Final Report of the Task Force on Oral Health in Maryland

Annapolis, Maryland
December 2022

Final Report of the Task Force on Oral Health in Maryland

As Required by House Bill 368 and Senate Bill 100 of 2021 (Chapters 599 and 600 of 2021)

December 2022

Task Force on Oral Health in Maryland

December 1, 2022

The Honorable Lawrence J. Hogan, Jr.
Governor, State of Maryland

The Honorable Delores G. Kelley
Chair, Senate Finance Committee

The Honorable Paul G. Pinsky
Chair, Senate Education, Health, and Environmental Affairs Committee

The Honorable Joseline A. Peña-Melnyk
Chair, House Health and Government Operations Committee

Re: Chapters 599 and 600 of the Acts of 2021
Final Report of the Task Force on Oral Health in Maryland

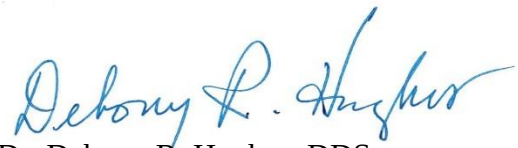
Dear Governor Hogan, Chair Kelley, Chair Pinsky, and Chair Peña-Melnyk:

In keeping with the requirements of Chapters 599 and 600 of the Acts of 2021, we respectfully submit the final report of the Task Force on Oral Health in Maryland (task force). The task force consisted of a diverse group of stakeholders including dental practitioners and representatives from organizations in the State focused on oral health and health care more broadly. The recommendations in this report reflect a unanimous vote of the task force membership present and voting at the final meeting. If you have any questions about this report, please contact Tyler.Babich@mlis.state.md.us, Ellen.Dalina@maryland.gov, or Lindsay.Rowe@mlis.state.md.us.

Chapters 599 and 600 required the task force to (1) analyze current access to dental services in the State with a focus on the socioeconomic status, race, ethnicity, age, and disability of residents as factors impacting access to dental services; (2) identify areas of the State where a significant number of residents are not receiving oral health care services, distinguishing between pediatric and adult populations; (3) identify barriers to receiving dental services in areas in need; (4) analyze the specific impact of such barriers; (5) assess options to eliminate such barriers, including the feasibility of establishing a program for dental therapy in the State; and (6) make recommendations to increase access to dental services in the State. The task force submitted an interim report on May 23, 2022.

The members of the task force appreciate the advice and assistance of the numerous private citizens and public officials who participated in the task force's activities. As co-chairs, we would also like to thank the task force members and staff for their time and effort, particularly in light of the challenges faced for the past two years and the need to accommodate virtual meeting formats.

Sincerely,



Dr. Debony R. Hughes, DDS
Task Force Co-chair
Director of the Office of Oral Health
Maryland Department of Health

Mark A. Reynolds, DDS, PhD
Task Force Co-chair
Dean
University of Maryland School of Dentistry

DRH/MAR:LAR/TNB:mhr

cc: Ms. Megan Peters, Acting Director, MDH Office of Governmental Affairs
Ms. Sarah Albert, Department of Legislative Services, 5 copies (MSAR #13233)

Contents

Introduction

Chapters 599 and 600 of 2021 established the Task Force on Oral Health in Maryland (task force). The purpose of the task force is to make recommendations to increase access to dental services in the State. To do so, the task force:

- analyzed current access to dental services in the State with a focus on the socioeconomic status, race, ethnicity, age, and disability of residents as factors impacting access to dental services;

- identified areas of the State where a significant number of residents are not receiving oral health care services, distinguishing between pediatric and adult populations;

- identified barriers to receiving dental services in areas in need;

- analyzed the specific impact of such barriers; and

- assessed options to eliminate such barriers, including the feasibility of establishing a program for dental therapy in the State.

Chapters 599 and 600 require the task force to submit a final report by December 1, 2022. This report presents the findings and recommendations of the task force, including research activities and methodology, findings made with respect to barriers to oral health faced by Marylanders, and recommendations addressing each barrier identified. The Maryland Department of Health (MDH) and the Department of Legislative Services (DLS) provided staff support for the task force and in drafting the report. **The findings of the task force represent the opinions of the members of the task force and do not reflect the policy positions of MDH or the recommendations of DLS.**

Appendix 1 lists the full membership of the task force. **Appendix 2** provides a brief overview of each of the task force's meetings. **Appendix 3** contains the draft workplan discussed and updated at the October 21, 2021 meeting of the full task force. **Appendix 4** includes a copy of Chapters 599 and 600, the task force's enacting legislation. **Appendix 5** contains information on Maryland Medical Assistance Program (Medicaid) dental rate increases effective July 1, 2022.

Background

Medicaid Dental Care Access

Maryland has implemented programs to improve access to oral health services through changes to Medicaid and by expanding public health dental infrastructure. According to MDH, Maryland continues to receive high grades from the federal government for its oral health initiatives because of State efforts to improve dental care access for low-income residents, especially those who are Medicaid-eligible, underserved, or underinsured.

MDH focuses its oral health improvement efforts to address gaps in oral health literacy, improve disease prevention, and increase availability and access to quality dental care in Maryland. The Office of Oral Health within MDH also continues to address other key issues, including provider access and ensuring that children and adults across the State have access to preventive services such as dental sealants and fluoride varnish. Medicaid and the Office of Oral Health have worked together to target outreach to pregnant women with the message that dental care is safe, important, and available through Medicaid.

Maryland's Medicaid dental benefits, collectively called the Maryland Healthy Smiles Dental Program (Healthy Smiles), are administered by a single statewide dental benefits administrator (DBA) responsible for coordinating all dental services for children, pregnant women, adults in the Rare and Expensive Case Management (REM) program, former foster care youth up to age 26, and adults aged 21 through 64 enrolled in both Medicaid and Medicare. Additionally, DBA is responsible for all functions related to the delivery of dental services for these populations, including provider network development and maintenance, claims processing, utilization review, authorization of services, outreach and education, and complaint resolution. SKYGEN USA (formerly known as Scion) has been serving as DBA since 2016.

MDH advises that utilization rates have increased, and provider networks have expanded since the department improved and rebranded the dental benefit as Healthy Smiles. According to MDH, Maryland dental utilization continues to outpace national averages. On January 1, 2021, MDH began covering dental services for postpartum women for up to 60 days and on April 1, 2022, expanded the postpartum period to 12 months.

Chapter 621 of 2018 required MDH to establish a pilot program to provide limited dental coverage to adult Medicaid enrollees. In response, Medicaid proposed a limited benefit program (basic diagnostic and preventive coverage with limited restorative and extractive services with a maximum benefit allowance of $800 annually) for adults ages 21 to 64 who are dually eligible for both Medicare and Medicaid (dual-eligibles). The program began in June 2019. Chapters 302 and 303 of 2022 expanded the adult dental benefit to all adults enrolled in Medicaid. MDH advises that the department is working on implementing the measure and intends for services to begin on the bill's effective date, January 1, 2023. The pilot, which provides services to dual-eligibles, will conclude when the benefit for all adults becomes available. More than 600,000 adults will be eligible for the new benefit.

The new adult dental benefit will be the same package of services pregnant women currently receive. This includes diagnostic, preventive, periodontal, and restorative services. There will be no maximum dollar amount placed on services received, unlike the pilot program. Participants who are currently enrolled in the pilot program will be transitioned into this new benefit January 1, 2023.

Effective July 1, 2022, MDH provided a one-time rate increase of 9.4% for 32 specific Medicaid dental codes. These codes include a selection of diagnostic, preventive, and restorative services and cover the following services areas: certain periodic, limited, and comprehensive oral evaluations as well as oral evaluations for patients younger than three years of age; certain intraoral, bitewing, and panoramic radiographic images; adult and child prophylaxis; multiple resin-based composite procedures and types of crowns; certain extractions or removals of teeth; and certain anesthesia and nitrous oxide codes. For a detailed list of these dental rate increases, see Appendix 5.

During the 2022 session, the fiscal 2023 budget directed $19.6 million ($9.1 million in general funds) to Medicaid to increase dental reimbursement rates, representing the largest increase since fiscal 2009. The 9.4% rate increase is a result of these efforts.

Oral Health Practitioners in Maryland and Other Jurisdictions

In Maryland

An individual must be licensed by the State Board of Dental Examiners (board) before the individual may practice dentistry or dental hygiene on a human being in Maryland. This requirement does not apply to a student of dentistry while engaged in an education program at an approved school of dentistry.

Dentists

The practice of dentistry includes the performance of any intraoral dental service or operation; the diagnosis and treatment of any disease, injury, malocclusion, or malposition of a tooth, gum, or jaw, or associated structures if included in the curricula of an accredited dental school or in an approved dental residency program of an accredited hospital or teaching institution; dental laboratory work; the placement or adjustment of a dental appliance; administration of anesthesia for the purposes of dentistry; patient evaluation, diagnosis, and determination of treatment plans; determination of treatment options, including the choice of restorative and treatment materials and diagnostic equipment; and determination and establishment of dental patient protocols, dental standards of care, and dental practice guidelines.

With specified exceptions, an applicant for a dental license must hold a degree of Doctor of Dental Surgery, Doctor of Dental Medicine, or the equivalent, from a college or university that is (1) authorized by any state or Canadian province to grant the degree and (2) recognized by the

board as requiring adequate preprofessional collegiate training and as maintaining an acceptable course of dental instruction.

Dental Hygienists

A licensed dental hygienist is authorized to perform a preliminary dental exam; perform a complete prophylaxis, including the removal of any deposit, accretion, or stain from the tooth surface or restoration; polish a tooth or restoration; chart cavities, restorations, missing teeth, periodontal conditions, and other features observed; apply a medicinal agent to a tooth for a prophylactic purpose; take a dental x-ray; perform a manual curettage in connection with scaling and root planing; administer local anesthesia or nitrous oxide under certain circumstances; or perform any other intraoral function authorized by the board.

Historically, dental hygienists in Maryland have practiced under the indirect supervision of a dentist, which means the dentist authorizes the procedure and remains in the office while it is being performed. To more efficiently serve patients and promote proper preventive oral health care, dental practices in Maryland have trended toward permitting dental hygienists to work under less restrictive supervisory requirements. For example:

- Chapters 164 and 165 of 2007 authorized dental hygienists authorized to practice under a licensed dentist's general supervision in a government-owned and -operated facility or public health department to apply fluoride, mouth rinse, or varnish.

- Chapter 316 of 2008 authorized dental hygienists who are permanent or contractual employees of the federal government, a State or local government, or a federally qualified health center, and working in specified facilities, to apply fluoride and sealants under the general supervision of a licensed dentist; Chapter 316 also expanded the types of facilities in which dental hygienists may practice under general supervision, specified that these facilities are not required to obtain a general supervision waiver, and repealed the requirement that a dentist or physician evaluate or diagnose a patient before dental hygienists can treat a patient in these facilities.

- Chapters 565 and 566 of 2009 expanded the scope of practice for dental hygienists to include manual curettage in conjunction with scaling and root planing and administration of local anesthesia.

- Chapter 733 of 2010 authorized dental hygienists to practice in a long-term care facility under the general supervision of a dentist; Chapter 381 of 2014 made these provisions permanent.

- Chapters 271 and 272 of 2011 authorized dental hygienists to monitor a patient to whom nitrous oxide is administered; Chapter 382 of 2014 made these provisions permanent.

- Chapter 220 of 2012 authorized dental hygienists to administer local anesthesia by inferior alveolar nerve block.

- Chapters 106 and 111 of 2016 authorized dental hygienists to administer nitrous oxide and local anesthesia, respectively, under certain circumstances and under the supervision of a dentist.

- Chapter 399 of 2019 authorized dental hygienists practicing under the general supervision of a licensed dentist to practice in nursing homes, assisted living programs, medical offices, or group homes or adult day care centers, rather than only in a long-term care facility; Chapters 677 and 678 of 2022 replaced the term "medical office" with "clinical office" thereby authorizing dental hygienists to work in the office of a registered nurse practitioner, certified nurse midwife, or licensed certified midwife who provides prenatal, postpartum, or primary care.

- Chapter 311 of 2020 authorized dental hygienists to prescribe or administer certain medications, after completing educational requirements established by the board.

Dental Assistants

In general, dental assistants in Maryland are not required to be licensed or certified by the board to perform the following intraoral duties under the direct supervision of a dentist: rinsing and aspiration of the oral cavity; retraction of the lips, cheek, tongue, and flaps; placement and removal of materials for the isolation of the dentition, provided that the material is not retained by the dentition; instructing on oral hygiene; taking impressions for study models or diagnostic casts; constructing athletic mouth guards on models; applying topical anesthesia; curing by the use of halogen light; checking for loose bands; and any other procedure authorized by the board by a rule or regulation. A dental assistant may also assist in performing intraoral photography, other than conventional or digital x-ray, under the general supervision of a licensed dentist who reviews the photography and authorizes the treatment plan.

Chapter 364 of 2022, which took effect October 1, 2022, established an "expanded function dental assistant" (EFDA) credential. A dental assistant certified as an EFDA by the board may assist with certain intraoral procedures while under direct supervision by a dentist. An individual may be certified by the board to help with a specific procedure after completing training for the specific procedure. An individual must hold an EFDA credential from the board to perform the following intraoral procedures:

- assisting in orthodontic procedures authorized by the board in regulation;

- placing dental sealants;

- coronal polishing only to remove stain or biofilm (1) in connection with a dental prophylaxis, as specified and (2) before a dentist performs an esthetic or cementation procedure;

- applying silver diamine fluoride;

- monitoring nitrous oxide by observing a patient (1) during the flow of nitrous oxide; (2) during the reduction of the flow of nitrous oxide; (3) during the shutting off of equipment controlling the flow of nitrous oxide; and (4) at all times in between the start of the flow of nitrous oxide until the nitrous oxide has been terminated and the patient has fully awoken and is coherent; and

- additional intraoral procedures authorized by the board in regulations.

As of October 2022, board staff were in the process of drafting regulations required under Chapter 364, but these regulations are not likely to take effect until 2023, pending public comment and approval from the Secretary of Health, at which time individuals will be able to seek certification as an EFDA.

A dental radiation technologist is an individual other than a licensed dentist or dental hygienist who practices dental radiation technology. An individual must be certified by the board as a dental radiation technologist to place or expose dental radiographs in Maryland.

In addition to dental practitioners, Maryland has a robust population of community health workers. A community health worker (CHW) is a frontline public health worker who serves as a liaison, link, or intermediary between health (including dental) and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Chapter 441 of 2018 established the State Community Health Worker Advisory Committee and required MDH to adopt regulations related to the training and certification of CHWs in the State; however, an individual is not required to be certified by MDH in order to work as a CHW in the State, only to use the title of certified CHW. Because certification is not required, the number of CHWs operating in the State is unknown. The U.S. Department of Labor estimated that 1,470 CHWs were working in Maryland in May 2021.

Total Practitioners in the State

According to the board, as of August 2021, 4,211 dentists held an active license in Maryland. This figure is consistent with the 4,229 dentists who held an active license in 2020. The board follows a biennial license renewal cycle, with approximately half of dental practitioners renewing each calendar year. Based on an estimated State population of 6,165,129 as of July 1, 2021, there was one practicing dentist per approximately 1,467 Marylanders.

The board does not maintain data on the *geographic* distribution of these practitioners nor would such data be a complete picture as practitioners may practice in more than one jurisdiction. The board website (https://mdbod.mylicense.com/Verification/Search.aspx_) allows the public to search for dental practitioners under its "license verification" feature, and the results will show a primary address for the practitioner.

Exhibit 1 provides a snapshot of board licensing activity in fiscal 2021, reflecting new, renewal, and inactive licenses issued during that year.

Exhibit 1
State Board of Dental Examiners Licensing Activity
Fiscal 2021

	Dental License	Dental Hygienist License	Dental Radiation Technologist Certificate	Total Activity
New	242	200	329	771
Renewal	2,229	1,682	2,996	6,907
Converted from Active to Inactive	84	61	n/a	145
Inactive	323	180	n/a	503

Note: Licenses and certificates are renewed on a biennial basis with approximately one-half of licensees and certificate holders renewing in each fiscal year. Thus, the total licensing activity does not reflect the total number of licensees and certificate holders practicing in that year.

Source: State Board of Dental Examiners

Salary Observations

In its research, the task force noted a difference in salaries for oral health practitioners employed by the State as compared to those working in the private sector, which has led to workforce shortages in public health facilities. **Exhibit 2** shows the salary range available for oral health practitioners employed by the State.

Exhibit 2
Salary Range for Oral Health Practitioners Employed by the State
Effective July 1, 2022

Job Title	Minimum Salary	Maximum Salary
Dental Assistant I	$25,502	$39,574
Dental Assistant II	27,048	42,102
Dental Assistant Trainee	24,056	37,204
Dental Hygienist I	30,472	47,710
Dental Hygienist II	34,390	54,186
Dental Hygienist III	36,557	57,808
Dentist I	68,959	110,729
Dentist II	73,612	118,197
Dentist III Community Health	78,595	126,186
Dentist III Residential	78,595	126,186

Source: Department of Budget and Management Salary Plan

By contrast, **Exhibit 3** shows the annual mean wage of oral health practitioners in Maryland (which includes both public and private sector workers) as estimated by the U.S. Bureau of Labor Statistics in May 2021.

Exhibit 3
State Occupational Wage Estimates for Oral Health Practitioners
May 2021

Job Title	Annual Mean Wage
Dental Assistants	$44,410
Dental Hygienists	89,340
Dentists, General	158,520
Dentists, All Other Specialists	166,340

Source: U.S. Bureau of Labor Statistics, Occupational Employment and Wage Statistics, May 2021

For every category of oral health practitioner shown, the estimated annual mean wage exceeds the maximum salary available in State employment. For dental hygienists, those making

the maximum State salary ($57,808) earn less than two-thirds of the average mean wage for dental hygienists in Maryland ($89,340). This wage disparity makes it difficult for the State to recruit and retain oral health practitioners, who often serve rural or economically disadvantaged communities.

Oral Health Practitioners in Other States

Dental Therapists

The advanced dental hygiene practitioner (ADHP) is a model developed by the American Dental Hygienists' Association. An ADHP is considered a mid-level oral health provider with a scope of practice beyond that of a dental hygienist but is not authorized to practice independently or at the level of a dentist. More commonly known as a "dental therapist," an ADHP is trained in a master's level program open to licensed dental hygienists who have a bachelor's degree.

The following 13 states have authorized dental therapists to practice in some form, with the year in which that practice was authorized indicated:

- Alaska, 2003 (in tribal settings);
- Arizona, 2018;
- Connecticut; 2019;
- Idaho, 2019;
- Maine, 2015;
- Michigan, 2018;
- Minnesota, 2009;
- Montana, 2019;
- Nevada, 2019;
- New Mexico, 2019;
- Oregon, 2011 (pilot project in tribal settings);

- Vermont, 2016; and
- Washington, 2017 (in tribal settings).

Though approved to practice in these states, the American Dental Association (ADA) reports that dental therapists are only *actively* practicing in Maine, Minnesota, and the tribal territories of Alaska and Oregon. In these states, dental therapists work primarily in settings that serve low-income, uninsured, and underserved populations.

The Commission on Dental Accreditation (CODA), established in 1975, is recognized by the U.S. Department of Education as the agency responsible for accrediting dental, allied dental, and advanced dental education programs. In 2015, CODA approved and implemented an accreditation process for dental therapy education programs. The standards identify those aspects of program structure and operation that CODA regards as essential to program quality and achievement of program goals. The standards also specify the minimum acceptable requirements for programs and provide guidance regarding alternative and preferred methods of meeting standards.

CODA accreditation includes standards for institutional effectiveness; community resources; the educational program; faculty and staff, including specified faculty-to-student ratios; educational support services, including admissions policies, specific facilities and resources that must be provided, student services, financial aid, and health services; and health, safety, and patient care provisions. Highlights of the education program requirements include:

- a minimum of three academic years of full-time instruction or equivalent;
- evaluation methods that measure defined competencies;
- development of professional competencies;
- achieved competence in the use of critical thinking and problem solving related to the scope of dental therapy practice;
- required curriculum achievement in general education, biomedical sciences, and dental sciences (didactic and clinical);
- required content including oral and written communications, psychology, and sociology;
- biomedical science instruction ensuring an understanding of certain enumerated basic biological principles;

- didactic dental sciences content ensuring an understanding of certain enumerated basic dental principles;

- instruction in the principles of ethical decision making and professional responsibility;

- achieved competence in providing oral health care within the scope of dental therapy practice with supervision as defined by the state practice acts including certain enumerated practice activities; and

- inclusion of community-based learning experiences.

CODA requires graduates to be competent in providing oral health care within the scope of dental therapy practice, with supervision as defined by the state practice acts, including:

- identifying oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians, or other health care providers, and managing referrals;

- comprehensively charting the oral cavity;

- providing oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;

- exposing radiographic images;

- providing dental prophylaxis, including subgingival scaling and/or polishing procedures;

- dispensing and administering via the oral and/or topical route nonnarcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed health care provider;

- applying topical preventive or prophylactic agents, including fluoride varnish, antimicrobial agents, and pit and fissure sealants;

- conducting pulp vitality testing;

- applying desensitizing medication or resin;

- fabricating athletic mouthguards;

- changing periodontal dressings;

- administering local anesthetic;
- conducting simple extraction of erupted primary teeth;
- performing emergency palliative treatment of dental pain limited to the procedures included in this scope;
- preparing and placing of direct restoration in primary and permanent teeth;
- fabricating and placing of single-tooth temporary crowns;
- preparing and placing of preformed crowns on primary teeth;
- performing indirect and direct pulp capping on permanent teeth;
- performing indirect pulp capping on primary teeth;
- performing suture removal;
- conducting minor adjustments and repairs on removable prostheses; and
- removing space maintainers.

Where graduates of a CODA-accredited dental therapy program are authorized to perform additional functions defined by the program's state-specific dental board or regulatory agency, program curriculum must include content at the level, depth, and scope required by the state.

The following schools in the United States offer dental therapy education programs:

- University of Minnesota;
- Metropolitan State University (Minnesota);
- Minnesota State University-Mankato;
- Normandale Community College (Minnesota);
- Ilisgavik Tribal College (Alaska);

- Vermont Technical College; and
- Skagit Valley College (Washington).

As of September 2022, Ilisgavik Tribal College and Skagit Valley College are the only dental therapy programs accredited by CODA, while Vermont Technical College is applying for CODA accreditation. Minnesota's schools operate under approval from the Minnesota Board of Dentistry.

The task force received presentations relating to the licensure of dental therapists in Minnesota and the use of community dental health coordinators (these can be CHWs focused on facilitating access to dental care) as an alternative to mid-level providers at its May 19, 2022 meeting. For details of this meeting, see Appendix 3. After studying the use of mid-level providers to improve dental access, the task force does not recommend the use of dental therapists or the dental therapy model in Maryland at this time.

Loan Repayment Assistance in Maryland

The Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP) is a student loan assistance repayment program for dentists who treat Maryland's most vulnerable populations. The purpose of MDC-LARP is to increase access to oral health care services for Maryland Medicaid enrollees by increasing the number of dentists treating this population. To be eligible to apply, an individual must be (1) a practicing dentist in Maryland who has graduated from an accredited U.S. dental school with a valid unrestricted license to practice dentistry in Maryland; (2) employed full-time as a dentist in Maryland providing care to Maryland Medicaid enrollees; (3) a dentist whose patient population comprises at least 30% Medicaid enrollees; and (4) currently paying off outstanding student loan debt. To be eligible for an award, an individual cannot be in default on a loan or have an incomplete service obligation. Eligible applicants may receive up to $23,740 per year for each year of obligated service, up to a maximum of three years of service. The promotion of this program is conducted by the State Board of Dental Examiners.

Research Activities and Recommendations

To focus the research efforts of the membership, the task force split into subgroups that worked separately to conduct research and gather statistics and information pertaining to the following populations facing barriers to oral health:

- pediatric;
- elderly;

- adult;
- individuals with intellectual and developmental disabilities;
- Medicaid; and
- immigrant populations in Maryland.

Each of the subgroups were asked to examine potential barriers to accessing oral health care and develop recommendations to address any barriers impacting the target population. Barriers included geography, racial and ethnic factors, socioeconomic factors, insurance issues, workforce issues, and lack of public education and outreach.

In the course of their research and discussions, many subgroups noted an overlap in the populations of focus; for example, many children and individuals with disabilities are served by Medicaid. As such, some subgroups identified similar barriers to care and in turn made the same or similar recommendations to address an identified barrier. These repeat recommendations are noted with an asterisk in each subgroup analysis and will be discussed amongst the other high-impact recommendations identified by the full task force at the conclusion of this report.

Pediatric

Medicaid's Maryland Healthy Smiles Dental Program

Healthy Smiles provides coverage for Medicaid enrollees younger than age 21 (in addition to other populations) and was an area of significant focus for the pediatric subgroup. A recurring theme of task force discussions was that Healthy Smiles reimbursement rates are too low. In 2010, there was discussion about raising reimbursement rates, but rate increases were never implemented. While the federal Patient Protection and Affordable Care Act increased Medicaid reimbursement rates for pediatricians in 2013, there were no dental rate increases at that time. In 2013, there was a nominal rate increase for only three fees: D1208-Topical fluoride; D2940-Protective Restoration; and D3120-Indirect Pulp Cap. As noted earlier, effective July 1, 2022, MDH provided a one-time rate increase of 9.4% for 32 specific Medicaid dental codes. For a detailed list of these dental rate increases, see Appendix 5.

In particular, in examining Medicaid reimbursement rates for anesthesia, the subgroup noted that anesthesia for dental cases is not paid at the same rate as medical anesthesia. Additionally, the full task force compared reimbursement rates in Maryland with those in neighboring jurisdictions and found that Maryland reimburses far less than three of five neighboring states for anesthesia treatment, as shown in **Exhibit 4**. These disparities make it difficult for dentists to schedule dental anesthesia in hospitals for pediatric patients, leading to long

wait times to treat severe dental issues. The subgroup further noted a nationwide trend away from in-office sedation, further compounding delays relating to hospital-based anesthesia.

Exhibit 4
Medicaid Reimbursement Rates for Dental Anesthesia by State

State	Reimbursement Rate for 15 Minutes of Anesthesia Treatment
Delaware	$296.0
District of Columbia	130.0
Maryland	**71.0**
Pennsylvania	71.0
Virginia	64.0
West Virginia	136.2

Source: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia Medicaid dental fee schedules accessed on April 22, 2022.

The subgroup also reviewed the number of providers participating in Healthy Smiles. **Exhibit 5** shows the ratio of dental providers to Healthy Smiles program enrollees by Maryland county. Two counties on the Eastern Shore (Kent and Worcester) have, significantly disproportionately, the highest number of enrollees per provider (or fewest providers for the county's enrollee population) in the State. When discounting these two outlying counties, the average ratio of enrollees per provider is 360. Only three additional counties (Baltimore, Charles, and Somerset counties) fall significantly below this ratio with more than 100 enrollees above the average per provider. If the outlying counties are included, however, the average increases to 514 enrollees per provider. These figures demonstrate a significant shortage of providers as compared to Healthy Smiles program enrollees on the Eastern Shore. While Charles County falls below the State average on the ratio of dental providers, Calvert and St. Mary's counties are the two leaders in these statistics. While this may demonstrate a comparative ease of dental provider access in Southern Maryland, other barriers may still exist.

Exhibit 5
Ratio of Dental Providers to Medicaid Enrollees by County

County	Ratio of Enrollees to Providers
Allegany	379:1
Anne Arundel	394:1
Baltimore	497:1
Baltimore City	393:1
Calvert	174:1
Caroline	369:1
Carroll	319:1
Cecil	408:1
Charles	507:1
Dorchester	459:1
Frederick	323:1
Garrett	449:1
Harford	317:1
Howard	245:1
Kent	2,319:1
Montgomery	259:1
Prince George's	367:1
Queen Anne's	435:1
Somerset	759:1
St. Mary's	113:1
Talbot	230:1
Washington	277:1
Wicomico	239:1
Worcester	2,102:1

Source: SKYGEN, LLC

The subgroup noted that Healthy Smiles has a utilization rate of 72%, meaning that over 280,000 children in the State received dental care in the surveyed year with the assistance of Healthy Smiles, but that more than one-quarter of pediatric participants did not receive oral health services through the program in the prior year.

Medicaid and Medical Application of Fluoride Varnish in Children

Maryland Medicaid reimburses Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) medical providers who apply fluoride varnish to children aged nine months to five years

old. Providers are eligible to receive a $24.92 reimbursement for each varnish applied during an approved well-child visit. To be eligible for reimbursement, a provider must be an EPSDT-certified pediatrician, family physician, nurse practitioner, or physician assistant licensed to practice in Maryland; participate in Medicaid; and successfully complete the Fluoride Varnish and Oral Health Screening online training program. The online training program consists of four modules that take approximately 70 minutes to complete and covers the important role that medical providers and staff can play in children's oral health, dental caries and early childhood caries and factors that influence the development of tooth decay, why certain children are at higher risk than others for dental caries, guidance on how an EPSDT medical provider can quickly and effectively conduct a caries risk assessment, and the purpose of anticipatory guidance and key issues that should be discussed with parents to promote children's oral health. The fourth module includes a description of fluoride varnish and its efficacy in preventing dental caries and step-by-step instructions for applying fluoride varnish with a video demonstrating the process. This module discusses referral to a dentist and the concept of the dental home, provides a fluoride varnish periodicity schedule, and covers fluoride varnish reimbursement.

In fiscal 2021, there were 552 active EPSDT medical providers certified to apply fluoride varnish. These providers administered 39,607 fluoride varnish applications to children enrolled in Medicaid. Members of the pediatric subgroup raised concerns that this program may actually be a detriment to the dental health of children because patients and parents are not educated on the limitations of the treatment and the need for additional dental care.

Identified Barriers to Care for the Pediatric Population

In its discussions, the subgroup identified barriers to care and developed recommendations for the barriers identified impacting the pediatric population. The subgroup's research on barriers to care included a survey conducted through the Maryland Rural Health Association, which remains ongoing at the time of this report, but which presented preliminary findings to the task force at its August 18, 2022 meeting.

Ultimately, the subgroup found transportation and geography to be major, compounding barriers preventing children from receiving dental health care. Racial and ethnic factors, socioeconomic factors, education, and an understaffed workforce also limit care.

Transportation and Geographic Factors

- the pediatric population is reliant on parents to transport them to appointments;
- unreliable transportation and the limited scheduling of transportation;
- parents' need to miss work and children to miss school to receive dental care;
- the cost of tolls and gas;

- past issues with transportation and the need to cross county borders for patient appointments; and

- the need to travel long distances to seek care, especially from specialists.

Non-emergency transportation (NEMT) is available for Medicaid recipients who have no other means of getting to their medical or dental appointments. NEMT typically covers ambulatory, ambulance, aero medical, and wheelchair transportation. Transportation services are provided by local jurisdictions. The fiscal 2022 and 2023 budgets each included $40.8 million for Medicaid NEMT, which is distributed to local health departments in the form of transportation grants. Transportation services must be scheduled a minimum of 24 hours in advance (except for hospital discharges) and are only available to recipients who can demonstrate that they have no other means of getting to their appointments. Task force members discussed how these limitations, combined with difficulty for certain patients in navigating the request system, may lead to underutilization of Medicaid NEMT. To address these and other concerns, Maryland Medicaid is engaged in a multi-year process to reform and improve the NEMT program, which began with a diagnostic assessment of the program. The State is now seeking a third-party statewide broker model to create an enhanced participant experience, provide quality service, streamline processes, improve program integrity, and achieve cost savings.

Racial and Ethnic Factors

- poor education in minority populations on the importance of oral health in children;

- the need to continue to increase the number of providers in Maryland, especially in rural areas; and

- issues with dietary choices common in minority populations (including food deserts, frequent consumption of high sugar drinks, and the prevalence of nighttime nursing).

Socioeconomic Barriers

- similar dietary issues noted in minority populations;

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits for unhealthy food and drink options (for example, juice rather than water);

- limited access to healthy food and drink options (food deserts);

- comparatively lower prices of high sugar drinks and snacks, which make these choices less expensive and easier to provide for families;

- lack of education on the importance of oral health, not only for children, but also for adults;
- the need to work multiple jobs or long hours, reducing time spent at home helping children with oral health care;
- difficulty in taking take time off work and finding care for other children; and
- child care policies that a child cannot be returned to child care once leaving may prevent a parent from returning to work after a dental appointment.

The subgroup also noted the need to address insurance issues for the pediatric population by expanding the provider network for Healthy Smiles, including recruiting specialists to participate in the program.

Workforce Issues

- loss of Healthy Smiles providers;
- increased costs of staff and supplies;
- lack of specialty providers in rural areas;
- lack of oral health care support staff (assistants and hygienists);
- barriers to treating children under general anesthesia in hospitals, including anesthesia reimbursement rates under Medicaid and the availability of operating room time in hospitals, which leads to long wait times for patients;
- increased regulation nationally of oral sedation resulting in an increased use of general anesthesia; and
- a lack of focus on oral health needs by medical providers.

Public Education and Outreach

The subgroup also identified the following issues relating to a lack of public education and outreach:

- guidance that children receive their first dental visit by age one is not known by the general population;

- lack of general education on the importance of oral care for "baby teeth";
- lack of education on diet and oral health;
- lack of education on the importance of preventive dental visits;
- lack of awareness in the general population on the impact of missed appointments on dental practices and other patients; and
- the stigma of fear surrounding visits to the dentist, including the possibility of parents projecting their own past experiences onto their children.

Recommendations for the Pediatric Population

Having identified these barriers impacting children's receipt of dental care in Maryland, the pediatric subgroup made the following recommendations:

1. ***Increase the Healthy Smiles provider network in areas that are in need. This could be accomplished by offering dental students/dentists incentives to open offices in these areas (similar to Armed Forces scholarships).**
2. ***Provide vouchers or transportation reimbursement for uninsured families that are trying to access dental care for use on tolls, public transportation, or ride-sharing services.**
3. ***Increase public education on the importance of oral health for children and parents.**
4. **Increase funding to dental assistants and dental hygiene programs to increase the number of programs and capacity of existing programs to increase the supply of oral health support staff.**
5. **Dental advocacy organizations should prioritize increasing collaboration between medical and dental practitioners.**
6. **Alter Medicaid dental coverage and reimbursement by:**
    - **(a) *significantly increasing reimbursement rates;**
    - **(b) *providing Medicaid coverage for in-office general anesthesia by an anesthesia provider; and**
    - **(c) *including Silver Diamine Fluoride as a reimbursable procedure under Maryland Healthy Smiles.**

7. ***Implement statewide mandatory dental screenings for children at ages 1, 3, 6, 9, and 12 as a requirement to enter child care or public school.**

8. ***Expand MDC-LARP to include dental hygienists and increase the reimbursement rate from $23,740 to $50,000 immediately with periodic evaluation of the reimbursement amount.**

9. ***MDH should convene a stakeholder workgroup to study and make recommendations relating to the establishment of a grant or no-interest loan program for providers to open practices in underserved areas. The group should include representatives from the Maryland Community Health Resources Commission, the Office of Oral Health, and the Community Dental Clinics Grant Program. As part of its work, the workgroup should make recommendations on an appropriate entity to manage the program and promotion of the program.**

Adult

Identified Barriers to Care for the Adult Population

As shown in **Exhibit 6**, cost is the most prevalent barrier to dental care affecting adults in the United States. Additionally, a study from the ADA Health Policy Institute found the percentage of adults reporting cost as a barrier to care increased from 2005 to 2019. Low-income adults are most likely to report cost as a barrier to care, but the barrier is reported across all income levels. *The State of Oral Health Equity in America 2022* report by the CareQuest Institute for Oral Health found a 5% increase from 2021 to 2022 in the number of adults citing finances as a reason to avoid dental care.

Exhibit 6
Top Reasons Given for Not Having Visited the Dentist In the Prior 12 Months Nationwide, 2015

Reason	Percentage of Adults
Cost	60%
Fear of the Dentist	25%
Inconvenient Location or Time for Appointment	22%
Trouble Finding a Dentist Who Accepts My Insurance	15%
No Original Teeth	12%
No Perceived Need for Dental Care	10%
Other	10%

Source: Dr. Marko Vujicic, *et. al*. American Dental Association Health Policy Institute's 2015 Oral Health and Well-Being Survey of 14,962 adults

Transportation and availability of providers also create barriers for adults in Maryland seeking to access dental care. Socioeconomic status often determines an individual's ability to utilize private transportation options or to rely on public transportation. In non-urban areas, public transportation is typically insufficient for individuals to access many dental practices. This access issue is exacerbated if a patient needs to see a specialist, which might require cross-county or interstate travel. For individuals who can attend visits, Medicaid may not cover all services needed. Members of the task force repeatedly mentioned that Medicaid does not provide for dentures, even though dentures impact a person's ability to maintain a healthy diet and communicate.

The adult subgroup also noted significant disparities by race and ethnicity regarding access to care in the CareQuest study. Nearly half of Hispanic adults, Asian adults, and Black adults experienced discrimination in an oral health care setting. Black adults and Native American adults are two to three times more likely to resort to an emergency department to receive dental care than White adults. Costs for emergency room visits for dental care dramatically outsize costs for comparable dental care provided in a dental office or clinic. These concerns exist in addition to the barriers discussed above.

Beyond physical health concerns, the subgroup noted that access to oral health care directly impacts individuals' mental health. Individuals with poor oral health are more likely to be embarrassed when interacting with other people. Employers are also less likely to hire an individual with signs of poor oral health. This problem can limit employment opportunities, which in turn hurts an individual's ability to access employer-sponsored insurance and earn money to afford dental care.

Recommendations for the Adult Population

Based on these findings, the adult subgroup made the following recommendations:

1. ***Expand services covered by Medicaid for adults.**

2. ***Increase Medicaid reimbursement rates.**

3. ***Authorize Medicaid reimbursement for denture services to cover functional needs for optimal oral and overall health and employability.**

4. **Streamline Medicaid recertification procedures for providers to remove barriers to participation by providers.**

5. ***Expand oral health literacy and education.**

6. ***Increase funding for dental workforce programs, such as MDC-LARP.**

7. ***Support additional strategies to encourage oral health care professionals to work in underserved areas.**

8. ***Provide transportation services to individuals who cannot reliably utilize public transportation or private transportation to attend appointments.**

Elderly

Sixteen percent of Maryland residents are age 65 and older – approximately 626,000 people in the State. More than 70% of seniors in Maryland do not have dental insurance coverage. Many seniors lose their private dental insurance when they retire because they receive their coverage through their employer. Newly retired individuals may not be aware of their dental coverage options or are unable to afford adequate coverage.

According to a 2015 nationwide survey conducted by the ADA Health Policy Institute, only 22.3% of seniors below the federal poverty level visited the dentist in the past 12 months. The elderly are the least likely age cohort to be covered by private dental insurance. An elderly individual without insurance is 2.5 times less likely to make a regular dental visit than an elderly individual with dental insurance. Individuals with some dental insurance coverage may find their coverage insufficient. Medicare Advantage coverage is highly variable and is often limited to radiographs and annual prophylaxis. Comprehensive Medicare Advantage plans usually require the payment of additional plan fees for added coverage. Acquiring a comprehensive plan through Medicare Advantage or a private insurer is cost prohibitive for many people. Medicaid recipients living in a long-term care facility can utilize an incurred medical expense (IME) to obtain medical

devices not normally covered by Medicaid, such as dentures. However, patients or dental providers cannot file for IME coverage. Instead, they depend on a long-term care facility's Medicaid caseworker. The subgroup reported that residents frequently struggle to receive cooperation from Medicaid caseworkers and ultimately cannot receive the proper benefit despite being eligible.

Upon admission to a long-term care facility, residents receive an initial physical examination that is then repeated annually. These examinations are often done by a provider without specific dental training, and therefore, the examination has a limited scope. These limited scope examinations can prevent a resident from receiving adequate health care if a resident's specific oral health needs are not detected by the examiner. Oral health care provided in long-term care settings can be improved with proper training for staff, particularly geriatric nursing assistants (GNA). GNAs are certified nursing assistants who have met particular federal and State training standards. GNAs can support residents with fundamental life and health functions, such as eating, hygiene, and taking vital signs. With further training, GNAs could additionally help residents practice good dental hygiene as well. This training can be led by a facility's dental health professional to expand a GNA's scope of practice and improve the oral health of residents. Long-term care facilities can utilize existing training programs rather than develop a program on its own.[1]

Individuals age 65 and older need to receive dental care to maintain a healthy life. Data from the ADA Health Policy Institute show that age has a direct correlation to an increased risk of oral cancer, and individuals with periodontal disease are 50% more likely to suffer a heart attack. Health issues impacting seniors are more significant for low-income and minority seniors. Among high-income seniors, 7% have untreated dental caries, while 33.5% of seniors living below the federal poverty level have untreated caries. Dental caries also vary based on ethnicity with 39% of Mexican-American seniors and 31.3% of non-Hispanic Black seniors have untreated caries, while 14.1% of non-Hispanic White seniors have caries.

Chapters 744 and 745 of 2021 required applicants for the renewal of a license or certificate issued by a health occupations board, including dental practitioners, to attest to completion of an approved implicit bias training program the first time the applicants renew their license or certificate after April 1, 2022. The subgroup discussed the value of this requirement to improving cultural competency of dental practitioners, but felt other actions need to be taken to eliminate barriers that prevent elderly Marylanders from accessing oral health care.

[1] Members of the task force identified the following examples to illustrate the type of courses that long term care facilities can utilize for staff training: "Mouth Care Without a Battle" produced by the University of North Carolina, https://www.mouthcarewithoutabattle.org/; "Oral Health for Caregivers" from the Washington State Dental Foundation; and Smiles for Life Oral Health, https://www.smilesforlifeoralhealth.org/all-courses/.

Recommendations for the Elderly Population

In light of these findings, the elderly subgroup made the following recommendations:

1. ***Improve communication between dental and other health professionals on the importance of oral health in overall general health.**

2. **Long-term care facilities should include and improve training programs for long-term care staff and caregivers on how to provide customized oral care for those who cannot provide adequate self-care.**

3. **School curriculum for dental care providers and continuing education should focus on including exposure to treating individuals with complex medical and cognitive needs.**

4. ***The State and local jurisdictions should provide funding to support tuition reduction to attract more dentists to underserved areas.**

5. **Improve resources to educate seniors on available dental benefits through Medicaid, on the Maryland Health Benefit Exchange (MHBE), and Medicare Part C.**

6. **Promote creation of a National Dental Medicare benefit program for our most vulnerable seniors.**

7. **Explore expanding the availability of Medicare Part C dental benefit by Medicare supplement insurance carriers in all Maryland counties.**

8. **Staff in long-term care facilities should educate seniors on utilization of incurred medical expenses under Medicaid to pay for dental health care.**

Individuals with Intellectual and Developmental Disabilities

The U.S. Centers for Disease Control and Prevention (CDC) reports that one in five adults in Maryland have a disability (approximately 22% of the adult population). Using the national prevalence rate of 1.58%, an estimated 95,522 of these Marylanders are individuals with developmental disabilities. The U.S. Census reports that 27.3% of individuals aged 16 and older with disabilities are employed, compared to 70.7% of people aged 16 and older without disabilities. Furthermore, 17.6% of individuals with disabilities in Maryland live below the federal poverty level, compared to only 6.9% of individuals without disabilities. These statistics indicate that the majority of individuals with disabilities are likely to use Medicaid as their primary insurance. The CDC also reports that health care costs for individuals with disabilities in Maryland account for 35% of the State's health care spending, or about $21,118 per individual with a disability. Adults

with disabilities are more likely to be overweight, smoke, have diabetes, and have heart disease. When people do not have access to oral health care, there is overlap with these health issues.

On January 14, 2022, Christy Russell, Director of Operations at the Maryland Developmental Disabilities Council and member of the subcommittee focused on individuals with disabilities, met with People on the Go of Maryland, the statewide self-advocacy organization. Ten individuals with developmental disabilities attended the meeting. Of that group, six individuals reported having visited a dentist in the past year, with most reporting a positive experience with a dentist willing to accommodate their disability. Of respondents who did not visit a dentist, reasons cited included transportation, cost, lack of coverage, lack of wheelchair accessibility, and lack of accommodation. The majority of the focus group expressed difficulty in finding a dentist as many dentists do not accept new patients under Medicaid or lack accessible dental offices, and that patients have difficulty finding accessible transportation. The focus group discussed particular issues individuals with intellectual and developmental disabilities face during dental visits and expressed the need for more dentists who understand disabilities.

Recommendations for the Disabled Population

To address these identified barriers, the subgroup focused on individuals with disabilities made the following recommendations:

1. *Require MDH to:

(a) create and distribute:

(1) plain language educational materials on the importance of regular dentist appointments; and

(2) plain language information on dental procedures; and

(b) encourage dental providers to distribute the materials created under (a) to patients.

2. *Require dental practitioners, at initial licensure and renewal, to provide information on whether they provide mobile or portable dental services. The board should incorporate this information into a searchable feature on the board's website. Providers should also seek continuing education on providing dental service through mobile or portable means.

Medicaid

Healthy Smiles provides coverage for children younger than age 21, former foster care recipients younger than age 26, pregnant and postpartum women age 21 years and older, and adults enrolled in the REM program. With the passage of Chapters 302 and 303, adults age 21 and older with full Medicaid benefits will also be eligible for dental benefits effective January 1, 2023. SKYGEN USA, LLC, is the DBA for the program. The total population covered by Maryland Medicaid is just under 1.5 million.

Early in the task force's work, the group received a presentation from Nancy Brown, Division Chief of Evaluation, Research, and Data Analytics at the Maryland Medicaid Office of Innovation, Research, and Development (see Appendix 3 for a summary of each of the full task force meetings). Ms. Brown shared data on the number of dentists participating in Medicaid by region as well as the number of active dentists in the State as compared to dentists participating in Healthy Smiles – see **Exhibit 7** and **Exhibit 8**. The figures in Exhibit 7 have been updated since Ms. Brown's presentation to reflect figures for calendar 2020 that were not yet available at the time of the presentation to the task force. These figures reflect the highest concentration of dentists participating in Medicaid in the Baltimore metropolitan and Washington suburban areas of the State, with fewer participating in the more rural areas of the Eastern Shore, Southern Maryland, and Western Maryland.

Exhibit 7

Dentists Participating in Medicaid Who Billed One or More Services By Region

Calendar 2016-2020

Region*	**2016**	**2017**	**2018**	**2019**	**2020**
Baltimore Metro	538	560	593	628	536
Washington Suburban	567	563	582	630	540
Southern Maryland	60	63	66	66	59
Western Maryland	122	145	152	164	133
Eastern Shore	86	97	100	98	76
Out-of-state	167	197	219	215	138
Total	1,540	1,625	1,712	1,801	1,482
Unique Total	**1,467**	**1,600**	**1,596**	**1,694**	**1,465**

Note: Baltimore Metro: Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties; Washington Suburban: Montgomery and Prince George's counties; Southern Maryland: Calvert, Charles, and St. Mary's counties; Western Maryland: Allegany, Frederick, Garrett, and Washington counties; Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties.

Source: Maryland Medicaid Office of Innovation, Research, and Development, Maryland Department of Health

Exhibit 8
Active Dentists and Dentists Participating in the Maryland Healthy Smiles Dental Program
Calendar 2019 and 2020

Region	Total Active Dentists		Active Pediatric Dentists		Dentists Enrolled in Maryland Healthy Smiles Dental Program		Dentists Who Billed One or More Services		Dentists Who Billed $10,000+	
	2019	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**
Baltimore Metro	1,903	1,890	113	82	756	715	628	536	476	426
Washington Suburban	1,700	1,691	94	70	788	788	630	540	477	443
Southern Maryland	140	137	*	*	110	102	66	59	52	44
Western Maryland	277	286	19	14	217	198	164	133	124	111
Eastern Shore	209	207	*	*	174	146	98	76	79	65
Out-of-state	–	–	–	–	244	201	215	138	89	50
Total	**4,229**	**4,211**	**240**	**181**	**1,738**	**1,630**	**1,694**	**1,465**	**1,244**	**1,138**

Source: 2021 and 2022 Annual Oral Health Reports, Maryland Medicaid Office of Innovation, Research, and Development, Maryland Department of Health

Barriers to Care for the Medicaid Population

The Medicaid subgroup examined the six potential barriers to accessing oral health care and developed recommendations to address these barriers. In developing its recommendations, the subgroup rated the impact of each recommendation from “high” to “low” based on the Medicaid population group and the identified barrier.

Barriers to oral care were identified and assessed in each geographic location (rural, suburban, and urban) and within each Medicaid population group. Because all Medicaid

population groups are unserved or underserved in rural areas, as opposed to in urban or suburban areas, the subgroup felt that recommendations made to address all six barriers to oral health services would be highest impact for rural populations.

For children, those recommendations relating to racial/ethnic factors, socioeconomic factors, insurance, and education were deemed to be of highest impact, while for dual-eligible adults, socioeconomic, insurance, and education recommendations were considered highest impact. Finally, the subgroup felt that recommendations to address socioeconomic factors would be of the highest impact to pregnant women in urban and suburban areas due to the prevalence of support systems and case managers (such as community health workers, doulas, and social service organizations) when compared to rural areas. When examining recommendations in relation to geography, the subgroup found that those recommendations targeting socioeconomic factors were identified as high impact for all populations located in urban areas. Additionally, recommendations addressing socioeconomic factors were identified as high impact for all geographic areas.

Telehealth, the practice of receiving licensed medical care remotely via telecommunications, increases patient access to health care providers. Telehealth is particularly valuable for individuals with physical, intellectual, or financial constraints that prevent them from traveling at will to see a provider. During the COVID-19 pandemic, telehealth utilization expanded as patients and providers worked to minimize the risk and spread of the virus. In response to the pandemic, MDH updated billing codes for its telehealth program for certain providers, including dentists. Dentistry delivered via telehealth, known as teledentistry, was expanded effective March 5, 2020, the same day that Governor Lawrence J. Hogan, Jr. declared a state of emergency in response to the pandemic. MDH continues to review the codes that may be appropriate for teledentistry. Further, Chapters 70 and 71 of 2021 required the Maryland Health Care Commission (MHCC) to conduct a study on the impact of telehealth as it relates to use of audio-only and audio-visual technologies in somatic and behavioral health interventions. MHCC is due to submit recommendations on telehealth coverage and payment levels relative to in-person care to the Senate Finance Committee and the House Health and Government Operations Committee December 1, 2022.

Recommendations for the Medicaid Population

To address socioeconomic factors impacting Medicaid populations, the subgroup made the following recommendations:

1. **Encourage CHW educators to implement or expand CHW training to include dental health literacy as part of the curriculum and integrate CHW training into the existing dental workforce curriculum.**

2. ***Allow Medicaid billing/reimbursement for CHW support services.**

The subgroup made the following recommendations that address insurance issues:

3. ***Increase Medicaid dental reimbursement rates and develop a periodic review of such rates.** (This recommendation was also made by this subgroup as a means of addressing workforce issues.)

4. ***Provide incentives to increase provider participation in Medicaid.**

The Medicaid subgroup identified barriers to oral health care, particularly for Medicaid patients located in rural areas, stemming from a shortage of providers located in rural communities. In addition to the recommendations noted above to address workforce issues, the subgroup made the following recommendations aimed at expanding the dental workforce:

5. ***Provide incentives for providers to relocate to geographic areas underserved by Medicaid providers.**

6. ***Increase funding to MDC-LARP and extend the program to include dental hygienists.**

7. **Increase the number of Medicaid EPSDT providers.**

Finally, to address the need to educate the public on the importance of dental care, the services covered by Medicaid, and the opportunity for eligible people to enroll in Medicaid, the subgroup made the following recommendations:

8. ***Expand dental promotion/education campaigns.**

9. **MDH should conduct a study on provider participation in Healthy Smiles. The study should include a review of administrative issues relating to initial enrollment and renewal and possible incentives to encourage participation, including certificates of appreciation, rewards, continuing education credits, or tax incentives.**

Immigrant Population in Maryland

According to the U.S. Census Bureau, approximately 15% of Marylanders were born in a country other than the United States. Immigrants in Maryland form a diverse group with differing countries of origin, socioeconomic status, and residency status. The immigrant subgroup examined conditions for citizen immigrants, noncitizen immigrants with a legal residency status, and noncitizen immigrants without a legal residency status.

At the May 19, 2022 meeting of the task force, Matthew Peters, Executive Director of the Chesapeake Multicultural Resource Center, presented information to the subgroup about the center and how it serves the immigrant population on the Eastern Shore. Since its founding 10 years ago,

the center has served individuals and families from over 30 countries. It provides a holistic approach that covers the health, legal, and social needs of immigrants. Mr. Peters estimated that 95% of adults in contact with the center do not have access to dental care. Children in contact with the center fare much better; less than an estimated 10% do not have access to dental care. To address medical needs, the center has certified navigators on staff who help people access insurance and manage their medical bills. Center staff also help individuals apply for WIC benefits. Legal services provided by the center include immigration services that are accredited by the U.S. Department of Justice, translation and interpretation services approved by Maryland courts and the Motor Vehicle Administration, and notary services. The center also promotes a sense of community and inclusion with child care services through an after-school program at Easton Elementary and summer programs. The center is funded primarily by donations.

Barriers to Care for the Immigrant Population

The immigrant subgroup reported that ineligibility for public insurance programs is a significant barrier to care for immigrants who are not lawfully present in the United States. Currently, Medicare and federal subsidies for qualified health plans offered through MHBE are not available to individuals who are not U.S. citizens. Thus, noncitizens typically must cover the cost of their dental services out-of-pocket or obtain a private insurance plan. Either option is often cost-prohibitive. Some noncitizen residents are eligible for Medicaid services, but individuals without legal residency status are entirely barred from Medicaid in most states. Uninsured or underinsured immigrants often turn to safety-net clinics, but these are not a proper replacement for complete and routine oral health care. Free or low-cost clinics offered by charitable organizations and government-sponsored entities are sporadic, overwhelmed with patients, and do not offer a complete range of dental services. California recently expanded its Medicare medical and dental eligibility to include individuals who are at least 50 years old, regardless of immigration status. New York similarly expanded Medicaid eligibility to include undocumented immigrants who are at least 65 years old.

Other barriers to care impacting immigrants regardless of insurance eligibility include:

- language barriers;
- transportation;
- appointment availability; and
- attitudes towards preventative dental care.

Individuals who do not understand English cannot directly communicate with their dental care provider and will have greater difficulty scheduling appointments. Even individuals with intermediate English fluency might struggle to understand advanced medical terminology. Transportation to appointments frequently created a barrier to care for immigrants living in rural

communities. Public transportation options are limited and time-consuming, which is a high opportunity cost for anyone with limited work leave and personal responsibilities such as child care or elder care. Some individuals will decline to schedule dental appointments or miss an appointment because the transportation options are too limited. A lack of providers in certain regions of the State mean there are limit appointment options and long wait times between appointments. Putting off care can result in a condition going untreated and worsening to a point that urgent care is needed in place of less expensive and safer preventive options.

Another barrier to care reported by the subgroup is misinformation about the legal impact of seeking public benefits and health care. Some immigrants in Maryland do not have an expectation of receiving preventive dental care and are not aware of the health risks created by ignoring a medical issue. A prevalent understanding that "problems will go away if left alone" keeps many people from even seeking dental care. Mr. Peters reported that many immigrants are given misinformation about WIC benefits and Medicare/Medicaid coverage having detrimental impacts on citizenship applications or legal residency status. This discourages people from accessing vital services. These barriers could be addressed by organizations that reach into communities with information and clinics to remove barriers of convenience and remove barriers caused by a lack of information and communication resources.

Recommendations for the Immigrant Population

Based on these findings, the immigrant subgroup made the following recommendations:

1. **Provide insurance to all individuals, regardless of citizenship status, and examine current requirements to become insured.**

2. ***Develop programs to increase the quantity of providers and quality of service provided in rural areas.**

3. ***Conduct education and awareness activities to promote an understanding of oral health fundamentals as well as addressing misunderstandings about seeking dental care.**

4. ***Offer dental care in more convenient locations through teledentistry and mobile clinics or in central locations such as schools and ensure that mobile or temporary clinics have greater capacity to meet a community's needs.**

5. **Dental practitioners should help connect patients and their families to other vital services such as child care, transportation, legal services, and insurance coverage opportunities through CHWs or other staff.**

High Impact Recommendations

A number of subgroups made similar or identical recommendations in their independent work. Because these were identified as impacting multiple target populations or identified by a subgroup as being particularly impactful for their target population, these have been identified as being the highest impact of the task force's recommendations. The list below highlights each of these high impact recommendations, followed by a reference to the subgroup or subgroups that addressed the recommendation in further detail in the discussions above.

- ***Workforce Shortages in Rural Areas of the State:*** The task force recommends efforts to:
  - increase providers by creating incentives and establishing low-interest loans and tuition reduction and waiver programs (pediatric, Medicaid, and immigrant subgroups);
  - expand loan repayment assistance programs (pediatric, Medicaid, and immigrant subgroups); and
  - increase utilization of CHWs (pediatric, Medicaid, and immigrant subgroups).
- ***Transportation Barriers:*** The task force recommends consideration of:
  - vouchers for uninsured individuals (pediatric subgroup);
  - mobile and portable provider education so more providers are aware of the services and are prepared to offer or participate in mobile and portable clinics or practices (disabled and immigrant subgroups); and
  - teledentistry reimbursement under Medicaid (immigrant subgroup)
- ***Medicaid:*** While each of the subgroups discussed the role of Medicaid, the pediatric, adult, and Medicaid subgroups identified the following specific recommendations, discussed in detail within the subgroup discussions:
  - increase reimbursement rates;
  - expand reimbursable procedures and services; and
  - increase provider participation in Maryland Healthy Smiles.
- ***Other Recommendations:*** The task force recommends efforts to:
  - increase non-dental health care provider and patient education on oral health (pediatric, adult, elderly, individuals with disabilities, Medicaid, and immigrant subgroups); and
  - require dental screenings for enrollment in child care and public schools (pediatric and Medicaid subgroups).

Appendix 1
Membership of the Task Force on Oral Health in Maryland

Co-chair Debony R. Hughes, DDS, Director, Office of Oral Health, Maryland Department of Health
Co-chair Mark A. Reynolds, DDS, PhD, MA, Dean, University of Maryland School of Dentistry

Mary Backley, Maryland Dental Action Coalition representative
Jennifer L. Briemann, Maryland Managed Care Organization Association representative
Nancy Brown[3], Maryland Department of Health Medicaid representative
Jean J. Carlson, DDS, Maryland Association of Community Colleges representative
Sarah L. Czyz, RDH, dental hygienist working in a federally qualified health center or other clinic providing dental services to underserved adults or children
Jonathan Dayton[2], Maryland Rural Health Association representative
Charles Doring, DDS, Maryland State Dental Association representative
Emily A. Dow, PhD, Secretary of the Maryland Higher Education Commission, or designee
Ricardo C. Kimbers, DDS, Maryland Dental Society representative
Hakan Koymen, DDS, MS, Dental Director of Maryland Healthy Smiles Dental Program, or designee
Christy Russell, Maryland Developmental Disabilities Council representative
Jennifer A. Suminski, CPhT, RDH, MS, Maryland Dental Hygienists' Association representative
Diane D. Romaine, DMD, Representative from a nonprofit organization that advocates for needs of poor
Dean Shifflett, representative of a dental plan organization
Nicole Steck-Waitt, representative of the nursing home industry
Vacant[1], Maryland Alliance for the Poor representative
Arpana S. Verma, DDS, FICD, State Board of Dental Examiners
Brooks Woodward, DDS, dentist working in a federally qualified health center or other clinic providing dental services to underserved adults or children

[1] MJ Kraska served as the Maryland Alliance for the Poor representative June 2021 through April 2022.
[2] Jonathan Dayton replaced Carol M. Masden as the representative for the Maryland Rural Health Association in March 2022.
[3] Nancy Brown joined the task force in May 2022 to replace former co-chair Alexander Shekhdar (Deputy Secretary for Public Health Services, or the Deputy Secretary's designee). At the time of Mr. Shekhdar's departure in January 2022, existing task force member Debony Hughes was appointed by MDH to fill the role of co-chair. Ms. Brown served on the task force in an advisory capacity and did not vote on any of the task force's recommendations.

Note: Anna L. Davis served as the representative for Advocates for Children and Youth until December 2021 when the organization was dissolved. Because the organization was specifically named in Chapters 599 and 600 of 2021, no replacement organization could be represented on the task force in its place.

Appendix 2
Overview of Task Force Meetings

Each meeting was video-recorded and can be viewed on the Maryland General Assembly website.

September 14, 2021

At its first meeting, task force members introduced themselves, reviewed the charter legislation, and discussed research methodologies and the anticipated timeline of task force activities, including the establishment of research subgroups and an online drive for sharing background reading and other materials. The task force also received a presentation from Nancy Brown, Division Chief of Evaluation, Research, and Data Analytics at the Maryland Medicaid Office of Innovation, Research, and Development. Ms. Brown presented on the 2020 Annual Oral Health Legislative Report. The presentation included an overview of the Maryland Medicaid dental program (also known as Maryland Healthy Smiles), the number of dentists participating in Maryland Medicaid, dental utilization, the adult dental pilot program created in response to Chapter 621 of 2018, and Maryland Medicaid's COVID-19 response.

October 21, 2021

The task force discussed the draft work plan (see Appendix 3) and received presentations by Katie Neral, Deputy Director of the Maryland Department of Health's (MDH) Acute Care Administration and Dr. Debony Hughes, Director of MDH's Office of Oral Health. In outlining its work plan, the task force discussed increasing the frequency of meetings from one to two meetings per month and allowing the use of proxies for the purposes of representation in discussions but not in voting or determining a quorum for a vote. The schedule of meetings was left open, subject to the results of an e-mail poll as to members' availability. In adopting a workplan, the task force opted to establish six subgroups focused on specific populations: adult; pediatric; elderly; immigrant; Medicaid; and individuals with intellectual and developmental disabilities. The task force also discussed barriers to care that may impact each of the target populations that should be considered by each subgroup.

Ms. Neral gave an overview of the Maryland Healthy Smiles Program; Maryland Medicaid's fee-for-service dental program, including covered groups; the role of the dental benefits administrator; and utilization data. Ms. Neral's presentation also covered upcoming regulations, including expanded postpartum dental coverage and orthodontic preauthorization, and claims for teledentistry services. Noting concerns that Medicaid has heard from providers, Ms. Neral discussed the limitations on increasing dental reimbursement rates and access to

operating rooms in hospitals. Following Ms. Neral's presentation, Dr. Hughes gave an overview of the Office of Oral Health, including programs administered by the office.

November 18, 2021

The co-chairs announced the assignment of task force members to the subgroups discussed at the October meeting and reviewed how the subgroups would function. Eme Augustini, Executive Director of the National Association of Dental Plans, and Bernard LaPine, Director of Regulatory and Legislative Affairs for Highmark/United Concordia, presented on private insurance coverage for dental care. Ms. Augustini's presentation had a national scope, while Mr. LaPine's presentation focused on carriers, plans, and claims in Maryland.

December 2, 2021

The Medicaid subgroup gave an initial report on its first meeting to develop a grid to guide future work. The elderly subgroup presented on research that looked at access to insurance, an overreliance on emergency departments for care, and how geography impacts health. The task force also heard from Dr. Chelsea Fosse, MDM MPH, a Senior Health Policy Analyst with the American Dental Association Health Policy Institute, and Dr. Cheryl Lerner, MDM, Dental Director for CareFirst BlueCross BlueShield. Dr. Fosse provided information regarding Medicare and Medicaid participation and utilization. Dr. Fosse also shared a study that examined the cost to provide extensive dental coverage in states that do not currently provide such coverage. Dr. Lerner provided an overview of differing types of private and government insurance plans.

December 16, 2021

The task force heard presentations about dental insurance from Dr. Norman Tinanoff, DDS, a professor in the Department of Orthodontics and Pediatric Dentistry at University of Maryland. Baltimore; Dr. Gretchen Seibert, DDS, Director of Dental Health for Allegany Health Department; and Dr. Eric Tranby, manager for Data and Impact at the CareQuest Institute for Oral Health. Dr. Tranby's presentation looked at surveys and related data documenting dental habits and availability of insurance. Dr. Tinanoff's presentation looked at data on dentist participation with Medicaid. Dr. Seibert presented on dental clinics offered by the Allegany County Health Department and the accelerating number of people coming to the clinic for help. Additionally, the subgroups focused on elderly, adult, disabled, and immigrant populations reported to the full task force.

January 6, 2022

The task force discussed the work plan and activities for the 2022 calendar year, including planning a work hiatus during the legislative session. The elderly and pediatric subgroups provided updates on their work and suggestions to eliminate barriers for these groups. As part of this discussion, the task force discussed limits as to policies the task force has the ability to impact versus policies that originate at the federal level. The full membership discussed speakers the group would like to hear from during its remaining meetings and discussed potential considerations for task force review.

April 21, 2022

After taking a break from its activities during the legislative session, the task force reconvened to discuss updates to its membership, received a presentation from the Department of Legislative Services on oral health legislation that passed during the 2022 session, and discussed future meetings. In discussion on future meetings, the membership opted to poll membership on preferred meeting times before the May meeting. The task force also reviewed and unanimously approved its interim report, which was due May 1, 2022. Finally, the task force received public comment from guests advocating for an increase in Medicaid reimbursement rates, specifically with regard to anesthesia rates for operating room cases.

May 19, 2022

Having polled the membership between the April and May meetings, at the May meeting, Dr. Hughes announced that future meetings would alternate meeting times between 10:00 a.m. and 12:00 p.m. and 4:00 p.m. and 6:00 p.m., reflecting the even split in time preferences expressed by the members. Dr. Hughes also announced that subgroups would be reporting out to the full task force at the June, July, and August meetings on population needs, access issues, and suggested solutions. These reports would give the full task force an opportunity to discuss final recommendations at the September meeting and vote on the final report at the October meeting. Dr. Hughes also announced that the interim report voted at the April meeting had not yet been submitted because it was undergoing review by MDH. Finally, Dr. Hughes announced that $19 million had been allocated in the Governor's budget for a rate increase in Medicaid, expected to be implemented on July 1.

The task force received a presentation from Matthew Peters, Executive Director of the Chesapeake Multicultural Resource Center, on services provided to the immigrant community on the Eastern Shore. Mr. Peters gave an overview of the center's clientele, staff, and services. Mr. Peters estimated that, of the people receiving services through the center, less than 10% of the children lack dental insurance, while 95% of the adults lack dental insurance. Mr. Peters discussed barriers particularly impacting immigrants, including language and cultural norms but noted that

barriers related to documentation have been removed through legislation in recent years. Mr. Peters also highlighted barriers to accessing care on the Eastern Shore generally, including the need to take time off of work and transportation.

The task force also heard from Dr. Paul Casamassimo, member of the Section of Dentistry at Nationwide Children's Hospital and Professor Emeritus at Ohio State University College of Dentistry, on barriers to care for pediatric populations. Dr. Casamassimo shared data comparing dental utilization among children by state, showing that Maryland is doing relatively well on this metric, and discussed unique challenges facing pediatric dentists and children seeking care. Dr. Casamassimo also made a series of recommendations to increase pediatric access to dental care and closed his presentation by discussing school-based care and the use of silver diamine fluoride.

June 16, 2022

The June meeting of the task force focused on the topic of mid-level providers. Three speakers presented on the experience of licensing dental therapists in Minnesota: Dr. Prasida Khanal, State Oral Health Director, Minnesota Department of Health; Nitika Moibi, Supervisor, Office of Rural Health and Primary Care, Minnesota Department of Health; and Dr. Karl Self, Director, Division of Dental Therapy at the University of Minnesota School of Dentistry. The representatives from Minnesota discussed the history and types of licensure, requirements for and authority of dental therapists in Minnesota, employment statistics, and impacts on access to dental care. Dr. Jane Grover, Director, Council on Access Prevention and Interprofessional Relations at the American Dental Association, spoke about community dental health coordinators as a resource to connect people to community health resources, assist with transportation issues, and provide help navigating health systems.

Dr. Hughes announced that, effective July 1, 2022, 32 current dental terminology codes (the most utilized) would have 9.5% rate increases with the aim of recruiting and retaining Healthy Smiles practitioners. At the close of the meeting, the elderly subgroup gave its final presentation on findings and recommendations.

July 21, 2022

The task force received presentations from Dr. Marko Vujicic, Health Policy Institute of the American Dental Association, and Nicole Edge, Health Policy Analyst, Maryland Health Benefit Exchange. Dr. Vujicic presented on the national landscape of Medicaid dental programs and issues around implementation of expanded adult dental benefits in Medicaid. Dr. Vujicic shared data demonstrating that the most commonly cited barriers to accessing needed dental care for adults ages 19 to 64 relate to cost. Dr. Vujicic discussed the need to ensure easy access to providers and the importance of appropriate measurements to demonstrate the ease of access,

including appointment wait times, health outcomes, and impact on health costs. Dr. Vujicic shared data on dentist participation in Medicaid and noted that Maryland has relatively low engagement of dentists in Medicaid compared to other states but also discussed the importance of understanding the location and availability of these dentists to serve Medicaid patients. Dr. Vujicic also shared information on the Medicaid reimbursement fee schedule, noting that Maryland's reimbursement rates outperform many other states. Despite this above-average reimbursement, rates have not enticed the participation of many providers.

Ms. Edge presented on dental coverage in Maryland's insurance marketplace, specifically with a focus on services available for senior citizens. Ms. Edge discussed the minimum requirements for standalone dental plans, gave comparisons of plan options, and discussed limitations on plan regulation, such as rate adjustments by geographic region and waiting periods. After the completion of outside presentations, the task force heard updates from the Medicaid and disabilities subgroups, as well as additional follow-up from the elderly subgroup.

August 18, 2022

Three subgroups reported to the full task force during this meeting. The pediatric subgroup presented its final findings and recommendations, including interim results of a survey conducted by the Maryland Rural Health Association, which will continue through the fall. The pediatric subgroup also invited Dr. Winifred Booker, incoming president of the Maryland State Dental Association, to give a brief presentation recommending legislation to require parents of a child enrolled in child care to provide evidence of the receipt of certain dental care for the child.

In presenting its final findings and recommendations, the adult subgroup noted that cost is the predominant concern reported by adults when asked why they have not seen a dentist recently, with the percentage of adults reporting cost as a concern having increased in the past decade. The subgroup finished by noting that its recommendations to address cost, transportation, and workforce levels are similar to the recommendations reported by other subgroups in the task force.

Lastly, the immigrant subgroup gave a presentation focused on undocumented immigrants. The subgroup analyzed four ways an individual can receive health insurance or dental insurance in the United States and the eligibility criteria for each. The subgroup reported that undocumented immigrants are barred from receiving coverage by some private insurers, Medicaid programs in almost all states, federal health insurance subsidies for qualified health plans under the Patient Protection and Affordable Care Act and Medicare. The subgroup also shared information on legislation in California and New York that expanded dental coverage to many undocumented immigrants.

September 15, 2022

The task force met to review a draft version of this final report and to discuss recommendations to be included in the report. The members engaged in thorough discussions to edit, remove, or add recommendations to the draft. The process was not completed within the scheduled two-hour meeting time.

September 29, 2022

The task force met to resume the unfinished business from the September 15 meeting. The group also reviewed new language provided by MDH after the September 15 meeting providing information about Medicaid and programs to expand access to oral health services. Some draft recommendations of the task force overlapped with these existing MDH efforts. Given the potential for redundancy, the group decided to remove some recommendations that overlapped with the newly provided information. Also, during the meeting, MDH was tasked with providing further information about teledentistry and a study on telehealth being conducted by the Maryland Health Care Commission. That information has been incorporated into this report.

October 20, 2022

The task force voted on the final draft of this report and discussed next steps for the task force.

Appendix 3
Workplan

Presented at the October 21, 2021 meeting and updated based on member feedback

Based on feedback from the first and second meetings of the task force, the chairs and task force staff are submitting the following workplan for consideration by the broader membership:

Bi-weekly Taskforce Meetings

Given the scope of work before the task force, as well as the aggressive timetable for both the interim and final reports, it is our recommendation that we begin convening the task force for two hours every two weeks beginning December 2021 on the first and third Thursdays of every month. The meeting agendas will include a mix of presentations, time for the task force to deliberate, and opportunities for public comment. Please note, the task force does not anticipate meeting in January, February, or March, or in the first week of April 2022.

Preliminary Task Force Areas of Inquiry

Many task force members expressed an interest in a variety of topics relating to oral health both within the contours of the enabling legislation, as well as peripheral to it. We also recognized comments from the task force cautioning us not to "silo" our considerations of interest. Consequently, we are suggesting a workplan whereby the task force will first consider how various populations access dental services and then move onto what types of barriers might impede that access. Below is a preliminary description of the aforementioned:

"Targeted Populations Access to Care"

- Pediatric
- Adult
- Individuals with disabilities, including intellectual and developmental
- Elderly
- Medicaid-covered populations
- Immigrant

"Barriers To Care"

- Geographic, including transportation and location of dental offices
- Racial/ethnic, including implicit bias, cultural competency, and language barriers
- Socioeconomic, including cost and existence of resources
- Insurance coverage
- Practitioner/workforce, including hours of operation
- Education/outreach to the public, including oral health literacy

Future Speakers and Stakeholder Perspective

The chairs and task force staff have received multiple suggestions for future speakers to help inform our deliberations. Some suggested speakers include: the American Academy of Pediatrics; local health departments; the Centers for Medicare and Medicaid Services; the Medicaid and Children's Health Insurance Program Payment and Access Commission; the American Dental Association; and CareFirst. As we move through our workplan, we will tailor our invitations to the appropriate shareholders.

Task Force Resource Library

As mentioned during the "kick-off" meeting of the task force, task force members will have access to a shared repository of information for their background. Members will be granted read-only access, and suggested contributions to the repository will be directed to the task force staff.

Appendix 4
Enacting Legislation

Chapter 599

(House Bill 368)

AN ACT concerning

Task Force on Oral Health in Maryland

FOR the purpose of establishing the Task Force on Oral Health in Maryland; providing for the composition, chair, and staffing of the Task Force; prohibiting a member of the Task Force from receiving certain compensation, but authorizing the reimbursement of certain expenses; requiring the Task Force to study and make recommendations regarding certain matters; requiring the Task Force to submit interim and final reports to the Governor and certain committees of the General Assembly on or before certain dates; providing for the termination of this Act; and generally relating to the Task Force on Oral Health in Maryland.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) There is a Task Force on Oral Health in Maryland.

(b) The Task Force consists of the following members:

(1) the Deputy Secretary for ~~Health Care Financing~~ Public Health Services, or the Deputy Secretary's designee;

(2) the Dean of the University of Maryland School of Dentistry, or the Dean's designee;

(3) the Secretary of the Maryland Higher Education Commission, or the Secretary's designee;

(4) the Dental Director of Maryland Healthy Smiles Dental Program, or the Dental Director's designee;

(5) the Director of the Office of Oral Health in the Maryland Department of Health, or the Director's designee;

(6) one representative from each of the following organizations, selected by the organization:

(i) the Maryland State Dental Association;

(ii) the Maryland Dental Society;

(iii) the Maryland Dental Hygienists' Association;

(iv) the Advocates for Children and Youth;

(v) the Maryland Developmental Disabilities Council;

(vi) the Maryland Alliance for the Poor;

(vii) the Maryland Association of Community Colleges, who is knowledgeable about community college–based dental auxiliary programs;

(viii) the State Board of Dental Examiners;

(ix) the Maryland MCO Association; ~~and~~

(x) the Maryland Dental Action Coalition; and

(xi) the Maryland Rural Health Association; and

(7) the following representatives appointed by the cochairs of the Task Force:

(i) one representative from a nonprofit organization that advocates for the health needs of the poor and that has experience organizing a Mission of Mercy project;

(ii) one dentist working in a federally qualified health center or other clinic providing dental services to underserved adults or children;

(iii) one representative of the nursing home industry;

(iv) one representative of a dental plan organization; and

(v) one dental hygienist who works in a federally qualified health center or other clinic providing dental services to underserved adults or children.

(c) The Deputy Secretary for ~~Health Care Financing~~ Public Health Services, or the Deputy Secretary's designee, and the Dean of the University of Maryland School of Dentistry, or the Dean's designee, shall be cochairs of the Task Force.

(d) The Maryland Department of Health and the Department of Legislative Services shall provide staff for the Task Force.

(e) A member of the Task Force:

(1) may not receive compensation as a member of the Task Force; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Task Force shall:

(1) analyze the current access to dental services for all residents of the State with a focus on ~~residents affected by poverty, disabilities, or aging~~ socioeconomic status, race, ethnicity, age, and disability of residents as factors impacting access to dental services;

(2) identify areas of the State where a significant number of residents are not receiving oral health care services, distinguishing between the pediatric and adult populations;

(3) identify barriers to receiving dental services in the areas identified under item (2) of this subsection, including:

(i) the impact of implicit bias and the socioeconomic status, race, and ethnicity of residents of the State;

~~(i)~~ (ii) the impact of low oral health literacy;

~~(ii)~~ (iii) the lack of understanding of oral health and its relationship to overall health;

~~(iii)~~ (iv) the cost or the existence of limited resources;

~~(iv)~~ (v) the young age of parents of pediatric Medicaid–eligible children;

~~(v)~~ (vi) the location of dental offices, focusing on a lack of transportation;

~~(vi)~~ (vii) language and cultural barriers;

~~(vii)~~ (viii) the lack of Medicaid dental coverage or dental insurance;

~~(viii)~~ (ix) inconvenient office hours; and

~~(ix)~~ (x) factors that relate to anxiety and lack of understanding of the need for dental services;

(4) analyze the specific impact of each barrier identified under item (3) of this subsection;

(5) assess options to eliminate the barriers identified under item (3) of this

subsection, including:

(i) methods to educate physicians of the need to refer their patients for dental care;

(ii) methods to facilitate children beginning to receive dental care by 1 year of age;

(iii) methods to facilitate the delivery of dental care to patients who are elderly, especially those in assisted living and nursing homes;

(iv) methods to begin reestablishing dental Medicaid for adults, including making a cost–benefit analysis;

(v) evaluating the benefits of mid–level providers, including a dental therapist, and the cost and efficacy of establishing an education program for dental therapy that meets Commission on Dental Accreditation standards;

(vi) in assessing the potential role for a dental therapist:

1. making an assessment of existing educational opportunities, if any, for the study of dental therapy and a determination of the feasibility of expanding educational opportunities in the State for the study of dental therapy;

2. performing an examination of the experience in Minnesota, including the number of dental therapists licensed, the number currently enrolled in programs, the cost of the dental therapy education, and the extent to which dental therapists are providing services in clinics and private practice serving low–income patients; and

3. making a determination whether the implementation of a dental therapist program in Maryland will significantly increase access to quality dental care to the underserved poor, disabled, or elderly;

(vii) the impact of reinstating hospital–based dental residency programs;

(viii) the expansion of current programs and initiatives, such as community dental health coordinators, across the State;

(ix) the expansion of public education programs in the schools, through local health departments, to show the need for preventive dental services; and

(x) financial support to dentists who agree to provide care in underserved areas, or who agree to provide lower–cost or pro bono dental services; and

(6) make recommendations regarding methods to increase access to dental services in the State.

(g) (1) On or before May 1, 2022, the Task Force shall submit an interim report of its findings and recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Education, Health, and Environmental Affairs Committee, the Senate Finance Committee, and the House Health and Government Operations Committee.

(2) On or before December 1, 2022, the Task Force shall submit a final report of its findings and recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Education, Health, and Environmental Affairs Committee, the Senate Finance Committee, and the House Health and Government Operations Committee.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2021. It shall remain effective for a period of 2 years and, at the end of June 30, 2023, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2021.

Appendix 5
Maryland Medicaid Dental Rate Increases Effective July 1, 2022

Maryland
DEPARTMENT OF HEALTH

Provider Transmittal: Dental Rate Increases
July 1, 2022

Effective July 1, 2022, the Maryland Medical Assistance Program will provide a one-time rate increase of 9.4 percent for specific dental codes.

During the 2022 legislative session, the Maryland FY 2023 Operating Budget directed $19.6 million ($9.1 million General Funds) to Medicaid to increase dental reimbursement rates, representing the largest increase since FY 2009. This 9.4 rate increase is a result of these efforts.

If you have any questions regarding program rates, please contact Claire Serio, Division Chief of Dental Clinics and Laboratories by email at claire.serio@maryland.gov.

Dental Payment Rates Effective July 1, 2022

Dental Code	Description	New Rate
D0120	Periodic Oral Evaluation – Established Patient	$31.81
D0140	Limited Oral Evaluation – Problem Focused	$47.26
D0145	Oral Evaluation, Patient Under Three Years Of Age And Counseling With Primary Caregiver	$43.76
D0150	Comprehensive Oral Evaluation – New or Established Patient	$56.34
D0220	Intraoral – Periapical First Radiographic Image	$9.85
D0230	Intraoral – Periapical Each Additional Radiographic Image	$6.56
D0272	Bitewings – Two Radiographic Images	$16.41
D0274	Bitewings – Four Radiographic Images	$24.07
D0330	Panoramic Radiographic Image	$45.95
D1110	Prophylaxis – Adult	$63.62
D1120	Prophylaxis – Child	$46.35
D2330	Resin-Based Composite – One Surface, Anterior	$91.90
D2331	Resin-Based Composite – Two Surfaces, Anterior	$111.59

Dental Code	Description	New Rate
D2332	Resin-Based Composite – Three Surfaces, Anterior	$136.75
D2335	Resin-Based Composite – Four or More Surfaces or Involving Incisal Angle (Anterior)	$165.19
D2391	Resin-Based Composite – One Surface, Posterior	$101.74
D2392	Resin-Based Composite – Two Surfaces, Posterior	$131.28
D2393	Resin-Based Composite – Three Surfaces, Posterior	$164.10
D2394	Resin-Based Composite – Four or More Surfaces, Posterior	$164.10
D2740	Crown – Porcelain/Ceramic Substrate	$328.20
D2750	Crown – Porcelain Fused to High Noble Metal	$410.25
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$168.48
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$196.92
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	$168.48
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$65.64
D7140	Extraction, Erupted Tooth Or Exposed Root	$112.69
D7220	Removal of Impacted Tooth – Soft Tissue	$157.54
D7230	Removal of Impacted Tooth – Partially Bony	$230.83
D7240	Removal of Impacted Tooth – Completely Bony	$303.04
D9222	Deep Sedation/General Anesthesia – First 15 Minutes	$77.67
D9223	Deep Sedation/General Anesthesia – Each 15 Minute Increment	$77.67
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	$19.69