Minnesota Dental Infrastructure Gap:

One-Time Infrastructure Investments Are Needed Now To Meet 2024 Minnesota Legislative Dental Target

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Content

Oral Care in Minnesota 2
Bridging Gaps in Creating Public Value for Minnesotans.....2
One-Time Investment to Secure Critical Access to Dental Care 3
1. One-Time General Fund Investment in Needed Infrastructure 3
2. Activate Dental Workforce Expansion and Job Growth 3
3. Set the Evaluation Metric for Reporting to the Legislature 3
Summary 3
References.....4

Oral Care in Minnesota

BACKGROUND

The 2021 Minnesota legislature passed historic bipartisan legislation[1], ushering in a new era of oral health for Minnesotans in need[2]. Because oral health and overall health are inextricably linked[3], immediate and ongoing work has been set in motion to remedy Minnesota's dental health inequities[4], unaddressed in over 30 years[5]. No one piece of legislation addresses the multifaced problem that includes reasonable reimbursement, adequate physical capacity, and enough workforce to deliver at least basic dental care. The 2021 Legislation began to address longstanding Minnesota **health disparities** with **patient-centered**, **community-centric**, **value-based** approaches to social determinants of health, health literacy, **and impact of oral health on overall health**.

MINNESOTANS IN NEED OF DENTAL CARE

Nearly one and a half million Minnesotans (107,943[6] in MinnesotaCare and 1,344,634 in Medicaid & CHIP[7]) from every county in the state are publicly insured[8]. The 2021 legislation sets a performance benchmark of one dental visit per year for 55% of this population. Currently state data shows that about 14% to 42% percent of those on public insurance receive that single annual dental visit (see tabular listing by county on last page). Conservatively, there is a 10% shortfall to meet the legislative benchmark. Our **Critical Access Dental (CAD) Providers** deliver two-thirds of the publicly insured dental visits. CAD providers are at maximum capacity with long waitlists, often in the hundreds and thousands of patients. **Additional one time infrastructure investments[9] are needed to expand capacity and deliver care to about 150,000 additional Minnesotans on public insurance and bridge the nearly 10% gap**.

In 2020, in all Minnesota counties, those on public insurance, had dental visit rates below 45%.

LOWERING TOTAL COST OF CARE

Being seen at least once per year for **prevention measures leads to better health and lower-cost treatments**. In 2021 periodontal benefits were restored by the legislature as part of the bipartisan package. Periodontal disease has been linked to chronic health conditions[10] such as diabetes, heart disease and even dementia. Dental Disease that goes untreated too often results in toothaches and expensive trips to the Emergency Room[11,12]. Research shows that early treatment[13] results in thousands of dollars in downstream savings accrued to the state as these patients are publicly insured. Remaining treatment gaps can be addressed by **increasing the provider capacity, increasing provider participation in the network, increasing availability of timely, local dental care, and helping reduce costly emergency department usage**[14]. The Minnesota Commissioner of Human Services is tasked with measuring the effectiveness of public investments in achieving the intended legislatively designated outcomes.

Bridging Gaps in Creating Public Value for Minnesotans

While much has been accomplished, major challenges remain. Achieving the legislative target of 55% of people with a dental visit requires a matching increase in the provider-network capacity. **Access is key to better health and lower overall spending.** For example, the commercially insured population in Minnesota, receives more frequent dental visits, despite suffering from about half the disease burden compared to publicly insured patients. In essence, **Minnesota's publicly insured population has twice the dental disease burden and barriers to care**.

CRITICAL ACCESS DENTAL CARE PROVIDERS

CAD providers disproportionately serve children, adults, people with disabilities and seniors on publicly insured Minnesota Health Care Programs (MHCP). CAD designation requires a dental practice to deliver at least 25% of rural and 50% of urban dental appointments. **Minnesota's Critical Access Dental Providers make up 12.5% of the licensed dentists in the state but they deliver about 2/3 of the state's publicly insured dental care.** Non-CAD providers make a small percentage (around 6%) of their appointments available to MHCP patients and deliver limited services to selected MHCP patients. Therefore, increasing the infrastructure of CAD providers, Minnesota's Medicaid dental workhorses, will have a stronger return on public investment to meet the legislative target.

One-Time Investment to Secure Critical Access to Dental Care

CAD providers, both private practice and nonprofits, are on the frontlines of care delivery and must have the additional infrastructure and staff to deliver the increased services required to Minnesotans in need. Our proposal is neutral on the administrative structure behind the delivery of dental care. Changing administration models and administrators without reducing infrastructure and workforce shortfalls, is not a viable solution. To reach the 55% utilization target mandated by the legislature, we must address infrastructure and workforce gaps head on. Infrastructure is a "brick and mortar" issue. As we have laid out, physical capacity and workforce have now become barriers to success in caring for our children, adults, and our elders in need. Therefore, we offer the following recommendation for consideration.

1. One-Time General Fund Investment in Needed Infrastructure

As the legislature has mandated, in order to deliver the additional services publicly insured Minnesotans need, we request consideration for additional one-time infrastructure investments to increase Minnesota's capacity to deliver dental care. This includes equipment replacement and enhancement, additional mobile dental care capacity, and facility expansion. We recommend investing in the infrastructure capacity Minnesota must have to meet the targets our legislators have set. We estimate this one-time investment at $20 million.

2. Activate Dental Workforce Expansion and Job Growth

Expanding infrastructure is inextricably linked to a proportional workforce expansion leading to additional jobs. This will also stimulate employment in the ring of suppliers that support the functioning of increased dental care delivery capacity. These additional jobs are private-sector and benefit-earning positions expanding the state's health care supplier sector. We estimate the investment to increase training and workforce capacity at $5 million. In a separate policy proposal, we will describe this requirement in greater detail.

3. Set the Evaluation Metric for Reporting to the Legislature

We cannot reliably improve what we do not measure. Therefore, we recommend that the impact of this investment be quantified and reported back by county to the legislature with data from DHS and dental providers. This way a correlation can be established between reaching the 55% utilization and the increased investment in capacity.

Summary

There is an infrastructure gap for Critical Access Dental providers to meet or exceed the legislative mandated 1-dental visit per year for 55% of the nearly 1.5 million Minnesotans on public insurance. Bipartisan legislative leadership is continuing to raise the bar on fiscally responsible, effective preventative dental care and improved access. Leadership from the Minnesota legislature, the Departments of Health and of Human Services remains vital and necessary to bridge the infrastructure gap so that CAD providers can serve our children, adults, and elders in need. We believe Minnesota can become an inspiring model for Oral Health for the entire nation.

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Percent Minnesota Public Insurance Patients That Visited a Dental Provider (2020 by County)

Between 14% to 40% on public insurance had 1 dental visit. The rest did not receive a single dental visit in 2020. **Over 65% of the visits were provided by Critical Access Dental (CAD) Providers. CAD are often at full capacity with long waiting lists in the hundreds and thousands of patients. Without additional capacity / infrastructure, state target of 55% cannot be reached.**

AITKIN	33.07	LYON	29.34
ANOKA	34.45	MAHNOMEN	34.80
BECKER	39.75	MARSHALL	26.83
BELTRAMI	33.89	MARTIN	36.26
BENTON	33.09	MCLEOD	35.49
BIG STONE	32.55	MEEKER	32.62
BLUE EARTH	32.70	MILLE LACS	29.77
BROWN	38.42	MORRISON	37.71
CARLTON	31.93	MOWER	29.80
CARVER	31.16	MURRAY	30.30
CASS	31.82	NICOLLET	31.76
CHIPPEWA	38.75	NOBLES	25.57
CHISAGO	29.31	NORMAN	36.73
CLAY	34.53	OLMSTED	36.10
CLEARWATER	36.48	OTTER TAIL	40.98
COOK	41.56	PENNINGTON	27.01
COTTONWOOD	35.05	PINE	28.49
CROW WING	33.43	PIPESTONE	14.38
DAKOTA	30.02	POLK	30.97
DODGE	33.89	POPE	39.64
DOUGLAS	41.98	RAMSEY	30.63
FARIBAULT	32.25	RED LAKE	29.25
FILLMORE	31.21	REDWOOD	30.11
FREEBORN	33.61	RENVILLE	33.15
GOODHUE	34.59	RICE	36.49
GRANT	40.40	ROCK	23.39
HENNEPIN	31.95	ROSEAU	28.77
HOUSTON	32.65	SCOTT	32.92
HUBBARD	38.70	SHERBURNE	32.29
ISANTI	29.55	SIBLEY	39.67
ITASCA	40.03	ST. LOUIS	31.54
JACKSON	28.50	STEARNS	34.97
KANABEC	35.72	STEELE	37.51
KANDIYOHI	37.68	STEVENS	37.39
KITTSON	28.08	SWIFT	31.49
KOOCHICHING	38.82	TODD	34.09
LAC QUI PARLE	39.63	TRAVERSE	35.87
LAKE	30.72	WABASHA	32.92
LAKE OF THE WOO...	31.95	WADENA	34.66
LE SUEUR	31.99	WASECA	35.17
LINCOLN	31.38	WASHINGTON	31.54
		WATONWAN	33.27
		WILKIN	34.51
		WINONA	36.17
		WRIGHT	32.78
		YELLOW MEDICINE	39.85

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