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**STATE OF EMERGENCY:
PROVIDING ORAL HEALTH CARE SERVICE TO
LOW-INCOME AND MEDICAID POPULATIONS IN BALTIMORE**

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TABLE OF CONTENTS

Executive Summary	i.
I. Introduction	1
II. Background	2
A. Federal Medicaid Program: Dental Service	2
B. The State of Maryland’s Medicaid Infrastructure of Dental Services	3
1. <i>Medical Assistance Program (Medicaid)</i>	3
2. <i>The Maryland Children’s Health Program (MCHP)</i>	3
C. A “Silent Epidemic”.....	4
1. <i>A Quantitative Analysis</i>	4
a. <i>Maryland’s Head Start Program: A Step to an Unhealthy Smile</i>	5
2. <i>A Qualitative Analysis: Barriers Preventing the Receipt of Oral Health Services</i>	6
a. <i>Dentists Unwillingness to Treat Medicaid Patients: Children</i>	6
i. <i>Case Study: The Driver Family</i>	6
b. <i>Unavailability of Dental Services for Medicaid-insured Adults</i>	10
c. <i>Oral Health Care Literacy: Adults and Children</i>	10
III. State Initiatives: Policy Recommendation and Implementation Challenges	11
A. Dental Action Committee (DAC)	11
1. <i>Establishing a “Dental Home”: Increase Dentists’ Participation</i>	12
a. <i>Michigan’s Model Blueprint: Medicaid’s Healthy Kids Dental Program</i>	12
b. <i>Maryland’s Initiatives to Increase Dentists’ Participation</i>	15
2. <i>Provide Low-cost Dental Services to Medicaid-insured Adults</i>	15
3. <i>Launch a Unified Oral Health Education Campaign</i>	16
a. <i>A Closer Look: Dental Care Services in Baltimore City</i>	17
IV. Maryland’s Oral Health Care Infrastructure Today.....	20
V. Recommendations: What’s next?.....	21
Table A.....	25
References.....	26

Executive Summary

Oral health is an essential part of an individual's overall well-being, where he or she can eat, sleep, and learn properly without pain from untreated tooth decay. However, the oral health care system in the State of Maryland is inefficient in providing comprehensive and preventive care to the Medicaid-insured population. The death of Deamonte Driver, a 12-year-old boy who died from a toothache infection that spread to his brain, serves as a case example.

Under federal and state guidelines, states are required to provide dental care services to Medicaid recipients of ages zero to 20, but the provision of dental services to adults is optional. This paper analyzes three barriers that the low-income and the Medicaid populations face in accessing adequate and preventative dental services. First, dentists are often unwilling to treat Medicaid patients under the age of 20 due to inadequate reimbursement rates, their dissatisfaction with the overly complex Medicaid procedures, and cultural barriers. Second, being under-educated about oral health care, low-income and Medicaid-insured individuals frequently choose emergency care over preventative care. Third, the unavailability of low-cost dental services for Medicaid-insured adults further exacerbates the situation because there develops a notion that dental care is not a main concern until pain arises. This is a pressing concern when considering many of the Medicaid-covered adults may be parents of young children. Baltimore City is a good example where a significant share of the population is of low-income status and often under-educated about oral health care. In 2006, Baltimore City out of all Maryland counties had the highest enrollment of children in HealthChoice—a Medicaid program—with nearly 120,672. But only 32,627 (27.0 percent) of them had at least one encounter with a dentist in 2006. Even in such programs as Head Start with an aim to prevent the onset of oral disease, young participants greatly suffer from tooth decay. This quandary

leads to the conclusion that although dental services are available to the Medicaid-covered populations in cities, there is a disconnect in the communities between the education aspect of seeking preventative care and the available dental services in cities.

In response to Deamonte Driver's death, the Dental Action Committee (DAC) was formed to draft recommendations on increasing dental services for Maryland's underserved children. The recommendations that the DAC has drafted in reaction to two of the barriers, which I have identified, include: 1) increase dentists' participation through initiating a statewide single Administrative Services Only (ASO) dental vendor and increase dental reimbursement rates and 2) develop and launch a unified and a comprehensive oral health campaign. As a case example, the State of Michigan initiated what it calls the Michigan's Healthy Kid's Dental Program to increase dentists' participation to treat Medicaid-insured children. In communities where there is a high concentration of low-income and Medicaid populations—such as Baltimore City—the levels of oral health literacy are considerably low. Besides educating the general public about oral health issues, solutions also need to be implemented in order to provide low-cost dental services for adults. By identifying the three barriers and analyzing the possible solutions that have been implemented in response to them, this paper will further examine what else Maryland can do to address the inefficiencies that persist in its oral health care system.

I. Introduction

The first U.S. Surgeon General’s Report on Oral Health in America stated in 2007 that “oral health and general health should not be interpreted as separate entities.”¹ All too often, though, they are divided into their own separate niches and dental care is often pushed to low priority—whereas providing preventative dental services to the low-income and the Medicaid populations is seen as an insignificant public health issue.

Under federal and state guidelines, dental services must be provided to the low-income and the Medicaid populations—populations who severely suffer from tooth decay.² States are required to provide comprehensive dental services to children, under federal guidelines, but the provision of dental services to adults is optional—which can negatively affect children of Medicaid-covered parents who do not have dental insurance.^a As national and state trends show, Medicaid-covered children are not receiving the comprehensive dental care to which they are entitled. For example, it is estimated that of all Maryland children, ages zero to 20, enrolled under Medicaid, only three in 10 of them receive dental services in a given year.³ Even in such programs as Head Start with an aim to prevent the onset of oral disease, young participants of the program greatly suffer from tooth decay. Thus, untreated tooth decay amongst low-income children stems from many problems and can negatively impact a child’s overall well-being.⁴

Numerous barriers prevent the low-income and the Medicaid populations from attaining adequate oral health care services. Some of the barriers include: dentists’ unwillingness to treat Medicaid patients (age zero to 20), the unavailability of low-cost dental care services for Medicaid-insured adults, and the lack of a vibrant oral health care literacy campaign amongst the low-income and the Medicaid populations.

^a Federal Guideline for providing dental services to Medicaid recipients can be found under: 42 United States Code (U.S.C.) section 1396d(r)(3). State of Maryland’s guideline for providing dental services to Medicaid recipients can be found under: Code of Maryland Regulations (COMAR) 10.09.05.

In order to eliminate these barriers, many states have initiated targeted programs. One example is Michigan's Healthy Kids Dental Program. At least one study has shown that this program may be having positive effects in the recruitment of dentists to treat Medicaid-covered children in Michigan.⁵ Even though the State of Maryland is taking an expansive initiative to ensure dental services for children, much work remains to be done in such fields as oral health advocacy and, collaboratively, providing inexpensive dental services to Medicaid-insured adults.

II. Background

A. Federal Medicaid Program: Dental Services

Established as a nationwide program partially financed by the federal government, Medicaid seeks to provide adequate and comprehensive care for low-income families. Although there are mandated federal guidelines for all states to follow, states have the ability to modify their Medicaid plans to meet their particular needs and financial circumstances. However, under federal law it is required for all states to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental services to children from birth through the age of 20. For instance, under EPSDT states are required to (1) recruit physicians, dentists, and other providers to participate in EPSDT, (2) assure that these providers perform the medical and dental examinations, diagnoses, and treatments, (3) provide all services needed to treat any condition identified by a screen even if the State does not include this service in its Medicaid plan, and (4) provide health education including anticipatory guidance to its Medicaid recipients.⁶ By anticipatory guidance, states are required to develop a dental periodicity schedule, which is a guide that provides the appropriate timing for a child to start receiving dental services and the recommended frequency of check-ups.⁷ On the other hand, the federal government does not require states to offer, in their Medicaid programs,

dental services to adults of age 21 or older.⁸ Though most states do offer emergency dental services to adults, the majority do not offer comprehensive and preventive dental care to them.⁹

B. The State of Maryland’s Medicaid Infrastructure of Dental Services

1. Medical Assistance Program (Medicaid)

In the State of Maryland, the Department of Health and Mental Hygiene (DHMH) administers the Medicaid program, also known as the Medical Assistance Program. Once a person is Medicaid qualified, he or she will then be referred to the HealthChoice Program. HealthChoice, which began in 1997, is the managed care program for Maryland’s Medicaid enrollees. It assists enrollees to choose a Managed Care Organization (MCO)^b and a Primary Care Provider (PCP); under HealthChoice each MCO is required to provide certain health care services to its enrollees—referred to as the MCO “Benefit Package.”¹⁰ For instance, each MCO is required to develop an adequate network of dentists who can provide comprehensive dental care services to its enrollees who are under the age of 20 and to make sure enrollees who reside in an urban area have access to a dentist within a 30-minute or a 10-mile radius. In return for providing these services, each MCO is paid at a fixed capitation rate by the Medicaid Assistance Program for each enrollee.^c Each MCO negotiates payments with dental care providers through fee-for-service rates.¹¹

2. The Maryland Children’s Health Program (MCHP)

DHMH also administers the Maryland Children’s Health Program (MCHP) through HealthChoice. MCHP covers children who fall into the following categories: birth to age one

^b Managed Care Organizations (MCOs) are health care organizations that provide services to Medicaid recipients. The participating Managed Care Organizations are: United HealthCare, Helix Family Choice, Maryland Physicians Care, Priority Partners, Jai Medical Systems, the Diamond Plan, and Amerigroup.

^c Under HealthChoice, each MCO is permitted to determine whether dental care providers are paid by capitation rates, a fixed amount paid to a dentist for each enrollee in exchange for his/her services, or fee-for-service, where the recipient pays for a service at the place of the healthcare provider of their choosing, submits a claim to the insurance company, and receives reimbursement. When HealthChoice was first implemented, most MCOs subcontracted with dental providers under a capitation agreement, but within a year, all had moved to a fee-for-service model to enlarge their dental network.

whose family's income ranges from 185 percent to 200 percent of the federal poverty level (FPL)^d; age one to age six whose family's income ranges from 133 percent to 200 percent of the FPL; age six to age 19 whose family's income ranges from 100 percent to 200 percent of the FPL.¹² In addition, children in households with incomes up to 300 percent of the FPL can enroll in MCHP for a small monthly premium.¹³ MCHP is required to provide comprehensive dental care services to its enrollees under the federal EPSDT guidelines.¹⁴

C. A “Silent Epidemic”

1. A Quantitative Analysis

Even with stringent federal and state guidelines requiring MCOs to assure dental care services to Medicaid-covered children of age 20 and under, significant disparities still exist in access to oral health services by the Medicaid recipients. This led the U.S. Surgeon General to announce, in his 2000 landmark report, *Oral Health in America*, that there is a “silent epidemic”.¹⁵ In his report the Surgeon General noted that dental caries (tooth decay) are five times more prevalent than asthma, especially among the low-income and the Medicaid populations.¹⁶ In 2005, nationwide, out of the 20.1 million children, aged two through 18, enrolled under Medicaid, 6.5 million of them suffered from tooth decay.¹⁷ Subsequently, the Center for Health Program Development and Management, located at the University of Maryland Baltimore County (UMBC), completed a survey of utilization rates of dental care services in the State of Maryland by Medicaid recipients who were enrolled through the HealthChoice Program. Its results indicated that in 2006, statewide, of the nearly 468,153 children (ages zero to 18) enrolled in HealthChoice, only 139,746 (29.9 percent) of them had at least one dental encounter. Baltimore City out of all Maryland counties had the highest enrollment of children in HealthChoice, in 2006, nearly 120,672, but of

^d In order to be eligible for the MCHP program, the maximum income limit for a family of size four with children is \$42,400. For each additional member add \$7,200 to determine income limit.

that number only 32,627 (27.0 percent) of them had at least one encounter with a dentist; this is somewhat lower than the statewide average rate. In 2006, the number of dentists practicing in Baltimore City who billed at least \$10,000 to HealthChoice was 63: the statewide number was 350 dentists. These numbers demonstrate that there are minimal levels of dentists who are willing to treat Medicaid recipients—who are mainly children.¹⁸

Problems with access to dental care are not limited to the Medicaid and MCHP programs. Even Maryland's Head Start Program, which was designed to help young and low-income children maintain their overall health care, including oral health care, has experienced rampant inefficiencies.

a. Maryland's Head Start Program: A Step to an Unhealthy Smile

Developed as a school readiness program, Head Start serves children (from birth through the age of five) of low-income families by providing them with health, educational, nutritional, and social services. In terms of oral health care, according to the Head Start Performance Standards, the program needs to make sure that the oral health status of the child is determined within 90 days of entry into the program. Thereafter the child must be assured of continuous access to dental care or assistance must be provided to parents in obtaining dental care for their child; and the child must be up-to-date on the EPSDT schedule of age-appropriate preventive and primary care. But if the child is not, then assistance must be provided to help the parents make a dental appointment in attaining care for their child.¹⁹

In 2000, a study was done on the oral health status of preschool children enrolled in the Head Start centers in the State of Maryland.^{20,e} The results indicate that the overall prevalence of tooth decay was nearly 52 percent, and by age-group the pervasiveness of tooth decay among four-

^e Clinical caries examinations were conducted on 482 children between ages 3-5 from 37 Maryland Head Start Centers in 2000. Additionally, 560 questionnaires were completed by their caretakers regarding their child's access to care, potential caries risk factors and history of toothaches.

year-olds was nearly 64 percent.²¹ Despite federally mandated, Head Start, and Medicaid requirements, dental caries are also prevalent among children enrolled in programs aimed to prevent the onset of oral disease.

2. A Qualitative Analysis: Barriers Preventing the Receipt of Oral Health Care Services

a. Dentists Unwillingness to Treat Medicaid Patients: Children

It is daunting to realize the number of dentists who are averse to providing their dental services to Medicaid children. Some of the issues that underlie this reluctance are the following: inadequate reimbursement rates, dentists' dissatisfaction with the complex Medicaid procedures, and cultural barriers, such as Medicaid patients are more likely to break an appointment—a costly occurrence for the dentist.²²

i. Case Study: The Driver Family

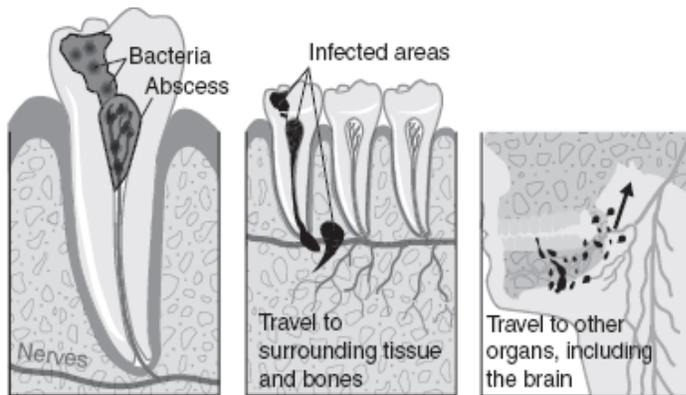
The Driver family, who lost their 12-year-old son Deamonte Driver due to a toothache infection that spread to his brain (Figure 1), ran straight into the problem of the lack of participating Medicaid dentists. Alyce Driver, mother of Deamonte, ran into roadblocks finding a dentist who would be willing to treat her younger 10-year-old son, DeShawn, who was enrolled in Medicaid's HealthChoice program and experiencing excruciating pain from several abscesses^f in his mouth. In her frustration at being unable to find a dentist, she contacted Laurie Norris^g, an attorney at the Public Justice Center (PJC)^h, to help her find a dentist who could provide treatment to her Medicaid-covered child.

^f A dental abscess is an infection that is caused by the bacteria from a cavity which moves into the soft tissues of the face and neck. It can be due to poor oral hygiene. (<http://www.webmd.com/oral-health/dental-abscess>)

^g Laurie Norris had first met the Driver family, in July 2006, through her work on homeless children's education rights in Prince George's County, Maryland.

^h Founded in 1985, the Public Justice Center (PJC) is a nonprofit legal advocacy organization that "seeks to enforce and expand the rights of people who suffer from injustice because of their poverty or discrimination."

Figure 1



How can tooth decay lead to death?

Untreated tooth decay can penetrate the tooth surface, allowing bacteria to infect the interior of the tooth, causing an abscess. From there, if the infection is not dealt with by antibiotics or other treatment, it can travel to surrounding tissue or other organs, including the brain, and on extremely rare occasions, **cause death.**

Source: Report to Congressional Requesters (2008). Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay. September 2008.

After taking on the quest, Norris ran into quite a few dead ends in her navigation through the complex maze of Maryland’s Medicaid dental care system. DeShawn Driver’s MCO was United Healthcare, where the Medicaid portion was called Americhoice. Norris contacted the Americhoice customer service line and was sent a list of dentists who were located near where the Driver family lived—which is in Prince George County, Maryland—and accepted as patients’ children covered by their plan. Norris started calling at the top of the list. The first 26 out of the 80 listed said they did not provide dental services to Medicaid recipients enrolled in Americhoice. Ultimately, a dentist was found to treat DeShawn Driver, but “it took the combined efforts of one mother, one lawyer, one helpline supervisor, and three health care case management professionals to make a dental appointment for a single Medicaid-insured child!”²³ Meanwhile DeShawn Driver’s older brother, Deamonte, who had not complained about any dental problems, started suffering from severe headaches, and after being hospitalized he was diagnosed with a brain infection. He died on February 25, 2007, after two brain surgeries, one tooth extraction, and six

weeks of hospitalization—from a treatable and a preventable tooth infection.²⁴ Thus, for those who are worried about tax-payer money that would be required to fix the deficient oral health care system, the ultimate care of Deamonte ended up costing over \$250,000 when an \$80 tooth extraction could have saved his life.²⁵

Why did the first 26 dentists on the list, who supposedly provided their dental services to Medicaid recipients, ended up crossing themselves off from the list when Norris contacted them? In 2003, the State of Maryland’s dental reimbursement rates were among the worst in the nation. Most of the rates were below the 25th percentile of the American Dental Association’s South Atlantic fees and others were below the 10th percentile (Figure 2).²⁶ Because dentists typically own and operate their own surgical suites, they are responsible for all logistical costs associated with operative treatments. If someone misses an appointment, it is an economic loss for the dentist. Unfortunately, it has been the experience of dentists that Medicaid patients are more likely to miss an appointment without prior cancellation. Another impediment that dentists frequently cite in justifying their reluctance to treat Medicaid patients is that Medicaid programs require dentists to comply with time-consuming administrative requirements, such as prior authorization requirements and eligibility verification. As a result, they often experience delays in payment of Medicaid claims as well.²⁷

The low participation of dentists often leaves Medicaid-covered children without a “dental home”ⁱ and contributes to the ballooning of misconceptions by low-income and undereducated families about the prioritization of oral health care—exacerbated further by the lack of low-cost

ⁱ A “dental home” is a regular primary care dentist who can assess a child’s risk for developing dental disease by age 1; provide education to the parents about preventing dental disease; check for developing cavities as well as clean the child’s new teeth every six months during toddlerhood and beyond; instruct the child of how to properly brush and floss their teeth; recommend fluoride treatments and dental sealants as he/she grows older.

dentel services available for adults.²⁸

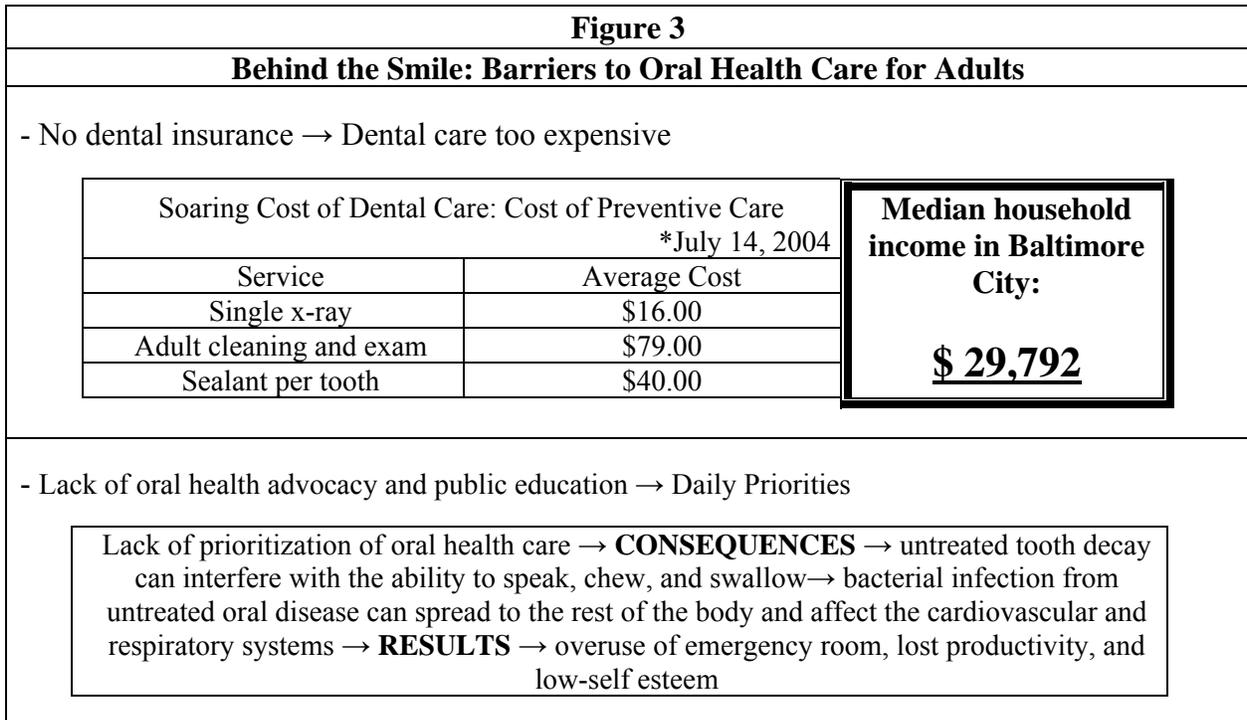
Figure 2
Current Dental Payment Rates by South Atlantic States

Dental Procedure	Code	State Medicaid Programs										MD State Employee Benefits	25% ADA Charges	50% ADA Charges	75% ADA Charges		
		MD	DE	DC	GA	NC	PA	SC	VA	WV							
Diagnostic																	
Periodic Oral Exam	D0120	\$15		\$35	\$22.77	\$27	\$20	\$22	\$20	\$20	\$20	\$20	\$20	\$23	\$28	\$33	\$39
Initial Oral Exam	D0150	\$20	85% of charges	\$78	\$39.33	\$45	\$20	\$30	\$31	\$30	\$30	\$30	\$39	\$45	\$55	\$65	
X-Rays, complete	D0210	\$57		\$91	\$72.45	\$75	\$45	N/A	\$71	\$62	\$63	\$62	\$63	\$85	\$93	\$105	
Panoramic X-Rays	D0330	\$42		\$80.	\$56.92	\$58	\$37	\$55	\$54	\$55	\$69	\$55	\$69	\$74	\$80	\$90	
Preventive																	
Prophylaxis	D1120	\$24	85% of charges	\$47	\$32.08	\$25	\$22	\$31	\$34	\$30	\$39	\$30	\$39	\$44	\$48	\$55	
Fluoride Treatment	D1203	\$14		\$29	\$17.59	\$15	\$17	\$17	\$21	\$15	\$22	\$15	\$22	\$20	\$24	\$28	
Sealant	D1351	\$9		\$38	\$27.94	\$30	\$25	\$27	\$32	\$24	\$27	\$24	\$27	\$32	\$36	\$42	
Restorative																	
Amalgam	D2150	\$88	85% of charges	\$115	\$69.34	\$79	\$50	\$75	\$76	\$72	\$73	\$72	\$73	\$97	\$111	\$130	
Resin X 2	D2331	\$102		\$135	\$91.08	\$77	\$55	\$88	\$89	\$85	\$96	\$85	\$96	\$117	\$135	\$156	
Crown	D2751	\$375		\$177	N/A	N/A	\$300	N/A	\$500	\$510	\$660	\$510	\$660	\$675	\$750	\$828	
Endodontics																	
Removal/Pulpotomy	D3220	\$60	85% of charges	\$134	\$90	\$78	\$50	\$87	\$83	\$42	\$99	\$42	\$99	\$115	\$140	\$175	
Endodontics	D3310	\$230		\$498	\$380	\$263	\$180	\$367	\$348	\$168	\$373	\$168	\$373	\$476	\$525	\$620	
Extraction	D7140	\$42		\$110	\$64	\$58	\$45	\$620	\$69	\$44	\$63	\$44	\$63	\$93	\$110	\$132	

Source: Dental Action Committee (2007). Access to Dental Services for Medicaid Children in Maryland-Report to Secretary John Colmers of Department of Health and Mental Hygiene. September 11, 2007.

b. Unavailability of Dental Services for Medicaid-insured Adults

Under federal Medicaid guidelines, states are not required to provide dental services to adults of age 21 and older. As a result, most states do not offer any preventive care to their Medicaid-insured adult populations. The unavailability of low-cost dental services for adults can lead to many consequences (as summarized by Figure 3).



Sources:

1. Masel Industries, Inc. (2009). "Dental cost calculator: Calculate the average cost of dental care in your hometown to find out if you are paying too much." Accessed at <http://www.bracesinfo.com/dentalcosts/> on February 20, 2009.
2. Medicaid/SCHIP Dental Association (2009). "Adult Dental Benefits In Medicaid: FY 2000, 2002, 2003, 2004 & 2005." Accessed at <http://www.medicaidental.org/Docs/AdultDentalBenefits2003.pdf> on February 10, 2009.

c. Oral Health Care Literacy: Adults and Children

Deamonte’s tragic death brought to the forefront known yet hidden barriers that low-income and Medicaid children have faced for decades in trying to obtain comprehensive, preventative, and restorative dental care services.²⁹ This includes being undereducated about the importance of oral health care.

Deamonte and his four siblings had insurance through MCHP; his mother, being uninsured and poor, did not go to the dentist regularly.³⁰ This is consistent with what studies have shown. According to the Surgeon General's report, published in 2000, poor children are less likely to see a dentist and are therefore more likely to suffer from untreated cavities than are non-poor children.³¹ Thus, oral health researchers have shown that infants whose mothers are of low socioeconomic status (which indicates they are more likely to be undereducated and unaware of the consequences of consuming sugary foods during their pregnancies) are 32 times more likely to suffer from tooth decay by the age of three than infants born to mothers of more affluent backgrounds. Tooth decay is an infectious disease that is transmissible from the mother to the infant, and, if left untreated, it can greatly impact a child in many aspects of his or her life.³² For example, when a child is in pain from untreated cavities, he or she cannot eat, sleep, and learn properly; and his or her self-esteem can be negatively impacted due to his or her poor appearance.³³ It is estimated that children across the nation miss more than 52 million hours of school due to dental-related issues.³⁴ Tooth decay is such a systemic predicament that it even affects low-income children who reside in fluoridated areas.³⁵ Consequently, the lack of comprehensive information available to poor and undereducated families about the importance of getting regular preventive dental care is a significant barrier.³⁶

III. State Initiatives: Policy Recommendations and Implementation Challenges

A. Dental Action Committee (DAC)

In response to Deamonte Driver's death, the Dental Action Committee (DAC or "Committee") was formed on June 12, 2007 by Secretary John Colmers of the Maryland's Department of Health and Mental Hygiene (DHMH). The Committee is composed of a spectrum of professionals from all different backgrounds who share a common interest in improving

children’s access to oral health care services in the State of Maryland.^j From June 12 to August 28, 2007, the Committee met seven times to discuss and draft recommendations on increasing dental care services for Maryland’s underserved children. The DAC presented its seven primary recommendations to Secretary Colmers on September 11, 2007, in a report entitled “Access to Dental Services for Medicaid Children in Maryland: Report of the Dental Action Committee”. The DAC urged the Secretary to adopt and implement the recommendations in order to transform Maryland into a model state in how it delivered dental care to its low-income children, and in the extent to which its low-income children received adequate dental care.³⁷

1. Establishing a “Dental Home”: Increase Dentists’ Participation

In order to increase the participation of dentists in the Medicaid dental program, the Committee offered two specific recommendations: (1) Maryland should initiate a statewide single Administrative Services Only (ASO) dental vendor, and (2) it should increase dental reimbursement rates to the 50th percentile of the American Dental Association’s South Atlantic region charges for all dental codes.³⁸ These recommendations were not unique to the State of Maryland. Other states had implemented similar measures and studied the effects on access to dental care for low-income children.

a. Michigan’s Model Blueprint: Medicaid’s Healthy Kids Dental Program

On May 1, 1998, Michigan officials established MICHild, which is what Michigan calls its

^j Representatives were included from the following organizations: Advocates for Children and Youth; Carroll County Health Department; Doral Dental, USA; Head Start; Maryland Academy of Pediatrics; Maryland Academy of Pediatric Dentistry; Maryland Assembly on School Based Health Care; Maryland Association of County Health Officers; Maryland Community Health Resources Commission; Maryland Dental Hygienists’ Association; Maryland Dental Society; Maryland Medicaid Advisory Committee; Maryland Oral Health Association; Maryland State Dental Association; Maryland State Department of Education; Medicaid Matters! Maryland; Mid-Atlantic Association of Community Health Centers; Morgan State University; National Dental Association; Parent’s Place of Maryland; Priority Partners; Public Justice Center; United Healthcare; and University of Maryland Dental School.

State Children's Health Insurance Program (SCHIP).^k The MICHild program was unique in that it administered its dental services through vendors at reimbursement levels identical to those paid by private dental insurance plans. This approach proved to be immediately successful because in the first year, dental utilization rates for MICHild enrollees were almost identical to utilization rates for privately insured children. Then, in 1999, the Michigan legislature appropriated \$10.9 million for FY 2000 to address the lack of access to adequate oral health care in its Medicaid population. About half of the appropriations were used to initiate a demonstration program called Healthy Kids Dental (HKD), which was modeled after Michigan's SCHIP—the MICHild Program. The population that the Medical Services Administration (MSA)—Michigan's Medicaid agency—chose for the demonstration program lived in the rural counties of Michigan, who had limited access to dental care.³⁹

HKD tackled two of the barriers that seem to deter dentists from treating Medicaid patients: (1) the lack of a single statewide dental vendor to administer all Medicaid dental benefits and (2) low reimbursement rates that are far below the dentists' usual and customary fees. In order to address the first barrier, the Michigan Department of Community Health (MDCH), which administers Michigan's Medicaid program and SCHIP ("MICHild"), contracted with Delta Dental Plan of Michigan (DDPM), a non-profit corporation, to administer all Medicaid dental benefits. Second, the dental reimbursement rates were raised to the levels of those in the DDPM's commercial dental plans. In the beginning stages of the HKD program, it was administered in only 22 of Michigan's 83 counties, but by October 2000, 37 counties were participating in the program. However, in 33 of the 37 counties DDPM was using its DeltaPremier Program and in the remaining four counties it was using the DeltaPreferred Option. In its DeltaPremier Program,

^k This is Michigan's equivalent to Maryland's MCHP Premium Program, and serves children from slightly higher-income households than the Medicaid program.

DDPM pays its dentists on a fee-for-service basis at 100 percent of each dentist’s current fees (unless the amount exceeds the 80th percentile of the average reimbursement rate for that service for all participating dentists). Approximately 90 percent of all dentists in Michigan were participating in the DeltaPremier Program. Conversely, the rest were participating in the DeltaPreferred Option (DPO). In DPO, dentists are reimbursed on a fee-for-service basis, but at a somewhat lower rate. In order to use any Delta network dentist, all HKD enrollees received a member identification card similar to the one given to commercial enrollees.⁴⁰

A study was done to assess the results of the first 12 months of the HKD Program. Compared to the traditional fee-for-service Medicaid Program substantially more Medicaid beneficiaries were receiving dental care under HKD (Figure 4) because more dentists were providing care to Medicaid enrollees (up 300 percent).⁴¹ The study also found that the

Figure 4

PERCENTAGE* OF CHILDREN† UTILIZING DENTAL CARE DURING STUDY PERIODS, BY COVERAGE TYPE AND ENROLLMENT DURATION.				
ENROLLMENT DURATION (MONTHS)	PERCENTAGE OF CHILDREN UTILIZING DENTAL CARE, BY COVERAGE TYPE AND STUDY PERIOD			
	Medicaid: 22 Counties,‡ April 1999-March 2000	HKD§: 22 Counties, May 2000-April 2001	Medicaid: 46 Counties¶, April 1999-March 2000	Medicaid: 46 Counties, May 2000-April 2001
Continuous (All 12 Months)	31.8	44.2	35.7	35.8
Partial (One to 11 Months)	11.1	17.2	14.4	13.6

* All 99 percent confidence intervals smaller than ± 0.1 percent.
† Children aged 20 years and younger.
‡ Michigan counties in which children enrolled in Medicaid were automatically switched to the Healthy Kids Dental demonstration program of Michigan Medicaid.
§ HKD: Healthy Kids Dental program.
¶ These 46 counties were not included in the Healthy Kids Dental program at any time.

Source: Eklund SA, Pittman JL, Clark SJ (2003). Michigan Medicaid’s Healthy Kids Dental program: an assessment of the first 12 months. University of Michigan School of Public Health, Department of Epidemiology, Ann Arbor 48104-3028, USA. saeklund@sph.umich.edu.

participating dentists’ were satisfied with the HKD program, were more likely to accept Medicaid children as patients, and believed they could spend more time on oral hygiene education with the

patients.⁴² The HKD program was certainly a revolutionary step in demonstrating how to provide comprehensive dental care services to Medicaid children; indeed a step Maryland is just starting to take.

b. Maryland's Initiative to Increase Dentists' Participation

Before the wake-up call of the tragic death of Deamonte Driver, Maryland did not heavily invest in recruiting dentists to treat more Medicaid patients. In 2000, the Maryland General Assembly had started a loan repayment program (MDC-LARP) to help pay the dental school loans of participating graduates in exchange for their spending a percentage of their time treating low-income patients. The program aimed to provide an incentive for new dentists to treat more Medicaid recipients. However, because of limited funding, only five Maryland dentists were selected to participate in the program for each of the first three years. The selected dentists have each received \$99,000 in educational loans in return for providing their dental services to at least 30 percent of their total patient population to the Medicaid population per year. In 2005, the MDC-LARP dentists provided oral health care services to 6,697 Medicaid patients.⁴³ However, numbers can be deceiving. More than 400,000 Medicaid-covered children and adults still lack access to needed dental care.⁴⁴

2. Provide Low-cost Dental Services to Medicaid-insured Adults

After Deamonte Driver's death, cities—such as Washington, D.C.—have taken their own initiatives to not only ensure access to dental services for Medicaid recipients (children), but also for adults. In 2004, according to the Kaiser Family Foundation, 27.8 percent of adults in the District had not visited the dentist or a dental clinic. Subsequently, in June 2007, the Mayor Adrian M. Fenty and D.C. Council member David A. Catania announced that dental benefits would be expanded to Medicaid adult recipients in the District—a move that affected 60,000

adults. The plan included for two general dental examinations and routine maintenance cleanings each year, fillings, surgical services, and X-rays. Although there are currently no studies available—assessing the outcomes and the effects that this move may have had on the utilization rates by the Medicaid-insured adults, it was nonetheless a progressive step made by the city. The City of Baltimore has yet to take this type of initiative.⁴⁵

3. Launch a Unified Oral Health Education Campaign

Developing an efficient and an effective dental care delivery system that provides preventive services to both Medicaid-covered adults and children is not enough. A unified oral health education campaign needs to be established. According to the *Healthy People 2010* definition of oral health literacy, it is “the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate oral health decisions.”⁴⁶ Under EPSDT, it is required for states to provide health education including anticipatory guidance to its Medicaid recipients. Thus, in order to tackle the issue of oral health literacy, the DAC offered the following recommendation: ‘the Department [DHMH] should 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.’⁴⁷ Unlike the State of Maryland, states, such as Michigan, have implemented strategies to raise the awareness of the importance of oral health care. For example, Michigan’s Oral Health Coalition has carried out the following strategies: implemented a Statewide Public Education and Awareness Campaign; developed an easy to read brochure—“Don’t Wait Until it Hurts—Your child needs healthy teeth to eat, talk and smile!”; as well as working with the Department of Education to continue oral health education in schools. Through the Michigan Model for Comprehensive School Health Education, the fastest growing school

health education program in the nation, Michigan schools teach limited oral health education to their students.⁴⁸ While Michigan has taken the step into the oral health education arena, the State of Maryland seems to be lagging behind—especially embedding an oral health education campaign in a poverty and a Medicaid concentrated area, Baltimore City.

a. A Closer Look: Dental Care Services in Baltimore City

As of 2004 the median household income in Baltimore City was \$29,792, and nearly 21.5 percent of its total population was living below the federal poverty level (FLP).⁴⁹ As stated previously, in 2006, nearly 120,672 children of Baltimore City were enrolled in the HealthChoice Program, but only 32,627 of them had at least one dental encounter. With such a high concentration of poverty in Baltimore City, other competing priorities of daily life often trump those that are perceived to be less important, until there arises a crisis that raises their priority. One example of this is the tendency of low-income families to seek dental care services only when there is pain.⁵⁰

In June 2004, the DHMH Office of Oral Health (OOH) contracted with the Children's Dental Health Project (CDHP) to evaluate current oral health programs and make recommendations for future improvements in order to advance the Maryland's Dental Public Health infrastructure. The OOH and CDHP collaboratively conducted meetings with community participants in seven regions across Maryland, and one of the regions was Baltimore City. The top concern that the Baltimore City participants articulated was that the problem is not so much with the availability of dental care service in their community, but more with the awareness of the need to use these services. The combination of such barriers as financial, transportation, and low-levels of oral health care education, has created a ring of fire to trap the underserved population of

Baltimore City, where preventive dental care is often avoided in favor of emergency services when care becomes crucial.⁵¹

In 2008, the OOH published an “Oral Health Resource Guide”, which lists dental providers from most jurisdictions of Maryland that provide some form of dental care to the low-income and the Medicaid population. For Baltimore City, 10 dental care providers are listed (Table A), including two dental clinics (the Eastern and the Druid Dental Clinics) operated by the Baltimore City Health Department (BCHD) Dental Program.⁵² In the past the BCHD had several other clinics and a mobile unit, but due to the diminution of funds and nominal staff, these were closed down. With about four full-time dentists, seven full-time dental assistants, and seven dental operatories, both of the currently operating dental clinics serve primarily low-income children and adults (Medicaid qualified or uninsured). However, the broken appointment rate at the two clinics is nearly 40 percent. According to the HealthChoice Utilization Data for FY 2003, the BCHD provided services to only one percent of the HealthChoice population of Baltimore City. Thus, the majority of the patients it serves are uninsured for dental care. Overall the clinics provide limited preventive care for children, and for adults it provides only emergency care, such as tooth extraction and temporary dental work services.

A major challenge that the BCHD continuously faces is budget constraint. It is unreasonable to expect that two dental clinics with only four dentists and no dental hygienists can adequately provide comprehensive dental services to the seeking population. Hence, due the lack of funding and shortage of staff, the dental clinics are unable to provide specialty dental care services to their patients.⁵³ At the same time, BCHD has persistently raised the concern, to the OOH, that there is a need to raise awareness about the importance of preventive oral health care among the low-income, uninsured, and Medicaid-covered populations. BCHD has already taken

some steps to address this problem, by sponsoring such programs as: The Infant and Children Kan Laugh Endeavor (T.I.C.K.L.E.) Program and Youth Adults with Healthy Smiles (YAWHS) Program.

Established in 2002, the T.I.C.K.L.E. Program was founded with the intent of helping to meet all federal dental requirements for Baltimore City Head Start enrollees. The T.I.C.K.L.E. program provides diagnostic, preventive, and restorative services to its participants of ages two and a half to four years. It also provides oral health care education services to children of 18 months to four years, parents, and Head Start staff. Some of the challenges the program has confronted in achieving its goals are: problems with transportation which interferes with getting to the dentist's office on time, parental availability for appointments due to work schedules, and dentists' unwillingness to treat Medicaid-covered children. In order to combat the lack of private dentists willing to take these children as patients, BCHD has set aside certain days at its two dental clinics for dentists to treat children in the T.I.C.K.L.E. program. If the parents cannot make it to the appointment then he or she can consent for a Head Start staff member to serve as a parental substitute for the child. Lastly, if needed, transportation is provided by the Program from the Head Start Center to the dental clinics. After the dental visit, the Program sends out a letter to each child's MCO listing all the services received by the child. Then, the MCO is supposed to provide case management services to the family to assist in obtaining any further dental treatment the child needs. The results of this Program highlight a positive trend with a lower no-show rate.⁵⁴

Another program sponsored by the BCHD is the YAWHS program, which provides dental care services to youth of ages 16 to 21 years in the Youth Opportunity Program (YO!). Its goal is to restore the value of oral health care for youth, such as its importance to the total health and well-being of a person. Nearly all enrollees in the YAWHS program are uninsured. When the program

first started in mid-2003, one of the challenges it faced was the low-levels of participation due to the mistaken but common notion that dental care is not needed until pain occurs. The YAWHS program has gradually begun to overcome this attitude by emphasizing the importance of preventive oral health care. Unfortunately, in 2005, due to a decrease in funding, services in the YAWHS program were significantly reduced to include only urgent dental care.⁵⁵

IV. Maryland's Oral Health Care Infrastructure Today

On November 18, 2008, Governor Martin O'Malley placed another brick in the path to rebuilding the deteriorating oral health care infrastructure of Maryland. In memory of Deamonte Driver, he announced the unveiling of the Deamonte Driver Dental Project, a mobile van that will provide much needed dental care to low-income and underserved children in targeted schools in the Prince George's County area. In consideration of the DAC's recommendations, he also announced that: the state will invest over \$68 million to recruit dentists to provide services to low-income patients; the state will move towards a single, statewide dental vendor to increase efficiency, simplify the existing program, and provide greater transparency and accountability; and through funding of programs, such as YAWHS, the state will help to increase the number of low-income young people that will receive dental services.⁵⁶

Besides assuring better access to dental services for Medicaid recipients, the State of Maryland still has tremendous work to do on the oral health literacy campaign. The DAC has made further recommendations on this issue: "that the unified oral health literacy education plan operate with the *Healthy People 2010* definition of oral health literacy and focus primarily on *prevention (the achievement and maintenance of oral health)* (through teaching effective home care, use of fluoride, sealants, etc.) and only secondarily on dental treatment." In order to study the impact of oral health education, the DAC has identified four potential focus group sites, for

research purposes, which include young pregnant women in Paquin School of Baltimore City and mothers of young children in such programs as Early Head Start and Head Start and Family Support Centers all located in Baltimore City.⁵⁷

Another initiative built upon the DAC's recommendation revolves around the idea that since pediatricians spend more time with patients in a social context setting, it would be costless for them to explain the importance of oral health care and some of the basic steps in preventing the onset of tooth decay to their patients. Thus, the DAC has offered the following recommendations for pediatricians to: (1) do oral health screenings on children starting in infancy, (2) develop a method by which the pediatricians can insure that children identified as needing dental care are linked to a dental home, and (3) provide oral health education to parents and children.⁵⁸ In consideration of these recommendations Maryland's Department of Health and Mental Hygiene, specifically the Office of Oral Health, will offer in the month of June 2009 several training sessions to Maryland licensed EPSDT physicians and nurse practitioners in how to apply fluoride varnish and how to do simple oral health screening tests. Then, beginning on July 1, 2009, the Maryland Medical Assistance Program will reimburse the trained EPSDT physicians and nurse practitioners to apply fluoride varnish to children nine months up to three years old as part of their scheduled well-child visit.⁵⁹ With the help from the DAC's recommendations, the State of Maryland is starting to implement policies to assure the provision of comprehensive and preventative oral health services to all Medicaid recipients, but, still, more remains to be done.

V. Recommendations: What's next?

In 2000, U.S. Surgeon General David Satcher stated that "safe and effective measures exist for preventing oral disease, but they are underused."⁶⁰ Why are they underused? Because the public oral health care system not only in the State of Maryland but all over the nation has been

inadequate in providing comprehensive and preventative dental services to the low-income and the Medicaid-covered populations. While other states have taken the initiative to improve oral health care services for their Medicaid-covered populations, Maryland has been slow in restructuring and investing in its system—up until recently. However, there is still much room for improvement.

Recommendation #1: Emphasize the Importance of Seeking Preventative Care

In cities with concentrated populations of Medicaid recipients, public health education initiatives should be the utmost priority. It is critical to raise the awareness of how important it is to seek preventative care instead of waiting for an emergency to arise—as revealed by the death of Deamonte Driver. Low-income families and the Medicaid populations tend not to seek oral health care until they perceive a need to do so, for example, when in pain.⁶¹ This delay in seeking care often ends up costing the state quite a hefty sum when preventive care could have solved the problem in its beginning stages at a minimal cost. In order to increase the likelihood that patients will seek preventative care, policy makers, dentists, and other healthcare providers, such as pediatricians, play a critical role in helping to develop a unified oral health literacy message. Thus, policy makers need to push forward for the State of Maryland to develop a social marketing campaign and not to just rely on the Medicaid carrier agencies to educate the Medicaid-insured population about the importance of preventative oral health care. For example, the Vermont Department of Health developed a social marketing campaign, called “Smile Vermont”, aimed at educating parents and caregivers about proper oral health care for their children. Vermont chose to target the “back to school” period in Fall of 2004 to educate parents about the importance of preventative oral health care through radio, television, and print advertisements along with an 800 number to call for more information. Consequently, almost all of the families that actively engaged in the “Smile Vermont” campaign by attending events or using the hotline reported

improvement in their knowledge of oral health practices. They began to understand the importance of: visiting a dentist every six months, brushing their children's teeth as soon as the first tooth erupts, eliminating bottles in bed for babies and requesting sealants for their children's molars.⁶² The component of self-care is important in preventing dental disease in both children and adults. Besides educating low-income and Medicaid-insured families about the importance of preventative oral health care, dentist's need to be recruited to provide the preventative care to Medicaid recipients.

Recommendation #2: Recruit Dentists to Accept Medicaid Recipients as Patients

Other than raising reimbursement rates and offering free training sessions to pediatricians in oral health screenings and in applying fluoride varnish, Maryland still needs to do more in terms of recruiting more dentists to treat more Medicaid patients. First, Maryland needs to enact a law whereby dentists have to accept a minimum number of Medicaid patients per year in order to renew their professional licenses. It is valid for a state to carry out such an action because under EPSDT, states are required to recruit physicians, dentists, and other providers to participate in EPSDT.⁶³ In order to address any question of constitutionality, Maryland could offer an incentive whereby the annual license renewal fee (according to the Maryland State Board of Dental Examiners the 2009 renewal fee for an active dentist is \$397.00) is waived if the dentist demonstrates that he or she has treated a specified minimum percentage of Medicaid-insured patients from his or her entire patient population. Although there is no available study assessing if a state has enacted such a law, it would seem logical that a dentist would be more willing to treat Medicaid-insured patients if there were a financial incentive to do so. Under this system, the dentist will still receive payment from the Medicaid patient's MCO and be able to renew his license for free in exchange for treating Medicaid-insured patients.

Recommendation #3: Provide Financial Incentives to Dentists to Treat Low-income Adults

Although the number of dentists willing to treat Medicaid-insured children may increase with recommendation number two, there will be no impact on access to dental care for low-income adults. Perhaps Maryland could implement a tax incentive for dentists to treat low-income adults who do not have dental coverage. This would be somewhat comparable to lawyers providing free legal services to the poor through pro bono cases. Dentists could be permitted to file for a tax credit equal to the value of care provided to uninsured adults at their own dental suite or through volunteering at a clinic—such as at the Eastern and the Druid Dental Clinics of Baltimore City which are recurrently under-staffed. For example, Michigan provides a tax credit to dentists of either \$5000 or the amount equal to uncompensated dental treatment of indigent individuals. Missouri has a tax credit for dentists who provide services to Medicaid recipients.⁶⁴

Recommendation #4: Provide Dental Insurance to Medicaid-insured Adults

However, the overarching recommendation that needs to be accomplished is providing dental coverage to the primary caregivers of Medicaid covered children. Since most low-income adults do not have access to dental insurance, they are less likely to go see a dentist because of dental care expense or other daily life priorities. This can negatively impact the young children of uninsured parents because they may be less likely to take their children to the dentist regularly, even if the child has dental coverage under Medicaid. Studies have shown that when parents have access to health care for themselves, they are more likely to take their children to the doctor and to have healthy children.^{65,66} Although Maryland provides dental care services to pregnant women, the coverage ends when the baby is born. If dental insurance is provided to Medicaid-insured adults, then parents maybe more likely to take their children to the dentist regularly since they have

access to such services themselves.⁶⁷ With these recommendations, the State of Maryland can become a model state in how it delivers dental services to Medicaid-insured children and adults.

TABLE A
Dental Care Providers located in Baltimore City¹

Dental Provider(s)	Eligibility	Services
Baltimore City Community College (Department of Dental Hygiene) 2901 Liberty Heights Ave.	Adults and children (including Head Start children)	Preventive services only: dental hygiene, x-rays, fluoride, periodontal treatment (deep scaling)
Baltimore City Health Department (Druid and Eastern Clinics) 1515 W. North Ave. 620 N. Caroline St.	3+ years Urgent care services only for adults ages 21-54 Medicaid eligible/Sliding fee scale Walk-in patients accepted Baltimore City resident	Preventive, emergency, restorative Clinic schedules vary; call for appointment
Chase Brexton Health Services, Inc. ¹ Dental Clinic, Mt. Vernon Ctr., Bldg. B, 10 W. Eager St.	Adults and children Maternity Medicaid eligible/Sliding fee scale Maryland resident	Preventive, prosthetic, restorative, pediatric services Emergency services available Call for appointment
Family Health Centers of Baltimore ¹ Dental Clinic 631 Cherry Hill Rd.	Adults and children 2+ years Maternity Medicaid, private insurance accepted Sliding fee scale Walk-in patients accepted Maryland resident	Preventive, restorative, prosthetic and emergency services
Kernan Hospital Restorative Dental Services Clinic Kernan Hospital, Ste. T500	Adults and children Medically and non-medically compromised Medicaid & private insurance accepted Call for appointment	Comprehensive dental services
Park West Medical Center ¹ 3319 W. Belvedere Ave.	Adults and children 1+ years Medicaid accepted Sliding fee scale with proof of income	Comprehensive dental services
People's Community Health Center, Inc. ¹ 3028 Greenmount Ave.	Adults and children 3+ years Maternity Medicaid/Reduced/Sliding fee scale Walk-in patients accepted Maryland resident	Comprehensive dental services Spanish language services
Total Health Care ¹ Dental Department 2400 Kirk Ave. Division Street Center 1501 Division St.	Adults and children 3+ years Maternity Medicaid eligible/ Sliding fee scale Walk-in patients accepted	Comprehensive dental services
University of Maryland Dental School 650 W. Baltimore St.	Adults and children Medicaid accepted Fee for service/below private practice fees Walk-in patients accepted in emergency clinic	Comprehensive dental services
University of Maryland Medical School 22 S. Greene St	Adults and children Medically compromised	Oral and maxillofacial surgery and trauma Oral cancer treatment Transplant & cardiac screening

Note: Federally Qualified Health Centers.

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