

**Update: Dental Access for
Minnesota Health Care Programs Beneficiaries
February 2003**

**Submitted to the Minnesota Legislature by
The Minnesota Department of Human Services
as required by Minnesota Statutes 2002, Section 256B.55**

Cost of completing this report:

Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.

Legislative Authority

Minnesota Statutes 2002, Section 256B.55, Dental access advisory committee.

Subdivision 1. **Establishment.** The commissioner shall establish a dental access advisory committee to monitor the purchasing, administration, and coverage of dental care services for the public health care programs to ensure dental care access and quality for public program recipients.

Subd. 2. **Membership.** (a) The membership of the advisory committee shall include, but is not limited to, representatives of dentists, including a dentist practicing in the seven-county metropolitan area and a dentist practicing outside the seven-county metropolitan area; oral surgeons; pediatric dentists; dental hygienists; community clinics; client advocacy groups; public health; health service plans; the University of Minnesota school of dentistry and the department of pediatrics; and the commissioner of health. (b) The advisory committee is governed by section 15.059 for membership terms and removal of members. Members shall not receive per diem compensation or reimbursement for expenses.

Subd. 3. **Duties.** The advisory committee shall provide recommendations on the following:

- (1) how to reduce the administrative burden governing dental care coverage policies in order to promote administrative simplification, including prior authorization, coverage limits, and co-payment collections;
- (2) developing and implementing an action plan to improve the oral health of children and persons with special needs in the state;
- (3) exploring alternative ways of purchasing and improving access to dental services;
- (4) developing ways to foster greater responsibility among health care program recipients in seeking and obtaining dental care, including initiatives to keep dental appointments and comply with dental care plans;
- (5) exploring innovative ways for dental providers to schedule public program patients in order to reduce or minimize the effect of appointment no shows;
- (6) exploring ways to meet the barriers that may be present in providing dental services to health care program recipients such as language, culture, disability, and lack of transportation; and
- (7) exploring the possibility of pediatricians, family physicians, and nurse practitioners providing basic oral health screenings and basic preventive dental services.

Subd. 4. **Report.** The commissioner shall submit a report by February 1, 2002, and by February 1, 2003, summarizing the activities and recommendations of the advisory committee.

Subd. 5. **Sunset.** Notwithstanding section 15.059, subdivision 5, this section expires June 30, 2003.

HIST: 1Sp2001 c 9 art 2 s 48; 2002 c 379 art 1 s 113

Table of Contents

| | |
|---|----|
| Legislative Authority | 3 |
| Executive Summary | 6 |
| I. Introduction and Background | 11 |
| II. Dental Access Since 2000 | 12 |
| III. Program Improvements | 17 |
| Critical access dental provider payment rate increases | 17 |
| Payment rate increases for children’s preventive services | 18 |
| Dental services demonstration project | 19 |
| Expanded authorization (collaborative agreements) for dental hygienists | 20 |
| Expanded duties for dental auxiliary personnel | 20 |
| Dental access grants | 21 |
| Dental access grants to teaching institutions and clinical training sites | 22 |
| Dental student loan forgiveness program | 22 |
| Retired dentist program | 23 |
| Managed care contract performance incentives | 23 |
| State Action for Oral Health Access grant proposal | 24 |
| New MHCP dental care model | 24 |
| IV. The Dental Access Advisory Committee | 26 |
| Committee appointments. | 26 |
| Committee activities | 26 |
| Summary of work group activities and discussion | 27 |
| Workforce work group | 27 |
| Patient issues work group | 27 |
| Purchasing/alternative practice models work group | 28 |
| Data/evaluation work group | 28 |
| V. Recommendations of the Dental Access Advisory Committee | 30 |
| Appendix A: Summary of CY 2002 Health Plan Implementation Plans for Critical Access Dental Provider Funds | 43 |
| Appendix B: Summary of DHS Dental Access Grants | 44 |
| Appendix C: Summary of MDH Clinical Dental Education Innovations Grants | 45 |
| Appendix D: Appointed Members of the Minnesota Department of Human Services Dental Access Advisory Committee | 46 |
| Appendix E. Suggested measures to evaluate the effectiveness of dental access improvement initiatives passed in 2001 | 49 |

- Appendix F. Recommended amendments to legislation authorizing collaborative agreements (Recommendation #1) 52
- Appendix G. Recommended amendments to expedite the expansion of duties for registered dental assistants and dental hygienists (Recommendation #2) 54

Executive Summary

Update: Dental Access for Minnesota Health Care Programs Beneficiaries February 2003

Background. Legislation passed in 2001 required the Minnesota Department of Human Services (DHS) to appoint a Dental Access Advisory Committee to monitor purchasing, administration, and coverage of dental care services to insure access and quality for Minnesota Health Care Programs (MHCP) beneficiaries. This report describes the appointment, membership, and activities of the Committee, and outlines its recommendations. In addition, the report provides updated information on access since the previous dental access report was submitted to the Legislature in January 2001 and information on the status of the major dental access initiatives passed in 2001. It also describes efforts to develop a proposal for a new dental care model for beneficiaries of Minnesota Health Care Programs.

Dental Access Since 2000. Data on four measures of dental access—utilization, provider participation, complaints/appeals and appointment availability—was updated since the 2001 report was presented to the Legislature. Utilization by managed care enrollees continued to be significantly higher than fee-for-service recipients, but utilization continued its decline among both groups. The group of providers that provided significant amounts of service maintained its size, but the larger group that provided smaller amounts of service declined, increasing the size of the group that provided no service to MHCP patients. The percentage of Ombudsman calls regarding dental access increased by about 75 percent, while the percentage of appeals involving dental care doubled. With few exceptions, the number of dentists with available appointments for new MHCP patients continued its decline.

It is inappropriate to use these findings to judge the results of the program improvements adopted since the 2001 report was issued. Many of those improvements had only recently been implemented or implemented later in the year. Furthermore, it is impossible to know what these figures would have shown had none of the improvements been made.

Program Improvements. Since DHS presented its report to the Legislature in January 2001, DHS has enacted several program improvements in response to the report's recommendations. Many of these improvements resulted from legislation that passed during the 2001 session. Following is a summary of the status and results of some of the major initiatives.

- **Critical access dental provider rate increases.** Providers were designated and rates were increased in 2002. Some 172 providers have been designated for fee-for-service payment rate increases of 40 percent and funds have been distributed to the MHCP managed care plans for payments to providers they designate under a state-approved plan. Results will be evaluated when data becomes available in Spring 2003.
- **Rate increases for children's preventive services.** As incentives for providers, payment rates for tooth sealants and fluoride treatments were raised substantially on October 1, 1999. Payment rates for diagnostic examinations and dental x-rays for children

were also raised substantially, effective January 1, 2001. The number of children receiving a preventive dental service did not increase following these rate increases, nor did the total percentage of MHCP children receiving any dental service.

- **Dental services demonstration project (managed care carveout).** DHS worked with the Minnesota Dental Association to recruit providers to participate in the project's five counties. By late Summer 2002, over 90 percent of the providers signed agreements to increase the number of MHCP visits they provide in return for a 40 percent payment rate increase. Initial results will be evaluated when sufficient data is available (approximately Spring 2003).
- **Expanded authorization (collaborative agreements) for dental hygienists.** Anecdotal reports indicate that very few collaborative agreements have been entered into since the enabling legislation was passed in 2001. Several members of the Dental Access Advisory Committee believe the primary reason for the low level of participation is that the legislation missed the mark, since collaborative agreements largely limit dental hygienists to cleaning teeth, and only in settings other than those where children can be seen. In addition, the current statute does not permit the application of sealants, a key preventive measure for children.
- **Expanded duties for dental auxiliary personnel.** The Board of Dentistry is following the standard rulemaking process to implement this legislation and has established the educational requirements. Rule language is being drafted with a targeted publish date of March 2003. Several members of the Committee believe that the rulemaking process is too lengthy and recommend the passage of legislation to define these duties. They also noted that the rulemaking process is much more costly than legislation. Others on the Committee believe the Board should continue to pursue the rulemaking route, noting that it is more appropriate for a professional licensing board to develop rules than for legislators to do so in a political process.
- **Dental access grants.** DHS received 31 preliminary proposals in response to its RFP in October 2001. Before the awards could be made, the Legislature froze grant funding, putting the process on hold until January 2002 when the funds were carried forward to SFY2003. DHS wrote contracts for seven projects beginning in September 2003. DHS will assess the results of these projects in state fiscal year 2004 and prepare a report.
- **Dental access grants to teaching institutions and clinical training sites.** In May 2002, the Minnesota Department of Health (MDH) issued a request for proposals from teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. Seven applications were received. In August 2002, MDH awarded five grants totaling \$806,144. MDH intends to evaluate the results upon completion of the grant contracts.
- **Dental student loan forgiveness program.** MDH began this program in July 2001. All 28 slots have been filled for the program's first biennium. Sixteen of the participants are practicing in the metro area, 12 are non-metro and one is still in school. Participants report the program is assisting them with being able to serve a population in great need of their services. MDH estimates that program participants will provide over 20,000 patient

visits this biennium and will be delivering over 50,000 visits when the program completes its start-up period in FY 2005.

- **Retired dentist program.** As of December 31, 2002, only one dentist had participated in this program. DHS and the Minnesota Dental Association have discussed the need to make this program more visible among Minnesota dentists. Some believe that more retired dentists would volunteer were it not for the state's continuing education (CE) requirements. Presently, a retired dentist needs to complete 75 hours of CE every five years. Some states have no CE requirements.
- **Managed care contract performance incentives.** These incentives are a part of the DHS prepaid MHCP contract and are intended to improve dental access for the contractor's enrollees. Receipt of the incentive is dependent on the health plan's increase in its members' aggregate dental access rate. The size of the incentive payment is proportional to the size of the increase of the access rate. For 2001, the first year the incentives were included, only one plan earned an incentive payment. Data to establish the 2002 incentive payments is not yet available.
- **State Action for Oral Health Access grant proposal.** Working with many of the groups represented on the Dental Access Advisory Committee and others who had been working on projects to improve dental access, DHS submitted a proposal to the Center for Health Care Strategies (CHCS) for a grant to test innovative and comprehensive state approaches to improving access to oral health services. The proposal included: demonstration of alternative ways of organizing dental service provision; demonstration of a disease management model that is effective for patients who seek care in non-conventional ways; development of new roles for the traditional dental workforce and new roles in oral health prevention for non-dental health care providers; development of a model to train dentists to serve persons with disabilities; and identification of effective new ways of providing financial incentives to improve provider participation.

Minnesota was one of ten finalists (from 37 states applying) but did not make the final cut. A CHCS official informed DHS that the organization remains highly interested in many of Minnesota's ideas and will further consider funding some of the project under CHCS's other funding sources in 2003. DHS and the collaborators on this proposal intend to continue to pursue funding.

- **New MHCP Dental Care Model.** At the urging of the DHS Assistant Commissioner for Health Care, the Dental Access Advisory Committee has been developing alternative models of care for MHCP patients. The assistant commissioner noted that the level of access provided under the current model is unacceptable and asked the Committee to think outside the box in developing new ideas. Many believe that the system is broken. Some have questioned whether the commercial model DHS employs to deliver health care services is the most effective way to deliver dental care to the MHCP population.

DHS and the Committee members, recognizing that the state's current budget situation may preclude additional funding for new state services, are exploring ways of extracting more value from the funds presently being spent on dental care. They note that new technology, alternative staffing patterns, and increased efficiency already being employed in many

settings may have potential for improving MHCP dental services. They are interested in exploring how modifications to the present environment, including Rule 101, payment rates, and expanded duties for dental auxiliaries, can be made to make the system more palatable to providers and more cost effective for the state. They are interested in developing a system that reconciles how dentists deliver their services in accordance with how MHCP patients seek and use dental care. DHS and the Committee seek solutions that are locally developed and implemented through public/private partnerships.

DHS has met several times with a core group of experts to piece together a framework on which the larger group can work. Tentative plans call for issuing a request for proposals (RFP) in late winter 2003. The RFP will require responders to follow specific measures as set forth by the Dental Access Advisory Committee. To maximize creativity, responders will be given as much latitude as possible within state and federal laws and regulations. DHS will work closely with the Committee in evaluating proposals and working with the successful responder(s) in developing one or more turnkey models.

The Dental Access Advisory Committee. The Commissioner appointed 29 members to serve on the DAAC. The first meeting occurred in January 2002. Per statute, membership includes representatives of metro area and non-metro area dentists, oral surgeons, pediatric dentists, dental hygienists, community clinics, client advocacy, public health, health plans, University of Minnesota (UM) School of Dentistry, UM Department of Pediatrics, and the Minnesota Department of Health. The Committee organized its work into four work groups: Workforce, Patient Issues, Purchasing/Alternative Practice Models, and Data/Evaluation.

Recommendations. The Dental Access Advisory Committee makes the following recommendations:

1. Amend legislation authorizing collaborative agreements/expansion of limited authorization for dental hygienists to include: a) sealants, b) services provided at school-based sites; c) services provided by non-profits.
2. Develop new expanded duties for registered dental assistants and dental hygienists.
3. Demonstrate increased productivity and expanded access through the use of new dental technologies.
4. Create a dental internship program for new immigrant groups.
5. Develop and institutionalize the role of the primary care medical provider in the prevention of dental caries.
6. Promulgate educational oral health information for public programs patients.
7. Identify the causes of MHCP patient dental appointment failures and implement strategies to reduce these failures.
8. Eliminate income tax for dental student loan forgiveness grants.
9. Reduce dental providers' administrative burden:
 - A. Develop model dental managed care contract provisions, or
 - B. Assign all MHCP dental services to a single administrator.
2. Pilot test new delivery models of dental care designed specifically to meet the needs of MHCP patients.
3. Maintain the MHCP dental benefit for children and adults.

Conclusions. (***)Jim/Brian--want to add a section on conclusions?)

Update: Dental Access for Minnesota Health Care Programs Beneficiaries February 2003

I. Introduction and Background

In January 2001, the Minnesota Department of Human Services (DHS) presented to the Legislature a report entitled “Dental Access for Minnesota Health Care Programs Beneficiaries.” The report was the culmination of 18 months of effort by DHS and a 21-member group of stakeholders convened by Department. The report contained an analysis of the problems faced by those who rely on Minnesota Health Care Programs (MHCP) in obtaining dental care and a wide-ranging set of recommendations. Many of these recommendations formed the basis for legislation passed during the 2001 session.

The 2001 Omnibus Health and Human Services bill¹ mandated that DHS appoint another dental access advisory committee to monitor purchasing, administration, and coverage of dental care services to insure access and quality for Minnesota Health Care Programs beneficiaries. The session laws require DHS to submit to the Legislature a summary report of the Committee’s activities and recommendations.

In accordance with the statute, this report describes the appointment, membership, and activities of the Dental Access Advisory Committee. It also lists the Committee’s recommendations. To more fully inform the Legislature about the dental access issue, the report provides updated information on dental access since the January 2001 report was submitted and information on the status of the major dental access initiatives passed in 2001. It also describes efforts in developing a proposal for a new dental care model for Minnesota Health Care Programs beneficiaries.

¹ Laws of Minnesota 2001, First Special Session, Chapter 9, Article 2, Section 48.

II. Dental Access Since 2000

The 2001 report to the Legislature, “Dental Access for Minnesota Health Care Programs Beneficiaries,” contained information on key indicators of dental access. DHS has gathered updated information on these indicators to track trends since data was gathered for the 2001 report.

Patient visits. The use of dental services (utilization) is a meaningful measure of dental access. A commonly accepted utilization measure is the percentage of patients who visit a dentist one or more times per year. The following table shows the trend over the past six years for which data is available. Comparisons can be made between MHCP beneficiaries who receive services under the DHS fee-for-service (FFS) system and those who are enrolled in managed care plans. To assure an accurate comparison, the FFS comparison groups includes only those eligibles who live in counties in which there is no managed care enrollment, and includes only those who would be enrolled if managed care contracts would have been executed for their counties.

| Dental Service Utilization Rates² | | | | | |
|--|-------------|----------------------|-------------------------|--------------------|--------------------------------|
| FFS recipients [1] | | | | | |
| Year | # Eligibles | # Eligibility Months | # Dental Recipients [2] | % of Eligibles [3] | Recipients Per 1000 Months [4] |
| 1997 | 321513 | 1983017 | 72078 | 22.4 | 36.3 |
| 1998 | 288300 | 1609995 | 56646 | 19.6 | 35.2 |
| 1999 | 262506 | 1303202 | 42839 | 16.3 | 32.9 |
| 2000 | 265335 | 1272777 | 38026 | 14.3 | 29.9 |
| 2001 | 288821 | 1286995 | 38645 | 13.4 | 30.0 |
| Managed care enrollees | | | | | |
| 1997 | 393847 | 3410334 | 137019 | 34.8 | 40.2 |
| 1998 | 408135 | 3474782 | 143171 | 35.1 | 41.2 |
| 1999 | 433129 | 3695224 | 146192 | 33.8 | 39.6 |
| 2000 | 447510 | 3843684 | 145596 | 32.5 | 37.9 |
| 2001 | 499832 | 4252531 | 140865 | 28.2 | 33.1 |
| NOTES: [1] For the purpose of comparison, FFS recipients include only those recipients who would otherwise be enrolled in managed care plans if DHS had managed care contracts in their counties [2] “Dental recipient” is an MHCP beneficiary who has received one or more dental services during the year. [3] Includes all eligibles regardless of length of enrollment during year. [4] Reflects varying lengths of enrollment during year. For example, in 2000, the average length of eligibility for a FFS enrollee was 4.8 months, in 2001 it was 4.46 months. | | | | | |

Provider participation. A commonly accepted measure of provider participation in state Medicaid programs is the percentage of providers who substantially participate (expressed as service volumes exceeding \$10,000 annually), providers who minimally participate (expressed as

²Minnesota Department of Human Services claims data warehouse. Data has been weighted to reflect the wide variance in enrollment among the counties.

service volumes less than \$10,000 annually), and providers who do not participate (no service provided during the course of a year). The following table reports the receipts of Minnesota dental practices for three years, 1999 to 2001. The data includes total volume from all revenue sources and volume from MHCP payers only.

| Reported receipts, Minnesota dentists and dental clinics ³ | | | |
|--|----------------|----------------|----------------|
| | 1999 | 2000 | 2001 |
| # dental providers reporting | 1,773 | 1,789 | 1,697 |
| Total receipts | \$1.07 billion | \$1.16 billion | \$1.24 billion |
| MHCP receipts | \$32.1 million | \$36.0 million | \$35.6 million |
| # providers reporting >\$10k MHCP receipts | 573 (32.3%) | 604 (33.7%) | 539 (31.8%) |
| MHCP receipts | | \$33.7 million | \$33.2 million |
| # providers reporting \$1 - \$9,999 receipts | 732 (41.3%) | 625 (34.9%) | 596 (35.1%) |
| MHCP receipts | | \$2.3 million | \$2.4 million |
| # providers reporting no MHCP receipts | 468 (26.4%) | 560 (31.3%) | 562 (33.1%) |
| NOTE: This data is reported by taxpayer identification number, which includes both solo and group practices. There are approximately 2,900 individual actively practicing dentists in Minnesota ⁴ . | | | |

³Minnesota Department of Revenue

⁴Minnesota Board of Dentistry.

Enrollee complaints and appeals. A third measure of access is complaint and appeal activity. The following tables document the volume of contacts the Office of the Managed Care Ombudsman had with MHCP beneficiaries regarding assistance in obtaining dental care and the number of appeals filed regarding dental services.

| Managed Care Ombudsman interactions⁵ | | |
|---|-------------|-------------|
| | 2000 | 2002 |
| Dental as a percent of all interactions* | 10% | 17.7% |
| * excludes simple information and referral calls; includes those calls requiring follow-up. | | |

| MHCP appeals⁶ | | |
|------------------------------------|-------------------------|-------------|
| | 1996-1999 (avg.) | 2002 |
| Dental as a percent of all appeals | 20% | 40% |

⁵Office of the Ombudsman, Minnesota Department of Human Services.

⁶Ibid.

Appointment availability. In the 2001 report, DHS reported on the number of dentists who had available appointments for new MHCP patients in selected counties. The following table updates that information. Data shows continued deterioration in most counties. A bright spot is Clay County, where a local group of dentists and public health officials has been working to improve access for low income persons.

| Availability of Dental Appointments for New MHCP Patients in Selected Counties | | | | |
|---|----------------------------------|---|----------------------------------|---|
| County | 2000 | | 2002 | |
| | Licensed Dentist FTEs [1] | Dentists with Available Appointments for New MHCP Patients [2] | Licensed Dentist FTEs [3] | Dentists with Available Appointments for New MHCP Patients [4] |
| Anoka | 122.5 | 15 | 117.1 | 3 |
| Clay | 21.48 | 2 | 19.0 | 4 |
| Clearwater | 3.9 | 0 | 1.95 | 0 |
| Cook | 2.0 | 0 | .5 | 1 |
| Douglas | 13.88 | 2 | 7.725 | 0 |
| Goodhue | 26.13 | 3 | 20.85 | 2 |
| Lincoln, Lyon, Murray, Pipestone | 17.16 | 1 | 12.8 | 1 |
| Marshall | 1.5 | 2 | 1.25 | 0 |
| Martin | 18.28 | 1 | 9.05 | 1 |
| Olmsted | 85.18 | 5 | 84.6 | 2 |
| Otter Tail | 23.45 | 1 | 18.375 | 2 |
| Nicollet | 11.95 | 1 | 11.275 | 1 |
| Red Lake | 1.0 | 0 | .9 | 0 |
| St. Louis | 113.45 | 24 | 93.725 | 15 |
| Sherburne | 17.15 | 0 | 14.075 | 0 |

[1] Minnesota Department of Health License Surveys, 1998. "FTE" means full time equivalent.
 [2] County Public Health Agency reports to the Minnesota Department of Human Services, October 2000.
 [3] Minnesota Department of Health License Surveys, 2001.
 [4] County Public Health Agency reports to the Minnesota Department of Human Services, October 2002.

Discussion. All indicators show a continuance of the deterioration documented in the 2001 report. While this may suggest that the program improvements adopted since the report was issued have been ineffective, it is premature to judge the results. Many of these program improvements had only been recently implemented or implemented later in the year for which this data includes. Furthermore, it is impossible to know what these figures would have reflected had none of the improvements been made.

III. Program Improvements

Since DHS presented “Dental Access for Minnesota Health Care Programs Beneficiaries” to the Legislature in January 2001, DHS has enacted several program improvements in response to the report’s recommendations. Many of these improvements resulted from legislation that passed during the 2001 legislative session. The following is a summary of the status and results of some of the major initiatives.

Critical access dental provider payment rate increases¹

Description: Legislation permitted DHS to raise payment rates for dental services by up to 50% above the normal rate to those providers deemed by DHS to be a “critical access provider.” The criteria for designation must include volume of care provided and geographic location of provider. Increased reimbursements are limited to the appropriations: SFY 2002, \$1,550,000; SFY 2003, \$1,550,000. Payment rate increases apply to services rendered on or after January 1, 2002.

Status: DHS divided the available funds between FFS and managed care, allotting the funds to each category in proportion to its share of total MHCP dental expenditures: 55 percent for FFS; 45 percent for managed care. For FFS, DHS designated 142 providers in January 2002 based on their total volume of care provided. Later in the year, DHS solicited applications from providers and designated an additional 32, effective January 1, 2003. These designations were based on projected volume. All designated providers are paid at rates that are 40 percent higher than the MA FFS rate. To continue participation, each designated provider must maintain or exceed the level of volume on which his/her designation was based. DHS anticipates that sufficient data to evaluate the performance of the original 142 providers will be available in February 2003. At that time, non-performing providers will be removed from the panel and additional providers will be designated to take their place if funds are available.

DHS allotted funds to the managed care plans based on each plan’s share of the total managed care enrollment. Funds were distributed on July 1, 2002 for calendar year 2002. DHS requested each plan to submit a proposal to designate and pay its critical access providers. The plans were instructed to follow the parameters of the enabling statute regarding volume and geography. Each managed care plan was sent a listing of the FFS critical access providers but was not required to use it. Appendix A summarizes the health plans’ critical access dental provider plans as approved by DHS. The managed care plans must report their initial evaluations of their critical access programs by April 1, 2003.

Discussion: Preliminary discussions with the Dental Access Advisory Committee revealed some discontent over how DHS administered the critical access dental provider funds. The primary concern centered around how providers are designated critical access, and how funds are distributed to these providers by DHS for the FFS system and by each of the health plans within their own provider network. While all payers must make these determinations within the parameters of the statute, ultimately a provider may be deemed critical access by one payer but not another, and the reimbursement of funds may be at a different level from one payer to the next. Some large volume providers believe this makes future MHCP receipts less predictable,

⁷ Minnesota Statutes, Section 256B.76.

making business planning more difficult. They recommend that DHS assume responsibility for distributing all critical access dental funds for all dental services whether FFS or managed care and distribute payment similar to DHS’s FFS reimbursement of community clinics.

DHS intends to involve the Committee in evaluating this program after data is available from both the FFS system and the health plans. DHS will consider modifications in the program after this evaluation is complete.

Payment rate increases for children’s preventive services¹

Description: Legislation passed in 2001 required DHS to raise payment rates for diagnostic examinations and dental x-rays for children under age 21 to 85 percent of median 1999 charges (or to the submitted charge, if lower). Payment rate increases apply to services rendered on or after January 1, 2002. Legislation passed in 1999 required DHS to raise payment rates for tooth sealants and fluoride treatments to 80 percent of median 1997 charges (or to the submitted charge, if lower). Payment rate increases apply to services rendered on or after October 1, 1999.

Status: The MA fee schedule was revised per statute.

Discussion: Sealants, fluoride treatments, exams and x-rays are key preventive services in children’s dental care. One purpose of the payment rates increases was to offer incentives to dentists to provide more of these services to children in their care. As the following table indicates, utilization did not increase following these payment rate increases. The downward trend occurring between 1997 and 2002 continued every year despite the increases.

| Utilization of Preventive Dental Services for Children Medical Assistance and MinnesotaCare Programs (includes prepaid and FFS) Number of Children Receiving Service per 1000 Eligibility-Months | | | | | | | | |
|--|----------|--------|----------|--------|-------|--------|-------|--------|
| Year | Sealants | | Fluoride | | Exams | | X-ray | |
| | MA | MNCare | MA | MNCare | MA | MNCare | MA | MNCare |
| 1997 | 5.2 | 8.4 | 22.2 | 32.6 | 30.7 | 46.0 | 23.6 | 37.2 |
| 1998 | 5.1 | 8.6 | 22.0 | 33.9 | 30.3 | 49.8 | 23.4 | 38.5 |
| 1999 | 5.0 | 7.8 | 21.2 | 32.0 | 29.7 | 47.4 | 22.8 | 35.8 |
| 2000 | 4.4 | 7.1 | 19.7 | 31.3 | 28.4 | 46.7 | 21.6 | 35.0 |
| 2001 | 3.9 | 6.4 | 17.7 | 27.6 | 26.7 | 43.0 | 20.2 | 32.2 |
| 2002 | 3.8 | 5.7 | 16.9 | 25.2 | 25.7 | 39.2 | 19.3 | 28.6 |

Dental experts on the DHS Dental Access Advisory Committee note that by itself, increased utilization of sealants and fluorides is not necessarily an indicator of improvement in care. They point out that these services should be targeted to children who are at high risk for dental caries. There is no way to tell from this data whether these services went to the highest-risk children.

⁸ Ibid.

Another purpose of these payment rate increases was to offer incentives to dentists to treat more children, since these services make up the bulk of those provided to children at a typical dental visit. As the following table indicates, the rate at which children on MHCP received any dental service continued to deteriorate in the years following the payment rate increases.

| Utilization Rates, MHCP Dental Services Children, ages 0 - 20⁹ | | | | | |
|---|----------------|-------------------------|----------------------------|--------------------|--------------------------------|
| FFS recipients [1] | | | | | |
| Year | # of Eligibles | # of Eligibility Months | # of Dental Recipients [2] | % of Eligibles [3] | Recipients Per 1000 Months [4] |
| 1997 | 180949 | 1146451 | 39107 | 21.6 | 34.1 |
| 1998 | 163083 | 930092 | 30080 | 18.4 | 32.3 |
| 1999 | 148088 | 760751 | 22906 | 15.5 | 30.1 |
| 2000 | 149320 | 734424 | 20152 | 13.5 | 27.4 |
| 2001 | 159234 | 749489 | 20809 | 13.1 | 27.8 |
| Managed care enrollees | | | | | |
| 1997 | 226210 | 1983298 | 79658 | 35.2 | 40.2 |
| 1998 | 233245 | 2005594 | 83094 | 35.6 | 41.4 |
| 1999 | 244975 | 2102562 | 83176 | 34.0 | 39.6 |
| 2000 | 250816 | 2162412 | 82183 | 32.8 | 38.0 |
| 2001 | 274417 | 2358773 | 77197 | 28.1 | 32.7 |
| NOTES: | | | | | |
| [1] For the purpose of comparison, FFS recipients include only those recipients who would otherwise be enrolled in managed care plans if DHS had managed care contracts in their counties | | | | | |
| [2] "Dental recipient" is an MHCP beneficiary who has received one or more dental services during the year. | | | | | |
| [3] Includes all eligibles regardless of length of enrollment during year. | | | | | |
| [4] Reflects varying lengths of enrollment during year. For example, in 2000, the average length of eligibility for a FFS enrollee was 4.8 months, in 2001 it was 4.46 months. | | | | | |

Dental services demonstration project¹ (managed care carve-out)

Description: Legislation required DHS to contract on a prospective per capita basis or establish a fee-for-service system for dental reimbursement for MHCP patients in Cass, Crow Wing, Morrison, Todd and Wadena counties in lieu of dental services provided through comprehensive Prepaid Medical Assistance Program contracts.

Status: DHS worked with the Minnesota Dental Association to promote this project to dentists in the designated counties. The Department began enrolling providers in July 2002. By August over 90 percent of the dentists in the affected counties applied to participate. Participating providers are paid at rates that are 40 percent higher than the MA FFS rate. Participating providers agreed to increase the number of visits he/she provides to MHCP patients.

⁹Minnesota Department of Human Services claims data warehouse.

¹⁰ Minnesota Statutes, Section 256B.69.

Discussion: Initial results will be evaluated when sufficient data is available (approximately Spring 2003). DHS will determine the effectiveness of the program by measuring the aggregate change in dental services provided by all participating providers.

Expanded authorization (collaborative agreements) for dental hygienists¹¹

Description: Legislation modified the dental practice act to allow dental hygienists employed or retained by certain entities serving large numbers of MHCP patients to perform certain dental hygiene services without the patient first being examined by a dentist. Qualifying entities are: hospitals; nursing homes; home health agencies; group homes serving the elderly, disabled or juveniles; state operated facilities licensed by DHS or the Department of Corrections; and federal, state or local public health facilities, community clinics, or tribal clinics. The hygienist must have two years practical experience with a dentist within the preceding five years and must enter into a collaborative agreement with a dentist. The agreement must specify that the dentist authorizes and accepts responsibility for the service performed by the hygienist.

Status: Anecdotal reports indicate that very few collaborative agreements have been entered into since the enabling legislation was passed in 2001.

Discussion: Several members of the Dental Access Advisory Committee believe the primary reason for the low level of participation is that the legislation missed the mark. They note that under the present statute, collaborative agreements limit dental hygienists to cleaning teeth in settings other than those where children can be seen. While teeth cleaning is an important foundation in prevention, the permitted settings focus on adults. The dental needs of adult MHCP patients tend more toward the restorative, as a result of dental caries and periodontal disease. In addition, the current statute does not permit the application of sealants, a key preventive measure for children.

The Committee has developed a recommendation to make collaborative agreements more responsive to the needs of children. See Section V for this recommendation and further discussion.

Expanded duties for dental auxiliary personnel¹²

Description: Legislation requires the Minnesota Board of Dentistry (BOD) to develop new expanded duties for registered dental assistants and registered dental hygienists. The Board must consult with the University of Minnesota School of Dentistry, the Minnesota State Colleges and Universities (MNSCU) schools that offer dental auxiliary training programs, MDH, licensed dentists, and dental auxiliaries practicing in private and public settings. The new duties may be under direct or indirect supervision of a licensed dentist and are limited to reversible procedures. The BOD must establish the necessary educational requirements.

Status: The BOD is following the standard rulemaking process to implement this legislation. As of January 2003, a BOD committee had established the educational requirements, agreeing on

¹¹ Minnesota Statutes, Section 150A.10.

¹² Ibid.

didactic, laboratory and clinical experience components. Rule language is being drafted with a targeted publish date of March 2003.

Discussion: The Dental Access Advisory Committee unanimously agrees that expanded duties be developed but does not agree on the time line or process. Several members believe that the intent of the enabling legislation is that the expanded duties be implemented without delay. They believe that the rulemaking process is too lengthy and recommend the passage of legislation to define these duties. They also contend that the rulemaking process is much more costly than legislation. Others on the Committee believe the Board should continue to pursue the rulemaking route, noting that it is more appropriate for a professional licensing board to develop rules than for legislators to do so in a political process. See Recommendation #2 in Section V for the Committee's views.

Dental access grants¹

Description: The legislature appropriated \$800,000 in grants funds for DHS to award to improve access to dental care during state fiscal year SFY2002. Eligible awardees include organizations that demonstrate the ability to provide dental services effectively to MHCP patients. DHS is required to evaluate the effects of the grants and submit a report to the Legislature in 2003.

Status: DHS issued a request for proposals (RFP) in October 2001. The department received 31 preliminary proposals which were reviewed by a committee. The committee recommended 12 of the proposed projects for further consideration. In December 2001, the committee began its review of the final proposals. Before final awards were offered, the Legislature froze grant funding, putting the process on hold.

In January 2002, the Legislature cancelled the grant funds for state fiscal year 2002 and carried them forward to SFY2003. In July 2002, DHS resumed the awards process, eventually awarding grants for eight projects. Seven of the awardees accepted the grants, one declined. DHS set aside the funds for the declined award (\$148,000) to be awarded later in the fiscal year under a new RFP targeted at the development of a new model of dental care. The contracting process for the seven projects began in September 2002. See Appendix B for a summary of the projects funded.

Discussion: DHS will assess the results of these projects in state fiscal year 2004 and prepare a report.

Dental access grants to teaching institutions and clinical training sites¹⁴

Description: In state fiscal year 2003, funds were appropriated to the Minnesota Department of Health (MDH) to award grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. Applicants must be affiliated with a training program that is accredited by an organization that meets Medical Education and Research Costs (MERC) accreditation requirements. MDH is required to consult with DHS in awarding the grants.

¹³ Minnesota Statutes, Section 256B.53.

¹⁴ Minnesota Statutes, Section 62J.692.

The source of funding for these grants is an existing Health Care Access Fund appropriation for the University of Minnesota's Academic Health Center. This appropriation increases the Prepaid Medical Assistance Program (PMAP) capitation rates, directing a portion of the federal matching funds received to the innovations pool. Approximately half of the matching funds received under this initiative will go to Hennepin County Medical Center, with the remaining funds going to the Clinical Dental Education Innovations Pool. Approximately \$1.3 million will be available to the pool in each fiscal year in which federal financial participation is available, beginning in SFY02.

Status: MDH issued a request for proposals in May 2002. Seven applications were received totaling nearly \$3.8 million over three years. In August 2002 five applicants were awarded clinical dental education innovations grants totaling \$806,144. See Appendix C for a summary.

Discussion: MDH intends to evaluate the results upon completion of the grant contracts. The contracts vary in length, with the first scheduled to end December 2003.

Dental student loan forgiveness program¹⁵

Description: Legislation established a loan forgiveness program, administered by the Minnesota Department of Health, for dentists who agree to treat underserved patients. The dental student must sign an agreement for a minimum three year service obligation in which at least 25 percent of the dentist's yearly patient encounters are with MHCP patients and other low to moderate income uninsured patients. MDH will make disbursements of up to \$10,000 per year of service, not to exceed \$40,000 or the balance of the loan amount. Up to 14 participants per year may be accepted. If fewer students apply, licensed dentists may apply for the unused slots.

Status: The program began in July 2001. All 28 slots have been filled for the program's first biennium. The program's first year began after the dental school graduation, and all 14 participants were practicing dentists. In the second year, seven participants were students when selected, and seven were dentists in practice. Applications to the program have been received at a faster pace than that of the state's physician loan forgiveness program in its early years. Nineteen participants are in solo or group private practice, eight are in a community clinic or other nonprofit setting, and one is still in dental school. Sixteen are practicing in the metro area, 12 are non-metro and one is still in school.

Discussion: Participants report that the program is assisting them with being able to serve a population in great need of their services. MDH estimates that program participants will provide over 20,000 patient visits this biennium and will be delivering over 50,000 visits when the program completes its start-up period in FY 2005. MDH is marketing the program in collaboration with the University of Minnesota and other dental organizations. The central marketing challenge is the misconception that a newly-graduated dentist cannot maintain a practice treating public program participants, even with loan forgiveness funds. Testimonials from current participants in the program are helping to dispel this mistaken belief.

Retired dentist program¹⁶

¹⁵ Minnesota Statutes, Section 144.1502.

¹⁶ Minnesota Statutes, Section 256B.958.

Description: Legislation established a program to reimburse a retired dentist's costs of license fee and malpractice insurance in exchange for the dentist's provision of 100 hours of dental services provided at a community dental clinic or MNSCU dental clinic within a 12-month period.

Status: As of December 31, 2002, only one dentist had participated in this program.

Discussion: DHS and the Minnesota Dental Association have discussed the need to make this program more visible among Minnesota dentists. In addition, some believe that more retired dentists would volunteer were it not for the state's continuing education (CE) requirements. Presently, a retired dentist needs to complete 75 hours of CE every five years. In some states, there are no CE requirements. One of these states is Wisconsin, from which dentists can volunteer in Minnesota clinics under the "guest licensure" law (Minnesota Statutes, Section 150A.06, subd.2c). Therefore, in Minnesota volunteer clinics, dentists are already able to volunteer without the CE requirement but only if they are licensed in another state that does not have this requirement.

DHS supports changing this regulation to encourage more volunteers.

Managed care contract performance incentives

Description: These incentives are a part of the DHS prepaid MHCP contract and are intended to improve dental access for the contractor's enrollees. Receipt of the incentive is dependent on the health plan's increase in its members' aggregate dental access rate from the base year of 1999. The size of the incentive payment is proportional to the size of the increase of the access rate.

Status: DHS has included a dental access incentive in each of its managed care contracts since 2001. For 2001, only one plan earned an incentive payment. Data to establish the 2002 incentive payments is not yet available.

Discussion: The health plans have been trying a variety of approaches over the past few years to improve dental access. They report that providers are largely unresponsive to their efforts. While it may be preliminary to judge the effect of the incentives based on a single year of experience, a preliminary conclusion may be that the market and the regulatory environment is such that managed care approaches and the limited resources available to improve access have reached their maximum potential. (It is important to note that, as documented in Section II above, dental utilization among MHCP managed care enrollees has been consistently higher than for MHCP fee-for-service recipients.)

State Action for Oral Health Access grant proposal

Description: In April 2002, the Center for Health Care Strategies (CHCS) and the Robert Wood Johnson Foundation announced the State Action for Oral Health Access grant program, a new funding opportunity for "states on the cutting edge of improving access to oral health services" for low-income, minority, and disabled populations. The program is designed to test innovative and comprehensive state approaches to improving access to oral health services. Funding of up to \$1 million was available for each of five- to-seven states.

Working with many of the groups represented on the Dental Access Advisory Committee and others who had been working on projects to improve dental access, DHS submitted a proposal for a project with four components:

- < A model for an urban urgent care dental clinic
- < A clinic model to demonstrate education, workforce and treatment innovations
- < A model for the delivery of dental services at non-traditional sites
- < Results-based payment incentives for increasing provider participation

Through the project, DHS intended to accomplish the following: demonstration of alternatives to organizing the provision of dental service; demonstration of a disease management model that is effective for patients who seek care in non-conventional ways; development of new roles for the traditional dental workforce and new roles in oral health prevention for non-dental health care providers; development of a model to train dentists to serve persons with disabilities; and identification of effective new ways to provide financial incentives to improve provider participation.

Status: Thirty-seven states applied for this grant. Minnesota's proposal was one of 10 selected for a site visit but did not make the final cut. A CHCS official informed DHS that the organization remains highly interested in many of Minnesota's ideas and will further consider funding some of the projects through CHCS's other funding sources in 2003.

Discussion: The development of this proposal energized many groups that had been working on dental access improvement and increasing and expanding their collaboration. Some components of the proposed projects have gone forward with alternative sources of support. Many components have evolved into the formation of a new dental delivery model for MHCP beneficiaries. DHS and many of the collaborators on this proposal intend to continue to pursue funding.

New MHCP dental care model

Description: In September 2002 DHS Assistant Commissioner Brian Osberg requested that the Dental Access Committee develop an alternative model of care for MHCP patients. Noting that the level of access provided under the current model was unacceptable, he asked the Committee to think outside the box in developing new ideas.

Status: The Purchasing/Alternative Practice Models Work Group began discussing ideas for a new model based on previous work they had done in identifying improved purchasing and delivery systems. DHS has met several times with a core group of experts to piece together a framework for use by the larger group.

Tentative plans call for DHS to issue a request for proposals (RFP) in late winter 2003. The RFP will require responders to follow specific measures as set forth by the Dental Access Advisory Committee. To maximize creativity, responders will be given as much latitude as possible within state and federal laws and regulations. DHS will work closely with the Committee in evaluating proposals and working with the successful responder(s) in developing a turnkey model or models.

Discussion: There is growing sentiment that "the system is broken." Some have questioned whether the commercial model DHS employs to deliver health care services is the most effective way to deliver dental care to the MHCP population. DHS and the Committee members recognize that the state's current budget situation does not look promising for additional funding for new state services.

Several Committee members are interested in exploring ways of extracting more value from the funds presently being spent on dental care. They note that new technology, alternative staffing patterns, and increased efficiency already being employed in many settings may have potential for improving MHCP dental services. Committee members are interested in exploring how modifications to the present environment, including Rule 101, payment rates, and expanded duties for dental auxiliaries, can be made to make the system more palatable to providers and more cost effective for the state. They are interested in developing a system that reconciles how dentists deliver their services with the patterns which MHCP patients seek and use dental care. Committee members seek solutions that are locally developed and implemented through public/private partnerships.

IV. The Dental Access Advisory Committee

DHS convened the present Dental Access Advisory Committee in January 2002. Per statute, membership includes representatives of metro area and non-metro area dentists, oral surgeons, pediatric dentists, dental hygienists, community clinics, client advocacy, public health, health plans, University of Minnesota (UM) School of Dentistry, UM Department of Pediatrics, and the Minnesota Department of Health. The Committee is authorized to function until June 30, 2003.

The specific charge to the Committee is to make recommendations on:

- X reducing administrative burden
- X developing an action plan to improve the oral health of children and persons with special needs
- X developing alternative ways of purchasing dental services
- X fostering responsibility for seeking and obtaining dental care among MHCP patients
- X developing innovative ways to reduce or minimize appointment no-shows
- X meeting barriers posed by language, culture and lack of transportation
- X involving pediatricians, family physicians and nurse practitioners in providing dental screenings and preventive dental services.

Committee appointments. The DHS Dental Access Advisory Committee was organized according to the Open Appointments Act. The Office of the Secretary of State published a notice of the Committee's open appointments on December 3, 2001. The Commissioner appointed 29 members to the Committee, observing the categories specified in the legislation. Thirteen of the appointees had served on the previous dental access advisory committee, while 19 appointees are new. (See Appendix D for brief profiles of the appointees.)

Committee activities . DHS convened the first meeting of the Dental Access Advisory Committee on January 28, 2002. At the meeting, the Committee:

- X reviewed its charge according to the 2001 legislation;
- X reviewed the other legislation passed in 2001 affecting dental access;
- X discussed in-depth the critical care dental provider program and legislation concerning new roles for dental auxiliaries; and,
- X formulated a work plan.

The Committee organized four work groups: Work Force; Patient Issues; Purchasing/New Practice Models; and, Data/Evaluation. A Committee member chairs each work group. Committee members were invited to participate in as many work groups as possible and participation also was open to interested members of the public. Several experts in the field of dentistry who are not Committee members also contributed to the work of these groups. The work groups met independently and reported back to the Committee at its quarterly scheduled meetings.

Summary of work group activities and discussion

Workforce work group . This work group considered several strategies to increase access within five broad areas:

- X Increase the supply of dental providers within current regulations: graduate more dentists; identify strategies to recruit more dentists in community clinics; offer loan forgiveness for dental hygienists; and, attract foreign-trained dentists to hygiene/assisting.
- X Increase the supply of dental providers by changing regulations: allow denturists to practice in Minnesota; make the 2001 collaborative agreement legislation more useful and effective, expand the duties of dental auxiliaries, and, use non-dental health providers for prevention.
- X Increase access with the current supply of dental providers: assess capacity of private workforce to provide access to public programs patients, increase productivity of dental practices and clinics; establish “pro-bono” dentistry; expand volunteer dentistry; and, fund expansion of community clinics.
- X Expand school based programs: use dental hygienists at school-based sites and use mobile models of care.
- X Use technology to improve access: identify ways in which the latest dental technology can be used to improve access.

The majority of the Committee felt that two strategies that hold the most promise are those for which legislation was passed in 2001: make the collaborative agreement legislation more useful and effective and expand the duties of dental auxiliaries. Regarding the collaborative agreement legislation, the Committee acknowledged that few collaborative agreements have been entered into since the legislation was passed. Many Committee members felt that this legislation’s potential to foster some major preventive efforts was thwarted because the collaborative agreements do not permit sealant application, nor do they allow services provided under them to be allowed in schools. Implications of sealant application in the absence of a previous exam by a dentist were discussed, as well as whether a patient would become a “patient of record” of a collaborating dentist.

Regarding expanded duties for dental auxiliaries, many members of the Committee expressed frustration at the lengthy rule making process that the Board of Dentistry follows. Ways to short-cut this process were discussed. The experiences of other states and the Indian Health Services were considered. More consensus was achieved on the role of the medical provider in oral health prevention efforts, with workforce members recognizing that medical providers are an important ally.

Patient issues work group . This work group focused on developing strategies to deal with patient appointment failures, providing education on preventive techniques, and increasing patient compliance with an oral health regimen. The group explored various techniques concerning appointment reminders, including calls and postcards, issuing cell phones to assure communication between patient and provider, making incentive payments for compliance and enlisting the assistance of county public health nurses.

The group examined how adults, both in their own right and as parents of young children and older teens, need to be educated about oral health, particularly regarding:

- X the infectious nature of dental caries;
- X how offending microorganisms move from a mother’s mouth to a child’s mouth;

- X how the mother's cavities and periodontal disease are correlated with the child's caries;
- X how the mother can manage her own oral disease; and,
- X how she can minimize transmission of disease from her mouth to her child's.

The group identified key elements of oral health education as:

- X the importance of brushing, flossing (for adults), and regular dental care for all, starting at one year of age;
- X the importance of nutrition;
- X the importance of fluoride as a preventive agent;
- X strategies to promote fluoride varnish application by dentists, dental hygienists, dental assistants, and those who provide medical care to young children (pediatricians, family practice physicians, and nurse practitioners who work with both); and,
- X the importance of sealants for older children.

Purchasing/alternative practice models work group . This group focused on two areas: purchasing mechanisms (independent of payment rates), and alternative ways of delivering care to the MHCP population. The group examined the potential for simplification of the present purchasing strategy employed by DHS as well as implications of a dental carve-out to a single administrator. Alternatively, the group identified ways of making the present system more “provider friendly.”

The group devoted one meeting to looking at opportunities to use provider or income tax incentives as a means of improving provider participation. An official of the Minnesota Department of Revenue and a federal relations official from DHS discussed the viability of various strategies. After thorough discussion, the group decided provider and income tax incentives were not viable options, with the exception of a recommendation to enhance the value of the student loan forgiveness program through tax relief.

The group examined alternative purchasing and delivery models, including the State of Michigan's successful Medicaid model, which the group believed would offer some improvement in access but at a greatly increased cost due to the model's commercially-based payment rates. The group also extensively reviewed a model of care being designed by a MHCP contracted health plan specifically to meet the needs and varied care-seeking patterns of the MHCP patients. The group endorsed the concept of an urgent care dental clinic and supported the group that is proposing such a clinic in Minneapolis. The group also reviewed the potential of mobile dentistry and teledentistry and supported their inclusion in the overall strategy of improving MHCP dental access.

Data/evaluation work group . In 2001, several new state statutes were passed to address the dental access problem in Minnesota. Arguably, if the new laws are effective, the dental access problem will diminish over time. DHS asked the members of this work group to lend their expertise and recommend measures to evaluate these initiatives. The group drafted outcome measures and discussion questions for many of the initiatives. (Refer to Appendix E.)

The work group noted that it likely would take several years following enactment of legislation before measurable effectiveness can be determined. Knowing what data should be collected now will allow DHS to identify baselines from which changes over time can be evaluated. Taken

collectively, rather than as individual instances, the new laws may produce a positive response to the dental access issue.

V. Recommendations of the Dental Access Advisory Committee

The Dental Access Advisory Committee makes the following recommendations:

Recommendation # 1: Amend legislation authorizing collaborative agreements/expansion of limited authorization for dental hygienists to include: a) sealants, b) services provided at school-based sites; c) services provided by non-profit.

Legislation was passed in 2001 expanding authorization for dental hygienists employed or retained by certain entities, enabling them to perform certain dental hygiene services without the patient first being examined by a dentist. Qualifying entities are: hospitals; nursing homes; home health agencies; group homes serving the elderly, persons with disabilities, or juveniles; state operated facilities licensed by DHS or the Department of Corrections; and, federal, state, or local public health facilities, community clinics or tribal clinics. The hygienist must have two years practical experience with a dentist within the preceding five years and must enter into a collaborative agreement with a dentist. The agreement must specify that the dentist authorizes and accepts responsibility for the service performed by the hygienist. The legislation authorized the Board of Dentistry to make recommendations to the 2002 Legislature on additional training requirements.

The Committee noted that this legislation might be too restrictive for this initiative to meaningfully impact access. To address this, and to further strengthen technical competence, quality and accountability, the Committee recommends the language be amended to:

1. Include the application of sealants and fluoride varnishes and the provision of oral health promotion/disease prevention education among the permitted services covered under collaborative agreements;
2. Include schools, Head Start programs and nonprofit organizations as authorized venues;
3. Change the dental hygienist's experience requirement to 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years;
4. Include the requirement for the hygienist to have completed a cardiac life support course;
5. Permit the collaborating dental hygienist to work with a dental assistant;
6. Permit the Board of Dentistry to allow a collaborating dentist to enter into a collaborative agreement with more than four dental hygienists;
7. Include in the collaborative agreement age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services;
8. Include in the collaborative agreement copies of consent to treatment and referral forms, which must include a statement advising that dental hygiene services do not substitute for a complete dental examination by a dentist; and,
9. Require annual review and update of the collaborative agreement by all parties.

See Appendix F for suggested bill language. The inclusion of sealant application by dental hygienists under collaborative agreements has been a controversial issue. The Minnesota Dental Association (MDA) sponsored a seminar on dental sealants on January 31, 2003. The seminar focused on:

Would collaborative agreements that permit dental hygienists to apply sealants without the patient first being examined by a dentist increase access to dental care and improve oral health without compromising quality?

MDA designed the seminar to build further awareness about this issue by offering a forum for oral health professionals to share their knowledge and perspectives. The seminar included a presentation on current sealant research by Dr. Robert Feigal of the University of Michigan School of Dentistry and a discussion of the policy implications. While the seminar occurred after the completion of this report, information from the seminar will be available for decision makers to consider during the 20033 Legislative session.

Proponents of the recommended changes note that many have been implemented in other states. According to a recent report of the American Dental Hygienists' Association, District VII,

X 20 states allow sealant placement without dentist diagnosis

X 34 states allow dental hygienists to practice in private institutions, public health settings and public institutions.

Recommendation # 2: Develop new expanded duties for registered dental assistants and dental hygienists

In 2001, the DHS Dental Access Advisory Committee recommended that the Legislature expand the duties of registered dental hygienists and dental assistants. The legislation passed, charging the Board of Dentistry to develop these new duties. The Board has started the process of rewriting rules and regulations; however, this process will take several years to complete. There is a lack of consensus within the Committee as to whether MHCP patients and the general public would be better served by letting this process run its course, or by adopting legislation to expedite the training and practice of dental assistants and dental hygienists in these new duties.

Proponents of the faster approach propose legislation that would authorize exceptions from Board of Dentistry oversight for allied dental health professionals serving MHCP patients in community clinics and non-profit organizations. See Appendix G for suggested bill language. The expedited approach could be limited to demonstration projects. Proponents of this approach note that access to dental services would be increased through the establishment of dental programs that can function as productively as Indian Health Service (IHS) clinics. The IHS has been using expanded function dental assistants (EFDAs) in its clinics for over 30 years. Proponents believe EFDAs improve access without compromising quality or patient safety.

According to the director of an IHS dental clinic in South Dakota, EFDAs can “increase access to care by 25 to 30 percent.”¹⁷ Productivity “increases from 25 to 50 percent, depending on the size of the clinic and the number expanded function therapists.”¹⁸ Regarding cost, in a study of

¹⁷Michael Crutcher, DDS, Chief Dental Officer and Clinical Director, Sioux San Hospital, Indian Health Service, Rapid City, SD, presentation at Minnesota Association of Community Dentists Dental Access Forum, September 27, 2002, Bloomington, MN.

¹⁸Ibid.

expanded function auxiliaries at Forsyth Dental Center in Boston, the cost of dental care to the public was 44% lower than usual fees of dentists working without EFDAs.¹⁹ Another study shows that the use of EFDAs in private practice increased output efficiency, maintained quality and allowed dentists to stabilize their fees in spite of inflation.²⁰

According to another published report, a four-year study of the utilization of dental assistants with expanded functions illustrated "...the potential benefits of the utilization of expanded functions auxiliaries to dentistry and the public. The findings of a double-blind examination indicated that the restorations completed by the dental auxiliaries were of comparable quality to those provided by the participating dentists. ...The utilization of dental auxiliaries resulted in decreased cost per service."²¹

The State of Pennsylvania has allowed EFDAs to practice in its state since the 1970s. One member of the Pennsylvania Board of Dentistry noted that his Board has not received a single complaint about a procedure provided by an EFDA since the enabling legislation was passed.²² From the State of Washington, where licensed dental hygienists may perform certain restorative procedures, comes a similar report that indicates that no complaints have been filed.²³

EFDAs can be trained in months instead of years. EFDA salary levels are considerably less than dentist salary levels, potentially reducing the cost of dental care without reducing the income of dentists. IHS dentists only perform the duties that require their expertise. One member of the Committee, a dentist, believes that under current Minnesota law dentists spend much time performing repetitive, simple reversible and noninvasive procedures that are being successfully performed by EFDAs in other jurisdictions.

Proponents of allowing the Board of Dentistry to complete the rulemaking process believe:

- X it is the purpose of the Board of Dentistry to develop these rules,
- X that it is more appropriate for a professional licensing board to develop rules than for legislators in a political process, and,

¹⁹"The Cost of Providing Restorative Dentistry in An Alternative Delivery Mode," Hankin, R. PhD, Research Assoc., Center for Medical Manpower Studies, Northwestern Univ., Boston Ma, Journal of Public Health Dentistry, Vol. 37, no.3, Summer '77.

²⁰"Production-economic effects of delegation & practice size in a private dental office." Mullins, M. DMD, MPH, et al., Assoc. Prof., Univ. of Ky. College of Dentistry, JADA, Vol. 98 April 1979.

²¹Joseph Abramowitz, DDS, MPH and Lawrence Berg, BS Journal of the American Dental Association, Vol. 87, September 1973, pages 623-635

²²Neil Gardner, DDS, MPH, Pennsylvania Department of Health, comment made during presentation at the National Conference of State Legislatures forum, Tools to Improve Access to Oral Health, July 11, 2002, Minneapolis.

²³Vicki L. Brown, Washington Department of Health, e-mail message to Colleen Brickle, RDH, EdD, January 27, 2003.

X that the Board has begun the rulemaking process and is expediting it as much as possible. The nuances of duties for allied dental workers and the levels of supervision are best addressed by a professional board.

Recommendation #3: Demonstrate increased productivity and expanded access through the use of new dental technologies

The Committee recommends that the Legislature endorse the study and adoption of new dental technologies as a means of improving dental access. An article published in 2001 in the *Journal of the American Dental Association* (“Practicing Dentistry in the Age of Telemedicine”) noted that, “Teledentistry has the ability to improve access to care, improve the delivery of health care and lower its costs.” With 50 percent or more of practicing Minnesota dentists projected to retire within the next 10-15 years,²⁴ the dental workforce shortage will become increasingly acute. The Committee believes it is time to explore new ways to address the access crisis by maximizing the potential of existing personnel.

This recommendation supports projects demonstrating the use of new dental technologies (such as electronic record keeping, intraoral cameras, digital radiography, and caries detection devices employing laser technology), specifically in community clinics and with other safety net providers. These technologies could benefit those most in need and increase access to services without the need to amend licensure laws. Pilot projects are recommended to demonstrate whether the technologies are effective and efficient when used in clinics serving public assistance patients—those safety net providers that are least likely to be able to afford the equipment on their own.

New dental technologies may be able to maximize dental productivity and be cost-effective, particularly when used in conjunction with the collaborative agreements between dentists and dental hygienists permitted under Minnesota Statutes, Section 150A.05, subdivision 1a. These arrangements would allow hygienists to deliver care without requiring the dentist to be present and while preserving the dentist’s responsibility to diagnose and formulate treatment plans. For example, use of “teledentistry” would allow dental hygienists to collect patients’ oral health assessment data and transmit it to a dentist in a different location. Once the dentist has made a diagnosis and treatment plan, the dental hygienist could provide needed preventive care (such as sealants, fluoride varnish, prophylaxes) without a dentist having to physically examine the patient, and without the need to change licensure laws if both the dentist and hygienist are licensed in Minnesota.

New technologies could also be employed to transmit patient data to dental specialists for diagnoses and treatment plans, saving the patient travel time costs and time lost from work. In addition, the potential would be created to allow the patient (and dentist) to receive advice from a dental specialist (such as an oral pathologist) which otherwise would not be feasible.

The use of dental technologies also could allow dentists whose physical disabilities prevent them from practicing clinically to continue practicing in a limited fashion, for example, by

²⁴Dental Workforce Profile, Office of Rural Health and Primary Care Newsletter, February 2002, Minnesota Department of Health.

electronically making diagnoses and treatment plans. (The Minnesota Board of Dentistry notes that changes in licensing requirements would need to be made to take advantage of this strategy.)

Because this initiative could be viewed as a “win-win” situation for many stakeholders, it is possible that many would be interested in taking the lead. Should state funds be made available, pilot project grants should be directed to dental and dental hygiene training programs, HMOs and community dental clinics for this purpose. Professional associations (i.e., the Minnesota Dental Association, the Minnesota Dental Hygienists’ Association and the Minnesota Dental Assistants’ Association), could lead by showing how such technologies are already used successfully in private practice settings. With available public or private funding, researchers at the U of M dental school could conduct trials of new technologies to determine their reliability and validity against the “gold standard” (mirror, explorer, and traditional radiographs). These funds also would allow for grants to be awarded to safety net providers to demonstrate the use of dental technologies.

Recommendation # 4: Create a dental internship program for new immigrant groups

The Legislature should endorse the creation of a dental internship program offered to young adults who are bilingual in English and a family language of one of the recent immigrant groups in Minnesota. Examples of languages include Spanish, Hmong, Somali, Bosnian, and Russian. This would be a work study program in dental clinics lasting from three to 12 months, offering didactic training about 10% of the time. Participants would be paid at a rate of about 50% - 75% of a dental assistant’s rate. Participants’ roles and training would include:

- X translation;
- X health education in the clinic and in the community;
- X insurance work and form completion;
- X escorting patients;
- X cleaning and preparing instruments and rooms;
- X childcare during treatment; and,
- X other duties now done by dental assistants that do not require certification.

The Committee recommends that the University of Minnesota School of Dentistry take the lead in developing this program. Internship participants would be rotated to outside clinics. By performing work now done by dental assistants, the internship participants would free up dental assistants for those duties that require credentials. By acquiring skills beyond only translation, intern participants would be able to work in smaller dental offices which then could accept more patients from these immigrant groups.

This program can be expected to increase the exposure and interest of young people from these ethnic groups to pursue careers in the dental health professions. Participation would increase their chances of being selected by a program and successfully completing it. This proposal would increase capacity for direct care to the ethnic groups. Further, it would decrease the need for expensive interpreters and increase the effectiveness of dental assistants, dentists, dental students and dental residents. Clinic revenue for the University and the community clinics would be increased.

Recommendation # 5: Develop and institutionalize the role of the primary care medical provider in the prevention of dental caries

The Committee endorses the role of the primary care medical provider as a key partner in the primary prevention approach to dental caries. Medical providers see young children (0-5 years of age) for well-child care on a regular, frequent basis. This initiative works to bring primary oral health preventive services to young children when they are seen at well-child care medical visits. Successful delivery of these primary preventive services will avoid the need for restorative care by dentists.

A setting where the medical provider could have one of the largest potential impacts in the prevention of caries is the Child and Teen Check-up (C&TC) visit. Presently, the C&TC oral health guideline mandated by the Center for Medicare and Medicaid Services (CMS) requires only a note from the examining physician be placed in the chart documenting that the parent has been advised to take the child in for dental care. However, parents who heed this advice from their child's doctor often find they are unable to obtain an appointment with a dentist to receive the recommended care.

Some members of the Committee recommend that DHS study the feasibility of including child and parent preventive education at the C&TC visit. At the visit, the physician or nurse practitioner could apply fluoride varnish and educate parents. This approach may be more likely to decrease caries than simply telling the parent to take the child to the dentist. Primary care intervention is more cost-effective than emergency room visits and restorations done under general anesthesia in the operating room.

Before the initiative can be implemented several groups would need to buy in to the concept, including: DHS; the Minnesota Chapter Academy of Pediatrics; and, the Minnesota Academy of Family Practice; Pediatric Nurse Practitioners Association, and the MHCP health plans. DHS and the health plans would need to reach agreement regarding payment to the medical providers for the services provided. In addition, medical providers must be taught how to apply fluoride varnish and must be provided with preventive educational information on oral health.

This initiative involves minimal cost. There will be some expense for training medical personnel on how to apply fluoride varnish and to be certified for that activity so they can be reimbursed by DHS for the service. Clinics may absorb the cost of copying educational materials to distribute to the parents of patients.

Recommendation #6: Promulgate educational oral health information for public programs patients

The Committee notes that dental access can be impacted by simply getting the message out about the importance of oral hygiene. The Committee recommends that DHS and the Minnesota Department of Health should promulgate educational materials which address oral health. Topics should include: the infectious nature of dental caries; the importance of brushing, flossing (for adults), and regular dental care for all, starting at one year; the importance of nutrition, including appreciation for how continuous exposure of the teeth to sugar is far more detrimental than intermittent exposure; the importance of fluoride in the water supply or as drops (along with multivitamins and iron for the breast fed infant) for children under one year of age; the

importance of fluoride varnish application to the surface of the teeth by dentists, dental hygienists, dental assistants, and those who provide medical care to young children (pediatricians, family practice physicians, and nurse practitioners who work with both); and, the importance of sealants for older children.

The overarching theme of this information is that dental caries is a result of an infectious process and so, akin to certain infectious childhood diseases (e.g., diphtheria, polio, measles, mumps, rubella, chicken pox), are totally preventable, not by immunization but by patient/parent proactive behavior.

A variety of informational formats should be considered, including:

- X public service announcements;
- X videos that can be shown in clinics, churches, or community centers;
- X websites for use in schools to educate students about dental health; and,
- X written materials for use at dental offices where one staff person is identified to educate all patients/parents (much like clinics often have one staff person designated as the diabetes counselor); and,
- X in the offices of medical providers.

Medical providers include those who provide primary care to children and internists (because the oral health of adults also must be considered). Since periodontal disease is associated with low birth weight and premature birth, obstetricians/gynecologists should be included. These specialists should promote sound oral health practices beginning with the first prenatal visit.

Education should target dental and medical workers, school personnel, parents and children. Special attention must be paid to the state's bilingual populations. It is important that initial education not overload the patients but be provided in small amounts.

The Committee urges the Minnesota Department of Health and the Minnesota Department of Children, Families and Learning to continue to work together to address these educational endeavors. Education could begin for those who are involved in Early Childhood Family Education and Head Start and continue all the way through 12th grade. A good modality to use is computers, with the materials being tested for cultural specificity and understandability. An effort should be made to educate not only parents but grandparents as well, particularly since some cultures, for example, Southeast Asians, Hispanics, Africans, live as extended families.

Most of the information already exists, though it would need to be formatted. A television station agreeing to air the public service announcement would need to create it. Pro bono assistance with video production and website development would be solicited. Written materials would be created from existing educational information. To the extent that funds are required, community resources, such as health plans, foundations, and soda pop producers and distributors who install their machines in public schools, would be tapped.

This initiative will increase demand but not access. It represents primary prevention which, if successful, will reduce the need for care over time or will result in need for less expensive care.

Recommendation #7: *Identify the causes of MHCP patient dental appointment failures and implement strategies to reduce these failures*

Failed appointments cause a major financial problem for dentists. National studies show that about one third of all Medicaid dental appointments are broken and local data shows that in some cases these rates exceed 40 percent.²⁵ Irrespective of the level of reimbursement, a failed appointment represents a 100% loss of revenue since there are few “walk-ins” in the practice of dentistry. In a recent survey, 81.8 percent of Minnesota dentists described MHCP patient appointment failures as a “very significant” problem, with another 13.9 percent describing them as “somewhat significant.”²⁶ Reducing MHCP appointment failures may prompt more dentists to see more patients.

The Committee recommends that DHS convene focus groups of MHCP patients to determine reasons for appointment failures. Reasons to consider include: fear of the dentist, failure to appreciate the importance of dental health and lack of transportation. The project would be proposed to the Carlson School of Management and the School of Public Health as a classroom field placement exercise. (Field placement exercises are a required part of each school’s curriculum.)

DHS should determine, either directly or by contract, which approaches lead to a reduction in failed appointments. The Committee recommends that DHS consider conducting this study in the five counties in which dental care has been carved out of the Department’s prepaid managed care contracts. Several approaches should be tested, including:

- X reminder postcards (less effective with a highly mobile population)
- X telephone reminders (useless for those without telephones or those who lose their telephone service on a regular basis. Clinics could have a toll-free number which a patient could call from a payphone without needing money to pay for the call.)
- X public health nurses reminding their patients
- X clinic-specific approaches, e.g., with three failed appointments, no care for a year
- X requiring patients to call the day before their appointment to confirm their intent to keep the next day’s appointment. Failure to confirm would automatically result in loss of appointment with the slot to be used for someone who calls in for episodic care or is called by the clinic from a wait list.

Strategies should focus on educating the parents or the adult patient to take responsibility for keeping a dental appointment or canceling the appointment if it is known that the appointment cannot be kept.

Recommendation #8: *Eliminate income tax for dental student loan forgiveness grant*

In 2001, the Legislature began funding a dental student loan forgiveness program to encourage more newly graduated dentists to provide care to MHCP patients. Students are awarded up to

²⁵J. Babcock, unpublished clinic data, January 2000 - August 2000, Pilot City Health Care Center, Minneapolis.

²⁶Wilder Research Center, Survey of Minnesota Dentists, November 2000.

\$10,000 in loan forgiveness per year for up to four years of study in dental school. (See Section III. Program Improvements, for further information about this program.)

The Committee noted that the amount of forgiveness offered through the program may be less than optimal when compared to the average student debt upon graduation and the expected amount of service to be provided to MHCP patients. The Committee also recognized the limitations of State funding. As a means of enhancing the value of the loan forgiveness grants, the Committee recommends granting a state income tax exemption to each recipient based on the value of the loan forgiveness granted.

Recommendation #9: Reduce dental providers' administrative burden

DHS purchases MHCP dental services directly through its fee-for-service system and indirectly through managed care contracts. In order to participate in these programs, a dentist must deal with each payer's different administrative requirements. These include application, credentialing, billing and prior authorization. Dentists report that the complexity is sometimes confusing and often costly and time consuming for one- or two-person practices, thus discouraging their participation in MHCP.²⁷ The Committee recommends this burden be reduced through the adoption of one of the following recommendations.

Recommendation #9a: Develop model dental managed care contract provisions

If this recommendation were adopted, DHS would convene a workgroup of the appropriate stakeholders including, but not limited to, MDH, MDA and the health plans to develop model contract provisions that can be used by both DHS and the health plans in contracts with dental providers. A model contract would include standard language but would allow for some provider-specific variations.

The goal is simplification of MHCP participation for the dental provider. The model contract would be designed to standardize to the extent possible all contract requirements. MHCP dental contracts would be more predictable and dentists would be able to more efficiently evaluate a health plan contract.

In developing the model contract, DHS must seek to balance the interests of all stakeholders. What dentists sometimes view as an administrative burden is often seen by the health plans as a way to effectively manage patient care. Health plans must have some administrative requirements to be good stewards of the public dollar. At the same time, plans must show flexibility in trying to streamline and simplify administrative issues.

A recommended starting point for this process would be a review of all state and federal laws required in contracts, as well as those contract items which are discretionary. Research on similar efforts in other states may also be fruitful.

Recommendation # 9b: Assign all MHCP dental services to a single administrator

²⁷Ibid.

If this recommendation were adopted, DHS would adopt a singly-administered system, either contracted to a third party or directly administered by DHS. If the latter approach were taken, the model would either be based on the Department's present fee-for-service (FFS) system or a modified FFS system. Under the present FFS system there are no provider credentialing requirements (as compared to the current requirements for dental benefits administrators contracting with Medicaid managed care organizations), and payment rates are generally lower than the rates the prepaid health plans pay.

The Committee believes that there is value in the integration of dental care with health care. Because a single administrator system could potentially exclude opportunities for this integration, exemptions should be allowed for those health plans that actively provide this integration. The Committee also noted that MHCP data show that dental access has chronically been lower for FFS patients than it has for managed care enrollees.

DHS sees pros and cons in both approaches. Lead time required for a complete state carve-out would be a minimum of one year. Administrative costs may accrue to the state in setting up a system based on the capitated payment to a single dental contractor. Anecdotally, dentists report that the contracted health plans presently pay at higher rates than DHS does under its FFS system. Under a DHS-administered carve-out, some loss of participation of dentists may be expected unless DHS's rates were increased. Furthermore, DHS notes that the elimination of credentialing will have an impact on quality control. In addition, DHS sees value in the integration of health and dental care. A few managed care contractors are now applying this integration, which may be lost under a complete carve-out.

Recommendation #10: Pilot test new delivery models of dental care designed specifically to meet the needs of MHCP patients

The Committee believes that DHS's present system of purchasing and providing dental care falls short of meeting the needs of many of MHCP beneficiaries. In recent years, much has been learned about the unique needs of public programs patients. Also, many recent advances have been made in the field of dentistry in the areas of technology, staffing, purchasing and administration. The Committee recommends that DHS pilot test at least one new model of care incorporating these changes.

The Committee reviewed the State of Michigan's highly successful Medicaid dental model whereby a single, contracted administrator pays providers at market rates. The Committee noted that this model appears to have promise for Minnesota, but if adopted, costs would be expected to rise dramatically given the market-based reimbursement rates.

Another approach recommended by the Committee is the development of new care delivery processes within care delivery systems that have the capacity to approach oral health care on a population basis. One such model examined by the Committee has three general components designed to meet the needs of the individuals within the care system: urgent care, disease assessment and management, and rehabilitative therapy.

Dental care and the management of dental diseases have, with few exceptions, been provided through clinical sites with relatively small patient populations and delivery capacity. The processes for providing care and guidance that will improve oral health typically are delivered to one patient at a time and sequential. Care processes generally flow directly from data gathering to diagnosis to preventive procedures to restorative and prosthetic procedures.

The model will implement care processes based on the principals that the procedures and guidance required to manage dental disease and to reduce the risk of contracting dental disease are largely not dentist dependent. The model will attempt to fully utilize alternative care providers, educators and social workers to assist the patient to manage disease, reduce risk of acquiring disease and reduce barriers to obtaining care. Group learning and alternative care settings may be employed. Rehabilitative procedures will be recommended and implemented after management of the disease processes and associated risk factors has been accomplished to the extent possible.

Critical to this strategy is the ability to utilize collaborative agreements with dental hygienists or comparable regulatory relief. The use of dental auxiliaries for the placement of glass ionomer material as part of atraumatic restorative technique for management of disease would be helpful.

The Committee recommends that DHS test new care model(s) in limited, defined geographic areas of the state. Experts from the Committee and elsewhere should be closely consulted in developing care models. Those whom DHS authorizes to test these models should have a commitment to pursue the design of care delivery processes that are in alignment with the general care model accepted by the Committee's Purchasing/Alternative Practice Model workgroup.

DHS notes that it has already begun pursuing new care models as outlined in Section III above.

Recommendation #11: Maintain the MHCP dental benefit for children and adults

In planning to deal with the state's projected SFY 2004-2005 budget deficit, DHS created budget scenarios which included the elimination of the dental benefit for adult MHCP beneficiaries. In developing these scenarios, DHS sought Committee input. More recently, the Committee expressed its concern to DHS that all MHCP dental benefits may be vulnerable based on some of the Legislature's discussion during the first weeks of the 2003 session.

The Committee recommends careful consideration of the following:

- X Eliminating dental care will result in increased visits to the emergency room with attendant costs. In the long run, greater expenditures and an avoidable loss of dentition will result.
- X The mouth is a part of the body; oral infections can be as dangerous to one's overall health as infections in other parts of the body. Elimination of dental care will result in increased levels of infections.
- X Evidence-based research has shown that dental disease has implications for many serious medical conditions, including: diminished growth in toddlers²⁸, low birth weight,²⁹

²⁸Ayhan H., Suskan E., Yildirim S. The effect of nursing or rampant caries on height, body weight and head circumference. J Clin Pediatric Dent 1996; 20:2009-12

²⁹"Women with severe periodontal disease were 7.5 times more likely than women without periodontal disease to have an infant with preterm low birth weight." Offenbacher S, Katz V, et al.

and diabetes.^{30 31} Periodontal diseases are a risk factor for heart disease, stroke, pre-term low birth-weight babies, the regulation of blood glucose levels in diabetes and respiratory diseases. The progression of periodontal disease is adversely influenced by a number of risk factors. Screening for periodontal diseases due to the aforementioned risk factors has begun to assume the same importance in the medical community as screening for hypertension and elevated blood cholesterol.

X Elimination of this benefit will affect the quality of life and economic prospects³² of those covered by MHCP. Eating,³³ appearance, communication, and freedom from pain³⁴ will be compromised.

X Many parents of young children concurrently schedule dental visits for both themselves and their children. If adult dental care is eliminated, the parent will no longer be able to access dental services for themselves, diminishing the likelihood of their scheduling appointments for their children. In Iowa, where the adult dental benefit was eliminated in 2002, dentists report their reluctance to schedule children's appointments because dentists don't want to be put in the uncomfortable position of denying care to the parents.

X MHCP's credibility with the dental community has long been tenuous due largely to payment and administrative issues. If the State eliminates the adult dental benefit, it is sending the message that the State does not consider oral health to be important, further discouraging dentists' MHCP participation.

The Committee strongly recommends maintaining the full MHCP dental benefit for adults and children. However, if the Legislature chooses to seek cost savings in the MHCP dental program, it recommends consideration of less-costly alternatives to elimination of the entire benefit. Some alternatives are:

Periodontal infection as a possible risk factor for preterm low birth weight. *J Periodontology* 1996; 67:1103-1113.

³⁰"Researchers are finding that periodontal infection may exacerbate the diabetic condition." Grossi SG, Genco RJ. Periodontal disease and diabetes mellitus: a two-way relationship. *Ann Periodontology* 1998; 3:51-61

³¹"Treating periodontal disease with systemic antibiotics and mechanical debridement (scaling and root planing) reduced the level of glycated hemoglobin (HbA1C) in diabetics patients." Grossi SG, Skrepcinski FB, et al. Response to periodontal therapy in diabetics and smokers. *J Periodontology* 1996; 67:1094-1102

³²"Oral and craniofacial diseases and their treatment place a burden on society in the form of lost days and years of productive work." US Department of Health and Human Services, *Oral health in America: a report of the surgeon general*. Rockville MD, p.147; "...(T)here were 3.7 days of restricted activity per 100 employed persons 18 years and older reported in the US in 1996 associated with an acute dental condition...Also, for youths 5 to 17 years of age, 3.1 days of school were lost per year (per 100 school children)." *Ibid.*, p.142.

³³"Undernutrition was observed in 50 percent of geriatric patients in a U.S. long term care facility; in many cases, it was linked to eating and swallowing problems." Keller HH, *Malnutrition in institutionalized elderly: how and why?*, *J Am Geriatr Soc* 1993 Nov; 41(11): 1212-8

³⁴"Oral-facial pain, as a symptom of untreated dental and oral problems and as a condition in and of itself, is a major source of diminished quality of life. It is associated with sleep deprivation, depression and multiple adverse psychosocial outcomes." US Department of Health and Human Services, p. 147.

- X Adopt cost saving measures such as disease management techniques, more efficient dental technology and expanded use of dental auxiliary personnel.
- X Retain coverage for the most vulnerable subpopulations: persons with disabilities and nursing home residents.
- X Retain urgent care dental coverage for all adults, allowing them to obtain relief from pain and receive care for other dental emergencies for which patients would otherwise seek care in hospital emergency rooms.

Appendix A: Summary of CY 2002 Health Plan Implementation Plans for Critical Access Dental Provider Funds

| Health Plan | Allotment for CY 2002 | Implementation Plan Summary |
|-------------------------------|-----------------------|---|
| Blue Plus | \$294,673 | Payments are distributed to providers who have provided 100 or more unique visits to MHCP enrollees during 2001. 75% of payment amount is based on provider's number of unique MHCP enrollees; remainder is based on provider's dollar claim value for all MHCP enrollees. Payments disbursed as lump sums. |
| First Plan Blue | \$23,929 | Payments are distributed to providers who have provided a certain number of services to MHCP enrollees during 2001. The number is to be determined based on a claims analysis. 75% of payment amount is based on provider's number of unique MHCP enrollees; remainder is based on provider's dollar claim value for all MHCP enrollees. Payments disbursed as lump sums. |
| HealthPartners | \$128,497 | All funds are distributed to dental providers within HealthPartners' network. Funds distributed as lump sum payments. HealthPartners Group Clinics and capitated providers are not included. 55% of funds are to be distributed to DHS-identified providers based on proportion of claims paid to the provider in 2001. 45% of funds are distributed to other providers based on proportion of claims paid to provider in 2001. |
| Itasca Medical Care | \$13,956 | All network dentists are deemed critical; all funds added to the plan's dental provider risk pool. |
| Medica | \$300,855 | "Disproportionate share payments" are made once during the year. Providers are designated by services provided in 2001. Payments weighted 50% total paid to provider; 50% for unique number of enrollees served. |
| Metropolitan Health Plan | \$56,085 | Enhanced payments are distributed to providers who see the majority of the plan's enrollees. Payment is based on the number of unique payments seen in 2001 and the number of services provided. Payments are distributed as lump sums. |
| South Country Health Alliance | \$28,601 | Pay increased provider payment rates to DHS-designated providers by an amount equaling MA FFS rate + 40 percent. |
| UCare Minnesota | \$203,404 | <ol style="list-style-type: none"> 1. Pay increased provider payment rates to DHS-designated providers by an amount equaling MA FFS rate + 40 percent. 2. Financial incentives are paid to providers who currently see UCare patients and agree to accept new UCare patients. 3. Remaining funds used to offset the costs of mobile dental unit to be put into service in August 2002. |

Appendix B: Summary of DHS Dental Access Grants

| Grantee | Project summary | Geographic area | Amount of award |
|--|--|---|-----------------|
| Apple Tree Dental | Collaborate with community clinics and agencies to serve additional low income patients at Head Start centers and nursing homes by utilizing dental hygienists | N.W. Minnesota, S.W. Minnesota | \$190,000 |
| Children's Dental Services | Use mobile dental equipment to expand services to new areas | Mpls., St. Paul, inner-ring suburbs | \$45,000 |
| Lake Superior College | Institute a new volunteer community dental clinic on a MNSCU campus | N.E. Minnesota | \$115,000 |
| Mt. Olivet Rolling Acres | Start a preventive program for developmentally disabled MHCP patients using dental hygienists | Hennepin, Anoka, Carver, Scott Counties | \$42,000 |
| Olmsted County/ Salvation Army | Open a new volunteer dental clinic for underserved low income patients | Olmsted County | \$125,000 |
| Peterson & Peterson DDS | Expand and upgrade clinic facility serving low income patients | Eastside St. Paul | \$125,000 |
| Red River Valley Dental Access Project | Urgent care dental clinic staffed by volunteer dentists | 11 counties in N.W. Minnesota | \$10,000 |

Appendix C: Summary of MDH Clinical Dental Education Innovations Grants

| Grantee | Project Summary | Affiliated Educational Program | Award |
|--|---|---|-----------|
| Houston County Public Health | Use Dental, Dental Hygiene, and Dental Assisting students to staff monthly public health dental clinics at various locations, provide oral health educational presentations at schools, Head Start centers and other locations. | UM Dental School students, dental hygiene students from Rochester CTC | \$100,000 |
| Children's Dental Services | Develop/expand culturally appropriate dental assisting curriculum and provide culturally appropriate public health dental training to 125 additional dental assisting students per year. Training to be provided by Hispanic, Hmong, and Somali instructors. | MCTC and Lakeland Medical-Dental Academy Dental Assistant Programs | \$100,000 |
| MN State University, Mankato | Expand existing dental clinic at Madelia Community Hospital to serve additional patients through use of dental hygiene students, conduct 3-day sealant clinic, provide oral cancer screenings and other services to elderly at area facilities, provide outreach to underserved Hispanic/Latino populations, develop telehygiene model. | MSU Dental Hygiene Program | \$250,000 |
| University of MN/Community University Health Care Center | Establish new child-only monthly clinic at CUHCC, additional hours of dental hygiene services, additional hours of family dentistry focused on immigrants/refugees, additional endodontics hours. | Dental students and residents, dental hygiene students from UM | \$181,422 |
| Apple Tree Dental, Inc. | Develop new curricula on expanded functions for dental hygienists and new clinical opportunities for hygiene students at elementary schools and nursing homes. Upgrade of facilities to accommodate teledentistry encounters and research into effectiveness and safety of teledentistry and expanded functions. | Dental Hygiene students at Normandale Community College | \$174,722 |

Appendix D: Appointed Members of the Minnesota Department of Human Services Dental Access Advisory Committee

Karla Abdo. Ms. Abdo represents Legal Services of Northwest Minnesota, a client advocacy organization, and is secretary-treasurer for the Red River Dental Access Committee. She served on the previous Dental Access Advisory Committee.

Craig Amundson, D.D.S. Dr. Amundson is Dental Director of HealthPartners, a health plan serving public programs enrollees in 17 counties. He served on the previous Dental Access Advisory Committee.

David O. Born, Ph.D. Dr. Born is Director of the Division of Health Ecology of the University of Minnesota School of Dentistry. He was appointed to the Committee in June 2002 and had served on the previous Dental Access Advisory Committee.

Colleen Brickle, R.D.H., Ph.D. Dr. Brickle has been a dental hygienist for over 25 years, and a dental hygienist educator for over 15 years.

Amos Deinard, M.D., M.P.H. Dr. Deinard is an Associate Professor in the Department of Pediatrics at the University of Minnesota. He has served public program patients for over 32 years and served on the previous Dental Access Advisory Committee.

Richard Diercks. Mr. Diercks is the Executive Director of the Minnesota Dental Association. He served on the previous Dental Access Advisory Committee, and is a member of Minnesota's National Governors' Association Oral Health Policy Academy Team.

Carl Ebert, D.D.S. Dr. Ebert is Vice President of Apple Tree Dental, a nonprofit organization that provides care to special needs populations in the Metro area and in northwestern Minnesota. He served on the previous Dental Access Advisory Committee.

Michael T. Flynn, D.D.S. Dr. Flynn has had a private dental practice in Winona since 1979. He represents outstate dentists on the Committee.

Sheila Fuchs. Ms. Fuchs is the Government Programs Administrator for Delta Dental of Minnesota, which administers benefits for over 200,000 public programs patients.

Patricia H. Glasrud, R.D.H., M.P.H. Ms. Glasrud is Assistant to the Dean, University of Minnesota School of Dentistry. She served on the previous Dental Access Advisory Committee while she was Executive Director of the Minnesota Board of Dentistry.

Linda Grupa, R.N., B.S.N. Ms. Grupa is the Public Health Director for Houston County. For the past four years she has been actively involved in an 11 county effort to improve dental access. She represents county public health on the Committee.

Deborah Jacobi, R.D.H., M.A. Ms. Jacobi has been a dental hygienist for 23 years. She presently works in a Minneapolis health clinic which serves uninsured low income persons. She represents the Minnesota Association for Community Dentistry.

Sharon James, R.D.H. Ms. James works as a dental hygienist for Hennepin Care South, a county-run clinic serving a large diverse population of public programs patients.

Robert W. Jones, D.D.S. Dr. Jones practices general dentistry in St. Paul and sees a large population of MHCP patients. He represents metro area general dentists on the Committee.

Clare Larkin, R.D.H. Ms. Larkin practices dental hygiene at a University outreach clinic in Minneapolis and at a private dental office in outstate Minnesota. She was employed as an oral health educator for Goodhue and Wabasha counties until the position was eliminated.

Jean O. Lundgren, M.D. Dr. Lundgren, of Eden Prairie, has been a practicing family physician for over 20 years. She is presently working on setting up a medical/dental clinic to serve needy patients.

Kathy McDonough. Ms. McDonough is a Staff Attorney at the Legal Services Advocacy Project, Minneapolis. She serves many low income and people with disabilities who are having trouble accessing dental care. She served on the previous Dental Access Advisory Committee.

Charles Neil, R.N., P.H.N. Mr. Neil is the Health Manager for Arrowhead Head Start in Virginia, and has been active locally on dental access issues since 1996. A member of the previous Dental Access Advisory Committee, he represents the state's Head Start programs.

Vacharee Peterson, D.D.S. Dr. Peterson operates a dental clinic in St. Paul which serves a large number of racially and ethnically diverse public programs patients. She served on the previous Dental Access Advisory Committee.

Mildred Roesch, R.D.H., M.P.H. Ms. Roesch is State Dental Coordinator at the Minnesota Department of Health. She represents the Commissioner of Health, as she had on the previous Dental Access Advisory Committee.

Dan Rose, D.D.S. Dr. Rose is director of extramural programs at the University of Minnesota School of Dentistry. A previous Committee member, he has developed outreach programs to many rural areas of the state.

Mary Ryan. Ms. Ryan is Public Affairs Director for UCare Minnesota, a health plan serving public programs patients in most areas of the state. She represents the Minnesota Council of Health Plans on the Committee.

Mark Schoenbaum. Mr. Schoenbaum is Planning Grants Administrator for the Minnesota Department of Health, Office of Rural Health and Primary Care. He represents the Commissioner of Health, as he had done on the previous Committee.

Karl Self, D.D.S., M.B.A. Dr. Self is the Executive Director of the Community University Health Care Clinic which serves a large, diverse low income population in Minneapolis. He represents the Minnesota Primary Care Association, of which he is a board member.

Daniel Shaw, D.D.S. Dr. Shaw has a private pediatric dentistry practice in Minnetonka. He has treated public programs patients for over 25 years and is past president of the Minnesota Dental Association. He represents pediatric dentists on the Committee.

Marshall Shragg, M.P.H. Mr. Shragg is Executive Director of the Minnesota Board of Dentistry.

Rose Stokke, D.H. Ms. Stokke is a practicing dental hygienist in Owatonna and is immediate past president of the Minnesota Dental Hygienists' Association. She represents the Association, as she had on the previous Committee.

Richard Weisbecker, D.D.S. Dr. Weisbecker practices oral surgery in South St. Paul, and is currently president of the Minnesota Society of Oral and Maxillofacial Surgeons. He represents oral surgeons on the Committee.

Colleen Wieck, Ph.D. Dr. Weick is Executive Director of the Governor's Council on Disabilities. She was appointed to the Committee in July 2002.

Sarah Wovcha, J.D., M.P.H. Ms. Wovcha is Executive Director of Children's Dental Services, a nonprofit dental clinic in Minneapolis serving low income children and pregnant women.

Denis Zack, D.D.S., M.P.H. Dr. Zack has over 30 years experience in public health, including directorships of Children's Dental Services and the Minneapolis Health Department's dental program.

Appendix E. Suggested measures to evaluate the effectiveness of dental access improvement initiatives passed in 2001

Payment rate increase for children's x-rays and exams (*Minnesota Statutes, Section 259B.69*)

- X How did expenditures for these services differ before and after this legislative change?
- X Did more children get their teeth x-rayed and examined?
- X What percentage of children's x-rays was provided for emergency or urgent care needs as opposed to routine check-ups?
- X How much disease was detected through these services and how much of that disease was later treated?
- X Did these services result in children receiving needed care? Or, were x-rays and exams performed *without* follow-up care?

Payment rate increases for critical access dental providers (*Minnesota Statutes, Section 259B.69*)

- X Did the increased payment rate result in more services being provided to more patients?
- X Or, were more services being provided to the same number of patients?
- X Or, was a different "mix" or type of services being provided?

Convening a DHS Dental Access Advisory Committee (*Minnesota Statutes, Section 256B.55*)

- X How many meetings were held and at what cost?
- X What did the Advisory Committee recommend? What recommendations were implemented?
- X Were the recommendations made by the Advisory Committee consistent with the statutory mandate given to the Committee?
- X Should the membership be expanded to include higher level decision-makers? Would a different committee membership result in recommendations that have a greater likelihood of resulting in more effective legislation, i.e., legislation that can produce change more rapidly, more cost-effectively?

Discussion: Higher level decision-makers may be able to effect significant changes within their own organizations/agencies that do not require legislative mandates.

Expanded authorization for dental hygienists (*Minnesota Statutes, Section 150A.10*)

- X How many "qualifying entities" (as defined in the law) report having used the services of dental hygienists under collaborative agreements?
- X How many services were provided to how many patients as a direct result of services being rendered under a collaborative agreement?
- X How many patients, if any, were "harmed" as a result of a hygiene service being rendered through a collaborative agreement? [NOTE: This is a necessary and objective question, not intended to mean that harm *will* result.]
[NOTE: These questions should be asked of dental hygienists and dentists. Surveying both groups would serve to educate hygienists and dentists about the new law that allows collaborative agreements.]

Expanded duties for dental auxiliary personnel (*Minnesota Statutes, Section 150A.10*)

- I. What educational requirements have been established by the Board of Dentistry through consultation with the U of M School of Dentistry and MnSCU schools that offer dental auxiliary training programs?
- II. What is the Board of Dentistry's time line on rulemaking for these expanded duties?
- III. How many dental auxiliaries choose to receive necessary training in order to perform the new duties? How many of them choose to practice in under-served areas?
- IV. How many dentists choose to delegate these new duties to appropriately trained auxiliaries?
- V. What is the effect on the productivity of those practices that choose to delegate the expanded duties to their auxiliaries?
- VI. How many more patients on public assistance programs received care because they were treated in a practice where this type of expanded duty auxiliary was employed?
- VII. How many patients, if any, were "harmed" as a result of receiving this type of care from a dental auxiliary? [NOTE: This is a necessary objective question that does not assume that harm *will* result.]

Licensure of foreign-trained dentists (*Laws of Minnesota 2001, First Special Session Chapter 9, section 71*)

- I. What is the status and time line on proposed Board of Dentistry rules related to licensure of foreign-trained dentists?
- II. How many foreign-trained dentists applied for Minnesota licensure—and of those who applied, how many actually were granted licensure?
- III. Did the foreign-trained dentists who received Minnesota licensure establish practice in under-served areas? Did they remain in Minnesota to practice? [NOTE: Minnesota's new law could be viewed as creating a "gateway" to licensure by other states: a dentist who possesses a dental license in one state typically is more easily licensed through the credentialing process by other states.]

Retired dentist program (*Minnesota Statutes, Section 256.958*)

- I. How many dentists participated in this program? Over time, do more (or fewer) dentists choose to take advantage of this opportunity?
- II. How many hours of service were provided through this program?
- III. In which parts of the state were services provided under this program?
- IV. What does this program cost the State annually?
- V. Do certain locations or population types, e.g., people with disabilities, children, the elderly, or various ethnic groups, seem to attract more of this type of volunteer service? If so, which one and why?

Volunteered services considered toward Rule 101 participation agreement (*Minnesota Statutes, Section 256B.0644*)

- I. In general, how has “Rule 101” affected the participation rate of dentists in state health programs?
- II. Of those participating dentists, how many report having provided voluntary services? Where? To how many patients?
- III. What percentage of overall billings for state program patients was provided on a volunteer basis?

Dental practice donation program (*Minnesota Statutes, Section 256.959*)

- I. How many inquiries were received by DHS about this program from dentists interested in donating their practice?
- II. How many inquiries were received by DHS about this program from dentists or dental students who wanted to assume operation of a donated practice?
- III. What volume of service to MHCP patients was provided?

Dental access grants (*Minnesota Statutes, Section 256B.53*)

- I. What kinds of projects were funded by these grants?
- II. In what parts of the state were the projects located?
- III. How many more patients—and how many new patients--did the receiving organization treat?
- IV. Did the “mix” of services rendered change after receiving the grant? If so, in what way?

Community clinic expansion grants (*Minnesota Statutes, Section 145.9268*)

- I. How many grants were made for dental projects and at what cost?
- II. Did the clinic expansion result in more public assistance patients receiving treatment?
- III. Did the clinic expansion result in shorter waiting times for patients to receive treatment?

Dental access grants to teaching institutions and clinical training sites (*Minnesota Statutes, Section 62J.692*)

- I. How many grants were made for dental projects and at what cost?
- II. Did the clinic expansion result in more public assistance patients receiving treatment?
- III. Did the clinic expansion result in shorter waiting times for patients to receive treatment?
- IV. Did students who received training in the site later choose to practice in an underserved area or treat public assistance patients in their practice (regardless of location)?

Appendix F. Recommended amendments to legislation authorizing collaborative agreements (Recommendation #1)

Minnesota Statutes, Chapter 150A.10 Allied dental personnel

Subdivision 1. **Dental hygienists.** Any licensed dentist, public institution, or school authority may obtain services from a licensed dental hygienist. Such licensed dental hygienist may provide those services defined in Section 150A.05, subdivision 1a. Such services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Such services shall be provided under supervision of a licensed dentist. Any licensed dentist who shall permit any dental service by a dental hygienist other than those authorized by the board of dentistry, shall be deemed to be violating the provisions of sections 150A.01 to 150A.12, and any such unauthorized dental service by a dental hygienist shall constitute a violation of sections 150A.01 to 150A.12.

Subd. 1a. **Limited authorization for dental hygienists.**

(a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care ~~facility~~ program, school authority, Head Start program, or non-profit organization that serves individuals who are uninsured or who are Minnesota Health Care Program recipients to perform dental hygiene services described under paragraph (b) without the patient first being examined by a licensed dentist if the dental hygienist:

~~(1) has two years practical clinical experience with a licensed dentist within the preceding five years; has been engaged in the active practice of clinical dental hygiene for not less than 2400 hours in the past eighteen months OR a career total of 3000 hours including a minimum of 200 hours of clinical practice in two of the past three years; and~~

(2) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist;

~~(3) has documented participation in courses in infection control and medical emergencies within one's current continuing education cycle, and~~

~~(4) has completed within the past two years an advanced or basic cardiac life support course recognized by the American Heart Association, the American Red Cross, or another agency whose courses are equivalent to the American Heart Association or American Red Cross courses.~~

(b) The dental hygiene services authorized to be performed by a dental hygienist under this subdivision are limited to oral health promotion/disease prevention education, removal of deposits and stains from the surfaces of the teeth, application of topical preventive or prophylactic agents including fluoride varnishes, application of pit and fissure sealants, polishing and smoothing restorations, removal of marginal overhangs, performance of preliminary charting, taking of radiographs, and performance of root planing. ~~and soft-tissue curettage. The dental hygienist shall not place pit and fissure~~

~~sealants, unless the patient has been recently examined and the treatment planned by a licensed dentist.~~ The dental hygienist shall not perform injections of anesthetic agents or the administration of nitrous oxide unless under the indirect supervision of a licensed dentist. Collaborating dental hygienists may work with unregistered and registered dental assistants who may perform duties for which registration is not required. The performance of dental hygiene services in a ~~health-care~~ facility, program or non-profit organization is limited to patients, students, and residents of the facility, program or organization.

(c) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with no more than four dental hygienists unless otherwise allowed by the board. The collaborative agreement must include:

(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services;

(2) age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by or a referral to a dentist should occur; and

(3) copies of consent to treatment and referral forms, which must include a statement advising that dental hygiene services do not substitute for a complete dental examination by a dentist. The collaborative agreement must be signed and maintained by the dentist, and the dental hygienist, and the facility, program or organization; must be reviewed and updated annually, and must be made available to the board upon request;

(d) For the purposes of this subdivision, a "health care ~~facility~~ program" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local public health facility, community clinic, or tribal clinic.

(e) For purposes of this subdivision, a "collaborative agreement" means a written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services authorized under this subdivision and the collaborative agreement may be performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan, unless specified in the collaborative agreement.

Appendix G. Recommended amendments to expedite the expansion of duties for registered dental assistants and dental hygienists (Recommendation #2)

Minnesota Statutes, Chapter 150A.10. Allied dental personnel.

Subd. 1b. Restorative procedures for dental hygienists.

A licensed dental hygienist who has successfully completed a board-approved course in the following restorative procedures may perform the following procedures if a dentist is in the clinic, authorizes the procedures, and remains in the clinic while the procedures are being performed:

- A. place, contour, and adjust amalgam restorations;
- B. place, contour, and adjust glass ionomer and preventive resin restorations; and
- C. adapt and cement stainless steel crowns.

Subd. 2. Dental assistants.

Every licensed dentist who uses the services of any unlicensed person for the purpose of assistance in the practice of dentistry shall be responsible for the acts of such unlicensed person while engaged in such assistance. Such dentist shall permit such unlicensed assistant to perform only those acts which are authorized to be delegated to unlicensed assistants by the board of dentistry. Such acts shall be performed under supervision of a licensed dentist. The board may permit differing levels of dental assistance based upon recognized educational standards, approved by the board, for the training of dental assistants. The board may also define by rule the scope of practice of registered and nonregistered dental assistants. The board by rule may require continuing education for differing levels of dental assistants, as a condition to their registration or authority to perform their authorized duties. Any licensed dentist who shall permit such unlicensed assistant to perform any dental service other than that authorized by the board shall be deemed to be enabling an unlicensed person to practice dentistry, and commission of such an act by such unlicensed assistant shall constitute a violation of sections 150A.01 to 150A.12.

Subd. 2a. Restorative procedures for dental assistants.

A registered dental assistant who has successfully completed a board-approved course in the following restorative functions may perform the following restorative procedures if a dentist is in the clinic, authorizes the procedures, and remains in the clinic while the procedures are being performed:

- A. place, contour, and adjust amalgam restorations;
- B. place, contour, and adjust glass ionomer and preventive resin restorations; and
- C. adapt and cement stainless steel crowns.

Subd. 3. Dental technicians. Every licensed dentist who uses the services of any unlicensed person, other than under the dentist's supervision and within such dentist's own office, for the purpose of constructing, altering, repairing or duplicating any denture, partial denture, crown, bridge, splint, orthodontic, prosthetic or other dental appliance,

shall be required to furnish such unlicensed person with a written work order in such form as shall be prescribed by the rules of the board; said work order shall be made in duplicate form, a duplicate copy to be retained in a permanent file in the dentist's office for a period of two years, and the original to be retained in a permanent file for a period of two years by such unlicensed person in that person's place of business. Such permanent file of work orders to be kept by such dentist or by such unlicensed person shall be open to inspection at any reasonable time by the board or its duly constituted agent.