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Maryland Department of Health and Mental Hygiene on Access to Dental Care for Children

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Chairman Kucinich and members of the subcommittee, my name is Susan Tucker. I am the Executive Director of the Office of Health Services within the Maryland Department of Health and Mental Hygiene. I appreciate the opportunity to testify before you today on the progress that we have made in improving access to dental care for children on the Maryland Medicaid Program and on future plans to address dental access issues for low-income Marylanders.

Background and Strategies for Improving Access to Dental Care

We acknowledge that Maryland, like all states, has a problem with access to adequate dental services for all low-income children. It is a problem that we have been working on for many years. While we have made progress in improving dental access for children on Medicaid and SCHIP, much more needs to be done. It is important to understand that this is a long-standing national problem, affecting more than just children on Medicaid and SCHIP. As bad as the national disparities are in access and outcomes in medical care, they are much worse in dental care. We also know that to make progress in improving oral health for children, we need significant efforts on the part of dental providers, public health programs, parents, Medicaid agencies and federal policymakers.

In 2006, the Agency for Healthcare Research and Quality released a report entitled "Children's Dental Care: Periodicity of Checkups and Access to Care, 2003." Highlights of the paper include:

- Only about half of all children between the ages of 2 and 17 have an annual dental check-up, with those between the ages of 2 and 5 are much less likely than older children to have checkups.

- There is a great disparity in access to care by race with white non-Hispanic children (59.5%) being far more likely to have usual, routine dental check-ups than either Hispanic (34%) or black non-Hispanic children (41.7%).
- Children in households where neither parent attended college were much less likely to have an annual dental checkup (33.2% versus 60.9%).
- Tooth decay continues to be the single most prevalent chronic disease among children in the United States, despite the fact that it is highly preventable through early and sustained oral hygiene and regular professional preventive services.

One of the first priorities of the new administration has been to address dental access issues. We are forming a dental action committee which will include a full array of stakeholders. The committee will make recommendations regarding:

- Reimbursement rates for dentists;
- Strategies to engage families in improving oral hygiene in the home and in seeking preventive dental services in order to ensure that children do not get to the point where they are looking for emergency dental services;
- Strategies to encourage the dental provider community to participate in the program;
- Strategies related to dental scope of practice, specifically to allow dental hygienists to provide more preventive services in underserved areas;
- Strategies to encourage the dental school to train more pediatric dentists; and
- Strategies to improve access at Federally Qualified Health Centers and School-Based Health Centers.

Maryland is committed to implementing the committee's recommendations to ensure access to oral health services for all of its Medicaid enrollees through increased availability and accessibility of dentists throughout the state and increased awareness of the benefits of basic oral care among enrollees.

Clearly the United States needs to do a better job addressing this complex health and social issue. At today's hearing, I have been asked to address the oversight mechanisms the Maryland Department of Health and Mental Hygiene uses to ensure access to oral health care for Maryland's Medicaid eligible children. We have also been asked to address any measures that we have taken to avoid another tragic loss like that of Deamonte Driver. Due to federal and state confidentiality restrictions, my testimony here today will focus on programmatic issues relating to the provision of dental care for Maryland Medicaid enrollees.

Oversight of Maryland Medicaid Managed Care Providers

The Maryland Medicaid Program implemented a mandatory managed care program called HealthChoice in 1997. Our main goal under HealthChoice was to improve access to medical and dental care for children. Prior to implementing the program:

- Maryland Medicaid dental payment rates for providers were extremely low.
- Only about 20% of children received dental services on an annual basis.
- Few dentists in Maryland participated in Medicaid. Low payment rates were only part of the problem. Dentists had sufficient patients even without caring for any Medicaid patients. In addition, for a variety of social reasons Medicaid patients are much more likely to make appointments and then not show up, leaving the dentist with an empty chair and no reimbursement.

One of Maryland's goals in implementing HealthChoice was to improve access and utilization to dental and other health services for children. We did this through a number of mechanisms. The Department monitors dental data to see whether or not children enrolled in MCOs are receiving dental services. We have seen a steady improvement in this area since moving to managed care. MCOs are required to develop and implement an annual outreach plan, and these plans are reviewed by an External Quality Review Organization. These plans describe outreach activities to encourage families to seek regular dental care.

The Department has increased funding for dental services in past years. We raised rates for most services in 2001 and targeted payment increases to twelve common restorative procedures in 2004. Despite these increases, we recognize that Maryland Medicaid payment rates are below the usual-and- customary payments that dentists receive from private paying patients. They are also lower than the rates paid by many other Medicaid state agencies.

The Department requires MCOs to demonstrate that they have adequate contracts with dentists. Specifically, MCOs are required to have a dentist to enrollee ratio of no higher than 1 per 2,000 for each MCO. As of July 2006, there were approximately 918 dentists enrolled as providers in the HealthChoice program, which is a statewide ratio of 1 dentist to 439 HealthChoice enrollees who are under age 21. This does not include dental services provided through Federally Qualified Health Centers or local health departments. Even though the statewide ratio of dentists to HealthChoice enrollees meets the regulation requirements, many dentists only accept a certain number of patients. As a result, Medicaid recipients often have problems finding dentists.

Mandates also exist to ensure that each of the MCOs has the appropriate infrastructure to assist enrollees with locating and accessing services. For instance, each MCO must operate a consumer services hotline to assist its enrollees with information about how to use and access the MCO and its provider networks, including locating a dentist. In conjunction with this effort, the Department operates a HealthChoice Enrollee Action Line and the HealthChoice Provider Hotline. The hotlines assist members with managed care problems and intercede on their behalf when they are having problems accessing services. These numbers are on the back of every Medicaid enrollee's membership cards.

Finally, Maryland provides both incentives and disincentives to encourage the managed care organizations to improve access to services. A key focus for the Department has been to work with the MCOs to improve dental services for children between the ages of 4 and 20.

Conclusion

As a result of many of these measures, utilization for dental services for children with Medical Assistance coverage has increased from 19.9% to 45.8 %. We take our oversight of MCO performance seriously and while pleased with this progress, the Department is committed to implementing additional strategies to increase access to dental services.