

**Dental Access for
Minnesota Health Care Programs Beneficiaries:
Report to the 2001 Minnesota Legislature**

**Submitted by the
Minnesota Department of Human Services
according to the Laws of Minnesota 1999, Chapter 245, Article 4, Section 113**

January 15, 2001

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Preface

In widespread areas of Minnesota, families and individuals covered by Medical Assistance (MA), General Assistance Medical Care (GAMC), or MinnesotaCare have difficulty obtaining adequate access to dental care services, despite the fact that this service is covered for all persons eligible for these programs. This problem – which has worsened in recent years – is well documented in the “Dental Services Access Report,” prepared by the Minnesota Department of Human Services (DHS) and presented to the Minnesota Legislature in March 1999.

In response to the report’s findings and recommendations, the 1999 Legislature approved several dental access initiatives. These initiatives address the problem by:

- ! increasing payment rates for dental services by 3 percent;
- ! increasing payment rates for sealants and fluorides – two key preventive services – to 80 percent of billed charges;
- ! issuing grants for local projects to increase access to dental care; and,
- ! authorizing the limited extension of dental hygienists’ services outside of traditional dental offices.

The 1999 Legislature also directed DHS to evaluate the effects of these initiatives, to further review the dental access problem, to make recommendations on other actions to improve dental access, and to prepare this report according to Laws of Minnesota, 1999, Chapter 245, Article 4, Section 113. In fulfilling this charge, the statute directs DHS to consult with the Minnesota Department of Health, dental providers, community clinic representatives, client advocacy groups and counties.

This document provides a comprehensive review of the dental access problem, and contains a wide-ranging set of specific recommendations to address the problem. It represents the breadth of the dialogue that has been carried on over the past 18 months by the major stakeholders. A supplementary document, which also will be presented to the 2001 Legislature, summarizes the evaluation of the effects of the 1999 dental access initiatives.

**Dental Access for Minnesota Health Care Programs Beneficiaries:
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EXECUTIVE SUMMARY

Background

Seeing the dentist on a regular basis is an ordinary part of most Minnesotans' personal health regimen. But for those whose health care is covered by the Minnesota Health Care Programs (MHCP) – as Medical Assistance, General Assistance Medical Care, and MinnesotaCare are collectively known – getting into the dentist's chair has been difficult. For some, knowledge of the importance and techniques of oral health care is limited, and seeking care is not a priority except in extreme situations. But even those who do seek care often find they cannot get an appointment, or must travel long distances outside their own community to get the care they need. Others simply give up in frustration, having contacted every dentist in the telephone book. Some wind up in hospital emergency rooms or resort to home remedies that are at best ineffective or at worst dangerous.

The immediate personal implications of oral health neglect are obvious: pain, difficulty eating or speaking, compromised appearance. Beyond the immediate, the implications are broader and more extensive. The report "Oral Health in America," recently released by the U.S. Surgeon General, notes that: "(O)ral health is integral to general health. You cannot be healthy without oral health. Oral health and general health should not be interpreted as separate entities."⁽¹⁾

Researchers have identified possible links between health problems and neglected oral health. Periodontal disease has been shown to be correlated with heart disease and premature low birth weight babies. Diabetic patients have been shown to have a significant increase in periodontal disease, resulting in reduced blood glucose control and three times greater tooth loss. New mothers may transmit decay to their infants, sometimes resulting in a condition known as "baby bottle mouth syndrome."

Children with dental pain often miss school days or find it difficult to pay attention in the classroom, and a parent often must stay home from work to care for them. Other adults miss work due to their own dental conditions. In the United States in 1996, acute dental conditions

⁽¹⁾ U.S. Department of Health and Human Services, "Oral Health in America: A Report of the Surgeon General," 2000, p. 18.

were responsible for 1.6 million school loss days, and 2.4 million work loss days.⁽²⁾ Socially, both children and adults whose appearance or speech is compromised by dental disease often develop self-esteem issues that can create barriers to obtaining employment and exacerbate dependency on public assistance.

There are also significant cost implications to the State. Lack of prevention, delayed treatment and the inability to obtain dental examinations often result in avoidable restorative work, and dental work that is performed in emergency rooms or inpatient hospital placements that could have been handled in an earlier stage in a general dentist's office. According to one authority, for every \$1 spent on preventive care, about \$4 is saved on dental costs.⁽³⁾

As required by the Minnesota Legislature, the Department of Human Services (DHS) studied MHCP dental access issues in depth. We studied the problem with the advisory assistance of the issue's major stakeholders: legal advocacy, organized dentistry, community clinics, county public health and human services, Head Start, the University of Minnesota School of Dentistry, the University of Minnesota Medical School Department of Pediatrics, the State Board of Dentistry, Minnesota Department of Health, and the State's major health and dental care contractors and subcontractors. We examined the problem from a variety of perspectives: from that of the marketplace, to prevention, to the workforce, to patient responsibilities, to the delivery system infrastructure, and beyond. We reviewed national research on the issue, and the efforts of others who are attempting to solve this problem in other states. We also evaluated recent changes in how MHCP beneficiaries get their dental care and recent legislative efforts made to improve dental access.

Findings

What is the extent of the dental access problem?

According to the Surgeon General's report, "it is abundantly clear there are profound and consequential disparities in the oral health of our citizens." Those who suffer the worst from this "silent epidemic" of oral diseases are the poor, particularly children and older persons. Members of racial and ethnic minority groups experience a disproportionate level of oral health problems, and the health of medically compromised people and those with disabilities is placed into further jeopardy by oral disease.⁽⁴⁾ The report notes that nationally, more than 80 percent of Medicaid-eligible children did not receive preventive dental services, and many states are unable to meet the mandatory dental components of Medicaid Early Periodic Screening, Diagnostic and

(2) National Center for Health Statistics, National Health Interview Survey, 1996, Series 10, no. 200, Hyattsville, MD, Public Health Service, 1996.

(3) National Institute of Dental Research, quoted by M. Kaufman, "A Balanced View of Managed Medicaid Dental Benefits," Delta Dental Plan of California, 2000.

(4) U.S. Department of Health and Human Services, op. cit., p. vii.

Treatment services (EPSDT) “partly because of low levels of reimbursement to providers and difficulties regarding access.”⁽⁵⁾

What is Minnesota’s situation?

Use of dental services – utilization – is a meaningful measure of the access problem. When compared to those who have commercial dental insurance, utilization by MHCP beneficiaries is considerably lower. In the mid-1990s, 70 percent of Americans with commercial insurance visited a dentist,⁽⁶⁾ while only 30 percent of MHCP beneficiaries did so.⁽⁷⁾ Within Minnesota, there are regional disparities among MHCP beneficiaries. For example, in Scott County, the number of beneficiaries utilizing dental care was 52.3 percent. In Clay County, the comparable number is 19.5 percent.⁽⁸⁾ Disparities also are found among the racial groups served by MHCPs. For example, white and Asian children were 60 percent more likely to have received dental services than Hispanic children.⁽⁹⁾ Statewide, utilization among beneficiaries has been declining over the past few years.

Why is dental utilization so low among MHCP beneficiaries?

Many factors contribute to Minnesota’s dental access problem. Some are interrelated, others are not, but all reduce the utilization of dental services by MHCP beneficiaries. These factors include:

- **Low level of provider participation.** Fewer than one third of Minnesota’s dentists and dental clinics provided most of the dental care (i.e., did more than \$10,000 in MHCP business) to MHCP beneficiaries in 1999. More than 28 percent provided *no* care to MHCP beneficiaries.⁽¹⁰⁾
- **Payment rates are low.** In virtually all states, Medicaid dental payment rates are considerably lower than average fees charged by dentists. When compared to other states

(5) Op. cit., p. 233.

(6) “Trends in Dental Care Among Insured Americans: 1980 - 1995,” Journal of the American Dental Association, vol. 128 (February 1997).

(7) “Dental Services Access Report,” Minnesota Department of Human Services, March 1999.

(8) Op. cit.

(9) Minnesota Department of Human Services, Executive Information System (EIS) claims data, 1999.

(10) Minnesota Department of Revenue, MinnesotaCare tax data, 1999.

in the North Central Region, Minnesota's rates are in the lowest 25 percent.⁽¹¹⁾ Dentists report that Minnesota's rates often do not even cover overhead costs. In state fiscal year 1999, DHS paid dental claims at an average of 54.5 percent of billed charges.⁽¹²⁾ Some Minnesota dentists report their overhead to be as high as 70 percent.⁽¹³⁾

- **Not enough providers.** In some rural areas of the state, the low number of practicing dentists creates access barriers for all area residents. While the number of new dental hygienists is increasing in Minnesota, they are not well-distributed across the state.⁽¹⁴⁾ A conservative projection of Minnesota's dental workforce trends suggests that the dental labor supply is barely keeping ahead of demand, and many variables could reverse this status in the future.⁽¹⁵⁾
- **Compromised market position.** MHCP beneficiaries, whose claims are paid at an average of \$.54 on the dollar,⁽¹⁶⁾ must compete for appointments with those who have commercial insurance, whose claims are often paid in excess of \$.80 on the dollar,⁽¹⁷⁾ and those who pay cash (\$1 on the dollar). This problem is particularly acute in areas where a shortage of providers creates a "seller's market."
- **MHCP beneficiaries are more challenging to serve.** MHCP beneficiaries are likely to have more life stressors than other dental patients. Many have additional barriers imposed by language, culture, disability, lack of transportation and factors associated with poverty. Dentists report that the MHCP patient appointment failure ("no show") rate is higher⁽¹⁸⁾ and the dentists cannot recover any of these costs by charging the patients.
- **The demand for dental care may be lower among MHCP beneficiaries.** For many low-income people, priorities resulting from life stressors associated with poverty may overshadow the priority they assign to the need for preventive health care. MHCP covers a disproportionately high number of people whose cultural backgrounds do not include mainstream health care practices.
- **Administrative burden.** Presently, dentists who treat MHCP beneficiaries from a single county must deal with up to three different payers. Each payer has its own billing and

(11) United States General Accounting Office, "Factors Contributing to Low Use Of Dental Services by Low-Income Populations," September 2000.

(12) Minnesota Department of Human Services, claims payment data, 2000.

(13) Minnesota Dental Association, personal communication with author.

(14) Minnesota Dental Hygienists' Association, personal communication with author.

(15) Born, D.O., "Treading Water: Minnesota's Dental Workforce in the Year 2000," Northwest Dentistry, September - October 2000, pp. 23 - 28.

(16) Minnesota Department of Human Services, claims payment data, 2000.

(17) Minnesota Dental Association, personal communication with author.

(18) Wilder Research Center, Survey of Minnesota Dentists, November 2000

other administrative requirements. Differences in coverage limits and co-payment collection requirements among eligibility types adds confusion and additional administrative hurdles.

- **Financial challenges for “safety-net” providers.** Safety-net providers, i.e. community, hospital-based, and other nonprofit clinics, are facing financial challenges. In some areas, these clinics are the only source of dental services for MHCP beneficiaries.
- **Scarcity of comprehensive data on oral health needs and data on best practices.** Planning for oral health initiatives, whether population based or for an individual project, is made much more challenging by the absence of this data.
- **Outdated, unintegrated State policy.** While most of the stakeholders in the dental access problem have made efforts to address the problem over the past several years, there is no singular, statewide MHCP dental access policy driving these efforts. No MHCP goals have been established for which to strive.

What efforts have been made to solve the dental access problem?

Most of the stakeholders in the dental access problem have made efforts to improve access over the past decade. These efforts include:

- The Legislature has **raised payment rates** four times over the past decade, and **reduced the Rule 101 participation requirement**⁽¹⁹⁾ for dental providers.
- The Minnesota Dental Association, county public health and human services agencies, private dentists, and DHS have sponsored various **summits and other meetings focused on dental access**. Providers, health plans and their dental subcontractors, advocates, Head Start agencies and others interested in the issue participated.
- The Legislature authorized **dental hygienist demonstration projects** to increase access by expanding the dental hygienist’s role.
- DHS-contracted health plans and dental subcontractors provide **transportation** to improve access, pay providers at **over-par rates** for certain emergency situations, and in many rural counties **waive contractual requirements** for “any willing dentist” who treats MHCP beneficiaries.
- For rural areas of the state, DHS added **increased payments to contracted health plans** specifically to address dental access.
- One of the largest MHCP contractors recently instituted a program to **reduce appointment failures**.
- The Legislature funded nine **dental access project start-up grants** in urban and rural areas.

⁽¹⁹⁾ Rule 101 requires each health care provider who treats those who are covered by the programs of the Minnesota Department of Employee Relations (largely state and local public employees) to accept MHCP beneficiaries until 20 percent of their practice’s patients are MHCP beneficiaries. At that point the provider can refuse to accept additional MHCP patients. In 1997, this threshold was reduced to 10 percent for dental providers only.

- A leading Minnesota dental supplier enhanced the value of the state dental access grant funds by providing generous **equipment discounts** to several of the grantees.
- A private/public funded nonprofit dental organization opened a **new clinic in Northwestern Minnesota, the area with some of the most severe access problems.**
- DHS issued a managed care carve-out request for proposals (RFP) **offering direct contracts with dentists** in an underserved rural area.
- In at least two areas of the state, private dentists have formed **health care cooperatives** specifically to serve MHCP beneficiaries, and are attempting to enter the marketplace.
- Some **county-based purchasing entities** are exploring **alternative ways of purchasing** and providing dental services.
- DHS is **reducing administrative burdens** by revising the dental portion of the administrative rule governing MHCP coverage policy.
- The Minnesota Department of Health is applying for the **designation of several additional dental health professional shortage areas**, to ensure the federal government’s recognition of Minnesota’s dental access problem in making future funding decisions.
- DHS included **dental services performance incentives in 2001 prepaid MHCP contracts.**
- DHS sent a **survey to each of the state’s actively practicing dentists** to ensure their opinions and experiences inform and shape MHCP dental policies.
- Through DHS’ efforts, Minnesota received a **one-year commitment of technical assistance from national experts** in children’s oral health through the National Governor’s Association, toward developing and implementing an **action plan to improve the oral health of Minnesota’s children** through the collaborative efforts of the Governor’s Office, the Legislature, and public and private stakeholders.

These efforts have met with varying degrees of success. Some are still in the early stages and have yet to yield results. While these efforts can undoubtedly help, it is clear that additional steps must be taken.

What new efforts have the best potential for increasing access?

The Legislature mandated DHS to consult with stakeholders and develop further strategies based on a comprehensive study of the problem. The DHS Dental Access Advisory Committee identified potential for increasing access through the following broad strategies:

- Create **financial incentives** for private sector dentists to treat MHCP beneficiaries.
- Promote additional **administrative simplification**, both in the purchasing models and among all of the payers.
- Preserve and expand the **“safety-net” clinics’ capacity for dental care.**
- Foster **greater responsibility among MHCP beneficiaries** in seeking and obtaining dental care.
- Explore **new delivery models and purchasing models.**

- Expand the dental workforce, **increasing the number of dentists and dental auxiliaries** who treat MHCP beneficiaries.
- Explore additional ways of increasing the dental workforce and increasing efficiency by **deploying dental auxiliaries, pediatricians, nurses, and other health professionals in nontraditional ways.**

These strategies form the basis of the Department of Human Services' recommendations.

Recommendations

Because of the MHCP dental access problem's complicated nature and disparate causes, solutions must address its root causes in a comprehensive manner. DHS, in consultation with the Dental Access Advisory Committee, developed 27 specific recommendations that comprise an overarching strategy. Some of the recommendations require substantial funding, while others do not. Some call for action from DHS, while others require the action of other parts of state government. Still other recommendations call on the efforts and commitment of non-governmental stakeholders. Some recommendations are long term, others more immediate.

DHS recommends that all of the recommendations be followed in full, but recognizes potential limitations in funding. As funding becomes available, DHS recommends the following initiatives be given priority:

- *Payment rate increases that are tied to the performance of providers in improving access to dental care*

Restructured payment rates would cover overhead costs and reward providers who maintain or increase access. These rates would be tied to regional pilot tests to assess their effectiveness.

- *Dental access improvement grants*

These grants could support a wide variety of activities outlined in the recommendations, including the establishment or expansion of mobile or other types of outreach clinics for underserved areas, development of a volunteer dental network, new ways of delivering dental care based on partnerships between local providers and public health agencies, projects to test methods of eliminating or reducing appointment "no shows," and new models of care that better meet cultural needs of MHCP beneficiaries.

- *A standing Minnesota Health Care Programs dental advisory committee*

A standing MHCP dental advisory committee would involve providers, beneficiaries and other key stakeholders in advising DHS on MHCP dental issues, including coverage, purchasing, service delivery and oversight of progress in improving dental access.

Administrative funds would allow DHS to staff this committee. DHS recommends a sunset period of six years to determine the effectiveness of the committee in improving dental access. If a statewide committee on oral health for the population as a whole is enacted, the activities of the MHCP committee should be integrated with it.

- *Development of new models of purchasing and delivering dental care*

Funding would allow DHS to investigate and test new ways of purchasing and new models of delivering care, as well as new ways of fostering cost-effective preventive care to MHCP beneficiaries.

Conclusions

Lack of dental access for MHCP beneficiaries is contributing to deteriorating oral health, missed school and work, additional barriers to self sufficiency, and higher costs to the State. The problem is long-standing and increasing in its gravity. Observation of several trends suggests that the situation will continue to deteriorate unless intervention is taken. Underfunding is a significant aspect, but the problem is complex. Solutions must be multi-factored and integrated.

The problem is not intractable. While the Legislature and other major stakeholders have made a wide range of efforts over the past decade, the Dental Access Advisory Committee has identified many additional strategies which can be employed. These include:

- expanded dental workforce,
- higher payment rates,
- new ways of purchasing,
- new ways of engaging the beneficiaries, and
- greater participation among dentists in making MHCP policy.

Many of these strategies require additional funding. If invested wisely, these expenditures will result in value to the State. In addition to improved oral health status, Minnesotans will realize social and economic pay backs.

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INTRODUCTION

Reflecting Minnesotans' belief in a strong safety-net and public supports to optimize the health of all of their fellow citizenry, Minnesota makes some of the most comprehensive health care coverage in the nation available to its low- and moderate-income citizens. This care is available through three public programs, Medical Assistance (as Medicaid is known in Minnesota), General Assistance Medical Care, and MinnesotaCare. Each of these programs (known collectively as Minnesota Health Care Programs or MHCP) offer comprehensive dental coverage of both preventive services such as exams, cleanings, and tooth sealants, and restorative services such as fillings, crowns, and dentures.

Yet, for many beneficiaries of these programs this coverage has long proven to be a hollow promise, as those who seek dental care often find that no dentist in their community will see them. For those who don't seek care, dental coverage amounts to an important but unused benefit that may or may not be available, should efforts to educate them on the value of dental care be successful. Either way, for the beneficiaries the result is poor oral health and its implications. For Minnesota taxpayers, there are the cost implications of paying for emergency services, expensive restorations, other health costs and protracted economic dependency that could have been prevented.

At the mandate of the Minnesota Legislature, the Department of Human Services (DHS) studied MHCP dental access in depth.¹ In doing so, DHS solicited advisory assistance from the issue's major stakeholders: legal advocacy, the state's largest professional associations representing dentists and dental hygienists, community clinics, county public health and human services, Head Start, the University of Minnesota School of Dentistry, the University of Minnesota Medical School Department of Pediatrics, the State Board of Dentistry, the Minnesota Department of Health (MDH), and the state's major health and dental care contractors and subcontractors. Together, we examined the problem from a variety of perspectives: from that of the marketplace, to prevention, to the workforce, to patient responsibilities, to the delivery system infrastructure, and beyond. We reviewed national research, and the efforts of others who are attempting to solve this problem in other states. We also evaluated recent changes in how MHCP beneficiaries get their dental care and the impact of recent legislated initiatives to improve dental access.

Based on this study, DHS has made a comprehensive series of recommendations to improve dental access, some of which require funding.

METHODOLOGY

To fulfill its legislative charge, DHS convened the Dental Access Advisory Committee, composed of 21 stakeholders in the dental access issue, including the groups named specifically in the statute. The Committee's charge was to review the access problem, study actions to improve access, and assist DHS in its evaluation of the dental access initiatives adopted by the 1999 Legislature. (See Appendix B for a list of Committee members.)

By and large, the Committee members and the groups they represent were selected because of their familiarity with the dental access problem, its causes and strategies to address it. For this reason, the Committee was directed to devote most of its activity to crafting viable, effective solutions, rather than spending more time examining the problem which had been done by previous committees. The first Committee meeting was held December 17, 1999, and the group completed its final input to DHS one year later in December 2000.

After examining the factors contributing to the dental access problems, and reviewing and generating strategies to increase dental access, the Committee organized itself into five work groups:

- ! Patient Barriers
- ! Provider Participation
- ! Purchasing/New Models/Administrative Simplification
- ! Rates
- ! Data/Bench marking

In developing strategy proposals, the work groups recognized that many of the causes and solutions to the problems are intertwined.

The Committee also evaluated the effects of the dental access initiatives adopted by the 1999 Legislature. (To avoid conflicts of interest, Committee members whose agencies received grants associated with these initiatives recused themselves from reviewing the grant projects.) The Committee reviewed a variety of data to study the effects of the 1999 initiatives on dental access, including data required of the grant awardees by DHS to be submitted in quarterly reports documenting the project's effect on dental access.

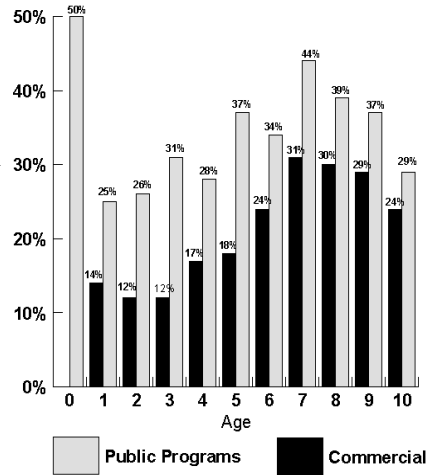
ISSUES

I. Oral health and income status

Researchers have established strong links between oral health and income status. In the recently released U. S. Public Health Service’s first comprehensive report on the oral health of Americans, Surgeon General David Satcher states, “it is abundantly clear there are profound and consequential disparities in the oral health of our citizens.”² The report says that those who suffer the worst from this “silent epidemic” of oral diseases are the poor, particularly children and older persons. Members of racial and ethnic minority groups experience a disproportionate level of oral health problems, and the health of medically compromised people and those with disabilities is placed into further jeopardy by oral disease. In spite of this greater prevalence of oral disease among low-income citizens, it is they who access dental care the least.

The relationship between income status and oral health status holds true in Minnesota. Figure 1 demonstrates the disparity between MHCP children and other insured children who received dental services based on an oral examination.

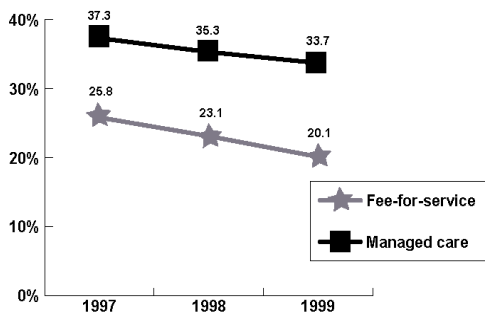
FIGURE 1
Percent of children seen at HealthPartners Dental Group Clinics who required restorative or surgical care, January 1, 1999 - June 30, 1999



Source: HealthPartners

II. Underutilization: Causes and effects

FIGURE 2
Percent of MHCP beneficiaries receiving one or more dental services.



Source: Minnesota Department of Human Services

MHCP beneficiaries do not visit the dentist nearly as often as their privately insured or cash-paying neighbors. In 1995, 70 percent of commercially insured Americans accessed dental care.³ The comparable number for MHCP beneficiaries is 30.5 percent in 1997.⁴ Furthermore, utilization by MHCP beneficiaries has been declining (see Figure 2).

There appear to be two basic reasons why MHCP beneficiaries are not receiving dental services: 1) there are not enough dentists who will treat MHCP beneficiaries; 2) many of the beneficiaries are not seeking care. Regarding the first reason, only about one third of Minnesota’s dental clinics and dentists provide significant amounts of services to MHCP patients, and more than one quarter of them provide no services whatsoever.⁵

As Table 1 indicates, in every part of Minnesota it is extremely difficult for any MHCP beneficiary who does not already have a dentist to get a dental appointment. (See Appendix F for data from all counties that participated in this survey.)

Table 1. Availability of Dental Appointments for New MHCP Patients in Selected Counties, October 2000 ⁶		
County	Licensed Dentist FTEs [1]	Dentists with Available Appointments for New MHCP Patients [2] [3]
Anoka	122.5	15
Clay	21.48	2
Clearwater	3.9	0
Cook	2.0	0
Douglas	13.88	2
Goodhue	26.13	3
Lincoln, Lyon, Murray, Pipestone	17.16	1
Marshall	10.5	2
Martin	18.28	1
Olmsted	85.18	5
Otter Tail	23.45	1
Nicollet	11.95	1
Red Lake	1.0	0
St. Louis	113.45	24
Sherburne	17.15	0

[1] SOURCE: Minnesota Department of Health License Surveys, 1998. "FTE" means full time equivalent.

[2] SOURCE: County Public Health Agency reports to the Minnesota Department of Human Services, October 2000.

[3] The "Number of Dentists Open to New MHCP Patients" may exceed the "Number of Licensed Dentist FTEs" because some public health agencies surveyed dentists in surrounding counties.

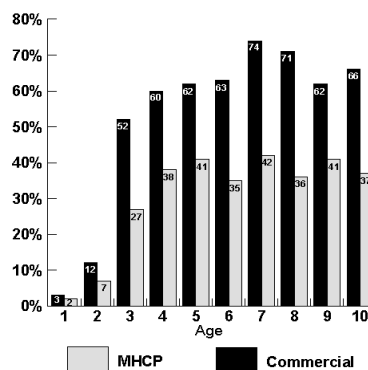
Preliminary data from a November 2000 survey of Minnesota dentists indicates that 43 percent of dentists were not accepting new MHCP patients.⁷ This number may be understated, as dentists who were presently seeing MHCP patients responded early to the survey in much greater numbers than did those who were not presently seeing MHCP patients.

In addition to the small proportion of private dentists who treat MHCP beneficiaries, the “safety-net” providers – community, hospital-based, and other nonprofit clinics available in limited areas of the state whose mission is to serve low-income people – are facing financial constraints with serious implications for access. The high proportion of MHCP patients and uninsured persons these clinics see pose unique challenges to their continued operation. Loss of these providers will further strain the system and private dentists cannot be expected to pick up the slack.

As might be expected, the limited number of available providers means that many MHCP beneficiaries cannot get appointments. In a recent quarter, over 10 percent of all interactions recorded by the state Office of the Managed Care Ombudsman were concerning dental services.⁸ On average, 1 in 5 MHCP appeals between 1996 and 1999 related to dental services.⁹ Anecdotal reports from county advocates that MHCP beneficiaries often feel it is futile to complain about dental access suggest it is likely that these numbers under-represent the problem.

It is unknown how much of MHCP beneficiaries’ low use of dental services is attributable to lack of success in getting an appointment versus failing to seek an appointment in the first place. However, data from HealthPartners, one of the larger MHCP prepaid contractors, provides some insight into this question. This data, which compares commercially insured enrollees with MHCP enrollees who access services through HealthPartners’ Dental Group Clinics, indicates that commercially insured children visit the dentist at a much higher rate than MHCP children (see Figure 3). Inability to obtain an appointment is not a factor for these enrollees, since HealthPartners group clinics have never refused an appointment for an MHCP enrollee due to payer status or lack of clinic capacity.

FIGURE 3
Children with one or more visits,
HealthPartners Dental Group Clinics,
1/1/99 - 6/30/99



Source: HealthPartners

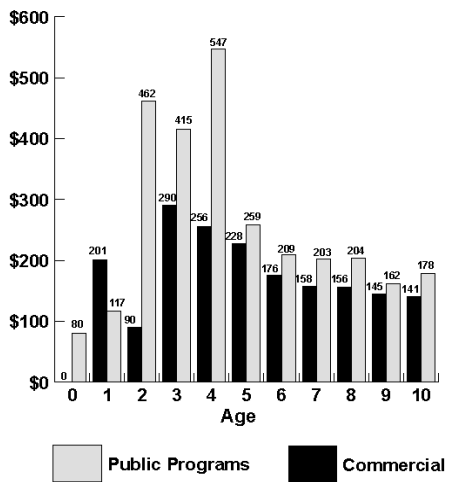
The consequences of poor oral health. U.S. Surgeon General David Satcher notes that oral diseases are linked to total health and well-being throughout life. Oral disorders “may interfere with vital functions such as breathing, eating, swallowing and speaking.”¹⁰ Researchers are investigating correlations between oral disease and overall health. Untreated oral disease can snowball into life-threatening situations. Periodontal disease, which strikes primarily in middle age, has been shown to correlate with heart disease. Though dental pathology is rarely associated with mortality, strong correlations with morbidity have been established in the areas of premature labor and low birth weights (with associated high cost neonatal intensive care unit stays), poorly controlled diabetes, and other serious health problems.

Poor oral health among participants of publicly-funded health care programs pose significant cost implications to Minnesota. The lack of preventive care and the inability to get appointments result in avoidable, expensive restorations and emergency room visits. For example, the federal Health Care Financing Administration estimates that nationally, Medicaid expenses for the operating room costs of treating toddlers with “baby bottle mouth” syndrome is \$100 million to \$400 million per year.¹¹ This condition is avoidable through early preventive care.

The higher levels of disease, insufficient timely treatment of existing disease, and lower frequency of preventive visits among MHCP beneficiaries are responsible for greater amounts of restorative work, for dental services which must be provided in a hospital, and for emergency room visits. A cavity requiring a simple filling escalates to an abscessed tooth, an extraction and subsequent prosthetic replacement or malocclusion. As access to dental care decreases, the backlog of unmet treatment needs increases in both quantity and severity, further compounding State costs.

The data in Figure 4 suggest that, in view of the higher costs of emergency and restorative care for MHCP beneficiaries compared to other Minnesotans, the overall cost incurred by the State would be reduced if more preventive services were provided.

FIGURE 4
Retail value* of restorative care for children,
HealthPartners Dental Group Clinics,
January 1, 1999 - June 30, 1999



* excludes hospital costs when operating rooms are required

Source: HealthPartners

Poor oral health can have social and economic implications for MHCP beneficiaries. Children suffering from painful tooth decay and more advanced disease miss school days (and their parents miss work days), or attempt to learn while in pain. Missing and rotting teeth can impede social interaction, and can prove major obstacles to getting and keeping a job. Nationally, experts estimate acute dental conditions are responsible for 1.6 million lost school days (ages 5-17) and 2.4 million work days (ages 18 and up).¹² At a time when Welfare-to-Work initiatives are being stepped up, this barrier to self-sufficiency needs to be overcome.

Lack of access to dental care is undoubtedly causing a deterioration in the oral health of MHCP beneficiaries, with consequences to both the patients’ quality of life and the State budget.

III. Characteristics of the population

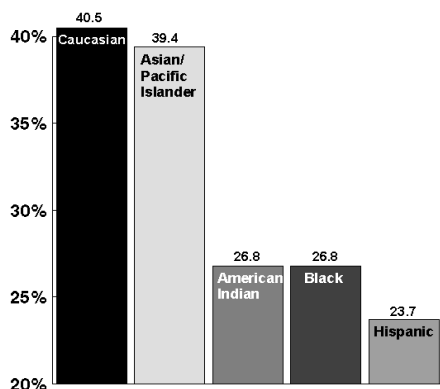
Stressors and needs. When compared with Minnesota’s general population, MHCP beneficiaries have many characteristics that differentiate their dental needs and costs. People on public assistance frequently have many additional stressors in their lives. These stressors are associated with poverty,⁽¹⁾ physical and mental illness, culture, and disability.

Access to basic needs, including health and dental care, is often more difficult for MHCP beneficiaries as they are less likely to have reliable transportation. In increasing numbers, they face language barriers. Cultural barriers also exist among the growing number of MHCP beneficiaries who are immigrants coming from cultures where Western medicine is unfamiliar.

For many, preventive health care in general may be seen as a lower priority when compared to meeting other, more immediate or more basic needs. Because of this, the primary objective of an MHCP beneficiary seeking dental care is frequently the relief of pain rather than the prevention of dental disease.

Researchers have found great disparities in the incidence of dental disease when comparing public assistance beneficiaries with the population at large. Nationwide, 80 percent of tooth decay occurs in only 25 percent of children and adolescents.¹³ In 1996, 10 percent of children from low-income families had an unmet need for dental care vs. 5 percent for children from families with higher incomes.¹⁴ Other recent studies show that poor children have on average five times more untreated tooth decay than higher income children, and poor adults are more

FIGURE 5
Percent of MHCP children by race/ethnicity receiving one or more dental services in 1999



Source: Minnesota Department of Human Services

likely to have lost six or more teeth to decay or gum disease.¹⁵ Nationwide, only 30 percent of low-income children received dental care in 1996;¹⁶ in Minnesota the number for MHCP children was slightly higher, as 35 percent received dental care in 1999.¹⁷

Disparities also exist within the MHCP population. Children within some racial and ethnic groups are much more likely to receive dental services than others. (See Figure 5)

Dentists report that MHCP patients fail to keep their appointments at a much higher rate than other patients. National studies show that about one third of all Medicaid dental appointments are broken, and in some cases, local data

(1) Current net annual income limit for an eligible adult in a household of one to receive Medical Assistance is \$7,224/year. For a family of four, an adult can have net annual family income of \$10,248/year. Income standards for children vary. For example, a 4-year-old child in a household of four may have net family income of \$22,680/year. (Minnesota Department of Human Services, December 2000.)

show rates exceeding 40 percent.¹⁸ The higher rates are not surprising, given the persistent life stressors present in the lives of many MHCP families. In addition, dentists report that many MHCP patients have a deep-seated fear of dental care resulting from extreme treatment measures that may have been taken in the past because of neglected care. Some Minnesota health care providers report that they have noticed a “desire to please” among some cultural groups. In such cases, patients agree to follow up appointments not because they agree with or understand the need for them, but because they fear loss of benefits or a threat to their immigration status if they are seen as uncooperative. These appointments frequently end up failed.

Dentists report that MHCP beneficiaries are less likely to follow after-treatment care instructions (such as a regimen of antibiotics or special rinses) than other patients. Dentists see patients who are less compliant with treatment plans as more difficult and less desirable to treat. Furthermore, lack of compliance with the care plan often leads to treatment outcome failure, or to protracted and more costly treatment at best. In preliminary responses to the November 2000 Survey of Minnesota Dentists, 86.8 percent of respondents cited MHCP patient non-compliance as a “somewhat significant” or “very significant” problem.¹⁹

Anecdotal reports from dental providers say that some MHCP beneficiaries may have a lack of understanding of the basics of oral hygiene and the implications of neglected oral health. In some cases, this lack of understanding is cultural: for many recent immigrants, the idea of preventive health care can be literally a foreign concept.

About 25 percent of MHCP beneficiaries have significant physical, behavioral, or mental disabilities.²⁰ The Surgeon General notes that people with disabilities are at “increased risk for oral diseases.”²¹ People with disabilities often have special needs that can result in higher costs of dental care to accommodate the person’s special needs and due to the need for more and longer visits. MHCP’s costs of providing dental care to people with disabilities is significantly higher than it is for non-disabled MHCP beneficiaries. (See Table 2)

Table 2. Medical Assistance Payments for Dental Services, 1998*			
Recipient category	# of recipients	Payments	Avg. payment/recipient
Disabled	37,895	\$7,516,985	\$198.36
All others	36,947	\$5,872,564	\$178.95
* Includes only DHS fee-for-service payments for people under age 65 during the period January 1, 1998 to December 31, 1998.			
SOURCE: Minnesota Department of Human Services, Community Services for Minnesotans with Disabilities.			

People with disabilities face reduced choices in the number of providers available, as many providers cannot accommodate special needs. Examples of these needs include wheelchair ramps, portable dentistry for people with physical disabilities (whereby dental care is brought to residential care facilities), anesthesia, or additional staff needed to accommodate people with

behavioral disabilities. Some patients with special needs have difficulty cooperating with dental professionals while receiving care, resulting in the need for longer appointment times. Some must have their care done under sedation, or in a hospital setting under general anesthesia. For some special needs patients, oral diseases may create or intensify behavior problems.

Discussion. DHS, the counties, and the health plans work to meet the diverse needs of MHCP beneficiaries and assist them in overcoming barriers to care in many ways. Interpreters and transportation are provided. Payment codes have been established to recognize the more costly needs of people with disabilities. The health plans agree in their contracts with DHS to include culturally competent providers in their networks. The federally mandated Child and Teen Checkup Program helps identify oral health problems among children through outreach and screenings. At the service delivery level, Minnesota has a small number of hospital-based dentistry clinics that provide services to medically fragile and severely disabled people, and two portable dentistry programs that bring dentists into group homes and nursing homes (for residents unable to travel to a clinic in the community), as well as schools and Head Start centers.

The federal Health Care Finance Agency (HCFA) has consistently prohibited compensation to providers for appointment failures, citing Medicaid regulations. In Minnesota, one of the largest MHCP prepaid health plans is testing an alternate method to address this problem. This health plan works with dental providers to identify MHCP beneficiaries who chronically miss appointments, and apply problem solving measures to help them keep their appointments.

In spite of the many measures that have been taken to address the circumstances of MHCP patients, access to dental care remains unacceptably low.

Strategies. As the population covered by MHCP becomes more diverse, it is clear that new care models need to be developed that take language and culture into consideration. While cultural factors can be formidable barriers to prevention and early intervention, Minnesota's experience in educating MHCP beneficiaries on the importance of preventive health care has been successful in other areas.

In the area of prenatal care, some MHCP contractors have improved the rate of compliance in prenatal visits through incentive programs, in which an expectant mother receives a small gift, such as a gift certificate for a local shop, when she completes each scheduled visit. While this approach is somewhat controversial among members of the Dental Access Advisory Committee, it has produced good results for the contracted health plans. Some Committee members believe it should be tested as a means to reduce MHCP appointment failures.

In the aforementioned MHCP contractor's appointment failure reduction project, dentists are instructed to call the health plan when an MHCP patient does not keep an appointment. A representative from the health plan's social services staff follows up with the patient, offering education and support such as transportation or child care. The Dental Access Advisory Committee found this program promising and believes it should be expanded to the other MHCP

patients if its evaluation shows a reduction in “no shows.”

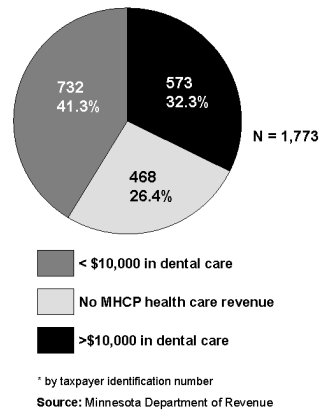
The Committee identified the public health nurse’s potential role in reducing appointment failures, improving compliance with treatment plans, and educating MHCP beneficiaries on the value and home care techniques of prevention. Public health nurses are frequently involved with MHCP beneficiaries. Helping patients overcome their fear of dentists, remember their dental appointments and arrange transportation (the health plans which care for MHCP beneficiaries all provide transportation) could be added to their responsibilities. More public health nurses would have to be hired but the net cost might be reduced (more prevention; less expensive restorative care and emergency room reimbursements).

To support dental care for patients with developmental disabilities, a Committee work group recommended the creation of a grant program modeled after the Ryan White AIDS program. The federally funded program makes grants to states and other localities. The grants are a recognition of the fact that AIDS patients find it considerably more difficult to access health care services than other patients.

IV. Provider participation

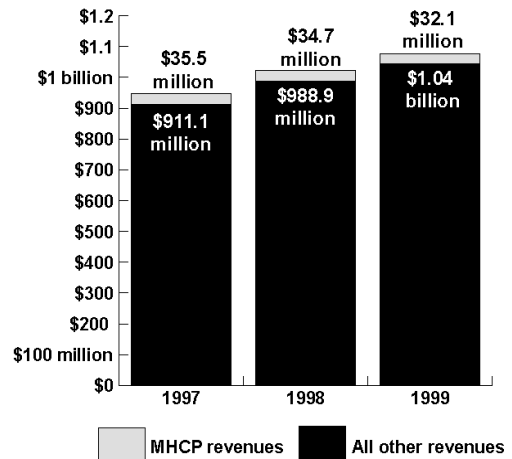
Limited participation. Between 1997 and 1999, the gross receipts of Minnesota’s dental practices increased by almost 14 percent. During the same period however, their total receipts for MHCP business decreased by almost 10 percent.²² (See Figure 6)

FIGURE 7
MHCP dental care revenues
Minnesota dentists and dental clinics, 1999*



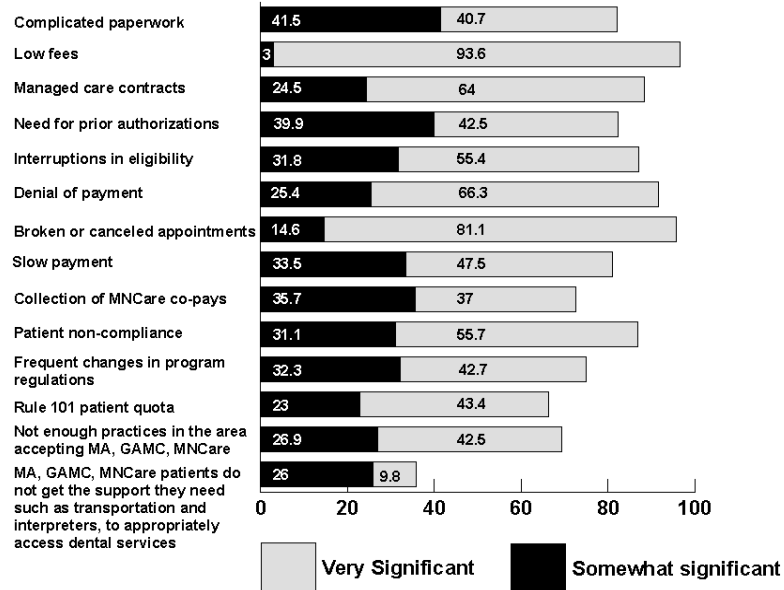
In 1999, only 73.6 percent of Minnesota’s dentists and dental clinics provided *any* care to MHCP beneficiaries. Among those who did treat MHCP patients, many did so at very low levels, with MHCP patients making up only a small portion of their patient base. Only 32.3 percent provided more than \$10,000 in care to MHCP beneficiaries.²³ (See Figure 7)

FIGURE 6
Minnesota dental practices’ revenues



Why is there such low MHCP participation rate among Minnesota dentists? Dentists frequently cite one or more of the following reasons: 1) payment rates are too low; 2) distrust of or philosophical objections to managed care; 3) onerous administrative barriers; 4) concerns about patient behaviors; 5) objection to the quotas required by Rule 101 (for explanation, see Rule 101 section, page 15.). (See Figure 8)

FIGURE 8
Dentists' perceptions of the significance of various reported MHCP dental problems



Responses to this survey statement: "Please indicate how significant you consider each problem to be when deciding to participate in these programs."

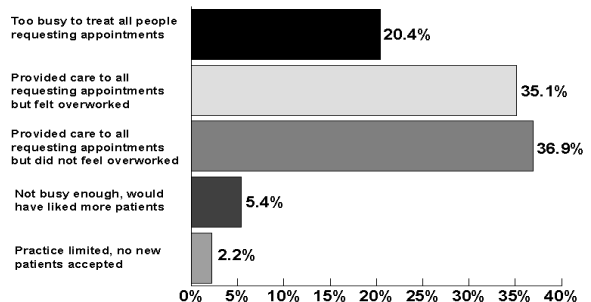
Source: Wilder Research Center, Survey of Minnesota Dentists, November 2000, preliminary results.

Many dentists who treat MHCP patients are taking no new patients because their practice is at capacity, or because they have reached their Rule 101 threshold.

Preliminary responses to the 2000 Survey of Minnesota Dentists suggest that for many providers, their level of busyness precludes or discourages their taking any new patients, regardless of payment source or public assistance status of the patient. (See Figure 9)

FIGURE 9
Busyness of Minnesota dental practices

Survey question: How would you best describe your practice during the past 12 months?



Source: Preliminary response data, Survey of Minnesota Dentists, November 2000, Wilder Research Center.

Payment rates. The Legislature has increased MHCP payment rates for dental services several times over the past decade. Despite these increases, rates still remain considerably below dentists' usual and customary charges, and below what many dentists report to be their overhead costs. According to the American Dental Association, the average dental office overhead is approximately 60 percent.²⁴ Some Minnesota dentists report overhead costs as high as 70 percent.²⁵

In state fiscal year 1999, the fee-for-service payment-to-charge ratio was 54.5 percent, statewide.²⁶ (Some dentists dispute this number, arguing that many dentists do not bill for MHCP patients at their usual and customary rate. Instead these providers bill at the MHCP rate, despite being advised by DHS that future rates are determined in part by billed charges. However, an analysis of recently billed charges submitted by dentists to DHS indicates that fewer than 3 percent of billed charges were submitted at the MHCP payment rate.)

Rates paid by the prepaid MA, GAMC and MinnesotaCare health plans are reportedly higher, though still not much more than on par with reported overhead costs. Some dentists claim, particularly in areas with a shortage of providers, that taking MHCP patients displaces higher reimbursed commercially insured or cash patients from their practices. In the November 2000 Survey of Minnesota Dentists, preliminary results show that less than 3 percent of the state's dentists report making a profit on MHCP business.²⁷ See the Reimbursement section, page 28, for further discussion of the payment rates issue.

Managed care. The conversion of MHCP to prepaid managed care has been arguably more controversial among dentists than any other group of providers. While managed care is long established and at least marginally accepted by most providers in most sectors of Minnesota's health care marketplace, the dental segment of the marketplace has only recently been introduced to managed care. As the majority of dental practices consist of single-dentist offices functioning at or near desired capacity, there is little interest or incentive for dentists to participate in managed care plans and many dentists strongly object to participating.

Minnesota dentists' objections to managed care are largely economic and philosophical. This sentiment expressed in a letter from a Northfield dentist to the local Human Rights Commission is typical: "Northfield dentists ... are philosophically opposed to managed care programs ... (P)atients are best served when treatment decisions are made by patients in consultation with their dentists. However, insurance companies and managed care plans interfere in these treatment decisions Recently, this interference has become more onerous due to the limited marketplace competition for the state's dominant dental insurance carrier."²⁸

Large numbers of dentists in some regions of the state have refused to sign contracts with the dominant prepaid MHCP dental administrator. A recent article in a regional professional publication reports that some Minnesota dental practices are even limiting unprofitable commercial insurance plans as a means of selecting new patients.²⁹

When DHS phased in the conversion of MHCP to managed care in some areas of the state, dentists who had been seeing at least a few MHCP patients refused to sign managed care contracts. Some advocates are concerned that dentists' resistance to managed care contracts has a significant impact on provider choice, and perhaps on access as well. In addition, dentists who do not provide services under a capitated model – either capitation of the dentist or capitation to a dental administrative organization with fee-for-service payments to providers – will not realize the potential incentives of a risk-based arrangement. (See Purchasing section, page 35, for further discussion of dental services and prepaid managed care.)

Administrative burden. Many dentists complain that the administrative requirements of serving MHCP beneficiaries are too burdensome. They note that the state's prepaid programs involve multiple payers, and they object to the varying administrative requirements of the different payers. At the request of the Dental Access Advisory Committee, a group of dental providers who work in both metro and rural private and community clinics met to discuss the administrative burdens they face when attempting to treat MHCP beneficiaries. In addition to the obstacles, they identified some measures that could be taken to reduce or eliminate these barriers. Following is a summary of the group's discussion.

- **Multiple contracts:** Because DHS purchases MHCP dental services both directly from providers under fee for service, and through managed care contracts in all 87 of the state's counties, a dentist must contend with multiple sets of administrative requirements relating to billing, credentialing, prior authorizations, etc. (See Figure 15, page 36.) This complexity makes serving MHCP beneficiaries more confusing and time consuming, and raises the provider's administrative costs.
- **Disputes over benefit coverage:** Many providers report a difference in what is covered for MHCP beneficiaries depending on who the payer is, despite the fact that DHS managed care contracts specify uniform benefits among the health plans and the DHS fee-for-service system. In particular, they cite one dental subcontractor as denying certain services outright, and combining payment codes for other services for the purpose of paying less to the provider. Some providers who treat individuals with disabilities say that the important services of gross oral cleaning and behavior management are either not reimbursed or are made administratively prohibitive by this payer.
- **MinnesotaCare co-payments:** One segment of MHCP beneficiaries, adults on MinnesotaCare whose income is more than 175 percent of the Federal Poverty Guidelines, are required to make co-payments for dental services. Providers find the identification of these individuals and collection of the co-payment to be onerous and costly, especially since the co-payments are based on MHCP rates which many providers deem unacceptably low.
- **Excessive prior authorizations:** Providers say that some payers require prior authorization too often for basic care procedures. For example, cleanings for special needs patients

(who often are unable to maintain good daily oral care by themselves) must be pre-authorized even if done within the payers' usual six-month frequency restrictions. In another example, a provider reported that his patient needed a missing front tooth replaced so the patient could seek employment. The payer required a prior authorization, which took 4-5 weeks to obtain, and was denied. When the provider contacted the payer about this, the payer told him he could appeal the decision and wait another 4-5 weeks to obtain an answer. Many dentists believe that payers employ such time-consuming, unwieldy processes in the hope that providers and patients will "give up" seeking authorizations.

- Claims payment problems: Providers note that a major MHCP dental subcontractor seems to reject a high rate of "clean" claims, adding days or weeks to the receipt of the payment warrant. Even when the claim is accepted on the first submission, providers say this payer is considerably slower than other MHCP payers. These slow payments can cause cash flow problems for providers. The greater the provider's volume of MHCP business, the greater the impact of slow payments.
- Refused payments for work done after loss of coverage: Dentists recognize that they will not be paid under MHCP for services provided after a patient loses eligibility for MHCP coverage. However, in the case of treatment plans for procedures spanning multiple appointments (e.g., placement of crowns or dentures), dentists are sometimes placed in a professionally compromised position. When the dentist completes his/her work after loss of coverage, rather than abandon the patient, the dentist must absorb costs not paid by DHS or the MHCP dental contractor.

Some of the dentists' objections are not unique to MHCP. They reflect the current health care marketplace, and the dentists encounter similar problems in treating commercially insured patients.

Inherent in any discussion of administrative issues and managed care is the tension between the provider's practice discretion versus the managed care organization's management techniques. Much of what the dentists see as administrative barriers are viewed by the MHCP-contracted health plans as tools to efficiently and effectively manage patient care. An elemental principle of the managed care model is that in return for accepting financial risk, the managed care organization is allowed to establish administrative procedures to ensure the delivery of cost-effective care. All payers, whether DHS or the health plans, must have some administrative requirements to assure that the public's money is spent appropriately.

Patient behavioral factors. Some dentists express concerns about serving MHCP beneficiaries because of attributes of the beneficiaries themselves.

Generally, dentists perceive MHCP patients as more difficult to care for. (See Figure 10)

A common concern is the previously mentioned high rate of appointment failures. While dentists sometimes charge patients for missed appointments, federal regulations prohibit dentists from billing Medicaid patients for missed appointments. Each appointment failure represents lost revenue, due to the fact that the overhead expenses accrue whether or not the patient keeps the appointment. When, for example, a family of four does not keep the appointments they make on a given day, the typical practice loses a substantial portion of the day's revenue.

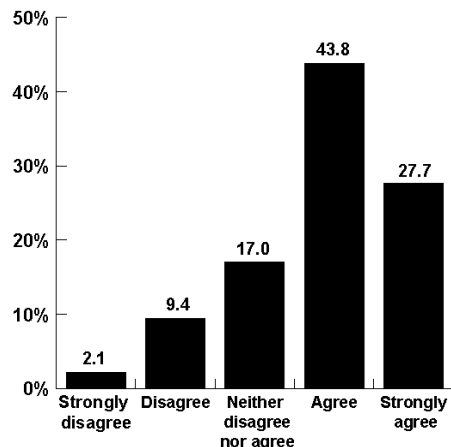
Rule 101. Minnesota enacted a state administrative rule several years ago intending to give incentives to health care providers to serve MHCP beneficiaries. This rule was later encoded as Minnesota Statutes, section 256B.0644, but is still commonly known as "Rule 101."

Rule 101 requires each health care provider who treats state or state university employees, employees of certain counties, cities and school districts, those whose treatment is paid by workers' compensation and a few other small groups of state-covered insureds (all collectively known as State Employees Group Insurance Plan, or SEGIP), to accept MHCP beneficiaries until 20 percent of their patients are MHCP beneficiaries. At that point, a provider may refuse to accept additional MHCP beneficiaries. (See Appendix G for the full text of this statute.)

Many dentists believe Rule 101 is overly coercive. According to preliminary results from the November 2000 Survey of Minnesota Dentists, 23 percent identify Rule 101 as a "somewhat significant" problem, and 43.4 percent see it as a "very significant" problem in deciding whether to participate in MHCP.³⁰

The Rule's effect on dental access has been mixed. Minnesota now has MHCP managed care contracts in all 87 counties. Dentists are not legally bound to sign managed care contracts. Dentists who choose not to contract are able to keep SEGIP patients by using a loophole: in each county, a small fraction of MHCP beneficiaries are excluded from managed care participation, so dentists can comply with Rule 101 by leaving their doors open to these beneficiaries. To fill this loophole, an even more regulatory approach has been discussed: tying state licensure to accepting MHCP beneficiaries. However, most agree this measure is politically unfeasible, and not conducive to good provider/patient relationships.

FIGURE 10
Perceived difficulty in treating MHCP patients



Responses to this survey statement: "The patients covered by these programs [MHCP] are more difficult to treat than other patients."

Source: Preliminary response data, Survey of Minnesota Dentists, November 2000, Wilder Research Center.

There is some discussion that Rule 101 is doing more harm than good by raising the ire of providers who see the rule as an “all or nothing” proposition. These providers believe that if they cannot limit the amount of work they do for MHCP beneficiaries at their own discretion, they will do none. In such cases, Rule 101 serves as a deterrent to providing services rather than an inducement. In many parts of the state, the marketplace is such that a dental practice can operate at full capacity by serving neither MHCP beneficiaries nor SEGIP beneficiaries. As an alternative to the “stick” approach of Rule 101, there is some sentiment to develop more “carrot”-type approaches, i.e., offering dentists what they may see as more positive incentives to treat MHCP beneficiaries.

Discussion. The Dental Access Advisory Committee directed much of its efforts to addressing what can be done to increase the number of dentists who treat MHCP patients, and to increase the number of MHCP patients among those dentists who already treat them. The Committee and its work groups examined payment rates and purchasing strategies and developed some new models (see Appendix D). Two key questions were raised by the discussion: 1) Is managed care an impediment to dental access? 2) How can DHS retain the benefits of managed care, while increasing dental access?

In recent years, there has been a number of efforts taken by various parties to increase the participation of dentists in MHCP. These include:

- In 1997, the Legislature lowered the Rule 101 threshold for dental providers to 10 percent MHCP beneficiaries (all other provider types remained at 20 percent). Utilization did not increase, but in fact decreased since the threshold was lowered. In 1997, the percentage of fee-for-service MHCP beneficiaries receiving dental services was 25.8; by 1999 this number had dropped to 20.1. For managed care beneficiaries, the 1997 percentage was 37.3; by 1999 it had dropped to 33.7.³¹ Looking at provider revenues, in 1997, Minnesota dentists received \$35.5 million in MHCP revenue (3.8% of total revenues); in 1999, dentists received \$32.1 million in MHCP revenue (3.0% of total revenues).³²
- In 1998, DHS invited proposals for dental services for MHCP beneficiaries in St. Louis County that would have carved dental services out of prepaid contracts and contract directly with provider networks. Although DHS received no proposals, follow-up dialogue with would-be proposers yielded helpful information for possible future requests for proposals, perhaps increasing the likelihood of successfully executed future contracts.
- In 1999, Medica Health Plan, the MHCP provider with the largest enrollment, instituted the “Will Show” program. This program, discussed previously in the Characteristics of the Population section (page 7), offers dentists a pro-active step to take in reducing the appointment failures among their MHCP patients.
- In 2000, DHS promulgated revisions to the dental coverage section of Rule 47, the state administrative rule that governs MHCP benefit policy. The revisions clarify definitions

of covered dental services and specify criteria governing service coverage. Specifically, the planned amendments delineate preventive services, restorative services, covered services, and excluded services. The revisions were developed in consultation with dentists, and eliminate many prior authorizations and other administrative hurdles. They bring the rule into substantial conformance with contemporary community standards of dentistry. The changes are intended to expand coverage criteria for dental services, increase dental provider enrollment, and broaden access to dental services.

- In 2001, DHS will pilot a new means of purchasing dental services for MHCP beneficiaries in Cass, Crow Wing, Morrison, Todd and Wadena counties. Most beneficiaries will be enrolled in prepaid health plans, but dental services will not be part of the contracts. Beneficiaries will obtain care through any MHCP dental provider who is willing to see them. Providers will be paid by DHS through its fee-for-service claims payment system, at an enhanced rate based on increased access.

In some areas of the state, the lack of dental providers who treat MHCP beneficiaries has been reportedly caused, at least in part, by providers' fear that if they accept MHCP patients while their local colleagues do not, they will be inundated with more patients than they can handle.

So what is a "fair share" of MHCP patients for a dentist? As a starting point, if MHCP patients were distributed evenly among all practicing dentists in Minnesota, each dentist would have 147.⁽²⁾ Due to the uneven distribution of dentists and MHCP beneficiaries, this number would be subject to significant regional variations.

Strategies. The Dental Access Advisory Committee identified and studied several strategies to increase dentists' participation in MHCP. These strategies include:

- Addressing the high appointment failure rate. Eliminating or substantially reducing the appointment failure rate is crucial to attracting more dentists to treat MHCP patients. Using intensive case management for those who chronically miss appointments is one strategy. The Committee also favored exploration of provider compensation for missed appointments. Also identified were strategies to provide patient incentives for keeping appointments and complying with care plans, which are described on page 9 in the Characteristics of the Population section.
- Improved communication between providers and health plan administrators. The Committee advocated regular meetings between provider representatives and MHCP dental administrators to monitor and ameliorate dentists' concerns as they emerge.

⁽²⁾ According to the Minnesota Department of Human Services eligibility files, there were approximately 411,400 MHCP beneficiaries in May 2000. According to the Minnesota Department of Health statistics (adjusted by the preliminary results of the Wilder Research Center's November 2000 Survey of Minnesota Dentists), there were approximately 2,800 practicing dentists in Minnesota in December 2000.

- Elimination of administrative burdens and lowering prior authorization requirements. Committee members questioned whether health plan administrators have examined whether the cost of paperwork outweighs any savings in costs gained by prior authorization requirements, citing United Health Care’s recent decision to ease its management practices on physicians.
- Allowing dentists to care for MHCP patients in settings away from their own offices, such as in safety-net clinics. Many dentists fear that by seeing a few MHCP patients, their practices would be overwhelmed by the pent up demand of MHCP beneficiaries in their communities who cannot obtain appointments from other dentists. To adopt this strategy, dentists should be able to count MHCP patients they treat in other settings toward their Rule 101 participation threshold. The health plans would need to agree to pay safety-net clinics for these services without requiring a direct contract with the dentist.
- Raising payment rates. Many who have examined present MHCP payment rates agree that dentists have legitimate concerns about the rate levels relative to the dentists’ costs of operating a business. This topic is discussed in full in the Reimbursement section, page 28.
- Fostering more involvement of dentists in structuring programs to serve MHCP beneficiaries. For example, a program that operates in several other states, the Donated Dental Services (DDS) Program, was designed to increase dental care access for certain Medicaid and other low-income persons. The program, operated by the National Foundation of Dentistry for the Handicapped, serves primarily disabled and medically complex individuals who do not have funds to purchase dental services for themselves. Dentists donate their time and expertise. Supplies and lab work also are donated. A paid program coordinator provides administrative support. The program has been designed by dentists, many of whom were disenchanted with serving Medicaid patients in more traditional ways. Through the DDS Program, participating dentists are able to determine which low-income or uninsured patients and how many of them they wish to treat.

V. Dental workforce and service delivery infrastructure

Workforce and labor supply. Some areas of Minnesota, largely rural, have few practicing dentists in their local communities, resulting in access barriers for everyone. Other areas of the state currently appear to have ample numbers of dentists, dental hygienists, and dental assistants working at their desired capacities, but not enough of these providers treat MHCP beneficiaries. In the future, overall demand is expected to exceed supply of dental professionals, making it even more difficult for MHCP beneficiaries to access care.

Dr. David O. Born of the University of Minnesota has published an assessment of Minnesota’s dental workforce in 2000.³³ He notes that, “As the profession and the public turn to the escalating problems of access to dental care, data on the professional workforce become ever more important.” Tables 3 and 4 were excerpted from his article.

Table 3. Supply and Distribution of Dentists in Minnesota: Dentist-to-Population Ratio						
	Statewide	Mpls./St. Paul Metro Area	Rural	Olmsted County	Stearns County	St. Louis County
1975	1:1,613					
1980-81	1:1,488					
1995	1:1,567	1:1,311	1:1,880	1:1,230	1:1,485	1:1,304
2000	1: 1,624	1:1,396	1:2,000	1:1,089	1:1,513	1:1,455
SOURCE: Excerpted from Born, D.O., "Trading Water: Minnesota's Dental Workforce in the Year 2000," Northwest Dentistry, September - October 2000, p 25.						

Table 4. Average Age of Active Licensed Dentists in Minnesota				
		Statewide	Mpls./St. Paul Metro Area	Rural
1993	average age	46.9 years	46.0 years	48.1 years
	age 60+	13.9 %	12.0 %	16.8 %
1995	average age	48.0 years	47.5 years	48.7 years
	age 60+	14.4 %	---	---
2000	average age	47.2 years	46.6 years	48.2 years
	age 60+	11.6 %	11.2 %	12.2 %
	age 56-60	9.8 %	---	---
	age 51-55	15.7 %	---	---
SOURCE: Excerpted from Born, D.O., "Trading Water: Minnesota's Dental Workforce in the Year 2000," Northwest Dentistry, September - October 2000, p 26.				

Dr. Born makes several observations about this data of relevance in improving dental access:

- In using ratios to assess access, the dentist-to-population ratio is an *approximate* indicator of supply and demand for dental services, but a variety of factors not reflected in the ratio have direct impacts. These factors include: ages of dentists, numbers, ages and types of auxiliaries employed, “style” of practices, age of equipment, geographical distance to patients, extent of dental insurance coverage, etc.
- Some experts suggest desirable dentist/patient ratios of 1:1,200 - 1:1,400, although others consider these to be arbitrary. A conservative approach is to look at the statewide average, regard it as normative and note significant variations from it.
- In the early 1970s, the University of Minnesota School of Dentistry graduated 85-90 dentists per year; by 1978, the number rose to 150 per year. In the 1980s, class size was reduced due to political, health status and economic factors. Today’s graduating class sizes are comparable to the level of the early 1970s.
- In 2000, the Minneapolis/St. Paul metro area had 11 percent fewer people per dentist compared to the state as a whole, so theoretically had better access. Rural Minnesota had approximately 22 percent more people per dentist, with presumably poorer access.
- Between 1973 and 1995, Minnesota’s dentist/population ratio declined, but in 1995, this trend reversed: the population as a whole began increasing faster than the supply of dentists.
- Within the next decade, roughly 21 percent of Minnesota’s currently practicing dentists will be at or past an expected retirement age of 65. Dentists presently over age 50 comprise 32 percent of all dentists. Each of them will reach the range of retirement within the next 15 years. Factors such as a strong stock market and continuing dentists’ frustration with managed care may result in an accelerated retirement rate.
- Retirement patterns, rural economic trends and demographic shifts are factors likely to impact the dental workforce in the immediate future. As social scientists predict for others in their age bracket, dentists presently in their 50s may increasingly choose to retire early and begin unrelated careers. Because dentists are often financially more able to do so than others, they may be over-represented in this phenomenon.
- The demand for dentists among the states will grow more competitive. The already low numbers of dentists graduating in Minnesota may be increasingly attracted by other states, tightening Minnesotans’ access to dental care.

In assessing the dental hygienist labor supply, using the dental hygienist/dentist ratio as a measure, the numbers appear more favorable: 1.04:1 in 2000 compared to .80:1 in 1993.³⁴

Furthermore, the average age of a Minnesota dental hygienist is 41.8, down from 49.9 in 1995.³⁵ However, one researcher has observed that many dental hygienists appear to be retaining their licenses while not working in the field, as many dentists report difficulty in hiring hygienists.³⁶

A recent expansion of Minnesota dental hygienist training programs has produced approximately 200 more practitioners per year. A new training program has just opened in the metropolitan area. Nonetheless, not all areas of the state benefit from this increase in providers.³⁷

What would be the ideal size for Minnesota’s dental workforce? Over recent decades, the economics have changed. On the demand side, the widespread expansion of fluoridation of local water supplies, the application of sealants to childhood molars, and individuals’ increased use of personal dental preventive practices have reduced the incidence of dental disease among the general public. On the supply side, there has been a corresponding decline in the number of dental providers in many communities throughout the state. At the micro level, the patient wants to be able to get an appointment in a “reasonable” amount of time, while the dentist wants to keep his/her chair full during his/her hours of practice. Regarding the workforce supply/demand ratio, the MHCP dental access problem begs the question: Has the pendulum swung too far?

Today’s tight dental labor market poses challenges to hospital and community clinics in hiring staff dentists. Safety-net clinics have increasingly fallen behind in the marketplace in attracting dentists. Table 5 shows salaries at several types of dental clinics.

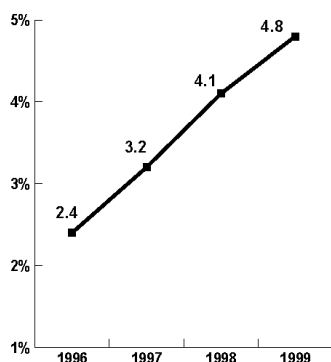
Table 5. Sample dentist salaries.	
setting	hourly salary
Community clinic, Metro area, 1998.	\$33.65
County public health dental clinic, Metro area, 1998	\$39.42
Private clinic with over 50% MHCP patients, Metro area, 1998.	\$41.35
Private clinic, north-central MN, 2000.	\$51.92
SOURCES: Minnesota Association for Community Dentistry; St. Paul Pioneer Press, November 11, 2000	

The role of dental auxiliaries. Nationally and in Minnesota, there is discussion about the role of dental auxiliary personnel in addressing the care needs of Medicaid and other low-income patients. This discussion has focused on whether their duties could or should be expanded following the medical model of provider extenders. For example, in some states, dental hygienists are permitted by law to provide services independently of dentists. In other states, dental hygienists have been granted an expanded scope of practice to serve in public health capacities with Medicaid and other low-income populations. In Minnesota, the Legislature permitted DHS to authorize dental hygienist demonstration projects to serve MHCP beneficiaries and other underserved populations beginning in 1999 (see Appendix A).

Several states and the U.S. Indian Health Services allow dental assistants a significantly expanded role. Performing under a dentist’s supervision, dental assistants have demonstrated the ability to competently perform many procedures that are restricted only to dentists in the Minnesota practice act.

Community and nonprofit clinics. “Safety-net providers” – community, hospital-based, and other nonprofit clinics – are facing financial challenges. Unlike private practices, the mission of these clinics is to treat underserved people, including uninsured (via a sliding-fee scale) and MHCP beneficiaries. They are designed and staffed with the needs of this population in mind, and often have such important features as professional interpreters and multilingual staff members who come from cultures similar to their patients.

FIGURE 11
Percentage of MHCP payments for dental services to community clinics, DHS fee-for-service



Source: MN Department of Human Services, Claims Payment Data

In local areas where private dentists are taking few new MHCP patients, Community Health Centers (CHCs) play an important part in making services available to those who would otherwise be unserved. CHCs, many of which were founded in the early 1970s, all provide medical care, some also provide dental care, and a few provide mental health care in addition. Since 1996, they have been providing an increasing volume of services to MHCP patients. (See Figure 11)

Many CHCs are designated as Federally Qualified Health Centers (FQHCs). These clinics are entitled under federal law to receive “reasonable cost” reimbursement for treating Medicaid patients. However, the federal Balanced Budget Act has begun phasing out cost-based reimbursement, with complete phase-out scheduled by 2004.⁽³⁾ Minnesota’s FQHCs project this phase-out to reduce their

Medicaid revenues by 40 percent, eliminating almost 15 percent of their total revenues.³⁸

Nine of Minnesota’s 15 FQHCs provide dental services, with two others offering dental services through voucher arrangements, and another providing dental services through a contract with a private, nonprofit dental clinic. Clinic sites are located in rural and urban areas throughout the state. Most patients receiving dental care at these clinics are covered by MHCP.

FQHC administrators believe that the reimbursement phase-out is a serious threat to the financial viability of their clinics. As revenues decline, clinic administrators will have to decide where to trim their budgets, and dental clinics, which are relatively expensive to operate, will be likely targets. The closing of an FQHC dental clinic could potentially eliminate the safety-net for local MHCP beneficiaries.

⁽³⁾ In December 2000, Congress replaced the Balanced Budget Act phase-out with a new Medicaid prospective payment system for FQHCs, to take effect January 1, 2001. Implementation guidance to state Medicaid agencies is pending.

Community clinics not designated as FQHCs face even greater financial challenges. Because they do not qualify for cost-based reimbursement, the more the clinic participates in MHCP, the greater the “write-off.” Solutions must be developed to keep safety-net dental clinics financially sound since the current system requires enormous financial sacrifices which, in turn, limit their abilities to be innovative and to expand to meet overwhelming demand.

In recent years, dentists in some Minnesota communities have expressed concern about planned expansions of nonprofit or public clinics in their areas, citing potential competition to their practices. However, given the lack of incentive for private dentists to participate in MHCP, the notion of competition for an undesired patient population seems without base. If MHCP patients had adequate access to dental care in a given geographic region, the financial feasibility for a public dental clinic would approach zero. Public dental clinics are established in areas of high dental needs and needs unique to public program and uninsured populations. Competition with private dentists for public program beneficiaries (or private pay patients) is antithetical to the mission of public dental clinics.

Compared to physicians, only a small percentage of dentists are involved in “public health” dental programs. This leaves few options for addressing dental access issues other than working with those involved in a very different marketplace of patients – competing for patients with more “high end” demands such as crown and bridge, implants, esthetic dentistry, maintenance level of care, etc. Without a public health presence in dentistry, patients with extreme dental needs and limited or no resources to obtain care would be held captive to the machinations of the private marketplace which views public program beneficiaries as financially detrimental to the viability of practices.

Hospital-based dental services. Hospital dental clinics are a key piece of the delivery system for MHCP beneficiaries. For many severely disabled or chronically ill individuals, they are the only clinics able to meet their special needs. In Minnesota, four hospital dental clinics accept MHCP patients. Dentists in these clinics function in the margin between medicine and dentistry, and possess knowledge of both fields. Patients include those whose chronic illness requires monitoring or immediate availability of emergency medical services; those whose care must be coordinated with medical care (e.g. bleeding disorders, transplant patients, chemotherapy patients); and people with developmental disabilities who require sedation or general anesthesia. One such clinic at the Fairview-University Hospital annually treats about 70 to 80 patients in the operation room, and approximately 400 more as outpatients. Patients from all over the state are referred by community clinics and private practitioners who feel they cannot treat them because they are too difficult, too medically complex, or too time consuming.

Hospital-based dental services are costly. Case preparation is time consuming. Coordination with an assistant or nurse is often part of the plan. These additional costs are not reimbursed by third party payers. Despite the higher cost, dental services provided under anesthesia are cost effective when considered in the larger context of total health care expenditures. Frequently, during a single hospital admission and a single general anesthetic event, patients receive multiple

health care services. While under anesthesia, the patient may receive eye and ear exams, direct laryngoscopy, hearing tests, CT scans and gynecological exams. Costs of multiple admissions, transportation and other logistics are saved. More importantly, the risk of anesthetic complications to the patient is reduced.

Hospital dental clinics at the University of Minnesota (U of M) and Hennepin County Medical Center (HCMC) provide postdoctoral training supported by Graduate Medical Education (GME) dollars. These clinics produce specialists who treat medically compromised or disabled people in a community setting, or if necessary in a community hospital. Clinic officials say federal cuts to GME and changes in Medicaid law have resulted in program cuts at these institutions. The clinics provide care to the underinsured as well as emergency care to the uninsured. Like community clinics, U of M and HCMC do not have a large commercially insured or private pay base from which to subsidize costs of serving MHCP and uninsured patients.

Minnesota also has hospital dental clinics in two of the state's Regional Treatment Centers.

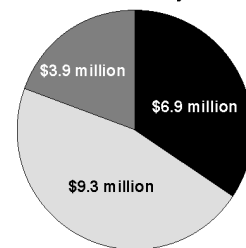
Rural infrastructure. Many Minnesota dentists who will retire within the decade practice in rural areas where few other dentists practice. Some dentists who are presently retiring report they are unable to find a buyer for their practice. At a recent meeting of a rural health care purchaser, one dentist from southwestern Minnesota told the group that in 1992, nine dentists were practicing in his county. Three years later, two of them retired. By 1999, two others also retired, and the dentist himself reported that he would be retiring in 2001. No new practices started during this period, and the four who retired were unable to sell their practices. His departure will leave the county with fewer than half as many dentists as it had less than a decade ago.³⁹

When practices are closed rather than sold, the area loses a major part of its local health care delivery system, and dental access problems worsen for all residents.

Discussion. Minnesota is already investing significant amounts of public funds in maintaining a well trained dental workforce. The 1999 Legislature appropriated approximately \$9.3 million for the U of M School of Dentistry. Tuition, virtually all of it from undergraduate dental students, amounted to approximately \$3.9 million, and clinic income, generated by both undergraduate and graduate students, was approximately \$6.9 million.⁴⁰ (See Figure 12)

The 1999 Minnesota Legislature also appropriated funds to expand the dental infrastructure in underserved areas of the state. An appropriation of \$600,000 was made to fund start-up costs of projects to increase dental access (see Appendix C). In addition, \$75,000 was appropriated for a clinic to serve a portion of northwestern Minnesota, the area of the state with the lowest dentist/patient ratio and some of the lowest MHCP utilization rates.

FIGURE 12
Income: University of Minnesota
School of Dentistry



■ Tuition
■ State appropriation
■ Clinic income

Source: University of Minnesota, School of Dentistry

The 1999 Legislature also authorized the creation of dental hygienist demonstration projects. This legislation allows DHS to approve projects that extend access to dental hygienists by providing the services outside traditional dental offices, without patients first having to be seen by a dentist (see Appendix A).

The Dental Access Advisory Committee reviewed the impact of the 1999 legislation and appropriations on MHCP dental access. Their findings are reported in “Dental Access for Minnesota Health Care Programs Beneficiaries: Supplemental Report to the 2001 Minnesota Legislature on the Evaluation of the Effects of the 1999 Legislated Dental Initiatives.”

The demand for dental services will increase among Minnesota’s general population due to population growth and aging, but the supply of dental manpower is declining. In this “seller’s market,” purchasing for MHCP beneficiaries is hampered by the low payment rates and the other concerns of dentists with accepting MHCP.

MHCP’s situation may be a harbinger of an access problem for the general population. As the gap between supply and demand widens, more and more Minnesotans may find their status in the marketplace will make it more difficult to get dental care. All Minnesotans have a stake in solving MHCP beneficiaries’ dental access problem. Successful efforts to ameliorate this problem will improve access not only for MHCP beneficiaries, but for the rest of Minnesotans as well.

Strategies. The Dental Access Advisory Committee explored the creation and deployment of new categories of dental personnel – “mid-level practitioners.” Representatives of the State Board of Dentistry, the Minnesota Dental Association, and the U of M School of Dentistry have discussed this concept. There is considerable support for a carefully designed demonstration project to examine effectiveness and impact.

Under this project, individuals with a background in dentistry would be trained as “dental public health nurses.” The training program would encompass dental public health, health education, and selected technical skills. Trainees would be placed in county public health departments and urban community clinics where their work would focus on MHCP beneficiaries and other underserved people. In addition, a number of registered dental assistants would be further educated in more advanced areas of dentistry and trained in advanced technical skills. These trainees would be placed in private practices, performing cavity restorations and other technical tasks, freeing supervising dentists to perform more advanced procedures.

The project would be rigorously evaluated, and upon a positive outcome, the U of M School of Dentistry would explore avenues for enacting new dental practice regulations to extend the availability of these new providers to a broader range of practitioners.

The development of this new type of provider is directly analogous to the creation of the medical nurse practitioner in primary care three decades ago. Nurse practitioners, initially opposed by the

medical profession, have established themselves as reliable care providers. Most primary care physicians today employ at least one nurse practitioner.⁴¹ Physicians can be more efficient and focus their time on their more challenging cases. Patients get good care. The dental mid-level provider could provide not only care, but also educate MHCP patients about the importance of oral health self care and prevention, potentially avoiding restorative care. The addition of this new level would make the dental auxiliary career track more attractive, potentially alleviating the current tight labor supply among auxiliaries.

The Dental Access Advisory Committee considered two proposed models that would expand the role of the dental hygienist, allowing these professionals greater capacity to foster oral health among Minnesotans, including MHCP beneficiaries. The *dental preventative practitioner* would be a licensed dentist or a licensed dental hygienist with certain established prerequisites and would further be educated in dental public health, health education, emergency response, considerations for children and older adults, and cultural diversity. This practitioner would be placed in county and state public health departments, urban community clinics, rural community clinics, schools, supervised living homes, prisons, nursing homes, and other nontraditional settings. The practitioner would focus on preventing dental disease through preventive and therapeutic services such as sealants, fluorides, tobacco cessation, and cleanings. The practitioner would work collaboratively with dentists and physicians and would obtain a prescription for dental services and be directly reimbursed for these services.

The *dental restorative practitioner* would be a licensed dental hygienist or registered dental assistant with certain established prerequisites and would be further educated and trained in cavity preparations and restorations. The dental restorative practitioner would be placed in urban community clinics and rural community clinics settings focusing on MHCP beneficiaries and other underserved populations. The dental restorative practitioner would work collaboratively with dentists and would obtain a prescription for dental services and be directly reimbursed for these services.

Expanding the role of auxiliaries is controversial in Minnesota, and policymakers must assess the impact of expanded scopes of practice on the public's access to care, health and safety.

Foreign-trained dentists are another potential source of additional practitioners identified by the Dental Access Advisory Committee. As in most states, there are a number of dentists living in Minnesota who were trained in a foreign country. There has been discussion about allowing them to practice, at least in a limited fashion, to ease the shortage of providers. Currently, the Minnesota Dental Practice Act allows only dentists who have graduated from schools in the United States or Canada to practice in Minnesota. Dr. Michael J. Till, past Dean of the U of M School of Dentistry, has promoted such licensure. He has written:

Possibly, the time has come to reconsider a mechanism whereby fully qualified foreign-trained dentists might be made eligible for licensure to practice or teach dentistry in Minnesota.

- *Shortages of dentists are becoming acute in Minnesota and the region, especially in rural areas. Foreign-trained dentists could provide a new source of workforce talent.*
- *Other states have recognized the potential of foreign-trained dentists and grant them licenses to practice. Thus, Minnesota is at a competitive disadvantage in attracting well qualified international dentists to our state.*
- *Although North American dental schools are among the best in the world, they are not the world's only producers of dental talent. Many international schools, and individuals who have graduated from these schools, have distinguished themselves in teaching, research and clinical service equal to, if not exceeding, this country.*
- *If the person with the most expertise is foreign trained, we should consider ourselves fortunate that he/she will consider a career in Minnesota. The citizens of Minnesota should have access to the best persons available to meet their oral health ...*⁴²

Licensure of foreign-trained dentists also would help the University attract and retain dental faculty members. Certain foreign-trained dentists possess exceptional abilities in various aspects of teaching and research. Salaries at most dental schools are based on faculty being able to supplement their income through private practice. Foreign-trained faculty are deprived of this opportunity. Other states such as Washington and North Carolina provide licensing mechanisms which allow university faculty to supplement their income through private patient care.

Another potential strategy to address workforce issues involves the Medical Education Research Committee (MERC) program. This program was created by the Legislature to “help offset lost patient care revenue for those teaching institutions affected by increased competition in the health care marketplace and to help ensure the continued excellence of health care research in Minnesota.”⁴³ Presently, MERC funds are channeled annually to educational sites with no conditions on their use. DHS should examine whether requirements could be developed to assure that the training sites that receive MERC funds direct a portion of the money to strategies that would expand dental access for MHCP beneficiaries.

In state fiscal year 2000, 17 sponsoring institutions received MERC grants totaling more than \$15 million. Of this amount, \$863 thousand (5.76 percent) was directed to the education of dental students. Three sponsoring institutions, Hennepin County Medical Center, Mayo Foundation, and University of Minnesota Academic Health Center, passed these funds on to 10 facilities where the training occurred. These facilities were: Anoka Metro Regional Treatment Center, Fairview-University Medical Center, HealthPartners, Hennepin County Medical Center, Mayo Clinic, Regions Hospital, Rochester Methodist Hospital, St. Mary's Hospital, U of M School of Dentistry, and West Side Community Health Services.⁴⁴

Another workforce improvement strategy is the federal designation of Health Professional Shortage Areas (HPSAs). Designation of these areas can be a means to obtain federal funding for health professional education and to qualify areas to receive placements of dentists participating in the National Health Service Corps. These dentists have a federal obligation to practice in provider shortage areas. Until recently, Minnesota had only four designated dental HPSAs. But in 2000, the Minnesota Department of Health (MDH) began aggressively pursuing the designation of additional dental HPSAs. MDH has submitted documentation for 25 additional areas, and is surveying another 15 areas for possible submission.⁴⁵ (See Appendix H)

Several states with dental access problems similar in scope to Minnesota’s have identified the lack of providers as a significant cause of the access problem in some parts of their states. In determining how best to meet their dental workforce needs, these states have commissioned studies to assess local and regional dental manpower capacity vs. demand. The results will allow policymakers to better target resources. Among the states conducting dental workforce studies are Illinois, Michigan, and South Carolina.

VI. Reimbursement

MHCP rates vs. usual and customary rates. Table 6 shows the estimated percentage of billed charges that is reimbursed by MHCP for selected health care services.

Table 6. Ratio of billed charges to payments for selected services Minnesota Health Care Programs, 1998	
Service	Ratio
Audiology	47.1 %
Chiropractor	55.5 %
Dental	56.3 %
General inpatient hospital	58.9 %
Outpatient hospital	69.2 %
Physical therapy	50.9 %
Vision	59.3 %
SOURCE: Minnesota Department of Human Services, claims payment data.	

While payment levels for many other MHCP covered services is similar to dental, none of these other covered services has access problems approaching that of dental care. Many argue that the current reimbursement structure for dental services for MHCP beneficiaries is insufficient to obtain a level of access that approaches that of the general public.

How do Minnesota's rates compare to those of other states? The U. S. General Accounting Office (GAO) did a comparison study of Medicaid dental rates in all 50 states.⁴⁶ GAO researchers selected 15 dental procedures and, for each state, compared each procedure's payment rate to the average regional dental fee. Of the 15 procedures, Minnesota's payment rates exceeded 2/3 of the average regional fee in only three of them. Among the 15 procedures, Minnesota's rates ranged from 49 percent to 79 percent of the average regional fee. Table 7 compares Minnesota's rates for selected procedures to neighboring states in the North Central Region.

Table 7. Medicaid Payment Rates as a Percentage of Average Regional Dental Fees for Selected Procedures, 1999: North Central Region

State	periodic oral examination	dental cleaning, child	metal filling, 2 surfaces	root canal treatment
IL	66	72	66	64
IN	87	103	98	109
IA	56	56	52	47
KS	51	83	76	76
MI	61	56	66	73
MN	56	59	55	52
MO	72	61	44	25
NE	70	56	77	57
ND	88	81	77	78
OH	73	60	73	73
SD	73	57	58	47
WI	66	68	59	54

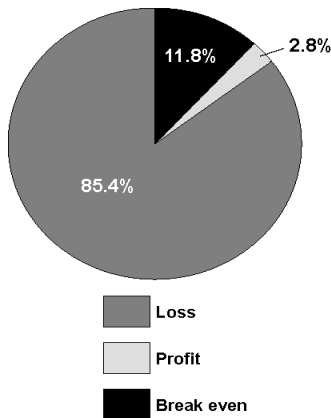
SOURCE: U.S. General Accounting Office, "Factors Contributing to Low Use Of Dental Services by Low-Income Populations," September 2000.

The amount of the payment a dentist receives for treating a MHCP patient varies by whether the patient is enrolled in a managed care plan, and if so enrolled, into which plan. Table 8 summarizes dentists' attitudes toward the fee schedules of DHS and the managed care payers.

Payer:	DHS		Delta		Health-Partners		Medica		Itasca		Altru	
	#	%	#	%	#	%	#	%	#	%	#	%
Degree of acceptability												
Unacceptable	299	79.1	206	67.8	64	59.3	131	65.2	0	0	2	40.0
Poor	70	18.5	80	26.3	27	25	53	26.4	1	20.0	1	20.0
Fair	9	2.4	17	5.6	15	13.9	15	7.5	1	20.0	1	20.0
Good	0	0	1	.3	1	.9	2	1.0	3	60.0	1	20.0
Outstanding	0	0	0	0	1	.9	0	0	0	0	0	0

SOURCE: Survey of Minnesota Dentists, November 2000, Wilder Research Center (preliminary results).

FIGURE 13
Percent of dentists reporting profit, loss or break even on MHCP business



Source: Wilder Research Center, Survey of Minnesota Dentists, November 2000, preliminary results

The vast majority of the state's dentists report they lose money when serving MHCP patients. (See Figure 13)

Coverage of overhead costs. DHS fee-for-service payment for MHCP dental services was 54.5 percent of billed charges in state fiscal year 1999. According to dental practice management professionals, the "ideal" overhead for a dental practice is 50 percent of total charges, but it is "acceptable" for overhead to be as high as 60 to 65 percent.⁴⁷ Some Minnesota dentists report overhead to be as high as 70 percent.⁴⁸ Newer providers tend to have higher overhead as they establish their practices, as they have not yet paid off their initial practice development debts. Type and location of practices are additional variables.

Because "walk-in" appointments are rare in dental practices, the impact of appointment failures is much greater than in primary care clinics. A typical dental practice schedules 30- or 60-minute appointments with few walk-ins, while a medical practice may have appointments of the same length but many walk-ins. With their walk-ins, productivity of primary care clinics may exceed 100 percent even with a 30 percent failure rate. Dentists don't discount their fees as much as medical providers, and are not able to cost-shift to other patients as readily as other medical practices.

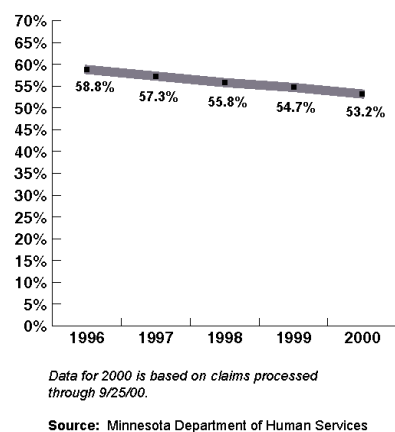
It is impossible for a practice to support a dentist’s salary by serving MHCP beneficiaries alone (unless the clinic receives federal or private dollars in addition to MHCP revenues). However, at least one private Minnesota dental clinic has found a way to treat significant numbers of MHCP patients in spite of the present payment rate. Over 30 percent of this clinic’s patients are covered by MHCP. Located in a rural area of the state, it draws MHCP patients from more than 100 miles away. The dentist who owns the clinic reports his clinic is able to accommodate such large numbers of MHCP patients due to efficiencies he has built into the practice. He reduces overhead costs by offering appointments seven days a week, including weekday evenings. The clinic is staffed with nine dentists, and auxiliaries are strategically employed to maximize the dentists’ productivity. Records are computerized, and scheduling is done in a way to minimize the effect of appointment failures.

Rate increases since 1990. The Minnesota Legislature increased the payment rate for dental services several times during the past decade.⁴⁹ In 1992, payment rates for MHCP dental services were set at the 50th percentile of 1982 usual and customary charges, with a 7.5 percent increase for diagnostic and routine services and a 5 percent increase for all other services. Further increases were made in subsequent years during the decade. Table 9 documents these increases.

Table 9. MHCP Dental Services Payment Rate Increases, 1990 - 2000.			
Year	MA	GAMC	MinnesotaCare
1992	25%	25%	(NA)
1997	5%	5%	15%
1998	3%	3%	3%
1999	fluorides & sealants: 80% of billed charges all other services: 3%	3%	fluorides & sealants: 80% of billed charges all other services: 3%
SOURCE: Minnesota Department of Human Services, “Dental Services Reimbursement Study,” January 1999.			

The Dental Access Initiatives Review Committee studied the effects of the most recent increases, passed by the Legislature in 1999. The Committee’s conclusions are documented in the supplemental report on dental access submitted to the 2001 Legislature. Despite the recent increases, MHCP dental payment rates are still below usual and customary reimbursement levels for Minnesota dentists. Part of this may be explained by provider charges increasing faster than the payment rate increases. Nationally, the number of dentists who say they raise their fees

FIGURE 14
Fee-for-service charge-to-payment ratio for dental providers



annually is 57 percent.⁵⁰ According to Delta Dental Plan of Minnesota, the state’s largest dental management organization, their dental claims have increased by approximately 10 percent over the past year.⁵¹ Dental costs have been rising faster than the MHCP payment rate increases, widening the gap between billed charges and payments. (See Figure 14)

Payment rates and access. Low payment rates are a disincentive for a provider to increase their volume of MA patients. Low payment rates may also be an incentive to “shed” MHCP patients in a marketplace where most patients pay cash, while many others covered by commercial insurance paying discounted rates of 80 - 90 percent⁵² versus 54.5 percent for MHCP patients.

The negative incentives posed by low payment rates to both private dentists and community clinics are illustrated by the following two tables. Table 10 shows patient and billing activity in a typical solo practice.

Table 10. Annual Dental Access at a Typical Dental Practice		
<i>All figures are average annual statistics for a solo dental practice.</i>		
	General dentists	Specialists
Patients		
Private and insurance	1,101	754
MHCP patients **	47	32
Total patients*	1,147	786
Dental visits		
Private and insurance	3,742	4,373
MHCP patients **	159	185
Total patient visits*	3,901	4,558
Submitted charges		
Private and insurance	\$333,621	\$506,274
MHCP patients	\$14,139	\$21,456
Total submitted charges	\$347,760	\$527,730
* Source: ADA 1997 Survey of Dental Practice		
** Source: DHS, MDA Dental Summit, 1998, "MHCP" includes MA, GAMC and MinnesotaCare		
Concept for this table was developed by Dr. Michael Helgeson.		

Table 11 shows the impact of MHCP fee-for-service payment levels on practices in the north central Minnesota counties of Cass, Crow Wing, Morrison, Todd and Wadena.

Table 11. Effect of MHCP Payment on a Typical Dental Practice in Selected Counties,* August 2000.							
% MHCP patients in practice	1%	3%	5%	10%	30%	50%	75%
# of patients	11	34	57	115	344	574	861
# of dental visits	39	117	195	390	1,170	1,951	2,926
Value of care & reimbursement							
Submitted Charges	3,478	10,433	17,388	34,776	104,328	173,880	260,820
Actual reimbursement **	2,108	6,322	10,537	21,074	63,223	103,553	158,056
Financial impact on practice							
Value of uncompensated care	(\$1,370)	(\$6,219)	(\$8,799)	(\$17,598)	(\$41,105)	(\$86,173)	(\$102,764)
<p>* Counties analyzed are Cass, Crow Wing, Morrison, Todd and Wadena. ** DHS FFS reimbursement for dental services in these counties averaged 60.6 % SOURCE: Minnesota DHS, Executive Information System. Concept for this table was developed by Dr. Michael Helgeson.</p>							

As the data indicates, the greater the volume of MHCP business a practice does, the greater its losses due to uncompensated care. This analysis does not factor in additional losses due to failed MHCP appointments, which in some clinics exceed 40 percent of all appointments made for MHCP patients.

Discussion. Data suggest that Minnesota’s payment rate increases have not allowed many dentists to make even a modest profit on MHCP business, and for some, MHCP business generates a loss. However, the effect of raising rates on creating additional access is not clear. In Minnesota, some stakeholders maintain that raising rates alone will eliminate the access problem. Others claim the access problem can be substantially reduced with no increase in rates. Instead, they argue that more “dentist-friendly” contracting will attract more providers.

What impact would a payment rate increase have on attracting more dentists to seeing MHCP patients? The answer appears to be complex. At a House Health and Human Services Committee Hearing held in western Minnesota in November 1999, a state legislator stated that his staff had spoken to several dentists in his district about the prospect of raising MHCP payment rates and none said they would be willing to take additional MHCP patients, even if the rates were increased to 100 percent of billed charges.⁵³ It must be noted that this legislator’s district includes the area of the state with the lowest dentist/person ratios.

Dentists who responded to the November 2000 Survey of Minnesota Dentists were asked to indicate acceptable reimbursement levels for several key services. When asked if they would participate if rates were adjusted to the levels they indicated as acceptable, preliminary results indicate that 63.9 percent said “Yes,” 4.6 percent said “No,” and 31.5 percent said “Maybe.” Those who responded “Maybe” specified a variety of other conditions for their participation, centering around patient compliance and appointment failures, Rule 101, the MinnesotaCare tax, and administrative burden.⁵⁴ These issues are discussed in the Provider participation section, page 10.

Some states have raised their Medicaid dental payment rates to 80 percent or higher. Results have been mixed. For example, according to North Dakota’s Medicaid director, when rates were raised to 80 percent, virtually no new dentists became Medicaid providers.⁵⁵ The net effect of the increase seemed to be a stemming of the exodus of providers from the program. But when South Carolina raised its rates to 75 percent of billed charges, the number of participating dentists reportedly grew by 33 percent.⁵⁶

In a recent study, the U.S. Government Accounting Office (GAO) investigated the correlation between Medicaid program payment rates and access nationwide. They found that 40 states have raised their rates within the last three years. Of these states,

- 14 reported an increase in either dentist participation or in utilization,
- 15 reported no change in either measure, and
- 11 reported it was too early to determine the effect.

A key finding of the GAO was that among states which increased their rates, improved dentist participation or increased utilization occurred in states that raised their rates to at least 2/3 of the regional usual and customary fee, while states with lesser increases saw no improvement.⁵⁷

Strategies. The Dental Access Advisory Committee discussed several ways of using payment rate increases to improve access. The Committee’s Finance Work Group maintains that a substantial increase must be made to MHCP payment rates to allow the programs to compete with private payers and commercial insurance plans. This increase is required due to the Committee’s estimation that providing care to MHCP patients is more costly than for other patients. Factors that increase the cost of care for MHCP patients include:

- the high rate of appointment failures;
- a greater burden of acute oral health needs which require difficult, time-consuming procedures;
- limitations in the MHCP benefit set with regard to contemporary community standards of care;
- need for more frequent consultation with physicians and other care givers, with no compensation; and,
- burdensome, non-uniform administrative demands which increase overhead costs.

The Finance Work Group recommends that MHCP payment rates be increased 150 percent, stating that such an increase would result in metro-area dentists receiving about 100 percent of usual and customary fees, and out state dentists receiving about 125 percent.

In addition, the Finance Work Group devised two payment models that would reward dentists who take on larger volumes of MHCP business. One of these models is based on volume of charges, the other is based on patient volumes. (See Appendix D) Strategies to reduce administrative barriers, discussed in the Provider participation section, page 17, also could potentially reduce overhead costs.

Taking measures to increase the efficiency of individual dental practices also could help narrow the gap between overhead costs and payment rates. For example, greater use of auxiliaries, sharing of equipment (as is done in group practices), extended clinic hours, and other measures could spread fixed costs over a higher level of productivity.

A third reimbursement strategy the Committee discussed was compensation for failed appointments. This approach would be most difficult to implement, as current Medicaid regulations do not permit reimbursement when no services are delivered. One reason for this prohibition is concern about fraudulent claims. While this strategy could not be implemented by direct Medicaid payments, a contracted health plan or dental plan may be able to do so. Another approach is the exploration of tax strategies to enable providers to recover some costs of appointment failures.

The Committee suggests that payment rates be examined to ascertain whether they reflect the added costs of serving persons with disabilities and medical complications. Rate enhancements or the addition of new codes may be necessary to preserve dental access for these patients.

For several years, there has been discussion among the states about the prospect of an increased federal match for Medicaid dental services. HCFA officials have advised states that such an increase would best be sought through congressional action. States were advised to pursue this through their governors' offices.⁵⁸

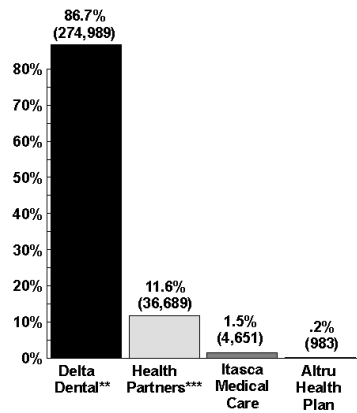
VII. Purchasing

Managed care. Since the early 1980s, Minnesota has been converting its MHCP fee-for-service system to prepaid managed care. As of January 2001, all MinnesotaCare participants are enrolled in managed care plans (health maintenance organizations), and most MA and GAMC beneficiaries are enrolled in managed care plans in 71 of the state's 87 counties.⁽⁴⁾ In addition, beginning in 2001, DHS may be contracting with up to 26 counties to provide MHCP services

⁽⁴⁾ At the present time, several groups of MA eligibles are not enrolled in managed care in PMAP counties. These groups, which include disabled persons under age 65, persons receiving refugee assistance, residents of state Regional Treatment Centers, etc., comprise about thirty percent of the average county's MA caseload.

under “county-based purchasing” arrangements, whereby a county or consortium of counties act as the purchaser of health and dental services. Some of these groups propose to subcontract dental services to DHS’ prepaid MHCP contractors, others are developing new networks and models for dental services.

FIGURE 15
Distribution of MHCP beneficiaries* by dental contractor, May 2000



* Includes MA, GAMC, MinnesotaCare and MN Senior Health Options programs.

** Delta Dental subcontracts to provide dental services to all MHCP beneficiaries of the following prepaid health plans: Blue Plus, First Plan Blue, Medica Health Plan, Metropolitan Health Plan and UCare Minnesota.

*** Includes HealthPartners and Group Health Plan.

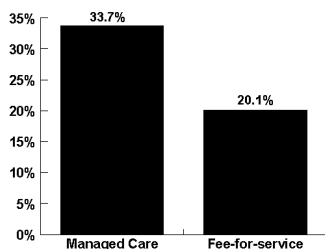
Source: Minnesota Department of Human Services

The conversion to managed care has had significant implications for providers. For his/her MHCP patients who are enrolled in a prepaid health plan, the dentist must become part of the health plan’s provider network by contracting with the plan or its dental subcontractor. Figure 15 shows the health plan contractors and subcontractors with which dentists must contract to see MHCP prepaid enrollees. (Note that dentists wishing to treat MHCP prepaid enrollees may sign a Delta contract in all 87 counties. The other three contractors’ counties do not overlap. Thus, in 23 counties a dentist would need to sign two contracts to treat prepaid enrollees in the county; in the remaining 64 counties, he/she would need to sign one contract.)

Each contractor or subcontractor has its own administrative requirements, prior authorization requirements (both of which may vary from DHS fee-for-service requirements) and credentialing (not required under fee-for-service).

In the November 2000 Survey of Minnesota Dentists, preliminary results indicated that 64 percent view managed care contracts as a “very significant” problem in deciding whether to participate in MHCP, with an additional 24.5 percent rating managed care contracts as a “significant” problem. In the same survey, 41.1 percent “strongly agreed” and 32.5 percent “agreed” that they would not want to sign an MHCP managed care contract because they do not want to be obligated to accept commercially insured managed care enrollees as well.⁵⁹

FIGURE 16
Percent of MHCP beneficiaries receiving one or more dental services in 1999



Source: Minnesota Department of Human Services

While it appears that fewer dentists serve MHCP beneficiaries through managed care contracts than fee-for-service, access (if utilization data is used as a proxy) is significantly better under managed care. (See Figure 16) The reason for this has not been studied, but some speculate that some health plans do a better job of promoting oral health services to their members and the health plan’s member services are an easier contact for the member, are more effective at finding dentists who will treat the patient, and provide transportation to patients who need it.

A confounding paradox is that, under managed care, fewer dentists are seeing MHCP beneficiaries even though health plans reportedly pay higher payment rates than fee-for-service. Furthermore, all MHCP plans and their dental subcontractors are reportedly “open panel” for dentists (i.e., a contract is offered to any dentist meeting the plan’s

credentialing requirements). One explanation for this paradox is that many of the dentists who refused to sign managed care contracts had been doing only a low volume of MHCP business.

A criticism frequently leveled at Minnesota's prepaid MHCP system is that health plans receive payments for dental care in their capitation payments for all enrollees, although many enrollees are not receiving dental services because they cannot get appointments. Critics charge that health plans should not be paid this money if enrollees cannot get appointments. Health plans argue that they are hampered in their efforts to obtain more utilization from their network dentists and attract additional dentists to their networks because of what they consider to be insufficient capitation payments. They argue that they work to get appointments for their enrollees who cannot get them themselves, sometimes paying premium rates to dentists with whom they have no contracts, and transporting enrollees to other communities when necessary.

Many dental providers argue that health plans profit because of low utilization of dental services by MHCP enrollees – the exact opposite of the providers' situation, whereby the providers lose money by accepting MHCP patients. Some providers believe that if MHCP dental services must be provided at a loss, health plans should share in the loss.

Discussion. The Advisory Committee discussed at length whether the present system of MHCP managed care contracting is an impediment to improving dental access. Many members advocate carving out the dental benefit. DHS has been willing to look at alternative models, including carve-outs, but based on utilization figures, does not believe restoring fee-for-service will improve dental access, and will more likely reduce it. DHS would not consider any carve-out option as viable unless it offers greater access than that obtained under current contracting arrangements.

The current managed care model has significant benefits for both MHCP enrollees and the State which would be lost in a carve-out. Under the comprehensive contracts used for MHCP, health plans spread the risk among all covered services. In those instances where dental care costs the plan more than the dental portion of the capitation, those costs can be made up with surpluses gained under other covered services. Another benefit that would be foregone is the opportunity for coordination of the enrollee's overall health care. The value of this opportunity is becoming more apparent as medical researchers find new linkages between oral pathology and medical pathology. If dental services are carved out of the contracts, new ways of coordinating dental health with overall health care must be sought.

Strategies. DHS has been exploring alternative purchasing strategies for dental services for a number of years. In 1997, DHS jointly issued a request-for-proposals (RFP) with the Department of Employee Relations to purchase dental services for both the State Employees Group Insurance Program (SEGIP) and MHCP beneficiaries. The RFP met with opposition, and no contracts were awarded. In 1998, DHS issued an RFP that carved out dental services from MHCP prepaid contracts and would have awarded non-risk based contracts to dental contractors. No qualifying bids were received. DHS is now developing a five-county demonstration project that will use a

modified fee-for-service payment system to test the effectiveness of the enhanced payment models proposed by the Dental Access Advisory Committee (see Appendix D). This project is scheduled to begin in 2001.

Another promising purchasing model examined by the Committee is the Reforming States Group/Milbank Foundation's model Medicaid dental insurance program.⁶⁰ This model, summarized in Appendix E, was developed by state legislators and dentists specifically to improve dental access for low-income children. A state-financed program in Pennsylvania based on many of the model's components actively engaged private dentists, and doubled the number of children who had a dental visit from 30 percent to 64 percent. It increased the percentage of patients with regular care from 51 percent to 86 percent, and reduced unmet dental treatment needs from 52 percent to 10 percent.⁶¹ The Milbank model is based on an actuarially sound level of funding. Its per person cost is higher than that now paid by MHCP for dental services.

VIII. Policy direction

Until the 1999 legislation and the 2000 revision of Rule 47's dental coverage policy, there have been few changes made in MHCP dental policy within the past decade. The Dental Access Advisory Committee members observed that their regular meetings were productive in bringing together the stakeholders to address the myriad issues involving dental policy. The Committee believes that MHCP dental policy should be more integrated and monitored on an ongoing basis by the stakeholders. What is purchased, how it is purchased, how much is paid, from whom it is purchased, and how utilization is to be increased should all be linked under a uniform integrated policy and monitored by a group of stakeholders.

Some of the policy needs identified by the Committee include:

- Establishing targets and increasing utilization: Where do we as a state want to be?
- Additional and better sources of more kinds of data are needed to describe and monitor the status of the oral health of Minnesotans.
- Involving practicing dental professionals in a meaningful way in the development and oversight of state policy.

RECOMMENDATIONS

The author of a recent comprehensive national study of states' approaches to improve dental access for Medicaid beneficiaries concludes:

“(S)tates are using multiple approaches to increase Medicaid beneficiaries’ access to dental services, as each approach offers only a partial solution. At a minimum, all states should have Medicaid rates that are competitive with commercial rates. ... However, rate increases alone are typically not sufficient to increase access. The best, most effective combination of approaches is contingent upon the historical, demographic, economic, political and technical conditions of each state, market and community.”⁶²

Based on its 1½ years of study, DHS concurs with this conclusion. With input from the Dental Access Advisory Committee, DHS has developed a single, overarching strategy to increase dental access in ways that best address the conditions unique to Minnesota.

Many of the recommendations are interdependent. While some individual recommendations may improve dental access marginally, DHS recommends that all be implemented in their entirety to achieve an increase in access that will make a significant improvement in the oral health of MHCP beneficiaries. Clearly, some strategies will have to be phased in as funding allows.

1. Improve financial incentives to dentists.

a. Restructure payment rates to cover overhead costs and reward providers who maintain or increase access.

The Legislature should fund the testing of whether access would be improved by increasing payment rates to cover dentists’ overhead costs and provide additional financial incentives to providers who maintain or increase services to MHCP beneficiaries. Rates should reflect the facts that dentists find MHCP beneficiaries more difficult to treat than commercially insured and cash-paying patients, and MHCP beneficiaries have higher appointment failure rates, yet dentists cannot recover the costs of these failures through billing the patient or third parties.

Tests should be conducted in limited geographic areas. Consideration for expansion should be given only upon favorable, pre-established results.

It is recognized that this increase is necessary but not sufficient by itself to significantly improve Minnesota dentists’ participation in MHCP. Other strategies must be employed to achieve a meaningful increase in participation.

b. Evaluate the establishment of tax incentives for providers who treat MHCP patients

Many Minnesota dentists say they would find additional incentive to treat MHCP patients if they were able to take a tax credit. DHS should work with the Minnesota Department of Revenue to explore the feasibility of using tax incentives for dental providers, specifically through the individual income tax program, and the MinnesotaCare provider tax program. In addition, as an alternative to compensation for missed appointments through the MA program (which are prohibited by Medicaid regulations), tax writeoffs should be explored.

c. Test the benefit of higher payment levels for high volume MHCP providers.

DHS should test one or more graduated incentive program models. These models would tie higher payments to providers' performance in increasing access. Consideration should be given to the two models proposed by the Advisory Committee work group, described in Appendix D. These models reward providers who provide significant amounts of services to MHCP patients. Tests should be conducted in limited geographic areas. Consideration for expansion should be given only upon favorable, pre-established results.

The primary hypothesis to be tested is that rewarding providers for doing more volume will gain additional access for MHCP beneficiaries.

d. Test the benefit of alternative ways of purchasing dental care

Currently, DHS employs two basic methods of purchasing dental services: contracting with risk-based health plans for dental services as part of comprehensive health plan benefits, and direct fee-for-service payments to dental providers. DHS should test one or more purchasing models that are substantially different from the current models. These models could include risk- and non-risk-based contracts with dental benefit organizations, direct contracts with providers, and modifications to the fee-for-service system. Models tested may include the enhanced payment concept described in Recommendation 1.a. Because data indicate that dental utilization is higher for MHCP beneficiaries enrolled in prepaid health plans than under fee-for-service, in any model where dental services are carved out of the managed care contracts, DHS should not consider returning these services to the existing fee-for-service system.

The tests should examine whether the model(s) increase access to care through such means as increased acceptance by providers, increased engagement of patients, new outreach methods, better care management models, etc. Evaluations of any models involving carve outs should include examination of the effects on the integration of health care and dental services.

In addition to exploring its own new ways of purchasing dental care, DHS should encourage and assist county-based purchasing projects to employ novel purchasing techniques and monitor their results for consideration for future state purchasing methods. In its current managed care contracts, DHS should experiment with additional contract provisions that would hold contractors more accountable in maintaining and expanding access to dental care for their enrollees.

e. Relieve administrative burden

DHS should continue its efforts to simplify MHCP requirements on providers. DHS should convene its health plan contractors and their dental subcontractors to identify administratively burdensome procedures and policies and seeking ways to mitigate their effect on provider participation in MHCP.

2. Preserve and expand the capacity of “safety-net” providers.

a. Maintain the level of reimbursement for Federally Qualified Health Clinics on a cost or other enhanced basis

The Legislature should reverse the negative financial impact of the Balanced Budget Act, which is phasing out cost-based reimbursement, with complete phase-out scheduled by 2004. The Legislature should do this by either:

- 1) appropriating state funds to reinstate payment levels to the pre-Balanced Budget Act (as modified by the Balanced Budget Refinement Act of 1999) level of 100% of reasonable costs; or
- 2) appropriating state funds and establishing a new prospective payment system that restores payments to approximate pre-Balanced Budget Act levels.

Stabilizing the funding for safety-net providers ensures the viability of FQHCs, whose dental operations are often the most financially fragile part of the clinic.

b. Establish mobile or other types of outreach clinics for underserved areas of the state

The Legislature should appropriate funds for purchasing equipment to establish mobile or other types of outreach clinics. Funds would be allocated as grants, targeted at areas with the greatest access problems. Ideally, these clinics should be operated by non-governmental entities.

Mobile clinics (and portable dentistry) are a solution that can be quickly implemented, particularly in areas where the number of dental practices are most rapidly declining. One unit could “circuit-ride” several communities, allowing for continuity of care through

regularly scheduled visits. This type of clinic is particularly advantageous for serving nursing home and non-ambulatory patients.

c. Explore the expansion of school-based dental clinics

Should state grant funds become available, DHS and MDH should determine whether the expansion of school-based clinics would improve access. Proponents believe these clinics would be effective because they have a “captive audience,” and would allow access to children who otherwise wouldn’t be seen in a dentist’s office due to the parent’s inability to get an appointment or lack of knowledge of the value of preventive dental care. These clinics may provide a logical venue for non-traditional providers to apply sealants and fluoride applications.

Models incorporating new ways of providing school-based dental screenings should be explored, including the provision of oral screenings (with referrals to dentists as necessary) by a dental auxiliary simultaneously with other types of screenings conducted in schools, such as hearing or vision.

d. Explore the development of a volunteer dental network

If grant funds become available for dental access projects, consideration should be given to awarding funds to establish a network of volunteer dentists to treat MHCP beneficiaries. Such programs have been established in several other states, and are further described elsewhere in this report.

e. Experiment with new ways to deliver dental care based on partnerships with local providers and public health agencies

The Legislature should appropriate funds to develop and implement one or more pilot projects to test new delivery models employing clinics integrating county public health agencies. The Dental Access Advisory Committee has proposed one such model, in which a clinic would be opened in a public health facility to serve one or more counties. Oral assessments and preventive services would be provided to all patients where necessary, and for those needing restorative services, the clinic dentist would prepare a written treatment plan and refer the patient to a local dentist. County public health or human services would help assure patient compliance with keeping appointments and adhering to treatment plans through supporting the patient with transportation, interpretation, education, and case management. Local dentists may be more willing to see patients for restorative services knowing they are being supported by such a model.

Development of this model should occur through a partnership with the Local Public Health Association and the State Community Health Services Advisory Committee. Local collaborative funds and future receipt of federal Children’s Health Insurance Program (CHIP) funds may be the means of funding this demonstration. This model could be staffed using new models of practice described in Recommendation 3.b.

f. Initiate expedited payment for high volume MHCP providers

DHS and the health plans should create a means to expedite payment for those providers who see large volumes of MHCP patients to assure sufficient cash flow to maintain their level of services. This is particularly important because such providers often have no, or a much smaller privately insured or cash patient base, to offset outstanding payment for MHCP patients. This measure will help safety-net providers avoid cash flow problems that cause delayed payments to staff, suppliers, etc. Currently, some safety-net providers must obtain short-term bank loans to cover their obligations while awaiting payment for services already provided to MHCP patients. Much of this problem is attributed to the unique “settle-up” method of reimbursing Federally Qualified Health Clinics.

3. Expand the dental workforce.

a. Encourage the licensure of qualified foreign-trained dentists

The Legislature should direct the State Board of Dentistry to study the modification of licensure standards to encourage recruitment and licensure of qualified dentists trained outside the United States or Canada. Regulations should protect the high quality standards of dentistry currently enjoyed by Minnesotans. More than a dozen states have similar provisions in their licensing standards.

This action will make “more hands” available to provide dental services to Minnesotans, including MHCP beneficiaries. These standards would apply to foreign-trained dentists now living in Minnesota, but also would be an incentive for more foreign-trained dentists to relocate here. Many foreign-trained dentists may be well equipped to meet linguistic and cultural needs of MHCP beneficiaries.

b. Evaluate ways of expanding the capacity of the dental workforce through new roles for dental practitioners

The legislature should direct the State Board of Dentistry, the U of M School of Dentistry, the state’s dental auxiliary training programs, MDH, and other relevant stakeholders to identify and evaluate if and how dental access could be improved by realigning the roles of dental practitioners. Concepts to be examined include the “mid-level dental practitioner,” and the expansion of the roles of the dental hygienist and/or the dental assistant, both of which are described elsewhere in this report.

It is imperative that scope of practice and employment issues that arose in previous such efforts are resolved prior to the establishment of any new training programs.

c. Designate additional dental Health Professional Shortage Areas

MDH should continue its pursuit of the designation of additional dental Health Professional Shortage Areas (HPSAs). Additional designations increase Minnesota's opportunities for federal funds for dental education. This action would facilitate federal and state dental scholarship and loan forgiveness programs.

MDH and DHS should also lobby federal officials on the need for a new federal formula that factors in managed care and Medicaid in HPSA designation criteria.

d. Implement a state loan repayment/scholarship program to attract dentists willing to treat MHCP patients

The Legislature should appropriate funds for a state loan repayment and scholarship program as incentives to dental students who agree to serve MHCP beneficiaries and other low-income patients. MDH would administer the program. This Recommendation should be considered a long-term solution, and it must be recognized that new dental practices are by nature not as productive as established ones.

e. Establish a state-funded loan program to encourage new graduates to establish practices in underserved areas

The Legislature should appropriate funds for loans to be made to new dental graduates to open or acquire dental practices in areas of the state with low access. Qualifying dentists would agree to accept a substantial number of MHCP patients and other low-income patients. The rate of the loan would be set at lower than market.

f. Establish conditions for the receipt of Medical Education Research Committee (MERC) funds that promote improvements in dental access

DHS and MDH should explore the development of new conditions for acceptance for the schools which receive Medical Education Research Committee (MERC) funds. The new conditions would require those schools to use a portion of the funds for educational activities and programs that will improve dental access for MHCP beneficiaries.

g. Explore available grant funding for studies of the state dental workforce

DHS and MDH should explore the availability of grant funding from non-state sources to study the adequacy of Minnesota's present and future dental workforce. Other states have examined their population trends and projections of dental school graduations and, like Minnesota's Dental Access Advisory Committee, have concluded that if present trends continue dental services will become less available for all state residents. These states have conducted, or are conducting, studies and will use the results in planning their dental educational systems.

Upon the availability of funding, MDH, the State Board of Dentistry, the U of M School of Dentistry, and the educational institutions with dental auxiliary training programs should proceed by discussing Minnesota's anticipated long-term needs for dental professionals in relation to the present and projected supply.

h. Involve primary care medical clinics in the dental treatment and outreach process

DHS should bring together interested groups to identify of new ways for pediatricians, family physicians and nurse practitioners who see children to become more involved in their patients' oral health needs. Examples include the provision of oral health screenings and certain preventive services (such as the application of fluoride varnishes) for MHCP children when they are seen by their medical providers. Educational materials would be produced and distributed to the state's physicians and nurse practitioners. The Minnesota Academy of Pediatrics, the Minnesota Academy of Family Practice, the nurse practitioners' association, and the Minnesota Dental Association would make recommendations to their members.

For many children aged 1-3, frequent, periodic visits to a pediatrician is their primary contact with the health care system. This recommendation capitalizes on that contact.

4. Engage the responsibility of beneficiaries.

a. Convene focus groups of beneficiaries to better understand their issues

DHS should convene focus groups on the topic of oral health in urban and rural areas of the state, and among cultural groups who make up the MHCP population. The results could be instructive for DHS, county public health and human services, and contracted health plans in modifying purchasing and delivery systems to increase access and utilization for MHCP beneficiaries.

b. Promote educational programs on the infectious and transmissible nature of dental disease

The Legislature should appropriate funds for the compilation and/or development of educational materials on the infectious and transmissible nature of pediatric dental diseases, and the link between dental disease and overall health status for all ages. These materials would be used both for public health outreach and professional education (pediatricians, family practice physicians, nurse practitioners, and other health professionals), and would stress the importance of prevention, improve outcomes, compliance and reduce appointment failures.

Understanding these relationships may lead to changes in patient behavior resulting in reduced levels of pathology and a reduced demand for restorative services.

c. Experiment with methods of eliminating/reducing appointment “no shows”

DHS should convene a work group and secure voluntary commitments among health plans and dental subcontractors, county public health nursing agencies, dental clinics and individual providers to identify and test methods of eliminating or reducing appointment failures. Methods could include case management and support, use of public health nurses, assignment of “dental homes,” incentives for patients who keep their appointments and cooperate with treatment plans, etc.

Reducing appointment failures would address one of the dentists’ most frequently expressed reasons for refusing MHCP patients.

5. Develop a comprehensive state MHCP dental policy addressing needs analysis, benefit coverage, administration, purchasing.

a. Establish a permanent Minnesota Health Care Programs dental advisory committee

The Dental Access Advisory Committee has found value in the regular meeting of diverse stakeholders in the dental access problem, and suggests that DHS continue this type of meeting permanently to oversee implementation of dental access initiatives, monitor dental access and coverage policy, and make future recommendations. This committee would have liberal opportunities for the participation of private, working dentists who see MHCP patients on a regular basis. The committee would perform continuous review of dental services policy; resolution or avoidance of conflicts as they emerge, and would strive to keep policy current with the dental community standard.

DHS recommends that this committee sunset at the discretion of Legislature or of the Commissioner of Human Services after six years, based on continued need for the committee.

b. Establish goals for increasing dental utilization

DHS, in consultation with dental and public health experts, should establish goals for dental utilization for MHCP beneficiaries. A baseline would need to be established, and based on assessment of resources, periodic goals to advance utilization levels toward those of Minnesota’s commercially insured population should be established. These goals should be the cornerstone for all contracting for dental services. The goals would help DHS and the general public assess whether the State’s reimbursement, coverage and purchasing policies are effective in increasing access.

c. Conduct a statewide oral health survey

The Legislature should appropriate funds for, or direct state agencies to obtain grant funding, to conduct a statewide oral health survey. The survey would cover such areas as:

- identification of high risk individuals,
- identification of populations lacking access by geographic area,
- identification of needs for health promotion and education programs for patients and providers,
- establishment of a base line for charting future progress,
- identification of access barriers, including high risk behaviors, knowledge levels and beliefs about oral health,
- identification of why patients keep and fail to keep dental appointments, and why they comply and fail to comply with treatment plans, and
- exploration of dental providers' attitudes regarding care for low-income populations.

The survey would be conducted through local public and private dental clinics and overseen by MDH, the U of M School of Dentistry, Minnesota Primary Care Association and the Minnesota Association for Community Dentistry. Such a survey has never been conducted in Minnesota, although other states have done so with positive results. Survey results would help target efforts to increase dental access. It would assist policy makers to know the depth and breadth of the access problem and would help in allocating resources and setting goals.

d. Establish a state dental data and dental studies clearinghouse

MDH and the U of M School of Dentistry should establish a clearinghouse to maintain uniform data for baseline impact studies and accurate and easy to find Minnesota-specific oral health data. This data would be valuable for impact studies and program planning. Information would be disseminated via newsletter, web site and an annual conference. This activity could be accommodated within the existing organization of MDH and U of M; new personnel would not be required.

CONCLUSIONS

Lack of dental access for Minnesota Health Care Programs beneficiaries is causing deteriorating oral health, missed school and work, additional barriers to self sufficiency, and higher costs to the State. The problem is long-standing and increasing in its gravity. Several trends suggest the situation will continue to deteriorate unless intervention is taken. Underfunding is a significant aspect, but the problem is multifaceted. Therefore, solutions must be multi-factored and integrated, not piecemeal.

The problem is not intractable. While the Legislature and the other major stakeholders have made a wide range of efforts over the past decade, the Dental Access Advisory Committee has identified many additional strategies which can be employed. These include:

- expanded dental workforce
- higher payment rates
- new ways of purchasing services
- new ways of engaging beneficiaries
- greater participation among dentists in making MHCP policy

Many of these strategies require additional funding. If invested wisely, these expenditures will result in value to the State. In addition to improved oral health status, Minnesotans will realize social and economic pay backs.

Appendix A: The 1999 Legislative Initiatives for Dental Care Access

The 1999 Legislature passed several initiatives addressing the dental access problem. Following is a summary of these initiatives.

Grants [*Laws of Minnesota 1999, Chapter 245, Article 1, Section 2 and Article 4, Section 78*]. The Legislature appropriated \$600,000 for the state fiscal year July 1, 1999 - June 30, 2000 to fund start up costs of dental access projects. The grantees must match grant funds on a dollar-per-dollar basis with non-state funds. Grants may be made to entities with a demonstrated ability to provide dental services effectively to public programs beneficiaries.

DHS issued a Request for Proposals (RFP) and received 16 proposals, requesting a total of \$1.48 million. A review committee awarded grants to eight of the entities. Appendix C summarizes the proposals received and the awards made.

In addition to start-up grants, the Legislature appropriated \$75,000 for FY 2000 for a grant to a nonprofit dental provider group in Clay County to increase access for MHCP beneficiaries in northwestern Minnesota. In response to its RFP, DHS received one proposal, from Apple Tree Dental, which operates a dental clinic in Hawley, Minnesota. The grant was awarded and a contract has been executed.

Rate increases for dental services [*Laws of Minnesota, 1999, Chapter 245, Article 4, Section 78*]. The Legislature appropriated \$561,000 for the 1999-2001 biennium to increase payment rates for all covered dental services by 3 percent over the rates in effect on December 31, 1999. This increase became effective for both fee-for-service and prepaid managed care rates on January 1, 2000.

In addition, the Legislature appropriated \$471,000 for the biennium to increase payment rates for certain preventive services. Payment rates for fluoride treatments and tooth sealants were raised to 80 percent of 1997 median charges. (Payment rates for these services were approximately 56 percent of median charges in 1997.) These increases were effective October 1, 1999 for fee-for-service claims, and January 1, 2000 for prepaid managed care rates.

Dental hygienist demonstration projects [*Laws of Minnesota, 1999, Chapter 245, Article 4, Section 118*]. Effective July 1, 1999, the Legislature authorized DHS to allow projects that extend access to the services of dental hygienists by providing services outside traditional dental offices, without the patient first having to be seen by a dentist. The services still must be authorized by a licensed dentist. These projects are permitted to serve patients who have “limited access” to dental care. Limited access is defined as unable to receive regular dental services in a dental office due to age, disability or geographic location. As of November 2000, DHS had received two requests for such projects. The proposed projects extend dental hygienist services to nursing facility residents, to children in Head Start programs, and to children in

elementary school settings. DHS granted both requests, although one was later withdrawn.

Appendix B: DHS Dental Access Advisory Committee Membership

DHS Dental Access Advisory Committee Members
Nita Aasen, Director, Nicollet County Public Health
Karla Abdo, Paralegal, Legal Services of Northwest Minnesota
Craig Amundson , D.D.S., Dental Director, HealthPartners
Jonathon Babcock, D.D.S., Chairman, Minnesota Association of Community Dentistry
Carrie Benson, R.D.H., Minnesota Dental Hygienists' Association
Doug Britton, Director of Planning and Contracts, St. Louis County Social Service Department
Lazette Chang-Yit, Medica Health Plan, representing Minnesota Council of Health Plans
Tarryl Clark, Executive Director, Minnesota Community Action Association
Rhonda Degelau, J.D., Executive Director, Minnesota Primary Care Association
Amos Deinard, M.D., M.P.H., Associate Professor, Department of Pediatrics, University of Minnesota School of Medicine
Richard Diercks, Executive Director, Minnesota Dental Association
Carl Ebert, D.D.S., Assistant Director, Apple Tree Dental
Patricia H. Glasrud, Executive Director, Minnesota Board of Dentistry
Kathy McDonough, Staff Attorney, Legal Services Advocacy Project
Chuck Neil, P.H.N., Health Manager, Arrowhead Head Start, representing Minnesota Head Start Association
Vacharee Peterson, D.D.S., Peterson and Peterson Dental
Mildred Roesch, R.D.H., M.P.H., State Dental Coordinator, Minnesota Department of Health
Ann Rogers, Government Programs Manager, Delta Dental of Minnesota
Dan Rose, D.D.S., School of Dentistry, University of Minnesota
Mark Schoenbaum, Planning Grants Administrator, Minnesota Department of Health, Office of Rural Health and Primary Care
Betty Windom-Kirsch, Administrator, Clay County Public Health

Appendix C: Summary of Dental Access Proposals Received and Grant Awards Made

Proposals receiving grant awards shown in **bold**.

RESPONDER	PROPOSAL SUMMARY	TARGET POPULATION	GEOGRAPHIC AREA	AMOUNT REQUESTED	AMOUNT AWARDED
Amherst Wilder Foundation St. Paul	Establish a school-based pediatric dentistry program	1,200 public school children, grades K-8	2 medically underserved areas in St. Paul	\$38,200	\$38,000
Apple Tree Dental Minneapolis	Purchase mobile dental vehicles, expand existing clinics, workforce recruitment, purchase computer & x-ray equipment	Minnesota Health Care Program (MHCP) eligibles, low-income, Head Start	13 counties in NW MN; 11 metro & adjacent counties	\$350,000	\$174,000
Children's Dental Services Minneapolis	Establish a new dental clinic	MHCP eligibles, uninsured	St. Paul ZIP codes 55103 & 55104	\$100,000	\$100,000
Clay County Public Health Moorhead	Develop a community dental clinic and establish a dental hygienist demo project	MHCP eligibles, uninsured	10 counties in NW MN	\$277,653	\$180,000
Duluth Dental Providers Duluth	Operate a 19-provider cooperative to serve public programs beneficiaries	MHCP eligibles	30 mile radius of Duluth; expansion to Iron Range	\$134,950	0
Fremont Community Health Services Minneapolis	Increase clinic hours through an extended contract with a service provider	MHCP eligibles, uninsured	Designated medically underserved areas in N. & NE Mpls.	\$27,200	\$25,000
Goodhue County Public Health Red Wing	Coordinate dental clinics providing visual exams and recommendations by volunteer dentists; coordinate a collaborative team to heighten awareness of dental health issues in the community	MHCP eligibles, uninsured, Head Start, schools, WIC	Goodhue County	\$13,253	0
Hennepin Care-South Clinic Richfield	Increase clinic efficiency through the purchase of a new x-ray machine	MHCP eligibles; including Spanish speaking	Metro area & Albert Lea to Zimmerman	\$8,166	\$8,000

Hennepin County Community Health Minneapolis	Establish a set of community dental indicators; develop a community dental access strategic plan; provide technical assistance to the MN Assoc. of Community Dentistry; develop a dental only option for uninsured persons	MHCP eligibles (study only); uninsured (subsidies)	Hennepin & Ramsey Counties	\$119,622	0
Migrant Health Services, Inc. Moorhead	Establish dental screenings for adult migrant farm-workers; extend screenings and treatment to children enrolled in migrant schools thru U of M School of Dentistry externships.	Migrant farm workers from S. Texas	Olivia, Montevideo & Breckenridge areas	\$34,400	0
Minnesota Dental Association St. Paul	Establish a donated dental services program for elderly, disabled and medically-compromised persons	Un- & under insured aged, disabled or medically compromised	Statewide	\$52,500	0
Open Door Health Center Mankato	Purchase new chair & equipment, contract with hygienist, purchase interpreter services, purchase dental supplies	Un- & under insured; low-income; persons "unable to receive services in a traditional setting"	9 counties in So. Central MN	\$50,300	0
Otter Tail County Health Dept. Fergus Falls	Expand county-operated public health dental clinic	MHCP eligibles	12 counties in NW MN	\$118,200	0
Pilot City Health Center Minneapolis	Keep a sub-clinic open by supplementing a budget shortfall	MHCP eligibles, uninsured, SE Asian immigrants	Metro area	\$28,500	0
Uptown Community Clinic Minneapolis	Replace dental chair and hand pieces	Uninsured	City of Minneapolis	\$25,236	\$25,000
West Side Community Health Services St. Paul	Increase clinic manpower, extend outreach	MHCP eligibles, uninsured; homeless, public housing residents.	Inner city St. Paul	\$100,000	\$50,000

Appendix D: Enhanced Payment Reimbursement Models

ENHANCED PAYMENT REIMBURSEMENT MODEL REVIEWED BY THE FINANCING WORK GROUP

Model # 1 (DRAFT)

Purpose: *To increase the number of public program patients accessing dental care by rewarding dental practices who actively serve MHCP patients*

1. Key Benefits and Principles

1. All dentists and clinics may choose whether or not to participate in the "Dental Access Rewards" program.
2. Rewards are based on the value of public program patient care actually provided, a clear and fair access measure.
3. Rewards increase continuously as number of patients and the value of dental services increase.
4. Rewards are paid AFTER the services have been provided, once per quarter, by sending a simple form directly to DHS.
5. New Patient Rewards may be given to dental practices which increase the number of new patients from quarter to quarter.
6. Essential information provided on "Reward Forms" tracks increases in access as well as any barriers to progress.
7. These models work well with PMAP Health Plans as well as with the fee-for-service model.
8. "Rule 101" would need to be suspended or not enforced to encourage new participating dentists.

2. Annual Dental Access at a Typical Dental Office

All figures are average annual statistics for a solo dental practice

	<u>General Dentists</u>	<u>Specialists</u>
<u>a. Patients Served</u>		
Private and Insurance	1,101	754
MHCP Patients**	47	32
Total Patients*	1,147	786
<u>b. Dental Visits Provided</u>		
Private and Insurance	3,742	4,373
MHCP Patients**	159	185
Total Patient Visits*	3,901	4,558
<u>c. Submitted Charges</u>		
Private and Insurance	\$333,621	\$506,274
MHCP Patients**	\$14,139	\$21,456
Total Submitted Charges	\$347,760	\$527,730

* Source: ADA 1997 Survey of Dental Practice

** Source: Jim Chase, MDA Dental Summit, 1998, "MHCP" includes MA, GAMC and MinnesotaCare

3. Rewarding Increased Dental Access - Four Alternatives

Note: Each model uses the MDA's estimate that MHCP's reimburse at about 45% of UCR in Minnesota.

A. The Current Program

- Uncompensated care increases as the percent of MHCP patients in a dental practice increases.

	<-- Percent of MHCP Patients in a Dental Practice -->						
<u>Patient Care Goals</u>	<u>1%</u>	<u>3%</u>	<u>5%</u>	<u>10%</u>	<u>30%</u>	<u>50%</u>	<u>75%</u>
Patients	11	34	57	115	344	574	861
Dental Visits	39	117	195	390	1,170	1,951	2,926
<u>Value of Care and Reimbursement</u>							
Submitted Charges	3,478	10,433	17,388	34,776	104,328	173,880	260,820
Current Reimbursement	1,565	4,695	7,825	15,649	46,948	78,246	117,369
"Dental Access Reward"	0	0	0	0	0	0	0
New Reimbursement	1,565	4,695	7,825	15,649	46,948	78,246	117,369
<u>Financial Impact on Dental Practice</u>							
% of UCR Reimbursed	45%	45%	45%	45%	45%	45%	45%
"Reward" Cost per Dental Visit	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Uncompensated Care	(\$1,913)	(\$5,738)	(\$9,563)	(\$19,127)	(\$57,380)	(\$95,634)	(\$143,451)

B. Modest Rewards Model

- Sets reimbursements at 65% of UCR to cover typical dental practice overhead.
- Increases reimbursements to 85% of UCR as practices serve up to 75% MHCP patients.
- Uncompensated care continues to increase as more patients gain access to care.

	<-- Percent of MHCP Patients in a Dental Practice -->						
<u>Patient Care Goals</u>	<u>1%</u>	<u>3%</u>	<u>5%</u>	<u>10%</u>	<u>30%</u>	<u>50%</u>	<u>75%</u>
Patients	11	34	57	115	344	574	861
Dental Visits	39	117	195	390	1,170	1,951	2,926
<u>Value of Care and Reimbursement</u>							
Submitted Charges	3,478	10,433	17,388	34,776	104,328	173,880	260,820
Current Reimbursement	1,565	4,695	7,825	15,649	46,948	78,246	117,369
"Dental Access Reward"	696	2,191	3,651	7,651	29,212	57,380	104,328
New Reimbursement	2,260	6,886	11,476	23,300	76,159	135,626	221,697
<u>Financial Impact on Dental Practice</u>							
% of UCR Reimbursed	65%	66%	66%	67%	73%	78%	85%
"Reward" Cost per Dental Visit	\$18	\$19	\$19	\$20	\$25	\$29	\$36
Uncompensated Care	(\$1,217)	(\$3,547)	(\$5,912)	(\$11,476)	(\$28,169)	(\$38,254)	(\$39,123)

C. Modest Gains Model

1. Sets reimbursements at 85% of UCR to cover most costs for average dental practices.
2. Increases reimbursements to 113% to cover above average costs to treat large MHCP populations.
3. Provides additional revenues to practices who increase services to MHCP patients.

	<-- Percent of MHCP Patients in a Dental Practice -->						
<u>Patient Care Goals</u>	<u>1%</u>	<u>3%</u>	<u>5%</u>	<u>10%</u>	<u>30%</u>	<u>50%</u>	<u>75%</u>
Patients	11	34	57	115	344	574	861
Dental Visits	39	117	195	390	1,170	1,951	2,926
<u>Value of Care and Reimbursement</u>							
Submitted Charges	3,478	10,433	17,388	34,776	104,328	173,880	260,820
Current Reimbursement	1,565	4,695	7,825	15,649	46,948	78,246	117,369
"Dental Access Reward"	1,391	4,277	7,303	14,954	53,207	102,589	177,358
New Reimbursement	2,956	8,972	15,128	30,603	100,155	180,835	294,727
<u>Financial Impact on Dental Practice</u>							
% of UCR Reimbursed	85%	86%	87%	88%	96%	104%	113%
"Reward" Cost per Dental Visit	\$36	\$37	\$37	\$38	\$45	\$53	\$61
Uncompensated Care	(\$522)	(\$1,461)	(\$2,260)	(\$4,173)	(\$4,173)	\$6,955	\$33,907

D. Enhanced Marketplace Model

1. Increases reimbursements to 113% of UCR to cover higher costs for treating MHCP patients.

	<-- Percent of MHCP Patients in a Dental Practice -->						
<u>Patient Care Goals</u>	<u>1%</u>	<u>3%</u>	<u>5%</u>	<u>10%</u>	<u>30%</u>	<u>50%</u>	<u>75%</u>
Patients	11	34	57	115	344	574	861
Dental Visits	39	117	195	390	1,170	1,951	2,926
<u>Value of Care and Reimbursement</u>							
Submitted Charges	3,478	10,433	17,388	34,776	104,328	173,880	260,820
Current Reimbursement	1,565	4,695	7,825	15,649	46,948	78,246	117,369
"Dental Access Reward"	2,365	7,094	11,824	23,648	70,943	118,238	177,358
New Reimbursement	3,930	11,789	19,648	39,297	117,891	196,484	294,727
<u>Financial Impact on Dental Practice</u>							
% of UCR Reimbursed	113%	113%	113%	113%	113%	113%	113%
"Reward" Cost per Dental Visit	\$61	\$61	\$61	\$61	\$61	\$61	\$61
Uncompensated Care	\$452	\$1,356	\$2,260	\$4,521	\$13,563	\$22,604	\$33,907

4. Sample "Dental Access Reward" Form

Submitted directly to DHS quarterly, at the same time the MinnesotaCare Tax form is completed.

A. Calculate Dental Practice Reward

1. Total Billings for Practice	\$347,760	
a. Subtotal for MHCP Patients	<u>\$10,433</u>	(3%, example "B" above)
b. Subtotal for all other billings	<u>\$337,327</u>	
2. Estimated MHCP Reimbursement (Use 45% of line 1.a.)	<u>4,695</u>	
3. Total Number of FTE Dentists (Use 33 hours of patient care per week)	<u>1.0</u>	
4. Dental Access Reward Amount (See table or use formula)	<u>\$2,191</u>	(3%, example "B" above)
5. New Patients Reward (Based on Gain over Previous Quarter)	<u>\$100</u>	(Amount is just for illustration)
6. Failed Appointments Reward	<u>\$100</u>	(Amount is just for illustration)

B. Dental Access Information (For illustration Only)

	<u>Patients</u>	<u>Visits</u>	<u>New Pts</u>
1. Public Program Patients and Visits	34	<u>117</u>	6
a. Medical Assistance	11	<u>39</u>	2
b. GAMC	11	<u>39</u>	2
c. MinnesotaCare	11	<u>39</u>	2
2. # New Public Program Patients		<u>6</u>	
3. Typical wait for a new appointment		<u>6 weeks</u>	
4. Characteristics of Patients Served			
a. Age Distribution of Patients			
b. Special Populations (Migrant, Nursing Home, Head Start.....)			
5. Counties and Locations where care is provided			
6. Steps being taken to increase service levels			
7. Recommendations for program improvement			

ENHANCED PAYMENT REIMBURSEMENT MODEL REVIEWED BY THE FINANCING WORK GROUP Model # 2 (DRAFT)

Proposed Model

Targeted Provider Reimbursement Initiative

Purpose: To provide incentive reimbursement to providers who either have established a large public programs patient population base to continue to see the current volume or who see a minimal volume of patients but would agree to take on new public program patients.

This model could be implemented in addition to any type of base payment arrangement such as: the state fee-for-service system, health plans, county-based purchasing, subcontractors, or other contracted entities. This assumes that there is no more than a 10% increase in the current fee-for-service fee-structure. This model works as an additional reconciliation process that takes place following the payment of the claim, and could be completed on either a quarterly or annual basis. Under this proposal several other payment considerations are possible. Additional payments could be made to providers who indicate a willingness to see additional patients the following year who have not shown up for their initial exam (it is possible that this component could include additional procedure codes). Another component could be to offer an incentive to patients to seek appropriate dental care. These payment options can be used individually or collectively. This model allows any dentist that desires to participate to do so.

In general, there are three concepts that will be described in this model.

- Incentive payments to providers,
- Additional payments to providers for new patients who do not show up for their appointments
- Patient incentives to receive appropriate dental care.

Incentive payments to providers

Providers would be offered on an annual basis the opportunity to increase their total reimbursement for public programs patients through a settle up process with the state. The provider would establish a volume of patients based on the number of patients served during the previous year. The provider would be offered several levels of reimbursement based on the previous year's patient's base, plus the number of additional patients the provider agrees to serve over the coming year. This leaves the choice up to the provider as to level of participation that is based on the desired volume of and reimbursement for public programs patients. The program would be monitored to assure that the new patient targets are met. There would need to be a standard deviation of \pm X number of patients built into the program. One advantage of this approach is that there would be a clear measure (volume of public programs patients) of the additional access that would be achieved using this model. Another advantage to this model is that *all* providers and clinics, both those who see few patients as well as those who see many patients, are incented and rewarded for seeing public patients. The attached chart describes the method to obtain the reimbursement levels used in the calculating the settle up amounts.

Additional payment to providers for patients who "no show"

An additional component would be the addition of a payment for any patient that "no shows". Public program patients are characterized by a high "no show" rate. Because of the small practice nature of so many dental offices, providers are acutely affected when a patient fails to keep an appointment. Providers fear that increasing the number of public programs patients would result in an even greater "no show" rate. Allowing the provider to collect a portion of the fee may lessen the financial impact of the "no show" rate, making the increase of additional patients financially viable. The provider would be reimbursed for a patient who misses their appointment. The proposed reimbursement is \$40 per missed appointment, which is roughly half of the cost of an average visit. This could be modified to include all patient visits to just initial appointment, and could also modify the amount of payment per "no show". This portion of the program would most likely be administered by DHS.

Patient incentives to receive appropriate dental care

Another component of the model is a patient incentive program. The Patient Barriers subgroup of the DHS Dental Advisory Committee suggested as a possible strategy to offer patient incentives. This model incorporates this concept by proposing that each new patient to a dental office voucher or small cash payment (\$5.00) if the patient keeps his or her initial appointment. A similar incentive program done with the migrant health program was found to be successful reducing the "no show" rate for the migrant health dental program. The "no show" rate may be lower in situations where dental care has been hard to obtain, with the goal being to reduce the "no show" rate by at least 50%. This portion of the program could be administered by either the DHS, by a health plan, or other subcontracted arrangement.

The three components link together in an overall strategy that includes incentive provider reimbursement, a reduction in the "no show" rate, and patient incentive program.

Model Description

A possible model for incentive reimbursement to providers would feature these elements:

1. Targeted reimbursement levels (measured as a percentage of billed charges) would be established on an annual basis for every provider who agrees to participate in the program for 2001.
2. A sliding scale would be established for the reimbursement levels (e.g. from 65% to 95% of the providers submitted charges) based on the estimated volume of public programs patients seen.
3. Providers wishing to participate in the targeted reimbursement program would set up an arrangement on an annual basis with DHS. The State/or the provider would calculate the number of unique public program patients the provider saw during the previous year (CY2000). Following the calculation, the provider would be asked to estimate the number of public programs patients they wish to serve during the CY2001. The providers' reimbursement amount will vary according to the targeted reimbursement level selected by the individual provider. The reimbursement level will determine what portion of submitted fees the provider will receive.

4. Providers would receive the incentive reimbursement payment after the end of CY2001, (the difference between the targeted reimbursement level and the actual claims payment made by the dental claims administrator and the through the patient copay) upon completion of a reconciliation audit by DHS to determine if the targeted volumes of public programs patients have been achieved.
5. This program would be administered by DHS. The state would be able to predict the number of new patients who would be seen under this model during the coming year.

The reimbursement would be calculated based on the factor presented in the chart.

Targeted Reimbursement level (providers submitted fee) - (patient copay + dollars paid under MHCP)

Example 1:

Provider currently sees 50 patients and has contracted with DHS to serve 75 additional patients during the coming year .This providers targeted reimbursement level would be .70.

Annual Settleup: .70 [(14,000) -(2500 +6000)]=\$3,850

Example 2:

Provider currently sees 125 patients and has contracted with DHS to serve 125 additional patients during the coming year .This providers targeted reimbursement level would be 80.

Annual Settleup: .80 [(35,000) -(6250 +15,000)] =\$11,000

Example 3:

Provider currently sees 200 patients and has contracted with DHS to serve 80 additional patients during the coming year. This providers targeted reimbursement level would be 85.

Annual Settleup: .85 [(56,000) -(10,000 +24,000)] =\$18,700

Example 4:

Provider currently sees 400 patients and has contracted with DHS to serve 400 additional patients during the coming year. This providers targeted reimbursement level would be 95.

Annual Settleup: .95 [(112,000) -(20,000 +48,000)] =\$41,800

Additional assumption: (CY2002)

The factor the second year would be based on the number of patients at the close of CY2001 and would be anchored unless the provider is willing to increase patient counts in 2002 in which case he/she would have the potential to increase their targeted reimbursement.

**MINNESOTA HEALTH CARE PROGRAMS
PROPOSED TARGETED REIMBURSEMENT INITIATIVE**

Calendar Year 2000	NUMBER OF ADDITIONAL NEW PATIENTS					
Unique Patients	0	<25	26-75	76-150	151-500	501+
0-9	0	0.65	0.7	0.75	0.8	0.85
10-25	0.65	0.7	0.75	0.8	0.85	0.85
26-75	0.7	0.7	0.7	0.75	0.85	0.85
76-150	0.75	0.75	0.8	0.8	0.85	0.85
151-500	0.8	0.8	0.8	0.85	0.9	0.95
501+	0.85	0.85	0.85	0.85	0.95	0.95

1) This graph is predicated on current rates paid to providers under MHCP Programs.

2) The values represented in this chart reflect the percentage paid based on provider's submitted fee.

Appendix E: Summary of the Reforming States Group/Milbank Foundation's Medicaid Dental Insurance Program Model

- 1) New approach to policy for state funding of dental care for the 20 million children who lack access to appropriate preventive and restorative services. Approach suggested, developed and pushed by several dentist-legislators. The policy finances adequate dental coverage for children eligible for the recently enacted federal-state Children's Health Insurance Program (CHIP).
 - Simplify interaction between dentists and public agencies
 - Increase provider reimbursements
- 2) New approach led to creation of an interactive model (available on the Web at <http://www.milbank.org/990716model.xls>) that can be used in any state to change assumptions about reimbursement and the number of eligible children and then to calculate the appropriate cost of the model plan (cost: approximately \$14.50 pmpm for direct services; \$2.50 pmpm for administrative costs).
- 3) Many reviewers of plan were skeptical about the appeal of plan to dentists, even though it would increase reimbursement from state programs.
- 4) Dentist-legislators emphasized that better access to dental care needs to be integrated with more effective programs of dental public health including outreach to poor children and their families, health promotion, attuning practitioners to the culture of their patients and school-related prevention and treatment.
- 5) Tooth decay is the most common chronic disease of childhood – five times more frequent than asthma. Twenty million children – 25% of persons under age 19 – suffer 80% of all tooth decay. For an estimated 4-5 million of these children, tooth decay interferes with routine activities.
- 6) Medicaid-eligible children experience twice the rate of untreated dental disease than their more affluent peers, but states spend only one-tenth as much in dental care for Medicaid enrollees as the national average for all children. Dental care is 25-27% of total health care spending for children, but it is only 2.3% of Medicaid spending for children.
- 7) The new dental insurance program uses public funds to achieve enhanced access and emphasizes broad participation by public and private-sector dentists, accountability and fiscal responsibility.
- 8) The program defines four levels of dental treatment needs based on disease severity and the cost of services necessary to prevent decay and restore a child's teeth to a healthy condition. The levels are:

Level 1: Diagnosis, Prevention and Disease Management Services

At Level 1 dentists have responsibility for diagnostic and preventive care, including the frequency and content of visits. Dentists could receive a fixed annual primary care case management fee that bundles a set of diagnostic and preventive services. Diagnostic services are those necessary to develop a comprehensive treatment plan that both addresses current disease findings and reflects a child's risk of future disease. Preventive services emphasize oral health counseling and fluoride regimens that are specific for each patient.

Dentists would use their clinical judgement to determine the extent of diagnostic work-up appropriate to a particular child (e.g., number and type of radiographs). State officials and the dental profession could devise principles to help practitioners determine the extent of diagnostic work-ups appropriate to children with various clinical presentations. Such guidance would also be useful in oversight to ensure that children receive adequate evaluations.

Assignment of children to Levels 2,3 and 4 with their attendant billing caps depends upon their initial evaluation. Individual dentists may elect to treat children at any level. Most Level 1 dentists would also take responsibility for Level 2; many for Level 3 as well. Dentists who provide large quantities of diagnostic and preventive care but fall below utilization management standards for providing reparative services would be candidates to be investigated for "skimming."

Level 2: Basic Restorative Care

Children requiring up to \$400 of reparative treatment (in 1999 dollars) based on reimbursement schedules (which could be statewide or regional) would receive Level 2 or Basic Care. Their dentists would submit charges on a fee-for-service basis using a standard American Dental Association claim form with no prior authorization requirements.

Dentists whose profiles reflect consistent billing near the \$400 Level 2 cap could be evaluated for possible fraud and abuse. Nearly 80 percent of beneficiaries and 25 percent of total program expenditures are likely to be in Level 2, according to the actuarial study commissioned for this report.

Level 3: Advanced Restorative Care

Children with service needs that require between \$400 and \$1,000 of treatment (in 1999 dollars) would receive Level 3, Advanced Care. Dentists would request prior authorization for all non-emergency care, in order to ensure that these children do not receive excessive or unnecessary care. The actuaries report that about 15 percent of children and 45 percent of expenditures are likely to be in Level 3.

Level 4: Catastrophic Care

Children with exceptional treatment needs – whose estimated reparative services exceed \$1,000 in costs – would receive Level 4, Catastrophic Care. These children would receive comprehensive treatment from dentists with whom the program contracts to provide tertiary-level services. Dentists providing comprehensive services for Level 4 patients would be reimbursed, where feasible, at negotiated modest discount from market-based fees, but with a guaranteed minimum payment per case.

Fees for Level 4 children would be discounted as a market offset for the greater volume of services these children require and the greater efficiency with which Level 4 dentists under contract can provide those more intensive services. The relatively small number of dentists with suitable training and/or experience to provide Level 4 care could compete for contracts to provide care for children with catastrophic needs. Level 4 care would require prior authorization that would include consultation with a specialist in pediatric dentistry. Children requiring Level 4 care frequently require dental surgery that is performed under general anesthesia or sedation. These few children – less than 5 percent of beneficiaries – are likely to absorb 30 percent of program expenditures.

Maintenance Care in Levels 1-4

Maintenance care regimens would be established for all children covered by the program. These regimens would be based on formalized risk assessment approaches that could be developed by state officials collaborating with a state's dental community. Maintenance care would normally be provided semiannually for Level 2 children and more frequently for children receiving services in Levels 3 and 4. This care would include ongoing risk assessment, health promotion, and disease prevention. Reimbursement for this maintenance care would be the same as for children who only receive Level 1 services.

States could offer additional financial incentives to dentists for identifying high-needs children and completing their care. Such incentives to provide comprehensive care could be funded by CHIP or Medicaid or through such sources as Title V Maternal and Child Health Block Grants, Head Start, state public health funds, and philanthropy.

Orthodontic Services

Medically necessary orthodontic services would be determined through an objective severity index and provided within Level 4 coverage by suitably qualified dentists. These services could be financed by a reserve fund estimated at 5 percent of the dental program, and reimbursed at 60 percent of the UCR fees in a state or region.

Age Eligibility

Caries is established as a disease process in infant and toddler years. Many experts recommend that children begin to receive dental care by their first birthday, especially anticipatory guidance to their caregivers and primary disease prevention. Medicaid programs cover children from birth through age 21, CHIP to age 18.

Successes:

- Western Pennsylvania – a plan modeled on commercial dental insurance and actively engaged private-sector dentists.
 - * The number of children who had a visit increased from 30% to 64%.
 - * The percentage who had a regular source of dental care increased from 51% to 86%.
 - * The percentage of those with unmet dental treatment needs decreased from 52% to 10%
- Michigan – \$600 of care yearly (eligibility limit) is provided by dentists participating in Blue Cross and Delta (85% of State's dentists) – Cost – \$9 pmpm. Meets all needs of 95% of enrolled children.

Higher reimbursement for dental services will not by itself increase provider participation. Other ways to increase the participation of dentists include effective linkage between school oral health and sealant programs and comprehensive dental care providers, active formation and support of programs by state and local agencies, tactics that reduce missed appointments and education to help families get access to dental care

Appendix F: Availability of Dental Appointments for New MHCP Beneficiaries in Selected Counties, October 2000

IMPORTANT NOTES: The reader is cautioned to take the following information into consideration when interpreting this data. Data on the number of dentists with available appointments was obtained from individual reports by public health agencies serving the counties listed. Not all agencies contacted all licensed dentists in their counties; some contacted only those dentists who had seen MHCP patients in the past. For two reasons, the Number of Dentists Open to New MHCP Patients may exceed the Number of Licensed Dentist FTEs: 1) some public health agencies surveyed dentists in surrounding counties; 2) this figure is not expressed in FTEs. Not all counties participated in this survey.

County	Number of Licensed Dentist FTEs in County [1]	# of Dentists Open to New MHCP Patients [2]	Comments
Aitken	2.8	3	1 is filling appointments rapidly 1 additional will take MA only, not MNCare 8 will keep seeing current MHCP patients but no new ones
Anoka	122.5	15	2 additional will put name on waiting list
Becker	10.25	0	1 additional will see Native Americans only 1 additional will take Head Start children only 1 additional will put names on a waiting list
Beltrami	14.98	1	1 additional will take 1 new MA patient per week; no new MNCare 1 additional will take 15 new MA patients each month
Benton	8.03	2	
Big Stone, Chippewa, Lac qui Parle, Swift, Yellow Medicine	19.14	8	Two limit the number of new MHCP patients to a fixed percentage each month
Blue Earth	33.6	18	
Brown	11.28	1	This clinic accepts MHCP patients because "no one else will"
Carlton	14.93	7	4 take FFS patients only, no PMAP enrollees 1 additional is a tribal clinic 1 additional will take emergencies
Carver	19.85	1	3 additional will put names on waiting list, two of these will take emergencies
Clay	21.48	2	These are the only two providers who see any MHCP patients in the county. For both providers, the appointments are booked out 4-5 months. Emergencies usually are not accommodated. The patient usually ends up seeing their regular physician, going to a walk-in clinic, or to the emergency room.
Clearwater	3.9	0	Local providers refer MHCP patients to a clinic 110 miles away
Cook	2.0	0	All MHCP patients must travel to other counties
Dakota	171.35	0	Four providers will take appointments for MNCare patients only; not MA
Dodge	2.83	2	An additional dentist in an adjoining county will accept MHCP patients, but only those under age 8

Douglas	13.88	2	Both available dentists are open only during the summer months One dentist reports he plans to discontinue seeing his current MHCP patients
Faribault	6.35	6	
Fillmore	5.03	7	Two additional will put name on waiting list
Freeborn	9.75	3	Two additional in adjacent counties will take new MHCP patients
Goodhue	26.13	3	
Houston	6.23	3	Two additional will put name on waiting list One additional will take patients only from the local zip code area One additional will take only age 12 and under One additional will take only age 13 and under One additional is limited to oral surgery Preventive services available at Rochester Community & Tech. College clinic
Hubbard	6.4	3	Two additional will accept MNCare patients only; not MA One additional will accept MA patients only; not MNCare
Isanti	8.75	0	8 additional in adjacent counties accept new MHCP patients on limited bases 2 additional located approximately 50 mi. and 100 mi. away, respectively, accept new MHCP patients
Jackson/Cottonwood	8.48	7	
Kanabec	6.45	1	The one dentist available is located in another county, 80-90 miles away.
Kandiyohi	20.88	9	One additional will see only patients in a 20 mile radius One additional will see only patients < 11 years old
Koochiching	5.4	6	
Lake	3.85	0	
LeSeuer	8.0	2	1 dentist plans to no longer serve his existing MHCP patients after 12/31/00
Lincoln/Lyon/Murray/Pipestone	17.16	1	One additional is limited to oral surgery One additional is limited to orthodontia
Marshall	10.5	2	One additional will accept only MHCP patients under 18 years old, scheduled at least one month in advance One additional may have openings in November 2000
Martin	18.28	1	6 providers currently see MHCP but will not accept new MHCP patients
Meeker	4.5	0	One will accept children only One will accept only MHCP patients from one local nursing home and one local mental health residential facility.
Mille Lacs	6.63	0	
Norman	5.25	0	Six dentists in adjacent counties will accept new MHCP patients
Olmsted	85.18	5	Two additional will accept MA/GAMC, but not MNCare patients Preventive care available through Rochester Community and Technical College Between January and September 2000, the Salvation Army funded dental services for 179 needy people, including MHCP patients who could not get appointments with dentists in the community.

Otter Tail	23.45	1	Only one dentist in the area will see MHCP children. County has run a dental clinic with U of M School of Dentistry since 1997, but is unable to do complicated extractions, bridges, crowns or dentures. The only other options are a clinic in Deerwood, MN (2 1/4 mile drive one way), or a dentist in Fargo, ND who is usually booked 3-4 months in advance.
Morrison	10.38	0	All dentists will take emergencies
Mower	18.45	1	One additional will take adults only
Nicollet	11.95	1	The one dentist who accepts new MHCP does not see PMAP or MNCare enrollees Seven dentists see existing MHCP patients but will take no new ones.
Red Lake	1.0	0	This dentist stopped taking new MHCP when MHCP made up 20-30% of his total patients.
Redwood	5.7	0	Eight dentists have current MHCP patients but none is open to new MHCP patients
Renville	5.53	1	
Rice	23.35	2	One will accept only FFS patients, not PMAP enrollees Child and teen check-up visits are referred to a provider in an adjoining county who will accept them
Roseau	6.15	0	New MHCP patients must travel to dentists in Crookston or Fergus Falls to obtain an appointment.
St. Louis (northern)	113.45 (entire county)	8	
St. Louis (southern)		16	
Scott	37.5	23	2 additional take MA only, no MNCare
Sherburne	17.15	0	New patients must travel to Metro area or St. Cloud
Sibley	5.15	1	1 additional will take MHCP patients on an emergency basis only
Steele	20.08	1	One additional will place names on a waiting list
Stevens/Traverse	4.85	2	1 additional will see new MHCP patients from Stevens County only, but at a "trickle" rate.
Wabasha	10.48	2	1 additional will accept one new MHCP patient per month
Wadena	4.93	2	1 of the 2 available to new patients has an 8 month waiting list.
Waseca	7.18	2	
Washington	85.23	28	
Wilkin	2.65	2	One additional will accept only age <15 as new patients One additional will accept only age 6+ as new patients Preventive services are available at a local dental auxiliary training site.
Winona	21.45	13	One additional will put names on a waiting list

- [1] Minnesota Department of Health License Surveys, 1996, 1997, 1998. "FTE" means full-time equivalent.
- [2] County Public Health Agency reports to the Minnesota Department of Human Services, October 2000. For two reasons, the Number of Dentists Open to New MHCP Patients may exceed the Number of Licensed Dentist FTEs: 1) some public health agencies survey dentists in surrounding counties; 2) this figure is not expressed in FTEs.

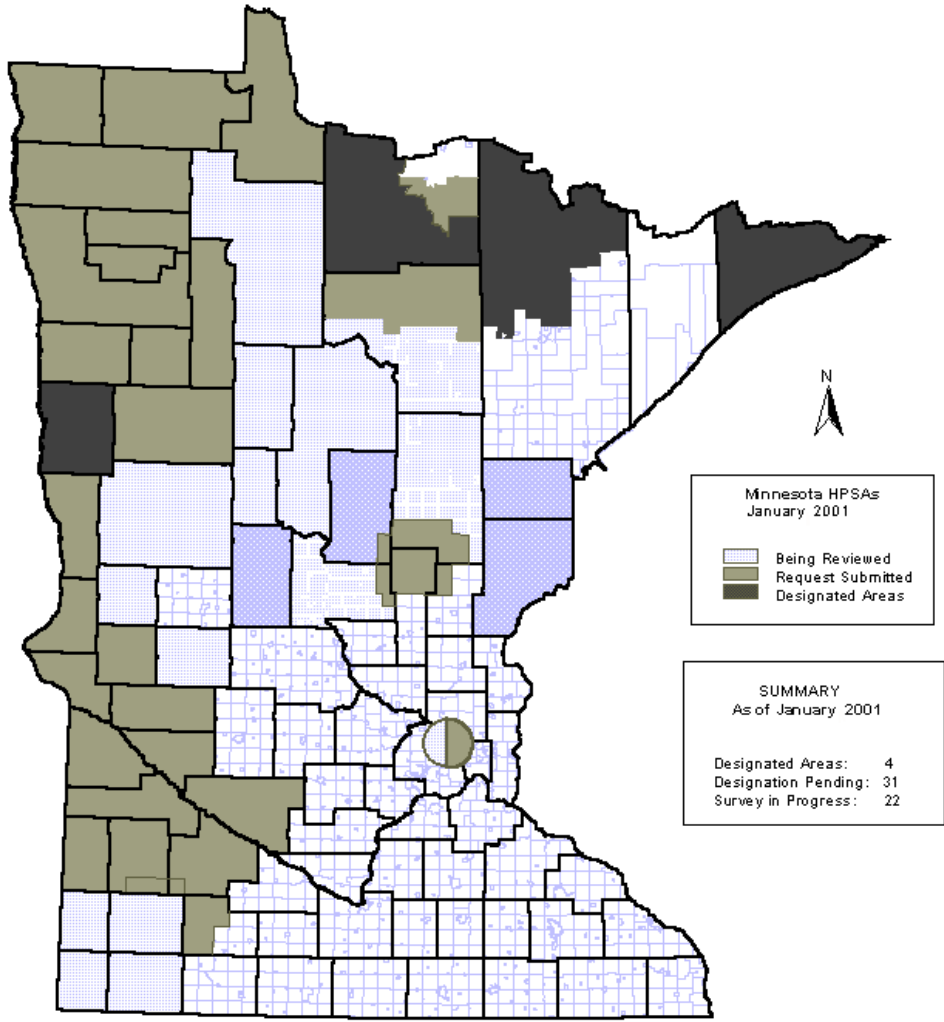
Appendix G: Minnesota Statutes, section 256B.0644 (“Rule 101”)

256B.0644 Participation required for reimbursement under other state health care programs.

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the department of human services. For providers other than health maintenance organizations, participation in the medical assistance program means that (1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients or (2) at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

Appendix H: Health Professional Shortage Areas, 2000: Low-income Dental Designations

Health Professional Shortage Areas, 2001
Low Income Dental Designations



Source: Minnesota Department of Health; Office of Rural Health and Primary Care

LOW-INCOME DENTAL HPSAs PENDING (as of 1/9/2001)

Area	Date Submitted*	Population-to-Provider Ratio
Becker	December 6	7,389:1
Big Stone	September 5	7,477:1
Bigfork	July 26	5,046:1
Chippewa	September 14	4,990:1
Clearwater	November 1	4,308:1
Columbia Heights	June 20	5,459:1
Far North Mpls	June 19	12,356:1
Kittson	November 30	4,366:1
Lac Qui Parle	September 11	4,842:1
Lake of the Woods	October 17	14,842:1
Lincoln	October 23	15,110:1
Lyon	October 20	8,398:1
Mahnomen	November 1	59,187:1
Marshall	November 30	30,305:1
Mille Lacs	August 1	38,300:1
Norman	November 30	11,755:1
North Mpls	June 19	7,557:1
Northeast	June 19	19,525:1
Northome/Blackduck	July 26	10,600:1
Pennington	October 18	4,110:1
Polk-Red Lake	July 26	6,951:1
Redwood	August 15	9,099:1
Renville	August 16	12,964:1
Roseau	October 18	4,365:1
Stevens	September 14	5,138:1
Swift	September 11	6,228:1
Tracy	August 15	9,979:1
Traverse	November 29	30,842:1
Westbrook	August 14	9,637:1
Yellow Medicine	September 14	7,858:1

* all submitted in the year 2000

Appendix I: Dental Performance Language from 2001 MHCP Prepaid Health Care Model Contract

Dental Care Incentive.

- (1) The HEALTH PLAN may be eligible for a financial performance incentive payment based on the HEALTH PLAN's dental services as reported in encounter data under Section 3.5.1. The payment will depend on the HEALTH PLAN's increase in access to dental services by Medical Assistance (MA), MinnesotaCare and MinnesotaCare/MA Enrollees under this Contract. For purposes of this Section, recipient means an Enrollee who received any dental service during the calendar year from the HEALTH PLAN; any dental service means any dental service which is reported using a dental HCPCS code on an ADA dental claim form; and Access means the number of unduplicated MA, MinnesotaCare and MinnesotaCare/MA recipients per 1000 Enrollee months who received any dental service from the HEALTH PLAN during the calendar year, with no rounding of decimal points.
- (2) MA, MinnesotaCare and MinnesotaCare/MA Enrollees are divided into two groups for the purposes of determining the incentive payments, if any, as follows:
 - (a) Group A includes all MA Enrollees, excluding MSHO Enrollees, and all MinnesotaCare and MinnesotaCare/MA Adults, age 18 and over.
 - (b) Group B includes all MinnesotaCare and MinnesotaCare/MA Children Enrollees, age 0 through age 17.
- (3) If the HEALTH PLAN has a calendar year 1999 baseline rate or calendar year 2001 baseline rate of dental Access which is below 25.00 recipients per 1000 Enrollee months for Group A or 30.00 recipients per 1000 Enrollee months for Group B, the HEALTH PLAN shall not receive an incentive payment unless the rate is equal to or greater than 25.00 or 30.00 for subsequent calendar years.
- (4) If the HEALTH PLAN has a calendar year baseline for Access to dental services in calendar year 1999 which is 38.00 or greater for Group A and/or 55.00 or greater for Group B, it shall be assigned a baseline rate of 38.00 or 55.00, respectively, for purposes of calculating the incentive for contract year 2001 and 2002.
- (5) Calculations shall be based on whole recipient numbers per 1000 Enrollee months with no rounding of decimal points.

- (6) Dental Access rates shall be based on encounter data submitted by the HEALTH PLAN pursuant to Section 3.5.1 no later than May 31, 2002 for dental services with dates of service in 2001, and no later than May 31, 2003, for dental services with dates of service in 2002. The STATE shall pay the HEALTH PLAN the incentive payment, if any, on the next available warrant 60 days after the finalization of the encounter data submission.
- (7) The total amount of incentive payment received for a calendar year by the HEALTH PLAN shall not exceed 80% of their increase in aggregate bill charges for these services, compared to those in calendar year 1999 for contract year 2001, and those in calendar year 2001 for contract year 2002.
- (8) If the HEALTH PLAN exceeds the dental access rate of calendar year 1999 for the contract year 2001 or contract year 2002, the HEALTH PLAN shall receive an incentive payment pursuant to the following schedule:
 - (a) Contract Year 2001
 - (i) For Group A Enrollees, the number of recipients per 1000 Enrollee months in calendar year 2001 minus the number of recipients per 1000 Enrollee months in calendar year 1999, multiplied by the number of Enrollee months in calendar year 2001, divided by 1000, multiplied by \$92.00.
 - (ii) For Group B Enrollees, the number of recipients per 1000 Enrollee months in calendar year 2001 minus the number of whole recipients per 1000 Enrollee months in calendar year 1999, multiplied by the number of Enrollee months in calendar year 2001, divided by 1000, multiplied by \$75.00.
 - (b) Contract Year 2002
 - (i) For Group A Enrollees, the number of recipients per 1000 Enrollee months in calendar year 2002 minus the number of recipients per 1000 Enrollee months in calendar year 1999, multiplied by the number of Enrollee months in 2002, divided by 1000, multiplied by \$92.00
 - (ii) For Group B Enrollees, the number of recipients per 1000 Enrollee months in calendar year 2002 minus the number of recipients per 1000 Enrollee months in calendar year 1999, multiplied by the number of Enrollee months in calendar year 2002, divided by 1000, multiplied by \$75.00.

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