and accessibility of dentists throughout the State participating in the Maryland Medical Assistance Program;
- (4) The outcomes that managed care organizations and dental managed care organizations under the Maryland Medical Assistance Program achieve concerning the utilization of 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
- (5) The allocation and use of funds authorized for dental services under the Maryland Medical Assistance Program.

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. Further, this section of the report includes information on the availability of dentists participating in the Maryland Healthy Smiles Program, access to care for Medicaid populations under administrative services organization (ASO) DentaQuest, and services offered by local health departments to low-income residents in dental Health Professional Shortage Areas (HPSAs).

Part 2 describes in further detail the Oral Health Safety Net Program administered by the Department's Office of Oral Health (OOH), including collaborations between the Department and other stakeholders to strengthen access to comprehensive dental care for low-income, disabled, and Medicaid populations through clinical dental programs, school-based oral health services, and other initiatives throughout the state. This section also provides a status update on the Department's follow-up survey concerning the oral health status of school children in the state.

Part 3 focuses on progress made by the OOH's Oral Cancer Mortality Prevention Initiative. This section documents the initiatives implemented to increase public and professional awareness of the importance of oral cancer screening, the impact of outreach

combined with broadening training efforts for dentists to conduct oral cancer screenings, and progress in detecting and treating oral cancer in Maryland residents since the initiative began in 2000.

II. Maryland's Oral Health Accomplishments

Part 1. Medicaid Dental Care Access

Part 1 of this report provides an overview of the changes to the dental program since Senate Bill 590, including the transition to ASO DentaQuest. It discusses the OOH's efforts that specifically address increasing access to oral health care and highlights CY 2012 Medicaid dental results under DentaQuest over a five-year period, as well as the Department's progress in implementing the DAC recommendations. This part 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.

Background

The Department's Medicaid program delivered oral health services to approximately 391,000 children and adult enrollees during 2012; 24,000 more than in 2011. 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's being recognized as an oral health leader by the Pew Center on the States,^{4, 5} CMS, and HHS.⁶ Despite these successes, Maryland continues to improve its dental program by confronting barriers to providing comprehensive oral health services to Medicaid enrollees.

In June 2007, the Secretary of the Department convened the 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, culminating in a comprehensive report to the Secretary on September 11, 2007. 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 receive 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.

⁴http://www.pewstates.org/uploadedFiles/PCS_Assets/2011/The_State_of_Childrens_Dental_health.pdf

⁵http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Pew_dental_sealants_report.pdf

⁶http://www.healthypeople.gov/2020/learn/LHI_OH_082012_Transcript.pdf

In June 2009, the DAC formally began its transition from a Department-based committee focused on improving dental access for underserved Maryland children to an independent, sustainable statewide oral health coalition. Now called the Maryland Dental Action Coalition (MDAC), its mission is to improve the oral health of all Marylanders. By March 2010, the MDAC received funding from the DentaQuest Foundation, secured an office, and hired an executive director. After establishing formal governance, enlisting new partners, and electing officers, the MDAC 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 several partners, including Medicaid and the OOH, to develop and launch a State Oral Health Plan in May 2011. This plan was highlighted at an Oral Health Summit that the MDAC co-sponsored in October 2011, and its proceedings were published in 2012 in a special issue of the *Journal of Public Health Dentistry*.

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

MDAC’s future plans include co-sponsoring two separate pediatric dentistry courses for general dentists from the public health and private sector who participate with Medicaid; convening a second Oral Health Summit in December 2013, which will monitor the progress of the state oral health plan; and continuing its strategic partnership with the OOH in extending HTHK.

Senate Bill 590, Chapter 113 of the Acts of 1998

Senate Bill 590 established the OOH within the Department’s Family Health Administration (now the Prevention and Health Promotion Administration), and required 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 the targets was the rate of service use of children under 21 years of age in 1997, which was 19.9 percent.⁷

⁷ The rate of 19.9 percent is based on enrollment in the same MCO for at least 320 days. According to the CMS 416 report, the utilization rate for 1997 was 14 percent. This rate was calculated based on services provided to children with any period of Medicaid eligibility and does not take into account a minimum enrollment period. It also includes children of all ages.

Implementing Change to Increase Utilization of Dental Services

In 2008, the OOH received a five-year state dental infrastructure grant from the Centers for Disease Control and Prevention (CDC). This award requires the development of a five-year State Oral Health Plan. The State Oral Health Plan was developed by the MDAC in coordination with many partners, including the OOH, and was unveiled at a 2011 press conference featuring Congressman Elijah Cummings and Department Secretary Dr. Joshua Sharfstein. The central theme of the State Oral Health Plan is development and implementation of strategies and policies to ensure that a majority of Maryland residents have access to a dental home. The progress of the State Oral Health Plan will be the subject of a new Oral Health Summit event, which is scheduled for December 2013 and will be co-sponsored by the MDAC.

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

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

Action Taken: The Department awarded a contract to DentaQuest to serve as the single statewide dental vendor. DentaQuest began managing dental services and paying claims in July 2009, and the new Medicaid dental program has been named “Maryland Healthy Smiles.” DentaQuest continues to attract new dental providers and has been successful in increasing service 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, budget constraints continue to delay subsequent rate increases.

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 (Ch. 527 of the Acts of 2007)/HB 30 (Ch. 528 of the Acts of 2007)).

Action Taken: The Governor’s FY 2014 budget allocated \$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 legislative session, the Maryland General Assembly unanimously passed legislation that facilitates the role of dental hygienists working for public health programs, allowing these dental professionals to provide services more efficiently and expeditiously within the scope of their practice in offsite settings (e.g., schools and Head Start centers). As a result, health department dental programs have recruited and enlisted public health dental hygienists, and additional school-based health centers have employed dental hygienists to provide preventive services. Through a grant from the American Public Health Association, the OOH completed an evaluation of this recommendation, which demonstrated the effectiveness of this initiative. The report will be disseminated and available to the public later this year.

DAC Recommendation 5: Develop a unified and culturally and linguistically appropriate oral health message for use throughout the State to educate parents and caregivers of young children about oral health and the prevention of oral disease.

Action Taken: In 2010, with the support of U.S. Senators Barbara Mikulski and Ben Cardin, the OOH secured \$1.2 million in federal funds to develop a statewide Oral Health Literacy Social Marketing and Media Campaign for the public. The purpose of the Oral Health Literacy Campaign was to inform parents and caregivers of low-income families about the importance of oral health for their children, how to prevent cavities, and how to access the oral health care delivery system. The campaign was informed by the results of a study that showed limited knowledge among adults about how to prevent tooth decay in children; the lowest understanding of the importance of oral health care existed among those with lower levels of education, without dental insurance, and enrolled in Medicaid.

In March 2011, the OOH contracted with the social marketing firm PRR, Inc. to plan, develop, and conduct the campaign. The OOH also formed a strategic alliance with the MDAC to brand and to monitor the campaign's implementation. The infrastructure advising and guiding the campaign's development and implementation consisted of a work group; an advisory committee; and a strategic network of partners comprised of more than 160 individuals representing the dental and medical professions; as well as a variety of social service, community and public health organizations. Together, these individuals helped craft the campaign messages, identify influencers, discover barriers, highlight benefits, develop tactics, and identify potential partners. They also pledged support and specific implementation assistance to the campaign by distributing brochures and oral health kits; offering to provide oral health education to target audience members; conducting training in oral health literacy for their staff; and promoting campaign messaging on their websites, in their printed materials and when interacting with patients.

The HTHK Oral Health Literacy Campaign launched on March 23, 2012 at The Dr. Samuel D. Harris National Museum of Dentistry. Speakers at the launch included Maryland Lieutenant Governor Anthony Brown, U.S. Senator Ben Cardin, U.S. Congressman Elijah Cummings, and OOH Director Dr. Harry Goodman. Volunteer dental professionals provided free dental screenings to preschoolers attending the launch, and attendees received free oral health educational materials.

After the launch, the HTHK campaign ran from late March through mid-July 2012, using traditional media, social media and other effective communication tools to reach its audience. The campaign included nine weeks of radio, television and transit advertising; a direct mailing of 120,000 brochures to women on Medicaid with children ages 0- 3; and the distribution of 80,000 oral health kits to at-risk mothers with children ages 0- 6 through Women, Infants and Children (WIC) clinics, Head Start centers and local health departments. The campaign also included ongoing involvement from more than 120 partner organizations that spread the campaign's message by distributing brochures and working one-on-one with mothers of young children. Partner organizations placed posters in clinics and medical offices, and banners or articles on their websites and in newsletters; linked to the campaign websites at www.healthyteethhealthykids.org, "liked" the campaign Facebook page, and posted comments or video to the Facebook page (located at www.facebook.com/HealthyTeethHealthyKids). Since the conclusion of the CDC grant period in August, 2012 the OOH has secured funding through a HRSA three-year grant to put in place critical resources and programs to help sustain the HTHK campaign. These resources, in addition to programs implemented through partnerships developed with MOHLA, a network of traditional and non-traditional oral health partners funded by DentaQuest and administered by MDAC, allow the OOH to take steps necessary to sustain the HTHK campaign. In order to retain expertise in the support and initiation of programs and activities to extend the HTHK Campaign, in September 2012 the OOH put in place a new contract to retain the Oral Health Literacy Campaign Program Director.

In October 2012, PRR and Maryland Marketing Source reported results from pre- and post-campaign surveys conducted to examine whether the target audience was aware of the campaign brand and messaging, and whether oral health habits, behaviors and attitudes were influenced by the campaign. Surveys were conducted by telephone, with 400 individuals surveyed in each wave of the survey. Participants were selected at random from a list of women 18-34 years of age who were identified as at-risk and caring for a child between 0-6 years of age and/or pregnant. Pre-campaign surveys took place in spring of 2012, and post-campaign surveys were conducted in the summer of 2012. Survey analyses revealed that:

- Overall, participants were very concerned about oral health issues, ranking it the same as heart health, diabetes, and cancer;
- Two thirds of respondents had heard of the HTHK campaign;
- There was a 13 percent increase in awareness of key campaign messaging that "Oral health is an important part of overall health;"

- Visits to the dentist increased by seven percent;
- Television and radio were rated by the respondents as the most effective tools used to communicate campaign messaging;
- Twenty-five percent of respondents recalled receiving the campaign brochure;
- Fifty percent recalled receiving an oral health kit from their health center; and
- 100 percent of those receiving oral health kits said that they used the products in the kit.

Based on these encouraging results, the OOH will continue the campaign and periodically reevaluate its effectiveness.

Over the past year, the HTHK campaign conducted the following activities through its strategic partnership between the OOH, MDAC, and by extension, MOHLA:

- 10,000 HTHK brochures and posters were distributed to 39 Judy Centers (early child care and family education centers) throughout Maryland;
- 20,000 HTHK brochures and posters were distributed through the MOHLA network of traditional and non-traditional partners that reach the target population of underserved pregnant women and at-risk mothers and caregivers of children under age six;
- HTHK materials and a Head Start oral health curriculum were distributed to 186 public libraries throughout Maryland, reaching 4,500 individuals statewide. The materials provide information on children's oral health for librarians and library visitors and were used by librarians to conduct oral health story time events with children and parents during National Children's Oral Health Month in 2012;
- The HTHK Director, MDAC Executive Director and MOHLA Project Consultant formed a partnership with representatives from WJZ-TV, Baltimore to explore opportunities for funding and partnering with the business community to create a "business roundtable" for oral health literacy, and to sustain the HTHK social marketing campaign;
- Through the collaborative efforts of MOHLA, the University of Maryland School of Public Health, MDAC, and the OOH, a HTHK Spanish language campaign launched in February 2012. The campaign targets low-income Hispanic women ages 18- 34. The campaign launch included a new, mirror-image, Spanish language website, www.DientesSanosNinosSanos.org, a nine-week Spanish language radio campaign running in various Spanish-speaking media outlets, and distribution of newly translated and produced Spanish language brochures and posters. The HTHK Spanish language website recorded 295 visits during the campaign with 485 page views and an average time spent on the website of one minute and 35 seconds. During this same time, the English language website recorded more than 1,800 visits and 4,102 page views, and had an average duration of time spent on the website of one minute and 24 seconds.

In December 2012, the OOH generated additional media coverage by contracting with Profiles, Inc., a Baltimore-based public/media relations firm, to develop and place oral health news stories in the media. To date, Profiles has generated 22 pieces of news

coverage in various media outlets including television, radio, and written and electronic press. While Profiles' contract with OOH is for eight months and will conclude in August 2013, HRSA funding will continue to support contracting with a media relations firm for three years so that the OOH can maintain media placement of important oral health stories on a regular basis.

The HTHK campaign is also expanding its social media efforts by:

- *Launching a new e-mail address.* In October 2012, info@healthyteethhealthykids.org was activated as a resource for dental and medical professionals, as well as social service, community and public health organizations to request campaign support materials such as brochures, posters, web banners, or campaign articles. The address receives approximately 20 requests for materials each month; as a result, the HTHK campaign continues to distribute campaign materials in both English and Spanish to health care and social service organizations such as Federally-Qualified Health Centers (FQHCs), community health centers, Head Start, Early Head Start, local health departments, Area Health Education Centers (AHECs), professional medical and dental associations, hospitals, day care centers, etc. Approximately 5,000 brochures are distributed each month;
- *Building a HTHK Facebook site with daily posts to engage our international Facebook audience with important oral health information.* Thousands of individuals often view these posts and share them with other Facebook users. Development of the HTHK Facebook site started in August 2012 with minimal user traffic, and has since developed into a highly-utilized site with more than 500 individual and organizational likes;
- *Expanding the role of the HTHK call center.* In addition to answering caller inquiries and providing assistance with finding a participating Medicaid dentist, the call center now facilitates all Spanish language calls, and collects basic data on each caller including location by zip code, gender, ethnicity, reason for call, and how the caller heard of the HTHK call center; and
- *Preparing for the launch of a mirror-image HTHK Spanish language campaign by launching the www.DientesSanosNinosSanos.org website in February 2013.* To date, the Spanish website has received more than 400, visits and the English website more than 6,500 visits.

On June 17, 2013, the HTHK Final Report compiled by PRR was submitted to CDC. The final report⁸ contains a complete overview of the campaign from concept through completion.

HTHK plans for the future may include:

- Expanding the HTHK campaign beyond Maryland's borders;

⁸ See http://www.prrbiz.com/guest/downloads/MDoral/MDoral_recap_040513_recapOnly.pdf.

- Integrating *The New Drink Pyramid*, a campaign created by the Western Kentucky Regional Dental Coalition, into the HTHK website;
- Starting a materials distribution initiative that includes hospital OB/GYN departments, ER waiting rooms, and urgent care centers;
- Exploring the use of Twitter and holding Twitter Chats;
- Exploring, along with DentaQuest, direct text messaging to Medicaid moms; and
- Holding a large-scale public event to promote the program.

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 that incorporates dental screenings with vision and hearing screenings for public school children. The dental screening program is likely 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. The MDAC, in coordination with the Department and other partners, developed a Proof of Concept paper which specified steps required for eventual enactment of a program. This paper helped these partners secure \$200,000 in grant funding from the Kaiser Foundation in June 2011 to support a pilot school dental screening program linked to an established school-based dental clinic in Prince George's County. The program began operations in October 2011, and the partnership will issue an interim report on its progress by the end of CY 2013.

DAC Recommendation 7: Provide training to dental and medical providers to provide oral health risk assessments, educate parents/caregivers about oral health, and to assist families in establishing a dental home for all children.

Action Taken: General dentists have received training in didactic and clinical pediatric dentistry so that they may competently treat young children. As of September 30, 2013, approximately 882 general dentists had received this training through various courses sponsored by the OOH, 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). Through a partnership between the MDAC, OOH, and University of Maryland School of Dentistry, two separate pediatric dentistry courses will be offered to public health and private sector Medicaid general dental practitioners, respectively, in fall 2013. For additional information concerning the Oral Health Safety Net Program, please see Part 2 of this report.

In July 2009, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical providers (which include pediatricians, family physicians, and nurse practitioners) certified by the OOH became eligible to receive Medicaid reimbursement for providing fluoride varnish treatments to children ages 9-36 months through Maryland Mouths Matter: Fluoride Varnish and Oral Health Assessment Program. As of June 2013, 751 providers had completed the training program, and 441 of these EPSDT medical

providers have enrolled with DentaQuest as fluoride varnish providers. Overall the program has improved utilization for children ages 0-3 years. Over the life of the program (July 2009 to June 2013), approximately 84,685 fluoride varnish treatments have been provided 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). Prior to the implementation of the Maryland Healthy Smiles dental ASO on July 1, 2009, dental care was a covered benefit provided by 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.⁹ While adult dental services are not a required benefit and are not funded by the Department, five of the eight HealthChoice MCOs currently offer basic oral health services to adults. HealthChoice adult dental benefits typically include cleanings, fillings, and extractions (see Table 11 for more information on HealthChoice adult dental benefits).

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

As of July 2008, there were approximately 743 dentists enrolled as providers in the HealthChoice program. The 2008 count was a point-in-time count of providers, and due to several provider outreach activities, increased by the end of 2008. In July 2008 the overall statewide ratio of dentists¹⁰ to HealthChoice enrollees under age 21 years was 1:679. Shortly after the July 1, 2008 rate increases and the Secretary's challenge to dentists to participate with Medicaid, approximately 65 additional dentists joined the HealthChoice Program.

Current Dentist Enrollment: Maryland Healthy Smiles Program

DentaQuest has been actively enrolling new dentists in the Maryland Healthy Smiles Program since its implementation in 2009. Through DentaQuest, providers can now participate with Medicaid via a single point of contact, rather than contracting with each HealthChoice MCO. DentaQuest handles credentialing, billing, and dental provider issues, which streamlines the process for providers. As a result, DentaQuest has been

⁹ Children are only covered up to age 19 under MCHP.

¹⁰ Only dentists listed in HealthChoice provider directories were counted.

able to build the Medicaid dental provider network. As of August 2013, there were 1,244 individual providers enrolled, resulting in a dentist-to-child enrollee ratio of approximately 1:519. Because of increases in the provider network since 2009, the Maryland Healthy Smiles Program has been working to assign each enrolled child to a dental home. The Department has received positive feedback from providers who have worked with DentaQuest.

Table 1: Dentists Participating in DentaQuest²

Regions ¹	DentaQuest				
	August 2009	July 2010	August 2011	August 2012	August 2013
Baltimore Metro	242	344	410	765	652
Montgomery/Prince George's Counties	208	296	365	695	588
Southern Maryland	29	39	51	90	64
Western Maryland	65	97	128	222	171
Eastern Shore	43	53	84	168	158
MD Bordering States	62	110	152	281	232
Total	649³	939	1,190	1,616⁴	1,865

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 transition between the HealthChoice MCOs and DentaQuest resulted in the loss of several providers at the start of implementation in July 2009.

⁴ The 2012 Annual Oral Health Legislative Report stated the DentaQuest network contained a total of 1,616 providers in August 2012. This count included 392 fluoride varnish providers erroneously. The 2012 total now reflects the correct number of dentists, excluding the fluoride providers, to conform with previous and future yearly data.

In June 2013, there were 4,248 dentists actively practicing in Maryland (Maryland State Board of Dental Examiners). Table 2 indicates the number of pediatric and general dentists practicing in Maryland and the number of dentists currently participating with DentaQuest as of August 2013. 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 significantly undercount the total number of dentists providing dental services to Medicaid enrollees.

Table 2: Active Dentists and Dentists Participating with DentaQuest

REGION¹	Total Active Dentists (June 2013)	Active Pediatric Dentists (June 2013)	Dentists Enrolled with DentaQuest (Percentage of Total Active Dentists) (August 2013)	Dentists Who Billed One or More Services in CY 2012 (Percentage of Total Active Dentists)	Dentists Who Billed \$10,000+ in CY 2012 (Percentage of Total Active Dentists)
Baltimore Metro	1,873	59	652 (34.8%)	465 (24.8%)	367 (19.6%)
Montgomery/Prince George's	1,710	48	588 (34.4%)	451 (26.4%)	319 (18.7%)
Southern Maryland	154	6	64 (41.6%)	52 (33.8%)	40 (30.0%)
Western Maryland	287	11	171 (59.6%)	126 (43.9%)	103 (35.9%)
Eastern Shore	224	9	158 (70.5%)	72 (32.1%)	60 (26.8%)
Out of State	--	--	232	125	51
TOTAL²	4,248	133	1,244 (29.3%)	1,220(28.7%)	908 (21.4%)

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 Please note that the totals for DentaQuest enrollment, dentists billing one or more services, and dentists billing more than \$10,000 in services do not equal the sum of all regions because an individual dentist may have offices in multiple regions. The totals listed reflect the number of unique dentists unduplicated statewide for CY 2012.

In 2008, less than 19 percent of Maryland licensed active dentists were participating with Medicaid. As of August 2013, 29.3 percent of Maryland dentists were enrolled with Medicaid (see Table 2). In CY 2012, 1,220 unduplicated dentists billed one or more Medicaid services, and 908 unduplicated dentists billed \$10,000 or more to the Medicaid program. This represents 28.7 percent and 21.4 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 1,057 dentists in 2010, to 1,155 dentists in 2011, to 1,220 dentists in 2012. The number of dentists billing more than \$10,000 to Medicaid also increased from 765 in 2010, to 881 in 2011, to 908 in 2012. Pediatric dentists remain a minority in the state, accounting for approximately 3.1 percent of the total number of active dentists in Maryland.

Addressing Dental Health Professional Shortage Areas (HPSAs)

Within Maryland, several areas have been designated as dental HPSAs, or areas designated by the Health Resources Services Administration as having a shortage of dental health providers. Regions designated as Dental HPSAs are portions of the Eastern Shore, Western Maryland, Southern Maryland, and Baltimore City (see Attachment 2). Residents living in all jurisdictions of the state now have access to low-cost dental

services available through community programs sponsored by FQHCs, local health departments, academia, and other private, non-profit health organizations (e.g., community hospitals).

As of June 2013, there were 16 Maryland jurisdictions served directly by on-site clinical or school-based dental programs administered by local health departments. This includes Kent and Queen Anne's counties, which had been identified in the past as having no dental public health services, as well as the Worcester County Local Health Department, which began operating its onsite clinical dental program in April 2011. The St. Mary's County Health Department, which is not included in this count, 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. Similarly, the Howard County Health Department subcontracts with an FQHC, Chase Brexton Health Services, for its clinical dental service program, and is not included in this count. In addition, four jurisdictions on the Eastern Shore without a local health department have dental programs served by two FQHCs – Choptank Community Health Systems (Caroline, Talbot, and Dorchester) and Three Lower Counties (Somerset). In FY 2010, Calvert and Cecil Counties began providing 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-based non-profit dental clinical program include Anne Arundel, Baltimore, Carroll, Charles, Kent, Montgomery, Prince George's, Queen Anne's, Washington, Wicomico, and Worcester Counties, and Baltimore City.

Table 3 provides an overview of available local health department and community providers as of June 2013. It is important to note that these community clinic providers offer varying levels of dental services, and that not all of them accept Medicaid.

Table 3: Community Clinic Dental Providers as of June 2013¹

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

1 Community clinic providers in Table 3 above may also be counted in DentaQuest provider directories (Table 1) if they accept Maryland Healthy Smiles.

2 Multiple sites.

3 Began treating Medicaid enrollees in FY 2013.

4 Maryland Community Health Resources Commission funding beginning in FY 2010.

5 Partnership between Howard County Health Department and Chase Brexton.

6 Does not currently treat Medicaid enrollees.

Maryland Healthy Smiles Program Dental Utilization Rates

Children and Dental Utilization

Under EPSDT requirements, dental care is a mandated health benefit for children under 20 years of age.¹¹ Utilization of dental services has historically been 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 received at least one dental service. This number was below the national average of 21 percent.¹²

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. To facilitate comparability across calendar years, the Department is presenting a five-year look back for each measure that includes fee-for-service and MCO participants across the Medicaid program. Coverage groups ineligible for dental services were excluded from the analyses.¹³

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 DAC made its 2007 recommendations, access to care for children enrolled in HealthChoice increased from 51.5 percent (CY 2007) to 59.0 percent (CY 2009), performing nearly 14 percentage points above the 2009 HEDIS™ national Medicaid average (see Table 4).

Since the transition from HealthChoice to DentaQuest in July 2009, Maryland has performed above the national average for providing dental services to children (see Table 4). In CY 2012, the percentage of all children in Medicaid receiving a dental service was 67.8 percent. As a comparison, the HEDIS™ 2012 (CY 2011) national average for Medicaid was 45.4 percent.¹⁴ For more detailed analysis, Attachment 3 shows child dental utilization data by age and region.

¹¹ Children are only covered up to age 19 under MCHP.

¹² Source: Academy of Pediatrics State Medicaid Report for Federal FY 1996 - Analysis of HCFA National Data for Medicaid Children's Dental Services Utilization.

¹³ To measure dental utilization rates for the Maryland Healthy Smiles program, the Department excluded the following ineligible coverage groups from analysis: participants in the Primary Adult Care Program (S09), undocumented or ineligible aliens (X02), Women's Breast and Cervical Cancer Health Program participants (W01), and individuals receiving Family Planning Program services only (P10).

¹⁴ Source: National Committee for Quality Assurance.

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

Year	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service	HEDIS™ National Medicaid Average*
CY 2008	260,488	142,193	54.6%	44.2%
CY 2009	301,582	183,648	60.9%	45.7%
CY 2010	333,167	213,714	64.1%	47.8%
CY 2011	362,197	241,365	66.6%	45.4%
CY 2012	385,132	261,077	67.8%	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.

** The study population for CYs 2008-2012 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including fee-for-service (FFS) and HealthChoice MCO enrollees. The following coverage groups were excluded from the analysis: S09, X02, W01, and P10.

In recent years, the Department began reporting utilization rates of children with any period of enrollment. Utilization rates are lower when analyzed for any period of enrollment because the population includes children who were in a HealthChoice MCO or Medicaid for only a short period. Children may have had turnover in eligibility or enrollment, or may have been new to the HealthChoice MCO or Medicaid, and therefore there was insufficient time to link the child to care. MCOs and ASOs have less opportunity to manage the care of these populations.

Of the 645,562 children enrolled in Medicaid for any period during CY 2012, 52.3 percent of these children received one or more dental service, as compared to 50.1 percent in CY 2011. 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, which is reflected in Table 5, is likely due to the change that took effect in July 2009, which allowed EPSDT certified pediatric physicians to apply fluoride varnish.

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

Age Group	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
0-3*	12.1%	18.1%	22.5%	25.1%	27.9%
4-5	46.9%	55.1%	59.7%	63.1%	64.8%
6-9	51.9%	59.5%	63.6%	66.3%	67.8%
10-14	47.4%	55.0%	58.7%	61.2%	62.9%
15-18	38.4%	44.9%	48.5%	51.3%	52.4%
19-20	22.3%	29.0%	32.1%	34.2%	35.1%
Total	35.8%	42.8%	47.0%	50.1%	52.3%

* 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.

** The study population for CYs 2008-2012 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including fee-for-service (FFS) and HealthChoice MCO enrollees. The following coverage groups were excluded from the analysis: S09, X02, W01, and P10.

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. Access to restorative services increased from 20.8 percent of all children in CY 2008 to 24.3 percent in CY 2012 (see Table 6). This increase in utilization is due in part to: raising the fees for twelve dental restorative codes in 2004, and twelve dental diagnostic and preventive procedure codes in 2008; and increasing outreach efforts to Medicaid participants and providers.

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

Year	Diagnostic	Preventive	Restorative
CY 2008	52.1%	49.1%	20.8%
CY 2009	58.8%	55.7%	23.2%
CY 2010	62.3%	58.5%	25.1%
CY 2011	64.8%	61.1%	25.2%
CY 2012	66.0%	62.5%	24.3%

* The study population for CYs 2008-2012 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including fee-for-service (FFS) and HealthChoice MCO enrollees. The following coverage groups were excluded from the analysis: S09, X02, W01, and P10.

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, 51.3 percent received a preventive or diagnostic visit in 2012 (see Table 7). Of those receiving a preventive or diagnostic visit, 30.8 percent received a follow-up restorative visit.

Table 7: Preventive/Diagnostic Visits Followed by a Restorative Visit by Children Enrolled for Any Period in Medicaid* (Ages 0-20), CY 2008 – CY 2012

Year	Total Enrollees	Preventive / Diagnostic Visit	Preventive / Diagnostic Visit Followed by Restorative Visit
CY 2008	526,970	182,618 (34.7%)	60,735 (33.3%)
CY 2009	562,019	234,806 (41.8%)	77,330 (32.9%)
CY 2010	598,037	275,613 (46.1%)	92,642 (33.6%)
CY 2011	626,207	307,712 (49.1%)	100,402 (32.6%)
CY 2012	645,562	331,496 (51.3%)	102,028 (30.8%)

* The study population for CYs 2008-2012 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including FFS and HealthChoice MCO enrollees. The following coverage groups were excluded from the analysis: S09, X02, W01, and P10.

Although there has been a modest utilization increase in restorative visits since the restorative fee increase in 2004, barriers to receiving restorative care remain. Children who do not receive timely restorative care may ultimately seek care in an emergency room. In CY 2012, 2,899 children with any period of enrollment in HealthChoice visited the emergency room with a dental diagnosis, not including accidents, injury or poison. The percentage of children with emergency room visits relative to the total Medicaid population eligible for dental services remains at less than one percent (see Table 8).

Table 8: Emergency Room Visits with a Dental Diagnosis* by Children Enrolled for Any Period in Medicaid (Ages 0-20), CY 2008 - 2012**

Year	Total Enrollees	Enrollees Who Had an ER Visit with a Dental Diagnosis	Number of Encounters for ER Visits with a Dental Diagnosis
CY 2008	526,970	2,680 (0.51%)	5,272
CY 2009	562,019	2,836 (0.50%)	5,729
CY 2010	598,037	2,982 (0.50%)	5,969
CY 2011	626,207	2,860 (0.46%)	5,698
CY 2012	645,562	2,899 (0.45%)	5,699

* 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.

** The study population for CY 2008 – CY 2012 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including FFS and HealthChoice MCO participants. The following coverage groups were excluded from the analysis: S09, X02, W01, and P10.

Pregnant Women and Dental Utilization

Prior to the implementation of HealthChoice in 1997, Medicaid did not cover adult dental care. Maryland Senate Bill 590 (1998) required that HealthChoice cover dental services for all pregnant women. In July 2009, DentaQuest took over

administration of dental services for pregnant women. DentaQuest identifies pregnant women by eligibility coverage groups and by using dental claims data to identify if a patient is pregnant at the time of treatment.

The percentage of pregnant women 21 years and over enrolled for at least 90 days receiving dental services was 30.1 percent in CY 2012 (see Table 9). The percentage of pregnant women 14 years and over enrolled for any period receiving a dental service in 2012 was 30.7 percent, as compared to 32.7 percent in 2011 (see Table 10). There is no comparable HEDIS™ measure for dental services for pregnant women.

Table 9: Percentage of Pregnant Women* 21+ Receiving Dental Services Enrolled in Medicaid for at Least 90 Days

Year	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service
CY 2008	13,869	2,889	20.8%
CY 2009	17,402	4,931	28.3%
CY 2010	19,837	5,875	29.6%
CY 2011	20,572	6,689	32.5%
CY 2012	21,708	6,537	30.1%

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 2008	20,005	4,354	21.8%
CY 2009	23,831	6,879	28.9%
CY 2010	26,175	7,997	30.6%
CY 2011	26,405	8,622	32.7%
CY 2012	27,092	8,330	30.7%

* 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) kick payments for live births in the CY capitation rate dataset, (3) payment for an individual in a Sixth Omnibus Budget Reconciliation Act (SOBRA) rate cell for pregnant women, and (4) delivery CPT codes. The study population for CYs 2008-2012 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including FFS and HealthChoice MCO participants. The following coverage groups were excluded from the analysis: S09, X02, W01, and P10.

HealthChoice Dental Utilization Rates

Non-Pregnant Adults and Dental Utilization

Apart from dental services covered for pregnant women and adults in the Rare and Expensive Case Management (REM) Program, adult dental services are not included in MCO or ASO capitation rates, and therefore are not required to be covered under HealthChoice or DentaQuest. In CY 2008, all seven HealthChoice MCOs provided a

limited adult dental benefit, and spent approximately \$8.86 M for these services. After transitioning to DentaQuest, the MCOs spent \$12.3 M on adult dental services in CY 2009, \$6.5 M in CY 2010, \$11.4 M in CY 2011, and \$11.1 M in CY 2012.

As of July 2013, five of eight HealthChoice MCOs provide limited dental services to non-pregnant adults (see Table 11). In CY 2012, 21.9 percent of non-pregnant adults enrolled in a HealthChoice MCO for at least 90 days received at least one dental service, down from 22.7 percent in CY 2011 (see Table 12).

Table 11: HealthChoice Dental Benefits for Non-Pregnant Adults as of July 2013	
MCO	Dental Benefits Offered
AMERIGROUP Community Care	Oral exam and cleaning twice a year; limited x-rays; no fillings or extractions; 20% off non-covered dental services.
Diamond Plan (Coventry)	No adult dental services offered. (No longer participating with HealthChoice, effective September 30, 2013.)
Jai Medical Systems	Oral exam and cleaning twice a year; limited x-rays; unlimited fillings; limited extractions; no discount on non-covered dental services.
Maryland Physicians Care	Oral exam and cleaning twice a year; limited x-rays; unlimited fillings; limited extractions; 20% off non-covered dental services.
MedStar Family Choice	Oral exam and cleaning twice a year; limited x-rays; limited fillings; limited extractions; no discount on non-covered dental services.
Priority Partners	No adult dental services offered.
Riverside Health	Oral exam and cleaning twice a year; limited x-rays; limited fillings; limited extractions; no discount on non-covered dental services.
UnitedHealthcare	No adult dental services offered.

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

Year	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service
CY 1999	111,753	16,139	14.4%
CY 2000	114,223	16,986	14.9%
CY 2001	111,694	16,795	15.0%
CY 2002	117,885	16,800	14.3%
CY 2003	116,880	21,288	18.2%
CY 2004	115,441	12,457	10.8%
CY 2005	116,266	11,093	9.5%
CY 2006	114,844	11,747	10.2%
CY 2007	138,212	18,290	13.2%
CY 2008	125,386	23,587	18.8%
CY 2009	177,474	26,063	14.7%
CY 2010	195,577	29,106	14.9%
CY 2011	223,582	50,675	22.7%
CY 2012	236,205	51,619	21.9%

Strategies to Improve Access to Dental Care

Prior to 2009, the Department monitored the number and percentage of oral health services provided by HealthChoice MCOs on a biannual basis using encounter data, a methodology that tracks participant interactions with providers (e.g., clinic visits, prescriptions). The Department reviewed MCOs' outreach plans, and held MCOs accountable for not meeting established dental utilization targets with Value Based Purchasing (VBP) incentives and sanctions. In CY 2008, the VBP target for an MCO to receive an incentive payment was 50 percent utilization for children, with sanctions given to an MCO with utilization of less than 47 percent.

Following the DAC recommendation to institute a single ASO to administer Medicaid dental benefits, the Department selected DentaQuest to function as the Department's ASO for all dental services for children, pregnant women, and REM Program adults. Since its start in July 2009, DentaQuest has been responsible for all functions related to the delivery of dental services including provider network development and maintenance, claims processing, utilization review, authorization of services, outreach and education, and complaint resolution. During the first contract year, utilization rates and provider networks increased. Also in July 2009, the Department began training and reimbursing primary care providers for the application of fluoride varnish for children up to three years of age. Consequently, utilization for children under the age of three has increased, and by June 2013, 441 unique EPSDT certified providers administered over 84,685 fluoride varnish treatments. In CY 2012, DentaQuest started working on its goal to assign all child recipients to a dental home.

The dental home initiative is operating in four Maryland counties to date, with more counties expected to launch dental homes in September 2013.

Funding

Medicaid dental funding for children and pregnant women has increased in recent years, from approximately \$12 M in CY 2000, to \$150.5 M for CY 2012 (see Attachment 4). This growth in funding reflects increases in the Medicaid fee schedule for selected codes to the 50th percentile of the ADA's South Atlantic region charges for dental services. It also reflects increased utilization due to improved outreach activities, and additional providers participating with the Medicaid program.

A detailed history of Medicaid dental funding is below:

- For CY 2004, the Department allowed sufficient funding for 40 percent utilization. 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 to that used for CY 2004. 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, in response to increased utilization in CY 2006, MCOs received \$42.5 M in dental capitation payments for children and pregnant women. The MCOs reported spending \$53.8 M, including \$5.36 M on adult dental services.
- In CY 2008, MCOs received \$55.4 M in dental capitation payments for children and pregnant women due to increased utilization. The MCOs reported spending \$71.4 M, including \$8.86 M on adult dental services.
- In CY 2009, MCOs were responsible for providing dental services for children and pregnant women for the first half of the year. Capitation rates for dental services for the first half of CY 2009 totaled \$39.6 M. Beginning July 1, 2009, DentaQuest began paying dental claims on a fee-for-service basis. The total dental expenses for the second half of 2009 totaled \$43.2 M, for a total of \$82.8 M spent in CY 2009. An additional \$12.3 M was spent by the MCOs for adult dental in CY 2009.
- In CY 2010, DentaQuest dental expenses totaled \$137.6 M for children and pregnant women. HealthChoice adult dental expenditures totaled \$6.5 M, for which MCOs did not receive reimbursement.

- In CY 2011, DentaQuest dental expenses totaled \$152.7 M for children and pregnant women. HealthChoice adult dental expenditures totaled \$11.4 M, for which MCOs did not receive reimbursement.
- In CY 2012, DentaQuest dental expenses totaled \$150.5 M for children and pregnant women. HealthChoice adult dental expenditures totaled \$11.1 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 67.8 percent in 2012. In 1999, utilization for children was ten percentage points below the national HEDIST™ average, and by 2012, utilization had increased to more than 22 percentage points above the most recent national HEDIST™ average. However, many children still are not receiving needed dental services, and the program needs additional improvements. The DAC addressed barriers to dental care access by making key recommendations to both increase reimbursement for Medicaid dental services, and institute a single dental ASO. The Department supports and, to a great degree, has effectively instituted the reforms recommended by the DAC to address the barriers to dental care access previously experienced in the state. Dental provider rates increased in 2008, and the Department is committed to a second round of rate increases once the state budget situation improves.

In conjunction with DentaQuest, the Department has reformed and rebranded the Medicaid dental program. 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 allowing 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 March 2013, DentaQuest has trained 727 fluoride varnish providers in Maryland. The utilization rate of children ages 0-3 years has experienced a steady increase from CY 2009 through CY 2012, 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 sixth “Access to Care Day” on September 19, 2013 as part of its annual organizational meeting. As in past “Access to Care Day” events, representatives from DentaQuest will be present at the meeting to enlist new dentists for the program. In addition, Dr. Harry Goodman, the OOH Director, gave a presentation on the progress of the reforms the state has instituted in response to the DAC’s recommendations. These events are part of the dental association’s efforts to partner with the Department in recruiting new dentists into the Maryland Healthy Smiles Program. Dentists and dental hygienists who attend the session receive free continuing education credits and training in pediatric dentistry. These annual programs have given dentists and their staff the opportunity to discuss the Maryland Healthy Smiles Program and other state oral health

issues with DentaQuest representatives, Departmental staff, and members of the newly organized MDAC.

The Department is committed to continued improvement upon successes in improving oral health in the Maryland Medicaid Program, and to working with the MDAC on recommended strategies to make access to dental care and a dental home a reality for all Maryland children.

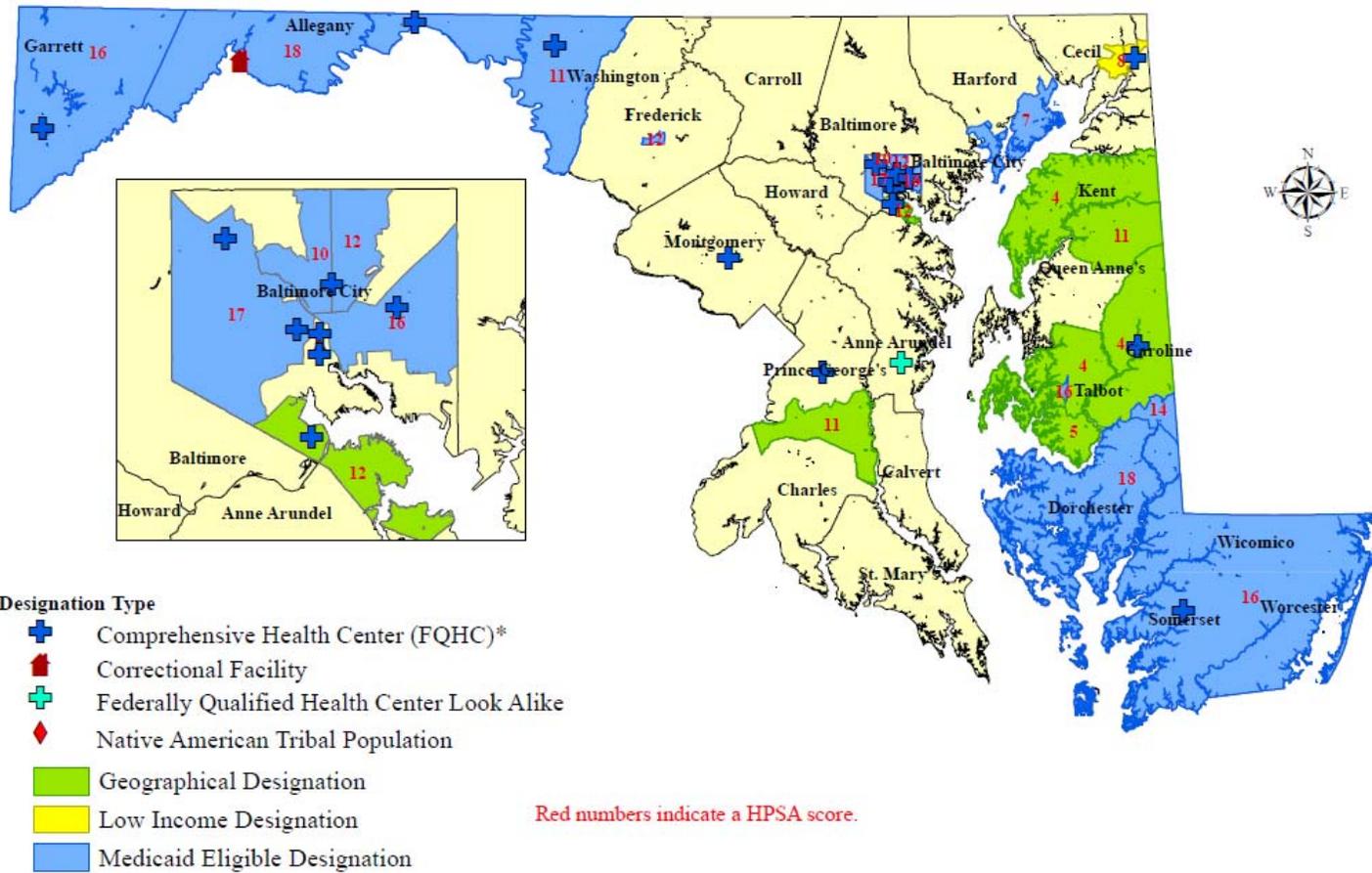
Attachment 1: Dental Procedures Targeted for FY 2009 Fee Increases

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

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

Attachment 2: Map of Maryland Health Professional Shortage Areas (HPSAs)

Maryland Health Professional Shortage Area (HPSA) Designations for Dental Care as of 08/13/2013



*Only the headquarter sites are displayed.

Created by Office of Primary Care Access, HSIA, Maryland DHMH. Last reviewed 08/13/2013
 Source: HRSA Data Warehouse and 2010 Census. For more information on federal shortage designations, visit <http://hpsafind.lrsa.gov>

Attachment 3: Medicaid Dental Utilization Rates, CY 2002 – CY 2012 (Enrollment in Medicaid ≥ 320 Days*, Ages 4-20)

Criteria	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Age											
4-5	33.7%	42.8%	43.6%	45.9%	46.2%	52.5%	57.0%	60.9%	67.8%	70.8%	72.3%
6-9	38.2%	48.0%	48.7%	51.1%	51.6%	57.6%	62.5%	65.6%	71.5%	73.8%	74.9%
10-14	35.5%	44.0%	44.8%	46.9%	47.5%	53.2%	57.2%	60.7%	66.4%	68.5%	69.8%
15-18	29.9%	38.0%	37.6%	39.7%	40.2%	44.3%	47.6%	51.2%	55.9%	58.5%	59.4%
19-20	20.8%	26.8%	26.8%	27.7%	26.9%	28.4%	33.2%	37.5%	38.6%	41.2%	43.0%
All 4-20	34.5%	43.2%	43.7%	45.8%	46.2%	51.5%	55.7%	59.0%	63.9%	66.4%	67.8%
Region**											
Baltimore City	27.8%	35.6%	35.8%	38.1%	38.8%	45.9%	51.8%	56.6%	62.4%	64.4%	65.0%
Baltimore Suburbs	37.7%	46.1%	46.1%	47.0%	47.1%	51.4%	54.8%	56.7%	61.7%	63.6%	66.0%
Washington Suburbs	39.6%	47.8%	46.4%	50.2%	49.5%	54.8%	58.8%	62.1%	65.8%	70.4%	71.9%
Western Maryland	42.8%	51.0%	56.1%	56.4%	55.7%	59.3%	61.9%	64.1%	56.9%	69.6%	69.4%
Southern Maryland	31.8%	39.6%	39.5%	40.0%	43.3%	46.7%	52.2%	56.1%	66.6%	57.5%	58.7%
Eastern Shore	31.3%	44.4%	48.2%	49.2%	51.8%	55.7%	55.7%	59.4%	69.6%	67.9%	69.1%
All Regions	34.5%	43.2%	43.7%	45.8%	46.2%	51.5%	55.7%	59.0%	63.9%	66.4%	67.8%

* The study population for CY 2012 measured dental utilization for all qualifying individuals in Maryland’s Medical Assistance program, including fee-for-service (FFS) and HealthChoice MCO enrollees. The following coverage groups were excluded from the analysis: S09, X02, W01, and P10.

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

Attachment 4: Medicaid Dental Funding, Expenditures, and Utilization Rates, FY 1997 – CY 2012

MCO and DentaQuest Funding and Expenditures for Dental Services, FY 1997 – CY 2012				
Utilization of Dental Services in HealthChoice and DentaQuest, FY 1997 - CY 2012				
Year	Amount Paid in MCO Capitation Rates or DentaQuest for Dental	Amounts Spent by MCOs for Dental[±] (Includes Adult Dental)	Utilization Rate for General Access (Children 4-20 Years with 320 Days of Enrollment)	Utilization Rate for Restorative (Children 4-20 Years with 320 Days of Enrollment)
FY 1997	N/A	\$2.7 M*	19.9%	6.6%
CY 2000	\$12.3 M (est.)	\$17 M (est.)	28.7%	9.3%
CY 2001	\$27.1 M	\$23.6 M	33.6%	10.8%
CY 2002	\$40.3 M	\$28.9 M	34.5%	10.3%
CY 2003	\$33 M	\$32.5 M	43.2%	13.6%
CY 2004	\$28 M	\$36.7 M	43.7%	13.8%
CY 2005	\$33 M	\$42.0 M	45.8%	15.8%
CY 2006	\$35.1 M	\$46.6 M	46.2%	16.4%
CY 2007	\$42.5 M	\$53.8 M	51.5%	19.3%
CY 2008	\$55.4 M	\$71.4 M	54.6% [†]	20.8% [†]
CY 2009**	\$82.8 M	\$39.3 M	60.9%	23.2%
CY 2010***	\$137.6 M	\$6.5 M	64.1%	25.1%
CY 2011	\$152.7 M	\$11.4 M	66.6%	25.2%
CY 2012	\$150.5 M	\$11.1 M	67.8%	24.3%

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

** In CY 2009, the total spent by the Department on dental services was \$82.8 M. This included \$39.6 M in MCO capitation rates for dental services from January 1, 2009 – June 30, 2009 and \$43.2 M for dental services under the new Maryland Healthy Smiles Program for the period July 1, 2009 – December 31, 2009.

*** Beginning in FY 2010, Maryland Healthy Smiles is reimbursed FFS and paid an administrative fee. The \$6.5 M in CY 2010 and \$11.4 M in CY 2011 spent by MCOs account for adult dental services only and is not reimbursed by the state.

[†] The study population for CYs 2008-2012 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including FFS and HealthChoice MCO enrollees. The following coverage groups were excluded from the analysis: S09, X02, W01, and P10.

[±] Source: HealthChoice Financial Monitoring Report.

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, Maryland House Bill 30 (Ch. 528 of the Acts of 2007) and Senate Bill 181 (Ch. 527 of the Acts of 2007) established the Oral Health Safety Net Program within the Department's OOH. The purpose of the program is to support collaborative and innovative ways to expand oral health capacity for low-income, disabled, and Medicaid populations by awarding community-based oral health grants to local health departments, FQHCs, and other non-profit 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 enabling legislation, the Department has recruited a licensed public health dentist for the OOH. The public health dentist provides dental expertise on policy development, legislation, surveillance, protocol evaluation, provider recruitment, and continuing education courses for providers that offer oral health treatment to underserved populations. This legislation has also enabled the OOH 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-based/linked dental initiatives that include mobile dental 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." Because it is such a valuable tool in evaluating the progress being made in the oral health of school children, the OOH has continued to update this survey on a regular basis. In June 2010, the OOH entered into a Memorandum of Understanding with the University of Maryland School of Dentistry to conduct the statewide needs assessment in late September 2011, coinciding with the beginning of the school year. The purpose of this needs assessment was to update oral health status trends in this population since the last oral health needs assessment, *The 2005-2006 Oral Health Survey of Maryland School Children*, and to recommend, develop, and/or revise statewide programmatic priorities and strategies in the overall oral health care delivery system based on the findings.

Great progress on the development of this oral health needs assessment has been made since last year. In June 2011, the study design was finalized and the necessary commitments to conduct the survey were secured from the majority of county school superintendents, as well as

from the Maryland State Superintendent of Schools. University of Maryland School of Dentistry researchers randomly selected 60 schools in 19 counties to create a sample representative of Maryland's statewide population. In August 2011, data collection schedules were established with sample schools. Public schools were eligible for selection in all school districts except Montgomery County, which did not participate. The final sample included 50 elementary schools (of the target 60) from 17 school districts (of the target 19), and despite one district declining participation, the sample size was still representative of all regions of the state and met the sample size requirement established by the CDC.

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

The final report, which will be available in the fall of 2013, will highlight the following types of analyses, stratified by grade, geographic region, dental insurance status, and eligibility for free/reduced school meals:

- Prevalence of lifetime dental caries experience;
- Prevalence of current decay (active disease);
- Prevalence of toothache pain;
- Having a usual source of dental care;
- Dental visit rates;
- Prevalence of dental sealants; and
- Treatment needs.

Carrying out Major Oral Health Recommendations of DAC

As discussed in Part 1 of this report, the Department convened the DAC to develop strategies to expand Maryland's oral health services to low-income individuals. The DAC recommended maintaining and enhancing the dental public health infrastructure through the Department's OOH by ensuring that residents in each local jurisdiction have access to a local health department dental clinic and/or other community oral health safety net clinic. In order for this to occur, the Oral Health Safety Net statute requires funding to fulfill the requirements outlined therein.

In light of the DAC's recommendation to the Secretary to strengthen the dental public health infrastructure, the Governor's FY 2014 budget for the Department's Prevention and Health Promotion Administration included \$1.5 M to bolster clinical dental treatment and preventive services for low-income Maryland children, especially those who are Medicaid-eligible or uninsured, and to support many of the requirements listed in the 2007 Oral Health Safety Net legislation. While these Oral Health Safety Net grant funds are being used statewide, they have been specifically targeted to provide dental services in jurisdictions previously identified as not being served by a public health dental clinical program (Calvert, Kent, Queen Anne's, St. Mary's, and Worcester Counties).

The OOH, in coordination with the Department's Office of Capital Planning, Budgeting, and Engineering Services, has issued capital infrastructure grants to Harford, Charles, and Worcester Counties over the past decade to acquire, design, construct, renovate, convert, and equip dental program facilities. The Worcester County Health Department began operating its dental clinic in April 2011, after receiving a capital infrastructure grant in 2008. In FY 2012, the OOH provided operational funds to these three local health department clinical dental programs, as well as to other jurisdictions throughout Maryland. As of the end of FY 2013 (June 30, 2013), OOH grants contributed to 29,449 children and 11,401 adults being seen in local health department dental programs, and 39,740 children and 19,359 adult clinical visits. Further, 3,156 adults received emergency treatment in local health department programs because of these grants.

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

In FY 2013, the OOH continued to fund new and established dental programs to address immediate service needs, and to increase the service capacity of dental practitioners. Since 2009, these grants have provided continued support for both new and established clinical programs to expand oral health services and school-based oral health services.

Addressing Immediate Service Needs

Support for New Clinical Programs Funded Since 2009

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

- *Calvert County.* Since its inception in September 2009, Calvert Memorial Hospital's project has provided direct services to Medicaid and other low-income children in Calvert and St. Mary's Counties. This program includes two volunteer dentists, three local dentists (including a pediatric dentist), three dental hygienists, and two dental assistants who provide preventive and restorative oral health services as well as basic oral surgeries. Originally an arrangement was negotiated with two local private dental offices to perform dental care services in their facilities. However, in FY 2012 the dental program moved into its own location in collaboration with the American Legion to provide an affordable leasing arrangement. This dental program is now woven into the fabric of the Lusby community and provides a dental home to many residents. The program also offers school-linked services to a low-income community in Calvert County (Lusby), and offers both risk assessments and preventive services through an arrangement with local Head Start, WIC, and Judy Center programs.
- *Kent/Queen Anne's Counties.* Having begun operations in fall 2009, the Kent County Local Health Department project aims to increase access to comprehensive oral health services and to enhance dental capacity for low-income pre-school and school children in Kent and Queen Anne's Counties. The project currently employs a dental hygienist under the general supervision of a local dentist to oversee a local mobile dental team and establish transportation for patients to regional dental homes through the purchase and operation of a wheelchair-accessible van. The project conducts risk assessments, and in order to ensure patients have dental homes, offers prevention services and links those patients requiring intensive oral health treatment with community dentists or dental programs.
- *Worcester County.* Since its creation in April 2011, the Worcester County Local Health Department program has provided comprehensive oral health education, prevention, and treatment services for Medicaid and low-income, uninsured children in the county. The project enhances regional efforts for screening and primary prevention in the community, including schools and Head Start programs. The OOH plans to maintain funding for the dental project until it is 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 Health Department whereby the local health department acts as an intermediary between Medicaid and local dental providers. This arrangement has led to enlisting the majority of dentists practicing in this jurisdiction to be Medicaid providers, and the local health department serving as an entry point to dental care for Medicaid patients. Due to the long-term success of this program, it was deemed unnecessary to provide financial support for this program similar to the type given to other "in-need" counties.

Support to Established Clinical Dental Programs to Expand Oral Health Services

The following counties receive funds annually from the OOH 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 extensive dental treatment needs.
- *Carroll County*. Carroll County Health Department funds a dentist to provide support for pediatric dental services for Medicaid and other low-income Carroll County children.
- *Charles County*. Charles County Health Department now provides adult dental services for low-income Charles County adults and seniors by supporting the cost of a dentist.
- *Harford County*. Harford County Health Department expanded the space for its dental clinical program in April 2012 and increased the number of dental chairs from three to six. This expansion was necessitated by the program's success in providing access for low-income county residents. The health department can now accommodate more patients.
- *Howard County*. Howard County Health Department began providing pediatric dental services for Medicaid and other low-income children in Howard County by contracting with FQHC Chase Brexton Health Services and supporting a dentist at that facility.
- *Prince George's County*. Prince George's County Health Department initiated provision of pediatric dental services for Medicaid and other low-income Prince George's County children by supporting bringing a dentist on staff. As of July 2013, the Prince George's County Health Department is now administering and operating the Deamonte Driver Dental Van Project (DDDVP), which targets low-income school children.
- *Worcester County*. Worcester County Health Department provides both restorative and preventive dental services for Medicaid and other low-income Worcester County children through an expansion of the fluoride varnish program provided by dental and

medical professionals, and provision of clinical and school-based/linked oral health services for children and adults.

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

New and established school-based funding initiatives from the OOH 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 OOH is supporting the following five school-based oral health models:

- *Deamonte Driver Mobile Dental Van Project (DDDVP).* The Prince George's County Health Department receives funding for this program to deliver school-based oral health care services, and to provide a dental home for children in Prince George's County and surrounding areas where there are no available dental services. This project has helped enroll additional Medicaid dental providers in the community who are willing to provide complex dental treatment for children unable to be treated on the van. The dental van provides diagnostic, preventive, and simple restorative dental services to low-income students in one Montgomery County school and in 20 Prince George's County schools. The Prince George's County Foundation School is one of these sites, and is where Deamonte Driver, the 12-year old Prince George's County child who died from a dental infection, attended school. During the 2012-2013 school year (as of June 30, 2013), the DDDVP saw 1,391 children, of which 55 needed immediate or urgent care and were referred to neighborhood dental clinics. The Van has scheduled visits to 20 schools during the 2013-2014 school year, and the DDDVP will also work collaboratively with the Colgate Bright Smiles/Bright Future Mobile Dental Unit to provide services to five Title I schools, which typically have 35 percent or more of their population enrolled in free and reduced meal programs.
- *School-Based Dental Sealant Services.*
 - In 2008, the Department's OOH received a five year grant award from the CDC for a *State-Based Oral Disease Prevention Program*. This grant builds upon the existing efforts of the OOH to plan, implement, and evaluate population-based oral disease prevention and promotion programs. As part of this grant, the OOH developed a school-based dental sealant demonstration project to examine the logistics and cost-effectiveness of school-based dental sealant services. School dental sealants are one of two evidence-based oral disease prevention services (along with community water fluoridation) highly recommended by many federal agencies. The OOH partnered with the University of Maryland School of Dentistry for this initiative, 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. The quantitative and qualitative findings from this demonstration program gave the OOH a greater understanding and perspective on how to conduct a statewide school-based dental sealant program.

- In 2012 the OOH received a 3-year HRSA *State Oral Health Workforce* grant that provided support for direct school-based and/or linked school dental sealant services. The OOH used these funds to issue a FY 2013 RFA exclusively for local health departments to develop statewide school-based and/or school-linked dental sealant programs for their own jurisdictions. Eleven local health departments received OOH awards to implement school dental sealant programs in FY 2013. Local health departments receiving these grants are: Allegany, Baltimore, Calvert, Cecil, Charles, Howard, Kent, Prince George's, Somerset, St. Mary's, and Washington Counties. By the end of FY 2013 (June 30, 2013) screening results for school children at these eleven health departments achieved the following results for schoolchildren: 7,180 screened, 3,254 referred for further treatment, 22,820 received oral health education, and 3,194 received dental sealants. The school dental sealants grant program has been well-received, and consequently expanded in FY 2014 with 12 grant awards to local health departments. In addition, school-based oral health access programs have been operating in 11 schools since FY 2010 in Kent and Queen Anne's Counties using a mobile dental team.
- CDC funds also allowed for the successful recruitment of a School-Based Dental Sealant Coordinator in March 2011. The OOH's dental sealant demonstration project has served as a guide for the development of new and existing policies and programs that support statewide oral disease prevention and community-based public health prevention services. As a result, using funds from a 3-year HRSA *State Oral Health Workforce* grant, the OOH for the first time issued a RFA in FY 2013 for local health departments to develop statewide school-based and/or school-linked dental sealant programs for their own jurisdictions. Eight local health departments were awarded grants for the first time under this RFA in July 2012. The OOH developed a dental sealant manual to assist local health departments in the implementation of school-based or school-linked dental sealant programs. The new statewide school-based/linked dental sealant project also includes a website - Mighty Tooth (<http://mightytooth.com/>). The statewide dental sealant program places a special emphasis on vulnerable populations, specifically school children in Title I schools. The high-risk, low-income students that attend Title I schools make these institutions appropriate venues for provision of preventive dental sealant and other prevention services such as topical fluoride modalities to inhibit the onset of dental decay.
- *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.

Community Water Fluoridation

Health experts endorse community water fluoridation as the single most effective public health measure to improve oral health by preventing tooth decay. Fluoride added to community drinking water at a concentration of 0.7 parts per million is one of two evidence-based oral disease prevention strategies (along with school-based dental sealants) that has repeatedly demonstrated that it is safe, inexpensive, and extremely effective in preventing tooth decay. Because community water fluoridation benefits everyone in the community, regardless of age and socioeconomic status, fluoridation is an especially important tool in providing protection against tooth decay in populations with limited access to prevention services. A U.S. Healthy People 2020 objective is to increase the percentage of persons on public water receiving fluoridated water to 79.6 percent. In Maryland, 93.1 percent of the population with public water receives fluoridated water.

To address water fluoridation needs in Maryland, the OOH partners with the Maryland Department of Environment. The agencies work collaboratively to create fluoridation plans, share fluoridation data, monitor fluoride levels, and generate annual reports. The OOH used funding support from its CDC and HRSA grants in FY 2013 to ensure that a high percentage of Marylanders continue to enjoy access to the benefits of optimally fluoridated water. The OOH entered into a partnership with the Maryland Rural Water Association (MRWA) in order to survey community water systems with the goal of providing technical assistance while gathering information on equipment needs, operator training levels, and a variety of other data points that play a part in the water fluoridation process. A total of 27 fluoridation stations across 14 water systems were surveyed. The surveys identified two key items that need to be addressed to ensure that properly fluoridated water continues to be provided to the majority of Marylanders: 1) fluoridation equipment maintenance, repair, and replacement; and 2) fluoridation training for water operators.

Almost all water systems surveyed had fluoridation equipment that needed maintenance, repair, and replacement. Unfortunately, these systems have limited budgets and available funds are typically used for what are more perceived to be more pressing concerns. Utilizing funding available through its CDC grant, the OOH began providing replacement fluoridation equipment to systems in need.

In addition to equipment maintenance, repair, and replacement, the surveys also identified a need for fluoridation-specific training for water operators. Most operators surveyed have some training on water fluoridation, but expressed a desire for more education. The two providers of water operator training in Maryland currently offer only one abbreviated fluoride class between them. Moving forward, utilizing HRSA grant funding, the OOH is working to expand its partnership with the MRWA to include offering a full day fluoridation training class for water operators on a quarterly basis at strategic locations throughout the state.

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 Commission has awarded 20 dental services grants totaling \$4.6 million. The MCHRC dental grant projects, which were awarded to local health departments, FQHCs, and private, non-profit foundations and hospitals throughout the state, have collectively served more than 35,000 low-income children and adults, resulting in nearly 84,000 visits.

The MCHRC seeks to support programs that will be sustainable after its initial grant funds have been expended. MCHRC dental grantees leveraged their grant resources to secure more than \$2.9 million in additional federal, local, private, and other resources to maintain programs in their underserved communities. The MCHRC continues to expand access to dental services for both adults and children. Following is a summary of recent grants awarded by the MCHRC:

- **Walnut Street Community Health Center (new)**, an FQHC located in Hagerstown, was awarded a two-year grant (\$98,000) in FY 2012 that supports a mobile dental program which provides dental sealants and cleanings in four Title 1 schools in Washington County, at Head Start locations, and at several community health centers. The mobile dental unit has two separate patient treatment areas, each with a dental chair. In addition to the mobile dental program, Walnut Street provides a pediatric dental program in its offices in downtown Hagerstown. Since its inception, the mobile dental program has provided dental services to nearly 500 patients.
- **Bel Alton Community Development Corporation (new)**, a non-profit organization in southern Maryland, was awarded a two-year grant (\$250,000) in FY 2012 to support a school-based dental outreach program and dental clinic for underserved communities in southern Maryland. In addition to grant funds, Bel Alton has leveraged federal capital resources to help pay the costs of dental equipment. Bel Alton has successfully screened 100 percent of the 4th and 5th grade students in six Title I Charles County schools, initiated dental screenings in two of the four targeted elementary schools in St. Mary's County, and finalized screening arrangements for the remaining two elementary schools in St. Mary's County. Furthermore, conversations are taking place with the Calvert County School Board to initiate screenings. Bel Alton reports providing dental services to more than 799 students at participating schools.
- **The Baltimore City Health Department (new)**, was awarded a two-year grant (\$58,428) in FY 2012 to help integrate oral health education and screening into the immunization services program operated by the Baltimore City Health Department. Since its inception, the project has reached more than 425 children, many of whom are uninsured and have no dental home. This one-of-a-kind, innovative project provided unique access to a high-risk population.

- **Choptank Community Health System**, an FQHC centrally located in Caroline County, was awarded a two-year grant (\$270,000) in FY 2011 to provide access to dental services in nearby Kent County, a Medically Underserved Area (MUA). The grant supported a partnership with the Chestnut River Hospital Center to provide pediatric dental surgery services. During the second year of the program, the hospital increased the number of children with complex dental needs served, providing services to 163 underserved children on the Eastern Shore. The hospital has committed to continuing the program beyond the expiration of the MCHRC funding.
- **Health Partners**, a free clinic in Charles County, was awarded a two-year grant (\$120,000) in FY 2011 to expand its dental capacity and school-based dental program. Since receipt of the MCHRC grant, Health Partners has reported serving more than 1,400 adults and children, far exceeding initial grant projections.
- **Access Carroll**, a free clinic in Carroll County, was awarded a two-year grant (\$300,000) in FY 2011 to support a new dental facility integrated with Access Carroll's current health care services. The grant enabled Access Carroll to provide access to emergency dental services, including extraction and repair of teeth for uninsured, underinsured, and low-income residents of Carroll County during the first project year. The project has provided dental services to more than 100 uninsured patients since its inception, and the number of patients served will expand with the new dental facility opened in 2013.

Pediatric Dental Fellows

The Pediatric Dental Fellows Program, administered by the University of Maryland School of Dentistry in partnership with the OOH, has been in existence for over a decade. The goal of the program is to place trained pediatric dentists in the community (local health departments, and FQHCs and community health centers) to provide comprehensive oral health services to Medicaid recipients. These dental fellows, most of whom are foreign dental graduates who have successfully completed U.S. pediatric dental residency programs, receive a Maryland dental license through this program. They are specially trained to provide care to children less than five years of age; some are also able to provide operating room care. Unfortunately, because of difficulties in obtaining U.S. visas, there are no pediatric dental fellows actively participating in the program. Despite the current situation, it is important to note that two pediatric dental fellows who successfully completed the program continue to provide dental care services to Medicaid patients in FQHCs in Montgomery and Washington Counties. One fellow is the dental director of his respective clinical dental program; the other fellow is a part-time employee of the Frederick County Local Health Department. Other fellows have established successful private dental practices in other locations and continue to treat Medicaid patients.

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

These programs are an outgrowth of the *Oral Health Demonstration Project: Maryland State Children's Health Insurance Program* conducted by the University of Maryland School of Dentistry from January 1999 through June 2001 in two regions in Maryland. The Eastern Shore Oral Health Outreach Program and the Lower Eastern Shore Dental Education Program expand the success of the earlier demonstration project to all Maryland Eastern Shore counties. One of the goals of these programs is to provide case management oral health services, education, screenings, and fluoride varnish and rinse programs for WIC and Head Start children, and their families on the Eastern Shore. This program is also currently working on a data collection tool to better identify children at risk for oral disease and to coordinate their care through the Medicaid dental administrator with local private and public oral health care resources.

Maryland Dent-Care Loan Assistance Repayment Program

The purpose of the Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP) is to improve access to oral health care services by increasing the number of dentists that provide services for Medicaid recipients. In CY 2012, a total of 15 dentists participated in the program; five of these dentists completed their three-year service obligation in December 2012. 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 2013, five new MDC-LARP dentists started the program, who will continue working with it through December 2015. During CY 2012, MDC-LARP dentists treated 12,946 non-duplicated patients, and had 32,365 dental visits by Medicaid recipients. MDC-LARP dentists have seen 97,391 non-duplicated patients through 243,477 patient visits since the inception of the program in 2001.

Part 3. Oral Cancer Initiative

Background

Maryland House Bill 1184 (Ch. 308 of the Acts of 2000) and Senate Bill 791 (Ch. 307 of the Acts of 2000) established the Department's Oral Cancer Initiative (Health-General Article, §18-801—802). This statute requires that the Department develop and implement programs to train health care providers on screening and referring patients with oral cancer, and provide education on oral cancer prevention for high-risk, underserved populations. This legislation requires that the OOH develop activities and strategies to prevent and detect oral cancer in the state, with a specific emphasis on high-risk, underserved populations. The major components of this initiative are oral cancer education for the public, education and training for dental and non-dental health care providers, screening and referral, if needed, and an evaluation of the program.

The Oral Cancer Mortality Prevention Initiative (the Initiative), directed by the OOH, enables counties to provide an education and awareness campaign to the public, and to address oral cancer screening training needs among health care providers. Since funds were made available for the Initiative in 2000, 21,380 people have been screened for oral cancer, and 4,660

health care providers have received oral cancer prevention and early detection education through OOH grants to local health departments throughout Maryland.

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

During this same period, the Maryland General Assembly created the Cigarette Restitution Fund Program (CRFP) (2000), which provides funds for cancer prevention, education, screening, and treatment for seven targeted cancers, including oral cancer. Some local jurisdictions have opted to provide oral cancer screening and/or education to residents. To date there have been 10,443 oral screening exams, and 15,890 health care providers have received oral cancer prevention and early detection education through CRFP grants. Two jurisdictions, Baltimore City and Garrett County, continue to use CRFP funding for oral cancer screening activities. In cooperation with the OOH, the CRFP develops and maintains the Oral Cancer Minimal Clinical Elements for screening, diagnosis, treatment, follow-up, and care coordination to provide guidance for public health programs that screen for oral cancer. In addition, Johns Hopkins University and the University of Maryland use CRFP cancer research funds to conduct oral cancer research.

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

Oral cancer mortality rates have decreased from 2006 to 2010. According to data from the CDC's most recent reporting period (2006-2010), Maryland ranks 21st among all states compared to 8th as reported for 1997-2001, and now has a mortality rate (2.3 per 100,000 population) similar to the national average. From 2006 to 2010, oral cancer mortality rates decreased at a rate of 6.0 percent per year for blacks and 4.1 percent per year for whites.¹⁵

The incidence of oral cancer in Maryland increased at a rate of 4.0 percent per year from 2006 to 2010.¹⁵ From 2006 to 2010, oral cancer incidence rates in Maryland decreased at a rate of 1.0 percent per year for blacks, and increased 5.5 percent per year for whites. The 2010 age-adjusted incidence rate for oral cancer (10.6 per 100,000 population) in Maryland is similar to the national average.¹⁶ In 2010, over 43 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), rather than the local stage (31 percent) which contributes to a low survival rate. Oral cancer has a far better prognosis when found early and at the local stage.

¹⁵ Maryland Cancer Registry.

¹⁶ U.S. Surveillance Epidemiological End Results (SEER).

In 2010, 37.8 percent of persons in Maryland 40 years of age and older reported they had an oral cancer exam in the past year, and 45.6 percent of adults ages 40 and over reported that they received an oral cancer examination at least once in their lifetime. The percent of Maryland residents receiving annual oral cancer examinations since the initial survey in 1996 continues to increase. Despite this progress, there remains considerable room for improvement with respect to the proportion of Marylanders who receive oral cancer examinations. Only 74.5 percent of Marylanders ages 40 and over reported that they had a dental visit of any type in the past year. Some progress in this area has been made for black non-Hispanics in Maryland with 23 percent of those ages 40 and over reporting having an oral cancer examination in the past year, an increase from 20.3 percent in 2002. Because of this progress, some of the oral cancer examination rates surpass the Maryland 2015 target of 48 percent in its Comprehensive Cancer Control Plan.¹⁷

Current Status

In July 2012, the Department awarded grants to local health departments to implement oral cancer prevention initiatives. County initiatives include providing oral cancer education, oral cancer screenings for the public, and education and training of health care providers on the correct method for conducting an oral cancer exam.

As of June 2013, in FY 2013 6,753 individuals received oral cancer screenings. Of those screened, 11 were referred to a surgeon for biopsy. There were also 21,411 individuals educated on oral cancer, and 380 healthcare providers that received education on oral cancer.

In April 2013, the Department observed Maryland Oral Cancer Awareness Month. The OOH provided updated information to county coordinators, including prevention materials, scripts for public service announcements, and articles for local newspapers. During the month, the OOH had a display in the lobby of 201 West Preston Street, which houses the Department of Health and Mental Hygiene, and utilized the building-wide TV monitors and Department-wide email access to share information on oral cancer, including the six steps to an Oral Cancer exam and how to quit smoking. The OOH 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 Maryland Tobacco Quitline brochure is included in the OOH's oral cancer brochure.

The OOH was a sponsor of the 5th Baltimore Oral Cancer Walk/Run for Awareness at Druid Hill Park in Baltimore on April 20, 2013. As a sponsor, the OOH had a display board at the event, and distributed oral cancer brochures, awareness ribbons, and OOH pens to participants.

In keeping with the OOH's efforts to "go green," materials for Oral Cancer Awareness Month were made available online.¹⁸ Every local health department's Tobacco Prevention Coordinator, Cancer Prevention Coordinator, and Oral Health Program Coordinator, along with dentists in the MDC-LARP, received an email notification about the available materials. A

¹⁷ See Maryland Behavioral Risk Factor Surveillance System (BRFSS), 2010.

¹⁸ <http://phpa.dhmh.maryland.gov/oralhealth/SitePages/OCAM%202013.aspx>

Facebook post also announced the availability of materials with the link to the OOH's website. Items available online included a color poster, brochure on oral cancer, a press release, audio and print public service announcements (PSAs), a proclamation, a sample editorial, a bulletin board for local use, a listing of internet resources, and information on the 5K Oral Cancer Walk/Run for Awareness.

The OOH will continue local health department funding to implement the oral cancer prevention program. Furthermore, the OOH will work with local health departments to identify model programs and best practices. Moving forward, the Department's Managing for Results (MFR) target is: "By calendar year 2014, reduce the oral and pharyngeal cancer mortality rate in Maryland to a rate of no more than 2.4 per 100,000 persons" with the aim of continuing to decrease the burden of oral cancer in Maryland.

Conclusion and Future Initiatives

The work outlined in this report continues to be a priority for both Medicaid and the OOH as they continue collaborative efforts to expand oral health access and address oral health disparities for Maryland's low-income and vulnerable populations. Medicaid and the OOH will continue to follow the DAC recommendations, and to work with dedicated state partners through the MDAC. In turn, both Departmental offices envision continued growth and support of the Maryland Healthy Smiles Program, the Oral Health Safety Net Program (including local health department and FQHC clinical dental programs), and the various projects which have stemmed from both offices, so long as there is sufficient funding.

The Department will continue to increase the number of dental service providers, expand education and outreach, and promote oral health literacy for the public, as well as provide funding support for the Oral Cancer Initiative. It also will aim to increase the provision of prevention, early intervention, and educational oral health services in high-risk, low-income venues such as Judy Centers, WIC and Head Start programs, and Title I schools and to supplement current efforts to assure that Maryland residents receive optimally fluoridated water. Oral cancer prevention activities will continue to be a high priority. The Department also envisions a further expansion and sophistication of its oral health surveillance system and aims to target additional populations, such as older adults, in order to better quantify and highlight their oral health needs.

Maryland has been recognized by CMS, the Pew Center on the States, and others as a national leader in access to oral health services. The accomplishments and activities highlighted in this report demonstrate that Maryland's leadership in oral health will continue.