

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Chicago Children's Surgery Center		
Street Address: 8658 S. Sacramento Avenue		
City and Zip Code: Chicago 60652		
County: Cook	Health Service Area: 6	Health Planning Area: 1

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Chicago Children's Surgery Center, LLC
Street Address: 8658 S. Sacramento Avenue
City and Zip Code: Chicago 60652
Name of Registered Agent: Jeffrey Wheeler
Registered Agent Street Address: 8658 S. Sacramento Avenue
Registered Agent City and Zip Code: Chicago 60652
Name of Chief Executive Officer: Jeffrey Wheeler
CEO Street Address: 300 Lenora Street, #4075
CEO City and Zip Code: Seattle 98121
CEO Telephone Number: (301) 318-7658

Type of Ownership of Applicants

☐ Non-profit Corporation	☐ Partnership	
☐ For-profit Corporation	☐ Governmental	
☒ Limited Liability Company	☐ Sole Proprietorship	☐ Other
- Corporations and limited liability companies must provide an Illinois certificate of good standing. - Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.		
APPEND DOCUMENTATION AS ATTACHMENT 1, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Mark Silberman and Juan Morado, Jr
Title: Partner
Company Name: Benesch, Friedlander, Coplan & Aronoff LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, Illinois 60606
Telephone Number: (312) 212-4952; (312) 212-4967
E-mail Address: msilberman@beneschlaw.com , jmorado@beneschlaw.com
Fax Number: (312) 767-9192

Additional Contact [Person who is also authorized to discuss the application for permit]

Name: Jeffrey Wheeler
Title: CEO
Company Name: New Core Healthcare, LLC
Address: 1220 Caraway Court, Suite 1050, Upper Marlboro, Maryland 20774
Telephone Number: (301) 318-7658
E-mail Address: jwheeler@newcorehealthcare.com
Fax Number: (301) 494-3333

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Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: New Core Healthcare, LLC
Street Address: 1220 Caraway Court, Suite 1050
City and Zip Code: Upper Marlboro 20774
Name of Registered Agent: Incorp Services, Inc.
Registered Agent Street Address: 919 North Market Street, Suite 950
Registered Agent City and Zip Code: Wilmington 19801
Name of Chief Executive Officer: Jeffrey Wheeler
CEO Street Address: 300 Lenora Street #4075
CEO City and Zip Code: Seattle 98121
CEO Telephone Number: (301) 318-7658

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City and Zip Code: Chicago 60652		
County: Cook	Health Service Area: 6	Health Planning Area: 1

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: NCH Growth Partners, LLC
Street Address: 1220 Caraway Court, Suite 1050
City and Zip Code: Upper Marlboro, MD 20774
Name of Registered Agent: Incorp Services, Inc.
Registered Agent Street Address: 919 North Market Street, Suite 950
Registered Agent City and Zip Code: Wilmington 19801
Name of Chief Executive Officer: Jeffrey Wheeler
CEO Street Address: 300 Lenora Street, #4075
CEO City and Zip Code: Seattle 98121
CEO Telephone Number: (301) 318-7658

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☐ Non-profit Corporation	☐ Partnership	
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☒ Limited Liability Company	☐ Sole Proprietorship	☐ Other
- Corporations and limited liability companies must provide an Illinois certificate of good standing. - Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.		
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Fax Number: (301) 494-3333

Post Permit Contact [Person to receive all correspondence after permit - **THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name: Jeffrey Wheeler
Title: CEO
Company Name: New Core Healthcare, LLC
Address: 1220 Caraway Ct., Suite 1050, Upper Marlboro, MD 20774
Telephone Number: 301-318-7658
E-mail Address: jwheeler@newcorehealthcare.com
Fax Number: 301-494-3333

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner: UIRC-Chicago, LLC
Address of Site Owner: 15700 West 103 rd Street Lemont, IL 60439
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee [Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Chicago Children's Surgery Center, LLC			
Address: 8658 S Sacramento, Chicago, IL 60652			
☐	Non-profit Corporation	☐	Partnership
☐	For-profit Corporation	☐	Governmental
☒	Limited Liability Company	☐	Sole Proprietorship
		☐	Other
- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements [Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<http://www.hfsrb.illinois.gov>). **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements [Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT**1. Project Classification**

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

- ☒ Substantive
☐ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

New Core Healthcare, LLC, NCH Growth Partners, LLC and the Chicago Children's Surgery Center, LLC ("CCSC") seeks to establish a one operating room ambulatory surgical treatment center ("ASTC") that focuses on General Dentistry and Oral and Maxillofacial procedures.

The ASTC will primarily serve pediatric patients and individuals with special needs who require General Dentistry and Oral and Maxillofacial procedures under general anesthesia in an outpatient operating room. The proposed facility will be located at 8658 S. Sacramento Avenue in Chicago.

This project is considered a substantive project because it will result in the establishment of a new facility.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	-	-	-
Site Survey and Soil Investigation	-	-	-
Site Preparation	\$69,388	\$161,012	\$230,400
Off Site Work	-	-	-
New Construction Contracts	\$2,240,000	\$960,000	\$3,200,000
Modernization Contracts			
Contingencies	\$154,798	\$359,202	\$514,000
Architectural/Engineering Fees	\$81,531	\$189,189	\$270,720
Consulting and Other Fees	\$280,000	\$120,000	\$400,000
Movable or Other Equipment (not in construction contracts)	\$318,798	\$136,628	\$455,425
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value of Leased Space or Equipment	\$1,244,799	\$2,888,501	\$4,133,300
Other Costs to Be Capitalized	-	-	-
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	\$4,389,314	\$4,814,531	\$9,203,845
SOURCE OF FUNDS			
Cash and Securities	\$2,664,641	\$812,504	\$3,477,145
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	-	-	-
Leases (fair market value)	\$1,244,799	\$2,888,501	\$4,133,300
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	\$479,874	\$1,113,526	\$1,593,400
TOTAL SOURCES OF FUNDS	\$4,389,314	\$4,814,531	\$9,203,845

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No Purchase Price: \$ N/A _____ Fair Market Value: \$ N/A _____
The project involves the establishment of a new facility or a new category of service ☒ Yes ☐ No If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100. Estimated start-up costs and operating deficit cost is \$1,086,898

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

- ☐ None or not applicable ☐ Preliminary
☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): July 1, 2025

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

- ☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable?

- ☐ Cancer Registry – **NOT APPLICABLE**
☐ APORS – **NOT APPLICABLE**
☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted – **NOT APPLICABLE**
☐ All reports regarding outstanding permits – **NOT APPLICABLE**

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the departments or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Not Reviewable Space [i.e., non-clinical]: means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers. [20 ILCS 3960/3]

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
ASTC 1 Operating Room	\$4,389,314	-	4,400	\$4,389,314	-	-	-
Total Clinical	\$4,389,314	-	4,400	\$4,389,314	-	-	-
NON-REVIEWABLE							
Administrative/Waiting Areas	\$4,814,531	-	10,210	\$4,814,531	-	-	-
Total Non-clinical	\$4,814,531	-	10,210	\$4,814,531	-	-	-
TOTAL	\$9,203,845	-	14,610	\$9,203,845	-	-	-
APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Facility Bed Capacity and Utilization- NOT APPLICABLE

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

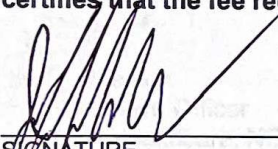
FACILITY NAME:			CITY: Chicago		
REPORTING PERIOD DATES:		From:	To:		
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long-Term Care					
Specialized Long-Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors.
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist).
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

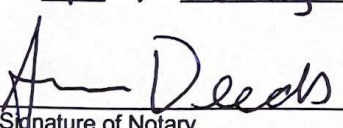
This Application is filed on the behalf of New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.


 SIGNATURE

Jeffrey Wheeler
 PRINTED NAME

CEO
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this 1st day of July


 Signature of Notary

Seal

 SIGNATURE

Kyle Welch
 PRINTED NAME

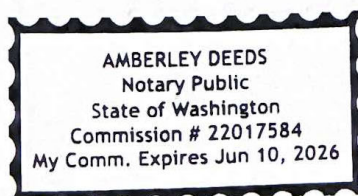
President
 PRINTED TITLE

Notarization:
 Subscribed and sworn to before me
 this ____ day of _____

 Signature of Notary

Seal

*Insert the EXACT legal name of the applicant



CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist).
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
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SIGNATURE

Jeffrey Wheeler

PRINTED NAME

CEO

PRINTED TITLE

SIGNATURE

Kyle Welch

PRINTED NAME

President

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this ____ day of _____

Notarization:

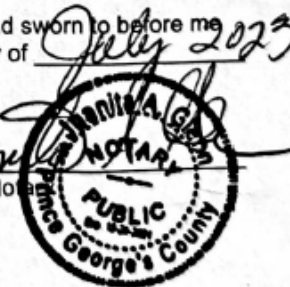
Subscribed and sworn to before me
this 7th day of July 2023

Signature of Notary

Seal

Signature of Notary

Seal



*Insert the EXACT legal name of the applicant

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
 - a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
 - b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.
 - c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
 - d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
 - e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.
4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)**PURPOSE OF PROJECT**

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost.
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes.
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality, and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
 - c. The project involves the conversion of existing space that results in excess square footage.
 - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC (1 Operating Room)	4,400	2,750	+1650	NO

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions, or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	ASTC	N/A	2,200	>1,500 Hours	YES
YEAR 2	ASTC	N/A	2,420	>1,500 Hours	YES

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.
3. Evidence that the shell space is being constructed due to:
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data is available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☐ Cardiovascular
☐ Colon and Rectal Surgery
☐ Dermatology
☒ General Dentistry
☐ General Surgery
☐ Gastroenterology
☐ Neurological Surgery
☐ Nuclear Medicine
☐ Obstetrics/Gynecology
☐ Ophthalmology
☒ Oral/Maxillofacial Surgery
☐ Orthopedic Surgery
☐ Otolaryngology
☐ Pain Management
☐ Physical Medicine and Rehabilitation
☐ Plastic Surgery
☐ Podiatric Surgery
☐ Radiology
☐ Thoracic Surgery
☐ Urology
☐ Other _____

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X
APPEND DOCUMENTATION AS <u>ATTACHMENT 25</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

SECTION VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [Indicate the dollar amount to be provided from the following sources]:

\$3,477,145	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion.
_____	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.
\$4,133,300	d) Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated. 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate. 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc. 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment. 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent.
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.
\$1,593,400	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
\$9,203,845	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS **ATTACHMENT 34**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.130 - FINANCIAL VIABILITY- WAIVER MET

All the applicants and co-applicants shall be identified, specifying their roles in the project funding, or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All the project's capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years		Projected
Enter Historical and/or Projected Years:			<u>2026</u>
Current Ratio			5.74
Net Margin Percentage			9.00%
Percent Debt to Total Capitalization			0.00%
Projected Debt Service Coverage			NA
Days Cash on Hand			59.06
Cushion Ratio			NA

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY**This section is applicable to all projects subject to Part 1120.****A. Reasonableness of Financing Arrangements**

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available.
- 2) That the selected form of debt financing will not be at the lowest net cost available but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors.
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

- 1) Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Sq. Ft. New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
ASTC	\$509.09		4,400						\$2,240,000
Contingency	\$35.18		4,400						\$154,798
TOTALS	\$544.27		4,400						\$2,394,798

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, **including the impact on racial and health care disparities in the community**, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 37.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)	Year	Year	Year
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI. CHARITY CARE INFORMATION

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI. SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: New Core Healthcare, LLC 1220 Caraway Court, Suite 1050
(Name) (Address)

Upper Marlboro MD 20774 (301) 318-7658
(City) (State) (ZIP Code) (Telephone Number)

2. Project Location: 8658 S. Sacramento Chicago Illinois
(Address) (City) (State)

Cook County
(County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (<https://msc.fema.gov/portal/home>) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the **Go to NFHL Viewer** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes No X

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? NO

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.

If the determination is being made by a local official, please complete the following:

FIRM Panel Number: _____ Effective Date: _____

Name of Official: _____ Title: _____

Business/Agency: _____ Address: _____

(City) (State) (ZIP Code) (Telephone Number)

Signature: _____ Date: _____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

APPEND DOCUMENTATION AS ATTACHMENT 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS			
ATTACHMENT NO.			PAGES
1	Applicant Identification including Certificate of Good Standing		25-28
2	Site Ownership		29-34
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.		35
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.		36
5	Flood Plain Requirements		37-38
6	Historic Preservation Act Requirements		39-44
7	Project and Sources of Funds Itemization		45-47
8	Financial Commitment Document if required		47
9	Cost Space Requirements		49
10	Discontinuation		n/a
11	Background of the Applicant		50-52
12	Purpose of the Project		53-169
13	Alternatives to the Project		170
14	Size of the Project		171
15	Project Service Utilization		172-173
16	Unfinished or Shell Space		174
17	Assurances for Unfinished/Shell Space		175
	Service Specific:		
18	Medical Surgical Pediatrics, Obstetrics, ICU		n/a
19	Comprehensive Physical Rehabilitation		n/a
20	Acute Mental Illness		n/a
21	Open Heart Surgery		n/a
22	Cardiac Catheterization		n/a
23	In-Center Hemodialysis		n/a
24	Non-Hospital Based Ambulatory Surgery		176-213
25	Selected Organ Transplantation		n/a
26	Kidney Transplantation		n/a
27	Subacute Care Hospital Model		n/a
28	Community-Based Residential Rehabilitation Center		n/a
29	Long Term Acute Care Hospital		n/a
30	Clinical Service Areas Other than Categories of Service		n/a
31	Freestanding Emergency Center Medical Services		n/a
32	Birth Center		n/a
	Financial and Economic Feasibility:		
34	Availability of Funds		214-215
35	Financial Waiver		n/a
36	Financial Viability		216
37	Economic Feasibility		217-220
38	Safety Net Impact Statement		221
39	Charity Care Information		223
40	Flood Plain Information		223-224

ATTACHMENT 1

Type of Ownership of Applicants

Included in this attachment are Certificates of Good Standing for:

- New Core Healthcare, LLC
- Chicago Children's Surgery Center, LLC
- NCH Growth Partners, LLC

ATTACHMENT 1
Certificate of Good Standing -
New Core Healthcare, LLC

Delaware
The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "NEW CORE HEALTHCARE, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-THIRD DAY OF JUNE, A.D. 2023.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "NEW CORE HEALTHCARE, LLC" WAS FORMED ON THE TWENTY-FOURTH DAY OF MAY, A.D. 2016.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.



6050133 8300

SR# 20232838793

You may verify this certificate online at corp.delaware.gov/authver.shtmlA handwritten signature in black ink, appearing to read "JB", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed.

Jeffrey W. Bullock, Secretary of State

Authentication: 203611169

Date: 06-23-23

ATTACHMENT 1
Certificate of Good Standing -
Chicago Children's Surgery Center, LLC

File Number 1338915-2



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

CHICAGO CHILDREN'S SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JUNE 19, 2023, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 2318003072 verifiable until 06/29/2024
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 29TH day of JUNE A.D. 2023 .


ALEXI GIANNOULAS
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing -
NCH Growth Partners, LLC

Delaware
The First State

Page 1

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "NCH GROWTH PARTNERS, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SEVENTH DAY OF JULY, A.D. 2023.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "NCH GROWTH PARTNERS, LLC" WAS FORMED ON THE SEVENTEENTH DAY OF MARCH, A.D. 2023.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.



7356447 8300

SR# 20232944422

You may verify this certificate online at corp.delaware.gov/authver.shtmlA handwritten signature in black ink, appearing to read "JBullock", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed.

Jeffrey W. Bullock, Secretary of State

Authentication: 203700926

Date: 07-07-23

ATTACHMENT 2

Site Ownership

The proposed site for the facility is owned by UIRC-Chicago IL, LLC. The Applicant will lease the site from the property owner. Attached as evidence of the control over the site is a copy of the letter of intent for use of the property and a copy of the most recent property tax statement showing ownership by UIRC-Chicago IL, LLC.

ATTACHMENT 2

Site Ownership



One Oakbrook Terrace Suite 400
22nd Street and Butterfield Road
Oakbrook Terrace IL 60181
tel 630 932 1234
fax 630 932 7258
www.hiffman.com

May 19, 2023- Final LOI

Andrew Kaplan
Jon Springer
CBRE, Inc.
321 North Clark Street
34th Floor
Chicago, IL 60654

RE: 8658 S Sacramento Avenue, Chicago, Illinois – NewCore Health dba Chicago Children's Surgery Center, LLC – Letter of Intent

Dear Andrew & Jon:

On behalf of UIRC-Chicago IL, LLC, we are pleased to present the following Proposal to lease space to NewCore Health dba Chicago Children's Surgery Center, LLC ("Tenant").

Premises:	8658 S Sacramento Avenue, Chicago, IL Tenant will lease +/-15,934 Rentable Square Feet
Commencement Date:	Upon substantial completion of construction and approval of Certificate of Need. Estimated to be March 1, 2024
Term:	Fifteen (15) Years, Eight (8) months
Rental Rate:	Tenant will pay \$15.00 NNN PSF/Yr on 15,934 RSF,
Rent Escalations:	Base rental rate will escalate two percent (2.5%) per RSF/Yr.
Rent Abatement:	The initial Eight (8) months of gross rent will be abated.
Security Deposit:	Dependent upon review of Tenant Financial Statements.
Real Estate Taxes and Operating Expenses:	Tenant will be responsible for the proportionate share of operating expenses and taxes. 2023 Estimates for Taxes: \$4.67/sf/yr 2023 Estimates for Ops: \$2.67/sf/yr Landlord shall exclude from operating expenses those items listed in <i>Exhibit A</i> to this letter (to be reviewed in lease). Tenant shall have a five percent (5%) cap on controllable expenses.
Landlord Responsibilities:	Landlord shall be responsible for common area maintenance (i.e. landscaping, lighting, snow plow, parking lot maintenance, etc.), structural, mechanical, electric, plumbing, repairs, etc.
Base Building:	Landlord shall ensure all HVAC and electrical systems are in good working order.

ATTACHMENT 2

Site Ownership

Tenant Improvements:	Landlord to provide TI allowance of \$100.00/SF. Tenant Improvement allowance may be applied by Tenant toward the payment of any other expenses, including but not limited to: the purchase and installation of furniture and telephone systems, cabling the premises for voice and data, architectural fees, moving costs, etc. Any unused portion of the Tenant Improvement Allowance shall be used as rent abatement against the first rent dollars owing under the lease.
Certificate of Need:	Any agreed upon terms shall be contingent upon Tenant receiving a Certificate of Need for the use.
Use:	Tenant will have the right to utilize the Premises as an Ambulatory Surgical Center for dental treatment.
Signage:	Landlord will grant tenant the right to install signage on the building façade. The location, design and installation will be subject to the prior approval of Landlord and approved by the Village.
Building Access:	Tenant shall have access 24 hours per day, 7 days per week, 365 days per year.
Utilities and Electricity:	Tenant will contract and pay for all utilities (electric and Gas). Water will be part of operating expenses. Premises shall be separately metered and any meter installation cost shall be a responsibility of the Landlord.
Janitorial:	Tenant shall be responsible for Janitorial within their premises.
Space Planning	Landlord will provide Tenant with an initial plan and two plan revisions at Landlord cost.
Right to Renew:	Tenant (including affiliate or successors) shall be entitled to two (2) options to extend the Lease Term for all or a portion of the Premises for a period of five (5) years by written notice to Landlord not less than nine (9) months prior to the expiration of the Lease Term. The rent payable by Tenant during the option term shall be equal to the then market rent for a tenant of like size, including market concessions, for the Premises. If Tenant and Landlord disagree on fair market rental, then a 3rd party arbitrator shall be utilized.
ROFR Options:	In the event any adjacent vacancies become available, Tenant shall have an ongoing right of first refusal.
Generator:	Landlord shall provide Tenant a pad site and Tenant will be granted the ability to install a emergency back-up generator at the property in a mutually agreeable location.
Restoration:	Tenant will leave the premises in "as-is" broom clean condition, and Tenant shall have the right to remove any and all trade fixtures installed during its leasehold.
Building Services:	In the event of any interruption in or failure to furnish any of the services required to be furnished by the Landlord pursuant to the lease, and as a result



ATTACHMENT 2

Site Ownership

thereof, Tenant is unable to utilize the premises during its normal business hours for the normal conduct of its business for a period of three (3) consecutive business days; then base rental, additional rental, and all other charges shall abate from the end of the third (3rd) day until the restoration of such services.

Maintenance & Repair:	Landlord is to be responsible, on a non-pass through basis, for construction defects, maintenance of the Building and grounds, and repair and replacement of roof, parking areas, structure and exterior glass, plumbing and wiring.
Holdover:	Tenant requires the right to remain in its premises for up to three (3) months after lease expiration under the same terms and conditions as the original lease at a rental rate and thereafter not to exceed 150% of the base rate then being paid. Tenant further requires the right to terminate this holdover upon thirty (30) days notice. Landlord will have the right to consequential damages after a sixty (60) day grace period.
Assignment & Subletting:	Tenant shall have the right to assign or sublet all or any portion of the Premises to any parent, subsidiary, or affiliate with Landlord's consent, and prior written notice. Tenant shall also have the right at any time during the lease term to sublease or assign all or any portion of the Tenant's Premises to any unrelated entities with Landlord's prior written consent, which will not be unreasonably withheld, conditioned or delayed. Sublease profits shall be shared 50/50 with landlord after deduction of sublease costs and concessions.
Parking:	Tenant employees and visitors will have access to the west parking lot of the building which has 68 surface parking spaces (including handicapped spaces).
Hazardous Materials & ADA Compliance:	Landlord's sole cost, will construct, maintain and operate the Building, property and Premises in accordance with all applicable governmental regulation, codes, rules and laws, including the Americans With Disabilities Act.
Securitization:	Dependent upon review of Tenant Financials.
Broker's Commissions:	NAI Hiffman represents and warrants to the other that, except as follows, no broker or finders have been engaged by it in connection with the transactions contemplated by this Agreement or, to its knowledge, is in any way connected with such transaction. NAI Hiffman's Adam Johnson and Brian Edgerton represent the Landlord and CBRE, Inc.'s Andrew Kaplan and Jon Springer represent the Tenant and will be paid a commission by the Landlord pursuant to a separate agreement.



ATTACHMENT 2

Site Ownership

This proposal is not intended as, and does not constitute, a binding agreement by any party, nor an agreement by any party to enter into a binding agreement but is merely intended to specify some of the proposed terms and conditions of the transaction contemplated herein. Neither party may claim any legal rights against the other by reason of the signing of this letter or by taking any action in reliance thereon. Each party hereto fully understands that no party shall have any legal obligations to the other, or with respect to the proposed transaction, unless and until all of the terms and conditions of the proposed transaction have been negotiated, agreed to by all parties and set forth in a fully executed lease. The only legal obligations, which any party shall have, shall be those contained in such signed and delivered definitive agreement referred to above.

Please review this proposal and call me with any questions. If these terms are acceptable, please sign below and we will prepare the lease. This offer will expire within Ten (10) business days from the date of this proposal.

Sincerely yours,

NAI HIFFMAN



Adam Johnson
Executive Vice President
ajohnson@hiffman.com
Direct: 630 317 0729

cc: Edgerton

AGREED AND ACCEPTED

By: _____

Date: _____



ATTACHMENT 2

Site Ownership

TOTAL PAYMENT DUE		2022 First Installment Property Tax Bill - Cook County Electronic Bill						
By 07/01/23	\$0.00	Property Index Number (PIN)	Volume	Code	Tax Year	(Payable In)	Township	Classification
		19-36-308-010-0000	412	72001	2022	(2023)	LAKE	5-17
IF PAYING LATE, PLEASE PAY		07/02/2023 - 08/01/2023 \$0.00	08/02/2023 - 09/01/2023 \$0.00	09/02/2023 - 10/01/2023 \$0.00	LATE INTEREST IS 1.5% PER MONTH, BY STATE LAW			
TAXING DISTRICT DEBT AND FINANCIAL DATA								
Your Taxing Districts	Money Owed by Your Taxing Districts	Pension and Healthcare Amounts Promised by Your Taxing Districts	Amount of Pension and Healthcare Shortage	% of Pension and Healthcare Costs Taxing Districts Can Pay				
Metro Water Reclamation Dist of Chicago	\$3,327,854,000	\$3,020,080,000	\$1,168,985,000	61.29%				
Chicago Park District	\$1,239,907,000	\$2,096,450,000	\$1,741,894,000	16.91%				
Board of Education Chicago	\$13,815,094,000	\$29,286,255,000	\$18,349,193,000	37.35%				
Chicago Community College Dist	\$498,542,277	\$90,248,733	\$90,248,733	0.00%				
City of Chicago	\$41,006,546,000	\$46,652,035,168	\$35,696,602,003	23.48%				
Cook County Forest Preserve District	\$233,103,051	\$540,107,634	\$328,420,280	39.19%				
County of Cook	\$8,019,310,814	\$29,739,673,504	\$17,090,063,066	42.53%				
Total	\$68,140,357,142	\$111,424,850,039	\$74,465,406,082					
For a more in-depth look at government finances and how they affect your taxes, visit cookcountytreasurer.com								
PAY YOUR TAXES ONLINE Pay at cookcountytreasurer.com from your bank account or credit card.								
TAX CALCULATOR				IMPORTANT MESSAGES				
2021 TOTAL TAX		114,831.53						
2022 ESTIMATE	X	55%						
2022 1st INSTALLMENT	=	63,157.34						
The First Installment amount is 55% of last year's total taxes. All exemptions, such as homeowner and senior exemptions, will be reflected on your Second Installment tax bill.								
				PROPERTY LOCATION		MAILING ADDRESS		
				8658 S SACRAMENTO AVE CHICAGO IL 60652		UIRC GSA CHGO ILL LLC 15700 W 103RD STREET LEMONT IL 604399610		

*** Please see 2022 First Installment Payment Coupon next page ***

ATTACHMENT 3
Certificate of Good Standing- Operating Licensee

File Number 1338915-2



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

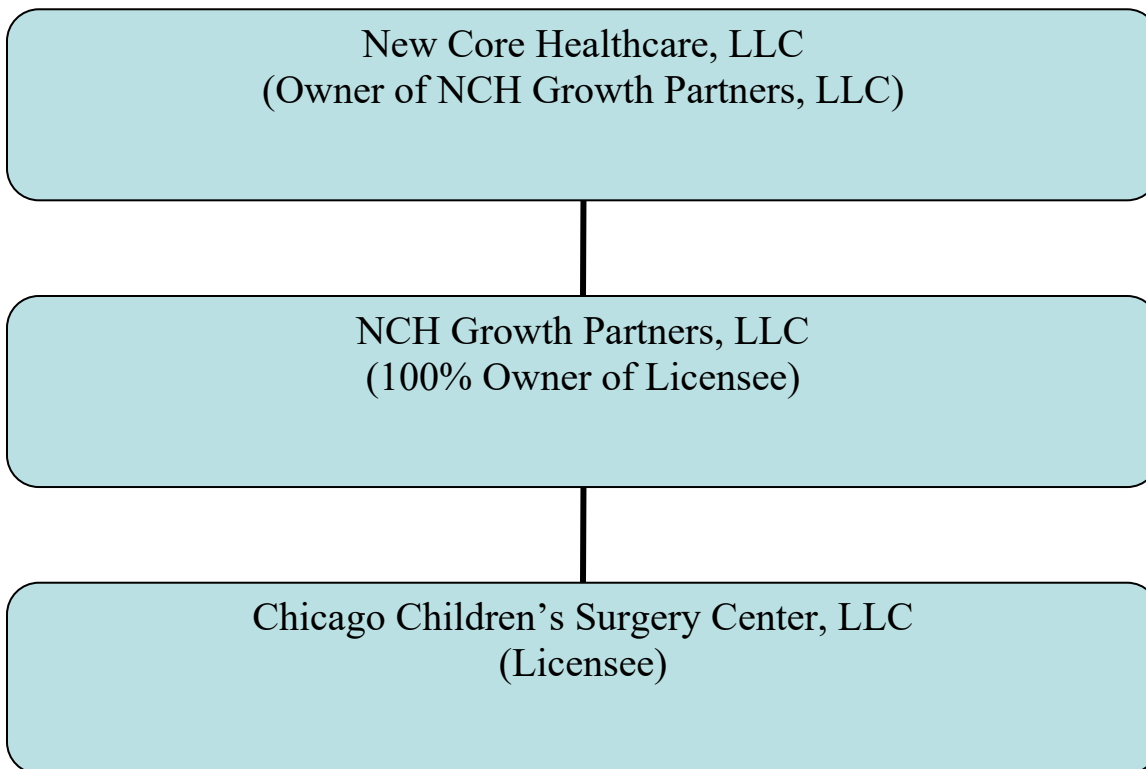
CHICAGO CHILDREN'S SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JUNE 19, 2023, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 2318003072 verifiable until 06/29/2024
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 29TH day of JUNE A.D. 2023 .

Alexi Giannoulis
SECRETARY OF STATE

ATTACHMENT 4
Organizational Chart**New Core Healthcare, LLC Ownership (List below includes owners with at least 5% ownership interest)**Grosberry, LLC (40.3%)¹Estero, LLC (39.9%)²¹ Jeff Wheeler is the single member of Grosberry, LLC.² Kyle Welch is the single member of Estero, LLC.

ATTACHMENT 5

Flood Plain Requirements

June 24, 2023

John P. Kniery
Board Administrator
Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

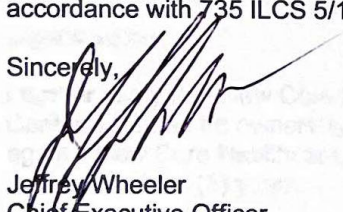
Re: Chicago Children's Surgery Center- Flood Plain Requirements

Dear Mr. Kniery:

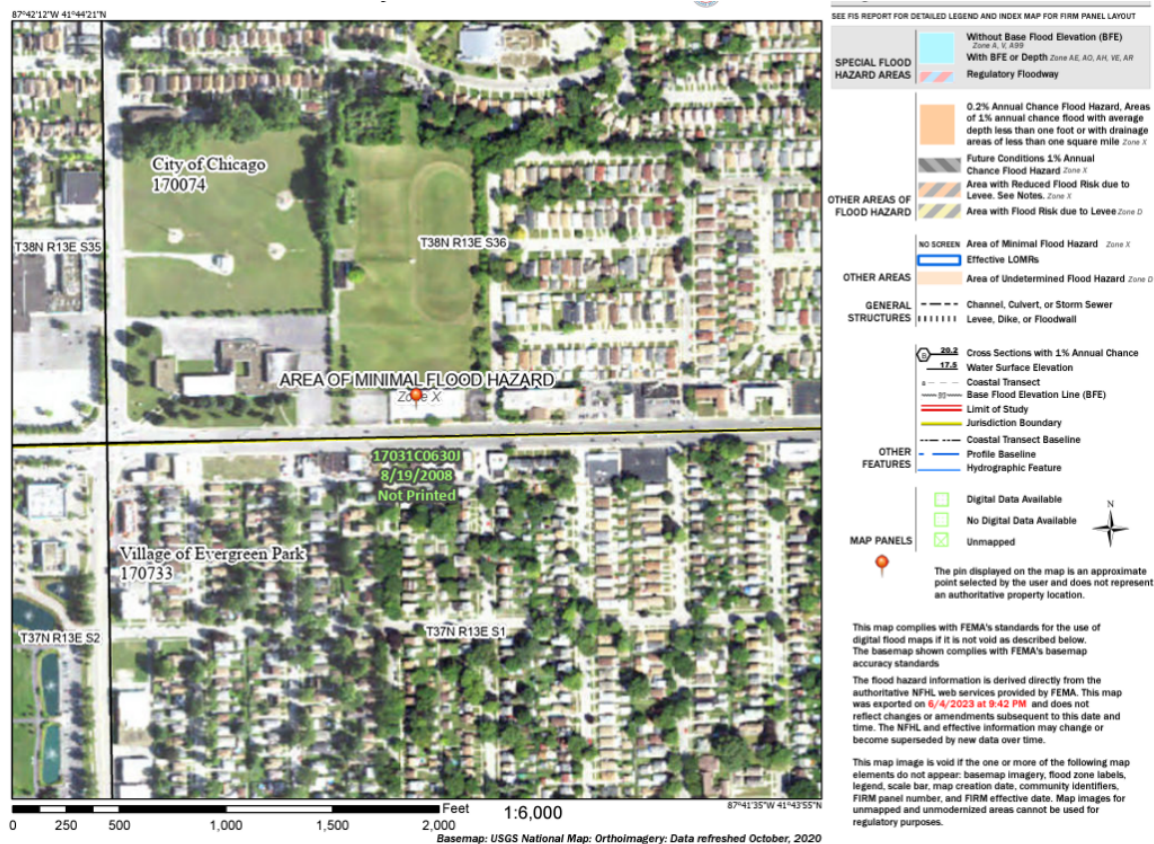
As representative of New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC, I Jeffrey Wheeler, affirm that the proposed location for the establishment of New Core Healthcare, NCH Growth Partners, LLC, complies with Illinois Executive Order #2005-5. The proposed location, 8658 S. Sacramento Ave., Chicago, IL 60652, is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

I hereby certify this true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,


Jeffrey Wheeler
Chief Executive Officer
New Core Healthcare, NCH Growth Partners, LLC,

ATTACHMENT 5 Flood Plain Requirements



ATTACHMENT 6
Historic Preservation

Juan Morado, Jr.
71 South Wacker Drive, Suite 1600
Chicago, IL 60606
Direct Dial: 312.212.4967
Fax: 312.757.9192
jmorado@beneschlaw.com

June 25, 2023

VIA EMAIL

Jeffrey Kruchten
Chief Archaeologist
Preservation Services Division
Illinois Historic Preservation Office
Illinois Department of Natural Resources
1 Natural Resources Way
Springfield, IL 62702
SHPO.Review@illinois.gov

Re: Certificate of Need Application for the Establishment of an Ambulatory Surgery Treatment Center- Chicago Children's Surgery Center, LLC

Dear Jeffrey:

I am writing on behalf of my clients, New Core Healthcare, LLC and Chicago Children's Surgery Center, LLC ("CCSC") to request a review of the project area under Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). CCSC is submitting an application for a Certificate of Need from the Illinois Health Facilities and Services Review Board. CCSC is proposing to establish an ambulatory surgery treatment center, to be located at 8658 S. Sacramento Ave., Chicago, IL 60652 (the "ASTC").

The proposed ASTC will occupy approximately an existing building. The ASTC will be a single-specialty ASTC providing oral/maxillofacial surgical procedures to support pediatric patients, and will have a patient waiting room, physician office space, a nursing station, examination rooms, and once operating rooms along with administrative and mechanical space. For your reference, we have included pictures of the topographic maps, areal maps, and existing lot images (Attachments 1-3) showing the general location of the project.

www.beneschlaw.com

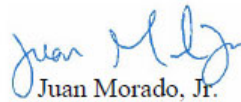
ATTACHMENT 6
Historic Preservation

Page 2

We respectfully request review of the project area and a determination letter at your earliest convenience. Thank you in advance for all of the time and effort that will be going into this review.

Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP



Juan Morado, Jr.

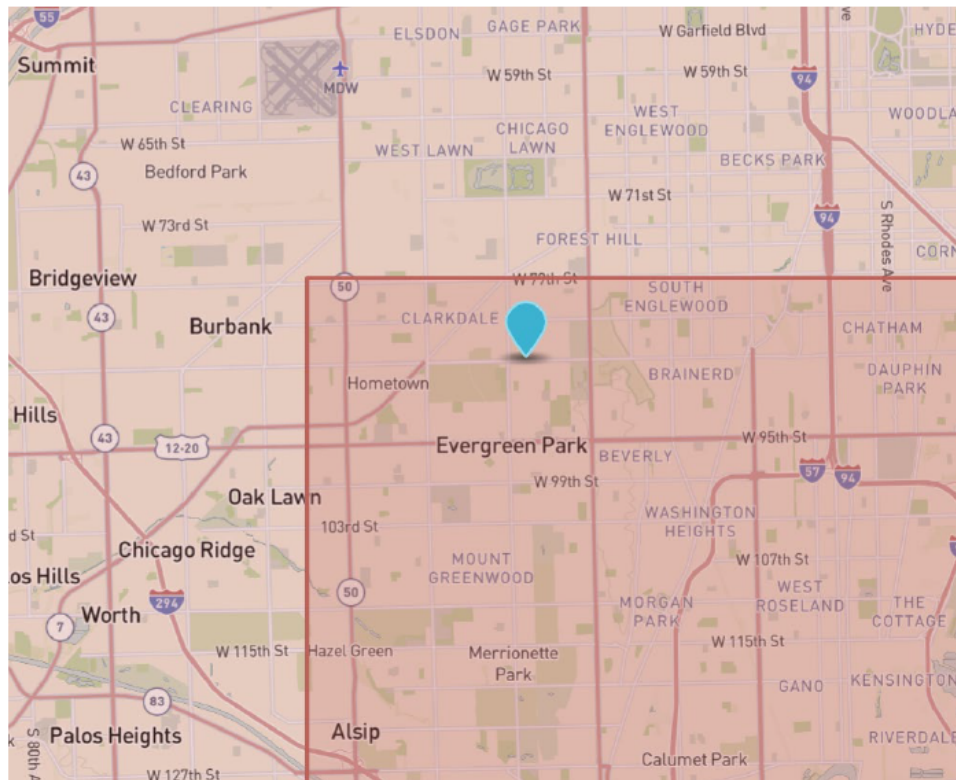
JM:
Enclosures

ATTACHMENT 6 Historic Preservation

Page 3

ATTACHMENT 1

Topographic Map



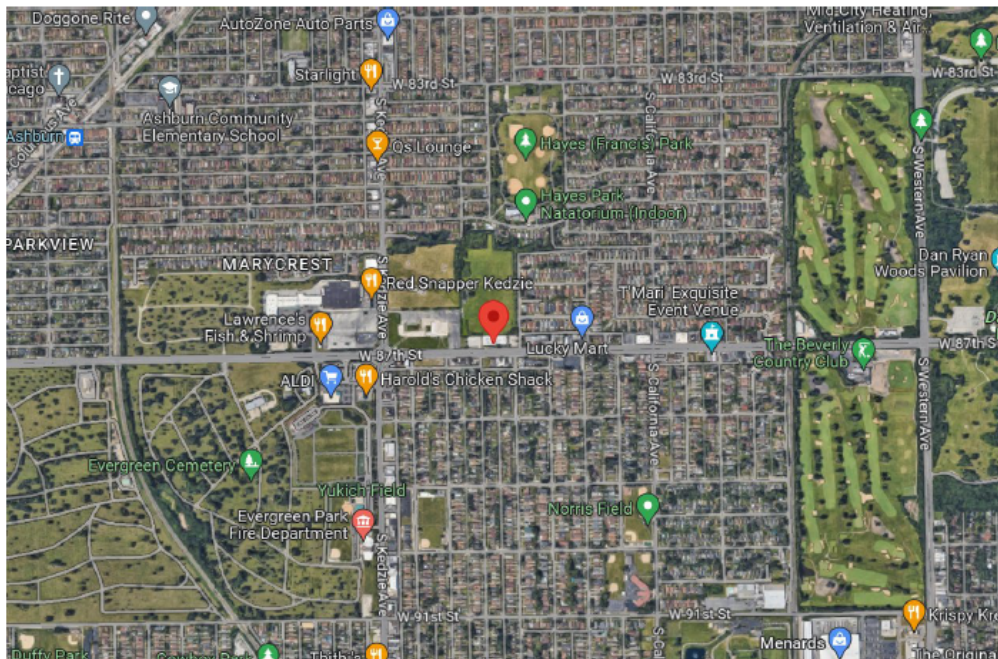
ATTACHMENT 6

Historic Preservation

Page 4

ATTACHMENT 2

Aerial Map



ATTACHMENT 6 Historic Preservation

Page 5

ATTACHMENT 3 Street View of Property



ATTACHMENT 6 Historic Preservation

Page 6



ATTACHMENT 7

Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	-	-	-
Site Survey and Soil Investigation	-	-	-
Site Preparation	\$69,388	\$161,012	\$230,400
Off Site Work	-	-	-
New Construction Contracts	\$2,240,000	\$960,000	\$3,200,000
Modernization Contracts			
Contingencies	\$154,798	\$359,202	\$514,000
Architectural/Engineering Fees	\$81,531	\$189,189	\$270,720
Consulting and Other Fees	\$280,000	\$120,000	\$400,000
Movable or Other Equipment (not in construction contracts)	\$318,798	\$136,628	\$455,425
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value of Leased Space or Equipment	\$1,244,799	\$2,888,501	\$4,133,300
Other Costs to Be Capitalized	-	-	-
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	\$4,389,314	\$4,814,531	\$9,203,845
SOURCE OF FUNDS			
Cash and Securities	\$2,664,641	\$812,504	\$3,477,145
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	-	-	-
Leases (fair market value)	\$1,244,799	\$2,888,501	\$4,133,300
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	\$479,874	\$1,113,526	\$1,593,400
TOTAL SOURCES OF FUNDS	\$4,389,314	\$4,814,531	\$9,203,845

ATTACHMENT 7

Project Costs and Sources of Funds

Site Preparations - The proposed project will be constructed in an existing building, but the site has been unused for some time and is in need of various repairs. The Applicant's costs are attributed to work necessary for the operation of an ambulatory surgical treatment center. The clinical site preparation costs are estimated to be \$69,388 or 2.8% of the total clinical construction and contingency costs.

Site Utilities	\$100,000
Exterior Signage and Lighting	\$30,400
Landscaping	\$40,000
Miscellaneous/Other	\$40,000
Site Survey	\$20,000

New Construction Contracts - The proposed project will be constructed in an existing building. The Applicant's costs are attributed to the required tenant improvements necessary for the operation of an ambulatory surgical treatment center. The projected building costs are based on national architectural and construction standards and adjusted to compensate for several factors. The clinical construction costs are estimated to be \$2,240,000 or \$509.09 per clinical square foot.

General Contractor	\$3,180,000
Bond	\$80,000

Contingencies - The Project's contingencies costs are designed to allow the construction team an amount of funding for unforeseeable events related to construction. Clinical construction costs for contingencies are estimated to be \$154,798 or 6.9% of projected clinical new construction costs.

Architectural/Engineering Fees - The clinical project cost for architectural/engineering fees are projected to be \$81,531 or 3.4% of the new construction and contingencies costs.

Architectural Fees	\$270,720
--------------------	-----------

Consulting and Other Fees - The Project's consulting fees are primarily comprised of various project related fees, additional state/local fees, and other CON related costs. These costs

CON Consultant Fees	\$50,000
Legal Fees	\$100,000
Process Improvement Consultant	\$50,000
Permitting Fees	\$40,000

Project Management	\$80,000
Systems Testing	\$20,000
Insurance	\$50,000
Miscellaneous	\$10,000

Moveable Equipment Costs - The moveable equipment costs are necessary for the operation of the surgery center, and proposed physician clinic/immediate care rooms. The total clinical cost for the equipment is \$318,798. This equipment includes:

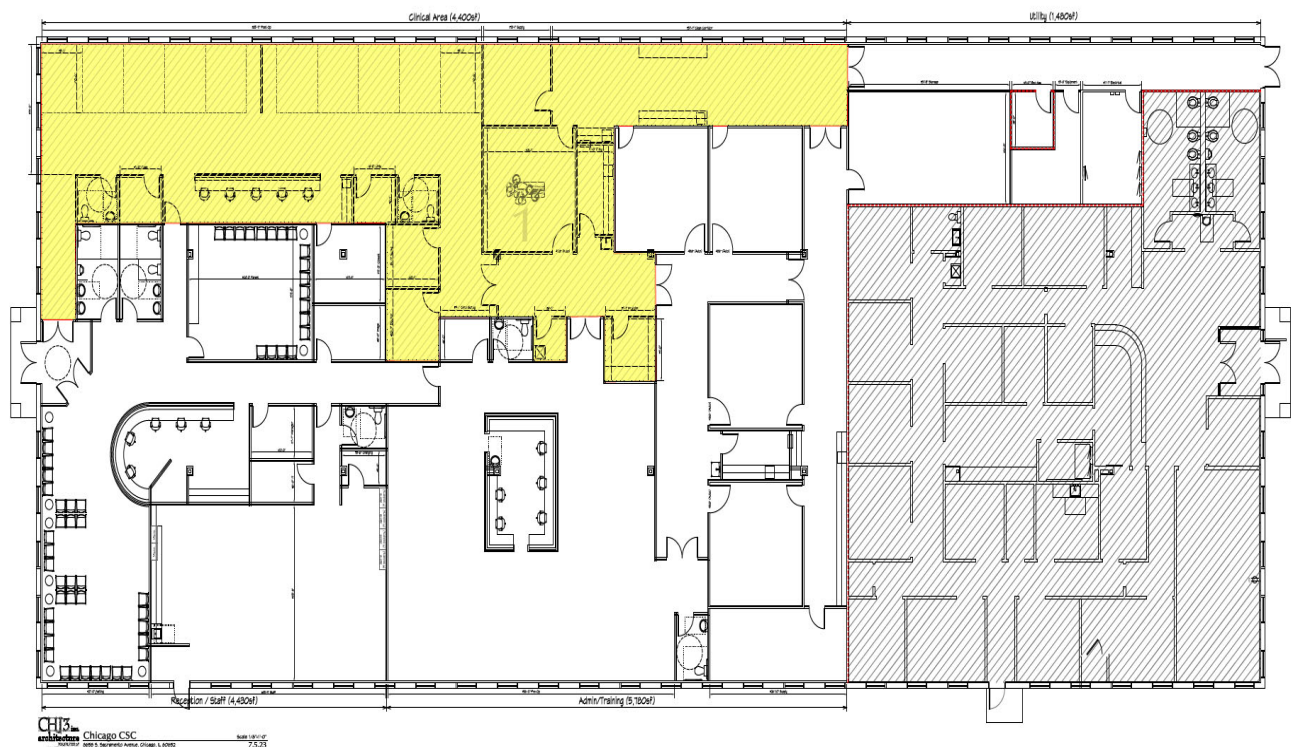
Suction Machines	1	\$40,000
OR Lights	3	\$60,000
Anesthesia Machines (Mindray A7)	1	\$80,000
Panoramic X-ray (Kavo)	1	\$84,000
Nomad x-ray	2	\$14,000
X-ray Sensors	2	\$28,000
Stryker eye gurneys	2	\$16,000
Patient warmer	2	\$4,000
Recovery Chairs	2	\$20,000
Glide scope	2	\$20,000
Anesthesia carts	1	\$300
Dental cart	2	\$4,000
Dental chair	1	\$5,000
Blanket warmer	2	\$4,000
Autoclave	1	\$5,000
Patient and medicine fridges	2	\$600
Firewall	1	\$1,000
Anesthesia patient monitors	2	\$10,000
Computers & monitors	6	\$9,000
Printers	3	\$525
Office Furniture- Chairs, Desks, Art, etc...	Multiple Pieces	\$50,000

Fair Market Value of Leased Space or Equipment: The lease was the result of an arm's length negotiation and has a 10-year term where the total value of the lease is \$4,133,300. Additionally, the lease includes a tenant improvement allowance in the amount of \$1,593,400.

ATTACHMENT 8

Project Status and Completion Schedules

The proposed project plans are still at the schematic state and the proposed project date is December 31, 2024. Financial Commitment for the project will occur following permit issuance.



ATTACHMENT 9

Cost Space Requirements

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
ASTC 1 Operating Room	\$4,389,314	-	4,400	\$4,389,314	-	-	-
Total Clinical	\$4,389,314	-	4,400	\$4,389,314	-	-	-
NON-REVIEWABLE							
Administrative/Waiting Areas	\$4,814,531	-	10,210	\$4,814,531	-	-	-
Total Non-clinical	\$4,814,531	-	10,210	\$4,814,531	-	-	-
TOTAL	\$9,203,845	-	14,610	\$9,203,845	-	-	-
APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

ATTACHMENT 11

Background of the Applicant

The following information is provided to illustrate the qualifications, background and character of the Applicants, and to assure the Review Board that the proposed Medical Office Building will provide a proper standard of health care services for the community.

New Core Healthcare, LLC and Chicago Children's Surgery Center, LLC

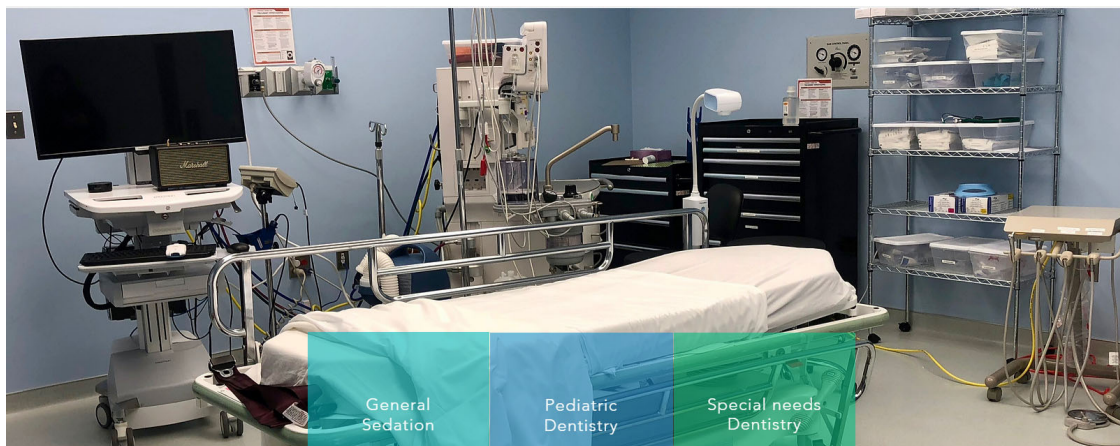
Chicago Children's Surgery Center, LLC ("CCSC") is a new Illinois limited liability company set up to own and hold the license for the proposed facility. CCSC does not own or operate any other healthcare facilities and is wholly owned by NCH Growth Partners, LLC ("NCH"), which itself is owned by New Core Healthcare, LLC.

New Core is a Delaware corporation that currently owns and operates two surgery centers, The Dental Surgery Center of DC, and Baltimore Surgery Center, LLC. New Core was founded by Jeffrey Wheeler and partners to develop surgery centers dedicated to providing oral/maxillofacial surgical procedures for children and special needs patients of all ages under General Anesthesia in a hospital-grade operating room. Their first state of the art surgery center, The Dental Surgery Center of DC was built in 2017. Their medical and nursing staff are ACLS and PALS certified, and they have treated nearly 10,000 patients to date.

New Core is a for-profit business founded to help change healthcare in the US. They have found that 62% of personal bankruptcies are related to medical expenses and New Core is committed to filling the gap that hospitals are not currently fulfilling. New Core is designed to save state Medicaid and private insurance companies' money across the country by shifting the site of care out of hospitals and into high-efficiency ASCs.

No officers nor owners of the Applicant entities maintain a 5% interest in any healthcare facilities in Illinois. Included with this attachment is a letter authorizing the HFSRB and IDPH to access records necessary to review and process this application.





BALTIMORE CHILDREN'S SURGERY CENTER

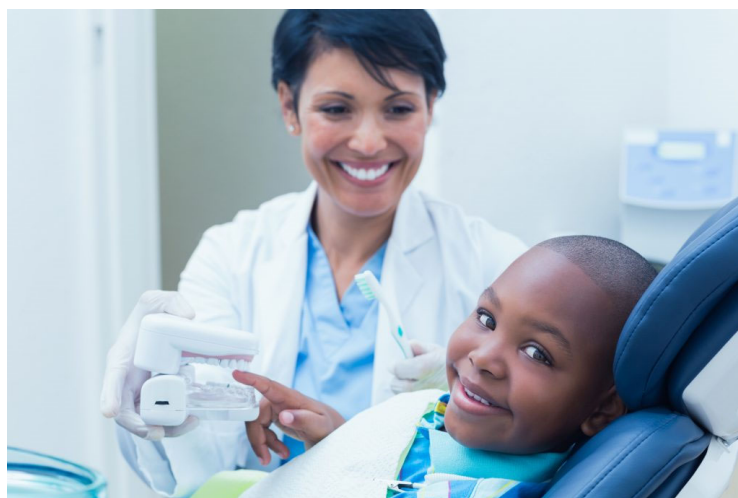


Special Needs General Anesthesia Dentistry

Patients with special needs are those, who due to physical, medical, developmental, emotional or cognitive conditions, require special consideration when receiving dental treatment. If you, your child or someone you know has special needs, talk with your dentist to discuss seeking treatment under general anesthesia at our facility.

Pediatric General Anesthesia Dentistry

The choice to have dental treatment for your child under general anesthesia involves many factors and is decided by you and your dentist together after a thorough exam. The general anesthesia used when completing dental treatment for your child is the same as that used in procedures like ear tube placement or tonsil removal. We are here to safely and effectively deliver professional, compassionate general anesthesia dentistry care your child needs.



ATTACHMENT 11

Background of the Applicant

June 25, 2023

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC – Certification and Authorization

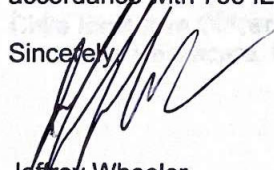
Dear Mr. Kniery,

As a representative of New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC, I, Jeffrey Wheeler, give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health ("IDPH") to access documents necessary to verify the information submitted including, but not limited to: official records of IDPH or other state agencies, the licensing or certification records of other states, and the records of nationally recognized accreditation organizations.

I further verify that New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC has no ownership in any other Illinois healthcare facility. There has been no adverse actions against New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC in the past three (3) years.

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,


Jeffrey Wheeler
Chief Executive Officer
New Core Healthcare, NCH Growth Partners, LLC,

ATTACHMENT 12

Purpose of Project

Chicago Children's Surgery Center, LLC ("CCSC") seeks to address the urgent shortage of medically complex dental services in HSA Region 6 and throughout Illinois. CCSC is rooted in the core value of serving the most medically vulnerable populations in the communities it serves. By establishing an Ambulatory Surgical Treatment Center ("ASTC") with one operating room and focused on dental and Oral and Maxillofacial procedures, the Metropolitan Chicago area will finally have an alternative for complex pediatric dental patients who otherwise resort to hospital emergency rooms.

The benefits of, and demand for, ASTC's are well documented. ASTC's fill the gaps in surgical care that exist beyond the property lines of a general acute care hospital. These facilities follow accreditation standards that are comparable to hospitals, and integrate emergency policies, procedures and staff training. The facility provides hospital-level pharmacy services, emergency room-equivalent staffing, and state-of-the-art surgical equipment.

The Applicant has experience developing similar projects in other states and begin planning for a Chicago-area facility over the last several months. Part of their diligence included contacting area federally qualified health centers, charitable organizations like Catholic Charities, dental schools, and government regulators. The Applicant learned that Illinois and the Chicagoland region have the same access issues that the saw in Baltimore and the District of Columbia. The Applicant learned from regulators that often pediatric dental patients and adults with special needs who are reliant upon Medicaid as the insurance or, have no insurance at all, have literally zero access to outpatient dental procedures and often end up emergency rooms or, if they are among the most fortunate, are able to be treated at area dental schools. ***This is the exact problem that CSCC seeks to address*** because this vulnerable patient population should have access to this necessary care.

An ASTC focused on dental services provides additional benefits, including medical professionals who develop core competencies around complex dental surgery. Interdisciplinary teams build efficiencies and routine familiarity with some of the most difficult maxillofacial and oral procedures. With so few surgery centers focused on dental care, referring physicians and dentists rarely know where to turn. Moreover, there will be the commitment to the necessary equipment and technology to provide quality care to this patient population. This proposed ASTC would become the default location for those needing complex dental surgical care.

As a result of the needs assessment conducted by CCSC, there is no question about the extensive need for these services. As part of their diligence CSCC identified 554 dental offices in the Chicago metro area that accept Medicaid. CSCC conducted a survey and reached to 52 of the dental offices in the Chicago area, the average response noted they observe 398 patients per month who require dental services in an operating room. Most dental offices refer the patients back to their own insurance company or to generic internet searches, while less than 10% of the offices refer their patients to UIC College of Dentistry or the hospital emergency department.

During its planning for CSCC, the Applicants reviewed their data for the number of Medicaid Cases in California³ and Maryland⁴ and CCSC estimates there to be 16,000-18,500 Medicaid dental patients in the Chicago metro area, and it's estimated that per 1 million individuals there are between 1,690 to 1,940 patients who require a dental procedure. This type of facility is designed to meet an existing but unmet need within the general Chicagoland area.

³ 1. Department of Health Care Services Medi-Cal Dental Program General Anesthesia Report, published 2022.

⁴ Maryland Medicaid Report on Pediatric Restorative Dental Surgery and Analysis of Rates for Anesthesia Services, MD DHMH, 2013

How many Medicaid OR dental cases are there in Chicago?

Geography	California ¹	Maryland ²	Chicago
Medicaid Dental patients	75,646	9,805	16,000-18,500
Total Population	39mm	5.8mm	9.5mm
Estimated Medicaid dental patients / 1mm pop	1,940	1,690	1,690 to 1,940

Including privately insured patients, there are likely 20,000 to 25,000 patients in the Chicago metro area who require OR dental care annually

Cost savings is another factor that is driving this application. When the Applicants were looking to establish their facility in Maryland, they reviewed a 2013 State Commission report that identified and verified the exact issues that Illinois is facing. Namely, the Commission found that hospitals in Maryland were not prioritizing dental cases and many dentists in the state were experience issues with long wait times for their Medicaid patients. Following changes passed in Maryland law and upon establishing their Baltimore Children's Surgery the Applicants were able to cut wait times to 3 weeks (down from 18-24 months previously), and lower costs for all patients. Increased access to care without increasing cost or sacrificing quality are the core tenants of this program – each of which are furthered by this project.

Case Study: Maryland Medicaid decided to pay a higher ASC facility fee in 2015, increased access to dental OR time for dentists

2013 State Commissioned Report¹

Impetus

- Dentists complained about access to care, long wait times
- Hospitals didn't prioritize dental cases

Findings

"Dentists have been told that hospitals would prefer to book higher-revenue services in the OR"

Dentist reports wait times of "about four months" to treat OR patients

"Anesthesiologists... believe that low Medicaid reimbursement rates [for anesthesia] are limiting access"

Recommendations

- Increase rates paid to anesthesiologists for dental OR cases
- Create a facility fee that would enable ASCs to keep their lights on while serving patients

Results for Maryland Medicaid Dentists

NCH Facilities exclusively treat dental patients in an OR setting; two existing facilities bill 10-15 cases per year²

Referred to NCH facilities can be treated within 3 weeks of referral

- Average wait time at local hospitals (Children's National and University of Maryland) are 18-24 months

Dentists prefer having cases done in an ASC

- Lower cost to patients (for privately insurance, no charge to Medicaid enrollees)
- Reduces patient time under anesthesia (lowering risk of adverse events)
- Shorter wait times

Significant savings to Maryland Medicaid as compared to treating patients in the hospital³

Most states are experiencing an issue with lack of access to care

The cost savings cannot be underestimated for complex dental care cases that are performed outside of the hospital and in an ASTC setting. Moving these cases to an outpatient setting has already resulted in substantial savings of taxpayer dollars. CCSC projects a total possible savings of \$13,202,866 to Illinois Medicaid due to lower costs of an ASTC (as compared to a hospital) and ER avoidance. In addition, the reduced wait time and removal of barriers has meaningful impact for this patient population.

Potential Savings from Increased Utilization of NCH ASCs for OR Dentistry

Hospital vs ASC	
# of dental OR cases per year ⁴ (est. 30% of total)	5,000
Hospital Facility fee per case ⁵	\$3,500
Hospital anesthesia fees per case ⁶	\$226
ASC Facility fee per case	\$1,100
ASC Anesthesia fee per case ⁶	\$204
Total savings per case	\$2,423
Potential savings to Medicaid from ASC dental care	\$12,114,100
Avoided ER Visits	
IL Medicaid dental ER visits ⁷	6,102
IL Medicaid dental ER visits avoided ⁸	25%
Cost per ER visit ⁹	\$714
Total savings from avoided ER visits	\$1,088,766
Annual Savings	
Savings from dental ASC	12,114,100
Savings from reduced ER visits	1,088,766
Potential savings to IL Medicaid	\$13,202,866

5

Limited access to pediatric dental surgery services is not limited to the greater Chicago area. The American Association of Pediatric Dentistry ("AAPD") Pediatric Oral Health Research and Policy Center notes that, "denial of access to hospital operating rooms for pediatric care is a growing problem in the

⁵ 4. Estimated IL treatments of 16,000 to 18,500 per year, based on calculations from Maryland Medicaid Report on Pediatric Restorative Dental Surgery and Analysis of Rates for Anesthesia Services, MD DHMH, 2013 and Department of Health Care Services Medi-Cal Dental Program General Anesthesia Report, published 2022. Assumes that 33% of Medicaid patients who need treatment actually receive it. 5. Our best estimates indicate that hospitals are paid \$3.5k per case by IL Medicaid. 6. Assumes a reduction from 5 time units (75 min average case) to 4 time units (60 min average case) in ASC plus 5 base units times IL CMS anesthesia rate of \$22.62. 7. Avg of 25 ER visits per month per 100K Medicaid population x 5 for estimated ~1.7mm IL Medicaid enrollees in Cook county, 165K enrollees in Du Page county and 150K enrollees in Will county. Source: <https://www2.illinois.gov/hfs/info/factsfigures/Pages/default.aspx>, accessed 3/30/2023. 8. Estimate from reducing hospital OR wait time. 9. \$547 from Oklahoma Medicaid HB 2906 ER Utilization report in 2013 increased by 3% annually.

U.S...”⁶ “The OR denial problem will likely not be reversed but ameliorated to some degree in various ways in different geographic areas of the U.S. with policy change, innovative alternatives such as ambulatory surgery centers and in-office general anesthesia.⁷ The lack of access to hospital rooms to address the oral health needs of patients “is the defining issue for pediatric dentists at this time,” said Dr. Howard Elson, a pediatric dentist and member American Dental Association’s Medicaid Provider Advisory Committee.⁸

The scarcity of pediatric dental services disproportionately impacts children with special needs. Aside from various medical conditions requiring regular pediatric dental care, the wait times for hospital-based pediatric dental care has a significant impact on this vulnerable population. “The lack of OR access for needed and covered dental procedures often results in wait times of 6-12 months for these patients, many of whom are children whose daily activities and school performance are often significantly affected in the interim.”

CCSC is prepared to step into a challenging financial model to serve a historically forgotten and ignored patient population. Serving a predominantly Medicaid pediatric population with some of the lowest reimbursement rates in the country help explain why the demand constantly outpaces the supply. This Project will help to close the gap in needed dental surgical services and is offered by experienced and successful operators.

⁶ “Denial of Access to Operating Room Time in Hospitals for Pediatric Dental Care.” American Association of Pediatric Dentistry. May 2021. <https://www.aapd.org/globalassets/media/advocacy/ord.pdf>

⁷ *Id.*

⁸ [Pediatric dentists sound alarm about being denied OR access ADA News : September 7, 2020 \(mydigitalpublication.com\)](https://mydigitalpublication.com/pediatric-dentists-sound-alarm-about-being-denied-or-access-ada-news-september-7-2020)

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Denial of Operating Room Access for Pediatric Dental Treatment: A National Survey

Thesis

Presented in Partial Fulfillment of the Requirements for the Degree Master of Science in
the Graduate School of The Ohio State University

By

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Graduate Program in Dentistry

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2021

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Abstract

Purpose: US pediatric dentists require access to hospital operating rooms (OR) to deliver safe and effective dental care to some children but have reported denial of access to ORs for general anesthesia (GA) causing lengthy waiting times, deferral of medically necessary dental care, and unmeasured pain and anxiety for patients. This pilot study examined the extent and possible underlying causes of OR access denial.

Methods: Public Policy Advocates (PPAs) of the American Academy of Pediatric Dentistry completed a written or electronic questionnaire about state-specific OR denials during March, 2020.

Results: Responses from 50 states and District of Columbia showed 34 PPAs (67%) acknowledging OR access problems, with 14/34 (41%) reporting a moderate or major problem. Western district PPAs reported fewest states affected (4/11; 36%). Hospitals and reimbursement emerged as frequent foci for denials in comment analysis.

Conclusion: OR access denial is a problem for pediatric dentists in the majority of US states and District of Columbia and in those states reporting it a problem, was considered moderate or major in significance by almost half.

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Dedication

This thesis is dedicated to my parents (Thanh Vu and Paul Vo) for being resilient and escaping the Vietnam War to provide a better life for their children.

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Acknowledgments

This study would not have been possible without the resources and guidance from my research advisor and committee members: Dr. Paul Casamassimo, Dr. Homa Amini, and Dr. Kim Hammersmith. Thank you for all for your wisdom, charisma, and mentorship.

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Chapter 1: Introduction

Dental Disease Occurrence and Treatment in Children

Dental caries (tooth decay) is the most common childhood disease, affects more than one in four children in the United States (US) and is more prominent in lower-income families.¹ Financial, cultural, and geographic factors are all potential barriers to accessing dental care.² Dentists can treat caries in a dental office utilizing local anesthetic, nitrous oxide, and/or in-office sedation. Children who are pre-cooperative, anxious, or have special health care needs may benefit from or require dental treatment under general anesthesia (GA). Pediatric dentists are: (1) trained to care for patients under GA in hospital or outpatient surgery center settings, and (2) eligible for medical staff membership with privileges to access operating rooms for treatment of these children.³

Due to subjective criteria, insurers do not view dental treatment in the same light as medical treatment and will often not offer full coverage. According to a 2014 American Dental Association Health Policy Institute brief,

“among Medicaid-enrolled adults, the top reasons for not visiting a dentist include many services not being covered by Medicaid (42.4 percent) and difficulty finding a dentist who accepts Medicaid (32.0 percent)”.⁴

Within Medicare, dental care is not seen as essential and that system provides no coverage.⁵

Dentistry evolved in the health system separately from medicine and third-party payers often consider dental treatment elective or not medically-necessary care (MNC). According to Guay et al, for dental to be considered insurable,

“occurrence should be uncertain, fairly rare and random; the consequence should be irreversible and not disappear spontaneously; financial consequences of risk should be significant and almost catastrophic for most people; and the affected person should have no control over the timing of the event or its consequences”.⁶

Third-party payers view MNC differently and have their own definitions, leading to discrepancies in coverage between medicine and dentistry. For example, even if a dental provider believes that medical necessity indicates dental treatment under GA, medical

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insurers can deny the claim if patient characteristics do not meet their criteria. Insurers may claim to provide coverage for children, but some may not cover GA services because patients do not meet established medical and behavioral criteria for MNC.

The dental community supports closer ties with medicine and systemic health, but its attempts to change its separation have encountered mixed results. Despite increased demands for dental surgical services, access to GA in a hospital setting is still limited and often overshadowed by other medical and surgical specialties.⁷ Under the Affordable Care Act (ACA), dental care for children, considered as one of ten essential health care benefits, did not truly expand coverage⁸ because interpretation by federal agency regulators was that only availability of coverage is mandated. Dental care for adults, even those with special health care needs, is not an essential benefit under the ACA, nor mandated in Medicaid.

Children experience improved quality of life after dental treatment under GA,⁹ but access to ORs for dentists remains limited, leaving providers frustrated. Almost two decades ago, Lewis and Nowak surveyed pediatric dental program directors and found that 81% requested more OR time and only 46% were granted it.¹⁰ Medical necessity is often cited as a factor in limiting dentists' OR access. The American Academy of Pediatric Dentistry (AAPD) defines MNC as

“the reasonable and essential diagnostic, preventive/treatment services (including supplies, appliances, and devices), and follow-up care as determined by qualified health care providers in treating any condition, disease, injury, or developmental malformation. MNC includes all supportive health care services necessary for the provision of preventive and therapeutic oral care as determined by the attending dentist. Relevant here is that these services may include sedation, GA, and utilization of surgical facilities”.¹¹

Financial challenges play a role in OR access for pediatric dentists. Hospitals can have extensive overhead costs. Before the early 1980s, Medicare and other insurers paid hospitals a variable cost plus a reasonable profit for services provided. For example, if it

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cost a hospital \$10,000 to conduct a procedure, the hospital would be paid \$10,000 plus a monetary incentive for treatment provided. Under the Reagan administration, in 1982, the

Tax Equity and Fiscal Responsibility Act (TEFRA) changed how Medicare paid hospitals based on a fee-for-service model rather than a variable cost model.¹² TEFRA incentivized hospitals and other providers to behave more like businesses, changing the culture of health care delivery as a whole. Since then, hospitals and insurers have functioned competitively, rather than synergistically --- hospitals want higher reimbursements to cover overhead costs plus reasonable profits and insurers want to pay the least amount possible while still getting the most they can.¹³

Healthcare financing changes have affected all surgical specialties, including dentistry. In a hospital setting, most anesthesiologists are compensated based on procedure time in addition to a variable base rate for each completed case.¹⁴ The American Society of Anesthesiologists' (ASA) Relative Value Guide states hospitals earn more through higher reimbursement rates for surgery patients that are more medically complex (ie, ASA Physical Status III or higher). Reimbursement rate is also dependent on the duration of productive time. These base values are billed as Current Procedural Terminology (CPT) or Centers for Medicare and Medicaid Services (CMS) codes.¹⁵ Time between cases is not considered "productive time" and therefore is a loss of hospital revenue,¹⁶ so hospitals balance revenue per case type with turnover time, selecting an optimal case mix that may not include dental cases. Medicaid often bundles payments for surgical cases, which further limits financial incentives to anesthesiologists and hospitals.

Dental treatment delivered under GA is less desirable for hospitals than other surgeries. For example, CPT and CMS codes are diagnosis-driven, so dental surgery reimbursement may not be as lucrative as general and specialty medical services. In general, dental cases have quicker procedures, operate on less medically complex patients, are typically low case acuity, with higher case turnovers than more complex medical cases such as cardiothoracic surgery. Therefore, hospitals may view dentistry as less profitable and favor other specialties that bring in higher reimbursement.¹⁷ In addition, Medicaid reimbursement rates for dental GA cases are low compared to

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cardiothoracic cases and Medicaid caps facility fee payment, irrespective of real costs. Some commercial insurers do not cover dental GA, require pre-authorization (often by a non-dentist), or require a physician's documentation to deem dental GA as MNC.

Surgery centers and in-office GA may be options for dentists excluded from hospitals, but some state Medicaid programs and private insurers do not reimburse for facility costs for treatment conducted in these settings. Lack of OR staff familiarity and disinterest in dental surgery as well as the purchase, use, and maintenance of unfamiliar equipment, may deter hospitals from offering OR time to dentists.

Surgical care, including that for dental disease is expensive. The Joint Legislation Audit and Review Commission reported that in 2013, out of pocket cost for GA in the hospital setting averaged from \$9,000 to \$23,300.¹⁸ The Healthcare Cost and Utilization Project reported in a 2013 statistical brief that the average cost per admission for children aged 1-17 was \$8,400.¹⁹ GA is too expensive for most families without insurance and Medicaid is often the payer for pediatric dental GA, although reimbursement for facility fees is low. The American Hospital Association reports that Medicare and Medicaid pay less than the cost of treatment and combined underpayments were \$76.6 billion dollars in 2018.²⁰ Both traditional fee-for-service and managed care-based Medicaid attempt to limit expenditures for dental cases under GA.

Uncontrolled pain, swelling, and infection are reasons for emergency dental care in some hospitals and may be the only way hospitals allocate OR time to pediatric dentists. This limitation has caused lengthy waiting time and deferral of dental treatment.²¹ Denial of OR access for children and adults with special health care needs occurred well before the COVID-19 pandemic, but now has become a more pressing national problem. Pediatric dentists struggle to provide GA treatment because of competition from medical surgeons resuming elective surgeries. The COVID-19 pandemic delayed dental treatment considered non-urgent or non-emergent, that is, without accompanying pain, disseminated infection or uncontrolled bleeding. Anecdotal reports suggest the pandemic legitimized and perpetuated an already growing pattern of denial to ORs.

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The extent of OR denials is unknown nationally. Anecdotal reports suggest finances and other stresses in the system, hospital, and payers as possible reasons. More information about pediatric dentists' denial of OR access is needed to understand etiologic factors and seek solutions. This study aims to: (1) identify the range and extent of OR denial for pediatric dentists in the US and (2) catalog the validated, proposed, and suspected reasons for OR denial.

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Chapter 2: Materials and Methods

This research was approved by the Institutional Review Board at Nationwide Children's Hospital (NCH), Columbus, Ohio, USA (research protocol no. 0968).

Sample

The sample comprised AAPD Public Policy Advocates (PPAs). PPAs are pediatric dentists and advocates for children in their states. The majority of PPAs work in private practice. PPAs are affiliated with their AAPD state chapter. All but three states had PPAs at the time of this study, so representatives from these three states and the District of Columbia (DC) were chosen for the study by their state pediatric dentistry chapter elected leadership. The survey was voluntary and subjects could withdraw participation in the survey at any time.

Instrument

A de novo survey was developed by investigators to assess prevalence and nature of OR denials based on anecdotal, suspected, and established factors. A draft questionnaire was reviewed by AAPD public policy staff, selected pediatric dentists with advocacy experience, and a legal firm engaged in national advocacy efforts and health care reimbursement issues. Modifications yielded a 12-question survey instrument, with staged exit opportunity from the questionnaire for respondents without OR denial issues in their states. Demographic data were limited to location and time as PPA or residency in that state.

Survey Process

The survey was administered in two ways. It was completed in person at the annual Pediatric Oral Health Advocacy Conference (POHAC), in Washington DC, on March 2, 2020, by PPAs in attendance (n=25) and emailed the following month to PPAs not in attendance, as well as selected representatives from non-PPA states. Respondents were encouraged to canvass other state pediatric dentists for their experiences and to include their responses either as support for item choices or as free-standing comments.

Data Analysis

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All data was securely stored and entered in Microsoft Excel (Microsoft Corporation, Seattle, WA), before analysis using statistical software R (version 3.6.2). Figures and table were created using Microsoft Excel. Descriptive statistics included frequency, percentage, mean and median.

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Chapter 3: Results

Response rate was 100%. The average tenure as a PPA or with state residency was 16.6 years (median 10 years). Figure 1 displays the distribution of state respondents' awareness of OR denial in their state (referred to as location hereafter). Figure 2 shows the distribution by AAPD districts. Fourteen of 51 respondents (27.5%) were unaware of OR denial as an issue, while the majority (37/72.5%) reported some concerns of OR denial. The AAPD western district emerged as least affected, with only 36% (4 of 11) of those respondents reporting a problem. In Table 1, respondents estimated the OR denial severity for their locations. Fourteen of 34 respondents (41%) who rated significance reported it to be a moderate or major issue.

Of the 37 respondents who reported OR denial concerns, 34 (92%) answered questions about possible causes. Thirty-one (84%) felt that medical staff appointment and privileges were not factors. Respondents reporting concerns most frequently reported smaller independent community hospitals (16/34, 47%) and large private hospital systems (15/34, 44%) as denying access (Figure 3).

The majority of respondents reporting concern stated that the most common reason for OR denial was financial (29/33, 88%) (Figure 4). Additionally, these respondents reported hospitals are not reimbursed adequately for dental cases (27/83%), dental cases conflict with more lucrative surgical cases (23/69%), and that the large number of Medicaid-funded dental cases result in lower reimbursement compared to private-pay non-dental surgical cases (23/69%). Fourteen of 29 respondents (48%) answering this question stated that anesthesiologists consider reimbursement for dental cases unacceptable. Ten of 26 respondents answering (38%) offered other reasons why dental cases are excluded, such as mission-driven health care, and dentistry's perceived marginal position within healthcare and its predominantly outpatient orientation. Less often stated reasons were that hospitals believe systemic illness and its treatment is their primary mission (4/34 or 12%), operating rooms are meant for general/medical specialty surgery (5/34 or 15%), and hospitals require medical surgeons to achieve mission-driven goals and thus give them priority access (7/34 or 21%).

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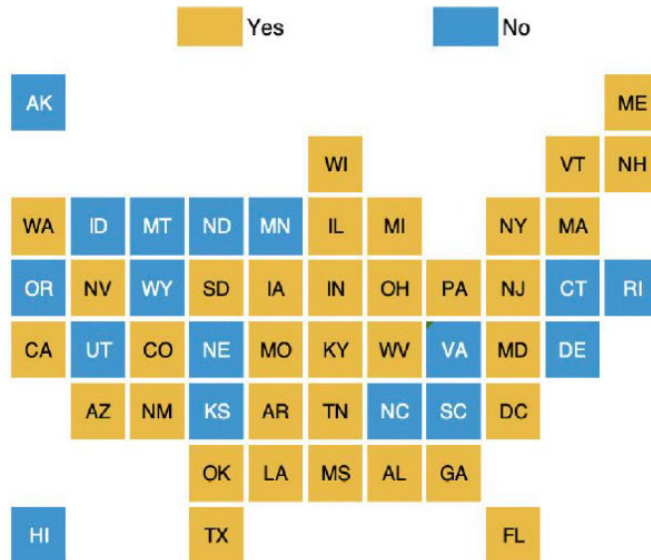
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Respondents were asked why else hospitals would deny pediatric dentists accessibility to ORs. Figure 5 indicates the majority (26/34, 76%) said little or no dental block assignment time was available overall, demand for OR time is high even among competing medical surgical specialties (23/34, 68%) and no excess or available time (e.g., non-block or competitive time) is accessible to pediatric dentists (68%). Coding decisions or errors may account for financial factors. Figure 6 shows reported coding issues that may contribute to low reimbursement and consequent denial of services.

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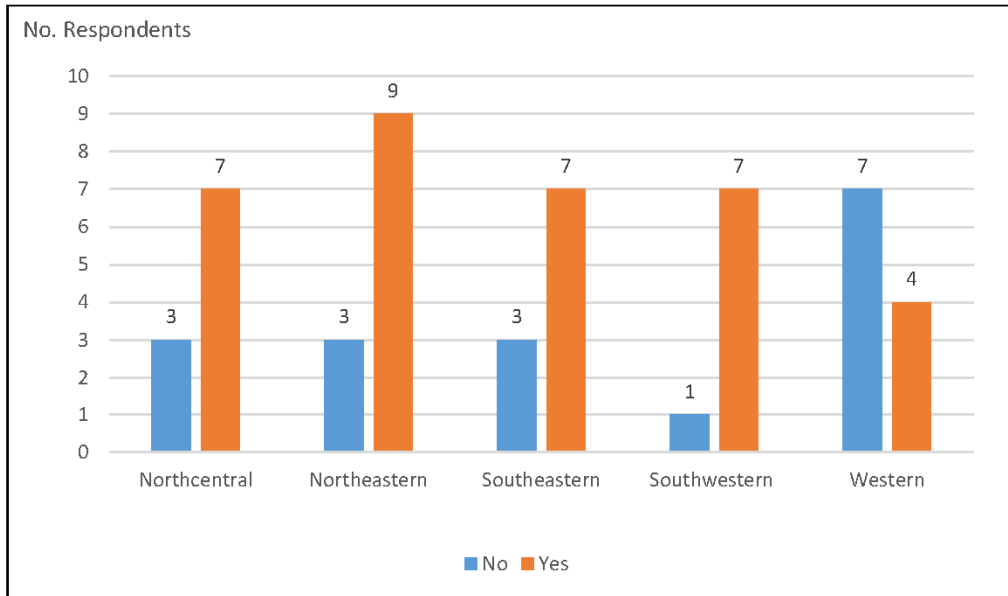
Figure 1. Distribution of Responses for Respondent Knowledge of Existence of OR Denial Awareness in States and District of Columbia



Legend: Fifty states and the District of Columbia responded (N= 51 or 100 percent) that a problem with OR access existed according to Public Policy Advocates or state pediatric dentistry leadership.

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Figure 2. Distribution of OR Denial Awareness by AAPD Districts



Legend: The bars indicate, by AAPD District, those state Public Policy Advocates (PPAs) who were aware of OR access problems (brown) or unaware (blue) in states within those districts.

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Table 1. Perceived Severity of the Problem of OR Denial by PPA Respondents

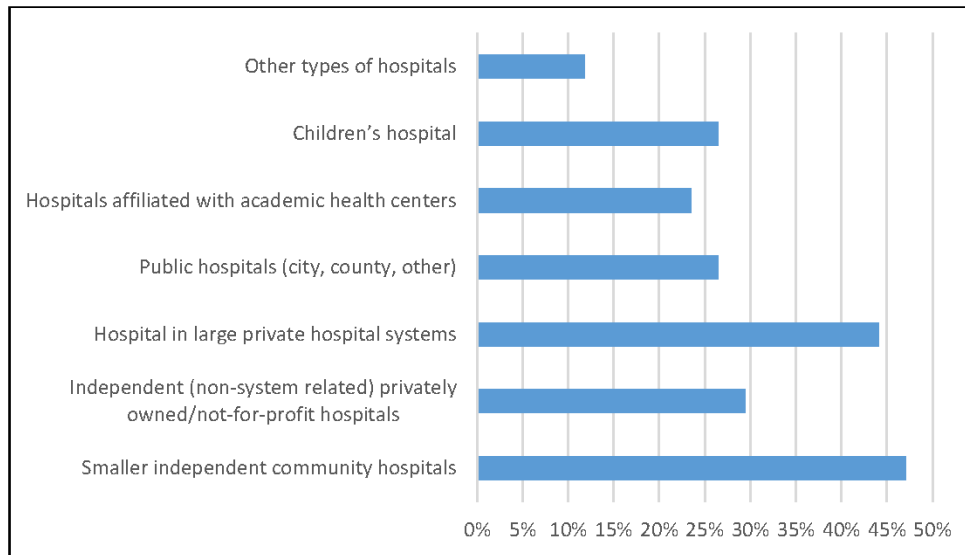
Region	Not issue at all	Minimal issue	Occasional issue	Moderately frequent issue	Major issue	Total
Northcentral	0	1	4	0	2	7
Northeastern	1	1	5	1	1	9
Southeastern	0	1	2	2	2	7
Southwestern	0	2	1	3	1	7
Western	0	1	1	0	2	4
TOTAL	1	6	13	6	8	34

Legend: Of the 51 PPA/state leaders responding, 34 stated a problem and these are distributed by AAPD District according to the perceived severity of the problem.

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Figure 3. Type of Hospital and Hospital System Reported to be associated with OR Denial

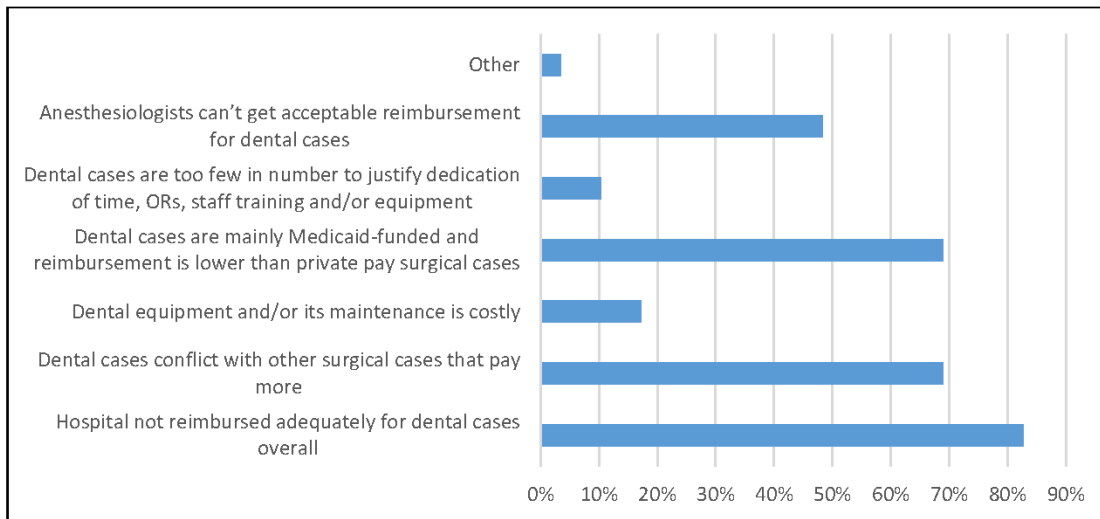


Legend: Of 51 respondents answering the questionnaire, 34 responded to this question and was the denominator of the percentages.

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Figure 4. Specific Perceived Financial Reasons for Excluding Pediatric Dentists from OR Access

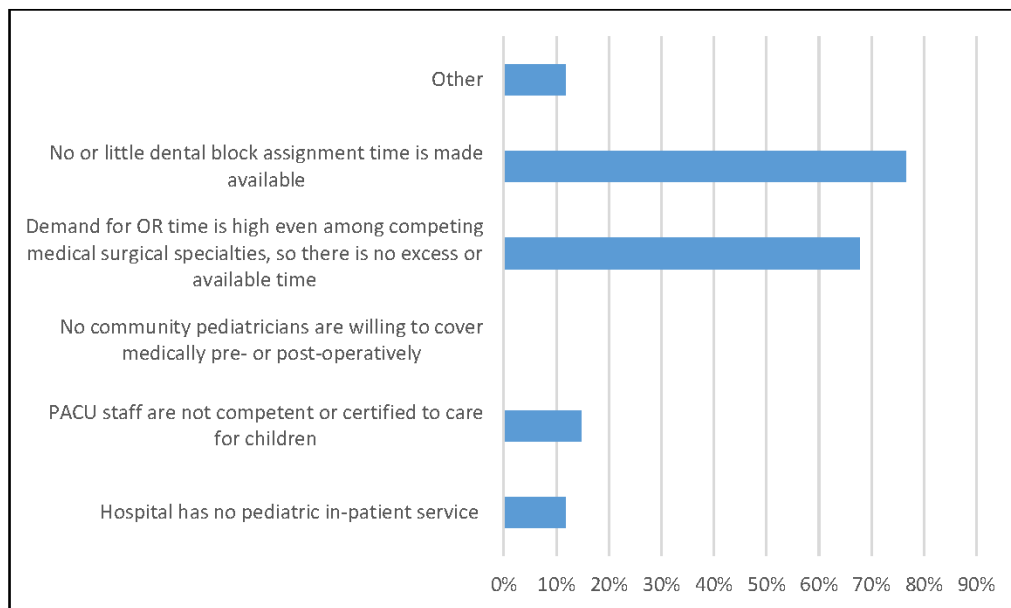


Legend: Of 51 respondents to the questionnaire, 29 responded to this question and was the denominator of the percentages.

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Figure 5. Other Perceived Factors that Limit Pediatric Dentists' Access to OR

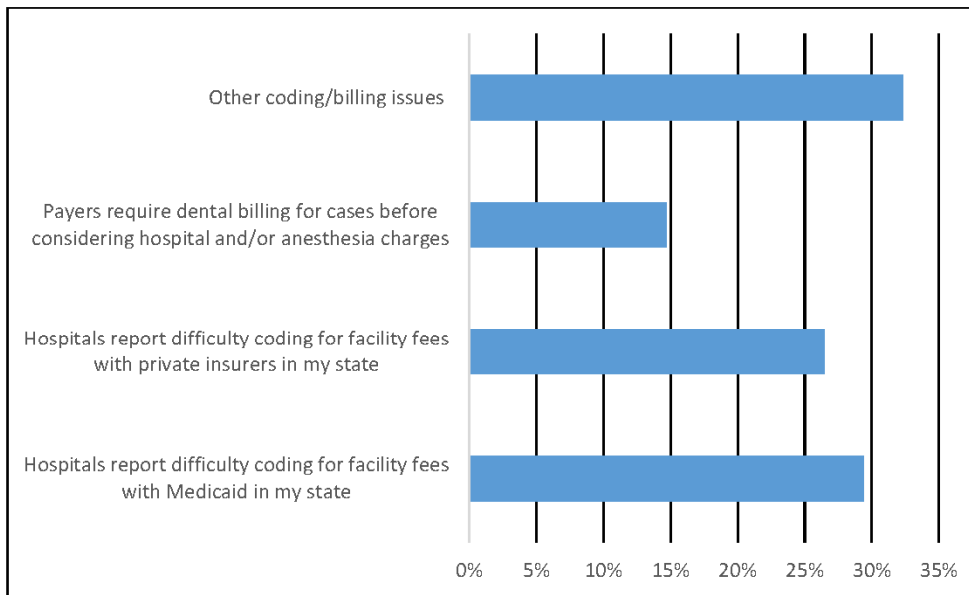


Legend: Of the 51 respondents who answered the questionnaire, 34 answered this question and was the denominator of the percentages.

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Figure 6. Perceived Coding or Billing Issues that Affect Pediatric Dentist OR Access



Legend: Of the 51 respondents who answered the questionnaire, 34 answered this question and was the denominator of the percentages.

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Chapter 4: Discussion

This study tried to validate and characterize anecdotal reports by US pediatric dentists on difficulties gaining access to hospital ORs. The results of this preliminary study, using key policy advocates in each state and DC as respondents, suggest a pervasive problem. The implications of this trend are serious and result in: (1) failure to provide significant MNC for dental disease in young children and persons with special health care needs, (2) forcing dental GA treatment into surgery centers and dental offices lacking emergency and supportive medical services found in hospitals, and (3) relegating dentists to use physical restraint for dental treatment, risking patient and provider injury and families' refusal of care. All of these can worsen oral health status of children. Of note is the extent of the problem, with almost three-quarters of PPAs voicing concern in their respective states.

The denial of access to ORs is largely perceived as a monetary issue driven largely by hospitals. Various financial challenges to the health care system, from closing of hospitals to hospital business decisions to bolster revenue by shaping case mix to maximize income contribute to this problem. The reality is that while the bottom line is critical to hospital health and survival, national variability suggests that some hospitals better accommodate dental treatment in the OR. On the other hand, the hospital system has for decades relied upon surgical service revenue to support less profitable, but perceived necessary, services considered a part of comprehensive healthcare.¹⁴ The homeostatic economic position of many hospitals is challenged by reduced payment for services, increased competition for OR time, and inappropriate use of emergency departments, among others.¹⁴ Dental care, perceived as a peripheral health service, as reported by respondents in this study, and one which is often challenged to pay its way, is often first to be eliminated in both ambulatory and surgical arenas during budgetary stress.

The COVID-19 pandemic has exacerbated the problem of OR access for dental GA. Hospitals have reduced volumes in most services, voluntarily reduced elective surgeries, and mandated testing of surgical patients. Reopening ORs for elective cases

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after the pandemic pits general surgeons against pediatric dentists, both of whom may have backlogs of surgical patients. Hospitals must decide priorities, and factors including revenue lost to the pandemic, future revenue needs, current financial commitments, mission-driven priorities, and potential loss of surgeon base if time is given to dentists, all work against access for dental cases.

Limitations of this study include potential for recall bias, incomplete or inaccurate information, and personal preferences of PPAs rather than actual statewide occurrence. The length of time respondents have resided in their state and held their current roles suggest that information should be current and representative. The specific nature of the questions and derivation from previous anecdotal reports might also be considered a limitation.

Our results suggest common themes, provide a national map of prevalence, and direct future studies. A future report will detail comments in terms of etiologies and possible solution strategies. The comments of respondents, though not reported here, offer a pathway for further research and homing in on possible strategies to ameliorate this public health problem which, like the COVID-19 pandemic, disproportionately affects poor and minority children covered by Medicaid. Lobbying efforts should aim for solutions that engage all involved in the care of children under GA -- hospitals, anesthesiologists, pediatricians, dentists, and payers-- to ensure safe and accessible care.

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Chapter 5: Conclusions

1. Access to ORs by pediatric dentists in hospitals has become a problem in the majority of US states, affecting the ability of pediatric dentists to treat young children with early childhood caries and children and adults with special health care needs.
2. Dentists perceive hospitals play the major role in determining access to GA care in the OR for pediatric dentists and are driven by financial factors to deny use of ORs. Fee increases may be necessary to make dental cases competitive and should be part of policy initiatives.
3. Financial considerations, among hospitals as well as anesthesiologists are perceived to be the major factor in denial of OR access for pediatric dentists and until reimbursement is improved, this problem will continue.

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Department of Health Care Services Medi-Cal Dental Program General Anesthesia Report

Reporting Period: Calendar Year 2020

Published Date: February 2022

Scope and Methodology

Pursuant to Welfare & Institutions Code Section 14132.915(a)(3)(F) and (j)(3), general anesthesia (GA) utilization is based on Medi-Cal members who required and received GA services for dental procedures through Medi-Cal dental and medical delivery systems. Medi-Cal dental is administered through two delivery systems – Fee-for-Service (FFS) and Dental Managed Care (DMC). A Medi-Cal member can receive GA either through a dental office visit for an authorized dental procedure that requires GA and is billed through dental claims, or through a hospital visit for emergency room, inpatient, and outpatient dental services that require GA and are billed through medical claims. This report captures GA requests and utilization for Medi-Cal members whose provider's oral health treatment planning included approved treatment authorization requests (TAR) for GA in dental offices, during Calendar Year (CY) 2020 (January 1, 2020 through December 31, 2020). Members who received GA are captured by dates of service in CY 2020 in both dental offices and hospitals settings and sorted by dental delivery system and age groups: children ages 0-20 and adults age 21 and older.

GA services billed through dental and medical claims are identified by the Current Dental Terminology (CDT) codes and Current Procedural Terminology (CPT) codes outlined below. Medi-Cal providers have six (6) months from the TAR approval date to render the service and one year from the date of service to submit the claim to Medi-Cal for reimbursement. Therefore, the number of TARs approved is higher than the number of services rendered for the same period, as time is needed for rendering services and processing for payment.

CDT Codes: D9220, D9221, D9222, and D9223. Note, the CDT 2020 code updates replaced D9220 and D9221 with D9222 and D9223 effective March 2020, which cover the first 30 minutes and the subsequent 15 minutes of GA.

CPT Codes: 00170 and 41899 are used to identify GA services in medical claims. CPT 00170 is the anesthesia on mouth for CDT procedures (D0100-D9999) and CPT 41899 is for dental surgery.

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CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES



CY 2020 GA Results

Number of Members	FFS Children (Age 0-20)	FFS Adults (Age 21+)	DMC Children (Age 0-20)	DMC Adults (Age 21+)
Approved TARs for GA	49,326	21,188	3,516	1,616
Received GA in a dental office	31,624	12,359	2,503	597
Received GA in a hospital	3,866	632	89	26

Data Source: DHCS Dental Fiscal Intermediary Data Warehouse and DMC Annual Reports as of December 2021 for dental TARs approved in CY 2020 and claims with date of service CY 2020. DHCS MIS/DSS Data Warehouse as of December 2021 for medical claims with date of service CY 2020.

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STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

October 23, 2013

The Honorable Edward J. Kasemeyer
Chair
Senate Budget & Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

**Re: 2013 Joint Chairmen's Report (p. 75) – Report on Pediatric Restorative Dental
Surgery and Analysis of Rates for Anesthesia Services**

Dear Chairmen Kasemeyer and Conway:

In keeping with the requirements of the 2013 Joint Chairmen's Report (p. 75), enclosed is the Department of Health and Mental Hygiene's (DHMH) report on pediatric dental surgery and payment rates for related anesthesia services. The committees requested that DHMH report to the budget committees on (1) the utilization of pediatric restorative dental surgery for fiscal years 2006-2013 by facility; (2) an analysis of the rates for anesthesia services performed in connection to pediatric restorative dental surgery compared to rates paid by Medicare and commercial payors; and (3) a justification for why Medicare rates should be considered the benchmark for Medicaid anesthesia rates. The language requesting the report withholds a \$100,000 appropriation made for the purpose of administration pending submission of this report.

Thank you for your consideration of this information. I respectfully request that the funds withheld pending submission of this report be released. If you have questions or need more information on the subjects included in this report, please contact Marie Grant, Director of Governmental Affairs at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Chuck Milligan
Tricia Roddy
Marie Grant
Patrick Dooley
Simon Powell

Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.maryland.gov

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**Report on Pediatric Restorative Dental Surgery
and Analysis of Rates for Anesthesia Services**

Submitted by
**The Maryland Department of Health
and Mental Hygiene**

2013 Joint Chairmen's Report, p. 75

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Executive Summary

Promoting the health and well-being of all children in Medicaid is one of the primary goals of the Maryland Department of Health and Mental Hygiene (the Department). The Department recognizes that high-quality dental care is an important contributor to children's overall well-being. Under Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, dental care is a mandated health benefit for children under 21 years of age. DentaQuest, an administrative services organization (ASO), provides dental coverage in the Maryland Medicaid program. DentaQuest began administering the dental benefit package in July 2009.

One of the mandated dental services under EPSDT is restorative dental surgery. The goal of pediatric restorative dental surgery is "to repair or limit the damage from caries, protect and preserve the tooth structure, reestablish adequate function, restore esthetics (where applicable), and provide ease in maintaining good oral hygiene."¹ Although this procedure is preventable, children need to be able to access this in a timely manner, if warranted, in order to maintain good health.

At the conclusion of the 2013 legislative session, the Senate Budget and Taxation Committee and the House Appropriations Committee requested that the Department provide a report on the utilization of pediatric dental surgery. Data were requested for fiscal year (FY) 2006 through FY 2013² by both facility and payer source, as well as the reimbursement rates for anesthesia services for pediatric restorative dental surgery, compared with rates paid by Medicare and commercial payers. The committees also requested that the Department justify why Medicare rates are the benchmark for Medicaid anesthesia rates (as they are for other physician service rates in Medicaid) given that Medicare uses a different methodology to reimburse anesthesia services than it does to reimburse other physician services. The Committees requested that the Department detail the advantages and disadvantages of using a different benchmark.

In addition to performing the requested analyses, the Department also compared Maryland Medicaid's reimbursement rate for anesthesia to that of surrounding states' Medicaid programs. To provide the reader with a framework for the consideration of increasing rates or retaining the current Maryland Medicaid rates, this report describes background information on coverage and payment of dental services by Medicare and Medicaid in Maryland as well as the neighboring Medicaid programs of Delaware, Pennsylvania, Virginia, West Virginia, and the District of Columbia. This report discusses practitioners' concerns with these methodologies and presents a trend analysis of findings relative to the utilization of pediatric dental surgery for FYs 2006 through 2012.

The Maryland Society of Anesthesiologists has expressed concern that anesthesiologists are not being fairly compensated when they provide services to Medicaid enrollees receiving dental services in hospital operating rooms (ORs), and that access is compromised as a result. Other stakeholders have suggested that hospitals are limiting operating space for these Medicaid dental

¹ American Academy of Pediatric Dentistry. (2012). *Guideline on pediatric restorative dentistry*. p. 214-221.

² Not all FY 2013 claims and encounters have been received; managed care organizations are allowed up to six months to submit an encounter or claim.

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cases, thereby creating an additional access challenge. Changing anesthesiologist payment rates or the methodology, however, will not impact the Medicaid facility fee paid to hospitals. The Department, based on the facility rates set and regulated by the Health Services Cost Review Commission (HSCRC), reimburses hospitals separately. Some dentists have suggested that Medicaid should begin paying a facility rate at freestanding ambulatory surgery centers (ASCs) for dental procedures in order to open a new source of access. Currently, Medicaid reimburses ASCs for other medical procedures but not for dental procedures. As a matter of emphasis, paying a facility rate at ASCs for dental procedures does not impact the rate at which anesthesiologists are compensated; again, the facility fee paid to the site and the professional fee paid to the anesthesiologist are two distinct fees.

Interviews were conducted with neighboring Medicaid programs to determine rates for the anesthesia services for dentistry in hospital settings. While Maryland's rate is about 76 percent of Medicare rates, it is higher than the Medicaid rates in all of the neighboring jurisdictions that responded to the Department's request for information (the District of Columbia, Pennsylvania, and Virginia).

The Department conducted an analysis of the overall volume of the dental anesthesia procedures by year. The number of Medicaid enrollees using this service increased the most for enrollees younger than six years, meaning that the number of Medicaid children using oral anesthesia for restorative dentistry has increased. The number of minutes of anesthesia per user also increased, which indicates that patients are undergoing longer dental procedures under anesthesia. Both the number of Medicaid enrollees receiving this service and the number of units per user peaked in FY 2009 and FY 2011, respectively, and the number of units per user declined somewhat in FY 2012. Nonetheless, the number of Medicaid enrollees receiving this service increased over 9 percent annually since FY 2006. The number of units per user increased 4.8 percent per year over the utilization rate in FY 2006.

The decline in the number of recipients and the number of units in FY 2012 may reflect a reduced demand for dental surgery due to increased access to preventive dental care. The Department made a number of changes to the Medicaid program in FY 2009 with the goal of increasing access to dentists. Specifically, \$14 million in total funds were used to increase reimbursement for some dental procedures—mainly preventive ones.³ The Department's initiatives resulted in more dentists seeing Medicaid patients. In 2009, only 893 dentists billed Medicaid for any service, whereas in 2012, 1,293 dentists billed Medicaid for any service. Still, although this marks a significant increase, fewer than half of the dentists in Maryland see Medicaid enrollees.

Prior research suggests that better insurance coverage for preventive care may lead to a reduced need for dental surgery. A study of Medicare patients⁴ found that participants who visited the dentist for regular preventive care were less likely to visit the dentist for non-preventive procedures. They also mentioned that those who use preventive care were far more likely to have

³ In 2004, 12 restorative codes were targeted for a fee increase as well. The Department also made incremental improvements prior to 2009.

⁴ Moeller, J. F., Chen, H., & Manski, R. J. (2010). Is preventive dental care a good investment for the Medicare population? A preliminary analysis. *American Journal of Public Health*, 100(11), 2262-2269.

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dental insurance coverage than those who do not. One study⁵ found that preventive dental visits reduced subsequent use of non-preventive dental services among children enrolled in the Children's Health Insurance Plan (CHIP), and another study⁶ found that having preventive dental visits by age 1 reduced the future use of non-preventive or emergency dental services. Meyerhoefer and colleagues⁷ found that having dental insurance coverage increases the probability of using both preventive and restorative dental care, but the increase in preventive care use (19 percent) is larger than that of basic (11 percent) and major (16 percent) restorative care use.⁸

The overall medical acuity of the population using this service, as measured by the distribution of beneficiaries by their Adjusted Clinical Group (ACG) scores,⁹ remained approximately constant, and the percentage of users who are enrollees in either long-term services and supports (LTSS) waivers or the Rare and Expensive Case Management (REM) program declined slightly. This means that participants receiving this procedure were not appreciably sicker, medically, in 2011 than they were in 2006. However, the ACG system is not meant to measure the acuity of enrollees' dental needs.

While the growth in volume and intensity of pediatric dental surgery is apparent, the Department was not able to conclusively determine whether actual, previously unmet dental needs are driving this increased utilization.

Key Findings

Highlights from this report include:

1. **Fees.** Maryland Medicaid's fee-for-service (FFS) anesthesia rates are higher than all neighboring state Medicaid programs that responded to the Department, but are below Medicare and commercial rates. The Maryland Medicaid FFS program reimburses about 76 percent of Medicare rates for Current Procedural Terminology (CPT) code 00170. All HealthChoice managed care organizations except for Priority Partners pay the same as FFS Medicaid; Priority Partners pays only slightly more than Medicaid FFS. Commercial insurance anesthesia rates may be as much as twice as high as Medicare rates.
2. **Utilization.** The number of Medicaid recipients receiving this procedure grew at an average annual rate of 9.2 percent from FY 2006 to FY 2012, so if the rates are considered to be below other payers, there have been more services at this rate. Looking at growth in

⁵ Sen, B., Blackburn, J., Morrissey, M. J., Kligore, M. L., Becker, D. L., Caldwell, C., & Menachemi, N. (2013). Effectiveness of preventive dental visits in reducing nonpreventive dental visits and expenditures. *Pediatrics*, 131, 1107-1113.

⁶ Savage, M., F., Yee, J., Kotch, J. B., & Vann, W. F. (2004). Early preventive dental visits: Effects on subsequent utilization and costs. *Pediatrics*, 114(4), e418-423.

⁷ Meyerhoefer, C. D., Zuvekas, S. H., & Manski, R. (2013). The demand for preventive and restorative dental services. *Health Economics*, DOI: 10.1002/hec.2899.

⁸ Basic restorative services include fillings and extractions. Major restorative services include crowns and root canals.

⁹ ACG scores are a measure of medical severity used to set rates for HealthChoice enrollees and used to prospectively predict utilization of medical services for all enrollees. The Hilltop Institute performed this analysis for HealthChoice, Primary Adult Care, and FFS users of the procedure.

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utilization by age, children aged one to five years were the fastest growing group and represent more than half of the total users of CPT code 00170. As the utilization rates by REM and LTSS waiver populations have grown more slowly than the general population, growth in the volume of anesthesia services is not being driven by populations that are often more difficult to treat. Volume grew in each year from FY 2006 to FY 2011 and declined slightly in FY 2012. The volume of commercial insurance claims for this CPT code declined slightly from FY 2009 to FY 2011, a period during which Medicaid volume was increasing.

3. **Intensity.** The average number of minutes per claim has grown significantly. This could indicate that enrollees are receiving more complex dental services in ORs. For CY 2011, private claims had an average duration of 52.9 minutes, compared to 64.8 minutes for Medicaid enrollees in FY 2011. The number of units per Medicaid claim grew significantly from FY 2006 to FY 2010; it declined in FYs 2011 and 2012.
4. **Hospital variation.** The volume of claims differs among individual hospitals. Shady Grove Adventist Hospital, the top biller in FY 2012, increased its volume of claims for CPT code 00170 much faster than the University of Maryland, which has historically maintained a high volume. The University of Maryland (less James Kernan hospital) was the second-largest biller for CPT code 00170 in FY 2012, and Kernan was the third largest. Users of CPT code 00170 are more medically complex than the average Medicaid enrollee. However, users of CPT code 00170 have maintained approximately the same level of medical complexity from FY 2006 to FY 2012 (i.e., the increase in utilization does not appear to be driven by increasing medical complexity).
5. **Literature.** A review of academic literature indicated that preventive dental visits did reduce the subsequent use of restorative and emergency dental services among children enrolled in Medicaid and CHIP. Maryland had an increase in enrollees receiving preventive/diagnostic dental services over the study period.
6. **Hospital OR restrictions.** Dentists believe that hospital restrictions on OR time may limit access to restorative oral surgery. Some dentists have been told that hospitals would prefer to book higher-revenue services in the OR. But some anesthesiologists claim that the hospital fees are not the issue; rather, these anesthesiologists suggest that anesthesiologists have argued against scheduling time for dental procedures because they result in lower fees for anesthesiologists. The HSCRC regulates the rates charged for hospital clinic services. Hospitals are assigned a per-minute clinic OR rate for all surgical procedures that occur in the clinic. A complex surgical procedure, therefore, is assigned more minutes, which translates to greater revenue. A similar methodology is applied to outpatient surgeries performed in hospital operating rooms. All outpatient surgeries are assigned a single OR rate. The rate will vary based on the amount of time required to perform the surgery. Complex surgical procedures that take the same amount of time to perform would not vary by compensation.
7. **Anesthesiologist input.** Anesthesiologists interviewed by the Department believe that low Medicaid anesthesia rates, when compared to other payers in Maryland, limits access. Raising these rates would support the notion of participation by anesthesiologists, but because facilities are reimbursed separately, changes in anesthesia rates by themselves are unlikely to encourage hospitals to schedule more OR time for dental surgery.

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8. **Dentist input.** Some dentists expressed a desire to operate on patients who needed oral surgery under anesthesia in ASCs. They feel that doing this would reduce their backlog. Presently, ASCs do not receive a facility fee from Medicaid, and they have not been willing to take Medicaid patients for these procedures. Of the 233 ASCs currently participating in Medicaid, currently seven perform dental cases for other payers who reimburse for dental procedures in ASCs.

Recommendations

The issues surrounding dental cases in the hospital ORs are complex and require more than one solution. The Department's multi-pronged recommendations are outlined below.

- **Increase the Medicaid rate for CPT code 00710 to 100 percent of Medicare.** The rate for anesthesia should be raised to promote fairness and access. Therefore, Medicaid recommends raising the rate to 100 percent of Medicare. The estimated cost to increase the rate for CPT code 00710 is \$475,818 (Total Funds). The Department does not recommend exceeding the Medicare payment rates for many reasons: CMS regulates Medicaid payments to certain institutional providers using Medicare payment principles, MedPAC reports annually on the adequacy of the Medicare payment rates to Congress, and even Congress uses Medicare as the benchmark when targeting Medicaid physician fee increases. Additionally, the GAO did not find a correlation between the variance in Medicare's rates and commercial payer rates and the supply of anesthesiologists. Based on these reasons, the Department recommends increasing the rate paid for CPT code 00710 to the Medicare rate.
- **Recommend that hospitals offer OR block times for dental cases.** According to providers, hospitals do not block time for dental cases. As a result, dentists are struggling to find OR time. Some suggest that hospitals are not scheduling dental services because other procedures that generate more revenue. The HSCRC regulates the rates charged for hospital clinic services. Hospitals are assigned a per-minute clinic OR rate for all surgical procedures that occur in the clinic. A complex surgical procedure, therefore, is assigned more minutes, which translates to greater revenue. A similar methodology is applied to outpatient surgeries performed in hospital operating rooms. All outpatient surgeries are assigned a single OR rate. The rate will vary based on the amount of time required to perform the surgery. Complex surgical procedures that take the same amount of time to perform would not vary by compensation. Given how the HSCRC regulates OR rates, the Department recommends that hospitals start blocking time for dental OR cases. This will provide dentists with set operating times and reduce the need to scramble to find OR times that are not regularly available.
- **Establish a facility rate to pay ASCs for dental cases.** By establishing a facility rate to pay ASCs for dental cases, the number of sites where dentists may perform OR procedures will increase, which reduces pressure on hospitals. The Department will implement this recommendation in a budget neutral way -- the facility rate will be set lower than the hospital facility rate in order to offset an increase in utilization. Of the 233 ASCs currently participating in Medicaid, 7 perform dental cases for other payers who reimburse the ASC for performing dental procedures. Combined with the recommendation that hospitals block OR time for dentists, this recommendation should

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shorten the existing wait time for dental OR cases. It should be noted, however, that most ASCs would need to purchase and install the necessary equipment for dental surgical procedures; simply establishing a rate by itself is not the only access issue to address regarding ASCs.

- **Continue to improve access to dental care.** Research shows that improving access to preventive dental care reduces the need for non-preventive procedures. Based on this research, the downward utilization trend in FY 2012 for CPT code 00170 might be caused by the result of additional enrollees receiving access to preventive dental care rather than an inability to access services. The Department recommends continuing to make investments that result in overall improvement in access to preventive dental care.
- **Require hospitals to report stipends paid to hospital-based physicians.** The Department is working with the HSCRC to determine the amount of stipends paid by hospitals to anesthesiologists primarily for the larger billers of dental OR cases. The results of this survey are not complete and, as a result, it is not possible to draw any definitive conclusions at this time. The Department recommends that the HSCRC reiterate its request and also expand the data requested from the hospitals to include all physicians and not just anesthesiologists. Further, the Department recommends that the HSCRC request this data annually as part of a standard reporting requirement. Although the HSCRC does not regulate physician services, it does consider the overall financial health of the hospitals—including unregulated services—when determining rate increases. All payers should be aware of these subsidies because such subsidies affect the analysis of the proper reimbursement rates for providers.

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Background

In 2007, the Secretary of the Maryland Department of Health and Mental Hygiene (the Department) convened the Dental Action Committee (DAC), a broad-based group of stakeholders, to develop strategies to improve children's access to dental services. Dental care providers believe that Medicaid faces barriers to access, such as low reimbursement rates causing few providers to participate in Medicaid, enrollees missing appointments, and lack of enrollee awareness of the benefits of basic oral hygiene.

Prior research suggests that better insurance coverage for preventive care may lead to a reduced need for dental surgery. One study¹⁰ found that preventive dental visits reduced subsequent use of non-preventive dental services among children enrolled in the Children's Health Insurance Plan (CHIP), and another study¹¹ found that having preventive dental visits by age one reduced the future use of non-preventive or emergency dental services. Meyerhoefer and colleagues¹² found that having dental insurance coverage increases the probability of using both preventive and restorative dental care, but the increase in preventive care use (19 percent) is larger than that of basic (11 percent) and major (16 percent) restorative care use.¹³ Therefore, it is in Maryland's interest to ensure that children have dental insurance and that they receive regular preventive dental care early.

The DAC recommended that dental homes be established for all eligible children, which would connect children to a dentist who would provide comprehensive and ongoing dental services. The DAC also recommended enhancements to education, outreach, dental public health infrastructure, provider participation, and provider scope of practice. The DAC was originally established by the Department, but it has since secured independent funding, transitioned to 501c(3) status, established numerous external partnerships, and renamed itself the Maryland Dental Action Coalition (MDAC).¹⁴

One major MDAC recommendation was to initiate a single, statewide dental administrative services organization (ASO) from a single vendor. This would enable smooth claims processing and give dental providers a single point of contact. The Department awarded a contract to DentaQuest, which began managing services and processing claims in July 2009. The Medicaid dental program has been renamed Maryland Healthy Smiles. Dentists report general satisfaction with the new ASO and that the pre-authorization process is easier to navigate.

¹⁰ Sen, B., Blackburn, J., Morrissey, M. J., Kligore, M. L., Becker, D. L., Caldwell, C., & Menachemi, N. (2013). Effectiveness of preventive dental visits in reducing nonpreventive dental visits and expenditures. *Pediatrics*, 131, 1107-1113.

¹¹ Savage, M., F., Yee, J., Kotch, J. B., & Vann, W. F. (2004). Early preventive dental visits: Effects on subsequent utilization and costs. *Pediatrics*, 114(4), e418-423.

¹² Meyerhoefer, C. D., Zuvekas, S. H., & Manski, R. (2013). The demand for preventive and restorative dental services. *Health Economics*, DOI: 10.1002/hec.2899.

¹³ Basic restorative services include fillings and extractions. Major restorative services include crowns and root canals.

¹⁴ Report on the Fiscal 2014 State Operating Budget (HB 100) and the State Capital Budget (HB 101) and Related Recommendations, §M00Q01.01

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The DAC also recommended that the State increase its dental reimbursement rates to the 50th percentile of the American Dental Association (ADA) South Atlantic regional charges, indexed to inflation, for all dental codes. In the absence of Medicare rates for dental services, the Department determined that the ADA survey represents a reasonable proxy for benchmark rates and agreed to the recommended charges at the 50th percentile. Previously, the State's rates were generally at or below the 25th percentile of the ADA South Atlantic regional charges, with a number of procedures falling below the 10th percentile.¹⁵ The Governor's fiscal year (FY) 2009 budget included \$7 million in general funds (\$14 million in total funds) for this rate increase effective July 2008. Subsequent planned rounds of rate increases have been delayed due to budget cuts.

These and other improvements have been effective at increasing enrollee access and enhancing provider experience with the Medicaid dental program. In 2010 and 2011, the Pew Center on the States named Maryland a national leader in improving dental care access for Marylanders with low income—especially those who are Medicaid-eligible or uninsured. As the only state to meet seven of the eight dental policy benchmarks, Maryland was ranked first in the nation for oral health.¹⁶ Most of these indicators are measures of preventive dental services. Table 1 shows the number of Medicaid enrollees aged 0 to 20 years by region, the number of dentists billing Medicaid by region, and the ratio of enrollees per dentist from calendar year (CY) 2008 to CY 2012. As the number of enrollees has increased, so too has the number of dentists participating, resulting in a gradual decrease in the number of enrollees per dentist from CY 2008 to CY 2012. The number of enrollees per dentist has increased in the Eastern Shore, however.

Table 1. Number of Medicaid Enrollees Aged 0-20 Years, Number of Dentists Billing Medicaid, and Number of Enrollees per Dentist, by Maryland Region, CY 2008-CY 2012

	Region	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Enrollees	Western Maryland	41,793	44,147	47,291	48,836	49,968
	Baltimore Metro	254,243	267,676	282,794	293,445	300,394
	Southern Maryland	24,743	26,742	28,477	29,906	30,744
	Eastern Shore	51,022	53,867	56,359	58,280	59,301
	Montgomery/Prince George's	154,306	168,530	181,762	194,380	204,020
	Other (e.g., out-of-state)	863	1,057	1,354	1,360	1,135
	Total	526,970	562,019	598,037	626,207	645,562
Dentists Billing Medicaid	Western Maryland	84	81	101	119	126
	Baltimore Metro	346	362	437	450	465
	Southern Maryland	34	35	47	49	52
	Eastern Shore	71	68	69	72	72
	Montgomery/Prince George's	286	288	356	413	451
	Other (e.g., out-of-state)	10	59	111	122	125
	Total	831	893	1,121	1,225	1,291

¹⁵ Centers for Medicare and Medicaid Services. (2010). *State of Maryland: Dental program review*.

¹⁶ Pew Center on the States. (2011). *The state of children's dental health*. Retrieved July 15, 2013, from http://www.pewstates.org/uploadedFiles/PCS_Assets/2011/The_State_of_Childrens_Dental_health.pdf

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	Region	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Enrollees per Dentist	Western Maryland	497.5	545.0	468.2	410.4	396.6
	Baltimore Metro	734.8	739.4	647.1	652.1	646.0
	Southern Maryland	727.7	764.1	605.9	610.3	591.2
	Eastern Shore	718.6	792.2	816.8	809.4	823.6
	Montgomery/Prince George's	539.5	585.2	510.6	470.7	452.4
	Other (e.g., out-of-state)	86.3	17.9	12.2	11.1	9.1
	Total	634.1	629.4	533.5	511.2	500.0

Even with these improvements, concerns about access do remain, and one of the concerns that stakeholders have raised is the low reimbursement rate for anesthesiologists providing services during dental procedures. Anesthesia is usually applied during restorative dental procedures.

Restorative dental surgery is surgery performed to restore diseased, injured, or abnormal teeth to normal function. The objectives of restorative treatment are to “repair or limit the damage from caries, protect and preserve the tooth structure, reestablish adequate function, restore esthetics (where applicable), provide ease in maintaining good oral hygiene, and maintain pulp vitality whenever possible.”¹⁷ Children who are from families with low income, who live in rural areas, who are of minority ethnicity, or who have poor access to dental care are at increased risk for dental caries that require restorative dental procedures. These children are also more likely to have diets that are high in sugar, which also places them at increased risk.

In addition, many children with special health care needs require restorative dentistry. The American Academy of Pediatric Dentistry (AAPD) defines special health care needs as “any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs.”¹⁸ Individuals with special health care needs may be at increased risk for oral disease throughout their lifetime. The Maryland Family Access Initiative Report, published in 2007,¹⁹ estimated that 15.2 percent of children in Maryland had special needs, which was higher than the national average of 12.8 percent. It can be difficult for families with children with special needs to find dental services equipped to care for them. Because these children often do not understand how to cooperate with the practitioner or because they require extensive dental work, they frequently require some sort of sedation. The AAPD recommends that general anesthesia, deep sedation, or conscious sedation be considered when patient mental status or age precludes cooperation or when the procedure is complex.²⁰

As noted earlier, Maryland Medicaid reimbursement rates for 12 dental codes were increased to the ADA’s 50th percentile of charges by dentists in the South Atlantic region for 2007. The targeted dental codes were mostly preventive codes, and the rate increase went into effect in FY

¹⁷ American Academy of Pediatric Dentistry. (2012). *Guideline on pediatric restorative dentistry*. p. 214-221.

¹⁸ American Academy of Pediatric Dentistry. (2012). *Guideline on management of dental patients with special health care needs*. 152-157.

¹⁹ Bronheim, S., Thomas, J., & McKay, K. (2007). *Families report on the state of the state*. Maryland Consortium for Children with Special Health Care Needs. Retrieved from <http://marylandcoc.com/uploads/SOS.pdf>

²⁰ Glassman, P. (2009). A review of guidelines for sedation, anesthesia, and alternative interventions for people with special needs. *Specialty Care Dentist*, 29(1), 9-16.

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2009. Since the rate increase, the percentage of enrollees receiving preventive visits increased from 50.1 percent in CY 2008 to 60.8 percent in CY 2011. The percentage of enrollees receiving restorative services increased from 21.3 percent in CY 2008 to 25.1 percent in CY 2011.

Nonetheless, stakeholders have raised concern that barriers to access to dental care in hospital operating rooms (ORs) remain.²¹ Anesthesiologists claim that low Medicaid reimbursements create the barrier to hospital care. The Department generally uses the Medicare fee schedule to establish its fees. Anesthesiologists claim that Medicare has historically undervalued anesthesia, reimbursing anesthesiologists at only 33 percent of private insurance rates.²²

On the other hand, dentists interviewed by the Department said that the barrier to hospital care is that hospitals are limiting OR availability for Medicaid patients. Interviewees felt that dentists are experiencing long wait times to access hospital ORs for both privately insured and Medicaid patients. Dentists have been told that hospitals do not want to offer block time for dental cases, regardless of payer, because there are other surgeries that bring in more profit for the hospitals. But some anesthesiologists claim that the hospital fees are not the issue; rather, these anesthesiologists suggest that anesthesiologists have argued against scheduling time for dental procedures because they result in lower fees for anesthesiologists. Referring patients to ambulatory surgery centers (ASCs), however, will not solve the problem. First, doing so does not address the anesthesiologist reimbursement concerns. Similarly, the long wait times for Medicaid patients cannot be alleviated by taking them to ambulatory surgery centers (ASCs), unlike with privately insured patients. Unlike with commercial payers, ASCs do not receive a facility fee for Medicaid dental cases and therefore are unwilling to accept patients with this coverage. There is also a concern that ASCs do not currently have the proper equipment for dental surgeries and that they may not want to make the investment. Of the 233 ASCs currently participating in Medicaid, seven perform dental cases for other payers who cover the ASC site for dental procedures.²³

How Medicare and Maryland Medicaid Formulate Reimbursement Rates for Medical Anesthesia Services

Maryland's Medicaid anesthesia reimbursement is based on the Medicare reimbursement methodology, although its calculation is slightly different. Medicare anesthesia payments are determined by four variables:

²¹ Maryland Department of Health and Mental Hygiene. (2012). 2012 Annual Oral Health Legislative Report as Required by Health-General Article, Sections 13-2504(b) and 13-2506 and HB 70 (Ch. 656 of the Acts of 2009). Retrieved from <http://phpa.dhmdh.maryland.gov/oralhealth/Documents/Maryland's%202012%20Annual%20Oral%20Health%20Legislative%20Report.pdf>

²² T. Sophocleus, Letter to Charles J. Milligan, Jr., May 21, 2013.

²³ The Department conducted a phone survey. Approximately 25 ACSs did not respond or call back.

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- The time required to provide anesthesia is converted to time units. In Medicare and in most state Medicaid programs, one time unit represents 15 minutes of anesthesia, although providers can bill for fractional units.²⁴
- Each service also has an associated number of base units, which reflect the difficulty of each procedure. The American Society of Anesthesiologists determines base units.
- Medicare sets regional rates, called conversion factors, for anesthesia services. These account for regional differences in the cost of providing services.
- Each procedure may also have one or more modifiers that may affect payment (e.g., for medical direction of a certified registered nurse anesthetist (CRNA)). Modifiers can be cumulative.

The Medicare payment is calculated as follows: (Time units + Base units) * Medicare conversion factor * Modifiers = Anesthesia payment.

Maryland Medicaid anesthesia time units are measured in 1-minute increments; Medicare anesthesia units are measured in 15-minute increments. Maryland also has a single, statewide conversion rate for anesthesia services (slightly different rates are provided for some anesthesia services). Because Medicare units are in 15-minute increments, the value of the base units is multiplied by 15 prior to adding the time units to calculate payments in fee-for-service (FFS) Medicaid claims. Otherwise the Maryland Medicaid anesthesia payment methodology is calculated identically to Medicare.²⁵

More complex cases that require additional time are increased at a higher rate under the methodology because the reimbursement methodology accounts for minutes the patient spends under the anesthesiologist's care. Additionally, the Department pays anesthesiologists less if they are medically directing two to four cases at once. The anesthesiologists claim, however, that these dental cases require more of their attention, and that they should be paid commensurate to the additional effort required.

The hospitals are compensated separately based on the facility rates established and regulated by the Health Services Cost Review Commission (HSCRC). The Department does not currently allow dentists and anesthesiologists to perform dental procedures in ASCs. In order to do this, the Department needs to develop the rates to pay ASCs for these procedures.

How Maryland Medicaid Reimbursement Compares with Surrounding States' Medicaid Programs and Medicare

During the period covered by this study, anesthesia for pediatric oral surgery rendered in a hospital was covered by FFS Medicaid through a carve-out (i.e., anesthesiology services for HealthChoice and FFS enrollees were all covered by FFS Medicaid). DentaQuest was only responsible for the dentists' own services. Managed care organizations (MCOs), in turn, made contracted payments to physicians providing these anesthesia services outside of the dental

²⁴ Government Accountability Office. (2007). Medicare physician payments: Medicare and private payment differences for anesthesia services. Retrieved from <http://www.gao.gov/new.items/d07463.pdf>

²⁵ COMAR 10.9.02

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health carve-out, which is funded from the MCO's capitation payments. (As of January 1, 2013, however, payment for anesthesia services related to dental procedures became included in the dental health carve-out and is paid for under the FFS program.²⁶)

The Current Procedural Terminology (CPT) code 00170 covers anesthesia for intraoral procedures, including biopsy. It cannot be rendered by a dentist; it must be delivered by either a physician anesthesiologist or a CRNA.

The American Society of Anesthesiologists has assigned base units to most CPT anesthesia codes. The base units reflect the difficulty of providing the anesthesia service and of pre- and post-operative care.²⁷ The Centers for Medicare and Medicaid Services (CMS) generally uses these base units and has assigned CPT code 00170 five anesthesia base units.²⁸ Maryland Medicaid FFS reimburses the CPT code 00170 at a rate of \$1.1486 per unit regardless of facility. MCO reimbursements for this code were as follows:

- Amerigroup Community Care reimbursed at a rate of \$1.1486 per unit and had been doing so from 2008 until January 1, 2013. Amerigroup uses one minute per time unit.
- Jai Medical Systems reimbursed at \$1.21 for dates of service July 1, 2006, and June 30, 2009, and \$1.15 for dates of service between July 1, 2009, and January 1, 2013. Jai uses one minute per time unit.
- Maryland Physicians Care reimbursed at \$1.2027 per unit for dates of service between January 1, 2008, and June 30, 2009, and at \$1.1486 per unit for dates of service from July 1, 2009, to January 1, 2013. Maryland Physicians Care uses one minute per time unit.
- MedStar Family Choice reimbursed according to Medicaid's methodology and rates.
- Priority Partners reimbursed participating providers at a rate of \$13.85 per unit for dates of service between May 1, 2004, and June 30, 2006; \$18.00 per unit for dates of service between July 1, 2006, and June 30, 2008; and \$18.04 per unit for dates of services between July 1, 2008, and January 1, 2013. This works out to \$1.203 per unit when denominated into one-minute increments. Priority Partners uses 15 minutes per time unit.
- United Healthcare reimbursed at a rate of \$1.15 per unit from July 1, 2008, until January 1, 2013. United uses one minute per time unit.

State Medicaid officials in the District of Columbia, Delaware, Pennsylvania, Virginia, and West Virginia were surveyed to determine their anesthesia rates. The Hilltop Institute calculated Medicare and other state payments for a 60-minute anesthesia session without modifiers to demonstrate the variances in anesthesia reimbursement amounts across the neighboring states and the Medicare program. Although West Virginia responded, it did not provide a fee for CPT

²⁶ Maryland Department of Health and Mental Hygiene, Maryland Medical Assistance Program, Dental Transmittal #45, December 20, 2012.

²⁷ American Society of Anesthesiologists. (2013). *Aetna anesthesia updates*. Retrieved from <http://www.asahq.org/For-Members/Advocacy/Office-of-Governmental-and-Legal-Affairs/Aetna-Anesthesia-Updates.aspx>

²⁸ Centers for Medicare and Medicaid Services. (2013). *2013 Anesthesia base units by CPT code*. Retrieved from <http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html>

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code 00170. In Delaware, anesthesia services are packaged under a prospective payment system and cannot be individually priced.

Table 2A shows the conversion rates for each state compared to the Medicare conversion rates for each state (or the most expensive area of the state in Maryland and Pennsylvania) using a 15-minute unit. In 2012, the average anesthesia claim for CPT code 00170 was 63 minutes. Table 2B shows the total payment for a 60-minute anesthesia session with no modifiers. Based on the formula used to calculate modifiers—(Time units + Base units) * Medicaid fee = Anesthesia payment—a 60-minute visit without any modifier would cost \$155.06 (i.e., $(60+75)*\$1.1486=\155.06).

**Table 2A. Anesthesia Conversion Factor Comparison for CPT Code 00170
(Does Not Include Base Units)**

State	Medicaid Conversion Rate for 15-Minute Unit	State Medicare Conversion Factor	Percentage of Medicare
MD	\$17.23	\$23.10 (Baltimore City and surrounding counties)	74.6%
DC	\$5.00	\$23.68	21.2%
DE	Anesthesia services packaged under DE Outpatient Prospective Payment System	\$21.66	N/A
PA	\$15.66	\$23.54 (Philadelphia)	66.5%
VA	\$12.84	\$21.34	66.2%
WV	State unable to release rate	\$21.74	N/A

Table 2B. Anesthesia Payment Comparison for CPT Code 00170

State	Medicaid Payment for 60-Minute Session	Medicare Payment for 60-Minute Session
MD	\$155.06	\$207.90
DC	\$45.00	\$213.12
DE	N/A	\$194.94
PA	\$140.94	\$211.86
VA	\$115.56	\$192.06
WV	NA	\$195.66

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Maryland's anesthesia rate is lower than the Medicare rate but greater than the Medicaid rates in other states that responded to the Department's survey.

In FY 2012, Maryland spent an estimated \$1,396,652 in total funds on anesthesia services for CPT code 00170. Raising the base rate to Medicare's base rate would increase Medicaid's spending by about 25.4 percent. The total spending on CPT code 00170 would become \$1,872,470, an increase of \$475,818.

How Maryland Medicaid Reimbursement Compares to Private Insurance Reimbursement

Stakeholders suggested that the Department contact FAIR Health as part of the data analyses. FAIR Health maintains a large data base of commercial claim transactions amounting to over 17 billion medical services. The data are available to various interest groups and is broken down into several modules. Each module offers providers billing charges by CPT code and geozip, which is arrayed in percentiles. FAIR Health advised the Department that typically its anesthesia module sells for \$30,000 to \$50,000. FAIR Health offered to sell the Department a custom data set at a reduced rate, although the custom data cost was quoted at roughly \$10,000. Unfortunately even the reduced price of FAIR Health's product is cost prohibitive for the Department. The Department did, however, work with the Maryland Health Care Commission (MHCC) to understand the amount reimbursed by commercial payers to anesthesiologists in Maryland for restorative dental surgery cases.

According to the MHCC and the Government Accountability Office (GAO),²⁹ private payers calculate anesthesia reimbursements using broadly similar methods as Medicare and Maryland Medicaid. Commercial insurers may negotiate rates with individual anesthesiologists and practices in response to market forces, such as the prevalence of managed care in the area and how many competing anesthesiologists there are in an area. Some private insurers do allow higher payments for certain factors, like extremes in patient age. According to the MHCC, payers in the commercial market paid an estimated average of \$52.86 per unit for CPT code 00170 in 2011, using 15-minute increments to measure time units. This estimate was derived by dividing the total reported reimbursement for all procedures with the above code by the number of total time and base units reported. Because some of these procedures would have been delivered under medical direction or by CRNAs, the actual average unit rate could be somewhat higher.

Table 3. Estimated Payment per Unit of Anesthesia, CY 2009-CY 2011

	CY 2009	CY 2010	CY 2011
Estimated Average Payment per Unit	\$46.10	\$48.88	\$52.86

Private payers reimbursing for CPT code 00170 also include 75 base units if measuring in 1-minute increments or 5 base units if measuring time in 15-minute increments. For a 60-minute session, commercial payers reimburse anesthesiologists approximately \$476 (\$52.86 * 5 base

²⁹ Government Accountability Office. (2007). *Medicare and private payment differences for anesthesia services*.

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units * 4 time units). As previously shown, Medicaid's reimbursement is roughly \$155, whereas Medicare's reimbursement is roughly \$208.

The GAO found that, in 2004, average Medicare payments to anesthesiologists for a set of seven services were 67 percent lower than average private insurance payments in 41 Medicare payment localities.³⁰ The GAO also determined that there was no correlation between the overall supply of anesthesia practitioners (that is, the total number of both anesthesiologists and CRNAs per 100,000 people). In reaching this conclusion, the GAO included in its analysis both the difference between Medicare and private insurance payments for anesthesia services as well as the concentration of Medicare beneficiaries in the Medicare payment localities.³¹

Provider Concerns with Medicaid Payments and Coverage Criteria

Different stakeholder groups have raised concern with the Department about access issues for pediatric restorative dental surgery. The Department first learned about the stakeholders' concerns during the 2013 legislative session. Two meetings were held between the Department and key stakeholders. Delegates Szeliga and Sophocleus attended as well as representatives from First Colonies Anesthesia Associates and others. The MHCC also contacted First Colonies Anesthesia to discuss the reimbursement issues, and the Department informally surveyed a number of dentists, who serve the Medicaid population.

Some anesthesiologists who corresponded with the Department have stated that reimbursement rates in the Maryland Medicaid program—combined with the complex nature of restorative dental surgery—limit their revenue. In their opinion, the low reimbursement rates they receive are compounded by their inability to oversee multiple simultaneous procedures.

Medicaid's coverage criteria (not the payment rates) are also supported by the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations), the American Society of Anesthesiologists, and the AAPD. Private insurance guidelines for coverage of anesthesia for dental procedures may vary substantially. One article found that two national insurers, Aetna and Cigna, had slightly different coverage guidelines in 2008.³² For example, Aetna covered deep sedation or general anesthesia for children up to age 6 requiring complex dental repairs, while Cigna covered deep sedation or general anesthesia for all children aged 3 or younger. Cigna, but not Aetna, specifically covered individuals with developmental disabilities. The article also noted that some states specifically mandated coverage of anesthesia associated with dental services for children; at the time, Maryland mandated such coverage up to age 7. The Appendix details the coverage guidelines.

³⁰ Ibid.

³¹ Ibid.

³² Glassman, P. (2009). A review of guidelines for sedation, anesthesia, and alternative interventions for people with special needs. *Specialty Care Dentist*, 29(1), 9-16.

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The American Association of Oral and Maxillofacial Surgeons (AAOMS) recommends moderate to deep sedation or general anesthesia in the following circumstances:

- The mental status, age, or level of maturity of the patient precludes cooperation or prevents the oral and maxillofacial surgeon from performing the planned procedure in an optimal fashion.
- Reduction of pain and anxiety is required or recommended due to an underlying medical condition.
- The type, complexity, and expected duration of surgical procedures require anesthesia.
- The individual has conditions (e.g., inflammation and infection) in which regional (local) anesthesia may not achieve adequate pain control due to anxiety/fear.
- Understanding that pain may accompany the surgical procedure, the individual requests sedation or general anesthesia services to be provided to them during the surgical procedure.

In contrast to anesthesiologists (some of whom believe that low Medicaid reimbursement rates are limiting access), dentists interviewed by the Department believe that limited access is related to hospitals restricting OR time because of low revenue generated from these procedures. In an informal survey conducted by the Department's Office of Oral Health, several dentists and practice managers responded that they face long wait times for OR access. This situation results, in part, from hospitals assigning OR "block time" to practitioners who guarantee that they will supply a full schedule of patients during fixed blocks of time during the week. The dentists feel that dental patients must compete with other patients for any OR time that remains unscheduled after block times are filled.

One respondent reported that OR time for Medicaid patients was reduced by the hospital at which the dentists typically work. Another respondent also reported difficulty obtaining OR time. Others reported facing long waits at hospitals regardless of the insurer; two dentists reported a wait time of approximately six to eight weeks, while another dentist said he had a wait time of about four months. Some of the respondents speculated that their OR time has been reduced because dental cases are not very lucrative for hospitals, which would prefer to book more expensive procedures.

Multiple dentists surveyed expressed a desire to operate on Medicaid patients in ASCs. They—particularly those who already have established relationships with surgery centers for their privately insured patients—believe that having another venue for operating would help alleviate some of the backlog of procedures for Medicaid patients. The limiting factor for these dentists is that ASCs would need to be paid a facility fee by Medicaid for these dental procedures. However, even with this facility fee, some dentists expressed concern that ASCs will not invest in the proper equipment. On the contrary, another dentist said that equipping an ASC to do dental surgery may not be expensive.

In addition, the dentists with whom the Department corresponded suggested that it is not practical to provide deep sedation for pediatric patients in a dentist office instead of general anesthesia in a hospital. The AAPD 2012 practice guidelines recommend that at least three

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individuals be present during deep sedation, including the dentist. The AAPD recommended that one of these individuals be solely responsible for monitoring the patient's airway and vital signs, and that the other be trained in and capable of providing advanced pediatric life support and cardiopulmonary resuscitation in emergencies.³³ Maryland has codified these requirements with slight differences, specifying that there must be at least one individual trained in basic life support to assist the dentist and another individual trained in basic life support who is in close proximity to the surgery site.³⁴ The dentists suggested that staffing a dental office at this level is not practical.

Anesthesiologists' Compensation Compared to Dentists' Compensation

One of the concerns that stakeholders have raised is the low reimbursement rate for physician services that anesthesiologists receive. They noted that the rate paid for anesthesia for dental restorative care was not increased as the result of fee increases aimed at improving pediatric access to dental care. State-level data were not available for levels of compensation, but national and regional averages were available. According to the Medical Group Management Association (MGMA) 2011 Physician Compensation and Production Survey, anesthesiologists nationally made \$427,956 on average and dentists made \$202,390.^{35 36} Nationally, anesthesiologists in single-specialty practices had a median income of \$435,100, and those in multi-specialty practices had a median income of \$382,828. For dentists, the sample size for single-specialty practices was too small to report compensation, while dentists in multi-specialty practices had a median income of \$181,903. On average, anesthesiologists made more than twice as much as dentists did in 2011 nationally.

MGMA presented compensation levels based on four different regions in the United States. Maryland was included in the Eastern Region, along with Connecticut, Delaware, the District of Columbia, Maine, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, and West Virginia. The median income for anesthesiologists was \$420,155 in this region. The median income was \$427,000 for anesthesiologists in single-specialty practices and \$369,792 for multi-specialty practices. The median income for dentists in the Eastern Region was \$153,554, which was also reported for multi-specialty practice dentists. No data were reported on compensation for single-specialty practice dentists in the Eastern Region. In this region, anesthesiologists overall and in multi-specialty practice made over 2.7 times more in annual compensation than dentists.

MGMA also reported average compensation for Health and Human Services (HHS) Region 3, which includes Maryland, Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia. In HHS Region 3, anesthesiologists made \$395,776 in 2011, and dentists made \$153,554. In this region of the United States, anesthesiologists made 2.5 times more than dentists based on 2011 median income. No data were presented for Region 3 on the difference in

³³ American Academy of Pediatric Dentists. (2012). *Guideline on use of anesthesia personnel in the administration of office-based deep sedation/general anesthesia to the pediatric dental patient. Reference manual V34(6)*.

³⁴ COMAR 10.44.12.13

³⁵ Medical Group Management Association. (2012). *MGMA physician compensation and production survey: 2012 report based on 2011 data*.

³⁶ MGMA instructs respondents to include the following sources of compensation: salary, bonus and/or incentive payments, research stipends, honoraria, and distribution of profits.

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compensation between physicians in single-specialty and multi-specialty practices.³⁷ (See table below for a summary of salary information.)

Table 4. Median Annual Income, 2011

Region	Anesthesiologists	Dentists
Eastern Region (Maryland Connecticut, Delaware, the District of Columbia, Maine, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, and West Virginia)	\$420,155	\$153,554
Health and Human Services Region 3 (Maryland, Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia)	\$395,776	\$153,554

Source: Medical Group Management Association. (2012).

Anesthesiologists often receive subsidies from hospitals. However, these amounts are not captured when you compare payment rates, as noted in a GAO report entitled Medicare and Private Payment Differences for Anesthesia Services.³⁸ There is a survey being conducted by the HSCRC concerning what subsidies are paid to physicians, if any. The results of this survey are not complete and, as a result, it is not possible to draw any definitive conclusions at this time, although the Department recommends that the HSCRC gather these data on an annual basis.

Discussion of Medicare Reimbursement Methods to Calculate Anesthesia Rates

Some providers have indicated to the Department that they are not adequately reimbursed for CPT code 00170 in particular. They have indicated that they are not being adequately compensated for the complexity of the patients they are seeing.

However, the base rates, which account for the inherent complexity of each code, are set by CMS using, with some exceptions, the Relative Value Guide from the American Society of Anesthesiologists.³⁹ In addition, anesthesiologists are compensated for the entire time of the procedure. Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the OR or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient (that is, when the patient may be safely placed under postoperative care).⁴⁰ Therefore, anesthesiologists are compensated for the inherent complexity of the procedure through the base units, and they are compensated for the complexity

³⁷ MGMA notes that there were limitations to their data. The report was based on voluntary response primarily by MGMA-ACMPE member practices. Therefore, it may not be representative of all providers in medical practices. Additionally, state-level data were not available in the report, so no conclusions about compensation levels for anesthesiologists and dentists in Maryland can be drawn from what is presented above.

³⁸ Government Accountability Office. (2007). *Medicare and private payment differences for anesthesia services*.

³⁹ Ibid., p. 10.

⁴⁰ Centers for Medicare and Medicaid Services. (2013). *Medicare claims processing manual*. Chapter 12 - Physicians/nonphysician practitioners, section 50-G. Retrieved from <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

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of preparing and anesthetizing the patient through the number of time units. Out of 277 anesthesia procedure codes reimbursed by Medicare in 2012, 144 have base units equal to or less than that of code 00170, and 133 have higher base units than code 00170.

Medicare's payment methodology appears to represent a standard accepted by payers and the American Society of Anesthesiologists, which participates in the development and updating of Medicare payments. Most other Medicaid programs in neighboring states use the same method based on Medicare. Commercial payers in Maryland use the same base units that Medicare uses; however, the conversion rate differs across payers.

Why Does Maryland Use Medicare Rates as a Benchmark to Pay Providers?

Federal statutory requirements state that the methods and procedures for making provider Medicaid payments must assure that such payments are "consistent with efficiency, economy, and quality of care."⁴¹ CMS relies on this provision as a general authority to regulate state reimbursement methodologies.⁴² In particular, this provision is the basis for the upper payment limit (UPL) regulations, which require that Medicaid payments for a class of institutional providers not exceed, in the aggregate, the amount that would have been paid for comparable services under Medicare principles.

Additionally, the federal government established the Medicare Payment Advisory Commission (MedPAC) through the Balanced Budget Act of 1997. MedPAC is tasked with advising Congress on issues affecting the Medicare program, including access to care. Each year, MedPAC reports on Medicare payment issues and makes recommendations to Congress. A similar commission—the Medicaid and CHIP Payment and Access Commission (MACPAC)—was created to handle Medicaid issues in the Children's Health Insurance Program Reauthorization Act of 2009. The MACPAC was later expanded and funded through the Patient Protection and Affordable Care Act (ACA). As MACPAC is fairly new, it does not have the historical, in-house data that permits the same level of deep analysis that MedPAC has been able to generate. It should also be noted that when a payment increase is targeted by the ACA for evaluation and management codes by certain providers, the ACA resorts to the Medicare rates for those codes as the benchmark. Medicaid is required to reimburse those codes and providers at 100 percent of Medicare rates for at least two years. The federal government will pay 100 percent of the increase for those codes by the specified providers. Maryland elected to reimburse all providers billing to those codes. The additional funding required to include the other providers is supported with 50 percent state funds and 50 percent federal funds. Because CMS regulates Medicaid payments to certain institutional providers using Medicare payment principles, MedPAC reports annually on the adequacy of the Medicare payment rates to Congress, and even Congress uses Medicare as the benchmark when targeting Medicaid physician fee increases, it makes sense for Maryland and other states to not exceed the payment thresholds established by Medicare.

⁴¹ 42 CFR § 430.25(iv)

⁴² Congressional Research Service. (2004). *Medicaid reimbursement policy*. CRS report for Congress.

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Why Does Maryland Not Use Medicare Rates as a Benchmark to Pay Dentists?

Medicare does not offer dental benefits to its enrollees. As such, there are no established Medicare rates for dental procedure codes. Accordingly, the Department is not able to use the Medicare rates as a benchmark. So when the Department worked with the DAC in 2007, it sought to identify an alternative benchmark for rates. The American Dental Association (ADA) conducts a comprehensive survey of dental fees across the United States. The DAC recommended that we use this publication as a benchmark for Maryland Medicaid dental fees. The recommendation was to use the fees surveyed in the South Atlantic Region. Additionally, the DAC recommended the charges at the 50th percentile. In the absence of Medicare rates for dental services, the Department determined that the ADA survey represents a reasonable proxy for benchmark rates and agreed to the recommended charges at the 50th percentile.

The DAC recommended three phases to a fee increase. The Governor's fiscal year (FY) 2009 budget included \$7 million in general funds (\$14 million in total funds) for this rate increase effective July 2008. The other planned rounds of rate increases have been delayed due to budget cuts.

Dental Reimbursement Rates Compared to ADA Benchmark

As shown in Table 5, in FY 2009, fees for 12 targeted dental procedures were increased by an average of about 94 percent. The second-to-last column shows the median (ADA's 50th percentile)⁴³ of fees charged by dentists in 2007 in the South Atlantic region. The last column shows how the ADA fees have increased for these codes since 2007.

Table 5: Dental Procedures Targeted for Fee Increase in FY 2009

Proc Code	Description	MD (FY 08)	DC	PA	VA	MD (FY 09)	Benchmark (ADA/NDAS) 2007	Benchmark (ADA/NDAS) 2011
		State Medicaid Fees						
D0120	Periodic Oral Examination	\$15.00	\$35.00	\$20.00	\$20.15	\$29.08	\$35.00	\$42.00
D0140	Oral Evaluation-Limited-Problem Focused	\$24.00	\$50.00	N/A	\$24.83	\$43.20	\$52.00	\$65.00
D0145	Oral Evaluation, Patient < 3 Years Old	\$20.00	\$0.00	N/A	\$20.15	\$40.00	\$40.00	\$53.00

⁴³ The median (50th percentile) of charges in the South Atlantic region means that 50 percent of dentists in this region charge this amount or less. It is important to note, however, that the South Atlantic median is based on the charges by dentists for the services performed, which may not equate to the payments received as reimbursement from insurance companies, public agencies, or private pay patients.

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Proc Code	Description	MD (FY 08)	DC	PA	VA	MD (FY 09)	Bench-mark (ADA/NDAS) 2007	Bench-mark (ADA/NDAS) 2011
D0150	Comprehensive Oral Examination	\$25.00	\$77.50	\$20.00	\$31.31	\$51.50	\$62.00	\$73.00
D1110	Prophylaxis Adult 14 years and Over	\$36.00	\$77.50	\$36.00	\$47.19	\$58.15	\$70.00	\$80.00
D1120	Prophylaxis Child Up to Age 14	\$24.00	\$47.00	\$30.00	\$33.52	\$42.37	\$51.00	\$59.00
D1203	Topical Application of Fluoride, child (Exclude Prophylaxis)	\$14.00	\$29.00	\$18.00	\$20.79	\$21.60	\$26.00	\$30.00
D1204	Topical Application of Fluoride, adult (Exclude Prophylaxis)	\$14.00	\$26.00	N/A	\$20.79	\$23.26	\$28.00	\$31.00
D1206	Topical Fluoride Varnish	\$20.00	\$0.00	\$18.00	\$20.79	\$24.92	\$30.00	\$35.00
D1351	Topical Application of Sealant per Tooth	\$9.00	\$38.00	\$25.00	\$32.28	\$33.23	\$40.00	\$46.00
D7140	Extraction Erupted Tooth or Exposed Root	\$42.00	\$110.00	\$60.00	\$69.00	\$103.01	\$124.00	\$150
D9248	Non- Intravenous Conscious Sedation	\$0.00	\$0.00	\$184.00	\$110.00	\$186.91	\$225.00	N/A

Prior to the increase in FY 2009, the last increase in dental fees occurred in 2004, when the Department increased fees for 12 restorative dental codes. This means that for many codes, rates have not increased since 2004. For instance, the Department's fee for dental code D7240 (removal of impacted tooth – completely bony) is currently \$103.01. ADA's 50th percentile of charges for that code is \$435.

Anesthesiologist Fee Increases and Comparison to Medicare

In 2005, the Maryland General Assembly created the Maryland Health Care Provider Rate Stabilization Fund to deal with the rising premiums of malpractice insurance and to increase Medicaid physician rates. From the Rate Stabilization Fund, the Department increased physician fees in 2006 (\$30 million TF); 2007 (\$25.2 million TF); 2008 (\$32.8 million TF); and 2009 (\$31.7 million TF). In the 2007 physician fee increase, anesthesia procedures were targeted for an increase. The Department increased the procedures from an average of 48 percent of Medicare to 100 percent of Medicare. Due to a tight budget in recent years, the Department implemented physician fee cuts – \$11.5 million in FY 2010 and \$6.52 million in FY 2012.

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Anesthesia codes were decreased in FY 2010. Today, anesthesia codes are 76 percent of Medicare.

Anesthesia Utilization and Spending in Maryland Medicaid for Pediatric Dental Anesthesia

Methodology for Determining Pediatric Dental Surgical Anesthesia Utilization

Using the Medicaid Management Information System (MMIS2), the Department identified medical (e.g., physician) claims or encounters that contained CPT code 00170, anesthesia for intraoral procedures. The Department identified this code as the one used for pediatric dental anesthesia. This code may be billed by an anesthesiologist, a physician who has training in administering anesthesia, or a CRNA. Reimbursements to CRNAs are 100 percent of the calculated fee if the CRNA does not have medical supervision. When medical supervision is involved, the CRNA is reimbursed 50 percent of the calculated fee. CRNAs may practice without direct supervision, but an anesthesiologist, licensed physician, or dentist must be physically available to the CRNA for consultation at all times during the administration of and recovery from anesthesia.

To review the trends in the utilization of pediatric surgical anesthesia, the Department had to employ a matching methodology because CPT codes are not reliably included in the institutional records (CPT codes are always included in the medical records). If an individual had a medical service with this CPT code on the same day that he or she had an institutional service, it was assumed that the procedure was performed by that hospital.⁴⁴ This analysis was conducted for FY 2006 through FY 2012 and calculated the number of unique participants, total claims, and total units of anesthesia by the following characteristics:

- Individual hospital
- Eligibility group (i.e., families and children, Maryland Children's Health Program, aged/disabled)
- Participation in a special coverage category, which included the REM program, an LTSS waiver, or residence in an institution (these categories were used as an estimate of special health care needs)

After conducting the match, the Department tabulated total payments for each hospital. For FFS claims, the reported payment amount on the claim was counted. For managed care encounters, the payment had to be shadow-priced⁴⁵ from the Medicaid FFS physician fee schedule and the methodology for calculating anesthesia payments described above.

⁴⁴ Please note that this match is an estimate and could potentially over-count hospital services in instances where the medical record matches to more than one institutional record. It could also undercount in cases where there is a medical record but no corresponding institutional record.

⁴⁵ The analysis assumed that the MCOs paid the same rate for the service as the Medicaid FFS program did, as specified by the physician fee schedule.

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The Department was not able to conduct an analysis on FY 2013 utilization as the claims run-out period for this fiscal year is still ongoing. The Department did not receive data on Medicare utilization for this service.

Analysis of Utilization Trends for Individual Medicaid Participants

This section presents data on utilization between FY 2006 and FY 2012. Table 6 presents the number of unique Medicaid participants who had a service with CPT code 00170 in each year of the study period, along with the average growth rate during that seven-year period. Increases in the number of participants over this period were concentrated among children aged five years and younger.

**Table 6. Number of Unique Participants Using CPT Code 00170 by Age Group,
FY 2006-FY 2012**

Age (Years)	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Under 1	22	19	15	20	27	19	31	5.9%
01 – 02	476	534	593	620	761	836	856	10.3%
03 – 05	1,899	1,959	2,097	2,678	3,367	3,852	3,726	11.9%
06 – 09	1,214	1,178	1,313	1,686	1,843	1,964	1,814	6.9%
10 – 14	521	446	468	528	599	600	610	2.7%
15 – 18	250	229	267	289	295	255	315	3.9%
19 – 39	210	213	255	280	371	427	469	14.3%
40 – 64	129	133	128	149	189	191	195	7.1%
65 and over	35	23	23	26	36	37	30	-2.5%
Total	4,756	4,735	5,162	6,276	7,489	8,183	8,047	9.2%
Percentage of Total Medicaid Population Using CPT code 00170	0.57%	0.55%	0.59%	0.66%	0.72%	0.72%	0.67%	2.8%

Table 7 shows the average number of claims/encounters per participant in each year. Older adults had more claims/encounters per recipient, while children, especially those in the younger age groups, averaged 1.4 claims/encounters or fewer per user. From FY 2006 to FY 2012, there was a small increase in the average number of claims per recipient for those aged 15 to 18 years and a decrease in the average number of claims per recipient for those aged 1 to 2 years.

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Table 7. CPT Code 00170 Claims per Participant by Age Group, FY 2006-FY 2012

Age (Years)	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Under 1	1.1	1.2	1.3	1.2	1.4	1.2	1.1	0.0%
01 – 02	1.2	1.2	1.3	1.3	1.3	1.2	1.1	-1.4%
03 – 05	1.2	1.2	1.3	1.4	1.3	1.2	1.2	0.0%
06 – 09	1.2	1.2	1.3	1.3	1.3	1.3	1.2	0.0%
10 – 14	1.2	1.2	1.3	1.4	1.5	1.4	1.2	0.0%
15 – 18	1.2	1.3	1.3	1.4	1.5	1.5	1.3	1.3%
19 – 39	1.2	1.2	1.3	1.5	1.5	1.5	1.3	1.3%
40 – 64	1.4	1.3	1.4	1.5	1.6	1.5	1.6	2.3%
65 and over	2.0	1.7	1.8	2.0	2.1	2.0	2.3	2.4%
Total	1.2	1.2	1.3	1.4	1.4	1.3	1.2	0.0%

Table 8 presents data on the number of units billed per claim/encounter based on age group. All age groups except those under age one year saw an average increase in the number of anesthesia units billed to the Medicaid program. However, the number of units per claim/encounter seems to be declining for children in most age groups from a high point in FY 2009 or FY 2010 (depending on the age group). On average throughout the program, the number of billed units per procedure peaked in FY 2009 and declined over the next three years. It is difficult to determine whether the overall increase is medically appropriate without reviewing recipients' medical charts.

Table 8. Average Units of CPT Code 00170 Services per Medicaid Claim/Encounter by Age Group, FY 2006 to FY 2012

Age Years	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Under 1	24.5	31.2	38.9	40.7	57.9	30.4	18.1	-4.9%
01 – 02	43.9	41.1	46.0	57.5	62.1	59.2	57.0	4.4%
03 – 05	54.3	54.3	63.9	77.1	77.5	73.1	71.4	4.7%
06 – 09	45.1	48.3	56.9	70.9	63.1	62.1	60.1	4.9%
10 – 14	38.7	40.2	50.4	57.7	59.4	55.2	51.8	5.0%
15 – 18	42.2	46.3	45.4	64.5	63.1	60.7	52.1	3.6%
19 – 39	58.8	54.7	65.2	69.5	61.9	57.5	64.6	1.6%
40 – 64	49.1	52.4	50.2	36.5	42.5	39.6	59.7	3.3%
65 and over	40.5	49.1	17.2	22.0	16.4	22.4	49.1	3.3%
Total	48.3	49.4	57.2	69.5	68.0	64.8	63.9	4.8%

Table 9 presents the number of recipients who received anesthesia services based on their coverage category. It includes all ages. Participants in the Families and Children (FAC) coverage

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group had the highest use of anesthesia for restorative dental surgery and experienced the greatest amount of average growth over the seven fiscal years.

Table 9. Number of Unique Participants Using CPT Code 00170 by Coverage Group, FY 2006-FY 2012

Coverage Group	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Aged/Disabled	545	540	563	654	719	747	778	6.1%
FAC	3,003	2,959	3,320	4,249	5,517	6,134	6,038	12.3%
MCHP	1,187	1,210	1,258	1,355	1,220	1,280	1,194	0.1%
Other	21	26	21	18	33	22	37	9.9%
Total	4,756	4,735	5,162	6,276	7,489	8,183	8,047	9.2%

Table 10 presents the average number of claims/encounter per participant by coverage group. There was very little average growth in the number of claims/encounters per user between FY 2006 and FY 2012. For participants in FAC and MCHP, there was a slight increase in FY 2009 and FY 2010, followed by a decrease in FY 2011 and FY 2012.

Table 10. Average Claims per Participant Using CPT Code 00170 by Coverage Group, FY 2006-FY 2012

Coverage Group	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Aged/Disabled	1.3	1.3	1.4	1.4	1.4	1.4	1.3	0.0%
FAC	1.2	1.2	1.3	1.4	1.4	1.2	1.2	0.0%
MCHP	1.2	1.2	1.3	1.4	1.4	1.2	1.2	0.0%
Other	1.5	1.3	1.3	1.4	1.3	1.5	1.4	-1.1%
Total	1.2	1.2	1.3	1.4	1.4	1.3	1.2	0.0%

Table 11 presents the average number of units that were billed per claim/encounter. Over the seven-year period, both FAC and MCHP saw modest average increases. However, except for the “Other” enrollment group, which was very small, there was a high point in FY 2009 and FY 2010 across all categories followed by a decline in the subsequent two years in the number of anesthesia units billed.

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**Table 11. Average Units per CPT Code 00170 Claim by Coverage Category,
FY 2006-FY 2012**

Coverage Category	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Aged/Disabled	56.34	61.72	65.20	76.27	71.69	63.81	75.50	5.0%
FAC	48.53	49.90	58.39	69.42	67.98	65.53	62.86	4.4%
MCHP	44.55	43.15	50.80	67.21	66.72	63.00	60.95	5.3%
Other	16.13	23.56	17.48	18.35	27.93	30.21	62.59	25.4%
Total	48.33	49.40	57.16	69.54	67.98	64.85	63.93	4.8%

Table 12 presents the number of participants in special coverage categories using dental anesthesia services. In each of the special categories, the number of recipients who received anesthesia services grew more slowly or decreased in comparison with those who did not fall into that category. REM participants were a small proportion of the users of anesthesia services, experiencing continuous annual growth in utilization.

Those in LTSS waivers were also a small subset of the overall number of users. The number of users receiving anesthesia increased noticeably between FY 2007 and FY 2008 and increased slightly between FY 2008 and FY 2012 (with a decrease in FY 2011). Participants residing in institutions had fewer claims from FY 2006 to FY 2012, while those who were not in institutions experienced an increase in the number of anesthesia claims.

**Table 12. Number of Unique Participants Using CPT Code 00170
by Special Program Status, FY 2006-FY 2012**

Program Category	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Non-REM Participant	4,670	4,648	5,068	6,176	7,383	8,062	7,929	9.2%
REM Participant	86	87	94	100	106	121	118	5.4%
Total	4,756	4,735	5,162	6,276	7,489	8,183	8,047	9.2%
Non-LTSS Waiver Participant	4,633	4,610	5,006	6,111	7,322	8,029	7,881	9.3%
LTSS Waiver Participant	123	125	156	165	167	154	166	5.1%
Total	4,756	4,735	5,162	6,276	7,489	8,183	8,047	9.2%

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Program Category	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Non-Institutional Resident	4,637	4,628	5,015	6,151	7,381	8,078	7,969	9.4%
Institutional Resident	119	107	147	125	108	105	78	-6.8%
Total	4,756	4,735	5,162	6,276	7,489	8,183	8,047	9.2%

Table 13 shows the number of claims/encounters for each participant in FY 2006 through FY 2012 by special coverage category. REM participants experienced little change from year-to-year and did not have more than 1.2 claims per participant, on average, during the study period. Individuals in LTSS waivers also experienced little change in the number of claims per user, though in some years they had more claims per user than those in REM. Individuals in institutions experienced an increase in the number of claims per user and, in FY 2010, had more than two claims per user on average. It is possible that this population's access to preventive dental care may be more limited by residing in an institution, which results in more need for dental surgery.

**Table 13. Number of Claims/Encounters per Participant Using CPT Code 00170
by Special Program Status, FY 2006-FY 2012**

Program Category	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Non-REM Participant	1.2	1.2	1.3	1.4	1.4	1.3	1.2	0.0%
REM Participant	1.2	1.2	1.1	1.1	1.1	1.2	1.2	0.0%
Total	1.2	1.2	1.3	1.4	1.4	1.3	1.2	0.0%
Non-LTSS Waiver Participant	1.2	1.2	1.3	1.4	1.4	1.3	1.2	0.0%
LTSS Waiver Participant	1.2	1.3	1.3	1.4	1.4	1.3	1.2	0.0%
Total	1.2	1.2	1.3	1.4	1.4	1.3	1.2	0.0%
Non-Institutional Resident	1.2	1.2	1.3	1.4	1.4	1.2	1.2	0.0%
Institutional Resident	1.7	1.3	1.4	1.9	2.1	1.9	1.9	1.9%
Total	1.2	1.2	1.3	1.4	1.4	1.3	1.2	0.0%

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Table 14 presents data on the number of units of anesthesia billed per claim/encounter for those in special coverage categories, including individuals enrolled in the REM and LTSS waiver programs and individuals residing in institutions. Participants in REM experienced a small increase in the number of units billed over time, but the increase was not as large as it was for those who were not in REM. In each year studied, REM participants received a larger number of units of anesthesia than their counterparts who were not in REM. Those in LTSS waivers experienced a larger increase in the number of units billed per claim compared to those who were not in LTSS. Individuals residing in institutions experienced a decrease, on average, in the number of units billed, and they received fewer units of anesthesia than their peers who were not in institutions in FY 2009 through FY 2012. The greater number of units billed per claim for REM and LTSS patients seems to indicate that their physical status and complex medical needs are being taken into account and that anesthesiologists are being compensated more for these more complex cases.

**Table 14. Number of Units per CPT Code 00170 Claim/Encounter
by Special Program Status, FY 2006-FY 2012**

Program Category	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Average Annual Growth Rate, Percentage
Non-REM Participant	47.44	48.20	56.08	68.67	67.23	64.03	63.31	4.9%
REM Participant	94.73	115.50	125.11	136.52	133.75	121.10	104.42	1.6%
Total	48.33	49.40	57.16	69.54	67.98	64.85	63.93	4.8%
Non-LTSS Waiver Participant	48.24	48.70	56.47	69.36	67.91	65.16	63.62	4.7%
LTSS Waiver Participant	51.52	74.33	79.92	75.90	70.99	49.13	78.53	7.3%
Total	48.33	49.40	57.16	69.54	67.98	64.85	63.93	4.8%
Non-Institutional Resident	47.50	48.89	56.89	70.05	68.21	65.24	64.19	5.1%
Institutional Resident	71.28	69.09	65.45	51.44	57.67	44.34	47.07	-6.7%
Total	48.33	49.40	57.16	69.54	67.98	64.85	63.93	4.8%

Table 15 highlights the types of dental procedures being performed in hospital ORs. Typically dentists perform multiple procedures or a full mouth restoration while the individual is under anesthesia. Also, the table highlights the Maryland Medicaid fee for the procedures and how the fees compare to the ADA's 2011 50th percentile of charges.

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Table 15. Top Dental Procedures Performed In Hospital ORs, FY 2012

Procedure Code	Description	MD Medicaid Fee	ADA 50th percentile, 2011 South Atlantic Region Charges	Percentage of ADA 50th percentile
D2930	PREFAB STAINLESS STEEL CROWN, PRIMARY	\$154.00	\$241.00	64%
D7140	EXTRACTION,ERUPTED TOOTH OR EXPOSED ROOT	\$103.01	\$150.00	69%
D2392	RESIN-BASED COMPOSITE-TWO SURFACES,POSTE	\$120.00	\$195.00	62%
D2391	RESIN-BASED COMPOSITE-ONE SURFACE,PROSTE	\$93.00	\$152.00	61%
D3220	PULPOTOMY-THERAPEUTIC(EX FINAL RESTORA)	\$60.00	\$169.00	36%
D2335	RESIN, 4 OR MORE SURFACES OR INCISAL ANG	\$151.00	\$259.00	58%
D0240	X-RAY INTRAORAL OCCLUSAL SINGLE	\$9.00	N/A	N/A
D0272	X-RAY BITEWINGS TWO FILMS	\$15.00	\$40.00	38%
D2330	RESTORATION COMPOSITE RESIN 1 SFC	\$84.00	\$140.00	60%
D3120	PULP CAP INDIRECT	\$15.00	\$65.00	23%
D0220	X-RAY INTRAORAL SINGLE	\$9.00	\$25.00	36%
D1351	SEALANT PER TOOTH	\$33.23	\$46.00	72%

Between FY 2006 and FY 2007, the payment rate for anesthesia increased from \$0.22 per unit to \$1.20 per unit. Then, in FY 2010, the payment rate per unit decreased slightly to \$1.15 per unit. Table 16 shows the changes in total estimated Medicaid spending for CPT code 00170 over the seven-year study period. Spending for managed care patients is estimated because the Department does not have access to MCOs' contracted payment rates to providers. Because of the extreme change in reimbursement levels compared to FY 2006, *the growth rate shown in the last column shows the average annual percentage growth from FY 2007 to FY 2012.* For the program as a whole, spending on CPT code 00170 increased at an average annual rate of 14.6 percent between FY 2007 and FY 2012. The rate of change in spending varies by age, coverage group, and county of residence, however.

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**Table 16. Total Spending for CPT Code 00170 Claims/Encounters
by Age, Coverage Group, and County, FY 2006-FY 2012**

	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Avg. Pct. Annual Growth FY 2007- FY 2012
Age (Years)								
00 - <1	\$673	\$2,859	\$2,225	\$2,956	\$4,563	\$2,742	\$3,332	3.1%
01-02	\$16,536	\$74,678	\$98,826	\$109,139	\$143,153	\$135,407	\$139,518	13.3%
03-05	\$68,863	\$308,264	\$374,018	\$571,078	\$704,609	\$707,112	\$687,753	17.4%
06-09	\$41,331	\$176,975	\$222,656	\$339,309	\$342,938	\$337,122	\$311,155	11.9%
10-14	\$17,989	\$61,253	\$73,311	\$95,657	\$115,373	\$100,679	\$96,554	9.5%
15 - 18	\$9,321	\$33,006	\$40,881	\$53,431	\$52,823	\$44,458	\$51,923	9.5%
19 - 39	\$10,988	\$31,053	\$41,990	\$57,187	\$66,511	\$71,514	\$76,332	19.7%
40 - 64	\$6,744	\$16,578	\$17,463	\$18,881	\$25,273	\$24,161	\$27,836	10.9%
65 and over	\$2,888	\$2,885	\$1,049	\$1,418	\$2,734	\$3,359	\$2,249	-4.9%
Coverage Group								
Aged/Disabled	\$29,583	\$83,859	\$97,921	\$129,079	\$134,037	\$129,994	\$135,406	10.1%
Families and Children (FAC)	\$104,923	\$444,099	\$567,316	\$844,717	\$1,080,072	\$1,071,739	\$1,052,981	18.8%
Maryland Children's Health Program (MCHP)	\$40,001	\$178,054	\$206,136	\$273,951	\$241,170	\$222,761	\$205,085	2.9%
Other	\$826	\$1,541	\$1,046	\$1,309	\$2,698	\$2,059	\$3,180	15.6%
County								
Allegany	\$7,530	\$39,458	\$39,381	\$37,496	\$34,021	\$38,560	\$28,820	-6.1%
Anne Arundel	\$11,848	\$39,824	\$58,368	\$117,742	\$114,613	\$109,363	\$106,239	21.7%
Baltimore City	\$38,443	\$128,018	\$142,809	\$205,929	\$231,618	\$223,236	\$211,328	10.5%
Baltimore County	\$24,398	\$98,186	\$115,032	\$154,815	\$192,157	\$181,103	\$180,965	13.0%
Calvert	\$2,385	\$9,361	\$9,734	\$12,316	\$17,200	\$18,824	\$17,368	13.2%
Caroline	\$2,260	\$7,960	\$6,223	\$11,153	\$7,520	\$12,732	\$10,123	4.9%
Carroll	\$4,424	\$19,330	\$21,620	\$34,776	\$43,480	\$29,301	\$32,673	11.1%
Cecil	\$3,330	\$25,137	\$26,247	\$45,393	\$53,123	\$62,959	\$45,230	12.5%
Charles	\$3,607	\$12,701	\$13,855	\$15,797	\$26,777	\$25,378	\$35,009	22.5%

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	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Avg. Pct. Annual Growth FY 2007- FY 2012
Dorchester	\$1,119	\$6,623	\$5,587	\$7,737	\$12,729	\$13,195	\$11,900	12.4%
Frederick	\$7,542	\$28,052	\$41,819	\$60,520	\$62,152	\$57,303	\$59,704	16.3%
Garrett	\$3,365	\$12,113	\$18,845	\$20,640	\$20,178	\$24,138	\$20,911	11.5%
Harford	\$5,851	\$35,452	\$48,873	\$44,718	\$51,615	\$48,045	\$52,961	8.4%
Howard	\$4,567	\$23,937	\$28,028	\$51,235	\$45,470	\$36,329	\$34,944	7.9%
Kent	\$806	\$3,081	\$3,135	\$4,111	\$3,346	\$4,636	\$4,692	8.8%
Montgomery	\$14,836	\$66,166	\$99,370	\$145,238	\$187,807	\$195,079	\$207,182	25.6%
Out of State	\$173	\$1,198	\$2,883	\$1,126	\$1,534	\$3,972	\$2,103	11.9%
Prince George's	\$17,653	\$63,790	\$87,323	\$144,633	\$199,032	\$186,752	\$189,006	24.3%
Queen Anne's	\$1,418	\$5,661	\$6,968	\$7,538	\$7,599	\$10,445	\$7,821	6.7%
Somerset	\$1,410	\$4,790	\$4,626	\$5,795	\$6,004	\$4,857	\$6,133	5.1%
St. Mary's	\$2,491	\$13,440	\$12,588	\$15,909	\$19,985	\$13,393	\$19,641	7.9%
Talbot	\$1,367	\$3,750	\$5,546	\$3,408	\$3,699	\$8,403	\$7,016	13.3%
Washington	\$8,717	\$39,419	\$48,554	\$64,457	\$76,587	\$84,633	\$76,263	14.1%
Wicomico	\$4,943	\$15,441	\$19,036	\$29,426	\$29,162	\$24,190	\$21,550	6.9%
Worcester	\$848	\$4,662	\$5,970	\$7,146	\$10,571	\$9,729	\$7,072	8.7%
Total	\$175,333	\$707,553	\$872,420	\$1,249,056	\$1,457,977	\$1,426,554	\$1,396,652	14.6%

Table 17 presents the information on spending for CPT code 00170 on a per participant basis. As with the data in Table 12, the annual growth rate is calculated from FY 2007 to FY 2012, because the large change in reimbursement during FY 2006 would distort the calculation. Spending per participant for all participants increased at an average annual rate of 3.0 percent between FY 2007 and FY 2012. The per participant growth rates were relatively similar among age groups, with the exceptions of declines in average spending for individuals younger than 1 year and for those aged 65 years and older. Spending increases were also similar for the major coverage groups of Aged and Disabled, Families and Children, and MCHP. Per participant spending changes varied more by geographic area, with some counties showing decreases in per participant spending and other counties with much higher than average rates of growth in such spending.

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**Table 17. Total per Participant Spending for CPT Code 00170 Claims/Encounters
by Age Group, Coverage Group, and County, FY 2006-FY 2012**

	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Avg. Pct. Annual Growth FY 2007- FY 2012
Age (Years)								
00 - <1	\$30.59	\$150.47	\$148.33	\$147.80	\$169.00	\$144.32	\$107.48	-6.5%
01 - 02	\$34.74	\$139.85	\$166.65	\$176.03	\$188.11	\$161.97	\$161.85	3.0%
03 - 05	\$36.26	\$157.36	\$178.36	\$213.25	\$209.27	\$183.52	\$184.19	3.2%
06 - 09	\$34.05	\$150.23	\$169.58	\$201.25	\$186.08	\$171.65	\$171.34	2.7%
10 - 14	\$34.53	\$137.34	\$156.65	\$181.17	\$192.61	\$167.80	\$157.51	2.8%
15 - 18	\$37.28	\$144.13	\$153.11	\$184.88	\$179.06	\$174.35	\$163.79	2.6%
19 - 39	\$52.32	\$145.79	\$164.67	\$204.24	\$179.27	\$167.48	\$162.41	2.2%
40 - 64	\$52.28	\$124.65	\$136.43	\$126.72	\$133.72	\$126.50	\$142.75	2.7%
65 - high	\$82.51	\$125.43	\$45.61	\$54.54	\$75.94	\$90.78	\$74.97	-9.8%
Coverage Group								
Aged/Disabled	\$54.28	\$155.29	\$173.93	\$197.37	\$186.42	\$174.02	\$173.38	2.2%
Families and Children (FAC)	\$34.94	\$150.08	\$170.88	\$198.80	\$195.77	\$174.69	\$173.93	3.0%
Maryland Children's Health Program (MCHP)	\$33.70	\$147.15	\$163.86	\$202.18	\$197.68	\$174.03	\$171.33	3.1%
Other	\$39.33	\$61.64	\$58.11	\$72.72	\$84.31	\$102.95	\$88.33	7.5%
County								
Allegany	\$46.48	\$228.08	\$195.93	\$189.37	\$200.12	\$198.76	\$173.61	-5.3%
Anne Arundel	\$36.57	\$154.96	\$188.28	\$266.99	\$233.43	\$176.11	\$177.66	2.8%
Baltimore City	\$41.38	\$148.34	\$171.44	\$195.94	\$185.29	\$175.91	\$173.36	3.2%
Baltimore County	\$37.71	\$153.42	\$172.72	\$205.32	\$196.68	\$177.03	\$176.04	2.8%
Calvert	\$30.58	\$148.59	\$126.42	\$135.34	\$134.38	\$136.41	\$131.58	-2.4%
Caroline	\$29.35	\$103.38	\$111.13	\$125.31	\$105.92	\$118.99	\$134.97	5.5%
Carroll	\$35.97	\$148.69	\$162.56	\$212.05	\$230.05	\$147.24	\$168.42	2.5%
Cecil	\$37.00	\$186.20	\$182.27	\$232.78	\$242.57	\$226.47	\$205.59	2.0%
Charles	\$30.06	\$145.99	\$173.19	\$179.51	\$226.92	\$162.68	\$213.47	7.9%
Dorchester	\$30.24	\$112.25	\$114.02	\$128.95	\$133.99	\$118.87	\$136.78	4.0%
Frederick	\$38.09	\$151.63	\$170.69	\$207.26	\$193.62	\$163.72	\$169.61	2.3%
Garrett	\$33.65	\$208.84	\$177.78	\$192.90	\$171.00	\$185.68	\$188.39	-2.0%
Harford	\$31.63	\$159.69	\$181.68	\$189.48	\$199.29	\$179.27	\$178.32	2.2%

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	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Avg. Pct. Annual Growth FY 2007-FY 2012
Howard	\$37.13	\$162.84	\$182.00	\$258.76	\$201.19	\$168.97	\$151.93	-1.4%
Kent	\$38.38	\$110.04	\$136.30	\$132.61	\$115.38	\$125.30	\$142.18	5.3%
Montgomery	\$33.95	\$142.60	\$168.14	\$202.56	\$217.62	\$187.22	\$187.33	5.6%
Out of State	\$28.83	\$171.14	\$411.86	\$187.67	\$153.40	\$209.05	\$140.20	-3.9%
Prince George's	\$36.85	\$130.18	\$174.30	\$204.57	\$216.81	\$187.69	\$179.83	6.7%
Queen Anne's	\$36.36	\$117.94	\$139.36	\$157.04	\$131.02	\$128.95	\$137.21	3.1%
Somerset	\$38.11	\$129.46	\$115.65	\$107.31	\$122.53	\$118.46	\$122.66	-1.1%
St. Mary's	\$26.22	\$111.07	\$114.44	\$125.27	\$121.86	\$107.14	\$137.35	4.3%
Talbot	\$36.95	\$110.29	\$154.06	\$113.60	\$115.59	\$109.13	\$123.09	2.2%
Washington	\$37.41	\$173.65	\$181.85	\$205.28	\$191.95	\$198.67	\$176.94	0.4%
Wicomico	\$32.74	\$107.98	\$114.67	\$130.78	\$116.18	\$116.30	\$114.02	1.1%
Worcester	\$30.29	\$119.54	\$132.67	\$134.83	\$127.36	\$135.13	\$112.25	-1.3%
Total	\$36.87	\$149.46	\$169.11	\$199.02	\$194.71	\$174.35	\$173.11	3.0%

Analysis of Service Utilization by Hospital Provider

Table 18 presents the number of claims/encounters for CPT code 00170 for the 20 hospitals that billed that code most frequently to the Medicaid program. Hospitals are presented in descending order based on the number of claims billed in FY 2012. In FY 2006, Shady Grove Adventist Hospital was the fourth highest biller of CPT code 00170. By FY 2012, Shady Grove was the most frequent biller of this service (billing for this service in FY 2012 was seven times higher than it had been in FY 2006). At its highest point, in FY 2011, Shady Grove billed 1,514 claims/encounters for that anesthesia service. However, in FY 2009, the Kernan Health System billed the most claims/encounters for this code out of all of the top twenty hospitals, with 1,544 claims.

Table 18. Top 20 Hospitals That Billed CPT Code 00170 by Number of Claims/Encounters, FY 2006-FY 2012

	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
	Total Claims	Total Claims	Total Claims	Total Claims	Total Claims	Total Claims	Total Claims
Shady Grove Adventist Hospital	177	322	420	546	1,219	1,514	1,251
All University of Maryland, including Children's Hospital	1,052	760	922	1,245	1,106	1,027	992
All Kernan Hospital	691	998	960	1,544	1,511	1,141	808
All Johns Hopkins Hospital	315	374	432	509	582	786	689
Franklin Square Hospital	98	213	295	437	422	447	350

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	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
	Total Claims	Total Claims	Total Claims	Total Claims	Total Claims	Total Claims	Total Claims
All Children's DC	48	324	290	157	568	424	291
Robinwood Surgery Center	1	0	35	232	234	260	268
Anne Arundel Medical Center	74	19	19	61	158	245	238
Western Maryland Hospital Center	0	0	0	0	118	376	207
All Greater Baltimore Medical Center	94	227	272	292	321	277	196
All Howard County General	132	153	234	297	365	319	176
Southern Maryland Hospital	80	93	89	77	141	161	170
Garrett County Hospital	127	29	141	149	184	188	160
All Mercy Medical Center	55	2	111	272	261	170	157
Sinai Hospital	21	37	43	64	109	146	150
Union Hospital of Cecil County	11	9	4	59	209	303	132
Chester River Hospital Center	46	40	60	32	38	80	126
All Holy Cross Hospital Units	34	48	80	120	134	168	116
Calvert County Memorial Hospital	5	43	76	100	148	150	112
St. Mary's Hospital	44	46	74	203	279	201	102
Sum of the Top 20	3,105	3,737	4,557	6,396	8,107	8,383	6,691
All Hospitals Claims During FY	4,508	5,197	6,102	8,065	9,805	9,744	8,014
Percentage of Claims in Top 20 Hospitals	68.9%	71.9%	74.7%	79.3%	82.7%	86.0%	83.5%

Table 19 shows the average rate of growth, by hospital, in billing CPT code 00170 from year to year and over the seven-year period. Shady Grove Adventist Hospital experienced the most growth in the claims/encounters billed out of the top 20 hospitals. Shady Grove Adventist Hospital's growth in billing this code is reflected in an increasing share of the market for providing these services. Shady Grove went from providing just under 4.0 percent of CPT code 00170 services in FY 2006 to 15.6 percent in FY 2012. In comparison, University of Maryland, which started out as the top biller in FY 2006, experienced a small decrease overall. Kernan Health System experienced only a 2.6 percent annual growth over the seven-year period, while Johns Hopkins Health System experienced a moderate amount of growth.

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**Table 19. Top 20 Hospitals That Billed CPT Code 00170 by Growth Rate,
FY 2006-FY 2012**

	2006 to 2007	2007 to 2008	2008 to 2009	2009 to 2010	2010 to 2011	2011 to 2012	2006 to 2012
	Growth Rate	Growth Rate	Growth Rate	Growth Rate	Growth Rate	Growth Rate	Average Annual Growth
Shady Grove Adventist Hospital	81.9%	30.4%	30.0%	123.3%	24.2%	-17.4%	38.5%
All University of Maryland, including Children's Hospital	-27.8%	21.3%	35.0%	-11.2%	-7.1%	-3.4%	-1.0%
All Kernan Hospital	44.4%	-3.8%	60.8%	-2.1%	-24.5%	-29.2%	2.6%
All Johns Hopkins Hospital	18.7%	15.5%	17.8%	14.3%	35.1%	-12.3%	13.9%
Franklin Square Hospital	117.3%	38.5%	48.1%	-3.4%	5.9%	-21.7%	23.6%
All Children's DC	575.0%	-10.5%	-45.9%	261.8%	-25.4%	-31.4%	35.0%
Robinwood Surgery Center	-	N/A	562.9%	0.9%	11.1%	3.1%	N/A
Anne Arundel Medical Center	-74.3%	0.0%	221.1%	159.0%	55.1%	-2.9%	21.5%
Western Maryland Hospital Center	N/A	N/A	N/A	N/A	218.6%	-44.9%	N/A
All Greater Baltimore Medical Center	141.5%	19.8%	7.4%	9.9%	-13.7%	-29.2%	13.0%
All Howard County General	15.9%	52.9%	26.9%	22.9%	-12.6%	-44.8%	4.9%
Southern Maryland Hospital	16.3%	-4.3%	-13.5%	83.1%	14.2%	5.6%	13.4%
Garrett County Hospital	-77.2%	386.2%	5.7%	23.5%	2.2%	-14.9%	3.9%
All Mercy Medical Center	-96.4%	5450.0 %	145.0%	-4.0%	-34.9%	-7.6%	19.1%
Sinai Hospital	76.2%	16.2%	48.8%	70.3%	33.9%	2.7%	38.8%
Union Hospital of Cecil County	-18.2%	-55.6%	1375.0 %	254.2%	45.0%	-56.4%	51.3%
Chester River Hospital Center	-13.0%	50.0%	-46.7%	18.8%	110.5%	57.5%	18.3%
All Holy Cross Hospital Units	41.2%	66.7%	50.0%	11.7%	25.4%	-31.0%	22.7%
Calvert County Memorial Hospital	760.0%	76.7%	31.6%	48.0%	1.4%	-25.3%	67.9%
St. Mary's Hospital	4.5%	60.9%	174.3%	37.4%	-28.0%	-49.3%	15.0%
Top 20 Growth Rate	20.4%	21.9%	40.4%	26.8%	3.4%	-20.2%	13.7%
All Hospitals Claims During FY	15.3%	17.4%	32.2%	21.6%	-0.6%	-17.8%	10.1%

Tables 20 A, B, C, and D show the historical distribution of patients by Maryland region for Shady Grove Adventist Hospital, the University of Maryland Hospital System less James Kernan Hospital, James Kernan Hospital, and the Johns Hopkins Health System. These are the four hospitals with the highest volume of CPT code 00170.

The geographic distribution of patients for these hospitals has generally remained unchanged over the last six years. The University of Maryland and the Johns Hopkins Hospital Systems

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have drawn most of these patients from the Baltimore Metropolitan Area, which includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties.

Shady Grove, which is located in Rockville, has drawn most of its patients from Montgomery and Prince George's Counties as well as from Western Maryland, which includes Allegany, Frederick, Garrett, and Washington Counties. In FYs 2006, 2008, and 2009, the Western Region accounted for the majority of Shady Grove's patients for CPT code 00170, with Prince George's and Montgomery Counties accounting for 34 to 43 percent. Since FY 2010, Prince George's and Montgomery Counties have accounted for more than 50 percent of Shady Grove's patients.

**Table 20A. Percentage of CPT Code 00170 Patients from Baltimore Metro Region,
FY 2006-FY 2012**

Hospital	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Adventist Hospital System	6.3%	4.2%	4.9%	5.5%	8.9%	5.5%	5.7%
University of Maryland Hospital System (excl. James Kernan)	86.7%	83.9%	87.4%	90.4%	85.4%	91.3%	90.5%
James Kernan Hospital	69.6%	72.7%	67.2%	65.4%	70.9%	77.2%	76.0%
Johns Hopkins Health System	87.2%	84.9%	91.6%	88.8%	88.0%	85.5%	87.5%

**Table 20B. Percentage of CPT Code 00170 Patients
from Prince George's and Montgomery Counties, FY 2006-FY 2012**

Hospital	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Adventist Hospital System	34.4%	53.4%	44.9%	43.0%	50.3%	57.8%	57.8%
University of Maryland Hospital System (excl. James Kernan)	4.9%	7.0%	7.1%	4.8%	7.3%	4.3%	5.7%
James Kernan Hospital	6.5%	10.6%	12.1%	13.0%	7.6%	5.8%	8.1%
Johns Hopkins Health System	1.2%	0.7%	1.2%	1.2%	1.5%	2.3%	1.6%

**Table 20C. Percentage of CPT Code 00170 Patients from Western Maryland,
FY 2006-FY 2012**

Hospital	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Adventist Hospital System	57.5%	39.6%	49.2%	50.1%	39.2%	33.6%	34.1%
University of Maryland Hospital System (excl. James Kernan)	2.8%	2.5%	1.7%	1.2%	1.3%	0.7%	0.5%
James Kernan Hospital	16.6%	10.5%	12.0%	8.1%	7.9%	6.2%	4.7%
Johns Hopkins Health System	2.1%	1.8%	0.9%	1.2%	1.5%	3.1%	2.7%

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**Table 20D. Percentage of CPT Code 00170 Patients
from Southern and Eastern Maryland, FY 2006-FY 2012**

Hospital	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Adventist Hospital System	1.3%	4.2%	1.3%	2.2%	1.9%	2.9%	2.5%
University of Maryland Hospital System (excl. James Kernan)	10.8%	15.3%	15.1%	10.1%	16.6%	9.0%	12.8%
James Kernan Hospital	11.0%	10.4%	14.4%	23.0%	25.0%	18.0%	20.4%
Johns Hopkins Health System	12.3%	23.6%	10.5%	15.6%	14.4%	17.0%	13.9%

Notes: Western Maryland includes Allegany, Frederick, Garrett, and Washington Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Eastern Maryland includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

Some clinicians expressed concern to the Department that children with special health care needs may require surgery under general anesthesia, which would be consistent with some private insurance guidelines.⁴⁶ However, the growth in overall utilization of this procedure cannot be attributed to enrollees in the REM program or in LTSS waivers, as the fraction of users who are REM or LTSS waiver participants has actually decreased slightly over the study period. As noted above, recipients in these coverage categories received more units per claim, which likely takes into account their complex physical health status.

To estimate the general medical acuity of the population using these services, the Department calculated Resource Utilization Bands (RUBs) for each enrollee, as specified by the Johns Hopkins University Adjusted Clinical Group (ACG) system, based on each enrollee's previous year's utilization of medical services and diagnoses. The six RUBs describe enrollees who 1) do not use any medical services, 2) are healthy users, 3) are low-morbidity users, 4) are moderate-morbidity users, 5) are high-morbidity users, or 6) are very high-morbidity users, respectively. These users were further grouped as low morbidity (RUBs 1 through 3, corresponding to users with no previous medical utilization or low morbidity), moderate morbidity (RUB 4), and high morbidity (RUBs 5 and 6, corresponding to high and very high morbidity users).⁴⁷ A beneficiary's RUB describes his or her overall medical acuity. However, readers should keep in mind that, while the ACG system does consider gingivitis and dental caries (i.e., cavities) in assigning enrollees to a RUB, the system is not meant to make detailed predictions about an enrollee's use of dental services.

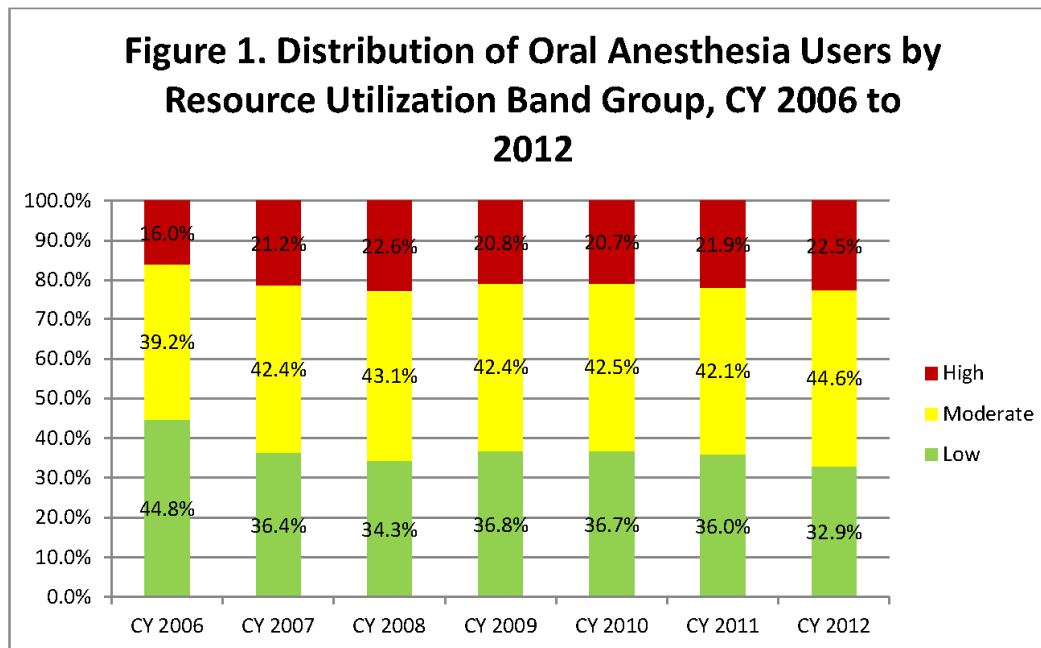
⁴⁶ Glassman, P. (2009). A review of guidelines for sedation, anesthesia, and alternative interventions for people with special needs. *Specialty Care Dentist*, 29(1), 9-16.

⁴⁷ Johns Hopkins Bloomberg School of Public Health. (2008). *Technical user guide, version 8.2*.

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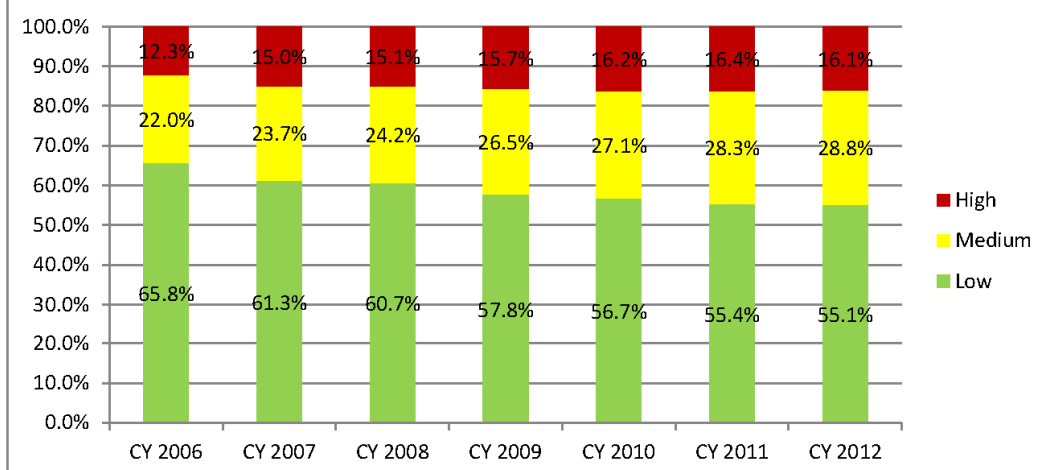
Figure 1 displays the distribution of CPT 00170 users over the RUBs, and figure 2 displays the distribution of all Medicaid enrollees over the RUBs. Using these measures, oral anesthesia users have not had an appreciable increase in medical acuity over the observation period. The proportion of users that were in high-utilization RUBs in the Johns Hopkins ACG risk adjustment system remained constant for most of the observation period. As expected, CPT code 00170 users had higher average medical acuity than the general Medicaid population.



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Figure 2. Distribution of All Medicaid Enrollees by Resource Utilization Band Group, CY 2006 to 2012



Readers should note that the ACG system is meant to predict utilization of medical services, not dental services; enrollees may have greater or lesser need for dental services than their RUB category indicates. Additionally, not all children with special needs are in the REM program or in LTSS waivers; these programs enroll children with the most severe medical conditions. Nonetheless, having a chronic condition is a risk factor for receiving dental treatment under general anesthesia.⁴⁸

Commercial Insurer Trends

Table 21 displays the volume of claims for CPT code 00170 for private payers. MHCC data indicate that the volume of claims for CPT code 00170 has been approximately flat from 2009 to 2011, with 11,385 claims in 2011.

Table 21. Number of CPT Code 00170 Claims for Private Payers, CY 2009-CY 2011

	CY 2009	CY 2010	CY 2011	Average Annual Growth Rate, Percentage
Total Number of Claims	11,910	11,615	11,385	-2.2%

⁴⁸ Chi, D. L., Momany, E. T., Neff, J., Jones, M. P., Warren, J. J., Slayton, R. L., Weber-Gasparoni, K., & Damiano, P. G. (2010). Impact of chronic condition status and severity on dental treatment under general anesthesia for Medicaid-enrolled children in Iowa State. *Pediatric Anesthesia*, 20(9), 856-865.

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MHCC data indicate that recipients of CPT code 00170 in commercial plans had claims averaging 52.9 minutes per claim in 2011, down from 63.4 minutes in 2009, as shown in Table 22. Private claims were approximately 9% shorter in duration than Medicaid claims in 2009, 18% shorter in 2010, and 18% shorter in 2011. Commercial plans typically insure working adults and their children, who are healthier on average than HealthChoice enrollees. It could be expected that Medicaid beneficiaries have longer claims than privately insured patients. The average claim duration for commercial insurers declined significantly from FY 2009 to FY 2011, a period during which the average Medicaid claim duration was also declining, albeit more slowly.

Table 22. Estimated Number of Minutes of CPT Code 00170 Services per Private Claim/Encounter, CY 2009-CY 2011

	CY 2009	CY 2010	CY 2011	Average Annual Growth Rate, Percentage
Estimated Average Number of Minutes per Claim	63.4	56.1	52.9	-8.7%

Factors That May Influence Utilization of General Anesthesia for Dental Services

Researchers in Iowa determined that medical acuity was a risk factor for receiving dental services under general anesthesia in an inpatient setting.⁴⁹ The medical acuity of enrollees using CPT code 00170 has been approximately similar from CY 2006 to CY 2012, as has the medical acuity of the general Medicaid population (See Figures 1 and 2, above).

Other studies have found that preventive dental visits reduced subsequent use of non-preventive dental (i.e., restorative and emergency dental) services among children enrolled in Medicaid or CHIP.^{50, 51, 52} Since CY 2008, Medicaid enrollees have also been receiving preventive and diagnostic services at an increasing rate, as shown in Table 23. Approximately 35% of enrollees received preventive/diagnostic dental services in CY 2008, compared to 51.3% in CY 2012. Furthermore, the utilization rate of preventive/diagnostic dental services for those continuously enrolled in Medicaid for at least 320 days is higher than the utilization rate for those enrolled in Medicaid for any length of time, as shown in Table 24. This may indicate that the Medicaid program has been able to successfully intervene in the care of continuously enrolled individuals.

⁴⁹ Chi, D. L., Momany, E. T., Neff, J., Jones, M. P., Warren, J. J., Slayton, R. L., Weber-Gasparoni, K., & Damiano, P. G. (2010). Impact of chronic condition status and severity on dental treatment under general anesthesia for Medicaid-enrolled children in Iowa State. *Pediatric Anesthesia*, 20(9), 856-865.

⁵⁰ Sen, B., Blackburn, J., Morrissey, M. J., Kligore, M. L., Becker, D. L., Caldwell, C., & Menachemi, N. (2013). Effectiveness of preventive dental visits in reducing nonpreventive dental visits and expenditures. *Pediatrics*, 131, 1107-1113.

⁵¹ Meyerhoefer, C. D., Zuvekas, S. H., & Manski, R. (2013). The demand for preventive and restorative dental services. *Health Economics*, DOI: 10.1002/hec.2899.

⁵² Basic restorative services include fillings and extractions. Major restorative services include crowns and root canals.

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**Table 23: Use of Any Preventive/Diagnostic Services by Enrollees Aged 0-20,
Any Length of Enrollment, CY 2008-CY 2012, by Age Group**

Age (Years)	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
3 or Less	12.0%	18.0%	22.4%	25.0%	27.9%
4 to 5	46.0%	54.5%	59.3%	62.7%	64.3%
6 to 9	50.8%	58.7%	62.9%	65.6%	67.2%
10 to 14	45.7%	53.4%	57.3%	59.8%	61.6%
15 to 18	36.0%	42.5%	46.3%	48.9%	50.0%
19 to 20	20.8%	27.3%	30.4%	32.4%	33.3%
Total	34.7%	41.8%	46.1%	49.1%	51.3%

**Table 24: Use of Preventive/Diagnostic Dental Services by Enrollees Aged 0-20,
Enrolled 320 Days or More, CY 2008-CY 2012, by Age Group**

Age (Years)	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
3 or Less	18.7%	26.8%	32.5%	36.1%	39.9%
4 to 5	55.2%	63.1%	67.3%	70.6%	71.8%
6 to 9	60.3%	67.1%	70.8%	73.2%	74.3%
10 to 14	54.2%	61.4%	64.9%	67.2%	68.5%
15 to 18	44.0%	50.0%	53.6%	56.1%	56.9%
19 to 20	30.0%	35.9%	38.3%	40.2%	41.0%
Total	45.0%	51.9%	56.1%	59.2%	61.1%

Conclusion

Maryland Medicaid's FFS anesthesia rates are currently higher than the FFS rates of Pennsylvania, Virginia, and the District of Columbia. The Maryland Medicaid FFS program reimburses about 76% of Medicare rates for CPT code 00170. All HealthChoice MCOs except Priority Partners pay essentially the same as FFS Medicaid; Priority Partners pays only slightly more than Medicaid pays. As of January 1, 2013, however, payment for anesthesia services related to dental procedures became included in the dental health carve-out and is paid for under the FFS program. Commercial insurance anesthesia rates may be as much as twice as high as Medicare rates.

The number of Medicaid recipients receiving this procedure grew at an average annual rate of 9.2 percent from FY 2006 to FY 2012. Looking at growth in utilization by age, children aged 1 to 5 years have been the fastest growing group and represent more than half of the total users of this CPT code. As the utilization rates by REM and LTSS waiver populations have grown more slowly than the overall growth in utilization, growth in the volume of anesthesia services is not being driven by populations that are often more difficult to treat. Volume grew each year from FY 2006 to FY 2011 and declined slightly in FY 2012. The volume of commercial insurance claims for this CPT code declined slightly from FY 2009 to FY 2011, a period during which Medicaid volume was increasing.

However, the average number of minutes per claim has grown significantly. This could indicate that the enrollees are receiving more complex dental services in ORs. For CY 2011, private

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claims had an average duration of 52.9 minutes, while Medicaid claims had an average duration of 64.8 minutes in FY 2011. The number of units per Medicaid claim grew significantly from FY 2006 to FY 2010 and declined in FYs 2011 and 2012.

There are differences in volume among individual hospitals. Shady Grove Adventist Hospital, the top biller in FY 2012, increased its volume of claims for this CPT code much faster than the University of Maryland, which has historically maintained a high volume. The University of Maryland (less James Kernan hospital) was the second-largest biller for CPT code 00170 in FY 2012, and Kernan was the third-largest provider. Users of CPT code 00170 are more medically complex than the average Medicaid enrollee. However, users of CPT code 00170 have maintained approximately the same level of medical complexity from FY 2006 to FY 2012 (i.e., the increase in utilization does not appear to be driven by increasing medical complexity).

A review of academic literature indicated that preventive dental visits did reduce the subsequent use of restorative and emergency dental services among children enrolled in Medicaid and CHIP. Maryland experienced an increase in enrollees receiving preventive/diagnostic dental services over the study period.

Dentists believe that hospital restrictions on OR time may limit access to inpatient oral surgery. Some have suggested that hospitals would prefer to book higher-revenue services in the OR. The dentists interviewed said that they had a backlog of Medicaid patients who needed oral surgery. Anesthesiologists believe that low anesthesia rates limit access, although because facilities are reimbursed separately, changes in anesthesia rates by themselves are unlikely to encourage hospitals to schedule more OR time for dental surgery.

At present, Medicaid and commercial payers appear to use reimbursement methods similar to Medicare's. Medicare does compensate anesthesiologists for the difficulty of each anesthesia procedure through the use of base units, and Medicare sets its base units per recommendations from the American Society of Anesthesiologists. In addition, anesthesiologists are compensated for the time needed to prepare a patient for anesthesia. The conversion rates, however, do vary across payers.

Recommendations

The issues surrounding dental cases in the hospital ORs are complex and require more than one solution. The Department's multi-pronged recommendations are outlined below.

- **Increase the Medicaid rate for CPT code 00710 to 100 percent of Medicare.** . The rate for anesthesia should be raised to promote fairness and access. Therefore, Medicaid recommends raising the rate to 100 percent of Medicare. The estimated cost to increase the rate for CPT code 00710 is \$475,818 (Total Funds). It makes sense for Medicaid not to exceed the Medicare payment rates for many reasons: CMS regulates Medicaid payments to certain institutional providers using Medicare payment principles, MedPAC reports annually on the adequacy of the Medicare payment rates to Congress, and even Congress uses Medicare as the benchmark when targeting Medicaid physician fee increases. Additionally, the GAO did not find a correlation between the variance in Medicare's rates and commercial payer rates and the supply of anesthesiologists. Based

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on these reasons, the Department recommends increasing the rate paid for CPT code 00710 to the Medicare rate.

- **Recommend that hospitals offer OR block times for dental cases.** According to providers, hospitals do not block time for dental cases. As a result, dentists are struggling to find OR time. Some suggest that hospitals are not scheduling dental services because other procedures that generate more revenue. The HSCRC regulates the rates charged for hospital clinic services. Hospitals are assigned a per-minute clinic OR rate for all surgical procedures that occur in the clinic. A complex surgical procedure, therefore, is assigned more minutes, which translates to greater revenue. A similar methodology is applied to outpatient surgeries performed in hospital operating rooms. All outpatient surgeries are assigned a single OR rate. The rate will vary based on the amount of time required to perform the surgery. Complex surgical procedures that take the same amount of time to perform would not vary by compensation. Given how the HSCRC regulates OR rates, the Department recommends that hospitals start blocking time for dental OR cases. This will provide dentists with set operating times and reduce the need to scramble to find OR times that are not regularly available.
- **Establish a facility rate to pay ASCs for dental cases.** By establishing a facility rate to pay ASCs for dental cases, the number of sites where dentists may perform OR procedures will increase, which reduces pressure on hospitals. The Department will implement this recommendation in a budget neutral way -- the facility rate will be set lower than the hospital facility rate in order to offset an increase in utilization. Of the 233 ASCs currently participating in Medicaid, seven perform dental cases for other payers who reimburse the ASC for performing dental procedures. Combined with the recommendation that hospitals block OR time for dentists, this recommendation should shorten the existing wait time for dental OR cases. It should be noted, however, that most ASCs would need to purchase and install the necessary equipment for dental surgical procedures; simply establishing a rate by itself is not the only access issue to address regarding ASCs.
- **Continue to improve access to dental care.** Research shows that improving access to preventive dental care reduces the need for non-preventive procedures. Based on this research, the downward utilization trend in FY 2012 for CPT code 00170 might be caused by the result of additional enrollees receiving access to preventive dental care rather than an inability to access services. The Department recommends continuing to make investments that result in overall improvement in access to preventive dental care.
- **Require hospitals to report stipends paid to hospital-based physicians.** The Department is working with the HSCRC to determine the amount of stipends paid by hospitals to anesthesiologists primarily for the larger billers of dental OR cases. The results of this survey are not complete and, as a result, it is not possible to draw any definitive conclusions at this time. The Department recommends that the HSCRC reiterate its request and also expand the data requested from the hospitals to include all physicians and not just anesthesiologists. Further, the Department recommends that the HSCRC request this data annually as part of a standard reporting requirement. Although the HSCRC does not regulate physician services, it does consider the overall financial health of the hospitals—including unregulated services—when determining rate

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increases. All payers should be aware of these subsidies because such subsidies affect the analysis of the proper reimbursement rates for providers.

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Appendix

Appendix Table 1: Aetna Medical Plan Coverage Guidelines for Deep Sedation or Anesthesia	
1.	Radical excision of lesions in excess of 1.25 cm (0.5 inches).
2.	Radical resection or ostectomy with or without bone graft.
3.	Patients exhibiting physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and which, under anesthesia, can be expected to produce a superior result. The conditions include, but are not limited to, cerebral palsy, epilepsy, cardiac problems, and hyperactivity (verified by appropriate medical documentation).
4.	Chronic disability that is attributable to a mental (e.g., mental retardation and Down's Syndrome) or physical impairment or a combination of both is likely to continue indefinitely and results in substantial functional limitations in one or more of the following: self-care, receptive and expressive language, learning, mobility, capacity for independent living, and economic self-sufficiency (verified by appropriate medical documentation).
5.	Patients who have sustained extensive orofacial and/or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.
6.	Local anesthesia is ineffective because of any of the following: acute infection, anatomic variation (e.g., due to previous surgery, trauma, or congenital anomaly), or allergy to local anesthesia.
7.	A child up to 6 years of age, with a dental condition (such as baby bottle syndrome) requiring repairs of significant complexity (e.g., multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions, or any combinations of these noted or other dental procedures).
8.	States that mandate coverage for anesthesia and/or facility charges associated with dental services. These include: California (age 6 or younger), Florida (age 7 or younger), Georgia (age 7 or younger), Kentucky (age 9 or younger), Maryland (age 7 or younger), Nebraska (age 8 or younger), North Carolina (age 8 or younger), North Dakota (age 8 or younger), Oklahoma (age 8 or younger), Tennessee (age 8 or younger), and Washington (age 8 or younger).
9.	Removal of two or more impacted teeth on the same day.

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Appendix Table 2: Cigna Medical Plan Coverage Guidelines for Deep Sedation or Anesthesia	
1. Patient who is age 3 or younger.	
2. Removal of two or more impacted third molars.	
3. Removal or surgical exposure of one impacted maxillary canine.	
4. Surgical removal of two or more teeth involving more than one quadrant.	
5. Routine removal of six or more teeth involving more than one quadrant.	
6. Full-arch alveoplasty.	
7. Periodontal flap surgery involving more than one quadrant.	
8. Radical excision of tooth related lesion greater than 1.25 cm or 0.5 inches.	
9. Tooth-related radical resection or ostectomy with or without grafting.	
10. Placement or removal of four or more dental implants.	
11. Tooth transplantation or removal from maxillary sinus.	
12. Extraction with bulbous root and/or unusual difficulty or complications noted.	
13. Confirmed allergy to local anesthesia.	
14. Presence of acute infection at the site of injection for local anesthesia.	
15. Mental retardation (including Down's syndrome).	
16. Alzheimer's disease.	
17. Spastic muscle disorders (e.g., epilepsy, cerebral palsy, and Parkinson's disease, but not attention deficit disorder).	
18. Documentation of attending a medical physician for renal failure, uncontrolled diabetes, or cardiac problems including hypertension.	

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AAPD and Key Partner Organizations Support CMS Proposal to Boost Facility Fee for Hospital Dental OR Cases

SHARE



AAPD-ADA-AAOMS have been working together in a concerted advocacy campaign to address the challenges pediatric dentists and other dentists around the country are experiencing in obtaining or maintaining hospital or ambulatory surgery center (ASC) operating room time for dental cases requiring care under general anesthesia.¹

The Center for Medicare and Medicaid Services (CMS) issued a notice of proposed rulemaking on July 26, 2022 that (among a host of other matters) proposes to change the Medicare Ambulatory Payment Classification (APC) of CPT code 41899 (unlisted procedure, dentoalveolar structures), which is the code frequently used by hospitals to bill the facility fee for dental operating room (OR) cases. The code is currently assigned to APC 5161 (Level 1 ENT Procedures) whose payment rate is approximately \$200, a rate that in no way reflects the average cost of providing facility-related (not dental professional) services it is meant to cover. CMS proposes to move the code to APC 5871 (Dental Procedures). **This would have the effect of raising the Medicare facility payment rate associated with this procedure code from \$203.64 to \$1958.92.²**

If finalized in regulation, effective January 1, 2023 this increased facility fee would apply to dental OR cases taking place in hospital outpatient settings for Medicare patients when CPT 41899 is billed. Many states use Medicare billing codes for Medicaid services and also use the codes' assigned billing rates to guide Medicaid reimbursement. AAPD will issue additional guidance and Q and A on implementation issues as this proposal moves forward in the regulatory process.

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This CMS proposal is a result of a sustained advocacy effort and addresses hospital access for these important oral health services. Since the rule does not propose to establish a new HCPCS code for use within ambulatory surgery centers (ASCs), AAPD-ADA-AAOMS will continue to pursue this effort in our ongoing discussions with CMS and Congress.

This proposal was strongly supported in the following regulatory comment letters submitted to CMS by the September 13, 2022 deadline. The comment letters described below also asked CMS to work towards a solution for dental cases performed in ASCs.

¹ For background information on these efforts see [here](#).

² For a copy of the proposed rule see [here](#). The dental section begins on page 168 of the PDF at the link above.

- **AAPD-ADA-AAOMS submitted a regulatory comment letter that was also endorsed by seven additional members of the Organized Dentistry Coalition. Click [here](#) for a copy of the letter.**
- **22 Members of the Consortium for Constituents with Disabilities (CCD) Health Task submitted a comment letter. Click [here](#) for a copy of the letter. The AAPD is also a member of CCD.**
- **20 Members of Congress submitted a [comment letter](#). This effort was led by Congresswoman Terri Sewell (D-Ala. 7th) and Congressman/dentist Drew Ferguson (R-Ga.3rd). The AAPD applauds their leadership on this critical issue.**
- **Several AAPD state chapters submitted commented in support of the proposal.**
- **The proposal was also supported by the Ambulatory Surgery Center Association.**

For any questions on this issue contact Chief Operating Officer and General Counsel C. Scott Litch at 773-938-4759 or slitch@aapd.org.

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Prepared by a taskforce of the AAPD Pediatric Oral Health Research and Policy Center:

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List of Definitions and Abbreviations Used

AAP – American Academy of Pediatrics
AAPD – American Academy of Pediatric Dentistry
AHA – American Hospital Association
ASA – American Society of Anesthesiologists
CMS – Centers for Medicare and Medicaid Services
COVID – severe acute respiratory syndrome coronavirus 2, coronavirus disease 2019, COVID-19
ECC – early childhood caries
ED – emergency department
ERISA – Federal Employee Retirement Income Security Act
GA – general anesthesia
H&P – history and physical examination
ICDAS – International Caries Detection and Assessment System
IOGA – in-office general anesthesia
MNC – Medically necessary care
OR – operating room
OSC – outpatient surgical center (same as: ambulatory surgery centers)
U.S. – United States

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Executive Summary

Denial of access to hospital operating rooms for pediatric dental care is a growing problem in the U.S., with the majority of states having some manifestation of this problem. Financial pressures have forced hospitals to prioritize surgical services based on profitability and necessity. Medical surgery procedures are better reimbursed than dental and displace dental cases from scheduling in many hospitals. Adding to financial forces are system procedures that further limit access such as justifying medical necessity, preauthorization, and variable insurance coverage.

The impact of operating room (OR) access on pediatric oral health and the system that provides care for children is significant. Delaying treatment of caries results in worsening dentition status, greater likelihood of emergency department visits, and medical complications. Chronic pain impacts behavior and social performance and ability to concentrate and learn. Pain effects are often difficult to discern in younger children and those with special health care needs. The effects on the system of care include greater reliance on case management, unnecessary emergency care, employment of behavior guidance techniques of last resort, and overuse of antibiotics and unnecessary pain medications. Poor and minority children covered by Medicaid are disproportionately affected, further exacerbating healthcare inequities. Non-surgical management of caries helps a small number of children waiting for definitive care.

The ideal solution of returning to the level of OR access available a decade ago is unrealistic. Obstacles to a reasonable resolution are the continuing financial woes of U.S. hospitals, refocusing of hospital missions to community health and other directions, continuing downward reimbursement trends, effects of the COVID-19 pandemic on hands-on patient care, and administrative procedures and policies. Pediatric dentistry has already invested in alternatives to hospital operating rooms, further complicating reversal of this trend.

The OR denial problem will likely not be reversed but ameliorated to some degree in various ways in different geographic areas of the U.S. with policy change, innovative alternatives such as ambulatory surgery centers and in-office general anesthesia. Legislative and regulatory advocacy may help in controlling the continued decline by stabilizing reimbursements. Dentist involvement in the process, including working with hospitals and payers as well as decision-makers can stall the decline and establish workable niches for dental care of children that is best done safely and effectively under general anesthesia.

Introduction

Every day, children awaken in pain from severe early childhood caries (ECC), the most prevalent infectious disease of childhood. Because of their age, inability to understand, or the irreversibility of the infection, these patients require care beyond what is possible in a dental office. In the best of circumstances, they receive dental care to address this infection in a hospital operating room under general anesthesia (GA) with a range of adjunctive services to insure a safe and efficient outcome. In reality, today, in many parts of this country, these children are forced to endure continued pain and infection, or end up in hospital emergency departments. Pediatric dentists compassionately treat many of these children in a dental office, but without the benefit of optimal humane management of their fear and pain offered by GA.

That is because access to hospital operating rooms for dental care is rapidly disappearing.

Across the country, in about two-thirds of states, pediatric dentists' access to hospital operating rooms has been curtailed or eliminated. As a result, children in need of the intensity of hospital care are put on long waiting lists, or denied care altogether.¹ Pediatric dentists must choose other care options for these children, often less than optimal, inconsistent with professional guidelines and best practices, not acceptable to parents, and often accompanied by unnecessary risk, pain, and fear (*Story Box 1*).

Story Box 1: The global effect on care access, practice location, and equity in care

Operating room denial can cascade into loss of access to specialty care impacting children beyond those denied care in hospitals.

Dr. Karli Williams opened her practice in Pierre, South Dakota, believing she would be helping the central region of the state by providing much needed access to pediatric dental care. Many children who came to her desperately needed hospital-based dental care. She successfully treated hundreds of children over years working in the local hospital operating rooms. When the hospital no longer provided OR time for her to schedule her patients, she was unable to properly care for them, closed her practice in Pierre, and returned to Rapid City on the far west side of South Dakota. Hers is one of the only pediatric dental practices in South Dakota with access to a hospital OR, so Williams' patients often travel up to four hours by subsidized medical ride services to get to Rapid City for care. Despite a highly coordinated effort to get her patients into surgery, Williams is once again at risk of losing OR access—the hospital cannot afford to allocate OR time to dental care.

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The SARS-Cov-2 (**COVID**) pandemic has exacerbated an already downward trend in pediatric dentists' access to general anesthesia for their patients in a hospital environment. The problem is reported to be moderate to severe in two-thirds of the states experiencing denial of access. According to a report by McKinsey on OR backlog, the competition for access among all surgical specialties will persist for years as a result of the pandemic.² This problem will likely not be resolved without advocacy action.

This brief describes the problem of denial of access to hospital ORs to pediatric dentists, specifically:

1. Origins and factors contributing to the problem,
2. Effects on children and their oral health and implications of failure to mitigate the lack of access,
3. Obstacles to solutions, and
4. Strategies for dental societies and individuals that may help address the problem.

The *purpose* of the brief is to educate child advocates, decision-makers and dental leaders on this growing problem and its effect on health and safety of children. The evolution of this problem shows that characteristics often differ geographically and suggests that strategies to address the problem can be tailored to those circumstances.

Origins of the Problem and Contributing Factors

A review of seven state Medicaid programs by Lee et al.³ could find no single factor explaining patterns of OR treatment under GA for dental caries, but the genesis of OR denial is believed to be financial¹. Hospitals across the U.S. are challenged financially. Many have closed, especially smaller ones, those in rural areas, and those providing care primarily to the poor.

Early in the pandemic, public health mandates forced hospitals to cancel all elective surgeries and provide only emergency care to preserve personal protection equipment (PPE) and reduce the transmission risk of COVID⁴. Emergency departments (ED) experienced a decline in visits in the ten weeks following the declaration of the COVID national emergency⁵. Hospitals nationwide have experienced steep revenue declines due to lower volumes of patients being seen, cancelled surgeries, and lack of providing elective and non-emergent procedures⁶. According to the American Hospital Association (AHA), the COVID pandemic has caused a financial impact leading to at least forty-seven hospitals to close or enter bankruptcy

leading to an estimate of \$323.1 billion dollars in financial losses.⁷ In the U.S., cancellations of elective surgeries caused an estimated revenue loss of \$16.3-17.7 billion per month⁸. After approval to resume elective surgeries, hospitals may have been more inclined to allow better access to OR time to higher paid surgeries to mitigate the hospital financial crisis. COVID has clearly made access to the OR for pediatric dentistry more challenging than ever before, and all evidence suggests that the situation will not get better soon, if at all.

In 2012, the American Academy of Pediatric Dentistry (AAPD) issued a brief describing the OR access problem⁹, but the focus was on payers and their reluctance to cover costs of GA dental services. A majority of states passed laws to require coverage, and the problem of OR access abated. Today, the reduction in reimbursement to hospitals by the Centers for Medicare and Medicaid Services (**CMS**) have eclipsed the problem of a decade ago and shifted its locus, causing a new crisis. Hospital financial challenges will continue to dominate access of dentists to operating rooms in spite of solutions.

Location of OR Services

There are predominantly five locations where pediatric dentists can obtain access to medical and dental professionals licensed to administer general anesthesia (**GA**) to children who require dental procedures requiring that level of behavior guidance. The five locations are: 1) community hospitals, 2) academic hospitals, 3) predominantly physician-owned ambulatory surgery centers, 4) predominantly dentist-owned ambulatory surgery centers, and 5) dental offices. Each location has limitations and advantages based on physical placement and resources, but hospitals and physician-owned surgery centers pose the immediate limitation to OR access.

Community hospitals typically do not have specialty-trained pediatric anesthesiologists and consequently may limit their pediatric cases to children classified by the American Society of Anesthesiologists (**ASA**) as Class I (normal) or Class II (mild systemic disease). Children with dental caries and co-morbidities greater than specified by ASA Class II are forced to seek care in other venues. Community hospitals may limit their financial loss by restricting the numbers of Medicaid recipients receiving general anesthesia. Across the country, Medicaid reimbursement for general anesthesia and GA-associated facility fee is woefully low. In addition, community hospitals may not be willing to purchase dental equipment including a dental drill and instrument cart with compressed air and dental portable X-ray unit, both costing over \$5000 today and needed to deliver restorative and surgical dental care in an OR.



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Unlike community hospitals, *academic hospitals* typically have specialty-trained pediatric anesthesiologists, as well as medical and pediatric anesthesiology residents. Many of the anesthesia training programs value the opportunity to teach trainees with low-acuity patients and those requiring nasal intubation techniques used with dental cases. Funding for capital equipment necessary for dental care is more easily attainable in the academic realm. Equipment and supplies are often provided by the hospital, which helps reduce costs for the patient. In addition, academic hospitals have more medical support to better address emergent situations and complications. However, with low reimbursement rates and an increased demand for time management in academic hospitals, access to ORs for dental services is under pressure and under scrutiny, often confined to dental training program patients. Today, even academic hospitals are reevaluating access to dental cases (*Story Box 2*).

In an effort to obtain easier access to OR time, physicians and dentists have both together and separately opened independent free-standing outpatient surgery centers (**OSC**). *OSCs controlled solely by physicians* may be dedicated solely to medical procedures. These OSCs also may limit the number of dental cases, not purchase dental equipment, as well as not allow patients without private insurance access to their facilities.

Dentist-owned OSCs and in-office GA are two hopeful alternatives for some general anesthesia care and are discussed under strategies.

Other Contributing Factors

While hospital revenue concerns remain the major cause of limits to OR access, other parts of the system contribute to diminished OR access. These include any of the following, alone or in combination:

Determination of Medical Necessity. Variable definitions of medical necessity in payment plans have been cited as inhibiting approval and timely scheduling of OR cases involving dental treatment. The American Academy of Pediatric Dentistry (**AAPD**), among other dental organizations, defines medical necessity,¹⁰ but medical insurers often have their own definitions of medically necessary care (**MNC**). Insurers may claim to provide coverage for children, but some may not cover GA services because patients do not meet established medical and behavioral criteria for MNC.

Complicated Rules for Approval of GA Dental Treatment. Payers may create hurdles for providers seeking approval for payment for general anesthesia care, such as pre-authorization of services that can extend the waiting period prior to approval, adding to scheduling delays already present. In some cases, payers may ironically ask for radiographic evidence of need before approval when behavior or disability precludes such supporting evidence.

Story Box 2: Training programs, specialty services, and coordinated care are threatened

Academic hospitals are also feeling the pinch.

Dr. Carolyn Kerins provides pediatric dentistry comprehensive services to young children and patients with special needs in Dallas, Texas, in an academic hospital. Her hospital has two OR options: the main OR is for children with illnesses and the PSC (pediatric surgery center) is for healthy children. There were five dental OR rooms in PSC, and two on most days in the main OR. There are about 100 dentists on staff. Since COVID began, the hospital decided not to reopen the PSC, claiming the hospital was losing money for dental cases due to low facility fee reimbursement. The hospital has eliminated different Medicaid medical plans or become "out of network" so getting a letter of authorization is next to impossible. Current status has all 100 dentists trying to schedule into five available days; the wait is at least three months. Dr. Kerins can do six cases on one day per week, but all other practitioners compete for one remaining day per week.

Medical Approval and Adjunct Procedures. For safety, hospitals may require medical participation in the admission of a patient for dental care under GA. This can include a pre-admission history and physical (**H&P**) by a licensed physician, a letter of medical necessity by a physician, and identification of a willing medical provider to cover medical needs during admission if complications arise. Physicians may not agree with medical necessity, require an office visit to validate patient health status, or refuse participation because of no compensation for their H&P services. The American Academy of Pediatrics (**AAP**) has policy on pediatrician participation in pre-operative medical services, but individual providers are not bound to follow this AAP policy.¹¹

Variable Insurance Status. Families occasionally choose to cover medical but not dental services when selecting insurance. The Affordable Care Act mandates availability, but not purchase, of dental coverage for children.¹² Financial or other reasons may cause families to defer dental insurance. Thus, medical costs of OR care may be covered, but dental services may not, leaving families with the cost of dental procedures that can be thousands of dollars.

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Story Box 3: Families forced to make difficult decisions, often with no good outcome

OR as a last and only resort forces choices no family should have to make.

Dr. Aaron Bumann, a pediatric dentist in Gladstone, Missouri, says insurance reimbursement is the central issue of children's access to the OR for dental care in his practice. Children denied quality care are typically those whose insurance offers lower rates of reimbursement, but that is not always the case. Some families do not have geographical access and others with high coverage deductibles may have to forgo hospital-based care due to the high cost. This is a problem countrywide. Dr. Melena Evancho, a pediatric dentist in Baltimore, Maryland, had three families opt out of much needed hospital-based care because of high deductible insurance plans. Without meeting the deductible, they would have been faced with a \$5,000-\$7,000 statement. They couldn't afford this and were forced to figure out what their options were to get the dental care their children need.

Other Systems Obstacles. Challenges facing access to OR time can be in part due to the arduous task of applying for hospital privileges, as well as the requirement by some hospitals for dentists to cover emergency call in return for access to OR time. Once privileges are granted, obtaining consistent block time to schedule an OR case can be difficult, due to competition with other surgeons. Without dedicated block time, it is challenging for a pediatric dentist to manage an outpatient clinical practice efficiently and predictably schedule the child for OR dental care.

Distance. While most American children have access to dental services in their community, those dependent on Medicaid coverage or in need of specialist services may live in dental deserts. With respect to treatment in the operating room, the lack of pediatric dentists in many rural areas is compounded by the unavailability of operating room time. This compound phenomenon has been addressed to some degree by alternatives covered later in this brief, such as in-office deep sedation and general anesthesia, but for those children and adults with special needs, whose medical co-morbidities make this form of care a greater risk, comprehensive humane care may be hundreds of miles away in rural states.

Effects on Children's Oral Health and Implications for the Future

Reports of effects on children's oral health and care access are limited and largely anecdotal (*Figure*). A survey of advocacy leaders in the 50 states and District of Columbia reported growing waiting lists of children.¹ Reports from other states and the American Dental Association (ADA) suggest that access has decreased. It is important to note that operating room availability for dental treatment has been inadequate for decades¹³ and this particular exacerbation amplifies an already pressing problem.

The extent of diminished OR access is difficult to quantify, and few studies have put the problem in numerical context except for reported incidence in states.¹ In fact, the dynamic nature of the problem may prevent an accurate picture from ever emerging, due to such factors as hospital closings and tightening budgets, changing disease rates, effects of the COVID-19 pandemic, and increased access for non-dental surgery created by Medicaid expansion. A cascade of factors often contribute to diminished access to hospital operating rooms for pediatric dental patients (*Figure*).

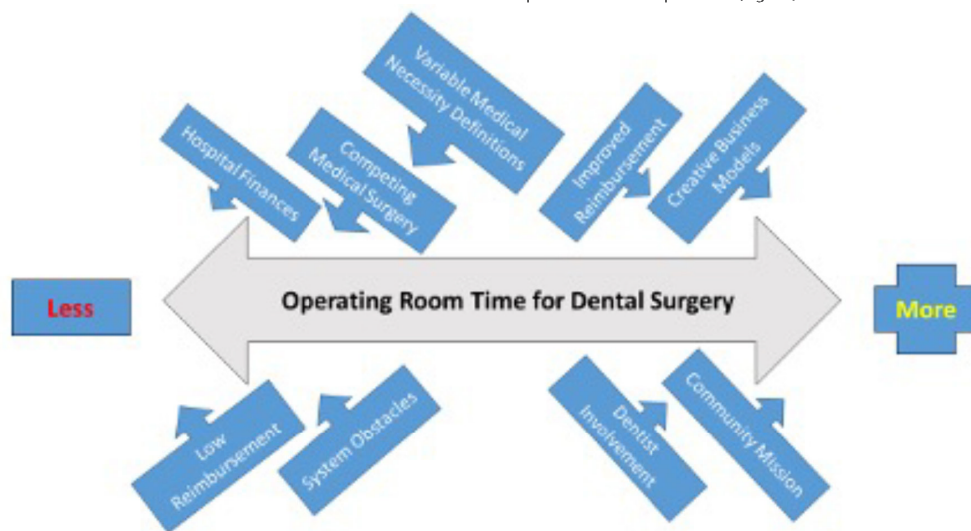


Figure: Factors contributing to better or worse OR access

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The consequences of denied access on pediatric oral health can be predicted. The story boxes included in this brief point to actual examples affecting children, their families and pediatric dentists:

- Children with untreated severe ECC will continue to grow in number, increasing the frequency of severe cellulitis and admissions to hospital emergency departments. For some children, this will be a back door into the operating room, but accompanied by immeasurable pain and further costs to the system.
- With few alternatives, pediatric dentists will, in desperation, attempt to stem the tide of untreated caries using non-surgical approaches like silver diamine fluoride, frequent fluoride varnish, interim restorative care, and other preventive measures. Unlike more definitive dental care, non-surgical approaches require frequent reassessment to insure stabilization of the dental disease. These non-surgical approaches will be marginally and temporarily effective for children with severe ECC. Compliance, travel, and social determinants of health will affect the efficacy of this approach. Many children will present with advanced dental caries and irreversible pain, already beyond the benefit of non-surgical care.
- Pediatric practices will face a different and novel reality --- instead of supervising treated children with renewed oral health after OR care, they will begin to accumulate a population of chronically diseased children with intermittent pain and infection. Pediatric dental practice will begin a shift in orientation from primary care to intensive care, controlling effects of disease rather than supervising health. Because of unremitting caries in the preschool population, and inability of the general dental provider community to care for these children, this problem will escalate. Gains made in reducing untreated primary dental caries will likely be reversed.¹⁴
- Practices will be challenged financially in ways no one could have predicted --- case management will assume a greater role without concomitant restructure of practice or reimbursement to substitute for the lost revenue from a stream already built into pediatric dental practice sustainability.
- Hope for oral health equity will diminish as those with the most disease are not treated. Ironically, in the past, children with severe ECC covered by Medicaid often had parity with commercially insured children for OR access. That is disappearing. Additionally, no universally applicable alternative to OR care for many children will emerge. Pediatric dentistry leads all other dental groups in caring for Medicaid-covered children,¹⁵ but without modification of the Medicaid reimbursement paradigm, these children won't be treated on a par with other children.

- Children with special health care needs (CSHCN) with dental disease will bear the brunt of denial of OR access. The extent of exclusion from ORs varies from place to place, but CSHCN are already affected. Unless dental and medically necessary medical surgical care are done in combination, solo dental cases for many CSHCN, not deemed involved enough to merit medical necessity, will not be permitted.

Story Box 4: Patient needs, care availability, OR access often merge in an untenable situation

OR denial is especially hard on families with special needs children who have to add it to their list of challenges.

Dr. Jeff Kahl, Colorado Springs, Colorado, illustrates how this impacts a patient of his. Brooklyn is a 22-year-old with special needs and medical complexity. Without sedation, care for Brooklyn is virtually impossible. Her exams involve careful physical restraint by dental assistants. At appointments, her mother is charged to control Brooklyn with her own body weight. Undeniably, Brooklyn is a candidate for hospital care, where she can be treated gently and safely and receive high quality care. In 2018, a hospital system change essentially removed dentistry from the hospital. Without a replacement site, pediatric patients began to be directed to a hospital in Denver, 1.5 hours away. Brooklyn's mother cannot drive her to Denver, as she can be combative during long drives. Brooklyn's only other option was to be scheduled through a general dentist with privileges at a local hospital. She was placed on one- to two-year wait list.

- Academic health centers will be overwhelmed. Most advanced training programs in pediatric dentistry and general dentistry enjoy a favored position in terms of OR access because of their academic missions. However, programs report a limit to the availability of OR time. Community dentists, if even allowed in academic centers, will experience a ceiling—many have already (*Story Box 2*). It is important to recognize that even within these academic centers, many programs have already maximized their access.
- Sadly, in spite of all the advances made in sedation and in-office general anesthesia safety, some children will die undergoing office-based care who would have ideally been treated in a hospital. Because the problem extends beyond Medicaid coverage, this will hurt families across all socioeconomic levels.
- In a worst-case scenario, operating room time will be allocated for dental care as it has been for years in other countries, solely for treatment of emergencies and restricted to extraction of teeth. Ironically, the denial of OR access to children with early ECC will demand its consideration in advanced cases.

Some of these scenarios can already be found; how extensive they become will depend upon action by all involved in care of children.

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Obstacles to Solutions

The complexity of the OR denial problem makes solutions difficult. Certain contributors to the problem are unlikely to improve and are difficult or impossible to address. The financial woes of hospitals illustrate the momentous tide against a reversal of the pattern. The following are obstacles to reverse the trend or temper its rate of growth. They also speak to the variance across communities and regions that adds complexity to crafting a simple solution.

- **The continuing decline of hospital access due to financial consolidation within the health system.** Earlier in this brief, the plight of hospitals is discussed. It is unlikely that any scenario of dental involvement in operating room care is or will be seen as profitable or given equal consideration in financial viability, even with improvement in facility fee reimbursement to hospitals. An example is the multi-fold difference in reimbursement for briefer, less expensive ENT procedures compared to dental care.
- **Conflict with mission and community needs of hospitals.** Hospitals serving communities with a constellation of health needs and required services may see oral health and dental treatment as a low priority and/or an ambulatory service better left outside the hospital. In competition between dental care and general and other medical specialty services in a community, dental care seldom wins. This may be because of a misperception of the value of oral health by decision makers, or the need by hospitals to nurture a full range of surgical services. This often means commitment of operating room time to non-dental surgery over dentistry. Depending on the health profile of the community, the triage of services by resource allocation may make sense and be unavoidable.
- **COVID-19.** The COVID-19 pandemic has undoubtedly worsened the problem and made reversal far more difficult. Hospitals reduced OR access for all surgical services for routine cases, in order to prevent spread of infection and loss of critical personnel. All surgical specialties were affected when elective cases were curtailed. Hospitals furloughed staff and closed ORs as well as down-sized peri-operative services. These reductions persist and will likely continue for the foreseeable future. The accumulated backlog of elective surgical cases will test whatever capacity remains as the pandemic abates, and dental care under GA will remain a low priority.
- **Investment and redirection of practice toward alternatives.** For decades, physicians and dentists have pursued and implemented alternatives to traditional operating room care in hospitals due to expense, convenience and personal preference. The slow chronic rejection of dentists from hospitals has spawned viable alternatives that would be difficult to abandon. IOGA is an example of an alternative to hospital care that may require capital investment to implement, but offers convenience to families and the dental team. IOGA may still not be an option for children covered by Medicaid, since reimbursement for general anesthesia is woefully low despite the location of care, and caregivers may not be able to pay out of pocket for IOGA.

Reverting to a hospital-based alternative may not be realistic or desirable for many providers. This acceptance does not mean that a solution has been found, but that pressure to provide OR access may stop.

- **Difficulty in alteration of payment schedules, regulations and other administrative and procedural obstacles.** Elsewhere in this brief, political action and administrative advocacy are discussed to ameliorate the problem of OR denial. For some communities, arguments about access to care and health equity will be successful; even in those situations, the work to end or reverse the trend of OR access denial may be overwhelming.

Strategies to Address the Problem

This section addresses alternatives to operating rooms in full-service hospitals and delineates the advantages and limitations of each model. In this section are: (1) alternatives to traditional hospital operating rooms, (2) legislative and advocacy strategies at the state and federal level, (3) local inter-professional relationships and strategies, and (4) non-surgical stabilization and delaying strategies.

1. Alternatives to Hospital OR Care

Freestanding Outpatient Surgery Centers

In contrast to physician-owned OSCs, dentist-owned OSCs have operating rooms fully outfitted with dental equipment. States may tie Certificate for Need for OSCs to require the facility to treat children with the state Medicaid coverage as a way to give that population access to care under general anesthesia. Obtaining block time is usually easier for dentists in these facilities. However, dental cases may be restricted to pediatric patients classified as ASA Class I and II. Pediatric patients classified greater than ASA Class II, smaller than 15 kg or classified as obese often have to seek care in another venue.

A more in-depth analysis of Ambulatory Surgery Center options for pediatric dentists is provided in a White Paper prepared for the AAPD by the Washington, D.C. law/consulting firm of Powers Pyles Sutter & Verville, PC.

In-office General Anesthesia

Another alternative to access to general anesthesia for pediatric dental care is the in-office general anesthesia concept,¹⁶ which means a pediatric dentist brings a licensed anesthesia provider to a private office to deliver general anesthesia. This option has advantages, including access to dental equipment and supplies, ease of scheduling, working with familiar staff members, reduction of additional commute time, and the ability to see patients sooner. Most pediatric dental GA patients are ASA classification I and II, so in-house dental anesthesiologists can provide access to care for children, especially those six and younger. Another benefit is elimination of or reduction in a facility fee that has become the crux of this access problem. Limitations of this alternate GA environment include any of the following:

- The anesthesia provider may restrict the cases allowed to ASA Class I and some IIs as well as limit by weight;

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- The anesthesia provider may also decide fees, insurance plan acceptance and method of payment;
- Pre-operative and recovery logistics can be constrained physically and by personnel;
- Few physician or dentist anesthesiologists may be available, and state regulations may limit their function in the office environment;
- State regulations may require comparative certification (general anesthesia certificate) for the dental provider;
- General safety concerns may be related to medical back-up, access to emergency services, and proximity to hospital and ED services. In addition, there may be less medical support in case a true dental emergency arises.
- Self-insured plans, utilized by many large companies, are regulated by the Federal Employee Retirement Income Security Act (ERISA). State insurance mandates such as the dental GA coverage laws do not apply to these plans, placing patients at a further disadvantage.
- There may be increased malpractice insurance costs for the dental provider.

More recently, the interest of the anesthesia communities, both medical and dental, in providing IOGA has created fiscal and safety models to address concerns and lingering issues with this approach. Although it is unlikely that IOGA will solve the OR access problem, it certainly will help.

2. Legislative and Regulatory Advocacy

The attachment to this brief summarizes the rationale and advocacy efforts by AAPD, ADA, and AAOMS to obtain a specific dental rehabilitation code under the CMS Healthcare Common Procedure Coding System (HCPCS), Level III, Category G, and thereby increase the abysmally low current facility fee for such hospital and ASC cases. This technically complicated effort is critical to putting dental cases on a more level playing field with other types of cases.

In addition to this effort at the federal level, which will have a ripple effect on state Medicaid programs as described in the attachment, pediatric dentists are encouraged to raise the issue with state and local legislators and public health officials, as well as hospital administrators.

At the state level, attempts to address the problem have included designating dental offices as facility sites in order to bill for a facility fee and defray some costs of care. Another emerging approach is to unify a hospital extension site, participating dentists, and anesthesiologists into an entity that provides care using previously independent contractors as employees. This "bundled" approach allow distribution of revenue, maximizes allowable roles of personnel, and streamlines the process to eliminate duplicative services such as scheduling and billing.

3. Inter-professional Relationships

In some communities, access to operating rooms for pediatric dentists remains intact in spite of circumstances that elsewhere have resulted in loss of block time and access. The constellation of circumstances that lead to retention of dental access varies, but the following have been reported anecdotally to help pediatric dentists retain OR access:

- Participation on boards of directors in critical areas of health from those overseeing ambulatory surgery centers to community public health. The ability to make decisions relative to allocation of operating room time can be important. Bringing the ECC epidemic to the fore in communities and engaging advocacy groups and community groups like Head Start in solving the problem can help.
- Active participation in hospital medical staff activities and decision making, as well as service as referral sources for hospital emergency departments, help characterize and prioritize the issue of OR care for children and institutionalize these services as a part of community commitment.
- Financial investment in non-hospital ambulatory surgery centers can place dentists in positions to allocate resources to make dental care possible.
- Unifying the primary stakeholders in the care of these children --- pediatric dentists, anesthesiologists, and hospitals in novel financial models, using the least costly, but optimally safest location and (1) bundling costs and revenue, and (2) lobbying payers and government in a unified manner to make this type of care feasible.
- Working with hospitals to utilize off-peak times when demand may be lower. Hospitals may be required to staff ORs for emergent cases but not utilize the time well.
- Engage in hospital strategic planning and community involvement. Today, hospitals are required to go beyond management of illness and develop community interactions that support healthy behaviors and services that prevent illness. Hospital missions may include attention to all aspects of health and thus open opportunity to make a case for oral health and related services. The prevalence of dental caries in the child population and its cost to a community may provide strong arguments to make access to care in operating rooms are part of strategies to achieve a goal of community health.

4. Non-surgical Stabilization and Delaying Strategies^{17, 18}

Non-surgical interventions for dental caries management can involve silver diamine fluoride, intermediate therapeutic restorations, and Hall technique stainless steel crowns alone or in combination. The success of the non-surgical approaches is dependent upon follow-up and evaluating progression of the lesions. Pushing the limits of minimally invasive techniques for children who have disease severity beyond that defined by the International Caries Detection and Assessment System (ICDAS) is fraught with potential problems like pulpal necrosis, on-going pain, and facial cellulitis. When numerous lesions greater than ICDAS 5 are present, definitive management under general anesthesia may be in the best interest of the child.

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Therefore, the availability of these non-surgical interventions is not a magical solution and does not obviate the need for care under general anesthesia in many cases.

The goal of non-surgical therapy for a child whose disease level is indicative of GA, can be dual-focused: first, keep dental caries present from advancing, so that a child awaiting GA does not experience pain or exacerbation of infection, and, second, in some cases, mitigate caries urgency so that a child can age and develop the ability to cooperate for in-office treatment, making GA care unnecessary.

In all cases of non-surgical intervention, providers need to establish a monitoring schedule and be ready to intervene for emergent situations. Non-surgical care should not be considered an equivalent option for GA; the nature of disease patterns that are best managed by non-surgical care are not the same as for GA. Delaying definitive treatment is a poor alternative that can easily lead to a second standard of care.

Summary

The health of children is impaired more than ever by a lack of OR access - delayed treatment, worsening dental disease, chronic pain, medical complications, and overuse of antibiotics and pain medications. Poor and minority children covered by Medicaid are disproportionately affected, making healthcare inequities worse. Conversely, children who promptly receive the care they need are on the road to improved health, better able to eat, sleep, play, learn and smile. That's why continued advocacy for access must be a priority. Pediatric patients with severe dental disease or special health care needs will need to be managed in a hospital environment, despite innovative strategies to work around lack of access to OR time. This brief will support pediatric oral health advocates by providing perspectives on the extent and trajectory of OR access, and offering possible solutions.

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Attachment

Summary of CMS HCPCS Dental Rehabilitation Code Advocacy

Medicare/Medicaid Coding Limitations

At this time, no suitable billing mechanism addresses or provides dental rehabilitation surgical services for complex dental patient cases that require operating room access for Medicare or Medicaid beneficiaries. Current CPT codes do not cover dental rehabilitation surgery, as the procedures performed do not typically involve physician time.

Coding is limited to an unlisted/miscellaneous code (CPT 41899). For hospital outpatient payment purposes, it has been placed with other miscellaneous codes in an APC (5161) with a national average 2020 APC rate of only \$203.64. This reimbursement level is grossly under the appropriate cost for complex dental surgery cases, and significantly less than the national geometric mean cost of the procedure billed to Medicare, which is \$2,334.87. The APC rate does not in any way recognize or cover a facility's time, expense, professional surgical services, anesthesia services, or equipment costs, which creates a challenge in hospitals agreeing to see Medicare patients in need of dental rehabilitation surgery. Ambulatory surgery centers are also limited in seeing these patients for dental surgery due to no recognized code for reimbursement. A majority of state Medicaid programs look to Medicare payment policy and rates as a benchmark for determining Medicaid policies for dental surgical services.

HCPCS Level II Category G-Code Proposal

The American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA), and American Association of Oral and Maxillofacial Surgeons (AAOMS) have requested that the Centers for Medicare and Medicaid Services (CMS) move forward this year to ensure dental rehabilitative services can be provided to children and the elderly. This valuable step toward access and equity in oral health care would require CMS to set up a new billing code for use by hospitals, and propose in the CY 2022 HOPPS rule (expected in July 2021) that the code also be covered for use by ambulatory surgical centers.

The specific request to CMS is to establish a new dental rehabilitation code new HCPCS Level II Category G-Code for dental rehabilitation surgery to address severe dental disease. The following language accurately describes the procedures involved in the provision of complex dental rehabilitation surgery:

Full or partial mouth dental rehabilitation – Comprehensive rehabilitation of dentition requiring multiple dental services, including for example, dental radiology, prophylaxis, tooth restoration, endodontics or extractions, requiring the administration of general anesthesia (facility services only).

AAPD, ADA, and AAOMS believe a new code using this descriptor is necessary to support the care of patients requiring complex dental services.

Congressional Advocacy

The AAPD has brought this issue to the attention of Members of Congress, requesting that they urge CMS to move forward on this proposal. The following clinical example (a four year-old with entire primary dentition affected) has been shared in Congressional meetings to illustrate the type of cases that need to be treated in the operating room under general anesthesia:



Dental rehabilitation means achieving the clinical goal or restoring good oral health.



Look for future updates on this advocacy effort in AAPD E-News, PDT, and www.aapd.org.



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Pediatric dentists sound alarm about being denied OR access

David Burger

ADA working with American Academy of Pediatric Dentistry to address 'crisis'

The ADA is moving ahead in its advocacy efforts related to what some pediatric dentists are calling an escalating obstacle of being routinely denied access to hospital and ambulatory surgical centers' operating rooms across the country, a problem exacerbated by the COVID-19 pandemic.

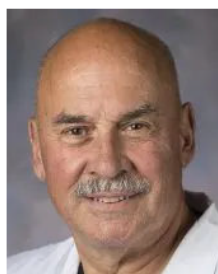


Dr. Meeske »



Dr. Elson »

"It has become a crisis for some pediatric dentists because they are unable to schedule cases or have had surgery block time reduced or taken away," said Dr. Jessica Meeske, vice chair of the ADA Council on Advocacy for Access and Prevention and Nebraska pediatric dentist. "As a result, these children with severe dental disease are getting worse."



Dr. Casamassimo »

The situation dominated the July and August proceedings of the ADA's Medicaid Provider Advisory Committee. Its members have heard complaints from pediatric dentists about encountering increasing resistance and limited access to hospital operating rooms and surgical centers to address the oral health needs of patients requiring general anesthesia services in an operating room.

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Dr. Elson

The lack of access is affecting some of the most challenging and vulnerable patients, said Dr. Howard Elson, a pediatric dentist and committee member.

"This is the defining issue for pediatric dentists at this time," he said. "COVID-19 has put a spotlight on the problem, and it's getting much, much worse."

The issue, Dr. Elson continued, stems in part from the fact that hospital administrators and other physicians don't acknowledge that dentistry is essential health care. The hospitals prioritize other cases over dental cases when scheduling treatment postponed by the pandemic, he said.

"Heart transplants, sure," Dr. Elson said. "Ingrown toenails? Maybe not."

The American Dental Association Board of Trustees adopted an ad interim policy stating dentistry is essential health care in July to help guide advocacy for the dental profession during the COVID-19 pandemic.

HPI publishing data

The ADA's Health Policy Institute is studying the issue and has generated data illustrating the problem. In August, HPI found that more than half of pediatric dentists surveyed reported a difference — negative — in scheduling OR time.

Of those experiencing limited or denied access, the pediatric dentists surveyed listed the reasons hospitals said they were limiting the scheduling of cases:

- 68%: Increased volume of other cases that are deemed more medically necessary.
- 32%: Concerns regarding aerosol generation.
- 27%: Reimbursement levels too low.
- 22%: Personal protective equipment shortages/prioritization for other cases.

Dr. Paul Casamassimo, a member of the Council on Advocacy for Access and Prevention and chief policy officer of the American Academy of Pediatric Dentistry, said that what worries him is the disparity in care, given that many of the children who need care in hospitals are from economically disadvantaged populations.

"A disproportionate percentage of people of color are affected by this issue—they're bearing the brunt of this," he said.

"These are the kids who need desperate help," Dr. Elson said.

Financial pressures

Dr. Casamassimo acknowledged that hospitals are suffering financially and as a result of the pandemic, this has gotten worse and they may be making decisions based on what procedures bring in more money to help them to stay in business. Providers treating Medicaid patients needing dental care typically report lower reimbursement rates.

The differences in dental offices and hospital operating rooms are great, Dr. Meeske said.

"If children are too young to cooperate in a traditional dental clinic setting, dentists find themselves forced to address their dental pain by either holding children down or sedating them," Dr. Meeske. "Both options are not always in the best interest of the child. If you need to complete extensive and treatment and the child is unable to sit still, you can't do your best care. This can lead to progression of dental caries or retreatment. That can lead to unnecessary child suffering, unhappy parents or insurers who don't want to pay."

She continued: "Hospitals and surgery centers are available to dentists who treat patients who are unable to sit for dental treatment. This includes children and adults with disabilities with extensive restorative

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and surgical needs (such as extracting multiple teeth), very young children, and those patients with medical and behavior conditions that prevent care in the dental clinic.

"The operating room provides the dentist and patient a safe environment where the patient is asleep under general anesthesia," she said.

Working together

The ADA has been collaborating with the American Academy of Pediatric Dentistry on the issue. Dr. Casamassimo conducted a survey of each AAPD state public policy advocate to assess the scope of the problem in each state. A resulting article is being prepared for submission to the journal Pediatric Dentistry, and is planned to be used in ADA and AAPD advocacy efforts.

The ADA is also planning a white paper to assist with consideration of a partnership with ambulatory surgery centers, who may be more receptive to dental cases than hospitals.

Dr. Meeske recommended some avenues in how dentists can work together to rectify access issues so that in the future, children needing medically necessary treatment in the operating room don't have to be put on waiting lists for six months or even a year.

"It is key that dentists be proactive to protect their surgery time," she said. "For example, serving on hospital committees and boards builds relationships with other physicians and shows you are willing to do all the same work they do. In addition, dentists who are willing to take referrals from emergency departments or will see same-day emergencies or consults send a message to their hospitals and physician colleagues that oral health is an integral part of general health. Of course, working with your surgery staff and hospital leadership to be a good steward of your time and showing a willingness to work with everyone goes a long way."

Dr. Charlie Czerepak, a Chicago-area pediatric dentist and past medical staff president of what is now Lurie Children's Hospital in Chicago, said that communication between legislators and the entire dental community is crucial.

"This is a fight for equal access and equity for Medicaid patients and the importance of dentistry as a health care profession," he said.

—burgerd@ada.org

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Dental access in Alabama is shrinking, what you need to know

Dental access in Alabama is shrinking

By [Jennifer Horton](#)

Published: Dec. 1, 2021 at 12:49 PM CST Updated: Dec. 1, 2021 at 1:09 PM CST

BIRMINGHAM, Ala. (WBRC) - Alabama dentists say the state is on the verge of a workforce crisis.

According to CDC data, nearly half of Alabama counties have less than 10 dentists, some have none. Those taking the hardest hit are patients in rural communities who drive hours for dental care.

It's a situation that will get worse without swift action and innovation. We explain the problem and possible solutions in this installment of [Bridging the Great Health Divide](#).

Access to dental care in Alabama

One-third of Alabama's dentists are 60 years old or older. At least half of those practice in rural Alabama, which means the majority of rural dentists are eyeing retirement.

"We are facing a real significant crisis right now," stated Dr. Stephen Mitchell, a dentist who serves as the director of [UAB's Civitan-Sparks Clinics](#). "We are seeing over eighty percent of Alabama dentists operating within the thirteen counties that are urban. That's leaving only twenty percent servicing the forty percent of Alabama citizens in our rural counties."

Alabama has the lowest dentist per population ratio in the country, when considering a dentist per 100,000 people Alabama is 51st in the nation.

Few are on track to fill this void, especially in rural areas.

"Even if they would like to do that they can't afford it," explained Dr. Richard Simpson, a practicing pediatric dentist. "The average dentist graduating from dental school nationally has over \$300,000 in debt. They need immediate income, so they are gravitating toward the large metropolitan areas, not the rural communities and to existing practices."

In fact, nearly half of the dentists that graduate from UAB leave for other states with higher insurance reimbursement rates or they go into specialty programs.

"The last several years, the average is out of a graduating class of fifty-five from our dental school, four go into rural area or small town each year," added Simpson.

Dentists who serve rural patients already see the impact.

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Mitchell has offered free school dental screenings for more than twenty years. The amount of tooth decay in Jefferson County students of all socio-economic backgrounds has rapidly decreased over the years.

“When we step as little as forty-five minutes outside of Jefferson County and get into some of our surrounding areas we start seeing children with much more significant levels of disease,” Mitchell explained. “We did a screening last week toward the Oneonta, Blount County area and what we saw there were many children with at least some level of disease and then a good number of children with things that we had to mark ‘this is urgent, you’ve got to get in and get help.’”

Simpson is a pediatric dentist in Tuscaloosa who serves children from 17 counties. Since the shutdown, Simpson’s seeing children with far more tooth decay and an ever-increasing number of new patients whose dentists retired as a result of COVID or stopped seeing Medicaid-eligible patients.

“Sometimes we have patients that are driving two hours to get to our office,” responded Simpson. “That’s a burden on the family; working parents have to take off an entire day of work to get their child to the dentist because there’s no one in the area to see them.”

Almost all health-related issues in Alabama are underpinned by lack of insurance coverage. Those in rural areas have less access to private health insurance. The reimbursement rates for government-funded insurance is often not enough for dentists to keep their doors open in rural areas.

“Eighty percent of [tooth] decay is in twenty percent of children,” Simpson said. “We see similar scenarios in adults because of lower socio-economic status. In rural areas with decreased access to care, we see a higher disease rate. Studies show that in schools that have at least seventy-five percent of students on free or reduced lunch, those students have twice the amount of decay as children in other communities.”

Insurance further complicates care for children with poor oral care.

Children who aren’t on private insurance receive dental care through CHIP, the federal Medicaid program managed by Blue Cross Blue Shield in Alabama or through the state’s Medicaid program.

In the past, dentists would admit children with severe oral issues and treat them under general anesthesia. Over the last few weeks, financially-strapped rural hospitals have decreased or cancelled dentists’ operating room access. While those with CHIP are covered, hospitals don’t break even with Medicaid patients.

“So they’re both federal and state programs, one set of kids can go and one set can’t,” added Simpson. So it’s a real access issue.”

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Simpson was in the operating room with twelve to sixteen patients a month, now it's two to three.

"We have nowhere to send them and the waiting list at Children's Hospital for young children that need this care or special needs kids is almost a year," Simpson admitted. "So when they do the exam of kids that are in pain and have significant disease state, by the time they're actually seen is ten to twelve months later."

Mitchell sees patients with developmental delays in the Birmingham-area, he's also limited by insurance.

"When I see them very often the only way to humanely treat them is to be able to get them into a hospital operating room, put them to sleep and try to do their work under general anesthesia", he explained. "In the state of Alabama, that becomes an office that is increasingly becoming an almost impossible goal to access."

His patients with special needs often have Medicaid, however when they turn 21 years old that coverage ends, no matter their condition.

"Once that ends, there's very little ability to get anybody to an operating room," Mitchell acknowledged.

Solutions for dental access

Both Mitchell and Simpson are advocating for better access to good insurance across the board. This would not only help patients maintain better overall health, it would also allow more dentists to reach underserved communities.

That could come by employers offering private dental insurance and expanding Medicaid in Alabama with a dental plan. Simpson added that states that have expanded Medicaid with dental coverage have seen a significant decline in those who are going to the emergency department with dental issues. Patients who are forced to visit an ER for preventable dental problems due to lack of access to care account for nearly \$2 billion dollars a year.

"If we expanded Medicaid and included dental benefits, we would actually see a rise not only in dental patients but probably a decline in other types of disease and problems, because oral health is so integral to overall health," stated Simpson.

Patients who see a dentist regularly and engage in prevention measures avoid costly and sometimes painful dental problems.

There is a new initiative called the [1st Look Program](#) which trains pediatricians to do risk assessments with children under the age of three and engage in preventative dental measures like applying fluoride. 120 pediatricians are currently participating.

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“I just spoke with over one hundred and twenty practices in northeast Alabama, that are very strongly interested now in working on getting trained in the 1st Look Program,” Simpson said.

Aside from prevention measures, additional work is being done to offer tele-dentistry and mobile dentistry in Alabama to reach underserved communities.

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ORAL HEALTH POLICIES: HOSPITALIZATION AND OPERATING ROOM ACCESS

Policy on Hospitalization and Operating Room Access for Oral Care of Infants, Children, Adolescents, and Individuals with Special Health Care Needs

Latest Revision

2020

How to Cite: American Academy of Pediatric Dentistry. Policy on hospitalization and operating room access for oral care of infants, children, adolescents, and individuals with special health care needs. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2022:144-5.

Purpose

The American Academy of Pediatric Dentistry (AAPD) advocates hospitalization and equal access to operating room facilities, when indicated, for oral care of infants, children, adolescents, and individuals with special health care needs. The AAPD recognizes that barriers to hospital oral care for patients who require treatment in that setting need to be addressed.

Methods

This policy was developed by the Dental Care Committee, adopted in 1989¹, and last revised by the Council of Clinical Affairs in 2015². A PubMed®/MEDLINE search was performed using the terms: access for dental/oral care in hospitals, operating room access for dental/oral care, and access to hospital dentistry; fields: all; limits: within the last 10 years, humans, English, birth through age 18. Additionally, websites for the American Medical Association, American Dental Association (ADA), AAPD, American Dental Association Commission on Dental Accreditation, and Centers for Disease Control and Prevention were reviewed.

Background

Pediatric dentists treat patients who present special challenges related to their age, behavior, medical status, developmental disabilities, or special needs. Caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function.³⁻⁵ These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development.⁵⁻⁸ Many medical (e.g., hematological, oncological) conditions are exacerbated by the presence of oral maladies and disease. To address these challenges and to provide the treatment needs effectively, pediatric dentists have developed and employ a variety of management techniques, including accessing anesthesia services and/or the provision of oral health care in a hospital setting with or without general anesthesia.⁹ Some children with particular compromising medical conditions may only be able to receive their dental treatment safely in a hospital setting. Hospital dentistry is an integral part of the curriculum of all accredited advanced pediatric dental training

programs. Pediatric dentists are, by virtue of training and experience, qualified to recognize the indications for such an approach and to render such care.^{10,11}

Pediatric dentists occasionally have experienced difficulty in gaining an equal opportunity to schedule operating room time, postponement/delay of non-emergency oral care, and economic credentialing. Economic credentialing (i.e., the use of economic criteria not related to quality of care or professional competency) to determine qualifications for granting/renewing an individual's clinical staff membership or privileges should be opposed.¹² The AAPD and the ADA urge hospital insurance carriers to include hospitalization benefits for dental treatment in both private and public insurance programs so the resources of a hospital are available to patients whose condition – in the judgment of the dentist – warrants treatment in the operating room.^{13,14}

Hospital governing boards and medical staffs are interested in improving the quality and efficiency of patient care. Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially the patients. Privileges should not be based on numbers of patients admitted to the facility or the patient's economic or insurance status.¹⁵

Policy statement

The AAPD shall work with all concerned medical and dental colleagues and organizations to remove barriers to hospital and operating room access for oral care for patients best treated in those settings. The AAPD affirms that hospitals or outpatient settings providing surgical treatment should not discriminate against pediatric dental patients requiring care under general anesthesia. Such patients and their care providers need access

ABBREVIATIONS

AAPD: American Academy Pediatric Dentistry. **ADA:** American Dental Association.

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Purpose of Project

ORAL HEALTH POLICIES: HOSPITALIZATION AND OPERATING ROOM ACCESS

to these facilities. The dental patient, as with any other patient, should have the right to be seen in a timely manner. Evidence has demonstrated dental treatment under general anesthesia in the operating room is a necessity, as well as an important component of comprehensive care, to assure optimal health for many, especially those considered high risk.¹⁶⁻¹⁸

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Pediatric dentists scramble as demand has them fighting for operating room space

 crainsdetroit.com/health-care/pediatric-dentists-scramble-demand-has-them-fighting-operating-room-space

August 7, 2021



Molly Doyle stretches her shoulder as she preps a syringe of Versed — a brand of midazolam drug engineered to sedate patients for medical procedures. The pediatric dentist is prepping for her first of three procedures for the day. This one is the last four of 12 crowns on a 4-year-old child.

Doyle's shoulder is injured from a previous special needs patient who, unaware of what was happening, violently squirmed and thrust to evade the dentist's drill.

Doyle's patients, and the patients of the other dentists at Motor Mouth Pediatric Dentistry in Dearborn, are awake though not lucid during these often complicated procedures. The child patients are outfitted with a nose tube, pumping nitrous oxide into their lungs to maintain sedation. But no one's laughing.

The dentists would prefer patients to be fully anesthetized, asleep during the drilling and wrenching of dental work, in a hospital operating room. But OR space is limited and more so since the pandemic as hospitals and anesthesiologists choose to sidestep dentists for more profitable procedures like hip replacements or bypass surgeries.

Medicaid only reimburses anesthesiologists about \$200 for dental procedures, where a typical general surgery is upward of \$2,000. Hospitals lose money allowing dentists to use their ORs for the average 90-minute procedures. Spectrum Health in Grand Rapids

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estimates it loses upward of \$3 million per year for dentist use of ORs, according to the Michigan Dental Association.

The result, particularly for practices like Motor Mouth's filled with low-income Medicaid patients, is an office ringing to a cacophony of screams from uncomprehending children.

Rodeo dentistry

Motor Mouth performs these procedures — where the child is sedated but still awake — on roughly six patients per day, four days per week.



Credit: Nic Antaya for Crain's Detroit Business

Dr. David Vazquez at Motor Mouth Pediatric Dentistry in Dearborn.

David Vazquez, proprietor of the office and a pediatric dentist, said he'd prefer to see about four of those six patients in an operating room under anesthesia.

"I have a large Medicaid population of kids with lots of problems," said Vazquez, talking over the playful "Let It Grow" song from Disney's "The Lorax" that is playing in a procedure room and waiting for sedation to calm his young patient. "Many of our patients are kids with special needs — on the autism spectrum, or neurological disorders or who have sickle cell anemia — that just don't do well with sedation."

2/6

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Vazquez and his dental assistant help the young patient into the chair, which is outfitted with Velcro straps to prevent tiny arms and legs from becoming weapons. Vazquez positions himself tightly near the child's head and rests his forearm near her jaw to keep her head stabilized during the procedure. He calls this "rodeo dentistry," having to prepare his body to safely perform with drills in a tiny mouth.

"I could keep them (operating rooms) busy all month," Vazquez said. "But the hospitals don't make enough off of us to make it worth their while."

Motor Mouth is able to secure space in one operating room for one procedure at Children's Hospital of Michigan in Detroit just once a month, he said.

Doyle, returning to the prep lab to prepare for another round of crowns on her young patient, says the mother of her patient didn't observe the procedure, instead choosing to sit in the waiting room.

"Honestly, it's better," Doyle said. "This isn't fun for me or anyone else. If the parent's in the corner crying, that's one more person I have to look out for. It's just not your best work in this capacity. It's ultimately difficult for me, the child and the parent."

Hospitals posit the lack of operating room space for dental care, while problematic, is a consequence of more acute care requirements from patients, especially during the COVID-19 pandemic.

"Currently, operating room access is limited throughout the state, and difficult decisions have to be made on which types of procedures can be performed," said Michigan Health and Hospital Association CEO Brian Peters. "Hospitals have an obligation to prioritize the patients under the care of their employed physicians and surgeons. In addition, hospitals throughout Michigan continue to operate at high capacity while caring for high volumes of non-COVID-19 patients, which we believe is a consequence of delayed care from the pandemic. The postponement of nonemergency medical procedures at the beginning of the pandemic is one specific example that has led to further demand for operating room space."

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Credit: Nic Antaya for Crain's Detroit Business

Dental assistant Gaby Montes prepares a room for a patient at Motor Mouth Pediatric Dentistry in Dearborn.

Matthew Denenberg, vice president of medical affairs for Spectrum Health, said the hospital is obligated to care for patients with the most acute needs. That isn't often dentistry.

"Our goal is to ensure operating room access for pediatric patients who require medical or oral surgical procedures of appropriate complexity," Denenberg said in a statement to Crain's. "As such, we have limited dental procedures in hospital operating rooms to high acuity procedures and appropriate clinical situations and are working with local dentists and physicians to offer lower acuity care in lower acuity settings."

Filling the decay

The funding model is complicated and no easy fix is evident, said Jeffrey Johnston, chief science officer for dental insurer Delta Dental of Michigan.

The legislative charter that allowed Delta Dental to form in 1957 only allows Delta Dental to reimburse board certified dentists, so it can't reimburse hospitals and anesthesiologists.

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"Even if they were reimbursed at a competitive rate for services, dentists simply don't bill out as much as say a cardiologist does for an angioplasty," said Johnston. "Your typical operating room dental procedure probably tops out at less than \$7,000, which is almost nothing compared to a knee replacement or bypass."

And dental plans have maximum payouts, which allows the coverage to be cheap enough for customers. Delta Dental's maximum payout is \$2,000 annually for its most expensive plan, meaning an expensive operating room procedure would have to be covered out of pocket by the pediatric patient's parents when it exceeds \$2,000. Which is far too rich for the patients often requiring these procedures.

"When you look at the population, the greatest need for this care is in the Medicaid population," Johnston said. "But they also have the lowest amount of funds to pay out of pocket."

Delta Dental is promoting two solutions to the problem: bringing pediatric anesthesiologists to the dentist office and to offer extended benefits to low-income dental patients to prevent 4-year-olds from needing 12 crowns in the first place.

Currently, pediatric anesthesiologists are certified by the Michigan Board of Medicine not the Board of Dentistry, therefore not allowing them to perform anesthesiology outside of medical establishments like a hospital or outpatient surgery center.

But Gov. Gretchen Whitmer signed a package of bills May that covered a wider use of anesthesiology services across the state. Under House Bill 4067, which doesn't go into effect until Sept. 1, 2022, the Dentistry Board can certify specialty fields such as oral radiology, oral public health and dental anesthesiologists.

Vazquez said it's a win for pediatric patients and dentists.

"For us to use an anesthesiologist here, in this setting where we're comfortable and the kids are more comfortable is a big deal," Vazquez said, taking a break from the drilling and screams of his young patient. "She won't remember this. The drugs give a temporary amnesia. But she's scared. She wouldn't be under the right anesthesia."

But there are only a limited number of pediatric anesthesiologists in the country capable of performing in the dental space, Johnston said. So prevention remains the biggest step to combating the issue.

In the fall, Delta Dental Foundation, the philanthropic arm of the insurer, is planning to increase its funding for low-income patients. This is allow for more teeth cleaning visits and other preventive care. The insurance provider will also pay for dentists to take online courses from the University of Pennsylvania specializing in special needs patients.

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"We need to encourage dentists to see more special needs patients," Johnston said. "If we can increase (dentistry) utilization in children, we can prevent all these problems and prevent these children from even needing an operating room."

Editor's note: A previous version of this article incorrectly identified the insurer Delta Dental as increasing low-income funding. The current version is correct.



By Dustin Walsh

Dustin Walsh is a senior reporter for Crain's Detroit Business, covering health care with a focus on industry change and operations, as well as the state's emerging cannabis industry. He is also a regular columnist on all things health, labor, economics and more.

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ADANews



Dental groups ask CMS to improve access to dental surgeries

Groups request meeting to discuss ongoing issue with access, coding

by Jennifer Garvin

July 07, 2022



The American Academy of Pediatric Dentistry, American Dental Association and American Association of Oral and Maxillofacial Surgeons are asking the Centers for Medicare & Medicaid Services to help improve access to dental surgical services for children and adults with special needs and disabilities.

In a [June 30 letter](#) to Meena Seshamani, M.D., Ph.D., deputy administrator and director, CMS Center for Medicare, and Daniel Tsai, deputy administrator and director, CMS Center for Medicaid and CHIP Services, the groups asked the agency for a meeting to address the dental community's "significant concerns" regarding pediatric and adult patient access to dental rehabilitation surgery in hospital outpatient and ambulatory surgical center locations.

They noted that "limitations in access have been exacerbated" by the pandemic, primarily affecting high-risk Medicaid and commercially insured patients who require an operating room setting when receiving extensive dental procedures due to their particular medical conditions. They also said that other stakeholders have raised these same concerns -

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Purpose of Project

notably, the Consortium for Citizens with Disabilities Health Care Task Force and American Academy of Pediatrics - and Members of Congress have also requested action by the agency. The latter sent a May 25 letter to CMS Administrator Brooks-LaSure emphasizing the urgency of the dental access problem and its consequences on health equity.

"The lack of OR access for needed and covered dental procedures often results in wait times of 6-12 months for these patients, many of whom are children whose daily activities and school performance are often significantly affected in the interim," the dental groups wrote. "We attribute most of this access challenge to the lack of a sustainable billing mechanism for hospitals and [ambulatory surgical centers] to report dental surgical services in both Medicare and Medicaid."

To fix the issue, the groups said they believe "the hardship experienced by our patients" could be considerably alleviated by the issuance of a new Healthcare Common Procedure Coding System codes for dental surgical procedures performed under general anesthesia and payment for the new code at a rate that reflects the costs involved, based on Medicare data.

The dental groups noted that the problem is twofold: First, dental rehabilitation surgical services for complex dental patient cases that require operating room access do not have specific CPT codes. And secondly, because Medicare regulations do not allow miscellaneous codes to be included on the Covered Procedures List for Ambulatory Surgery Centers, these dental surgical services are not covered in the ambulatory surgical centers.

"While Medicare's coverage of dental surgical procedures is admittedly limited, these issues impact almost all of those Medicare patients whose dental surgery is performed ancillary to a covered surgical procedure," they wrote. "Our organizations are not otherwise requesting any expansion of Medicare dental services to address this situation."

The groups also said that "even more significantly, Medicaid programs often either adopt Medicare payment rates or utilize them as a benchmark, and both Medicaid and commercial payers generally utilize Medicare's [ambulatory surgery centers] list to determine which procedures are eligible for coverage. The lack of appropriate payment and the absence of these procedures on the ambulatory surgery center list, therefore, has a significant ripple effect on OR access for Medicaid patients."

ATTACHMENT 12

Purpose of Project



CMS establishes new payment code for dental surgeries performed in hospital ORs

ADA, stakeholders continue to press agency to increase access to ambulatory surgical centers

by Jennifer Garvin

November 15, 2022



The Centers for Medicare & Medicaid Services has agreed to establish a new dental billing and payment arrangement to improve access for dental surgeries performed in hospital operating rooms.

Health Care Common Procedure Coding System code G0330 is applicable to facility services for dental rehabilitation procedures furnished to patients who require monitored anesthesia and use of an operating room.

The new code is the result of an advocacy campaign spearheaded by the ADA, American Academy of Pediatric Dentistry and American Association of Oral and Maxillofacial Surgeons.

ATTACHMENT 12

Purpose of Project

In a [June letter](#), the ADA, AAPD and AAOMS asked CMS to address the dental community's "significant concerns" regarding pediatric and adult patient access to dental rehabilitation surgery in hospital outpatient and ambulatory surgical center locations. In that letter, the dental organizations noted that "limitations in access have been exacerbated" by COVID-19, primarily affecting high-risk Medicaid and commercially insured patients who require an operating room setting when receiving extensive dental procedures due to their particular medical conditions.

"The lack of OR access for needed and covered dental procedures often results in wait times of 6-12 months for these patients, many of whom are children whose daily activities and school performance are often significantly affected in the interim," they wrote. "We attribute most of this access challenge to the lack of a sustainable billing mechanism for hospitals and ambulatory surgical centers to report dental surgical services in both Medicare and Medicaid."

The ADA, AAPD and AAOMS will continue to work with Congress and CMS in advocating for allowing dental services to be billed as a covered procedure by ambulatory surgical centers.

Follow all of the ADA's advocacy efforts at [ADA.org/Advocacy](https://ada.org/Advocacy).

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[ADA releases new clinical practice guideline on caries restorations](#)

ATTACHMENT 13

Alternatives

Status Quo

No additional financial Cost / Significant adverse impact upon access to care

This project is specifically designed to address fundamental concerns with the status quo. There are significant obstacles to accessing care for dental surgical procedures for individuals reliant upon Medicaid for their healthcare reimbursement. This is particularly true for pediatric patients. Oftentimes, the ability to obtain necessary services is so compromised that no care is obtained until the circumstances become emergent and care is sought in an emergency room. No one should have to face a status quo where the standard practice is to experience delayed access to care such that situations are allowed (if not required) to fester until emergency care is required. There is limited access to this care (only UIC Dental School) is providing this care, and the delay in being able to access care is extended. Moreover, the need for these services far exceeds the available capacity. Finally, the second patient population to be served by this facility are individuals with special needs who require access to the specialized care and staff proposed by this project who also face unnecessary obstacles to being able to obtain the baseline care their require. For these reasons, this alternative was rejected.

Utilization of Existing Facilities

No additional financial Cost / Significant adverse impact upon access to care

There are significant issues with the concept of utilizing existing facilities to provide the care envisioned by this project. The biggest obstacle is the lack of the specialized staff capable and trained to provide this care. Equally important is the lack of the equipment and technology necessary to provide care. Hospitals have shied away from the provision of dental care and the result of that is the lack of a commitment to having the necessary equipment and technology – a problem that only gets worse and worse as we move forward. This is compounded by the inherent and resulting lack of staff trained to provide the care. These are two vulnerable patient populations that deserve having access to care in a meaningful way. Moreover, even if the staff that is envisioned to provide these services were available to travel from facility to facility to provide the necessary care, the additional administrative challenges of patients being able to identify the qualified providers, the additional obstacles of availability and a commitment to serving a Medicaid population would still exist. The percentage of Medicaid patients envisioned to be served by the proposed project exceeds 80 percent – a level that virtually all existing surgery centers and even hospitals would be resistant to committing to – even if the obstacle of technology and equipment could be overcome. Accordingly, this alternative was also rejected.

Project as Proposed

Costs as described in the Application

The project is novel to Illinois – but is not novel. The applicants have identified these problems in other jurisdictions (e.g., Washington D.C. and Baltimore, MD). The model proposed in this application was borne from these jurisdictions and has evolved to meet a previously unmet need in these communities. The result has been a sustainable model that allows meaningful access to care for pediatric Medicaid patients who have otherwise been unable to obtain care. It has allowed access to care for patients with special needs who have faced unnecessary challenges in accessing care in facilities with staff trained to meet their needs, with access to technology and equipment to meet their needs, and without the unnecessary administrative burdens of having to search for (and wait for) access to necessary care. Simply put, this option improves access to care and improves the lives of the individuals the facility serves. For these reasons, this option was selected.

ATTACHMENT 14

Size of the Project

The square footage identified in this application for the proposed project includes one operating room, recovery stations and is necessary, not excessive, and is over the standards identified in Appendix B of 77 Ill. Admin. Code Section 1110, as documented below. However, when evaluating communities within Chicago with the greatest need, the South Side of Chicago presented the best opportunity to have a substantial immediate impact. To keep costs for construction down, the Applicants looked to identify an existing structure that would accommodate an ambulatory surgical treatment center and meet Illinois Department of Public Health life safety codes.

The building chosen for the proposed facility offered many advantages, geographic location, parking, and room for future growth. While the space is currently designed to utilize all non-clinical space, should it be necessary the Applicants would be able to convert additional space for clinical use.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC (1 Operating Room)	4,400	2,750	+1650	NO

ATTACHMENT 15

Project Services Utilization

The annual utilization of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish one surgical room, making the objective for demonstrating utilization in excess of 1500 hours. Although the facility has no historical utilization, with known population of dental patients who rely on Medicaid as a payor, the Applicants are confident that their estimated patient volume for the facility would allow them to not only meet but exceed the state standard by its first year of operation.

UTILIZATION					
	DEPT/ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	ASTC	N/A	2,200	>1,500 Hours	YES
YEAR 2	ASTC	N/A	2,420	>1,500 Hours	YES

The number of 2,200 predicted procedures are derived from patients and procedures envisioned emanating directly from the proposed patient base the facility intends to serve. While the application contains no referral letters the Applicants have evaluated the conditions on the ground and based on their previous experience opening surgical centers with the same model and proposed patients base they expect to serve upwards of 2,200 patients in year 1 of operation and 2,420 patients in year 2 of operation.

In their existing facilities the Applicants have found that their patient base is made up of 85% pediatric dental cases, and 15% special needs patients. The average procedure time for pediatric dental patient is 1.33 hours which includes (59 minutes of procedure time and 10 minutes for room prep and 10 minutes for room clean-up). The average procedure time for special needs dental patient is 1.6 hours which includes (75 minutes of procedure time and 10 minutes for room prep and 10 minutes for room clean-up).

YR1 Proposed Procedures	2,200	(Assumes 1,870 pediatric patients and 330 Special Needs patients)
YR2 Proposed Procedures	2,420	(Assume 2,057 Pediatric patients and 363 Special Needs patients)
Average Procedure Time for Children (In Hours)	1.33	
Average Procedure Time for Special Needs (In Hours)	1.6	
Yr1 Surgical Hours (70% Children/30% Special Needs)	3,015	
Yr 2 Surgical Hours (85% Children/15% Special Needs)	3,875	

ATTACHMENT 15

Project Services Utilization

Based on the Board standards for facility operation, it is expected that in year 1 of operation the facility will be operating above a 150% capacity.⁹

Utilization Calculation	
Operational Days	250
Average Hours of Operation	7.5
Available Surgical Time	1875
Procedure Hours Per Operating Room Year 1	3015
Number of Operating Rooms	1
Total Procedure Hours	3015
Average Procedure Time (hours)- Pediatric Patients	1.33
Average Procedure Time (hours)- Special Needs Patients	1.6
First Year Proposed Procedures	2,200
First Utilization	161%
Second Year Proposed Procedures	2,420
Second Year Utilization	207%

⁹ Applicants are aware that a project of this nature, to add access to a service-line that has been historically absent, has a predictive aspect to it. Based upon and in acknowledgement of that fact, Applicants concluded they were far more comfortable seeking approval for a single operating room, proving the overwhelming need for this care and committing to return before this Board to obtain approval to add another operating room when the utilization justifies it. The space we have acquired would allow for this, as we do expect this to prove necessary.

ATTACHMENT 16

Unfinished or Shell Space

NOT APPLICABLE - The proposed project does not include plans for shell space.

ATTACHMENT 17

Assurances

NOT APPLICABLE - The proposed project does not include plans for shell space.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents – 1110.235(c)(2)(B)

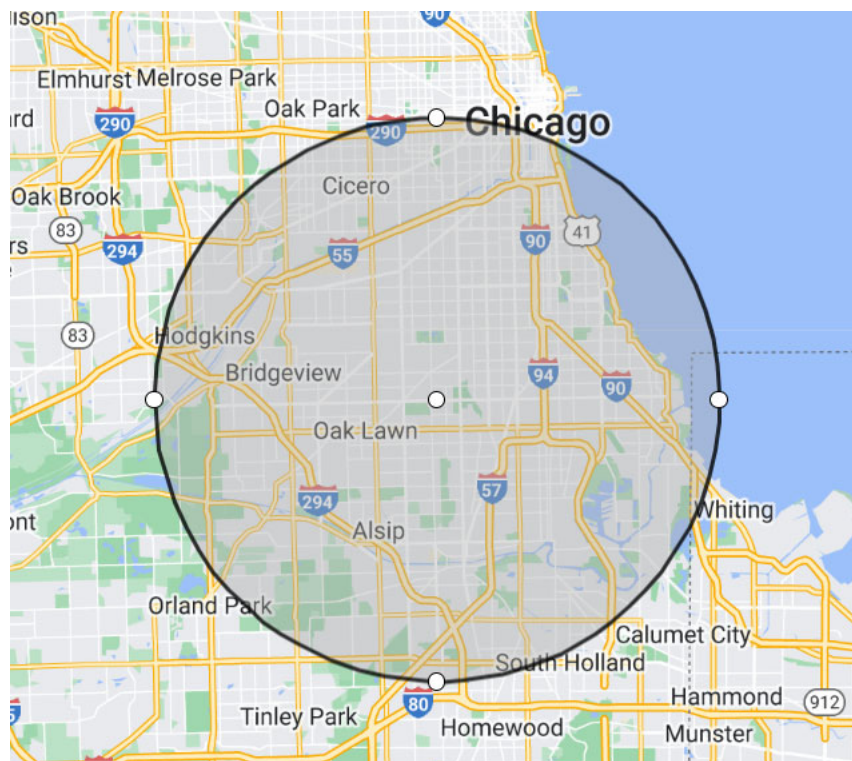
Chicago Children's Surgery Center, LLC ("CCSC") seeks to meet the needs of the residents of the planning area. As noted in this application, the proposed project involves the conversion of an existing building and treatment of patients that currently have no ASTC options available and a limited number of hospitals that both equipped and willing to perform these types of procedures.

With one operation room, the ASTC will provide an outlet for patients with nowhere else to turn. It is expected that the facility will be at target utilization within the first year of operation. There are also significant costs incentives to move these types of procedures out of the hospital surgical suite and into an outpatient setting.

The primary purpose of this project is to provide necessary healthcare to the resident of the geographic service area ("GSA") in which the ASTC will be located. Listed on the following pages, in accordance with 77 Illinois Admin. Code Section 1110.235(c)(2)(8) is the GSA consisting of all zip code areas that are located within a 10-miled radius of the proposed site of the ASTC. The zip codes and area within a 10-mile radius of the proposed facility is listed below. We have also included a map of the multiple direction travel radiuses of the proposed ASTC site.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents – 1110.235(c)(2)(B)

10 Mile Radius from 8658 S. Sacramento Avenue, Chicago, IL 60652



ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents – 1110.235(c)(2)(B)

ZIP	CITY	POPULATION (2020 Census)
60652	Chicago	40,898
60499	Bedford Park	602
60456	Hometown	4,343
60805	Evergreen Park	19,945
60629	Oak Lawn	114,453
60454	Burbank	58,362
60459	Chicago Ridge	29,451
60636	Bridgeview	34,800
60620	Alsip	66,514
60655	Worth	27,837
60453	Hickory Hills	58,362
60638	Summit Argo	56,928
60621	Justice	29,570
60415	Crestwood	14,433
60632	Blue Island	92,237
60643	Palos Hills	47,831
60455	Cicero	17,098
60803	Berwyn	22,189
60609	Robbins	65,770
60619	Lyons	63,303
60482	Palos Heights	11,216
60457	Midlothian	14,420
60501	La Grange	11,746
60628	Riverdale	62,832
60637	Posen	53,555
60458	Riverside	14,504
60418	Brookfield	10,813
60406	Willow Springs	24,011
60465	Palos Park	18,530
60615	Oak Park	43,502
60804	Hines	85,673
60402	Harvey	64,706
60623	Markham	87,649
60472	Oak Forest	4,671

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents – 1110.235(c)(2)(B)



Local hospitals don't do dental cases²

Chicago

- ☐ University of Chicago Medical Center
- ☐ Advocate Lutheran General Hospital
- ☐ Loyola University Medical Center
- ☐ Advocate Christ Medical Center
- ☐ Elmhurst Memorial Hospital
- ☐ Northwest Community Hospital
- ☐ Advocate Children's Hospital
- ☐ Lurie Children's Hospital of Chicago

Peoria

- ☐ OSF Saint Francis Medical Center
- ☐ UnityPoint Health
- ☐ Pekin Memorial Hospital



No Dental



Dental

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents – 1110.235(c)(2)(B)

Facility Name	Distance to Proposed Site	Categories of Services	No. of Operating Rooms
Hyde Park Surgery Center	10.3 miles	-Neurology -Ophthalmology -Orthopedic -Pain Management	1
Vascular Access Center of Illinois	4.7 miles	*	0
Southwestern Medical Center	4.5 miles	-Gastroenterology -General Surgery -OB/Gynecology -Ophthalmology -Pain Management -Podiatry	3
Center for Reconstructive Surgery	5.4 miles	-Ophthalmology -Orthopedic -Pain Management	4
Oak Lawn Endoscopy	5.6 miles	*	0
Willow Springs Surgery Center	9.1 miles	-General Surgery -Podiatry	2
Palos Hills Surgery Center	7.9 miles	-Orthopedic -Pain Management -Podiatry	2
Palos Surgicenter	8.1 miles	- Laser Eye Surgery -Ophthalmology -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry	3
Willow Springs Surgery Center, Ltd.	9.1 miles	-General Surgery -Podiatry	2

*Not reported in most recent Board Inventory Report

ATTACHMENT 24

Non-Hospital Based Ambulatory Surgery Treatment Room Need Assessment 1110.235(c)(5)

The annual utilization of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish one surgical room, making the objective for demonstrating utilization in excess of 1500 hours. Although the facility has no historical utilization, with known population of dental patients who rely on Medicaid as a payor, the Applicants are confident that their estimated patient volume for the facility would allow them to not only meet but exceed the state standard by its first year of operation.

UTILIZATION					
	DEPT/ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	ASTC	N/A	2,200	>1,500 Hours	YES
YEAR 2	ASTC	N/A	2,420	>1,500 Hours	YES

The number of 2,200 predicted procedures are derived from patients and procedures envisioned emanating directly from the proposed patient base the facility intends to serve. While the application contains no referral letters¹⁰ the Applicants have evaluated the conditions on the ground and based on their previous experience opening surgical centers with the same model and proposed patients base they expect to serve upwards of 2,200 patients in year 1 of operation and 2,420 patients in year 2 of operation.

In their existing facilities the Applicants have found that their patient base is made up of 85% pediatric dental cases, and 15% special needs patients. The average procedure time for pediatric dental patient is 1.33 hours which includes (59 minutes of procedure time and 10 minutes for room prep and 10 minutes for room clean-up). The average procedure time for special needs dental patient is 1.6 hours which includes (75 minutes of procedure time and 10 minutes for room prep and 10 minutes for room clean-up).

YR1 Proposed Procedures	2,200	(Assumes 1,870 pediatric patients and 330 Special Needs patients)
YR2 Proposed Procedures	2,420	(Assume 2,057 Pediatric patients and 363 Special Needs patients)
Average Procedure Time for Children (In Hours)	1.33	
Average Procedure Time for Special Needs (In Hours)	1.6	
Yr1 Surgical Hours (70% Children/30% Special Needs)	3,015	
Yr 2 Surgical Hours (85% Children/15% Special Needs)	3,875	

¹⁰ The Board's requirements for referrals are broken down into historical referrals (which there are none, as this service is simply not available) and projected referrals (which require a physician to attest to the "total number of patients who have received care at existing facilities" in the area over the last year). Since this project is driven by creating a facility at which patients can obtain care that **has not been historically available** it is predictive in its nature. The need, however, for these services is undeniable.

ATTACHMENT 15

Project Services Utilization

Based on the Board standards for facility operation, it is expected that in year 1 of operation the facility will be operating above 150% utilization.¹¹

Utilization Calculation	
Operational Days	250
Average Hours of Operation	7.5
Available Surgical Time	1875
Procedure Hours Per Operating Room Year 1	3015
Number of Operating Rooms	1
Total Procedure Hours	3015
Average Procedure Time (hours)- Pediatric Patients	1.33
Average Procedure Time (hours)- Special Needs Patients	1.6
First Year Proposed Procedures	2,200
First Utilization	161%
Second Year Proposed Procedures	2,420
Second Year Utilization	207%

¹¹ Applicants are aware that a project of this nature, to add access to a service-line that has been historically absent, has a predictive aspect to it. Based upon and in acknowledgement of that fact, Applicants concluded they were far more comfortable seeking approval for a single operating room, proving the overwhelming need for this care and committing to return before this Board to obtain approval to add another operating room when the utilization justifies it. The space we have acquired would allow for this, as we do expect this to prove necessary.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service Accessibility 1110.235(c)(6)

A review of the services available in the proposed service area reveal that this facility will both be improving access to care and doing so in a way that should not adversely impact the existing facilities within the GSA.

This facility has 9 existing ASTCs in the area, ranging from 4.5 miles to just over 10 miles away from the proposed facility. None of the existing facilities are approved to provide either dental or oral/maxillofacial surgical services by this Board or by IDPH. See 1110.235(c)(6)(C). Only two hospitals, Advocate's Children's Hospital and Lurie Children's Hospital of Chicago providers dental cases and neither have the capacity or the geographic proximity to the proposed patient population. Moreover, the predicted reimbursement mix of this facility being over 80% Medicaid presents an additional obstacle to identifying a location for the universe of patients to be served by this ASTC at existing facilities (not to mention the lack of specially trained staff or the requisite equipment).

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Unnecessary Duplication /Maldistribution/Impact on Area Providers
1110.235.(c)(7)(a)-(c)

The proposed project seeks to treat patients (Medicaid and Special Needs) that are currently without options for outpatient dental care requiring them to be under anesthesia. This application has documented the various access issues faced by these patients who, because of the lack of these services being available, too often end up in hospital emergency rooms seeking treatment. However, an emergency room is a facility that is often both ill-equipped and ill-staffed to treat the patient and results in the advancement of conditions to an emergent level that could have been resolved earlier, with less cost, less disruption, and less discomfort.

The business model for this facility is unlike any other that has come before this board in the last several years. The goal of this facility is overwhelmingly to serve a Medicaid population of patients. These are patients that often ASTCs in this state either seldomly treat or provide no treatment at all. Many ASTCs elect not to participate in Medicaid based upon what they consider to be unfavorable reimbursement levels. This project looks beyond that to the need for care.

We believe the impact to area facilities will be minimal and coupled with the fact that there are no ASTCs within the GSA of the proposed facility that even offer the same services, thus there will be no duplication or maldistribution of services. The only locations with the ability to perform these types of procedures are area hospitals and for the various reasons stated herein, a hospital emergency operating room is not the appropriate setting for patients seeking these types of procedures.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Staffing – 1110.235(c)(8)

The facility will appoint Joseph Field, D.D.S. to serve as medical director of the facility (curriculum vitae attached). The applicant has not traditionally had any difficulties in staffing their facilities in other states and does not anticipate any issues staffing the proposed ASTC. Currently the proposed staffing plan calls for using Medical and Dental anesthesiologists (dentists who have completed a residency in anesthesia), and in the future the facility will likely utilize CRNAs in coordination with a medical or dental anesthesiologist. The facility intends to hire at least 2 nurses to be supervised by a Nurse Manager, who will also be supported by Medical Assistants. The facility proposes to have 3 Dental Assistants assisting the dental surgeons chairside and helping with setting up dental supplies and equipment. Finally, the proposed facility will have an administrator overseeing operations on a day-to-day basis.

ATTACHMENT 24

Non-Hospital Based Ambulatory Surgery Staffing – 1110.235(c)(8)

Joseph Field

99 Third Street • Los Altos, California 94022
Phone: 650-948-5524 • E-Mail: jfield@pccd.net

Education

Diplomate American Board of Oral Implantology / Implant Dentistry, October 2016

Graduate Implant Maxi Course (AAID), June 2011

D.D.S University of Southern California School of Dentistry (USC), May 2008

B.S. Physiology, Brigham Young University (BYU), August 2004

Leadership

• President and Founder of Peninsula Implant Continuum	02/11 - Present
• Western District Board American Academy of Implant Dentistry	06/16 - Present
• Board of Directors American Dental Education Association	06/07 - 06/08
• Vice President ADEA Council of Students	03/07 - 03/08
• President Alpha Omega, Tau Chapter	05/06 - 05/07
• Student Director AYUDA International Dental Clinics	04/06 - 04/08
• President USC Student Research Group	04/06 - 04/07
• Vice Chair ADEA Council of Students	03/06 - 03/07
• Editor Alpha Omega, Tau Chapter	05/05 - 05/06
• President USC Academic Dentistry Organization	03/05 - 03/07
• Regional Representative ADEA	03/05 - 03/06
• Representative USC Committee for the Associate Student Body	09/04 - 05/08

Awards

• Fellow in the American Academy of Implant Dentistry	05/17
• Fellow in the International Congress of Oral Implantologists	06/14
• Fellow in the Academy of General Dentistry	07/12
• John Ingle Award for Excellence in the Basic Sciences	05/08
• Oral Biology Award for Excellence in Oral Science	05/08
• AYUDA Humanitarian Award for Service in Belize	04/07
• Karl Hilton Young Memorial Award for Academic Excellence	05/06 - 05/08
• AYUDA Humanitarian Award for Service in Mexico	04/06
• Dexter Smith Memorial Scholarship Award	04/06
• AYUDA Humanitarian Award for Service in Costa Rica	04/05

ATTACHMENT 24

Non-Hospital Based Ambulatory Surgery Staffing – 1110.235(c)(8)

Joseph Field
Page 2

- ADEA Regional Representative of the Year Award 03/05
- USC Dean's List 01/05 - 05/08

Publications/Presentations

- American Student Dental Association News: *Guidelines for Anesthesia* 09/07
- Journal for the American Student Dental Association; *Understanding Conscious Sedation*, Volume 27 number 2 pgs 24-25 06/07
- Peking School of Dentistry, Beijing, China; *The Effects of the Community Health Model* 10/05

Research Experience

- IV Sedation Training at USC 08/06 – 06/08
- *Pulpotomies in Permanent Molars; An Alternative to Extraction and Endodontic Therapy* 06/05 - Present
- *Using Cone Beam Technology to Facilitate Extractions and Implant Placement* 11/04 - 06/05
- Research Assistant 09/04 - 09/05

Teaching Experience

- Lecturer for Align Technology 07/14 - Present
- Lecturer for Straumann, Hiossen and Neoss Implants 07/14 - Present
- Founder and Director of the Peninsula Implant Continuum 09/12 - Present
- Instructor, Full Mouth Rehabilitation course at USC 03/08 - Present
- Instructor, IV Sedation course at USC 07/07 - Present
- Teaching Assistant, Dental Morphology course 05/06 - 08/06

Professional Development

- Co-Founder, USC Student Professional and Ethics Club 06/07
- Consultant, DenMat Cooperation 06/06 - 12/07
- Member, USC Executive Curriculum Committee 03/06

ATTACHMENT 24

Non-Hospital Based Ambulatory Surgery Staffing – 1110.235(c)(8)

Joseph Field
Page 3

- Member, USC Associate Student Body Ethics Task Force 11/05

Service/Community Involvement

- Smiles for Troops annual event, free dental care for veterans 10/14 - Present
- Volunteer, monthly free dental clinics 09/04 - Present
- Union Rescue Mission Clinic, Los Angeles, CA 09/07-12/07
- USC Mobile Dental Clinic, Visalia, CA 05/07
- USC International Dental Clinic, Belize 04/07
- Dental Explorers camp for underserved minorities 06/06
- Children's Dental Center, Inglewood, CA 04/06 - 01/07
- USC International Dental Clinic, Mexico 04/06
- Give Kids a Smile Program 02/06
- USC International Dental Clinic, Costa Rica 04/05
- Elementary School dental health awareness program 09/04 - 06/05

Affiliations/Memberships

- Academy of Cosmetic Dentistry 04/06 - Present
- Academy of General Dentistry 05/08 - Present
- Academy of Osseointegration 05/09 - Present
- Alpha Omega Dental Society 09/04 - Present
- American Association of Dental Research 09/04 - Present
- American Dental Association 09/04 - Present
- American Dental Education Association 09/04 - Present
- American Society for Dental Ethics 03/08 - Present
- American Student Dental Association 09/04 - Present
- California Dental Association 09/04 - Present
- LDS Academy of Dentists 05/08 - Present

Interests/Hobbies

- Basketball, golf, photography, website design, attending sporting events, dental journals, hiking, camping, scuba diving and spending time with my family

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery Center
Charge Commitment- 1110.235(c)(9)

June 25, 2023

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

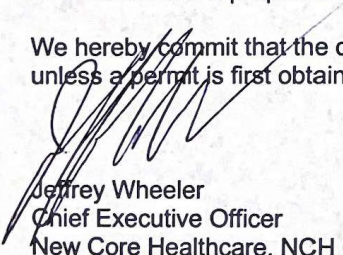
Re: New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC – Charge Commitment

Dear Mr. Kniery,

As a representative of New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC, I, Jeffrey Wheeler, hereby attest that a peer review program exists or will be implemented that evaluates whether patient outcomes are consistent with quality standards established by professional organization for the ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

Furthermore, I hereby attest that in order to meet the objectives of the Act, which are to improve the financial ability of the public to obtain necessary health services; and to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; and cost containment and support for safety net services that we have enclosed a list of CPT codes and a proposed fee schedule.

We hereby commit that the charges will not increase, at a minimum, for the first 2 years of operation unless a permit is first obtained pursuant to 77 Ill. Admin. Code. 1130.310(a). Sincerely,



Jeffrey Wheeler
Chief Executive Officer
New Core Healthcare, NCH Growth Partners, LLC,

ATTACHMENT 24

Non-Hospital Based Ambulatory Surgery Center Charge Commitment- 1110.235(c)(9)

A list of the relevant CPT and CDT codes, procedures and charge for the proposed ASTC is outlined below. In submitting this information, the Applicant verifies that it will not increase these charges for a minimum of 24 months.

The ASTC will charge the standard CPT codes 41899 and may charge any CDT code listed below (based on the specific contract with commercial and state payers and the scope and extent of the work performed by the dental surgeon). ***The Applicant is committed to not increasing the billed amounts for a period of no less than 24 months.***

The ASTC will charge the standard CPT codes G0330 and 41899 to commercial insurances, as per common practice in the industry. It is important to note that for these procedures Illinois Medicaid uses the 3M EAPG software for ASTC billing, which dictates the complex process for reimbursement. The facility is required to obtain a copy of the rendering dentist's treatment records and bills and then submits a copy of those treatment records and CDT codes billed to the dental insurance to 3M's software, and the 3M EAPG software uses an APG grouper methodology to estimate the relative weight (complexity) of the treatments that were rendered in the ASTC. Based on the relative weight, that amount is then multiplied times a base rate for the state's Medicaid program, and the Applicants are paid based on the result of the calculation. The fees charged will be different for each patient based on the complexity and extent of treatment rendered. A rendering dentist can bill any CDT code, depending on the medical necessity of the patient treated in the ASTC. The Applicant is committed to charging the billed amounts for a period of no less than 24 months.

CPT / CDT Code	CPT / CDT Description	Proposed Fee Schedule
41899	Dental services when performed in a hospital outpatient setting	\$7,500
D0120	Periodic Oral Evaluation - Established Patient	\$7,500
D0140	Limited Oral Evaluation - Problem Focused. Bill For Emergency Treatment To Control Blood.	\$7,500
D0145	Oral Evaluation For A Patient Under Three Years Of Age And Counseling With Primary Caregiver	\$7,500
D0150	Comprehensive Oral Evaluation - New Or Established Patient	\$7,500
D0160	Detailed And Extensive Oral Evaluation - Problem Focused By Report	\$7,500
D0170	Re-Evaluation-Limited Problem Focused (Established Patient; Not Post-Operative Visit)	\$7,500
D0171	Re-Evaluation - Post-Operative Office Visit	\$7,500
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	\$7,500
D0190	Screening Of A Patient	\$7,500
D0191	Assessment Of A Patient	\$7,500
D0210	Intraoral - Complete Series Of Radiographic Images	\$7,500
D0220	Intraoral - Periapical First Radiographic Image	\$7,500

D0230	Intraoral - Periapical Each Additional Radiographic Image	\$7,500
D0240	Intraoral - OCclusal Radiographic Image	\$7,500
D0250	Extra-Oral - 2D Projection Radiographic Image Created Using A Stationary Radiation Source And Detector	\$7,500
D0251	Extra-Oral Posterior Dental Radiographic Image	\$7,500
D0270	Bitewing - Single Radiographic Image	\$7,500
D0272	Bitewings - Two Radiographic Images	\$7,500
D0273	Bitewings - Three Radiographic Images	\$7,500
D0274	Bitewings - Four Radiographic Images	\$7,500
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	\$7,500
D0290	Posterior-Anterior Or Lateral Skull And Facial Bone Survey Radiographic Image	\$7,500
D0310	Sialography	\$7,500
D0320	Temporomandibular Joint Arthrogram Including Injection	\$7,500
D0321	Other Temporomandibular Joint Radiographic Images By Report	\$7,500
D0322	Tomographic Survey	\$7,500
D0330	Panoramic Radiographic Image	\$7,500
D0340	2D Cephalometric Radiographic Image - Acquisition Measurement And Analysis	\$7,500
D0350	2D Oral/Facial Photographic Image Obtained Intra-Orally Or Extra-Orally	\$7,500
D0351	3D Photographic Image	\$7,500
D0364	Cone Beam Ct Capture And Interpretation With Limited Field Of View - Less Thanone Whole Jaw	\$7,500
D0365	Cone Beam Ct Capture And Interpretation With Field Of View Of One Full Dentalarch - Mandible	\$7,500
D0366	Cone Beam Ct Capture And Interpretation With Field Of View Of One Full Dentalarch - Maxilla With Or Without Cranium	\$7,500
D0367	Cone Beam Ct Capture And Interpretation With Field Of View Of Both Jaws Withor Without Cranium	\$7,500
D0368	Cone Beam Ct Capture And Interpretation For Tmj Series Including Two Or More exposures	\$7,500
D0369	Maxillofacial Mri Capture And Interpretation	\$7,500
D0370	Maxillofacial Ultrasound Capture And Interpretation	\$7,500
D0371	Sialoendoscopy Capture And Interpretation	\$7,500
D0380	Cone Beam Ct Image Capture With Limited Field Of View - Less Than One Whole Jaw	\$7,500
D0381	Cone Beam Ct Image Capture With Field Of View Of One Full Dental Arch - Mandible	\$7,500
D0382	Cone Beam Ct Image Capture With Field Of View Of One Full Dental Arch -Maxilla With Or Without Cranium	\$7,500

D0383	Cone Beam Ct Image Capture With Field Of View Of Both Jaws With Or Withoutcranium	\$7,500
D0384	Cone Beam Ct Image Capture For Tmj Series Including Two Or More Exposures	\$7,500
D0385	Maxillofacial Mri Image Capture	\$7,500
D0386	Maxillofacial Ultrasound Image Capture	\$7,500
D0391	Interpretation Of Diagnostic Image By A Practitioner Not Associated Withcapture Of The Image Including Report	\$7,500
D0393	Treatment Simulation Using 3D Image Volume	\$7,500
D0394	Digital Subtraction Of Two Or More Images Or Image Volumes Of The Same Modality	\$7,500
D0395	Fusion Of Two Or More 3D Image Volumes Of One Or More Modalities	\$7,500
D0414	Laboratory Processing Of Microbial Specimen To Include Culture And Sensitivity Studies Preparation And Transmission Of Written Report	\$7,500
D0415	Collection Of Microorganisms For Culture And Sensitivity	\$7,500
D0416	Viral Culture	\$7,500
D0417	Collection And Preparation Of Saliva Sample For Laboratory Diagnostic Testing	\$7,500
D0418	Analysis Of Saliva Sample	\$7,500
D0422	Collection And Preparation Of Genetic Sample Material For Laboratory Analysis And Report	\$7,500
D0423	Genetic Test For Susceptibility To Diseases - Specimen Analysis	\$7,500
D0425	Caries Susceptibility Tests	\$7,500
D0431	Adjunctive Pre-Diagnostic Test That Aids In Detection Of Mucosal Abnormalities Including Premalignant And Malignant Lesions Not To Include Cytology Or Biopsy Procedures	\$7,500
D0460	Pulp Test	\$7,500
D0470	Study Models	\$7,500
D0472	Accession Of Tissue Gross Examination Preparation And Transmission Of Written Report	\$7,500
D0473	Accession Of Tissue Gross And Microscopic Examination Preparation And Transmission Of Written Report	\$7,500
D0474	Accession Of Tissue Gross And Microscopic Examination Including Assessment Of Surgical Margins For Presence Of Disease Preparation And Transmission Of Written Report	\$7,500
D0475	Decalcification Procedure	\$7,500
D0476	Special Stains For Microorganisms	\$7,500
D0477	Special Stains Not For Microorganisms	\$7,500
D0478	Immunohistochemical Stains	\$7,500
D0479	Tissue In-Situ Hybridization Including Interpretation	\$7,500

D0480	Accession Of Exfoliative Cytologic Smears Microscopic Examination Preparation And Transmission Of Written Report	\$7,500
D0481	Electron Microscopy	\$7,500
D0482	Direct Immunofluorescence	\$7,500
D0483	Indirect Immunofluorescence	\$7,500
D0484	Consultation On Slides Prepared Elsewhere	\$7,500
D0485	Consultation Including Preparation Of Slides From Biopsy Material Supplied By Referring Source	\$7,500
D0486	Accession Of Transepithelial Cytologic Sample Microscopic Examination Preparation And Transmission Of Written Report	\$7,500
D0502	Other Oral Pathology Procedures By Report	\$7,500
D0600	Non-Ionizing Diagnostic Procedure Capable Of Quantifying Monitoring And Recording Changes In Structure Of Enamel Dentin And Cementum	\$7,500
D0601	Caries Risk Assessment And Documentation With A Finding Of Low Risk	\$7,500
D0602	Caries Risk Assessment And Documentation With A Finding Of Moderate Risk	\$7,500
D0603	Caries Risk Assessment And Documentation With A Finding Of High Risk	\$7,500
D0999	Presurgical Work Up	\$7,500
D1110	Preventive Prophylaxis Bill An Additional Code For Exam If Performed At The Same Time.	\$7,500
D1120	Preventive Phrophylaxis 15 + Bill An Additional Code If Exam Is Performed At The Same Time.	\$7,500
D1206	Topical Application Of Fluoride Varnish	\$7,500
D1208	Topical Application Of Fluoride - Excluding Varnish	\$7,500
D1310	Diet Plan For Control Dental	\$7,500
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	\$7,500
D1351	Dental Sealants	\$7,500
D1352	Preventive Resin Restoration In A Moderate To High Caries Risk Patient -Permanent Tooth	\$7,500
D1353	Sealant Repair - Per Tooth	\$7,500
D1354	Interim Caries Arresting Medicament Application	\$7,500
D1510	Fixed Band Type	\$7,500
D1515	Space Maintainer-Fixed Bilateral	\$7,500
D1520	Fixed Cast Type	\$7,500
D1525	Removable Bilateral Space Main	\$7,500
D1550	Re-Cement Or Re-Bond Space Maintainer	\$7,500
D1555	Removal Of Fixed Space Maintainer	\$7,500

D1575	Distal Shoe Space Maintainer - Fixed - Unilateral	\$7,500
D1999	Unspecified Preventive Procedure By Report	\$7,500
D2140	Amalgam-One Surface Primary Or Permanent	\$7,500
D2150	Amalgam-Two Surfaces Primary Or Permanent	\$7,500
D2160	Amalgam-Three Surfaces Primary Or Permanent	\$7,500
D2161	Amalgam-Four Or More Surfaces Primary Or Permanent	\$7,500
D2330	Resin-One Surface Anterior	\$7,500
D2331	Resin-Two Surfaces Anterior	\$7,500
D2332	Resin-Three Surfaces Anterior	\$7,500
D2335	Resin-Four Or More Surfaces Or Involving Incisal Angle (Anterior)	\$7,500
D2390	Resin-Based Composite Crown Anterior	\$7,500
D2391	Resin-Based Composite - One Surface Posterior	\$7,500
D2392	Resin-Based Composite - Two Surfaces Posterior	\$7,500
D2393	Resin-Based Composite - Three Surfaces Posterior	\$7,500
D2394	Resin-Based Composite - Four Or More Surfaces Posterior	\$7,500
D2410	Gold Foil One Surface	\$7,500
D2420	Gold Foil Two Surfaces	\$7,500
D2430	Gold Foil Three Surfaces	\$7,500
D2510	Inlay Gold One Surface	\$7,500
D2520	Inlay Gold Two Surfaces	\$7,500
D2530	Inlay Gold Three Surfaces	\$7,500
D2542	Onlay-Metallic-Two Surfaces	\$7,500
D2543	Onlay - Metallic - Three Surfaces	\$7,500
D2544	Onlay - Metallic - Four Or More Surfaces	\$7,500
D2610	Inlay Porcelain	\$7,500
D2620	Inlay-Porcelain/Ceramic-Two Surfaces	\$7,500
D2630	Inlay-Porcelain/Ceramic-Three Or More Surfaces	\$7,500
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	\$7,500
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	\$7,500
D2644	Onlay - Porcelain/Ceramic - Four Or More Surfaces	\$7,500
D2650	Inlay - Resin-Based Composite - One Surface	\$7,500
D2651	Inlay - Resin-Based Composite - Two Surfaces	\$7,500
D2652	Inlay - Resin-Based Composite - Three Or More Surfaces	\$7,500
D2662	Onlay - Resin-Based Composite - Two Surfaces	\$7,500
D2663	Onlay - Resin-Based Composite - Three Surfaces	\$7,500
D2664	Onlay - - Resin-Based Composite - Four Or More Surfaces	\$7,500
D2710	Crown - Resin-Based Composite (Indirect)	\$7,500

D2712	Crown - 3/4 Resin-Based Composite (Indirect)	\$7,500
D2720	Plastic With Metal	\$7,500
D2721	Crown-Resin With Predominantly Base Metal	\$7,500
D2722	Crown-Resin With Noble Metal	\$7,500
D2740	Porcelain	\$7,500
D2750	Porcelain With Metal	\$7,500
D2752	Crown-Porcelain Fused To Noble Metal	\$7,500
D2780	Crown - 3/4 Cast High Noble Metal	\$7,500
D2781	Crown - 3/4 Cast Predominantly Base Metal	\$7,500
D2782	Crown - 3/4 Cast Noble Metal	\$7,500
D2783	Crown - 3/4 Porcelain/Ceramic	\$7,500
D2790	Gold(Full Cast)	\$7,500
D2791	Crown-Full Cast Predominantly Base Metal	\$7,500
D2792	Crown-Full Cast Noble Metal	\$7,500
D2794	Crown-Titanium	\$7,500
D2799	Provisional Crown - Further Treatment Or Completion Of Diagnosis Necessary prior To Final Impression	\$7,500
D2910	Re-Cement Or Re-Bond Inlay Onlay Veneer Or Partial Coverage Restoration	\$7,500
D2915	Re-Cement Or Re-Bond Indirectly Fabricated Or Prefabricated Post And Core	\$7,500
D2920	Re-Cement Or Re-Bond Crown	\$7,500
D2921	Reattachment Of Tooth Fragment Incisal Edge Or Cusp	\$7,500
D2929	Prefabricated Porcelain/Ceramic Crown - Primary Tooth	\$7,500
D2930	Prefabricated Stainless Steel Crown-Primary Tooth New Code(S) D2930 Or D2931	\$7,500
D2931	Prefabricated Stainless Steel Crown-Permanent Tooth New Code(S) D2930 Or D2931	\$7,500
D2932	Prefabricated Resin Crown	\$7,500
D2933	Prefabricated Stainless Steel Crown With Resin Window	\$7,500
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	\$7,500
D2940	Protective Restoration	\$7,500
D2941	Interim Therapeutic Restoration - Primary Dentition	\$7,500
D2949	Restorative Foundation For An Indirect Restoration	\$7,500
D2950	Core Build-Up Including Any Pins When Required	\$7,500
D2951	Pin Retention-Per Tooth In Addition To Restoration	\$7,500
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	\$7,500
D2954	Prefabricated Post And Core In Addition To Crown	\$7,500

D2955	Post Removal	\$7,500
D2957	Each Additional Prefabricated Post - Same Tooth	\$7,500
D2960	Labial Veneer (Laminate)-Chairside	\$7,500
D2961	Labial Veneer (Resin Laminate)-Laboratory	\$7,500
D2962	Labial Veneer (Porcelain Laminate)-Laboratory	\$7,500
D2971	Additional Procedures To Construct New Crown Under Existing Partial Denture Framework	\$7,500
D2975	Coping	\$7,500
D2980	Crown Repair Necessitated By Restorative Material Failure	\$7,500
D2981	Inlay Repair Necessitated By Restorative Material Failure	\$7,500
D2982	Onlay Repair Necessitated By Restorative Material Failure	\$7,500
D2983	Veneer Repair Necessitated By Restorative Material Failure	\$7,500
D2990	Resin Infiltration Of Incipient Smooth Surface Lesions	\$7,500
D3110	Pulp Cap Direct Excluding Fina	\$7,500
D3120	Pulp Cap Indirect	\$7,500
D3220	Pulpotomy	\$7,500
D3221	Pulpal Debridement Primary And Permanent Teeth	\$7,500
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth With Incomplete Root Development	\$7,500
D3230	Pulpal Therapy (Resorbable Filling)-Anterior Primary Tooth (Excluding Final Restoration)	\$7,500
D3240	Pulpal Therapy (Resorbable Filling)-Posterior Primary Tooth (Excluding Final Restoration)	\$7,500
D3310	Endodontic Therapy Anterior Tooth (Excluding Final Restoration)	\$7,500
D3320	Endodontic Therapy Bicuspid Tooth (Excluding Final Restoration)	\$7,500
D3330	Endodontic Therapy Molar (Excluding Final Restoration)	\$7,500
D3331	Treatment Of Root Canal Obstruction; Non-Surgical Access	\$7,500
D3332	Incomplete Endodontic Therapy; Inoperable Unrestorable Or Fractured Tooth	\$7,500
D3333	Internal Root Repair Of Perforation Defects	\$7,500
D3346	Retreatment Of Previous Root Canal Therapy-Anterior	\$7,500
D3347	Retreatment Of Previous Root Canal Therapy-Bicuspid	\$7,500
D3348	Retreatment Of Previous Root Canal Therapy-Molar	\$7,500
D3351	Apexification/Recalcification - Initial Visit (Apical Closure/Calcific Repair Of Perforations Root Resorption Etc.)	\$7,500
D3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repair Of Perforations Root Resorption Pulp Space Disinfection Etc.)	\$7,500

D3353	Apexification/Recalcification-Final Visit (Includes Completed Root Canal Therapy-Apical Closure/Calcific Repair Of Perforations Root Resorption Etc.)	\$7,500
D3355	Pulpal Regeneration - Initial Visit	\$7,500
D3356	Pulpal Regeneration - Interim Medication Replacement	\$7,500
D3357	Pulpal Regeneration - Completion Of Treatment	\$7,500
D3410	Apicoectomy - Anterior	\$7,500
D3421	Apicoectomy - Bicuspid (First Root)	\$7,500
D3425	Apicoectomy - Molar (First Root)	\$7,500
D3426	Apicoectomy (Each Additional Root)	\$7,500
D3427	Periradicular Surgery Without Apicoectomy	\$7,500
D3428	Bone Graft In Conjunction With Periradicular Surgery - Per Tooth Single Site	\$7,500
D3429	Bone Graft In Conjunction With Periradicular Surgery - Each Additional Contiguous Tooth In The Same Surgical Site	\$7,500
D3430	Retrograde Amalgam	\$7,500
D3431	Biologic Materials To Aid In Soft And Osseous Tissue Regeneration In Conjunction With Periradicular Surgery	\$7,500
D3432	Guided Tissue Regeneration Resorbable Barrier Per Site In Conjunction With Periradicular Surgery	\$7,500
D3450	Root Amputation	\$7,500
D3460	Endosseous Implants	\$7,500
D3470	Intentional Replantation (Including Necessary Splinting)	\$7,500
D3910	Gingival Curettement	\$7,500
D3920	Hemisection	\$7,500
D3950	Canal Preparation And Fitting Of Preformed Dowel Or Post	\$7,500
D3999	Unspecified Endodontic Procedure By Report	\$7,500
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Boundedspaces Per Quadrant	\$7,500
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Boundedspaces Per Quadrant	\$7,500
D4212	Gingivectomy Or Gingivoplasty To Allow Access For Restorative Procedure Pertooth	\$7,500
D4230	Anatomical Crown Exposure - Four Or More Contiguous Teeth Per Quadrant	\$7,500
D4231	Anatomical Crown Exposure - One To Three Teeth Per Quadrant	\$7,500
D4240	Gingival Flap Procedure Including Root Planing - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	\$7,500
D4241	Gingival Flap Procedure Including Root Planing - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	\$7,500

D4245	Apically Positioned Flap	\$7,500
D4249	Clinical Crown Lengthening-Hard Tissue	\$7,500
D4260	Osseous Surgery (Including Elevation Of A Full Thickness Flap Entry And Closure) - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	\$7,500
D4261	Osseous Surgery (Including Elevation Of A Full Thickness Flap Entry And Closure) - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	\$7,500
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	\$7,500
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	\$7,500
D4265	Biologic Materials To Aid In Soft And Osseous Tissue Regeneration	\$7,500
D4266	Guided Tissue Regeneration - Resorbable Barrier Per Site	\$7,500
D4267	Guided Tissue Regeneration - Nonresorbable Barrier Per Site (Includes Membrane Removal)	\$7,500
D4268	Surgical Revision Procedure Per Tooth	\$7,500
D4270	Pedicle Soft Tissue Grafts	\$7,500
D4273	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) First Tooth Implant Or Edentulous Tooth Position In Graft	\$7,500
D4274	Mesial/Distal Wedge Procedure Single Tooth (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	\$7,500
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site And Donor Material) First Tooth Implant Or Edentulous Tooth Position In Graft	\$7,500
D4276	Combined Connective Tissue And Double Pedicle Graft Per Tooth	\$7,500
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) First Tooth Implant Or Edentulous Tooth Position In Graft	\$7,500
D4278	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites) Each Additional Contiguous Tooth Implant Or Edentulous Tooth Position In Same Graft Site	\$7,500
D4283	Autogenous Connective Tissue Graft Procedure (Including Donor And Recipient Surgical Sites) - Each Additional Contiguous Tooth Implant Or Edentulous Tooth Position In Same Graft Site	\$7,500
D4285	Non-Autogenous Connective Tissue Graft Procedure (Including Recipient Surgical Site And Donor Material) - Each Additional Contiguous Tooth Implant Or Edentulous Tooth Position In Same Graft Site	\$7,500
D4320	Provisional Splinting (Intraco	\$7,500
D4321	Provisional Splinting (Extraco	\$7,500

D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	\$7,500
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	\$7,500
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation - Full Mouth After Oral Evaluation	\$7,500
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis	\$7,500
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Intodiseased Crevicular Tissue Per Tooth	\$7,500
D4910	Periodontal Maintenance	\$7,500
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist Or Their Staff)	\$7,500
D4921	Gingival Irrigation - Per Quadrant	\$7,500
D4999	Unspecified Periodontal Procedure By Report	\$7,500
D5110	Complete Upper Denture	\$7,500
D5120	Complete Lower Denture	\$7,500
D5130	Partial Denture Wireclasp/Acry	\$7,500
D5140	Partial Denture Castframework/	\$7,500
D5211	Upper Partial-Resin Base (Including Any Conventional Clasps Rests And Teeth)	\$7,500
D5212	Lower Partial-Resin Base (Including Any Conventional Clasps Rests And Teeth)	\$7,500
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps Rests And Teeth)	\$7,500
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps Rests And Teeth)	\$7,500
D5221	Immediate Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps Rest And Teeth)	\$7,500
D5222	Immediate Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps Rests And Teeth)	\$7,500
D5223	Immediate Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps Rests And Teeth)	\$7,500
D5224	Immediate Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps Rests And Teeth)	\$7,500
D5225	Maxillary Partial Denture - Flexible Base (Including Any Clasps Rests And Teeth)	\$7,500
D5226	Mandibular Partial Denture - Flexible Base (Including Any Clasps Rests And Teeth)	\$7,500
D5281	Removable Unilateral Partial Denture-One Piece Cast Metal (Including Clasps And Teeth)	\$7,500

D5410	Complete Denture	\$7,500
D5411	Adjust Complete Denture - Mandibular	\$7,500
D5421	Adjust Partial Denture - Maxillary	\$7,500
D5422	Adjust Partial Denture - Mandibular	\$7,500
D5510	Repair Broken Complete Denture Base	\$7,500
D5520	Replace Missing Or Broken Teeth-Complete Denture (Each Tooth)	\$7,500
D5610	Repair Broken Complete Denture	\$7,500
D5620	Repair Denture 1 Broken Toot	\$7,500
D5630	Repair Or Replace Broken Clasp - Per Tooth	\$7,500
D5640	Replace Fx Broken Tooth On	\$7,500
D5650	Add Tooth To Partial Denture	\$7,500
D5660	Add Clasp To Existing Partial Denture - Per Tooth	\$7,500
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	\$7,500
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	\$7,500
D5710	Duplicate Upper Or Lower Compl	\$7,500
D5711	Rebase Complete Mandibular Denture	\$7,500
D5720	Duplicate Upper Or Lower Parti	\$7,500
D5721	Rebase Mandibular Partial Denture	\$7,500
D5730	Comp Upper Reline Chair Epsdt	\$7,500
D5731	Reline Lower Complete Mandibular Denture (Chairside)	\$7,500
D5740	Reline Upper Or Lower Partial	\$7,500
D5741	Reline Mandibular Partial Denture (Chairside)	\$7,500
D5750	Comp Upper Reline Lab Epsdt	\$7,500
D5751	Reline Complete Mandibular Denture (Laboratory)	\$7,500
D5760	Partial Upper Reline Epsdt	\$7,500
D5761	Reline Mandibular Partial Denture (Laboratory)	\$7,500
D5810	Denture Temp(Complete)Upper Or	\$7,500
D5811	Interim Complete Denture (Mandibular)	\$7,500
D5820	Denture Temp(Partial)Upper Or	\$7,500
D5821	Interim Partial Denture (Mandibular)	\$7,500
D5850	Complete Upper Reline Adult	\$7,500
D5851	Tissue Conditioning Mandibular	\$7,500
D5862	Precision Attachment By Report	\$7,500
D5863	Overdenture - Complete Maxillary	\$7,500
D5864	Overdenture - Partial Maxillary	\$7,500
D5865	Overdenture - Complete Mandibular	\$7,500

D5866	Overdenture - Partial Mandibular	\$7,500
D5867	Replacement Of Replaceable Part Of Semi-Precision Or Precision Attachment (Male Or Female Component)	\$7,500
D5875	Modification Of Removable Prosthesis Following Implant Surgery	\$7,500
D5899	Unspecified Removable Prosthodontic Procedure By Report	\$7,500
D5911	Facial Moulage (Sectional)	\$7,500
D5912	Facial Moulage (Complete)	\$7,500
D5913	Nasal Prosthesis	\$7,500
D5914	Auricular Prosthesis	\$7,500
D5915	Orbital Prosthesis	\$7,500
D5916	Ocular Prosthesis	\$7,500
D5919	Facial Prosthesis	\$7,500
D5922	Nasal Septal Prosthesis	\$7,500
D5923	Ocular Prosthesis Interim	\$7,500
D5924	Cranial Prosthesis	\$7,500
D5925	Facial Augmentation Implant Prosthesis	\$7,500
D5926	Nasal Prosthesis Replacement	\$7,500
D5927	Auricular Prosthesis Replacement	\$7,500
D5928	Orbital Prosthesis Replacement	\$7,500
D5929	Facial Prosthesis Replacement	\$7,500
D5931	Obturator Prosthesis Surgical	\$7,500
D5932	Obturator Prosthesis Definitive	\$7,500
D5933	Obturator Prosthesis Modification	\$7,500
D5934	Mandibular Resection Prosthesis With Guide Flange	\$7,500
D5935	Mandibular Resection Prosthesis Without Guide Flange	\$7,500
D5936	Obturator/Prosthesis Interim	\$7,500
D5937	Trismus Appliance (Not For Tm Treatment)	\$7,500
D5951	Feeding Aid	\$7,500
D5952	Speech Aid Prosthesis Pediatric	\$7,500
D5953	Speech Aid Prosthesis Adult	\$7,500
D5954	Palatal Augmentation Prosthesis	\$7,500
D5955	Palatal Lift Prosthesis Definitive	\$7,500
D5958	Palatal Lift Prosthesis Interim	\$7,500
D5959	Palatal Lift Prosthesis Modification	\$7,500
D5960	Speech Aid Prosthesis Modification	\$7,500
D5982	Surgical Stent	\$7,500
D5983	Radiation Carrier	\$7,500

D5984	Radiation Shield	\$7,500
D5985	Radiation Cone Locator	\$7,500
D5986	Fluoride Gel Carrier	\$7,500
D5987	Commissure Splint	\$7,500
D5988	Surgical Splint	\$7,500
D5991	Vesiculobullous Disease Medicament Carrier	\$7,500
D5992	Adjust Maxillofacial Prosthetic Appliance	\$7,500
D5993	Maintenance And Cleaning Of A Maxillofacial Prosthesis (Extra- Or Intra-Oral) Other Than Required Adjustments By Report	\$7,500
D5994	Peridontal Medicament Carrier With Peripheral Seal - Laboratory Processed	\$7,500
D5999	Maxillary Surg Splints	\$7,500
D6010	Surgical Placement Of Implant Body Endosteal Implant	\$7,500
D6011	Second Stage Implant Surgery	\$7,500
D6012	Surgical Placement Of Interim Implant Body For Transitional Prosthesis Endosteal Implant	\$7,500
D6013	Surgical Placement Of Mini Implant	\$7,500
D6040	Surgical Placement Eposteal Implant	\$7,500
D6050	Surgical Placement Transosteal Implant	\$7,500
D6051	Interim Abutment	\$7,500
D6052	Semi-Precision Attachment Abutment	\$7,500
D6055	Connecting Bar - Implant Supported Or Abutment Supported	\$7,500
D6056	Prefabricated Abutment - Includes Modification And Placement	\$7,500
D6057	Custom Fabricated Abutment - Includes Placement	\$7,500
D6058	Abutment Supported Porcelain/Ceramic Crown	\$7,500
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	\$7,500
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	\$7,500
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	\$7,500
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	\$7,500
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	\$7,500
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	\$7,500
D6065	Implant Supported Porcelain/Ceramic Crown	\$7,500
D6066	Implant Supported Porcelain Fused To Metal Crown (Titanium Titanium Alloy High Noble Metal)	\$7,500
D6067	Implant Supported Metal Crown (Titanium Titanium Alloy High Noble Metal)	\$7,500

D6068	Abutment Supported Retainer For Porcelain/Ceramic Fpd	\$7,500
D6069	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (High Noble Metal)	\$7,500
D6070	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Predominantly Base Metal)	\$7,500
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Noble Metal)	\$7,500
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)	\$7,500
D6073	Abutment Supported Retainer For Cast Metal Fpd (Predominantly Base Metal)	\$7,500
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)	\$7,500
D6075	Implant Supported Retainer For Ceramic Fpd	\$7,500
D6076	Implant Supported Retainer For Porcelain Fused To Metal Fpd (Titanium Titanium Alloy Or High Noble Metal)	\$7,500
D6077	Implant Supported Retainer For Cast Metal Fpd (Titanium Titanium Alloy Or High Noble Metal)	\$7,500
D6080	Implant Maintenance Procedures When Prostheses Are Removed And Reinserted Including Cleansing Of Prostheses And Abutments	\$7,500
D6081	Scaling And Debridement In The Presence Of Inflammation Or Mucositis Of A Single Implant Including Cleaning Of The Implant Surfaces Without Flap Entry And Closure	\$7,500
D6085	Provisional Implant Crown	\$7,500
D6090	Repair Implant-supported Prosthesis By Report	\$7,500
D6091	Replacement Of Semi-Precision Or Precision Attachment (Male Or Female Component) Of Implant/Abutment Supported Prosthesis Per Attachment	\$7,500
D6092	Re-Cement Or Re-Bond Implant/Abutment Supported Crown	\$7,500
D6093	Re-Cement Or Re-Bond Implant/Abutment Supported Fixed Partial Denture	\$7,500
D6094	Abutment Supported Crown - (Titanium)	\$7,500
D6095	Repair Implant Abutment By Report	\$7,500
D6100	Implant Removal By Report	\$7,500
D6101	Debridement Of A Peri-Implant Defect Or Defects Surrounding A Single Implant And Surface Cleaning Of The Exposed Implant Surfaces Including Flap Entry And Closure	\$7,500
D6102	Debridement And Osseous Contouring Of A Peri-Implant Defect Or Defects Surrounding A Single Implant And Includes Surface Cleaning Of The Exposed Implant Surfaces Including Flap Entry And Closure	\$7,500
D6103	Bone Graft For Repair Of Peri-Implant Defect - Does Not Include Flap Entry And Closure	\$7,500

D6104	Bone Graft At Time Of Implant Placement	\$7,500
D6110	Implant/Abutment Supported Removable Denture For Edentulous Arch - Maxillary	\$7,500
D6111	Implant/Abutment Supported Removable Denture For Edentulous Arch - Mandibular	\$7,500
D6112	Implant/Abutment Supported Removable Denture For Partially Edentulous Arch - Maxillary	\$7,500
D6113	Implant/Abutment Supported Removable Denture For Partially Edentulous Arch - Mandibular	\$7,500
D6114	Implant/Abutment Supported Fixed Denture For Edentulous Arch - Maxillary	\$7,500
D6115	Implant/Abutment Supported Fixed Denture For Edentulous Arch - Mandibular	\$7,500
D6116	Implant/Abutment Supported Fixed Denture For Partially Edentulous Arch - Maxillary	\$7,500
D6117	Implant/Abutment Supported Fixed Denture For Partially Edentulous Arch - Mandibular	\$7,500
D6190	Radiographic/Surgical Implant Index By Report	\$7,500
D6194	Abutment Supported Retainer Crown For Fpd (Titanium)	\$7,500
D6199	Unspecified Implant Procedure By Report	\$7,500
D6205	Pontic - Indirect Resin Based Composite	\$7,500
D6210	Cast Gold	\$7,500
D6211	Pontic-Cast Predominantly Base Metal	\$7,500
D6212	Pontic-Cast Noble Metal	\$7,500
D6214	Pontic - Titanium	\$7,500
D6240	Porcelain Fused To Metal	\$7,500
D6241	Pontic-Porcelain Fused To Predominantly Base Metal	\$7,500
D6242	Pontic-Porcelain Fused To Noble Metal	\$7,500
D6245	Pontic - Porcelain/Ceramic	\$7,500
D6250	Plastic Processed Top Metal	\$7,500
D6251	Pontic-Resin With Predominantly Base Metal	\$7,500
D6252	Pontic-Resin With Noble Metal	\$7,500
D6253	Provisional Pontic - Further Treatment Or Completion Of Diagnosis Necessaryprior To Final Impression	\$7,500
D6545	Retainer-Cast Metal For Resin Bonded Fixed Prosthesis	\$7,500
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	\$7,500
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	\$7,500
D6600	Retainer Inlay - Porcelain/Ceramic Two Surfaces	\$7,500
D6601	Retainer Inlay - Porcelain/Ceramic Three Or More Surfaces	\$7,500

D6602	Retainer Inlay - Cast High Noble Metal Two Surfaces	\$7,500
D6603	Retainer Inlay - Cast High Noble Metal Three Or More Surfaces	\$7,500
D6604	Retainer Inlay - Cast Predominantly Base Metal Two Surfaces	\$7,500
D6605	Retainer Inlay - Cast Predominantly Base Metal Three Or More Surfaces	\$7,500
D6606	Retainer Inlay - Cast Noble Metal Two Surfaces	\$7,500
D6607	Retainer Inlay - Cast Noble Metal Three Or More Surfaces	\$7,500
D6608	Retainer Onlay - Porcelain/Ceramic Two Surfaces	\$7,500
D6609	Retainer Onlay - Porcelain/Ceramic Three Or More Surfaces	\$7,500
D6610	Retainer Onlay - Cast High Noble Metal Two Surfaces	\$7,500
D6611	Retainer Onlay - Cast High Noble Metal Three Or More Surfaces	\$7,500
D6612	Retainer Onlay - Cast Predominantly Base Metal Two Surfaces	\$7,500
D6613	Retainer Onlay - Cast Predominantly Base Metal Three Or More Surfaces	\$7,500
D6614	Retainer Onlay - Cast Noble Metal Two Surfaces	\$7,500
D6615	Retainer Onlay - Cast Noble Metal Three Or More Surfaces	\$7,500
D6624	Retainer Inlay - Titanium	\$7,500
D6634	Retainer Onlay - Titanium	\$7,500
D6710	Retainer Crown - Indirect Resin Based Composite	\$7,500
D6720	Retainer Crown-Resin With High Noble Metal	\$7,500
D6721	Retainer Crown-Resin With Predominantly Base Metal	\$7,500
D6722	Retainer Crown - Resin With Noble Metal	\$7,500
D6740	Retainer Crown - Porcelain/Ceramic	\$7,500
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	\$7,500
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	\$7,500
D6752	Retainer Crown - Porcelain Fused To Noble Metal	\$7,500
D6780	Retainer Crown - 3/4 Cast High Noble Metal	\$7,500
D6781	Retainer Crown - 3/4 Cast Predominantly Based Metal	\$7,500
D6782	Retainer Crown - 3/4 Cast Noble Metal	\$7,500
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	\$7,500
D6790	Retainer Crown - Full Cast High Noble Metal	\$7,500
D6791	Retainer Crown - Full Cast Predominantly Base Metal	\$7,500
D6792	Retainer Crown - Full Cast Noble Metal	\$7,500
D6793	Provisional Retainer Crown - Further Treatment Or Completion Of Diagnosisnecessary Prior To Final Impression	\$7,500

D6794	Retainer Crown - Titanium	\$7,500
D6920	Connector Bar	\$7,500
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	\$7,500
D6940	Stress Breaker	\$7,500
D6950	Precision Attachment	\$7,500
D6980	Fixed Partial Denture Repair Necessitated By Restorative Material Failure	\$7,500
D6985	Pediatric Partial Denture Fixed	\$7,500
D6999	Unspecified Fixed Prosthodontic Procedure By Report	\$7,500
D7140	Extraction Erupted Tooth Extraction. Single Tooth	\$7,500
D7210	Extraction Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap If Indicated	\$7,500
D7220	Removal Of Impacted Tooth-Soft Tissue	\$7,500
D7230	Removal Of Impacted Tooth-Partially Bony	\$7,500
D7240	Removal Of Impacted Tooth-Completely Bony	\$7,500
D7241	Removal Of Impacted Tooth-Completely Bony With Unusual Surgical Complications	\$7,500
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	\$7,500
D7251	Coronectomy - Intentional Partial Tooth Removal	\$7,500
D7261	Primary Closure Of A Sinus Perforation	\$7,500
D7270	Tooth Reimplantation And/Or Stabilization Of Accidentally Evulsed Or Displaced Tooth	\$7,500
D7272	Tooth Transplantation	\$7,500
D7280	Exposure Of An Unerupted Tooth	\$7,500
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	\$7,500
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	\$7,500
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone Tooth)	\$7,500
D7286	Incisional Biopsy Of Oral Tissue - Soft	\$7,500
D7287	Exfoliative Cytological Sample Collection	\$7,500
D7288	Brush Biopsy - Transepithelial Sample Collection	\$7,500
D7290	Surgical Repositioning	\$7,500
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy By Report	\$7,500
D7292	Placement Of Temporary Anchorage Device (Screw Retained Plate) Requiring Flap; Includes Device Removal	\$7,500
D7293	Placement Of Temporary Anchorage Device Requiring Flap; Includes Device Removal	\$7,500

D7294	Placement Of Temporary Anchorage Device Without Flap; Includes Device Removal	\$7,500
D7295	Harvest Of Bone For Use In Autogenous Grafting Procedure	\$7,500
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth	\$7,500
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces Per Quadrant	\$7,500
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces Per Quadrant	\$7,500
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces Per Quadrant	\$7,500
D7340	Perarch Uncomplicated	\$7,500
D7350	Stomatoplasty Complicated	\$7,500
D7410	Excision Of Benign Lesion Up To 1.25 Cm	\$7,500
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm	\$7,500
D7412	Excision Of Benign Lesion Complicated	\$7,500
D7413	Excision Of Malignant Lesion Up To 1.25 Cm	\$7,500
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm	\$7,500
D7415	Excision Of Malignant Lesion Complicated	\$7,500
D7440	Excision Malig Tumor Les/Dia T	\$7,500
D7441	Excision Malig Tumor Les/Dia O	\$7,500
D7451	Removal Of Benign Odontogenic Cyst Or Tumor-Lesion Diameter Greater Than 1.25 Cm	\$7,500
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor- Lesion Diameter Up To 1.25 Cm	\$7,500
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor- Lesion Diameter Greater Than 1.25 Cm	\$7,500
D7465	Destruction Of Lesion(S) By Physical Or Chemical Methods By Report	\$7,500
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	\$7,500
D7472	Removal Of Torus Palatinus	\$7,500
D7473	Removal Of Torus Mandibularis	\$7,500
D7485	Reduction Of Osseous Tuberosity	\$7,500
D7490	Radical Resection Of Maxilla Or Mandible	\$7,500
D7510	Incision Drainage Abscess Int	\$7,500
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	\$7,500
D7520	Incision Drainage Extraoral	\$7,500
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	\$7,500

D7530	Removal Of Foreign Body From Mucosa Skin Or Subcutaneous Alveolar Tissue	\$7,500
D7540	Removal Of F/B Musculoskeletal	\$7,500
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	\$7,500
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body	\$7,500
D7610	Fx Open Reduction Maxilla	\$7,500
D7620	Fx Closed Reduction Maxilla	\$7,500
D7630	Fx Open Reduction Mandible	\$7,500
D7640	Fx Closed Reduction Mansible	\$7,500
D7650	Fx Open Reduction Zygomatic Ar	\$7,500
D7660	Fx Malar Or Zygom Arch Simpl	\$7,500
D7670	Alveolus - Closed Reduction May Include Stabilization Of Teeth	\$7,500
D7671	Alveolus - Open Reduction May Include Stabilization Of Teeth	\$7,500
D7680	Fx Facial Bones Complica Reduc	\$7,500
D7710	Fx Maxilla Open Reduction	\$7,500
D7720	Maxilla-Closed Reduction	\$7,500
D7730	Fx Mandible Open Reduction	\$7,500
D7740	Fx Mandible Open Reduction	\$7,500
D7750	Fx Malar/Zygomatic Arch Open	\$7,500
D7760	Fx Malar/Zygomatic Arch (Comp)	\$7,500
D7770	Alveolus - Open Reduction Stabilization Of Teeth	\$7,500
D7771	Alveolus Closed Reduction Stabilization Of Teeth	\$7,500
D7780	Facial Bones-Complicated Reduction With Fixation And Multiple Approaches	\$7,500
D7810	Open Reduction 0F Dislocation	\$7,500
D7820	Closed Reduction Of Dislocatio	\$7,500
D7830	Manipulation Under Anesthesia	\$7,500
D7840	Condylectomy	\$7,500
D7850	Meniscectomy	\$7,500
D7852	Disc Repair	\$7,500
D7854	Synovectomy	\$7,500
D7856	Myotomy	\$7,500
D7858	Joint Reconstruction	\$7,500
D7860	Arthrotomy	\$7,500
D7865	Arthroplasty	\$7,500
D7870	Arthrocentesis	\$7,500

D7871	Non-Arthroscopic Lysis And Lavage	\$7,500
D7872	Arthroscopy-Diagnosis With Or Without Biopsy	\$7,500
D7873	Arthroscopy Lavage And Lysis Of Adhesions	\$7,500
D7874	Arthroscopy Disc Repositioning And Stabilization	\$7,500
D7875	Arthroscopy Synovectomy	\$7,500
D7876	Arthroscopy Discectomy	\$7,500
D7877	Arthroscopy Debridement	\$7,500
D7880	Occlusal Orthotic Appliance	\$7,500
D7881	Occlusal Orthotic Device Adjustment	\$7,500
D7899	Unspecified Tmd Therapy By Report	\$7,500
D7910	Sutures	\$7,500
D7911	Debridement Repair Of Soft T	\$7,500
D7912	Diameter Up To 2 Inches (50.8	\$7,500
D7920	Skin Grafts	\$7,500
D7921	Collection And Application Of Autologous Blood Concentrate Product	\$7,500
D7940	Osteoplasty(Prognathism Microg	\$7,500
D7941	Osteotomy - Mandibular Rami	\$7,500
D7943	Osteotomy - Mandibular Rami With Bone Graft; Includes Obtaining The Graft	\$7,500
D7944	Osteotomy-Segmented Or Subapical	\$7,500
D7945	Osteotomy-Body Of Mandible	\$7,500
D7946	Lefort I (Maxilla-Total)	\$7,500
D7947	Lefort I (Maxilla-Segmented)	\$7,500
D7948	Lefort Ii Or Lefort Iii (Osteoplasty Of Facial Bones For Midface Hypoplasia Or Retrusion)-Without Bone Graft	\$7,500
D7949	Lefort Ii Or Lefort Iii-With Bone Graft	\$7,500
D7950	Osseous Osteoperiosteal Or Cartilage Graft Of The Mandible Or Maxilla - Autogenous Or Nonautogenous By Report	\$7,500
D7951	Sinus Augmentation With Bone Or Bone Substitutes Via A Lateral Open Approach	\$7,500
D7952	Sinus Augmentation Via A Vertical Approach	\$7,500
D7953	Bone Replacement Graft For Ridge Preservation - Per Site	\$7,500
D7955	Repair Of Maxillofacial Soft And/OR Hard Tissue Defect	\$7,500
D7960	Frenulectomy - Also Known As Frenectomy Or Frenotomy - Separate Procedure Notincidental To Another Procedure	\$7,500
D7963	Frenuloplasty	\$7,500
D7970	Excision Hyperplastic Tissue P	\$7,500
D7971	Excision Of Pericoronal Gingiva	\$7,500

D7972	Surgical Reduction Of Fibrous Tuberosity	\$7,500
D7981	Excision Of Salivary Gland	\$7,500
D7982	Sialodochoplasty	\$7,500
D7983	Closure Of Salivary Fistula	\$7,500
D7990	Emergency Tracheotomy	\$7,500
D7991	Coronoidectomy	\$7,500
D7995	Synthetic Graft-Mandible Or Facial Bones By Report	\$7,500
D7996	Implant-Mandible For Augmentation Purposes (Excluding Alveolar Ridge) By Report	\$7,500
D7997	Appliance Removal (Not By Dentist Who Placed Appliance) Includes Removal Of Archbar	\$7,500
D7998	Intraoral Placement Of A Fixation Device Not In Conjunction With A Fracture	\$7,500
D8010	Limited Orthodontic Treatment Of The Primary Dentition	\$7,500
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	\$7,500
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	\$7,500
D8040	Limited Orthodontic Treatment Of The Adult Dentition	\$7,500
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	\$7,500
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	\$7,500
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	\$7,500
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	\$7,500
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	\$7,500
D8210	Removable Appliance Therapy	\$7,500
D8220	Fixed Or Cemented	\$7,500
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	\$7,500
D8670	Periodic Orthodontic Treatment Visit	\$7,500
D8680	Orthodontic Retention (Removal Of Appliances Construction And Placement Of Retainer(S))	\$7,500
D8681	Removable Orthodontic Retainer Adjustment	\$7,500
D8690	Orthodontic Treatment (Alternative Billing To A Contract Fee)	\$7,500
D8691	Repair Of Orthodontic Appliance	\$7,500
D8692	Replacement Of Lost Or Broken Retainer	\$7,500
D8693	Re-Cement Or Re-Bond Fixed Retainer	\$7,500
D8694	Repair Of Fixed Retainers Includes Reattachment	\$7,500
D8999	Unspecified Orthodontic Procedure By Report	\$7,500

D9110	Palliative Treatment Of Dental	\$7,500
D9120	Fixed Partial Denture Sectioning	\$7,500
D9210	Local(Not W/Surgical Operative	\$7,500
D9211	Regional Block Anesthesia	\$7,500
D9212	Trigeminal Division Block Anesthesia	\$7,500
D9215	Local Anesthesia In Conjunction With Operative Or Surgical Procedures	\$7,500
D9219	Evaluation For Deep Sedation Or General Anesthesia	\$7,500
D9223	Deep Sedation/General Anesthesia - Each 15 Minute Increment	\$7,500
D9230	Inhalation Of Nitrous Oxide/Anxiolysis Analgesia	\$7,500
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each 15 Minute Increment	\$7,500
D9248	Non-Intravenous Conscious Sedation	\$7,500
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than	\$7,500
D9311	Consultation With A Medical Health Care Professional	\$7,500
D9410	House/Extended Care Facility Call	\$7,500
D9420	Hospital Or Ambulatory Surgical Center Call	\$7,500
D9430	Consultant Evaluation Exam	\$7,500
D9440	Office Visit	\$7,500
D9450	Case Presentation Detailed And Extensive Treatment Planning	\$7,500
D9610	Therapeutic Parenteral Drug Single Administration	\$7,500
D9612	Therapeutic Parenteral Drugs Two Or More Administrations Different Medications	\$7,500
D9630	Drugs Or Medicaments Dispensed In The Office For Home Use	\$7,500
D9910	Application Of Desensitizing M	\$7,500
D9911	Application Of Desensitizing Resin For Cervical And/Or Root Surface Per Tooth	\$7,500
D9920	Special Consultation Appointme	\$7,500
D9930	Complications Unusual Circumst	\$7,500
D9932	Cleaning And Inspection Of Removable Complete Denture Maxillary	\$7,500
D9933	Cleaning And Inspection Of Removable Complete Denture Mandibular	\$7,500
D9934	Cleaning And Inspection Of Removable Partial Denture Maxillary	\$7,500
D9935	Cleaning And Inspection Of Removable Partial Denture Mandibular	\$7,500
D9940	Occlusal Guards By Report	\$7,500
D9941	Fabrication Of Athletic Mouthguard	\$7,500
D9942	Repair And/Or Reline Of Occlusal Guard	\$7,500

D9943	Occlusal Guard Adjustment	\$7,500
D9950	Occlusion Analysis (Mounted Ca	\$7,500
D9951	Occlusal Adjustment-Limited	\$7,500
D9952	Occlusal Adjustment-Complete	\$7,500
D9970	Enamel Microabrasion	\$7,500
D9971	Odontoplasty 1 - 2 Teeth; Includes Removal Of Enamel Projections	\$7,500
D9972	External Bleaching - Per Arch - Performed In Office	\$7,500
D9973	External Bleaching - Per Tooth	\$7,500
D9974	Internal Bleaching - Per Tooth	\$7,500
D9975	External Bleaching For Home Application Per Arch; Includes Materials Andfabrication Of Custom Trays	\$7,500
D9991	Dental Case Management - Addressing Appointment Compliance Barriers	\$7,500
D9992	Dental Case Management - Care Coordination	\$7,500
D9993	Dental Case Management - Motivational Interviewing	\$7,500
D9994	Dental Case Management - Patient Education To Improve Oral Health Literacy	\$7,500
D9999	Unlisted Dental Procedure	\$7,500

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery Center
Assurances- 1110.235(c)(10)

June 25, 2023

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

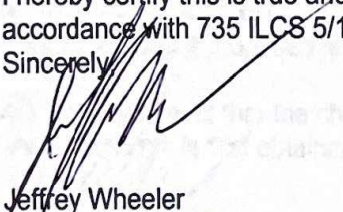
Re: New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC – Assurances

Dear Mr. Kniery,

As a representative of New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC, I, Jeffrey Wheeler, attest that it is the Applicant's full anticipation that, by the end of the second year following the expansion of the facility, the facility will operate at or in excess of the utilization standards identified in 77 Illinois Admin. Code Section 1125.210(c).

I hereby certify this is true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,


Jeffrey Wheeler
Chief Executive Officer
New Core Healthcare, NCH Growth Partners, LLC,

ATTACHMENT 34

Availability of Funds

The total estimated project cost is \$9,203,845 and \$5,070,545 of that amount is attributed to construction and equipment purchases. A portion of the construction costs will be paid by the landlord of the site through a tenant improvement allowance of \$1,593,400. The Applicants will fund the remaining project construction and equipment with existing cash and securities. Finally, the lease for the facility makes up the balance of the project's costs in an amount of \$4,133,300. In addition, a letter of commitment from NCH Growth Partners is enclosed to evidence Applicant's ability to finance the remainder of the project costs.

ATTACHMENT 34

Availability of Funds

Subject: Financial Commitment Letter

To Whom It May Concern:

I am writing to confirm the financial commitment of NCH Growth Partners, LLC to New Core Healthcare, LLC, in support of the development and opening of the ambulatory surgery center, Chicago Children's Surgery Center, in Chicago, Illinois.

As the CEO of NCH Growth Partners, LLC I, Jeffrey Wheeler, hereby commit NCH Growth Partners to providing equity capital to New Core Healthcare, LLC, as needed, up to the amount of \$3,500,000 in exchange for an equity stake in the project. This commitment is made with the intent of facilitating the successful establishment and operation of the Chicago Children's Surgery Center, which I firmly believe will significantly enhance healthcare services for children in the Chicago area.

I understand that NCH Growth Partners, LLC's financial commitment may be utilized to cover various expenses associated with the development, construction, equipment acquisition, licensing, regulatory compliance, and operational requirements of the Chicago Children's Surgery Center. These expenses may include, but are not limited to, construction costs, medical equipment, staff recruitment, training, and marketing initiatives.

To ensure the timely availability of funds, NCH Growth Partners, LLC is prepared to provide the committed capital as requested by New Core Healthcare, LLC, subject to reasonable financial due diligence and legal documentation necessary to protect the interests of all parties involved, with not less than one month's notice before capital is required.

Please consider this letter as a binding commitment, valid until a full amount up to \$3,500,000 has been disbursed to New Core Healthcare, LLC. Any amendments or modifications to this commitment shall be agreed upon in writing by both parties. NCH Growth Partners, LLC has raised \$10,000,000 for the purposes of building and operating Ambulatory Surgery Centers to treat children on Medicaid who need dental services.

I firmly believe in the mission and vision of New Core Healthcare, LLC and its dedication to improving pediatric surgical care. I am confident in the competence and expertise of the management team and the potential success of the Chicago Children's Surgery Center.

Yours sincerely,



Jeffrey Wheeler
CEO
NCH Growth Partners, LLC

ATTACHMENT 36

Financial Viability

Provide Data for Projects Classified as: Enter Historical and/or Projected Years:	Category A and Category B (last three years)			Category B (Projected)
	2020	2021	2022	2026
Current Ratio				5.74
Net Margin Percentage				9.00%
Percent Debt to Total Capitalization				0.00%
Projected Debt Service Coverage				NA
Days Cash on Hand				59.06
Cushion Ratio				NA

ATTACHMENT 37
Economic Feasibility
Project Operating Costs and
Total Effect of the Project on Capital Costs

July 10, 2023

John Kniery
Board Administrator
Health Facilities and Services Review Board
525 West Jefferson Street, Floor 2
Springfield, Illinois 62761

Re: Chicago Children's Surgery Center, LLC
III. Admin. Code Section 1120.120(a) Available Funds Certification
III. Admin. Code Section 1120.140(a) Reasonableness of Financing Arrangements

Dear Mr. Kniery:

As a representative of Chicago Children's Surgery Center, LLC and NCH Growth Partners, LLC, I, Jeffrey Wheeler, attest that the project costs will be \$9,203,845. The project will be funded with \$3,477,145 in cash and existing securities from NCH Growth Partners, LLC, \$1,593,400 in funding from the site owner through a tenant improvement allowance as described in the lease letter of intent, and the remainder of the project costs will be paid through the lease of the space in the amount of \$4,133,300.

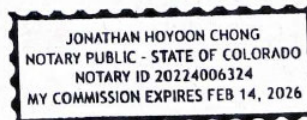
NCH Growth Partners, LLC has sufficient and readily accessible internal resources to fund their obligation required by the project, and to fully fund other ongoing obligations.

I further certify that our analysis of the funding options for this project reflected that the funding strategy outlined herein is the lowest net cost option available.

Sincerely,

Jeffrey Wheeler
CEO
NCH Growth Partners, LLC

7/11/2023



A handwritten signature in black ink, appearing to read "Jonathan Chong", written over the notary seal.

ATTACHMENT 37 Economic Feasibility

CHICAGO CHILDREN'S SURGERY CENTER BALANCE SHEET 2024-2026

ASSETS	<u>2024</u>	<u>2025</u>	<u>2026</u>
<u>Current Assets</u>			
Cash in Bank	\$ 81,508	\$ 250,498	\$ 466,671
Accounts Receivable, net	\$ 291,270	\$ 606,813	\$ 946,628
Total Current Assets	\$ 372,778	\$ 857,310	\$ 1,413,298
<u>Fixed Assets</u>			
Building Improvements	\$ 3,121,720	\$ 3,121,720	\$ 3,121,720
Equipment	\$ 355,425	\$ 355,425	\$ 355,425
Accumulated Depr - Improvements	\$ (208,115)	\$ (416,229)	\$ (624,344)
Accumulated Depr-Equipment	\$ (71,085)	\$ (142,170)	\$ (213,255)
Total Fixed Assets	\$ 3,197,945	\$ 2,918,746	\$ 2,639,546
<u>Other Assets</u>			
Security Deposit	\$ 19,918	\$ 19,918	\$ 19,918
Total Other Assets	\$ 19,918	\$ 19,918	\$ 19,918
TOTAL ASSETS	\$ 3,590,640	\$ 3,795,974	\$ 4,072,762
LIABILITIES & STOCKHOLDER'S EQUITY			
<u>Current Liabilities</u>			
Accounts Payable	\$ (83,793)	\$ (90,829)	\$ (96,140)
Accrued Payroll Expense	\$ (50,833)	\$ (55,454)	\$ (73,736)
Accrued Taxes	\$ (65,536)	\$ (70,997)	\$ (76,458)
Total Current Liabilities	\$ (200,162)	\$ (217,279)	\$ (246,334)
<u>Stockholder's Equity</u>			
Owner's Equity	\$ 3,600,000	\$ 3,600,000	\$ 3,600,000
Net Income	\$ 190,802	\$ 222,451	\$ 305,843
Retained Earnings	\$ -	\$ 190,802	\$ 413,253
Total Stockholder's Equity	\$ 3,790,802	\$ 4,013,253	\$ 4,319,096
TOTAL LIABILITIES & STOCKHOLDER'S EQUITY	\$ 3,590,640	\$ 3,795,974	\$ 4,072,762

ATTACHMENT 37 Economic Feasibility

CHICAGO CHILDREN'S SURGERY CENTER

Profit and Loss

2024-2026

<u>Revenue</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>
Facility Fee	\$ 2,912,700	\$ 3,155,425	\$ 3,398,150
Net Revenue	\$ 2,912,700	\$ 3,155,425	\$ 3,398,150
<u>Cost of Goods Sold</u>			
Supply Cost	\$ (360,000)	\$ (390,000)	\$ (420,000)
Administrator	\$ (187,500)	\$ (191,250)	\$ (195,075)
Head Nurse	\$ (162,500)	\$ (167,375)	\$ (167,375)
RNs	\$ (250,000)	\$ (279,388)	\$ (301,275)
Medical / Dental Assistants	\$ (675,000)	\$ (754,346)	\$ (813,443)
Total Cost of Goods Sold	\$ (1,635,000)	\$ (1,782,359)	\$ (1,897,168)
Gross Profit	\$ 1,277,700	\$ 1,373,066	\$ 1,500,983
<u>G&A Expenses</u>			
Admin Labor	\$ (250,000)	\$ (271,250)	\$ (292,500)
Legal and accounting	\$ (20,000)	\$ (20,600)	\$ (21,218)
Billing	\$ (72,818)	\$ (78,886)	\$ (84,954)
Rent	\$ (239,010)	\$ (243,790)	\$ (248,666)
RE Taxes	\$ (74,412)	\$ (75,156)	\$ (75,907)
Common Charges	\$ (42,544)	\$ (42,969)	\$ (43,399)
Utilities	\$ (15,000)	\$ (15,450)	\$ (15,914)
General & Liability Insurance	\$ (20,000)	\$ (20,600)	\$ (21,218)
Worker's Comp Insurance	\$ (5,000)	\$ (5,150)	\$ (5,305)
Renter Insurance	\$ (5,000)	\$ (5,150)	\$ (5,305)
Office Supplies	\$ (5,000)	\$ (5,500)	\$ (6,050)
Equipment Repairs	\$ (40,000)	\$ (61,800)	\$ (63,654)
Other Office Expenses	\$ (40,000)	\$ (41,200)	\$ (42,436)
Depreciation Expense	\$ (208,115)	\$ (208,115)	\$ (208,115)
Corporate Overhead	\$ (50,000)	\$ (55,000)	\$ (60,500)
Total G&A Expenses	\$ (1,086,898)	\$ (1,150,616)	\$ (1,195,139)
Net Income	\$ 190,802	\$ 222,451	\$ 305,843
<i>Net Profit Margin</i>	<i>6.6%</i>	<i>7.0%</i>	<i>9.0%</i>

ATTACHMENT 37

Economic Feasibility

Cost and GSF by Service

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Sq. Ft. New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
ASTC	\$509.09		4,400						\$2,240,000
Contingency	\$35.18		4,400						\$154,798
TOTALS	\$544.27		4,400						\$2,394,798
* Include the percentage (%) of space for circulation									

Pursuant to Illinois Admin. Code Section 1120.Appendix A (a)(3) a project's cost must be at or below the RS Means for the new construction of an ASTC. At the time of this application the RS Means for the new construction of a ASTC in this area of the state is \$453.37 per GSF. This project is slated to be completed by July 1, 2025 making the applicable RS Means standard slightly higher. The proposed cost per GSF for this project \$544.27, and thus this project does not meet the Board's criteria. However, we would ask the Board to consider that this project is being built out with an expectation that a second operating room will prove to be necessary, sooner rather than later.

There are certain economies of scale that can (and must) be taken into consideration during the build out phase and the applicants are sufficiently confident in the overall need for and success of this undertaking (as they have demonstrated the ability to successfully complete similar projects in other states) that they would prefer to build this facility to the size and standard that these patients require rather than manipulate the project to obtain a positive finding for this criteria.

Furthermore, as previously discussed with HFSRB staff during a technical assistance meeting, there was a less expensive property available, but that property was located farther away and not easily accessible from the current proposed service area – particularly for residents reliant upon public transportation. Establishing the facility elsewhere would only serve to obtain a positive finding for this criteria and it would come at the expense of the idea that residents of this proposed service area, who are most at risk based upon the identified patient population, deserve to have a facility nearby, rather than to establish a facility that requires travel to another community.

ATTACHMENT 38

Safety Net Impact Statement

Chicago Children's Surgery Center, LLC ("CSCC") is a new entity and has no applicable historical data for this section of the application. However, it is anticipated that the proposed facility will not have a material impact on the essential safety net services in the community. New Core Healthcare, LLC the sole owner of CSCC has long maintained a commitment to serving patients regardless of their ability to pay.

The facility is designed to not only accept Medicaid but to be a destination for Medicaid and low-income patients in need of this necessary care. This is of significant importance because the commitment to a Medicaid population is a substantial basis to justify the need for this facility.

The Applicants have undertaken a robust community engagement effort and scheduled meetings with representatives of the Illinois Medicaid Program to discuss their intentions and received positive feedback on their proposed business plan and intent to increase access in the community. The Applicant have also made efforts to reach out to area Dental Schools in the area who are often a last resort for patients in need of care and unable to find it area ASTCs.

Too often, area ASTCs do not accept Medicaid because of the lower reimbursement from Medicaid as compared to private insurance. However, a significant percentage of the patient population is reliant upon Medicaid for its primary (or secondary) insurance and, for those patients, access to care can be a significant challenge. The commitment to participation in Medicaid, including in the various Medicaid managed care plans, is an important part of the expansion of safety net services that will be accomplished by this project's approval.

ATTACHMENT 39

Charity Care

Chicago Children's Surgery Center, LLC is a new entity and has no applicable historical data for this section of the application. The project patient mix by payor source, anticipated Revenue by Payor are included below.

Payor Type	Estimated % of Patients by Payor Source	Expected Revenue % by Payor Source
Commercial	15%	20%
Medicare	0%	0%
Medicaid/Medicaid/MCO	85%	80%

**ATTACHMENT 40
Flood Zone Letter**

June 24, 2023

John P. Kniery
Board Administrator
Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

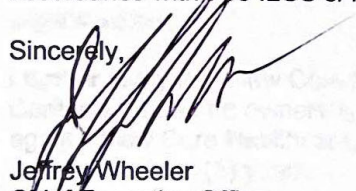
Re: Chicago Children's Surgery Center- Flood Plain Requirements

Dear Mr. Kniery:

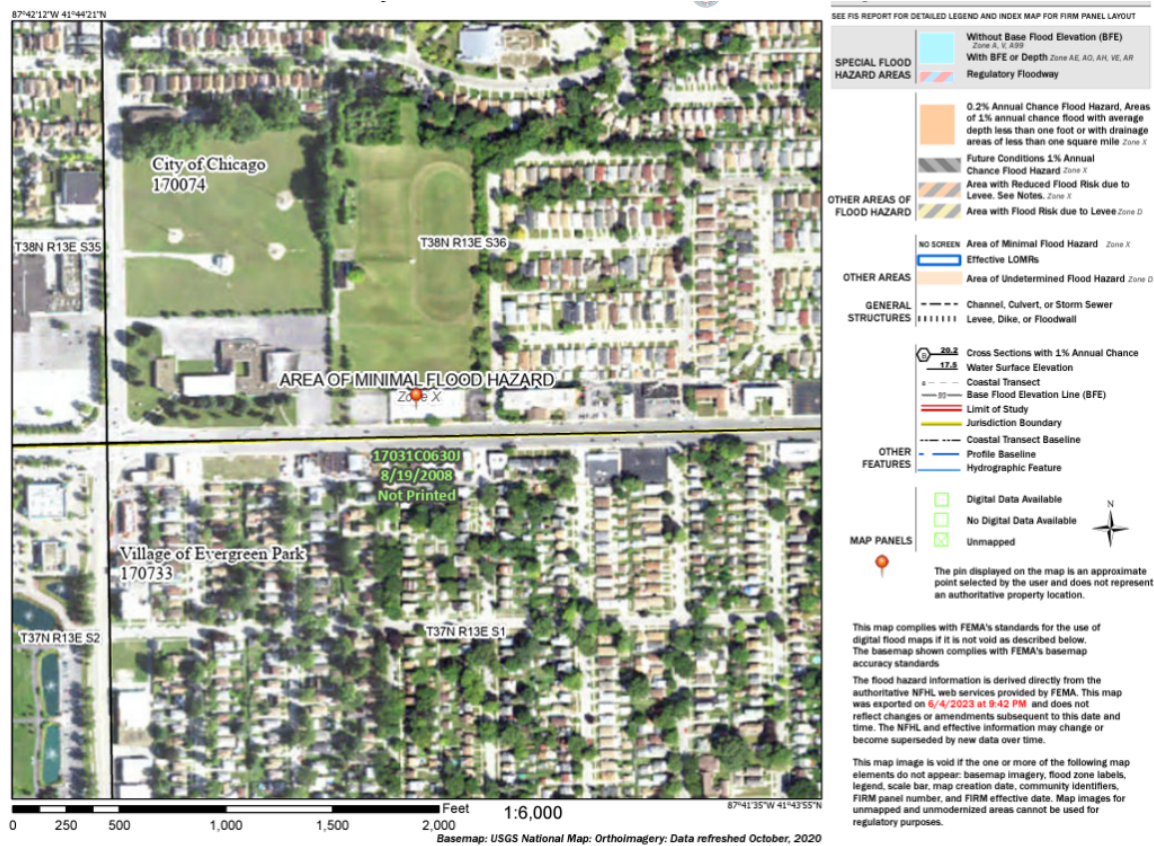
As representative of New Core Healthcare, NCH Growth Partners, LLC, and Chicago Children's Surgery Center, LLC, I Jeffrey Wheeler, affirm that the proposed location for the establishment of New Core Healthcare, NCH Growth Partners, LLC, complies with Illinois Executive Order #2005-5. The proposed location, 8658 S. Sacramento Ave., Chicago, IL 60652, is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

I hereby certify this true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,


Jeffrey Wheeler
Chief Executive Officer
New Core Healthcare, NCH Growth Partners, LLC,

ATTACHMENT 40 Flood Plain Letter



After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

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