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Written Testimony in Support of SB 237

Madam Chair, and members of the Senate Finance Committee, thank you for the opportunity to provide written support in favor of HB290. My name is Alexandra Fitzgerald and I am a general dentist practicing in Frederick, Maryland. Along with providing care in a private practice setting, I additionally serve as the President-Elect of the Maryland State Dental Association (MSDA).

Expanding the Maryland Dent-Care Loan Assistance Repayment Program may play a large role in encouraging dentist to serve the underserved of Maryland. According to the ADA Health Policy Institute, US dental school enrollment is surging at 26,228 students enrolled – the most ever. This will translate to an increase in the number of practicing dentists. Additionally, there are now 70 dental schools in the United States, compared to 54 in 2000. In 2020, nationally the average dental school graduated $304,824 in student loan debt. Looking more closely at the University of Maryland Baltimore and its professional programs: the 2019 DDS graduates had $253,313 in student loan debt, over $100,000 more than the MD graduates at $151,725, who also completed a 4-year doctoral program. Student debt can play a factor in the decisions of whether to specialize, where to work, and practice modality. I have attached an article from the Journal of the American Dental Association that expands upon these relationships. There is a tendency to migrate to where practices are well established, where the population of patients can best afford and avail themselves to receive dental care. Expanding the Maryland Dent-Care Loan Assistance Repayment Program may play a large role in encouraging dentists and dental hygienists to serve the underserved of Maryland.

There are additional portions of this bill that will expand upon the importance of oral health. Establishing guidelines for dental screenings for children in child care and school systems will lead to an opportunity for providers to discuss this importance with both our pediatric patients and their caregivers. It will also require the Department of Health to distribute material in plain language to better discuss the variety of dental procedures to be performed and the importance of regular dental care on a person's systemic health. The conclusions of the Oral Health Task Force established in 2021 have been well-documented and this legislation has the potential to improve the health of Marylanders for decades to come.

Thank you,

Alexandra Fitzgerald, DDS

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ADA CE Program ARTICLE 3

The relationship between education debt and career choices in professional programs

The case of dentistry

Kamyar Nasseh, PhD; Marko Vujicic, PhD

ABSTRACT

Background. The authors examined the relationship between education debt and career choice, particularly dentists' decisions to specialize, participate in public health insurance programs, and join dental management service organizations (DMSOs).

Methods. The authors used data from the American Dental Association 2015 office database, which contains dentist demographic information and identifies dentists who participate in public health insurance programs for pediatric dental care services. The authors merged this database with the 2002-2015 American Dental Association Survey of Dental Graduates, which contains information about education debt, to assess the relationship between education debt and career choices. The authors used probit and multinomial logit models to determine the relationships among education debt, demographic characteristics, and dentist career choices.

Results. For each $10,000 increase in education debt, dentists were 0.9% more likely to join a DMSO (relative risk ratio, 1.009; 95% confidence interval, 1.0021 to 1.0164) and 0.6% less likely to join a non-DMSO group practice (relative risk ratio, 0.994; 95% confidence interval, 0.9897 to 0.9987) over a solo practice. Education debt did not have a statistically significant association with the decision to participate in public health insurance programs, but it did have a statistically significant association with the decision to specialize.

Conclusions. Education debt had a modest association with some career choices among dentists. Demographic characteristics, such as race and sex, had a greater association.

Practical Implications. Dental education debt has increased substantially in recent years. Debt had only a modest association with some career choices. Policy makers could consider this when considering education debt relief.

Key Words. Education debt; dental management service organizations; career choice; Medicaid participation.

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Relative to average annual dentist earnings, dental school debt has increased substantially over the past 20 years. The ratio of debt to income has increased from approximately 70% in 1996 to approximately 97% in 2010.[1] As one of us has written, some speculate that dentistry might be showing signs of an education bubble.[1] Since 2000, inflation-adjusted annual dentist earnings have remained flat. Although dentists reported increased busyness levels in 2015 compared with those in previous years, there is still unused capacity in the dental care system.[2] Since 2005, the supply of dentists per capita has expanded and is projected to increase in the future.[3] The demand for dental services among working-age adults has decreased steadily since 2003.[4] These combined trends could put downward pressure on future dentist earnings.

There is mixed evidence about whether education debt has an association with career choice. For physicians, results from some studies did not indicate a statistical relationship between education debt and residency preferences.[5-7] However, results from other studies, such as that by Colquitt and colleagues,[8] showed that education debt can induce students to choose a

This article has an accompanying online continuing education activity available at: http://jada.ada.org/ce/home.

career in family practice or internal medicine. Results from other studies have shown that increased medical school debt deters graduates from pursuing a career in primary care or internal medicine.[9-16] However, Frintner and colleagues[17] showed that increased education debt among pediatrics medical residents was associated with an increased likelihood of entrance into a primary care practice and a lower likelihood of matriculation into a fellowship program. Salter and Kimball[18] found that education debt does not affect the choice to enter a solo practice but could affect the decision to enter into a fellowship. Results from another study showed that education debt has only a small overall effect on specialty choice.[19]

Investigators also have analyzed the potential of dental school debt to influence dentists' career choices,[20-23] including Medicaid participation or practice ownership.[24,25] Nicholson and colleagues[26] concluded that dentists with high education debt were more likely to enter private practice and work longer hours. However, the authors did not find a relationship between education debt and practice ownership, setting of practice, or the decision to participate in Medicaid. Wanchek and colleagues[27] found that increased debt makes dental graduates more likely to choose private practice over government service, advanced education, and teaching. These study investigators concluded that the overall association of education debt with dentist career choice is small. Demographic characteristics such as sex and race have a bigger association with dentists' career choices.[26,27] Investigators in other studies also concluded that increased education debt levels make it less likely for dentists to specialize.[22,26,28]

In this article, we examine the relationship between education debt and 3 career choices. The first is whether to join a dental management service organization (DMSO) or a non-DMSO group practice or practice as a nonaffiliated solo dentist. DMSOs are entities that offer management services to dental practices.[29] A number of characteristics distinguish DMSOs from other dental organizations.[30] Many DMSOs identify under a particular brand name. Depending on state law, a DMSO practice can be owned by a single dentist, a group of dentists, a private equity firm, or an outside corporation. Some states require dentists to own a dental practice. Dentists employed by a DMSO can be owners, partners, or employees of a corporation. To our knowledge, investigators have not attempted previously to measure the relationship between education debt and graduates' likelihood of joining a DMSO.

The second career choice is whether to participate in pediatric public health insurance programs (Medicaid or the Children's Health Insurance Program [CHIP]). Although previous researchers examined the link between education debt and Medicaid participation[26] and between Medicaid reimbursement and Medicaid participation,[31,32] we also control for practice type (for example, DMSO) in our analysis. Finally, we measure the relationship between education debt and the decision to specialize.

METHODS

Data and sample selection. Previous researchers primarily used survey data to measure education debt, Medicaid participation, practice type, and specialization. However, in our research, the main outcome variables are based on administrative data rather than being self-reported by dentists. We use Medicaid provider participation data from the Centers for Medicare & Medicaid Services (CMS), DMSO data from a list of DMSO companies, dentist office data from the American Dental Association (ADA) 2015 office database, and education debt data from the 2002-2015 ADA Survey of Dental Graduates (SDG). We believe that these sources of data are more representative of the dentist workforce in the United States.

The 2015 ADA office database is based on a snapshot of professionally active dentists listed in the ADA master file as of November 2015. The ADA master file, a census of dentists in the United States, is used as the primary source of all business addresses in the office database. Business addresses are fed into the ADA master file via the ADA Distribution of Dentists survey, the 2002-2015 ADA SDG, and state and local dental associations. We also merged business address data from the National Provider Identifier dentist registry, which is maintained by CMS.[33] From the ADA master file, we merged demographic data, including dentist specialty, race or ethnicity, sex, age, year of graduation, and school of graduation, into the office database. We identified DMSO group practice locations and dentists by using a list of companies provided by the Association of Dental Support Organizations (ADSO).[34] From September through December 2015, we visited the websites of 138 group practices, including all ADSO members based in the United States for whom we could find websites identifying dentists and office locations. We considered a dentist to be affiliated with a DMSO if at least 1 of his or her 2015 practice locations was a member of ADSO or part of American Dental Partners, Western Dental Services, or Kool Smiles (3 large DMSOs that are not members of ADSO). We considered a dentist to be affiliated with a non-DMSO group practice if his or her practice consisted of more than 1 dentist or more than 1

ABBREVIATION KEY. **ADA:** American Dental Association. **ADSO:** Association of Dental Support Organizations. **CHIP:** Children's Health Insurance Program. **CMS:** Centers for Medicare & Medicaid Services. **DMSO:** Dental management service organization. **FQHC:** Federally Qualified Health Center. **GP:** General practice. **IKN:** Insure Kids Now. **SDG:** Survey of Dental Graduates.

location. Using exact and fuzzy matching methods, we flagged dentists in the ADA office database as affiliated with DMSO or non-DMSO group practices.

We flagged dentists participating in public health insurance in the ADA office database by using data from Insure Kids Now (IKN), a website maintained by CMS that identifies dentists who participate in Medicaid or CHIP.[35] For each state, CMS provided us a full list of Medicaid and CHIP providers in September, October, and November 2015. After removing duplicate observations, we used fuzzy matching methods to merge IKN records into the ADA office database. In instances in which IKN provided only the address of a Medicaid or CHIP participating location but no dentist information, we considered all dentists working at that address as public health insurance providers. Finally, on the basis of November 2015 street address data provided by the Health Resources and Services Administration,[36] we identified dentists in the ADA office database working at Federally Qualified Health Centers (FQHCs). We considered all dentists working at FQHCs to be public health insurance providers.

After merging data from the ADA master file, National Provider Identifier dentist registry, Health Resources and Services Administration FQHC file, and IKN, the 2015 ADA office database had 194,851 professionally active dentists, 188,894 of whom we were able to assign an office location (Table 1). To determine the education debt of professionally active dentists, we merged data from the 2002-2015 ADA SDG into the ADA office database. Most dental graduates receive this survey within 1 year after graduating from dental school. The composite response rate for the 2002-2015 ADA SDG was 59.7% based on 47,866 responses to 80,225 surveys. Respondents were asked to report their education debt at the time of their graduations. As of November 2015, 45,885 professionally active dentists had a record in the 2002-2015 ADA SDG and the 2015 ADA office database. From these records, 24,866 dentists reported their education debt. We restricted our sample to dentists from the ages of 24 through 50 years who graduated from a dental school in the United States and had education debt at or below $600,000. After eliminating records with inconsistent graduation and survey years and missing observations on race or ethnicity, our final sample contained 24,573 dentists.

Our dentist-level file included the following variables: education debt, age, sex, race or ethnicity (white, African American, Hispanic, Asian, other race), public health insurance participation, practice type (DMSO group practice, non-DMSO group practice, nonaffiliated solo practice), the state where the primary business practice is located, whether the office location is urban or rural, specialty (general practice [GP] dentist, pediatric dentist, other specialist), dental school type (private or public), and graduation year. We inflated education debt to 2014 dollars by using the Consumer Price Index All Items Index.[37] To this dentist-level file, we merged a state-level policy variable: the Medicaid ratio of fee to commercial charge for a pediatric prophylaxis procedure (Current Dental Terminology code D1120[38]). For each state, we collected the Medicaid reimbursement fee in 2015 for D1120. Also at the state level, we computed the average commercial insurance charge for D1120 by using 2015 data from FAIR Health. From these 2 variables, we computed the Medicaid ratio of fee to commercial charge for D1120.

TABLE 1

Sample selection.*

CRITERION	NO. OF DENTISTS
ADA† Masterfile of Professionally Active Dentists	194,851
No. of Dentists With an Assigned Office Location	188,894
No. of Dentists in ADA Masterfile Surveyed by Survey of Dental Graduates From 2002-2015	45,885
No. of Dentists Who Reported Education Debt and Are in ADA Masterfile With an Assigned Office Location	24,866
Survey Year Not Consistent With Graduation Year	24,845
Graduation Year Before 2001	24,839
Age at Graduation From 24 Through 50 years	24,784
Nonmissing Race or Ethnicity	24,668
Attended Dental School in the United States	24,599
Education Debt at or Below $600,000	24,573

* Source: 2015 ADA office database and 2002-2015 ADA Survey of Dental Graduates.
† ADA: American Dental Association.

Methodology. To measure the statistical association between education debt at graduation and dentist career choices, we ran a series of regression models. In our first model, we used a multinomial logit model to regress the provider type categorical variable on education debt, controlling for age, sex (reference category: male), graduation year, race or ethnicity (reference category: white), and whether the dentist attended a private dental school. In this regression model, we used nonaffiliated solo practice dentists as the baseline category for practice type career choice. In our second career choice model, we also used a multinomial logit model to measure the statistical association between choice of dental specialty and education debt, controlling for the same variables as in the provider type career choice model. In this multinomial logit model, we used GP dentists as the baseline category for specialty career choice. To account for correlation in unobserved school characteristics among dentists who attended the same dental school, we clustered standard errors according to dental school.

We calculated relative risk ratios to determine whether education debt and the control variables had a positive or negative relationship to career choice

TABLE 2

Summary statistics.*

VARIABLE	MEAN (STANDARD DEVIATION)
Age at Graduation, y	28.62 (3.46)
Current Age, y	36.4 (5.34)
Female, %	0.44 (0.50)
Total Education Debt in 2014 Dollars, in Thousands	19.45 (11.27)
No Education Debt, %	0.08 (0.27)
White, %	0.72 (0.45)
African American, %	0.04 (0.19)
Hispanic, %	0.05 (0.21)
Asian, %	0.18 (0.38)
Other Race, %	0.02 (0.14)
DMSO† Group Dentist, %	0.11 (0.32)
Non-DMSO Group Dentist, %	0.74 (0.44)
Solo Dentist, %	0.15 (0.36)
Medicaid, CHIP,‡ or FQHC§ Dentist, %	0.48 (0.50)
General Practice Dentist, %	0.81 (0.39)
Pediatric Dentist, %	0.05 (0.23)
Other Specialist, %	0.13 (0.34)
Rural Dentist, %	0.11 (0.32)

* Source: 2015 American Dental Association office database and 2002-2015 American Dental Association Survey of Dental Graduates.
† DMSO: Dental management service organization.
‡ CHIP: Children's Health Insurance Program.
§ FQHC: Federally Qualified Health Center.

decisions. In the provider type career choice multinomial logit model, a relative risk ratio greater than 1.0 indicates that an increase in the explanatory variable of interest is associated with an increased probability that a dentist will choose to join a DMSO or non-DMSO group practice over a nonaffiliated solo practice. In the dental specialty career choice multinomial logit model, a relative risk ratio greater than 1.0 indicates that an increase in the explanatory variable of interest is associated with an increased probability that a dentist will choose a career in pediatric dentistry or other specialty over GP dentistry.

In our final career choice model, we used a probit model to regress dentist participation in Medicaid or CHIP on education debt, practice type, specialty, age, sex, race or ethnicity, whether the dentist practiced at a rural location, whether the dentist attended a private school, and the Medicaid ratio of fee to commercial charge for a pediatric prophylaxis procedure (D1120). For this model, we clustered standard errors according to state because Medicaid policy is determined at the state level. We also included a state-level policy variable, the Medicaid ratio of fee to commercial charge for a pediatric prophylaxis procedure, in our regression. We calculated marginal effects to determine the relative effects of the independent variables on dentist participation in Medicaid or CHIP. The regression models used in this analysis address only statistical association, not causation.

Limitations. We acknowledge that our categorization of group practices and nonaffiliated solo practices is not optimal. Ideally, we would group practices that share revenues and expenses, but we are not able to do this with our data. In addition, some practices that we categorize as non-DMSO group practices may be DMSO group practices that are not ADSO members, but we have no way of identifying such group practices. This is why we decided to use a list of organizations provided by ADSO[34] to identify DMSOs. Our definition of both non-DMSO and DMSO group practices may result in underestimation of the number of solo-practice dentists. Another limitation in our analysis is that we cannot control for generational preferences in our career choice models. We control for age, but our data do not allow us to control for individual preferences. We also do not have data on the salary offerings made by DMSOs or other types of practices. If DMSOs offer new dental graduates higher salaries out of dental school, this could affect career choice.

RESULTS

In Table 2, we present summary statistics for key demographic and career choice variables used in our analysis. Average age as of graduation was 29 years and average current age was 36 years. Inflation-adjusted education debt was approximately $194,000. Eight percent reported no education debt. In our sample, 81% of dentists were GPs, 5% were pediatric dentists, and 13% practiced another specialty. Eleven percent of dentists were in a DMSO group practice, 74% were in a non-DMSO group practice, and 15% were in a nonaffiliated solo practice. Forty-eight percent of dentists in our sample participated in Medicaid or CHIP. Forty-four percent of dentists in our sample were female, and 72% were white. Eleven percent of dentists practiced in a rural location.

As Table 3[37] shows, inflation-adjusted dental school debt increased from approximately $144,000 in 2001 to $245,000 in 2014, a 70% increase. Among private dental school graduates, education debt increased from $190,000 to approximately $294,000, a 55% increase. Education debt among dentists who attended a public dental school increased from $114,000 in 2001 to $215,000 in 2014, an 88% increase. The percentage of recent graduates who reported no education debt remained constant from 2001 (9.4%) to 2014 (8.3%).

In Table 4, we show career choices according to graduation year. Recent graduates were more likely to join a DMSO and were less likely to be in a nonaffiliated solo practice. Furthermore, dentists who recently graduated were more likely to be GP dentists than specialists. However, this finding is not surprising given that it takes

TABLE 3

Education debt according to graduation year (in thousands).*

GRADUATION YEAR	PERCENTAGE WITH NO DEBT	INFLATION-ADJUSTED† EDUCATION DEBT, $	INFLATION-ADJUSTED† EDUCATION DEBT (PRIVATE SCHOOL GRADUATE), $	INFLATION-ADJUSTED† EDUCATION DEBT (PUBLIC SCHOOL GRADUATE), $
2001	9.4	143.67	190.02	114.26
2002	7.9	155.45	202.92	122.24
2003	8.8	158.85	204.76	127.22
2004	7.6	167.60	213.71	135.25
2005	7.0	175.08	222.94	145.74
2006	5.7	187.03	232.65	161.54
2007	6.4	195.76	242.82	167.41
2008	7.3	197.80	246.58	166.75
2009	7.1	205.73	248.04	181.81
2010	7.1	217.84	260.35	190.89
2011	7.6	222.62	273.09	191.41
2012	8.8	233.28	276.61	205.45
2013	7.5	246.33	294.29	214.29
2014	8.3	244.46	293.52	215.24
Overall	7.7	194.48	240.52	165.20

* Source: 2015 American Dental Association office database and 2002-2015 American Dental Association Survey of Dental Graduates.
† Education debt adjusted to 2014 dollars by using Consumer Price Index All Items Index.[37]

TABLE 4

Career choices according to graduation year.*

GRADUATION YEAR	PERCENTAGE OF DMSO† GROUP DENTISTS	PERCENTAGE OF NON-DMSO GROUP DENTISTS	PERCENTAGE OF NONAFFILIATED SOLO DENTISTS	PERCENTAGE OF MEDICAID, CHIP,‡ OR FQHC§ DENTISTS	PERCENTAGE OF GENERAL PRACTICE DENTISTS	PERCENTAGE OF PEDIATRIC DENTISTS	PERCENTAGE OF OTHER SPECIALISTS
2001	5.9	68.0	26.2	40.0	74.6	6.1	19.3
2002	5.8	70.1	24.1	39.5	76.3	5.9	17.8
2003	7.1	71.4	21.5	41.8	74.6	5.6	19.8
2004	8.7	68.9	22.4	45.1	75.1	6.8	18.1
2005	8.4	74.2	17.4	46.1	77.2	6.2	16.6
2006	11.0	74.2	14.9	52.0	77.5	6.5	16.1
2007	13.3	74.0	12.8	51.7	79.7	6.2	14.1
2008	12.7	73.8	13.5	54.3	77.8	7.5	14.7
2009	11.2	79.4	9.4	53.0	82.0	5.8	12.2
2010	15.3	75.6	9.1	54.5	83.1	6.3	10.6
2011	14.9	76.7	8.4	53.0	81.6	5.7	12.8
2012	17.4	74.8	7.8	53.0	89.5	3.8	6.7
2013	16.4	76.3	7.3	49.0	94.3	3.3	2.4
2014	12.5	79.6	7.8	40.4	99.5	0.1	0.5
Overall	11.3	73.7	15.0	47.8	81.3	5.4	13.2

* Source: 2015 American Dental Association office database and 2002-2015 American Dental Association Survey of Dental Graduates.
† DMSO: Dental management service organization.
‡ CHIP: Children's Health Insurance Program.
§ FQHC: Federally Qualified Health Center.

multiple years for dentists to enter into a field of specialization outside of GP dentistry.

Education debt had a modest but statistically significant association with practice type (Table 5). Holding all other variables fixed, a $10,000 increase in education debt was associated with a 0.9% increase in the likelihood of a dentist joining a DMSO (relative risk ratio, 1.009; 95% confidence interval, 1.0021 to 1.0164) and a 0.6% decrease in the likelihood of a dentist joining a non-DMSO group practice (relative risk ratio, 0.994; 95% confidence

TABLE 5

Multinomial logit: Factors influencing career choices into type of practice.*,†

VARIABLE	RELATIVE RISK RATIO (95% CONFIDENCE INTERVAL)
Career Choice: DMSO‡ Group Practice	
Age	0.99§ (0.97 to 1.0008)
Female	1.48¶ (1.34 to 1.64)
African American	2.58¶ (1.90 to 3.52)
Hispanic	1.43# (1.07 to 1.91)
Asian	1.67¶ (1.35 to 2.07)
Other race	1.72¶ (1.19 to 2.49)
Total education debt	1.009# (1.002 to 1.02)
Private school graduate	1.28# (1.05 to 1.56)
Career Choice: Non-DMSO Group Practice	
Age	0.96¶ (0.95 to 0.97)
Female	1.29¶ (1.19 to 1.39)
African American	1.30§ (0.99 to 1.70)
Hispanic	1.16§ (0.97 to 1.38)
Asian	1.03 (0.90 to 1.18)
Other race	0.88 (0.70 to 1.09)
Total education debt	0.994# (0.990 to 0.999)
Private school graduate	1.15# (1.02 to 1.29)

* Source: 2015 American Dental Association office database and 2002-2015 American Dental Association Survey of Dental Graduates.
† The number of observations is 24,573. Standard errors are clustered according to school. The graduation year indicator variables are included in the regression but excluded in the table. The base category for career choice decision is nonaffiliated solo practice.
‡ DMSO: Dental management service organization.
§ Significant at the 10% level.
¶ Significant at the 1% level.
# Significant at the 5% level.

TABLE 6

Multinomial logit: Factors influencing career choices into type of specialty.*,†

VARIABLE	RELATIVE RISK RATIO (95% CONFIDENCE INTERVAL)
Career Choice: Pediatric Dentistry	
Age	0.93‡ (0.90 to 0.95)
Female	1.63‡ (1.41 to 1.89)
African American	1.16 (0.91 to 1.48)
Hispanic	0.95 (0.69 to 1.30)
Asian	1.02 (0.85 to 1.21)
Other race	0.97 (0.61 to 1.52)
Total education debt	1.00 (0.99 to 1.01)
Private school graduate	0.97 (0.73 to 1.28)
Career Choice: Other Specialty	
Age	0.92‡ (0.90 to 0.94)
Female	0.52‡ (0.47 to 0.57)
African American	0.92 (0.69 to 1.24)
Hispanic	0.62‡ (0.47 to 0.82)
Asian	0.74‡ (0.62 to 0.90)
Other race	1.03 (0.79 to 1.33)
Total education debt	0.991‡ (0.986 to 0.996)
Private school graduate	1.18 (0.87 to 1.60)

* Source: 2015 American Dental Association office database and 2002-2015 American Dental Association Survey of Dental Graduates.
† The number of observations is 24,573. Standard errors are clustered according to school. The graduation year indicator variables are included in the regression but excluded in the table. The base category for career choice decision is general practice dentistry.
‡ Significant at the 1% level.

interval, 0.9897 to 0.9987) over a nonaffiliated solo practice. Demographic characteristics had a larger statistical association with practice type career choices. Compared with male dentists, female dentists were 48% more likely to join a DMSO group practice and 29% more likely to join a non-DMSO group practice. Compared with white dentists, African American dentists (158%), Hispanic dentists (43%), and Asian dentists (67%) were more likely to join a DMSO group practice. Older dentists were more likely to be in a nonaffiliated solo practice. Compared with dentists who graduated from a public dental school, private dental school graduates were 28% more likely to join a DMSO and 15% more likely to join a non-DMSO group practice.

Education debt also had a modest but statistically significant association with specialty career choices (Table 6). Holding all other variables fixed, a $10,000 increase in education debt was associated with a 0.9% decrease in the likelihood of dentists choosing a specialty outside pediatric or GP dentistry. As with practice type career choices, demographic characteristics had a larger statistical association with choice of specialty. Compared with male dentists, female dentists were 63% more likely to choose pediatric dentistry but 48% less likely to choose another field of specialization outside of GP dentistry. Compared with white dentists, Hispanic and Asian dentists were less likely to choose a specialization outside of pediatric or GP dentistry.

Unlike other career choice decisions, education debt did not have a statistically significant association with Medicaid or CHIP participation (Table 7), but other factors did. Compared with white dentists, African American dentists were approximately 15% more likely to participate in pediatric public health insurance programs. DMSO and non-DMSO group practice dentists were significantly more likely than nonaffiliated solo practice dentists to participate in Medicaid or CHIP. Compared with GP dentists, pediatric dentists were approximately 23% more likely to participate in Medicaid or CHIP. However, dentists in other specialties were approximately 8% less likely to participate in pediatric public health insurance programs. Rural dentists were 23% more likely than urban dentists to participate in Medicaid or CHIP. Increases in reimbursement had a modest association with dentist

participation in Medicaid or CHIP. A 1.0 percentage point increase in the pediatric prophylaxis Medicaid ratio of fee to commercial charge was associated with a 0.4% increase in public health insurance program participation, but this elasticity was statistically significant only at the 10% level.

DISCUSSION

Dental school debt had a modest but statistically significant association with a dental school graduate's decision on what type of practice to join (DMSO group practice, non-DMSO group, or nonaffiliated solo practice) and whether to specialize. An increase in dental school debt was associated with a slightly greater likelihood of a dentist joining a DSMO group practice over a nonaffiliated solo practice. Although statistically significant, the association between education debt and the decision to join a DMSO group practice may not be statistically meaningful because the magnitude is small. Education debt levels have increased substantially over the past 15 years, and new dentists may believe entering a DMSO group practice will offer more earnings stability early in their career. Our analysis results, consistent with those from previous research,[22,26,28] also showed that increases in education debt make it less likely dentists will specialize. Increased debt levels may make specialization less attractive for new dentists, considering the additional time and investment it requires.

Increases in education debt did not have a statistically significant association with a dentist's decision to participate in Medicaid or CHIP. Nicholson and colleagues[26] found that an increase in education debt was not associated with dentists having a greater percentage of poor patients in their patient panels. To our knowledge, we are the first to show that the type of practice a dentist works in has a statistically significant association with a dentist's decision to participate in Medicaid or CHIP—namely, dentists in DMSO practices, all else equal, are much more likely to participate in Medicaid or CHIP than are dentists in other settings. As in previous research,[32] we also found that increases in Medicaid reimbursement had a small but statistically significant association with dentist participation. Compared with GP dentists, pediatric dentists were more likely to participate in Medicaid or CHIP.

An important part of our analysis is the relationship between education debt and DMSO affiliation. Approximately 7.4% of dentists in the United States currently are affiliated with a DMSO, and this percentage varies widely by state.[39] Large group practices grew substantially from 1992 to 2002, driven in part by consolidation in the industry.[40] Additional research is needed to identify other main drivers behind the decrease in solo practices and the increase in practice consolidation.

TABLE 7

Probit model: Factors influencing dentist participation in pediatric public insurance programs.*,†

VARIABLE	MARGINAL EFFECT (95% CONFIDENCE INTERVAL)
Age	0.0084‡ (0.005 to 0.011)
Female	−0.038 (−0.027 to 0.019)
African American	0.15‡ (0.10-0.19)
Hispanic	0.040 (−0.02 to 0.10)
Asian	0.024 (−0.060 to 0.11)
Other Race	0.042 (−0.03 to 0.12)
Total Education Debt	0.001 (−0.0003 to 0.003)
DMSO§ Group Dentist	0.31‡ (0.25 to 0.38)
Non-DMSO Group Dentist	0.21‡ (0.18 to 0.25)
Pediatric Dentist	0.23‡ (0.16 to 0.29)
Other Specialist	−0.08‡ (−0.11 to −0.04)
Rural Dentist	0.23‡ (0.19 to 0.28)
Medicaid Ratio of Fee to Commercial Charge (D1120)	0.004¶ (−0.0004 to 0.008)
Private School Graduate	−0.02 (−0.08 to 0.04)

* Source: 2015 American Dental Association office database and 2002-2015 American Dental Association Survey of Dental Graduates.
† The number of observations is 24,573. Standard errors are clustered according to state. The graduation year indicator variables are included in the regression but excluded in the table.
‡ Significant at the 1% level.
§ DMSO: Dental management service organization.
¶ Significant at the 10% level.

Because we have only 1 year of DMSO data, we cannot conclude that the upward trend in education debt is associated with a higher percentage of DMSO practices over time. Additional research and data would be needed to answer that question.

We believe that the results of our analysis have some important implications for the future of dentistry. In our opinion, the percentage of dentists who choose to join a DMSO will continue to grow in the future, for a wide variety of reasons. In medicine, more primary care physicians have moved from smaller to larger group practices.[41,42] Fewer physicians are involved in the day-to-day administrative aspects of their practice.[43] We believe that a similar phenomenon could occur in dentistry, although much more gradually, over a much longer period. Because of practice consolidation, dentists may have more negotiating power with insurers over reimbursement, which would be an interesting topic to explore in future research. Large DMSO group practices also may have the scale and capacity to treat more patients receiving Medicaid. We found that dentists in DMSOs were significantly more likely to participate in Medicaid. Medicaid is a growing market in dentistry, as more patients gain dental benefits because of the Affordable Care Act's Medicaid expansion.[44] DMSO

practices could play a more substantial role in meeting the demand for dental care from these new patients. Finally, although education debt often is mentioned as the key factor pushing dentists into different practice models, our research results suggest a much weaker effect.

CONCLUSIONS

Education debt had a modest association with some career choices among dentists. Demographic characteristics had a larger association. Changes in the dental industry, particularly the growth of large group practices and DMSOs, have the potential to affect the delivery of dental care. Future research should focus on how consolidation in the dental industry will affect access to and affordability of dental care, particularly for low-income people, because such practices are more likely to participate in Medicaid or CHIP. ■

Dr. Nasseh is a health economist, Health Policy Institute, American Dental Association, 211 E. Chicago Ave., Chicago, IL 60611-2637, e-mail nassehk@ada.org. Address correspondence to Dr. Nasseh.

Dr. Vujicic is the chief economist and vice president, Health Policy Institute, American Dental Association, Chicago, IL.

Disclosure. Drs. Nasseh and Vujicic did not report any disclosures.

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SB237_Anupama Rao Tate_Fav.pdf
Uploaded by: Anupama Tate
Position: FAV

Children's National

February 10, 2023

Division of Oral Health

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Program Director,
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Jonelle Anamelechi, DDS
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George Obeid, DDS
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Endodontics
Julian Moiseiwitsch, BDS, PhD

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Justin Nunes, DDS
Sam Nicholson, DMD
Marisa Werger, DMD
Marquise Snipes, DMD
Mike Sartarini, DMD

Practice Manager
Ninochka Stroman

Department of Pediatrics
The George Washington University School of Medicine and Health Sciences

I would like to thank the chair and committee members for the opportunity today to speak in favor of Senate Bill 237.

I received my MPH from John's Hopkins School of Public Health and for more than 20 years, I have been a pediatric dental Attending at Children's National Hospital where I have seen first-hand the impact untreated dental decay on children and their families. Oral infections, avoidable hospital admissions, and days lost for school all from a preventable disease.

One of the most important components of this bill is the provision for early dental screening. Early preventive dental visits not only save dollars, they also lead to better health outcomes. As a trustee for the American Academy of Pediatric Dentistry and my current position on the board of the American Board of Pediatric Dentistry I have advocated for he "Age One" dental visit, which is modeled after the American Academy of Pediatrics' medical home concept. All parents deserve time spent one on one with an oral health care professional who knows their child and their families' disease risk patterns who can partner with them, so parents gain the self-efficacy they need to raise health children.

Behavior change is hard, it is always better to prevent a problem rather than treat it. These early dental visits allow for relationships to grow and for families to build trust with their oral health care providers through guided conversations about preventive treatment options such and dental hygiene, fluoride therapy and dietary counseling.

We know that young children with dental decay in their baby teeth are three times more likely to develop decay in their permanent teeth[1], early and effective prevention of dental cavities in children has the potential to reduce suffering and expense.

I love seeing young children in our clinic it is some of the most hopeful and joyful work I do. Parents are so engaged and full of questions. We want children to grown up pain free, in environments where oral health is valued, and families are armed with knowledge and skills to raise a cavity-free child.

I ask for a favorable report on Senate Bill 237.

Sincerely,

Anupama Rao Tate, DMD MPH
Director, Advocacy & Research
Children's National Hospital
111 Michigan, Ave NW
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Associate Professor of Pediatrics
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SB237 - MDHA Testimony in SUPPORT.pdf
Uploaded by: Caitlin McDonough
Position: FAV

February 14, 2023

The Honorable Melony Griffith
Senate Finance Committee
6 Bladen Street
3 East
Annapolis, MD 21401

TESTIMONY IN SUPPORT: SENATE BILL 237 – PUBLIC HEALTH – DENTAL SERVICES – ACCESS

Dear Chair Griffith and Members of the Committee:

The Maryland Dental Hygienists Association (MDHA) is an organization seeking to improve the public's total health by advancing the art and science of dental hygiene, including ensuring access to quality oral health care, increasing awareness of the cost-effective benefits of preventative dental services, promoting the highest standards of dental hygiene education, licensure, practice and research, and representing and promoting the interests of dental hygienists in Maryland. In keeping with that mission, MDHA takes this opportunity to voice its support for Senate Bill 237 – Public Health – Dental Services – Access, which would implement a variety of provisions relating to improving and increasing oral health by (1) prioritizing and monitoring oral health among Maryland's children, (2) increasing workforce development opportunities for dental hygienists providing services in Maryland, and (3) increasing investment in Maryland's Medicaid dental providers.

Oral health is an often overlooked and undervalued aspect of overall health, particularly among children and vulnerable populations. The Maryland General Assembly has done a great deal to increase focus on this important element of health and prioritize access and regular usage of quality dental services, and SB237 would add another important tool to those efforts. Currently, Maryland children and students seek and obtain regular medical care, often as a direct result of requirements for health screenings by physicians and other qualified healthcare practitioners that are relating to accessing fundamental public services like education. Establishing similar requirements for dental screenings helps create parity for how oral health is viewed by Maryland families and maximize its role as a key health priority. These screenings will also help Maryland better track how and if children have access to the services they need and, if not, create better opportunities for that access.

MDHA is always supportive of efforts to support individuals coming into the profession and we applaud Senator Klausmeier and this committee for looking to expand existing loan assistance programs beyond dentists and to be more inclusive of preventative care providers. Dental

hygiene is an area that has been particularly hard hit by healthcare workforce shortages, particularly for providers that serve significant Medicaid-eligible and other vulnerable patient populations. Anything the State can do to increase access to education, training and licensure for this profession is essential to addressing dental access needs across the State. MDHA stands ready to work with the sponsor and Committee to modify the Maryland Dent-Care Program to better address the needs of dental hygiene students.

Finally, MDHA adds its support to the widespread call for increased investment in Maryland dental care providers that service Medicaid populations. Unfortunately, prior to a limited increase appropriated in Fiscal Year 2023, Maryland had not seen a real increase in Medicaid dental rates for more than a decade, meaning the State's rates lag significantly behind other states, commercial dental insurance rates and Medicaid rates for medical services. Conversely, Maryland dental providers have seen the cost of providing services grow significantly due to inflation and supply chain impacts, increased cost associated with personal protection equipment, higher wage demands for essential services providers, and the implementation of expanded Medicaid coverage, including the newly established adult dental benefit. Stagnant reimbursement rates substantially limit the ability of Medicaid providers to absorbs those rising costs, and regular and reasonable analysis of and increases to those rates is essential to Maryland maintaining a robust and effected dental health safety net.

Thank you for your consideration of the comprehensive legislation and we urge the Committee's favorable consideration of Senate Bill 237.

The Maryland State Dental Association supports SB
Uploaded by: Daniel T Doherty, Jr.
Position: FAV

The Maryland State Dental Association supports SB 237 – Public Health – Dental Services – Access

A. **Background:**

In 2021 Maryland enacted HB 368 and SB 100 to study the barriers to access to dental services, and to make recommendations directed to improving access to dental care among underserved populations in the State. The Task Force held many meetings on a regular basis, received testimony from a variety of witnesses, made findings as to the barriers to Marylanders accessing dental care, and focused on what actions would be beneficial in improving the oral health of the residents of Maryland. The Final Report of the Task Force to Study Oral Health in Maryland was issued December 1, 2022.

B. SB 237 – Public Health – Dental Service – Access.
SB 237 was drafted by Staff to the Task Force as a first step in implementing the Task Force's recommendations.

1. **Dental Screenings:** It provides that the parent or guardian of a child shall have to provide evidence to the system or facility that the child has received a dental screening within six months of specified birthdays. In the public school system, a screening from a licensed dentist within 6 months before the child's sixth, ninth and twelfth birthdays. A child in a child care facility shall have provided by its parent or guardian evidence that he or she has received a dental screening within 6 months after the child's first birthday, and within six months before its third and sixth birthdays.

Among the positive results from these dental screening are: a) early detection of caries before more serious dental disease develops; b) provides the opportunity for dental education of the child and the parent/guardian on proper oral hygiene; and c) establishes a dental home for the child to receive regular dental exams, prophylaxis, and needed remedial services.

2. Expansion of the Maryland Dent-Care Program. The Task Force recommended expanding the Maryland Dent-Care Loan Assistance Repayment Program to include dental hygienists and to establish increase reimbursement rates for dentists, and to establish the reimbursement amounts for dental hygienists.

The purpose of this program is to increase access to oral health services for underserved

Maryland Medical Assistance recipients by increasing the number of dentists and dental hygienists who treat that population. The Office of Student Financial Assistance, with the assistance of the Maryland Department of Health, Office of Oral Health shall: a) recruit dentists and dental hygienists to participate in the program; b) determine if the applicant's practice setting is located near or is readily accessible to underserved Medicaid recipients; c) determine that the applicant qualifies for the program; d) determine if the applicant's practice setting(s) serves the required number of Medicaid recipients; and d) a Maryland licensed applicant demonstrates financial need, and agrees that at least 30% of the patients treated each year for a 3-year period will be Maryland Medicaid recipients. HB 290 provides that the amount of the loan grant be increased to at least $50,000 per year for 3 years for a dentist; and be established at not more than $10,000 per year for 2 years for a dental hygienist. This is a measure that will increase the number of dentists and dental hygienists who are accessible to the dental Medicaid population.

3. Changes to the Dental Medicaid Program. Among the issues affecting Medicaid recipients' access to dental care are: a) concerns about the legal ramifications of seeking public benefits and health care, including an impact on citizenship applications or legal residency status; and b) a lack of knowledge as to how to navigate the system.

a) SB 237 minimizes the fear of legal ramifications that inhibit this population from seeking dental treatment and services. It provides that the Secretary of Health may not condition or limit eligibility for dental services under the Program based on citizenship or immigration status.

b) This legislation also provides assistance to these recipients by providing that the Department shall provide reimbursement for services provided by a certified community health worker that assists a recipient to access dental service. A community health worker serves as a liaison between health and social services and the community to: a) facilitates access to services; b) improve the quality and cultural competence of the delivery of dental services; c) increase health knowledge and self-sufficiency; and d) other important services.

c) The bill will require the Department of Health in fiscal year 2024 to provide a 4% increase for dental services under the Program over the funding provided in the legislative appropriation for fiscal year 2023. The Department is also charged to annually evaluate reimbursement rates for dental services.

4. Plain Language Dental Information. SB 237 requires the Department of Health to create and distribute to dental practices plain language materials regarding: a) the importance of regular dental care for a person's overall health; and b) various dental procedures.

5. Mobile and Portable Dental Services. Under SB 237 the State Board of Dental Examiners shall require applicants for an initial license or a license renewal to report whether the applicant provides or intends to provide mobile or portable dental services. The Board is the required to publish on its website a searchable list of dentists and dental hygienists who provide these services in the State.

6. Required studies under the auspices of the Maryland Department of Health. SB 237 also sets up two studies: a) The first is to be conducted by a workgroup convened by the Department, to study the establishment of a grant or no-interest loan program for dental providers to open practices in underserved areas; and b) The Department is to conduct a study on dental provider participation in the Maryland Healthy Smiles Program. It shall include a review of administrative issues relating to enrollment of providers in the Program, and possible incentives that may be used to encourage participation in the Program.

The Maryland State Dental Association respectfully requests that SB 237 be given a favorable report.

Submitted by Daniel T. Doherty, Jr
On behalf of the Maryland State Dental Association
January 14, 2023

SB237 Public Health - Dental Services - Access SOD

Uploaded by: Dean Mark Reynolds

Position: FAV

UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

Office of the Dean

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Testimony in support of SB 237: Public Health – Dental Services - Access
Before the Finance Committee
February 14, 2023

Good afternoon, Chair Griffith, Vice Chair Klausmeier, and members of the Finance Committee. My name is Dr. Mark Reynolds, and I serve as Dean of the University of Maryland School of Dentistry. Over the last year, I served as co-chair of the Task Force on Oral Health in Maryland. The Task Force was established during the 2021 Legislative Session, by passage of House Bill 368 and Senate Bill 100 to:

- Conduct a comprehensive, multi-disciplinary assessment of oral health care in the State, including access to care and other systemic limitations to receiving dental services;
- Inform strategies to improve access to care; and,
- Make recommendations to address current and emerging oral health challenges.

I am pleased to share that the Oral Health Task Force submitted its final report to the Governor on December 1, 2022. As co-chair of the Task Force, I want to extend my strong support of Senate Bill 237, which aligns closely with recommendations found in the report.

Among the most consequential recommendations proposed by the Task Force relative to pediatric dentistry is the implementation of statewide mandatory dental screenings for children at ages 1,3, 6, 9 and 12 as a requirement to enter childcare or a public school. Equally aligned components of the bill include increased public education on the importance of oral health for children and adults, addressing Medicaid reimbursable procedures and services, and expanding the Maryland Dent-Care Loan Assistance Repayment Program to include dental hygienists, among others.

While Maryland has made much progress in the last decade to improve the oral health status of its residents, access to care remains a significant concern. Oral health is a critical component of overall health, and sustainable strategies to improve access to oral health care are imperative. We at the University of Maryland School of Dentistry are excited to continue our work to advance oral health and improve the quality of life in Maryland communities, particularly those most vulnerable.

Thank you for your consideration.

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Uploaded by: Maryland State of
Position: FAV

Maryland

Board of Dental Examiners

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Acting Secretary

Arpana S. Verma, President – Christy Collins, Executive Director
55 Wade Avenue Catonsville, MD 21228 Phone: 410-402-8501; Email: mdh.mddentalboard@maryland.gov

February 14, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401-1991

Re: SB 237 – Public Health - Dental Services - Access - Letter of Support

Dear Chair Griffith and Members of the Senate Finance Committee:

The Maryland State Board of Dental Examiners is submitting this Letter of Support for Senate Bill (SB) 237 - Public Health-Dental Services-Access. The bill requires that children enrolled in public schools and various care homes receive periodic dental screenings from a licensed dentist. Specifically, the bill requires that the parent or guardian of a child enrolled in the Maryland public school system provide evidence to the school that the child received a dental screening from a licensed dentist within 6 months before the child's sixth birthday, ninth birthday, and twelfth birthday. The parent or guardian of a child in a family child care home or large family child care home must provide to the family child care home or large family child care home evidence that the child has received a dental screening from a licensed dentist within 6 months after the child's first birthday, before the child's third birthday, and before the child's sixth birthday. The parent or guardian of a child in a child care center must provide to the child care center evidence that the child has received a dental screening from a licensed dentist within six months after the child's first birthday, before the child's third birthday, and before the child's sixth birthday.

In addition, the bill requires that the Maryland Department of Health, Office of Oral Health recruit dental hygienists as well as dentists to participate in the Maryland Dent-Care Program, and offers higher education loan assistance for dentists and dental hygienists participating in the Program who demonstrate financial need and be employed full time as a dentist or a dental hygienist. The bill also requires that the Maryland Department of Health create and distribute "Plain Language" materials regarding the importance of regular dental appointments, and various dental procedures to dental practices, and encourage dentists and dental hygienists to distribute the materials to their patients. Finally, the bill requires applicants for an initial dental license and a renewal dental license to report whether the applicant provides or intends to provide mobile dental services or portable dental services. The Dental Board must then publish a searchable list of dentists and dental hygienists who provide mobile dental services or portable dental services on its website.

The Dental Board supports SB 237. Requiring that elementary age children receive periodic dental screenings will certainly help prevent tooth decay and prevent other dental related issues while contributing to the overall health of the child. If tooth decay remains undetected and

untreated, it will only worsen and eventually reach the root canal. When cavity-causing bacteria infect the nerve endings, children will likely suffer with daily discomfort along with difficulty speaking and chewing. Pain associated with severe cavities can affect a child's educational and social development. Discomfort from tooth pain is distracting and can cause a child to fall behind in school. Children suffering with severe decay may also develop speech impediments. Very simply, the earlier tooth decay can be detected the easier it is to treat and resolve.
The Board also supports the incentive surrounding the inclusion of dental hygienists in the Maryland Dent-Care Program and providing loan assistance grants for doing so. The result should be an increase in the overall number of dental providers who treat the State's underserved population.

For these reasons, the Dental Board requests that SB 237 receive a favorable report.

I hope that this information is helpful. If you would like to discuss this further, please contact me at 240-498-8159, asverma93@gmail.com, or Dr. Edwin Morris, the Board's Legislative Committee Chair at 410-218-4203. In addition, the Board's Executive Director, Dr. Christy Collins may be reached at 410-402-8518, christy.collins1@maryland.gov.

The opinion of the Maryland State Board of Dental Examiners expressed in this letter of support does not necessarily reflect that of the Department of Health or the administration.

Sincerely,

Arpana S. Verma, D.D.S.
Board President

SB237-SponsorAmendment1
Uploaded by: Senator Klausmeier
Position: FAV

SB0237/373726/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

13 FEB 23
19:45:49

BY: Senator Klausmeier
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 237
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 3, after "requiring" insert ", on or after a certain date,"; in line 7, strike "prohibitions and"; and in line 8, strike "eligibility for dental services and the".

On pages 1 and 2, strike in their entirety the lines beginning with line 25 on page 1 through line 1 on page 2, inclusive.

AMENDMENT NO. 2

On page 2 in line 22, and on page 3 in lines 1 and 17, in each instance, strike "**THE**" and substitute "**ON OR AFTER JULY 1, 2024, THE**".

On pages 6 through 9, strike in their entirety the lines beginning with line 14 on page 6 through line 28 on page 9, inclusive.

On page 9, in line 30, strike "**THE**" and substitute "**ON OR AFTER JANUARY 1, 2025, THE**".

SB237-SponsorAmendment2
Uploaded by: Senator Klausmeier
Position: FAV

SB0237/213825/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

13 FEB 23
19:30:49

BY: Senator Klausmeier
(To be offered in the Finance Committee)

AMENDMENT TO SENATE BILL 237
(First Reading File Bill)

On page 10, in line 19, after "**MATERIALS**" insert "**, INCLUDING MATERIALS TARGETING AND AGE APPROPRIATE FOR CHILDREN,**".

SB 237_PJC_FWA_FIN.pdf
Uploaded by: Ashley Black
Position: FWA

Ashley Black, Staff Attorney
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SB 237
Public Health - Dental Services - Access
Hearing of the Senate Finance Committee
February 14, 2023
1:00 PM

FAVORABLE WITH AMENDMENTS

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization which seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Health and Benefits Equity Project advocates to protect and expand access to healthcare and safety net services for Marylanders struggling to make ends meet. We support policies and practices that are designed to eliminate economic and racial inequities and enable every Marylander to attain their highest level of health. **The PJC supports SB 237 with amendments.** SB 237 would require parents and guardians of children enrolled in the Maryland Public School System and other specific settings to provide evidence that the child has received a dental screening within certain time periods. It would also expand the Dent-Care Program's loan assistance grants to dental hygienists and require the Maryland Department of Health (MDH) to reimburse Community Health Workers for services provided to dental patients. While we support the spirit and intention of SB 237, we have concerns with the provisions described below and the potential unintended impact.

Childhood Dental Screenings Requirement

Access to pediatric dental care has been an advocacy priority for PJC for many years since one of our client's children, 12-year-old Deamonte Driver, died of an untreated tooth infection in 2007. While we believe Maryland should continue to increase access to dental care for children, we have concerns that the requirement for parents and guardians to obtain a dental screening for their children could create unintentional barriers to education and may place additional strain on Maryland's dental system.

We thank the House Health and Government Operations Committee and Senate Finance Committee for passing legislation to require Maryland's Medicaid program to cover adult dental care. Dental providers and advocates are working to build capacity in the community to successfully meet the needs of newly covered adult dental patients, many of whom have been waiting for years to address chronic dental conditions and pain. Due to the tremendous focus on capacity building for the adult Medicaid community, families, especially those with more than one child, may experience hardship in obtaining timely dental screenings and needed follow up care and may

have to delay school enrollment as a result. Similarly, this provision would create a significant increase in demand for pediatric dental screenings which could also unintentionally hinder dental providers from building the capacity needed to serve the adult Medicaid population. It is also unclear whether pediatric dental providers will have capacity to schedule timely dental screenings and follow up care for thousands of children in Maryland.

We respectfully recommend striking this language and replacing it with a requirement for MDH and the Maryland State Department of Education to collaborate on educational materials and outreach for families on the importance of childhood dental screenings and how to obtain such screenings. These materials could be developed in plain language in collaboration with the state-designated Consumer Health Information Hub. PJC believes that education and outreach would be a more effective pathway towards improving childhood oral health.

CHW Medicaid reimbursement for services provided to dental patients

PJC strongly supports expanding access to community health workers as a way to improve health equity and access in Maryland. However, we believe that the requirement to reimburse CHWs for services provided to dental patients should be part of a comprehensive package to reimburse all CHW services under Medicaid in a wider variety of settings. CHWs are frontline public health workers who are members of and have a deep understanding of the communities they serve; provide culturally-competent health education, care coordination, and social and emotional support; help people navigate health and social service systems; and advocate for individuals and communities. Though CHWs help address social determinants of health, improve health outcomes, and reduce costs[1], CHWs are still not reimbursed by Maryland Medicaid.

This is a glaring issue that has led to some CHWs leaving the field or being terminated from positions with providers who do not have funding to support the services. We are concerned that only reimbursing CHWs who provide services to dental patients could create unintentional inequities in the field as not all CHWs work with dental patients. We respectfully recommend that this type of reimbursement expansion first be studied to determine how best to provide sustainable funding, including Medicaid reimbursement, to CHWs working in a variety of settings with patients with dental and other health needs.

Thank you for your consideration of these concerns and recommendations. We thank Delegate Bagnall for championing this important oral health access legislation and urge the committee to issue a **FAVORABLE** report for **SB 237 with amendments to address the concerns above.** If you have any questions about this testimony, please contact Ashley Black at 410-625-9409 x 224 or blacka@publicjustice.org.

[1] Chidinma A. Ibe and Obie S. McNair. Abell Foundation. *Advancing and Sustaining the Community Health Worker Workforce in Baltimore City: A Call to Action for Key Stakeholders.* (October 2021).

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

SB 237.Dental Health and Screening Reporting to Sc

Uploaded by: John Woolums

Position: FWA

MABE
MARYLAND ASSOCIATION OF BOARDS OF EDUCATION

621 Ridgely Avenue, Suite 300, Annapolis, Maryland 21401
410-841-5414 · 800-841-8197 · Fax: 410-841-6580 · MABE.org

BILL: **Senate Bill 237**
TITLE: **Public Health - Dental Services - Access**
DATE: **February 14, 2023**
POSITION: **SUPPORT WITH AMENDMENTS**
COMMITTEE: **Finance**
CONTACT: **John R. Woolums, Esq.**

The Maryland Association of Boards of Education (MABE) supports Senate Bill 237 with an amendment to remove the requirements for parents and guardians to report their children's dental visits to public schools.

Local boards of education appreciate the importance of dental health in the lives of our nearly 900,000 students. However, MABE does not support the requirement that schools collect all of the dental visit verifications required by this bill for all six, nine, and 12 year olds. The focus of the bill on expanding family and student access to dental health services through programs administered by the Maryland Department Health. Therefore, it would appear to be more appropriate for dentists to provide verification of all dental screenings directly to state health officials in order to inform public health policy.

Local school systems are actively engaged in promoting and advancing the health of our students through a number of programs. However, these programs and standards typically relate to services that can reasonably be provided through outside providers on school premises, such as vision screening, or involve the array of communicable diseases addressed through vaccination requirements linked to school admission. Other significant student health issues are addressed through legislation governing students with chronic conditions such as diabetes or sickle cell disease, and involve the role of school nurses and other school staff. MABE has often supported legislative initiatives in these student health areas.

By contrast, this legislation would require schools to implement an information gathering and record keeping system without any clear connection to any school system role in the provision of dental health services. Again, MABE certainly recognizes the importance of the State's continued efforts to ensure that children are receiving dental health services. Although the overwhelming majority of students do receive routine dental care, problematic gaps in coverage do exist. MABE believes that Senate Bill 237 is intended to make meaningful improvements in the provision of children's dental health services, and will continue to do so without mandating the enormous statewide dental record reporting and retention requirement for public schools proposed by this bill.

For these reasons, MABE requests a favorable report on Senate Bill 237 with an amendment to strike lines 20 through 31 on page one of the bill to remove the requirements for parents and guardians to provide verification of their students' dental visits to their students' school.

2023 MDAC SB 237 Senate Side FWA.pdf
Uploaded by: Michael Paddy
Position: FWA

Maryland Dental Action Coalition

10015 Old Columbia Road, Suite B-215
Columbia, Maryland 21046
www.mdac.us

To: **Senate Finance Committee**

Bill: **Senate Bill 237 - Public Health - Dental Services - Access**

Date: **February 14, 2023**

Position: **Support with Amendments**

The Maryland Dental Action Coalition supports *Senate Bill 237 – Public Health – Dental Services – Access* with amendments. The bill proposes to codify recommendations from the final report of The Oral Health Task Force.

MDAC thanks the Committee for its strong, continuous support of expanding access to dental services. Over the past five years, Maryland has made tremendous progress:

- 2018: *Senate Bill 284 – Maryland Medical Assistance Program – Dental Coverage for Adults* established a pilot program for dental coverage for dually-eligible adults.
- 2020: The Supplemental Budget provided funding for postpartum coverage in the Medicaid Program.
- 2022: *Senate Bill 150 – Maryland Medical Assistance Program – Dental Coverage for Adults* expanded dental coverage to include all adult Medicaid participants. As a result, about 800,000 more people have dental coverage as of January 1, 2023.
- 2022: The budget included $19 million for a much-needed rate increase effective July 1, 2022.
- 2023: The budget includes another proposed $20 million for dental rate increases.

MDAC supports Senate Bill 237 as it provides continued policy focus on improving the oral health of Marylanders. We recognize that the Department of Health may not be able to implement every provision in the bill, as the implementation of adult coverage has just begun and takes tremendous resources. Therefore, we ask that the Committee prioritize the following items:

- **Expansion of the Loan Assistance Repayment Program:** Maryland has 62 areas considered dental provider shortage areas, also known as health professional shortage areas.[i] We strongly support updated the amount that dentists receive under the Loan

Repayment Program. We also support the addition of dental hygienists to the program.

- **Dental Assistants:** We request an amendment that would establish a stakeholder group to study and make recommendations regarding tuition assistance for dental assistants, as there is also a shortage of dental assistants.

- **Loan Programs for Private Practices:** The bill proposes a study group to examine low-interest loans or grants to support establishing private practices in underserved areas. We wanted to note that it may also be possible to build this initiative into the *Health Equity Resource Communities Program* under the Maryland Community Health Resources Commission.

- **Community Health Centers – Operating Grants:** We would ask for an amendment that provides funding for the Office of Oral Health to make operating grants to community health centers that have a high concentration of Medicaid patients. With the establishment of adult dental coverage, community health centers are important partners in building provider capacity.

- **Community Health Centers – Capital Grants:** In 2019, the Maryland General Assembly established the Community Dental Clinics Grant Program under House Bill 332. To date, the program has not been implemented because of a lack of funding. We ask for consideration of funding as part of the strategy to build provider capacity for the Medicaid Adult Coverage Program.

We ask for a favorable report. We would be pleased to support the Committee as it considers how to prioritize provisions of the bill. If we can provide any additional information, please contact Robyn Elliott at relliott@policypartners.net.

[i] https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

2023 MCHS SB 237 Senate Side FWA.pdf
Uploaded by: Robyn Elliott
Position: FWA

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 255 – Public Health – Dental Services - Access**

Hearing Date: **February 14, 2023**

Position: **Support with Amendments**

The Maryland Community Health System (MCHS) supports *Senate Bill 255 – Public Health – Dental Services – Access* with amendments. The bill delineates key recommendations of the Task Force on Oral Health in Maryland.

MCHS is a network of federally qualified health centers that focus on providing somatic, behavioral, and oral health services to underserved communities. We appreciate the strong partnership of the Maryland General Assembly in expanding access to dental coverage. With *SB 150 - Maryland Medical Assistance Program – Dental Coverage for Adults* from the 2022 session, the Maryland Medicaid Program has been able to extend dental coverage to 800,000 more adults.

Senate Bill 255 provides for further steps to improve access to dental services. We request consideration of two amendments:

- **Study of required reports of dental screenings for children in public schools and child care center programs:** The bill requires parents to report dental screenings at regular intervals to a child's school or child care center. Rather than implement this provision, we request an amendment to require the Department to convene stakeholders and study the issue further. We are concerned that the provider community may not have the capacity to support implementation of the proposed requirement, so more consideration is needed.

- **Operating Grants for Community Health Centers:** The bill has several provisions to address building provider capacity among the private practice community. We request adding a provision to require funding for operating grants for community health centers under the Office of Oral Health. Community health centers are critical partners in providing services to Medicaid participants.

Thank you for your consideration of our requests. We ask for a favorable report. If we can provide any additional information, please contact Robyn Elliott at relliott@policypartners.net.

Oppose SB0237 Dental Services.pdf
Uploaded by: Peggy Williams
Position: UNF

SB0237 (OPPOSE) Public Health – Dental Services – Access

Dear Committee Members:

Dental conditions are not a communicable disease. Why would this be incorporated into school requirements, other than to again infringe on parenting practices? As you can see here (https://www.mouthhealthy.org/all-topics-a-z/hpv-vaccine) , the dental industry is pushing the HPV vaccine. One can only presume that this too will be incorporated into school requirements.

Please oppose this bill.

Sincerely,

Peggy Williams

Severna Park

D33

4 - SB 237 - FIN - MDH - LOO.docx.pdf
Uploaded by: State of Maryland (MD)
Position: UNF

February 14, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

Re: SB 237 – Public Health – Dental Services – Access – Letter of Opposition

Dear Chair Griffith and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of opposition for Senate Bill (SB) 237 – Public Health – Dental Services – Access. SB 237 implements a wide variety of programmatic changes intended to improve dental access in Maryland, including mandatory dental screenings for children at certain ages, coverage of dental services regardless of immigration status, requiring Medical Assistance to reimburse community health workers, as well as rate increases for dental services.

MDH recognizes the importance of dental care starting at a young age. However, MDH is concerned by the bill's provision that a child enrolled in public schools and child care facilities shall provide evidence of a dental screening at certain age milestones, beginning after a child turns 1 years old and lasting until the child is 12 years old. Specifically, MDH is concerned there are not enough dental providers to deliver the required screenings to children. As of August 2022, there were only 193 active pediatric dentists in Maryland statewide. If there are not enough pediatric dentists, this creates a barrier for the child to complete the screenings. As a result, children may be at risk of missing key developmental and educational milestones and working families would be unduly burdened without access to these services.

MDH estimates the bill will require $327 million to implement for Fiscal Year (FY) 2024, with $183.8 million coming from Federal Funds and $143.2 million from General Funds. Costs are expected to increase each fiscal year thereafter. MDH anticipates that implementation of coverage for dental services for individuals regardless of immigration status, estimated to be 115,856 individuals, will require at least 80 additional staff persons as well as significant programming changes. Service costs for these individuals is estimated to be $24.8 million annually and MDH will not be eligible to receive a federal match for these service costs.

SB 237 further requires coverage for Community Health Workers (CHW) services. Currently, CHWs are not a Medical Assistance covered provider type. As drafted, it is unclear whether the intent of the legislation is to require coverage only for dental-related services. Conservatively, MDH estimates such coverage would cost $279.5 million annually, with $170.5 million coming

from Federal Funds and $109.9 million from General Funds. This is inclusive of services delivered and costs for needed system changes. However, costs will be substantially higher if coverage of a broader array of services will also be required or if CHW services must be reimbursed for individuals regardless of immigration status.

MDH is dedicated to ensuring vulnerable Marylanders are able to access critical dental services. Effective January 1, 2023, MDH implemented coverage for dental services for adults enrolled in Medical Assistance. This substantial expansion will provide access to services for more than 800,000 individuals. During the 2022 legislative session, the Maryland FY 2023 Operating Budget directed $19.6 million ($9.1 million General Funds) to the Medical Assistance program to increase dental reimbursement rates, representing the largest increase since FY 2009. Effective July 1, 2022, MDH provided a one-time rate increase of 9.4 percent for 32 specific dental codes prioritized by stakeholders. These codes include a selection of diagnostic, preventive, and restorative services. An additional $20 million is included in the Governor's budget to support another rate increase in FY23. If implemented, these funds will be sufficient to support an additional 5.75% increase for all dental rates. Additionally, the Medicaid program is adding silver diamine fluoride to its benefit package and increasing ambulatory surgery rates for dental procedures.

If you would like to discuss this further, please do not hesitate to contact Megan Peters, Acting Director of Governmental Affairs at megan.peters@maryland.gov or (410) 260-3190.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Acting Secretary

EACtestimony.SB237.pdf
Uploaded by: Leslie Margolis
Position: INFO

Education Advocacy Coalition

for Students with Disabilities

SENATE FINANCE COMMITTEE
SENATE BILL 237: PUBLIC HEALTH—DENTAL SERVICES--ACCESS

DATE: FEBRUARY 14, 2023

POSITION: LETTER OF INFORMATION

The Education Advocacy Coalition for Students with Disabilities (EAC), a coalition of nearly 40 organizations and individuals concerned with education policy for students with disabilities in Maryland provides this letter of information regarding Senate Bill 237, which would increase access to dental care for children throughout Maryland while at the same time requiring parents to provide periodic evidence of dental screening to their child's school or child care center.

Senate Bill 237 could potentially have the unintended consequence of causing some children to be excluded from school or child care:

1) Children with disabilities: Some children with disabilities have significant sensory or behavior challenges that make them unable to tolerate routine dental care. These children may require sedation for routine dental care, making dental screening an onerous and major medical procedure. Some children have a constellation of disabilities that makes sedation unsafe. Additionally, many parents of children with disabilities have great difficulty finding dentists who are willing to treat their children. If dental screening is a prerequisite for school or child care attendance, these children—children who need special education and related services and are guaranteed those services by law—would be excluded from school.
2) Children whose legal status makes them ineligible for Medical Assistance: All children, regardless of their legal status, have a right to attend school. However, some children may not be at a point in the immigration process at which they have access to Medicaid. House Bill 290 presupposes that children will be eligible for Medicaid or otherwise have dental insurance. If children are unable to access a dental screening because they do not have dental insurance or Medicaid, they will be excluded from school if dental screening is a prerequisite for school attendance.
3) Both of these issues could be addressed by an amendment stating that children cannot be excluded from school if they are unable to access dental screening because of disability or lack of insurance.

Please contact Leslie Seid Margolis, Chairperson, at lesliem@disabilityrightsmd.org or 410-370-5730 with any questions. (Over)

Respectfully submitted,

Selene Almazan, Selene Almazan Law, LLC
Rene Averitt-Sanzone, The Parents' Place of Maryland
Linda Barton, MSED, Education Advocate
Beth Benevides, Howard County Autism Society
Rich Ceruolo, Parent Advocacy Consortium
Michelle Davis, ABCs for Life Success
Jennifer Engel Fisher, Weinfeld Education Group
Lisa Frank, Andrea Bennett, Jen Ritchotte and Amy Tonti, Special Kids Company
Ann Geddes, Maryland Coalition of Families
Beth Ann Hancock, Charting the Course, LLC
Kalman Hettleman, Independent Advocate
Morgan Durand Horvath, M.Ed., Abilities Network
Nicole Joseph, Esq., Law Offices of Nicole Joseph
Ande Kolp, The Arc Maryland
Rachel London, Maryland Developmental Disabilities Council
Leslie Seid Margolis, Disability Rights Maryland
Mark B. Martin, Law Offices of Mark B. Martin, P.A.
Ellen O'Neill, Atlantic Seaboard Dyslexia Education Center
Ronza Othman, National Federation of the Blind of Maryland
Maria Ott, Attorney
Rebecca Rienzi, Pathfinders for Autism
Jaime Seaton, BGL Law
Karleen Spitulnik and Winifred Winston, Decoding Dyslexia Maryland
Ronnetta Stanley, Loud Voices Together
Wayne Steedman, Steedman Law Group, LLC
Maureen van Stone, Annie Carver and Tyler Cochran, Project HEAL at Kennedy Krieger Institute
Jessica Williams, Education Due Process Solutions, LLC
Liz Zogby, Maryland Down Syndrome Advocacy Coalition

SB237_The Arc.MDDC.DRM.pdf
Uploaded by: Rachel London
Position: INFO

Senate Finance Committee

SB 237: Public Health – Dental Services - Access
February 13, 2023
Letter of Information

The Arc Maryland, the Maryland Developmental Disabilities Council, and Disability Rights Maryland are statewide organizations that work to protect and advance the rights and quality of life of people with disabilities. We understand the intention of the bill to increase access to dental care for children throughout Maryland and agree that access to dental care is important. We want to highlight potential unintended consequences for children with disabilities.

1) **Some children with disabilities are not able to get routine dental care.** Because of sensory or behavior challenges that make them intolerant to routine dental care, or because their family cannot find a dentist that will even see them. Others require sedation for routine dental care. As a result, any dental screening is either a costly medical procedure, or completely unrealistic. Some children with certain health conditions are at enhanced risk under sedation or unable to medically tolerate sedation altogether and therefore cannot always get dental screening. **If dental screening is a prerequisite for school or child care attendance, these children—children who need special education and related services—would be excluded from school.** This may be a direct violation of their rights to access a free and appropriate public education, and may also jeopardize federal funding for schools.

2) Single parent, and/or low-income families may not have access to the financial resources and time off from work to obtain the dental screenings, comply with prescribed timelines, and produce evidence of care. While dental care is so important for overall health, more safety net services are needed for easier access to affordable and appropriate dental care such as mobile school clinics on school grounds or other alternatives. Students with disabilities, who are experiencing poverty, food insecurity, and other barriers to school success, should not also face exclusion from a place they may be counting on for a meal, structure, and oversight.

3) All children, regardless of their legal status, have a right to attend school. However, some children may not be at a point in the immigration process to provide them with access to Medicaid. SB 237 assumes that children will be eligible for Medicaid or other dental insurance. If children are unable to access a dental screening because they do not have dental insurance or Medicaid, they will be excluded from school under this bill.

4) There is no clear process for the parent or guardian requirements. There is no process or outline of how a parent or guardian is to provide notification. This may cause an additional burden for families, especially those who have language barriers, or lack the means to provide a signed form.

We appreciate the opportunity to provide comments, and remain available for any questions.

Contact:

Ande Kolp, Executive Director, The Arc Maryland akolp@thearcmd.org
Rachel London, Executive Director, Maryland Developmental Disabilities Council, rachell@md-council.org
Leslie Margolis, Managing Attorney, Disability Rights Maryland, LeslieM@DisabilityRightsMD.org