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Tragedy and Policy Change: Expanding Access to Oral Health Care for Children in Maryland

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In 2007, Deamonte Driver, a twelve-year-old boy living in Baltimore, died from an untreated tooth abscess that led to a larger infection in his nervous system. His family had been trying to access dental care, but lacked insurance, and struggled to navigate the complicated state Medicaid system. Left untreated, Deamonte experienced headaches, and was hospitalized. The failure to receive a simple tooth extraction necessitated expensive emergency care and two brain surgeries, but these were unable to stop the spread of bacteria to his brain.[1]

Deamonte's death shone a light on the large and potentially deadly gaps in oral health access in Maryland and elsewhere. At the time of his death fewer than 20 percent of dentists accepted Medicaid coverage in the state. Arthur Fridley, a former president of the Maryland Dental Association, summed up the situation by saying, "whatever we got is broke. It has nothing to do with access to care for these children."[2] Representative John Sarbanes from Maryland said, "Deamonte took us by the hand and escorted us through the healthcare system and pointed out all the places where we could improve," creating pressure both for changes in national policy and in the state of Maryland in particular.[2]

This case study examines efforts to expand access in oral health care for kids, explaining how Maryland went from one of the worst to one of the best states in the country, both by broadening eligibility and reducing the type of administrative burdens that stymied the Driver family, and also discouraged providers from accepting Medicaid coverage. While use of oral health service has been gradually increasing since Deamonte's death, less than half of children with Medicaid coverage received a preventive dental service in 2018, with substantial variation between states, ranging from 18 percent in North Dakota to 68 percent in Texas. Understanding how states can expand access is therefore substantively important.[3]

Administrative Burdens in Pediatric Oral Health Services

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in the Medicaid program ensures that children up to age 21 with Medicaid have coverage for all medically necessary screening and treatment services. EPSDT-covered oral health services cannot be limited to emergency services only and at a minimum, must include relief of pain and infections, restoration of teeth, maintenance of dental health, and all other services that are medically necessary.[4] Specific pediatric oral health services covered in the state of Maryland are outlined in Appendix A.

The guaranteed coverage for medically necessary oral health services does not necessarily translate into access to or utilization of oral health services. Children and their parents/caregivers must overcome various hurdles to obtain oral health care. First, they must access and maintain enrollment in Medicaid. Second, they must find a willing provider for dental services.

Many barriers come in the form of administrative burdens. Some burdens make it difficult for individuals to enroll in Medicaid and maintain coverage. Enrollees may face difficulties obtaining information about benefits and when and how to obtain services.[5–7] Language barriers can further limit the ability for children and their families to navigate coverage and the health care delivery system, access and receive care, and follow treatment plans.[5,7,8] Administrative burdens result in learning, compliance, and psychological costs (see Table 1 for examples).[9]

Table 1. Types of Costs for Enrollees[*,10]

Cost	How Costs Emerge for Families
Learning costs	Parents/caregivers of enrollees may be unaware of dental benefit
	Parent/caregiver lack of knowledge around when, how, and where to obtain dental services or the benefits of dental care
	Shortage of dental providers makes it difficult to know where to find dental services
	Ability to read and understand administrative forms/materials, communication from Medicaid agency, health plans, and/or providers, and other health materials
	Caregivers and children may have different health insurance and/or benefits
	Dental services run separately from medical services
	Dental health data will likely be stored separately from medical data
Compliance costs	Processes to determine initial and continued eligibility such as income reporting requirements; family members may be subject to different eligibility criteria
	Time costs in the form of time-consuming enrollment processes that delay receipt of coverage or prior authorizations that delay ability to receive care
	General transportation costs, exacerbated by scarcity of providers, especially in rural and lower income areas
	Many services require prior authorization, adding extra administrative barriers to accessing care
	Dental benefits may be run separately from medical services meaning different steps need to be taken to access services
	Frustration with difficulty accessing provider that is nearby and accepts Medicaid
Psychological costs	Frustration with re-enrollment requirements
	Sense of stigma from seeking and being denied care as a Medicaid recipient

[*]Table adapted from Adams, Herd, & Moynihan. (2022). "Identifying and reducing administrative burdens in Medicaid access to oral health care." Retrieved from https://georgetown.app.box.com/s/qd5w3h0e88krantvtsugqhowhq5etw7k

Some administrative burdens impact oral health providers, limiting the number that accept Medicaid coverage. A 2008 review of 16 states with Medicaid pediatric dental utilization rates at or below 30 percent identified that the shortage of dental providers was the primary barrier preventing children from receiving oral health care.[5–7,11] Only about four in ten dentists across the United States take Medicaid and/or CHIP.[12] This is partly a function of reimbursement rates that are lower than for private insurance. But providers are also wary of administrative burdens, including extensive credentialing, billing, and enrollment processes, as well as strict limitations on which services can be provided to which enrollees.[5–7,115,13,14] Examples of the ways in which learning, compliance, and psychological costs as a result of administrative burdens emerge for providers are summarized in Table 2 below.

Background – Oral Health in Maryland

In the 1990s, Maryland ranked as one of the worst states for pediatric oral health in the nation. This was partially driven by poor access to oral health services for children with low incomes; only half of state jurisdictions had access to public health dental services.[15] Maryland had one of lowest average reimbursement rates in nation.[15] In 1997, only 19 percent of children with Medicaid coverage in the state received an oral health service, compared to the national average of 27 percent.[15]

Table 2. Types of Costs to Providers[†,10]

Cost	How Costs Emerge for Providers
Learning costs	Keeping up with extensive and changing administrative requirements
	Coverage policies and payment rates may differ across managed care organizations in a state
	Understanding prior authorization requirements for various services
	Navigating service limitations that vary by population
Compliance costs	Cumbersome and time-consuming credentialing process; need to be revalidated every 5 years
	Communication with administrative service provider and/or Medicaid agency
	Manage multiple applications to participate in network of multiple managed care organizations
	Many oral health services require prior authorization from Medicaid or managed care organizations
	Comply with changing administrative requirements
Psychological costs	Frustration with difficulties communicating with state agency and/or administrative services organization
	Frustration with coordinating across managed care organizations and having to apply to participate in multiple networks
	Frustration with billing difficulties, claims processing, and delays in reimbursement or incorrect claims denials
	Frustration with credentialing and re-validation requirements
	Frustration with high missed appointment numbers for Medicaid patients

Around this time, a state legislator recognized the issues and convened a workgroup tasked with creating a 5-year plan for the state to improve pediatric oral health.[15] Following the formation of the workgroup, a few key actions were taken, setting Maryland on a path of incremental and modest change.

First, in 1996, the Maryland Office of Oral Health was established to focus on improving access to care for children with Medicaid coverage.[16] Second, Maryland Medicaid initiated a managed care system to manage the coordination and reimbursement of services provided to Medicaid enrollees.[15] Managed care organizations are institutions that contract with state Medicaid programs to take on financial risk for some or all enrollees and become responsible for connecting enrollees to the care that they need.[17] Managed care organizations receive a capitated per member per month payment to cover the cost of care for the enrollees for which they are responsible, creating an incentive for controlling costs and reducing unnecessary utilization, while promoting wellness and prevention.[18] In Maryland, when the program was initiated, the managed care organizations subcontracted with dental management organizations/vendors to manage the dental benefit for children.[15]

† Table adapted from Adams, Herd, & Moynihan. (2022). "Identifying and reducing administrative burdens in Medicaid access to oral health care." Retrieved from https://georgetown.app.box.com/s/qd5w3h0e88krantvtsugqhowhq5etw7k

In 1998, Senate Bill 590 was passed into law, which included a 5-year plan that placed the Office of Oral Health in statute, called for a state Oral Health Advisory Committee, mandated a plan to increase the number of oral health providers engaging in the Medicaid program, and required an oral health needs assessment for children in Maryland schools.[16]

Until 1997, the Division of Dental Health of Maryland's Health Department did not have a budget. It also lacked relationships with advocates or dental health stakeholders. The Division relied solely on grants from the Division of Maternal and Child Health.[15] In addition, Maryland legislators and administrative leaders lacked the motivation to fully act on, fund, and pass into law the recommendations that came out of the workgroup formed in 1996.[15]

However, the passage of Senate Bill 590 in 1998 placed the Office of Oral Health in statute, providing dedicated stakeholders with resources and authority. In addition, the legislative successes provided the Office of Oral Health with some important momentum and motivated the office to focus on prevention. The successes also garnered some external support for reforming Maryland's oral health system.[15]

In 2000, Senate Bill 519 was passed to establish a loan repayment program for dentists who provided services to children enrolled in Medicaid.[15] In 2003, dental service reimbursement rates were raised for the Medicaid managed care organization, HealthChoice.[15]

The Death of Deamonte Driver

By the time Deamonte Driver died in 2007, Maryland had made some halting progress in expanding oral health, but significant gaps remained, gaps laid bare by his tragic death.

Deamonte grew up in a family with low income. His mother, Alyce Driver, worked a series of jobs that did not provide her with dental insurance.[1] As a result, she and her sons went without dental care for a long time. At one point, Alyce and two of her sons lacked housing and temporarily resided in an emergency shelter.[2]

Alyce Driver was willing to seek help. In 2006, she enlisted the help of a lawyer from the Public Justice Center in Baltimore to find a dentist for her son DaShawn, who was experiencing pain and swelling in his mouth.[2] DaShawn's last dentist would not treat him anymore because he "squirmed too much in the dental

chair."[2] DaShawn had multiple infected teeth and needed immediate treatment; at this point in time, he was enrolled in Medicaid. The lawyer, Laurie Norris, shared that Alyce Driver "had reached the limit of her understanding and ability to navigate Maryland's complex Medicaid system."[2] Norris was also challenged by the complicated web of Medicaid managed care contractors and dental subcontractors enlisted by the state to manage the health care for pediatric enrollees. To find an in-network dentist, Norris worked with a case manager from the state, a case manager from the Prince George's County Health Department, and an employee at the managed care plan UnitedHealthcare/AmeriChoice in which DaShawn was enrolled.[2]

Weeks later, DaShawn was finally able to see a dentist who accepted Medicaid and was referred to an oral surgeon, with whom an appointment was made for a few months later to get six teeth extracted.[2] Having navigated the administrative thicket, help seemed finally at hand. By the time DaShawn was supposed to see the oral surgeon in January, however, Alyce found out that the family's Medicaid coverage had lapsed. She suspected that the re-enrollment materials had been sent to the homeless shelter she had temporarily lived in with her sons.[2] Such "churn" on and off Medicaid and other safety net programs is common.

Around this time, DaShawn's brother Deamonte, became very ill. He started complaining about headaches, and was taken to the hospital, where he was treated for headaches, sinusitis, and a tooth abscess.[2] After deteriorating further, he was hospitalized again and diagnosed with meningitis. The bacteria from his untreated tooth abscess had spread to his brain. Following two brain surgeries, Deamonte ultimately passed away six weeks later.[2]

Figure 1. News Articles in the Aftermath of Deamonte Driver's Death in 2007‡

Flurry of action after boy dies from neglected teeth

BY LYNN ANDERSON
[SUN REPORTER]

Six-year-old Mychael Greene doesn't like the look of the hooked tool that dentists use to scrape plaque from teeth, or the sour taste their latex-gloved hands leave in his mouth. But his mother, Shawn Greene, made sure her son opened wide during a recent checkup at the University of Maryland Dental School in Baltimore.

Her reason: the death earlier this year of Deamonte Driver, a 12-year-old Prince George's County boy who died after an infection from an abscessed tooth spread to his brain. Deamonte's Medicaid coverage had lapsed, but even with it, his mother said, it was difficult to find a dentist who would see her children.

Advocates and politicians have latched onto Deamonte's death to publicize inadequacies in dental care for the nation's poor — especially children. Democrats in Congress are using the case in a push to improve dental care for poor children covered by Medicaid and the State Children's Health Insurance Program.

And in Maryland, health officials have convened a Dental Action Committee that will make recommendations on Medicaid reimbursement rates and other issues. Medicaid and SCHIP provide health care benefits for about 400,000 Maryland children and young

[Please see DENTAL, 6A]

University of Maryland dental student Tushara Gunatilaka examines the teeth of Mychael Greene, 6. It is difficult to find a dentist who will accept Medicaid patients.
DOUG KAPUSTIN [SUN PHOTOGRAPHER]

Boy's death of untreated dental decay puts spotlight on gaps in medical aid

By Mary Otto
WASHINGTON POST

WASHINGTON — Earlier this year, the death of a local boy from untreated dental decay shed a grim spotlight on gaps in federal and state medical assistance programs charged with providing care to 30 million poor children.

Deamonte Driver, 12, gave a face to the two-thirds of Medicaid children who receive no dental care, and his name became a rallying cry for a multitude of reform efforts now unfolding.

A congressional inquest that began in May with lawmakers angrily interrogating federal health officials and insurance executives continues to probe failings in the system. This month, members of Congress will push ahead with a bill that would strengthen dental care for the children of the working poor. Officials in Maryland, where Deamonte lived, will consider recommendations for a major overhaul of the state's Medicaid dental program that serves nearly 500,000 poor children.

"In letters and speeches, we all mention Deamonte Driver," said Representative Elijah Cummings, a Maryland Democrat. "We want to keep the memory of this boy alive. We want to make sure that life comes out of his death."

Maryland's eight-member Democratic congressional delegation says it plans to fight to get a guaranteed dental benefit included in the reauthorization of the State Children's Health Insurance Program, or S-CHIP, a decade-old federal-state program set to expire Sept. 30.

The dental guarantee and several other related provisions are in a House version of a bill that must be reconciled with a Senate version. The Senate does not include the dental guarantee but does have an amendment, sponsored by Senator Benjamin Cardin, a Maryland Democrat, that would authorize $200 million in grants to states to improve dental care for children. The entire bill, however, remains under a veto threat from President Bush.

Another bill awaiting approval, sponsored by Representative Albert Wynn, a Maryland Democrat, would provide tax credits for dentists serving the poor and $3 million annually for four years for outreach projects in areas with few dentists.

And Cummings is sponsoring a measure that would authorize $10 million annually for four years to support the hiring and training of dentists serving poor communities.

He is calling it Deamonte's Law, he said, because the tragedy struck a personal chord for him.

"As a young boy, I grew up in a very poor family. . . . This story brought back a lot of painful memories," Cummings said. "I used to think toothaches were just a part of living."

Cummings and other members of a congressional subcommittee also are continuing to press for answers about shortcomings in federal and state management of the Medicaid program. At a May hearing, the panel probed the barriers Deamonte's mother, Alyce Driver, faced in obtaining dental care for her children in the months before Deamonte died after an infection from an abscessed tooth spread to his brain.

"Federal law requires these services be made to children," Representative Henry Waxman, a California Democrat and chairman of the committee on oversight and reform, said as he angrily questioned a Medicaid official. "You're not doing a good enough job if two out of three kids do not get pediatric dental care and they are eligible for it.

"Don't you have any responsibility for this? Do you have a suggestion for changing the law? Is there any reason you're not enforcing the law?" Waxman asked.

Dennis Smith, director of the federal Center for Medicaid and State Operations, said it was the states' responsibility to meet the requirements.

Mary Kahn, a spokeswoman for the Centers for Medicare and Medicaid Services, said that the center is "working on a response to the questions" from the subcommittee.

Proposed dental reform would come at a cost to state

By ANDY ZIEMINSKI
Capital News Service

ANNAPOLIS — The state should spend at least $80 million to extend dental coverage to all Maryland children, according to a special committee report presented to the state health department this week.

The money would be used to increase reimbursements for Medicaid dentists, reach out to parents and minority families, and boost access to care through schools and local health clinics, among other things.

Maryland Health Secretary John M. Colmers conceded that some of the seven recommendations from the Dental Action Committee have "serious budget implications," but he said they are all going to get "full consideration."

"Clearly there are many things that we can be doing to improve dental care to the Medicaid and low-income population in Maryland," said Colmers, who received the report Tuesday afternoon.

The Dental Action Committee was formed after Deamonte Driver, a 12-year-old from Prince George's County, died in February from an untreated tooth infection that spread to his brain. Driver's mother said she could not find a dentist to treat her son who accepted Medicaid.

"The cost of not doing anything is very high, and Deamonte Driver is an excellent example of that," said Leigh Stevenson Cobb, a committee member and the health policy adviser for Advocates for Children and Youth.

The committee's most expensive suggestion was to spend an additional $40 million to make Medicaid rates for Maryland dentists comparable to other states in the region. For example, Maryland repays dentists $9 per sealant, whereas the District gives its dentists $38 and Pennsylvania $25.

"It's horrible. It's just embarrassing," Cobb said.

With repayment rates so low, only 19 percent of Maryland dentists see Medicaid children, according to the report. "With so few dentists providing these services, families have limited choices for dental care," the report said.

Delegate James W. Hubbard, D-Prince George's, said now is "a good time to put these numbers on the table" so that health officials and legislators can weigh them in light of the state's projected $1.5 billion structural deficit.

"If we don't find the money for it now, that $40 million will turn into $120 million three years or four years down the road," when children develop serious conditions that require more expensive care, Hubbard said. Another key recommendation, which does not come with a cost estimate, is to consolidate Medicaid dental services through a single vendor, said Jane Casper, a dental hygienist and chair of the committee.

The state currently uses several vendors, which is "very confusing for everyone" and makes dentists "shy about participating in the program," Casper said.

The committee of 25 health advocates and dental professionals also called for incorporating dental screenings and exams with the vision and hearing checks that children now get in school.

"It would be too cost-prohibitive to do screenings every year," Casper said. "But hopefully we would catch the worst cases, the cases most in need of treatment the first time around."

At a cost of at least $20 million, committee members also recommended the state "maintain and enhance the dental public health infrastructure," by funding oral health services at local health clinics.

While committee members said their recommendations will save money in the long run, some outside experts could only see the immediate price tag.

"While any social service can be improved, there are other services that have a higher claim on the public purse," said George W. Liebmann of the Calvert Institute for Policy Research, who pointed to the "huge, looming deficit" for retired state employee pensions.

‡ News article pictures from The Baltimore Sun on June 1, 2007, The Boston Globe on September 16, 2007, and The Star-Democrat on September 14, 2007, respectively.

Media publicity as a result of Deamonte Driver's death captured the attention of members of Congress and state legislators and put pressure on the state to act.[16] Given that Maryland is situated next to Washington, D.C., the story garnered national attention from major news outlets, putting a spotlight on Maryland's oral health delivery system.[15]

Deamonte's death also shaped national policy discussions. At the time, the federal Children's Health Insurance Program was both in need of reauthorization and did not currently require inclusion of dental benefits.[2] As an optional benefit, not every state provided coverage for dental care. During Capitol Hill hearings on the reauthorization of the program, advocates and members of congress discussed Deamonte's death to depict the failings of the current health care system and demonstrate the need for expanding the program. In a hearing focused on this issue, Representative Elijah Cummings from Maryland asked, "how did we so thoroughly fail this boy?"[2]

"What are we going to do about this?"

Prior to Deamonte's death, the Maryland legislative dental health workgroup had identified problems but had problems winning support for solutions. The tragedy changed what was possible. After hearing the news, Maryland's newly elected governor, Martin O'Malley, asked his administration, "what are we going to do about this?"[2]

The work done by the legislative working group in the preceding years began to pay off. Maryland was able to use the 5-year legislative plan developed in 1996 as a useful foundation for deciding which steps needed to be taken to improve oral health access in the state. In addition, champions emerged in the legislature, administration, and in the public, including Maryland Department of Health Secretary John Colmers, Governor Martin O'Malley, U.S. Representative Elijah Cummings, and U.S. Representative John Sarbanes.[15,16]

John Colmers, O'Malley's appointed Secretary of the Maryland Department of Health, quickly established the Dental Action Coalition (DAC) in response. Discussing the formation of the Dental Action Coalition, Debony Hughes, the current director of the Office of Oral Health (as of 2022), stated, "we were so shocked by Deamonte's death that we vowed this was something that we couldn't let happen again."[19] Colmers shared that he wanted the coalition to present actionable, cost-effective strategies to improve the state's Medicaid oral health care coverage and delivery.[2]

The DAC put forth multiple recommendations regarding Medicaid reimbursement and alternate payment models for oral health services, provider participation, capacity and scope of practice, public health strategies, and oral health education and outreach.[20] Almost all of the DAC's recommendations were acted upon at some point in the following years by the state legislature.

In 2007, Maryland Governor O' Malley signed the Oral Health Safety Net bill, funding health departments, federally qualified health centers, an oral disease and injury prevention program, and a program that provided sealants in schools across the state.[16] Legislation was passed in 2008 to establish Public Health Dental Hygienists as a new oral health provider. Public health dental hygienists became able to provide services within scope of practice without a dentist present or having to see a patient first.[15]

Medicaid dental services were carved-out of managed care. A single dental benefits vendor was contracted by Maryland to manage all benefits, as well as provider credentialing, the application process, and other administrative services.[15] Lastly, medical providers became eligible to receive Medicaid reimbursement for fluoride varnish provided at well-child visits for children ages 9-36 months.[15]

In 2010, the DAC was transitioned into an independent organization, the Maryland Dental Action Coalition, with the goal of continuing cross-stakeholder collaboration that was guiding state reform efforts.[15] While the issue had previously lacked a coherent stakeholder group to lobby for the issue, this was no longer the case. The Maryland Dental Action Coalition continued to work with the Office of Oral Health and push forward recommended programs and policies. For example, the group authored the Maryland State Oral Health Plan in 2011, which outlined a strategic policy roadmap for continuing to improve oral health for residents in the state through improving access, prevention, and oral health education.[15]

Maryland maintained legislative momentum and continued to pass legislation addressing the state of oral health years after Deamonte's death. In 2014, Maryland Medicaid received approval from the Centers for Medicare and Medicaid Services for a state plan amendment that allowed ambulatory surgical centers to perform specific dental procedures for children.[21] In 2017, Maryland Medicaid began to reimburse oral health services for young adults who age out of foster care until they turn 26 years old.[22]

In 2018, Maryland Medicaid increased age eligibility for the Maryland Mouths Matter program, a fluoride varnish and oral health screening program for children. The program allows for screenings and fluoride

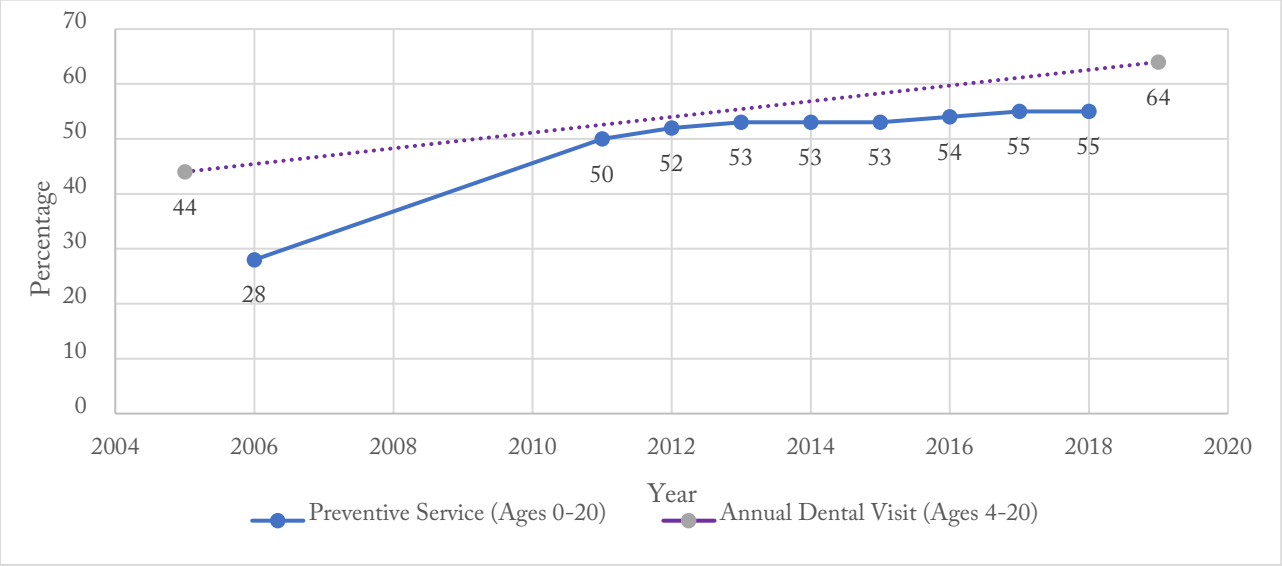
varnishes to be reimbursed by Medicaid when provided during an approved well-child visit. The new age eligibility was set at nine months through age five.[23]

Overall Evidence of Success

Across a range of measures, access to oral health for children increased in Maryland.

- From 2005 to 2019, the percentage of continuously enrolled children in Medicaid ages 4 to 20 that received an annual dental visit increased from 44 to 64 percent (Figure 2).[24]
- The percentage of children under 20 that received a preventive dental service increased from 28 percent in 2006 to 43 percent in 2009 (Figure 2).[24]
- The number of enrollees that received at least one dental service increased from 286,000 in 2009 to 316,000 in 2018.[19,24]
- The number of dentists in the state that accepted Medicaid coverage for pediatric oral health services increased from 743 dentists in July of 2008 to around 1600 in 2018.[19,24]

Figure 2. Percentage of continuously enrolled children that received a preventive dental service or completed an annual dental visit (2005-2019)[3,24]



In 2011, Pew Charitable Trusts rated states in terms of how they measured against 8 national oral health policy benchmarks for addressing pediatric oral health outcomes and needs.[25] The benchmarks were:

- Share of high-risk schools with sealant programs meets or exceeds 25 percent

- Hygienists can place sealants without dentist's prior exam
- Share of residents on fluoridated community water supplies meets or exceeds 75 percent
- Share of Medicaid-enrolled children getting dental care meets or exceeds 38.1 percent
- Pays medical providers for early preventive dental health care
- Authorizes new primary care dental providers
- Tracks data on children's dental health

They noted that Maryland was the only state to meet 7 out of 8 policy benchmarks and recognized the state as a national leader in children's oral health.[25] The only benchmark that the state did not meet was authorizing new primary care dental providers.[25]

Conclusion

Twenty-five years ago, the state of Maryland was home to some of the worst pediatric oral health outcomes in the nation. After motivated changemakers were able to garner support and resources within the state, and public attention grew following the tragic death of Deamonte Driver, the state changed direction and implemented a series of reforms to address barriers to positive oral health for children. Policymakers instituted offices with decision-making power and funding within the state government, organizing influential oral health stakeholders to push for legislative change, redesigning the delivery of oral health services in the Medicaid program, creating better incentives for dentists to accept Medicaid coverage, and reducing overall barriers to accessing oral health care for children with low incomes.

Appendix A. Medicaid Pediatric Oral Health Benefits in Maryland[26,27]

Service	Covered in Maryland
Preventive Services	
Cleanings	X
Fluoride treatments (including varnishes)	X
Sealants	X
Space maintainers	X
Diagnostic Services	
Oral health screening or assessment	
Dental examinations	X
Assessment of risk for tooth decay	
X-Rays	X
Treatment Services	
Anti-microbial treatments that stop decay from spreading	
Fillings	X (silver amalgam and tooth colored composite)
Crowns	X (stainless steel covered, metal-only, metal/porcelain or porcelain only covered with prior authorization)
Root canals	X
Gum therapy	X (with prior authorization)
Dentures	X (with prior authorization)
Bridges	
Retainers (with prior authorization)	X (with prior authorization)
Braces	X (with prior authorization)
Oral Surgery	
Simple extractions	X
Surgical extractions	X
Care of abscesses	X
Cleft palate treatment	X (with prior authorization)

Cancer treatment	
Treatment of fractures	
Biopsies	X (with prior authorization)
Treatment of jaw joint problems (TMJ)	
ER services provided by a dentist	X (with prior authorization)
Inpatient hospital services	X (with prior authorization)
General anesthesia	X
Intravenous conscious sedation	X
Non-intravenous conscious sedation	X
Analgesia (nitrous oxide)	X

Appendix B. Timeline of Actions Taken in Maryland to Address the Oral Health Crisis

Year	Information
1967	The Medicaid benefit for children and adolescents, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) was introduced in Congress, which required that all medically necessary services be covered for children, including oral health services.[28]
1996	The Maryland Office of Oral Health was established to address poor access to care for children enrolled in Medicaid.[16]
1997	Maryland Medicaid initiated a managed care system. The contracted managed care organizations subcontracted with dental management organizations/vendors to manage dental benefits.[15]
1998	Senate Bill 590 was passed into law. The bill included a 5-year plan that placed the Office of Oral Health in statute, called for a state Oral Health Advisory Committee, mandated a plan to increase the number of oral health providers engaging in the Medicaid program, and required an oral health needs assessment for children in Maryland schools.[16]
2000	Senate Bill 519 was passed to establish a loan repayment program for dentists who provided services to children enrolled in Medicaid.[15]
2003	Dental service reimbursement rates were raised for the Medicaid managed care organization, HealthChoice.[15]
2007	Deamonte Driver, a 12-year-old child enrolled in Medicaid, died from an untreated tooth abscess, calling attention to the issues in the oral health care system in the state.[16]

	The Dental Action Coalition (DAC) was established by the Secretary of the Maryland Department of Health in response to Deamonte's death. The DAC put forth multiple recommendations regarding Medicaid reimbursements and alternate payment models for oral health services, provider participation, capacity and scope of practice, public health strategies, and oral health education and outreach.[20] The Oral Health Safety Net bill was passed into law which funded health departments, FQHCs, an oral disease and injury prevention program, and a program that provides sealants in schools.[16]
2008	Legislation was passed to establish Public Health Dental Hygienists as a new oral health provider. Public health dental hygienists became able to provide services within scope of practice without a dentist present or having to see a patient first.[15]
2009	Medicaid dental services were carved-out of managed care. A single dental benefits vendor was contracted to manage all benefits, as well as provider credentialing, the application process, and other administrative services.[15] Medical providers became eligible to receive Medicaid reimbursement for fluoride varnish provided at well-child visits for children ages 9-36 months.[15]
2010	The DAC was transitioned into a nonprofit called the Maryland Dental Action Coalition, consisting of oral health stakeholders that work closely with state legislators.[16]
2014	Maryland Medicaid received approval for a State Plan Amendment that allowed ambulatory surgical centers to perform specific dental procedures for children.[21]
2017	Maryland Medicaid began to reimburse oral health services for young adults who have aged out of foster care until they turn 26 years old.[22]
2018	Senate Bill 284 was passed into law, forming the Maryland Medical Assistance Program – Dental Coverage for Adults – Pilot Program.[29] Maryland Medicaid increased age eligibility for the Maryland Mouths Matter program, a fluoride varnish and oral health screening program for children. Screenings and fluoride varnishes are eligible for reimbursement when provided during an approved well-child visit. The new age eligibility was set at nine months through age five.[23]
2019	Maryland Medicaid launched its pilot program, the Adult Dental Pilot Program, to cover basic dental services for some adults ages 21 through 64 enrolled in both Medicaid and Medicare.[30]

2021	Task Force on Oral Health in Maryland was created through Maryland Senate Bill 100. Charged with examining oral health in Maryland, including insurance coverage. Identify barriers that prevent patients from seeking oral and dental care.[22]
2022	Senate Bill 150 was passed into law, requiring the Medicaid program to cover certain dental services for enrolled adults over the age of 21.[31,32] The requirements will take effect on January 1, 2023.[31]

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