Testimony of Becca Matusovich, Executive Director
Partnership for Children's Oral Health
on LD 1501, An Act to Protect Oral Health For Children in Maine

Before the Joint Standing Committee on Health and Human Services
Public Hearing: April 26, 2021

Good afternoon, Senator Claxton, Representative Meyer and distinguished members of the Committee on Health and Human Services. My name is Becca Matusovich and I am Executive Director of the Partnership for Children's Oral Health (Partnership). The Partnership is a collaborative effort, funded by philanthropic dollars, to build a broad network of individuals and organizations to create a Maine where no child suffers from preventable dental disease. I am here today to speak in strong support for LD 1501.

The Partnership is working on improving and reforming our oral health systems from multiple angles. The elements in this bill – staffing the state's critical public health leadership role on this issue, and expanding the School Oral Health Program – are key pieces in this puzzle. Many of the other speakers will speak to the importance of the primary elements of this bill, so I want to focus my testimony on a couple of the other provisions that might not get as much attention.

First, this bill calls for inclusion of children's oral health, school-based services, and methods of maximizing Medicaid funding for these services in the MaineCare program's annual reporting to HHS.

In the attached handouts, you will see that on the CMS-416 reports that states submit to the federal government, Maine has fallen to 49th in the nation on the % of Medicaid-insured children who receive at least one preventive dental service (only North Dakota was worse). When you look at Maine's performance on the whole "*Child Core Set*" Quality measures for Medicaid, we perform quite well, above the national median or right around it, on 16 of the 20 measures the state reports annually. There are only four measures where we were significantly below the median in 2019, and the % of children receiving preventive dental care is the <u>only one</u> where we are more than 10 points below.

For years now, there has been no position in the Executive Branch responsible or accountable for monitoring and addressing these trends. As a result, it has been far too easy for oral health issues to fall through the cracks. Comprehensive dental care is a required service under federal Medicaid law. It is a good idea for you, as the HHS Committee, to require this annual reporting so that you can ensure the state upholds its responsibility to make this care accessible to all MaineCare children.

Secondly, this bill directs MaineCare to initiate a value-based purchasing pilot for school-based oral health services. This aligns well with the Department's stated goal of moving more services to value-based payment models, and school oral health services are a prime candidate for this approach. (While time doesn't allow me to expound on this now, I'm happy to answer questions.)

The Partnership feels very strongly about the goal of **maximizing Medicaid funding** to pay for school-based oral health services, as this increases the financial sustainability and brings in federal match funds that more than triple the state's investment. I am not an economist, but in talking with economists, I have come to understand the importance of this point. There is a handout attached with my testimony that explains how this plays out. For each State General Fund (SGF) dollar that is paid out to a provider for children's oral health services, the state receives $2.50 in federal "FMAP" match (this factors in that there is a higher FMAP rate for CHIP than for regular Medicaid). When that $3.50 ($1 SGF plus $2.50 FMAP) is spent by the provider organization - on staff wages, rent, supplies, etc - it generates $5 worth of economic activity as it circulates in the local economy and beyond through what's known as the economic multiplier effect.

There are not very many investments the state can make where 1 State General Fund dollar can generate $5 worth of immediate economic activity. Some portion of that $5 even comes right back into the State General Fund in the form of payroll, income, and sales taxes. And that doesn't even account for all the positive impacts of improving children's health outcomes – that's just the case that can be made on the economic side for why a modest investment of state funds to increase Medicaid delivery of children's oral health services provides a really big "bang for the buck."

The biggest challenge with this whole diagram is at the entry point. In order for both the financial and health benefits to flow, the provider has to be able to deliver the service. In our traditional approach to children's oral health care, the entire burden is on the family and there are MANY barriers that stop MaineCare families from accessing the preventive care appointment needed to kick both cycles into gear. **By making oral health services widely available in schools and pre-schools, we can remove most of those barriers and circumvent the bottleneck at the entry point.** The benefits on both the economic and the health side of this diagram can then get a positive cycle going in a way that will pay off, both immediately and for the long term.

This bill asks for the bare minimum in funding support to equip the state to work together with the rest of us in a public-private partnership to fill the gaps in our current system and get this cycle of progress moving forward. This is a winnable battle if we all do our part, and this bill provides the critical corner pieces to the puzzle. It is good policy and it is the right thing to do for our children. Having lived in Maine for almost 30 years now, I know that three things Mainers love best include doing right by our kids, supporting our schools and communities, and getting a good value for our money. LD 1501 hits a home run on all three.

Thank you for your support. I would be happy to answer questions and/or bring any additional information to the work session.

LD 1501: An Act to Protect Oral Health for Children in Maine

Sponsor: Rep. Lori Gramlich

All Maine children deserve oral health care so they can stay healthy and show up at school ready to learn.

LD 1501 would:

- Expand Maine's school-based oral health program to all schools statewide by 2025.
- Re-establish a full-time oral health coordinator position at the Maine CDC, which was eliminated 7 years ago.
- Direct MaineCare to begin a value-based payment pilot for oral health services in school and childcare settings and consider how to maximize federal matching funds for these services, and
- Build into MaineCare's annual report to the HHS committee the status of oral health services provided in schools and methods for maximizing Medicaid funding for school-based oral health services.

Dental pain is the most common chronic childhood disease and one of the top reasons children miss school, yet dental disease is largely preventable using cost-effective methods.

This bill is needed because:

- About 40% of children consistently insured with MaineCare and 30% of children with consistent commercial insurance did not receive preventive oral health services in the last year.[1]
- Poor oral health causes pain, impedes school readiness and attendance,[2] and later affects employment opportunities and financial stability.[3]
- Maine's ability to address oral health has been weakened by reduced funding for public health and loss of staff positions in DHHS.
- More than 400 of Maine's 600+ schools are currently unable to participate in Maine CDC's School Oral Health Program due to current eligibility guidelines that leave behind children from low-income families who attend schools with less than 40% of their student body receiving free and reduced lunch.
- 44% of Maine children qualify for free and reduced lunch,[4] and poverty is a risk factor for poor oral health.
- COVID has affected the ability of children to get oral health care at the dentist,[5] and hygienists in schools are reporting worsening oral health among the kids that they are seeing.

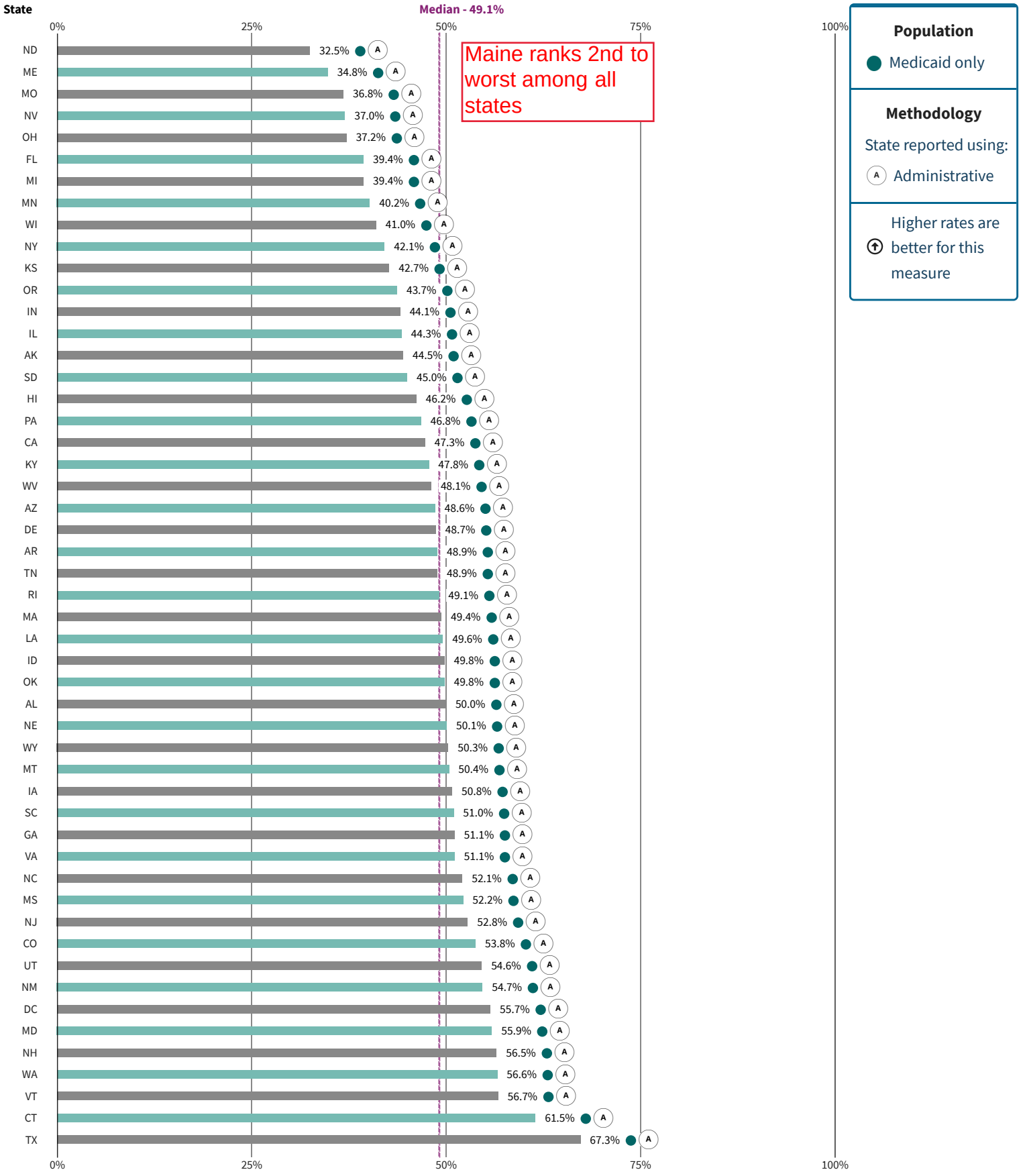
This is a winnable battle with a significant impact on our children's health and lifetime success in return for modest state investment.

References

[1] https://mainepcoh.org/publications/databrief.pdf
[2] https://ajph.aphapublications.org/doi/10.2105/AJPH.2010.200915
[3] https://dentistry.uic.edu/news-stories/the-many-costs-financial-and-well-being-of-poor-oral-health/
[4] https://datacenter.kidscount.org/data/tables/1566-school-children-eligible-for-subsidized-school-lunch#detailed/2/any/false/574,1729,37,871,870,573,869,36,868,867/any/12834,3339
[5] https://mottpoll.org/sites/default/files/documents/021521_DentalCare.pdf

Medicaid.gov
Keeping America Healthy

Percentage of Eligibles Who Received Preventive Dental Services: Ages 1 to 20



Source: Mathematica analysis of Federal Fiscal Year (FFY) 2019 Form CMS-416 reports (annual EPSDT report), Lines 1b and 12b as of July 1, 2020, for the Child Core Set FFY 2019 reporting cycle; see 2019 Child and Adult Health Care Quality Measures. For more information on the Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH) measure, visit Child Health Care Quality Measures.
https://www.medicaid.gov/state-overviews/scorecard/eligibles-who-received-preventative-dental-services/index.html

2019 CMS Child Health Care Quality Measures Reported by Maine

Domain	Measure Name	Measure Abbreviation	State Rate 2019	National Median 2019	State compared to median		Rate Definition
Behavioral Health Care	Follow-Up Care for Children Prescribed ADHD Medication: Ages 6 to 12	ADD-CH	**67.2**	48.6	138%		Percentage Newly Prescribed ADHD Medication with 1 Follow-Up Visit During the 30-Day Initiation Phase: Ages 6 to 12
Behavioral Health Care	Follow-Up Care for Children Prescribed ADHD Medication: Ages 6 to 12	ADD-CH	**70.2**	58.6	120%		Percentage Newly Prescribed ADHD Medication with at Least 2 Follow-Up Visits in the 9 Months Following the Initiation Phase: Ages 6 to 12
Primary Care Access and Preventive Care	Well-Child Visits in the First 15 Months of Life	W15-CH	**72.3**	64	113%		Percentage who had 6 or More Well-Child Visits with a Primary Care Practitioner during the First 15 Months of Life
Maternal and Perinatal Health	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-CH	**89.6**	80.7	111%		Percentage of Women Delivering a Live Birth with a Prenatal Care Visit in the First Trimester or within 42 Days of Enrollment in Medicaid or CHIP
Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life: Ages 0 to 3	DEV-CH	**35**	32.7	107%		Percentage Screened for Risk of Developmental, Behavioral, and Social Delays Using a Standardized Screening Tool: Ages 0 to 3
Primary Care Access and Preventive Care	Children and Adolescents' Access to Primary Care Practitioners: Ages 12 Months to 19 Years	CAP-CH	**94.3**	91.1	104%		Percentage with a PCP Visit in the Past Two Years: Ages 7 to 11 Years
Primary Care Access and Preventive Care	Children and Adolescents' Access to Primary Care Practitioners: Ages 12 Months to 19 Years	CAP-CH	**93**	90.3	103%		Percentage with a PCP Visit in the Past Two Years: Ages 12 to 19 Years
Primary Care Access and Preventive Care	Children and Adolescents' Access to Primary Care Practitioners: Ages 12 Months to 19 Years	CAP-CH	**90.1**	87.7	103%		Percentage with a PCP Visit in the Past Year: Ages 25 Months to 6 Years
Maternal and Perinatal Health	Live Births Weighing Less Than 2,500 Grams	LBW-CH	**9.1**	9.5	96%	*lower rate is better	Percentage of Live Births that Weighed Less Than 2,500 Grams
Care of Acute and Chronic Conditions	Ambulatory Care: Emergency Department (ED) Visits: Ages 0 to 19	AMB-CH	**39.9**	43.6	92%	*lower rate is better	Emergency Department Visits per 1,000 Beneficiary Months: Ages 0 to 19
Behavioral Health Care	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 1 to 17	APC-CH	**1.3**	2.6	50%	*lower rate is better	Percentage on Two or More Concurrent Antipsychotic Medications: Ages 1 to 17
Primary Care Access and Preventive Care	Children and Adolescents' Access to Primary Care Practitioners: Ages 12 Months to 19 Years	CAP-CH	**96.7**	95.5	101%		Percentage with a PCP Visit in the Past Year: Ages 12 to 24 Months
Dental and Oral Health Services	Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk	SEAL-CH	**23**	22.7	101%		Percentage at Elevated Risk of Dental Caries (Moderate or High Risk) who Received a Sealant on a Permanent First Molar Tooth: Ages 6 to 9
Primary Care Access and Preventive Care	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	W34-CH	**69**	69	100%		Percentage who had 1 or More Well-Child Visits with a Primary Care Practitioner: Ages 3 to 6
Care of Acute and Chronic Conditions	Asthma Medication Ratio: Ages 5 to 18	AMR-CH	**69.3**	69.4	100%		Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 5 to 18
Primary Care Access and Preventive Care	Adolescent Well-Care Visits: Ages 12 to 21	AWC-CH	**49.5**	50.6	98%		Percentage with at Least 1 Well-Care Visit with a Primary Care Practitioner or Obstetrician/Gynecologist: Ages 12 to 21
Behavioral Health Care	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17	FUH-CH	**37.4**	41.9	89%		Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 7 Days after Discharge: Ages 6 to 17
Behavioral Health Care	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17	FUH-CH	**57.7**	66.3	87%		Percentage of Hospitalizations for Mental Illness or Intentional Self-Harm with a Follow-Up Visit Within 30 Days after Discharge: Ages 6 to 17
Primary Care Access and Preventive Care	Chlamydia Screening in Women Ages 16 to 20	CHL-CH	**41.1**	49.9	82%		Percentage of Sexually Active Women Screened for Chlamydia: Ages 16 to 20
Dental and Oral Health Services	**Percentage of Eligibles Who Received Preventive Dental Services: Ages 1 to 20**	**PDENT-CH**	**34.8**	**49.1**	**71%**		**Percentage Enrolled in Medicaid or Medicaid Expansion CHIP Programs for at least 90 Continuous Days with at Least 1 Preventive Dental Service: Ages 1 to 20**

Not reported:

Care of Acute and Chronic Conditions	Asthma Medication Ratio: Ages 5 to 18	AMR-CH	**NR**	72.8			Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 5 to 11
Care of Acute and Chronic Conditions	Asthma Medication Ratio: Ages 5 to 18	AMR-CH	**NR**	64.6			Percentage with Persistent Asthma who had a Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater: Ages 12 to 18

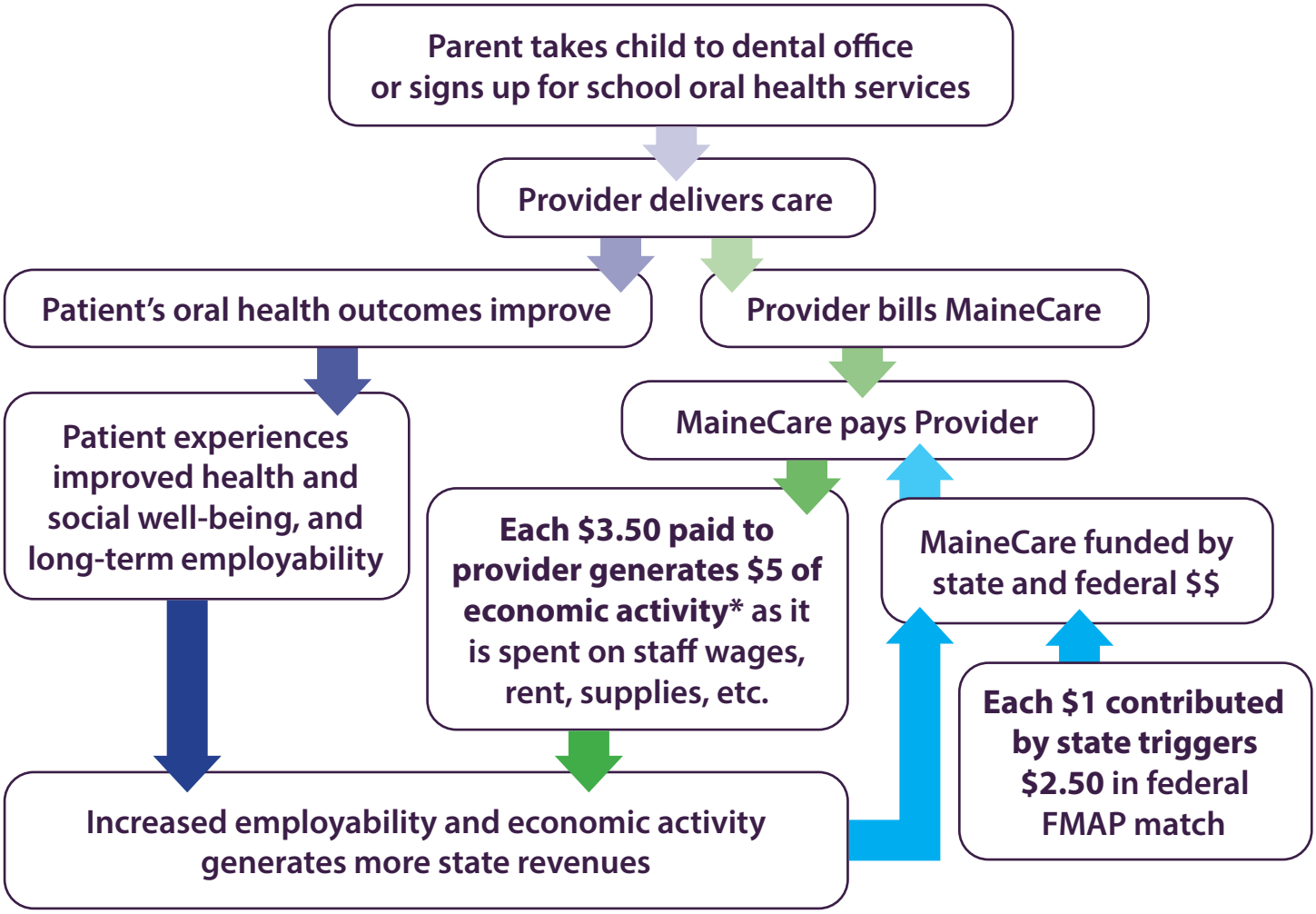
Source: https://data.medicaid.gov/Quality/2019-Child-Health-Care-Quality-Measures-Quality/napm-9as8/data

Partnership for Children's Oral Health

A network to ensure that all children in Maine can grow up free from preventable dental disease

Spending more on MaineCare preventive dental services is good for health AND Maine's economy

Every $1 of State General Fund spent by MaineCare on children's dental services brings the state another $2.50 in federal FMAP match funding and generates $5 of economic activity.



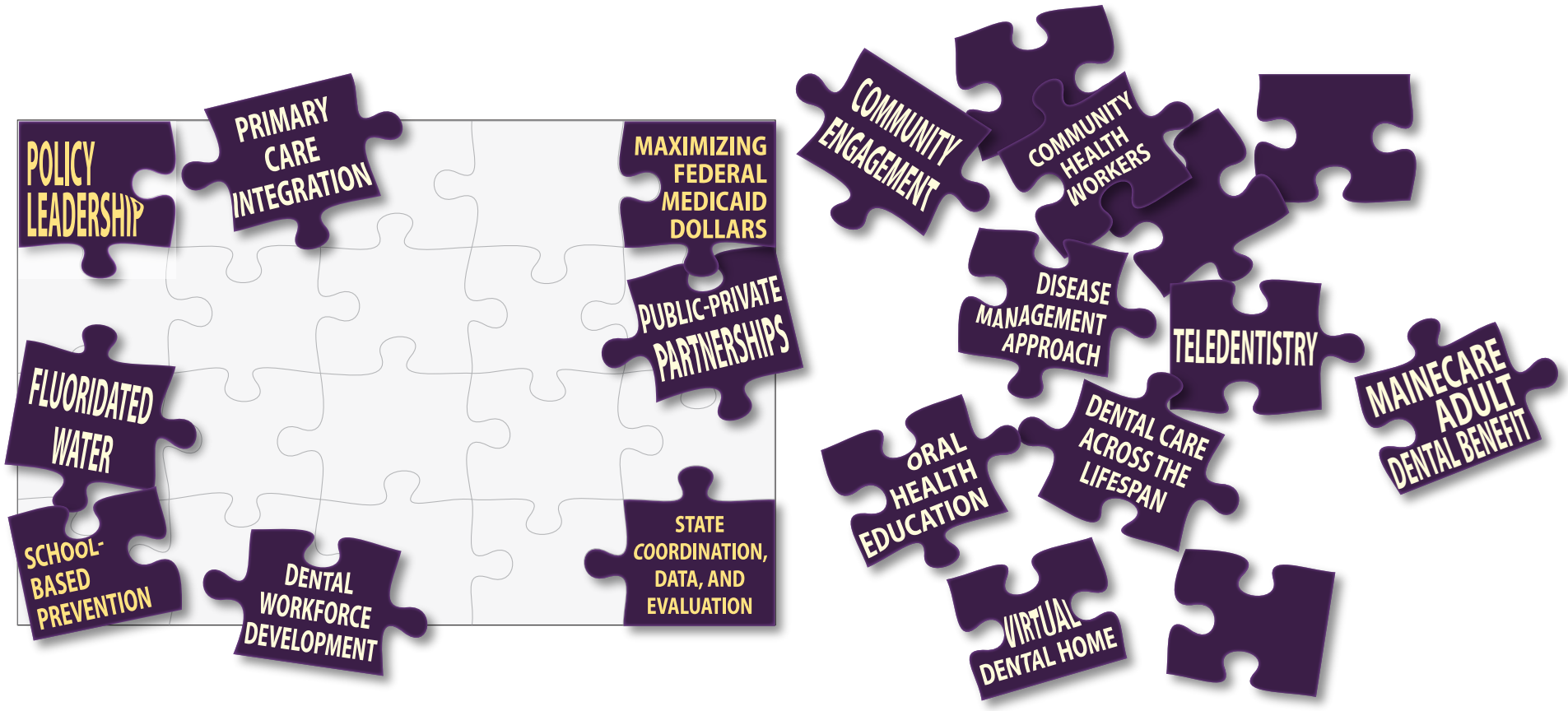
LD 1501 calls for expansion and support of the state's school Oral Health Program (SOHP), a value-based purchasing pilot for oral health services in school/childcare settings, and a Department analysis of maximizing Medicaid funding for such services. Here's how it works:

- Oral health services delivered by public health hygienists who reach children in schools. Access to dental care improves as school-based services remove barriers for families to access care.
- DHHS changes make these services more easily billable to Medicaid/MaineCare so state dollars spent on the services bring in federal matching funds. Reimbursement revenue is spent in the local economy (staff wages, rent, supplies, etc) so increased payroll and income taxes come to the State General Fund and directly replenish the state funds originally spent on children's oral health services.
- Children's oral health (and related physical health) outcomes improve as do social well-being and long-term employment prospects in adulthood. Better health and employment contributes to future lower health care costs and increased state tax revenues.

* Calculated based on a weighted average of CHIP FMAP and regular Medicaid FMAP; economic multiplier estimated based on mainepcoh.org/publications/ADA_HPI_Estimating_the_Cost_of_MADB_in_Maine_FINAL.pdf

Maine's Oral Health Puzzle: Together we can do this!

LD 1501, An Act to Protect Oral Health for Children in Maine, provides the key corner pieces of this puzzle



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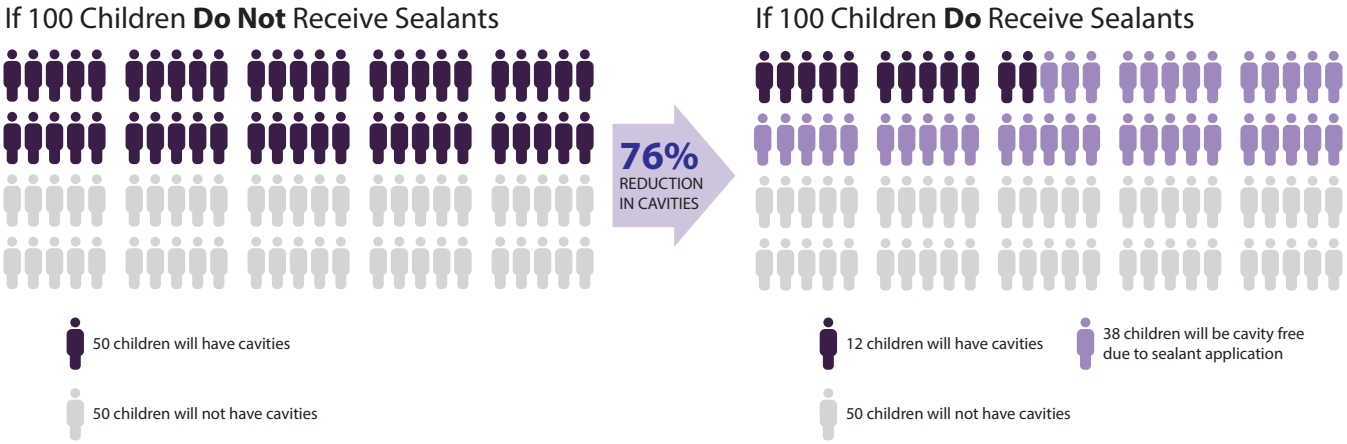
Prevention is a cost-effective investment

Fluoride Varnish:

For every 100 children, spending $2,800 on school fluoride varnish programs results in almost **$5,000 savings** in dental bills.

Sealants:

If 100 children receive sealants, the number who will get cavities drops from 50 to 12 (**76% reduction**).



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Citations:

Fluoride

% of children with cavities age 6-11 and avg # of decayed surfaces per kid
www.nidcr.nih.gov/research/data-statistics/dental-caries/children

Filling cost: (p. 5) mainecare.maine.gov/Provider%20Fee%20Schedules/Rate%20Setting/Section%20025%20-%20Dental%20Services/Archive/Section%2025%20-%20Dental%20Services%202017.pdf

% Prevention with fluoride: Marinho VCC, Worthington HV, Walsh T, Clarkson JE. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews. 2013; Issue 7. Art. No.: CD002279. DOI: 10.1002/14651858.CD002279.pub2.

Sealants

American Dental Association, jada.ada.org/article/S0002-8177(16)30473-1/fulltext

Children's Oral Health Has Suffered During COVID-19

No child should have to suffer from dental pain and infection made worse because of a lack of services due to the pandemic

LD 1501 *An Act to Protect Oral Health for Children in Maine* will help ensure all children can get the dental care they need

Kids are going without dental care during the pandemic

By Jen Rose Smith, CNN

Updated 12:16 AM ET, Mon February 15, 2021

Some parents were unable to get their kids in to see the dentist at all. Among families with private dental insurance who sought care, 4% were unable to secure an appointment. That shoots up to 15% for families whose children rely on Medicaid coverage, who are more likely to be Black, multiracial or Latino than their counterparts with private insurance.

https://www.cnn.com/2021/02/15/health/kids-missing-dental-care-pandemic-wellness/index.html

Dental care is kids' No. 1 unmet health need during pandemic

By Theresa Pablos, DrBicuspid.com editor in chief

February 9, 2021 -- Dental care topped the list of children's unmet healthcare needs during the COVID-19 pandemic, according to a study published on February 6 in the *Journal of the American Dental Association*. That risk was even higher for children whose parents lost a job or income.

https://www.drbicuspid.com/index.aspx?sec=ser&sub=def&pag=dis&ItemID=328050

The pandemic has made it harder to see a dentist; caused many household incomes to plummet, making it harder to afford healthy food and dental care supplies; and reduced the limited oral health services some children were getting in schools.

Number of Dental Claims - Maine		
	Commercial	MaineCare
January - June 2019	257,688	46,198
January - June 2020	162,785	21,571
# Fewer claims in first half of 2020	94,903	24,627
Percentage Decrease	37%	53%

https://mhdo.maine.gov/tableau/data.cshtml# Accessed 12/12/20

There is a backlog of need among Maine's children for core preventive oral health services, and fewer people are getting oral health care because of the pandemic – especially MaineCare members.

Some children are fortunate to receive preventive oral health care in their school, but fewer schools are participating than in previous years. The hygienists who provide this care in schools are reporting much higher rates of decay in children this year.

Maine is doing so much to help mitigate the cascading impact of missed classes and services for children. Oral health cannot be left out of this rebuilding effort.

LD 1501 will have a significant impact on our children's health and lifetime success in return for modest state investment.

Partnership for Children's Oral Health

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4/26/21