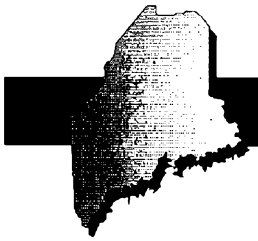

MAINE DEPARTMENT OF

Professional & Financial Regulation

Report of the Governor's Task Force on Expanding Access to Oral Health Care for Maine People

To the

Joint Standing Committee on
Business, Research and Economic Development

And the

Joint Standing Committee on
Health and Human Services

Submitted Pursuant to Executive Order 06 FY 08/09

December 1, 2008

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REPORT OF THE GOVERNOR'S TASK FORCE ON EXPANDING ACCESS TO ORAL HEALTH CARE FOR MAINE PEOPLE

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I. Introduction

For many years, individuals and organizations committed to providing dental care to Maine citizens have worked hard to piece together initiatives designed to increase access to oral health care throughout the state, and have advocated funding increases at both the state and federal levels to support programs, raise reimbursement rates in public programs, and achieve other measurable objectives. In the process, there has developed a growing recognition of, and consensus about, the range of factors that affect access, including workforce concerns, reimbursement levels, the role of prevention, and the understanding of oral health as a significant health issue by policy-makers and the public. In addition, the integration of oral health with total health is increasingly recognized as fundamentally important to early intervention and prevention of disease.

Federal funding for oral health initiatives has actually increased during the past decade, but such funding has generally been directed at specific federal objectives. Only recently have these initiatives been directed at developing programs to support changes in systems that can have a positive impact on the variety of factors affecting access to oral health services. Although Maine has competed successfully for this support, the amounts awarded have been small and the timeframes short, resulting in short-term focused initiatives rather than in longer term programs or systems support.

During the same decade, state-funded programs have experienced level funding or cuts, with new initiatives financed by the Fund for a Healthy Maine being the only exception. These monies have supported a program offering a subsidy to private non-profit dental clinics to offset their costs for providing dental care to low-income persons and a related competitive grant program intended to build capacity administered by the Maine Center for Disease Control within Department of Health and Human Services; a program that coordinates the provision of free care by volunteer dentists to low-income, uninsured disabled, elderly or medically-compromised individuals; and a dental education loan and loan repayment program administered by the Finance Authority of Maine.

Maine has been consistent in its attempts to increase access to oral health services, particularly for children, and to develop new initiatives that foster systems change. The state has also consistently monitored best and promising practices elsewhere in the country. Many programs operated in other states have been discussed in Maine and in some instances implemented to varying degrees. Opportunities do exist to improve the oral health of Maine people and to

increase access to oral health services. However, many of these depend on financial support that is simply not available at this time. For example, absent sufficient funding in recent years for significant increases in MaineCare dental reimbursement rates, the Department of Health and Human Services has focused on changes in policy, processes and procedures, recognizing that these changes are also necessary to improve the MaineCare Dental Program and can help to sustain gains that might be realized later with increased reimbursement. Although other programs and initiatives have developed with potential for positive impact at the state and community levels, their effectiveness in increasing access to oral health services is ultimately threatened by the lack of predictable funding.

In April of 2003, "A National Call to Action to Promote Oral Health"[1] was released by the Office of the Surgeon General to follow up on efforts suggested by an earlier report. The 2003 document outlines five Actions to stimulate "partnerships at all levels of society to engage in programs to promote oral health and prevent disease." The *Call to Action* encourages inclusion of oral health promotion, disease prevention, and oral health care in all health policy agendas set at local, state and national levels. Across the country, an increasing number of states have responded by developing state oral health plans, either independently or as a result of similar processes similar to the work of this Task Force.

II. Governor's Task Force on Expanding Access to Oral Healthcare in Maine

On September 14, 2007, Governor John E. Baldacci signed Executive Order 06 FY 08/09 establishing a task force of interested groups and dental care professionals and directing them to explore ways to remove barriers to and expand access to oral health care in Maine. Governor Baldacci recognized that a high profile, coordinated initiative was needed to make oral health care as high a priority as primary health care in order to ensure that all Maine citizens have access to oral health care (see Appendix A for the text of the Executive Order). The purpose of the Task Force, as noted in the Executive Order, is "to develop recommendations for short-term and long-term solutions to expand access to high quality oral health care programs for all Maine citizens, particularly children, the elderly, the underinsured and the uninsured."

The Task Force was directed to "identify existing barriers to access and provide recommendations for removing those barriers and for expanding access to adequate oral health care for Maine citizens, review relevant data and information on the status of oral health in Maine, as well as national studies on access to oral health care; define a multi-year systems development approach to improving oral healthcare infrastructure, access to dental services and oral health status in Maine."

Further, the Task Force was directed to consult with public and private organizations and individuals who currently provide medical and oral health care for the purpose of building upon existing relationships and partnerships, develop and recommend short-term and long-term

[1] US Department of Health & Human Services. *A National Call to Action to Promote Oral Health.* Rockville, MD: US Department of Health & Human Services, Public Health Service, Centers for Disease Control and Prevention and the National Institutes of Health, National Institute of Dental & Craniofacial Research. NIH Publication No. 03-5303, May 2003.

solutions to expand the oral health care provider workforce; initiate more comprehensive public awareness and education programs; evaluate and improve oral healthcare delivery systems; and increase funding of and reimbursement for oral health care services.

The Governor appointed representatives of groups and organizations with differing perspectives on expanding access to oral health care, They include staff members from state departments, members of the public, representatives of the provider community and the insurance industry, and representatives of a full range of professional associations representing dentists, dental hygienists and denturists, as well as representatives of institutions currently offering educational programs in related health care professions. The President of the Senate and the Speaker of the House were asked to appoint two senators and two representatives to serve on the Task Force. A list of the appointees, the organizations with which they are affiliated, and their delegated representatives, is included in Appendix A.

The final product of the Task Force was to be submitted in written form with recommendations to the Governor and the Joint Standing Committees on Business, Research and Economic Development and Health and Human Services no later than December 1, 2008.

The Task Force met 11 times between November 2007 and November 2008. Meetings were scheduled for four hour time periods and held at the Department of Professional and Financial Regulation in Gardiner. Members of the Task Force were provided background materials as they began their process. Other articles and resources were provided to members over the course of several meetings. Appendix B provides a list of speakers and materials.

III. Recommendations – Summary

The Task Force reached consensus on 14 recommendations that it determined would expand access to oral health care in Maine. These recommendations are listed in priority order by general subject. Certain recommendations suggest legislative action, some require funding or financing, and others can be achieved by building on existing relationships and programs.

Section IV presents these recommendations individually with notations about fiscal impact and possible legislative action, background information to provide context for the recommendation, and action steps to advance each recommendation. Supplemental information resulting from or relevant to the Task Force's discussions is included in appendices or attachments, as noted. The Task Force recognized Maine's 2007 Oral Health Improvement Plan[2] as a thoughtful and well-developed document that offers a framework for further actions. Many strategies in the 2007 Plan complement recommendations made in this Report and are adapted as Action Steps here. The goals and strategies of that Plan are included as Attachment I.

The Task Force realized that policy changes at many levels (e.g., governmental, professional, organizational, community) will be necessary to expand access to quality oral health care services in Maine – that is, to respond to the charge given to it by the Governor. In its

[2] The Maine Oral Health Improvement Plan may be viewed at http://www.mainedentalaccess.org/p_mohip.html.

discussions, the Task Force noted that "policy" could be used as the umbrella for all of its recommendations, but particularly those with financial implications; therefore, there is no separate section labeled "policy." Several recommendations refer to "dental care professionals." In the context of this report, "dental care professionals" includes licensed dentists, denturists and dental hygienists.

A. Reimbursement

Recommendation 1: Increase MaineCare reimbursement rates to the 75th percentile of the New England regional survey of dental fees.

Recommendation 2: Establish program of payments to reward dental service providers who provide services to a high volume of MaineCare members.

B. Public Safety and Quality

Recommendation 3: Integrate comprehensive oral health care into overall health care.

Recommendation 4: Develop and maintain a coordinated public education campaign.

C. Workforce

Recommendation 5: Support efforts to enhance student loan and loan repayment opportunities for dental professionals.

Recommendation 6: Support and enhance opportunities for training more dental professionals in Maine.

D. Finance

Recommendation 7: Develop financial strategies to enhance access to comprehensive oral health services.

Recommendation 8: Develop tax incentives to encourage dental professionals to provide comprehensive oral health care to underserved populations.

E. Health and Wellness Promotion

Recommendation 9: Provide early dental care for pre-school children.

Recommendation 10: Facilitate school-based/school-linked oral health promotion and dental disease prevention programs.

Recommendation 11: Support dental screenings conducted at time of required health screenings for children entering school.

Recommendation 12: Encourage adoption and implementation of community water fluoridation.

F. Service Expansion

Recommendation 13: Expand the MaineCare Dental Program to cover preventive and restorative services for patients in nursing facilities.

Recommendation 14: Expand MaineCare to cover pregnant women over age 21 for preventive and routine restorative care.

IV. Recommendations – Discussion and Action Steps

A. Reimbursement

Recommendation 1: Increase MaineCare reimbursement rates to the 75th percentile[3] of the New England regional survey of dental fees conducted by the American Dental Association.

Fiscal Impact: Yes
Recommended Actions: **Legislation, DHHS Rulemaking**

Generally, MaineCare reimburses dental care providers for services rendered to children and also for adult urgent care or emergency dental services rendered to certain adults. 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 and 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.

Increased reimbursement is needed to maintain the provider base and assure access, especially for children, in areas where there are clearly demonstrable needs. At the same time, ongoing attention must be paid to further reducing and streamlining administrative procedures and paperwork that are recognized as barriers to initiating and sustaining provider participation.

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.

[3] 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 percent of the observations may be found.

Discussions during Task Force meetings identified the inadequacy of MaineCare's dental reimbursement rates as a serious barrier to care. Almost without exception, current rates are less than the 25th percentile of regional fees. The Task Force moved from recommending a substantial increase in the rate of reimbursement in one year to a recommendation for an incremental increase over a multi-year period. Attachment II provides information describing the impact of increasing reimbursement to the 50th and 75th percentiles over two years. The Task Force agreed that this plan should be implemented over no more than three years, first to compensate for the low level of Maine's current rates and second, because the impact of the increase would likely be compromised by rising health care costs and inflation if spread out over five years.

- Example: Based on FY 2008 expenditures, for an increase to the 50th percentile, the fiscal impact to the state is estimated to be $14.3 million in two years, an increase of $7.5 million a year. At Maine's current federal participation rate (38.65%), this would be matched with $25.8 million federal dollars in that two year period. This estimate is based on an across-the-board increase for **all** dental reimbursement fees, excluding orthodontic procedures. Orthodontic procedures would add an additional $1.9 million state dollars. An increase to the 75th percentile would mean an increase of $16.5 million in state dollars over two years and would be matched by $29.8 million in federal funds.

Throughout the group's discussions, members of the Task Force were reminded of, and challenged by, the reality of state budgetary constraints and the strong likelihood that a request for additional expenditures for MaineCare will not be approved. However, members also believed strongly that analyses and models should be investigated now to substantiate proposals for rate increases, which have been successful in other states at increasing provider participation and expanding access. Such work done now can provide a foundation and starting point for future proposals.

Action Steps: The first step in implementing this recommendation would include creating financial models to show the impact of an across-the-board increase as well as targeted increases for selected procedures. Additional steps would include identifying other strategies for targeting fee increases, negotiating policy changes, developing a legislative proposal and exploring methods of further streamlining administrative procedures and paperwork for dental service providers participating in the MaineCare program.

Recommendation 2: Establish program of payments to reward dental service providers who provide services to a high volume of MaineCare members.

Fiscal Impact: Yes (to be determined)
Recommended Actions: **Legislation, Rulemaking**

In its discussions, the Task Force determined that dental care providers should be rewarded for providing a significant volume of dental care for MaineCare members (sometimes referred to as "disproportionate share providers"), with particular attention to those who offer ongoing and comprehensive care for children and emergent care for some adults. For the past several years, MaineCare has authorized a higher allowance for a "comprehensive oral exam" as an incentive,

with the understanding that this would be billed and paid following the provision of groups of preventive services for new patients taken into a practice. This initiative was adopted as a state policy with the objective of encouraging dental practices to take new patients and provide a source of ongoing and comprehensive dental care, that is, to provide a dental home.[4] However, experience has shown inconsistent results, and the Office of MaineCare Services is presently developing other cost-neutral options toward that objective with potential to be more effective.

Action Steps: To implement this recommendation, fiscal analyses should be conducted to examine factors such as unduplicated patient counts and services provided. In order to negotiate policy changes and draft a legislative proposal, best practice and evidence-based approaches to assess potential effectiveness would need to be completed. Finally, Maine's experiences with similar incentive-type programs with other health providers should be used as models.

B. Public Safety and Quality

Recommendation 3: Integrate comprehensive oral health care into overall health care.

Fiscal Impact: To be determined
Recommended Actions: **Various, To be determined**

A fundamental concept of great concern to the Task Force is that comprehensive oral health care in Maine is not accorded the same attention and importance as medical care by medical providers, insurance companies and the state. Put more bluntly, oral health care is not considered integral to comprehensive health care. A primary concern of the Task Force is that bold steps be taken now to underscore the importance of oral health care to overall health care and to integrate it into comprehensive health care.

It has been stated many times, most clearly by the US Surgeon General in the landmark report, "Oral Health in America,"[5] that oral health care is a key component in overall health. Oral disease – poor oral health – is consequential. Oral health is more than healthy teeth and being free from dental and oral disease. Without good oral health, a person cannot be fully healthy. Poor oral health has many social and economic consequences in addition to having an adverse impact on overall health. Poor oral health in children and young people as well as in adults may result not only in dental decay, eventual tooth loss, and impaired general health, but also in days lost from school and work, in compromised nutrition, and a compromised ability to obtain or advance in education and employment.[6] There is also increasing evidence of the relationships

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[4] Defined at http://www.aapd.org/media/Policies_Guidelines/D_DentalHome.pdf (American Academy of Pediatric Dentistry): "The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate."

[5] US Department of Health & Human Services, *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: US Department of Health & Human Services, National Institute of Dental & Craniofacial Research, National Institutes of Health, 2000.

[6] There are various sources available to document these relationships. In January 2001, the Maine Department of Human Services published "The Status of Access to Oral Health Care in Maine" where these are discussed. The report may be accessed at http://www.maine.gov/dhhs/boh/Status%20of%20Access.pdf. Other sources that provide

between oral health and systemic health.[7] The Task Force had extensive discussions about the need to increase general understanding and recognition of the importance of oral health to overall health and to educate policy-makers about the critical need to integrate oral health concerns into broader health programs and initiatives.

Maine's oral health infrastructure is comprised of private practice dentists and a small but crucial safety net comprised of Federally Qualified Health Centers and several community-based non-profit organizations that provide dental services. Maine's safety net for oral health is relatively small, with fewer than 25 non-profit dental centers and clinics scattered throughout the state. In some areas they may represent the only local source of dental care. See Appendix C for a list and map.

Although many Maine people enjoy good oral health, there are also many who suffer from tooth decay, periodontal diseases, partial or complete tooth loss, and other chronic oral conditions and injuries. The use of preventive measures and treatments such as water fluoridation, school-based oral health promotion and dental sealant programs, as well as increased use of topical fluorides such as rinses and varnish, can and do significantly reduce the incidence of tooth decay in children, but oral diseases still persist among Maine residents of all ages. Although it is generally agreed that in Maine and nationally 20 to 25 percent of children have about 80 percent of the need, those needs often go unmet and result in urgent treatment that could and should be prevented. Needs among adults are often substantial and have ramifications for overall health, costs to the healthcare system, and other socio-economic implications. See Attachment III for selected data describing the oral health status of Maine people.

Though the Task Force discussed a number of initiatives to address this recommendation, several of which appear as recommendations later in this document under Health and Wellness Promotion, Task Force members believed this recommendation is sufficiently important to appear in a separate category. Oral health should have parity with other health issues, and the state should encourage the use of resources to promote and support integration of oral health with overall health. The Task Force recognized the importance of training primary care health providers in basic oral health concepts and of developing further mechanisms that encourage integration of oral health with overall health.

One example developed by the Task Force that illustrates this integration at a systems level comes from extended discussion of the feasibility of developing models for co-locating dental services in hospitals in certain areas of the state or developing systems to encourage affiliations between hospitals and dental providers. Such arrangements could not only reduce inappropriate use of the health care system, particularly hospital emergency departments and thereby help contain health care expenditures, but would also make better use of existing resources and help connect people to the care they need. The development of mechanisms or models for

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this documentation can be accessed via a number of web-sites, such as http://www.cdc.gov/OralHealth/index.htm, http://www.mchoralhealth.org, and others.

[7] A growing evidence-based literature supports these relationships. See for example, U.S. Department of Health and Human Services. National Call to Action to Promote Oral Health. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, spring 2003, pp. 22 and 23.

collaborations between hospitals and dental providers to facilitate and/or provide emergent services should be encouraged.

Inappropriate use of hospital emergency departments for dental pain results in thousands of dollars in outpatient and in-patient charges, pharmacy costs, and visits to primary care providers, but not in the resolution of the dental problem, since the individuals do not receive the dental care they need. This scenario adds a strain to the health care delivery system as a whole and contributes to unnecessary health care expenditures.

A preliminary analysis indicates that for selected dental diagnosis codes, for paid claims with ER procedures and dental diagnoses, adjusted amounts paid by MaineCare to Maine hospitals for state fiscal years 2007 and 2008 totaled nearly $2.5 million dollars at a minimum.[8] The preliminary analysis looks only at paid claims with ER procedures for dental codes, so it does not include any other services provided to those patients, whether in the hospital ER, incurred if they were admitted, pharmacy costs, or follow-up. The Task Force stresses that this figure underestimates actual costs to MaineCare. There are also costs incurred to the health care system for individuals without any health care coverage who present at hospitals with dental issues, which hospitals must absorb, write off, or attempt to collect. Additional analysis is needed to better estimate these costs to the health care system, including private and public expenditures.

Action Steps:

1. Identify innovations and enhancements to the oral health infrastructure that facilitate the integration of the delivery oral health care with overall health care.
   a. Seek best practice and evidence-based approaches to develop demonstration and/or pilot programs to test their applicability to Maine.
   b. Explore mechanisms and funding for collaborations between hospitals, particularly Critical Access Hospitals, and dental providers to integrate/facilitate access to emergent dental services.
2. Incorporate oral health objectives and activities into Maine's emerging public health district structure.
3. Continue to include a specific section for oral health in Maine's State Health Plan.
4. Promote and/or facilitate training for primary care health providers in basic oral health concepts, screening and assessment, and interdisciplinary training for dental and non-dental health providers to enhance their mutual understanding of integrating oral health and overall health for better patient outcomes.
5. Encourage professional associations to regularly and collaboratively provide interdisciplinary training opportunities.

Recommendation 4: Develop and maintain a coordinated public education campaign.

Fiscal Impact: To be determined
Recommended Action: **Resolve**

[8] Data provided by the Office of MaineCare Services, DHHS, 10/17/08.

Task Force members recognized the lack of understanding by the general public that there is a close connection between oral health and overall health, and that tooth decay is a preventable disease. Educational campaigns to focus public attention on other health issues – tobacco use and underage drinking, for example – have been effective over relatively short periods of time. The Task Force strongly supports the development and implementation of communications strategies, such as those used in the "Watch Your Mouth" campaign (2005-2006), that seek to improve awareness of the importance of oral health and the connection between oral health and overall health. Such strategies, directed at the general public, would provide oral health education, stress the importance of prevention and early intervention, change negative perceptions, and increase awareness regarding the impact of good oral health on overall health throughout the life span.

Action Steps:

1. Develop and maintain a coordinated public education campaign to increase understanding of the importance of oral health and preventive practices, and the relationship to overall health.
    a. Utilize relationships with Healthy Maine Partnership organizations, the new regional public health districts, and school health education initiatives for coordination and dissemination of messages.
    b. Encourage appropriate organizations within and outside state government to incorporate oral health content with other health messages that promote the integration of oral health, such as oral cancer prevention messages, into existing cancer prevention and tobacco-use reduction efforts.
2. Promote environmental changes that in turn promote oral health, such as policy changes with respect to soda and snacks at schools.

C. Workforce

Recommendation 5: Support efforts to enhance student loan and loan repayment opportunities for dental care professionals.

Fiscal Impact: Yes (to be determined)
Recommended Action: **Legislation, Rulemaking**

A significant obstacle to obtaining dental care in Maine is the apparently insufficient number of practicing dentists and their geographic distribution. The distribution of dental hygienists, who can provide preventive services within and outside traditional dental office and dental clinic settings, generally follows that of dentists. Along with considerations of enhancing access to oral health care, concerns about the distribution and adequacy of the dental workforce must be addressed. The cost of a dental professional education is also of concern, and the availability of educational loans and loan repayment programs is increasingly important in recruitment and retention of these health care professionals. Maine must compete nationally to attract dental care professionals to open new private practices, join or purchase existing practices, and to work at community-based dental clinics. Appendix D provides additional background information describing Maine's dental professional workforce.

A variety of programs and efforts are underway to increase the dental workforce by supporting professional education, with a traditional focus on the supply of dentists. Maine's Dental Education Loan and Loan Repayment Program, funded by the Fund for a Healthy Maine and administered by FAME, has 12 positions reserved for dental students receiving loans and dentists who receive funding to repay loans. The program is full, however, and more applications have been received than can be funded within the current legislative allocation. The State Loan Repayment Program is funded by a federal grant but Maine did not receive funding for the 2008-2010 budget period. Maine will reapply for funding in 2010. See Appendix E for a description of loan and loan repayment programs and their requirements.

State programs like these, although beneficial conceptually, do not produce or attract practicing dentists at the same rate that dentists are lost to retirement. Further, these programs should now be expanded to include not only dentists, but also denturists and dental hygienists--dental care professionals who wish to work in private and public dental care settings.

Action Steps:

1. Develop and adopt a definition of "underserved" that addresses the needs of Maine, including populations, geographic areas, and/or other characteristics relevant in defining eligibility for these opportunities and other programs that may be developed with the intent to increase access, and that will remain flexible and adaptable to changes in Maine.
   a. Review existing state and federal legislation, rules, and programs to analyze definitions.
   b. Amend existing legislation and/or rules as necessary to reflect a common definition.
2. Advocate changes in state and federal loan and loan repayment programs for students and new dental school graduates that will offer incentives to new dentists to practice in Maine, as well as for other qualified dental professionals.
   a. Support legislative changes in FAME's dental education loan and loan repayment programs to maximize flexibility and the use of available funds.
   b. Address funding and match issues in the State Loan Repayment Program.
   c. Advocate as appropriate with Maine's Congressional delegation for changes in relevant federal loan and loan repayment programs.
   d. Advocate on the state and federal levels for maximizing the potential of other loan programs (e.g., FAME's Health Professions Loan Program and federal matching loan programs such as the State Loan Repayment Program) for dental professionals
3. Explore alternatives for loan repayment and forgiveness requirements that provide incentives for dental professionals to work in underserved areas (see also Recommendation #8).

Recommendation 6: Support and enhance opportunities for training more dental professionals in Maine.

Fiscal Impact: To be determined
Recommended Actions: **Resolve, Others to be determined**

The availability of an adequate number of dental care professionals – dentists, denturists, and dental hygienists – is necessary to meet the oral health needs of all Maine residents. As noted in

the **Sunrise Review of Oral Health Care Issues,** submitted to the Joint Standing Committee on Business, Research and Economic Development on February 15, 2008 by the Department of Professional and Financial Regulation, "The need for many different categories of dental care, including the services provided by denturists, dental hygienists and dentists, is ever increasing. Given access to care realities in Maine, dental professionals should be investigating ways in which to work as teams."[9,10] These issues underlie considerations of workforce development as well as those related to many of the Task Force's recommendations listed in other categories.

The function and role of licensed denturists was also discussed by the Task Force. The role of a denturist is to impact patients whose oral health is at a crisis point by providing removable prosthetic services. Patients who choose to see a denturist are likely to be seeking dental care for the first time in many years. A denturist can play an important role in prevention and oral health education. A patient being treated by a denturist also receives the benefit of the denturist's ability to refer the patient to other dental care providers for care outside the denturist's scope of practice. Denturists provide a vital layer of protection to the oral health needs of Maine citizens, particularly those who have lost 50% or more of their natural teeth, have no dental home and have no access to traditional dental care. Currently, there are 23 denturists in Maine providing dental services.

The role of dental hygienists continues to evolve, with ongoing redefining of definitions of their scope of practice and of the services they can provide in public health and non-traditional settings. Dental hygienists can provide a range of preventive services but under current Maine statute (the Maine Dental Practice Act) cannot diagnose, interpret x-rays, or provide restorative treatment. During its Second Session, the 123rd Legislature enacted legislation to establish a new practice status, the Independent Practice Dental Hygienist; how this will affect the availability of preventive dental care and overall access to dental services is not known at this time.

In Maine and across the country, there is ongoing discussion and debate about the definition and establishment of a "mid-level" or new dental practitioner. This would mean an entirely new license category requiring different and/or additional requirements for education, clinical training and experience than currently required for licensure or certification. Various models and proposals have been developed for this "emerging" practitioner, among them the Advanced Dental Hygiene Practitioner (American Dental Hygienists' Association), and the Dental Health Aide Therapist (used in Alaska, Canada, and New Zealand). For all, appropriate training will be necessary to assure public health and safety. Maine might also develop its own model. Discussion at one meeting recalled suggestions made during the 2007 Sunrise Review that a "midlevel" dental practitioner would be analogous to a physician's assistant, for example, noting that based on the medical model; a "true" midlevel practitioner would have a relevant four-year undergraduate degree followed by the equivalent of two years of specialized clinical training. Such training should be approved by an appropriate accrediting body. The majority of Task Force members were not supportive of developing a new practitioner whose scope of practice would be limited to providing services only to low-income children.

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[9] http://www.maine.gov/pfr/legislative/documents/Resolve2007Chapter85-final.doc

[10] Dental professions are defined and their respective scopes of practice are described in the Maine Dental Practice Act, at http://www.mainedental.org/statutes.htm

Predicting Maine's needs must include analysis of complex factors. Meeting those needs means not only utilizing current professionals in innovative ways and to the maximum of their educations, but also means developing and implementing strategies to recruit practicing dental professionals to Maine and encouraging more young people to pursue dental careers. Such strategies will contribute to our ability to increase access to dental care and will enable expansion of currently available services.

In 2006, the University of New England (UNE) began a planning process to determine the feasibility of a dental school for Maine and Northern New England. The Task Force believes this development represents a great potential for Maine with positive implications for access to dental care, improvements in oral health status, and workforce development. Attachment IV provides a description of the planned dental school as a context for some of the recommended action steps associated with Recommendation 6. It is worth noting, however, that the ability of the UNE dental education program to offer expanded access to oral health care is inextricably linked with the state's success in raising reimbursement rates for services provided by Maine dental care professionals.

Action Steps:

1. Demonstrate the Task Force's support for the University of New England's development of a College of Dental Medicine.
    a. Support legislation (i.e., a Resolve) to support the establishment of the dental school and to identify the school as a major safety net provider of dental services.
    b. Direct the Department of Education to determine whether funds for public higher education could be used to support dental education on an annual basis with the understanding that UNE would have articulation agreements with public universities.
    c. Advocate for the dental school to receive state funding, with the understanding that the site will be a location for care for disabled individuals whose care is generally paid for by MaineCare and will include components such as a special needs unit for children and adults with severe disabilities.
    d. Direct the Department of Health and Human Services to pursue a federal waiver to increase MaineCare payments to the dental school for agreeing to treat a large portion of the MaineCare population.
    e. Direct the Department of Economic and Community Development to explore ways to support the effort to establish a dental school. Bringing this type of educational and clinical activity to rural parts of the state could stimulate economic activity.
    f. Support FAME in efforts to increase scholarships and loan repayment available to Maine students who stay in Maine for their dental professional education.
2. Support expansion of Expanded Function Dental Assistant (EFDA) training programs.
    a. Promote and support distance learning technology to provide programs more broadly throughout Maine.
    b. Encourage the use of uniform (core) curricula by all teaching institutions.
3. Develop the role and educational pre-requisites for a "mid-level" dental practitioner and alternatives for the establishment of appropriate education and training program(s) in Maine through collaborative efforts of professional associations of dentists, denturists and dental hygienists.

4. Support the establishment or expansion of dental residency programs in Maine.[11]
5. Provide or facilitate access to dental schools for Maine students by developing agreements with dental schools in other parts of New England and regions of the country.
6. Promote the use of distance learning to create efficiencies in dental professional training and education and to extend learning opportunities to more rural areas; identify existing technologies and programs; and encourage collaboration and synergies that can extend the benefits as broadly and cost-effectively as possible.
7. Create/coordinate a supportive "pipeline" for Maine middle and high school students to pursue dental professional careers.
    a. Bring Maine Department of Education into discussions to develop best approaches to increase awareness of dental health careers by Maine high school students.
    b. Convene Maine college leaders in a forum to discuss developing pipeline approaches for secondary school students.
8. Collaborate with Maine's Congressional delegation to identify additional oral health funding and legislative initiatives to support this recommendation.
9. Encourage dental care professional associations to work collaboratively and to advocate for appropriate expansions of existing scopes of practice for the purpose of increasing access to dental care and creating a model for "dental teams" that will ensure the integrity of the team approach to providing oral health care.

D. Finance

Recommendation 7: Develop financial strategies to enhance access to comprehensive oral health services.

Fiscal Impact: To be determined
Recommended Actions: **Legislation or Resolve, Others to be determined**

Throughout its discussions, the Task Force was challenged by the knowledge that state government's ability to provide financial resources for new programs and initiatives is likely to be limited for at least the short term. Task Force members were reminded that although state government must be considered primarily responsible for funding MaineCare oral health services, enhancements and innovations to improve the overall oral health infrastructure and services can be supported by the private sector to complement governmental programs and efforts. State government can very appropriately act as a collaborator and willing partner in such efforts.

Action Steps:

1. Collaborate with other health care workforce efforts, such as Maine's Health Workforce Forum and the New England Rural Health Roundtable, to assure consideration of the dental professional workforce in their efforts.
2. Expand education/workforce partnerships by developing incentives and business strategies that increase access to oral health services; explore the establishment of local

[11] There is an established residency program at the VA Center at Togus and another about to start at Penobscot Community Health Care in Bangor.

oral health or health care workforce economic opportunity zones to provide incentives for creating job growth (for example, by opening new dental practices).
3. Support legislation or other changes that would require direct reimbursement through third party payment for services by all dental professionals.
4. Support legislation or other changes that would require third party payers (i.e., private insurers) to cover the provision of fluoride varnish, an effective preventive intervention, in non-dental settings.
5. Encourage the creation of a funding mechanism (grants or low interest loan funds) to upgrade and/or replace aging dental equipment in dental practices. Work with business and philanthropic communities to develop and implement programs of this kind.
6. Advocate as appropriate with Maine's Congressional delegation in support of oral health funding and legislative initiatives to support this recommendation.

Recommendation 8: Develop tax incentives to encourage dental professionals to provide comprehensive oral health care to underserved populations.

Fiscal Impact: Yes (to be determined)
Recommended Action: **Legislation, Rulemaking**

In the Second Session of the 123rd Legislature, two bills presented to the Joint Committee on Taxation were passed and enacted:

- LD 1984 (PL Ch 689) offers a tax deduction to dentists with military pensions who see MaineCare patients. There was no explicit evaluation mechanism in the bill; how the impact of this deduction on access to care will be measured remains to be seen.
- LD 2192 (PL Ch 690) provides an income tax credit (up to $15,000 annually) for dentists opening new practices in designated underserved areas. There will be a limited impact in that only five dentists per year (starting in 2009 and 2010 only) will be able to qualify for up to five years in this program, which will expire at the end of 2014. A report on the program's initial impact is due in March 2011.

The Task Force considered how other tax related incentives might expand access to dental care. Substantial concerns were raised with any idea that would tie licensure to participation in MaineCare; in particular, this would be seen as counterproductive to attempts to recruit dentists to Maine. However, participation in MaineCare could be considered relative to incentives. The Task Force was sensitive to issues of equity with other health professionals, and to the financial impact tax incentives can have on state revenues. Discussions did not generate specific ideas but did result in guidelines for further strategies and action steps.

Guidelines:

1. Take geographic distribution issues into consideration in developing programs that involve tax incentives.
2. Give priority to developing incentives for providers who see MaineCare patients by directing MaineCare reimbursement to a deferred compensation (tax-exempt) account for participating dental care professionals.
3. Explore exempting loan repayments from state income tax liability.

E. Health and Wellness Promotion

The Task Force focused on making recommendations that, if acted on, would improve the general oral health of Maine citizens. Prevention programs should be encouraged and supported. These programs present a viable way to reach underserved populations, to reduce the incidence of oral and dental diseases, and to reduce and contain costs associated with the treatment of disease. Prevention programs focus on changing personal oral health behaviors as well as community factors and environmental influences. Such programs benefit people of all ages, but can be of particular benefit for young children and pregnant women.

Scope of practice and supervision issues for dental hygienists and dental assistants are often discussed nationally when considering the expansion of access to dental care, particularly preventive care for children, and were recognized as such by the Task Force. There is growing agreement that oral health care for young children should include risk assessment, screening, examinations, and guidance for parents and that all of these can be provided by dental hygienists and some by other non-dental health professionals as well. But when restorative treatment is needed, for adults and children, current Maine law requires that it must be provided by dentists. So as effective as it may be to have hygienists practicing regularly in public health settings such as schools, Head Start centers, school-based clinics, or other community-based settings, in terms of *preventing* dental disease, there must also be a system of identifying and referring to dentists those individuals who need restorative care. There is also substantial agreement that children in particular need an identified dental home – a source of regular and comprehensive dental care – and that they not be simply referred to dentists when a need for treatment is identified and has become acute; such referrals should be followed up to assure the needed treated is obtained. These concerns also apply to adolescents and adults of all ages, who also benefit from greater access to preventive dental care.

Recommendation 9: Provide early dental care for pre-school aged children.

Fiscal Impact: To be determined
Recommended Actions: **To be determined**

The involvement of primary medical care providers must be considered as key in the delivery of preventive oral health services, particularly for children. Children are likely to see primary health care providers at earlier ages more often than a dental provider. Primary care providers can offer education for parents, conduct risk assessments, deliver preventive interventions such as fluoride varnish applications, and make appropriate referrals to dental professionals. These interventions can and should be provided in the primary medical care setting by a number of health professionals, including physicians, nurses, nurse practitioners, physician assistants, and medical assistants, as well as by dental hygienists. Children who have their first preventive dental visit by age one are less likely to have visits to hospital emergency departments or need restorative dental care, and their average dental-related health expenses are almost 40% lower

over a five year period than children whose first preventive visit occurs after age one.[12] The inclusion of dental screenings and early preventive oral health interventions in routine health care visits and providing reimbursement for those services would allow children more access to preventive care.

Action Steps:

1. Support efforts to ensure that all children receive at least one preventive care visit by age one to identify early dental problems, establish a dental home, and educate parents and caregivers regarding the methods and importance of good oral health care.
   a. Facilitate inclusion of guidelines for oral health care into primary care providers' well child visit schedules.[13]
   b. Explore resources to enable primary care providers to receive public and private insurance reimbursement for providing preventive oral health care.[14]
2. Encourage relationships between Head Start officials and local dental providers to facilitate the ability of Head Start centers to meet their requirements for dental exams[15] (within 90 days of enrollment) and the identification of a dental home.
3. Support and promote training, resource development and collaborative relationships that facilitate integration of oral health promotion and dental disease prevention activities in Head Start and Early Head Start Programs, and similarly, utilize other community-based programs such as WIC to the extent possible within relevant program constraints.
4. Promote oral health training for child care providers as part of the DHHS certification process.
5. Encourage collaboration among educators, prenatal care providers, home care personnel and DHHS to promote positive and preventive oral health behaviors among their clients.

Recommendation 10: Facilitate school-based and/or school-linked oral health promotion and dental disease prevention programs.

Fiscal Impact: To be determined
Recommended Action: **Resolve, Others to be determined**

School-based and school-linked oral health programs generally target vulnerable populations that are less likely to receive dental care, such as children eligible for free and reduced cost lunch programs. When these programs provide preventive services, they can reduce or eliminate many

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

[13] MaineCare has adopted the American Academy of Pediatric Dentistry's "Recommendations for Preventive Pediatric Oral Health Care (periodicity guidelines) to guide primary care medical providers; see http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf. Periodicity refers to the frequency, timing, and content of preventive health visits scheduled at key developmental ages. Although states have flexibility in developing periodicity schedules, they are generally based on recognized medical standards.

[14] MaineCare reimburses for fluoride varnish via the physician policy (effective 9/08) but not for an oral health risk assessment, as do a number of other states. Private insurers do not reimburse for either procedure in Maine.

[15] Federal Head Start regulations require that the dental examination be provided by a licensed dentist.

obstacles to preventive dental care such as lack of transportation and missed appointments, and may reduce others, such as language barriers. In its report on School and Adolescent Oral Health Programs, the Association of State and Territorial Dental Directors states: "School and adolescent oral health programs promote, protect, and assure the oral health and well-being of school-aged children and adolescents. Through these programs, children and adolescents are encouraged to accept self-responsibility for their oral health, develop life-long healthy behaviors, receive preventive treatment, and are assisted with receiving oral health care services."

Best practice criteria for such programs focus on 1) impact and effectiveness; 2) assessing whether high-risk children are targeted for program services; and 3) documentation of service/program benefits or outcomes. These criteria examine efficiency of programs by tracking a unit cost for each child enrolled in the program and/or for services provided through the program. They also take into account demonstrated sustainability, consistency of the program's funding source, time limitations, and whether integration, collaboration and/or coordination with other health-related school and community-based programs is possible. See Attachment V for information about school-based and school-linked programs in Maine.

Action Steps:

1. Support school-based oral health education and dental sealant programs.
   a. Maintain school-based and school-linked oral health education and prevention programs in schools and communities where there are demonstrated needs for community-based services; develop incentives for schools to adopt fluoride mouth rinse and dental sealant programs.
   b. Educate parents, school personnel and community members about the efficacy of utilizing preventive measures and treatments for children, such as fluoride mouth rinse, fluoride varnish, and dental sealants.
   c. Support increased resources, financial and personnel, for implementing preventive services in schools, especially those that demonstrate unmet oral health needs.
2. Support DOE and the Coordinated School Health Program in ongoing efforts to incorporate oral health issues into school health curricula. Do this by providing resources and information regarding oral health to classroom and health education teachers to insure that oral health is integrated within comprehensive health education.
3. Establish protocols for school-based oral health programs to ensure good communication and coordination among schools, dental services providers and funding sources and to facilitate development of effective referral mechanisms for children needing treatment and a dental home.
4. Explore resources and partnerships with philanthropic foundations, dental professional associations and community groups to support preventive oral health programs in schools and communities.

Recommendation 11: Support dental screenings conducted at time of required health screenings for children entering school.

Fiscal Impact: To be determined
Recommended Action: **Legislation or Resolve, Others to be determined**

Requirements for school entrance (particularly kindergarten) include screening for vision, hearing and scoliosis. These screenings are usually conducted by school nurses, and are intended to identify abnormalities or deviations that require further attention. Just as a child's readiness to learn is adversely affected by compromised vision or hearing, untreated dental disease causes pain and discomfort that interfere with a child's ability to participate fully in a classroom. Dental screenings are intended to identify children with unmet treatment needs and those who have no regular source of dental care. School entrance dental screening programs in other states generally use methods to exclude children who have already had a dental exam and who have a regular source of dental care. The issue of an unfunded mandate and resources for follow-up (appropriate and timely referral) are often identified as problematic.

In parts of Maine, schools have made arrangements with local dental professionals, often through their professional associations, or with local community organizations providing dental services, to conduct screenings for new kindergarten students. These programs are locally organized and implemented, and anecdotally, have been successful in their objectives to identify children with unmet dental needs, obtain treatment for children who need it, and connect children without a regular source of care to a dental home.

Action Steps:

1. Review relevant Maine statutes and rules with the Department of Education.
2. Review mandatory oral health screening programs in other states for best practices and lessons learned.
3. Review existing programs and initiatives in Maine.
4. Determine resources needed (personnel, funding, etc.).

Recommendation 12: Encourage adoption and implementation of community water fluoridation.

Fiscal Impact: None to state
Recommended Action: **Resolve**

Community water fluoridation, recognized by the federal Center for Disease Control as one of ten great public health achievements of the 20th century, helps to prevent tooth decay safely and effectively. The water fluoridation process adjusts the amount of fluoride occurring naturally in a community's water to a level that will prevent tooth decay. Fluoride added to community drinking water at a concentration of 0.7 to 1.2 parts per million has repeatedly been shown to be a safe, inexpensive and extremely effective method of preventing tooth decay. Community water fluoridation benefits everyone in the community, regardless of age and socioeconomic status. Everyone gains from living in a healthier community, where fewer days are lost from work or school because of dental pain or the need to obtain treatment that could have been prevented, and where fewer tax dollars are spent on subsidized dental care. *The annual cost of water fluoridation over a lifetime is usually less than the cost of a typical restoration for one tooth.*

In 2008, just under half of Maine's population lives in communities with public water systems, and an estimated 84 percent of these people have access to optimally fluoridated drinking water, with 63 systems providing water in 135 communities. However, this translates to about only 40% of Maine's total population receiving this simple health benefit.

Task Force members recognized that Maine law limits authorization of fluoridation to vote by local referendum, but agreed that strong support for community water fluoridation as a preventive measure should be a recommendation of this report. See Attachment VI for a further description of the process for authorizing water fluoridation in Maine.

Action Steps:

1. Affirmatively support community water fluoridation at the state government level with a Resolve.
2. Continue to provide technical assistance and consultation to communities seeking to implement water fluoridation.
3. Explore mechanisms to provide financial support to public water systems that are directed by local referenda to implement water fluoridation.

F. Service Expansion

Recommendation 13: Expand MaineCare to cover preventive and restorative services for patients in nursing facilities.

Fiscal Impact: Yes (to be determined)
Recommended Action: **Legislation, Rulemaking**

The lack of MaineCare coverage for older adults, particularly those in nursing facilities, was discussed several times in Task Force meetings. Medicare does not cover dental care, and MaineCare covers only a small number of services within its adult urgent care guidelines, none of them preventive. Task Force members strongly support coverage for preventive and restorative procedures for at least those elders who reside in a nursing facility.

Action Steps:

1. Develop pilot/model programs for preventive and restorative services in nursing facilities that can be funded or reimbursed through MaineCare, possibly with a federal waiver.
2. Promote oral health screenings and/or yearly oral exams in elder care facilities in order to identify and refer urgent care needs and to help monitor oral health status.
3. Explore the potential role of hygienists and denturists in nursing facilities.
4. Explore applicability of other MaineCare policies that might expand access to preventive and restorative oral health services in nursing facilities.
5. Develop legislative proposal(s) to expand MaineCare coverage.

Recommendation 14: Expand MaineCare to cover pregnant women over age 21 for preventive and routine restorative care.

Fiscal Impact: Yes (see Attachment VII)
Recommended Action: **Legislation, Rulemaking**

A growing body of evidence suggests a link between oral health, particularly periodontal disease (gum disease) and adverse birth outcomes. Pregnant women who have poor oral health may be more likely to have preterm, low birth weight babies. There is also evidence that individuals with diabetes have a greater challenge with glycemic control if they have periodontal disease. There is little question that the healthier the mother is throughout her pregnancy, the better off she and her child will be.

Health care providers can assess the pregnant woman's oral health status, oral health practices, and access to a dental home; discuss with her how oral health affects general health; and offer assistance for referrals to oral health professionals for treatment if needed. Primary health care providers can also educate the pregnant woman about diet and oral hygiene for infants and children, and how to limit the transmission of the bacteria that causes tooth decay,[16] thus helping to prevent early childhood caries, a particularly virulent form of tooth decay in young children. Caregivers – usually mothers – are a primary source of those bacteria.

When LD 282, "An Act To Provide Dental Care for Pregnant Women and New Mothers Receiving MaineCare Benefits" was presented in the 123rd Legislature, the fiscal analysis suggested that an appropriation of $297,266 for 2007-08 and $412,255 for 2008-09 would be needed for the state share of the additional MaineCare costs of extending dental and oral health services to pregnant women and new mothers eligible for MaineCare benefits. These funding levels assumed that an estimated 3,688 women would use the extended services annually at an estimated average cost of $293 per person per year. The proposal was not funded. Task Force members support the development of another proposal, based on further research and refined analysis of MaineCare utilization data.

Action Steps:

1. Review relevant scientific literature.
2. Review MaineCare utilization data in terms of selected procedures.
3. Conduct fiscal analysis.
4. Develop legislative proposal.
5. Draft necessary policy changes.

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The Task Force to Expand Access to Oral Health Care in Maine appreciates the Governor's support and encouragement in the important process of addressing and improving Maine's oral health status. As a group, the Task Force stands ready to reconvene and move forward on these

[16] Oral Health and Health in Women: A Two-Way Relationship. www.mchoralhealth.org/PDFs/WomensFactSheet.pdf © 2004 by the National Maternal and Child Oral Health Resource Center, Georgetown University. www.mchoralhealth.org
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recommendations and welcomes comments and feedback from all interested parties. It is the Task Force's hope that it can earn the support of the Joint Standing Committees on Health and Human Services and Business, Research and Economic Development in the process of expanding access to oral health care through legislative action on these recommendations.

Glossary of Terms

Access: For this report, the Task Force defines access as "the ability to obtain needed and appropriate health services in a timely manner."

Caries: Early Childhood Caries is defined as the presence of one or more decayed (non-cavitated or cavitated lesions), missing (due to caries) or filled tooth surfaces in any primary tooth in a preschool-age child between birth and 71 months of age.

Dental care professional: Any one of a number of health professionals trained, licensed, or otherwise certified to provide dental care. The table on the following page lists dental professionals practicing in the State of Maine and provides definitions.

Denturism: the discipline within the field of dentistry practiced by a denturist.

MaineCare coverage:

- MaineCare, Maine's Medicaid program, provides coverage for a full range of preventive and restorative dental services to eligible individuals (members) up to the 21st birthday.

- Adult dental care requirements provide for adults 21 years of age or older to receive selected procedures as necessary to relieve or eradicate acute pain, control bleeding, eliminate acute infection and prevent imminent tooth loss. Although some non-covered services may meet the broad criteria of urgent or emergency, the use of these terms does not extend to services not normally covered by MaineCare.

For more information, see www.maine.gov/sos/cec/rules/10/ch101.htm, Chapter 25.

Oral Health Professionals in Maine: Definitions

Dentist (DMD or DDS)	Dentists graduate from a 4 year graduate (post college) dental training program that confers the degree of DMD or DDS. Dentists provide the diagnosis, prevention & treatment of diseases of the oral tissues, especially the restoration, and replacement of defective teeth. They can practice general dentistry or specialize. Dental specialists include endodontists (root canals), periodontists (gum diseases), oral and maxillofacial surgeons (surgery), pedodontists (pediatric dentistry) and orthodontists (braces). Dentists practice under the direction of the Maine Board of Dental Examiners and must be licensed and registered every two years.
Dental Hygienist (RDH)	Hygienists graduate from a two to four year post- secondary college program and receive the title of Registered Dental Hygienist (RDH) in addition to the appropriate college degree. They work under the direct or general supervision of a dentist, and in Maine may also work under public health supervision. Hygienists can work in dental offices and public health settings, and provide a wide range of preventive services and other procedures depending on their work settings and patient needs. Hygienists who practice under Public Health Supervision Status can provide preventive services in settings such as schools and nursing homes, at local community events, and others. Hygienists practice under the direction of the Maine Board of Dental Examiners and must be licensed and registered every two years.
Independent Practice Dental Hygienist (IPDH)	An Independent Practice Dental Hygienist is licensed by the Maine Board of Dental Examiners and may practice without supervision by a dentist to the extent permitted by the enabling statute (MRSA Title 32, Chapter 16, Subchapter 3-B). To be licensed as an IPDH, an individual must have a valid license to practice dental hygiene issued by the Board and meet certain education and experience requirements as a dental hygienist. IPDHs may provide a range of dental services as defined by the statute. They practice under the direction of the Maine Board of Dental Examiners and must be licensed and registered every two years.
Dental Assistant (DA) and Certified Dental Assistant (CDA)	A dental assistant works under the direct supervision of a dentist. Assistants can be trained on the job or may attend a certificate program (usually less than one year). They provide assistance to a dentist during patient treatment to help complete a variety of tasks related to operative and surgical procedures. In Maine dental assistants who take x-rays must pass a test and be licensed and registered by the State Board of Dental Examiners as Dental Radiographer; radiographers are licensed and registered every five years. With additional training or by documenting at least two years of experience, and after passing a certification examination administered by the Dental Assisting National Board, a dental assistant may become certified (CDA).
Expanded Function Dental Assistant (EFDA)	This is a certified dental assistant (CDA) or a licensed dental hygienist who has successfully completed a Board approved EFDA training program and who has been issued a license by the Maine Board of Dental Examiners to perform reversible procedures under the direct supervision of a dentist. These may include the placement and contouring of amalgam and composite restorative materials. Training requirements may include completion of specific, Board-approved continuing education courses, or EFDA certification may be obtained by credentialing from another state or province, provided that the coursework completed is accepted by the Board of Dental Examiners.
Denturist (LD):	A member of the dental profession who has graduated from an accredited post-secondary denturist program. Denturists are licensed and registered by the Maine Board of Dental Examiners to practice the specialty of fabricating removable dentures – that is, dentures that do not attach to natural or restored teeth. They practice under the direction of the Maine Board of Dental Examiners and must be licensed every two years.

APPENDIX A

OFFICE OF
THE GOVERNOR

NO. 06 FY 08/09

DATE September 14, 2007

AN ORDER ESTABLISHING THE GOVERNOR'S TASK FORCE ON EXPANDING ACCESS TO ORAL HEALTH CARE FOR MAINE PEOPLE

WHEREAS, oral health is essential to the general health and well-being of all Maine people; and

WHEREAS, access to oral health care services and programs should be available to Maine people; and

WHEREAS, there is a severe shortage and maldistribution of oral health care professionals in the State of Maine; and

WHEREAS, Maine's most vulnerable citizens do not have equal opportunity to access oral health care;

NOW, THEREFORE, I, John Elias Baldacci, Governor of the State of Maine, do hereby establish the Governor's Taskforce to Expand Access to Oral Health Care for the Benefit of Maine Citizens (hereinafter "Task Force").

Purpose

The purpose of the Task Force is to develop recommendations for short-term and long-term solutions to expand access to high quality oral health care programs for all Maine citizens, particularly children, the elderly, the underinsured and the uninsured. The Task Force must identify existing barriers to access and provide recommendations for removing those barriers and for expanding access to adequate oral health care for Maine citizens.

1. The Task Force shall review relevant data and information on the status of oral health in Maine, as well as national studies on access to oral health care. The Task Force shall define a multi-year systems development approach to improving oral healthcare infrastructure, access to dental services and oral health status in Maine.

2. It shall consult with public and private individuals and organizations that provide medical and oral health care currently for the purpose of building upon existing relationships and partnerships.

3. It shall develop and recommend short-term and long-term solutions to expand the oral health care provider workforce; provide more comprehensive public awareness and education programs; evaluate and improve oral healthcare delivery systems; and increase funding of and reimbursement for oral health care services.

Membership

The Governor shall appoint up to 16 members to the Task Force, who will serve at the pleasure of the Governor.

- The Commissioner of the Department of Professional and Financial Regulation or a designee who shall serve as Chair;
- The Commissioner of the Department of Health and Human Services or a designee;
- The Commissioner of the Department of Education or a designee;
- A representative of the Governor's Office of Health Policy and Finance;
- Two members shall be public members not associated with a formal organization but who have an interest in oral health;
- A representative of a dental insurance company;
- A representative of the Maine Board of Dental Examiners;
- One member shall be a graduate level educator specializing in oral health education; and
- Seven (7) members shall represent the following organizations respectively--Maine Dental Association, Maine Society of Denturists, Maine Dental Hygienists Association, Maine Primary Care Association, Maine Medical Association, Maine Equal Justice Partners, and Maine Dental Access Coalition.

The President of the Senate may appoint two members of the Senate, and the Speaker of the House may appoint two members of the House of Representatives to serve. Members shall serve at the pleasure of their appointing authority.

The Chair will schedule, set the agenda for, and preside at Task Force meetings. All members shall serve without compensation.

Staff

The departments of state government named above shall provide appropriate staff to assist the Task Force.

Meetings

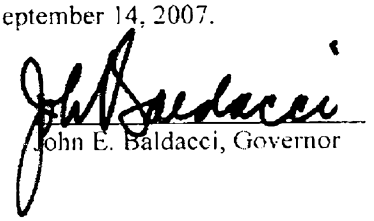
Public meetings in locations throughout the state will be scheduled and publicized, as needed.

Report

The Task Force shall submit a written report with recommendations to the Governor and the Joint Standing Committees on Business, Research and Economic Development and Health and Human Services no later than December 1, 2008, after which the Task Force shall dissolve.

Effective Date

The effective date of this Executive Order is September 14, 2007.



John E. Baldacci, Governor

Members: Task Force on Expanding Oral Health Care in Maine

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Maine Dental Access Coalition

Senator Debra D. Plowman
Hampden

Senator Nancy Sullivan
Biddeford

Rep. Donna Finley
Skowhegan

Rep. Nancy Smith
Monmouth

Description of Task Force Process

The Task Force met 11 times between November 2007 and November 2008, generally on the third Thursday afternoon of each month for four hour meetings. Ten meetings were held at the offices of the Department of Professional and Financial Regulation in Gardiner and one meeting was held at the Cross State Office Building in Augusta. Meetings were recorded to assist staff to memorialize discussions and to structure recommendations. Task Force leaders developed a list of suggested topics for presentation during the year; the following speakers presented information on the listed topics:

- **Medical and Dental Loan Forgiveness and Loan Repayment Programs of the Finance Authority of Maine**--Kathryn Gabrielson, Assistant General Counsel, and Claude Roy, Education Services Officer, Finance Authority of Maine

- **State and federal loan and loan repayment programs and the significance of dental health professional shortage area designations**--Charles Dwyer, Director, Maine Office of Rural Health and Primary Care (See also Appendix C.)

- **Statistics on Use of Emergency Department for Dental Care**--Judy Feinstein, Director, Oral Health Program, DHHS

- **Planning process for Dental School at the University of New England**--Ellen Beaulieu, Associate Provost of the University of New England

- **Model for the Advanced Dental Hygiene Practitioner under development by the American Dental Hygienists' Association**--Jane Walsh, Assistant Professor of Dental Hygiene at the University of New England and a member of the task force

- **Planned expansion at University of Maine at Augusta's University College of Bangor, Dental Health Program, Bangor campus, of its certified dental assisting education program to include distance learning, and future plans to implement a training program for Expanded Function Dental Assistants**--Diane Blanchette, faculty member

- **Strategies for meeting dental workforce needs, developing and integrating service delivery models and achieving policy changes that result in enhanced access to oral health services and improved oral health status**--Shelley Gehshan, formerly a senior program director with the National Academy of State Health Policy

- **Creating a patient-centered medical home and implications for including oral healthcare in the medical model**--Dr. Joshua Cutler, Director, Maine Quality Forum

Task Force members were also provided with background materials as it began its process, and other articles and resources were provided over the course of several meetings. Appendix B provides a list of those materials.

APPENDIX B

Materials Distributed to Oral Health Task Force members:

- *Access to dental care: The triad of essential factors in access-to-care programs.* Albert H. Guay, D.M.D. Journal of the American Dental Association, Volume 135, No 6, 779-785.

- *Bringing a New Chapter—Meeting Dental Workforce Needs.* Shelly Gehshan, M.P.P., National Academy for State Health Policy, September 2007

- Trends in State Public Health Legislation--January 1, 2006-December 31, 2006, *Chapter 3: Oral Health.* Healthy States Initiative, Council of State Governments. January 12, 2007.

- DHHS (Office of Data, Research and Vital Statistics, Bureau of Health) Fact Sheet – Dentists and Dental Hygienists: 1998/1999

- DHHS (Office of Data, Research and Vital Statistics, Bureau of Health) Fact Sheet – Dentists in Maine: 2002

- DHHS (Office of Data, Research and Vital Statistics, Bureau of Health) Fact Sheet – Dental Hygienists in Maine 2004

- DHHS (Office of Data, Research and Vital Statistics, Bureau of Health) Fact Sheet – Dental Hygienists in Maine 2004: Practice, Education, and Benefits

- Dental Safety Net Sites, Maine 2007. Created by the Maine Office of Public Health Emergency Preparedness, September 28, 2007

- *Dental School Feasibility Study: Maine, New Hampshire and Vermont. Report for Northeast Delta Dental,* Howard Bailit, DMD, PhD. and Tryfon Beazoglou, PhD. July 10, 2007

- *Dental Workforce Trends—Opportunities for Improving Access.* Shelly Gehshan, M.P.P., National Academy for State Health Policy, March 2008

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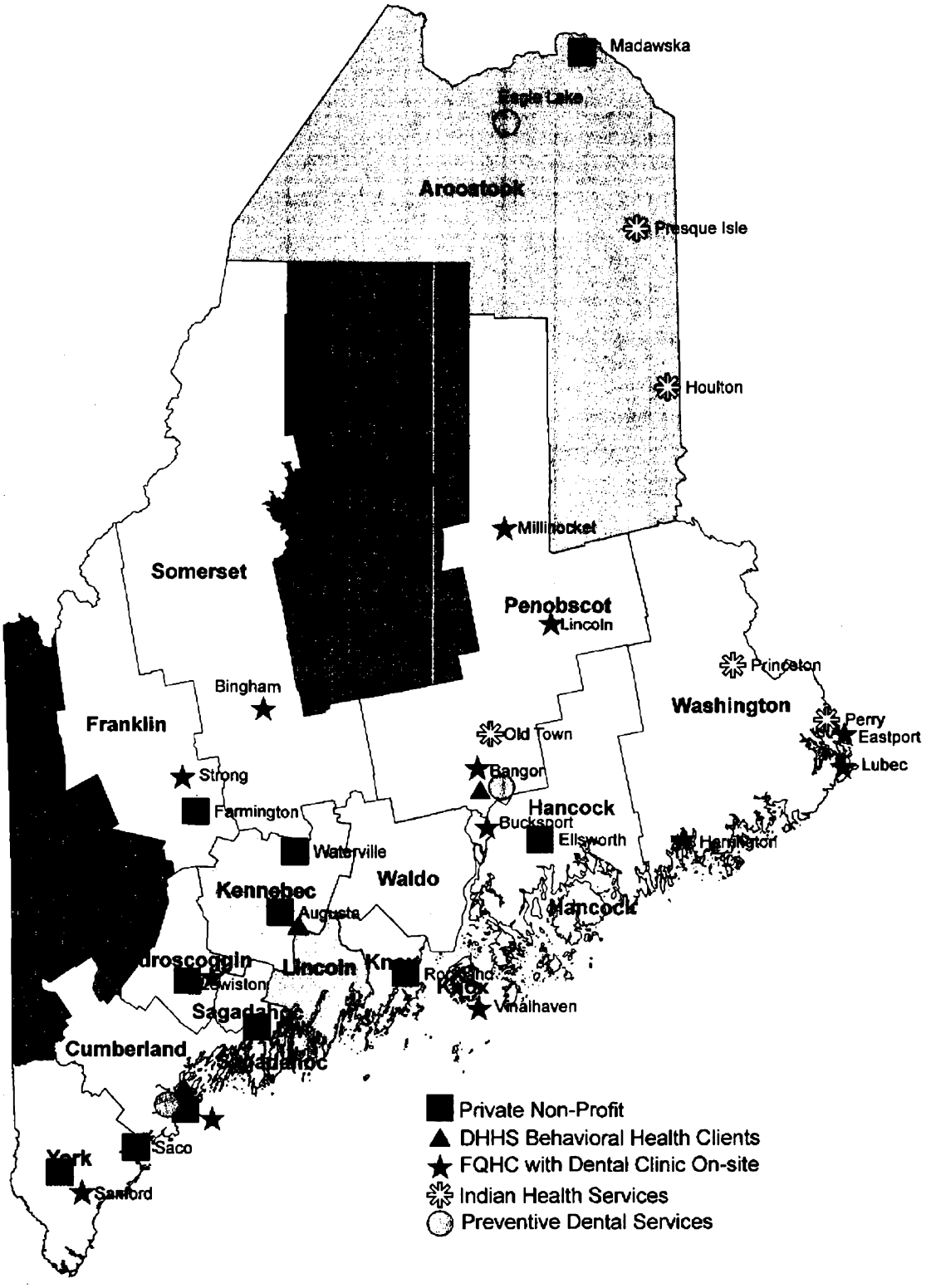
APPENDIX C

Dental Safety Net Sites
Maine 2008



Updated November 20, 2008
Map created by the Office of Public Health Emergency Preparedness

Private and Public Non-Profit Dental Clinics in Maine

Federally Qualified Health Centers

B Street Dental Program
B Street Health Center
57 Birch St.
Lewiston, ME 04240
Tel. 753-5400

Bingham Area Dental Center
237 Main Street, PO Box 746
Bingham, ME 04416
Tel. 672-3519

Bucksport Regional Health Center
74 Main Street, Suite 200
Bucksport, ME 04416
Tel. 469-2359

City of Portland, Homeless Health Clinic
20 Portland St.
Portland, ME 04101
Tel. 874-8450

Eastport Health Care Inc.
30 Boynton Street
P.O. Box H
Eastport, ME 04631
Tel. 853-6001

Harrington Family Health Center
Route #1, P.O. Box 82
Harrington, ME 04643
Tel. 483-4502

Health Access Network
HAN Family Dental Care
9 Main St.
Lincoln, ME 04457
Tel. 794-6700

Islands Community Dental Services
15 Medical Center Loop, P.O. Box 812
Vinalhaven, ME 04863
Tel. 863-4341

Katahdin Valley Health Center
50 Summer Street
Millinocket, ME 04462
Tel. 723-6565

Penobscot Community Dental Clinic
1048 Union Street
Bangor, ME 04401
Tel. 992-2152, Option #4

Regional Medical Center at Lubec
43 South Lubec Road
Lubec, ME 04652
Tel. 733-5541

York County Community Health Care
6 Spruce Street
Sanford, ME 04073
Tel. 490-6900 or 1-800-965-5762

Strong Area Health Center
177 North Main Street
Strong, ME 04938
Tel. 684-3045

Private Non-Profit Dental Centers

Maine Coast Community Dental Clinic
70 Kingsland Crossing Suite A
Ellsworth, ME 04605
Tel. 667-0293

The Community Dental Center
93 Main Street
Waterville, ME 04901
Tel. 872-8891

Jessie Albert Memorial Dental Center
171 Congress Avenue
Bath, ME 04530
Tel. 443-9721 or 1-888-304-8020

Community Dental - Rumford
60 Lowell St.
Rumford, ME 04276
Tel. 369-3600

Community Dental - Sanford
941 Main Street, Suite 101
Sanford, ME 04073
Tel. 324-5508

Community Dental - Saco
Kimball Health Center, 333 Lincoln Street
Saco, ME 04072
Tel. 282-1305

Community Dental - Portland
640 Brighton Avenue
Portland, ME 04102
Tel. 874-1028

Community Dental - Farmington
131 Franklin Commons, Suite 1
Farmington, ME 04938
Tel. 779-2659

Community Dental - Lewiston
177 Main St.
Lewiston, ME 04240
Tel. 777-7442

Kennebec Valley Dental Center
269 Water Street,
Augusta, ME 04330
Tel. 623-3400

St. John Valley Dental Center
309 St. Thomas Street, Suite 103
Madawaska, ME 04756
Tel.728-7557

Volunteer & Voucher Programs

Knox County Health Clinic Dental Program
22 White Street
Rockland, ME 04841
Tel. 594-6996

Portland Volunteer Dental Clinic
20 Portland St.
Portland, ME 04101
Tel. 874-8450

Waldo County Dental Project
Waldo Community Action Partners
9 Field Street, Suite 305
Belfast, ME 04915
Tel. 338-6809

State Clinics

DHHS clinics for former & current clients

Dorothea Dix Psychiatric Center
P.O. Box 926
Bangor, ME 04402
Tel. 941-4120

Capital Community Clinic
250 Arsenal St.
Augusta, ME 04332
Tel. 624-3942 or 1-800-834-3339

Clinical Services
63 Preble Street
Portland, ME 04101
Tel. 822-0232 or 1-800-572-4928

Tribal Programs (Indian Health Services)

- **Micmac Service Unit**
  8 Northern Rd.
  Presque Isle, ME 04769
  Tel. 764-1792
- **Houlton Band of Maliseet Indians**
  Tribal Health Program
  12 Clover Circle
  Houlton, ME 04730
  Tel. 532-4229 or 1-888-594-8272
- **Passamaquoddy Tribe of Indian Township**
  Indian Township Health Center
  PO Box 97
  Princeton, ME 04668
  Tel. 796-2322 (clinic)
- **Passamaquoddy Tribe of Pleasant Point**
  Pleasant Point Health Center
  PO Box 351
  Perry, ME 04668
  Tel. 853-0644 (health center)
- **Penobscot Nation Health Department**
  23 Wabanaki Way
  Indian Island
  Old Town, ME 04468
  Tel. 817-7400

Preventive Services

Dental Hygiene Schools

University of New England, Westbrook College, Portland: School of Dental Hygiene – provides preventive services, Sept. – April. (797-8999)

University of Maine, University College, Bangor: Dental Health Programs – provides preventive services, Sept. – April. (262-7872)

Federally Qualified Health Centers

Eagle Lake Health Center (444-5973) – provides limited dental hygiene services, refers to dentist(s) in Fort Kent.

Preventive Dental Hygiene Programs,

agencies, etc. They provide services via contracts & other arrangements with schools, Head Start and WIC agencies, other community agencies such as Boys & Girls Clubs, and others.

- Prevention Partners, Inc. (633-9716) – primarily southern & central Maine, but also statewide (mobile)
- Tooth Fairies, Inc. (754-8784) – primarily western Maine (mobile)
- Maine Dental Health Outreach, Inc. (Tooth Angels) (377-7003) – based in Winthrop, works with surrounding school systems
- Saving Smiles, Inc. (445-2852) – central Maine and Waldo County (mobile)

Sebasticook Valley Hospital Dental Clinic, Pittsfield (487-5238): Provides preventive dental services within the hospital's defined service area.

Washington County Children's Program, Machias: (255-3426) operates the "Tooth Ferry", a mobile dental unit that travels to the various schools and other agencies that the WCCP's dental program works with, providing screenings, sealants, and dental health education.

Waterville Pediatrics (873-5437): Employs a dental hygienist part-time within the practice who provides preventive dental services to eligible children (those who do not have a family dentist).

Aroostook County Action Program, Presque Isle: (768-3026) employs a full-time dental hygienist in its WIC program who provides preventive dental services to eligible children (those who do not have a family dentist).

ME DHHS, Center for Disease Control, Oral Health Program (287-2361): School Oral Health Program provides grants for classroom-based preventive oral health education and weekly fluoride mouthrinse in grades K-6 in eligible elementary schools, and sealants to 2nd graders. Eligibility is based on community-based criteria related to access to fluoridated water, MaineCare enrollment, poverty rate, and student eligibility for free and reduced lunch.

Definitions:

A **dental clinic** is a dental program with a fixed site, permanent equipment (rather than portable), employed staff and regular hours, where people may receive a full range of preventive and restorative dental care. Specialty services may or may not be available.

Mobile programs may either use a vehicle, such as a specially outfitted truck or coach, in which dental equipment has been installed, or may be mobile in the sense that they bring portable equipment to the various locations where they provide services.

Volunteer or voucher programs depend largely on health professionals who donate their time to provide dental services. Such programs in Maine are individually designed and no two are alike. A voucher program coordinates the referral to services of qualified individuals and may or may not provide some services prior to referral.

Preventive Dental Hygiene programs offer a range of preventive services provided by registered dental hygienists practicing under Public Health Supervision status.

Prepared by the Maine Center for Disease Control & Prevention
Oral Health Program
Maine Department of Health & Human Services
For more information call 287-2361
Nov. 2008

Understanding Health Professional Shortage Area Dental Designation Criteria and Dentist to Population Ratios

I. US Health Resources and Services Administration, Bureau of Health Professions. Relevant excerpts from 42 code of federal regulations (cfr), chapter 1, part 5, Appendix B (October 1, 1993, Pp. 34-48)

A. Criteria.
A geographic area will be designated as having a shortage of dental professional shortage if the following three criteria are met:

1. The area is a rational area for the delivery of dental services.

2. One of the following two conditions prevails in the area:
   (a) The area has a population to full-time-equivalent dentist ratio of at least **5,000:1**, or
   (b) The area has a population to full-time-equivalent dentist ratio of less than **5,000:1** but greater than **4,000:1** and has unusually high needs for dental services or insufficient capacity of existing dental providers.

3. Dental professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.

B. Specific population groups within particular geographic areas will be designated as having a shortage of dental care professionals if the following criteria are met:
   1. The area in which they reside is rational for the delivery of dental care services.
   2. The ratio of the number of persons in the population group to the number of dentists practicing in the area and serving the population group is at least **4,000:1**.
   3. Dental care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration. Overutilization is based on a population to provider ratio of **3,000:1**.

For a more in-depth description of the Dental Designation Criteria, please go to http://bhpr.hrsa.gov/shortage/hpsacritdental.htm

The advantage of HPSA designation is that areas with designations may be eligible for certain federal programs and resources, including for example, eligibility for loan repayment programs for qualified individuals and eligibility of practice sites for National Health Service Corps scholars (individuals who are obligated for 4 years to practice in designated areas). More than 34 federal programs depend on the shortage designation to determine eligibility or as a funding preference. Designation also affects reimbursement rates in the federal Medicare and Medicaid programs.

NOTE: these criteria are due to be updated and significant changes are expected, when the relevant regulations are published in the Federal Register. It is not known when this will happen.

II. How these ratios are calculated (Maine Office of Rural Health & Primary Care)

The ratios account for dentist time as an FTE or percentage of an FTE, along with an adjustment made for auxiliary staff, and only include general practice and pediatric dental practices.

The HPSA ratios change fairly often because 1) as dentists get older their equivalency weights decrease; 2) dentists retire or relocate to a different DCAA (see following pages) or move out of state; 3) dentists may reduce their hours or change their MaineCare patient caseload ; and 4) one dentist situational change may affect "contiguous area" resources for HPSA designation purposes.

III. Dentist to Population ratios as listed in Maine Dentists – 2006 (Cooperative Health Workforce Resource Inventory) [Table 2]

These ratios are derived from 2004 US Census data and the number of dentists responding to the state survey as licensed and actively practicing in Maine. That number includes all such dentists, regardless of specialty, and makes no adjustments for time or auxiliary staff. Thus, these ratios will always be different from the Dental HPSA ratios (above), and in some cases, significantly so. The two measures cannot and should not be compared to each other.

Each measure should be considered a starting point or an element for consideration in further analysis and understanding of workforce issues and shortage areas.

APPENDIX D

Maine's Dental Professional Workforce

Data collected in 2006 by the Maine Office of Data, Research and Vital Statistics (ODRVS) showed 585 dentists actively practicing in Maine (of 627 licensees), resulting in a dentist to population ratio of one dentist to 2,552 residents, a significant difference from the U.S. ratio of one dentist for each 1,700 people. Dentist to population ratios are a very gross measure of access to care, and should only be considered as a starting point for further analysis and understanding. Of Maine's actively practicing dentists, 79% (464) were general practitioners, according to self-report of primary specialties. Of the dentists who reported specialty information, the next most frequently reported specialties - orthodontics (40 dentists) and oral surgery (32 dentists) – together represented just 12% of all dentists. Only 11 dentists reported pediatric dentistry as their specialty; several of these but not all have had specialty training. It is expected that the 2008 survey will show a similar distribution of specialists, although the number of pediatric specialists has reportedly increased to 14. Approximately 20 percent of Maine dentists reported in the 2006 survey that they did not expect to be practicing dentistry in Maine in 5 years (that is, by the end of 2011).

Low dentist-to-population ratios in rural areas of the state compound the access problem. Many low-income families and individuals in rural areas have long been challenged to find a dentist accepting new patients, particularly one who will accept MaineCare. Regardless of ability to pay, there are reports statewide of traveling significant distances to obtain care, or waiting a long time for routine appointments. This can be particularly problematic when specialty care is sought.

The ODRVS conducted a Dental Hygienist Resource Inventory in 2006. According to the Maine Board of Dental Examiners, in early 2008 there were 1,238 registered dental hygienists licensed by the state of whom 1,130 had Maine addresses. Based on responses to that 2006 survey, some 800 to 900 of these individuals can be assumed to actively practicing. The data showed that on average, they worked 28.5 hours a week in direct and indirect patient care. Some 57% of Maine's hygienists were under 45 years of age, compared to more than 75% in 1999. The great majority of hygienists who responded to the survey (89%) expected to be working in Maine in 5 years. Hygienists are being surveyed again at the end of 2008.

Maine also licenses denturists. Of almost 70 denturist licenses issued by the Board of Dental Examiners, 23 currently practice in the State of Maine. They are not included in the statutorily required surveys of health professionals as are dentists and dental hygienists, so other data is not readily available.

Dental assistants may be either trained on the job or may enroll in an educational program resulting in certification, but licensure is not required. Many are licensed as radiographers (so that they may take and develop dental X-rays). The number of licensed radiographers may be used to approximate the number of dental assistants but should be understood to be an underestimation of their actual number. As of November 2008, there are 1260 licensed radiographers in Maine.

APPENDIX E

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

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

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

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

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

The State Loan Repayment Program offers $25,000 per year for a minimum 2-year contract. The dentist may enter into two single contracts for a total of four years ($100,000). The dentist must also document that he or she has outstanding educational loans that amount to the requested payments and must claim the loan repayment monies as income on his or her tax forms. This program is funded with 50% National Health Service Corps monies and 50% matching state dollars provided by FAME (the source is Maine's tobacco settlement dollars). Note: The Maine SLRP did not receive NHSC funding for 2007-2008 and is currently seeking alternative avenues of funding.

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

In addition, the Maine Dental Education Loan Program offers students from Maine who have been accepted to dental school forgivable loans of $20,000 per year for up to 4 years if they agree to serve in areas of need in Maine after they complete their dental school education. Loan

forgiveness is available at the rate of 25% per year for services and the loan recipient must provide dental services regardless of the patient's ability to pay. This program is also funded entirely by state tax dollars (the source is Maine's tobacco settlement dollars).

For more information about the Federal Loan Repayment Program and the State Loan Repayment Program, contact the Office of Rural Health & Primary Care at (207) 287-5562.

For more information about the Maine Dental Education Loan and Loan Repayment Programs, contact the Finance Authority of Maine at (207) 623-3263 or (800) 228-3734.

Name of Program	Minimum # Year Commitment	Must be FDDHPSA?	Repayment/Yr. First 2 years	Repayment/Yr. Year 3 & 4	Source of funding
Federal Loan Repayment (NHSC)	TWO	YES	$25,000	$35,000	100% Federal
State Loan Repayment	TWO	YES	$20,000	$20,000	50% Federal 50% State
Maine Dental Education Loan/ Loan Repayment	ONE	NO*	$20,000	$20,000	100% State

* Must meet state requirements for need, but less stringent than FDDHPSA

ATTACHMENT I

State Oral Health Improvement Plan Goals and Strategies

(* denotes a strategy for which there are activities underway and/or some degree of progress has been achieved as of September 2008)

A. Change Perception and Increase Awareness

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

Goal 1 – Inform Policy Makers and Elected Officials

Increase the awareness and knowledge of policy makers and elected officials regarding the importance of good oral health and the needs of the population as a whole in order to ensure that all oral health initiatives identified in this document are supported.

Strategies:

1. Collaborate with public health stakeholder groups throughout the state, for example, the Public Health Infrastructure Work Group and the new regional public health districts and Comprehensive Community Health Coalitions, to facilitate communication regarding implementation and monitoring of oral health initiatives.*
2. Maintain adequate funding and staffing of the state Oral Health Program within the Maine Center for Disease Control in order to maintain, coordinate, and evaluate services provided by state government, and to provide technical assistance and consultation in public health functions.
3. Provide data on the burden of oral disease on the people of Maine to policy makers and elected officials to strengthen the commitment for oral health funding and resources.*
4. Develop and distribute a data report to accompany this plan, and assure that it can be updated at appropriate intervals.
5. Support agency actions and policy initiatives that will secure adequate funding for the strategies outlined in this Plan and to supplement the State Health Plan to ensure support for oral health programs.*
6. Provide evidence of successful programs and services in Maine and other states.
7. Explore the inclusion of oral health care in the Dirigo Health Plan.
8. Determine a method for demonstrating overall savings to be realized from implementing the Oral Health Plan.
9. Invite policy makers and elected officials to attend and to be involved in oral health conferences and events.

Goal 2 - Increase General Public Awareness

Design and implement educational campaigns targeting the general public to provide oral health education, to change negative perceptions, and to increase awareness regarding the impact of good oral health, particularly the importance of early intervention, on overall health throughout the life span.

Strategies:

1. Utilize communications strategies, such as those used in the "Watch Your Mouth" (2005-2006) campaign, that seek to improve awareness of the importance of oral health and the connection between oral health and overall health.
2. Collaborate with Healthy Maine Partnership organizations, the new regional public health districts and Comprehensive Community Health Coalitions, and coordinated school health education initiatives.*

3. Coordinate educational activities with state and national health campaigns, such as Children's Dental Health Month, Dental Hygiene Month, Nutrition Month, National Public Health Week and others.*
4. Design focused messages for specific at-risk populations.
5. Incorporate oral health messages with other health messages that promote the integration of oral health, such as oral cancer prevention messages into existing cancer prevention and tobacco-use reduction efforts.*

B. Increase Prevention and Expand Access

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

Goal 3 - Expand Prevention Programs in Schools and Communities
Expand the use of topical fluoride rinses, dental sealants and other preventive interventions in school-based and school-linked programs and promote community water fluoridation in areas not currently being served to benefit all individuals, regardless of age.

Strategies:
1. Maintain school-based and school-linked oral health education and prevention programs in schools and communities where there are demonstrated needs for community-based services; develop incentives for schools to adopt fluoride mouth rinse and dental sealant programs.*
2. Explore resources and partnerships with philanthropic foundations, dental professionals and community groups to support preventive oral health programs in schools and communities.*
3. Establish protocols for school-based oral health programs to ensure good communication and coordination among schools, dental services providers and funding sources.
4. Educate parents, school personnel and community members regarding the efficacy of utilizing preventive measures and treatments for children, such as fluoride rinses and fluoride varnish as well as dental sealants.*
5. Support increased resources, financial and personnel, for implementing preventive services in schools, especially those that demonstrate unmet oral health needs.
6. Provide resources and information regarding oral health to classroom and health education teachers to insure that oral health is integrated within comprehensive health education.*
7. Promote water fluoridation in communities that are not already being served.
8. Develop and expand collaborations with other health and community organizations (such as but not limited to voluntary health organizations, school nurses, Healthy Maine Partnership organizations, community coalitions) to promote the integration of preventive oral health activities and messages into their work.*

Goal 4 - Promote Dental Care for Pregnant Women
Ensure oral health prevention and treatment services for all pregnant women, regardless of age, who do not have dental insurance.

Strategies:
1. Explore models from other states to design the most effective and accessible programs for Maine.*
2. Research national standards for dental care of pregnant women.*
3. Evaluate expanding MaineCare coverage for pregnant women past the 21st birthday as well as the feasibility of adding uninsured pregnant women to MaineCare priorities for dental care.*
4. Explore new resources for funding from private insurance and public programs.

5. Collaborate with obstetricians, nurse midwives, and other primary care medical providers to promote dental care and oral health education for pregnant women.*
6. Promote the incorporation of oral health education and preventive care information to existing Birth and Parent Education classes and in other settings where women of childbearing age can obtain health related information.*

Goal 5 - Ensure Early Childhood Preventive Care
Support efforts to ensure that every child receives at least one preventive care visit by the age of one to identify early dental problems and to educate parents and caregivers regarding the methods and importance of good oral health care.

Strategies:
1. Implement a promotional campaign regarding the importance of preventive care that involves and is directed to medical and dental providers, parents, teachers and child care providers.
2. Facilitate inclusion of anticipatory guidance (child health supervision guidelines) for oral health care into primary care providers' well child visit schedules.*
3. Explore resources to enable primary care providers, after certified training, to receive public and private insurance reimbursement for providing preventive oral health care.
4. Promote oral health training for child care providers as part of the certification process.
5. Support and promote oral health training, resource development and collaborative relationships that facilitate integration of oral health promotion and dental disease prevention activities in Head Start and Early Head Start Programs.*
6. Encourage collaboration among educators, prenatal care providers, DHHS, and home care personnel to promote positive and preventive oral health behaviors among their clients.*

Goal 6 - Use Non-traditional Settings and Innovative Approaches to Reach Underserved Groups
Expand preventive dental care and educational capacity with the use of nontraditional settings (e.g. schools, community settings, childcare programs) and innovative approaches to reach underserved individuals of all ages.

Strategies:
1. Research existing models in Maine and other states of oral health services provided in non-traditional settings that have not usually included dental care.*
2. Explore models to integrate oral health and primary health care services.*
3. Connect oral health education and screenings to existing school health programs, services and school-based health centers.*
4. Promote oral health screenings in all schools and yearly oral exams in elder care facilities in order to identify and refer urgent care needs and to help monitor oral health status.
5. Explore the current role of hygienists in schools and in facilities for the elderly.
6. Explore and evaluate the use of mobile dental programs for their effectiveness in Maine.*
7. Collaborate with workplace wellness programs to include oral health services and education.
8. Support inclusion of oral health in priorities of Healthy Maine Partnerships, the new regional public health districts and Comprehensive Community Health Coalitions, and provide adequate funding.*
9. Expand dental preventive services in WIC clinics for women and children and in other programs that provide services to children and families; for example, promote training in techniques for oral health screening, preventive education, and early interventions for home visitation program staff.*
10. Promote training for care providers in techniques for maintaining oral health for residents in nursing homes, long-term care and hospice facilities.

C. Improve Service Delivery

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

Goal 7 - Improve Current System Infrastructure

Examine the current infrastructure to improve delivery systems, determine the unmet needs of specific population groups, and expand public and non-profit community-based oral health services (the safety net) to better serve the oral health needs of all population groups.

Strategies:

1. Analyze data regarding the distribution of dental providers, dental centers and clinics, uninsured persons, and related demographic factors to assess the current delivery system, gaps, and unmet needs.*
2. Review data and relevant information from other sources, for example, the Board of Dental Examiners, reports from dental hygienists working in public health supervision status, community organizations, hospitals, Head Start Centers, WIC agencies, and others.
3. Work with the Office of MaineCare Services, the Public Health Infrastructure Work Group, and others to support improvements in the processes of, enhancements to, and incentives in the MaineCare Dental Program that may increase access to dental services such as, but not limited to, reviewing and adjusting reimbursement rates.*
4. Assess the capacity and sustainability of the existing public health delivery system relative to the provision of oral health care.
5. Develop effective strategies for recruitment and retention of professionals who are providing dental public health services.*
6. Explore models and create opportunities to integrate the provision of oral health services in settings not currently providing these services, for example, hospital-based programs (such as the Maine-Dartmouth Family Medicine Institute) and volunteer/free medical clinics.*
7. Support initiatives that maximize the ability of allied dental personnel (dental hygienists, expanded function dental assistants, and dental assistants) to provide preventive services within the oral health infrastructure, and particularly in public and non-profit community-based oral health settings.*
8. Investigate funding sources to support the public health infrastructure system for the provision of oral health care.
9. Explore changes in private insurance contracts in Maine to support coverage of preventive oral health services provided outside of traditional dental office settings by licensed providers other than dentists.*

Goal 8 - Increase Oral Health Knowledge Base

Disseminate up-to-date and scientific, evidence-based oral health information to all health professionals and encourage timely implementation of new knowledge and techniques in order to improve oral health outcomes for consumers of all ages.

Strategies:

1. Provide information and opportunities for training that focus on oral health to health related associations and organizations.*
2. Encourage inclusion of oral health in health related association and organization strategic plans, especially in physician groups.*
3. Ensure all trained health professionals hold a basic level knowledge of oral health issues and early intervention as a component of overall health and well-being before exiting their professional training programs.*

4. Promote the provision of continuing education credits for non-dental professionals to encourage training in oral health promotion and dental disease prevention interventions. *
5. Distribute guidelines for prevention and treatment of oral diseases for all age groups to primary medical care providers and encourage their use. *
6. Focus educational efforts for pediatricians and other primary care physicians to support oral health, and provide appropriate materials to physician offices. *
7. Promote collaborations and sharing of information and innovative techniques between oral and medical health professionals. *

Goal 9 - Provide Evidence-Based Evaluation

Evaluate oral health programs and services in Maine in terms of their impact on access, health outcomes and their application of best practices, to define future statewide oral health needs.

Strategies:

1. Develop and maintain a comprehensive oral health surveillance system to identify and monitor oral health status and access to oral health services. *
2. Determine best data collection tools to standardize measurement of outcomes. *
3. Examine best and "promising" practices in Maine and in other states for models for programs, financing, and evaluation that can be replicated and/or adapted for use.
4. Disseminate best practice methods in clinical practice and policy. *
5. Implement ongoing monitoring and evaluation of milestones to analyze the impact of oral health initiatives on health status.

Goal 10 - Increase Partnerships

Collaborate with other State departments and agencies to facilitate integration of oral health with general health initiatives and cultivate public-private partnerships to support oral health improvements for all residents of Maine.

Strategies:

1. Explore methods to enable partnerships that promote oral health services and awareness. *
2. Identify state-level programs for possible collaborations, such as Head Start and WIC. *
3. Utilize existing tools, programs (for example, tobacco and cancer control), and policies that support the integration of oral health with other health programs. *
4. Engage the business community in supporting oral health initiatives.
5. Provide guidance and support, with the Maine Department of Education, for the implementation of oral health promotion and education within the Maine Learning Results.
6. Promote the inclusion of oral health activities in schools, elder facilities and worksite wellness programs. *
7. Increase awareness of the importance of oral health through education and collaboration with the Coordinated School Health Program. *
8. Collaborate with home health agencies, Area Agencies on Aging and others to promote inclusion of dental care and oral health services for the homebound and elderly, in conjunction with the Office of Elder Services of the Department of Health & Human Services.
9. Encourage employers with employee dental plans to promote oral health initiatives.

D. Expand the Dental Workforce

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

Background and Challenges:

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.

Strategies:

1. Support implementation of the Expanded Function Dental Assistant (EFDA) legislation that passed in 2005. (PL Ch. 322, 2005) *
2. Review and monitor the development of emerging models for new dental health care team members, including for example advanced practice models for dental hygienists (such as the Advanced Dental Hygiene Practitioner) and preventive oral health services providers in medical settings, and evaluate these for effectiveness in Maine. *
3. Assess and evaluate the impact of public health supervision status for dental hygienists on access to preventive services for underserved populations, and explore the development of models based on current programs and initiatives to maximize effectiveness*
4. Explore development of appropriate certifications and/or quality assurance mechanisms that facilitate interdisciplinary approaches to improving oral health in Maine and improve overall workforce capacity and productivity.
5. Integrate oral health care with well baby, well child and adult annual medical visits. *
6. Encourage education in oral health promotion and dental disease prevention for physicians and their staff. *

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.

Strategies:

1. Support initiatives in secondary schools and colleges to interest students in, and prepare them for, oral health care careers.*
2. Consult research on retention in host states of medical students and physicians serving externships, internships and residencies for relevance and lessons learned for application to Maine initiatives with dental providers.*
3. Support collaboration to expand dental residency programs in Maine.
4. Explore the feasibility of establishing a dental school in northern New England or of developing cooperative relationships with dental schools in the Northeast.*
5. Expand externship programs for dental students to encourage relocation to Maine.*
6. Encourage the expansion of loan forgiveness programs, especially for those serving at-risk and underserved populations.*
7. Encourage increasing the supply of dental providers by recruiting from the military and from out-of-state.
8. Explore methods to assure transfer of practices from retiring dentists to new dental professionals in order to provide continuity of access and care.
9. Encourage and support coordinated and cost-effective recruitment efforts.*

Goal 13 - Expand Breadth and Diversity of Education Available to Oral 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.

Strategies:
1. Identify and promote opportunities for skills development training programs for dental professionals on working with children, individuals with behavioral health concerns, older adults and the elderly, and children and adults with developmental disabilities.*
2. Explore the use of financial incentives for dental professionals to serve at-risk and under-served populations.*
3. Support collaborations that facilitate and provide cross-training of health professionals; for example, the Maine Dental Association and the American College of Obstetricians and Gynecologists (ACOG) would offer a CE course on oral health during pregnancy that would benefit both groups of health professionals.*

ATTACHMENT II

MaineCare Dental Rates
Comparison with ADA Northern New England Rates

	State Share	Federal Share	Total
Current annual $	$ 6,839,580.81	$ 12,329,647.92	$ 19,169,228.73
Rate increase to 50th percentile of ADA NNE rate	$ 14,342,396.57	$ 25,854,903.24	$ 40,197,299.82
Rate increase to 75th percentile of ADA NNE rate	$ 16,526,862.40	$ 29,792,819.22	$ 46,319,681.62
Orthodontic codes			
Current annual $	$ 1,737,903.74	$ 3,132,902.71	$ 4,870,806.45
109% increase (50th percentile)	$ 3,632,218.82	$ 6,547,766.66	$ 10,179,985.48
141% increase (75th percentile)	$ 4,188,348.02	$ 7,550,295.53	$ 11,738,643.54

Source: Data and analysis provided by staff of MaineCare on November 24, 2008

ATTACHMENT III

Oral Health in Maine – Selected Data

Children's Oral Health Status

Maine State Smile Survey, 1999:

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

Maine Child Health Survey, 2003-04*

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

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

Pregnant Women

In 2004, nearly half (46%) of Maine women who had a baby had a dental visit during their pregnancy.

- More likely to have a dental visit: women 35 years old or older
- Least likely to have a dental visit: women younger than 25
- Of those who had a dental visit, fewer were likely to be enrolled in the WIC Program or to be MaineCare members
- About 25% of new mothers said they needed to see a dentist for a dental problem during their pregnancies. They were more likely to be 20-24 years old, enrolled in WIC, be MaineCare members, and have annual incomes less than $16,000.
- 60% of the women who were not MaineCare members saw a dental provider during pregnancy compared to only 28% of MaineCare members
- 40% of all women, but only 26% of MaineCare members, said a health care worker talked with them during their pregnancy about how to care for their teeth and gums.

Data is from the Pregnancy Risk Assessment Monitoring System

Adults

- Data for 1995-97 indicated that for people age 65 and over, Maine was the 5th most edentulous (toothless) state in the country
- In 2002, the percentage of adults aged 65 and older who reported loss of all their natural teeth was 30.4%, and 43.8% reported retention of "most" of their natural teeth
- In 2006, 3.8% of adults aged 25-34 and 7.6% of those aged 35-44 reported they had lost six or more teeth
- In 2006, having lost all teeth was reported by 4.3% of people 45-54, by 11.5% who were 55-64, and by 26.2 4% of those 65 and older. For this last age group, Maine was ranked in the middle third of all states.
- 70% of Maine adults (age 18+) reported a dental visit within the past year (with a dentist or to a dental clinic)

Data is from the Behavioral Risk Factor Surveillance System

ATTACHMENT IV

Attachment IV: Concept for the proposed UNE College of Dental Medicine

Preliminary work conducted several years ago to develop a dental residency program provided the basis for UNE's decision to investigate the possibility of a dental school. Characteristics of the dental school are expected to include elements such as but not necessarily limited to the following: a small, efficient basic teaching facility, complemented by the utilization of web-based instructional technology to the greatest extent possible, the establishment and utilization of distributed clinical sites that have an organizational relationship to the dental school, and extensive use of rural placements in the third and fourth years; interdisciplinary learning and team-based clinical experiences; a community health and public health focus for all students; and the development of a research component that complements teaching goals. The expected use of rural placements with clinical sites in underserved areas, and a plan to place students in rotations in rural sites for six to 12 months represents increased manpower that can have an impact on improving access to care while also producing revenue that can help support the sites. There will be a comprehensive approach to dental care, covering the continuum from prevention through treatment. Clinical sites will have relationships with the communities and regions in which they are located; students will work with community organizations, such as schools, Head Start and WIC programs, etc. Dental students will follow a curriculum that includes the first 18 credits of the graduate public health program at UNE and will receive a Certificate of Advanced Graduate Study in public health.

The addition of post-graduate dental residency (specialty) programs is likely once the school is established. There has been some discussion of how the proposed dental school and the existing dental hygiene program at UNE would relate, as well as how the dental school would relate to other health professional training programs at UNE (e.g., the medical school); clearly, there would be relationships but details are yet to be developed. Whether these programs would include "midlevel" dental practitioner training and/or denturism are also yet to be explored. There is also interest in assessing the feasibility of developing combined degree programs that facilitate students starting dental school after the junior year at an undergraduate institution, especially one in Maine, therefore finishing dental school after seven years.

ATTACHMENT V

School-Based and School-Linked Oral Health Programs

In Maine, the public and private sectors contribute efforts toward promoting oral health for school-aged children:

- The Maine CDC's Oral Health Program (OHP) administers a long-standing school-based oral health education program (SOHP) in eligible Maine elementary schools that incorporates classroom-based preventive education for all children in participating schools, a weekly fluoride mouthrinse component for children with parental permission, and for the last 10 years, a dental sealant program for second-graders. An evaluation of the SOHP was conducted in 2002 with Maine's Department of Education as part of a school health infrastructure improvement initiative. In that evaluation, eligibility criteria for funding through the SOHP were examined, resulting in the development of a formula that includes the proportion of students eligible for the Free & Reduced Lunch Program and MaineCare, as well as the proportions of the community receiving fluoridated public water and whose family income is at the federal poverty level. In this way, the SOHP is directed toward those communities and schools where children are more likely to have problems accessing dental services, since socio-economic status is directly related to the ability to obtain dental care. Grants have been made to schools, school districts and some community agencies on behalf of groups of schools in five-year cycles using funds from the Maine CDC's General Fund allocations. In SFY2009, there are about 75 grants for local programs in nearly 250 schools, involving over 45,000 students in grades K-6. About three-quarters of these children participate in the weekly fluoride mouthrinse component. The related sealant program provides sealants in half of the SOHP schools. Adding more schools to the SOHP and the sealant program has been limited by available funding for several years, and current financial constraints will limit further expansion. Although the OHP is enrolled as a MaineCare billing provider and has received some reimbursement for sealants, this revenue does not contribute significantly to the program's budget. In SFY09, expenditures for the SOHP and sealant program are slightly under $250,000; annual costs per child are estimated at about $6. The sealant program provides an average number of 3.2 sealants per child with grants based on $30 per child.

- Maine is fortunate to have a number of other school-based and school-linked oral health programs available in many parts of the state. The cities of Portland and Bangor, funded by the state SOHP, have expanded their school-linked programs; Portland provides other preventive services as well as sealants, and offers sealants to students in other grades, whereas the state program is limited to second-graders. Private non-profit organizations, including but not necessarily limited to Community Dental, the Maine Coast Community Dental Center, several Federally-Qualified Health Centers, Prevention Partners, Maine Dental Health Outreach, Tooth Fairies and Saving Smiles, have developed a variety of programs for schools that include preventive dental hygiene services as well as educational presentations, and in some cases direct linkages to restorative dental care when needed. These organizations bill MaineCare and usually also offer a sliding fee scale or a discounted rate for children who have no insurance for dental care. Each of these organizations has its own programs and policies and makes its own arrangements with schools for providing dental services, usually at school during school hours.

- There are 27 School-Based Health Centers located in middle and high schools in17 Maine communities[1]; of these, six receive small amounts of additional funding via the Oral Health Program's allocation from the Fund for a Healthy Maine to assist them in providing preventive oral health services on-site.

- The Coordinated School Health Program (CSHP) is a federal CDC-funded program jointly managed by the Maine CDC and the Maine Department of Education. The CSHP addresses 8 areas related to the role of schools in contributing to youth health and education, including health education. Maine's health education standards (Maine Department of Education, 2002, Chapter 127, "Instructional Requirements and Graduation Standards" require that health education be taught every year from kindergarten through eighth grade. Comprehensive School Health Education (CSHE) includes curriculum, instruction and assessment that is sequential from kindergarten through high school and that meets the health education standards outlined in the Maine Learning Results. CSHE addresses physical, mental, emotional, and social aspects of health, and provides knowledge and skills that promote and enhance lifelong healthy behaviors. Oral health is incorporated into these efforts.[2]

[1] See http://www.measbhc.org
[2] See http://www.mainecshp.com/ for more information, click on Health Education > Documents > scroll down to Updated Guide to Linking Key Concepts to find Oral Health.

ATTACHMENT VI

Water Fluoridation in Maine

Maine law requires that water fluoridation be authorized by a referendum vote in the community or communities that will be directly affected by the decision. The wording of the question, "Shall fluoride be added to the public water supply for the intended purpose of reducing tooth decay?" is mandated by Maine law. Communities interested in adding fluoride must follow a process to put the question on the ballot and conduct a campaign. If they are successful, the water utility is then directed to proceed with adding fluoride, usually within 9 months. The water utility must purchase needed equipment and supplies, may need to construct or adapt building space for the equipment, and has to assure adequate training and safety measures for staff. Implementation of water fluoridation may result in additional costs to the rate-payers, but this is estimated nationally to vary from 50 cents to perhaps $5 annually, depending on the number of people served.

There is no dedicated funding available either through the state Oral Health Program or the Drinking Water Program to assist communities and water utilities in purchasing equipment or making plant renovations. Both programs will provide consultation and technical assistance in their areas of expertise, with the Oral Health Program being involved in providing information used in referendum campaigns. The Maine Dental Association also assists community groups working to implement water fluoridation.

ATTACHMENT VII

An Act To Provide Dental Care for Pregnant Women and New Mothers Receiving MaineCare Benefits

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §3174-FF, sub-§3, ¶I is enacted to read:

I. A member who is eligible under section 3174-G, subsection 1, paragraph A is eligible for dental and oral health services.

SUMMARY

This bill extends MaineCare dental and oral health services to a woman who is eligible for MaineCare because of pregnancy and for 60 days following the delivery of the child.

LD 282 **LR 1763(01)**

An Act To Provide Dental Care for Pregnant Women and New Mothers Receiving MaineCare Benefits

Fiscal Note for Original Bill
Sponsor: Rep. Faircloth of Bangor
Committee: Health and Human Services
Fiscal Note Required: Yes

Fiscal Note

	2007-08	2008-09	Projections 2009-10	Projections 2010-11
Net Cost (Savings)				
General Fund	$297,266	$412,255	$428,911	$446,239
Appropriations/Allocations				
General Fund	$297,266	$412,255	$428,911	$446,239
Federal Expenditures Fund	$512,724	$711,363	$740,102	$770,102

Fiscal Detail and Notes

Provides a General Fund appropriation of $297,266 for 2007-08 and $412,255 for 2008-09 for the state share of the additional MaineCare costs of extending dental and oral health services to pregnant women and new mothers eligible for MaineCare benefits. Also provides an allocation of federal Medicaid matching funds. These funding levels assume an estimated 3,688 women would use the extended services annually at an estimated average cost of $293 per person per year. Also assumes a 10/1/07 start date for the extended benefits.

Number of births for women over 21 (2005)		9,219			
Assumed % of MaineCare members using dental services (2004)		40%			
Estimated costs of dental services provided by member (2005 inflated to 2008)		$293			
Total estimated costs		$1,079,987	$1,123,618	$1,169,012	$1,216,240
10/1/07 Start Date	75%	$809,990			
State Share		$297,266	$412,255	$428,911	$446,239
Federal Share		$512,724	$711,363	$740,102	$770,002