DEPARTMENT OF HUMAN SERVICES

Legislative Report

Analysis of State Medicaid Dental Programs and Dental Provider Hesitancy

Purchasing and Service Delivery

April 6, 2022

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $30,000.

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Contents

I. Executive Summary

Access to dental care has historically been a major problem in Minnesota for individuals enrolled in public programs. The 2021 Minnesota Legislature directed the Department of Human Services (DHS) to conduct a review of Medicaid dental program delivery systems in states that have enacted and implemented a "carve out" dental delivery system. The legislation also directed DHS to conduct an analysis of dental provider hesitancy to participate in the Medical Assistance (MA) program as an enrolled provider. DHS contracted with Health Management Associates (HMA) to conduct the analyses mandated in the legislation. HMA reviewed the Medicaid dental program delivery systems in states that have implemented a carve-out dental delivery system, including comparing state program designs, program costs and rates where available, and quality metrics for children one through 20 years of age with at least one preventive dental service within a year. HMA also surveyed dental providers to better understand hesitancy to participate in Medicaid and opinions on policy approaches to improve provider participation.

Based on their analysis of state dental carve out experiences and the dental provider survey results, HMA's assessment is that:

- Minnesota could use any of the carve-out dental delivery models and make progress toward its oral health goals. The analysis compared a variety of program elements and found no correlation between a particular carve-out dental delivery structure and quality and cost outcomes.

- Reimbursement is the top issue driving dental provider hesitancy to participate in medical assistance and MinnesotaCare programs, but other factors also create hesitancy including lack of capacity to take on new patients, multiple prior authorization processes, and inadequate care coordination.

- A carve-out model, as envisioned by the Minnesota legislature, includes a variety of elements that can address some provider hesitancy factors.

    - **Prior Authorization.** Under an Administrative Services Only (ASO) carve-out, providers would only have one administrator to work with and one set of prior authorization policies and procedures. Under a Prepaid Ambulatory Health Plan (PAHP) carve-out, the state could limit the number of dental plans to two.

    - **Care Coordination.** Under either an ASO or PAHP dental carve-out, DHS can include contractual provisions for care coordination ranging from assisting eligibles in finding dental providers, to coordinating care between dental providers and other providers and services such as sedation and medical services with a dependency related to dental services.

- DHS can include the same dental benefit management requirements in carve-in managed care organization (MCO) arrangement, ASO carve-out arrangements, and PAHP carve-out arrangements. There are different contract monitoring enforcement and accountability burdens on the state associated with each of these models. With a carve-in model, focus on dental as part of an overall MCO oversight program can be diluted either because of the larger scope of the contracts, or the fact that in most cases there is a dental subcontractor that is generally removed from direct involvement with the state

Medicaid agency. In a carve-out model, DHS would have a separate contract oversight mechanism dedicated to dental. This may require additional state resources and may yield better outcomes as a result of focus and attention by both the state and the contracted entity.

- A change from the current dental carve-in model to a carve-out model will require stakeholder education, including with the dental provider community. The provider survey indicated that dentists in Minnesota are not generally familiar with the meanings of the terms ASO or dental benefit administrator.

II. Legislative mandate

Laws of Minnesota 2021, 1st Special Session, Chapter 7, Article 1, Section 37:

Sec. 37. **DENTAL PROGRAM DELIVERY STUDY**.

(a) The commissioner of human services shall review the Medicaid dental program delivery systems in states that have enacted and implemented a carve out dental delivery system. At a minimum, the review must compare in those states program design, provider rates, program costs, including administrative costs, and quality metrics for children one through 20 years of age with at least one preventive dental service within a year.

(b) The commissioner, in consultation with interested stakeholders, shall also conduct an analysis of dental provider hesitancy to participate in the medical assistance program as an enrolled provider.

(c) By February 1, 2022, the commissioner shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance the results of the review and analysis described in this section. The commissioner may combine the requirements in this section with the dental home demonstration project report due on February 1, 2022.

III. Health Management Associates (HMA) Report

The HMA report follows this summary.

HMA

HEALTH MANAGEMENT ASSOCIATES

Evaluation of State Medicaid Dental Programs

PREPARED FOR
MINNESOTA LEGISLATURE

BY:
HMA

FEBRUARY 2022

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

The Minnesota Department of Human Services (DHS) engaged Health Management Associates to develop an Evaluation of State Medicaid Dental Programs report to satisfy the requirement that DHS submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. This report provides the results of a review of state Medicaid "carve-out" dental delivery systems and an analysis of dental provider hesitancy to participate in the medical assistance program as an enrolled provider. This report was mandated in the context of the State of Minnesota making significant investments in increasing access to dental care for children and adults eligible for medical assistance, and the establishment of dental access performance benchmarks for medical assistance and MinnesotaCare managed care plans and county-based purchasing plans. The new law creates a dental "carve-out" trigger if medical assistance and MinnesotaCare managed care plans and county-based purchasing plans do not, in the aggregate, meet the 2024 dental access performance benchmark.

Minnesota medical assistance and MinnesotaCare currently use a dental "carve-in" model wherein the State's contracted managed care organizations (MCOs) and county-based purchasing plans are responsible for delivering a comprehensive benefit package including dental services. Currently, five of Minnesota's eight contracted medical assistance and MinnesotaCare MCOs subcontract with a dental benefit management organization to manage dental benefits, while the other three manage the dental benefit themselves. In the dental carve-out scenario included in the new legislation, should the MCOs and county-based purchasing plans not meet the 2024 dental access performance benchmarks, the State would exclude dental services from the MCO and county-based purchasing plan contracts, and contract separately with a dental administrator to administer dental benefits.

States administer dental carve-outs in a variety of ways. Some states contract with one or more at-risk dental management organizations to perform as a Prepaid Ambulatory Health Plan (PAHP), such as Florida and Texas. In other states, such as Colorado, the State Medicaid Agency contracts with an entity to perform as an Administrative Service Only (ASO) contractor to manage the Medicaid dental carve-out benefit via fee-for-service.

HMA reviewed the Medicaid dental program delivery systems in states that have implemented a carve-out dental delivery system, including comparing state program designs, program costs and rates where available, and quality metrics for children one through 20 years of age with at least one preventive dental service within a year. We also surveyed dental providers to better understand hesitancy to participate in Medicaid and opinions on policy approaches to improve provider participation.

Based on our analysis of state dental carve-out experiences and our dental provider survey results, HMA's assessment is that:

- Minnesota could use any of the carve-out dental delivery models and make progress toward its oral health goals. Our analysis compared a variety of program elements and found no correlation between a particular carve-out dental delivery structure and quality and cost outcomes.

- Reimbursement is the top issue driving dental provider hesitancy to participate in medical assistance and MinnesotaCare programs, but other factors also create hesitancy including lack of capacity to take on new patients, multiple prior authorization processes, and inadequate care coordination.
- A carve-out model, as envisioned by the Minnesota legislature, includes a variety of elements that can address some provider hesitancy factors.
    - **Prior Authorization.** Under an ASO carve-out, providers would only have one administrator to work with and one set of prior authorization policies and procedures. Under a PAHP carve-out, the state could limit the number of dental plans to two.
    - **Care Coordination.** Under either an ASO or PAHP dental carve-out, DHS can include contractual provisions for care coordination ranging from assisting eligibles in finding dental providers, to coordinating care between dental providers and other providers and services such as sedation and medical services with a dependency related to dental services.
- DHS can include the same dental benefit management requirements in carve-in MCO arrangement, ASO carve-out arrangements, and PAHP carve-out arrangements. There are different contract monitoring enforcement and accountability burdens on the state associated with each of these models. With a carve-in model, focus on dental as part of an overall MCO oversight program can be diluted either because of the larger scope of the contracts, or the fact that in most cases there is a dental subcontractor that is generally removed from direct involvement with the state Medicaid agency. In a carve-out model, DHS would have a separate contract oversight mechanism dedicated to dental. This may require additional state resources and may yield better outcomes as a result of focus and attention by both the state and the contracted entity.
- A change from the current dental carve-in model to a carve-out model will require stakeholder education, including with the dental provider community. The provider survey indicated that dentists in Minnesota are not generally familiar with the meanings of the terms ASO or dental benefit administrator.

50-State Review of Medicaid Dental Delivery Systems

HMA completed a 50-state plus the District of Columbia review of Medicaid dental delivery systems to categorize them as requested in the Minnesota Department of Human Services' request for proposals (RFP). Completion of this review was a predecessor to completing analysis of the states with dental delivery systems other than "Integrated delivery systems." The categories identified in the RFP included:

- **Integrated delivery systems.** Integrated delivery systems states include states that operate their Medicaid dental benefit delivery in the same fashion as they operate their other primary Medicaid medical benefit delivery. These states may operate a comprehensive Medicaid managed care program where the states' contracted Medicaid Managed Care Organizations (MCOs) are responsible for administering medical and dental benefits under a risk-based arrangement. These states are commonly referred to as dental carve-in states. Alternatively, a state may operate both its medical and dental benefits under a fee-for-service (FFS) model. In a FFS model, participating Medicaid providers, including dentists, are reimbursed directly by the state for each unit of dental services they provide to Medicaid enrollees. Minnesota Medicaid currently operates an integrated delivery system and is a dental carve-in state.
- **Carve-out to state management.** Carve-out to state management states exclude Medicaid dental services from Medicaid MCO contracts and provide dental benefits through the state's

FFS program. These states may administer the Medicaid dental FFS benefit themselves or through their contracted Medicaid fiscal intermediary. In these cases, we refer to the state as a dental carve-out state with state administered FFS. Alternatively, a state may establish a non-risk-based contract with a dental benefit administrator (DBA) to administer the dental benefit on a FFS basis on the state's behalf. In such cases, the DBA usually receives an administrative payment per member per month (PMPM) for their administrative services. In return the DBA develops and maintains a dental provider network; performs utilization management, provider services, member services, program integrity functions, and other services identified in their contract; and processes and pays dental provider claims. The State Medicaid Agency reimburses the DBA for claims payment based on the DBA's submission of dental encounters. In these cases, we refer to the state as a dental carve-out to an Administrative Services Only (ASO) contract.

- **Carve-out to contracted management.** Carve-out to contracted management states exclude Medicaid dental benefits from Medicaid MCO contracts and provide them through one or more dental managed care contracts for all Medicaid enrollees in the state. Dental managed care contracts, like Medicaid MCO contracts, include risk-based payments to the contractor for provision of all administrative services and for management of the dental benefit. The State Medicaid Agency pays the contractor an actuarially sound per member month capitation. The contractor is responsible for managing the Medicaid dental benefit inclusive of administrative services and claims and is motivated to do so within its aggregate capitation payment for the population. In these cases, we refer to the state as a dental carve-out to a Prepaid Ambulatory Health Plan (PAHP). A PAHP is one of the Medicaid managed care delivery vehicles defined at 42 CFR 438.2 and refers to entities that provide services on the basis of capitation, do not provide or cover inpatient hospital or institutional services, and cover a limited service such as dental rather than comprehensive services.
- **Other Non-Integrated Models.** Other non-integrated models would include any state dental delivery model that does not fall into one of the above categories.

HMA used publicly available data sources to complete its review and create an inventory. These sources include State Medicaid Agency websites, RFPs, dental ASO and PAHP contracts, data and reports; and other publicly available information about states' Medicaid programs to complete the 50-state plus the District of Columbia review. Some of the sources are housed in our own HMA Information Services portal, a subscription service where we accumulate state RFPs including those for Medicaid MCOs, Dental PAHPs, and Dental ASOs; state data and reports; and calendars for state Medicaid MCO and Dental RFP activities and outcomes.

The resulting inventory documents for each state and the District of Columbia:

- The state's "Minnesota RFP Category"
- The state's Medicaid dental contracting model—the subcategory within the Minnesota RFP Category
- The state's contracted dental vendor if applicable
- The state's status for Adult Medicaid expansion under the Patient Protection and Affordable Care Act
- The state's Medicaid enrollment, including total enrollment, Children's Health Insurance Program (CHIP) enrolment, total Medicaid and CHIP enrollment, and Medicaid Child and CHIP enrollment
- Notes where appropriate

- Designation of whether the state's Medicaid dental delivery system will be included in subsequent analysis

Summary of Dental Delivery Systems in Medicaid

Attachment 1 includes the full 50-state plus the District of Columbia inventory. And Table 1 below summarizes the inventory.

Table 1: SUMMARY OF STATE MEDICAID DENTAL DELIVERY SYSTEMS

MN RFP Category	Medicaid Dental Delivery System	No of States	States
Integrated	State Administered FFS	9	AL, AK, ME, MT, NH, ND, OK, VT, WY
Integrated	MCO Carve-In	18	AZ, DC, GA, IL, IN, KS, KY, MN, MS, MO, NJ, NM, NY, OH, OR, PA, WV, WI
Integrated	Dental ASO	2	CT, SD
MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	8	CA, CO, HI, MD, MA, SC, TN, VA
MCO Carve-Out to Dental FFS	MCO Carve-out: State Administered FFS	3	DE, NC, WA
MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	8	FL, IA, LA, MI, NE, RI, TX, UT
Other Non-Integrated	Dental PAHP	2	AR, ID
Other Non-Integrated	Hybrid	1	NV

Analysis of Non-Integrated Dental Programs

From the 50-State plus District of Columbia Medicaid Dental Delivery inventory, we identified 22 states that operate their Medicaid dental programs using one of the three non-Integrated categories. We completed additional research and analysis on 20 of these 22 states to assess whether various program elements were influential in the state's decision of their Medicaid dental delivery model, and whether different dental delivery models drive different outcomes.

HMA excluded two non-integrated states from subsequent analysis: California and Hawaii. Each of these states carves the dental benefit out of its Medicaid managed care contracts and contracts with a dental ASO to manage dental benefits under a fee-for-service model. We excluded California based on its Medicaid enrollment of 11,514,302 which exceeds Minnesota's Medicaid enrollment of 1,212,920 by over 10 million enrollees. The sheer size of the program paired with other facts about California's Medicaid program, Medi-Cal, make it a poor point of comparison or reference for this analysis. We also excluded Hawaii. This exclusion was based on the geographic realties of the state that make it, also, a poor point of comparison or reference for this analysis.

Our research and analysis included elements specified in the RFP, and additional elements that HMA determined may provide insight into selection of a dental delivery model, or outcomes of a state's Medicaid dental program. Table 2 identifies the elements included in researching each of the 20 targeted non-Integrated states.

Table 2: RESEARCH ELEMENTS FOR NON-INTEGRATED MEDICAID DENTAL DELIVERY STATES

Research and Analysis Elements from RFP	Additional Research and Analysis Elements
■ Program design ■ Administrative control ■ Care management ■ Provider rates ■ Program costs, including administrative costs ■ Quality metrics for children one through 20 years of age and adults ages 21 and older, with at least one preventive dental service within a year	■ Other benefit carve-outs ■ CHIP Model ■ Quality Withholds ■ Adult dental benefits ■ Pregnancy dental benefits ■ Other population benefits ■ Dental providers ■ Dental providers per capita

We created a profile for each of the 20 targeted non-Integrated states documenting the results of our research. We provide these state profiles in Attachment 2.

Findings from Analysis of State Dental Delivery Profiles

We analyzed the information collected in the State Dental Delivery Profiles to identify trends, variations, and other findings that may serve as a valuable reference point for the Minnesota legislature and Department of Human Services comparing characteristics of non-integrated states and Minnesota to assess the potential benefits and risks of different models for implementation in Minnesota. Below we present several of these comparisons and conclude this report section with our assessment of the overall analysis's findings with regard to dental delivery model options for Minnesota.

Medicaid Enrollment Does Not Appear to Drive States' Dental Delivery Model

HMA analyzed whether Medicaid enrollment effects states' non-integrated dental delivery model. Appendix B lists the 20 research states in order from smallest to largest enrollment. Our observations related to Medicaid enrollment include:

- The three states with the largest enrollment all use a dental managed care model (TX, FL, MI)
- The next two largest states, though both currently self-administering dental under a fee-for-service model, have demonstrated some interest in a dental managed care model:
    - In North Carolina, Senate Bill 61 was introduced to the General Assembly of North Carolina's 2021-2022 Session. The bill seeks to require the state to enter capitated contracts with at least two PAHPs for the provision of dental services to Medicaid recipients. The bill passed its first reading and was referred to the Committee on Rules and Operations. No action has occurred on the bill since 2/9/2021.
    - Washington planned to implement a managed care dental program for Medicaid eligibles beginning January 1, 2019, and selected dental plans (Amerigroup (Anthem), Dentegra, and MCNA) based on a competitive procurement process. Subsequent to award, the state delayed implementation and then the 2019 State Legislature directed

the Washington State Health Care Authority to continue to administer Medicaid through fee-for-service.

- States with between approximately 1 million and 1.5 million Medicaid enrollees use a carve-out to a dental ASO.
- Of the three states with the smallest enrollment, two use a managed dental model (NE, RI) but each of these has a waiver from the Centers for Medicare and Medicaid services allowing them to offer only one plan option. Without the waiver, these states would be required to contract with two managed dental plans, and the level of enrollment would likely be insufficient to split between two vendors to bear the financial risk.

Because not all states offer an adult Medicaid benefit, another view of dental model relative to enrollment is Medicaid Child and CHIP enrollment. Appendix C lists the 20 research states in order from smallest to largest Medicaid Child and CHIP enrollment.

- Texas and Florida remain the largest enrollment and use of dental managed care
- The eight States with child enrollment between 600K and 900K predominantly use the ASO fee-for-service model (with the exceptions of LA, and WA)

State's Medicaid Dental Delivery System Alone Does Not Appear to Drive Child Utilization

Table 3 and 4 show utilization of dental services by EPSDT eligible children from Federal Fiscal Year 2015 through Federal Fiscal Year 2020. Table 3 provides the percent of all EPSDT eligible children in the state who had any dental service in the year, and Table 4 provides the percent of all EPSDT eligible children in the state that had a preventive dental service in the year using data from the CMS 416. Form CMS-416 is used by CMS to collect basic information on State Medicaid and CHIP programs to assess the effectiveness of EPSDT services. Percentages in green font represent an increase from the prior year, and percentages in red font represent a decrease from the prior year.

- Texas' child dental utilization rates are significantly higher than even the next highest state (WA), though there is no correlation to dental model. Their utilization rates were already well above other states in 2015, and still increased annually from 2015 through 2018 with a slight dip in 2019, and a significant dip in 2020 as was experienced by all states as a reflection of decreased utilization during the first year of the COVID-19 pandemic.
- Though Washington's utilization rates are second highest of the 20 research states, and with only 2019 and 2020 as exception to dental utilization increases year over year, the overall increase in utilization from 2015 to 2019 were modest, equaling a .66% increase in utilization of any dental service, and a .3% increase in utilization of preventive services
- The five states with the highest utilization of preventive services in 2019 (TX, WA, MD, CO, UT) represent all three carve-out dental models
- The four states that experienced an overall decrease in dental utilization from 2015 to 2019 (NE, TN, AR, MA) represent two models (ASO and PAHP) and a hybrid model
- Florida, a PAHP carve-out state, achieved the highest increase in both utilization measures from 2015 to 2019, 6.22% and 6.7% increases, and their actual utilization rate increased each year. The state remains, however, with the second lowest utilization rates of the 20 research states.

Table 3: UTILIZATION OF DENTAL SERVICES BY EPSDT ELIGIBLE CHILDREN, FEDERAL FISCAL YEAR 2015-2019 – % EPSDT Eligibles Receive Any Dental Service

State	2015	2016	2017	2018	2019	Dental Model
TX	58.33%	60.71%	62.33%	62.74%	62.06%	PAHP
WA	56.09%	56.15%	56.53%	56.58%	56.75%	State Administered FFS
MD	52.88%	52.92%	55.45%	55.18%	56.34%	ASO-FFS
UT	45.28%	45.26%	43.37%	45.97%	46.61%	PAHP
CO	49.33%	50.84%	51.33%	51.07%	52.23%	ASO-FFS
NC	48.33%	48.68%	49.25%	49.60%	50.12%	State Administered FFS
VA	47.00%	47.33%	49.90%	50.26%	49.11%	ASO-FFS
SC	47.06%	46.36%	47.48%	47.78%	48.74%	ASO-FFS
IA	48.21%	48.59%	50.09%	49.95%	49.83%	PAHP
NE	50.07%	50.47%	50.93%	50.34%	47.61%	PAHP
ID	45.51%	57.46%	60.77%	47.72%	49.00%	PAHP
LA	46.53%	46.17%	48.45%	49.19%	49.09%	PAHP
MA	50.12%	50.51%	50.71%	52.07%	47.29%	ASO-FFS
RI	44.74%	48.34%	48.25%	47.59%	49.28%	PAHP
AR	48.74%	46.85%	46.74%	38.28%	46.88%	PAHP
TN	47.98%	47.77%	46.16%	45.31%	47.43%	ASO-FFS
DE	45.37%	46.02%	39.82%	45.33%	46.31%	State Administered FFS
MI	36.66%	40.88%	42.57%	40.04%	38.82%	PAHP
FL	32.57%	35.69%	37.58%	38.43%	38.79%	PAHP
NV	33.70%	38.82%	38.83%	39.26%	39.24%	Hybrid

Table 4: UTILIZATION OF DENTAL SERVICES BY EPSDT ELIGIBLE CHILDREN, FEDERAL FISCAL YEAR 2015-2020 – % EPSDT Eligibles Receiving Preventive Dental Service

State	2015	2016	2017	2018	2019	2020
TX	66.1%	67.4%	67.5%	67.6%	67.3%	59%
WA	56.1%	56.2%	56.1%	56.3%	56.6%	49.6%
MD	52.9%	53.7%	55.2%	54.9%	55.9%	48.2%
UT	53.3%	52.6%	50.4%	53.4%	54.6%	50.9%
CO	49.0%	50.6%	50.1%	52.2%	53.8%	46.6%
NC	49.7%	50.6%	51.0%	51.4%	52.1%	44.5%
VA	49.9%	49.7%	52.8%	52.8%	51.1%	42.5%
SC	48.4%	49.5%	49.9%	50.3%	51.0%	44.5%
IA	50.0%	50.6%	52.1%	52.5%	50.8%	42.5%
NE	53.2%	53.9%	53.9%	53.1%	50.1%	42.5%
ID	46.9%	59.3%	Did not report	48.9%	49.8%	Did not report
LA	47.2%	46.7%	48.8%	50.0%	49.6%	40.9%
MA	51.6%	54.6%	53.7%	54.1%	49.4%%	40.7%

State	2015	2016	2017	2018	2019	2020
RI	43.6%	47.4%	46.9%	47.4%	49.1%	37.8%
AR	49.9%	48.4%	48.0%	18.3%	48.9%	42.1%
TN	48.2%	47.9%	46.8%	46.0%	48.9%	41.3%
DE	47.9%	48.5%	42.4%	47.7%	48.7%%	41.7%
MI	40.1%	41.8%	42.7%	40.5%	39.4%	32.5%
FL	32.7%	35.9%	37.4%	38.6%	39.4%	33.2%
NV	37.6%	43.2%	42.9%	38.4%	37%	35.5%

An analysis by Milliman[1] assessed CMS Scorecard Data for the quality metric percentage of children ages 1 to 20 with at least one preventive dental service, using 2018 CMS PDENT scores, by program. They categorized states into four categories: FFS, ASO, Carve-in, and Carve-out. Their findings included:

- Median PDENT statistics were between 45% and 55% for all program types.
- FFS and Carve-out programs have wider variation in PDENT outcomes.
- There does not appear to be a statistical difference among program types,
- The ASO model may result in slightly higher PDENT performance overall, but report authors were hesitant to draw any major conclusions based on this one statistic due to its limitations.

The report cautioned that the PDENT indicates absolute levels of child Medicaid dental utilization which can depend on state-specific characteristics such as geography, number of licensed and participating dental providers, and demographics of the population.

The report concluded that a state's Medicaid dental program structure does not appear to be a main driver of pediatric dental utilization.

Medicaid Agency Payment to Dental ASOs and PAHPs

HMA research the known payment arrangements for each of the research states, where available. Though the type of rate (administrative versus comprehensive capitation) is driven by the state's Medicaid dental delivery model, there are other variations for consideration including: regional versus statewide rating, age band rate cell variation, and population rate cell variation. Under an ASO model, a state normally pays its ASO vendor an administrative per member per month (PMPM) and either pays the claims directly or reimburses the ASO for paid claims. ASOs do no incur claims risk. Under a PAHP model, a state pays its PAHP a comprehensive capitation payment. Capitation is also PMPM, but PAHPs assume claims risk and the PMPM is required to be actuarially sound.

Appendix D includes the ASO and PAHP PMPM payments that the research states pay to their dental vendors. Though this information does not aid in analysis of the non-integrated models, the information is helpful in considering the payment and financial risk considerations of the different models.

[1] Milliman, White Paper, Medicaid dental program delivery systems, Exploring state-specific delivery systems and initiatives to improve dental utilization, May 2020, Joanne Fontana, Annie Hallum, Catherine Lewis, https://us.milliman.com/-/media/milliman/pdfs/articles/medicaid-dental-program-models-factors.ashx

Other Benefit Carve-Outs: Behavioral Health, Pharmacy, and NEMT

HMA analyzed research states' benefit carve-outs in addition to dental, in particular whether behavioral health, pharmacy, and non-emergency medical transportation (NEMT) services are carved-in or carved-out of their comprehensive Medicaid managed care contracts. The only obvious trend is that states that have all three of these benefits carved-in to Medicaid managed care contracts, but have dental carved-out, administer dental via a carve-out to PAHP. Appendix E details whether these three benefits are carved into or out of comprehensive managed care contracts. Of the 20 research states:

- Three do not operate a comprehensive Medicaid managed care program so do not have any carve-ins or carve-outs.
- No state has all three benefits carved-out, three states have two of the three carved-out, and seven states have only one of the three carved-out.
- Eight states have all three of the benefits carved-in. Five of those administer dental via an MCO carve-out to PAHP. Two state administers dental via MCO Carve-out to ASO. And one state, North Carolina, administers dental via an MCO Carve-out to State administered FFS. It is worth noting that North Carolina only recently implemented comprehensive managed care, on July 1, 2021. Further, there is at least some interest in the state to explore moving dental to a PAHP model. On 2/8/2021, Senate Bill 61 was introduced to the General Assembly of North Carolina's 2021-2022 Session. The bill seeks to require the state to enter capitated contracts with at least two PAHPs for the provision of dental services to Medicaid recipients. The bill passed its first reading and was referred to the Committee on Rules and Operations of the Senate on February 9, 2021. However, there has been no action on the bill since 2/9/2021.
- States most frequently carve-out NEMT.
    - Ten have NEMT carved-in to Medicaid managed care contracts, and eight carve NEMT out.
    - Of the eight NEMT carve-out states, two administer dental carved-out to State administered FFS, three administers dental via MCO carve-out to ASO, two deliver dental via MCO carve-out to PAHP, and the final operates a hybrid dental program but where dental is carved out of managed care, so too is NEMT.
- Fourteen states have behavioral health carved-in, and four have it carved-out. Of the four behavioral health carve-out states one administers dental carved-out to State administered FFS, one administers dental via MCO carve-out to ASO, and two deliver dental via MCO carve-out to PAHP
- States infrequently carve-out pharmacy. Sixteen have pharmacy benefits carved-in, and only one has pharmacy carved out to a single Medicaid Pharmacy Benefit Manager (PBM)
    - It is worth noting that another research state (Louisiana) issued an RFP for a single statewide Medicaid Managed Care PBM with intent to require Medicaid managed care organizations to contract with the state selected PBM. The pharmacy benefit will technically remain carved-in to managed care contracts despite mandated subcontracting.

Medicaid Dental Expenditures

HMA assessed state Medicaid dental expenditures as represented on the CMS-64 report. Like enrollment, expenditures are an indicator of program size that may influence programmatic decisions. The analysis uses 2020 Medicaid dental expenditure data from the automated Medicaid Budget and

Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) which captures and reports on states' Form CMS-64 submissions[2]. The total Medicaid expenditure data does not include administrative costs, and accounting adjustments[3], and was estimated by the Urban Institute based on data from CMS (Form 64), as of September 2021.

While the CMS-64 report provides valuable detail by service line for all FFS expenditures, our analysis was inconclusive due to data limitations:

- The CMS-64 does not capture how spending directed to Medicaid MCOs, PAHPs, and PIHPs is allocated by category of service. Therefore, it is not possible to calculate total PAHP spending by service line.
- PAHP expenditures may include more than dental PAHP expenditures
- Some dental PAHP states did not report any PAHP spend
- Some dental PAHP states reported both PAHP expenditure and dental service line expenditures.

State's Adult Dental Benefit Design Does Not Appear to Drive Dental Delivery Model

Early, Periodic Screening Diagnosis and Treatment (EPSDT) is a mandatory benefit of the Medicaid Program for children through age 20. All states are required to cover comprehensive and preventive health care services for children, including dental. States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health. With the EPSDT mandate, all states' Medicaid child dental benefit can be considered comprehensive.

Conversely, Adult dental benefits are an optional benefit, and there are no federal minimum requirements for adult dental coverage. State elect whether to provide adult dental benefits and structure an adult dental benefit design if they elect to provide a benefit. Benefit design includes covered services, limitations, benefit limits, and cost sharing decisions. Table 5 summarizes the 20 research states' adult dental benefit. For analysis purposes, this report categorizes states as having either an extensive benefit, a limited benefit, or an emergency benefit.[4] Appendix F provides additional detail on states' adult dental benefit.

An extensive benefit is one providing comprehensive coverage (more than 100 dental procedures) and with either no annual limit or a limit over $1,000. A limited benefit is one with more restrictive benefits (fewer than 100 dental procedures covered) and has an annual limit less than $1,000. An emergency benefit is one limited to emergency services such as extractions and pain management.

[2] CMS, Financial Management Report for FY 2020, https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html

[3] Kaiser Family Foundation, State Health Facts, Total Medicaid Spending, FY 2020

[4] Center for Health Care Strategies, Inc., Medicaid Adult Dental Benefits Coverage by State, September 2019, confirmed with state Medicaid and dental plan benefit descriptions

- Three of the research states **do not offer** an adult dental benefit. Of these, one manages Medicaid dental through an MCO Carve-out to ASO, and two manage it through an MCO Carve-out to PAHP.
- Two of the research states **offer only emergency** adult dental coverage. Of those, one manages Medicaid dental through an MCO Carve-out to ASO, and one operates a hybrid program but for purposes of comparison would be considered a MCO Carve-out to PAHP.
- Five of the research states **offer a limited** adult dental benefit. Of these, one manages Medicaid dental through an MCO Carve-out to ASO, and four manage it through an MCO Carve-out to PAHP. Minnesota also offers a limited adult dental benefit through its integrated MCO dental carve-in model.
- Ten of the research states **offer an extensive** adult dental benefit. Of those, three manage Medicaid dental through an MCO Carve-out to ASO; four manage it through a PAHP with one of those not operating a comprehensive managed care program, and three manage it through MCO Carve-out: State Administered FFS.

What is not captured in Table 5 is that regardless of a state's adult dental benefit, if the state operates a managed care program, the participating MCOs may offer value-added dental services to enrolled members, or a subset of enrolled members such as pregnant members.

Table 5: Summary of Research States' Adult Medicaid Dental Benefit

State	Adult Medicaid Dental Benefits[5]	Medicaid Dental Delivery System
MINNESOTA	**LIMITED**	**INTEGRATED**
Arkansas	Limited	Dental PAHP
Colorado	Extensive	MCO Carve-out: ASO
Delaware	Extensive	MCO Carve-out: State Administered FFS
Florida	Extensive	MCO Carve-out: PAHP
Idaho	Extensive	Dental PAHP
Iowa	Extensive benefits in year one of enrollment	MCO Carve-out: PAHP
Louisiana	Limited	MCO Carve-out: PAHP
Maryland	Emergency[6]	MCO Carve-out: ASO
Massachusetts	Extensive	MCO Carve-out: ASO
Michigan	Limited	MCO Carve-out: PAHP
Nebraska	Limited	MCO Carve-out: PAHP
Nevada	Emergency	Hybrid

[5] Center for Health Care Strategies, Inc., Medicaid Adult Dental Benefits Coverage by State, September 2019, confirmed with state Medicaid and dental plan benefit descriptions

[6] In June 2019, Maryland implemented a pilot program through an amendment to its §1115 waiver to provide limited dental benefit to dual eligible enrollees (21-64) not enrolled in a managed care organization (MCO). The benefits include diagnostic, preventive, extractions, and restorative services up to a maximum of $800 per enrollee per calendar year. These benefits are administered through the state's DBA. For services that exceed the $800 cap, participating providers are required to charge the enrollee the same rates as the Medicaid dental rates, not commercial or the usual and customary provider rates.

State	Adult Medicaid Dental Benefits[5]	Medicaid Dental Delivery System
North Carolina	Extensive	MCO Carve-out: State Administered FFS
Rhode Island	Extensive	MCO Carve-out: PAHP
South Carolina	Limited	MCO Carve-out: ASO
Tennessee	None	MCO Carve-out: ASO
Texas	None	MCO Carve-out: PAHP
Utah	None	MCO Carve-out: PAHP
Virginia	New- Effective 7/1/2021	MCO Carve-out: ASO
Washington	Extensive	MCO Carve-out: State Administered FFS

State Assessments of Dental Delivery Models

Minnesota is joined by several other states in its desire to assess Medicaid dental delivery models. Maryland and Washington states each undertook similar efforts recently. Appendix A includes a detailed description of Maryland and Washington's analyses.

Overall Analysis's Findings about Dental Delivery Model Options for Minnesota

HMA's assessment is that Minnesota could use any of the non-integrated dental delivery models and make progress toward its oral health goals. Analysis of the state dental delivery profiles in Attachment 2 did not reveal that state Medicaid program elements such as enrollment, adult benefits, and other carve outs are correlated with a particular non-integrated dental delivery structure, nor did it reveal that a specific non-integrated dental delivery structure necessarily resulted in better quality outcomes for children one through 20 years of age with at least one preventive dental service within a year.

There are many commonalities between the ASO and PAHP models, and some variables. Table 6 identifies dental program management elements and who has responsibility for that element in different dental models as long as included in the contract.

Table 6: Accountability for Dental Program Management Functions by Delivery Model

Program Management Element	State Administered	ASO	PAHP
Rate Setting (Fee Schedule Development)	State	State	Vendor
Provider Network Development and Maintenance	State	Vendor	Vendor
Provider Credentialing	State	Vendor	Vendor
Claims Processing	State	Vendor	Vendor
Benefit Design	State	State[7]	State[8]
Provider Services/Relations	State	Vendor	Vendor
Member Services	State	Vendor	Vendor
Member Outreach and Engagement	State	Vendor	Vendor
Care Coordination	State	Vendor	Vendor

[7] Under the ASO and PAHP models, states generally require dental benefit administrators to administer a state defined dental benefit package. Within that benefit package, states allow various levels of flexibility for vendors to define medical necessity, establish service limitations, and determine which services require prior authorization.
[8] Ibid

Program Management Element	State Administered	ASO	PAHP
Community Outreach and Engagement	State	Vendor	Vendor
Utilization Management- Prior Authorization Processing	State	Vendor	Vendor
Utilization Management- Monitoring	State	vendor	Vendor
Program Integrity	State	Vendor	Vendor
Quality	State	Vendor	Vendor
Grievance and Appeals	State	Vendor	Vendor
Reporting	State	Vendor	Vendor

As noted in Table 6, the only function that a PAHP has that an ASO will not have is rate setting. Under ASO arrangements, the ASO vendor uses rates determined by the state, while PAHPs establish and negotiate rates with providers. All other functions can be included in both ASO and PAHP contracts.

There are, however, other factors that differentiate ASO and PAHP arrangements that may drive state decision making between dental delivery models.

Financial Risk

ASOs do not assume financial risk, whereas PAHPs assume full or partial risk. Some states prefer a risk model where the PAHPs take on full or partial risk based on ability to hold the PAHP fully accountable for program delivery and outcomes, and to create budget predictability. Within PAHP contracts, states use capitation withholds, bonus payment structures, and penalties to further incentivize contractor performance and achievement of target outcomes. Within a ASO model, a state retains full financial risk for the dental benefit cost; can include functions in the contract that drive toward desired outcomes; and can include performance-based payment structures, and services level agreements and associated penalties in the contract for non-performance.

The Commonwealth of Virginia's recent Dental ASO RFP, issued November 24, 2021, illustrates states' ability to include a comprehensive scope of work with accountability for not only administrative performance, but also meeting access standards, meeting outreach activity standards, meeting quarterly utilization goals, and meeting or exceeding the NCQA National Medicaid average for percentage of children having at least one dental exam annually. The RFP requires bidders to sufficiently describe its solution for meeting the state's utilization goals within the basis for its ASO administrative PMPM cost proposal. With a comprehensive scope and potential penalties for outcomes, a state should expect a higher administrative PMPM as vendors plan for and execute activities designed to achieve outcomes.

Because dental reimbursement is a critical factor in provider participation in Medicaid, states cannot assume that contractual obligations to an ASO vendor alone will achieve access and outcome goals.

For PAHPs, capitation rates include an administration load and must be sufficient to attract vendors and allow them to meet operational and outcome expectations for which they are accountable. Federal requirements for actuarially sound capitation rates guard against insufficient PAHP capitation rates to some extent. Actuarial soundness requirements include medical loss ratio (MLR) related standards, and capitation payments must be calculated in such a way that PAHPs would reasonably achieve the MLR standard of at least 85% for the rate year. States must hold PAHPs accountable for MLR requirements in

which they calculate and report MLR. States have an option of whether to establish a remittance requirement if a PAHP fails to meet an established MLS which must be set at 85% or higher.

Because ASOs do not set rates or carry risk related to dental benefit cost, they are not in a position to independently develop and offer value-based payment arrangements with dental providers. Any value-based payment arrangements under an ASO model would require state collaboration and funding. For example, a state and ASO could develop a pay-for-performance approach whereby the ASO captures provider performance via claims and pays the providers the performance-based payment associated with a narrow set of measures, and the state reimburses the ASO for those bonus payments.[9] PAHPs are in a position to independently implement pay-for-performance strategies, and could also implement other value-based payment arrangements with ready providers.[10]

State Administrative Burden

The three non-integrated dental delivery models have different levels of administrative burden for state Medicaid agencies. Under a state administered FFS model, the entire burden of Medicaid dental program administration and oversight lies with the state Medicaid agency. Under an ASO model, the administrative burden largely shifts to the ASO vendor and the state's responsibility narrows to rate setting, benefit design, and contract monitoring and oversight of a single dental ASO vendor. Under a PAHP model, the state's responsibility narrows to rate setting and contract monitoring and oversight. However, in a PAHP model, there are usually two PAHP vendors that the state must oversee. There are two states that have a single dental PAHP, but both of those (ID and NE) have small Medicaid enrollment that justified CMS approval of allowing only one PAHP vendor.

State contract monitoring and oversight is critical to the success of both the PAHP and ASO models. The contract can include comprehensive requirements but if the vendor reporting requirements and state oversight mechanisms are insufficient to hold vendors accountable for performance, program goals are compromised. Just as is true for comprehensive managed care programs, states need staff who know what is in ASO or PAHP contracts, and systems for monitoring performance under those contracts and holding vendors accountable.

The flip side of the oversight burden is that dental ASO and PAHP vendors can bring dental specific expertise and resources to a state that the state Medicaid agency is unable to source from within. Examples include information technology systems, best practices, and experience from operating in other state Medicaid programs. Because the same vendors can act as dental subcontractors to Medicaid MCOs in a Carve-in model and as a dental ASO or PAHP in a Carve-out model, that expertise and those resources may technically be available to a state in a Carve-in model, but the contracting and oversight mechanism do not facilitate maximizing their benefits.

Provider Administrative Burden

Under both state administered FFS and the carve-out to ASO models, providers have one Medicaid payer to work with, meaning a single Medicaid related contract, single set of clinical practice guidelines,

[9] Moving Toward Value-Based Payment in Oral Health Care, Center for Health Care Strategies, February 2021, https://www.chcs.org/media/Moving-Toward-VBP-in-Oral-Health-Care_021021.pdf
[10] Ibid

single prior authorization list, and single source for provider services. Under a PAHP model, providers will have two Medicaid payers to work with. Whereas dental providers generally prefer a single Medicaid payer to work with to reduce complexity, multiple PAHPs create a competitive environment where some providers may be able to leverage that environment in rate negotiations.

Member Choice and Complexity

The FFS and ASO models offer Medicaid eligibles the most simplicity of the non-integrated models. The PAHP model introduces complexity by requiring selection of a plan or being assigned to one. Eligibles making an election will be comparing two options based on provider network, value added benefits, and a variety of other tangible and intangible factors. While this choice introduces complexity, it also can represent options for eligibles that would not be present in a FFS or ASO model that has no competitive element whereby PAHPs compete for enrollment market share.

Dental Provider Input

Provider Hesitancy to Participate in Minnesota's Medical Assistance Program

The key to delivering any health care service is having a broad, accessible network of providers who can provide early and preventive care, manage chronic conditions, and be available for unforeseen emergencies. Oral health is not different in this regard than physical or behavioral health. The challenge is overcoming any provider hesitancy in accepting Medicaid and CHIP members. A myriad of issues can cause oral health provider hesitancy to participate in Medicaid and CHIP, including:

- Reluctance due to Medicaid and CHIP members' previous limited access to oral health that has created significant caries and many other serious dental issues that require extensive services.
- Reluctance due to perceptions about Medicaid and CHIP members and expectations of no-shows to scheduled appointments or non-compliance with prescribed treatment or health behaviors, and payment and rate concerns. Medicaid and CHIP members can face many life challenges, such as limited access to transportation to get to their dental appointments, poor nutrition due to food insecurities, and even homelessness that make it challenging for them to complete dental care plans and maintain their oral health.
- Reluctance due to lower Medicaid reimbursement rates compared to commercial insurance. Providers must balance their practices' administrative load, overhead, and payer mix to ensure their financial viability.

Understanding the drivers of provider reluctance in Minnesota is critical to aid the legislature and DHS in assessing options to reduce provider hesitancy to participate in the medical assistance program as an enrolled provider and improve access to and quality of Medicaid dental services for Minnesota Healthcare Program members. Not all drivers of hesitancy can be addressed by a delivery model or purchasing strategy such as a carve-in versus carve-out approach, but some models or strategies may provide the state with additional avenues to reduce reluctance, such as reducing administrative burdens or improving care coordination with whole-person care and supports. Feedback from Minnesota providers can help the state assess programmatic levers, including characteristics of different delivery models, that hold promise in reducing provider hesitancy and improving provider acceptance of participating in medical assistance programs.

Dental Program Stakeholder Input

The HMA team collected stakeholder feedback about provider hesitancy to participate in the medical assistance program as an enrolled provider using key informant interviews and a provider survey. In addition to providing important information about the efforts underway in Minnesota, the input from these stakeholder input activities augments existing quantitative data.

Key Informant Interviews

As a first step in the development of a provider hesitancy survey, HMA worked with DHS project staff and leadership to identify key informants for interviews to focus our question development. Based on our discussions with DHS, we partnered with the Minnesota Dental Association and conducted key informant interviews of providers representing a spectrum of perspectives on provider hesitancy and potential solutions to improve dental providers' participation in the medical assistance program.

HMA developed an interview guide for individual interviews. The questions were designed to gather stakeholder perceptions about the strengths and weaknesses of the current dental delivery system, access to dental services, program gaps and barriers, and unmet needs; and explored potential causes of provider hesitancy for participating in the medical assistance program. We customized the questions for each stakeholder engagement to include applicable elements.

Several major themes emerged across the interviews:

- Many dentists are participating because they feel it is the "right thing to do". Their patients are part of their community.
- Many providers are not participating due to several reasons:
    - **Inadequate reimbursement.** Providers seek to fill a chair with a better paying insured patient.
    - **Lack of capacity.** Especially now, since COVID, dentists are facing challenges in finding adequate staff to increase their patient base.
    - **Limited adult benefit.** The limited Medicaid adult benefit creates challenges for providers as they feel they are unable to offer the services that best meet their patients' needs.
    - **Multiple Prior Authorization processes.** Providers dislike having to comply with multiple prior authorization processes that exists across the Medicaid MCOs
    - **Inadequate care coordination.** Providers have not received adequate assistance with care coordination for patients with special needs or multiple medical and oral health needs. One interviewee noted that no one has ever reached out to the office to explore issues with patients, offer to help assist with challenging patient health/situations, or coordinate sedation needs for other procedures to align with medical.
    - **Lack of Specialists for Referral.** Dentists face challenges in finding specialty dental providers that will accept Medicaid for services that are beyond the dentist's scope of practice.

- Regarding the new rate increase:
    - It is too early to know exactly what new rate increase will accomplish.
    - It will help to support the current providers to maintain participation.
    - It may not be enough to draw in new providers
- Some dentists are not seeking critical access designation, although it pays better, due to the high (50%) percentage of Medicaid patients they must commit to seeing.

Provider Survey Methodology

These key informant interview themes informed the development of a provider survey that was sent to dental providers, including members of the Minnesota Dental Association (MDA). We used an online survey platform called Qualtrics to solicit feedback from a broad range of dental providers regardless of their Medicaid participation status.

HMA partnered with the MDA in communicating with their membership about the survey and encouraging survey participation from as many Minnesota dentists as possible. The MDA sent out the survey link to its membership of over 2,500 dentists and an additional 833 non-members in its database. DHS identified additional survey recipients to whom they emailed the invitation. As the greatest risk related to the survey was a low response rate, we closely monitored responses throughout the fielding period, and sent multiple reminders.

We fielded the survey for 19 days, from January 12, 2022, to January 31, 2022. During the 19-day fielding, we sent weekly reminders to participate. To bolster response rate, survey participation was anonymous.

Survey Results

There were 417 total responses to the survey. We did not calculate a formal response rate because we do not know how many recipients of the survey invitation are retired or not practicing. However, we do know that of the 284 individuals who responded to the survey question about whether they are practicing, 269 (95%) actively practice. One-hundred and twenty-seven (30.5%) respondents did not finish their survey, though to garner more information, surveys that were more than 78% complete were included in the data analysis. Therefore, the analysis contains 304 responses, including 14 partially complete responses. Percentages are calculated based on the number of respondents to each question. Please see Attachment 3 for survey questions, and Attachment 4 for full top line survey results. Table 7 provides a demographic overview of respondents:

Table 7: Demographic Overview of Survey Respondents

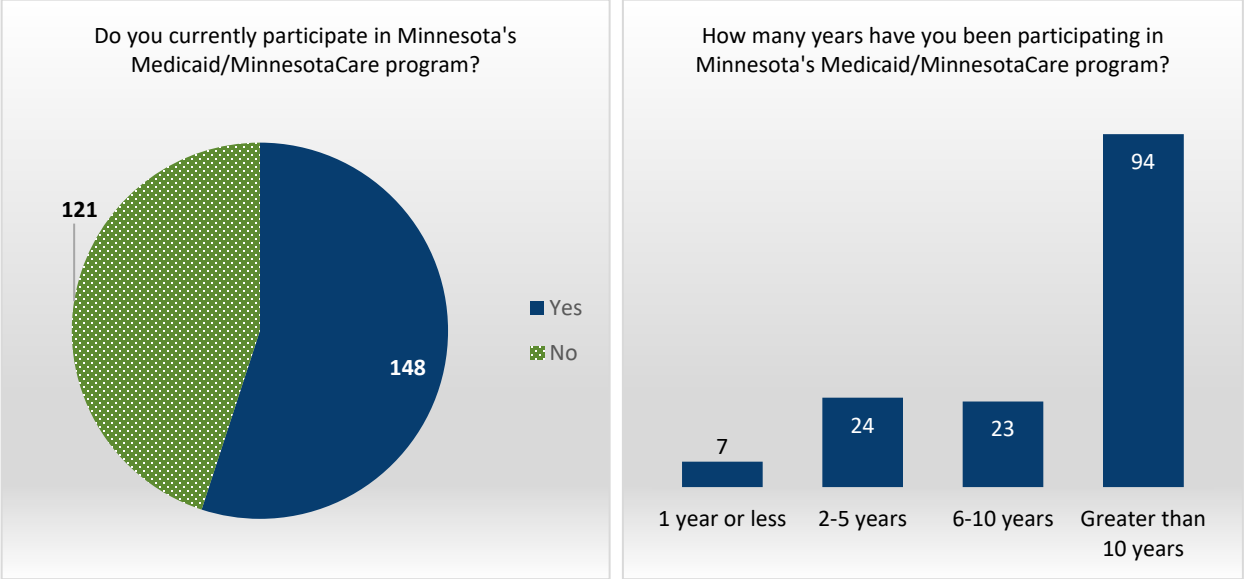
Factor	Respondent Breakdown
Race	White, 242 (84.9%); Black, 1 (0%); Asian American, 9 (3%); multi-racial, 5 (1.7%); Prefer not to answer and other, 28 (9.8%)
Gender	Male, 187 (65.4%); Female, 88 (30.8%); Prefer not to answer, 11 (4.1%)
Age	<40, 81 (28.6); 40-49, 63 (22.2%); 50-59, 55 (19.4%); 60-69, 64 (22.6%); ≥70, 20 (7%)
Type of Dentistry	General, 240 (84.5%); Pediatric only, 14 (4.9); Endodontic, 5 (1.8%); Orthodontics/dentofacial orthopedics, 9 (3.2%); Periodontics 3 (1.1%); Prosthodontics, 3 (1.1%); Oral and Maxillofacial, 10 (3.5%)

Factor	Respondent Breakdown
Type of Practice	Private for-profit clinic, 250 (93%); Private non-profit clinic, 11 (4%); Public clinic, 4 (1.5%); Hospital setting, 3 (0.1%); Other, 1 (0%)
Size of Practice	Solo practice, 105 (39%); Small group practice with 2–4 dentists, 137 (51%); Medium group practice with 5–9 dentists, 17 (6.3%); Large group practice with 10 or more dentists, 9 (3.1%)
Location of Practice	Urban, 39 (14.6%); Suburban, 125 (46.8%); Rural, 102 (102%); Other, 1 (0%)

Participation in Minnesota's Medicaid/MinnesotaCare Program

Respondents were asked whether they participate in Minnesota's Medicaid/MinnesotaCare program. Figure 1 graphically depicts responses: 148 (55%) responded "Yes". For those participating in Minnesota's Medicaid/MinnesotaCare program, 94 responses indicated the provider has been doing so for more than 10 years.

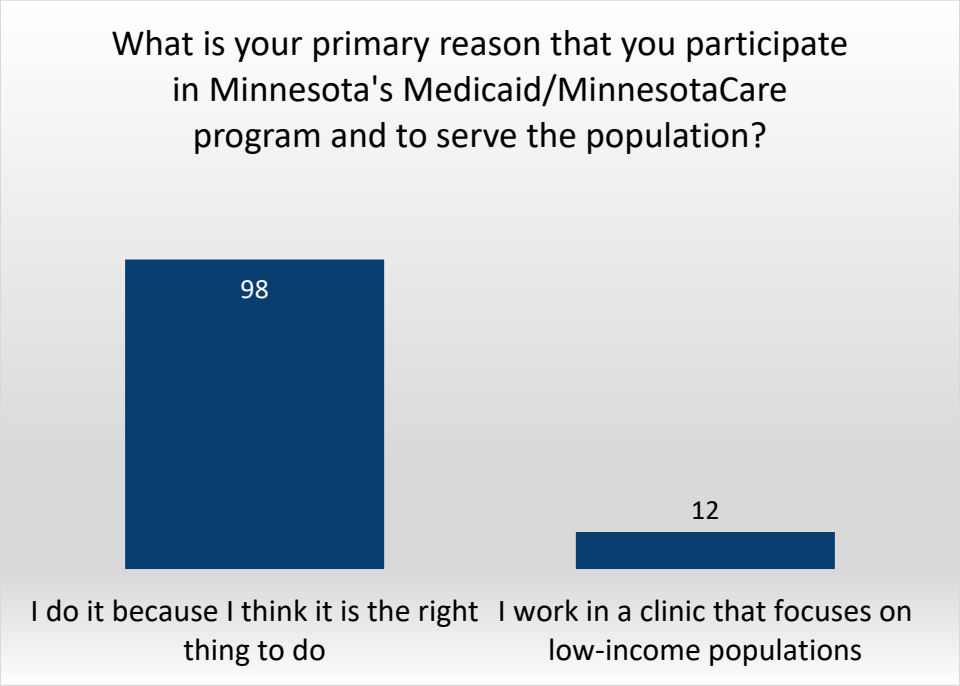
Figure 1: Participation in Minnesota's Medicaid/MinnesotaCare Program



Of the 121 respondents who do not participate in Minnesota's Medicaid/MinnesotaCare program, 44 (36.7%) reported that they had previously participated, while 76 (63.3%) responded that they had not.

As shown in Figure 2, for those who participate in Minnesota's Medicaid/MinnesotaCare program when asked why they participate, 98 (67.1%) said that they do it because it's the right thing to do, and 12 (8.2%) said they work in a clinic that focuses on low-income populations. There were a number of respondents (36, 24.7%) who chose "Other". Some respondents said that they participate to increase volume, or that they have to participate. Other respondents say that while they participate now, they will no longer participate in the future.

Figure 2: Primary Reason for Participating in Medicaid

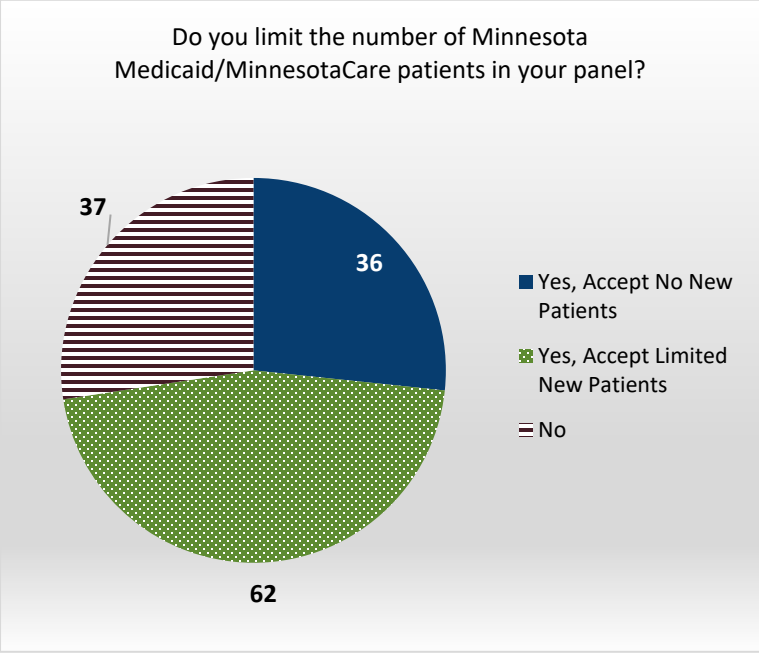


"Pay so low and was getting too many when open for all. Now only seeing new children."

"We are at about 25%, limit to a radius around our practice."

For providers who participate in Minnesota's Medicaid/MinnesotaCare program, when asked if they limit the number of Minnesota's Medicaid/MinnesotaCare patients in their panel, the majority of respondents said yes. As shown in Figure **Error! Reference source not found.**3, of those that limit these patients, 62 (45.9%) are accepting a limited number, while 36 (26.7%) are accepting no new Medicaid patients. Thirty-seven (27.4%) of respondents who participate in Minnesota's Medicaid/MinnesotaCare program do not limit the number of Minnesota's Medicaid/MinnesotaCare patients in their panel.

Figure 3: Medicaid/MinnesotaCare Dental Provider Limits on Minnesota Medicaid Patients in Panel

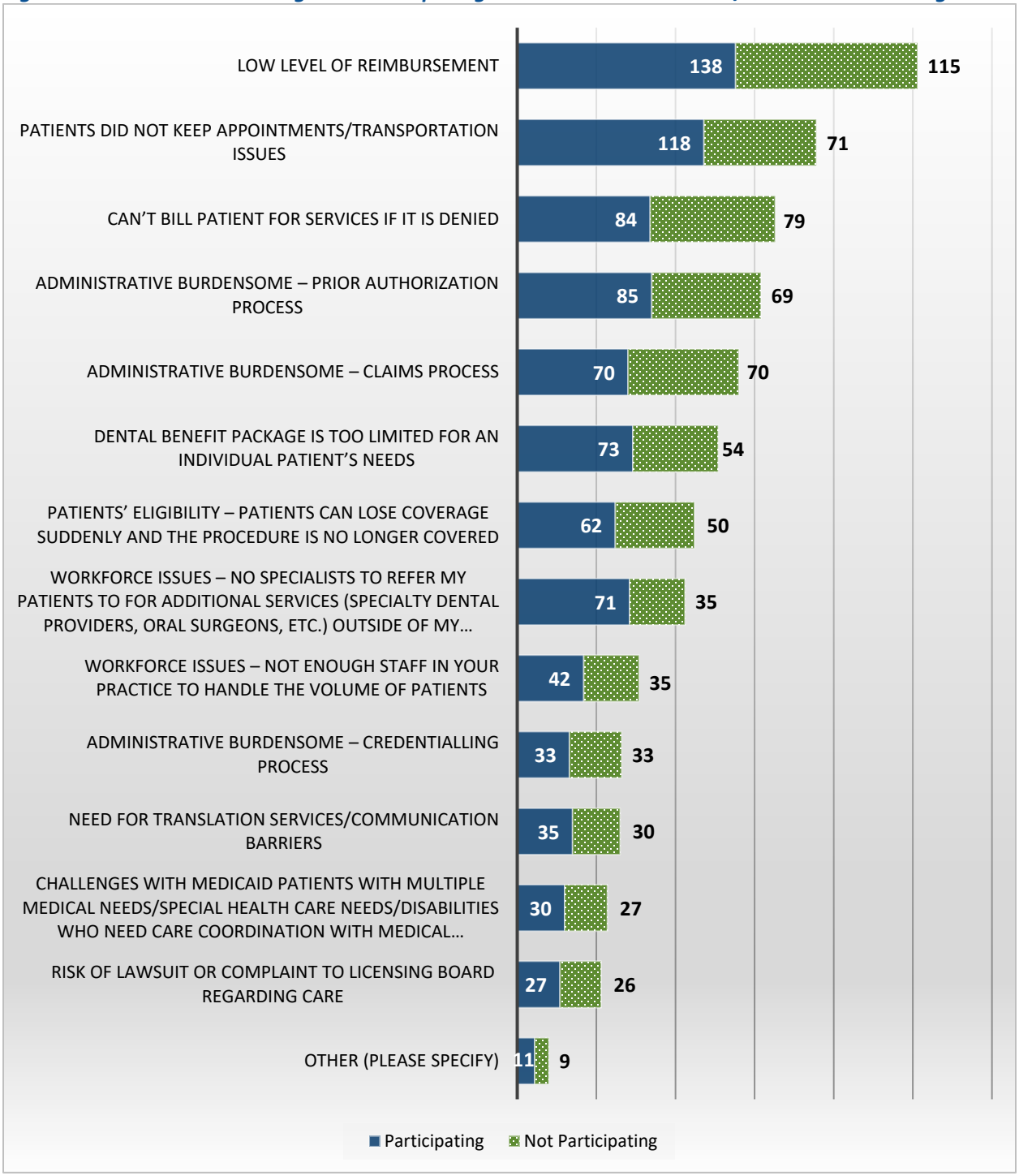


One hundred seventeen (117, 89%) of those who participate reported that they spend less than 5 hours weekly on Minnesota's Medicaid/MinnesotaCare administrative tasks, while 11 (8.4%) spend between 5 and 10 hours, and 3 (2.3%) spend more than 15 hours.

Challenges of Working with Minnesota's Medicaid/MinnesotaCare Program

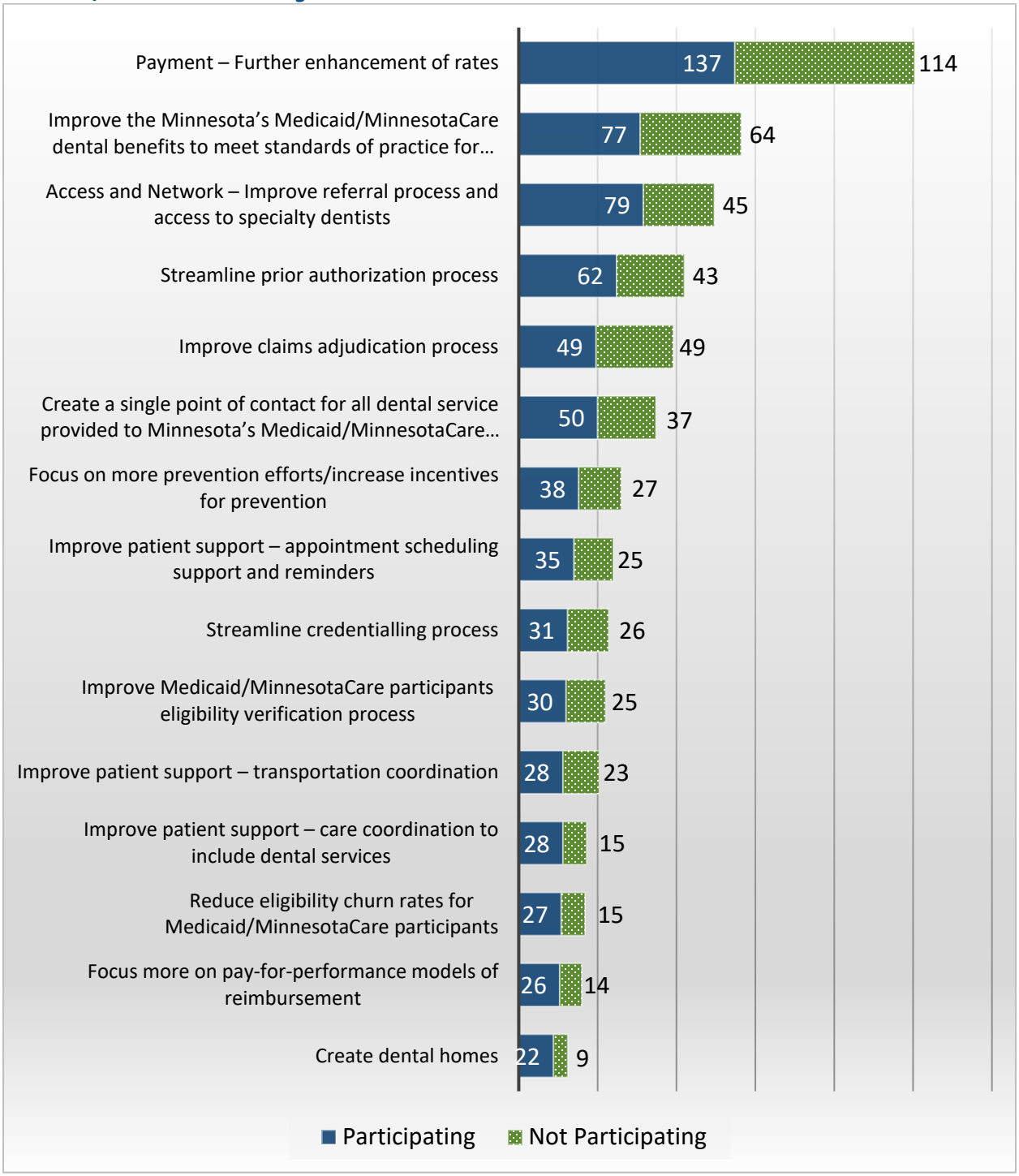
All survey respondents were asked what the top challenges are with participating in Minnesota's Medicaid/MinnesotaCare program. Regardless of whether the respondent did or did not participate in the program, the top response was "Low level of reimbursement", which 253 (83.2%) of all survey respondents chose. The second most frequent response was "Patients did not keep appointments/transportation issues", which 189 (62.2%) of respondents chose. Please see Figure 4 for a full breakdown of responses.

Figure 4: Barriers and Challenges to Participating in Minnesota's Medicaid/MinnesotaCare Program



Similarly, respondents were asked what changes or improvements would be needed to increase provider participation in Minnesota's Medicaid/MinnesotaCare Program. The majority of respondents (251, 82.6%) chose "Payment – Further enhancement of rates". Figure 5 provides a full response breakdown.

Figure 5: Changes or Improvements Needed to Increase Provider Participation in Minnesota's Medicaid/MinnesotaCare Program



The survey included an open-ended request for anything else the respondents wanted to share about Minnesota's Medicaid/MinnesotaCare program or implementation. There were 109 comments, and 76 (69.7%) of them mentioned reimbursement. Capacity and access issues (such as access to specialists, and over-full schedules) were also brought up frequently (22, 20.2% of comments). Concerns about the

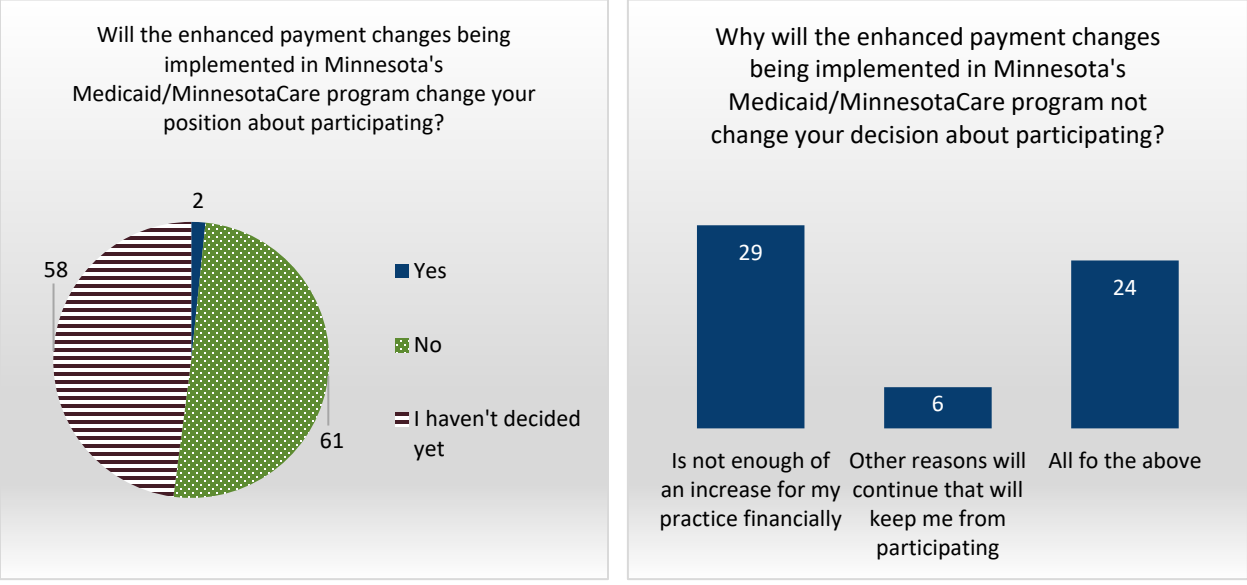
patient population of Medicaid, such as their ability to take dental care seriously or show up to appointments, also made up a large portion of the comments (20, 18.3%).

> *"Re-imbursement is far below rates from other insurance or even in other states. Overhead in the dental field is rising quickly after the pandemic and private insurance companies are cutting their re-imbursement. The obvious solution is to reduce the low paying Medicaid patients. It is not that we do not care for our patients but we have staff who depend on us for their jobs and wages are also increasing."*

Impact of Increased Rates on Participation in Medicaid and MinnesotaCare

Respondents who do not participate in Minnesota's Medicaid/MinnesotaCare program were asked if the enhanced payment would change their mind about participating, to which only 2 (1.7%) responded "Yes". Sixty-one (50.4%) chose "No", and 58 (47.9%) have not decided yet. For those respondents who chose "No", the most frequently chosen reason (29, 49.2%) was that the increase is not large enough. Six (10.2%) respondents said that they had other reasons for not changing their mind, and 24 (40.7%) said that both options were applicable. Please see Figure 6.

Figure 6: Opinions on Enhanced Payment



Dental Delivery Model Preferences and Understanding

Respondents who participate in Minnesota's Medicaid/MinnesotaCare program were asked about which delivery system they prefer for the delivery of program dental benefits and 61 (60.4%) prefer fee-

for-service, while 40 (39.6%) prefer contracted health plans. Please see Table 8 and Table 9 for direct quotes from respondents.

Table 8: Direct Quotes in Favor of Fee For Service

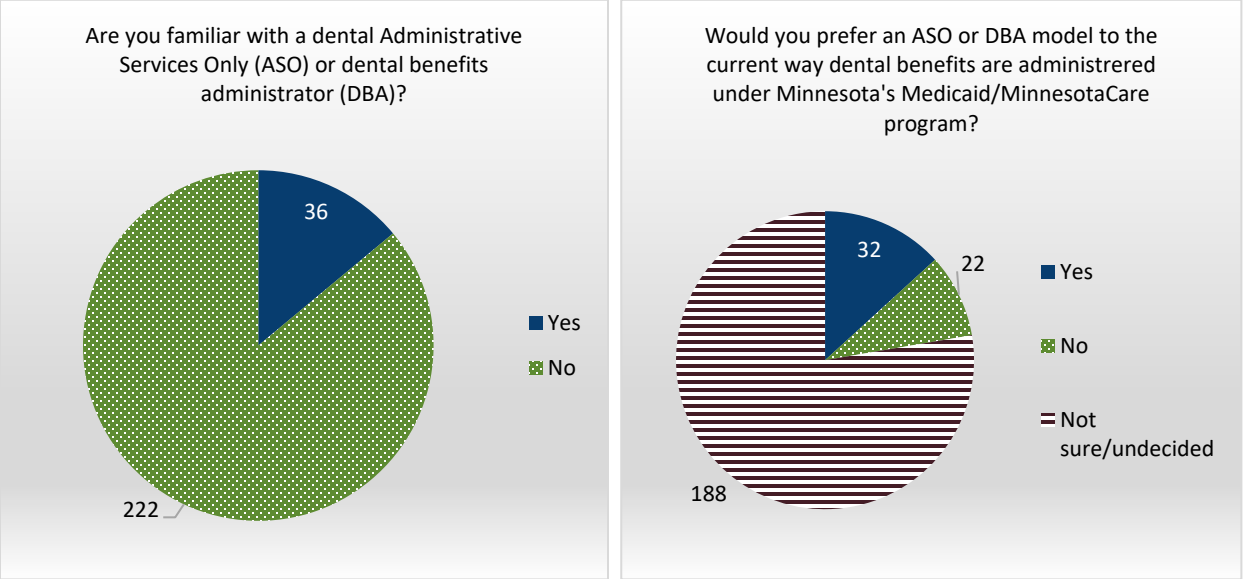
Fee for Service
"Patients then have some responsibility for their care, financially speaking"
"Direct accountability and simplicity"
"Less red tape. We generally do not like to be tied to plans. Like independence of treatment decisions and more transparency. Contracted plans seem to be lower reimbursements and more rules typically."
"The office is billing for the actual services being done."
"Less paperwork"

Table 9: Direct Quotes in Favor of Contracted Health Plans

Contracted Health Plans
"Encouraged to do what is right for patient instead of generating billing."
"Easy for patients to navigate"
"Health partners manages administrative burden"
"Most of our patients are under contracted health plans and the system is streamlined for treating these patients"
"Simplest for us and better reimbursement"

All survey respondents were asked if they were familiar with a dental Administrative Services Only (ASO) or dental benefits administrator (DBA), to which most (222, 86%%) responded "No" (Figure 7).

Figure 7: ASO and DBA Familiarity and Preference Relative to Carve-in Model



When asked if they would prefer an ASO or DBA model to the current carve-in model, most respondents (188, 77.6%%) were "Not sure/undecided". A small number, 32 (13%) favored an ASO or DBA model over the current model, and 22 (9%) replied that they would not prefer an ASO or DBA model.

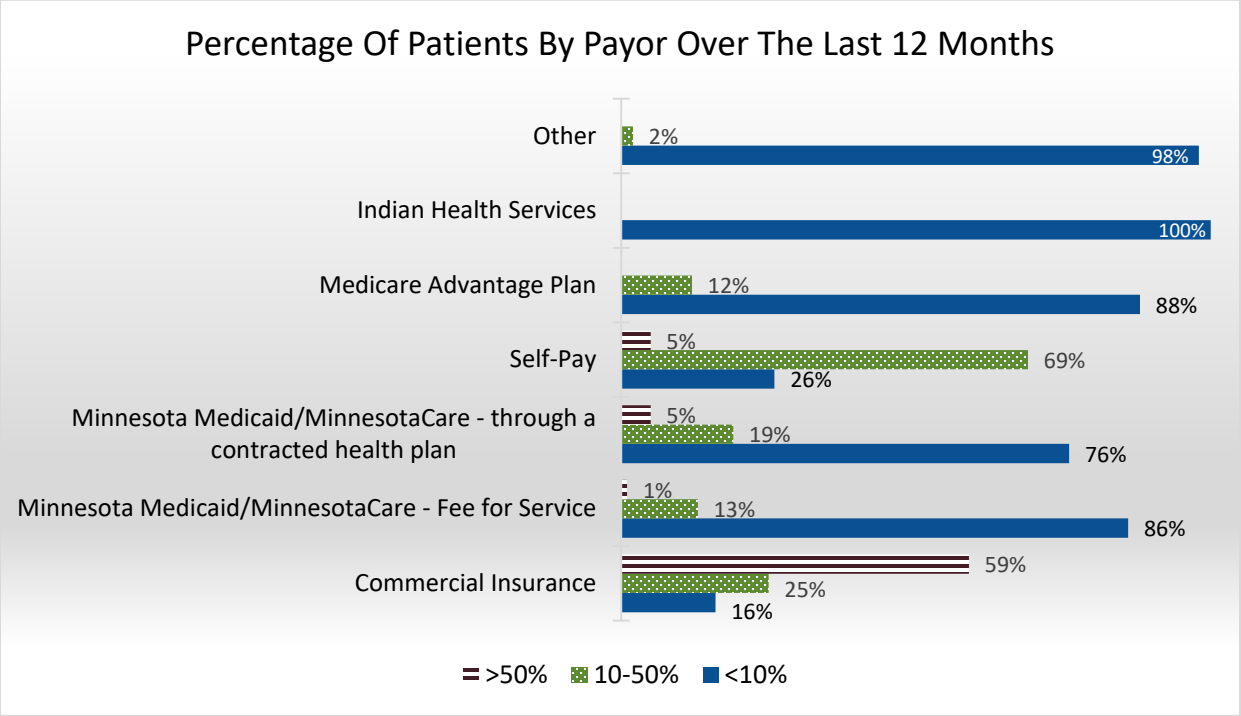
"Yes, if it streamlines the processes involved and improves efficiency"

"No, competition keeps payers honest. Have good relationship with our county plan."

Practice Payer Mix

Respondents were asked to estimate the percentage of patients they saw by payor over the last 12 months. All respondents reported Indian Health Services as less than 10% of their payer mix. Medicare Advantage was limited as a payor, with 254 (88%) of respondents reporting that less than 10% of their patients had Medicare Advantage as a payer, as would be expected given that dental is an optional benefit under Medicare Advantage. (Figure 8). Similarly, respondents reported a low percentage of their patients as covered by Medicaid or MinnesotaCare, whether through a contracted managed care organization or through fee-for service: respectively, 218 (76%) and 243 (86%) respondents reported that less than 10% of their patients were covered by Medicaid or MinnesotaCare. Conversely, only 4 (1%) and 14 (5%) indicated that greater than 50% of their patients were covered by Medicaid or MinnesotaCare. The only payer type with a large number of respondents reporting more than 50% of their patients had such coverage was commercial insurance: 168 (59%) of respondents indicated commercial insurance comprised greater than 50% of their patients.

Figure 8: Percentage of Patients By Payor Over The Last 12 Months



Key Survey Findings

Minnesota's providers provided input to assist in understanding provider hesitancy in Minnesota's Medicaid/MinnesotaCare Program via a provider survey provided in partnership with the Minnesota Dental Association. Representing both urban/suburban and rural areas of the state, the majority of the survey respondents were in small or solo practices. The key findings were:

- **Dentists participate because it's the right thing to do, but some place limits:** Almost half of the those who responded currently participate in Medicaid, with most for greater than 10 years. A third were not accepting new Medicaid patients, and another third accept but limit the number, while the rest accept without limitations. The main reason for participating was reported as the "right thing to do". Some reported that they didn't have enough staff to support expanding access.
- **The level of Reimbursement is the major reason cited for hesitancy:** It was noted by both those participating and those who were not participating as a major barrier. Of those not accepting Medicaid/MinnesotaCare Program, about half of them felt the new rate increases wouldn't change their interest in participating. The majority of respondents would like to see further enhancement of reimbursement.
- **Streamlined administrative processes would be valuable with a single dental plan administrator, but many prefer to see competition amidst multiple entities:** Different prior authorization processes and challenges in finding needed specialty providers were identified as issues, with some noting that one dental benefit administrator would improve efficiency, while others had good relations with their local county plans and the Medicaid managed care organizations.

- **Education on contracting arrangements and their meaning for providers is needed:** Majority of the respondents were not familiar with the specific contracting arrangements described as Administrative Service Only contracts or dental benefits administrators.

Concluding Findings

Based on our analysis of state dental carve-out experiences and our dental provider survey results, HMA's assessment is that:

- Minnesota could use any of the carve-out dental delivery models and make progress toward its oral health goals. Our analysis compared a variety of program elements and found no correlation between a particular carve-out dental delivery structure and quality and cost outcomes.
- Reimbursement is the top issue driving dental provider hesitancy to participate in medical assistance and MinnesotaCare programs, but other factors also create hesitancy including lack of capacity to take on new patients, multiple prior authorization processes, and inadequate care coordination.
- A carve-out model, as envisioned by the Minnesota legislature, includes a variety of elements that can address some provider hesitancy factors.
    - **Prior Authorization.** Under an ASO carve-out, providers would only have one administrator to work with and one set of prior authorization policies and procedures. Under a PAHP carve-out, the state could limit the number of dental plans to two.
    - **Care Coordination.** Under either an ASO or PAHP dental carve-out, DHS can include contractual provisions for care coordination ranging from assisting eligibles in finding dental providers, to coordinating care between dental providers and other providers and services such as sedation and medical services with a dependency related to dental services.
- DHS can include the same dental benefit management requirements in carve-in MCO arrangement, ASO carve-out arrangements, and PAHP carve-out arrangements. There are different contract monitoring enforcement and accountability burdens on the state associated with each of these models. With a carve-in model, focus on dental as part of an overall MCO oversight program can be diluted either because of the larger scope of the contracts, or the fact that in most cases there is a dental subcontractor that is generally removed from direct involvement with the state Medicaid agency. In a carve-out model, DHS would have a separate contract oversight mechanism dedicated to dental. This may require additional state resources and may yield better outcomes as a result of focus and attention by both the state and the contracted entity.
- A change from the current dental carve-in model to a carve-out model will require stakeholder education, including with the dental provider community. The provider survey indicated that dentists in Minnesota are not generally familiar with the meanings of the terms ASO or dental benefit administrator.

Appendix A: Maryland and Washington

State Assessments of Dental Delivery Models

Minnesota is joined by several other states in its desire to assess Medicaid dental delivery models. Maryland and Washington states each undertook similar efforts recently.

Maryland

On October 19, 2021, the Maryland Department of Health submitted a report to the Joint Chairs of the Senate Budget and Taxation Committee and the House Appropriations Committee, "Medicaid Dental Services Review."[11] The report was prepared pursuant to requirements of the 2020 Joint Chairmen's Report which requested the following:

> *p. 117 "…review the different models used by states for dental services, in particular the use of an independent managed care organization. In that review, MDH should look specifically at performance in delivering quality dental care, cost versus the current ASO model in place in Maryland, and how states have been able to expand dental services with savings generated by changing service delivery models."*

Maryland covers dental benefits through a carve-out to ASO model. The state transitioned to this model from a dental carve-in model in 2009. In early 2009, the state carved dental out of its Medicaid MCO contracts and contracted for a Maryland Healthy Smiles ASO to manage the Medicaid dental benefit. The Maryland Health Smiles ASO vendor is SKYGEN USA, formerly known as Scion Dental. SKYGEN is responsible for acting as a single point of contact for providers, handling billing, managing dental provider issues, and maintaining a call center.

The state's ASO This carve-out was based on recommendations from the Dental Action Committee (DAC) convened by the Maryland Health Secretary in 2007[12]. The DAC published its recommendations in a report issued in September 2007. The report included seven primary recommendations each of which was subsequently supported by the Maryland Health Secretary and Governor, and all funding recommendations were included in the Governor's FY 09 budget:

1. Statewide ASO dental vendor
2. Over three years, increase dental rates to ADA 50th percentile
3. Begin to restore dental public health infrastructure with funding for new dental public health programs including new facilities

[11] Maryland 2020 Joint Chairmen's Report (p.117)- Delivery Models for Dental Services, 10/19/21, https://hlthmgt.sharepoint.com/sites/MNDHSDentalStudy/Shared%20Documents/General/Non-Integrated%20State%20Profiles/Maryland/Maryland%202020%20Joint%20Chairmen%E2%80%99s%20Report%20(p.%20117)%20%E2%80%93Delivery%20Models%20for%20Dental%20Services101921.pdf?CT=1643226159505&OR=ItemsView

[12] Access to Dental Services for Medicaid Children in Maryland, Report of the Dental Action Committee for John Colmers, Secretary, Department of Health and Mental Hygiene, September 11, 2007, https://health.maryland.gov/phpa/oralhealth/Documents/DACFullReport2007.pdf

4. Create public health dental hygienist role
5. Trained general dentist in pediatric care
6. Institute school-based oral health screening
7. Unified oral health educational program targeted to parents, providers, policy makers

The DAC summarized the situation in Maryland at the time of their report, "In sum, our oral health care support structure for low-income, special needs, and other underserved at-risk Marylanders lacks adequate dental provider capacity and oversight. Despite the requirements of EPSDT, we fail to assure that Medicaid-enrolled children access needed dental treatment services. We also fail to provide sufficient dental care for low-income children and adults not covered by Medicaid, who require urgent or other dental treatment services. The need for more providers, more dental treatment services, more specialized care, and more targeted case management add to the complexity of designing a system that will cost effectively meet the extensive oral health care needs of disadvantaged, underserved people throughout Maryland."

The DAC presented the following as rational for its recommendation to move to a dental ASO model:

- Simplification of the current delivery system for the public in terms of access to dentist panels, social marketing, case management, enrollment, and eligibility, and simplification for dental providers in terms of billing, credentialing and prior authorization
- Demonstrate to the dental community and others that the state is willing and able to address legitimate concerns in a straightforward comprehensive manner
- More transparency with greater knowledge about how money is spent and who is being held responsible for assuring access to services; the simplification of the system will allow more accountability and easier oversight by DHMH
- Decrease costs because dealing with administrative costs and profits of only one entity rather than multiple MCO and dental vendors
- Increases the State's ability to negotiate contract terms through issuance of a new Request for Proposal (RFP) in which the Department and many dental stakeholders can together determine the elements of a contractor bid that meets the oral health needs of Medicaid-enrolled children and adults

The report did outline several noted concerns about the transition. These included potential increased costs due to separate medical and dental case management which also reduces the potential for a medical and dental connection; increased risk because of a single dental vendor; the long time it will take to develop an RFP, and the potential loss of the current Medicaid adult program for adults. The DAC acknowledged these concerns and determined to proceed with the recommendation based on its understanding that MCOs were losing money on the carved-in dental program, and that while all seven MCOs were providing adult dental benefits as a value-added service, that the MCOs had "been inconsistent over the years in offering this benefit and information about such coverage remains confusing to both the public and providers alike."

In the 2021 report assessing the use of an independent dental managed care organization, the Maryland Department of Health met with three states to learn more about their experiences administering dental benefits, with a focus on costs, quality, and the rate-setting process: Florida, Texas, and Washington.

Florida and Texas both use a dental carve-out to PAHP model, where Washington self-administers Medicaid dental through FFS. Washington was of particular interest because it had recently gotten part way toward the transition to a PAHP model with selection of PAHP vendors through competitive bidding, and then canceled PAHP implementation and is, for now, remaining as state administered FFS.

FLORIDA. Florida has vacillated on its Medicaid dental services delivery model. From 2006-2013, Florida provided dental services through the Statewide Prepaid Dental Health plan program. Beginning in 2014 through 2018, dental services were carved in to managed care as part of the implementation of the Statewide Medicaid Managed Care (SMMC) program. In 2016, the legislature directed the AHCA to provide Medicaid recipients with dental benefits separate from SMMC and the state then procured for dental PAHP services with implementation in March 2019. Maryland's report indicated that Florida Medicaid is still in the process of assessing both the fiscal and quality of care impacts of their current carved-out managed dental care program.

However, it is noteworthy that the Florida House filed a proposed committee bill (PCB) on managed care, PCB FFS 22-01, which among other things proposes carving dental back into the SMMC and requires plans to establish programs to improve outcomes and increase utilization of preventative services, including a patient education component and a patient incentive program. AHCA is required to establish and regularly assess dental performance and outcome measures, which must be published.

The proposed bill was discussed at the January 27 House Finance and Facilities Subcommittee. The bill analysis reported that "when dental benefits were integrated into the MMA program, and for some years prior, Florida experienced consistent increases in child dental service performance in the federally required measurements; and that after the separation of dental benefits from other benefits, improvement stalled or regressed in many categories, while complaints were higher. Some decline may be attributable to a decline in utilization in Summer, 2020, due to the pandemic-related lockdown and supply shortage." Discussion at the subcommittee included:

- Whether there is enough data and experience to carve-dental back in based on such a short carve-out period, especially with a portion of the experience being during the pandemic. The rationale presented for proceeding with carve-in at this point in time was that the timing of this decision is being driven by the timing of the anticipated SMMC MCO procurement.
- Whether the stalled or regressed dental performance was being fairly compared to MCO utilization performance during the pandemic.
- Whether under the bill an MLR requirement flowed to dental subcontractors under a carve-in or could be included.
- Question about assertion that if were designing the program today, would have done integrated carve-in, given the fact that the legislature directed carve-out in 2016.

Three entities provided testimony. Two entities opposed the PCB, and one was a proponent. Of note, the Florida Dental Association provide **opponent testimony**, arguing that the proposed changes would undermine benefits of the current model: PAHPs can work directly with ACHA around the contract and issues, limited number of PAHPs (three) is manageable for dental providers, MLR applies to the PAHPs' contracts and 85% of capitation must go to direct services. A carve-in would add an additional administrative layer wherein the state would contract with MCOs, and MCOs would subcontract with dental plans, in some cases the same dental plans that were under PAHP contract with the state. The

Florida Dental Association testimony also argued that issues discussed by the Subcommittee such as sedation and emergency department utilization are contract issues rather than legislative issues. Lastly, the testimony highlighted that dental utilization in the private sector tanked during the pandemic. Dental utilization under private insurance dropped 75% in March 2020 from March of 2019. The Medicaid dental utilization during the pandemic should not be unexpected and is not fundamentally related to the carve-out.

During debate, several committee members asserted lack of support for the carve-in based on lack of supporting data, and disruption for Medicaid eligibles and dental providers. Some of these committee members indicated intent to vote in favor of the PCB as a larger bill despite this lack of support with intent to refine the bill as it moves through the process. The Subcommittee vote was 14 yeas and 4 nays to move the PCB to the floor.

TEXAS. Texas also operates a dental carve-out PAHP model with two participating dental managed care plans. Texas' dental PAHP model has been in place since 2012. The Maryland report specified, Texas indicated dental expenditures have decreased year after year, suggesting savings may be realized under the managed care model. Texas officials further noted that use of a managed care model helped the state to enhance utilization management and better monitor providers who were outliers with respect to billing, leading to savings.

WASHINGTON. Washington operates its Medicaid dental under a state administered FFS model. Maryland selected them for assessment for the 2021 report because Washington had recently gotten part way toward the transition to a PAHP model with selection of PAHP vendors through competitive bidding, and then canceled PAHP implementation and is, for now, remaining as state administered FFS.

Washington planned to implement a Managed Care Dental Program for Medicaid eligibles beginning January 1, 2019. The state used a competitive procurement process to select dental plans with issuance of an RFP in May of 2018, and awards announced on 8/1/2018 to Amerigroup (Anthem), Dentegra, and MCNA. Subsequent to award, the state announced a delay in implementation from 1/1/2019 to 7/1/2019. Then on 4/29/2019, the 2019 State Legislature directed the Washington State Health Care Authority (HCA) to continue to administer the dental Medicaid program through fee-for-service. The HCA was prohibited from proceeding with a carved-out or carved-in managed care dental option, and contracts that were procured or in the process of being procured were directed not to be implemented.

The Maryland report indicated that the state and the bidders could not agree on appropriate rates. Additionally, analysis of prospective costs by Milliman suggested that shifting models and driving improved access to care, particularly for adults, would require increasing the existing FFS base rates and a corresponding increase in administrative expenditures based on enhanced service utilization.

The Washington State Health Care Authority, at the direction of Engrosses Substitute House Bill 1109 (2019) section 211 (52), developed and submitted a report to the governor and appropriate committees of the legislature a plan to improve access to dental services for Medicaid clients including assessment of options for carve-in, carve-out, FFS and other models. Washington's report and findings are profiled in the next section.

The Maryland 2021 report did not make specific recommendation for changes to the Medicaid dental benefit and concluded, "Based on a review of the different service delivery models, each one has unique benefits to offer the State, providers, and enrollees. Preliminary analysis suggests that there are opportunities to continue to make improvements to drive quality and reduce costs under the existing ASO/DBA model. The potential for savings to MDH through adoption of a managed care model—either carve-in or carve-out—may be greater still, but requires further evaluation. While findings by the stakeholder DBM suggest savings under the existing model have not been optimized and could be increased under managed care, fiscal models from other states suggest further evaluation is needed."

Washington

On November 14, 2019, the Washington Health Care Authority submitted a report to the Legislature, "Apple Health Dental Program, Options for Improved Access.[13]" The report was prepared pursuant to requirements of Engrosses Substitute House Bill 1109; Section 211 (52); Chapter 415; Laws of 2019 which directed that the Washington Health Care Authority:

> *"continue providing Medicaid dental services through fee-for-service and may not proceed with either a carved-out or carved-in managed care dental plan option. Any contracts that have been procured or that are in process of being procured shall not be entered into or implemented. By November 15, 2019, the authority shall report to the governor and appropriate committees of the legislature a plan to improve access to dental services for Medicaid clients. This plan should address options for carve-in, carve-out, fee-for-services, and other models that would improve access and outcomes for adults and children. The plan should include the cost for any options provided."*

The report outlined the benefits and risks associated with administering dental benefits using carve-in, carve-out, fee-for-service, and other service delivery models. However, it concluded with the finding that "successfully increasing access and utilization has less to do with the service delivery model and more to do with tailoring a program that is reflective of the state's population and needs. If the goal is to increase not just access but also drive utilization, the state should consider raising provider reimbursement rates and setting long term achievable goals for increasing access and utilization numbers. This approach may include a change to the service delivery model, but this approach could also include implementing an oral health strategy like identifying a dental home for Apple Health clients, employing a full-time dental champion, or collaborating with the local health jurisdiction to provider care coordination for the Medicaid population."

The Washington Health Care Authority report included as an Appendix a report by Milliman commissioned by the Health Care Authority to, among other things, assess whether and how dental delivery models effect or are effected by different factors. The Milliman report, "Medicaid Dental Program Models and Success Factors", included the following findings:

[13] Washington Health Care Authority, Apple Health Dental Program Options for Improving Access, November 15, 2019, https://www.hca.wa.gov/assets/program/apple_health_dental_program_20191115.pdf

- Dental delivery models do not have measurably different dental benefits costs specific to the delivery model. Benefit costs changes will be driven by changes in access and utilization, and by changes in the dental reimbursement.
- While it appears that the ASO model may results in the best child dental utilization numbers overall, Milliman was hesitant to draw any major conclusions based on the PDENT measure due to its limitations.
- Medicaid dental delivery model does not appear to be related to the utilization gap between Medicaid and commercial populations.
- There is no significant correlation between adult benefit levels and Medicaid dental delivery model.
- Using states' Federal Medicaid Matching Assistance (FMAP) as a proxy for state wealth, the median FMAP was similar for FFS, Carve-in, and Carve-out to PAHP states. The ASO states were most prevalent among low FMAP (i.e. higher relative wealth) states, although many low FMAP states also use FFS, Carve-in, and Carve-out to PAHP models.

Appendix B: Research States by Medicaid Enrollment and Dental Delivery System

State	Medicaid Dental Delivery System	Medicaid Enrollment
Delaware	MCO Carve-out: State Administered FFS	255,645
Nebraska	MCO Carve-out: PAHP	288,787
Rhode Island	MCO Carve-out: PAHP	301,346
Idaho	Dental PAHP	363,357
Utah	MCO Carve-out: PAHP	373,468
Iowa	MCO Carve-out: PAHP	693,978
Nevada	Hybrid	747,208
Arkansas	Dental PAHP	880,279
South Carolina	MCO Carve-out: ASO	1,054,989
MINNESOTA	**INTEGRATED**	**1,212,920**
Maryland	MCO Carve-out: ASO	1,365,929
Tennessee	MCO Carve-out: ASO	1,487,009
Colorado	MCO Carve-out: ASO	1,497,818
Virginia	MCO Carve-out: ASO	1,542,540
Massachusetts	MCO Carve-out: ASO	1,578,945
Louisiana	MCO Carve-out: PAHP	1,598,851
North Carolina	MCO Carve-out: State Administered FFS	1,772,364
Washington	MCO Carve-out: State Administered FFS	1,891,805

State	Medicaid Dental Delivery System	Medicaid Enrollment
Michigan	MCO Carve-out: PAHP	2,665,706
Florida	MCO Carve-out: PAHP	4,122,539
Texas	MCO Carve-out: PAHP	4,405,074

Appendix C: Research States by Medicaid Child and Chip Enrollment and Dental Delivery System

State	Medicaid Dental Delivery System	Total Medicaid Child and CHIP Enrollment
Delaware	MCO Carve-out: State Administered FFS	118,134
Rhode Island	MCO Carve-out: PAHP	123,427
Nebraska	MCO Carve-out: PAHP	184,806
Idaho	Dental PAHP	199,271
Utah	MCO Carve-out: PAHP	224,901
Nevada	Hybrid	344,806
Iowa	MCO Carve-out: PAHP	367,749
Arkansas	Dental PAHP	400,346
MINNESOTA	**INTEGRATED**	**588,645**
Colorado	MCO Carve-out: ASO	631,743
Maryland	MCO Carve-out: ASO	674,178
South Carolina	MCO Carve-out: ASO	701,706
Massachusetts	MCO Carve-out: ASO	711,288
Louisiana	MCO Carve-out: PAHP	772,505
Virginia	MCO Carve-out: ASO	842,704
Washington	MCO Carve-out: State Administered FFS	867,721
Tennessee	MCO Carve-out: ASO	898,643
Michigan	MCO Carve-out: PAHP	1,039,452
North Carolina	MCO Carve-out: State Administered FFS	1,300,093
Florida	MCO Carve-out: PAHP	2,750,804
Texas	MCO Carve-out: PAHP	3,867,146

Appendix D: Medicaid Dental ASO and PAHP Payment Arrangements for Target States

State	Medicaid Dental Delivery System	Payment Arrangement
Arkansas (AR) Description	Dental PAHP	Plans bid on capitation rates within state establish bounds. Each winning bidder bid a rate equal to the state's lower bound. 5/19/2017 through 12/31/2019[14]
AR Rates	Ages 0-1 CHIP	$2.51
AR Rates	Ages 0-1 Medicaid	$0.31
AR Rates	Ages 2-5 CHIP	$20.44
AR Rates	Ages 2-5 Medicaid	$18.65
AR Rates	Ages 6-18 CHIP	$29.71
AR Rates	Ages 6-18 Medicaid	$27.95
AR Rates	Ages 19-20 Expansion Frail	$21.46
AR Rates	Ages 19-20 Expansion QHP	$11.54
AR Rates	Ages 19-20 Medicaid	$11.54
AR Rates	Ages 21-54 Expansion Frail	$20.48
AR Rates	Ages 21-54 Expansion QHP	$10.68
AR Rates	Ages 21-54 Medicaid	$10.68
AR Rates	Ages 55-64 Expansion Frail	$15.16
AR Rates	Ages 55-64 Expansion QHP	$6.31
AR Rates	Ages 55-64 Medicaid	$6.31
AR Rates	Ages 65+ Medicaid	$2.97
Colorado (CO) Description	MCO Carve-out: ASO	Administrative PMPM[15]
CO Rates	SFY 2019-20	$0.68
CO Rates	SFY 2020-21	$0.69
CO Rates	SFY 2021-22	$0.70
CO Rates	SFY 2022-23	$0.71
CO Rates	SFY 2023-24	$0.72
Delaware (DE) Description	MCO Carve-out: State Administered FFS	NA
Florida (FL) Description	MCO Carve-out: PAHP	The state establishes rates by rate Cell and Region. Region 1 is shown here as example. October 2019-September 2020[16] Medically Needy 0-20 and Medically Needy 21+ Agency capitation rates are set on a statewide basis.
FL Rates	Medicaid Only/Dual Eligible 0-20	$12.37
FL Rates	Medicaid Only 21+	$8.37
FL Rates	Dual Eligible 21+	$6.83
FL Rates	Medically Needy 0-20	$3.41
FL Rates	Medically Needy 21+	$5.01
Idaho (ID) Description	Dental PAHP	PMPMs for Initial three-year contact term of 10/3/2016 to 10/2/2019[17]

[14] Delta Dental of Arkansas Medicaid Dental Contract, Effective May 19, 2017 through December 31, 2019; and Managed Care of North America (MCNA) Medicaid Dental Contract, Effective May 19, 2017 through December 31, 2019

[15] Colorado Department of Health Care Policy and Financing Contract Amendment #1 to Contract 20-139364 with DentaQuest USA Insurance Company, Inc, Amendment Contract Number 20-12964A1

[16] Florida Statewide Medicaid Managed Care Dental Program Model Contract

[17] Idaho Department of Health and Welfare contract RC076600 with MCNA Insurance Company

State	Medicaid Dental Delivery System	Payment Arrangement
		Each fiscal year after the initial 3-year service period, the IDHW will determine an annual price adjustment.
ID Rates	Basic Children (Under 21)	$15.66
ID Rates	Basic Adults (Over 21)	$1.90
ID Rates	Enhanced Children (Under 21)	$17.19
ID Rates	Enhanced Adults (Over 21)	$10.61
ID Rates	Identified Pregnant Women (Over 21)	$8.56
Iowa (IA) Description	MCO Carve-out: PAHP	SFY 2022 Dental Wellness Plan Gross Capitation Rates[18] Iowa imposes a 2% withhold to the gross capitation rates
IA Adults Rates	TANF 19-34 F	$16.99
IA Adults Rates	TANF 19-34 M	$11.97
IA Adults Rates	TANF 35-49 F	$18.55
IA Adults Rates	TANF 35-49 M	$15.22
IA Adults Rates	TANF 50+	$18.25
IA Adults Rates	Pregnant Women	$11.29
IA Adults Rates	Wellness Plan 19-34 F	$14.28
IA Adults Rates	Wellness Plan 19-34 M	$11.20
IA Adults Rates	Wellness Plan 35-49 F	$17.42
IA Adults Rates	Wellness Plan 35-49 M	$14.68
IA Adults Rates	Wellness Plan 50+	$18.80
IA Adults Rates	Community Duals <65	$23.87
IA Adults Rates	Community & LTSS Disabled	$17.93
IA Adults Rates	Community & LTSS Elderly	$12.94
IA Kids Rates	CHIP Children 0-1	$4.01
IA Kids Rates	CHIP Children 2-5	$16.15
IA Kids Rates	CHIP Children 6-18	$17.42
IA Kids Rates	Children 0-1	$4.01
IA Kids Rates	Children 2-5	$16.15
IA Kids Rates	Children 6-18	$17.42
Louisiana (LA) Description	MCO Carve-out: PAHP	LDH develops actuarially sound rates according to CMS rules and regulations. LDH does not use a competitive bidding process to develop capitation rates. LDH offered the rate to bidders on a "take it or leave it" basis. Dental Capitation Rates 1/1/2022-12/31/2022[19] Louisiana imposes a 2% withhold to the gross capitation rates
LA Rates	LaCHIP Affordable Plan	$26.50
LA Rates	Medicaid Child/CHIP	$21.32
LA Rates	Medicaid Adult	$1.34
LA Rates	Medicaid Expansion Child	$19.71
LA Rates	Medicaid Expansion Adult	$0.91
Maryland	MCO Carve-out: ASO	Administrative PMPM 2020 $0.39[20]
Massachusetts	MCO Carve-out: ASO	Administrative PMPM 7/1/2021-6/30/2024[21] $0.51

[18] State of Iowa, Department of Human Services, SFY Dental Wellness Plan Capitation Rate Development, Gross and Net Capitation Rates

[19] Amendment 3 to MCNA and DentaQuest Approved Contracts, January 20, 2022

[20] Supplement B, Department of Budget and Management Action Agenda May 8, 2019

[21] Amendment 9 for the Dental TPA contract between the Commonwealth of Massachusetts and Dental Services of Massachusetts

State	Medicaid Dental Delivery System	Payment Arrangement
Michigan	MCO Carve-out: PAHP	MDHHS establishes actuarially sound capitation rates in accordance with federal requirements for actuarial soundness and incorporates bidders' proposed rates into their actuarial computations. Michigan imposes a 1% withhold to the gross capitation rates. Rates were unavailable via published records.
Nebraska (NE) description	MCO Carve-out: PAHP	Nebraska's PAHP does not operate at full risk.
NE Jul 20-Jun 21 Rates	0-1	$3.06
NE Jul 20-Jun 21 Rates	2-5	$23.52
NE Jul 20-Jun 21 Rates	6-18	$23.29
NE Jul 20-Jun 21 Rates	19-24	$12.60
NE Jul 20-Jun 21 Rates	25-54	$17.52
NE Jul 20-Jun 21 Rates	55-64	$17.27
NE Jul 20-Jun 21 Rates	65+	$13.04
NE Oct 20-Jun 21 Dental Rates	19-24	$11.95
NE Oct 20-Jun 21 Dental Rates	25-54	$17.25
NE Oct 20-Jun 21 Dental Rates	55-64	$21.05
Nevada (NV) Description	Hybrid	Rates Effective 1/1/2020-3/31/2020[22]
NV TANF/CHIP Rates	< 1 yr old M&F	$0.31
NV TANF/CHIP Rates	1-2 yrs old M&F	$6.67
NV TANF/CHIP Rates	3-14 yrs old M&F	$20.68
NV TANF/CHIP Rates	15-18 yrs old F	$18.73
NV TANF/CHIP Rates	15-18 yrs old M	$16.54
NV TANF/CHIP Rates	19-34 yrs old F	$5.58
NV TANF/CHIP Rates	19-34 yrs old M	$5.05
NV TANF/CHIP Rates	35+ F	$7.55
NV TANF/CHIP Rates	35+ M	$6.82
NV TANF/CHIP Rates	Composite	$14.84
NV Check-up Rates	< 1 yr old M&F	$0.39
NV Check-up Rates	1-2 yrs old M&F	$8.24
NV Check-up Rates	3-14 yrs old M&F	$27.08
NV Check-up Rates	15-18 yrs old F	$22.71
NV Check-up Rates	15-18 yrs old M	$20.59
NV Check-up Rates	Composite	$24.62
NV Expansion Rates	19-34 yrs old F	$6.15
NV Expansion Rates	19-34 yrs old M	$4.95
NV Expansion Rates	35+ F	$9.18
NV Expansion Rates	35+ M	$8.55
NV Expansion Rates	Composite	$12.65
North Carolina (NC) Description	MCO Carve-out: State Administered FFS	NA

[22] Amendment 6 to the contract between The State of Nevada Department of Human Services and Liberty Dental Plan of Nevada, Inc.

State	Medicaid Dental Delivery System	Payment Arrangement
Rhode Island (RI) Description	MCO Carve-out: PAHP	RIteSmile Capitation Rates July 1, 2020 – June 30, 2021
RI Rates	Age 0-2	$4.83
RI Rates	Age 3-5	$16.53
RI Rates	Age 6-10	$23.56
RI Rates	Age 11-15	$25.62
RI Rates	Age 16-21	$20.10
RI Rates	Composite	$19.74
South Carolina (SC) Description	MCO Carve-out: ASO	Unavailable via published records.
Tennessee (TN) Description	MCO Carve-out: ASO	Administrative Capitation Rates
TN Rates	TennCare Children's and TPPOHP	$0.50
TN Rates	TennCare ECF CHOICES	$0.01
TN Rates	CoverKids Group 1 Child	$14.70
TN Rates	CoverKids Group 2 Child	$20.67
TN Rates	CoverKids AI/NA	$18.19
Texas (TX) Description	MCO Carve-out: PAHP	Unavailable via published records.
Utah (UT) Description	MCO Carve-out: PAHP	Utah's dental plan RFP required bidders to propose rates which would subsequently need to be confirmed as actuarially sound and be approved by CMS. The rates of the 2 PAHPs are not available publicly.
Virginia (VA) Description	MCO Carve-out: ASO	Administrative PMPM 7/1/21 through 6/30/22[23] Children = $0.47 Adults and Pregnant= $0.64
Washington (WA) Description	MCO Carve-out: State Administered FFS	NA

[23] Commonwealth of Virginia, Department of Medical Assistance Services, Emergency Procurement Disposition Form and Price Reasonableness Determination to Continue the Terms of Contract #10064 for Virginia Smiles for Children Program

Appendix E: Pharmacy, Behavioral Health, and NEMT Benefit Delivery in Research States

State	Behavioral Health	Pharmacy	NEMT	Medicaid Dental Delivery System
Arkansas	NA	NA	NA	Dental PAHP
Colorado	In	In	In	MCO Carve-out: ASO
Delaware	Out	In	Out	MCO Carve-out: State Administered FFS
Florida	In	In	In	MCO Carve-out: PAHP
Idaho	NA	NA	NA	Dental PAHP
Iowa	In	In	In	MCO Carve-out: PAHP
Louisiana	In	In[24]	In	MCO Carve-out: PAHP
Maryland	Out	In	Out	MCO Carve-out: ASO
Massachusetts	In	In	Out	MCO Carve-out: ASO
Michigan	Out	In	In	MCO Carve-out: PAHP
Nebraska	In	In	In	MCO Carve-out: PAHP
Nevada	In	In	Out	Hybrid
North Carolina	In	In	In	MCO Carve-out: State Administered FFS
Rhode Island	In	In	Out	MCO Carve-out: PAHP
South Carolina	In	In	Out	MCO Carve-out: ASO
Tennessee	In	Out	In	MCO Carve-out: ASO
Texas	In	In	In	MCO Carve-out: PAHP
Utah	Out	In	Out	MCO Carve-out: PAHP
Virginia	In	In	In	MCO Carve-out: ASO
Washington	In	In	Out	MCO Carve-out: State Administered FFS

[24] Louisiana released a Medicaid Managed Care Organization RFP on July 1, 2021. Related to pharmacy benefits, the RFP stated, "particularly advancing the efficiency and economy of the pharmacy program by moving to a single PBM for the entire Louisiana Medicaid Managed Care Program." Louisiana released its RFP for a Single Medicaid Pharmacy Benefit Manager on January 14, 2022.

Appendix F: Summary of Research States' Adult Medicaid Dental Benefit

State	Adult Medicaid Dental Benefits[25]	Medicaid Dental Delivery System
MINNESOTA	**LIMITED**	**INTEGRATED**
Arkansas	Limited $500 annual limit (Most extraction and denture services are excluded from the $500 limit.	Dental PAHP
Colorado	Extensive $1,500 annual limit	MCO Carve-out: ASO
Delaware	New- effective 10/1/2020 Extensive $1,000 annual limit with up to $1,500 additional if services are prior authorized	MCO Carve-out: State Administered FFS
Florida	Extensive Adult dental benefits were limited to emergency services covered by MCOs until 12/1/2018 when the state implemented expanded adult benefits through the PAHPs	MCO Carve-out: PAHP
Idaho	Extensive	Dental PAHP
Iowa	Extensive benefits in year one of enrollment To maintain these, enrollees must complete "Healthy Behaviors". Failure to complete "Healthy Behaviors" results in a monthly premium to keep extensive benefits, or transition to a limited benefit $1,000 annual limit	MCO Carve-out: PAHP
Louisiana	Limited	MCO Carve-out: PAHP
Maryland	Emergency[26]	MCO Carve-out: ASO
Massachusetts	Extensive	MCO Carve-out: ASO
Michigan	Limited Dental benefits are carved-in to the state's Medicaid managed care contracts only for non-elderly adults in the Medicaid expansion group	MCO Carve-out: PAHP

[25] Center for Health Care Strategies, Inc., Medicaid Adult Dental Benefits Coverage by State, September 2019, confirmed with state Medicaid and dental plan benefit descriptions

[26] In June 2019, Maryland implemented a pilot program through an amendment to its §1115 waiver to provide limited dental benefit to dual eligible enrollees (21-64) not enrolled in a managed care organization (MCO). The benefits include diagnostic, preventive, extractions, and restorative services up to a maximum of $800 per enrollee per calendar year. These benefits are administered through the state's DBA. For services that exceed the $800 cap, participating providers are required to charge the enrollee the same rates as the Medicaid dental rates, not commercial or the usual and customary provider rates.

State	Adult Medicaid Dental Benefits[25]	Medicaid Dental Delivery System
Nebraska	Limited $750 annual limit	MCO Carve-out: PAHP
Nevada	Emergency	Hybrid
North Carolina	Extensive	MCO Carve-out: State Administered FFS
Rhode Island	Extensive	MCO Carve-out: PAHP
South Carolina	Limited $750 annual limit	MCO Carve-out: ASO
Tennessee	None	MCO Carve-out: ASO
Texas	None	MCO Carve-out: PAHP
Utah	None	MCO Carve-out: PAHP
Virginia	New- Effective 7/1/2021 Extensive	MCO Carve-out: ASO
Washington	Extensive	MCO Carve-out: State Administered FFS

Attachment 1: 50 State+DC Inventory of Medicaid Dental Delivery Systems

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Alabama	A. Integrated	State Administered FFS	NA	N	854,004	180,990	1,034,994	717,102		N
Alaska	A. Integrated	State Administered FFS	NA	Y	234,706	12,875	247,581	101,548		N
Arizona	A. Integrated	MCO Carve-in	NA	Y	1,916,492	128,112	2,044,604	Data not reported	Children in foster care are carved-out of managed care and their medical and dental services are provided through CMDP, a program operated by the Department of Economic Security (DES), Division of Youth and Families. The department does not currently contract with a third party dental benefits manager,	N
Arkansas	D. Other Non-Integrated	Dental PAHP	Managed Care of North America (MCNA) Dental, Delta Dental	Y	880,279	37,195	917,474	400,346	With the exception of PASSE (a small managed care program for individuals with complex behavioral health, developmental, or intellectual disabilities-Provider-Led Arkansas Shared Savings entity), Arkansas does not use full risk managed care for Medicaid or its CHIP program (ARKids First).	Y
California	B. MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	Delta Dental	Y	11,514,302	1,296,140	12,810,442	5,036,629		N

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Colorado	B. MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	DentaQuest	Y	1,497,818	65,627	1,563,445	631,743		Y
Connecticut	A. Integrated	Dental ASO	BeneCare Dental Plans	Y	933,715	17,848	951,563	353,468	Connecticut does not use full risk managed care for Medicaid. The state manages Medicaid using a managed Fee-for-Service model, meaning it contracts with ASOs to administer different benefits.	N
District of Columbia	A. Integrated	MCO Carve-in	NA	Y	250,354	17,244	267,598	95,951		N
Delaware	B. MCO Carve-Out to Dental FFS	MCO Carve-out: State Administered FFS	NA	Y	255,645	11,400	267,045	118,134	The exception to the dental carve out is for the newly implemented adult dental benefit under Medicaid effective October 1, 2020. Beginning 10/1/2020, individuals ages 19-65 who are enrolled in a managed care Medicaid plan will receive their adult dental services through that plan. Adults who are enrolled in fee-for-service Medicaid will receive their adult dental services through state administered fee-for-service.	Y

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Florida	C. MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	MCNA Dental, DentaQuest, Liberty Dental Plan	N	4,122,539	159,123	4,281,662	2,750,804	Florida has vacillated on its Medicaid dental services delivery model. From 2006-2013, Florida provided dental services through the Statewide Prepaid Dental Health plan program. Beginning in 2014 through 2018, dental services were carved in to managed care as part of the implementation of the Statewide Medicaid Managed Care (SMMC) program. In 2016, the legislature directed the AHCA to provide Medicaid recipients with dental benefits separate from SMMC and the state then procured for dental PAHP services.	Y
Georgia	A. Integrated	MCO Carve-in	NA	N	1,895,196	264,748	2,159,944	1,506,836		N
Hawaii	B. MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	Delta Dental	Y	382,429	24,447	406,876	156,596	Exception: starting in October 2018, MCOs AlohaCare and Ohana Health Plan include basic adult dental care for adults who have Medicaid as their sole source of medical insurance coverage. Liberty Dental Plan will manage the dental network for the two MCOs.	N
Idaho	D. Other Non-Integrated	Dental PAHP	MCNA Dental	Y	363,357	31,079	394,436	199,271	Idaho does not operate a comprehensive managed care program and provides most services via a fee-for-service delivery system.	Y
Illinois	A. Integrated	MCO Carve-in	NA	Y	3,012,554	319,060	3,331,614	1,464,103		N
Indiana	A. Integrated	MCO Carve-in	NA	Y	1,745,657	104,446	1,850,103	907,355		N

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Iowa	C. MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	Delta Dental, MCNA Dental	Y	693,978	81,732	775,710	367,749		Y
Kansas	A. Integrated	MCO Carve-in	NA	N	377,229	66,692	443,921	307,538		N
Kentucky	A. Integrated	MCO Carve-in	NA	Y	1,474,673	107,408	1,582,081	613,887		N
Louisiana	C. MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	DentaQuest, MCNA	Y	1,598,851	146,973	1,745,824	772,505		Y
Maine	A. Integrated	State Administered FFS	NA	Y	305,968	14,283	320,251	124,438		N
Maryland	B. MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	SKYGEN USA	Y	1,365,929	144,361	1,510,290	674,178	Emergency only dental services for adults are covered under managed care.	Y
Massachusetts	B. MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	DentaQuest	Y	1,578,945	200,473	1,779,418	711,288		Y

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Michigan	C. MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	Blue Cross Blue Shield of Michigan, Delta Dental Plan of Michigan	Y	2,665,706	67,779	2,733,485	1,039,452	Dental benefits are carved in to the state's Medicaid managed care contracts only for non-elderly adults in the Medicaid expansion group. However, the Governor's proposed budget, released on 2/9/2022, proposed consolidating all Medicaid dental into a single statewide dental managed care contract with dental health plans, in combination with Medicaid dental procesure reimbursement rate increases at outpatient hospitals and ambulatory surgical centers. These changes will have to be approved by the state legislature as part of the budget process.	Y
Minnesota	A. Integrated	MCO Carve-in	NA	Y	1,212,920	1,187	1,214,107	588,645		N
Mississippi	A. Integrated	MCO Carve-in	NA	N	618,767	82,642	701,409	473,542		N
Missouri	A. Integrated	MCO Carve-in	NA	Y	1,023,144	41,143	1,064,287	663,835		N
Montana	A. Integrated	State Administered FFS	NA	Y	260,726	28,060	288,786	125,232		N
Nebraska	C. MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	MCNA Dental	Y	288,787	35,413	324,200	184,806		Y

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Nevada	D. Other Non-Integrated	Hybrid	Liberty Dental Plan of Nevada	Y	747,208	43,160	790,368	344,806	Medicaid and CHIP dental benefits are carved out of the state's Medicaid and CHIP managed care contracts in the two counties in which the state uses managed care: Clark and Washoe. In these 2 counties, the state contracts separately for a dental PAHP. Medicaid eligibles outside of this 2 county area receive all benefits via state administered fee-for-service.	Y
New Hampshire	A. Integrated	State Administered FFS	NA	Y	202,381	18,468	220,849	100,133		N
New Jersey	A. Integrated	MCO Carve-in	NA	Y	1,731,991	241,344	1,973,335	895,414		N
New Mexico	A. Integrated	MCO Carve-in	NA	Y	794,881	43,709	838,590	362,534		N
New York	A. Integrated	MCO Carve-in	NA	Y	6,240,559	592,141	6,832,700	2,522,833		N
North Carolina	B. MCO Carve-Out to Dental FFS	MCO Carve-out: State Administered FFS	NA	N	1,772,364	299,838	2,072,202	1,300,093	On 2/8/2021, Senate Bill 61 was introduced to the General Assembly of North Carolina's 2021-2022 Session. The bill seeks to require the state to enter capitated contracts with at least two PAHPs for the provision of dental services to Medicaid recipients. The bill passed its first reading and was referred to the Committee on Rules and Operations of the Senate on February 9, 2021. No action on the bill since 2/9/2021. https://www.ncleg.gov/BillLookUp/2021/S61	Y

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
North Dakota	A. Integrated	State Administered FFS	NA	Y	109,013	2,344	111,357	51,719		N
Ohio	A. Integrated	MCO Carve-in	NA	Y	2,835,813	215,515	3,051,328	1,282,599		N
Oklahoma	A. Integrated	State Administered FFS	NA	Y	753,336	134,644	887,980	596,094	Oklahoma released a SoonerSelect Dental RFP for the procurement of statewide PAHPs to deliver risk-based dental benefits to Medicaid eligibles on 10/15/2020. Proposals were due 12/15/2020. Awards were announced 2/17/2021 to three dental PAHPs: DentaQuest, LIBERTY Dental Plan of Oklahoma, Inc., and MCNA Dental. The procurement was subsequently cancelled based on a 6/1/2021 ruling by the Oklahoma Supreme Court that the Oklahoma Health Care Authority does not have the authority to implement a managed care plan for the state's Medicaid system. The state intends to re-issue the RFP, and in the meantime continues to administer dental benefits under fee-for-service.	N
Oregon	A. Integrated	MCO Carve-in	NA	Y	1,045,272	152,866	1,198,138	457,554		N
Pennsylvania	A. Integrated	MCO Carve-in	NA	Y	3,186,365	157,790	3,344,155	1,502,001		N

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Rhode Island	C. MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	UnitedHealthcare Dental	Y	301,346	33,210	334,556	123,427		Y
South Carolina	B. MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	DentaQuest	N	1,054,989	104,855	1,159,844	701,706		Y
South Dakota	A. Integrated	Dental ASO	Delta Dental	N	110,437	17,392	127,829	89,479		N
Tennessee	B. MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	DentaQuest	N	1,487,009	132,669	1,619,678	898,643		Y
Texas	C. MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	DentaQuest, MCNA, UnitedHealthcare	N	4,405,074	595,253	5,000,327	3,867,146		Y
Utah	C. MCO Carve-Out to Dental Managed Care	MCO Carve-out: PAHP	MCNA, Premier Access	Y	373,468	41,663	415,131	224,901		Y
Vermont	A. Integrated	State Administered FFS	NA	Y	173,389	4,299	177,688	64,431		N

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Virginia	C. MCO Carve-Out to Dental FFS	MCO Carve-out: ASO	DentaQuest	Y	1,542,540	165,626	1,708,166	842,704		Y
Washington	B. MCO Carve-Out to Dental FFS	MCO Carve-out: State Administered FFS	NA	Y	1,891,805	73,596	1,965,401	867,721	Washington planned to implement a Managed Care Dental Program for Medicaid eligibles beginning January 1, 2019, and used a competitive procurement process to select dental plans with issuance of an RFP in May of 2018, and awards announced on 8/1/2018 to Amerigroup (Anthem), Dentegra, and MCNA. Subsequent to award, the state announced a delay in implementation from 1/1/2019 to 7/1/2019, and then on 4/29/2019, the 2019 State Legislature directed the Washington State Health Care Authority (HCA) to continue to administer the dental Medicaid program through fee-for-service. The HCA was prohibited from proceeding with a carved-out or carved-in managed care dental option, and contracts that were procured or in the process of being procured were directed not to be implemented.	Y
West Virginia	A. Integrated	MCO Carve-in	NA	Y	548,426	32,903	581,329	230,293		N
Wisconsin	A. Integrated	MCO Carve-in	NA	N	1,193,182	75,957	1,269,139	582,702		N

State	Minnesota RFP Category	Medicaid Dental Delivery System	State Dental Vendor(s) (where applicable)	Adult Expansion State (Y/N)	Medicaid Enrollment	CHIP Enrollment	Total Medicaid and CHIP Enrollment	Total Medicaid Child and CHIP Enrollment	Of Note	For Phase 2 Analysis?
Wyoming	A. Integrated	State Administered FFS	NA	N	63,133	4,705	67,838	44,596	Prior to 10/1/2020, Wyoming's CHIP program used a dental carve-in to CHIP managed care contracts. When the state last issued an RFP to reprocure its CHIP managed care plan, there were no respondents. The state cancelled the procurement and transitioned operations of the Kid Care CHIP to the FFS procedures uses to manage the Wyoming Medicaid program.	N

May 2021 Medicaid & CHIP Enrollment Data Highlights, Centers for Medicare and Medicaid Services, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

Sources: HMAIS

Attachment 2: Profiles of Non-Integrated Medicaid Dental Delivery Systems

See Attachments

Attachment 3: Dental Provider Survey

Minnesota Dental Provider Survey

KEY:

Questions shown only to providers who do participate in Minnesota's Medicaid/MinnesotaCare program are shown in bold.

Questions shown only to providers who do not participate in Minnesota's Medicaid/MinnesotaCare program are shown in underlined.

Questions shown to all respondents are shown in regular font.

Start of Block: Introduction

Intro In partnership with the Minnesota Dental Association, the Minnesota Department of Human Services (DHS) is seeking your input about dentists' willingness to participate in the state's medical assistance program. DHS administers federal and state funded health care programs for low-income, indigent, and special needs populations, including Medicaid. The Department serves over one million individuals through various health care programs. These programs include Medical Assistance (MA), which is Minnesota's Medicaid program, and MinnesotaCare. These two programs together are referred to as the Minnesota Healthcare Programs (MHCP). MHCP pays providers either directly through fee-for-service or through contracted health plans such as Blue Plus, Hennepin Health, HealthPartners, Itasca Medical Care, Medica, PrimeWest Health, South Country Health Alliance, UCare, and UnitedHealthcare-MN.

Thank you in advance for taking time out to participate in this important dental study. Be assured that, throughout the survey process, your responses will remain completely confidential and will not be identified with you in any way.

If you have any questions regarding the survey, please contact Brittany Thompson at HMA at bthompson@healthmanagement.com or (541) 292-8071 or Rebecca Mendoza at HMA at rmendoza@healthmanagement.com or (202) 601-7743.

Instructions We recognize that you may not practice exclusively in Minnesota. However, please answer the questions regarding your professional duties in **Minnesota only.**

When the survey asks you about DHS health plans that administer dental benefits to Minnesota Medicaid and MinnesotaCare patients, we are referring to the DHS contracted health plans such as Blue Plus, Hennepin Health, HealthPartners, Itasca Medical Care, Medica, PrimeWest Health, South Country Health Alliance, UCare, and UnitedHealthcare-MN.

End of Block: Introduction

Start of Block: Demographics

Q1 Please choose the gender you most identify with:

- ○ Male
- ○ Female
- ○ Other
- ○ Prefer not to answer

Q2 What is your age?

- ○ Under 40 years
- ○ 40–49 years
- ○ 50–59 years
- ○ 60–69 years
- ○ 70 years and over

Q3 What is your race?

- ○ White
- ○ Black or African American
- ○ Asian American
- ○ American Indian or Alaskan Native
- ○ Native Hawaiian or Pacific Islander
- ○ Multi-racial
- ○ Other (specify) _____
- ○ Prefer not to answer

Q4 Do you identify as Hispanic or Latino?

- ○ Yes
- ○ No
- ○ Prefer not to answer

Q5 How long have you had a dental license in any state, including Minnesota? (Select only one)

- ○ Less than 2 years
- ○ 2–5 years
- ○ 6–10 years
- ○ 11–20 years
- ○ More than 20 years

Q6 When do you plan to retire? (Select only one)

- ○ Within the next 2 years
- ○ In the next 2 to 5 years
- ○ More than 5 years from now

Q7 What type of dentistry do you practice?

- ○ General Dentistry
- ○ Pediatric Dentistry only
- ○ Endodontics
- ○ Orthodontics/dentofacial orthopedics
- ○ Periodontics
- ○ Prosthodontics
- ○ Oral and Maxillofacial Surgeon

End of Block: Demographics

Start of Block: Questions

Q8 Are you an actively practicing dentist performing dental services to patients?

- ○ Yes
- ○ No

Skip To: Q37 If Are you an actively practicing dentist performing dental services to patients? = No

Q9 Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-service provider or through a contracted health plan?

- ○ Yes
- ○ No

Skip To: Q14 If Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-s... = No

Q10 How many years have you been participating in Minnesota's Medicaid/MinnesotaCare program?

- ○ **1 year or less**
- ○ **2-5 years**
- ○ **6-10 years**
- ○ **Greater than 10 years**

Q11 Are you a Medicaid critical access provider?

- ○ **Yes**
- ○ **No**

Q12 Do you limit the number of Minnesota Medicaid/MinnesotaCare patients in your panel?

- **Yes (How/In what way?)** _____
- **No**

Q13 In a typical week, how many additional hours do you spend doing Minnesota Medicaid/MinnesotaCare administrative tasks related to patient care that is more than you would normally do for commercial patients? (e.g., charting, phone calls, referrals, paperwork, etc.)?

Please provide your best estimate.

_____

Display This Question:

If Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-s... = No

Q14 Did you previously participate in Medicaid?

- Yes
- No

Q15 How would you describe your current practice? (Select only one)

- Clinic/Office – Private for profit
- Clinic/Office – Private, not for profit
- Clinic/Office – Public such as in a Federally Qualified Health Center, a Rural Health Center, or a community health center
- Indian Health Services/tribal health center
- Jail or prison facility
- Hospital-setting
- Other (please specify) _____

Q16 Which best describes your ownership in or employment status at the dental practice where you are performing the majority of your dental services? (Select only one)

- ○ A full or part owner of the practice
- ○ An employee of the practice or health system
- ○ An independent contractor
- ○ A volunteer—no ownership/employment
- ○ Other (please specify) _____

Q17 What is the size of your primary practice, that is, the practice in which you spend the most time? (Select only one)

- ○ Solo practice
- ○ Small group practice, 2–4 dentists
- ○ Medium group practice, 5–9 dentists
- ○ Large group practice, 10 or more dentists (Please specify number of dentists)

  _____

Q18 Please describe the location of your primary practice, that is, the practice in which you spend the most time. (Select only one)

- ○ Urban
- ○ Suburban
- ○ Rural
- ○ Frontier
- ○ Other (please specify) _____

Q19 In a typical week, how many new or established patients do you see? (Please provide your best estimate)

- ○ Estimated number of **new** patients seen in a typical week

  _____
- ○ Estimated number of **established** patients seen in a typical week

  _____

Q20 Please estimate the percentage of patients in your practice by lines of business/payor over the last 12 months.

- ○ Commercial Insurance
- ○ Minnesota Medicaid/MinnesotaCare – Fee for Service
- ○ Minnesota Medicaid/MinnesotaCare – through a contracted health plan
- ○ Self-Pay
- ○ Medicare Advantage Plan
- ○ Indian Health Services
- ○ Other (please describe)
- ○ **Total**

Q21 Does your practice employ dental therapists?

- ○ Yes (How many?) _____
- ○ No

Q22 In addition to English, in what languages are you or your staff fluent and able to communicate effectively to non-English speaking patients? (Select all that apply)

- ☐ Spanish
- ☐ Hmong
- ☐ Cushite
- ☐ German
- ☐ Vietnamese
- ☐ Chinese
- ☐ French
- ☐ Russian
- ☐ Laotian
- ☐ Arabic
- ☐ Amharic
- ☐ American Sign Language
- ☐ Other (please specify) _____
- ☐ No other languages than English

Q23 Do you participate in mobile access vans for dentistry in your area?

- ○ Yes
- ○ No
- ○ N/A There are no mobile access dentistry vans in my area

Q24 Do you do sealants in your office for children?

- ○ Yes
- ○ No

Q25 Do you participate in a Minnesota school-based sealant program for children?

- ○ Yes
- ○ No

Display This Question:

If Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-s... = No

Q26 What is the reason you are not participating in Minnesota's Medicaid/MinnesotaCare program? (Check all that apply)

- ☐ Low level of reimbursement
- ☐ Administrative burdensome – prior authorization process
- ☐ Administrative burdensome – claims process
- ☐ Administrative burdensome – credentialling process
- ☐ Patients did not keep appointments/transportation issues
- ☐ Workforce issues – not enough staff in your practice to handle the volume of patients
- ☐ Dental benefit package is too limited for an individual patient's needs
- ☐ Workforce issues – no specialists to refer my patients to for additional services (specialty dental providers, oral surgeons, etc.) outside of my specialty
- ☐ Challenges with Medicaid patients with multiple medical needs/special health care needs/disabilities who need care coordination with Medical providers
- ☐ Need for translation services/communication barriers
- ☐ Can't bill patient for services if it is denied
- ☐ Patients' Eligibility – Patients can lose coverage suddenly and the procedure is no longer covered
- ☐ Risk of lawsuit or complaint to licensing board regarding care
- ☐ Other (please specify) _____

Display This Question:

If Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-s... = No

Q27 What do you see as the primary or most critical barrier to your willingness to participation in Minnesota's Medicaid/MinnesotaCare program?

- ☐ Low level of reimbursement
- ☐ Administrative burdensome – prior authorization process
- ☐ Administrative burdensome – claims process
- ☐ Administrative burdensome – credentialling process
- ☐ Patients did not keep appointments/transportation issues
- ☐ Workforce issues – not enough staff in your practice to handle the volume of patients
- ☐ Dental benefit package is too limited for an individual patient's needs
- ☐ Workforce issues – no specialists to refer my patients to for additional services (specialty dental providers, oral surgeons, etc.) outside of my specialty
- ☐ Challenges with Medicaid patients with multiple medical needs/special health care needs/disabilities who need care coordination with Medical providers
- ☐ Need for translation services/communication barriers
- ☐ Can't bill patient for services if it is denied
- ☐ Patients' Eligibility – Patients can lose coverage suddenly and the procedure is no longer covered
- ☐ Risk of lawsuit or complaint to licensing board regarding care
- ☐ Other (please specify) _____

Display This Question:

If Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-s... = Yes

Q28 What is your primary reason that you participate in Minnesota's Medicaid/MinnesotaCare program and to serve the population?

- ○ **I do it because I think it is the right thing to do**
- ○ **I work in a clinic that focuses on low-income populations**
- ○ **Other (please specify)** _____

Display This Question:

If Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-s... = No

Q29 Will the enhanced payment changes being implemented in Minnesota's Medicaid/MinnesotaCare program change your decision about participating?

- Yes
- No
- I haven't decided yet

Display This Question:

If Will the enhanced payment changes being implemented in Minnesota's Medicaid/MinnesotaCare program... = No

Q30 Why will the enhanced payment changes being implemented in Minnesota's Medicaid/MinnesotaCare program not change your decision about participating?

- Is not enough of an increase for my practice financially
- Other reasons will continue that will keep me from participating
- All of the above

Display This Question:

If Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-s... = Yes

Q31 What are the top issues or challenges of working with Minnesota's Medicaid/MinnesotaCare program? (Please select all that apply)

- **Low level of reimbursement**
- **Administrative burdensome – prior authorization process**
- **Administrative burdensome – claims process**
- **Administrative burdensome – credentialling process**
- **Patients did not keep appointments/transportation issues**
- **Workforce issues – not enough staff in your practice to handle the volume of patients**
- **Dental benefit package is too limited for an individual patient's needs**
- **Workforce issues – no specialists to refer my patients to for additional services (specialty dental providers, oral surgeons, etc.) outside of my specialty**
- **Challenges with Medicaid patients with multiple medical needs/special health care needs/disabilities who need care coordination with Medical providers**
- **Need for translation services/communication barriers**
- **Can't bill patient for services if it is denied**
- **Patients' Eligibility – Patients can lose coverage suddenly and the procedure is no longer covered**

- ☐ **Risk of lawsuit or complaint to licensing board regarding care**
- ☐ **Other (please specify)** _____

Display This Question:

If Do you currently participate in Minnesota's Medicaid/MinnesotaCare program, either as a fee-for-s... = Yes

Q32 Overall which delivery system for Minnesota's Medicaid/MinnesotaCare program dental benefits do you prefer and why:

- ○ **Fee-for-Service (Why?)** _____
- ○ **Contracted health plans (Why?)** _____

Q33 Has the COVID-19 pandemic changed or otherwise impacted your participation in Minnesota's Medicaid/MinnesotaCare program? If so, how?

- ○ Yes (How?) _____
- ○ No

Q34 What changes or improvements are needed to increase provider participation in Minnesota's Medicaid/MinnesotaCare program by dentists in the state? (Select all that apply)

- ☐ Payment – Further enhancement of rates
- ☐ Access and Network – Improve referral process and access to specialty dentists
- ☐ Focus on more prevention efforts/increase incentives for prevention
- ☐ Focus more on pay-for-performance models of reimbursement
- ☐ Create dental homes
- ☐ Improve patient support – care coordination to include dental services
- ☐ Improve patient support – appointment scheduling support and reminders
- ☐ Improve patient support – transportation coordination
- ☐ Streamline prior authorization process
- ☐ Improve claims adjudication process
- ☐ Streamline credentialling process
- ☐ Improve the Minnesota's Medicaid/MinnesotaCare dental benefits to meet standards of practice for commercial dental benefits
- ☐ Reduce eligibility churn rates for Medicaid/MinnesotaCare participants
- ☐ Improve Medicaid/MinnesotaCare participants eligibility verification process
- ☐ Create a single point of contact for prior authorizations, credentialling, claims adjudication, and problem resolution for all dental service provided to Minnesota's

Medicaid/MinnesotaCare participants regardless of if they receive their medical benefits through fee-for-service or contracted health plans

Q35 Are you familiar with a dental Administrative Services Only (ASO) or dental benefits administrator (DBA) model where one entity administers the provider network, prior authorizations, credentialling, claims, and dental benefits to all Medicaid patients regardless if they receive their medical benefits through fee-for-service or a contracted health plan?

- ○ Yes
- ○ No

Q36 Would you prefer an ASO or DBA model to the current way dental benefits are administered under Minnesota's Medicaid/MinnesotaCare program?

- ○ Yes (Why?) _____
- ○ No (Why?) _____
- ○ Not sure/undecided

Q37 Is there anything else you would like us to know about Minnesota's Medicaid/MinnesotaCare program or about ways to improve provider participation and access to dental services?

_____

_____

_____

_____

_____

End of Block: Questions

See Attachment

Attachment 4: Dental Provider Survey Topline Results

Table 1: Q1 – Gender

Please choose the gender you most identify with:

QUESTION CHOICE	NO.	PERCENT
MALE	187	65.4%
FEMALE	88	30.8%
OTHER	0	0.0%
PREFER NOT TO ANSWER	11	3.8%

Figure 1: Gender

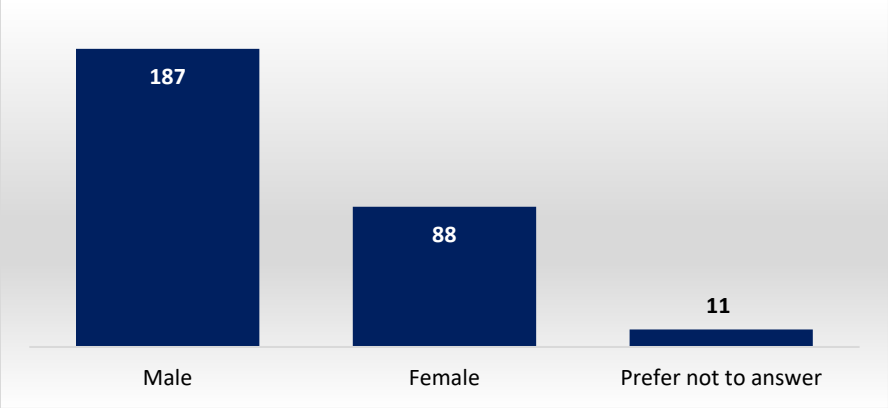


Table 2: Q2 – Age

What is your age?

QUESTION CHOICE	NO.	PERCENT
UNDER 40 YEARS	81	28.6%
40–49 YEARS	63	22.3%
50–59 YEARS	55	19.4%
60–69 YEARS	64	22.6%
70 YEARS AND OVER	20	7.1%

Figure 2: Age

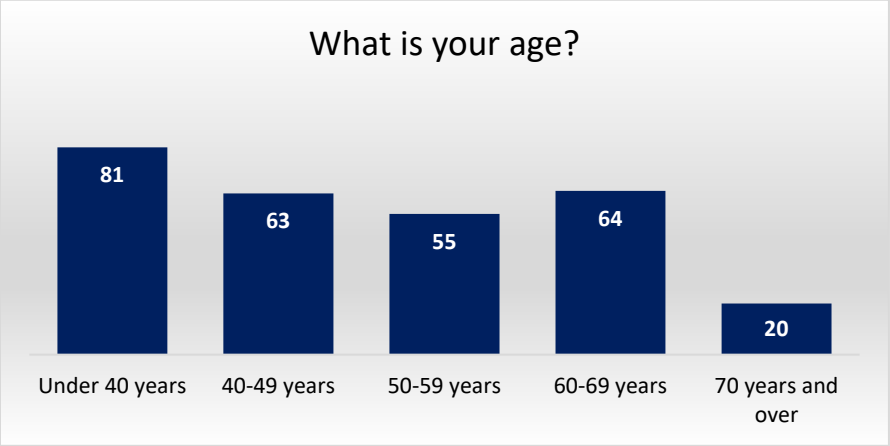


Table 3: Q3 – Race

What is your race?

QUESTION CHOICE	NO.	PERCENT
WHITE	242	84.9%
BLACK OR AFRICAN AMERICAN	1	0.4%
ASIAN AMERICAN	9	3.2%
AMERICAN INDIAN OR ALASKAN NATIVE	0	0.0%
NATIVE HAWAIIAN OR PACIFIC ISLANDER	0	0.0%
MULTI-RACIAL	5	1.8%
OTHER (SPECIFY)	2	0.7%
PREFER NOT TO ANSWER	26	9.1%

Figure 3: Race

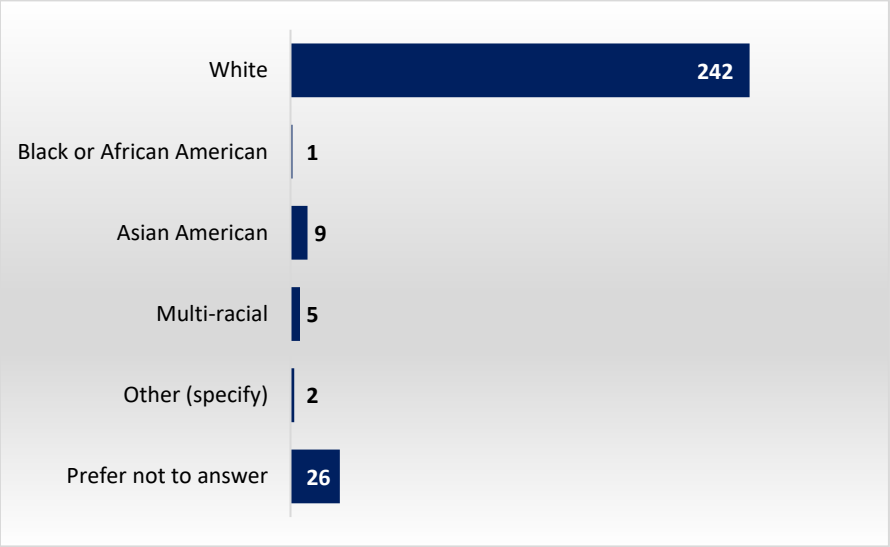


Table 4: Q4 – Ethnicity

Do you identify as Hispanic or Latino?

QUESTION CHOICE	NO.	PERCENT
YES	2	0.7%
NO	252	90.0%
PREFER NOT TO ANSWER	26	9.3%

Figure 4: Ethnicity

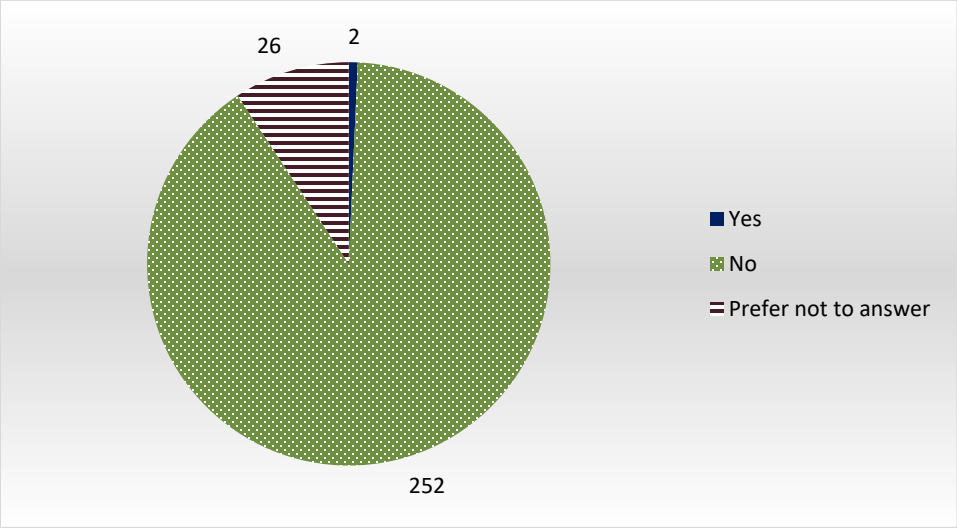


Table 5: Q5 – Duration of Licensure

How long have you had a dental license in any state, including Minnesota?

QUESTION CHOICE	NO.	PERCENT
LESS THAN 2 YEARS	5	1.8%
2–5 YEARS	29	10.2%
6–10 YEARS	39	13.7%
11–20 YEARS	67	23.6%
MORE THAN 20 YEARS	144	50.7%

Figure 5: Duration of Licensure

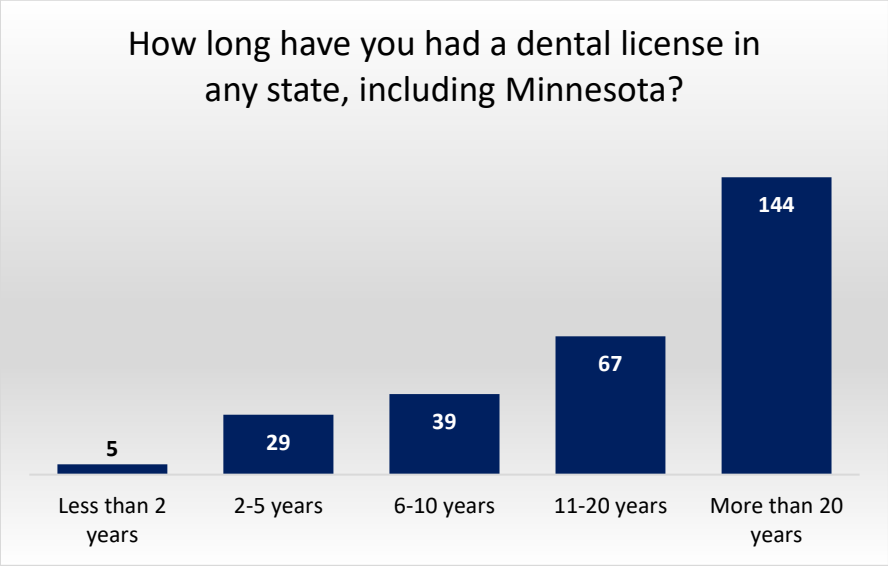


Table 6: Q6 – Retirement

When do you plan to retire?

QUESTION CHOICE	NO.	PERCENT
WITHIN THE NEXT 2 YEARS	44	15.5%
IN THE NEXT 2 TO 5 YEARS	44	15.5%
MORE THAN 5 YEARS FROM NOW	195	68.9%

Figure 6: Retirement

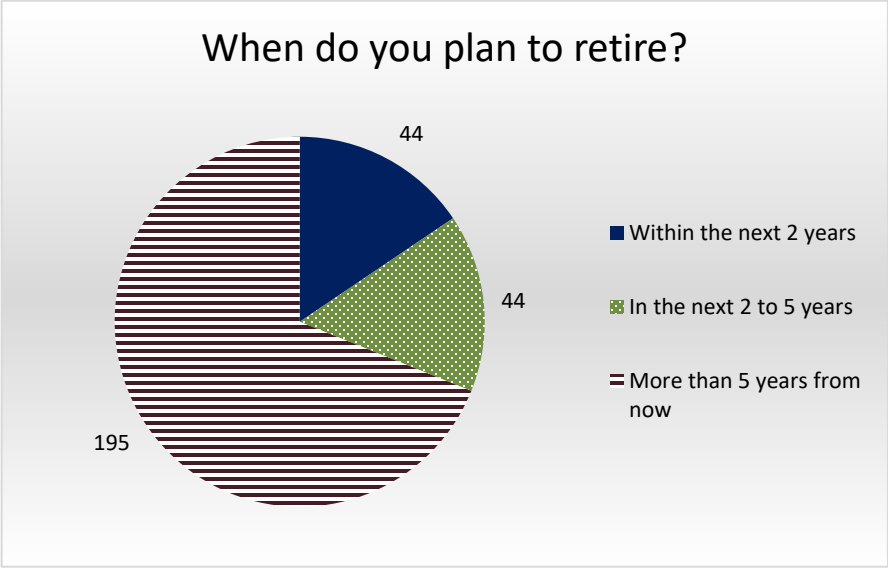


Table 7: Q7 – Practice Type

What type of dentistry do you practice?

QUESTION CHOICE	NO.	PERCENT
GENERAL DENTISTRY	240	84.51%
PEDIATRIC DENTISTRY ONLY	14	4.93%
ENDODONTICS	5	1.76%
ORTHODONTICS/DENTOFACIAL ORTHOPEDICS	9	3.17%
PERIODONTICS	3	1.06%
PROSTHODONTICS	3	1.06%
ORAL AND MAXILLOFACIAL SURGEON	10	3.52%

Figure 7: Practice Type

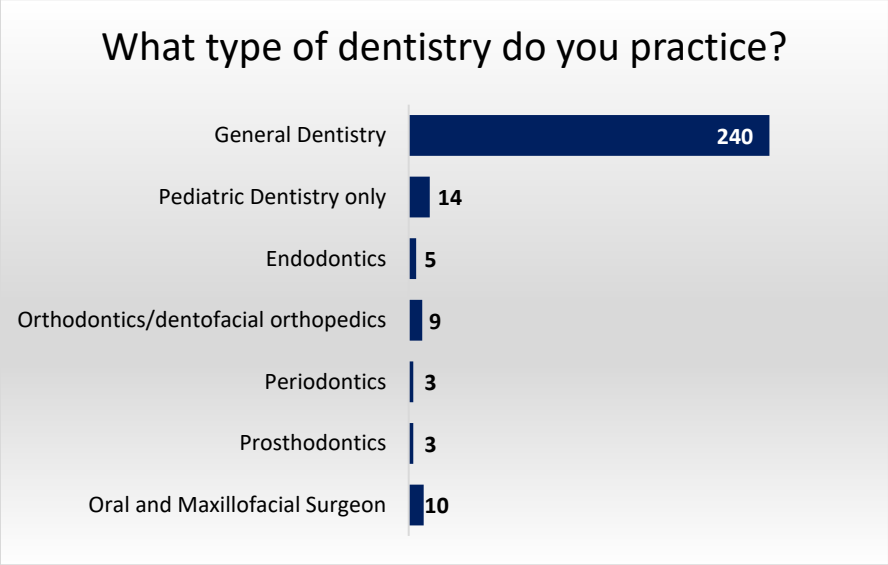


Table 8: Q8 – Practice Status

Are you an actively practicing dentist performing dental services to patients?

QUESTION CHOICE	NO.	PERCENT
YES	269	94.39%
NO	16	5.61%

Figure 8: Practice Status

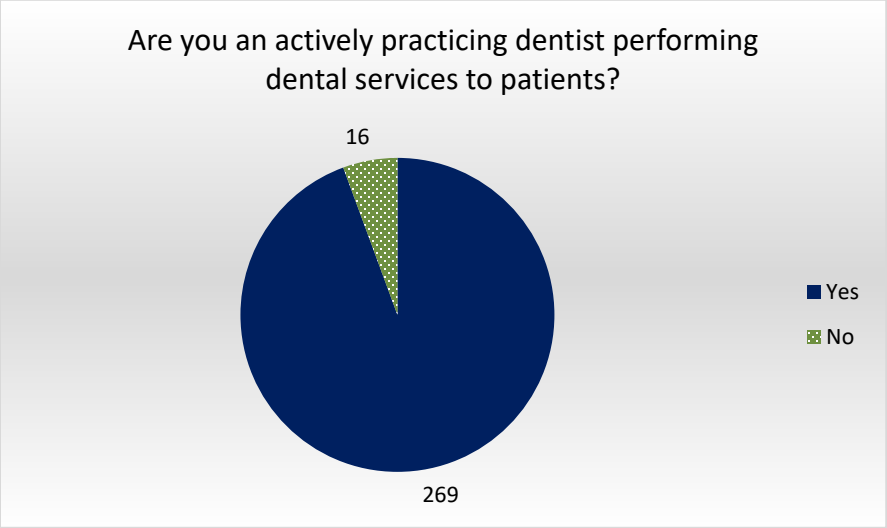


Table 9: Q9 – Participation in Minnesota Medicaid and MinnesotaCare

Do you currently participate in Minnesota's Medicaid/MinnesotaCare program?

QUESTION CHOICE	NO.	PERCENT
YES	148	55.0%
NO	121	45.0%

Figure 9: Participation in Minnesota Medicaid and MinnesotaCare

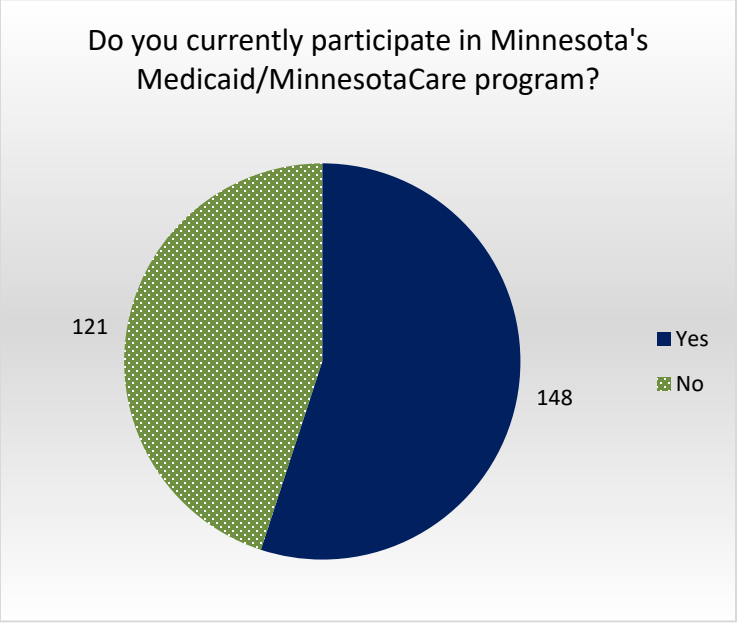


Table 10: Q10 – Duration of Participation

How many years have you been participating in Minnesota's Medicaid/MinnesotaCare program?

QUESTION CHOICE	NO.	PERCENT
1 YEAR OR LESS	7	4.7%
2-5 YEARS	24	16.2%

QUESTION CHOICE	NO.	PERCENT
6-10 YEARS	23	15.5%
GREATER THAN 10 YEARS	94	63.5%

Figure 10: Duration of Participation in Minnesota's Medicaid and MinnesotaCare Programs

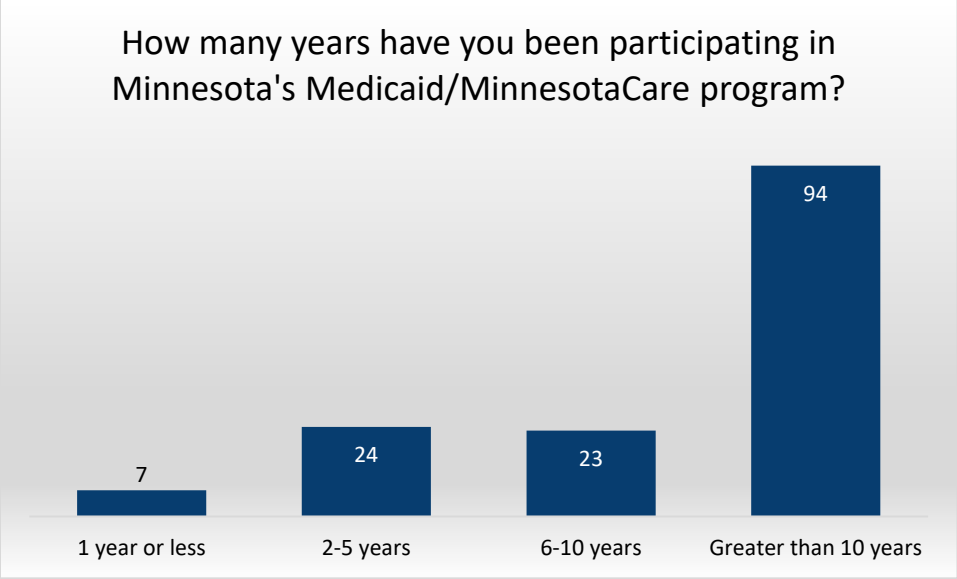


Table 11: Q11 – Critical Access Provider Status

Are you a Medicaid critical access provider?

QUESTION CHOICE	NO.	PERCENT
YES	39	26.35%
NO	109	73.65%

Figure 11: Critical Access Provider Status

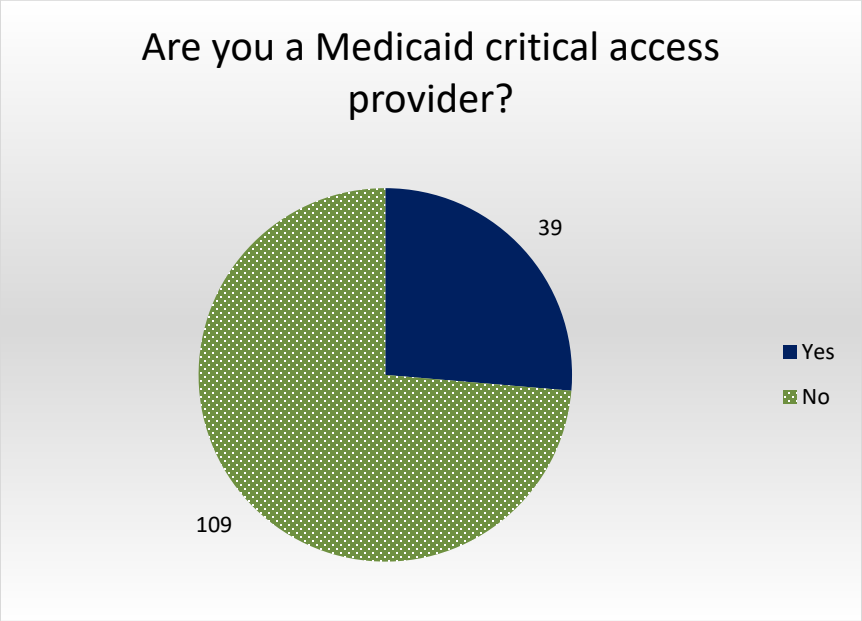


Table 12: Q12 – Limitations on Participation

For those who participate in Medicaid and MinnesotaCare, do you limit the number of Minnesota Medicaid/MinnesotaCare patients in your panel?

QUESTION CHOICE	NO.	PERCENT
YES, ACCEPT NO NEW PATIENTS	36	26.7%
YES, ACCEPT LIMITED NEW PATIENTS	62	45.9%
NO	37	27.4%

"Pay so low and was getting too many when open for all. Now only seeing new children."

"We are at about 25%, limit to a radius around our practice."

Figure 12: Limitations on Medicaid and MinnesotaCare Participation

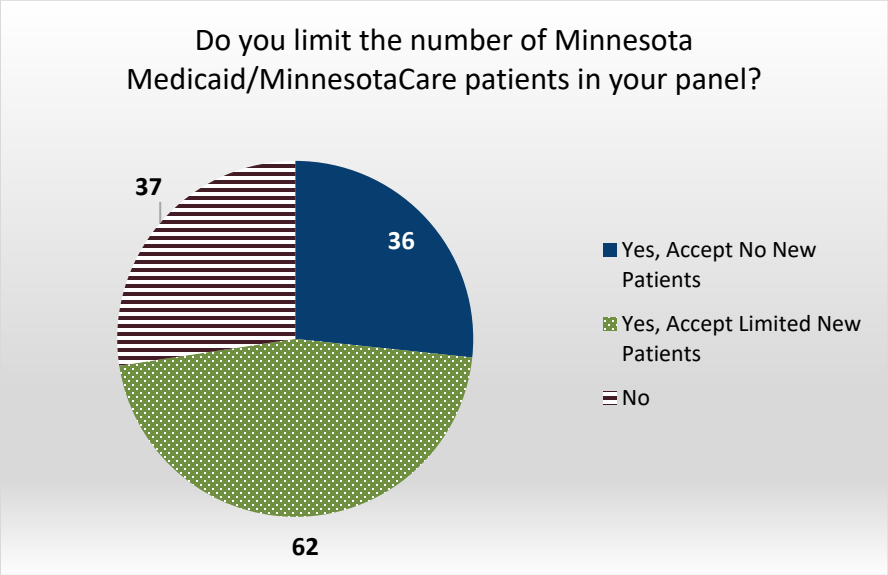


Table 13: Q13 – Hour on Medicaid Administration

For those who participate in Medicaid, how many additional Hours/Week Spent on Minnesota Medicaid/MinnesotaCare Administrative Tasks?

QUESTION CHOICE	NO.	PERCENT
LESS THAN 5	117	89.3%
BETWEEN 5 AND 15	11	8.4%
MORE THAN 15	3	2.3%

Figure 13: Hour on Medicaid Administration

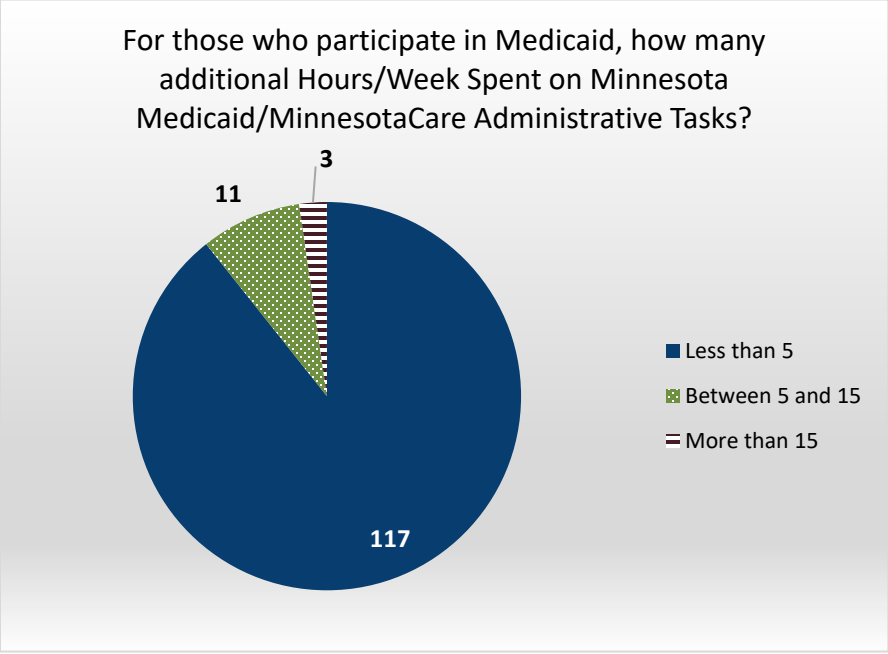


Table 14: Q14 – Prior Medicaid Participation

For those who do not participate in Medicaid, did you previously participate in Medicaid?

QUESTION CHOICE	NO.	PERCENT
YES	44	36.7%
NO	76	63.3%

Figure 14: Prior Medicaid and MinnesotaCare Participation

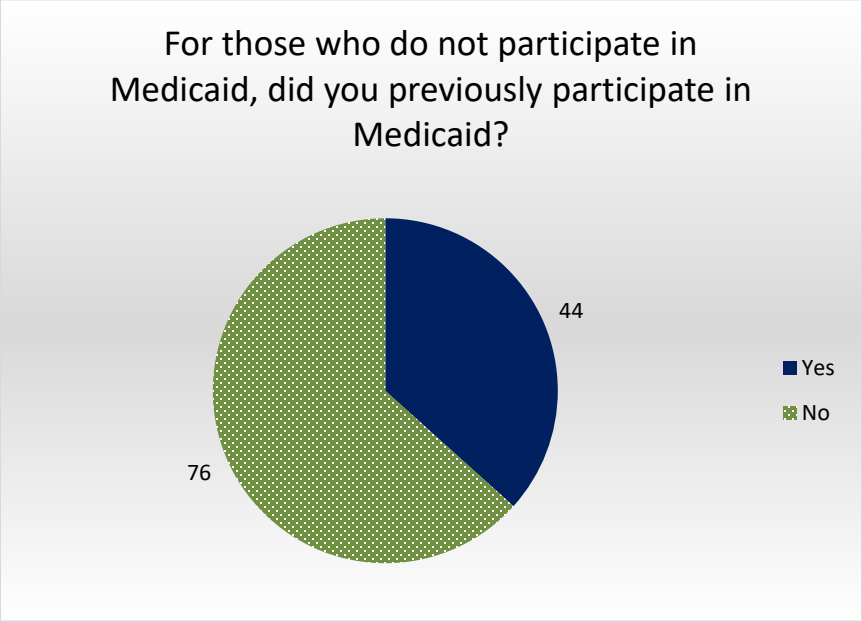


Table 15: Q15 – Practice Business Type

How would you describe your current practice?

QUESTION CHOICE	NO.	PERCENT
CLINIC/OFFICE – PRIVATE FOR PROFIT	250	92.9%
CLINIC/OFFICE – PRIVATE, NOT FOR PROFIT	11	4.1%
CLINIC/OFFICE – PUBLIC SUCH AS IN A FEDERALLY QUALIFIED HEALTH CENTER, A RURAL HEALTH CENTER, OR A COMMUNITY HEALTH CENTER	4	1.5%
INDIAN HEALTH SERVICES/TRIBAL HEALTH CENTER	0	0.0%
JAIL OR PRISON FACILITY	0	0.0%
HOSPITAL-SETTING	3	1.1%
OTHER (PLEASE SPECIFY)	1	0.4%

Figure 15: Practice Business Type

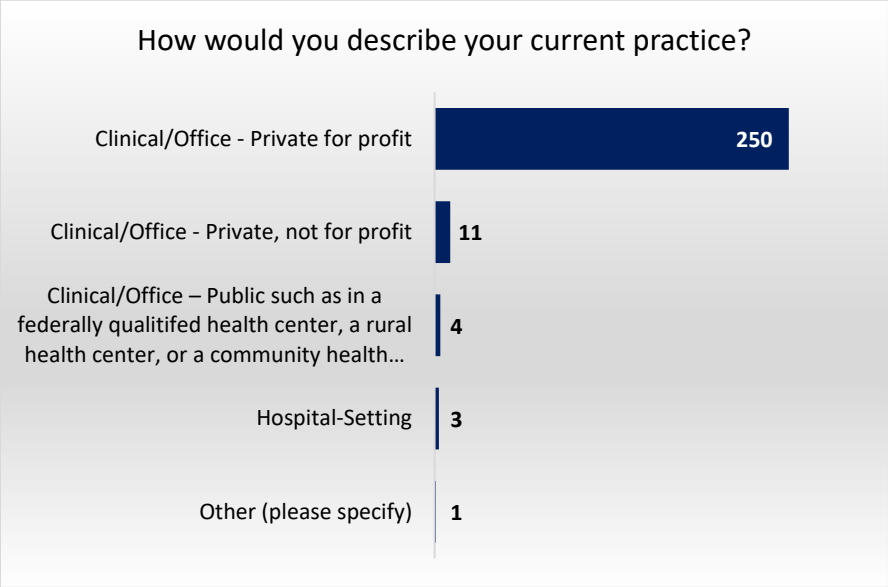


Table 16: Q16 – Respondent Relationship to Practice

Which best describes your ownership in or employment status at the dental practice where you are performing the majority of your dental services?

QUESTION CHOICE	NO.	PERCENT
A FULL OR PART OWNER OF THE PRACTICE	212	79.1%
AN EMPLOYEE OF THE PRACTICE OR HEALTH SYSTEM	48	17.9%
AN INDEPENDENT CONTRACTOR	8	3.0%
A VOLUNTEER—NO OWNERSHIP/EMPLOYMENT	0	0.0%
OTHER (PLEASE SPECIFY)	0	0.0%

Figure 16: Respondent Relationship to Practice

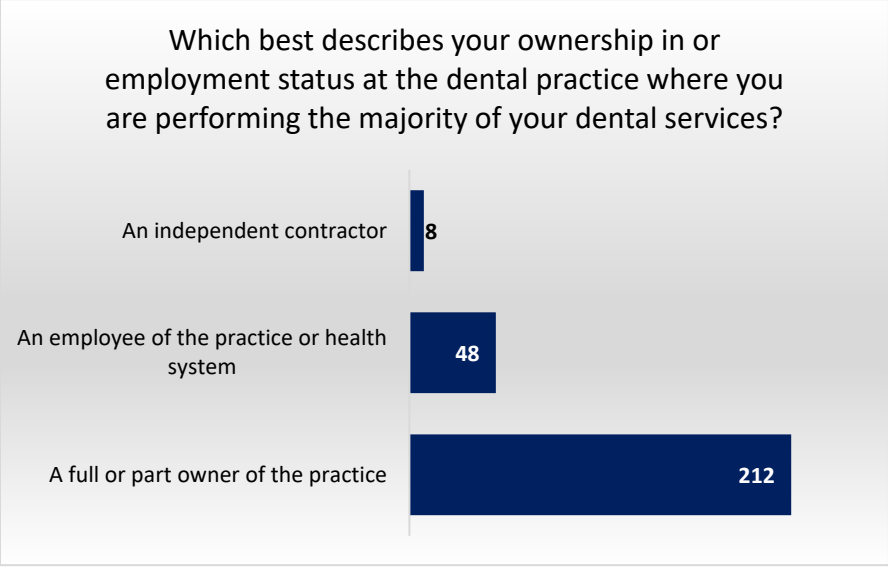


Table 17: Q17 – Practice Size

What is the size of your primary practice, that is, the practice in which you spend the most time?

QUESTION CHOICE	NO.	PERCENT
SOLO PRACTICE	105	39.2%
SMALL GROUP PRACTICE, 2–4 DENTISTS	137	51.1%
MEDIUM GROUP PRACTICE, 5–9 DENTISTS	17	6.3%
LARGE GROUP PRACTICE, 10 OR MORE DENTISTS	9	3.4%

Figure 17: Practice Size

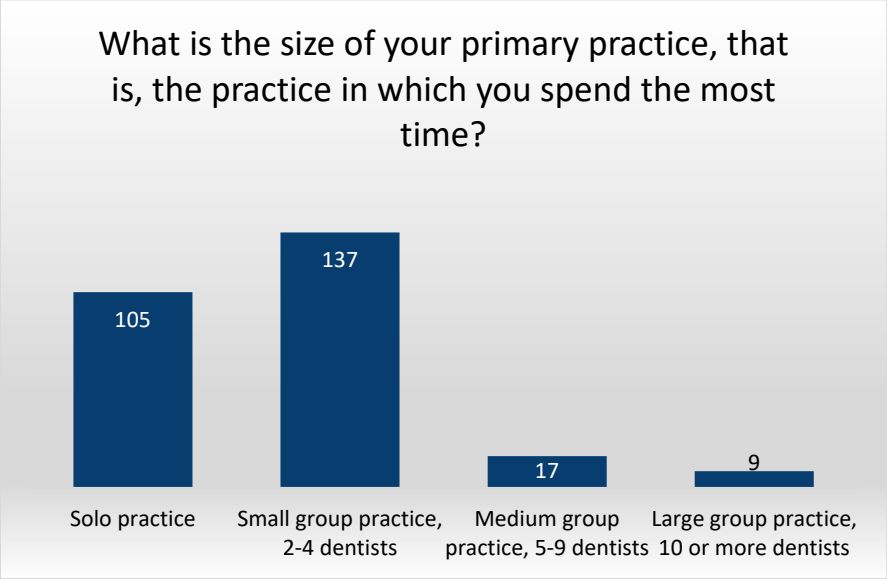


Table 18: Q18 – Practice Location

Please describe the location of your primary practice, that is, the practice in which you spend the most time.

QUESTION CHOICE	NO.	PERCENT
URBAN	39	14.6%
SUBURBAN	125	46.8%
RURAL	102	38.2%
FRONTIER	0	0.0%
OTHER (PLEASE SPECIFY)	1	0.4%

Figure 18: Practice Location

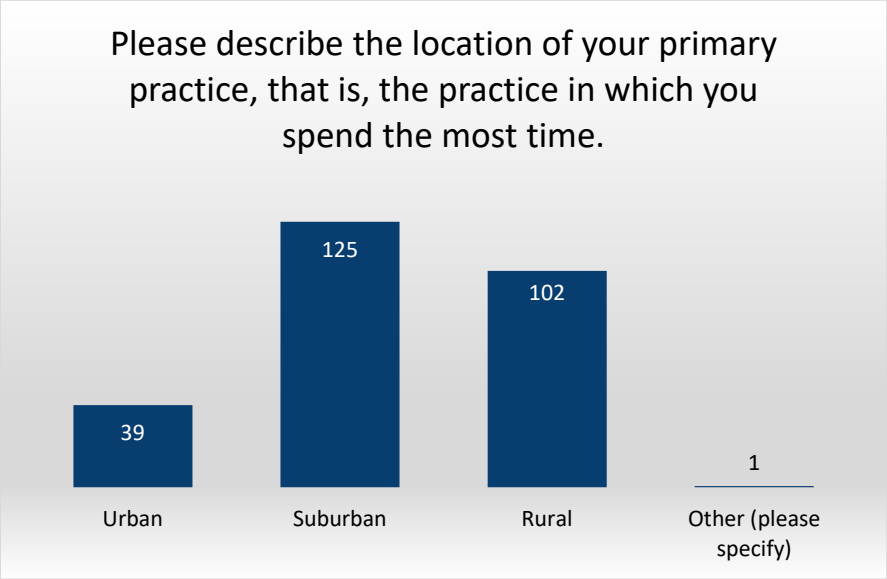


Table 19a: Q19a – Weekly New Patients

In a typical week, how many new patients do you see?

QUESTION CHOICE	NO.	PERCENT
LESS THAN 10	168	64.1%
BETWEEN 10 AND 50	90	34.4%
MORE THAN 50	4	1.5%

Table 19b: Q19b – Weekly New Patients

In a typical week, how many established patients do you see?

QUESTION CHOICE	NO.	PERCENT
LESS THAN 50	65	25.4%
BETWEEN 50 AND 100	113	44.1%
MORE THAN 100	78	30.5%

Figure 19: New Patients per Week

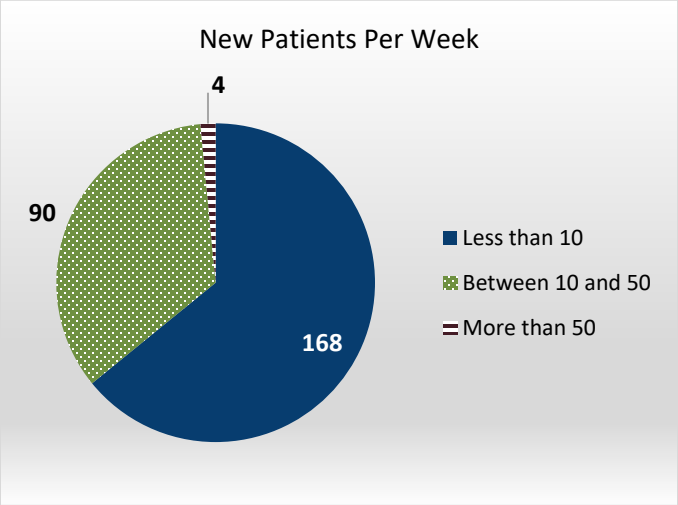


Figure 20: Established Patients per Week

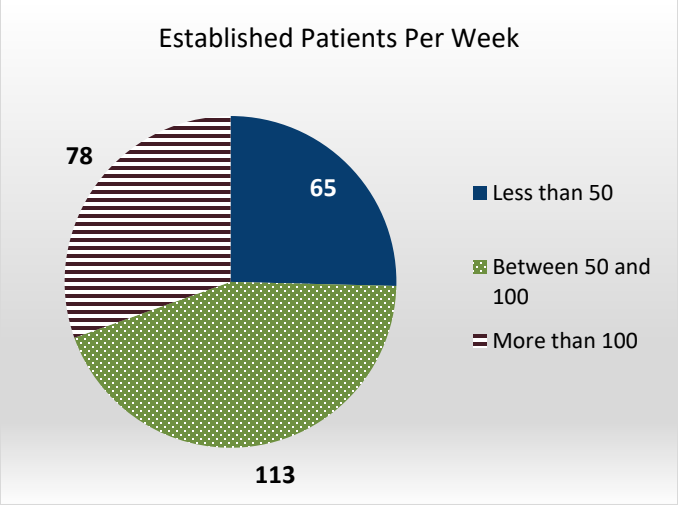


Table 20: Q20 – Payer Mix

Percentage Of Patients By Lines Of Business/Payor Over The Last 12 Months

QUESTION CHOICE	LESS THAN 10	BETWEEN 10 AND 50	MORE THAN 50
COMMERCIAL INSURANCE	46	73	168
MINNESOTA MEDICAID/MINNESOTACARE – FEE FOR SERVICE	243	36	4
MINNESOTA MEDICAID/MINNESOTACARE – THROUGH A CONTRACTED HEALTH PLAN	218	54	14
SELF-PAY	76	198	14
MEDICARE ADVANTAGE PLAN	254	34	0
INDIAN HEALTH SERVICES	287	1	0
OTHER	281	7	0

Figure 21: Payer Mix

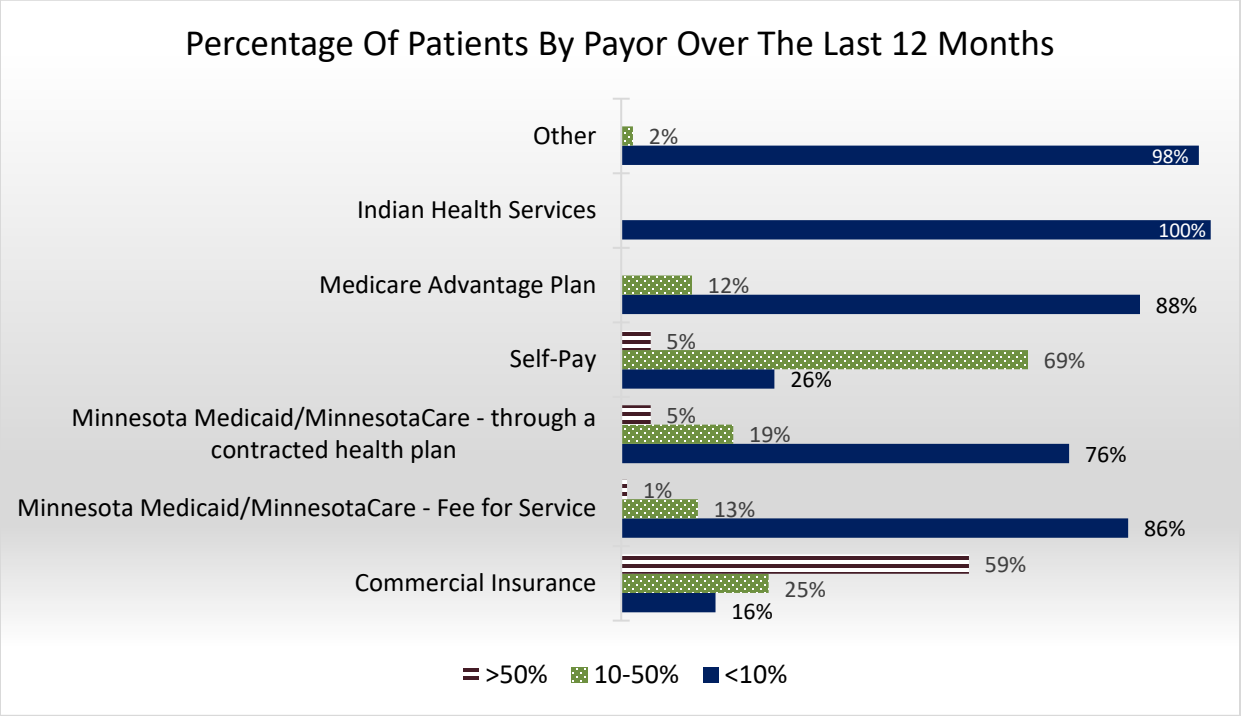


Table 21: Q21 – Employment of Dental Therapists

Does your practice employ dental therapists?

QUESTION CHOICE	NO.	PERCENT
YES	23	8.7%
NO	242	91.3%

Figure 22: Employment of Dental Therapists

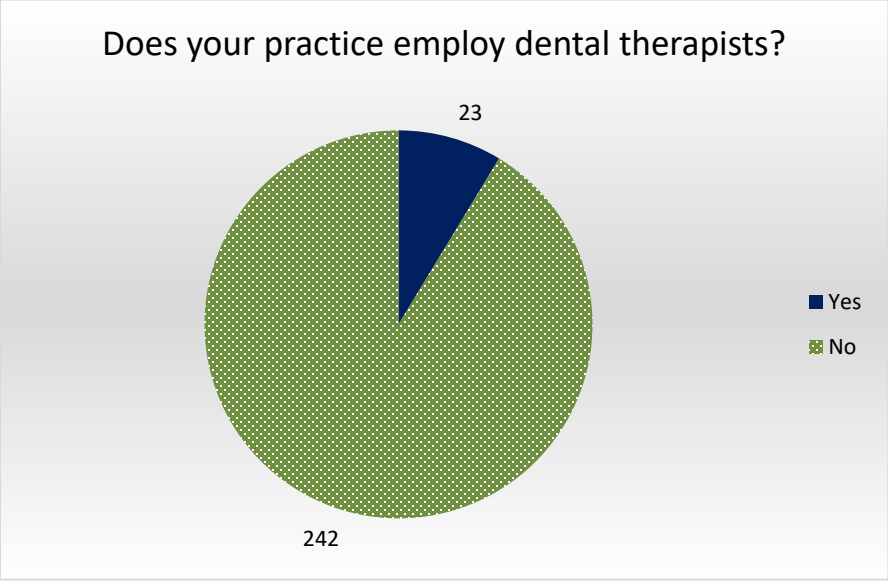


Table 22: Q22 – Languages Spoken at Practice

In addition to English, in what languages are you or your staff fluent and able to communicate effectively to non-English speaking patients?

QUESTION CHOICE	NO.
NO OTHER LANGUAGES THAN ENGLISH	154
SPANISH	52
HMONG	15
OTHER (PLEASE SPECIFY)	13
VIETNAMESE	7
ARABIC	7
CHINESE	6
RUSSIAN	6
AMERICAN SIGN LANGUAGE	6
FRENCH	5
GERMAN	4
LAOTIAN	4
CUSHITE	2
AMHARIC	2

Figure 23: Languages Spoken at Practice

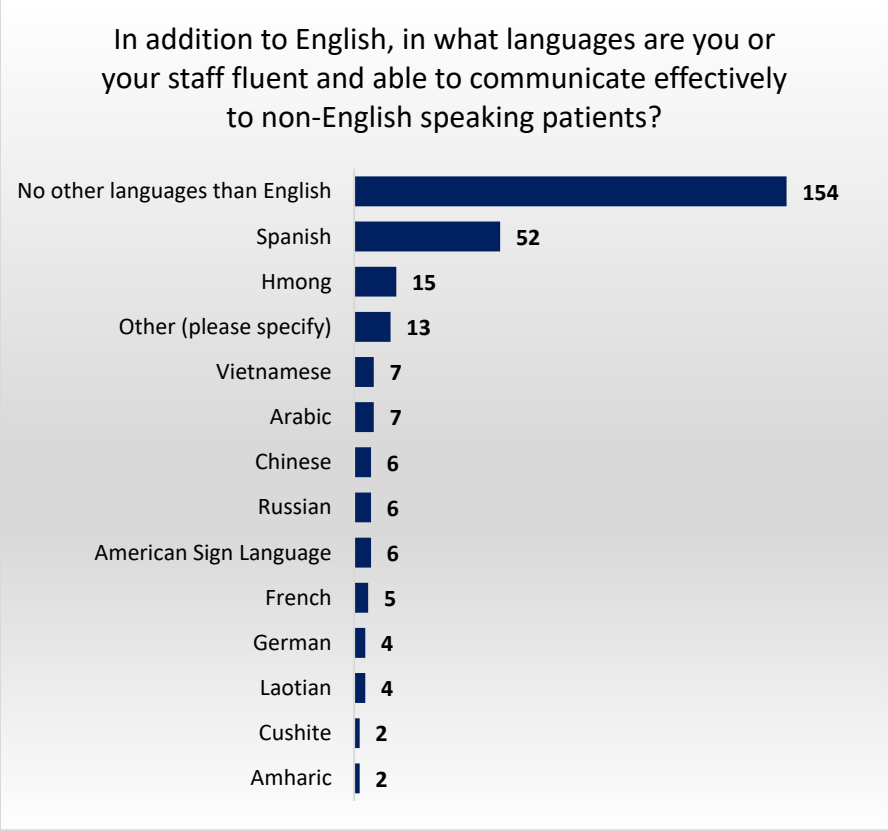


Table 23: Q23 – Mobile Access Van Participation

Do you participate in mobile access vans for dentistry in your area?

QUESTION CHOICE	NO.	PERCENT
YES	9	3.4%
NO	226	84.6%
N/A THERE ARE NO MOBILE ACCESS DENTISTRY VANS IN MY AREA	32	12.0%

Figure 24: Mobile Access Van Participation

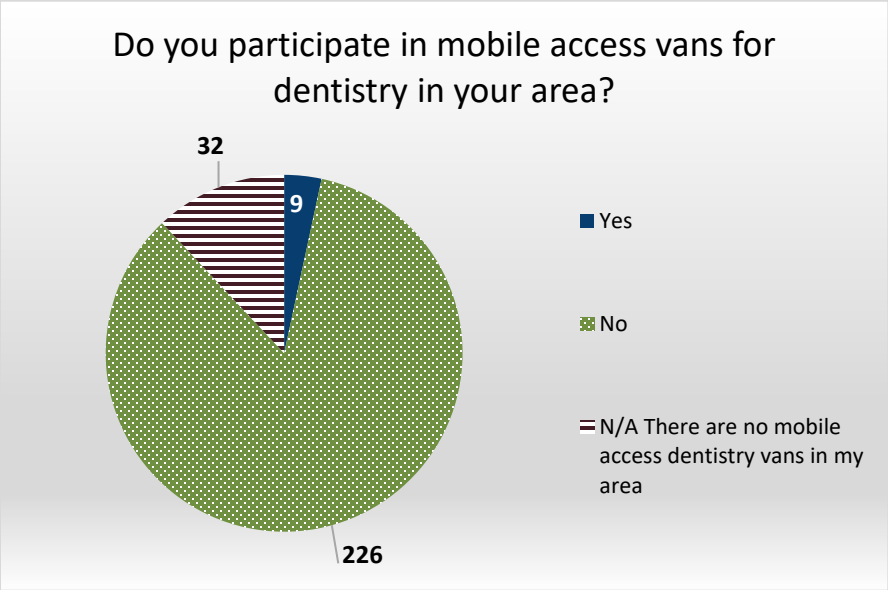


Table 24: Q24 – Dental Sealants for Children

Do you do sealants in your office for children?

QUESTION CHOICE	NO.	PERCENT
YES	232	86.9%
NO	35	13.1%

Table 25: Q25 – Dental Sealants for Children

Do you participate in a Minnesota school-based sealant program for children?

QUESTION CHOICE	NO.	PERCENT
YES	4	1.5%
NO	264	98.5%

Figure 25: Sealants for Children

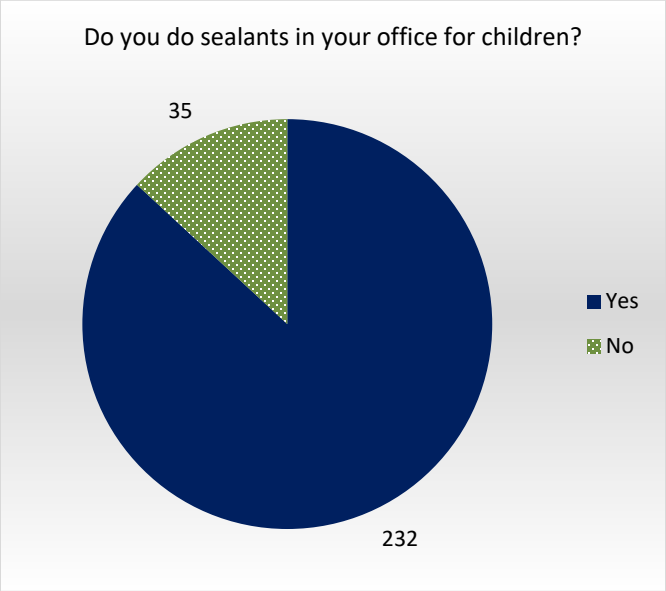


Figure 26: Sealants for Children

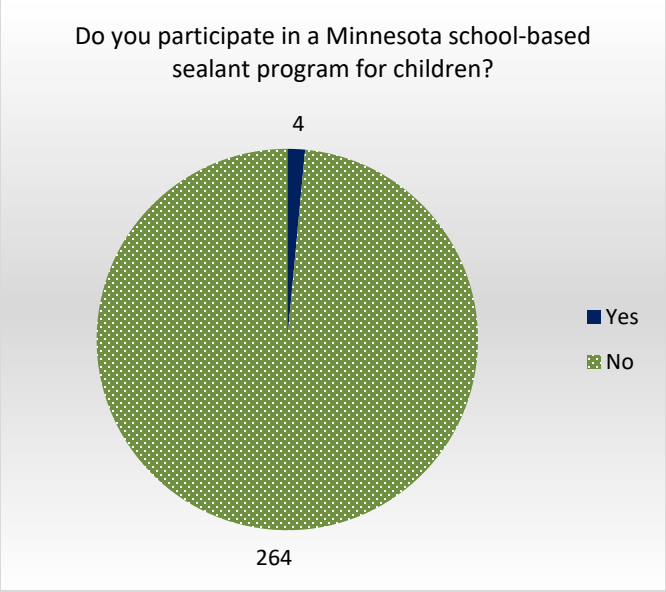


Table 26: Q26 – Reasons for Not Participating in Medicaid

For those not participating in Medicaid and MinnesotaCare, what are the reasons you are not participating?

QUESTION CHOICE	NO.
OTHER (PLEASE SPECIFY)	9
CHALLENGES WITH MEDICAID PATIENTS WITH MULTIPLE MEDICAL NEEDS/SPECIAL HEALTH CARE NEEDS/DISABILITIES WHO NEED CARE COORDINATION WITH MEDICAL PROVIDERS	27
RISK OF LAWSUIT OR COMPLAINT TO LICENSING BOARD REGARDING CARE	26
NEED FOR TRANSLATION SERVICES/COMMUNICATION BARRIERS	30
ADMINISTRATIVE BURDENSOME – CREDENTIALLING PROCESS	33

QUESTION CHOICE	NO.
WORKFORCE ISSUES – NO SPECIALISTS TO REFER MY PATIENTS TO FOR ADDITIONAL SERVICES (SPECIALTY DENTAL PROVIDERS, ORAL SURGEONS, ETC.) OUTSIDE OF MY SPECIALTY	35
WORKFORCE ISSUES – NOT ENOUGH STAFF IN YOUR PRACTICE TO HANDLE THE VOLUME OF PATIENTS	35
PATIENTS' ELIGIBILITY – PATIENTS CAN LOSE COVERAGE SUDDENLY AND THE PROCEDURE IS NO LONGER COVERED	50
DENTAL BENEFIT PACKAGE IS TOO LIMITED FOR AN INDIVIDUAL PATIENT'S NEEDS	54
ADMINISTRATIVE BURDENSOME – PRIOR AUTHORIZATION PROCESS	69
ADMINISTRATIVE BURDENSOME – CLAIMS PROCESS	70
PATIENTS DID NOT KEEP APPOINTMENTS/TRANSPORTATION ISSUES	71
CAN'T BILL PATIENT FOR SERVICES IF IT IS DENIED	79
LOW LEVEL OF REIMBURSEMENT	116

"I can't afford to do it but it's the right thing to do and these are people I have seen for years and I don't want to send them away"

Figure 27: Reasons for Not Participating in Medicaid

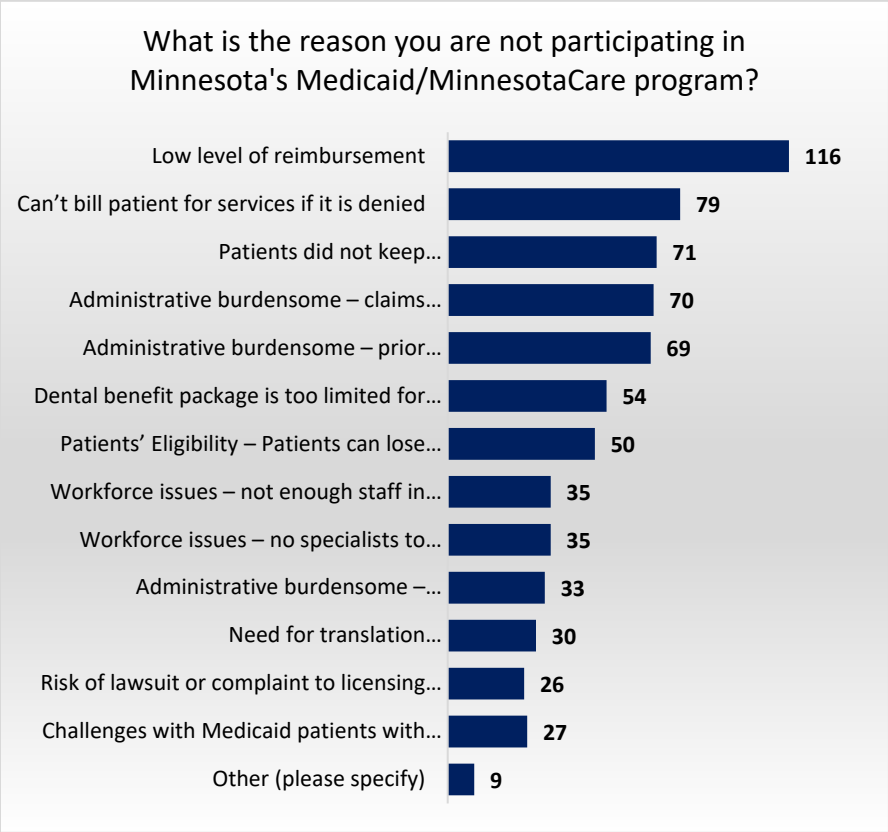


Table 27: Q27 – Barriers to Participation in Medicaid

What do you see as the primary or most critical barrier to your willingness to participation in Minnesota's Medicaid/MinnesotaCare program?

QUESTION CHOICE	NO.
LOW LEVEL OF REIMBURSEMENT	104
ADMINISTRATIVE BURDENSOME – CLAIMS PROCESS	4
ADMINISTRATIVE BURDENSOME – CREDENTIALLING PROCESS	0
DENTAL BENEFIT PACKAGE IS TOO LIMITED FOR AN INDIVIDUAL PATIENT'S NEEDS	2
WORKFORCE ISSUES – NO SPECIALISTS TO REFER MY PATIENTS TO FOR ADDITIONAL SERVICES (SPECIALTY DENTAL PROVIDERS, ORAL SURGEONS, ETC.) OUTSIDE OF MY SPECIALTY	2
CAN'T BILL PATIENT FOR SERVICES IF IT IS DENIED	2
ADMINISTRATIVE BURDENSOME – PRIOR AUTHORIZATION PROCESS	1
CHALLENGES WITH MEDICAID PATIENTS WITH MULTIPLE MEDICAL NEEDS/SPECIAL HEALTH CARE NEEDS/DISABILITIES WHO NEED CARE COORDINATION WITH MEDICAL PROVIDERS	0
RISK OF LAWSUIT OR COMPLAINT TO LICENSING BOARD REGARDING CARE	1
PATIENTS' ELIGIBILITY – PATIENTS CAN LOSE COVERAGE SUDDENLY AND THE PROCEDURE IS NO LONGER COVERED	0
WORKFORCE ISSUES – NOT ENOUGH STAFF IN YOUR PRACTICE TO HANDLE THE VOLUME OF PATIENTS	2
PATIENTS DID NOT KEEP APPOINTMENTS/TRANSPORTATION ISSUES	0
NEED FOR TRANSLATION SERVICES/COMMUNICATION BARRIERS	1
OTHER (PLEASE SPECIFY)	1

Figure 28: Barriers to Participation in Medicaid

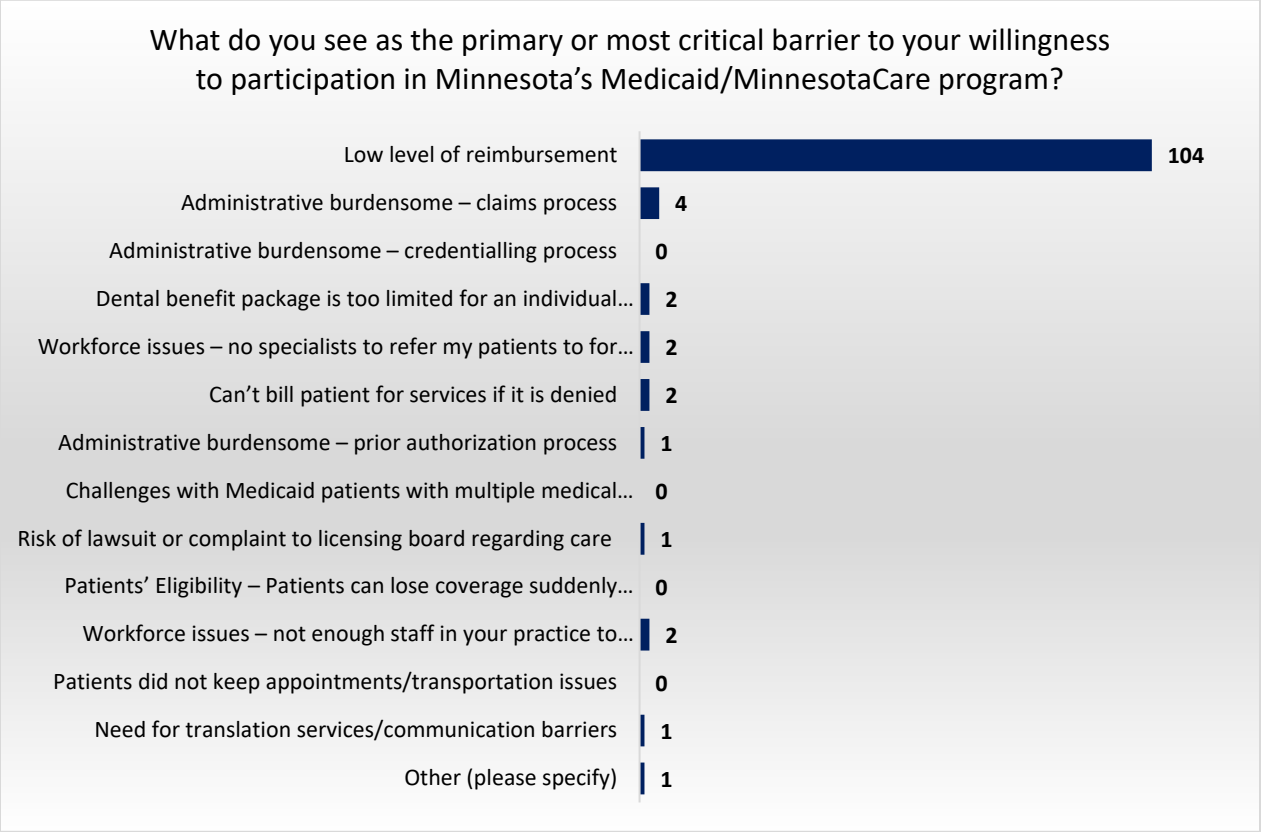


Table 28: Q28 – Reason for Participating in Medicaid

What is your primary reason that you participate in Minnesota's Medicaid/MinnesotaCare program and to serve the population?

QUESTION CHOICE	NO.	PERCENT
I DO IT BECAUSE I THINK IT IS THE RIGHT THING TO DO	98	67.1%
I WORK IN A CLINIC THAT FOCUSES ON LOW-INCOME POPULATIONS	12	8.2%
OTHER (PLEASE SPECIFY)	36	24.7%

Of respondents who chose "Other", some said that they participate to increase volume, or that they have to participate. Other respondents say that while they participate now, they will no longer participate in the future.

Figure 29: Reason for Participating in Medicaid

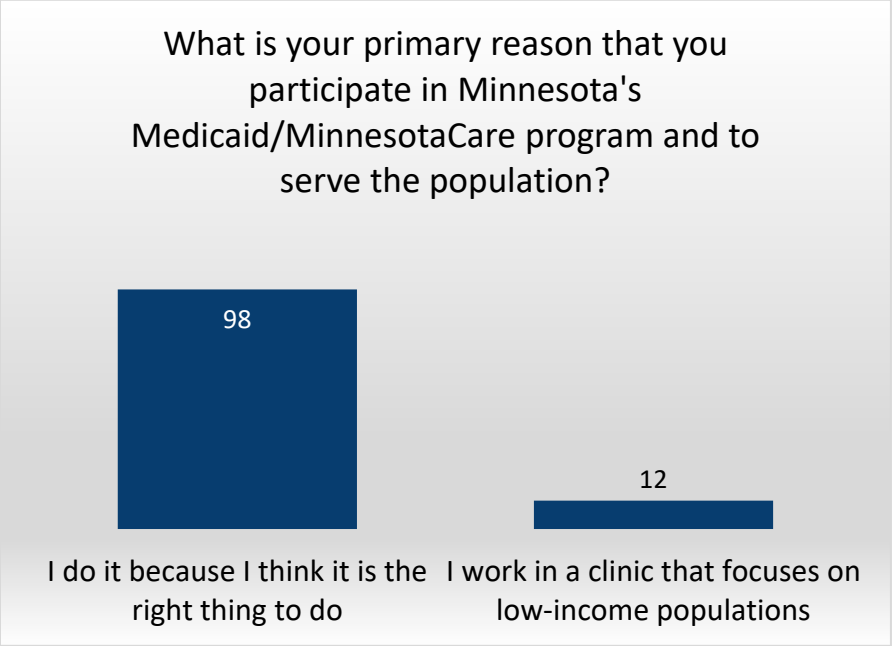


Table 29: Q29 – Impact of Dental Rate Increase on Medicaid Participation

Will the enhanced payment changes being implemented in Minnesota's Medicaid/MinnesotaCare program change your decision about participating?

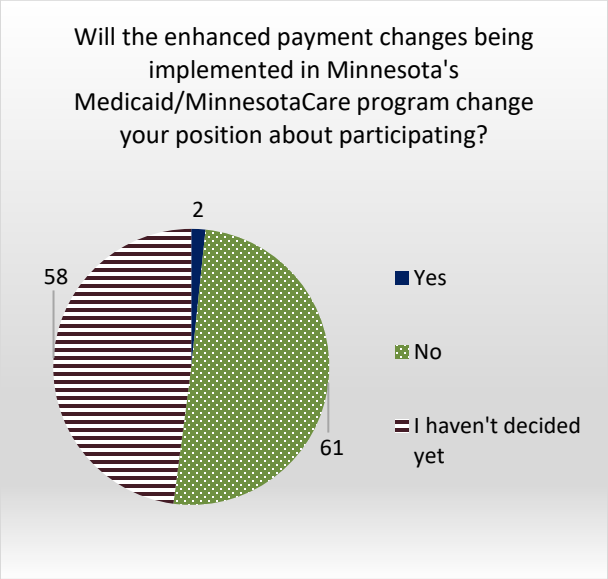
QUESTION CHOICE	NO.	PERCENT
YES	2	1.7%
NO	61	50.4%
I HAVEN'T DECIDED YET	58	47.9%

Table 30: Q30 – Impact of Dental Rate Increase on Medicaid Participation

Why will the enhanced payment changes being implemented in Minnesota's Medicaid/MinnesotaCare program not change your decision about participating?

QUESTION CHOICE	NO.	PERCENT
NOT ENOUGH OF AN INCREASE	29	49.2%
OTHER REASONS KEEP ME FROM PARTICIPATING	6	10.2%
ALL OF THE ABOVE	24	40.7%

Figure 30: Impact of Dental Rate Increase on Medicaid Participation



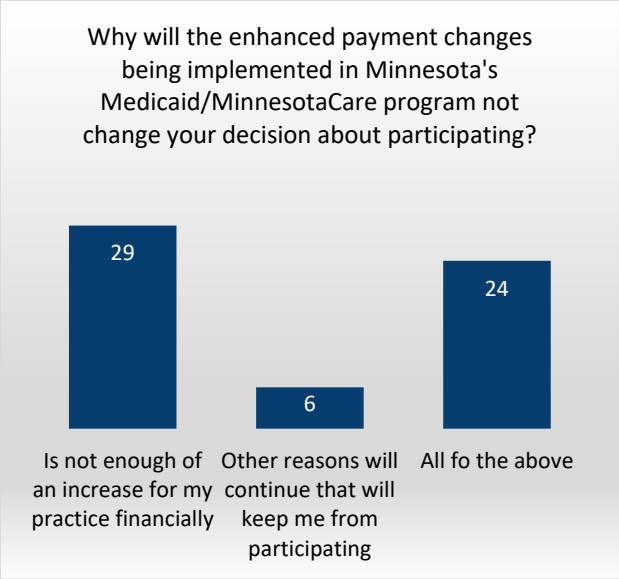


Table 31: Q31 – Top Challenges Working with Medicaid

What are the top issues or challenges of working with Minnesota's Medicaid/MinnesotaCare program?

QUESTION CHOICE	NO.
OTHER – (PLEASE SPECIFY)	11
RISK OF LAWSUIT OR COMPLAINT TO LICENSING BOARD REGARDING CARE	27
CHALLENGES WITH MEDICAID PATIENTS WITH MULTIPLE MEDICAL NEEDS/SPECIAL HEALTH CARE NEEDS/DISABILITIES WHO NEED CARE COORDINATION WITH MEDICAL PROVIDERS	30
ADMINISTRATIVE BURDENSOME – CREDENTIALLING PROCESS	33
NEED FOR TRANSLATION SERVICES/COMMUNICATION BARRIERS	35
WORKFORCE ISSUES – NOT ENOUGH STAFF IN YOUR PRACTICE TO HANDLE THE VOLUME OF PATIENTS	42
PATIENTS' ELIGIBILITY – PATIENTS CAN LOSE COVERAGE SUDDENLY AND THE PROCEDURE IS NO LONGER COVERED	62
ADMINISTRATIVE BURDENSOME – CLAIMS PROCESS	70
WORKFORCE ISSUES – NO SPECIALISTS TO REFER MY PATIENTS TO FOR ADDITIONAL SERVICES (SPECIALTY DENTAL PROVIDERS, ORAL SURGEONS, ETC.) OUTSIDE OF MY SPECIALTY	71
DENTAL BENEFIT PACKAGE IS TOO LIMITED FOR AN INDIVIDUAL PATIENT'S NEEDS	73
CAN'T BILL PATIENT FOR SERVICES IF IT IS DENIED	84
ADMINISTRATIVE BURDENSOME – PRIOR AUTHORIZATION PROCESS	85
PATIENTS DID NOT KEEP APPOINTMENTS/TRANSPORTATION ISSUES	118
LOW LEVEL OF REIMBURSEMENT	138

Figure 31: Top Challenges Working with Medicaid

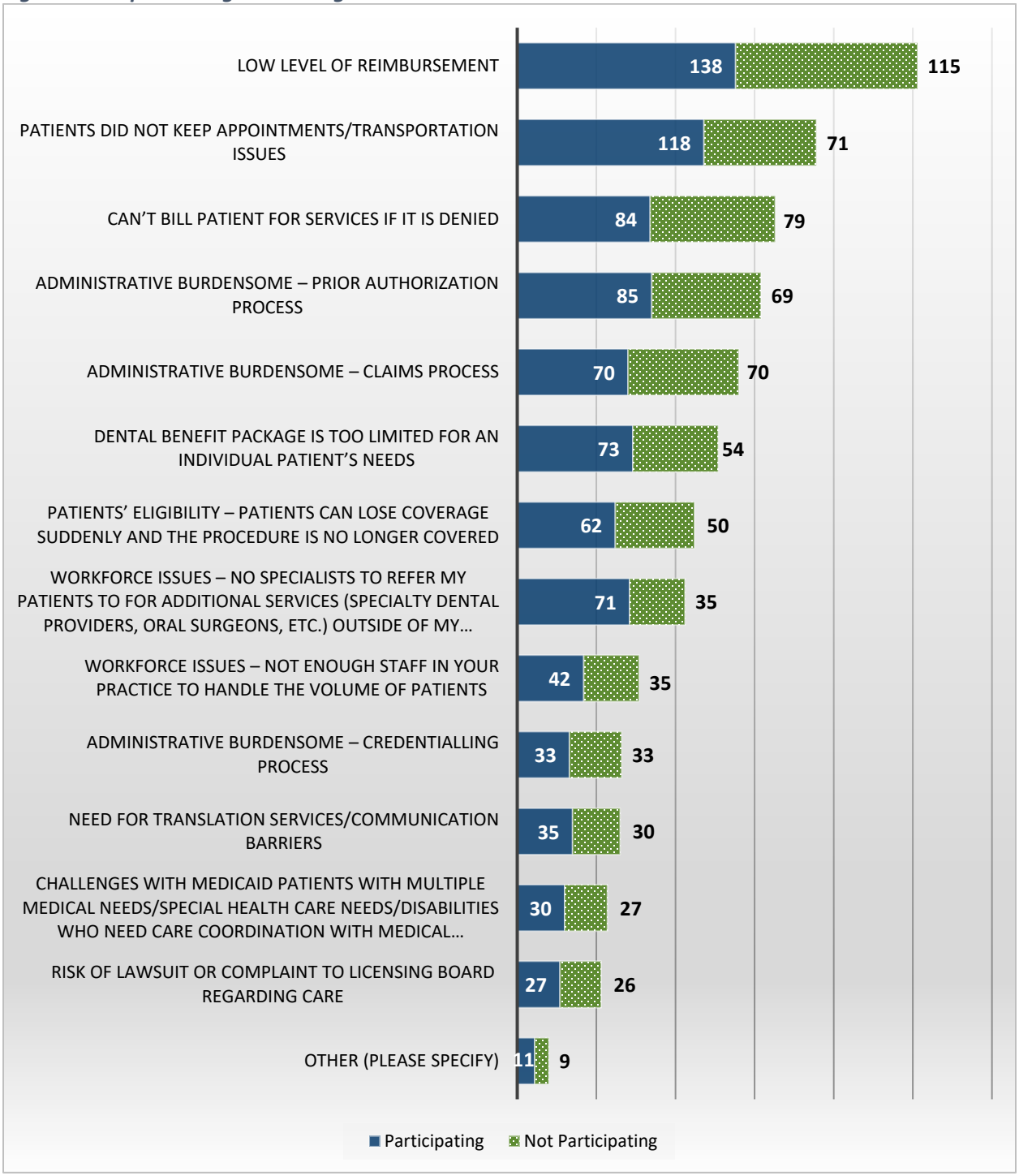


Table 32: Q32 – Preferred Medicaid Dental Delivery (participating)

Of those who participate in Medicaid, overall which delivery system for Minnesota's Medicaid/MinnesotaCare program dental benefits do you prefer?

QUESTION CHOICE	NO.	PERCENT
FEE-FOR-SERVICE	61	60.4%
CONTRACTED HEALTH PLANS	40	39.6%

Table 33: Direct Quotes in Favor of Fee For Service
"Patients then have some responsibility for their care, financially speaking"
"Direct accountability and simplicity"
"Less red tape. We generally do not like to be tied to plans. Like independence of treatment decisions and more transparency. Contracted plans seem to be lower reimbursements and more rules typically."
"The office is billing for the actual services being done."
"Less paperwork"

Table 34: Direct Quotes in Favor of Contracted Health Plans
"Encouraged to do what is right for patient instead of generating billing."
"Easy for patients to navigate"
"Health partners manages administrative burden"
"Most of our patients are under contracted health plans and the system is streamlined for treating these patients"
"Simplest for us and better reimbursement"

Table 35: Q33 – COVID-19 Impact on Medicaid Participation

Has the COVID-19 pandemic changed or otherwise impacted your participation in Minnesota's Medicaid/MinnesotaCare program?

QUESTION CHOICE	NO.	PERCENT
YES	55	21.6%
NO	200	78.4%

"Yes, cost of supplies has increased and so has cost of wages"

Figure 32: COVID-19 Impact on Medicaid Participation

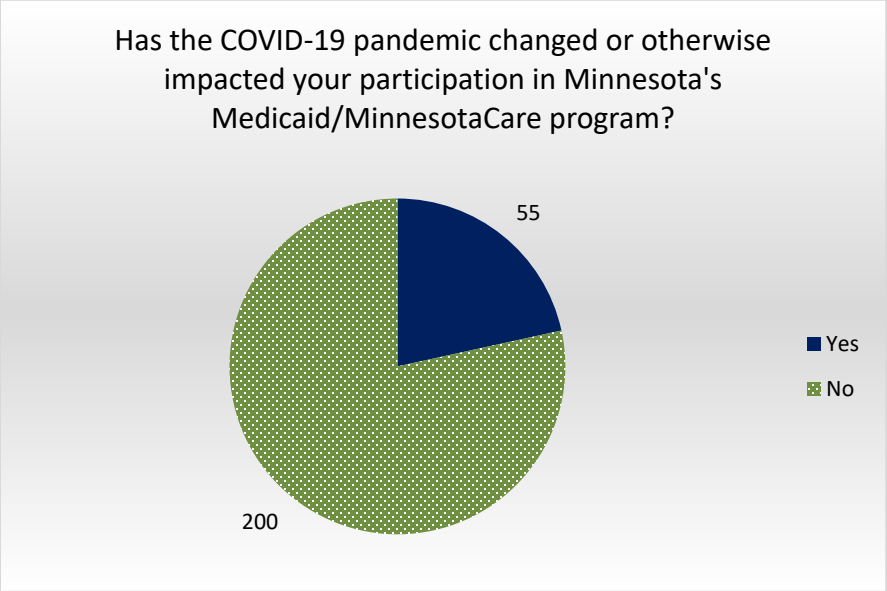


Table 36: Q34 – Change to Increase Medicaid Participation

What changes or improvements are needed to increase provider participation in Minnesota's Medicaid/MinnesotaCare program by dentists in the state?

QUESTION CHOICE	NO.
CREATE DENTAL HOMES	31
FOCUS MORE ON PAY-FOR-PERFORMANCE MODELS OF REIMBURSEMENT	40
IMPROVE PATIENT SUPPORT – CARE COORDINATION TO INCLUDE DENTAL SERVICES	43
REDUCE ELIGIBILITY CHURN RATES FOR MEDICAID/MINNESOTACARE PARTICIPANTS	42
IMPROVE PATIENT SUPPORT – TRANSPORTATION COORDINATION	51
IMPROVE MEDICAID/MINNESOTACARE PARTICIPANTS ELIGIBILITY VERIFICATION PROCESS	55
STREAMLINE CREDENTIALLING PROCESS	57
IMPROVE PATIENT SUPPORT – APPOINTMENT SCHEDULING SUPPORT AND REMINDERS	61
FOCUS ON MORE PREVENTION EFFORTS/INCREASE INCENTIVES FOR PREVENTION	65
CREATE A SINGLE POINT OF CONTACT FOR PRIOR AUTHORIZATIONS, CREDENTIALLING, CLAIMS ADJUDICATION, AND PROBLEM RESOLUTION WHETHER MEDICAL BENEFITS ARE FEE-FOR-SERVICE OR HEALTH PLANS	88
IMPROVE CLAIMS ADJUDICATION PROCESS	98
STREAMLINE PRIOR AUTHORIZATION PROCESS	105
ACCESS AND NETWORK – IMPROVE REFERRAL PROCESS AND ACCESS TO SPECIALTY DENTISTS	125
IMPROVE THE MINNESOTA'S MEDICAID/MINNESOTACARE DENTAL BENEFITS TO MEET STANDARDS OF PRACTICE FOR COMMERCIAL DENTAL BENEFITS	141
PAYMENT – FURTHER ENHANCEMENT OF RATES	253

Figure 33: Change to Increase Medicaid Participation

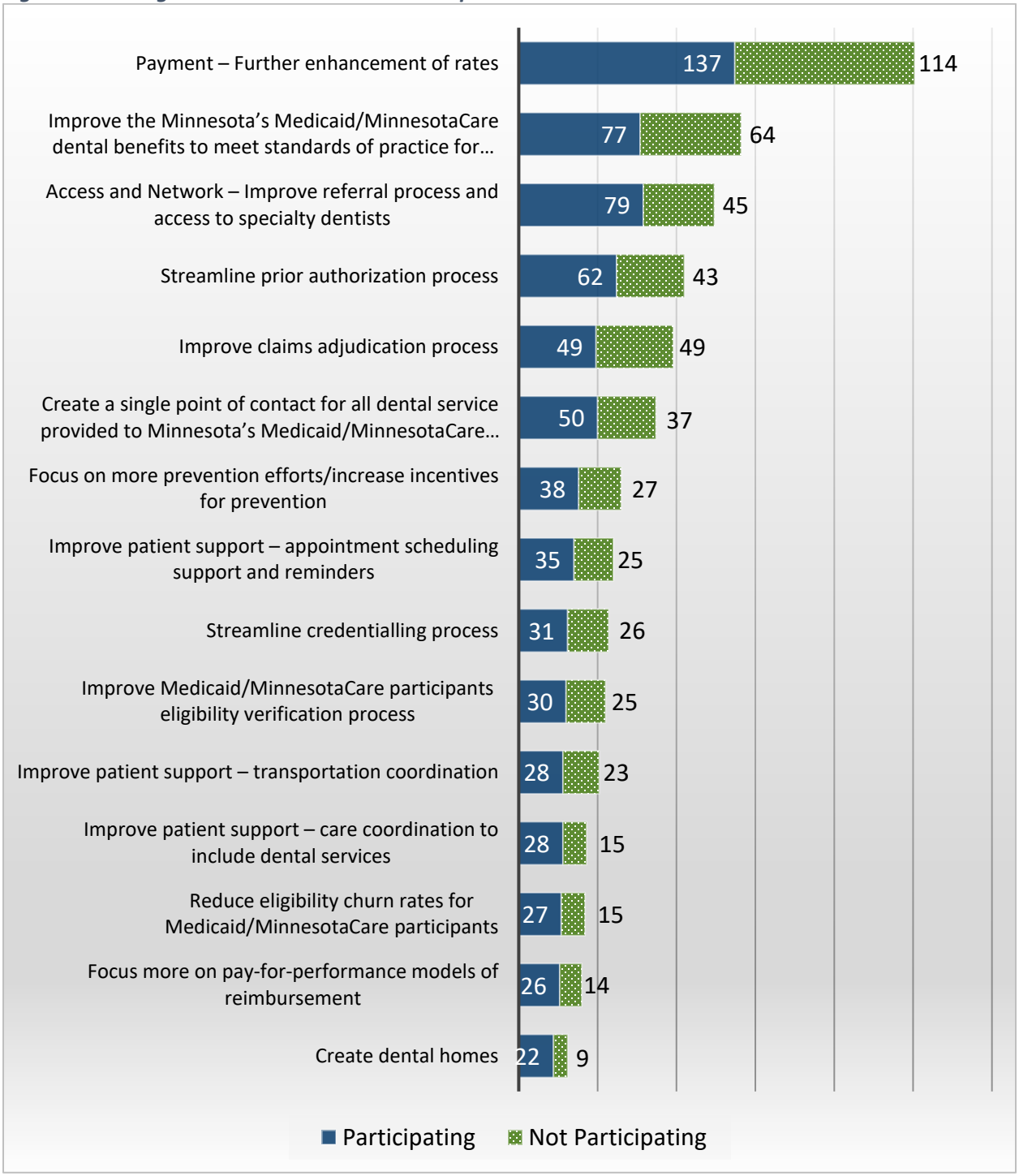
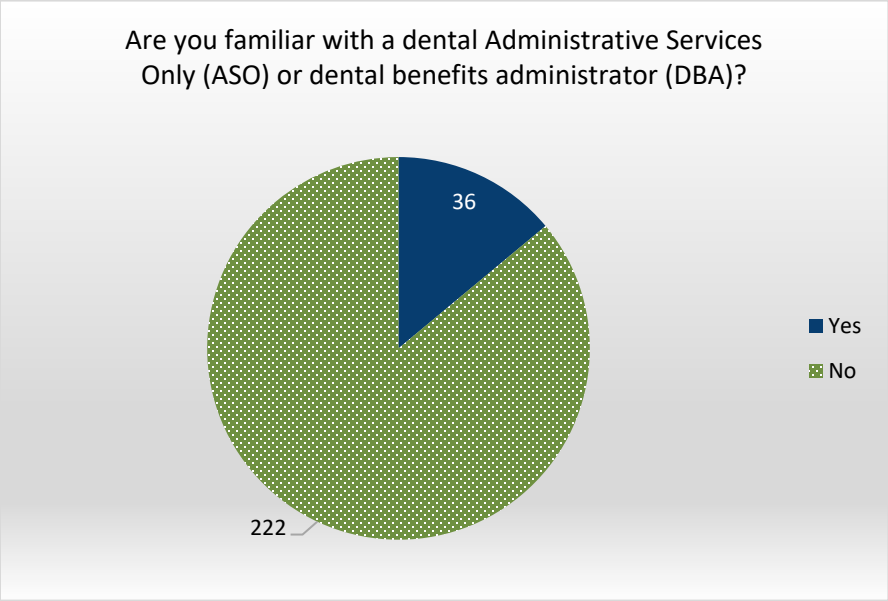


Table 37: Q35 – Familiarity for ASO and DBA

Are you familiar with a dental Administrative Services Only (ASO) or dental benefits administrator (DBA)?

QUESTION CHOICE	NO.	PERCENT
YES	36	14.0%
NO	222	86.0%

Figure 34: Familiarity for ASO and DBA



"Yes, if it streamlines the processes involved and improves efficiency"

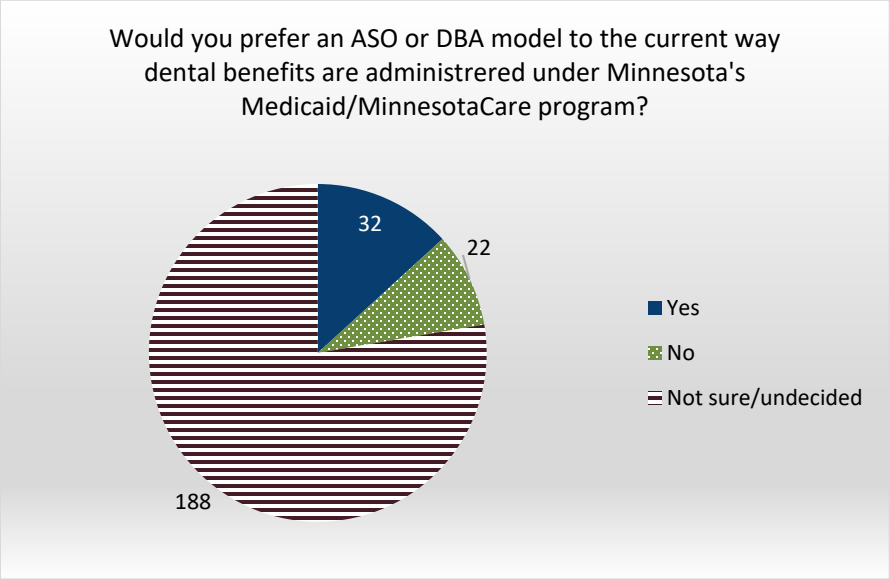
"No, competition keeps payers honest. Have good relationship with our county plan."

Table 38: Q36 – Preferred Medicaid Dental Delivery (All)

Would you prefer an ASO or DBA model to the current way dental benefits are administered under Minnesota's Medicaid/MinnesotaCare program?

QUESTION CHOICE	NO.	PERCENT
YES	32	13.2%
NO	22	9.1%
NOT SURE/UNDECIDED	188	77.7%

Figure 35: Preferred Medicaid Dental Delivery Model (All)



"Re-imbursement is far below rates from other insurance or even in other states. Overhead in the dental field is rising quickly after the pandemic and private insurance companies are cutting their re-imbursement. The obvious solution is to reduce the low paying Medicaid patients. It is not that we do not care for our patients but we have staff who depend on us for their jobs and wages are also increasing."

The final question of the survey was open-ended, requesting any additional feedback from respondents. There were 109 comments:

- 76 (69.7%) mentioned reimbursement
- 22 (20.2%) mentioned capacity and access issues (such as access to specialists, and over-full schedules)
- 20 (18.3%) mentioned concerns about the Medicaid patient population such as ability to take dental care seriously or keep appointments.