



## Dental Public Health Activities & Practices

**Practice Number:** 23005  
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### SECTION I: PRACTICE OVERVIEW

**Name of the Practice:**

St. Mary's County Pilot Dental Program

**Public Health Functions:**

Assurance – Building Linkages and Partnerships for Interventions  
 Assurance – Building Community Capacity for Interventions  
 Assurance – Access to Care and Health System Interventions

**HP 2010 Objectives:**

21-10 Increase utilization of oral health system.

**State:**

Maryland

**Region:**

Mid-Atlantic  
Region III

**Key Words:**

Medicaid, pilot project, oral health utilization, access to care, partnerships

**Abstract:**

The St. Mary's County (Maryland) Pilot Dental Program began in June 2000 as a result of a unique partnership fashioned between the St. Mary's County Local Health Department and the Maryland State Office of Oral Health with two Medicaid managed care organizations and the Patuxent Dental Society, a component society of the Maryland State Dental Association. Prior to the partnership and the program, only 2% of dentists (1 of 44 dentists) in St. Mary's County participated in the Maryland Medicaid Program (MMP) (statewide average – 18%) resulting in poor utilization of dental services for Medicaid-eligible residents. Through the efforts of the partnership, and under the leadership of the St. Mary's County Health Officer, the development and consensus for the pilot project plan was finalized in April 2000. The purpose of the pilot program is to increase the number of practicing dentists in St. Mary's County who participate in the MMP with the assumption being that increased provider participation will result in increased access to dental care. There are 5 key components to the program, each addressing provider's major objections to participation with the program: (1) Higher reimbursement levels; (2) Reduced administrative burden on participating dentists; (3) Facilitation of credentialing and contracting process with MMP managed care organizations; (4) Elimination of pre-determination for all dental procedures except orthodontic and hospital-based services; and (5) Program administered by St. Mary's Local Health Department to address negative history with MMP and historical high no-show rate of patients. As a result of this program, the following interim outcomes (as of April 2002 except where noted) have been achieved: (a) Fee schedule for participating dentists in the pilot project increased to 72.5% of area fees (state average - < 20%); (b) 1554 unduplicated patients have received at least one dental visit since the start of the program representing an increase of 360% (338 unduplicated patients prior to the pilot project); (c) For FY 2000, estimates of the dental services utilization rate was within a range of 35% - 40% (state average in FY 2000 was 22%); (d) 21 dentists or 48% of St. Mary's County dentists participating in the program, representing an increase of 2000%, including 2 pediatric dentists, 1 orthodontist and 1 periodontist; (e) The compliance rate of patients keeping appointments for their first dental appointment is greater than 95%, and for the second appointment it is approximately 92%.

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## SECTION II: PRACTICE DESCRIPTION

### **History of the Practice:**

In June 1999, the St. Mary's County Health Officer approached the Director, Office of Oral Health to discuss acute dental access problems and related oral health problems in his County and asked what could be done to resolve these issues. Access and oral health status was poor in St. Mary's County because of the extremely low participation of dentists in the Maryland Medicaid Program (MMP) which contracts with managed care organizations to manage and operate the program. At the time, only 1 dentist in St. Mary's County was participating in the MMP and very few patients had received even one dental visit in the past year. The Health Officer was fielding numerous complaints from the public because of their lack of access and from the hospital system in the County because of a high volume of emergency room admissions for dental problems. The Health Officer and Office of Oral Health Director developed a plan that the Local Health Department (LHD), under the Health Officer's leadership, would take responsibility for the dental Medicaid program in the County. It was agreed that the LHD would serve as an access point for the public and providers and/or become a managed care dental provider itself and subcontract with local dentists. The Office of Oral Health Director secured permission to conduct such a pilot project from the Department of Health and Mental Hygiene in July 1999 and the St. Mary's County Health Officer formed a partnership by October 1999 which included two managed care organizations, the State Office of Oral Health, the local dental society (Patuxent Dental Society) and the local Rotary Club. After many meetings that included negotiations between the Health Officer and the local dental society and the managed care organizations, the pilot project plan was finalized in April 2000. The St. Mary's Dental Pilot Project began in June 2000 and remains a viable, successful program.

### **Justification of the Practice:**

A statewide needs assessment conducted by the University of Maryland Dental School (UMDS), under the auspices of Maryland Department of Health and Mental Health (DHMH), found that nearly 60 percent of Maryland schoolchildren have had dental decay as compared with 45 percent in the United States. Additionally, it was found that 55 percent of children in Maryland have untreated tooth decay compared with 21 percent nationwide. Children eligible for Medicaid or free and reduced school lunch programs had 30 percent more tooth decay than their more well-off peers. While there have been considerable Medicaid dental program funding increases in recent years, Maryland has historically ranked very low in the country with respect to dental reimbursements in its managed care Medicaid program. Dentists continue to receive less than 20% of their usual, customary and reasonable (UCR) fees. Other barriers cited by statewide dentists include paperwork burdens, a cumbersome contractual and credentialing process, and the non-compliance appointment keeping behaviors of Medicaid patients. As a result, the majority of dentists in the State had chosen not to participate as Medicaid dental providers and even fewer specialists participated in the program, especially in rural areas.

St. Mary's County is a rural county in southern Maryland. The County was found in the UMDS study to have the second highest dental caries rate for schoolchildren in the State. Prior to initiation of the practice, only 1 of 44 practicing dentists participated in the Maryland Medicaid Program (MMP), translating to a 2% participation rate, making access to dental services extremely limited for Medicaid-eligible patients. County dental providers were resistant to contracting with managed care organizations (MCOs) operating the State MMP for the following reasons: a) dissatisfaction with reimbursement levels; b) dentist cost of administration due to multiple MCOs and dental vendors, each with separate benefit schedules, application materials, credentialing standards and claims submissions guidelines; c) unwillingness to contract with MCOs for fear that a third party will control clinical decision-making; d) negative history with the MMP; and e) lost revenue as a result of a high no-show rate of Medicaid-eligible patients, claim denials and eligibility changes.

A strategy was needed to address these barriers in order to enhance access to these critical dental services for the MMP population.

### **Administration, Operations, Services, Personnel, Expertise and Resources of the Practice:**

Two full-time employees of the St. Mary's County Health Department (county funded) with skills in administration and social work administer the program. Their effort and salaries are in-kind; they were already full-time employees who were transferred to this new program because of the high priority that the Health Officer placed on it. Approximately 90-100% of their effort as local health

department employees goes to the pilot dental program. Other resources include state and private grants aimed at subsidizing the program and serving as a reserve fund in their troubleshooting and outreach efforts (for reimbursement of no-show patients and resolution of claims denials, if needed).

There are 5 key components of the program, each addressing provider's major objections to participation with the program:

1. Improve Reimbursement Levels – The MCOs agreed to offer a unique fee schedule for St. Mary's County that provides an increase in compensation commensurate with local dental fees (72.5% of local fee charges) but which still reflects a significant discount from the area's Usual and Customary Fees. As care is delivered, provider claims are paid according to the fee schedule directly by the dental administrators. Costs by MCO are tracked at 3-month increments, and if costs exceed the amount budgeted (which has yet to occur), the program will be re-evaluated, and any necessary adjustments made.
2. Reduce administrative burden on participating dentists – In this program, the St. Mary's Health Department played an integral role in supporting dental care delivery to the HealthChoice population, thereby reducing or eliminating participating dentists' perceived administrative barriers to participation. The proposed process for care delivery under this pilot program is as follows:
  - The Local Health Department will be listed as the chief point of contact in St. Mary's County on the MCO Provider Directory. Recipients then contact the Local Health Department to access care, which then coordinates an appointment with one of the participating dentists. Thus, dentists only need to complete one MCO application and one credentialing review when working with the Local Health Department.
  - The Local Health Department verifies eligibility, and identifies which carrier will provide coverage.
  - Once the appointment is coordinated, the Local Health Dept issues the member patient a "voucher" that the patient provides to the dentist upon arrival for their appointment. This "voucher" also acts as a claim form, which is pre-printed with the appropriate carrier claim address.
  - The Local Health Department performs the initial outreach to ensure that the patient knows their scheduled time and has transportation to their appointment. If transportation is not available, the Local Health Department issues vouchers or arranges transportation.
  - Once dental care is delivered, the dentist sends the "voucher/claim" directly to the MCO carrier.
  - The dentist is reimbursed directly by the carrier. There will be two options for reimbursement, detailed below under "Provider Credentialing/Contracting."
  - Monthly, MCO carriers provide utilization reports to the Local Health Department, so that all involved can track which patient members issued a "voucher" actually followed up for treatment.
  - The Local Health Department checks the utilization report against "vouchers" issued, and performs additional outreach on any members who did not follow up for care.
  - Overall costs of the program have been tracked via these reports. If after 3 months, costs are in excess of those allocated, the MCOs and Local Health Department would re-convene and determine the next steps. In particular, overhead costs to Health Dept for administering the program would be assessed, and strategies for providing funding for these costs, if necessary, would be developed and implemented. To date, there has not been a change in the costs.
3. Provider Credentialing/Contracting – Providers electing to participate in the program have had two options in establishing a relationship with the MMP. In BOTH OPTIONS, the Local Health Department appears on MCO Dental Vendor directories as the sole contact in the area, so that all care can be coordinated through the Local Health Department and dentists need not fear that they will be "over inundated" with new MMP patients.
  - **Option 1:** Local Health Department signs a Provider Agreement with the MCOs and acts as primary provider. In this option, dentists may then submit credentialing data to the Health Department and will function as an Associate Practice to the Primary Provider (Local Health Department). When recipients are treated under these offices, the Associate Practice would then submit the "voucher" directly to the appropriate MCO. Reimbursement would be made to the Primary Provider (Local Health Department) in accordance with the agreed upon schedule who would then forward payment to the Associate Practice. This option is designed for area dentists who are interested in supporting the MMP, but are unwilling to enter into a financial agreement with an MCO dental vendor. MCO dental vendors would work together to develop one common credentialing package for each dentist, so that participating providers would not

have to complete full applications for each MCO. The Local Health Department would assist in gathering necessary credentialing data. To date, Option 1 has not been used by any participating dentist.

- **Option 2:** Dentists contract directly with MCO. Once care is delivered "vouchers" are submitted directly to MCO and dentist is reimbursed directly, in accordance with the agreed-upon schedule.

To date, upon presentation of the program to the local dental society, dentists were satisfied with the plan to the degree that they directly contracted with the MCOs rather than subcontract with the Local Health Department. Thus the Local Health Department has served as a central contact, ombudsman, and case manager for patients but so far has not had to subcontract with any dentists.

4. Clinical Decision-Making – With the exception of pre-determination for orthodontic and hospital-based services, no clinical review of pre-authorizations are required during the pilot period.
5. Negative History with Maryland Medicaid Program – From the provider perspective, this program would be administered by the Local Health Department and act as troubleshooter and ombudsman. There is a positive history of cooperation between the Local Health Department and dental community in this area, so this pilot program capitalizes on this relationship. The Local Health Department represents the dentist in any negotiation with the MCO regarding claims denials. In addition, the Local Health Department is responsible for outreach and case management of patients in terms of complying with their initial visit with dentists, assuring dentists that their downtime and related costs due to missed appointments would be minimized. Further, the Local Health Department reimburses the dentist if a patient does not show for the visit.

As a result of this program, the following interim outcomes (as of April 2002 except where noted) have been achieved:

- Fee schedule for participating dentists in the pilot project increased to 72.5% of area fees (state average is < 20%).
- 1554 unduplicated patients have received at least one dental visit since the start of the program representing an increase of 360% (338 unduplicated patients prior to the pilot project).
- Analysis is still ongoing but there are estimates that for FY 2000, the dental services utilization rate was within a range of 35% - 40% (state average in FY 2000 was 22%).
- 21 dentists or 48% of St. Mary's County dentists are participating in the program, representing an increase of 2000% (includes 2 pediatric dentists, 1 orthodontist and 1 periodontist and to date, only 1 oral surgeon has dropped out of the program).
- Compliance rate of patients keeping appointments for their first dental appointment is greater than 95%, and for the second appointment it is approximately 92%.

#### **Budget Estimates and Formulas of the Practice:**

Salaries for the full-time employees are in-kind (approximate value is \$70,000). Other fiscal resources include grant funds from the Office of Oral Health and a local Rotary Club, which total approximately \$60,000. The MCOs also contribute indirectly to the program by agreeing to raise their dental benefit fee schedule to 72.5% of area dental fees.

#### **Lessons Learned and/or Plans for Improvement:**

There are numerous lessons to be learned from working on this program – a good lesson is "never say never." Our "thinking out of the box" plan resulted in our being told on numerous occasions by many people that this couldn't be done; not only has it been done but it has been very successful and gained notoriety in the state as an innovative strategy. Lessons from the program itself include the necessity for continued monitoring of the program; there is constant troubleshooting required because of unannounced policy changes, company takeovers, mistakes, etc. Being a small community and with the power of word of mouth, there is a constant fear that one major problem in the program may lead to a mass exodus of the dentists. Issues such as eligibility verification, multiple MCO changes, paperwork issues, inconsistent adherence to policy, changes in coverage of dental procedures, customer service errors, and other issues adds to an already labor intensive strategy.

#### **Available Resources - Models, Tools and Guidelines Relevant to the Practice:**

Locally developed resource materials for the pilot dental program are available.

## SECTION III: PRACTICE EVALUATION INFORMATION

### **Impact/Effectiveness**

*Does the practice demonstrate impact, applicability, and benefits to the oral health care and well-being of certain populations or communities (i.e., reference scientific evidence and outcomes of the practice)?*

In only 20 months, his pilot project has had a significant impact on increasing access of underserved Medicaid-eligible patients as well as significantly increasing the number of dental practitioners providing care to this needy population. Outcomes (documented elsewhere in this worksheet) already have been very positive regarding utilization, provider participation, and no-show rates because of intensive case management/outreach activities. This is an innovative, new practice that has gained statewide notoriety for its impact upon the community.

### **Efficiency**

*Does the practice demonstrate cost and resource efficiency where expenses are appropriate to benefits? Are staffing and time requirements realistic and reasonable?*

This practice is very labor intensive and does depend on the in-kind effort and salary contributions of full-time staff who have been transferred to this program from other areas because of the high priority given this project by the County Health Officer. Outside of these in-kind efforts, the project receives continuing grants to subsidize certain activities. The relatively low cost of this project makes its cost-benefit ratio very appealing. Staffing and time requirements are realistic but only if recruiting the appropriate staff people since this program, being very labor intensive, is very dependent on the expertise, energy and dependability of staff.

### **Demonstrated Sustainability**

*Does the practice show sustainable benefits and/or is the practice sustainable within populations/communities and between states/territories?*

The program is very sustainable in terms of the County priorities and funding sources. It has become a sense of pride for the County because of the successful outcomes it has achieved, so there is a perception that every effort would be made to maintain the program. In fact, the County Health Officer has since left the County and the program has maintained its viability and effectiveness. The only threats to the program would be that the managed care organizations decide to reduce the benefit fee schedule affecting dentists' participation or an unforeseen problem of enormous consequences emerges that undermines support for this program by dentists or any of the partners.

### **Collaboration/Integration**

*Does the practice build effective partnerships/coalitions among various organizations and integrate oral health with other health projects and issues?*

The practice could not have occurred without effective partnerships, of which there were many including key participation by the MCOs and the local dental society.

### **Objectives/Rationale**

*Does the practice address HP 2010 objectives, the Surgeon General's Report on Oral Health, and/or build basic infrastructure and capacity for state/territorial oral health programs?*

The pilot project supports efforts to address the HP 2010 objectives related to increasing utilization of the oral health system, indirectly reducing caries experience and untreated dental decay, increasing sealants and other preventive dental services for low-income children. In addition, the pilot project supports efforts called for in the Surgeon General's Report on Oral Health to reduce disparity in oral diseases and access to care.

### **Extent of Use Among States**

*Is the practice or aspects of the practice used in other states?*

It is not known if other states have such a practice but when presenting the details of this practice at professional and scientific meetings, there appears to be a great deal of interest, inferring that this practice likely is not being used in other states.