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Access to Oral Health Care for Children on MaineCare Living in the Lakes Region Towns of
Bridgton, Casco, Sebago, and Naples

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October 21, 2015

Access to Oral Health Care for Children on MaineCare Living in the Lakes Region Towns of
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STATEMENT OF NEED

Dental caries is the most common chronic disease that affects children and it is five times more common than childhood asthma (Rozier, Stearns, Pahel, Quinonez, & Park, 2010 and Benn, 2003). According to Centers for Disease Control and Prevention (CDC), 16.9 percent of children ages 6-19 years old had untreated tooth decay from 2007 to 2010 (2014). Consequences of untreated dental decay include pain, difficulty chewing, missed school days, infection, costly restorative treatments, and in severe cases, the need for hospitalization to perform treatment under general anesthesia. (Isong et al., 2011). Once dental caries is established, the rate of tooth decay recurrence is high, even with the most aggressive treatment (Milgrom, Weinstein, Huebner, Graves, & Tut, 2011).

Children with poor oral health who lack access to dental care are typically from low-income families, are minorities, or have other special health care needs. Additionally, all children are almost three times as likely to lack dental insurance as they are to lack medical insurance (Mouradian, Wehr, & Crall, 2000). Coverage of dental services is mandatory through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children who are enrolled in Medicaid, but less than 30 percent of children with Medicaid coverage have an annual dental visit (Lin et al., 2012 and Benn, 2003). Utilization of dental services by children

enrolled in Medicaid usually occurs after the preschool period, which typically means the child's dental needs are beyond preventive and symptoms are at their peak.

BARRIERS TO DENTAL CARE

A review of the literature suggests that there are four main reasons why access to dental care for children from low-income families may be limited. Most of this literature focuses on Medicaid recipients. The four areas include: 1) reluctance of caregivers to seek services, 2) low Medicaid reimbursement rates to dentists, 3) a higher rate of missed appointments, and 4) not enough dentists in the area to account for the population. These issues will be discussed in greater detail below.

Reluctance of caregivers to seek services

A 2005 study by Kelly, Binkley, Neace, and Gale examining perceived barriers to receiving dental care found various reasons caregivers with children on Medicaid were not seeking dental care for their children. Some of these reasons included the caregivers' own experiences and fear related to going to the dentist, a lack of understanding about the importance of accessing oral health care, not being aware of the range of dental services covered under Medicaid, and other barriers such as finding transportation to the appointment, coordinating time off with their employer, and finding childcare for their other children.

Low Medicaid reimbursement rates to dental providers

Medicaid reimbursement rates to dental providers are between 30 and 70 percent below market rates for service fees, with an average across the United States of 40 percent (Beazoglou, Lazar, Guay, Heffley, & Bailit, 2012). This discrepancy is often cited as a major reason why so few dentists accept Medicaid. The logic goes that since reimbursement rates need to meet the

minimum cost of providing service for dentists to break even, that dentists cannot afford to take Medicaid. However, other studies found that increasing reimbursement alone may not be sufficient to increase a dental provider's willingness to take patients covered by Medicaid (Borchgrevink et al., 2008, and Lin et al., 2012). Dentists also cite administrative burdens in processing Medicaid claims, so streamlining some of these processes may help offset the lower reimbursement rates (Borchgrevink et al., 2008). Buchmueller, Orzol, and Shore-Sheppard also looked at Medicaid reimbursement rates and found that although increasing the rate may increase the number of participating dentists, this would still lead to more patients at a lower reimbursement rate for the dentist which may not be cost-effective (2013).

Despite these findings, the American Dental Association (ADA) has advocated for increased Medicaid reimbursement rates as the primary strategy for increasing the number of dentists participating in Medicaid and the ADA's Future of Dentistry report recommended more public sources be found to increase Medicaid reimbursement rates (Buchmueller et al., 2013 and Benn, 2003).

Missed appointments are more common in Medicaid patients

Many dentists cited patient behaviors, such as a higher tendency toward missed appointments, as a reason why they did not participate in Medicaid programs (Borchgrevink et al., 2008). Studies by Lee and Horan and Kelly et al. found that transportation to appointments was often an issue cited by patients. A Connecticut study by Lee and Horan evaluated access to dental care from the family's perspective and found that transportation vendors often failed to provide timely service, which resulted in missed appointments (2001). They also found that since so many families had trouble finding a dentist who accepted Medicaid in their area, they had to travel farther. With distant locations, the allowed mileage limit may be exceeded according to the

transportation subcontract under the health plan (2001). Research by Kelly et al. discovered that many of these families did not have a car and relied on public transportation, which also limited the service radius for those dental providers that they would be able to access (2005).

Efficient administration may also help offset the number of missed appointments. Swedish Medical Center in Washington established a free dental clinic when nonemergency dental services were eliminated for adults in the Medicaid program and the administration of the clinic is so efficient that there is a less than 2 percent no-show rate (Aston, 2013). Unfortunately, this study did not specify how the administrative efficiency was achieved, nor how it was effective in reducing the number of no-shows.

Although we know that children covered by Medicaid often do not receive needed dental services, the extent of the problem in Maine is not fully understood. In particular, rural communities in Maine may face challenges for families to access dental services for their children given low reimbursement rates and fewer available providers. This project addresses these gaps in knowledge by examining MaineCare- funded utilization and dental care access for children with MaineCare in four rural Maine towns in the Lakes Region. The following research questions were examined:

- How far are children with MaineCare who live in the Lakes Region traveling for dental services?
- What are the patterns of dental service use among children with MaineCare and how do they vary by age?
- How can services be expanded by using other providers to issue care?

METHODS

The research questions were studied using a combination of qualitative and quantitative methods. An inventory of dentists and independent practice dental hygienists who accept MaineCare in the Lakes Region was taken by using a “secret-shopper” survey approach. Area dental offices were called and asked if they were accepting patients with MaineCare. If the office was not, they were asked for a recommendation to an office that might be accepting patients with MaineCare.

Quantitative data analysis relied on MaineCare data to look at 1) comparison of MaineCare membership of children in the Lakes region with county- and state-level membership; 2) analysis of number of children with MaineCare compared to number of dental claims submitted and; 3) number of providers submitting dental claims who are in the Lakes region. An analysis of provider data noting where providers are located in relation to the Lakes Region was mapped to give visual representation of the distance these children are traveling to receive dental services.

Current policy in Maine, as well as other states, was reviewed regarding the use of independent practice dental hygienists and other practitioners to see how the use of non-traditional dental providers may be able to improve access and fill in gaps in service availability.

FINDINGS

Taking an Inventory

All four of the Lakes Region towns of focus, Bridgton, Sebago, Casco and Naples, are considered to be a designated dental Health Professional Shortage Area. In these four towns, there are only three dentists and one independent practice dental hygienist. Expanding to Windham, Raymond and Standish adds eight more to the total in the immediate surrounding

area. When called and asked if the practice was accepting new MaineCare patients, only one of the twelve said yes. For those that were not accepting MaineCare, when asked if they could make a referral to a provider who might be taking children with MaineCare coverage, all suggested Community Dental in Portland, even though there is an independent practice dental hygienist in Bridgton who was accepting new patients who are covered by MaineCare.

Analyzing MaineCare data

Pre-existing MaineCare data from 2011, 2012, and 2013 were analyzed to determine trends in dental care use. From 2011 to 2012, children enrolled in MaineCare for the state of Maine decreased by 1.7%, while Cumberland County saw an increase of 2.2%, and the Lakes Region (Bridgton, Sebago, Casco and Naples) had an increase of 10.5%. The data from 2012 to 2013 were similar from the previous year for the state of Maine with a decrease in enrollment of 1.9%, however, Cumberland County and the Lakes Region saw greater increases than the year before of 16% and 15.4%, respectively.

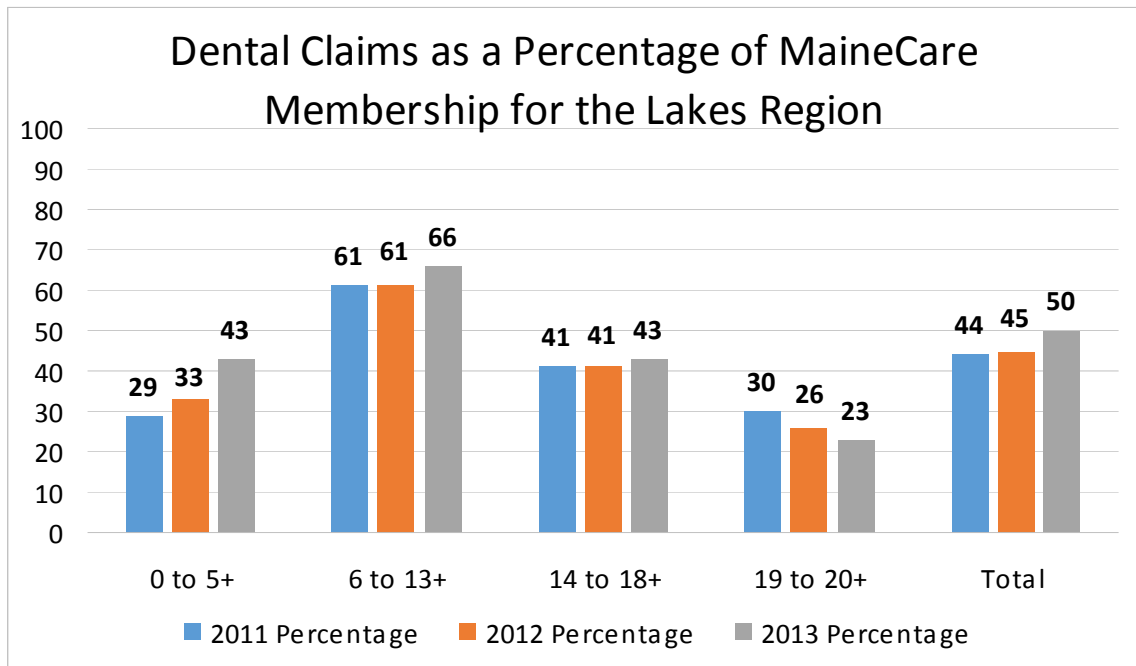
Over the three year period, the total number of dental claims has increased, with the exception of a minimal drop for the state of Maine (see Table 1).

Table 1. MaineCare Dental Claims for Children <21 by Year. Dental services were identified by Dental Procedure Codes on claims – Any Dental Procedure Code.

	Maine	Cumberland County	Lakes Region
2011	72,249	7,919	506
2012	74,854 (+3.6%)	8,461 (+6.8%)	576 (+13.8%)
2013	74,500 (-0.5%)	10,366 (+22.5%)	742 (+28.8%)

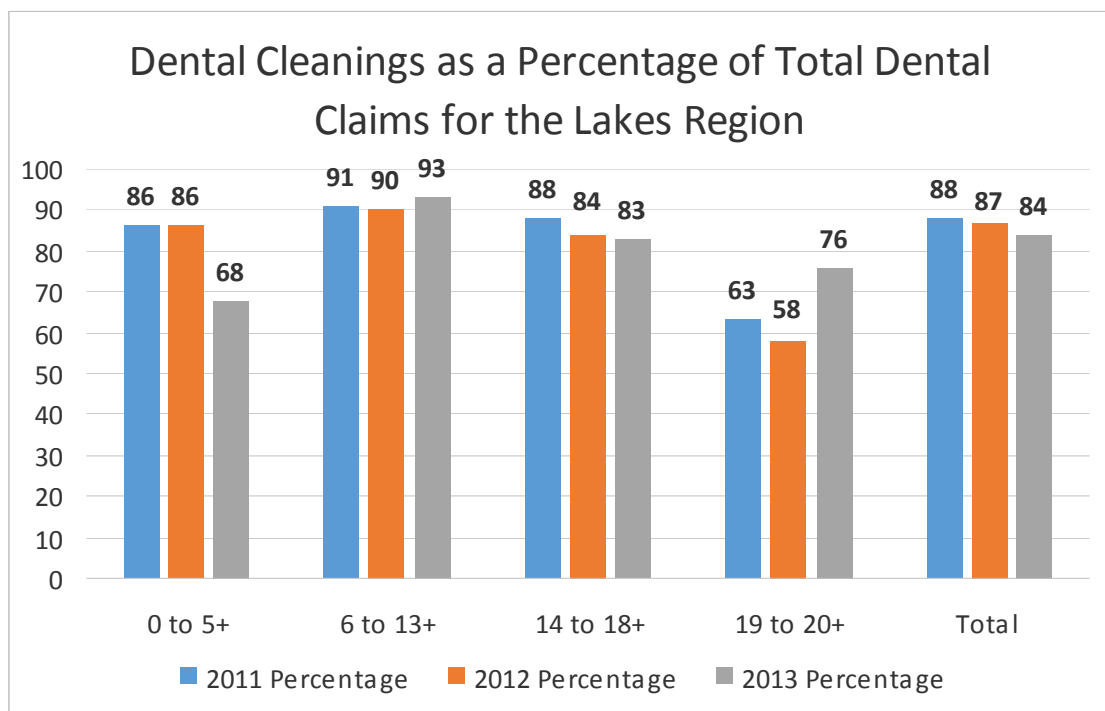
For those enrolled on MaineCare, I looked at how many had at least one dental claim (see Chart 1). The total in 2013 was only at 50%, indicating that half of the children on MaineCare had no dental claims billed for them. This does not include children who may have received care, but paid out-of-pocket or who may have received free care, but the majority of encounters is probably captured here. Across all three years studied, children aged 6 to 13 years had the highest rates of dental care use. The 0 to 5 age group saw the highest growth, with an increase of 4% from 2011 to 2012, and then a larger jump by 10% in 2013. The oldest cohort, those aged 19 to 21 years, was the only age group to see a decrease in dental care use over the three years. This may reflect the further difficulty for this particular cohort to find a dentist to accept them, as many pediatric dentists stop seeing patients who are older than 15 years old and many adult dentists do not take MaineCare because MaineCare’s dental benefits only cover persons to age 21.

Chart 1. Percentage of children with MaineCare in the Lakes Region with at least one dental claim



For those in the Lakes Region who did have a MaineCare claim for dental services, I looked at the percentage of claims that were for preventive care (see Chart 2). Overall, the totals show a decrease in claims that were for dental cleanings. The 6 to 13 age group also had the highest percentage of claims that were for dental cleanings. The 19 to 21 age group saw a 5% decrease in 2012, but then had an increase of 18% from 2012 to 2013, which was the largest jump, up or down, for any of the age groups. The 0 to 5 cohort had the largest decrease in dental cleanings with a drop of 18% from 2012 to 2013. These children had also had the highest increase of dental claims per member in 2013, indicating that they were submitting more claims, but these claims were not for preventive care.

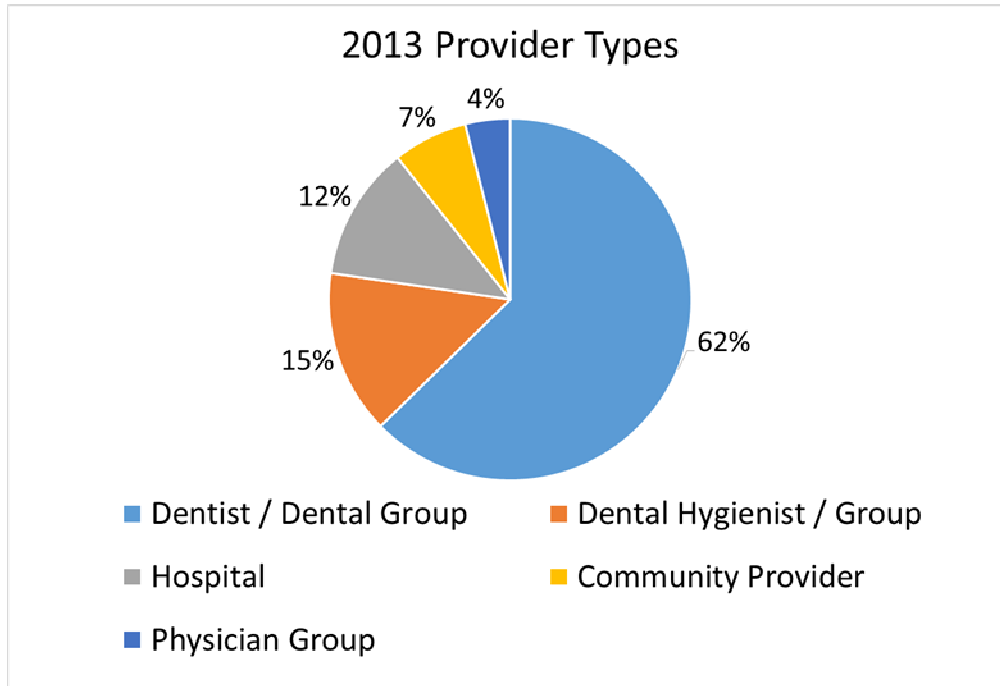
Chart 2. Percentage of dental claims that were for dental cleanings



The data broke out the types of providers who had submitted dental claims for the children in this region (see Chart 3). The majority of providers who submitted claims were dentists and dental hygienists. There were a number of hospitals who submitted dental claims,

however, and presumably, these claims may have been for emergency care, or at least were not for routine preventive services.

Chart 3. Providers with MaineCare Dental Claims for Children in the Lakes Region for 2013



Over the three years, providers who submitted MaineCare claims for children who lived in any of the four Lake Region towns were located in 12 Maine counties and one in New Hampshire (Carroll). Cumberland County had the highest number of providers represented in the data in all three years. The map in Appendix I illustrates the location of the 75 providers who submitted a MaineCare dental claim for children in these communities in 2013. Most providers are clustered locally to the Lakes Region or Portland. Although the secret-shopper phone calls found that most dental providers in the Lakes Region were not taking new MaineCare patients, each of those providers had billed for MaineCare services, indicating that these providers may be keeping existing patients who were recently enrolled on public insurance or have treated a child at least once for dental need. There are some outliers like that in Aroostook County, but the

dataset cannot explain if this location was the only place where a child could find a dental home or if this was a case of an emergency need for care during a vacation or family visit.

REVIEW OF POLICY OPTIONS TO EXPAND DENTAL ACCESS

Expansion of Services by Non-Dentists

Thirty-seven states have a policy that allows dental hygienists to have direct access to patients, including initiating treatment without the prior authorization of a dentist based on his or her own assessment of the patient and then treating the patient without a dentist present (American Dental Hygienists' Association, 2014). The requirements and services vary from state to state. In Maine, there are two types of dental hygienists that qualify for direct access: Independent Practice Dental Hygienists (IPDH) and Public Health Dental Hygienists (PHDH). IPDHs must be licensed as such and are allowed to practice without a supervising dentist, but must provide a referral plan to a dentist for those patients in need of additional oral care. They require either a bachelor's or associate degree from an accredited Commission on Dental Accreditation (CODA) dental hygiene program and a specific number of clinical work hours. IPDHs can provide more expansive services including applying sealants, application of topical antimicrobials, and placing temporary restorations. PHDHs provide services in public or private schools, hospitals and other settings that are considered non-traditional. A dentist does not need to be present when services are provided, however, PHDHs must perform services that are under the standing orders of a supervising dentist. PHDHs must apply to the board who consider whether the program will fulfill an unmet need and whether a supervising dentist is available. Both IPDHs and PHDHs are allowed direct reimbursement by MaineCare.

Maine has recently passed H.P. 870, An Act to Improve Access to Oral Health Care in 2014, which introduced licensure for a dental hygiene therapist. These practitioners must practice under the supervision of a dentist and are limited to providing service in the following health settings: hospital, clinic, Federally Qualified Health Center, a public health setting that serves underserved populations, a setting in a designated dental shortage area, or a private dental practice with at least 25% of their patients being covered by MaineCare. The care and services that the dental hygiene therapists can deliver, in addition to those already included in a dental hygienist's scope of practice, include administration of anesthesia, extraction of permanent teeth, and prescription of anti-inflammatories and antibiotics.

Other States' Policies for Providing Dental Care to the Underserved

Alaska initiated a Dental Health Aide Therapist (DHAT) in 2003 to reach the majority of Alaska's Natives who live in remote villages that are accessible only by snowmobile, four-wheeler, boat or plane. Modeled after a program that New Zealand began in 1921, the DHATs work under supervision of dentists who are located at regional offices and have been trained to perform cleanings, restorations and uncomplicated extractions. The primary goal of the DHATs was to relieve pain due to untreated dental caries, with the expectation to expand focus on preventive measures, including education. This position is similar to the dental hygiene therapist that Maine recently enacted and could be a good model for reaching rural communities, like those in the Lakes Region.

Minnesota was the first state to establish licensure for dental therapists in 2009 in an effort to create a mid-level oral health provider to provide care at a level between that of a dental hygienist and a dentist. Under 2014 Minnesota Statute 150A.105 Dental Therapist, a licensed dental therapist has a limited practice in critical access dental provider settings that serve low-

income patients, the uninsured or the underserved, or in a dental health professional shortage area.

Also in 2009, Illinois enacted Public Act 096-0067 that allows grant funding to communities to develop dental clinics in an effort to increase access for low-income clients, including children referred through the Medicaid EPSDT program. Entities that are allowed to apply for this funding include local health departments, Federally Qualified Health Centers and rural health clinics. This also could be a good model policy for rural communities in Maine. A limitation, however, would be the availability of funding. The Illinois public act also stipulates that this program is subject to funding availability, which comes from the Capital Development Fund for dental grants under Senate Bill 1393.

In 2011, New Mexico passed HB 187, which is a bill that provides for expanded-function dental auxiliaries and community dental health coordinators. The expanded-function dental auxiliary has the ability to perform additional procedures beyond those of a dental hygienist, under the direct supervision of a dentist, similar to the dental hygiene therapist position enacted in Maine. The community dental health coordinators typically provide services that are outside of dental clinics and dental offices, under supervision of a dentist.

CONCLUSIONS & RECOMMENDATIONS

In summary, there are few dentists in the Lakes Region who were accepting new MaineCare patients, however most have billed for services for children with MaineCare. These providers may have existing clients with MaineCare and just cannot accept new patients, may be keeping an existing patient who had private insurance and recently switched over to public

insurance, may be seeing children for one-time emergency care, or for some other reason not listed above.

About half of children on MaineCare in the Lakes Region did not receive MaineCare covered dental services in 2013, indicating that many are not getting dental care. There have been improvements for most age groups, when comparing the numbers from previous years.

Children aged 0-5 may have an increased need for non-preventive dental care, as they have shown an increased number in dental claims over the three year period, but a decrease in the claims being for routine dental cleanings.

Families are traveling considerable distances to access dental services. Many of the providers who submitted MaineCare dental claims for children in the Lakes Region were in Portland or farther away.

There are a few recommendations to be made based on these findings. Increasing MaineCare payments to dental providers may persuade more of them to accept patients with MaineCare. The creation of a dental hygiene therapist position may be able to fill some of the gaps in service availability, particularly for those in more rural towns. The regions where these therapists are currently practicing should continue to be reviewed and potentially expanded based on data related to access.

LIMITATIONS

There were several limitations to this study. I only focused on one dimension of access, supply. Future studies will need to consider the other barriers that parents may face in getting their kids to the dentist, such as lack of knowledge about the importance of early dental care. The data only included MaineCare claims and does not account for those who may have paid out-of-

pocket, or received free or donated care, although the majority of children were likely captured in these data. The small number of cases may have skewed some proportions and the variations may not actually be as meaningful as they would appear. The aggregated dataset limited the types of analysis that could be performed and no statistical analysis was performed.

Despite these finding, this study provides important information on the number of providers accepting patients with MaineCare. The data showed a higher rate of dental service access than the 30% that is cited nationally. The data also indicate that a high percentage of those who are accessing dental services are receiving preventive care.

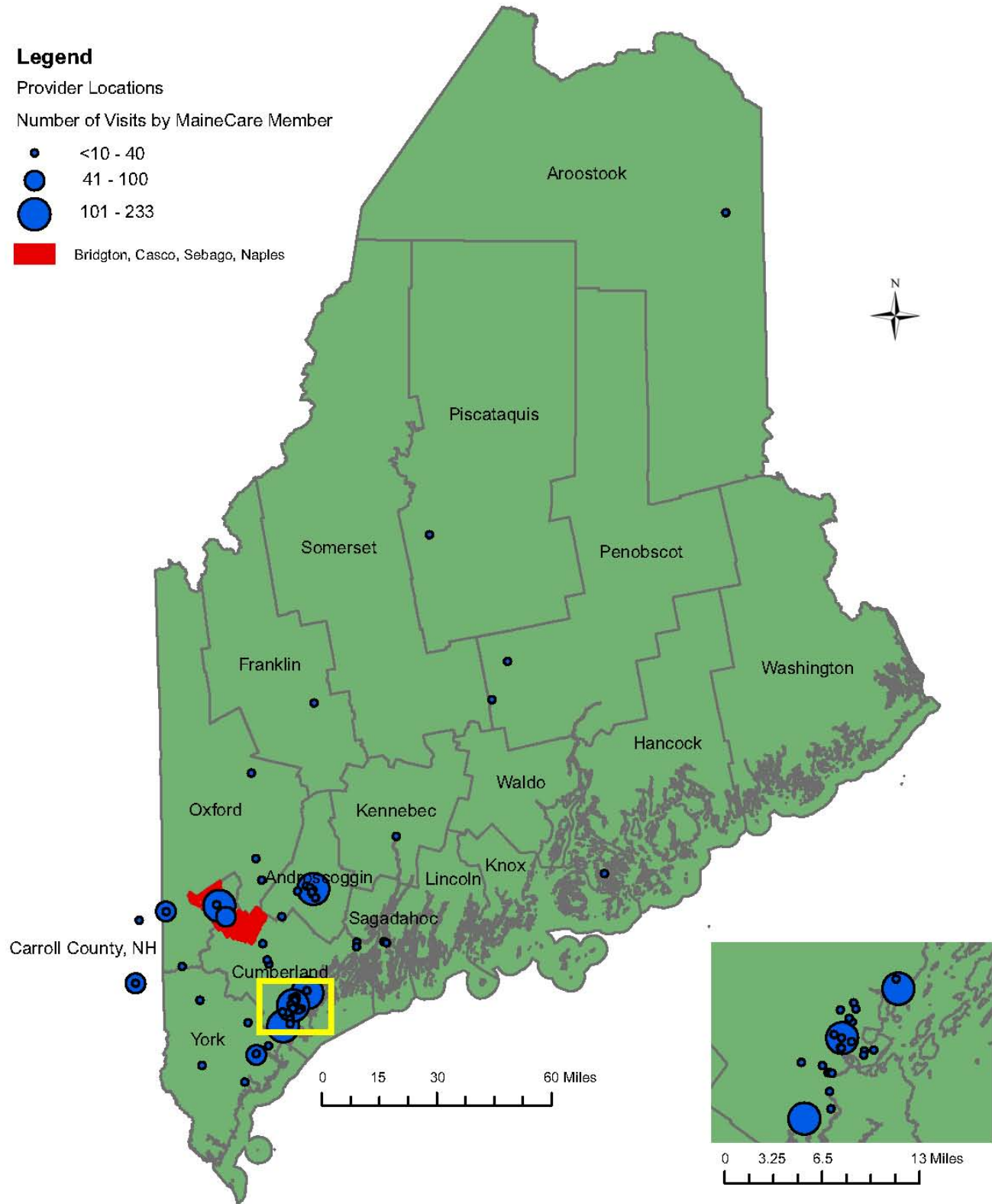
References

- American Dental Hygienists' Association (2014). *Direct Access States*. Retrieved 11 April 2015 from http://www.adha.org/sites/default/files/7513_Direct_Access_to_Care_from_DH.pdf
- Aston, G. (2013). Easing the bite on the ED. *Hospitals and Health Networks*, 87(9), 44-46.
- Beazoglou, T.J., Lazar, V.F., Guay, A.H., Heffley, D.R., and Bailit, H.L. (2012). Dental therapists in general dental practices: An economic evaluation. *Journal of Dental Education*, 76(8), 1082-1091.
- Benn, D.K. (2003). Professional monopoly, social covenant, and access to oral health care in the United States. *Journal of Dental Education*, 67(10), 1080-1090.
- Borchgrevink, A., Snyder, A., and Gehshan, S. (2008). The effects of Medicaid reimbursement rates on access to dental care. National Academy for State Health Policy.
- Buchmueller, T.C., Orzol, S., and Shore-Sheppard, L.D. (2013). The effect of Medicaid payment rates on access to dental care among children. National Bureau of Economic Research. Cambridge, MA.
- Centers for Disease Control and Prevention (2014). Oral and dental health. Retrieved November 9, 2014 from: <http://www.cdc.gov/nchs/fastats/dental.htm>
- Isong, I.A., Silk, H., Rao, S.R., Perrin, J.M., Savageau, J.A., and Donelan, K. (2011). Provision of fluoride varnish to Medicaid-enrolled children by physicians: The Massachusetts experience. *Health Services Research*, 46(6 part 1), 1843-1862.
- Kelly, S.E., Binkley, C.J., Neace, W.P., and Gale, B.S. (2005). Barriers to care-seeking for children's oral health among low-income caregivers. *American Journal of Public Health*, 95(8), 1345-1350.
- Lee, M. and Horan, S.A. (2001). Children's access to dental care in Connecticut's Medicaid

- managed care program. *Maternal and Child Health Journal*, 5(1) 43-51.
- Lin, M., Sappenfield, W., Hernandez, L., Clark, C., Liu, J., Collins, J., and Carle, A.C. (2012). Child- and state-level characteristics associated with preventive dental care access among U.S. children 5-17 years of age. *Maternal and Child Health Journal*, 16, 320-329.
- Milgrom, P., Weinstein, P., Huebner, C., Graves, J., and Tut, O. (2011). Empowering Head Start to improve access to good oral health for children from low income families. *Maternal and Child Health Journal*, 15, 876-882.
- Mouradian, W.E., Wehr, E., and Crall, J.J. (2000). Disparities in children's oral health and access to dental care. *Journal of the American Medical Association*, 284(20), 2625-2631.
- Rozier, R.G., Stearns, S.C., Pahel, B.T., Quinonez, R.B., and Park, J. (2010). How a North Carolina program boosted preventive oral health services for low-income children. *Health Affairs*, 29(12), 2278-2285.
- Tuthill, J. (2013). The role of the dental assistant in addressing access to care. *The Dental Assistant*, 82(12), 8-12.

Appendix I

2013 MaineCare Dental Providers for Children in Lakes Region



This map depicts the providers with at least one MaineCare dental claim in 2013 for a child under the age of 21 with MaineCare who lived in one of the Lake Region towns of Bridgton, Casco, Sebago, or Naples.