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## **Initiatives For Children's Oral Health Care**

### **A Report to the Joint Committee on Health and Human Services**

**Submitted pursuant to consideration of LD 1250, An Act to Implement an Oral  
Health Capitation System for Children on MaineCare,  
presented by Senator Peter Mills  
during the First Regular Session of the 123<sup>rd</sup> Legislature**

**January 28, 2008**

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## **Executive Summary**

Oral health is important for all children, and oral disease – poor oral health – is consequential. To provide more care to more young children involves a multitude of challenges, including the current system of financing and delivering dental care, the availability of prevention programs, and the availability and distribution of dental health professionals throughout the state. For many people in Maine, particularly low-income children and adults, finding access to affordable dental care has become a serious financial and logistical challenge.

For many years Maine has been consistent in attempts to increase access to oral health services for children and to develop new initiatives, and in monitoring best and promising practices in other states. Much of what we see in other states has been discussed here and/or implemented to varying degrees. Many opportunities exist to improve the oral health of Maine's children and increase access to oral health services. For a number of these, the likelihood of a fiscal impact will present challenges to implementation or active participation by state government in the near future.

Absent sufficient funding in recent years for significant changes in MaineCare dental reimbursement rates, DHHS has focused on changes in policy, processes and procedures, recognizing that these changes are also necessary to improve the MaineCare Dental Program and can help to sustain gains that might be realized later with increased reimbursement. Absent such funding, other programs have developed and although they have grown slowly, they have significant potential for positive impact. State government can maximize its role as a partner with the private sector and other interested parties to support further development of the types of programs and initiatives described in this report. To the extent that they are implemented soundly and following evidence-based and best practices, providing coordinated and quality care to children, they are a good investment for all concerned and are more likely to result in better health outcomes and lower health care costs.

Specific activities undertaken by DHHS, with involvement by the MaineCare Dental Advisory Committee, have revolved around streamlining and enhancing processes and procedures within the MaineCare program. Continuing financial constraints have generally precluded any substantial changes in reimbursement rates, although some have been adjusted during the past several years. Challenges for the MaineCare program revolve around two central issues – that MaineCare reimbursement rates are inadequate and that the supply of dentists in Maine is inadequate to meet the demand for services. These two issues in combination mean that dental practices can often fill their patient panels with a mix of self-pay and privately insured patients. In addition, the challenges presented by MaineCare's claims management system have had an adverse impact on the active participation in MaineCare by dentists.

State government agencies (specifically the Office of MaineCare Services and the Maine Center for Disease Control) have also been involved in other collaborative initiatives, focusing on capacity-building, increased opportunities for preventive interventions, and workforce development.

The body of this report describes activities in other states as well as several initiatives underway in Maine. Given current financial concerns and constraints, however, review of this report must start with the recognition that to achieve improvements in children's oral health, an ongoing

coordinated and collaborative effort will be necessary. Along with parents and families, it will take cooperation between and among multiple government agencies, professional organizations and non-profit agencies, as well as dental professionals, health and social service providers, child care providers, school personnel, public officials and others to increase access to oral health care for Maine children.

The conclusions and recommendations included below (see also pp. 19-21) can provide useful direction but will require financial support to implement and sustain them; the challenge of dental access for Maine's children will continue if this commitment cannot be made.

In reviewing activities within and outside of Maine, **the following conclusions emerge:**

- **Reimbursement rates need improvement. Incentives should be considered, particularly for high volume MaineCare providers who offer comprehensive care for children.** *Maine currently ranks 38<sup>th</sup> in dental reimbursement.*
- **Prevention programs need to be encouraged and supported. These programs are a viable way to reach underserved populations, to reduce the incidence and prevalence of oral and dental diseases, and to contain and reduce costs associated with the treatment of disease. Prevention programs focus on changing personal oral health behaviors as well as community factors and environmental influences.** *Prevention programs benefit people of all ages, but can be of particular benefit for young children and pregnant women.*
- **Concerns about the distribution and adequacy of the dental workforce must be addressed along with any considerations of enhancing initiatives for children's oral health care.**
- **The involvement of primary medical care providers should be considered as key in the delivery of preventive oral health services for children.** *Children are more likely to see primary health care providers at earlier ages than they usually see a dental provider. Primary health providers can provide education for parents, conduct risk assessments, offer preventive interventions such as fluoride varnish applications and make appropriate referrals to dental providers. Primary medical care providers in 32 states are allowed to perform reimbursable services such as applying fluoride varnish and sealants.*

**Recommendations:** Table II (p.12) lists strategies that we feel have potential for Maine, provided there are adequate financial resources to support them. To improve the oral health of Maine's children, the following actions are recommended as having potential for increasing access to dental care for Maine's children and improving their oral health. Many of these recommendations are based on successes or notable progress in other states, or build on activities and initiatives underway here in Maine. DHHS recommends that state government, the legislature and interested parties individually and/or collaboratively pursue the following:

1. **Investigate an enhanced payment for dental providers with a disproportionately high volume of MaineCare members on their patient panels.** This helps to maintain the provider base and to assure access for children in areas where there are clearly demonstrable needs.

2. **Improve reimbursements and prioritize improved reimbursements.** The MaineCare Dental Program's reimbursement schedule should be increased to reflect a meaningful level of payment in terms of the costs of providing care. This is crucial in order to increase provider participation as well as to prevent further deterioration of the provider base. Once increased, fees need to be maintained with regular adjustments to account for inflation. Ongoing attention should be paid to further reducing and streamlining administrative procedures and paperwork that have been recognized as barriers to initiating and sustaining provider participation.

3. **Consider using some of the limited 10% SCHIP administrative funds for dental sealant or other preventive services programs for at-risk children.** Sealants are proven in their effectiveness. Other preventive measures, such as the use of fluoride varnish, are also effective when they are integrated into ongoing programs.

4. **Prioritize risk assessment, screening, and examinations for young children and anticipatory guidance for parents.** Permit physicians, physician assistants, and nurse practitioners to deliver and receive reimbursement for preventive oral health services, including fluoride varnish, to MaineCare members with an emphasis on those up to 3 years of age.

5. **Extend coverage for preventive and routine restorative services to pregnant women over age 21.** Pregnant women who have access to preventive services are more likely to have better oral health through their pregnancies; better pregnancy outcomes that are in turn more likely to result in healthier infants; reduced risk of premature and/or low birth weight deliveries, and better understanding of how to promote good oral health in those infants. Transmission of the bacteria that causes tooth decay is likely to be delayed when pregnant women have better access to preventive services and receive oral hygiene instructions for themselves and their babies.

6. **Support changes that maximize the effectiveness of all dental professionals,** and work to facilitate the role that hygienists can play in the treatment of at-risk young children.

7. **Direct resources specifically to supporting key community prevention and intervention strategies for oral health,** such as school-based oral health education, dental sealant programs, early education and intervention programs for young children and their parents, general community oral health education, and community water fluoridation.

## **I. Background**

For many people in Maine, particularly low-income children and adults, finding access to affordable dental care has become a serious financial and logistical challenge. The problem of access to oral health services is complex, and well documented. Maine residents who are MaineCare members, without insurance, or those who are unable to pay in full for services at the time they are provided, often have particular difficulty finding a dentist who will treat them.

Through MaineCare, DHHS provides coverage for preventive, diagnostic, and treatment and restorative oral health services to all MaineCare children. In March 2007, there were 115,132 children under age 19 enrolled in MaineCare; of these, 37,087 were under age six. Coverage, however, does not necessarily guarantee access to services. Many families have to travel significant distances in order to get the care they need. For dental services, this added challenge can be particularly acute. A significant obstacle to obtaining dental care in Maine is the apparently insufficient number of dentists in the state, and their geographic distribution. (See Attachment I for further discussion of workforce issues.)

During SFY 07, DHHS provided reimbursement for dental services provided to 60,992 children and 22,333 adults. Payments totaled \$27,561,737, including those services provided in Federally Qualified Health Centers (FQHCs), which are paid on a cost-reimbursement basis.<sup>1</sup> Dental care was provided via several settings, identified as follows:

Table I. Provider type and number and number of MaineCare members  
receiving dental services in State FY 2007.<sup>2</sup>

<b>Provider type</b>	<b>Number</b>	<b>MaineCare members served</b>
Private practice dentists	201	33,449
Dental hygienists (preventive services only)	11	7,141
Private non-profit dental clinics	9	19,480
FQHCs	9	11,987

Oral health is important for all children, and oral disease – poor oral health – is consequential. Children with untreated oral disease experience pain and infection, will be distracted from normal activities including learning, may miss school, and may need hospitalization and surgical intervention. They may also experience speech and eating dysfunctions and growth delay. Nationally, 22% of US children lack dental insurance – triple the proportion lacking health insurance. Having insurance is no guarantee of receiving services, but generally individuals with insurance are more successful in obtaining health care. In Maine, as a rural state, we need to be cognizant that rural children are less likely to have dental insurance than urban children, and as a relatively poor state, we need to remember that children in poverty are less likely to receive preventive dental care independent of insurance coverage. According to a national study, over 50% of all children younger than age 5 did not see a dentist in the prior year.<sup>3</sup>

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<sup>1</sup> From DHHS presentation to the Joint Committee on Health & Human Services, October 30, 2007

<sup>2</sup> From DHHS presentation to the Joint Committee on Health & Human Services, October 30, 2007

<sup>3</sup> Liu J, Probst J, et al. Disparities in Dental Insurance Coverage and Dental Care Among US Children: The National Survey of Children's Health. *Pediatrics Supplement*. 2007;119:S12-S28.

We are unable to quantify the number or proportion of children not eligible for MaineCare but who are underinsured or uninsured and unable to access dental care, whether on a regular, ongoing basis or in more acute circumstances. There are between 13,000 and 14,000 children born annually in Maine, so by extension we might estimate that (without regard to their insurance status) some 30-35,000 Maine children younger than age 5 have not yet had a dental visit. Attachment II provides limited data to describe the oral health status of some Maine children.

During the past decade and longer, many groups have spent much time and effort trying to better manage and resolve issues around dental access. These include but are not limited to DHHS staff, the MaineCare Dental Advisory Committee, the Maine Dental Access Coalition, the Maine Dental and Dental Hygienists' Associations, the Maine Primary Care Association, and a number of private foundations. Most recently, on September 14, 2007, Governor Baldacci signed an Executive Order establishing the Task Force on Expanding Access to Oral Health Care for Maine People. The Task Force is charged to develop recommendations for "short-term and long-term solutions to expand access to high quality oral health care programs for all Maine citizens," particularly children, the elderly, the underinsured and the uninsured, and to identify existing barriers to access and provide recommendations for removing those barriers and for expanding access to adequate oral health care for Maine citizens. The Task Force includes a representative of DHHS (from the Office of MaineCare Services), and staffing assistance is being provided by the Oral Health Program in the Maine Center for Disease Control. A list of Task Force members and a matrix displaying the issues they identified at their first meeting are included as Attachment III to this report.

Specific activities undertaken by DHHS, with involvement by the MaineCare Dental Advisory Committee, have revolved around streamlining and enhancing processes and procedures within the MaineCare program. Continuing financial constraints have generally precluded any substantial changes in reimbursement rates, although some have been adjusted during the past several years.

Challenges for the MaineCare program revolve around two central issues – that MaineCare reimbursement rates are inadequate and that the supply of dentists in Maine is inadequate to meet the demand for services. Related to these are the following observations<sup>4</sup>:

- The participation rate in MaineCare by general dentists in private practice is about 30% (based on SFY07 claims data). It is important to note that many dental practices are effectively closed to new patients, regardless of their insurance status; those that are not closed may be taking very few new patients at any given time.
- The provision of preventive services has increased, with about 41% of members receiving such services, but treatment/restorative services remain low at just under 14%.
- Anecdotal reports indicate a perception that MaineCare members miss appointments more frequently than patients covered by other insurers or who pay out-of-pocket (MaineCare members cannot be billed for no shows).

A **presentation to the HHS Committee** on October 30, 2007 focused on dental issues as part of the Committee's review of MaineCare between the 1<sup>st</sup> and 2<sup>nd</sup> sessions. This presentation included representatives from DHHS, the Maine Dental Association, the Maine Dental Access Coalition and Maine Equal Justice Partners. The DHHS presentation described recent system changes and enhancements in the MaineCare Dental Program (as noted above), and indicated priority areas for future financial investments (noted below in section IV). The remarks offered by the Maine Dental

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<sup>4</sup> From DHHS presentation to the Joint Committee on Health & Human Services, October 30, 2007



Association noted the integration of oral health into overall health, workforce concerns (including the supply of dentists and changes in scope of practice for dental hygienists and assistants), the inadequacy of a dental “safety net” and lack of equivalent to a medical emergency room and the importance of prevention efforts, as well as reimbursement issues.

## **II. Current Activities and Initiatives – National Perspective:**

Nationally, many states face similar issues. This section of the report is included to allow comparison to other states and provide a larger context for activities and concerns in Maine. Examples that may be useful to Maine are noted here.

In January 2007, the Council of State Governments issued a report summarizing trends in state level public health legislation,<sup>5</sup> and includes a chapter focused on oral health legislation introduced in 39 states during 2006. Enacted measures deal with appropriations for dental services, licensure requirements for dental professionals, access to dental care services, Medicaid reimbursement rates, and scope of practice for dental hygienists. During 2006, of 16 states where bills were introduced, 10 states enacted legislation to increase Medicaid provider reimbursement. Appropriations in several states allocated funds to maintain funding for previously established dental programs or service levels, but several approved funding for new programs or services. Often related to appropriations bills were measures that intended to increase access to oral health services, and/or that increased Medicaid provider reimbursement. An update was issued in August of 2007.<sup>6</sup> Examples of these measures are listed in Attachment IV.

The August 2007 report also summarized legislation related to the dental professional workforce:

In their aim to improve dental healthcare, legislators have attempted to expand the pool of available dentists by establishing new programs, restoring previously cut Medicaid services, and increasing reimbursement rates; they have also attempted to provide more dental services to low-income citizens or those in underserved areas by increasing the scope of practice for dental hygienists. The number of bills introduced on this topic nearly quadrupled from 2006 to 2007.

Scope of practice issues are discussed throughout this report, and specifically in Section III.

In April 2007, the National Academy for State Health Policy published a policy brief entitled “Improving Oral Health Care for Young Children.”<sup>7</sup> The paper examines the challenges that must be addressed in the policy, financing, and workforce arenas to improve access to oral health care for young children. In addition to enumerating these challenges, this paper describes promising models of care and discusses options for policy makers seeking to improve access to oral health care for young children. We found that this paper presented a useful summary of the kinds of options that Maine might consider that would support improving children’s oral health and access to care. The paper is clear that to serve more young children involves a multitude of challenges, noting that nationally “the current system of financing and delivering dental care is fragmented and inadequate

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<sup>5</sup> Trends in State Public Health Legislation, January 1, 2006 – December 31, 2006. Issued January 12, 2007. Report completed for the Council of State Governments by the Health Policy Tracking Service, a service of Thomson West ([www.healthystates.csg.org](http://www.healthystates.csg.org)).

<sup>6</sup> Trends in State Public Health Legislation, Status of 2007 Legislative Activity, 2007 Mid-Year Report. Issued August 8, 2007. Report completed for the Council of State Governments by the Health Policy Tracking Service, a service of Thomson West ([www.healthystates.csg.org](http://www.healthystates.csg.org)).

<sup>7</sup> Improving Oral Health Care for Young Children. Shelly Gehshan and Matt Wyatt. National Academy for State Health Policy, April 2007. Publication No. 2007-203. [www.nashp.org](http://www.nashp.org)

even without expanding the target population.” Furthermore, the authors suggest that “Part of the challenge in serving high risk young children is that Medicaid dental programs don’t work very well, despite many state efforts to improve them,” and continues:

There are too few dentists willing to accept Medicaid and many who do limit the number of Medicaid patients they see. Dentists are reluctant to become Medicaid providers because reimbursement rates are often below the cost of providing the service, paperwork and preauthorization burdens are onerous, and payment is slow. In addition, care-seeking behavior among Medicaid recipients is spotty and the no-show rate for dental appointments is high.

Noting that after the question of financing comes the “critical question” of who can provide that care, the paper cites “ample evidence for concern that there aren’t enough practitioners to care for young children now, let alone if more seek care.” Although not all parties agree there is currently a shortage of dentists, there is agreement that there aren’t enough who treat publicly funded and special needs patients. Similarly, not all parties agree that there will be a shortage of dentists as the number of dentists retiring begins to exceed the number graduating dental school and starting to practice, expected by many to begin in 2014.

Maine is working on issues around the supply of dentists, as described below in Section III; we also have dentists supported by the National Health Service Corps and a separate state loan repayment program administered by the Finance Authority of Maine. (See Attachment V for a general description.) Maine’s Dental Education Loan and Loan Repayment Program, funded through the Fund for a Healthy Maine, has 12 slots for dental students receiving loans and dentists who receive repayment. The program is full and has more applicants than can be funded within the current legislative allocation. For all of these programs, there is a service obligation that means that the dentist must see all patients regardless of their ability to pay, which means having a sliding fee scale for those who have no insurance and accepting MaineCare members.

Along with concerns about the supply of dentists, scope of practice and supervision issues for dental auxiliaries (hygienists and assistants) are factors in considerations of expanding access to dental care for young children. The NASHP paper notes that Bright Futures, the federal guide to best practices, indicates that oral health care for young children needs to include risk assessment, screening, examinations, and anticipatory guidance for parents and that all of these can be provided by dental hygienists. But when restorative treatment is needed, it must be provided by dentists. So as effective as it may be to have hygienists practicing regularly in public/public health settings such as schools, Head Start centers, or school-based clinics in terms of preventing dental disease, there must also be a system of identifying and referring to dentists those children who need restorative care. There is also concern that children have an identified dental home, a source of regular and comprehensive dental care, and that they not simply be referred to dentists when a need for treatment is identified and has become acute.

The NASHP paper describes changes in state dental practice acts. Hygienists in many states, including Maine, can provide preventive dental services without the patient first being seen by a dentist, in public health settings such as schools, clinics, Head Start programs, and others.

When services are provided by a dentist that could be provided by a hygienist, or only when a dentist is present, the cost of providing care is higher than it needs to be and care is less easily available. Hygienists are a key first line of defense in prevention of dental caries, patient and family education, and screening for problems a dentist must address. Expanding their ability to provide preventive hygiene services in public health settings is a good upstream strategy to save states

money in Medicaid and SCHIP programs that is now spent downstream on dental restorative services.

The role of hygienists continues to evolve, with ongoing refining of definitions of the services they can provide in public health and non-traditional settings. Dental hygienists can provide a range of preventive services but cannot diagnose, interpret x-rays, or provide restorative treatment. The value of preventive services has been widely documented; preventive interventions, including early and routine preventive care and dental sealants, are cost-effective in reducing the burden of dental disease and associated expenses.<sup>8</sup>

State dental practice acts have also changed scopes of practice for dental assistants, who after receiving additional training may provide certain procedures with less supervision. The NASHP paper comments:

Expanded Function Dental Assistants (EFDAs) are licensed and in practice in 17 states. They work under the direct supervision of a dentist to prepare or finish up restorations, take x-rays, apply sealants and fluoride varnishes, and polish teeth... EFDAs can greatly expand the productivity of dentists and make serving Medicaid and SCHIP patients more profitable.

Maine passed legislation in 2005 authorizing the development of EFDAs pending the implementation of an accepted training program, which was initiated in the fall of 2007 at York County Community College. It is not expected that EFDAs will provide services in non-traditional settings (i.e., outside the usual dental office). Their immediate value is their potential to increase the efficiency and productivity of the dental practice and thereby allow more patients to be seen.

In recent years, there has been a move toward the involvement of primary medical care providers in the delivery of preventive oral health services for children, sometimes with Medicaid reimbursement. In some cases, this has evolved through grant-funded programs involving dental schools; in other instances, programs have been initiated at the state level. Pediatric medical providers often see infants, very young children and their parents/caregivers many times before the age of three for immunizations and well-child care.

Pediatric providers, particularly those who see low-income, minority and other high-risk families, could make a sizable impact in screening, oral health education, prevention and disease suppression, and identifying and referring to dentists those children who need restorative care... There are a number of issues that need to be addressed when incorporating medical professionals into oral health care delivery. Not all state medical and dental practice acts permit it, additional training is generally necessary, referral mechanisms between medical and dental sites are needed, and reimbursement from Medicaid or other payers must be arranged.<sup>9</sup>

In Maine, there is increasing interest in expanding this kind of involvement. Few of Maine's general dentists have additional training in pediatric dentistry procedures, creating a shortage of dentists who are prepared to treat very young children. Primary health care providers increasingly recognize the importance of early dental disease prevention strategies for very young children, and the role that they can play in promoting oral health for their young patients. As noted by many, and also reflected in the actions recommended by the Surgeon General's *Call to Action*, a follow up to the landmark report,

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<sup>8</sup> Children's Dental Health Project Policy Brief, "Cost Effectiveness of Preventive Dental Services" February 23, 2005 <http://www.cdhp.org/CDHPPubs/IssuePolicyBriefs.asp>

<sup>9</sup> NASHP, 2007, op. cit.

*Oral Health in America*, changes in the delivery of oral health services are necessary to meet current and emerging needs of underserved geographic areas and populations.

Several initiatives are described in the next section. The Maine Oral Health Program and the Sadie & Harry Davis Foundation have particular interests as noted below, and are compiling a matrix of states' actions relative to reimbursement of non-dental providers for certain preventive dental services, particularly the provision of fluoride varnish.

The following table displays potential strategies identified from the NASHP paper along with others identified through internal discussions within DHHS, noting fiscal impact, responsible parties, current Maine status, and status in other states. Attachment VI provides the full Findings section from that paper, which may be accessed at [www.nashp.org/Files/Improving\\_Oral\\_Health.pdf](http://www.nashp.org/Files/Improving_Oral_Health.pdf).

Following the table are descriptions of initiatives and activities underway in Maine that incorporate some of the strategies as summarized in the table. Some of these are further along in development than others.

The Department's conclusions and recommendations are presented following those descriptions, starting on page 19.

Table II. Summarized Oral Health Access Initiatives Derived from Internal Strategy Sessions within DHHS and from April 2007 “Improving Oral Health Care for Young Children” Report by the National Academy for State Health Policy ([www.nashp.org/Files/Improving\\_Oral\\_Health.pdf](http://www.nashp.org/Files/Improving_Oral_Health.pdf))

<b>Strategy (with comments)</b>	<b>Fiscal Impact</b>	<b>Responsible Party(ies)</b>	<b>Current Maine Status</b>	<b>Other States/ comments</b>
Extend preventive and routine restorative dental services to pregnant women over age 21.	Yes	OMS	No	Some
Allow fluoride varnish application as a reimbursable service by medical providers.	Yes	OMS	No	Yes (17 states +)
Protect EPSDT services as a traditional Medicaid benefit, rather than electing one of the four allowable benchmark packages available to states, which would add a burden to MaineCare members and providers and serve as a barrier to access. Rather, enhancements to the Medicaid package should come as wraparound benefits.	No	OMS	Yes	Some
Protect SCHIP dental services that mirror EPSDT benefits. Imposing co-payments or benefit caps for SCHIP recipients will negatively impact access, create an undue burden on providers (thus discouraging providers from participating in MaineCare), and reduce costly but critically necessary restorative care. Seven states cap benefits and 11 require co-pays for dental restorative services.	No	OMS	Yes	Yes, 39 states including Maine
Investigate an enhanced payment for providers with disproportionately high volume MC members on patient panel.	Yes	OMS	No	Unknown
Consider using some of the limited 10% SCHIP administrative funds for a sealant program for at-risk children.	No?	OMS, MCDC	No	Yes; 3 states
Improve reimbursements: continue to work with the MaineCare Dental Advisory Committee to shift the current \$150 incentive payment to higher reimbursement rates for yet-to-be finalized procedures. Prioritize improved reimbursements, since overhead for dentists averages above 60%, and most dentists are sole proprietors in private practice, limiting their ability to accept Medicaid and SCHIP rates.	Yes, TBD	OMS	In process	Maine ranks 38 <sup>th</sup> in reimbursement rates for dental services
Prioritize risk assessment, screening, examinations, and anticipatory guidance for parents as outlined as best practices in Bright Futures, and promote these preventive efforts by increasing school-based and day care oral health programs/hygienists.	Yes	OMS, MCDC, public & private non-profit oral health programs	To some degree	Yes



### **III. Current Activities and Initiatives – Maine:**

#### **A. Current Programs and Efforts**

As noted above, the Office of MaineCare Services has worked consistently over many years to implement, refine, and sustain systems enhancements to the Dental Program. Absent sufficient funding for significant changes in reimbursement rates, DHHS has focused on changes in policy, processes and procedures, recognizing that these changes are also necessary to improve the Dental Program, and can help to sustain gains that might be realized with increased reimbursement.

The Maine CDC's Oral Health Program administers a long-standing school-based/school-linked oral health education program (SOHP) in eligible Maine elementary schools that incorporates classroom-based preventive education for all children in participating schools, a weekly fluoride mouthrinse component for children with parental permission, and for the last 10 years, a dental sealant program for second-graders. School eligibility for the SOHP is determined by a formula that includes the proportion of students eligible for the Free & Reduced Lunch Program and for MaineCare, as well as the proportions of the community receiving fluoridated public water and whose family income is at the federal poverty level. In this way, the SOHP is directed toward those communities and schools where children are more likely to have problems accessing dental services, since socio-economic status is directly related to the ability to obtain dental care.

Grants are made to schools, school districts and some community agencies on behalf of groups of schools, using funds available to the OHP from the MCDC's General Fund allocation. The OHP also uses an internal allocation from the state match to the federal Maternal & Child Health Block Grant to support the SOHP. For the school year that ended in June 2007, there were 79 grants for local programs in 242 schools, involving 45,146 students in grades K-6. Of these, about two-thirds participated in the weekly fluoride mouthrinse program; the mouthrinse is purchased directly by the OHP. About 125 schools participated in the SOHP dental sealant component in the last school year, and about 1400 children, mostly second-graders, received sealants (an average of 3.25 sealants each). The total expended for this program during FY08 is just over \$251,000, or an average of \$5.56 per child. The school grants are calculated at approximately \$3 per capita and the sealant awards at \$30 per capita. However, further expansion of the SOHP and the sealant program is likely to be limited by available funding. The OHP is enrolled as a billing provider with MaineCare and has been able to bill for dental sealants on a limited basis. Revenue funds existing programs. The OHP is also looking at obtaining federal Medicaid match funds for the SOHP, but it is unclear if any revenue generated will return to the OHP or if it will revert to the state General Fund.

During the 2006 legislative session, a proposal to include an oral health screening in school entrance health screenings was heard by the Education Committee and funded at \$25,000 annually. DHHS and the Department of Education co-convened a task force to develop definitions and explore models for school entrance oral health screenings, with a referral component. Due to a variety of constraints and extenuating circumstances, implementation has been delayed but the project should be in place by the end of SFY08.

With the development of Public Health Supervision Status (PHS) for dental hygienists in Maine, several private, non-profit organizations have developed that provide preventive dental hygiene services in public health and community settings (among them schools, Head Start centers, WIC programs, and child care programs). The numbers of hygienists utilizing this status varies from time to time and has ranged from as few as 35 to 65 or more at any given point in time. Some work regularly with the agencies just mentioned; others work intermittently with schools to provide dental sealants

through the state-sponsored School Oral Health Program; some use PHS to participate in one-time community events such as health fairs. The availability of PHS has facilitated access to preventive oral health care for many Maine children (and adults) who otherwise would have had great difficulty accessing that care. As noted at the beginning of this report, in Table I, during SFY 07, 11 hygienists provided services to over 7,000 MaineCare members. These numbers only begin to estimate the reach of hygienists practicing in PHS status. It should be noted that Maine's rules for this type of practice are among the most liberal in the country.

## **B. New Activities and Initiatives**

1. **The Maine Oral Health Improvement Plan** provides a framework for the improvement of state and local policies for oral health and increased public awareness of the inseparable connection between oral health and overall health and well-being. (A copy of the Plan is provided with this report, and it may be accessed via [www.mainedentalaccess.org](http://www.mainedentalaccess.org) or [www.mainepublichealth.gov](http://www.mainepublichealth.gov).) The Plan has 13 goals, organized within four Key Action Areas, each with a guiding principle:

### ***A. Change Perception and Increase Awareness***

Guiding principle: Define and support state and local policies by increasing public understanding of the value and importance of oral health to overall health and to promote optimal oral health for the people of Maine.

Goal 1. Inform Policy Makers and Elected Officials

Goal 2. Increase General Public Awareness <sup>†</sup>

### ***B. Increase Prevention and Expand Access***

Guiding principle: Increase population-based prevention, early intervention programs and expanded access to high quality oral health services for Maine people throughout the lifespan.

Goal 3. Expand Prevention Programs in Schools and Communities <sup>†</sup>

Goal 4. Promote Dental Care for Pregnant Women <sup>†</sup>

Goal 5. Ensure Early Childhood Preventive Care <sup>†</sup>

Goal 6. Use Non-Traditional Settings and Innovative Approaches to Reach Underserved Groups <sup>†</sup>

### ***C. Improve Service Delivery***

Guiding principle: Enhance oral health partnerships and infrastructure to improve the knowledge base of all health providers and assure the delivery of quality services.

Goal 7. Improve Current System Infrastructure <sup>†</sup>

Goal 8. Increase Oral Health Knowledge Base

Goal 9. Provide Evidence-Based Evaluation

Goal 10. Increase Partnerships <sup>†</sup>

### ***D. Expand the Dental Workforce***

Guiding principle: Expand the capacity and ability of the dental workforce to provide access to cost-effective, high quality oral health services for all Mainers.

Goal 11. Redefine and Expand Roles of Dental and Medical Professionals <sup>†</sup>

Goal 12. Recruit and Retain Dental Professionals <sup>†</sup>

Goal 13. Expand Breadth and Diversity of Education Available To Oral Health Professionals <sup>†</sup>

<sup>†</sup> = goals with strategies likely to have associated activities that would impact children's oral health care

These goals and their associated strategies can be related to varying extents to the strategies in Table II. Two of the Plan's goals specifically mention MaineCare. The first appears in Key Action Area B, Increase Prevention and Expand Awareness. Prevention programs are a viable way to reach underserved populations and to reduce the incidence and prevalence of oral and dental diseases, and focus on changing personal oral health behaviors as well as community factors and environmental



influences. Preventive care is inexpensive compared to the treatment costs associated with these diseases. Providing education and early preventive interventions for children reduces the future demand for dental services; in addition, however, community involvement is necessary in order to build support for those interventions.

The first MaineCare related goal stated in the Plan is “Promote Dental Care for Pregnant Women.” Pregnant women who have access to preventive services are more likely to have better oral health through their pregnancies, better pregnancy outcomes that are in turn more likely to result in healthier infants, and better understanding of how to promote good oral health in those infants. Transmission of the bacteria that causes tooth decay is likely to be delayed when pregnant women have better access to preventive services and receive oral hygiene instructions for themselves and their babies. The Plan suggests a number of strategies for this goal, including evaluating expanding MaineCare coverage for pregnant women past the 21<sup>st</sup> birthday as well as the feasibility of adding uninsured pregnant women to MaineCare priorities for dental care.

Status: LD 282, proposing expansion of MaineCare benefits to provide coverage for preventive and routine restorative care for pregnant women over age 21 was heard in the 1<sup>st</sup> regular session of the 123<sup>rd</sup> Legislature by the Joint Committee on Health & Human Services. It sent the bill to the Appropriations Committee for consideration; the Appropriations Committee returned it to the Committee, which voted it Ought Not to Pass. Nevertheless, it is expected that other efforts will address oral health education of pregnant women.

The second specific mention of MaineCare appears as a strategy in Key Action Area C, Improve Service Delivery. The Plan suggests that oral health services can be delivered more effectively and with maximum quality by enhancing partnerships and collaborations within the existing oral health infrastructure, while utilizing current professionals both in innovative ways and to the maximum of their education, training and abilities. Goals and strategies here intend to support efforts to examine the current infrastructure to improve delivery systems, determine the unmet needs of specific population groups, and to expand public and non-profit community-based oral health services to better serve the oral health needs of all population groups. Under the goal “Improve Current System Infrastructure,” the following strategy is included: “Work with the Office of MaineCare Services, the Public Health Work Group, and others to support improvements in the processes of, enhancements to, and incentives in the MaineCare Dental Program that may increase access to dental services such as, but not limited to, reviewing and adjusting reimbursement rates.”

Status: A review and the potential adjustment of MaineCare reimbursement rates are important to the potential of expanding access to dental services because of the likelihood of increasing dental provider enrollment and participation. Other states have seen such changes after adjusting rates. It is important to note that these kinds of changes tend to be relatively short-lived when rate increases are implemented without accompanying system changes and other supporting activities. At the same time, however, these changes are also necessary to improve the MaineCare Dental Program and can help to sustain gains that might be realized later with increased reimbursement. The involvement of the Work Group and others is also important for increasing and enhancing a broader understanding of the importance of oral health to overall health. Strategies within this Action Area can include support for reimbursement for non-dental health providers for certain preventive oral health services. A number of activities have been initiated by various parties that respond to the strategies summarized in Table II, as well as others described in the Oral Health Plan. The stakeholders involved in the Plan’s development will be responsible for pursuing strategies that are consistent with their missions and

goals, working together when appropriate. Progress will be monitored by the Maine Dental Access Coalition ([www.mainedentalaccess.org](http://www.mainedentalaccess.org)).

2. As noted above, the **Governor's Task Force** on Expanding Access to Oral Health Care for Maine People was established by Executive Order in September 2007 and convened in November; a list of Task Force members and a matrix displaying the issues they identified at their first meeting are included as Attachment III to this report.

3. Several proposals dealing with **scope of practice and regulation issues** were heard by the Committee on Business, Research, and Economic Development during the 1<sup>st</sup> Regular Session of the 123<sup>rd</sup> Legislature.<sup>10</sup> All were directed into a Sunrise Review process now underway by the Department of Professional and Financial Regulation, with a report due to the BRED Committee in February of 2008. The report and the Committee's response will also inform the work of the Task Force. Maine's Dental Practice Act already allows for dental hygienists to practice in what is called Public Health Supervision status, which facilitates hygienists providing preventive services in public health settings without the on-site presence of a dentist. Evolving since the mid-1990's, this status was formalized in 2001. Maine is seen as a leader in this regard, as noted previously.

4. Also developed at the state level is the 2007 update to "*Invest Early in Maine: A State Plan for Humane Early Childhood Systems*," a product of Maine's **Early Childhood Initiative** (ECI) and the First Lady's Task Force on Early Childhood. It notes the addition of oral health as an area needing attention and integration. To that end, a full set of strategies have been added to the 2007 update, under the heading "Maine Children Birth to 3½ Years Will Receive Comprehensive, Preventive Oral Health Care." The section's objectives are to reduce the incidence of dental disease among Maine's children; to increase the number of children 0-3 ½ years who receive preventive oral health care; and to eradicate the fallacy that parents don't want dental care for their children. Many of the strategies in this section (see Attachment VII) correspond to the goals and strategies of the State Oral Health Improvement Plan and to the objectives of the following initiatives.

5. In September 2007, the Oral Health Program of the Maine CDC received notification of federal funding for a new project, the **Maine Preventive Oral Health Partnerships Project** (MPOHPP). The goals of this four-year project are to:

- A. Educate, build awareness and integrate oral health into existing health delivery systems
- B. Enable non-dental providers to better recognize and understand oral diseases and conditions
- C. Enable non-dental providers to better engage in anticipatory guidance, preventive interventions, and appropriate referral for improved oral health and oral health access

The Oral Health Program (OHP) will work collaboratively within this project and with other partners to bring together existing resources and relationships, toward improving the oral health of young children and integrating oral health initiatives into overall health care. The Project will focus its activities in two major areas: the promotion, implementation and evaluation of "Maine Smiles Matter," a curriculum developed for non-dental health professionals to enhance their skills in early oral health education and dental disease prevention; and efforts to increase and support collaborative networks throughout Maine to promote effective relationships between medical and dental providers concerning the oral health of young children. Expected outcomes are that (1) more children will receive earlier

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<sup>10</sup> One bill proposed independent practice for dental hygienists; one proposed the development of a "mid-level" dental hygienist; another proposed changes in regulations around the licensure in Maine of foreign-trained dentists; and the last proposed a separate regulatory board for hygienists.

preventive care; (2) their parents/caregivers will have better access to appropriate education; and (3) dental and non-dental health providers will better coordinate their interactions so that children are referred appropriately. In the long-term (4) there will be a reduced demand for early restorative services as a result of early interventions and (5) a reduced incidence of dental disease in Maine's children.

6. In the private sector, the new Sadie and Harry Davis Foundation launched its early prevention oral health initiative, "**From the First Tooth**," in late July 2007. It is modeled closely on North Carolina's *Into the Mouths of Babes*, a program that trains medical providers to deliver preventive oral health services to high-risk children from the time of tooth eruption until age 3 (noted in Table II). The Foundation's goal is to reduce the incidence of dental disease among Maine children by increasing the number of young children ages 0-3½ who receive preventive oral health care by integrating early prevention oral health intervention into primary care medical practices and other settings where young children receive services. In its first two years, the Foundation will provide training and funding for five medical and social service organizations that represent the diversity of Maine's communities and regions. Support includes coordination by a dental hygienist and training for sites in risk assessment and fluoride varnish application procedures. The Foundation also plans to communicate with MaineCare and private payers regarding project impact, with the objective of demonstrating the effectiveness of prevention and early intervention, and gaining reimbursement for these interventions. Subsequent grantees will be selected through a competitive process.

7. The **Maine Chapter of the American Academy of Pediatrics (ME-AAP)** successfully competed for a Healthy People 2010 Grant from the national AAP's Friends of Children Fund, "Oral Health Risk Assessment in the Pediatric Practice." Starting in 2008, this two-year project will focus on training pediatricians and providing outreach and offering training to Early Head Start personnel in early oral health risk assessment. Recognizing that many children do not receive regular preventive oral health care and that there is a need to find different models for delivering these services, the ME-AAP plans to train other health professionals in oral health risk assessment. Their project will address this issue by facilitating the provision of such assessments in the places where children are, and complements both the MPOHPP and "From the First Tooth" in its intent to facilitate oral health assessments for infants and toddlers within pediatric practices and to connect pediatric practices with dental professionals.

8. Since access to dental care for children younger than 3 is problematic, **additional training and skills-building for dental professionals** to enable them to more readily meet the expected demand must also take place. Maine's Oral Health **Workforce Development Initiatives Project**, funded by a 3-year grant from HRSA's Bureau of Health Professions to the Oral Health Program and the Office of Rural Health and Primary Care in the Maine CDC, supports the development of a series of **continuing professional education** courses with a focus on 0 to 3-year-olds for general dentists and their staff. The first course, on dental disease risk assessment and behavior management for young children, took place at the end of October 2007. A second course will be co-sponsored with the Maine Dental Association at its annual meeting in June 2008. This federal grant also supports efforts to develop a coordinated, collaborative approach to the recruitment and retention of dental professionals, particularly dentists, to Maine, and provides support for the inclusion of a dental track in the Health Careers program at several of Maine's career and technical high schools.

#### **IV. Conclusions and Recommendations**

Maine has been consistent for many years in attempts to increase access to oral health services for children, to develop new initiatives, and in monitoring best and promising practices in other states. Much of what we see in other states has been discussed here and implemented to varying degrees. Absent sufficient funding for significant changes in MaineCare dental reimbursement rates, DHHS has focused on changes in policy, processes and procedures, recognizing that these changes are also necessary to improve the Dental Program, and can help to sustain gains that might be realized with increased reimbursement. Absent other significant funding, other programs have developed and have grown slowly. Until the completion of the Maine Oral Health Improvement Plan in November 2007, there has been no comprehensive plan to offer the coordinated vision of a long-term and comprehensive approach.

Table II (p.12) lists strategies that we feel have potential for Maine, provided there are adequate financial resources to support them. These strategies have potential for increasing access to dental care for Maine's children and improving their oral health. For a number of these, there is likely to be a fiscal impact that may preclude implementation in the near future. At the same time, the Department suggests that state government can maximize its role as a partner with the private sector and other interested parties to support further development of the types of programs and initiatives listed in the table and described elsewhere in this report. To the extent that they are implemented soundly and following evidence-based and best practices, providing coordinated and quality care to children, they are a good investment for all concerned and more likely to result in better health outcomes and lower health care costs.

In its presentation on October 20, 2007, DHHS told the Committee on Health & Human Services that it will continue to work on finding an effective plan for an incentive payment to dental providers, within existing resources. In addition, with any future financial investments, DHHS will further evaluate how private non-profit dental clinics (other than federally qualified health centers) may bill MaineCare such that reimbursement can reflect the treatment of a higher proportion of MaineCare members, and would support reimbursement of medical providers for fluoride varnish applications and the inclusion of dental benefits for pregnant women over age 21. Why these latter two options can result in better oral health and ultimately lower costs is briefly discussed here.

Link between primary care providers and oral health care providers: Children are more likely to see primary health care providers at earlier ages than they usually see a dental provider. Primary health providers can provide education for parents, conduct risk assessments, offer preventive interventions such as fluoride varnish applications and make appropriate referrals to dental providers. These interventions can be provided in the primary medical care setting by a number of health professionals, including physicians, nurses, nurse practitioners, physician assistants, and medical assistants, as well as by dental hygienists. Children who have their first preventive dental visit by age one are less likely to have ER visits or need restorative dental care, and their average dentally related health expenses are almost 40% lower over a five year period than children whose first preventive visit occurs after age one.<sup>11</sup> The inclusion of dental screenings and early preventive oral health interventions in routine preventive health care visits and providing reimbursement for those services would allow children more access to preventive care. Fluoride varnish is one of these interventions. Its use to prevent and

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<sup>11</sup> Children's Dental Health Project Policy Brief, "Cost Effectiveness of Preventive Dental Services" February 23, 2005 <http://www.cdhp.org/CDHPPubs/IssuePolicyBriefs.asp>

control dental caries in children is expanding in both public and private dental practice settings and in non-dental settings that incorporate health risk assessments and counseling. The US CDC and the American Dental Association recommend at least biannual applications at 6 month intervals as effective in controlling or reducing dental caries in primary or permanent teeth for moderate or high risk children.<sup>12</sup>

Expansion of prenatal care to include oral health services: A growing body of evidence suggests a link between oral health, particularly periodontal disease (gum disease) and adverse birth outcomes. Pregnant women who have poor oral health may be more likely to have preterm, low birth weight babies. Health care providers can assess the pregnant woman's oral health status, oral health practices, and access to a dental home; discuss with her how oral health affects general health; and offer assistance for referrals to oral health professionals for treatment if needed. Primary health care providers can also educate the pregnant woman about diet and oral hygiene for infants and children, and how to limit the transmission of the bacteria that causes tooth decay.<sup>13</sup> These actions are part of an assertive oral disease prevention strategy and can also help to improve overall health.

### Conclusions:

- ⇒ **Reimbursement rates need improvement. Incentives should be considered, particularly for high volume MaineCare providers who offer comprehensive care for children.**
- ⇒ **Prevention programs need to be encouraged and supported. These programs are a viable way to reach underserved populations, to reduce the incidence and prevalence of oral and dental diseases, and to contain and reduce costs associated with the treatment of disease. Prevention programs focus on changing personal oral health behaviors as well as community factors and environmental influences.**
- ⇒ **Concerns about the distribution and adequacy of the dental workforce must be addressed along with any considerations of enhancing initiatives for children's oral health care.**
- ⇒ **The involvement of primary medical care providers should be considered as key in the delivery of preventive oral health services for children.**

**Recommendations:** To improve the oral health of Maine's children, the following actions are recommended. Many of these recommendations are based on successes or notable progress in other states, or build on activities and initiatives underway here in Maine. DHHS recommends that state government, the legislature and interested parties individually and/or collaboratively pursue the following:

1. **Investigate an enhanced payment for dental providers with a disproportionately high volume of MaineCare members on their patient panels.** This helps to maintain the provider base and to assure access for children in areas where there are clearly demonstrable needs.

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<sup>12</sup> Fluoride Varnish: an Evidence-Based Approach. Research Brief published by the Association of State and Territorial Dental Directors, August 2007. [www.astdd.org/docs/Sept2007/FINALFlvarnishpaper.pdf](http://www.astdd.org/docs/Sept2007/FINALFlvarnishpaper.pdf).

Note: The U.S. Preventive Services Task Force document, *Prevention of Dental Caries in Preschool Children: Recommendations and Rationale*, rates preventive interventions by levels of efficacy and bases recommendations on these ratings. The ADA (2006) rates the quality of evidence for the efficacy of fluoride varnish in preventing and controlling dental caries in the primary teeth of high-risk children as HIGH and has strongly recommended its use.

<sup>13</sup> Oral Health and Health in Women: A Two-Way Relationship. [www.mchoralhealth.org/PDFs/WomensFactSheet.pdf](http://www.mchoralhealth.org/PDFs/WomensFactSheet.pdf) © 2004 by the National Maternal and Child Oral Health Resource Center, Georgetown University. [www.mchoralhealth.org](http://www.mchoralhealth.org)

2. **Improve reimbursements and prioritize improved reimbursements.** The MaineCare Dental Program's reimbursement schedule should be increased to reflect a meaningful level of payment in terms of the costs of providing care. This is crucial in order to increase provider participation as well as to prevent further deterioration of the provider base. Once increased, fees need to be maintained with regular adjustments to account for inflation. Ongoing attention should be paid to further reducing and streamlining administrative procedures and paperwork that have been recognized as barriers to provider participation.
3. **Consider using some of the limited 10% SCHIP administrative funds for dental sealant or other preventive services programs for at-risk children.** Sealants are proven in their effectiveness. Other preventive measures, such as the use of fluoride varnish, are also effective when they are integrated into ongoing programs.
4. **Prioritize risk assessment, screening, and examinations for young children and anticipatory guidance for parents.** Permit physicians, physician assistants, and nurse practitioners to deliver and receive reimbursement for preventive oral health services to MaineCare members with an emphasis on those up to 3 years of age.
5. **Extend coverage for preventive and routine restorative services to pregnant women over age 21.** Pregnant women who have access to preventive services are more likely to have better oral health through their pregnancies; better pregnancy outcomes that are in turn more likely to result in healthier infants; reduced risk of premature and/or low birth weight deliveries, and better understanding of how to promote good oral health in those infants. Transmission of the bacteria that causes tooth decay is likely to be delayed when pregnant women have better access to preventive services and receive oral hygiene instructions for themselves and their babies.
6. **Support changes that maximize the effectiveness of all dental professionals,** and work to facilitate the role that hygienists can play in the treatment of at-risk young children.
7. **Direct resources specifically to supporting key community prevention and intervention strategies for oral health,** such as school-based oral health education, dental sealant programs, early education and intervention programs for young children and their parents, general community oral health education, and community water fluoridation.

## Workforce Concerns

A significant obstacle to obtaining dental care in Maine is the apparently insufficient number of dentists in the state, and their geographic distribution. Data collected in 2006 by the Maine Office of Data, Research and Vital Statistics (ODRVS) showed 585 dentists actively practicing in Maine (of 627 licensees), resulting in a dentist to population ratio of one dentist to 2,552 residents, a significant difference from the U.S. ratio of one dentist for each 1,700 people. Of Maine's actively practicing dentists, 79% (464) were general practitioners, according to self-report of primary specialties. Of the dentists who reported specialty information, the next most frequently reported specialties - orthodontics (40 dentists) and oral surgery (32 dentists) – together represented just 12% of all dentists. Only 11 dentists reported pediatric dentistry as their specialty; several of these but not all have had specialty training.

Low dentist-to-population ratios in rural areas of the state compound the access problem. Many low-income families and individuals in rural areas have long been challenged to find a dentist accepting new patients, particularly one who will accept MaineCare. The 2006 survey indicates that while 86% of respondents are accepting new patients, only 49% treat MaineCare members, and 65% of those limit the proportion of MaineCare members in their practices; only 24% said they accept new MaineCare patients, and there is no information relative to the numbers of new patients accepted. Regardless of ability to pay, there are reports statewide of traveling significant distances to obtain care, or waiting a long time for routine appointments. This can be particularly problematic when specialty care is sought.

Of Maine's 46 Dental Care Analysis Areas, 37 have been federally designated as Dental Health Professional Shortage Areas (24 population designations, including two Indian reservations, and 13 service area designations), along with the two state-administered mental health facilities. However, two areas, those including the cities of Portland and Lewiston, where there are significant low-income populations, may no longer qualify and are expected to lose their designations. There are 23 private non-profit dental clinics in Maine (of which 11 are federally qualified health centers), three state operated clinics that serve behavioral health clients, and three Indian Health Services dental clinics; there are also a number of preventive dental services programs and two programs that rely on volunteer dentists and referral networks. These resources, however, are not well distributed throughout the state, and although there are dentists in all Maine's counties, there are areas where any access is very limited, regardless of ability to pay. However, in the past 5 to 7 years, the number of private non-profit clinics has effectively doubled, and two of the FQHCs recently hired pediatric dentists.

**Children's Oral Health Status\***

Maine State Smile Survey, 1999:

- 20% of children, grades K & 3, needed treatment (untreated decay)
- 31% of grade K and 45% of 3rd graders had a history of tooth decay
- 47% of 3rd graders had at least one sealant, and 57% needed at least one more

Maine Child Health Survey, 2003-04\*\*

- 15% of kindergartners and 17% of 3rd graders screened needed treatment
- 11% of kindergartners screened had never seen a dentist
- 27% of grade K and 41% of 3rd graders screened had a history of tooth decay
- 57% of 3rd graders screened had at least one sealant, and about 50% needed at least one more

\*These data are from surveys conducted by the ME CDC and represent statewide data, not only MaineCare members.

\*\*Due to a low response rate, the 2004 survey was not representative of all children – just those who were screened.

Maine data indicates that the need among Maine children is comparable to national estimates – about 20% of children have about 80% of the total decay and the need for care.

**Free and Reduced Lunch Participants**

- Had significantly poorer oral health
- More likely to have untreated dental disease
- More likely to be in need of sealants
- Less likely to have annual dental visits
- More likely to have dental insurance\*\*\*
- Experienced barriers in receiving care

\*\*\* It is likely most of these children were eligible for MaineCare dental coverage



**Governor's Task Force on Expanding Access to Oral Health Care for Maine****Members**

<i>Name</i>	<i>Representing (as per Executive Order)</i>
Anne Head, Chair .....	DPFR Commissioner or Designee, Chair
Brenda McCormick .....	DHHS Commissioner or Designee
Nancy Dube .....	DOE Commissioner or Designee
Jude Walsh .....	Governor's Office of Health Policy and Finance
Lisa Kavanaugh .....	Maine Dental Access Coalition
Jack Comart .....	Maine Equal Justice Partners
Gordon Smith/Dr. William Alto .....	Maine Medical Association
Mary Jude .....	Maine Primary Care Association
Michelle Gallant .....	Maine Dental Hygienists' Association
Paul Levasseur .....	Maine Society of Denturists
Jane Walsh .....	Graduate level educator, oral health education
Dr. Jeffrey Fister .....	Maine Board of Dental Examiners
William Lambrukos .....	Dental Insurance Company
Kathryn Johnson .....	Public Member
Bonita Pothier .....	Public Member
Dr. Mark Zajkowski/Dr. Jim Schmidt ....	Maine Dental Association
Sen. Nancy Sullivan .....	Maine Senate
Sen. Deb Plowman .....	Maine Senate
Rep. Nancy Smith .....	Maine House
Rep. Donna Finley .....	Maine House

Staff: Judith Feinstein, DHHS, ME Center for Disease Control & Prevention

## Oral Health Task Force Meeting 11/29/07: Summary of Issues, Information Needs and Possible Presentations

IDENTIFIED ISSUES OF INTEREST	INFORMATION NEEDS	WHY INFO IS NEEDED	EXISTING RESOURCES (existing data or source of info)	PRESENTATIONS/ presenters
Inappropriate/ineffective use of healthcare dollars	1. ER Data (utilization of ER for dental needs) 2. Dental Claims billed to health care system (more than Emergency Depts)	To demonstrate how much money is being spent not fixing a problem; look at how to estimate how much could be redirected	MaineCare data MHDO (MDAC has some recent data) Delta Dental	Written summaries with discussion (staff)
Dental school (and dental residency programs) in ME	More about how these are conceptualized, timelines, opportunities for collaborations	To support any recommendations for state support; coordination in planning; best use of limited \$\$ resources	UNE Delta Dental Penobscot Community Health Care	Dental School/residency concepts UNE Delta Dental Penobscot Community Health Care
Cooperative arrangements with dental schools elsewhere	1. Current utilization 2. Other states' experiences	To assess utility of developing these for ME	MDA MORHPC MPCA	Could be done with a written summary (staff)
Incentives for dental professionals to come to ME and to stay (R & R) <b>Note:</b> should address RDHs	1. What exists now in ME 2. 'Best' Practices elsewhere 3. Impact	To assess utility of developing these for ME	Task Force members	Could be done with a written summary (staff)
Dental Education Loan and Loan Repayment Programs (federal & state) <b>Note:</b> should address RDHs	List of all that are available, limits (\$\$), utilization	To support any recommendations for state support or other expansion	MORHPC FAME	Overview of programs MORHPC (Charles Dwyer) FAME (staff to be invited)
Workforce concerns: <ul style="list-style-type: none"> <li>Supply &amp; distribution</li> <li>Maximizing skills of existing professionals</li> <li>Development of new providers</li> </ul>	1. Current data 2. Current efforts 3. Development 4. New practice models	To support any recommendations for state support; coordination in planning; best use of limited \$\$ resources	MORHPC, OHP, MCDC FAME Board of Dental Examiners (BDE) MDA MDHA DPFR (Sunrise Review Report [ > Feb 08])	Overview of workforce development efforts MORHPC (Charles Dwyer) FAME (staff to be invited) Task Force members  Shelly Gehshan (NASHP – see presentation in TF notebook)

IDENTIFIED ISSUES OF INTEREST	INFORMATION NEEDED	WHY INFO IS NEEDED	EXISTING RESOURCES (existing data or source of info)	PRESENTATIONS/ Presenters
Integration of oral health with primary care	1. Current efforts and programs 2. More about how these are conceptualized, financed, and opportunities for collaborations 3. Insurance issues (limits, coverage, etc)	To support any recommendations for state support; coordination in planning; best use of limited \$\$ resources	Task Force members OHP MORHPC MPCA	Task Force members  Representatives of other programs in Maine (e.g., preventive hygiene programs, Sadie & Harry Davis Foundation)  Representatives of programs in other NE states if relevant or in written summary
Funding • Reimbursement (MC)  • Support for loan & repayment programs, matching programs, incentives	Compare “UCRs” for Maine with other NE states  1. What exists now in ME 2. ‘Best’ Practices elsewhere 3. Impact	1. To support recommendations for increased rates  2. To support any recommendations for state support; coordination in planning; best use of limited \$\$ resources	ADA 2007 Survey of Dental Fees (MDA has)  Data regarding utilization of existing programs in ME Summary data from other states	Written summary  Written summary

Key to acronyms:

ADA = American Dental Association DPFR = Department of Professional & Financial Regulation FAME = Finance Authority of Maine MC = MaineCare MCDG = Maine Center for Disease Control MDAC = ME Dental Access Coalition	MDA = Maine Dental Association MDHA = ME Dental Hygienists’ Association MHDO = ME Health Data Organization MORHPC = ME Office of Rural Health & Primary Care [MCDG] MPCA = ME Primary Care Association	NASHP = National Academy of State Health Policy OHP = Oral Health Program [MCDG] RDH = Registered dental hygienist R & R = Recruitment & Retention UCR = usual and customary rate UNE = University of New England
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### **Trends in State Level Public Health Legislation, Oral Health, 2006**

- Connecticut allocated \$2.95 million for FY 07 to enhance dental access under the HUSKY program, its children's state health insurance program (SCHIP)
- New Mexico allocated \$500,000 in FY 07 to expand Medicaid child dental programs.
- Colorado approved a 3.25% reimbursement rate increase for primary care providers, including dentists, beginning July 1, 2006.
- Georgia restored dental codes cut in the previous year's budget.
- Minnesota directed its Department of Health to "annually establish a reimbursement schedule for critical access dental providers and provider-specific limits on total reimbursement received..." and after January 1, 2007 to "increase payment rates to dentists and dental clinics deemed ...to be critical access providers by 50 percent above the payment that would otherwise be paid..."
- Virginia directed its Department of Medical Assistance Services and the Department of Health "to work with representatives of the dental community to expand the availability and delivery of dental services to pediatric Medicaid recipients and to streamline the administrative processes and to remove impediments to the efficient delivery of dental services."

From August 2007 update:

- North Dakota appropriated state and federal funds for two years (July 1, 2007 to June 30, 2009) to increase funding of children's dental services through the medical assistance program.
- New Mexico proposed to allocate \$100,000 to the Department of Health to contract with a non-profit company to provide dental services to underserved children at risk for dental disease.
- North Carolina proposed to allocate substantial funds for two fiscal years to provide dental services for "special care populations."
- Montana amended an existing statute by directing its Department of Public Health and Human Services to adopt rules allowing it to cover "significant dental needs" beyond those covered in the basic plan of the Children's Health Insurance Program.
- Mississippi adopted legislation in April 2007 to increase Medicaid reimbursement for dental services as an incentive to increase the number of dentists providing Medicaid services.
- As of August 2007 two bills were pending in North Carolina that would increase Medicaid reimbursement for dental services; a third would require Medicaid reimbursement for dental services at the same rate as for other medical services.

Legislation related to changes in the scope of practice for dental hygienists:

- North Carolina allows hygienists, under certain conditions, to perform specified duties without a dentist being physically present. One such condition is that the services be performed in areas identified or approved as "dental access shortage areas," such as rural or community clinics.
- Idaho authorized its Board of Dentistry to issue volunteer licenses to dental hygienists under certain conditions.
- New Mexico allows hygienists to administer fluoride treatments without supervision in public and community medical facilities, school, hospitals, long-term care facilities, and other approved settings.
- Virginia authorized dental hygienists administer topical fluorides pursuant to a written or oral order or a standing protocol issued by a dentist or a physician.
- Illinois had legislation pending that would allow dental hygienists, without the supervision of a dentist, to provide fluoride treatments, teeth cleaning, and sealants to children eligible under the state Medicaid program.

From: Trends in State Public Health Legislation, January 1, 2006 – December 31, 2006 (issued January 12, 2007); and Trends in State Public Health Legislation, Status of 2007 Legislative Activity, 2007 Mid-Year Report (issued August 8, 2007). Reports completed for the Council of State Governments by the Health Policy Tracking Service, a service of Thomson West ([www.healthystates.csg.org](http://www.healthystates.csg.org)).

**Maine Office of Rural Health and Primary Care  
Loan Repayment Programs Summary**

The Office of Rural Health and Primary Care (ORHPC), located in the Maine Center for Disease Control, assists in the administration of the Federal Loan Repayment Program and administers the State Loan Repayment Program. The Finance Authority of Maine (FAME) administers the Maine Dental Education Loan Repayment Program and the Maine Dental Education Loan Program.

The dental care needs as well as the mental health, and primary care needs of the State are reviewed periodically by this office to determine where the needs exist for increased services. Once areas in need of additional health professionals are identified, requests for designation of the areas are submitted to the federal Office of Shortage Designation for official action. Once an area has been designated as a Federally Designated Dental Health Professional Shortage Area (FDDHPSA), that area is able to compete for federal or state subsidy in the form of loan repayment for the recruited dentist.

These loan repayment programs offer monies to be used by a dentist to repay his or her undergraduate or graduate loans. The dentist must sign a contract agreeing to work 40 hours per week and agree to accept all patients regardless of the patient's ability to pay; must accept Medicaid patients; and must offer a sliding fee scale to those patients who are unable to pay full costs.

The Federal Loan Repayment Program offers \$25,000 per year for a minimum 2-year contract. Loan repayment money received is exempt from income taxes. The contract can be renewed for a third and fourth year for loan repayment of \$35,000 per year. This program is funded with National Health Service Corps monies.

The State Loan Repayment Program offers \$25,000 per year for a minimum 2-year contract. The dentist may enter into two single contracts for a total of four years (\$100,000). The dentist must also document that he or she has outstanding educational loans that amount to the requested payments and must claim the loan repayment monies as income on his or her tax forms. This program is funded with 50% National Health Service Corps monies and 50% matching state dollars provided by FAME (the source is Maine's tobacco settlement dollars).

The Maine Dental Education Loan Repayment Program does not require that the area being served be designated a FDDHPSA, but it must still be designated by the ORHPC as an area of need. This program offers \$20,000 per year for a minimum contract of one year that can be renewed up to four years for a total of \$80,000 of outstanding education loan debt. This loan repayment must also be included on income tax forms. This program is funded entirely by state dollars (the source is Maine's tobacco settlement dollars).

In addition, the Maine Dental Education Loan Program offers students from Maine who have been accepted to dental school forgivable loans of \$20,000 per year for up to 4 years if they agree to serve in areas of need in Maine after they complete their dental school education. Loan forgiveness is available at the rate of 25% per year for services and the loan recipient must provide dental services regardless of the patient's ability to pay. This program is also funded entirely by state tax dollars (the source is Maine's tobacco settlement dollars).

**Findings, “Improving Oral Health Care for Young Children,”** National Academy for State Health Policy, April 2007, pp 25-26. [www.nashp.org/Files/Improving\\_Oral\\_Health.pdf](http://www.nashp.org/Files/Improving_Oral_Health.pdf)

Policy makers at the federal, state, community, and organization level have many options to consider for improving oral health for young children. They can provide funding for services, focus on education of the dental workforce, ensure there is a workforce adequate to meet their needs, and enhance public health efforts.

### *Financing*

- States should consider reimbursing pediatric providers for oral health screening, prevention and education services, as several states now do with excellent results. This would provide early encounters with caregivers for families and children and open up opportunities to prevent dental caries.
- Congress should consider making dental services a mandatory benefit, and a required part of well child check-ups, in the reauthorization of the SCHIP in 2007. Since almost all states cover such benefits anyway, mandating dental benefits would allow states to build their programs and relationships with providers without interruption, and ensure that children get needed care.
- States should consider raising reimbursement rates for dental services in Medicaid and SCHIP to attract and retain dentists. At the very least, states should consider paying rates that are above what it costs to provide the service. Modestly higher rates have proven sufficient to persuade dentists to participate so that low-income, high-risk families have access to dental services.

### *Education*

- Federal and state governments should consider increasing funding for dental education, particularly for scholarships or loan repayment with a service obligation. The high cost of a dental education, and high debt levels among dental graduates, make it less feasible and likely that they will accept Medicaid and SCHIP when they establish practices.
- Dental and hygiene professional schools should consider ways to diversify their student body, and teach cultural and linguistic competence. Diversity and cultural competence make care more accessible to those who need treatment.
- State policy makers should study their long-term workforce needs with an eye to increasing the number of pediatric dentists, general dentists, and those dentists interested in treating publicly-funded patients. Not all states face shortages now, but forecasts are troubling across the board. Since it takes years to produce more dentists, policy makers and state agency officials should consider and plan for their future needs.
- Dental schools should consider including more training for general dentists in how to care for young children and children with special needs. If the shortage of pediatric dentists persists, and no progress is made on developing other dental providers who can fill the need, general dentists will need an increased capacity and comfort level in treating children. One component that should be added is more training in working with a variety of allied dental providers, such as EFDAs and hygienists with expanded duties, and with medical providers.

### *Workforce*

- States that haven't already done so should consider improving the productivity and reach of their existing workforce by loosening supervision requirements for hygienists so they can provide preventive services in public health settings such as schools, child care centers, clinics, and Head Start programs. Fully 20 states have already moved to do this. Allowing hygienists to

see children in these settings would target resources where they are most needed and prevent problems before they are expensive to treat and difficult for children to bear.

- State policy makers should work with organized medicine and dentistry to revise medical and dental practice acts to remove barriers and explicitly permit medical professionals to provide preventive oral health services for young children and health education for their parents. Local dental societies in a few states have been instrumental in training physicians and nurse practitioners to do screening and education, and apply fluoride varnish and anti-microbials.
- States should consider establishing loan repayment programs for dentists to remedy maldistribution and assist in retaining practitioners in underserved areas. Nearly half the states already have such programs. Increases in funding could assist clinics that serve low income people in hiring dentists and hygienists.
- States should study and consider adopting new models for dental providers that show promise for meeting the needs of young children and other underserved people, including dental therapists, Expanded Function Dental Assistants (EFDAs), and – when plans are final – Advanced Dental Hygiene Practitioners (ADHPs) and Community Dental Health Coordinators (CDHCs). While each state's workforce needs are unique, all face demand in excess of supply in expanding dental care for young children. Dental therapists are used worldwide in treating children, but would be new to all states but Alaska. EFDAs would be a welcome addition to and expand the productivity of the dental team in states that don't now use them. ADHPs and CDHCs, while still in the planning stages, could offer significant advantages in certain settings and functions as well. Each state policy community at large (including policy makers, program administrators, educators, providers, payers, and advocates) bears the responsibility to come to consensus on how to meet the needs of at risk young children who are now underserved.

#### *Public Health*

- States should consider spending unused SCHIP administrative funds for oral public health measures targeted at high-risk children. Three states currently have approval from the Centers for Medicare and Medicaid Services to spend some administrative SCHIP funds for public health.
- States should consider investing more funds in targeted prevention in communities with a high proportion of at-risk children. Prevention saves money in treatment, and helps children stay healthy and prepared for school. Screenings, fluoride varnish application, education, and sealants are effective but underfunded.
- States and communities should reconsider their efforts to ensure equal access to community water with optimal fluoride levels. Despite being one of the top ten public health accomplishments in the 20<sup>th</sup> century, fluoridated water is still under-utilized as a source of dental caries prevention.

**Oral health section from “Invest Early in Maine: A Working Plan for Humane Early Childhood Systems” (2007 edition, October 2007 draft)**

**2.7** More Maine children birth to 3½ years will receive comprehensive, preventive oral health care.

**Where We Are Now**

- ❖ HP 2010 Grant awarded in spring 2007 (\$20,000 for two years) to AAP, Maine Chapter
- ❖ Dental Access Coalition developing workplans for implementation of strategies (summer 07).
- ❖ Partnership between home visiting and early Head Start is established to provide dental care for pregnant women in Kennebec County.
- ❖ Funding provided from Sadie and Harry Davis Foundation to five (5) diverse sites effective July 2007 for two years. Further funding via competitive process expected after 18 months.
- ❖ Maine Oral Health Program and the Office of Rural Health and Primary Care are co-managers of federal grant supporting efforts in dental workforce recruitment, training of dental & non-dental health professionals, and promotion of dental careers to young people.
- ❖ Head Start Oral Health Forum held and Oral Health Plan developed.

**Where We Want to Be**

- ❖ Policymakers believe that oral health is a priority for Maine’s children and understand that children in many areas do not have access to quality oral health services and supports.
- ❖ It is widely understood that all parents want dental care for their children.
- ❖ Maine’s children have reduced incidence of dental disease through improved oral health services and supports.
- ❖ At eruption of first tooth, children are seen by a dental professional.
- ❖ Children with disabilities in all areas of the state have access to dental care.

**How to Get There**

**2.7.1.** Work with the Maine Chapter, AAP, as it commences its HP 2010 grant, “Oral Health Risk Assessment in the Pediatric Practice.”

**2.7.2.** Engage Early Head Start personnel in early oral health risk assessment training (“Lunch and Learn” Sessions).

**2.7.3.** Follow progress of intensive training with pediatric practices including a “review” of the information or support provided related to care for children with disabilities.

**2.7.4.** Refine/adapt lessons learned into model training program for early care and education providers focusing on oral health early intervention, prevention and referral.

**2.7.5.** Use dental hygienists from innovative Office of Oral Health and speech therapists programs to provide training; build it into grant funding.

**2.7.6.** Advance the State Oral Health Improvement Plan.

**2.7.7.** Tell the story behind the numbers and clearly explain the issues beyond federal dental shortage areas. Identify barriers such as long wait lists, great distances, and dentists only willing to provide simple procedures and how this affects children with special health needs. Eradicate fallacy that parents don’t want dental care for their children.

**2.7.8.** Obtain baseline data and generate report on birth to 5 child access to comprehensive oral health services. Use Head Start/Early Head Start PIR data to understand what areas have the largest gaps between the number diagnosed as needing dental services and the number getting services. Share report with Task Force on Early Childhood, Children’s Cabinet, Legislators, and public.



- 2.7.9.** Increase public awareness of the importance of oral health to overall health and development and the relationship to speech development.
- 2.7.10.** Develop plan to expand prevention and treatment programs through policy change.
- 2.7.11.** Promote dental care for pregnant women by replicating partnership model between home visiting and Early Head Start (MOU, crosswalk to Head Start requirements via Home Visiting prenatal curricula).
- 2.7.12.** Add Oral Health indicator in Home Visiting performance measures (via Home Visiting Tracking System).
- 2.7.13.** Explore expansion of oral health data in Kid's Count.
- 2.7.14.** Support and promote other initiatives that focus on early preventive care, capacity-building, and infrastructure development as a means to support oral health.
- 2.7.15.** Promote the work of the Sadie and Harry Davis Foundation in its goal to provide early preventive oral care to children (birth to 3½) in a range of health care settings.
- 2.7.16.** Engage state leadership in work around oral health workforce development (in conjunction with state Oral Health Program & ME Office of Rural Health & Primary Care), particularly through the Children's Cabinet.
- 2.7.17.** Include oral health as a function of the child care health consultant in public health district offices.
- 2.7.18.** Ensure that special populations have access to quality oral health to include children in foster care and children with disabilities.