MaineCare Services

An Office of the
Department of Health and Human Services

**Paul R. Lepage, Governor** **Mary C. Mayhew, Commissioner**

# Report of the Resolve, To Study Expenditures for Oral Health Care in the MaineCare Program (Public Law Chapter 146) Working Group

**February, 2011**

## Acknowledgements

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We want to offer a special acknowledgement to Dr. David Kerr who helped to guide our data analysis and who devoted countless hours outside of the working group meetings to reviewing and analyzing the MaineCare emergency department data which provided the basis for this report.

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This report reflects the consensus opinions of all workgroup members who donated their time and expertise to the development of this report.

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# Report of the Resolve, To Study Expenditures for Oral Health Care in the MaineCare Program (Public Law Chapter 146) Working Group

## I. Executive Summary

### Background

LD 624, *Resolve, To Implement Certain Recommendations of the Report of the Governor's Task Force on Expanding Access to Oral Health Care for Maine People* was introduced in the 124th Maine Legislature. The purpose of this initial proposal was to increase MaineCare reimbursement rates. The bill was carried over to the Second Session of the 124th Legislature and amended to set up a work group made up of interested stakeholders that would:

> …review MaineCare dental coverage, reimbursement and utilization and shall identify ways to reduce or redirect expenditures with the goal of providing more cost-effective, high-quality care for MaineCare members. The working group shall review alternative payment methodologies, the use of emergency departments and urgent care settings for the treatment of dental disease, the use of preventive and specialty services, such as orthodontics and endodontics, and inpatient hospitalization.[1]

This report is the result of that study and is to be delivered to the Health and Human Services Committee of the 125th Legislature in 2011.

**Resolve, To Study Expenditures for Oral Health Care in the MaineCare Program**
Sec.1 Study. Resolved: That the Department of Health and Human Services shall convene a working group to perform a study of oral health care in the MaineCare program. The study must be chaired by the director of the division of health care management in the Office of MaineCare Services and must include representatives of the MaineCare Dental Advisory Committee, the Maine Dental Access Coalition, the Maine Center for Disease Control and Prevention and MaineCare members. The working group shall review MaineCare dental coverage, reimbursement and utilization and shall identify ways to reduce or redirect expenditures with the goal of providing more cost-effective, high-quality care for MaineCare members. The working group shall review alternative payment methodologies, the use of emergency departments and urgent care settings for the treatment of dental disease, the use of preventive and specialty services, such as orthodontics and endodontics, and inpatient hospitalization. The working group shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters during the First Regular Session of the 125th Legislature. After reviewing the report, the joint standing committee of the Legislature having jurisdiction over health and human services matters may report out a bill related to the subject of the report to the First Regular Session of the 125th Legislature.

The Resolve required the Director of the Division of Health Care Management in the MaineCare program to chair the working group. Group members included representatives of the MaineCare Dental Advisory Committee, the Maine Dental Access Coalition, Maine Center for Disease Control and Prevention and MaineCare members. MaineCare members were represented through Maine Equal Justice Partners and the review of several recent reports that gathered input from MaineCare members about their health

[1] Resolve Chapter 146 LD 624. (2010).

needs. Other working group members included the Maine Dental Association, Medical Care Development, dental providers and dental clinics. See Appendix B for a listing of working group members.

Support was provided to the working group by MaineCare staff and the Director of the Maine CDC's Oral Health Program. Additional staff support was provided by the University of Southern Maine, Muskie School of Public Service who provided research, policy and data analysis and drafting of this report. As its work progressed the work group adopted a consensus approach to decision making.

The work group reviewed different strategies and models, best practices from other states and utilization of services. The initial review and analysis of emergency department data determined the dental diagnosis codes that should be used to identify which emergency department visits and inpatient services could be linked to dental pain. To ensure that the data review captured all services being provided for dental pain, all outpatient claims which originated from a dental diagnosis were reviewed, not just those from an emergency department visit. This data was broken down by two age groups: those MaineCare members under 21, who are eligible to receive MaineCare dental services; and MaineCare members who are aged 21 and over who do not receive dental benefits under MaineCare except for a small number of "urgent care" services. Additionally, so that comparisons could be made between MaineCare members, uninsured patients and privately insured patients and their use of emergency departments for dental pain, the group also requested and reviewed information produced by the Maine Health Data Organization about emergency department visits and inpatient claims for these groups.

The Managed MaineCare Initiative (MMI) was under way while this group was meeting, so the possibility of dental services delivered to MaineCare members through managed care played a part in the discussions of the work group. As the work group was finalizing its recommendations, decisions were made by the MMI that beginning in 2012 managed care would include dental services under a fee- for-service model. The timing of this decision allowed the work group to frame its recommendations to address the delivery of dental services under managed care. However, regardless of how the MaineCare program is administered and dental services are provided, the recommendations remain applicable: provision of coverage for adults, an increase in reimbursement rates, continuation and expansion of member support services and dental provider outreach, and the lack of adequate dental workforce needs to be addressed.

**Problem/Need Statement**

Dental disease or poor oral health is recognized as one of the most significant unmet health needs facing Maine. Access to dental treatment is a problem for MaineCare adults who do not have coverage for dental services as well as for children who are covered for dental services under MaineCare but who may still have limited access to dental services. The following statements, from a variety of sources, can serve to demonstrate the extent of the need:

- MaineCare adult members aged 21 or older receive dental care only when needed to alleviate pain, infection or prevent imminent tooth loss. Ongoing comprehensive dental care is not covered, creating a significant barrier for many low-income individuals seeking dental care and precipitating the use of the emergency room.

- In a 2006 study, dental disease was the number one reason why MaineCare members ages 15–44 went to the emergency department for services that could have been avoided.[2]

- In 2009, MaineCare spent $6,590,888 on avoidable emergency department visits and other outpatient services for dental pain that did not definitively treat the dental disease.[3]

- "…access to dental care rose to the top"[4] and was identified by participants as "one of the most important, far-reaching actions that could be taken to improve their health,"[5] in a recently conducted survey that looked at ways to improve the health of Maine people.

- "If you don't have the preventive [coverage] on the dental, it is going to go into medical anyways eventually and MaineCare is still going to pay – why not pay up front and it would be cheaper…Because you are going to end up in the ER – that is what I am saying…Preventive care!"[6]

- "…dentists cite low payment rates, administrative requirements, and patient issues such as frequently missed appointments as the reasons why they do not treat more Medicaid patients."[7]

- A lack of dental providers in their area or lack of dental providers who treat poor children on the MaineCare program was the most common reason parents expressed as a concern for their children's health care needs.[8]

**Findings**

1. Adult MaineCare members do not currently receive ongoing comprehensive dental care as a covered benefit causing them to seek non-definitive treatment for pain and infection in emergency rooms and other outpatient settings.

2. Adult MaineCare members have expressed interest in coverage for dental services under MaineCare. Access to dental care has been identified as one of "the most important, far-reaching actions that could be taken to improve their health."[9]

3. Maine's dental workforce is not currently meeting the needs of MaineCare members. Assuring an adequate distribution and supply of dental providers able to see MaineCare members will be important in assuring the success of the delivery of dental services under the Managed MaineCare Initiative.

4. Increased reimbursement rates, while improving provider participation and enrollee utilization, will cost more, but dental expenditures will still remain a very small percentage of the overall MaineCare budget.

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[2] Kilbreth, B., et al. (2010) p. 14.
[3] See Table 7. MaineCare Outpatient Claims.
[4] Collaborative Strategies Planning Team. (2010). p. 5.
[5] Ibid. p. 7.
[6] Muskie School of Public Service. (2010). p. 5.
[7] General Accounting Office. (2000). p. 4.
[8] Anderson, N. & Thayer, D. (2009).
[9] Collaborative Strategies Planning Team. (2010). p. 7.

5. Good relations with dental providers will be important under managed care to encourage provider participation, maintaining their involvement and increasing the number of MaineCare members they are able to treat.

6. With adequate reimbursement rates, involvement of providers and other stakeholders, and an effective administration, managed care provides new opportunities for improved quality, expanded access and efficiencies for the delivery of dental service to MaineCare members.

7. Current MaineCare policies for adults age 21 and over do not fully cover the restoration of teeth that have had root canals. For adults age 21 years or older MaineCare covers root canals for acutely painful teeth and restorations necessary to restore previously endodontically treated teeth. MaineCare does not cover the final restoration of teeth that have had root canals. With a temporary filling or cap the tooth is susceptible to further damage if the treatment is not finished with a permanent filling and/or crown. MaineCare members must come up with the funds to cover the expense of the final restoration, or risk further damage to the tooth or extraction. Reimbursement endodontic treatment for adults falls below what would be considered acceptable standards of care resulting in subsequent loss of tooth and further cost and loss of the initial investment in treatment.

**Recommendations**

*Recommendation 1*. Expand MaineCare coverage to include preventive and basic restorative services for adults**.**

*Recommendation 2*. Increase MaineCare reimbursement rates to the 75th percentile of the New England regional survey of dental fees conducted by the American Dental Association. This could be an incremental increase put in over a three year period.[10]

*Recommendation 3*. Through its Request for Proposals process, the Managed MaineCare Initiative must assure that any managed care administrator seeking to provide managed care services in the state is adequately prepared to cover dental services.

*Recommendation 4*. The dental program administrator should continue and expand upon the MaineCare Member Services' patient and dental provider outreach and support initiatives currently being provided, or provide similar services.

*Recommendation 5*. There are a number of collaborative initiatives underway in the state to divert avoidable emergency department visits for dental services. No one approach will fit all Maine communities, so multiple models should be considered. These efforts should be evaluated and reviewed by the dental program administrator as ways to facilitate access.

*Recommendation 6*. Address the need for an adequate dental workforce both in terms of numbers and distribution.

[10] Governor's Task Force on Expanding Access to Oral Health Care for Maine People. (2008). p. 7.

# Report of the Resolve, To Study Expenditures for Oral Health Care in the MaineCare Program (Public Law Chapter 146) Working Group

## II. Introduction

### 1. Legislative Background

LD 624, *Resolve, To Implement Certain Recommendations of the Report of the Governor's Task Force on Expanding Access to Oral Health Care for Maine People* was introduced in the 124th Maine Legislature. The purpose of this initial proposal was to "increase MaineCare dental reimbursement rates in accordance with recommendation # 1 of the 2008 *Report of the Governor's Task Force on Expanding Access to Oral Health Care for Maine People*."[11] The Governor's Task Force recommendation was: "Increase MaineCare reimbursement rates to the 75th percentile[12] of the New England regional survey of dental fees conducted by the American Dental Association" and to implement the increase incrementally over a three year period.[13]

LD 624 was carried over to the Second Session of the 124th Legislature and the resolve was amended to set up a work group made up of interested stakeholders that would study the MaineCare oral health program. They were charged to review:

> …MaineCare dental coverage, reimbursement and utilization and shall identify ways to reduce or redirect expenditures with the goal of providing more cost-effective, high-quality care for MaineCare members. The working group shall review alternative payment methodologies, the use of emergency departments and urgent care settings for the treatment of dental disease, the use of preventive and specialty services, such as orthodontics and endodontics, and inpatient hospitalization.[14]

The work group was directed to report back to the Joint Standing Committee on Health and Human Services of the 125th Maine Legislature, which may report out a bill related to the report.

### 2. Methods - Working Group Process

The Resolve required that the Director of the Division of Health Care Management in the MaineCare program chair the working group. Required members included representatives of the MaineCare Dental Advisory Committee, the Maine Dental Access Coalition, the Maine CDC and MaineCare members. MaineCare members were represented through Maine Equal Justice Partners and the review of several recent reports that gathered input from MaineCare members about their health needs. Other working group members included the Maine Dental Association, Medical Care Development, dental providers and dental clinics. See Appendix B for a listing of working group members.

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[11] Resolve Chapter 146 LD 624. (2010). Summary.

[12] The report explains: "A percentile is the value of a variable below which a certain percent of observations fall. For example, the 20th percentile is the value (or score) below which 20% of the observations may be found." (p. 5)

[13] Governor's Task Force on Expanding Access to Oral Health Care for Maine People. (2010).

[14] Resolve Chapter 146 LD 624. (2010).

Support was provided to the working group by MaineCare staff who scheduled meetings, prepared agendas and minutes, and provided information to the group as requested. Group meetings were facilitated by MaineCare's Manager of Health Network Services and the Director of the Maine CDC's Oral Health Program. Additional staff support was provided by the USM Muskie School of Public Service who provided research, policy and data analysis, and drafting of this report.

The group formed two subcommittees: one to focus on data and one to focus on models. Other small groups met on a more limited basis to review and make recommendations to the full group around specific topics such as endodontic services, managed care and dental homes. One opportunity that presented itself during the process was a series of three webinars hosted by the Institute for Healthcare Improvement, *Web & Action: Reducing Avoidable Emergency Department Visits.* Six members of the working group participated in this program. For a more complete description of the IHI process see Appendix C.

The full working group met eight times between February 2010 and November 2010. As work progressed the group adopted a consensus approach to decision making. The Models Work Group met five times between May and November. The Data Work Group met two times in April. Tasks were taken on by group members between full and sub-group meetings. The Models Work Group reviewed different strategies and models, best practices from other states, and utilization of services. This group worked on developing the recommendations for approval by the full working group. The Data Work Group defined the data needs for the work group. Once these needs were defined, different data production and analysis tasks were taken on by group members and Muskie staff, who brought the results of their work back to the full working group. Others from MaineCare, MDA and Muskie occasionally attended meetings to either make presentations or follow the work of the group. A final report was produced containing six recommendations that were reached by consensus. This report it is to be delivered to the Joint Standing Committee on Health and Human Services of the 125$^{th}$ Legislature in 2011 legislative session.

**3. Data Analysis Approach**

The initial review and analysis of emergency department (ED) data was conducted by group member Dr. David Kerr who determined the dental diagnosis codes that should be used to identify which emergency department visits and inpatient services could be linked to dental pain. MaineCare data for three years was reviewed.

To ensure that the data review captured all services being provided for dental pain, the work group worked with the Muskie School of Public Service to review all outpatient claims originating from a dental diagnosis, not just emergency department claims. This data was broken down by two age groups: MaineCare members under 21, who are eligible to receive comprehensive dental services; and MaineCare members who are 21 and over who do not receive comprehensive dental services under MaineCare. Additionally, so that comparisons could be made between MaineCare members, uninsured patients, and privately insured patients and their use of emergency departments for dental pain, the data group also reviewed information about emergency department visits for these groups produced by the Maine Health Data Organization.

To fulfill its charge, the workgroup also reviewed data regarding the utilization of dental services by MaineCare members, including endodontic and orthodontic services.

**4. Managed Care**

The Managed MaineCare Initiative (MMI) was under way while this group was meeting, so the possibility of dental services delivered to MaineCare members through managed care played a part in the discussions of the work group. As the work group was finalizing its recommendations, decisions were made by the MMI that, beginning in 2012, managed care would include dental services under a fee- for-service model. The timing of this decision allowed the work group to frame its recommendations to address the delivery of dental services under managed care. However, regardless of how the MaineCare program is administered and dental services are provided, the recommendations remain applicable: provision of coverage for adults, an increase in reimbursement rates, continuation and expansion of member support services and dental provider outreach, and the lack of adequate dental workforce needs to be addressed.

# III. Problem/Need Statement

## Highlights

Dental disease or poor oral health is recognized as one of the most significant unmet health needs facing Maine. The following statements, from a variety of sources, can serve to demonstrate the extent of the need:

- MaineCare adult members 21 or older receive dental care only when needed to alleviate pain, infection or prevent imminent tooth loss. Ongoing comprehensive dental care is not covered, creating a significant barrier for many low-income individuals seeking dental care.

- "Oral health is essential to the general health and well-being of all Americans...Oral health means more than sound teeth. Oral health is integral to overall health..."[15]

- "I am only 29 years old and in three weeks I am losing the rest of my regular teeth and I have to have dentures paid out of my pocket by myself."[16]

- Dental disease was the number one reason why MaineCare members ages 15 – 44 went to the emergency department.[17]

- In 2009 MaineCare spent $6,590,888 on avoidable emergency department visits and other outpatient services for dental pain that did not definitively treat the dental disease.[18]

- Dental pain and infection is one of the top five reasons for MaineCare <u>avoidable</u> emergency department visits.[19]

- In a recently conducted survey that looked at ways to improve the health of Maine people "…access to dental care rose to the top"[20] and was identified by participants as "one of the most important, far-reaching actions that could be taken to improve their health."[21]

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[15] U.S. Department of Health and Human Services. (2000). p. 1.
[16] Muskie School of Public Service. (2010). p. 5.
[17] Kilbreth, B., et al. (2010). p.14.
[18] Table 7. MaineCare Outpatient Claims
[19] MaineCare claims data
[20] Collaborative Strategies Planning Team. (2010). p. 5.
[21] Ibid. p. 7.

- Nationally, "dental problems may represent the biggest unmet health care need among adults." [22]

- Of the State's population, 39%[23], or 520,812 Maine people, live in a federally designated Dental Health Professional Shortage Area, making access to dental providers a challenge even for those MaineCare members under 21 who do have dental benefits.[24]

- A lack of dental providers in their area or lack of dental providers that treat poor children on the MaineCare program was the most common reason parents expressed as a concern for their children's health care needs.[25]

- "…dentists cite low payment rates, administrative requirements, and patient issues such as frequently missed appointments as the reasons why they do not treat more Medicaid patients."[26]

## 1. MaineCare Members Identify the Lack of Dental Services as Having a Negative Impact on Health

### Maine Health Access Foundation report *Improving the Health of Maine People: Getting Down to Basics.*

In January 2010 the Maine Health Access Foundation released a report, *Improving the Health of Maine People: Getting Down to Basics.* This report was the result of a combined effort between Maine Department of Health and Human Services and seven nonprofit organizations called the Collaborative Strategies Planning Team. This initiative looked at best practices, conducted focus groups and surveys, and made patient and family-centered recommendations to improve the health of Maine people. The report highlights four recommendations to address issues that emerged as "Most likely to stand in the way of improved health."[27]

The recommendations were also those that "are designed to have an immediate impact within existing structures and systems and are the most important interventions to pursue right away, even if some must be pursued incrementally because of cost limitations."[28]

Noting that: "Though not initially part of the research, access to dental care rose to the top in response to the open-ended question, *what else would help*" from survey respondents and focus groups;[29] the report states: "Survey and focus group participants identified dental care as one of the most important, far-reaching actions that could be taken to improve their health."[30]

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[22] Gehshan, S., et al. (2009) p. 4.
[23] U.S. Census Bureau. (2010, December).
[24] U.S. Department of Health and Human Services. (2010).
[25] Anderson, N. & Thayer, D. (2009).
[26] General Accounting Office. (2000). p. 4.
[27] Collaborative Strategies Planning Team. (2010). p. ii.
[28] Ibid.
[29] Ibid. p. 5.
[30] Ibid. p. 7.

The Collaborative Strategies Planning Team report makes two recommendations pertinent to the efforts of the Resolve Working Group:

1. "For health improvement and cost-savings reasons, the team recommends that MaineCare extend coverage for oral health preventive and restorative services to all its adult members."
2. "…support all efforts to increase the number of oral health care providers in Maine who are willing and able to treat MaineCare members."[31]

**MaineCare Listening Sessions**

As part of the Managed MaineCare Initiative (MMI), in the fall of 2010, Maine DHHS contracted with the Muskie School of Public Service to conduct four listening sessions with MaineCare members around the state. Regarding dental services, the *MaineCare Listening Sessions* report states that:

> The lack of available dental coverage for adults enrolled in MaineCare is a topic that was brought up at every one of the four Listening Sessions. Participants felt that preventive dental care is essential for maintaining overall health. They expressed frustration that MaineCare will pay for dental emergencies rather than paying up front for routine, preventive care. Many believed that a system offering preventive dental care would save MaineCare money in the long-run, while allowing them access to basic routine care for keeping their teeth healthy.[32]

In their comments, MaineCare members clearly articulated their understanding of the impact that the lack of dental services has on their overall health as well as the cost-effectiveness of providing for preventive services.

> 'Preventive dental care isn't just about your teeth. When it comes to diabetes or heart disease, even self esteem issues, preventive dentistry can help alleviate the high blood sugar and it helps prevent heart disease, which will actually save the system money in the long-run.'
>
> 'Studies have shown preventive care works way more effectively, efficiently cost-wise and every other way as far as protecting your teeth.'
>
> 'The only thing that MaineCare allows right now for adults is emergency pulling and emergency fixing…If you are a diabetic they will pull your teeth, but you have to have uncontrolled diabetes before they will do that.'
>
> 'It would be really nice just to be able as an adult to see a dentist once a year – a general appointment and a cleaning – once a year.'[33]

**2. MaineCare Members Turn to Hospital Emergency Departments and other Outpatient Services for Dental Pain**

A recent study by the Muskie School of Public Service entitled *Analysis of Emergency Department Use in Maine* looked at statewide emergency department usage for the year 2006 and identified the top eight diagnoses for a visit. There were 3,430 emergency department visits for dental disease from MaineCare

[31] Ibid. p. 7-8.
[32] Muskie School of Public Service. (2010). p. 4.
[33] Ibid. p. 5.

members age 15 through 24, the top reason for an emergency department visit for this age group. There were 4,949 visits for members age 25 – 44 for dental disease, also making it the number one reason for an emergency department visit for this group. The total number of emergency department visits for all top eight diagnoses for the two groups in 2006 was 31,542.[34]

The study also looked at the diagnoses of those individuals who visited the emergency department four or more times. Dental disease was the top diagnosis for MaineCare members age 15 through 24 at 44.8%. Dental disease was the fourth highest diagnosis for MaineCare members age 25 – 44 at 43.6%.[35]

In comparison, the same report's findings for privately insured people, does not show the same types of diagnoses or the high numbers of visits or high percentage of frequent users. In fact, dental disease is not listed in the top eight diagnoses for this group.[36]

Analysis of 2009 MaineCare data produced for this report shows that 8,091 MaineCare members turned to emergency departments or other outpatient settings for relief of dental pain. The total MaineCare expenditure for these non-definitive services was $6,590,888. Non-definitive services include pain medication and antibiotics for infection. It does not address the underlying dental disease, which would still require treatment by a dentist. Of these MaineCare members, 2,256 were under 21 and eligible for MaineCare dental benefits that could treat the underlying dental disease. There were 5,835 adult MaineCare members who were not eligible for dental benefits but who sought services in emergency departments or outpatient settings at a cost of $4,104,938 for non-definitive services for dental pain. (See Table 7. Maine Care Outpatient Claims.)

**3. Importance of Oral Health and Impact of Oral Health on Overall Health**

*Oral Health in America: A Report of the Surgeon General* was released in May 2000 by then Surgeon General David Satcher, MD, PhD. It focused on the relationship between oral health and overall health throughout the lifespan. It called for national partnerships to provide opportunities for individuals, communities and health professionals to work together to maintain and improve the nation's oral health.

Among the Surgeon General's findings were the following:

> **Oral diseases and disorders in and of themselves affect health and well-being throughout life**… [They] undermine self-image and self-esteem, discourage normal social interaction, cause other health problems, and lead to chronic stress and depression as well as incur great financial cost. They may also interfere with vital functions such as breathing, food selection, eating, swallowing, and speaking and with activities of daily living such as work, school, and family interactions….
>
> **There are profound and consequential oral health disparities within the American population.** Disparities for various oral conditions may relate to income, age, sex, race or ethnicity, or medical status…. not all health providers may be aware of the services needed to improve oral health. In addition, oral health care is not fully integrated into many care programs. Social, economic, and cultural factors and changing population demographics affect how health services are delivered and used, and how people care for themselves….

[34] Kilbreth, B., et al. (2010).
[35] Ibid.
[36] Ibid.

> **The mouth reflects general health & well-being….Oral diseases and conditions are associated with other health problems.** Oral infections can be the source of systemic infections in people with weakened immune systems, and oral signs and symptoms often are part of a general health condition. Associations between chronic oral infections and other health problems, including diabetes, heart disease, and adverse pregnancy outcomes, have also been reported.[37]

In 2003, the Office of the Surgeon General issued the *National Call to Action to Promote Oral Health* that included principles for a national oral health plan to help eliminate health disparities and to improve quality of life. The plan's objectives included the following areas:

> Objective 1: Change perceptions of the public, policy makers and health providers regarding oral health and disease so that oral health becomes an accepted component of general health….
>
> Objective 2: Remove known barriers between people and oral health services….
>
> Objective 3: Accelerate the building of the scientific and evidence base and accelerate the application of research findings to improve oral health….
>
> Objective 4: Ensure the adequacy of public and private health personnel and resources to meet the oral health needs of all Americans and enable the integration of oral health effectively with general health. The focus is on having a responsive, competent, diverse, and flexible workforce….
>
> Objective 5: Expand public-private partnerships and build upon common goals to improve the oral health of those who suffer disproportionately from oral diseases.[38]

# VI. Findings & Recommendations

## A. Findings

**1. MaineCare adult members do not currently receive ongoing comprehensive dental care as a covered benefit.** Lack of coverage for dental services creates a barrier for many low income people seeking treatment. Consequently they turn to emergency departments for alleviation of dental pain and infection, but do not receive definitive treatment for their dental disease.

**2. Adult MaineCare members have expressed interest in coverage for dental services under MaineCare.** Lack of dental coverage was raised in the MaineCare Listening session regarding managed care. Access to dental care has been identified as "the most important, far-reaching actions that could be taken to improve their health."[39]

**3. Maine's dental workforce is not currently meeting the needs of MaineCare members**. The numbers and distribution of dental providers seeing MaineCare members and able to accept new MaineCare members limits access to dental services for MaineCare members. Assuring an adequate distribution and supply of dental providers able to see MaineCare members will be important in assuring

[37] Ibid. p. 10 – 11.
[38] U.S. Department of Health and Human Services. (2003, Spring). p. 23 – 31.
[39] Collaborative Strategies Planning Team. (2010). p. 7.

the success of the delivery of dental services under the Managed MaineCare Initiative. Contributing to this challenge are the following:

- Maine's Office of Data Research and Vital Statistics estimates there were 608 licensed active dentists practicing in Maine in 2008 resulting in a statewide ratio of one dentist for every 2,493 residents.[40]

- Maine's dental workforce is not evenly distributed across the state; with a range of 1,633 people per active dentist in Cumberland County to 4,671 people per active dentist in Somerset County.[41]

- Complicating the fact that there are a limited number of dentists able to see MaineCare members, the state as a whole has 46 federally designated Dental Health Professional Shortage Areas.[42]

- "Among parents who reported being less than "very satisfied" with MaineCare, a lack of dental providers in their area or lack of dental providers who accept MaineCare members, was the most common reason for dissatisfaction."[43]

- In 2008, 87% of active Maine dentists were currently accepting new patients, while 26% indicated they were accepting patients insured through MaineCare.[44]
- Among the providers who accept MaineCare, 58% report limiting the proportion of MaineCare insured patients seen in their practice. [45]

- As of December 1, 2010, 323 dentists in Maine were seeing MaineCare members.[46]

**4. Although the increased reimbursement rates that are necessary to improve provider participation and enrollee utilization will cost more, dental expenditures will still remain a very small percentage of the overall MaineCare budget.** While expenditures may initially rise, this is an investment in prevention and restoration that should pay off in the future, due to greater access for MaineCare members and improved oral health as a result of the provision of definitive dental treatment.

In her 2008 report, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, Borchgrevink found that:

- More Medicaid members will use more services provided by more dentists;
- At first costs will be more because as a successful program, more dentists will be participating;
- Administrative costs will increase as will overall expenditures; however
- Dental expenditures make up a small percent of total Medicaid budgets. (Usually < 2%)[47]

**5. MaineCare is already doing much to maintain good relations with dental providers and needs to continue to foster these relations** with providers to increase the level of participation. Good relations

[40] Maternal and Child Health Services. (2010). p. 186.
[41] Ibid.
[42] U.S. Department of Health and Human Services. (2010).
[43] Maternal and Child Health Services. (2010). p. 193. From Anderson, N. & Thayer, D. (2009). *Children Served by MaineCare: 2008 Survey Findings.*
[44] Maine Department of Health and Human Services, Office of Data, Research and Vital Statistics, compiled by Stuart Bratesman. (2009).
[45] Maternal and Child Health Services. (2010). p. 190.
[46] Curtis, N. Molina Medicaid Solutions. (personal communication, December 8, 2010).
[47] Borchgrevink, A., et al. (2008). p. 14.

with providers will be important under any dental program administrator in order to encourage providers to participate, to maintain their involvement, and to increase the numbers of MaineCare members they are willing to treat.

Dentists who already see MaineCare members must be encouraged to increase the number of members they are able to see, and more dentists need to be encouraged to see MaineCare members. Dental provider participation in MaineCare is critical to access to oral health services for MaineCare members. To this end, MaineCare must ensure that any dental program administrator will have the staffing resources it needs to foster relationships with dental providers. Efforts should include:

- Adoption of ongoing examination of administrative practices and procedures to remove barriers or perceived barriers to treating MaineCare members, such as elimination of prior authorization requirements;

- Implementation of many of the other best practices discussed elsewhere in this report;

- Working with the MaineCare Dental Advisory Committee, the Maine Dental Association, and local dental societies to make increased participation of dental providers a priority; and

- Identifying ways to remove or prevent administrative barriers and enhance relationships between dental providers, MaineCare, the managed care entity and MaineCare members.

**6. Managed care provides opportunities if key issues can be addressed.** The move to a managed care system for MaineCare by DHHS beginning 2012 may offer new opportunities for improved quality, expanded access and efficiencies for the delivery of dental service to MaineCare members. However, for such a system to be successful, Maine DHHS must ensure that several key issues are addressed by any potential managed care administrator. These issues include adequate reimbursement rates for providers so that their costs are covered; involvement of providers and other stakeholders; an effective administration; and rewards for expanded access. Additionally, to reduce avoidable emergency department and outpatient visits for dental pain, a basic package of restorative and preventive services should be offered to adults.[48]

**7. Current legislative language for adult dental coverage limits reimbursement for the provision of endodontic treatment such that services provided under MaineCare reimbursement do not meet acceptable standards of care.** MaineCare policies for adults age 21 and over do not cover the permanent restoration of teeth that have had root canals, effectively imposing an artificial or arbitrary interruption in endodontic treatment that falls below what would be considered acceptable standards of care when Mainecare adults cannot pay for further treatment that is required to meet the standard of care.

It is the finding of the work group that MaineCare endodontic treatment for adults age 21 and over should include coverage for restorative services that would allow the overall endodontic treatment to meet acceptable standards of care. The service should be reimbursed by MaineCare if in the dentist's professional judgment it will prevent imminent tooth loss.

## B. Recommendations

[48] Edelstein, B. (2003). p 14.

As the work group was finalizing its recommendations, decisions were made by the Managed MaineCare Initiative (MMI), that beginning in 2012 managed care would include dental services under a fee-for-service model. The timing of this decision allowed the work group to frame its recommendations to anticipate the delivery of dental services under managed care. One of the recommendations provides specific guidance to the MMI around what it should include in its RFP process to assure that any managed care entity seeking to administer the MaineCare program is adequately prepared to provide dental services to MaineCare members. The following recommendations, however, address some fundamental problems related to access to dental services for MaineCare members, and given the uncertainties that still remain around the MMI, the work group intentionally crafted these recommendations to be applicable regardless of how MaineCare dental services are administered.

***Recommendation 1.*** **Expand MaineCare coverage to include preventive and basic restorative services for adults.** Expand MaineCare coverage for adults to include a basic package of preventive adult dental services. Proposed legislative language is as follows:

22 § 3174-F. Coverage for Adult Dental Services

1. G. Specified preventive and restorative services that the Department determines by rule are most likely to reduce avoidable future expenditures to the program.

Table 1 includes a list of recommended basic and preventive services that are designed to promote oral health, prevent tooth loss and reduce or avoid the need to for avoidable emergency services and their associated costs. These services should be promulgated in rule by the Department and codified in the *MaineCare Benefits Manual*.

**Table 1. Proposed Expanded Basic Adult Dental Benefits and Codes**

| Description | Limitations | Code |
|---|---|---|
| Comprehensive oral examination | Every 5 years | D0150 |
| Periodic oral examination | Annual, or as needed for medical necessity | D0120 |
| Limited problem focused examination | As needed | D0140 |
| Panoramic Radiograph/FMX-diagnostic | Every 5 years | D0330 |
| Four bite wing radiographs | Annual | D0274 |
| Individual periapical radiographs | As needed | D0220/D0230 |
| Prophylaxis | Annual, or as needed for medical necessity | D1110 |
| Scaling and Root planing four or more | Every 3 years | D4341 |
| Anterior composite restorations | As needed | D2332 |
| Posterior amalgam restorations | As needed | D2393 |
| Post and Core buildup | anterior and posterior | D2950 |
| Full Dentures | Every 10 years | D5110 |
| Partial Dentures | Every 10 years | D5211 |
| Full Denture reline | Every 5 years | D5730 |

***Recommendation 2.*** **Increase Reimbursement Rates.** The Resolve work group recognizes the importance of providing adequate reimbursement for services to Maine's dental professionals to help meet their costs and encourage and support their acceptance of MaineCare clients. It supports the recommendations of the Governor's Task Force regarding the appropriate level of fees and recommends that any MaineCare program administrator providing dental services:

Increase MaineCare reimbursement rates to the 75th percentile of the New England regional survey of dental fees conducted by the American Dental Association.[49] This could be an incremental increase put in over a three year period.

***Recommendation 3.*** **Through its RFP process, the Managed MaineCare Initiative must assure that any managed care administrator seeking to provide services in the state is adequately prepared to cover dental services.** As Maine DHHS moves toward implementation of a managed care system for MaineCare dental services effective 2012, it will be necessary for the state to gather information about how any potential managed care provider intends to address the oral health needs of all MaineCare members, both children and adults. It is our recommendation that in any RFP process the state undertakes it includes the following or similar language:

*Maine DHHS is seeking proposals on "innovative, viable and sustainable strategies to improve the administrative and operational components of the current" MaineCare dental program that will encourage provider enrollment and enhance utilization of services "while assuring quality of comprehensive dental care consistent with a dental home concept" for both children and adults participating in MaineCare programs.*[50]

*Based on the experience of other states, Maine has determined that in order for dental programs to be successful under managed care, there must be: "sufficiency of payment; sufficiency of provider availability; and strong program oversight."*[51] *These goals are obtained when payments are: "at market rates," there is "simplified program administration, active engagement of stakeholders in designing and implementing reform," and improved access is rewarded.*[52]

*Therefore, responses to this request should include the following elements of best practice to improve access for dental programs:*

- *Ongoing and meaningful collaboration of all stakeholders, including dentists and hygienists,[and other dental professionals], safety-net providers, hospitals, advocates for the poor, and beneficiaries;*
- *Streamlined administration including electronic eligibility verification and claims management, elimination of most prior authorization requirements, rapid claims payment, use of professionally accepted coding systems and claim forms, and facile mechanisms for rapid conflict resolution;*
- *Improved performance reporting;*
- *Strong vendors incentives that are regularly awarded and sanctions that are routinely enforced;*
- *Engagement of community health centers, school-based clinics, and other safety-net providers;*
- *Integration of medical and dental care through tracking forms and facilitated referrals;*
- *Strong provider and beneficiary support;*[53]*and*
- *Utilization of prenatal and nutrition counseling and education and other preventive interventions.*

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[49] Governor's Task Force on Expanding Access to Oral Health Care for Maine People. (2008). p. 5.
[50] Adapted from: New Hampshire Department of Health and Human Services. (2010).
[51] Edelstein, B. (2003). p. 14.
[52] Ibid.
[53] Edelstein, B. (2003). p. 13.

*At a minimum, services should meet the specialty care, geographical and timely access standards as set forth in the current Rule 850 of the Maine Bureau of Insurance.*[54] *Furthermore, it is expected that a mechanism to ensure that services can be provided in accordance with professionally accepted standards of dental and oral health practice will be implemented.*

*Maine is also seeking proposals that will expand access for adults to oral health services. Data indicate that a significant amount of expenditures in emergency departments, outpatient settings and inpatient services occur as a result of adults seeking treatment for oral health problems. Data also indicate that a lack of oral health care exacerbates other chronic conditions such as diabetes and cardiovascular disease and results in transmission of oral disease from mothers to their children. Accordingly, Maine is seeking proposals that would provide basic oral health services to adult MaineCare members. Those services should be sufficient to prevent oral disease, to alleviate pain, infection and imminent tooth loss and to be cost effective compared with other MaineCare services. A list of the services comprising the adult basic oral health plan is included under Recommendation 1, in Table 1 Proposed Expanded Basic Adult Dental Benefits and Codes of this report.*

In addition to incorporating the best practices listed above, the RFP process should also encourage applicants to:

1. review emergency department, outpatient claims and inpatient data related to dental visits from MaineCare members;
2. provide approaches to direct those visits to definitive dental care; and
3. address the need for prevention and education such as prenatal counseling, good dietary nutrition, educating patients about good preventive behaviors and other preventive interventions that will have a long term influence on the cost of dental care.

***Recommendation 4.*** **MaineCare member service patient and dental provider outreach and support initiatives currently being provided should be continued and expanded.** MaineCare needs to assure that any dental program administrator have adequate staffing to continue the initiatives that MaineCare has already undertaken to support MaineCare members seeking dental services and reach out to dental providers. Given the recommendation to provide adult benefits and increase rates which will lead to adult members seeking services and higher utilization by children, the need for greater dental provider enrollment will make this particularly important.

***A. Continue and expand the current MaineCare Member Services patient outreach to more dental providers and MaineCare members*** to help reduce the number of missed appointments. The dental program administrator will need to work with dental providers and MaineCare members to address barriers such as the need for transportation, help finding a dental provider and help educating MaineCare members about provider cancellation policies and the need to keep appointments.

***B. The dental program administrator should continue and expand efforts of the MaineCare Emergency Room Work Group*** to follow-up with MaineCare members who had an "avoidable" emergency department visit to help members understand when use of the emergency department is appropriate and make a referral to a dental provider who will be willing to see them for future dental care needs. For adult MaineCare members without coverage for preventive and basic restorative services covered under MaineCare, use of emergency departments and other outpatient providers for treatment of dental pain will

[54] www.maine.gov/sos/cec/rules/02/031/031c850.doc

likely remain their most feasible options. Given the number of outpatient, non-emergency department claims there are for both children and adults, this work group should consider expanding its focus to also working with those outpatient providers.

***Recommendation 5.*** **Encourage collaborative initiatives.** There are a number of collaborative initiatives underway in the state to divert avoidable emergency department visits for dental services. These efforts should be considered by the dental program administrator. However, it should be cautioned, these collaborative initiatives will only be effective at expanding access, if, as recommended above, systems changes are made at the state level to expand benefits to adults and increase dental provider participation.

***A. Develop guidelines and referrals for treating dental pain*** **-** As local alternatives to avoidable emergency department visits are developed and as the MaineCare Emergency Room Work Group expands its efforts, it is also recommended that MaineCare and the dental program administrator work with the MDA, the Maine Hospital Association and emergency department representatives to develop guidelines and protocols for hospital emergency departments for best practices, referrals and for treating dental pain. It must be noted, however, that this recommendation will not be effective unless MaineCare provides adult dental benefits and unless there are an adequate number of dental providers treating both children and adults. From the MaineCare member's perspective, without those provisions, emergency departments and other outpatient settings may remain the most feasible place for MaineCare members to receive relief for dental pain.

***B. Create urgent care access outside of emergency departments*** **-** Support the recommendation of the Governor's Office on Health Policy and Finance to: "Develop an initiative with the Maine Dental Association, dental surgeons, and other dental providers to create urgent care access for patients in settings other than EDs."[55] It is clear from the data that many MaineCare members already seek services in outpatient settings other than emergency departments. Unfortunately, especially for adults, these services still do not provide definitive treatment, pointing once again to the need for adult coverage. This recommendation should be expanded to encourage the dental program administrator to work with local dental associations and primary care providers to develop local solutions that meet the urgent care needs of the community, while also exploring the development of dental homes for MaineCare members, both adults and children.

***C. Community partners developing local solutions*** **-** In many cases, facilitating access to dental services for MaineCare members will need to be worked out at the local level and will depend on the resources and arrangements that exist or that can be developed between and among emergency departments, primary care providers, Federally Qualified Health Centers, dental clinics, dental providers, local dental associations and other interested community members, as discussed above. The Institute for Healthcare Improvement Web & Action course, *Reducing Avoidable Emergency Department Visits* (see Appendix C) describes a strategy for bringing community partners together to develop such arrangements.

***Recommendation 6.*** **Address the need for an adequate dental workforce both in terms of numbers and distribution.** The Resolve work group recognized the need to address the adequacy of Maine's dental professional workforce, in terms of the numbers and distribution, relative to providing access to oral health care in the long term. However, the group's charge and the limited time available did not provide the opportunity to address this issue. Moreover, much work has been done previously in Maine and is ongoing in this area and the Resolve work group endorses those efforts:

[55] Governor's Task Force on Expanding Access to Oral Health Care for Maine People. (2008). p. 6.

***A. Support recommendations regarding dental professional workforce shortages*** from the December 2008 Report of the Governor's Task Force on Expanding Access to Oral Health Care for Maine People:

> Recommendation 5. Support efforts to enhance student loan and loan repayment opportunities for dental care professionals….
> Recommendation 6. Support and enhance opportunities for training more dental professionals in Maine.[56]

***B. Support oral health workforce goal of the 2010-12 State Health Plan*** to: "Increase access to oral health care through the support, education and training of dental hygienists, denturists and other health professionals."(GOAL VII.3)[57]

***C. Support overall goals and recommendations in the Recommendations Guide of the MCDC Health Workforce Forum*** to address dental professional workforce shortages and maldistribution.[58]

***D. Support the recommendations of the Maine Oral Health Improvement Plan related to addressing workforce needs***:

> Goal 11. Redefine and Expand Roles of Dental and Medical professionals. Increase effectiveness of the dental workforce by redefining and expanding the roles of dental and medical professionals, within and according to their respective scopes of practice….
>
> Goal 12. Recruit and Retain Dental Professionals. Recruit and retain an adequate number of qualified dental professionals to meet the oral health needs of the people of Maine….
>
> Goal 13. Expand Breadth and Diversity of Education Available to Health Professionals. Promote educational opportunities and experiences to enable oral health professionals to expand services to the at-risk and under-served populations of all age groups, including older adults and elders as well as children….[59]

# V. Review of MaineCare Dental Coverage

## A. Covered Services

### 1. Maine Statute Regarding Adult Dental Services

Maine statute provides for a limited scope of dental services to be provided to MaineCare adults age 21 and over:

> **22 §3174-F. Coverage for Adult Dental Services**

[56] Ibid. p. 10, 11.
[57] Governor's Office of Health Policy and Finance with the Advisory Council on Health Systems Development. (2010). p. iii.
[58] Scala, E. & Sutton, S. (2010). p. 7.
[59] Maine Dental Access Coalition. (2007). p. 19 - 21.

**1**. **Coverage provided.** The Department of Health and Human Services shall provide dental services, reimbursed under the United States Social Security Act, Title XIX, or successors to it, to individuals 21 years of age and over, limited to:

A. Acute surgical care directly related to an accident where traumatic injury has occurred. This coverage will only be provided for the first 3 months after the accident;

B. Oral surgical and related medical procedures not involving the dentition and gingiva;

C. Extraction of teeth that are severely decayed and pose a serious threat of infection during a major surgical procedure of the cardiovascular system, the skeletal system or during radiation therapy for a malignant tumor;

D. Treatment necessary to relieve pain, eliminate infection or prevent imminent tooth loss; and

F. Other dental services, including full and partial dentures, medically necessary to correct or ameliorate an underlying medical condition, if the department determines that provision of those services will be cost-effective in comparison to the provision of other covered medical services for the treatment of that condition.[60]

**2. *MaineCare Benefits Manual***

**MaineCare Members Under Age 21**

MaineCare members under the age of 21 are eligible to receive dental services which are defined in the *MaineCare Benefits Manual* as:

> …all services provided by or under the supervision of a dentist in the practice of dentistry. These include: treatment of the teeth and associated structures of the oral and maxillofacial regions, and of disease, injury, abnormality, or impairment that may affect the oral or general health of the individual.
>
> …Dental Services also include denturism, hygienist services provided by Maine's schools of dental hygiene, hygienist services provided by public health entities, and school-based and/or school-linked programs under contract arrangement with the Maine Center for Disease Control and Prevention, Oral Health Program.[61]

**MaineCare Members Age 21 and Older**

MaineCare adult members 21 or older are eligible for a limited set of urgent care (often and commonly referred to as emergency) dental services. Described in the *MaineCare Benefits Manual*, coverage is

[60] 22 MRSA § 3174-F.
[61] Maine Department of Health and Human Services. (2010). p. 1.

limited to only those services necessary to relieve or eradicate acute pain, control bleeding, eliminate acute infection and prevent imminent tooth loss. Covered procedures include: acute diagnostic and surgical procedures and care related to traumatic injury; extractions; and restorations necessary to prevent imminent tooth loss.[62]

**Dentures** are available when they are "medically necessary to correct or ameliorate an underlying medical condition if the Department determines that it is cost-effective" [63] to provide them compared to the cost that would otherwise result if they were not made available to the member. (See 22 MRSA § 3174-F. 1.F. above)

### 3. Adult Dental Coverage in Other States

In 2008 the National Academy for State Health Policy issued a report on Medicaid coverage for adult dental services. The report pointed out that there is a wide range of benefits provided by states in terms of scope of coverage, total amount provided, with some states including a cap on the amount paid. At that time they found that:

- Six states do not cover any dental services for adults.
- Sixteen states offer only emergency services (for example, only paying for extractions of diseased teeth) for all adult enrollees.
- Thirteen states exclude coverage in at least one category of service, generally periodontal and advanced restorative services (such as root canals and crowns).
- Sixteen states offer coverage in all service categories for all adult enrollees.
- Six states impose annual caps on the amount they will pay for adult dental services. Annual limits vary. California has an annual limit of $1,800 per Medicaid beneficiary while Vermont's annual limit is set at $495.[64]

Since the State Health Policy report was issued, several states have proposed or passed cuts or limited coverage for children or adults as a means to address state budget shortfalls. (California, Michigan, Maryland, Hawaii, North Carolina and Washington)[65] Other states, (Arkansas, Alaska and Washington, D.C.) have added or expanded coverage for adults.

A study by the Kaiser Commission on Medicaid and the Uninsured of the elimination of adult dental services in Massachusetts showed significant impact for adult Medicaid members, but the overall savings to the Massachusetts Medicaid budget was less than 1%. Additionally, some of the costs were shifted to the state's uncompensated care fund payments to community health centers to reimburse dental services, which saw an increase of 54%.[66]

## B. Reimbursement Rates

### 1. Comparison to Regional Rates

Table 2, MaineCare Rates for Selected Services Compared to American Dental Association New England Fees, provides a list of the more commonly provided dental services that are available to children.

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[62] Ibid. p. 28-29.
[63] Ibid. p. 29.
[64] McGinn-Shapiro, M. (2008). p. 3.
[65] McKenna, M. (2010). p. 18A.
[66] Pryor, C., et al. (2005). p. 4.

(MaineCare does not cover these services for adults.) It includes the current MaineCare reimbursement rate and provides a comparison to New England fees for all insurers, not just Medicaid. The 50th percentile indicates the amount at which half of the fees fall below and half of the fees fall above. For the 75th percentile, 25% of the fees are above the amount listed.

## 2. Relationship to Dental Provider Enrollment and Participation

**Nationally**, it has been found that based on providing Medicaid dental services to children, a number of strategies must be undertaken to expand access. In her report regarding Medicaid reimbursement rates, Borchgrevink explains:

- Rate increases are necessary – but not sufficient on their own – to improve access to dental care. Easing administrative processes and involving state dental societies and individual dentists as active partners in program improvement are also critical. Administrative streamlining and working closely with dentists can help maximize the benefit of smaller rate increases, and mitigate potential damage when state budgets contract.

- … rates need to at least cover the cost of providing service, which is estimated to be 60 to 65 percent of dentists' charges.

- Working with patients and their families about how to use dental services is a core element of reforms. States have successfully used case management, educational brochures, and patient support provided by contractors to reduce barriers and address one of dentists' chief complaints.[67]

**Table 2. MaineCare Rates for Selected Services Compared to American Dental Association New England Fees** Ω

| Description of Service | Code | MaineCare Rate^ | 50th percentile* ADA | 75th percentile* ADA |
|---|---|---|---|---|
| Comprehensive oral examination | D0150 | $55 | $78 | $90 |
| Periodic examination | D0120 | $30 | $41 | $45 |
| Limited problem focused examination | D0140 | $20 | $72 | $80 |
| Panoramic Radiograph/FMX-diagnostic | D0330 | $43 | $110 | $125 |
| Four bite wing radiographs | D0274 | $20 | $59 | $67 |
| Individual periapical radiographs | D0220/D0230 | $8/first, $6.50 each additional | $26/21 | $30/24 |
| Prophylaxis | D1110 | $40 | $85 | $94 |
| Scaling and Root planing four or more | D4341 | $40 | $231 | $253 |
| Extraction of nonrestorable teeth | D7140 | $91 | $150 | $175 |
| Surgical extraction of nonrestorable teeth | D7210 | $110 | $263 | $295 |
| Anterior composite restorations | D2332 | $109/3 surfaces | $205 | $229 |
| Posterior amalgam restorations | D2393 | $103/3 surfaces | $247 | $271 |
| Endodontic therapy | D3310 | $220+ | $732+ | $825+ |
| Endodontic therapy | D3300 | $338+ | $1041+ | 1195+ |
| Post and Core buildup | D2950 | $150 | $269 | $300 |

[67] Borchgrevink, A., et al. (2008). p. vi.

| | | | | |
|---|---|---|---|---|
| Full Dentures | D5110 | $393 | $1,401 | $1,695 |
| Partial Dentures | D5211 | $280 | $1,073 | $1,259 |
| Full Denture reline | D5730 | $78 | $315 | $375 |

Ω ADA, Survey Center, *2009 Survey of Dental Fees, General Practitioners: New England Region*
+Excludes final restoration
*The 50th and 75th ADA percentiles are the values below which 50% or 75% of the fees may be found.
^ 10-144 Chapter 101, MaineCare Benefits Manual, Chapter III, Section 25, Allowances for Dental Services, 12/18/09

## Other States

In their report, *State Health Reform: How Do Dental Benefits Fit In?* Snyder and Gehshan discuss the impact of increasing dental rates on the numbers of providers participating in the state Medicaid programs as well as on utilization rates (measured by an increase in children's visits).

- Alabama tripled expenditures while the number of children with visits rose 5% and providers increased by 16% (1999 – 2002).
- When Indiana matched commercial rates, the number of children with dental visits increased 14% and the number of dentists increased by 42% (1997 – 2000).
- Michigan increased payments by 2.5 times and the number of child visits increased by one third. The distance to providers decreased and the number of providers increased (2000).
- When Tennessee raised rates from 40% of private rates to be comparable with those rates, the number of child visits went up 23% and the number of dentists doubled (1999 – 2005).
- When Virginia increased rates by 30% (2005 – 2006), the number of child visits increased by 8% and the number of dentists went 57%.[68]

Davis and Brown reviewed Medicaid dental administration in a number of states for their report *Managing California's Medicaid Dental Program: Lessons from Other States* and found:

- Stakeholder involvement and buy-in is critical to the success of any reform effort. Senior level executive and legislative branch leadership is also important.
- Reforming the Medicaid dental program does not lead to cost savings in the short term because of pent-up demand. However, cost-effectiveness improves as utilization changes from restorative to preventive care.
- Administrative and payment issues are critical for providers and contribute to low rate of provider participation.
- Integration of physical and oral health has not yet been a priority, although some states and healthplans are beginning to focus on this. [69]

## Maine Dental Provider Views Regarding Rates and MaineCare

Concerns raised by Maine dental providers regarding MaineCare mirror the concerns that have been raised across the country:

> Based on the 2008 Maine Cooperative Health Manpower Survey of dentists, among active dentists who do not accept MaineCare, approximately half would consider accepting MaineCare if reimbursements were increased (52%), administrative paperwork was reduced (53%), or if they

[68] Snyder, A., et al. (2008). p. 17.
[69] Davis, C., et al. (2009). p. 6.

> were compensated for missed appointments (48%). While nearly 4 out of 10 active Maine dentists treat children insured by MaineCare, only 26% treat adult MaineCare insured patients.[70]

The *2008 Maine Dentist Survey* also found that of the actively licensed dentists responding to the survey:

- 87% are accepting new patients
- 26% are accepting new MaineCare patients
- 47% treat MaineCare patients
- 42% treat MaineCare patients under 21
- 26% treat MaineCare patients 21 and over
- 58% of those accepting MaineCare patients limit the % of MaineCare patients on their caseload.[71]

In 2010 at a 48% rate, Maine ranked in the top 16 states in the number of dentists treating Medicaid patients. Of those dentists and clinics treating MaineCare members, 45% billed over $100,000 per year.[72]

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

An examination of fees was completed by the Governor's Task Force on Expanding Access to Oral Health Care for Maine People and released in their December 2008 Report. The report found:

> Generally, MaineCare reimburses dental care providers for services rendered to children and also for adult emergency dental services. The level of state and federal funding and the level of reimbursement by MaineCare for oral health services has been problematic for two decades and has continued to diminish over time in comparison to the actual costs of providing those services. Reimbursement rates need to be increased and rates should be rebased using acceptable and credible external fee data for benchmarking. Without additional funding, the ability of the oral health infrastructure (including private practice dentists as well as non-profit organizations) to provide services will be increasingly limited, and in turn, the overall health of Maine citizens will decrease. A variety of methodologies should be examined to determine their effectiveness in increasing and maintaining provider participation in the MaineCare dental program, but increased reimbursement is paramount….
>
> Inadequate MaineCare reimbursement limits access to oral health care. In turn, health care costs increase when people (1) enter the oral health care system with more serious treatment needs than if they had been able to obtain care earlier in the disease process; or (2) when they seek dental care at hospital emergency departments.[73]

**Office of MaineCare Services Report to the Legislature**

In their February 22, 2010 12th Annual Report to the Joint Standing Committee on Health and Human Services, *Improving MaineCare Dental Access for Maine Children*, the Office of MaineCare Services concluded that like much of the country, dental access in Maine remains a problem:

- The supply of dentists in Maine is inadequate to meet demand,
- The reimbursement rates are inadequate,

[70] Maternal and Child Health Services. (2010). p. 190. Compiled by Bratesman, S. *2008 Maine Dentist Survey.*
[71] Ibid. p. 190 – 191.
[72] Bastey, John. Maine Dental Association. (personal communication, January 6, 2011). [unpublished research].
[73] Governor's Task Force on Expanding Access to Oral Health Care for Maine People. (2008). p. 5-6.

- MaineCare participation rate by general private practice dentists (not including dental specialties) continues to be low even though there has been a rise in this calendar year (based on SF 07 claims data),
- Prevention rates for children have risen to 41% but treatment/restorative services remain low at just under 14%.[74]

## C. Utilization and Current Expenditures

### 1. Trends and Current Expenditures

During the last three years the number of MaineCare members receiving dental services increased, and reflective of that increased utilization, the total amount paid for those services has also increased. Table 3a provides information about the utilization of dental services in 2009. Table 3b compares utilization and expenditures for 2007, 2008 and 2009. In 2009, there were roughly twice as many MaineCare members 21 and under, 58,221, that utilized dental services than those members who were 21 and over, 24,095. In 2009, $32,368,226 was spent on dental services for MaineCare members, of which $9,746,772 was spent on adult members who do not receive comprehensive prevention or restorative treatment.

### 2. Use of Preventive and Specialty Services

### Preventive Services

As discussed above, MaineCare members under age 21 may receive "all services provided by or under the supervision of a dentist in the practice of dentistry,"[75] including preventive services (excludes those services that are purely cosmetic and orthodontic treatment that does not meet the required score on the malocclusion scale). MaineCare members 21 and older do not receive any preventive services, and only receive coverage necessary to relieve or eradicate acute pain, control bleeding, eliminate acute infection, and prevent imminent tooth loss.

**Table 3a. 2009 MaineCare Dental Services Utilization – Professional Paid Claims***

| | All Users | | | | Age < 21 | | | | Age >= 21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ |
| Dental Claims) | 554,310 | 181,774 | 74,540 | $30,093,674 | 423,711 | 138,269 | 53,901 | $21,257,033 | 130,599 | 43,505 | 20,639 | $8,836,641 |
| FQHC Claims | 24,850 | 16,362 | 9,464 | $2,014,124 | 15,558 | 9,642 | 5,279 | $1,218,138 | 9,292 | 6,720 | 4,185 | $795,986 |
| Indian Health Services | 548 | 541 | 281 | $145,261 | 399 | 392 | 181 | $106,797 | 149 | 149 | 100 | $38,464 |
| RHC Claims | 1,288 | 1,246 | 973 | $115,167 | 364 | 354 | 300 | $39,486 | 924 | 892 | 673 | $75,681 |
| **Totals (FQHC, RHC, IHS, Dental):** | **580,996** | **199,923** | **82,316** | **$32,368,226** | **440,032** | **148,657** | **58,221** | **$22,621,454** | **140,964** | **51,266** | **24,095** | **$9,746,772** |
| All Others* | 16,569 | 11,117 | 7,908 | $615,912 | 9,476 | 4,974 | 3,725 | $320,393 | 7,093 | 6,143 | 4,183 | $295,519 |

*Limited To Claim Type = Professional, Dental See Appendix D for details.
^Total Paid includes the cost of the entire claim (not just individual claim lines)
Source: Muskie7, MaineCare CY 2009

**Table 3b. MaineCare Dental Services Utilization – Professional Paid Claims 2007, 2008, 2009***

[74] Office of MaineCare Services. (2010). p. 16.
[75] Maine Department of Health and Human Services. (2010). p.1.

| | All Users | | | | Age <21 | | | | Age >=21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Year** | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ |
| **2009** | 580,996 | 199,923 | 82,316 | $32,368,226 | 440,032 | 148,657 | 58,221 | $22,621,454 | 140,964 | 51,266 | 24,095 | $9,746,772 |
| **2008** | 540,241 | 189,326 | 78,836 | $28,290,331 | 412,338 | 142,682 | 56,202 | $19,748,616 | 127,903 | 46,644 | 22,634 | $8,541,715 |
| **2007** | 508,031 | 194,246 | 76,848 | $26,064,541 | 389,838 | 148,207 | 54,301 | $18,069,699 | 118,193 | 46,039 | 22,547 | $7,994,842 |

* Limited To Claim Type = Professional, Dental ^Total Paid includes the cost of the entire claim (not just individual claim lines)
Source: Muskie7, MaineCare CY 2007, 2008, 2009

## Orthodontics

Federal Medicaid guidelines provide for the restoration of teeth and the maintenance of dental health to correct or ameliorate abnormalities that might become serious conditions. Under this provision, MaineCare provides limited orthodontics to members under age 21 to address the early stages of a problem to lessen the severity or future effects of the malformation and eliminate its cause, and may include localized tooth movement. Examples include correcting crowding, providing partial treatment to open spaces or upright a tooth for a bridge or implant and partial treatment for closure of a space(s).

Comprehensive orthodontics is provided to members under 21 when a condition is "extreme, and if left untreated, would become an acute dental problem and/or cause irreversible damage to the teeth or supporting structures."[76]

**Orthodontics** are not provided to members over 21 except in those limited cases where the "treatment is being performed to correct a post-traumatic or post-surgical disfigurement, or in those cases where these services are a continuation of ongoing treatment started before age 21."[77]
Table 4 provides a comparison of orthodontic utilization for 2007, 2008 and 2009. It shows a drop of 22% in the number of users from 2007 to 2009, but an increase in expenditures of almost 30% for that same time period. The average cost per orthodontic user in 2007 was $907 compared to $1,665 in 2009.

**Table 4. MaineCare Orthodontic Paid Claims 2007, 2008, 2009***

| | All Users | | | | Age <21 | | | | Age >=21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Year** | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid |
| **2009** | 9,478 | 8,232 | 2,952 | $4,915,920 | 9,227 | 8,024 | 2,905 | $4,886,059 | 251 | 208 | 47 | $29,861 |
| **2008** | 16,121 | 14,465 | 3,367 | $3,894,159 | 15,866 | 14,247 | 3,309 | $3,871,582 | 255 | 216 | 58 | $22,577 |
| **2007** | 23,834 | 20,831 | 3,784 | $3,432,292 | 23,557 | 20,612 | 3,734 | $3,414,016 | 277 | 219 | 50 | $18,275 |

*Procedure Codes: D8070, D8080, D8670, D8090
Data Source: Muskie7, MaineCare CY 2007, 2008, 2009

## Endodontics

For adults age 21 years or older MaineCare covers root canals for acutely painful teeth and restorations necessary to restore previously endodontically treated teeth. MaineCare does not cover the final restoration of teeth that have had root canals.[78]

[76] Maine Department of Health and Human Services. (2010). p. 20.
[77] Ibid. p. 31.
[78] Ibid. p. 28 – 29.

Without a final restoration the MaineCare member is left with a hollowed out tooth with a temporary filling or cap that is susceptible to further damage if the treatment is not finished with a permanent filling and/or crown. MaineCare members must come up with the funds to cover the expense of the final restoration, or risk further damage to the tooth or extraction.

Table 5 shows that between 2007 and 2009 the overall number of endodontic users rose 35% which was consistent with the 35% increase in the total paid for endodontic services. However, the table shows a distinct difference between expenditures for MaineCare members under 21, which increased from $297 to $327 per endodontic user between 2007 and 2009 and MaineCare members age 21 and over who saw a decrease in the amount paid per user from 2007 at $317 to $299 in 2009.

**Table 5. MaineCare Endodontic Dental Paid Claims 2007, 2008, 2009***

| | All Users | | | | Age <21 | | | | Age >=21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Year** | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid | Total Claim Lines | Total Claim Headers | Total Distinct Uers | Total Paid |
| **2009** | 1,440 | 1,289 | 1,143 | $352,152 | 402 | 368 | 341 | $111,780 | 1,038 | 921 | 802 | $240,371 |
| **2008** | 1,298 | 1,053 | 939 | $283,091 | 482 | 404 | 369 | $112,108 | 816 | 649 | 570 | $170,982 |
| **2007** | 892 | 816 | 738 | $228,936 | 311 | 288 | 272 | $80,947 | 581 | 528 | 466 | $147,989 |

*Procedure Codes D3310, D330, D3320. FQHC claims include entire amount.
Data Source: Muskie 7, MaineCare CY 2007, 2008, 2009

Endodontic treatment allows a person, in some cases, to retain a tooth that would otherwise likely be extracted. Studies show that "the vast majority of patients (97%) reported an improved quality of life and satisfaction with their decision to have endodontic treatment rather than extraction."[79] MaineCare data provided in Table 6 also shows that MaineCare members experience improved oral health as a result of their treatment and are able to avoid extractions and repeat root canals at rates consistent with national averages.[80]

**Table 6. MaineCare Paid Claims for Root Canals and Extractions**

| Year | Distinct Members Root Canal (D3310,D3320,D3330) | Distinct Members Extraction (D7140,D7210,D7250) | Distinct Members Repeat Root Canal (D3346,D3347,D3348) |
|---|---|---|---|
| 2005 | 819 | 14,799 | 7 |
| 2006 | 858 | 14,734 | 3 |
| 2007 | 739 | 15,683 | 9 |
| 2008 | 940 | 16,910 | 10 |
| 2009 | 1,144 | 17,911 | 11 |
| 2010 to date | 825 | 12,938 | 11 |
| Total All Years | 4,851 | 71,349 | 49 |
| Extraction Following Root Canal | | Repeat Root Canal Following Root Canal | |
| Years Between Services | Distinct Members | Years Between Services | Distinct Members |
| <1 | 201 | <1 | 9 |
| 1 | 133 | 1 | 7 |
| 2 | 82 | 2 | 2 |
| 3 | 63 | 3 | 2 |

[79] Salehrabi, R., et al. (2004). p. 849 – 850.
[80] Ibid. p. 848 and unpublished MaineCare data. 10/20/10.

| | | | |
|---|---|---|---|
| 4 | 28 | 4 | 1 |
| 5 | 5 | Total Distinct Members | 20 |
| Total Distinct Members | 477 | | |
| Distinct Members with a Root Canal and No Extraction or Repeat Root Canal | 4,359 | | |

Data Source: MMDSS (MECMS) Date Run: 10/20/2010
January 1, 2005 – August 31, 2010 by claim line from service date

## D. Emergency Department, Outpatient Care and Inpatient Hospitalization

### 1. Services

Individuals who visit hospital emergency departments with a dental diagnosis are typically seeking relief from dental pain and infection. The treatment they receive there is not definitive care, i.e. they do not receive treatment for the disease or underlying cause of the infection or pain. They will ultimately need to see a dentist in order to receive that definitive care. The treatment provided by emergency departments includes pain management, treatment for dental infection and possibly a referral to a dentist. MaineCare will pay for extractions when a member has infection and/or pain. Without the financial resources to pay for treatment, other than the extractions that MaineCare covers, it is quite likely that the individual will return to the emergency department when pain and infection return. In some instances, the lack of definitive dental care requires inpatient treatment for the infection and other possible complications in addition to the treatment for pain and infection received in the emergency department.

### 2. Expenditures

Table 7a shows that in 2009 MaineCare members received a total of $7,458,226 in services from emergency departments of other outpatient services, and that $6,590,888, or 88% of that amount had no related dental procedure code meaning that no definitive treatment was provided. Only 12%, or $867,338 of the services provided had a related dental procedure code meaning that some sort of definitive dental treatment was provided. $2,809,307 was spent on emergency department visits and $3,781,581 was spent on other outpatient claims. Of the MaineCare members seeking outpatient or emergency department services 71% were 21 and over.

**Table 7a. 2009 MaineCare Outpatient and Emergency Room Paid Claims***

| | All Users | | | | Age < 21 | | | | Age >= 21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ |
| All Outpatient Claims with an ER Visit W/Dental Dx | 35,273 | 12,794 | 8,687 | $2,809,307 | 7,580 | 2,773 | 2,207 | $579,561 | 27,693 | 10,021 | 6,480 | $2,229,746 |
| All Non-ER Outpatient Claims with only a Dental Diagnosis | 24,840 | 12,833 | 8,091 | $3,781,581 | 8,161 | 2,809 | 2,256 | $1,906,389 | 16,679 | 10,024 | 5,835 | $1,875,192 |
| **SubTotal:** | **60,113** | **25,627** | **15,303** | **$6,590,888** | **15,741** | **5,582** | **4,190** | **$2,485,950** | **44,372** | **20,045** | **11,113** | **$4,104,938** |
| All Outpatient Claims Without an ER Visit and With A Dental Procedure Code | 3,008 | 387 | 382 | $867,338 | 2,641 | 333 | 331 | $763,567 | 367 | 54 | 51 | $103,770 |
| **All Outpatient Total:** | **63,121** | **26,014** | **15,596** | **$7,458,226** | **18,382** | **5,915** | **4,458** | **$3,249,517** | **44,739** | **20,099** | **11,138** | **$4,208,709** |

*Limited to Claim Type = Outpatient ^Total Paid includes the cost of the entire claim (not just individual claim lines)
Source: Muskie7, MaineCare CY 2009

Table 7b provides a comparison between 2007, 2008 and 2009 and shows that the number of MaineCare members 21 and over seeking emergency department of outpatient services has been relatively consistent, but that there has been an 11% increase in the number of MaineCare members under 21 seeking services. There was also an increase in the total amount paid of 25% between 2007 and 2009.

**Table 7b. MaineCare Outpatient and Emergency Room Paid Claims 2007, 2008, 2009***

| | All Users | | | | Age <21 | | | | Age >=21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Year** | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ |
| **2009** | 63,121 | 26,014 | 15,596 | $7,458,226 | 18,382 | 5,915 | 4,458 | $3,249,517 | 44,739 | 20,099 | 11,138 | $4,208,709 |
| **2008** | 62,669 | 26,111 | 15,400 | $6,599,999 | 17,255 | 5,645 | 4,232 | $2,831,353 | 45,414 | 20,466 | 11,168 | $3,768,647 |
| **2007** | 63,283 | 26,462 | 15,191 | $5,617,243 | 15,511 | 5,436 | 3,969 | $2,230,477 | 47,772 | 21,026 | 11,222 | $3,386,767 |

*Limited to Claim Type = Outpatient ^Total Paid includes the cost of the entire claim (not just individual claim lines)
Source: Muskie7, MaineCare CY 2007, 2008, 2009

Table 8 provides comparison information about the emergency department usage of privately insured (not dental insurance) and uninsured users for treatment of dental pain or infection. As with MaineCare members, adults are the greatest users of emergency departments, and this was particularly true for the uninsured. Between 2007 and 2009, the number of privately insured users decreased by 36% and their total charges decreased by 9%. Between 2007 and 2009, the uninsured saw increases in both the number of emergency department users, up 8%, as well as an increase in total charges of 28%.

**Table 8. Emergency Room Claims for Privately Insured and Uninsured Patients**

| Emergency Room Commercial Payer Claims^ | | | | | | Uninsured Emergency Room Patients | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2007 | 2008 | 2009 | | 2007 | 2008 | 2009 | |
| Count of Discharges | 0-20 | 3,882 | 3,703 | 2,471 | | 444 | 420 | 362 | |
| | 21+ | 14,111 | 13,138 | 8,788 | | 4,836 | 5,354 | 5,386 | |
| | **Total** | **17,993** | **16,841** | **11,259** | | **5,280** | **5,774** | **5,748** | |
| Count of Patients | 0-20 | 3,282 | 3,218 | 2,143 | | 402 | 371 | 339 | |
| | 21+ | 10,682 | 10,370 | 6,845 | | 4,157 | 4,461 | 4,602 | |
| | **Total** | **13,964** | **13,588** | **8,988** | | **4,559** | **4,832** | **4,941** | |
| Total Charges | 0-20 | 946,867 | 1,186,140 | 762,812 | | 180,707 | 177,011 | 175,963 | |
| | 21+ | 4,371,614 | 4,713,542 | 4,074,858 | | 1,914,160 | 2,237,122 | 2,737,930 | |
| | **Total** | **5,318,481** | **5,899,682** | **4,837,670** | | **2,094,867** | **2,414,133** | **2,913,893** | |
| Avg. # Discharges per Patient | 0-20 | 1.18 | 1.15 | 1.15 | | 1.10 | 1.13 | 1.07 | |
| | 21+ | 1.32 | 1.27 | 1.28 | | 1.16 | 1.20 | 1.17 | |
| | **Total** | **1.29** | **1.24** | **1.25** | | **1.16** | **1.19** | **1.16** | |
| Avg. Charges per Discharge | 0-20 | 244 | 320 | 309 | | 407 | 421 | 486 | |
| | 21+ | 310 | 359 | 464 | | 396 | 418 | 508 | |
| | **Total** | **296** | **350** | **430** | | **397** | **418** | **507** | |
| Avg. Charges Per Patient | 0-20 | 289 | 369 | 356 | | 450 | 477 | 519 | |
| | 21+ | 409 | 455 | 595 | | 460 | 501 | 595 | |
| | **Total** | **381** | **434** | **538** | | **460** | **500** | **590** | |

Source: Maine Health Data Organization Data Request #615105
Notes: Emergency room claims identified by the presence of revenue code 45x
Dental conditions identified by diagnosis code list provided by DHHS
^The data represents paid claims for individuals seen in hospital emergency rooms for dental conditions.
Commercial Payers included (e.g.: Aetna, Anthem, Cigna), no governmental payers (e.g.: Medicare, MaineCare, CHAMPUS/VA)

## Inpatient Expenditures

Tables 9a and 9b show that the number of MaineCare members requiring inpatient services related to dental diagnosis remains consistently small for both children and adult MaineCare members. However, the costs of those inpatient services is not insignificant, despite a 9% decrease in the total paid from 2007 to 2009 with total claims paid in 2009 of $3,122,002.

**Table 9a. 2009 MaineCare Inpatient Paid Claims Related to Dental Diagnosis***

| | All Users | | | | Age < 21 | | | | Age >= 21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ |
| All Inpatient Claims with an ER Visit | 1,766 | 146 | 139 | $1,157,193 | 237 | 22 | 21 | $179,847 | 1,529 | 124 | 118 | $977,347 |
| All Inpatient Claims without an ER Visit | 1,560 | 241 | 169 | $1,964,808 | 534 | 78 | 58 | $680,647 | 1,026 | 163 | 111 | $1,284,162 |
| **All Inpatient Total:** | **3,326** | **387** | **275** | **$3,122,002** | **771** | **100** | **70** | **$860,493** | **2,555** | **287** | **205** | **$2,261,509** |

*Limited to Claim Type = Inpatient ^Total Paid includes the cost of the entire claim (not just individual claim lines)
Source: Muskie7, MaineCare CY 2009

**Table 9b. MaineCare Inpatient Paid Claims Related to Dental Diagnosis 2007, 2008, 2009***

| | All Users | | | | Age <21 | | | | Age >=21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Year** | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ |
| **2009** | 3,326 | 387 | 275 | $3,122,002 | 771 | 100 | 70 | $860,493 | 2,555 | 287 | 205 | $2,261,509 |
| **2008** | 3,526 | 415 | 290 | $3,852,413 | 856 | 102 | 75 | $1,253,930 | 2,670 | 313 | 215 | $2,598,483 |
| **2007** | 3,256 | 387 | 291 | $3,434,962 | 683 | 93 | 73 | $860,966 | 2,573 | 294 | 218 | $2,573,996 |

*Limited to Claim Type = Inpatient ^Total Paid includes the cost of the entire claim (not just individual claim lines)
Source: Muskie7, MaineCare CY 2007, 2008, 2009

Table 10 provides a comparison with inpatient claims for uninsured patients with a dental diagnosis and shows that comparable to MaineCare members, the numbers are small and almost exclusively adults, but that the related costs are not insignificant.

**Table 10. Inpatient Claims for Uninsured Patients with a Dental Diagnosis**

| Uninsured Inpatient with a Dental Diagnosis | | | | |
|---|---|---|---|---|
| Year | | 2007 | 2008 | 2009 |
| Count of Discharges | 0-20 | 1 | 2 | 1 |
| | 21+ | 48 | 55 | 60 |
| | **Total** | **49** | **57** | **61** |
| Count of Patients | 0-20 | 1 | 2 | 1 |
| | 21+ | 47 | 52 | 55 |

| | | | | |
|---|---|---|---|---|
| | **Total** | **48** | **54** | **56** |
| Total Charges | 0-20 | 10,389 | 39,666 | 5,050 |
| | 21+ | 510,839 | 683,202 | 1,044,359 |
| | **Total** | **521,228** | **722,868** | **1,049,409** |
| Avg. # Discharges per Patient | 0-20 | 1.00 | 1.00 | 1.00 |
| | 21+ | 1.02 | 1.06 | 1.09 |
| | **Total** | **1.02** | **1.06** | **1.09** |
| Avg. Charges per Discharge | 0-20 | 10,389 | 19,833 | 5,050 |
| | 21+ | 10,642 | 12,422 | 17,406 |
| | **Total** | **10,637** | **12,682** | **17,203** |
| Avg. Charges Per Patient | 0-20 | 10,389 | 19,833 | 5,050 |
| | 21+ | 10,869 | 13,139 | 18,988 |
| | **Total** | **10,859** | **13,386** | **18,739** |

Source: Maine Health Data Organization Data Request #615105
Notes: The data on this table represents inpatient discharges for individuals admitted to hospitals through emergency departments with dental conditions. Patients included in this data have no insurance coverage of any type (uninsured patients) Admissions from emergency departments were identified by the presence of revenue code 45x. Dental conditions identified by diagnosis code list provided by DHHS.

## 3. Case Studies

Following are two examples of individuals who were initially seen in an emergency department and then on multiple occasions for treatment of dental pain. They never received the definitive dental treatment they needed from a dentist, their conditions worsened and ultimately they also required treatment as inpatients.

### Case Study X

An otherwise healthy middle aged male had **three emergency department visits in one week** for a toothache and dental infection. The infection progressed to the point that the patient was admitted to the hospital and an emergency airway was performed as the patient was losing his airway secondary to the progressing dental infection. The patient was stabilized and the next day transferred to Maine Medical Center. The patient was again taken to the operating room for an incision, drainage of the infection and removal of the diseased teeth. The patient was eventually discharged with home health care for 2 ½ weeks for intravenous antibiotics. DHHS paid **$11,670.**[81]

### Case Study Y

An otherwise healthy middle aged male with poor dentition and no dental home presented to an emergency room for **six different visits** in a period of five days. He was treated with routine oral antibiotics as is customary but developed increasing dental pain and infection. A CT scan was performed on the fifth day suggesting the patient was developing respiratory distress secondary to dental infection. He was admitted to the hospital for intravenous antibiotics, additional studies, incision and drainage the next day. The patient was discharged home that same day for two weeks of home health care and intravenous antibiotics. The patient continued to do poorly and was transferred to another hospital for

[81] Based on treatment for a specific MaineCare member and related claims data.

more aggressive care which resulted in an operation to remove 18 infected teeth. DHHS paid **$71,106.00.**[82]

# VI. Providing More Cost-effective, High-Quality Care for MaineCare Members

## A. Ways to Reduce or Redirect Expenditures

### 1. Current MaineCare Initiatives to Address Access to Dental Care

Dental pain and infection is one of the top five avoidable Emergency Department visits.[83] To address this, MaineCare is reaching out to Maine hospital emergency departments in several different ways to facilitate the development of a referral process and/or a treatment plan for MaineCare members who have dental pain and infection so that they are able to avoid future use of the emergency department. MaineCare also has several initiatives in process to provide assistance to MaineCare members and dental providers and to address general issues around access to dental care, which could assist in the avoidance of emergency department visits.

**Emergency Room Work Group**
In May of 2009, the Division of Health Care Management started an initiative that targeted "avoidable" emergency department visits, including dental pain and infection. MaineCare members who have two or more visits in a three month period receive letters explaining the appropriate use of the emergency room, and follow-up phone calls from MaineCare nurses explaining appropriate reasons to use an emergency department, provide alternative remedies for conditions that led to the ER visit, and offer assistance in finding a provider when necessary. Providers are also notified of their patients who went to the emergency department two or more times in a quarter and are offered assistance with additional member education.

**Dental Pain/Infection Treatment and Referral Plans**
HCM is working closely with Maine's dental community to develop more effective ways to manage high rates of untreated dental pain and infection in MaineCare for members 21 and over. When a MaineCare member visits an emergency department with any kind of dental pain, the ER is not equipped to resolve the problem when it is related to dental problems. Ordinarily, the ER doctor can provide antibiotics and pain-killers but not treat the true reason for the dental pain and infection. MaineCare staff are working with individual hospitals and facilitating a treatment and referral plan for MaineCare members to nearby general dentists. To date, plans have been developed with Penobscot Bay Health Center (Rockland), Miles Memorial Hospital (Damariscotta), St. Andrews Hospital (Boothbay), and Sebasticook Valley Hospital (Pittsfield), with arrangements under way for a number of other hospitals. As a new initiative the scope of this project is developing and its impact still needs to be evaluated.

**Maine General Pilot Project**
DHHS and Maine General have developed and implemented a forum of case managers and caregivers to review the records of patients who are the top individual users of Maine General's emergency department,

[82] Ibid.
[83] MaineCare claims data.

including those seeking treatment for dental pain. The group brings together every person in the member's medical life to review emergency department visits and to discuss with physicians who have treated them the core problem and what resources may be useful and effective. DHHS case management includes contacting family members, health providers, etc., to find the root cause behind the member's visits to the emergency department. The group reviews each case and utilizes as many community resources as possible to help the member access resources appropriately. If these members need assistance with substance abuse, housing, medications, transportation, etc., the group identifies the most appropriate person to intervene with the member, their case managers and families to deliver the needed services. Although the services provided to each individual are extensive, as a pilot project, the number of high emergency department users for dental pain is one of many diagnoses identified.

**MaineCare Member Services Telephone Referral Services, Education, Awareness and Resource Guide**

For MaineCare members under age 21, a toll free number is maintained to help members find a dentist, schedule an appointment, make a referral, follow-up on missed appointments and find orthodontic care. Brochures about the importance of keeping dental appointments are included in periodic mailings to MaineCare members and individually to those members who have missed an appointment. The MaineCare Resource Guide is used to provide MaineCare members with information about which dentists are seeing MaineCare members or accepting new patients.[84] For those MaineCare members who may require additional assistance, home visiting services through a memorandum of agreement between MaineCare Services and the Maine Center for Disease Control and Prevention's Public Health Nursing program are available to them.

**Payment of fluoride varnish in a physician's office**

For the last few years MaineCare has reimbursed physicians for the application of fluoride varnish for young children. Studies indicate that the fluoride varnish will prevent caries in young children preventing the need for dental treatment services later on making this step an important investment in good dental health.

**Outreach Efforts to Dental Care Providers**

One significant concern of dentists is missed appointments by MaineCare members. Consequently, MaineCare members who are not able to keep their dental appointments may see emergency departments as an alternative source for treatment of dental pain. Under the outreach program, dentists can notify MaineCare Member Services when they have a patient who does not keep appointments. MaineCare Member Services then provides follow-up with the MaineCare member about the importance of keeping their dental appointments, information about the specific provider's cancellation policies, transportation assistance or other support services.[85]

**MaineCare Dental Advisory Committee**

This Committee is made up of dental providers from a range of settings, along with representatives from the Maine Dental Association, Maine Dental Hygiene Association and the Maine Dental Access Coalition, who come together to address access to dental services for MaineCare members across the state. They meet quarterly and provide advice to MaineCare and the Department on dental issues.[86]

**Maine Dental Access Coalition**

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[84] Office of MaineCare Services. (2010).
[85] Ibid. p. 10.
[86] Ibid.

The Office of MaineCare Services is an active member of the Maine Dental Access Coalition whose mission is to:

> …improve access to quality oral health care services throughout Maine through the development of a system that emphasizes the importance of preventive and restorative oral health care….The Coalition continues to serve as a sounding board for ideas and strategies geared toward improving access, and to provide the structure, through its committees, to propose options for improving access and pursuing strategies toward that goal.[87]

### 2. Examples of Referral Approaches in Other States

Expanding access to dental care is a national issue. Following are a number of different models or examples of approaches that have been adopted to divert Medicaid members away from emergency departments and toward definitive care with a dentist. It is important to note that Washington and Wisconsin provide Medicaid coverage for adult dental services and the success of these programs in diverting avoidable emergency department visits may be dependent on that coverage.

**Dental ED Diversion Project** – Providence Centralia Hospital ED staff asks patients with non-emergency dental needs to fill out a contact information form, which is then faxed to Valley View Community Health Clinic to set up a follow-up dental appointment.[88]

The **Wisconsin Medicaid program** found that to address the needs of racial and ethnic minorities, they need to consider the following approaches:

> …implement programs and target expansion of the dental workforce and dental homes in minority communities and DHPSA (Dental Health Professional Shortage Area) communities. This step could include establishing oral health triage centers with expanded hours within primary care practice…expanded duty auxiliary dental personnel, who are supervised by dentists, could staff these centers…provide tax benefits or start-up funds to dentists who are willing to set up practices in underserved communities that have high unmet dental needs…establish Medicaid dental outreach hotlines to link enrollees with a dental home in their community….explore use of social marketing tools in teaching Medicaid enrollees about the importance of seeking care for NTDC in dental offices rather than in EDs or POs.[89]

In her 2008 article reviewing safety net hospitals and non-urgent care patients, Felland discusses a number of strategies used by hospital emergency departments to divert those non-urgent patients and how to meet their needs in other ways. Effective strategies include: move non-urgent patients more quickly through the emergency department; referrals and directing patients elsewhere for more appropriate definitive treatment; educating patients about the types of services that are most appropriately provided by an emergency department; dental professionals and clinics providing more convenient appointments with extended hours and walk-in clinics elsewhere and addressing the need for supportive services like child care and transportation.[90]

## B. Alternative Payment Methodologies

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[87] Ibid. p. 14.
[88] Washington State Department of Social and Health Services. (2007).
[89] Okunseri, C., et al. (2008). p. 1664-1665.
[90] Felland, L., et al. (2008). p. 2-4.

A variety of payment methodologies are used by Medicaid programs around the country. Following are examples of what have proven to be some of the more successful models. Given Maine's move toward a managed care approach for MaineCare, the work group focused its review of alternative payment methodologies on the delivery of dental services through managed care.

**1. Other State Medicaid Models**

In their review of state health reform, the National Academy for State Health Policy highlighted the following successful programs:

- Michigan – Michigan Healthy Kids Dental program enrolls Medicaid-eligible children in a dental care insurance plan managed by Delta Dental and pays a capitated rate of $14.61 per member per month. Dentists receive reimbursements that are close to commercial fees, and have the same administrative processes as for privately insured patients. Evaluations have found increased access, decreased travel time for recipients, and higher satisfaction among dentists.

- Tennessee – Tennessee enrolls Medicaid-eligible children through an "administrative services only" contract with Doral Dental, and pays claims on a fee-for-service basis. Fees have been raised to commercial levels (the 75th percentile of a regional survey of dentists' fees).

- Alabama – The state raised its reimbursement rates in 2000 to 100 percent of the Blue Cross/Blue Shield average regional rates for most procedures. It also has a special unit that conducts outreach to providers, helps them navigate the program, and helps beneficiaries use the services.[91]

**2. Managed Care**

A 1999 report of The Urban Institute, *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey,* provides a summary of the various approaches states had chosen at that time to provide dental services. Although the results may be somewhat dated, the survey does illustrate the variety of options that states have used in providing dental services to both adults and children:

> Twenty-four states carved out dental care services from HMO capitation. Most pay for dental care on a fee-for-service basis. Florida, North Carolina, and Wisconsin gave plans the option to provide dental services for higher capitation rates. Similarly, in New York, local service districts that are responsible for contracting with plans may capitate or carve out dental care at their discretion. This flexibility in contracting may reflect a low level of participating dentists in managed care. Two states separated carve-outs for adults versus children. Mississippi carved out adult dental services, whereas West Virginia carved out only children's dental care.[92]

In their report, *Understanding the Connecticut Dental Medicaid Reform Proposal: State Options in Contracting Dental Care in Medicaid,* the Connecticut Health Foundation offered a number of approaches that states may consider:

- Administer dental Medicaid programs directly or contract them through medical or dental managed care organizations;

[91] Snyder, A., et al. (2008). p. vii.
[92] Holahan, J., et al. (1999). p. 19.

- Retain administrative responsibility or not and opt to pass financial risk onto outside vendors;
- Include dental services in medical managed care contracting or carve-out dental services for separate management; or
- Contract with a single vendor or with multiple vendors for all or part of their enrolled populations or geographic areas.[93]

Regardless of the approach taken, however, several factors were identified as being critical to a program's success: "1. Market-based payment rates to dental providers, 2. Engagement of sufficient numbers of providers, and 3. Effective program oversight."[94]

The report concludes by stating:

> A handful of states that have significantly increased access have done so by utilizing a variety of program arrangements. Yet, these diverse programs share several common elements that lead to their success, namely:
>
> - Funding at market rates,
> - Simplified program administration,
> - Active engagement of stakeholders in designing and implementing reform, and
> - Rewarding access improvements.[95]

## C. Alternative Delivery Settings

### 1. Use of Emergency Department and Urgent Care Settings

A common element of successful diversion programs are referral arrangements with dentists who are willing to see Medicaid members referred by an emergency department. In addition to setting up a referral system, some emergency departments have also begun to develop policies or guidelines about what treatment they will provide to patients seeking services for dental pain. It should be noted that for the most part, referral strategies will only work if preventive and definitive dental treatment is provided to adults.

**Guidelines** – In their study, Effect of Education and Guidelines for Treatment of Uncomplicated Dental Pain on Patient and Provider Behavior, Ma et al. found that guidelines can help reduce the rate of return visits by providing a referral source for patients and information about: what types of conditions are best treated in the emergency department; the effectiveness of nonprescription pain medication; the limited services that an emergency department can provide for dental pain; and guidance for emergency department staff on the treatment of dental pain. They concluded that the implementation of guidelines for emergency department management provides a consistent approach to patient education, referral to dental services and the use of non-steroidal analgesics.[96]

### 2. Partnerships and Collaborations

Solutions for addressing access to dental care for Medicaid members will vary depending on the resources that exist within any given state or community. Some approaches will need to be implemented at the state level and others will be developed by the stakeholders and resources that exist at a local level.

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[93] Edelstein, B. (2003). p. 3.
[94] Ibid.
[95] Ibid. p. 14.
[96] Ma, M., et al. (2004).

The **American Association for Dental Research**, in a memo to the US DHHS Medicaid Commission, offers suggestions about developing models of care that are feasible for Maine given initiatives that are already underway in this state including the development of a dental school:

> Develop models of care that allow primary care providers to gather data, assess triage and refer patients to appropriate dental professionals for diagnosis and treatment. States should be encouraged to adopt models of care that develop stronger linkages between pediatricians, family physicians, geriatricians and other primary care provider s as team members with dentists in assessing oral health status….This would permit more cost-effective treatment of Medicaid beneficiaries before their dental disease manifests in a medical emergency requiring more expensive and costly treatment.
>
> Develop innovative programs that increase access to oral health care, including collaborative partnerships between state Medicaid programs and academic dental institutions….Dental schools offer several advantages that fill gaps in state Medicaid oral health programs including:
>
> 1) access to research on oral disease and prevention;
> 2) model programs in educating the public regarding good oral health; and
> 3) experience in providing oral health services to Medicaid populations including those with special needs.[97]

**Health Commons Approach –** The Health Care Commons approach discussed by Beestra looks at addressing the oral health needs of rural populations by integrating oral health into primary care uses:

> …enhanced, community-based, primary care safety net practices that include medical, behavioral, social, public and oral health services. Successful intervention requires a comprehensive approach, including attention to enhancing dental service capacity, broadening the scope of the dental skills of locally available providers, expanding the pool of dental providers, creating interdisciplinary teams in enhanced community-based sites, and developing more comprehensive oral health policy.[98]

**Wisconsin Hospital Association Resource Guide for Increasing Dental Access** – The Wisconsin Hospital Association and the Rural Wisconsin Health Cooperative took the lead in encouraging their member hospitals to work with others in their own communities on finding solutions to dental needs.[99]

**Maine Emergency Departments Referral Plans**

Maine has some good emerging models for emergency department referrals to dental providers. MaineCare is facilitating dental pain and infection treatment and referral plans with a number of Maine hospitals and local dentists. Penobscot Bay Health Center, discussed above, and the other hospitals being approached by Health Network Services to develop referral plans with local dentists are all good examples of how an established relationship between an emergency department and a dentist can help to direct MaineCare members to definitive care and encourage them to seek future dental treatment outside the emergency department.

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[97] Hovland, E., et al. (2005). p. 4.
[98] Beestra, S. (2002). p. 12.
[99] Wisconsin Hospital Association. (2002).

**Rumford experience –** Community Dental, a nonprofit organization that operates a network of dental centers, formed a partnership between its dental center in Rumford and Rumford Hospital to reduce avoidable emergency department visits for dental pain by directing emergency department patients to the Dental Center. Patients presenting to the ED with dental pain were:

- assessed and triaged by the ED RN
- examined by the ED physician
- evaluated and provided palliative care for pain and an antibiotic for treatment of the dental infection by the physician, and provided discharge instructions to see a dentist.

A connection is made for patients who do not have a dentist. Prior to the patient leaving the ED, the ED secretary faxes the front page of the patient information to the Rumford Dental Center. The fax informs the Dental Center that the patient was seen in the ED and referred for care.

Fewer than 13% of patients who have been treated at the Rumford Dental Center have returned to the ED with dental pain in the same year. The number one reason cited for not visiting the Dental Center is lack of financial resources, despite the Center's income based sliding fee scale. Funding will be needed by the Rumford Dental Center to cover the costs of uninsured patients and adult MaineCare members.[100]

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22 MRSA § 3174-F. Coverage for adult dental services.

# VIII. Appendices

## Appendix A. Resolve Chapter 146 LD 624, item 1, 124th Maine State Legislature

### Resolve, To Study Expenditures for Oral Health Care in the MaineCare Program

Sec.1 Study. Resolved: That the Department of Health and Human Services shall convene a working group to perform a study of oral health care in the MaineCare program. The study must be chaired by the director of the division of health care management in the Office of MaineCare Services and must include representatives of the MaineCare Dental Advisory Committee, the Maine Dental Access Coalition, the Maine Center for Disease Control and Prevention and MaineCare members. The working group shall review MaineCare dental coverage, reimbursement and utilization and shall identify ways to reduce or redirect expenditures with the goal of providing more cost-effective, high-quality care for MaineCare members. The working group shall review alternative payment methodologies, the use of emergency departments and urgent care settings for the treatment of dental disease, the use of preventive and specialty services, such as orthodontics and endodontics, and inpatient hospitalization. The working group shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters during the First Regular Session of the 125th Legislature. After reviewing the report, the joint standing committee of the Legislature having jurisdiction over health and human services matters may report out a bill related to the subject of the report to the First Regular Session of the 125th Legislature.

## Appendix B. Resolve Work Group Members and Staff

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## Appendix C. Summary of Institute for Healthcare Improvement Web & Action Course

Members of the LD624 work group participated in the recent Institute for Healthcare Improvement Web & Action course: Reducing Avoidable Emergency Department Visits. The purpose of the course was to introduce the IHI framework and allow them to put into practice, in a limited fashion, the principles of the framework and obtain feedback from the IHI staff. The work group used a program already in place in Rumford as their test site. This program directs individuals who present at the Rumford hospital emergency department (ED) with dental pain to Community Dental, a local not-for -profit dental clinic.

The IHI framework for reducing avoidable ED visits requires a paradigm shift from viewing ED visits as "non-urgent/inappropriate" to "avoidable" and a shift of focus for solutions from the individual level to a systems level. Many individuals come to the Emergency Department of their hospital for conditions that could be appropriately treated at lower cost elsewhere. ED staff tends to label these visits as "inappropriate." This focus on medical solutions to ED visits fails to recognize that the factors that bring the individuals to the ED have less to do with the medical condition itself than with community and social conditions that prevent them from getting assistance elsewhere. From the patient perspective the ED is an "appropriate" place to get medical attention if they are unaware of or unable to access health care in other settings. Taking the patient's perspective allows us to think about these visits as avoidable and look for community or systems solutions that would create options for treatment outside the ED.

The IHI framework involves creating high-level coalitions to address health issues of a population grouping within the community. This population (patient stream) must be one that will generate enough interest to attract a coalition from the wider community. The coalition is needed because the solutions to the problems faced by the patients are community based, not medical. The coalition will do the community work and attract any funding necessary to implement the solution. The identification of the patient stream to the ED to be addressed comes from data collection on patients, and is not necessarily based on diagnosis. Potential categories include age (newborns, elderly) day of week (weekends) or ethnic background (cultural obstacles). Ways of identifying the patient stream most relevant to an individual ED can include a quick scan of data. However, the critical step is to interview patients in a manner that defines the problem from their perspective. The result of the process of identification of the patient stream should be a reasonably homogeneous group of patients with clearly identifiable boundaries, large enough to warrant interventions and amenable to practical measurement strategies. The example, repeated numerous times throughout the course, was school-aged children with asthma. There are many members of the community interested in keeping children with asthma out of the ED. For example, the school district is interested in decreasing absenteeism and could be recruited to participate in a program.

The patient interview recommended by the IHI is a simple three-question interview that can be conducted with approximately five or six patients in a follow-up call within two to three days of an ED visit. The three questions are:

When did you first notice you were having a problem?
When did you realize you might need medical assistance?
When did you decide you needed to go to the ED?

The answers to these questions will help determine whether or not the patient stream is indeed homogeneous enough to require a simple strategy. The answers should suggest a strategy as well. With the population (patient stream) identified, possible strategies for solution can be implemented and refined using the Plan-Do-Study-Act (PDSA) cycles of. PDSA cycles allow the group to implement

change in a limited fashion, observe the results and act on what is learned. This approach focuses the group on learning and emphasizes that failures are as important to learning as successes. Since the changes are implemented in a limited fashion large amounts of resources are not committed to a potentially ineffective solution. The IHI recommends the "Rule of One," -implementing a change in one location for one day. Potential partners are more likely to co-operate with this sort of limited change.

The learning process will help the group refine the membership of the coalition. The coalition is needed to fully support the system level changes needed in order to address the problems of the population (patient stream) that have led these individuals to the emergency department for treatment that could be provided elsewhere as effectively and at a lower cost. It is these system level changes, and not a medical intervention, that will ultimately reduce avoidable ED visits.

## Appendix D.

**2009 MaineCare Professional Claims Limited To Professional and Dental Claim Type with All Other Detail** (For Table

| | All Users | | | | Age < 21 | | |
|---|---|---|---|---|---|---|---|
| | Total Claim Lines | Total Claim Headers | Total Distinct Users | Total Paid^ | Total Claim Lines | Total Claim Headers | Total Disti Us |
| Dental Claims (Claim Type = 4) | 554,310 | 181,774 | 74,540 | $30,093,674 | 423,711 | 138,269 | 53,9 |
| FQHC Claims (Billing Speciality = 63) | 24,850 | 16,362 | 9,464 | $2,014,124 | 15,558 | 9,642 | 5,2 |
| Indian Health Services (Billing Speciality = 210) | 548 | 541 | 281 | $145,261 | 399 | 392 | 1 |
| RHC Claims (Billing Speciality = 43) | 1,288 | 1,246 | 973 | $115,167 | 364 | 354 | 3 |
| **Totals (FQHC, RHC, HIS, Dental):** | **580,996** | **199,923** | **82,316** | **$32,368,226** | **440,032** | **148,657** | **58,2** |
| All Others* | 16,569 | 11,117 | 7,908 | $615,912 | 9,476 | 4,974 | 3,7 |
| All Others Defined | | | | | | | |
| 6: PHYSICIAN | 15,652 | 10,487 | 7,720 | $573,742 | 9,166 | 4,756 | 3,6 |
| 9: DENTIST | 383 | 272 | 141 | $27,059 | 119 | 85 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 10: PHARMACY | 29 | 10 | 2 | $430 | 4 | 3 |
| 12: COMMUNITY SUPPORT | 2 | 2 | 1 | $341 | 0 | 0 |
| 14: INDEPENDENT LABORATORY | 275 | 169 | 155 | $6,344 | 87 | 48 |
| 16: DME/SUPPLIES | 10 | 6 | 6 | $724 | 4 | 2 |
| 27: SPEECH & HEARING AGENCY | 18 | 14 | 3 | $1,028 | 18 | 14 |
| 29: AMBULANCE | 2 | 1 | 1 | $183 | 0 | 0 |
| 30: AMBULATORY CARE CLINIC | 23 | 21 | 16 | $591 | 23 | 21 |
| 31: PHYSICAL THERAPIST | 33 | 32 | 7 | $1,377 | 7 | 7 |
| 32: CHIROPRACTOR | 55 | 37 | 7 | $1,041 | 16 | 13 |
| 47: SPEECH LANGUAGE PATHOLOGIST | 24 | 17 | 2 | $1,136 | 24 | 17 |
| 60: NURSE PRACTITIONER | 63 | 49 | 43 | $1,916 | 8 | 8 |

^Total Paid includes the cost of the entire claim (not just individual claim lines) *All Others excludes claim type CID (5, 7, 12, 16)
2009 MaineCare Professional Claims Limited to Claim Type = Professional and Dental Data Source: Muskie7 MaineCare CY 2009