Minnesota Department of
Human Services

Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

Report to the Legislature

Minnesota Health Care Programs

Critical Access Dental Program - Results and Recommendations

Laws of Minnesota 2006
Chapter 282, article 22, section 2, subdivision 2

May 2008

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Appendices

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EXECUTIVE SUMMARY

The Department of Human Services was directed by the 2006 Legislature to prepare a report on the results of the critical access dental payment program (CADPP) with recommendations on funding sources to the legislature.

The purpose of the CADPP has been to sustain dental practices that serve a high volume of Minnesota's low income populations and increase access to dental care. These populations experience oral health disparities and barriers which influence their ability to gain and utilize services. Efforts to increase access to dental care for the underserved in Minnesota continue to be a topic discussed by the public, health care professionals, and the Legislature. Despite numerous changes and additions to dental statutes in recent years, an increase in access to dental care has been elusive.

Results:

- The percent of continuously enrolled patients served by all Minnesota Health Care Program (MHCP) dental providers dipped to 38.5 percent during 2002, the first year of the CADPP. It increased to 42.2 percent in 2006. The number of continuously enrolled MHCP enrollees increased 29 percent over the same time period. Without the CADPP, MHCP dental providers may not have been able to care for the growing population.
- Practice patterns do not appear to vary greatly between CADPP providers and non-critical access providers.
- The percentage of non-critical access provider patients in the exam service category has decreased slightly while the same percentage has increased slightly for CADPP providers. Additionally, until 2006, the percentage of patients in the preventive service category has decreased slightly for both the CADPP and non-critical access providers.
- The payment to charge ratio for CADPP providers has been 8 to12 percent higher than that of non-critical access providers.
- The CADPP has made the Department increasingly cognizant of quality of care issues which are of growing concern.

The Department of Human Services recommends that:

- Funding for the CADPP should continue to assist in sustaining dental providers who see a high volume of MHCP recipients or practice in designated underserved areas. Funding should be directed to clinics with high quality and evidence based practices.
- Funding sources for the CADPP should remain as currently established with no limitations on the total allowable adjustments. Medical Assistance add-on payments should continue to be funded through the general fund budget and MinnesotaCare add-on payments through the Health Care Access Fund.
- To facilitate increasing the percentage of patients in the preventive services category, revise MN Statutes related to CADPP to include collaborative practice dental hygienists.
- Administrative streamlining for MHCP dental programs continue to be explored and implemented.
- Payment rates for MHCP dental programs be studied.
- Evidence based alternative dental workforce models which are effective in increasing access to dental care be considered.

BACKGROUND

In 2006, H.F. No. 4126, 3rd Engrossment – 84th Legislative Session (2005-2006) directed that the commissioner of the Department of Human Services (DHS) "shall report to the legislature on the results of higher payments to critical access dental providers and with recommendations on funding sources to continue these higher payments". The full statute language is attached as Appendix A. The DHS executed an analysis of designated critical access providers, the services rendered, and the costs associated with the Critical Access Dental Payment Program (CADPP). This report highlights the results of the analysis. The report is intended to provide an evaluation of the CADPP as it relates to the provision of dental services, expenditures for dental care, and the practice patterns of those designated.

Introduction

Access to dental care has been an issue of increasing concern for many low income Minnesotans and public health officials. A report to the legislature in 2001 outlined the extent of the problem and concluded that the underutilization of dental services by Minnesota Health Care Program (MHCP) recipients was a multi-factorial problem that should be addressed in multiple ways concurrently.[1]

There are approximately 666,000 persons currently enrolled in MHCP. Of this number, 507,000 are enrolled in the Medical Assistance (MA) program, monthly averages of 33,000 are enrolled in the General Assistance Medical Care (GAMC) program, and 126,000 are enrolled in MinnesotaCare.[2] All enrollees receive dental benefits; however, the extent of the benefits varies by program and care plan (Appendix B).

While disparities and barriers to utilization among MHCP enrollees influence their readiness and ability to seek oral health care services, it is recognized that these low income populations are often those who are at a greater risk for oral disease and more complex systemic health problems. An increasing amount of research exists which demonstrates that oral health and systemic health are interrelated.[3] If expenditures for dental care can significantly reduce expenditures for systemic disease, then health care appropriations for oral health should be allocated in such a manner so as to encourage oral health providers to see public program recipients.

The purpose of the CADPP is to serve as an incentive for dental providers to see public program recipients. The program targets enrolled practices that serve a high number of these recipients and allocates increased reimbursements to them. MHCP dental providers can thus make a significant impact on the general health of the State's low income residents.

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[1] McRae JA and Fields TR, *Perspectives of Dentists and Enrollees on Dental Care Under Minnesota Health Care Programs*, Minnesota Department of Human Services, 2002.

[2] DHS data. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_136855

[3] National Institute of Dental and Craniofacial Research, *Archive: The Oral-Systemic Health Connection.* http://www.nidcr.nih.gov/HealthInformation/DiseasesAndConditions/OralSystemicHealthConnection/OralSystemic.htm

Evolution of the Critical Access Dental Payment Program

The CADPP was created by the Legislature in May of 2001 (Appendix C). Since 2002, the program has strategically provided increased reimbursement to providers who treat large numbers of MHCP recipients and those that practice in designated underserved areas. It addresses the most frequent barrier cited by dental providers to accepting MHCP patients: low reimbursement rates. The program supplements a provider's MHCP receipts through add-on payments. Add-on rates have been set to bring total payments closer in line with commercial market conditions. The CADPP manages funding by targeting payments only to providers who see a large number of MHCP patients.

The number of critical access dental practices has changed each year as the criteria for designation has evolved (Table 1).

Table 1

Designated Critical Access Providers
2002-2006

Year	Number
2002	147
2003	147
2004	175
2005	182
2006	109

Despite changes in the criteria, 58 practices have consistently been designated over each of the consecutive years. They have represented 31 to 53 percent of the total number of CADPP providers during the program years. These 58 practices were examined further and will be discussed later in this report in relation to the geographic area that they are located in to assess the number of patients who accessed care, the visits associated with their care and the practice patterns that they have exhibited.

REPORT METHODOLOGY

The CADPP records and data stored in the DHS data warehouse were utilized to prepare this report. The data warehouse stores information that is produced by the Medical Management Information System (MMIS) to track fee-for-service claims activity and encounter data from the health plans. The data extracted are dependent on the information furnished by the providers on claims and on the reporting mechanisms of the managed care plans.

This report utilizes:

- MHCP provider enrollment data
- Medical Assistance (MA) fee-for-service and managed care dental claims data generated from January 1, 2000, through December 31, 2006;
- GAMC fee-for-service dental claims generated from January 1, 2000, through December 31,2006;
- Managed care plan reported MA and MinnesotaCare dental encounter data from January 1, 2000 through December 31, 2006; and
- CADPP managed care reporting records maintained by the DHS.

Data limitations:
A practice is considered to include all providers whose taxes are reported under the same Federal Employer Identification Number (FEIN).

- Practices may be enrolled as solo providers or group practices.
- The number of individual providers enrolled in a group practice changes over time and these changes are often not reported. As a result, the accuracy of data on the individual providers in group practices is problematic.

The most noteworthy limitation of the data is related to the CADPP criteria for designation. The criteria have changed on an annual basis. The variability in the criteria made it difficult to analyze characteristics of these practices and limited the consecutively designated practices to 58 for the study.

SUMMARY OF THE RESULTS

Patients Served

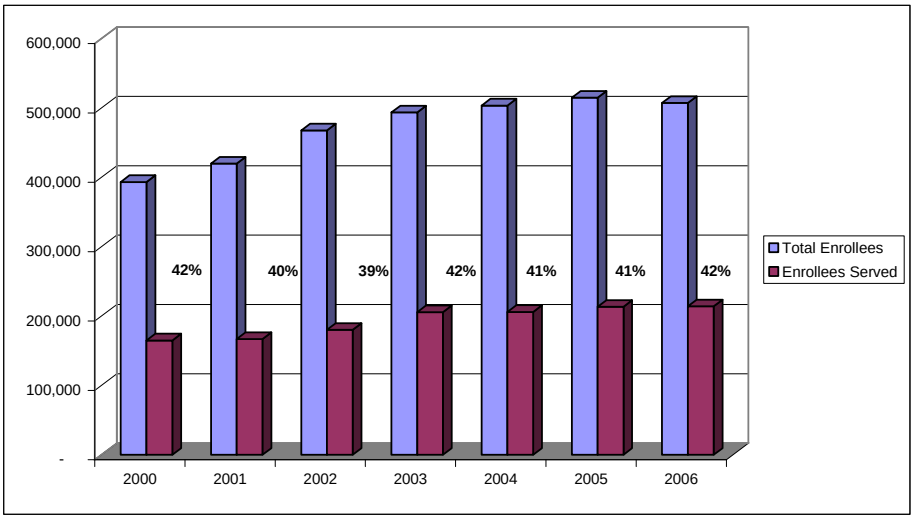
According to the Centers for Disease Control, 69 percent of the U.S. population aged 18 and over visited a dentist in 2004. During the same year in Minnesota, 79 percent of those aged 18 and over visited a dentist. Persons with higher income and educational level have a greater probability of visiting the dentist.[4]

MHCP enrollees represent those individuals who live below the federal poverty line or on the fringe of poverty. They may be homeless, unemployed, unemployable, homebound, disabled, or the working poor. For these individuals, dental care may be viewed as financially out of reach and problematic when attempting to find care. All MHCP enrollees have a dental benefit; however, only 43.6 percent of MA enrollees, 36.5 percent of GAMC enrollees, and 51percent of MinnesotaCare enrollees visited a dentist in 2006.[5]

The number of MHCP enrolled persons has grown significantly during the course of the CADPP; however, the percent of those continuously enrolled who received at least one dental visit in a given year has experienced little change. (Table 2) To be considered continuously enrolled, an enrollee must have had at least 11 months of enrollment during a calendar year.

Table 2

Enrollees Served by Minnesota Health Care Program Dental Providers as a Percent of Continuously Enrolled Minnesota Health Care Program Enrollees by Calendar Year



[4] Centers for Disease Control, National Oral Health Surveillance System, 2004. http://apps.nccd.cdc.gov/nohss/bystate.asp?stateid=27

[5] DHS data report, mkw rpt 11/1/07 Dental_M/Dental Access2/DQ Log Number 491v2.xls

Consecutively Designated Practices

The 58 practices that were designated as critical access over all consecutive years of the program were examined. In 2006, these practices saw 67,526 patients and provided 133,931 visits (Appendix D). Of these patient visits, 58.1 percent of the services were provided in the enrollee's county of residence. This was of no surprise as the percent of patients with services provided in their county of residence for all MHCP recipients for the same year was 57 percent. The percent of patients with services provided in their county of residence by non-critical access providers was 55 percent. This could be an indication that patients who were seen by critical access providers are slightly less likely to go out of their county of residence for services.

CADPP providers are seeing a greater number of patients and providing a greater number of patient visits; nevertheless, the overall percentage of MHCP enrollees obtaining services by CADPP and non-designated providers has not increased over the program years.

As the overall MHCP enrolled patient population increased over the years, the percent of patients seen and percent of patient visits by all providers has remained fairly constant. Had the CADPP not been in existence, MHCP providers may not have been able to care for the growing number of MHCP enrollees.

The percent of patients served by all MHCP dental providers over the years was found to be fairly consistent despite the addition of the CADPP in 2002 (Table 3).

Table 3

Total Patients Served by all MHCP Dental Providers as a Percent of Continuously Enrolled MHCP Enrollees by Calendar Year

	2000	2001	2002	2003	2004	2005	2006
FFS	41.6%	40.8%	41.0%	41.9%	41.4%	41.7%	42.9%
Managed Care	42.1%	39.3%	37.5%	41.6%	40.7%	41.4%	41.9%
Total	42.0%	39.8%	38.5%	41.7%	40.9%	41.5%	42.2%

Data was examined to further evaluate the effect of the CADPP on access to dental care (Appendix E)**. The data revealed that:**

- **The rate of visits to MHCP providers per 1000 enrollee months has slightly increased.**
- **The percent of continuously enrolled patients served by all MHCP dental providers has remained stable with slight increases between some years.**
- **The rate of patients served by MHCP providers per 1000 enrollee months by calendar year dipped to 31 in 2002. Slight increases were seen in subsequent years.**

Dental Services by Service Categories (Consecutively Designated Practices)

In evaluating the CADPP, it was important to examine the number of patients served, as well as the number of patient visits. The possible need for seeing a patient for multiple appointments is well recognized. The FFS and managed care encounter data was examined to determine if practice patterns were evident for both of these elements. A comparison was made to those MHCP dental providers who were non-critical access providers.

Appendix F and G identify the number of dental patients and visits by calendar year and selected categories of service for critical access and non-critical access providers. Data from these tables were extrapolated to compose graphs for ease of comparison.

Practice patterns do not appear to vary greatly between CADPP providers and non-critical access providers; however, some patterns are worth noting (Appendices H-K). These include:

Patients (Appendices H and I)

- The percent of dental patients seen by CADPP providers for examinations in 2002-2004 was lower than that of non-critical access providers. Between 2005 and 2006, the percentage began increasing for CADPP providers.
- CADPP practices saw a lower percentage of patients for preventive services than non-critical access providers.
- CADPP providers saw relatively the same percentage of patients for restorative procedures than non-critical access providers. This percentage remained stable since 2003.
- The percent of patients seen for non-surgical periodontal, oral surgery, surgical, periodontal and prothodontic services has remained low. CADPP providers saw a slightly greater percent of patients for non-surgical periodontal and oral surgery services. The slightly greater percent of patients seen for oral surgery services may be a direct result of the criteria for CADPP designation which automatically allows a requesting oral surgery specialist to be designated.

Patient Visits (Appendices J and K)

- The percent of visits for examinations was slightly greater for CADPP providers than non-critical access providers.
- The percent of dental visits for preventive services has been decreasing for both CADPP and non-designated providers. CADPP providers completed a lower percentage of preventive visits than non-designated providers.
- The percent of dental visits for restorative procedures remained stable for both CADPP and non-designated providers.
- The percent of visits for non-surgical periodontal, oral surgery, surgical periodontal and prosthodontic services has remained very low. CADPP providers appear to provide a slightly greater percentage of dental visits for these services than non-designated providers.

Patients Visiting One or More Providers

A medical home, which provides primary health care, is best delivered where comprehensive, accessible, coordinated, compassionate and culturally effective care is available and delivered by primary care specialists. As in the medical realm, the establishment of a dental home is critical especially for infants, children, adolescents, and individuals with special needs.[6] Unfortunately, the number of enrollees who visited one or more providers in a calendar year is not an indication that a person's dental needs were comprehensive or complete. It does provide a general idea of utilization patterns by enrollees.

For this evaluation, the counts were based on the provider listed on the claim as the provider paid for the service so this provider may be a solo or group practice. A patient was counted as having seen multiple providers only if more than one provider was paid for services.

In calendar year 2006, 81.7 percent of MHCP enrollees who received dental services were seen by one practice (Table 4). Enrollees who were seen by two providers may be those who were referred to specialists for more complicated procedures. For those enrollees who may have seen three or more practices:

- The possibility of the patient having complex dental needs and requiring multiple referrals in a given year is greater.
- Poor quality of care for a specific service may have resulted in the patient seeing an additional provider.
- The likelihood that these may have been drug seeking individuals is greater.
- Further analysis would be needed to determine the percent of these patients who were first seen by a critical access provider

Table 4

MHCP Dental Patients Visiting One or More Providers
Calendar Year 2006

Number of Providers	Number of Patients	Percent of Total Patients
1	224,482	81.7%
2	42,347	15.4%
3 or more	7,972	2.9%
Total	274,801	

[6] American Academy of Pediatric Dentistry Reference Manual, 07-08:29(7): 22-23.

Safety Net System

Stakeholders involved with the development of the CADPP were concerned with maintaining the State's dental safety net providers. These safety net providers were originally viewed as existing community clinics with dental programs that are an integral practice component or the DHS designated community dental clinics. These practices see a much higher volume of MHCP enrollees and enable the uninsured to receive services with payments based on sliding fee schedules. Community clinics receive rate increases of 20 percent in addition to the CADPP add-on payments of 30 percent for MA and 50 percent for Minnesota Care.

During the course of the CADPP, a number of for-profit MHCP dental practices changed their status to non-profit and subsequently pursued community clinic designation by the DHS. This change in status allowed for considerable rate increases for the practices involved. A number of these clinics are well recognized for providing care to special population groups which include: children and pregnant women, immigrants, the elderly, and the disabled.

In 2002, seven community clinics were first designated as CADPP providers. This number grew to nine in 2004. In 2006, these clinics represented 8.3 percent of the CADPP providers.

Federally Qualified Health Centers, Rural Health Clinics and Indian Health Service Clinics are also viewed by some community stakeholders as a part of the safety net system. These providers became eligible for designation as CADPP providers in 2007; however, the funding resources and mechanism of payment for these providers are significantly different. Consequently, critical access payments for this group of providers are made only for MinnesotaCare dental services which are not eligible for cost based reimbursement.

Expenditures

From 2002 through 2006, total yearly gross adjustments for FFS and managed care critical access add-on payments for the CADPP have ranged from $4,502,838 to $9,489,170 (Appendix L).

Since 2004, managed care plans have been reporting aggregate data regarding the expenditures for critical access providers and the DHS has been making add-on payments based on these amounts. As a result, it is impossible to assess the payment to charge ratio involved with these expenditures; therefore, further analysis was limited to the FFS side of MHCP.

While detailed analysis of the managed care plans is not possible, it is known that for some managed care organizations, base rates can exceed 100 percent of the MA FFS rates. When compounded with community clinic add-ons critical access add-on payments, services provided through the Managed Care Organizations (MCO) for MA or MinnesotaCare can approach or exceed rates paid by commercial dental insurers.

The average critical access adjustment per visit was higher for managed care than FFS in 2006 for the first time. This observation was most likely a direct result of the reimbursement cap that was placed on the total amount of add-on payments CADPP providers could earn during that year. The cap was often reached by practices when the quarterly payments by the health plans for

critical access add-ons were made. It was then impossible for the provider to receive additional FFS payments. The yearly reimbursement cap has since been removed.

For FFS MHCP dental services, the base rate is the 50th percentile of the rate in effect in 1989 less 8.4 percent, with the following exceptions. The rate for tooth sealants and fluoride treatments is 80 percent of the 1997 median charge. The base rate for diagnostic exams and dental x-rays provided to children under the age of 21 is 85 percent of the 1999 median charge. Beyond the base rates, dentists have realized four overall rate increases since 1997, totaling between 12 and 22 percent increases.[7]

With these payment rates, dental practices report that low reimbursements are the primary reason why they do not participate as providers of MHCP. The CADPP utilizes these rates and provides add-on payments as incentives to providers to render care to MHCP enrollees. To evaluate if these add-on payments provide an incentive to providers to enroll in the program, the FFS payment to charge ratio was examined.

The FFS payment to charge ratio is equal to the sum of the FFS reimbursement (includes critical access adjustments) and the FFS third-party payments and co-payments divided by the FFS total charges. Table 5 shows the FFS payment to charge ratio for critical access and non-critical access providers. Throughout the designated period, the critical access ratio has been 8-12 percent higher than that of non-critical access providers. Despite this higher FFS payment to charge ratio which can be achieved through the CADPP, non-MHCP providers continue to state that they cannot afford to participate in MHCP until the ratio is at a point at which they can at least break even. The break even payment to charge ratio is viewed as .75 by most dental practices.

Table 5

FFS Payment to Charge Ratio by Critical Access and Non-Critical Access
Calendar Years 2001-2006

	2000	2001	2002	2003	2004	2005	2006
Critical Access Providers	N/A	N/A	0.62	0.61	0.61	0.58	0.51
Non-Critical Access Providers	0.50	0.48	0.50	0.50	0.49	0.46	0.43
All Providers	0.50	0.48	0.57	0.56	0.56	0.53	0.47

[7] Minnesota Statutes, Section 256B.76 (a) (5) (b)

An assessment of the average FFS and critical access adjustments revealed that the average FFS reimbursement per visit for CADPP providers has been higher than that of non-critical access providers (Table 6). Further analysis is needed to determine if the higher average FFS reimbursement per visit for CADPP providers is related to whether they provide more services or more costly services than non-critical access providers.

While this could be interpreted to mean that CADPP providers are more comprehensive than those that are non-critical access, this demonstrated history is of concern. Many of the limits related to FFS dental services were removed in 2002 and this has led to inconsistencies in the provision of services. Many of these inconsistencies have come to light through the CADPP and as a result, limits on services are being restored by the DHS.

Table 6

Average FFS Reimbursement and Critical Access Adjustments
Calendar Years 2004-2006

		Average Reimbursement per Visit		
		FFS	Critical Access Adjustment	Total
2006	Critical Access	$136.67	$27.48	$164.15
	Non Critical Access	$108.51		$108.51
2005	Critical Access	$132.00	$52.40	$184.40
	Non Critical Access	$93.91		$93.91
2004	Critical Access	$129.71	49.53	$179.24
	Non Critical Access	$92.85		$92.85

CONCERNS REGARDING THE CADPP

Critical access dental providers are not exempt from the possible misuse of MHCP funds. When patterns of service or reimbursement warrant, the Department's Surveillance and Integrity Review unit or dental management companies contracted by the managed care plans investigate the providers. Six CADPP practices are currently under investigation by the Department's Surveillance and Integrity Review unit or dental management companies.

The designation process that has evolved has brought to light a number of troubling issues some of which are related to providers maximizing add-on payments. These include:

- Inappropriate billing patterns
- Questionable practice patterns
- Quality of care issues
- A failure by some practices to file their MinnesotaCare tax return with the Department of Revenue

With the evolution of the CADPP, a growing concern for the creation of Medicaid dental mills exists. Practice patterns have been exhibited in which providers maximize profitability by rendering multiple, sometimes unnecessary procedures that are performed with little regard to evidence based dentistry, quality of care, or the patient's desires.

Four CADPP large group practices have anecdotally marketed themselves to dental professionals who do not accept MHCP program enrollees. These practices state that they will accept all MinnesotaCare and Medical Assistance patients and appear to rely on high volume. They reimburse staff on a commission basis, which may promote the over utilization of services. Monitoring of these practices has been initiated by the DHS and dental administrators for some of the managed care plans.

The CADPP has become an avenue through which a number of practices have based their expansion. The designation process has revealed that one for-profit practice has spun off a non-profit practice which has been designed specifically for MHCP enrollees. When the intent of this non-profit is to segregate enrollees so that they can maximize reimbursement by MHCP through the CADPP, equity and quality of care may become an issue.

RECOMMENDATIONS

Innovative funding programs that increase access to dental care are being discussed and slowly implemented across the country. Experience in other states has shown that while rate increases are necessary, they are not sufficient on their own as a means to improve access to dental care.[8]

As measured by the overall number of enrollees obtaining dental services, the CADPP has demonstrated that add-on payment rates have not led to an increase in dental access for MHCP enrollees. Regardless of this finding, the program should continue to serve as a viable means of sustaining dental practices that see high volumes of MHCP enrollees and provide high quality evidence based care.

The DHS makes the following recommendations to the Legislature:

1. Continue funding the CADPP to assist in sustaining dental providers who:

- **See a high volume of MHCP recipients**
- **Provide high quality evidence based care**
- **Practice in designated underserved areas**

2. Funding sources for the CADPP should remain as currently established.
To maintain the current level of CADPP provider satisfaction and access to dental care for MHCP enrollees, the funding sources for the CADPP should remain as they currently are established with no limitations on the total allowable adjustments. MA add-on payments should continue to be funded through the general fund budget and MinnesotaCare through the Health Care Access Fund.

3. Revise Statute 256B.76 and 256L.11 to include collaborative practice dental hygienists.
Minnesota Statute 150A.10 allows for a ***collaborative practice dental hygienist*** to provide authorized dental services without the patient first being examined by a dentist. These allied dental health professionals serve a critical role in settings where traditional dental practice models will not venture. Hygienists practicing in this capacity may enroll as MHCP providers and bill directly for their services. Statute 150A.10 was created in an effort to increase access to care yet hygienists who are serving communities in this capacity and directly billing MHCP are not eligible for CADPP designation because Minnesota Statutes 256B.76 and 256L.11 limit critical access dental reimbursement to dentists or dental clinics. Collaborative practice hygienists have been functioning in a significant capacity by providing screenings, triage and referrals to dentists for Head Start children. This is an efficient model which should be encouraged and expanded to other settings to increase access to care.

The current CADPP statute language allows for critical access add-on payments to collaborative practice hygienists only if services are billed through a collaborating dentist who is a critical access provider. This is a restriction which does not encourage expansion of this practice model because of the limitations on reimbursement. This restriction should be eliminated through

[8] Borchgrevink A, Snyder A, and Geshan S. The Effects of Medicaid Reimbursement Rates on Access to Dental Care. National Academy for State Healtlh Policy. March 2008. http://www.nashp.org/Files/CHCF_dental_rates.pdf

statutory language changes so that collaborative practice hygienists who are direct billing for their services can be reimbursed at the same level.

4. Administrative streamlining for MHCP programs should continue to be explored.
The Minnesota Dental Association and MHCP enrolled providers have expressed the desire to streamline administrative processes. This topic should be studied closely.

5. Payment rates for MHCP dental programs should be studied.
Like many other states, MHCP establishes its FFS reimbursement schedule on median fees submitted by dentists for services they provided to MHCP enrollees in a base year set by the legislature. This Medicaid rate is less than the fees charged by roughly 50 percent of the dentists who submit Medicaid claims.

In January of 2001, a letter from the Health Care Financing Administration to state Medicaid directors noted that "fee percentiles can be exceptionally helpful as a basis for estimating the number or proportion of dentists in the state who might participate in Medicaid, at selected payment levels. States can use this form of analysis to adjust dental payments so that they are likely to enlist a sufficient number of dental providers and assure prompt access equal to that experienced by the general public." [9]

The American Dental Association (ADA) has since suggested that instead of Medicaid rates, states should use a fee percentile to establish market based Medicaid reimbursement rates. Fee percentiles offer a way to represent dentists' fees in a specific area.[10] States that have moved toward this type of payment mechanism have largely evolved into dental carve-outs in which a single dental administrator exists. This concept warrants further study and has been proposed by the MDA during the current legislative session.

The ADA believes that Medicaid fees that approach the 75th percentile will increase the number of dentists who participate in a Medicaid program. The ADA also acknowledges that rate increases need to be combined with efforts to improve Medicaid administration, patient outreach and coordination.[8]

6. Continue to allow the DHS the flexibility to refine the designation criteria for the CADPP to allow for a more effective use of funding resources.
Concerns which have come to light need to be addressed to ensure that program funds are utilized in a manner which strongly encourages patient education, preventive services, and the timely treatment of oral disease. These components are essential for oral health, general health, and the cost-effective use of limited financial resources.

7. Increase the DHS ability to measure quality and institute evidence based guidelines.
Inappropriate billing, questionable practice patterns, and quality of care issues which are of growing concern are being addressed. In an effort to involve community stakeholders regarding

[9] Westmoreland T, HCFA State Medicaid Director Letter of January 18, 2001, #01-011, Access of low income children to necessary dental services. http://www.cms.hhs.gov/smdl/downloads/smd011801a.pdf
[10] Crall J and Schneider D. with American Dental Association (Ed.) Medicaid Reimbursement – Using Marketplace Principles to Increase Access to Dental Services. 2004.

the resolution of these concerns, the DHS would like to engage a new work group which would assist in reviewing evidence based standards of dental care to support the policy making process.

8. Evidence based alternative dental workforce models which are effective in increasing access to dental care should be considered.
Workforce models which are in existence in Alaska and numerous foreign countries have been shown to be effective in reducing oral health disparities and access to care problems.[11,12] These models could serve as an effective means to increase access to dental care in Minnesota.

CONCLUSIONS

The CADPP was created to provide increased reimbursement to providers who treat a large number of MHCP recipients and increase access to dental care; however, data has demonstrated that the program has not led to an overall increase in the percent of recipients who have received dental care. Overall access to dental care has remained fairly consistent over the duration of the program.

The percent of dental visit for preventive services has been decreasing for both CADPP and non-designated providers. This pattern is of concern because it is well established that the prevention and early intervention of oral disease reduces expenditures over time. To address the decreasing percent of dental visits for preventive services, existing CADPP payment barriers should be removed so that collaborative practice dental hygienists can be encouraged to serve as a dental care point of entry for MHCP recipients who may have difficulty in finding a dentist who will see them.

The CADPP providers for consecutive years 2002-2006 demonstrated slight increases in the number of patients that they served and percent of patient visits that were completed; however, during this same time, the number of MHCP enrollees grew significantly. Subsequently, the overall result was neither a gain nor loss in access for MHCP enrollees.

The CADPP should continue to function as a means of sustaining dental practices which provide high quality evidence based care and see a high volume of MHCP recipients or are located in designated underserved areas. Concern exists as to whether the current level of access to dental care could be maintained without the program. Significant changes in the program could severely affect the number of enrollees able to find providers to care for their needs.

Additional efforts to increase access to care should continue to be explored and implemented when deemed appropriate. Multiple approaches which include changes to the MHCP administrative structure, dental workforce, and delivery of care should all be considered if improvement in access is to be gained.

[11] Nash A and Nagel R, Confronting Oral Health Disparities Among American Indian/Alaska Native Children: The Pediatric Therapist. American Journal of Public Health. 95, no. 8 (2005): 1325-1329.
[12] Nash A, Friedman J, Kardos T, et al. Dental Therapists: A Global Perspective. Manuscript.

Appendix A

H.F. No. 4162, 3rd Engrossment - 84th Legislative Session (2005-2006)
Posted on May 22, 2006

(d) By February 15, 2007, the commissioner shall report to the legislature on the results of higher payments to critical access dental providers and with recommendations on funding sources to continue these higher payments in effect after June 30, 2007.

(e) Notwithstanding any provision to the contrary in this article, this provision shall expire June 30, 2008.

Appendix B –

MHCP Dental Benefits Chart

Managed Care Organization (MCO) Product Code	Plan Description	Preventive	Restorative	50% copay / * copay thru 6/30/07
BB01 & GM03	MinnesotaCare Basic Plus One	X	X	X*
BB02 & BB22	MinnesotaCare Limited Benefit	No Dental Coverage		
BB21 & GM23	MinnesotaCare Basic Plus One - State Paid Dental	X	X	X*
FF01 & JJ01	MinnesotaCare Basic Plus Two	X	X	X*
FF02 & JJ02	MinnesotaCare Basic Plus	X	X	
FF21 & JJ21	MinnesotaCare Basic Plus Two - State Paid Dental	X	X	X*
FF22 & JJ22	MinnesotaCare Basic Plus - State Paid Dental	X	X	
GM01	GAMC	X	X	X
GM21	GAMC- State Paid Dental	X	X	X
KK01 & LL01	MinnesotaCare Expanded	X	X	
KK21 & LL21	MinnesotaCare Expanded - State Paid Dental	X	X	
MA01	Medical Assistance	X	X	
MA02	Minnesota Senior Health Options (MSHO)	X	X	
MA12	Medical Assistance	X	X	
MA15	Minnesota Disability Health Options (MnDHO)	X	X	
MA21	Medical Assistance - State Paid Dental	X	X	
MA30	Minnesota Senior Care	X	X	
MA35	Minnesota Senior Care with EW	X	X	
NM01	Medical Assistance	X	X	
NM12	Medical Assistance	X	X	
NM21	Medical Assistance - State Paid Dental	X	X	
NM30	Minnesota Senior Care	X	X	
NM35	Minnesota Senior Care with EW	X	X	
Major Programs (fee-for-service)				
EH	Emergency MA for some non-citizens		X	
GM	GAMC	X	X	X
IM	GAMC with MA benefits	X	X	
MA	Medical Assistance	X	X	
HH	Call Provider Call Center for dental eligibility (authorizations must go through Program HH - not CDMI)	X	X	
RM	Refugee	X	X	

The following major programs do not signify eligibility for dental payment by MHCP: AC, FP, QM, CC, DD, OO, UN, VV, WD, YY. GM Hospital only-GHO covers authorized inpatient dental services only. The $500 dental cap ended December 31, 2005.

State Paid Dental Programs ended December 31, 2006. State paid dental refers to a program available to a recipient residing in 1 of 5 carve out counties in Minnesota (Cass, Crow Wing, Morrison, Todd, or Wadena). Dental services for MCO enrollees are billed fee-for-service until December 31, 2005. Effective January 1, 2007, all MCO enrollees who live in these 5 counties will receive their dental service through their MCO.

Appendix C

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT

(c) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the health plan companies in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

256L.11 PROVIDER PAYMENT

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, paragraph (c), by 50 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, paragraph (c).

Appendix D

Percent of Patients by Geographic Area and Calendar Year
Practices that have been Designated as Critical Access from 2002-2006

	2001		2002		2003		2004		2005		2006	
	Number of Patients	Percent of Total	Number of Patients	Percent of Total	Number of Patients	Percent of Total	Number of Patients	Percent of Total	Number of Patients	Percent of Total	Number of Patients	Percent of Total
Northwest MN	1,687	3.6%	1,988	3.7%	2,797	4.4%	3,748	5.6%	4,160	6.2%	4,321	6.4%
Northeast MN	4,578	9.7%	4,565	8.5%	4,509	7.1%	4,220	6.3%	4,323	6.4%	4,371	6.5%
Central MN	6,683	14.2%	7,835	14.6%	9,028	14.1%	8,855	13.3%	8,613	12.8%	9,188	13.6%
MN Metro Area	26,005	55.2%	30,350	56.4%	37,310	58.4%	39,462	59.1%	39,563	58.7%	39,094	57.9%
Southwest& South Central MN	3,327	7.1%	3,587	6.7%	4,720	7.4%	4,944	7.4%	5,169	7.7%	5,050	7.5%
Southeast MN	4,790	10.2%	5,491	10.2%	5,481	8.6%	5,491	8.2%	5,530	8.2%	5,502	8.1%
Total	47,070		53,816		63,845		66,720		67,358		67,526	

Percent of Visits by Geographic Area and Calendar Year
Practices that have been Designated as Critical Access from 2002-2006

	2001		2002		2003		2004		2005		2006	
	Number of Visits	Percent of Total	Number of Visits	Percent of Total	Number of Visits	Percent of Total	Number of Patients	Percent of Total	Number of Visits	Percent of Total	Number of Visits	Percent of Total
Northwest MN	3,546	4.0%	4,366	4.2%	5,560	4.5%	8,295	6.5%	9,227	7.2%	9,572	7.1%
Northeast MN	8,803	9.8%	8,696	8.5%	9,042	7.4%	8,376	6.6%	8,484	6.6%	8,869	6.6%
Central MN	12,691	14.2%	15,086	14.7%	16,950	13.8%	16,807	13.2%	16,375	12.7%	17,890	13.4%
MN Metro Area	48,515	54.3%	56,418	54.9%	70,987	57.8%	73,517	57.9%	74,217	57.6%	76,695	57.3%
Southwest& South Central MN	6,192	6.9%	6,741	6.6%	8,747	7.1%	9,236	7.3%	9,377	7.3%	9,133	6.8%
Southeast MN	9,680	10.8%	11,443	11.1%	11,589	9.4%	10,732	8.5%	11,144	8.7%	11,772	8.8%
Total	89,427		102,750		122,875		126,963		128,824		133,931	

Notes:
1) Critical Access Designation began in 2002.
2) A practice is defined as the entity that is identified on the claim to be paid for dental services. A practice may be an individual or a group of dental providers.
3) A patient may be counted more than once if services were received by more than one practice.
4) Counts of visits are limited to one per patient per practice per service day.
5) Northwest MN includes: Becker, Beltrami, Clay, Clearwater, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake, Roseau, and Wilkin Counties
Northeast MN includes: Aitkin, Carlton, Cook, Itasca, Kanabec, Koochiching, Lake, Pine, and St. Louis Counties
Central MN includes: Benton, Cass, Chisago, Crow Wing, Douglas, Grant, Isanti, Mille Lacs, Morrison, Otter Tail, Pope, Sherburne, Stearns, Stevens, Todd, Traverse, Wadena, and Wright Counties
MN Metro Area includes: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties
Southwest & South Central MN includes: Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Faribault, Jackson, Kandiyohi, Lac Qui Parle, Le Sueur, Lincoln, Lyon, McLeod, Martin, Meeker, Murray, Nicollet, Nobles, Pipestone, Redwood, Renville, Rock, Sibley, Swift, Waseca, Watonwan, and Yellow Medicine Counties
Southeast MN includes: Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona Counties

Appendix E

Table 1: Rate of Visits to Dental Providers per 1000 Enrollees Months by Calendar Year

	2000	2001	2002	2003	2004	2005	2006
FFS	70	74	74	75	70	72	78
Managed Care	77	68	68	76	72	74	77
Total	74	70	70	76	72	74	77

Table 2: Percent of Continuously Enrolled MHCP Patients Served by Dental Providers by Calendar Year

	2000	2001	2002	2003	2004	2005	2006
FFS	41.6%	40.8%	41.0%	41.9%	41.4%	41.7%	42.9%
Managed Care	42.1%	39.3%	37.5%	41.6%	40.7%	41.4%	41.9%
Total	42.0%	39.8%	38.5%	41.7%	40.9%	41.5%	42.2%

Table 3: Rate of Patients Served Per 1000 Enrollee Months by Calendar Year

	2000	2001	2002	2003	2004	2005	2006
FFS	33	31	32	32	32	32	33
Managed Care	35	33	31	34	33	34	34
Total	35	32	31	34	33	33	34

Notes:

Table 1

a) Visits are limited to one per recipient per practice per service date. A practice is defined as the provider who was paid for the visit. A practice may be an individual, clinic, or other group of dental providers.
b) Months are counted as FFS or Managed Care months according to each enrollee's monthly designation.
c) The rate of visits per 1000 enrollee months is equal to the number of visits divided by the number of enrollee months multiplied by 1000.

Table 2

a) A patient is defined as an Minnesota Health Care Program (MHCP) eligible enrollee who received at least one dental service during the calendar year.
b) To be considered continuously enrolled, an enrollee must have at least 11 months of enrollment during a calendar year.

Table 3

a) A patient is defined as an MHCP eligible enrollee who received at least one dental service during the calendar year.
b) Months are counted as FFS or Managed Care months according to the designation of the enrollee during the last enrollment month during the calendar year.
c) The rate of patients serviced per 1000 enrollee months is equal to the number of patients divided by the number of enrollee months multiplied by 1000.

Tables 1 and 3 display rates per 1000 enrollee months. Statistics of visits and patient served as a rate per 1000 enrollee months are displayed because this rate takes into consideration each enrollee's length of enrollment. Specifically, the rate includes all enrollees regardless of how many months each was enrolled. Aditionally, the rate does not count months in which no service could be provided.

Appendix F

Percent of Dental Patients by Calendar Year and Selected Service Categories - Critical Access Providers Only

	2000		2001		2002		2003		2004		2005		2006	
	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count
Exam					75,145	87.7%	95,544	87.8%	98,545	87.9%	104,954	88.7%	86,115	90.2%
Preventative					57,705	67.3%	72,747	66.8%	75,040	66.9%	78,772	66.6%	63,891	66.9%
Restorative					25,469	29.7%	39,089	35.9%	40,792	36.4%	42,870	36.2%	35,345	37.0%
Non-Surgical Periodontic					6,544	7.6%	8,375	7.7%	7,622	6.8%	8,828	7.5%	8,243	8.6%
Oral Surgery					7,970	9.3%	23,470	21.6%	25,836	23.0%	27,064	22.9%	21,009	22.0%
Surgical Periodontic					113	0.1%	120	0.1%	107	0.1%	93	0.1%	89	0.1%
Prosthodontics					5,402	6.3%	6,959	6.4%	6,697	6.0%	7,304	6.2%	5,841	6.1%
Unduplicated Counts					85,693		108,871		112,103		118,298		95,461	

Percent of Dental Patients by Calendar Year and Selected Service Categories - Non Critical Access Providers Only

	2000		2001		2002		2003		2004		2005		2006	
	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count	Number of Patients	Patients as a Percent of Unduplicated Count
Exam	179,967	88.1%	183,680	89.8%	128,325	88.3%	145,447	88.1%	140,752	88.2%	145,750	88.3%	167,064	88.6%
Preventative	154,931	75.8%	151,640	74.1%	105,060	72.3%	118,768	72.0%	114,474	71.8%	118,001	71.5%	137,001	72.7%
Restorative	65,379	32.0%	65,678	32.1%	45,789	31.5%	61,340	37.2%	59,972	37.6%	63,319	38.3%	72,451	38.4%
Non-Surgical Periodontic	8,465	4.1%	10,236	5.0%	6,813	4.7%	8,789	5.3%	8,205	5.1%	9,299	5.6%	13,050	6.9%
Oral Surgery	12,021	5.9%	12,551	6.1%	7,356	5.1%	22,471	13.6%	24,046	15.1%	25,848	15.7%	32,981	17.5%
Surgical Periodontic	461	0.2%	396	0.2%	230	0.2%	174	0.1%	171	0.1%	113	0.1%	158	0.1%
Prosthodontics	13,073	6.4%	12,913	6.3%	8,360	5.8%	8,539	5.2%	6,985	4.4%	7,033	4.3%	9,178	4.9%
Unduplicated Counts	204,321		204,596		145,349		165,002		159,527		165,133		188,470	

Note:
1) Patient counts are limited to one patient per procedure code category so a patient will be counted once in each category but may be counted in more than one category. Please note that the patient may have had multiple visits for the same procedure code or may have had multiple procedure codes that fall into a single category or into multiple categories.
2) Visit counts are limited to one procedure code category per patient per service date per practice. This means that a visit is counted once in each category but may be counted in more than one category. Practice is defined as the entity that is paid for the service. A practice may be a solo practitioner or a practice may be a clinic or other group of providers.
3) Codes in each service category are limited and do not reflect the total scope of services provided. Procedures Codes included in each category are:
Exam includes D0120, D0140, and D0150.
Preventive includes Fluoride: D1201, D1203, D1204, D1205, and D1206; Prophylaxis: D1110 and D1120; and Sealant: D1351.
Restorative includes Amalgams: D2140, D2150, D2160, and D2161; Composites: D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394; and Crowns: D2930, D2931, D2932, and D2933.
Non-Surgical Periodontic includes D4341, D4342, D4355, and D4910.
Oral Surgery includes D7111, D7140, D7210, D7220, D7230, D7240, D7241, and D7250.
Surgical Periodontic includes D4000-4999 excluding D4341, D4342, D4355, and D4910.
Prosthodontics includes Removable: D5110-D5899 and Fixed: D6200-D6999

Appendix G

Percent of Dental Visits by Calendar Year and Selected Service Categories - Critical Access Providers Only

	2000		2001		2002		2003		2004		2005		2006	
	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count
Exam					95,393	63.8%	123,824	60.1%	127,664	60.9%	136,924	61.5%	115,455	60.8%
Preventative					73,054	48.8%	94,829	46.0%	99,051	47.2%	104,002	46.7%	85,238	44.9%
Restorative					37,306	24.9%	58,473	28.4%	58,643	28.0%	61,473	27.6%	54,112	28.5%
Non-Surgical Periodontic					8,793	5.9%	11,388	5.5%	10,163	4.8%	11,831	5.3%	11,721	6.2%
Oral Surgery					8,597	5.7%	27,119	13.2%	30,035	14.3%	31,611	14.2%	24,691	13.0%
Surgical Periodontic					134	0.1%	152	0.1%	133	0.1%	115	0.1%	119	0.1%
Prosthodontics					7,481	5.0%	9,400	4.6%	8,544	4.1%	9,175	4.1%	7,514	4.0%
Unduplicated Counts					149,597		206,033		209,720		222,603		190,001	

Percent of Dental Visits by Calendar Year and Selected Service Categories - Non Critical Access Providers Only

	2000		2001		2002		2003		2004		2005		2006	
	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count	Number of Visits	Visits as a Percent of Unduplicated Count
Exam	234,179	61.6%	239,472	62.6%	168,717	62.5%	190,400	59.4%	184,735	60.5%	192,604	60.1%	226,666	59.6%
Preventative	203,209	53.4%	198,767	51.9%	139,944	51.9%	157,691	49.2%	152,971	50.1%	158,723	49.6%	186,222	49.0%
Restorative	98,331	25.9%	98,475	25.7%	69,764	25.9%	92,435	28.8%	86,707	28.4%	91,807	28.7%	108,793	28.6%
Non-Surgical Periodontic	11,739	3.1%	14,275	3.7%	10,177	3.8%	12,093	3.8%	11,235	3.7%	12,646	3.9%	18,948	5.0%
Oral Surgery	12,985	3.4%	13,615	3.6%	8,243	3.1%	25,902	8.1%	27,948	9.1%	29,977	9.4%	38,586	10.1%
Surgical Periodontic	523	0.1%	437	0.1%	287	0.1%	193	0.1%	188	0.1%	130	0.0%	184	0.0%
Prosthodontics	17,172	4.5%	16,851	4.4%	10,940	4.1%	11,325	3.5%	8,821	2.9%	8,729	2.7%	11,404	3.0%
Unduplicated Counts	380,365		382,624		269,814		320,563		305,483		320,317		380,183	

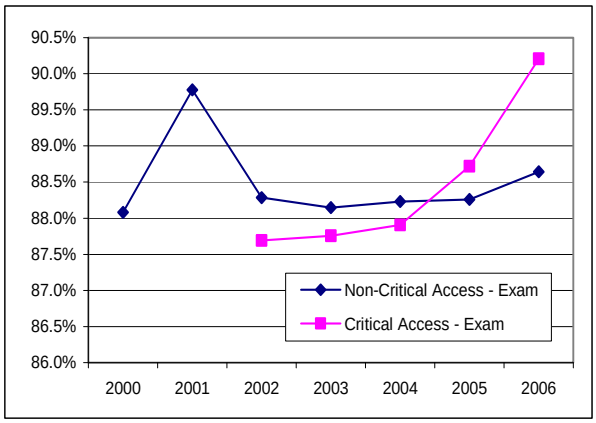
Note:
1) Patient counts are limited to one patient per procedure code category so a patient will be counted once in each category but may be counted in more than one category. Please note that the patient may have had multiple visits for the same procedure code or may have had multiple procedure codes that fall into a single category or into multiple categories.
2) Visit counts are limited to one procedure code category per patient per service date per practice. This means that a visit is counted once in each category but may be counted in more than one category. Practice is defined as the entity that is paid for the service. A practice may be a solo practitioner or a practice may be a clinic or other group of providers.
3) Codes in each service category are limited and do not reflect the total scope of services provided. Procedures Codes included in each category are:
Exam includes D0120, D0140, and D0150.
Preventive includes Fluoride: D1201, D1203, D1204, D1205, and D1206; Prophylaxis: D1110 and D1120; and Sealant: D1351.
Restorative includes Amalgams: D2140, D2150, D2160, and D2161; Composites: D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394; and Crowns: D2930, D2931, D2932, and D2933.
Non-Surgical Periodontic includes D4341, D4342, D4355, and D4910.
Oral Surgery includes D7111, D7140, D7210, D7220, D7230, D7240, D7241, and D7250.
Surgical Periodontic includes D4000-4999 excluding D4341, D4342, D4355, and D4910.
Prosthodontics includes Removable: D5110-D5899 and Fixed: D6200-D6999

Appendix H

Percent of Dental Patients for Selected Service Categories by Calendar Year
Critical Access and Non-Critical Access Providers

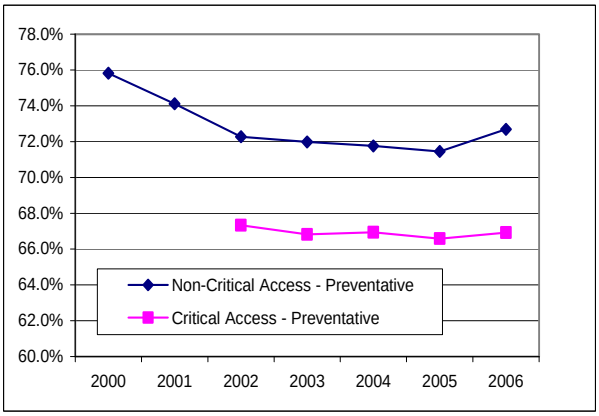
February 15, 2008

Exams



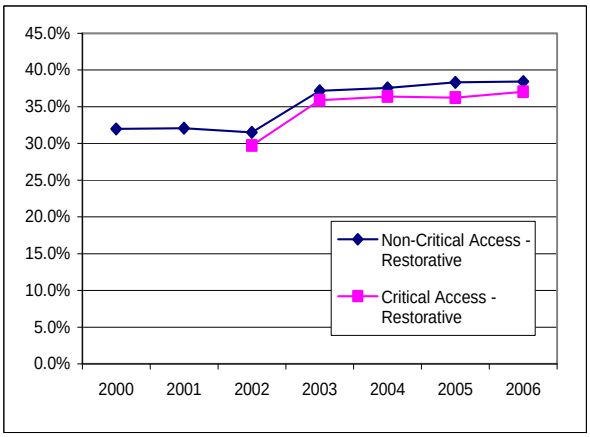
Percentages range between 87 & 90%

Preventative



Percentages range between 66 & 76%

Restorative



Percentages range between 30 & 38%

Notes:
1) Percent scales vary significantly due to the large differences in the proportion of patients receiving services in specific categories.
2) Patient counts are limited to one patient per procedure code category so a patient will be counted once in each category but may be counted in more than one category. Please note that the patient may have had multiple visits for the same procedure code or may have had multiple procedure codes that fall into a single category or into multiple categories.
3) Dental providers are designated as critical access or non-critical access on an annual basis.
4) Codes in each service category are limited and do not reflect the total scope of services provided. Procedures Codes included in each category are: Exam includes D0120, D0140, and D0150. Preventive includes Fluoride: D1201, D1203, D1204, D1205, and D1206; Prophylaxis: D1110 and D1120; and Sealant: D1351. Restorative includes Amalgams: D2140, D2150, D2160, and D2161; Composites: D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394; and Crowns: D2930, D2931, D2932, and D2933.
5) The percent of dental patients is the count of patients in each category as a percent of the total number of patients each year. For the total number of patients each year, a patient is counted once per practice regardless of the number of visits.

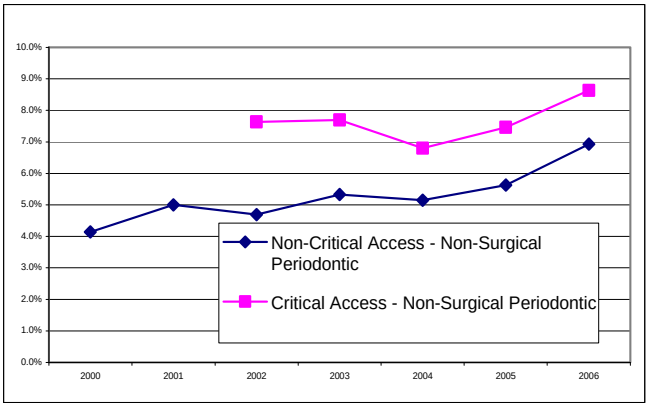
DHS PMQI SKM: 0039

Appendix I

Percent of Dental Patients for Selected Service Categories by Calendar Year
Critical Access and Non-Critical Access Providers

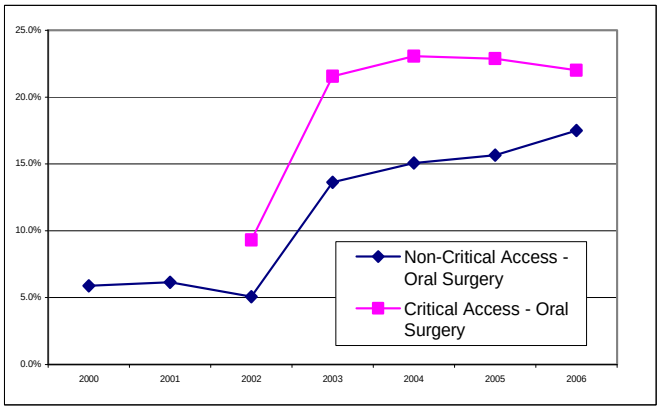
February 15, 2008

Non-Surgical Periodontic



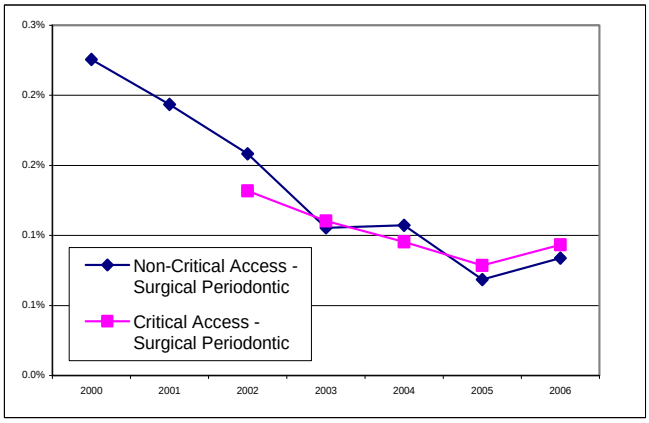
Percentages range between 4 & 9%

Oral Surgery



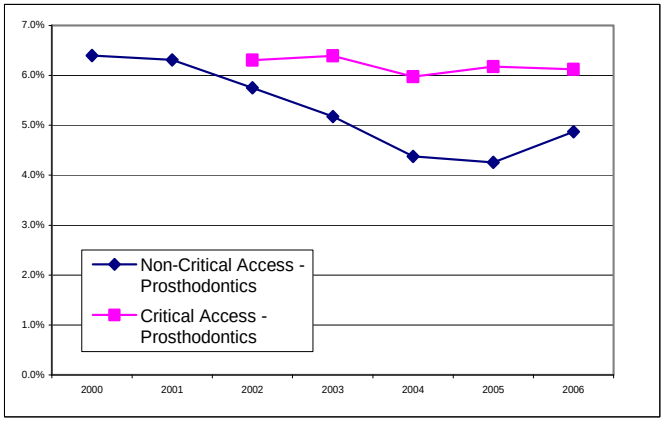
Percentages range between 5 & 23%

Surgical Periodontic



Percentages range between 0 & 0.2%

Prosthodontics



Percentages range between 4 & 7%

Notes:

1) Percent scales vary significantly due to the large differences in the proportion of patients receiving services in specific categories.
2) Patient counts are limited to one patient per procedure code category so a patient will be counted once in each category but may be counted in more than one category. Please note that the patient may have had multiple visits for the same procedure code or may have had multiple procedure codes that fall into a single category or into multiple categories.
3) Dental providers are designated as critical access or non-critical access on an annual basis.
4) Codes in each service category are limited and do not reflect the total scope of services provided. Procedures Codes included in each category are: Non-Surgical Periodontic includes D4341, D4342, D4355, and D4910. Oral Surgery includes D7111, D7140, D7210, D7220, D7230, D7240, D7241, and D7250. Surgical Periodontic includes D4000-4999 excluding D4341, D4342, D4355, and D4910. Prosthodontics includes Removable: D5110-D5899 and Fixed: D6200-D6999.
5) The percent of dental patients is the count of patients in each category as a percent of the total number of patients each year. For the total number of patients each year, a patient is counted once per practice regardless of the number of visits.

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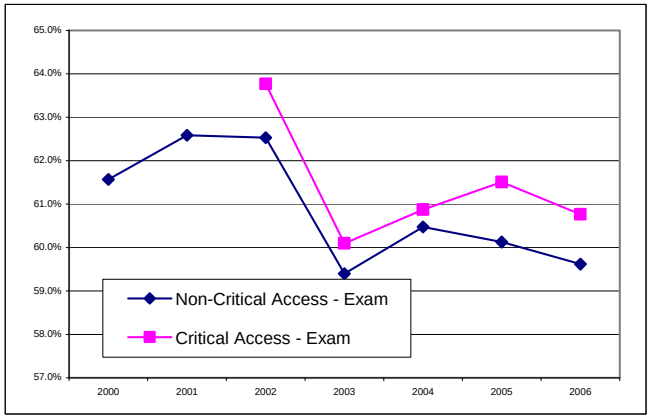
Appendix J

Percent of Dental Visits for Selected Service Categories by Calendar Year
Critical Access and Non-Critical Access Providers

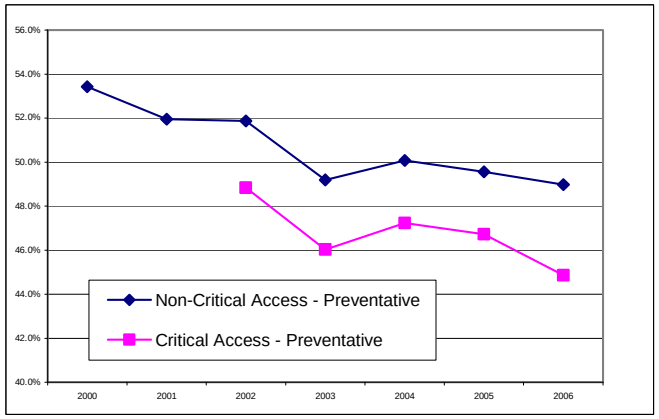
February 15, 2008

Exams



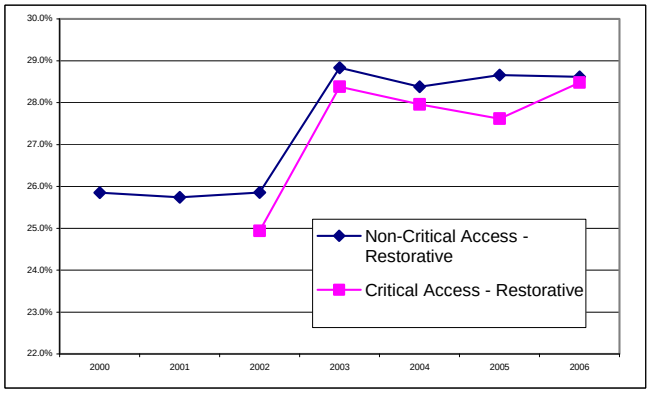
Percentages range between 59 & 64%

Preventative



Percentages range between 45 & 53%

Restorative



Percentages range between 25 & 29%

Notes:

1) Percent scales vary significantly due to the large differences in the proportion of patient visits for services in specific categories.

2) Visit counts are limited to one procedure code category per patient per service date per practice. This means that a visit is counted once in each category but may be counted in more than one category. Practice is defined as the entity that is paid for the service. A practice may be a solo practitioner or a practice may be a clinic or other group of providers.

3) Dental providers are designated as critical access or non-critical access on an annual basis.

4) Codes in each service category are limited and do not reflect the total scope of services provided. Procedures Codes included in each category are:

Exam includes D0120, D0140, and D0150.

Preventive includes Fluoride: D1201, D1203, D1204, D1205, and D1206; Prophylaxis: D1110 and D1120; and Sealant: D1351.

Restorative includes Amalgams: D2140, D2150, D2160, and D2161; Composites: D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394; and Crowns: D2930, D2931, D2932, and D2933.

5) The percent of dental visits is the count of visits in each category as a percent of the total number of visits each year. The total number of visits each year is limited to one per patient per service date per practice.

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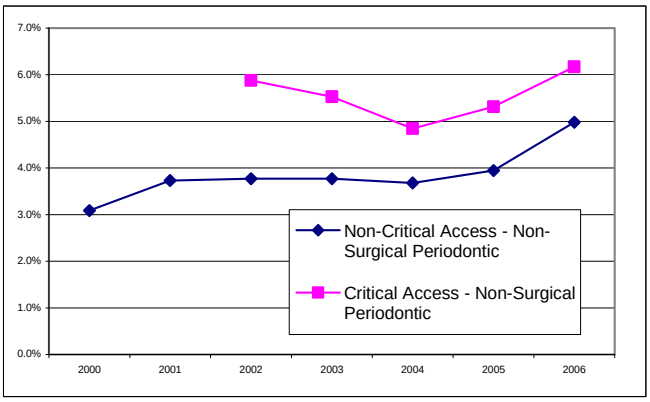
Appendix K

Percent of Dental Visits for Selected Service Categories by Calendar Year
Critical Access and Non-Critical Access Providers

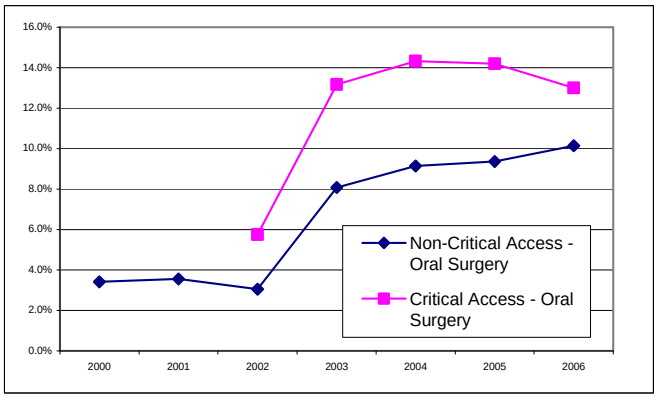
February 15, 2008

Non-Surgical Periodontic



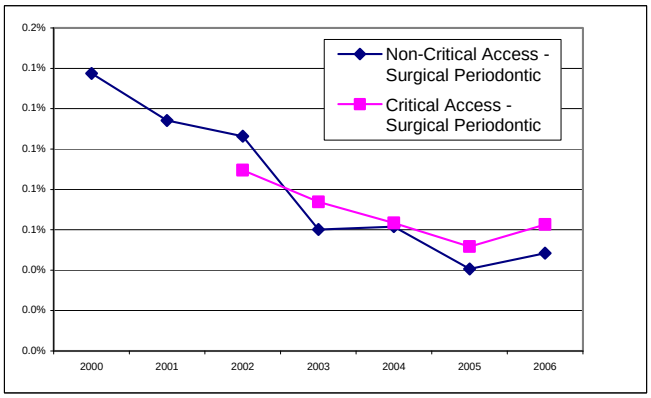
Percentages range between 3 & 6%

Oral Surgery



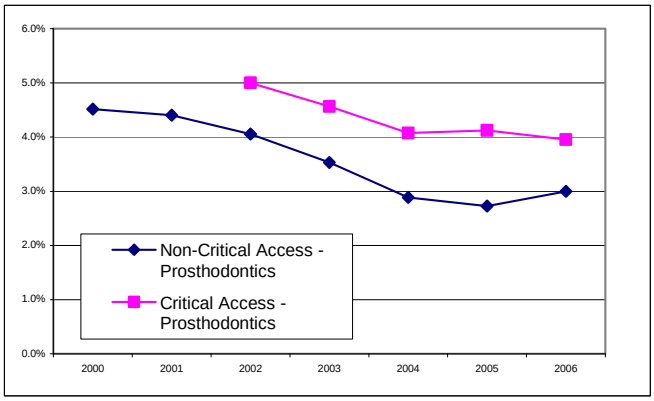
Percentages range between 3 & 14%

Surgical Periodontic



Percentages range between 0 & .1%

Prosthodontics



Percentages range between 3 & 5%

Notes:

1) Percent scales vary significantly due to the large differences in the proportion of patient visits for services in specific categories

2) Visit counts are limited to one procedure code category per patient per service date per practice. This means that a visit is counted once in each category but may be counted in more than one category. Practice is defined as the entity that is paid for the service. A practice may be a solo practitioner or a practice may be a clinic or other group of providers.

3) Dental providers are designated as critical access or non-critical access on an annual basis.

4) Codes in each service category are limited and do not reflect the total scope of services provided. Procedures Codes included in each category are:

Non-Surgical Periodontic includes D4341, D4342, D4355, and D4910.

Oral Surgery includes D7111, D7140, D7210, D7220, D7230, D7240, D7241, and D7250.

Surgical Periodontic includes D4000-4999 excluding D4341, D4342, D4355, and D4910.

Prosthodontics includes Removable: D5110-D5899 and Fixed: D6200-D6999.

5) The percent of dental visits is the count of visits in each category as a percent of the total number of visits each year. The total number of visits each year is limited to one per patient per service date per practice.

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Appendix L

2002-2006 Critical Access Dental Program Reimbursements

		Number of Visits	Critical Access Adjustments	Average Critical Access Adjustment Per Visit
2006	FFS	101,692	$ 2,794,642.89	$ 27.48
	Managed Care	102,840	$ 3,782,644.42	$ 36.78
2005	FFS	98,929	$ 5,183,773.10	$ 52.40
	Managed Care	141,870	$ 4,305,397.13	$ 30.35
2004	FFS	94,496	$ 4,680,837.97	$ 49.53
	Managed Care	132,388	$ 4,198,849.99	$ 31.72
2003	FFS	94,377	$ 3,908,780.28	$ 41.42
	Managed Care	131,989	$ 1,073,625.00	$ 8.13
2002	FFS	82,067	$ 3,452,838.70	$ 42.07
	Managed Care	95,926	$ 1,050,000.00	$ 10.95

Notes:

1) The count of visits is limited to one visit per recipient per practice per service date. A practice is defined as the provider who was paid for the visit. A practice may be an individual, clinic, or other group of dental providers. To be included the practice must have been designated as a critical access provider during the calendar year listed.
2) Critical Access Adjustments are payments made in addition to standard reimbursement.
3) Average Critical Access Adjustment Per Visit is equal to the Critical Access Adjustments divided by the number of visits.