Minnesota Department of Human Services Health Care

Mission Statement

The Department of Human Services, in partnership with the federal government, county and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to helping them attain the maximum degree of self-sufficiency consistent with their individual capabilities.

To these ends, the Department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.

A Report to the 1999 Minnesota Legislature as required by Laws of Minnesota 1998, Chapter 407, article 4, section 67 and by Minnesota Laws 1997, Chapter 203, article 4, section 71

Dental Services Access Report

Expanding Access to Dental Services for Recipients of the Medical Assistance, General Assistance Medical Care and MinnesotaCare Programs

Increases in Participation of Dental Services Providers due to the Change in the Provider Participation Requirements

Executive Summary

Report: Expanding Access to Dental Services for Recipients of the Medical Assistance, General Assistance Medical Care and MinnesotaCare Programs

Increases in Participation of Dental Services Providers due to the Change in the Provider Participation Requirements

The 1998 Legislature mandated two reports to be completed regarding dental services to enrollees of the three Minnesota Health Care Programs (MHCP): Medical Assistance(MA), General Assistance Medical Care (GAMC) and MinnesotaCare. This report deals with how to expand access to dental services, including recommendations and a determination of which areas of the state are experiencing a significant access problem. The first report dealt with costs of dental care services and was in a separate report from the Department of Human Services.

This report also fulfills the requirements of the report required by the 1997 legislature regarding any increase in participation of dental services providers in the public assistance programs, due to the change in the provider participation requirements.

The 1998 legislation states:

> Laws of Minnesota, 1998, Chapter 407, Article 4, Section 67(b)
>
> The commissioner of human services shall present recommendations to the legislature by February 1, 1999, on how access to dental services for medical assistance, general assistance medical care, and MinnesotaCare recipients can be expanded. The commissioner shall also determine which areas of the state are experiencing a significant access problem. In developing recommendations, the commissioner shall evaluate the feasibility of a disproportionate share adjustment for dental services.

The 1997 legislation states:

> Laws of Minnesota, 1997, Chapter 203, Article 4, Section 71
>
> The commissioner shall report to the legislature any increase in participation of dental services providers in the public assistance programs due to the change in the provider participation requirements under the 1997 amendments to Minnesota Statutes, section 256B.0644, by January 15, 1999.

The Problem

There is a problem with insufficient access to dental care for enrollees in Minnesota Health Care Programs. This is not a new problem. The Department has been working with dental providers and stakeholders to improve dental access since the early 1990's, and issued a report jointly with the Minnesota Dental Association entitled *Findings and Recommendations for Change in the Minnesota Medical Assistance Dental Program* in August 1992.

The percent of Minnesota Health Care Program enrollees who received a dental service in 1997 was 25.8% in the fee-for-service program for "managed care look-alikes) and 37.3% under managed care. This is far below the national average reported in a survey for all populations for the period from 1989-1994 of 64.6%, and even below the national average for populations with income under $10,000 for the period of 1988-1994 of 40.9%.[1] Dental access for MHCP enrollees continues to be a problem.

A disturbing outcome in national studies is the disparate impact on blacks and other minorities, who are the most likely to experience unmet dental care wants.[2] Hispanics and blacks are much less likely to visit a dentist than are whites, at all ages, incomes and education levels. The authors of one study hypothesized that the reasons for this include differences in attitudes toward dental care, differences in dental health status, and presence of barriers to care, including cultural or language barriers, and discrimination.[3] The Department has not yet looked at its data stratified into sub-populations.

Areas of the State Experiencing a Significant Access Problem

As part of this report, the Department was asked to determine the areas of the state which are experiencing a significant dental access problem. The Department looked at its dental fee-for-service claims and managed care encounter utilization data on a statewide and county-by-county basis for 1997, the most recent year in which it has complete claims and encounter data.[4] Fee-for-service was looked at in two groups: those who would be eligible for managed care MA and GAMC (managed care look-alikes) and those in the non-managed care cohort. The final data for

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[1] Isman, R., Isman, B. *Oral Health America White Paper: Access to Oral Health Services in the United States 1997 and Beyond.* December 1997. Oral Health America.

[2] Mueller, Curt; Schur, Claudia; Paramore, L.C. Access to Dental Care in the United States. JADA April 1998; 129: 429-437. And Manski, Richard; Magder, Laurence. Demographic and Socioeconomic Predictors of Dental Care Utilization. JADA February 1998; 129: 195-200.

[3] Manski, Richard; Magder, Laurence. Demographic and Socioeconomic Predictors of Dental Care Utilization. JADA February 1998; 129: 195-200.

[4] HealthPartners dental data for 1997 has not yet been received and data in this report exclude HealthPartners members.

the non-managed care cohort were not available for this report. An addendum to this report will be filed by April 15, 1999, which shows utilization among the fee-for-service non-managed care cohort. The Department also reviewed the active enrolled dentists statewide and on a county-by-county basis.

While dental access is below national norms in all areas of the state, some areas have worse problems than others. According to utilization data reviewed by the Department, the following counties have the lowest utilization in fee-for-service for the managed care look-alike population:

- Beltrami,
- Clay,
- Mahnomen,
- Mille Lacs,
- Pipestone,
- Rock and
- Wilkin.

The counties which have the lowest utilization for their managed care enrollees are:

- Becker,
- Clay,
- Mahnomen,
- Norman,
- Polk and
- Red Lake

Within the seven county Metro area, Hennepin County has the lowest dental utilization, with Ramsey County not much higher. This is true both in fee-for-service (managed care look-alikes) and in managed care.

Grant County does not have any dentist who was actively enrolled as a dental provider for MHCP fee-for-service enrollees during FY 98; Cook, Lake of the Woods, Mahnomen, Red Lake, Traverse and Wilkin Counties have only one dentist who was actively enrolled. Not only do those counties have few dentists, the ratio of eligibles to dentists is four times higher than the average in other counties.

Anecdotally, the Department still hears many complaints from St. Louis County, where the high utilization in their metro area may mask low utilization in the range area; and from Washington and Crow Wing Counties, where analysis of utilization data does not give an appearance of lower utilization than their neighboring counties.

Previously Attempted Solutions

As a result of the 1992 Report, the Department introduced a new reimbursable procedure and increased payment for gross oral cleanings of neglected mouths, made changes in prior

authorization requirements, and increased dental reimbursements rates 25%. With the advent of the MMIS II claims payment system in 1994, the Department increased claim processing capabilities, including the ability to accept electronically submitted claims and speeding up claim processing timelines.

In 1997, the legislature attempted to resolve some of these dental access problems by increasing dental reimbursement rates for Medical Assistance and General Assistance Medical Care by 5% and for MinnesotaCare by 15%, effective July 1, 1997. The 1998 legislature added an additional 3% increase effective July 1, 1998. The current MA dental payment rates equate to approximately 57% of usual and customary charges for MA and 56% of usual and customary charges for GAMC. These are among the highest cost to charge ratios paid to any providers in the Minnesota Health Care Programs fee-for-service system. The following chart illustrates the increases from the 1982 rates.

Year	Increases added to 1982 Rates
1982	7.5% for diagnostic and routine; 5% other
1992	25%
1997	5% MA and GAMC; 15% MinnesotaCare
1998	3%

Currently in Minnesota, in order for a health care professional to be able to participate in the State Employee Group Insurance Program (or SEGIP, which serves state and University employees and retirees), the professional must agree to be a provider for the three Minnesota Health Care Programs: MA, GAMC, and MinnesotaCare. Providers are allowed to limit their participation to 20% of their caseload. In addition to the increases in reimbursement in the fee-for-service program, the legislature lowered the maximum percentage of public program participants a dentist could have and still serve State Employee Group Insurance Plan enrollees from 20% to 10% for the two-year period from July 1, 1997 to June 30, 1999. It was hoped that these changes would serve to increase access for MHCP enrollees.

Results

On July 1, 1997 there were 2,568 dentists enrolled in MHCP. On December 31, 1998 there were only 2,491 dentists enrolled, a drop of 3 percent. During that period, an additional eleven counties implemented PMAP and PGAMC, leaving fewer enrollees in the fee-for-service program. The drop in enrollees may have encouraged some providers to leave the program and could explain some of that decrease, yet provider participation, measured by the number of enrolled providers, did not increase.

Although health plans passed on the dental payment increases to their network providers, dentists in the managed care program were not affected by the drop in the provider participation requirements. Dentists in managed care must see the number of patients that they agree to in their contracts with health plans, and are not governed by these provider participation requirements.

MA and GAMC also saw decreases in utilization in the fee-for-service program. (MinnesotaCare was entirely in managed care beginning January 1, 1997). MA utilization, measured as the percent of eligibles who received any dental service, decreased from 27.9% to 25.4% from FY 1996 to FY 1998. GAMC utilization decreased from 21.9% to 20.2% from FY 1996 to FY 1998. There were eligibility changes in MA and GAMC during this period of time resulting in a 19% and 34% drop in enrollment, respectively, which could have indirectly influenced this outcome. This is illustrated by the following table:

Year	MA Utilization	# of Eligibles	GAMC Utilization	# of Eligibles
FY 1996	27.9%	439,995	21.9%	69,371
FY 1997	26.5%	398,065	20.8%	57,508
FY 1998	25.4%	354,269	20.2%	45,831

It is universally recognized by all stakeholders in Minnesota that there is a problem with insufficient access to dental services for MHCP enrollees. And it appears that the measures put into place by the Legislature in 1997 have not improved that access; indeed, provider participation and dental utilization continue to decline in spite of those attempts. This report makes the following recommendations as the next steps.

Recommendations

The Department recommends an increase in the general fund budget of $4,272,000 in FY 2000 and $4,827,000 in FY 2001, and an increase in the Health Care Access Fund budget of $1,849,000 in FY 2000 and $2,545,000 in FY 2001, to increase access to dental services for enrollees in Minnesota's Health Care Programs through overall dental payment increases and dental incentive payments, as follows:

1. Overall Payment Increases: a one-time 5% increase for payment rates in dental services over the rates in effect on September 30, 1999, to bring dental payments closer to market rates.

2. Incentive Payment Proposals:

Although health plans passed on the dental payment increases to their network providers, dentists in the managed care program were not affected by the drop in the provider participation requirements. Dentists in managed care must see the number of patients that they agree to in their contracts with health plans, and are not governed by these provider participation requirements.

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Recommendations

The Department recommends an increase in the general fund budget of $4,066,000 in FY 2000 and $4,328,000 in FY 2001, and an increase in the Health Care Access Fund budget of $1,844,000 in FY 2000 and $2,535,000 in FY 2001, to increase access to dental services for enrollees in Minnesota's Health Care Programs through overall dental payment increases and dental incentive payments, as follows:

1. Overall Payment Increases: a one-time 5% increase for payment rates in dental services over the rates in effect on September 30, 1999, to bring dental payments closer to market rates.

2. Incentive Payment Proposals:

a. Disproportionate Share Payment: The Department proposes to increase payments by 20% over the October 1, 1999 fee-for-service rates for those fee-for-service providers for whom public programs (MA, GAMC, and MinnesotaCare) account for more than 20% of their practice.

b. Balanced Budget Act (BBA) Approach for reimbursement of FQHCs and RHCs: Currently, reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are paid on a cost-based reimbursement system, which ends in Minnesota on January 1, 2000. Under the BBA, states without an 1115 waiver were required to phase-out cost-based reimbursement over a six year period. The Department proposes to match the federal phase-out timeline, gradually phasing out cost-based reimbursement through September 2003. This would allow FQHCs and RHCs to continue serving the dental patients they currently have and would help to prevent additional declines in utilization.

c. Enhanced payment for improved access: The number of public program patients seen per dentist has fallen over the past several years, and past rate increases have failed to result in increased utilization. To encourage providers to add new public program patients to their practices, the Department proposes to fund two pilot programs in areas where clients are underserved by dentists and allow the commissioner to increase rates if the percentage of public program recipients with at least one dental visit per year increases.

d. Preventive Services for Children: Tooth sealants and fluoride treatments can improve the long-term oral health of children. The Department proposes to encourage providers to provide these basic services by increasing rates paid for preventive services to 80% of median 1997 charges.

e. Pilot project for community clinics or other nonprofit community organizations: In underserved areas of the state, where the number of dental providers is sufficient only to meet the needs of the commercial and private payment population, the Department proposes to provide funding for: coordinating access for enrollees, establishing new or upgrading existing facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in that region, on a pilot basis.

3. Direct access to dental hygienists: The Department proposes to allow Medical Assistance payments for dental services to dental hygienists when they are able to

provide preventive services to clients in underserved areas within their scope of practice.

4. Administrative Simplification. The Department intends to constitute a rule committee to review the Medical Assistance Payments Rule (Rule 47) for Dental Services, Minnesota Rules 9505.0270, regarding payment limitations and services covered, with the intent to bring the rules up to date with dental community standards.

It is hoped that instituting these recommendations will be instructive as to what the Department must do on a statewide basis in order to improve dental access for MHCP enrollees.

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Introduction

The Department, the Legislature, enrollees, advocates, dentists, hygienists and other stakeholders have been concerned about insufficient access to dental care for enrollees in Minnesota Health Care Programs (or MHCP, consisting of: Medical Assistance or MA, General Assistance Medical Care or GAMC, and MinnesotaCare) since the early 1990's. In 1991 the Minnesota Dental Association and the Department of Human Services convened a Minnesota Medicaid Dental Advisory Task Force which submitted its findings and recommendations in August of 1992.

As a result of or concurrent with the 1992 report, the Department took the following steps:

- Introduced a new procedure code and increased payment for gross oral cleanings of neglected mouths;
- Made changes in prior authorization requirements, bringing them in line with dental community standards;
- Increased dental reimbursements 25%.

With the advent of MMIS II, the new claims processing system implemented by the Department in 1994, claims processing timelines speeded up considerably, and the Department now has the ability to accept claims which are submitted electronically.

Despite these changes, dental access continued to be a problem, at least anecdotally.

In 1997, the legislature attempted to resolve dental access problems by increasing dental reimbursement rates for MA and GAMC by 5% and for MinnesotaCare by 15%. Simultaneously, it lowered the maximum percentage of MHCP enrollees a dentist must have and still be able to serve State Employee Group Insurance Plan (SEGIP) enrollees from 20% to 10%[5], for a two year period from July 1, 1997 to June 30, 1999. The legislature required the Department to report on any increases in provider participation based on the changes to these provider participation requirements for dentists.

On July 1, 1997 there were 2,568 dentists enrolled in MHCP. On December 31, 1998 there were only 2,491 dentists enrolled, a drop of 3 percent. During that period, an additional eleven counties implemented PMAP and PGAMC, leaving fewer enrollees in the fee-for-service program. The drop in enrollees may have encouraged some providers to disenroll and could explain some of that decrease, but clearly provider participation, measured by the number of enrolled providers, did not increase.

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[5] Minnesota Statutes, Section 256B.0644, and Minnesota Rules 9505.5200-9500.5240, commonly known at Rule 101.

Although health plans passed on the dental payment increases to their network providers, dentists in the managed care program were not affected by the drop in the provider participation requirements. Dentists in managed care must see the number of patients that they agree to in their contracts with health plans, and are not governed by these provider participation requirements.

MA and GAMC utilization also decreased in the fee-for-service program. (MinnesotaCare was entirely in managed care beginning January 1, 1997). MA utilization decreased from 27.9% to 25.4% from FY 1996 to FY 1998. GAMC utilization decreased from 21.9% to 20.2% from FY 1996 to FY 1998. There were eligibility changes in MA and GAMC during this period of time resulting in a 19% and 34% drop in enrollment, respectively, which could have indirectly influenced this outcome. This is illustrated by the following table:

Year	MA Utilization	# of Eligibles	GAMC Utilization	# of Eligibles
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In 1998, the legislature added an additional 3% increase to all dental rates. The current MA dental payment rates equate to approximately 57% of usual and customary charges for MA and 56% of usual and customary charges for GAMC. These are among the highest cost to charge ratios paid to any providers in the Minnesota Health Care Programs Fee-For-Service Program.

The following chart illustrates the dental rate increases from the 1982 rates.

Year	Increases added to 1982 Rates
1982	7.5% for diagnostic and routine; 5% other
1992	25%
1997	5% MA and GAMC; 15% MinnesotaCare
1998	3%

The Department has participated in meetings with the Minnesota Dental Association, the Primary Care Association, the Minnesota Association for Community Dentistry, Delta Dental, Appletree Dental, Head Start and the Minnesota Dental Hygienists Association; attended a National Conference on Dental Access for Medicaid Directors, and the Red River Region Community Dental Care Access Meeting, as well as communicating with scores of individual dentists, all to the end of understanding and trying to resolve problems with access to dental care for MHCP

enrollees. The Department also formally receives input from counties participating in the managed care PMAP/PGAMC programs on an annual basis, as well as PMAP/PGAMC development staff hearing from counties implementing PMAP/PGAMC on a regular basis about dental access problems. The Department regularly hears concerns about dental access problems in the fee-for-service program from counties. Additionally, the Department monitors the complaints and appeals received from enrollees about dental concerns on a regular basis.

What are the causes of the dental access problem? A national survey stated that dental care may appear to be more discretionary from the consumer's perspective, except during acute dental episodes that require immediate attention.[6] In a survey of Washington State dentists for Medicaid enrollees the reasons given by dentists for not seeing Medicaid clients include: low reimbursement levels, payment not timely, bureaucratic system, population difficult to work with (high no-shows and cancels, and noncompliance).[7] The other barriers included stereotypes held of Medicaid recipients by dentists, and education of the recipients of the need for preventive dental care.

These beliefs are supported by a recent survey and report on Medicaid managed dental care done by the National Academy for State Health Policy (NASHP)[8]. The findings in that report indicated that the lack of utilization among Medicaid beneficiaries is due to two major factors. The first factor is a lack of dentists willing to serve Medicaid because the payment rates are low and the administrative burdens for providers are perceived as high. The second factor is the low priority some Medicaid families may place on their own oral health. Because of competing needs among low-income families, unawareness of the importance of dental care, and transportation issues, many Medicaid families fail to seek dental care, or fail to actually receive dental care.[9]

The reasons the Department hears about the lack of dental access in Minnesota mirrors what is heard nationally: reimbursement levels are too low; administrative burdens of multiple payment systems are unwieldy; enrollees treat dental care as discretionary given the other burdens in their life, resulting in more frequent no-shows or cancellations; shortage of dentists and dental auxiliaries so dental offices can't staff appropriately; transportation, interpretation and communication issues; dentists and hygienists aren't taught to deal with patients with difficult

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[6] Mueller, C., Schur, C. And Paramore, L.; *Access to Dental Care in the United States.* JADA, April 1998; 129:429-437.

[7] Milgrom, Peter; Riedy, Christine. *Survey of Medicaid Child Dental Services in Washington state: Preparation for a Marketing Program.* JADA, June 1998; 129:753-76 ,753.

[8] Kaye, N. and Pernice, C. *Dental Care in Medicaid Managed Care: Report from a 19 State Survey*, November 1998, published by National Academy for State Health Policy.

[9] *Ibid.*, page 1.

dental problems; problems of migrant workers and other transient populations with accessing dental care; and antiquated rules for dental services covered by the Department which are not in line with dental community standards.

It is universally recognized by all stakeholders in Minnesota that there is a still problem with insufficient access to dental services for MHCP enrollees.

This report will define what is meant by access, describe areas of the state where access to dental care appears to be particularly problematic, describe possible solutions, and make recommendations about which solutions should be undertaken this biennium.

Measuring Access to Dental Care

There are many ways of measuring access to dental care, including: 1) the distribution of human resources (dentists); 2) dental utilization in the aggregate or by subgroups of the population; 3) process indicators, such as time and distance to travel to a dentist or waiting time to get to an appointment; and 4) satisfaction with the dental care.[10]

Access: supply vs. demand.

The authors of a 1998 report on dental care in Medicaid managed care discuss various reasons for low dental utilization among Medicaid recipients.[11] These reasons can be categorized as "supply side": manpower shortages, lack of willingness of providers to see people on public assistance, provider dissatisfaction with reimbursement rates, etc.; and "demand side": enrollee is not aware of the benefits of prevention, enrollee does not regularly access care because of other stressors in their life situation, etc.

The Department believes that improving utilization by addressing demand side issues is important, and fosters such strategies as screening, enrollee education and outreach programs. For managed care enrollees, these strategies are implemented by the health plans in response to various requirements found in the Department's prepaid contracts, including use of the Early and Periodic Screening, Diagnosis, and Treatment Program (or EPSDT), also known in Minnesota as the Child and Teen Check-up Program (or C&TC). Providers who see fee-for-service enrollees also identify dental needs through the use of C&TC.

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[10] Isman, R. And Isman, B., *Oral Health America White Paper: Access to Oral Health Services in the United States 1997 and Beyond,* December 1997

[11] Kaye, N. And Pernice, C., *Dental Care in Medicaid Managed Care: Report from a 19 State Survey*, National Academy for State Health Policy, November 1998.

The Department believes that, while there may be room for improvement, there is a strong demand for dental services among the state's Minnesota Health Care Programs enrollees. However, analysis of complaint and appeal data and a multitude of anecdotal evidence, leads the Department to believe that much of the demand is presently unmet, due to a variety of reasons on the supply side.

Issues in the measurement of access.

There are many ways to measure access, but there are difficulties in relying on only one to make an accurate assessment and to design effective strategies for access improvement.

Utilization:

Low service utilization rates are one of the primary ways in which health care access problems manifest themselves in a quantifiable manner. According to Dr. Burton Edelstein, consultant to the U.S. Department of Health and Human Services, Health Resources and Services Administration, nationally, low income children have a much lower rate of dental care utilization than do children in the general population. In his policy brief for the National Center for education in Maternal and Child Health, Edelstein cites data showing that 80 percent of the tooth decay occurs in 25 percent of children and adolescents, and notes that the greatest unmet treatment needs are found among children who meet Medicaid eligibility standards.[12] The Department of Human Services believes that this disparity is also present in Minnesota.

Process Indicators:

The Minnesota Department of Health (MDH), when it is certifying service areas for HMOs and CISNs, requires that dental care be accessible geographically so that the maximum travel distance or time is 60 miles or 60 minutes within the service area. However, health plans may request an exception from this requirement if it can demonstrate with data that it is not feasible in a particular service area or part of a service area.[13] Therefore the fact that an HMO or CISN is certified by MDH does not necessarily guarantee that there is a dental provider within 60 minutes or 60 miles of an enrollee. And of course, there is no such thing as geographic accessibility requirements in the fee-for-service program.

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[12] Edelstein, Burton L., *Crisis in Care: The Facts Behind Children's Lack of Access to Medicaid Dental Care,* National Center for Education in Maternal and Child Health Policy Brief, May 1998.

[13] Minnesota Rules, 4685.1010, Subp. 3. B.

Distribution of Human Resources:

Another commonly used access measure is a simple ratio of the number of dentists per population. Minnesota's ratio, 1:1527[14], appears quite favorable when compared to the national ratio of 1:1859[15], or that of a neighboring state, for example North Dakota, with a ratio of 1:2268[16]. However, such statewide ratios mask the maldistribution of dentists. In a 10-county area of northwestern Minnesota, the ratio is 1:2420[17]. The statewide ratio is lower due to the much greater concentration of dentists in the Metro area.

A complicating factor in ratios is the aging out of the dentists who are in the rural areas of the state. The Minnesota Department of Health, Office of Rural Health and Primary Care published a Report in 1996, entitled "Findings from the 1994 Minnesota Dentist Survey."[18] In 1994 there were 3,928 dentists licensed in Minnesota, 94.7% of whom (3,719) responded to the MDH survey. Three out of five dentists practice in the seven-county metro area. Most dentists are in their late 30s or in their 40s. But in the northwest region, two out of every five are over the age of 50. This contrasts with the metro area, where only 30% of the dentists are over 50.

While the number of dentists in a given area is a starting point, it is not sufficient as a sole measure on which to determine the adequacy of access. Even when analyzed at the most local level of detail, data on the number of practitioners may not reveal the actual capacity of the area's complement of practitioners. To illustrate, if in a given county there are 10 licensed dentists, but one is semi-retired, while another chooses to practice only 3 days a week, while another splits his time equally with an office in a neighboring county, the capacity of the manpower complement is not equal to that of a county with 10 licensed dentists, all of whom practice full time, solely within the county. Some states have devised an "FTE" (full-time equivalent) measure to more accurately reflect the situation.

Capacity can be further reduced by factors other than manpower. In the previous example, if some of the dentists refuse patients with dental insurance, access to care is further reduced for those with such insurance. Another factor that can reduce access is individual practice capacity,

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[14] Minnesota Depart of Health and Minnesota Planning, Demographer's Office data

[15] North Dakota Department of Health Data

[16] *Ibid.*

[17] Minnesota Depart of Health and Minnesota Planning, Demographer's Office data

[18] Minnesota Department of Health, Division of Community Health Services, Office of Rural Health and Primary Care, Data Unit. Findings from the 1994 Minnesota Dentist Survey. August 1996.

such as when a dental practice is no longer able to take new patients due to staffing limitations. This problem is especially aggravating in areas of human resource shortage.

Access for people on medical assistance is affected by additional issues which overlay those described above. Dentists in fee-for-service whose practices include no State Employees Group Insurance Program (SEGIP) enrollees[19] are free to refuse to see MHCP enrollees, as are dentists in fee-for-service whose practice exceeds 10% MHCP enrollees.[20]

Dentists in areas where MHCP recipients are enrolled in managed care (presently 50 counties for MA and GAMC, 87 counties for MinnesotaCare) may avoid seeing the bulk of their area's MHCP enrollees by refusing to sign managed care contracts.

Access is further reduced for those MHCP enrollees who have special needs. People with physical disabilities are restricted to those practices that are handicapped accessible, and people with behavioral disabilities are restricted to those practitioners who have the commitment and expertise to deal with behavior problems. People with language or cultural barriers may require special supports, such as interpreters or native speaking practitioners, before they can access dental care.

Factors affecting access: two Minnesota case studies.

The following two brief case studies illustrate how dental access problems for public assistance recipients can be caused by very different reasons.

The first case study is the Iron Range area of St. Louis County, where access to dental care has long been difficult for MHCP enrollees, despite the fact that there are 64 licensed dentists, for a dentist/general population ratio of approximately 1:1400 (compared to the statewide ratio of 1:1527)[21]. Even before managed care was implemented in 1996, county officials reported many instances of difficulty in receiving dental care, despite the fact that 62 of the 64 licensed dentists were certified as MA providers. With the advent of managed care in January of 1996, fewer than twenty of these dentists signed contracts with the health plans, despite the fact that the plans' reimbursement rates averaged 118% of the MHCP fee-for-service rates. Predictably, the county human services and public health agencies continued to receive a high number of access complaints. As of the writing of this report, the managed care plans have not been able to recruit additional numbers of dentists, despite the aggressive efforts of the Department, of the health

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[19] State and university employees, worker's compensation cases and other groups managed by the state Department of Employee Relations.

[20] Minnesota Statutes Section 256B.0644, and Minnesota Rules 9500.5200 - 9500.5240.

[21] Minnesota Department of Health and Minnesota Planning, Demographer's Office data.

plans, and of their dental subcontractor[22]. However, in spite of the small proportion of providers joining health plan networks, dental utilization data show a slight *increase* between 1995 and 1997 in St. Louis County.[23] Health plans attribute this to their aggressive efforts in securing care out of network, and providing transportation to distant providers. The issue this raises is that utilization data do not show where enrollees are accessing care, nor does it describe the problems that can ensue in a person's life when he or she has to travel long distances in order to receive care: for people who are working, which most MinnesotaCare enrollees are, it means they may need to take a full day off their jobs in order to access dental care; for people with children at home, it means finding day care for their children for the time it takes them to access dental care as well as the necessity of coordinating transportation.

The second case study is the Red River Valley area of northwestern Minnesota, where access to dental care has also been a longstanding problem. But unlike the Iron Range, the primary problem seems to be a lack of manpower. In a ten-county region surrounding Moorhead, there are only 93 dentists, for a ratio of approximately 1:2400[24]. At a bi-state forum on the area's dental access problems[25], participants reported it is common to wait six months to get a routine dental appointment for anyone, regardless of MHCP status or insurance status.

As the two examples illustrate, reasons for lack of access can be very different, requiring very different solutions.

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[22] In February 1999 there were four health plans in St. Louis County with MHCP enrollment. Three of the four plans subcontract for the same dental network, while the fourth plan maintains a different network. The first network, used by the three plans enrolling 33% of the county's total MHCP participants, has 19 dentists available in the Iron Range area. The second network, used by the health plan enrolling 66% of the county's total MHCP participants, has ten dentists in the Iron Range area. All ten dentists in the second network are also members of the first network's panel, so only 19 of the area's 64 licensed dentists (29.7%) are available to MHCP managed care enrollees.

[23] Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division data.

[24] Minnesota Department of Health and Minnesota Planning, Demographer's Office data.

[25] Red River Region Community Dental Care Access Meeting, Fargo, North Dakota, December 1998, sponsored by Oral Health America and Dakota Medical Foundation.

Which Areas of Minnesota are experiencing a significant access problem for MHCP enrollees?

The Department's Performance Measurement and Quality Improvement Division produced dental utilization data for Calendar Years 1995 to 1997. In determining where there are significant dental access problems, the Department used the 1997 data, the most recent year for which it has complete dental claims, in both fee-for-service and in managed care.[26] The fee-for service enrollees were broken into two groups, those who would be eligible for managed care (managed care look-alikes), and those who would be excluded from managed care (non-managed care cohort). The final data for the non-managed care cohort are not available for analysis at the time of finalizing this report. An addendum to this report will be filed by April 15, 1999, showing dental utilization for the non-managed care cohort of the fee-for-service enrollees.

Dental Utilization in Managed Care: Statewide

The first step was an unpublished report written by the Department's Performance Measurement and Quality Improvement, entitled "Dental Service Provision in Public Health Care Programs 1995-1997"[27]. The report compared dental services provided for persons in managed care programs with dental services provided for a set of persons in fee-for-service who are managed care look-alikes, that is it only looked at people in fee-for-service who would be eligible for managed care if PMAP existed in their counties, excluding persons who would be excluded.[28]

The report used as a comparison over the three years, the number of all dental service recipients per 1,000 eligibility months, and also broke that down into age categories of children, adults 21-64, and adults over 65. The following chart, Figure 1, shows the comparison for All ages:

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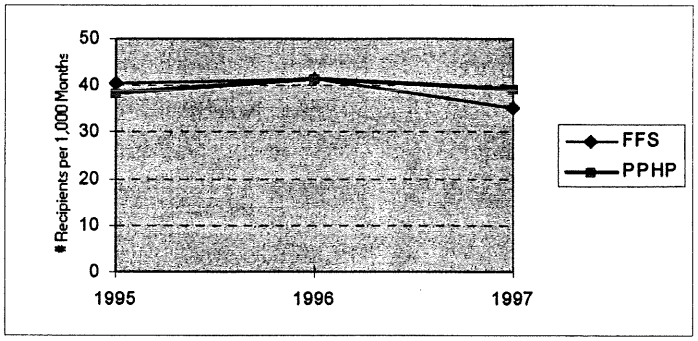
[26] HealthPartners dental data has not yet been received for Calendar Year 1997, so enrollees in HealthPartners are excluded from these calculations

[27] *Dental Service Provision in Public Health Care Programs 1995-1997: Comparison of Managed Care Service Provision Rates to Fee-For-Service Service Provision Rates.* Department of Human Services, Performance Measurement and Quality Improvement. January 1999.

[28] Minnesota Rules 9500.1452, Supb.2 lists Medical Assistance eligibility categories ineligible to enroll in PMAP.

FIGURE 1

Number of Dental Service Recipients per 1,000 Eligibility Months– Statewide --All Ages



The report gives us information about utilization, specifically finding:

- "For all age groups combined, the managed care # of Recipients per 1000 Eligibility-Months rate was slightly behind the corresponding fee-for-service-rate in 1995, but for all dental services combined, and for most specific services, exceeded fee-for-service in 1996 and 1997."

- "For all age groups combined, the fee-for-service # of Recipients per 1000 were relatively flat from 1995 to 1997, while # of Visits per 1000 Eligibility-Months trended downward. The Sealants and Treatment services varied slightly from this pattern."

These findings describe what's happening to utilization of dental services, but don't in and of themselves answer the question about whether there's a problem with access to dental services, or where in the state those problems occur.

Dental Utilization in Minnesota Health Care Programs: County-by-County

The Department's second step was to review utilization data on a county-by-county basis. The analysis was done by breaking MHCP enrollees into three groups: 1) those in managed care, including MinnesotaCare, PMAP, and PGAMC; 2) those in fee-for-service who would be in managed care if PMAP and PGAMC were implemented in their counties, called "managed care look-alikes"; and 3) those in fee-for-service who would be excluded from managed care if PMAP and PGAMC were implemented in their counties, called "non-managed care cohort".[29] The final data for the non-managed care cohort were not available at the time of finalizing this report, but will be reported in an Addendum. This grouping allows for an "apples to apples" comparison of the managed care group and the managed care look-alike group. The Department also speculated that utilization might be different, and worse for the non-managed care cohort, due to more difficult dental problems, a more difficult time communicating their dental concerns or problems

[29] Minnesota Rules Part 9500.1452, Subp. 2.

complying with dental care recommendations, as well as transportation issues. The data were mapped on a county-by-county basis.

Managed Care Utilization:

The first map, *Map 1: Dental Service Provision in Public Health Care Programs 1997: Managed Care Utilization Rates, All Services, All Ages,* shows the percent of eligibles of all ages enrolled in managed care, who received any dental service in 1997, broken into the county of residence of the enrollee. If utilization is computed for specific dental services (Diagnosis, Prevention, DSL, DTX) or age groups (Children, Adults 21-64, Adults 65+) we get slightly different results, but not significant enough to warrant reporting them separately. The map groups every ten percentage points together.

At first glance it appears that Itasca Medical Care has among the worst dental utilization rate for its managed care enrollees, however approximately 75% of the dental claims submitted by Itasca Medical Care were rejected because they did not pass state edits, and rejected claims are excluded from the computation. It is not possible to determine a credible dental utilization rate for Itasca County managed care.

It must be noted that 1997 was a transition year for PMAP/PGAMC in Becker, Clay, Faribault, Isanti, Kandiyohi, Martin, Mahnomen, Norman, Swift, and Wright counties, so using this measure of the percentage of eligibles who received a dental service may not be an accurate indication of dental utilization in those counties

Based on these dental utilization figures for managed care, it appears that there is a dental access problem in Becker, Clay, Mahnomen, Norman, and Polk counties; however, of those five counties all but Polk County were in transition to managed care, so those four counties need to be looked at using a different method. The next lowest dental utilization group of counties includes Cook, Faribault, Isanti, Kandiyohi, Martin, Red Lake, Stearns, and Swift. Of this group all but Stearns and Cook Counties were in transition to managed care, so those six counties need to be looked at using a different method.

It appears from this first map that utilization in managed care, measured as the percent of eligibles who received any dental service, is best in Lac Qui Parle, Pope and Traverse Counties, all of which have only MinnesotaCare managed care enrollment. The next best group of counties is quite large, but with the exception of Scott County, consists of counties which have only MinnesotaCare managed care enrollment.

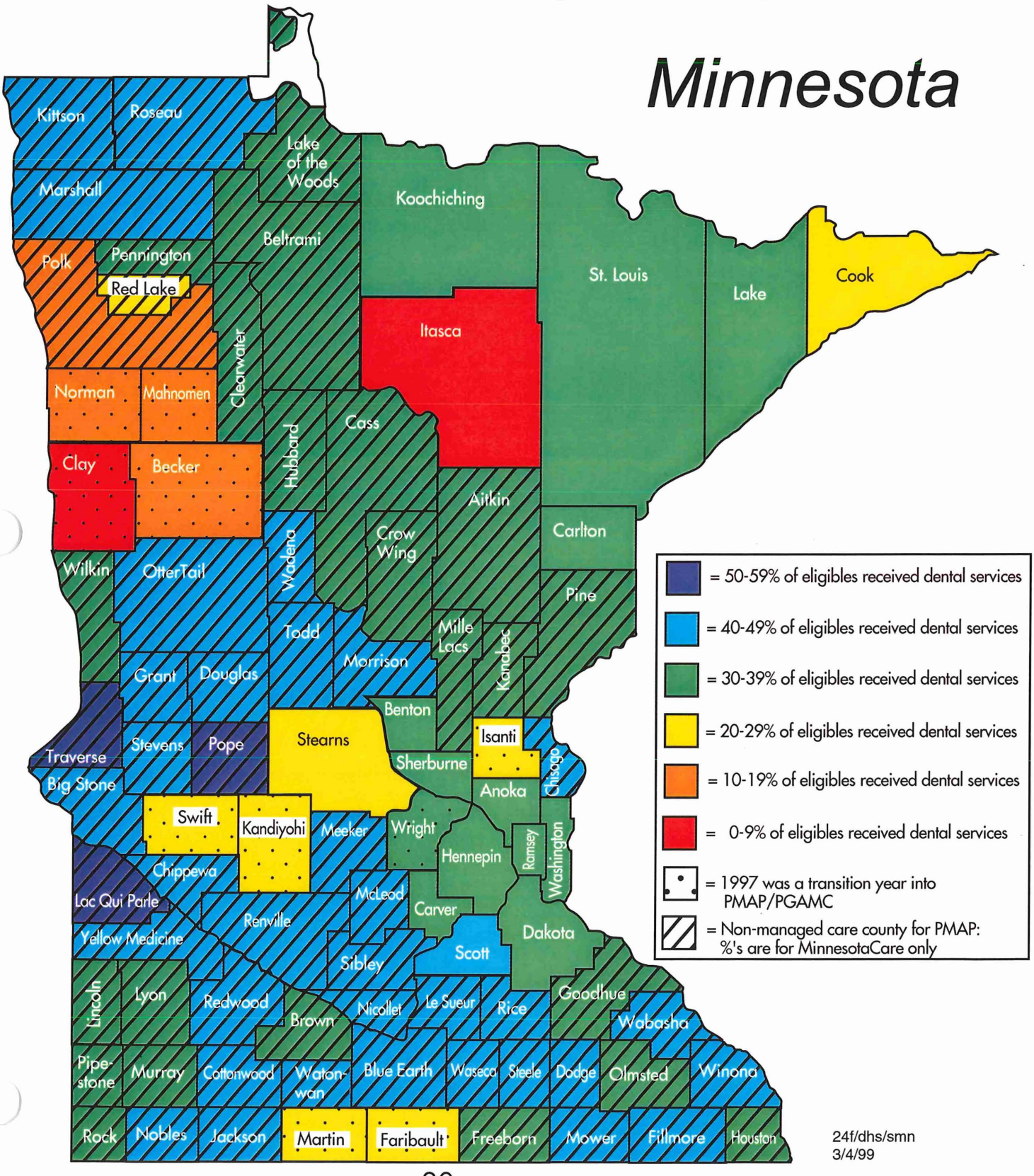
The entire Metropolitan area of counties is part of the median group of counties, as far as percent of eligibles who receive a dental service, in the 30-39% range. The seven county metro area has been in managed care the longest, the last of these counties to enter into managed care was in September of 1994.

MAP 1

Dental Service Provision in Public Health Care Programs 1997

Managed Care Utilization Rates

All Services, All Ages, Percent of Eligibles Receiving Dental Services



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Because of the problems with percent of eligibles data when counties are in transition between fee-for-service and managed care, examination was also made of the number of recipients per 1,000 eligibility months who received any dental service. This rate takes into account the number of months each person was actually eligible for the system in which he/she is receiving care. Thus, a person who was in fee-for-service for five months and in managed care for seven months would be counted as five months in one program and seven months in the other, respectively. This rate takes into consideration persons who are eligible for a partial year.

The second map, *Map 2: Dental Service Provision in Public Health Care Programs 1997: Managed Care Utilization Rates: All Services, All Ages,* portrays the of number of recipients per 1,000 eligibility months who received any dental service on a county-by-county basis.

Of the ten counties transitioning into managed care in 1997, seven show a significant improvement in dental utilization. Faribault, Isanti, Kandiyohi, Martin, Swift, and Wright Counties all moved into the above average ranges. Becker moved into the just below average range. Clay, Mahnomen and Norman remained in the below average range.

The lowest dental utilization in managed care still appears to be in Clay, Mahnomen and Norman Counties, with Becker, Red Lake, and Polk Counties also lagging behind.

It appears from this second map that dental utilization in managed care, measured as the number of recipients per 1,000 eligibility months is best in Big Stone, Blue Earth, Cottonwood, Chippewa, Douglas, Kandiyohi, Kittson, Lac Qui Parle, Le Sueur, McLeod, Nicollet, Pope, Renville, Scott, Sibley, Steele, Stevens, Swift, Traverse, Wabasha, Waseca, and Winona Counties, all but one of which, Scott County, have only MinnesotaCare managed care enrollment.

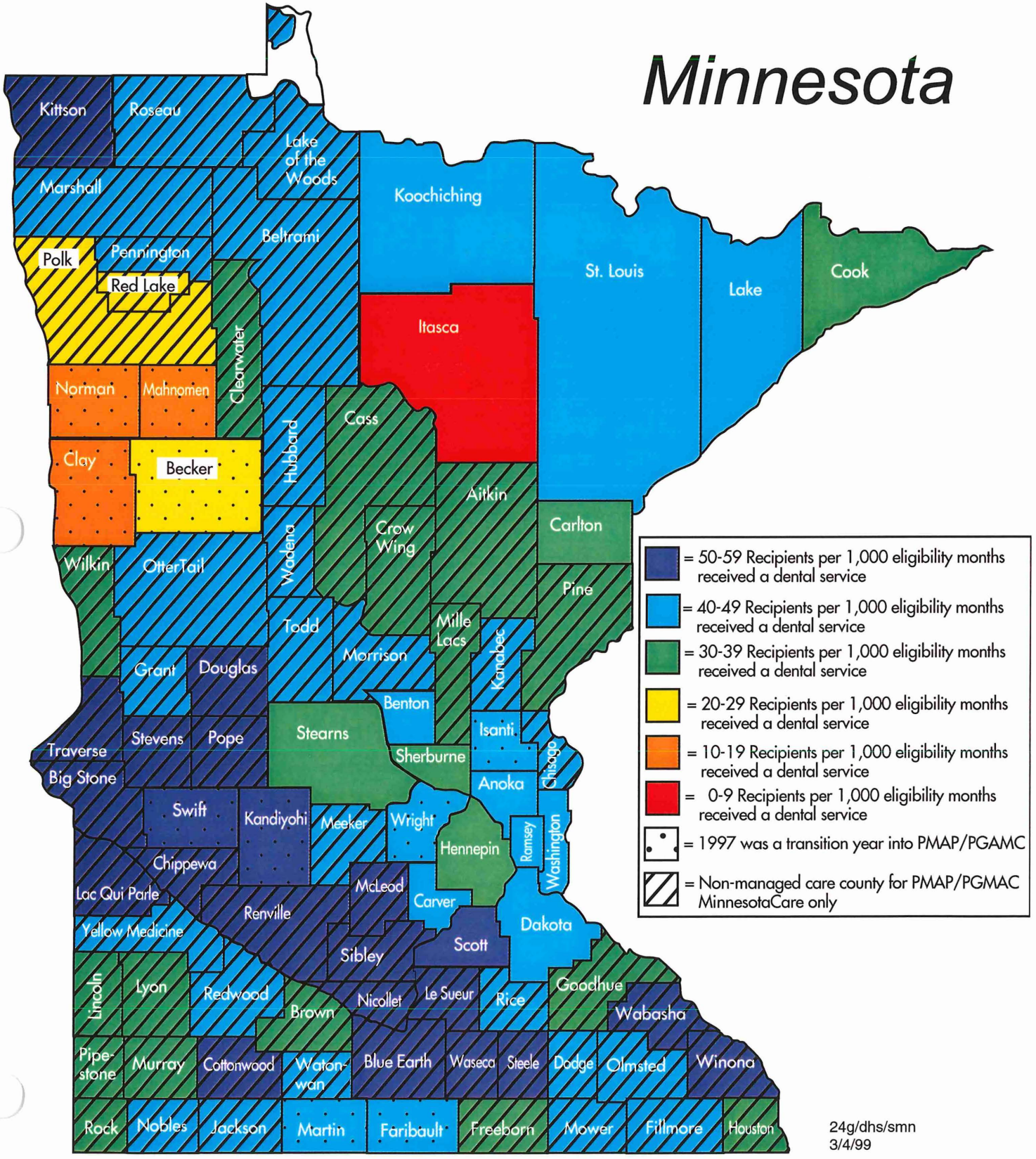
Dental utilization for managed care enrollees in the metropolitan area appears better than using the percent of eligibles utilization measure, with the exception of Hennepin County, which remained in the median range.

MAP 2

Dental Service Provision in Public Health Care Programs 1997

Managed Care Utilization Rates

All Services, All Ages, Recipients Per 1,000 Eligibility Months



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Dental Utilization in Fee-for-Service: Managed Care Look-Alikes

Map 3, Dental Service Provision in Public Health Care Programs 1997, Fee For Service (Managed Care Look-Alikes) Utilization Rates, All Services, All Ages, displays the percent of eligibles in fee-for-service who received any dental service in 1997 among those persons who would be in managed care if PMAP/PGAMC were established in their counties.

For those ten counties for which 1997 was a transition year into managed care: Becker, Clay, Faribault, Isanti, Kandiyohi, Mahnomen, Martin, Norman, Swift, and Wright Counties, this measure of dental utilization is problematic.

For the counties which were managed care counties: Anoka, Benton, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, Sherburne, Stearns, and Washington, the dental utilization rates look particularly poor. However, it must be noted that these measures are looking only at those people who would be eligible for managed care. Therefore, in a managed care county, this group would include those eligibles who have not yet chosen a health plan and are on fee-for-service on a very temporary basis, or for some other eligibility reason have moved back into fee-for-service for a temporary period. Given the reasons these people are on fee-for-service and the temporary nature of their stay in that group, one would not expect them to be accessing dental care to a great extent. On the other hand, the Department still hears complaints about lack of access to dental care from counties which are managed care counties. Part of these concerns could be difficulty finding fee-for-service dentists willing to serve these groups.

Dental utilization in fee-for-service/managed care look-alikes appears to be lowest in Hennepin County, measured as the percent of eligibles receiving dental services. The next lowest utilization is found in Anoka, Benton, Carlton, Carver, Clay, Cook, Dakota, Itasca, Koochiching, Lake, Mahnomen, Ramsey, St. Louis, Sherburne, Stearns, Washington, and Wilkin Counties. However, for the reasons cited above, the numbers for all but Wilkin County would need closer evaluation. Wilkin County does appear to have a significant access problem for its fee-for-service enrollees of MHCP.

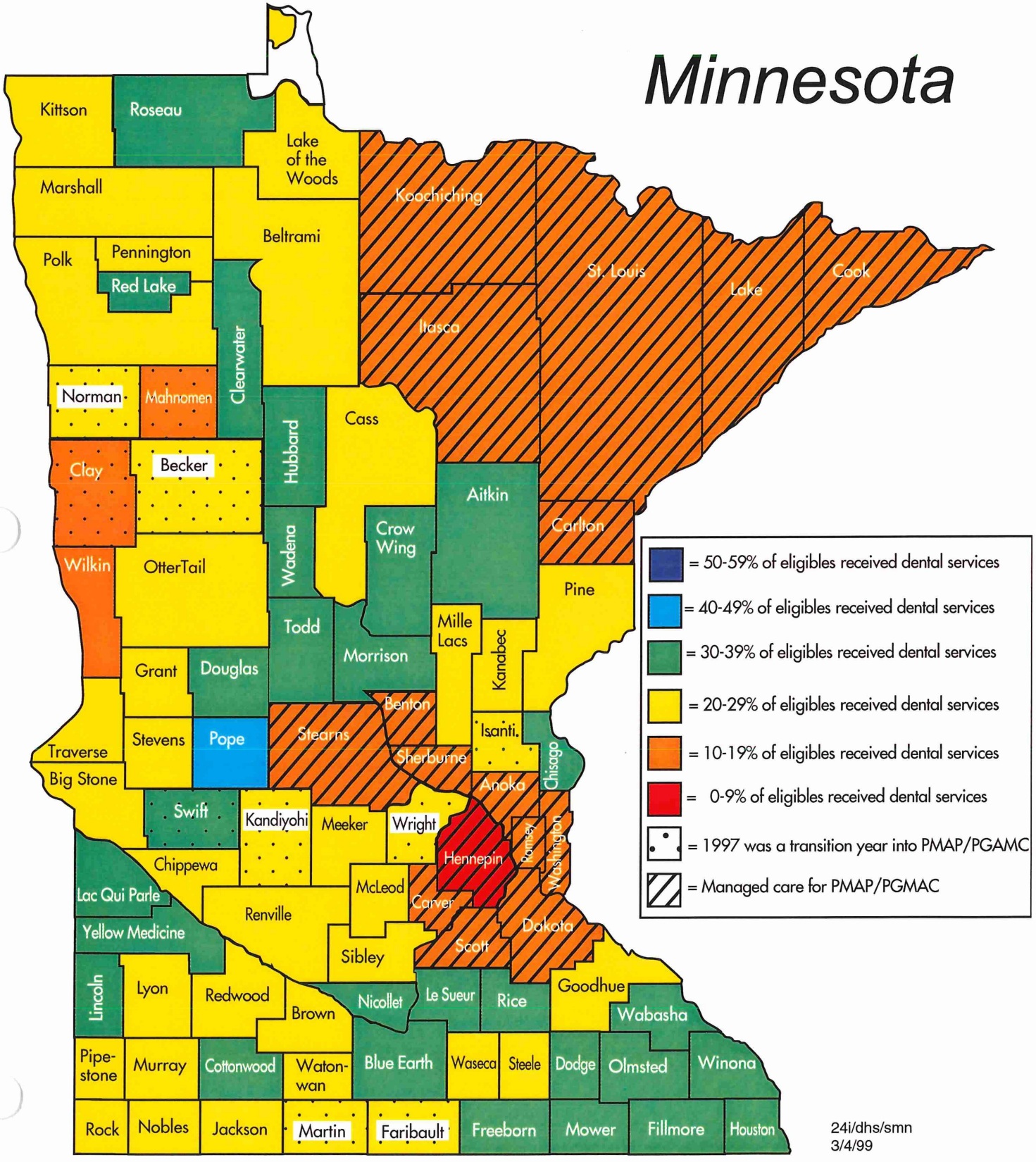
Dental utilization in fee-for-service/managed care look-alikes appears to be highest in Pope County, measured as the percent of eligibles receiving dental services.

MAP 3

Dental Service Provision in Public Health Care Programs 1997

Fee-For-Service (Managed Care Look-Alikes) Utilization Rates

All Services, All Ages, Percent of Eligibles Receiving Dental Services



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Map 4: Dental Service Provision in Public Health Care Programs 1997: Fee For Service (Managed Care Look-Alikes), All Services, All Programs, displays the Number of Recipients per 1,000 eligibility months for managed care look-alikes in fee-for-service in 1997. This measurement of utilization takes into consideration the low number of months in counties that are transitioning to managed care.

Among the ten counties that are in transition to managed care in 1997, this dental utilization analysis shows significant improvement from the percent of eligibles utilization measure in Becker, Faribault, Isanti, Kandiyohi, Martin, Norman and Wright Counties. Swift County was already at a median level of utilization, but moved to above average utilization. Clay and Mahnomen Counties continue to show less dental utilization than other counties using this measure.

There is less dental utilization in Beltrami, Carver, Carlton, Cook, Hennepin, Mille Lacs, Pipestone, Rock and Wilkin Counties. In Carlton, Carver, Cook and Hennepin Counties, PMAP/PGAMC is already in place, so the persons in this eligibility group would include those eligibles who have not yet chosen a health plan and are on fee-for-service on a very temporary basis, or for some other eligibility reason have moved back into fee-for-service for a temporary period. Given the reasons these people are on fee-for-service, and the temporary nature of their stay in that group, one would not expect them to be accessing dental care to a great extent. Beltrami, Mille Lacs, Pipestone, Rock and Wilkin

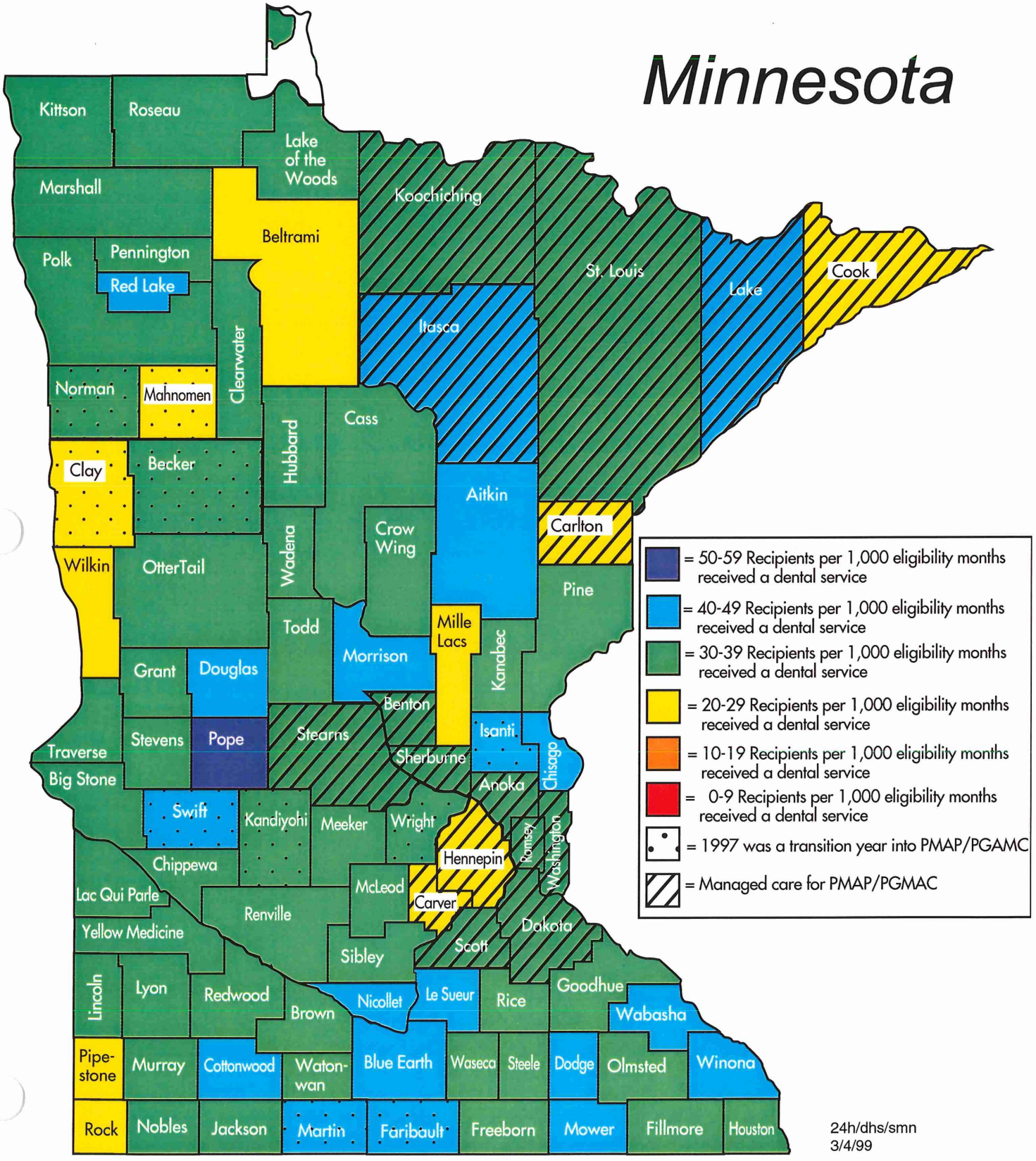
Dental utilization appears to be highest in Pope County.

MAP 4

Dental Service Provision in Public Health Care Programs 1997

Fee-For-Service (Managed Care Look-Alikes) Utilization Rates

All Services, All Ages, Recipients Per 1,000 Eligibility Months



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Active Dentists Enrolled in MHCP Fee-for-Service

The third step the Department took was to look at human resources distribution, at least as far as dentists in fee-for-service are concerned. The Department did not make a similar comparison for dentists in the managed care program, as not all data are available at this time.

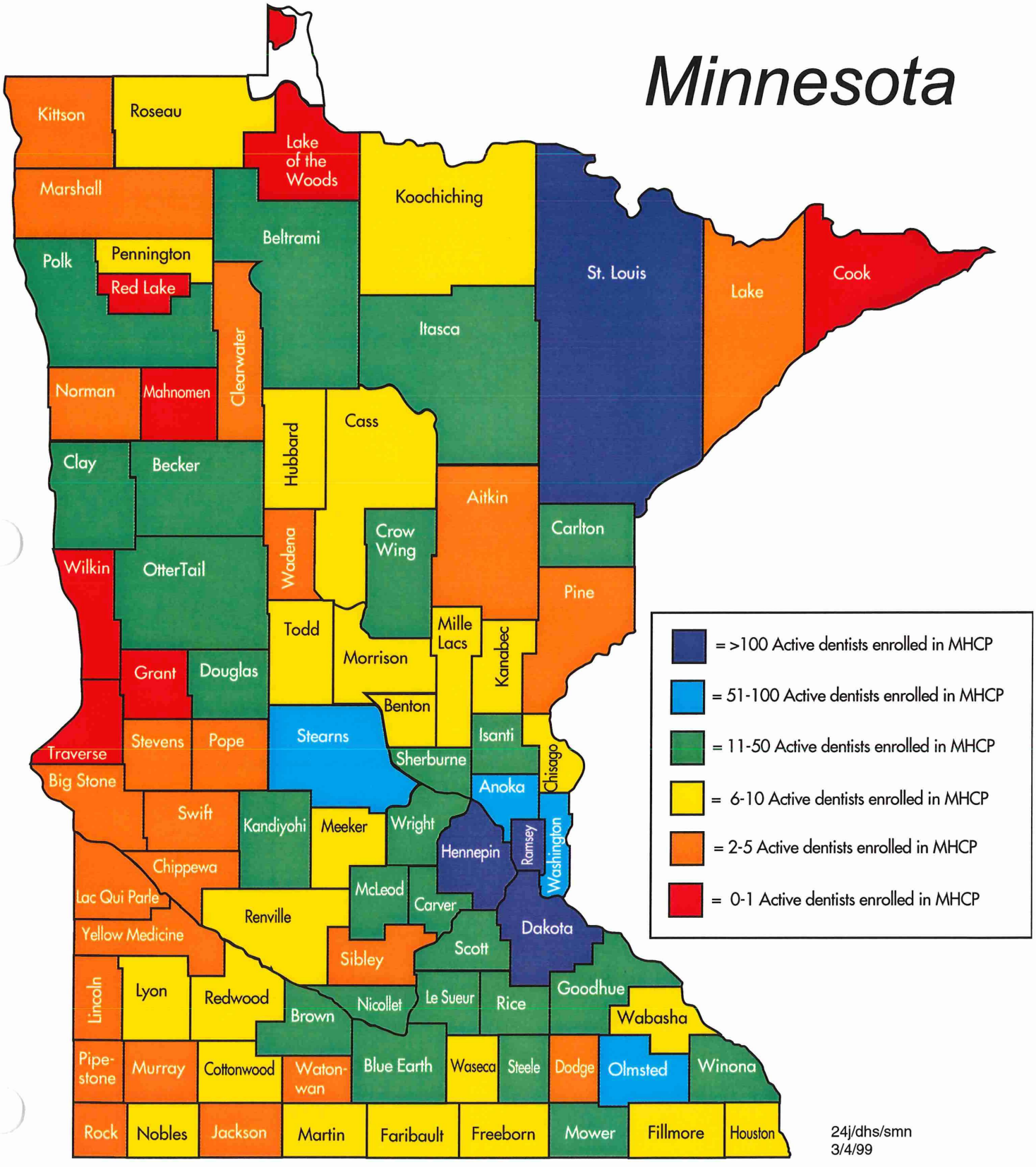
This study pulled the number of enrolled dentists, on a county-by-county basis, who had received any payment for MHCP enrollees during FY 98. *Map 5: Active Dentists Enrolled in MHCP Fee-For-Service FY 1998* shows the results.

Grant County had no active enrolled dentists in the fee-for-service program. Cook, Grant, Lake of the Woods, Mahnomen, Red Lake, Traverse and Wilkin Counties only had one active dentist enrolled in the fee-for-service program. However, low numbers of dentists in a county may or may not be problematic, depending on the enrollment in the county, and the percentage of those eligibles each dentist is willing to serve. See the discussion in *Issues in Measuring Access*, above.

The next step was to look further at the ratio of dentists to recipients. The chart in Appendix A, Table 2, shows these ratios. This is not a true reflection of all of the patients a dentist would serve in a county, as looked at earlier, this ratio only shows the relationship between the potential number of MHCP fee-for-service recipients per dentist.

Of the counties which had 0-1 dentists enrolled, problems in Cook County are mitigated by the fact that the ratio of enrolled dentists to eligibles is 1:85, lower than the statewide average ratio of 1 dentist for every 94 enrollees. The other seven counties with zero or one dentist have high ratios of eligibles to dentists. Other counties with high ratios include: Pine, Cass, Wadena, Aitkin, Beltrami, Marshall, and Red Lake, all with ratios at least 4 times higher than average.

MAP 5
Active Dentists Enrolled in MHCP Fee-For-Service FY 1998



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Areas of Minnesota Experiencing a Significant Dental Access Problem for MHCP Enrollees

While dental utilization for MHCP enrollees is below national norms in all areas of the state, there are areas with worse problems than others. According to utilization data reviewed by the Department, the Counties of Beltrami, Clay, Mahnomen, Mille Lacs, Pipestone, Rock and Wilkin have the lowest utilization in the state in fee-for-service for the managed care look-alike population. Becker, Clay, Mahnomen, Norman, Polk and Red Lake have the lowest utilization for their managed care enrollees. Within the seven county Metro area, Hennepin County has the lowest dental utilization, with Ramsey County's utilization only slightly higher. This is true for the managed care population and for the fee-for-service managed care look-alike population.

Grant County does not have any dentist who was actively enrolled as a dental provider for MHCP fee-for-service enrollees during FY 98; Cook, Lake of the Woods, Mahnomen, Red Lake, Traverse and Wilkin Counties have only one dentist who was actively enrolled. Not only do those counties have few dentists, the ratio of eligibles to dentists is four times higher than the average in other counties.

Anecdotally, the Department still hears many complaints from St. Louis County, where the high utilization in their metro area may mask low utilization in the range area; and from Washington and Crow Wing Counties, where analysis of utilization data does not give an appearance of lower utilization than their neighboring counties.

Utilization data is useful for assessing access to dental care, as it quantifies the services that have actually been delivered to a given population. However, utilization alone is not a proxy for access. In using utilization data, an understanding of what it represents and its limitations is crucial. The following considerations are important in interpreting the utilization maps.

The maps show utilization of dental services by the MHCP enrollees in each county. They do not show where the care was accessed. The map indicates that utilization by Olmsted County residents is of the same level of many other counties in that part of the state. However, county officials have told DHS that very few dentists in Rochester will accept MHCP enrollees, so enrollees are forced to travel to neighboring counties. DHS recently received a call from a dentist in Goodhue County complaining about the MHCP enrollees from Rochester who have approached him for care; the dentist feels he is "doing his share" by seeing MHCP enrollees from his own community and resents feeling pressured to see people from Rochester because dentists in that community refuse to do so.

The map also shows utilization in Cook County to be similar to that of its neighbors. In fact, there is but one dental clinic in the county: many county residents, both MHCP enrollees and not, must travel to Two Harbors (a 75-100+ mile one way trip) or Duluth (a 95-100+ mile one way trip) to obtain dental care. In many other counties, disabled MHCP enrollees face a similar dilemma. Because local dentists are not willing or able to see people with behavioral problems,

the enrollees must be transported out of the community. One county human services director in the northwestern part of the state described four-hour, one-way trips to a state Regional Treatment Center as common for group home residents in his county.

Unique geographic and demographic features may also mask access problems. On the map, St. Louis County MHCP enrollees appear to have similar utilization rates to those of neighboring counties. However, as described elsewhere in this report, county officials report a severe access problem on the Iron Range, in the northern part of the county. Approximately half of the county's population lives on the Iron Range, while the remainder lives in the Duluth area, where there is not a reported access problem. Because data for the map was available only at the county level, the higher utilization rate among enrollees in the southern area of the county minimizes the lower rate in the northern area.

Possible Solutions for expanding access

These suggestions were gleaned from the Department's meeting with the Minnesota Dental Association, the Minnesota Association for Community Dentistry, the Minnesota Dental Hygienists Association, the Red River Region Community Dental Care Access Meeting, and suggestions from individual dentists and other stakeholders, as well as ideas gleaned from a national literature search.

Overall dental payment increases.

A statement that the Department hears often from dentists is that the MHCP dental reimbursements are too low to cover the dentist's overhead for the services, and that a dentist loses money every time they treat an MHCP enrollee. A national report on the dental coverage in Medicaid and other state programs[30] stated that "Little is known about the impact of raising reimbursements to dentists on access and utilization. Evidence suggests that raising fees sufficiently is a necessary but not sufficient condition for access and utilization adjustments."[31] An report by Dr. Edelstein cited the example of California, which raised Medicaid payments to 80% of usual and customary charges: accessibility went up sharply, but utilization only went up marginally.[32] In other words, reimbursements for dental fees must be increased in order to increase access, but reimbursement increases will not necessarily, in and of themselves, increase access--it's part of the solution, but not the only solution.

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[30] Edelstein, B., *Public Financing of Dental Coverage for Children: Medicaid, Medicaid Managed Care and State Programs,* Children's Dental Health Project, November 1997.

[31] *Ibid.*, at 2.

[32] *Ibid.*, at 10.

Incentives for dentists to serve public program clients

1. Disproportionate share adjustment for dental services. These additional reimbursements will target higher payments to dentists and community dental clinics who serve high proportions of public program patients, providing the resources needed to expand care.

   Payment issues in public programs represent the most significant factor. In fact, some community dental clinics may be incapable of sustaining their efforts without significant funding increases in the near future.

   A disproportionate share approach would lend support to community clinics which are serving a high proportion of public program recipients. It will enable them to expand and provide care for larger numbers of the underserved and encourage those providers who serve significant numbers of public program patients to serve more.

2. BBA Approach for reimbursement of FQHCs and RHCs: Currently, reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are paid on a cost-based reimbursement system, which ends in Minnesota on January 1, 2000. Under the BBA, states without an 1115 waiver were required to phase-out cost-based reimbursement over a six year period. The Department proposes to match the federal phase-out timeline, gradually phasing out cost-based reimbursement through September 2003. This would allow FQHCs and RHCs to continue serving the dental patients they currently have and would help to prevent additional declines in utilization.

3. Enhanced payment for improved access: The number of public program patients seen per dentist has fallen over the past several years, and past rate increases have failed to result in increased utilization. To encourage providers to add new public program patients to their practices, the Department proposes to fund two pilot programs in areas where clients are underserved by dentists and allow the commissioner to increase rates if the percentage of public program recipients with at least 1 dental visit per year increases.

4. Missed visit reduction pilot. Many dentists choose not to serve Medicaid enrollees because they find that Medicaid enrollees are more likely to break appointments or not show up. Because of the way dentists schedule patients, it is more of a problem for them than for other professionals.[33] For example, primary care clinics routinely have a walk-in business of persons who need immediate care, and who

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[33] Brown, J., *Children's Dental Services Under Medicaid: Access and Utilization,* Department of Health and Human Services Office of Inspector General, April 1996 at 7.

fill up any slots left by cancellations or no-shows. No-shows in dental clinics much more frequently result in lost revenue to dentists.

Medicaid families have competing family priorities and many are unaware of the importance of good oral health.[34]

Funding could be used to develop outreach to public program recipients for things like postcard reminders for families without a telephone; coordination of programs; health promotion educational materials in various languages; and school-based K-12 and Head Start dental programs.

5. Preventive Services for children. Children's oral health has dramatically improved in the 20th century, however, "dental caries remains the single most common chronic disease of childhood, affecting more than half of all children by second grade."[35] The difference is that dental concerns have shifted from affecting all children to affecting children in low-income families.[36] In a national June 1998 report written about dental services for children, Medicaid statistics for dental services to children were compared state by state.[37] Minnesota's average cost per child for FY 95 was $132.00, well below the average of $151.00 per child. That report concluded: "Even after adjusting expenditures for deeply discounted payments to dentists, the average payment expended for each child who utilizes dental treatment is too low to provide comprehensive dental care to those children who access care."[38]

   Tooth sealants and fluoride treatments can improve the long-term oral health of children. The Department proposes to encourage providers to provide these basic services by increasing rates paid for preventive services to 80% of median 1997 charges.

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[34] *Ibid.*, at 8.

[35] Edelstein, B., *Public Financing of Dental Coverage for Children: Medicaid, Medicaid Managed Care and State Programs,* Children's Dental Health Project, November 1997, at 5.

[36] *Ibid.,* at 5.

[37] Edelstein, B., and Bendor, D., *Medicaid Pediatric Dental Utilization and Expenditure Data: From the American Academy of Pediatrics Medicaid State Reports -- FY 1995*, Children's Dental Health Project, June 1998

[38] *Ibid.,* at 3

6. Pilot Project for community clinics: In underserved areas of the state, where the number of dental providers is sufficient only to meet the needs of the commercial and private payment population, the Department proposes to provide funding for: coordinating access for enrollees, establishing new or upgrading existing facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in that region, on a pilot basis.

   Community clinic pilot projects would stimulate the development and expansion of innovative outreach programs, prevention and education programs, and collaborations with social service and local health agencies. Many public program patients' needs are not compatible with the predominant dental practice model. Taking these patients' needs into account has allowed community dental clinics to improve that compatibility. Some pilot projects which could be developed include:

   a. Development of dental outreach programs for medically and behaviorally complex patients and other targeted high needs populations: including medical consults, interpretive services, cultural sensitivity, involvement of legal guardians, and extended appointment times.

   b. Development of meaningful assessment systems and performance goals.

   c. Establishment of prevention and educational programs, targeting at-risk populations. Early intervention can reduce costly restorative and rehabilitative dental care and promote better health.

   d. Development of dental internships for underserved populations and incentives for establishing dental practices in community clinics, rural regions, and other underserved areas.

7. Direct access to dental hygienists. In Minnesota it is illegal for a hygienist to treat a patient, even routine cleaning work, without a dentist's supervision. Several states have allowed hygienists to see patients on their own, some of them restricted to public programs patients or to underserved areas. [39] The purpose is to provide specific preventive services to those individuals who are excluded, either by disability, age, income, or location, from the present dental delivery system. Referral to dentists would occur for any services beyond preventive care hygienists can already perform under supervision.

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[39] Perlman, E. Governing, December 1998 Volume 12, number 3, page 30

8. Minnesota Loan Repayment Programs. Currently dentists and dental hygienists can qualify for the Federal National Health Service Corps (NHSC) loan repayment program. Dentists be added to the professionals who qualify for the Minnesota NHSC State Loan Repayment Program (SLRP) and hygienists could be added to professionals who qualify for the Rural Midlevel Loan Forgiveness Program. The purpose of these programs is to provide loan repayments to health care professionals who agree to practice in medically underserved areas of the State. Loan repayment services both health care professionals and communities in need of health care providers. Providers must practice at an approved site within a rural or urban federally designated Health Profession Shortage Area (HPSA). Participants practice a minimum of two years at an approved site and may request one or two year extensions, with a maximum of four years total. Currently physicians are eligible for loan repayment of up to $20,000 per year and professionals in the rural mid level practitioner program are eligible for loan repayments of up to $3,5000 per year.

9. Simplify administration of public programs. Identified concerns from dentists include: inaccurate and time-consuming eligibility verification processes; inability to bill for some of all of the value of multiple-appointment services (prosthodontics, orthodontics, etc.) already provided when a previously eligible patient becomes ineligible; non-standard claim forms; burdensome and non-standard prior authorization processes among various health plans, and slow payments. In addition, health plans frequently do not pay for all DHS fee-for-service reimbursable services.

   Recommendations from dentists include:

   Require that all health plans meet or exceed the DHS fee-for-service guidelines for prior authorization, set of covered dental services, and timeliness of payment of claims.

   Ensure payment for dental services which require extended time frames to complete if the health plan switches health plans or leaves public programs.

   Establish an electronic card payment/verification system

   Improve eligibility verification system or establish a central clearinghouse for program eligibility

   Establish a minimum of one year-long enrollment periods for dental care.

   Eliminate some of all prior authorizations for select providers.

10. Establish a "Dental Access Task Force". This task force would include all key dental and community stakeholders in a cooperative effort to provide ongoing recommendations for administrative and policy improvements for dental care services in the states' public programs.

    Include members of MDH, DHS to create and carry out. Task force members would be charged with developing solutions to the problems encountered by patients and providers in public dental programs, including funding, administrative, patient, and broad policy issues. Stakeholders would include providers, patient and patient representatives, health plans, social services representatives, county health representatives, public health representatives, and legislators.

11. Dental Externships and preceptorships. Expose dental students to dental care in underserved areas, under affiliation of a local hospital.

12. Co-location of dental clinics in Schools, Head Start, Family Service clinics or mobile van for school sites.

13. State Tax Credits for dentists who agree to serve Medicaid clients. Georgia legislators introduced this proposal in 1995, which would have given a credit of $50 against State income taxes due from physicians or dentists for each indigent patient treated in a public clinic and from whom no compensation is received. Providers could carry forward unused credits.[40]

14. "Share the Care" voluntary effort by dentists. Several states and counties have started programs whereby dentists agree to take one to three new Medicaid cases yearly or quarterly. County EPSDT staff refer the patients and track to ensure no dentist gets more than the agreed upon number of patients. County staff also work to educate the patients about the need for dental care, schedule appointments and arrange for any necessary transportation. North Dakota adds public recognition of dentists who participate, by giving them "exemplary service" awards.[41]

15. Provider Training Programs. The State of Iowa has undertaken a program through the University of Iowa, collaborating with their Medicaid program and their dental public health program, to train dentists about pediatric dental issues, including

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[40] *Children's Dental Services Under Medicaid, Ibid.,* at 9 and B-7.

[41] *Children's Dental Services Under Medicaid, Ibid.,* at 12, B-11.

establishing panels of dentists who are willing to treat very young or disabled children.[42]

Recommendations

An increase in the general fund budget of $4,272,000 in F.Y. 2000 and $4,827,000 in F.Y. 2001, and an increase in the Health Care Access Fund budget of $1,849,000 in F.Y. 2000 and $2,545,000 in F.Y. 2001 to maintain and increase access to dental services for enrollees in Minnesota's public health care programs through overall dental payment increases and dental incentive payments, as follows:

Overall Payment Increases:

A one-time 5% increase for payment rates in dental services to bring dental payments closer to market rates.

Incentive Payment Proposals:

1. Disproportionate Share Payment: The department proposes to increase payments by 20% over 1998 fee-for-service rates for those fee-for-service providers for whom public programs (MA, GAMC, and MinnesotaCare) account for more than 20% of their practices.

2. Balanced Budget Act (BBA) approach for reimbursement of FQHCs and RHCs: Currently, reimbursement for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are paid on a cost-based reimbursement system, which ends in Minnesota on January 1, 2000. Under the BBA, states without an 1115 waiver were required to phase-out cost-based reimbursement over a six year period. The Department proposes to match the federal phase-out timeline, gradually phasing out cost-based reimbursement through September 2003. This would allow FQHCs and RHCs to continue serving the dental patients they currently have and would help to prevent additional declines in utilization.

3. Enhanced payment for improved access: The number of public program patients seen per dentist has fallen over the past several years, and past rate increases have failed to result in increased utilization. To encourage providers to add new public program patients to their practices, the department proposes to fund two pilot programs in areas where clients are underserved by dentists and allow the commissioner to increase rates if the percentage of public program recipients with at least 1 dental visit per year increases.

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[42] *Ibid.*, at B-12.

4. Preventive Services for Children: Tooth sealants and fluoride treatments can improve the long-term oral health of children. The department proposes to encourage providers to provide these basic services by increasing rates paid for preventive services to 80% of median 1997 charges.

5. Pilot project for community clinics: In two underserved areas of the state, where the number of dental providers is sufficient only to meet the needs of the commercial and private payment population, the department proposes to provide funding for start-up costs for community clinics, on a pilot basis.

6. Direct access to dental hygienists: The department proposes to allow medical assistance payments to dental hygienists when they are able to provide preventive services to clients in underserved areas.

7. Administrative Simplification. The Department intends to constitute a rule committee to review the rules regarding dental prior authorization requirements and dental services covered (Rule 47) with the intent to bring the rules up to date with dental community standards.

Appendix

Table 1: CY97 Comparison of managed care utilization rates to ffs utilization rates, by county

(1) Programs included are MA, GAMC, MnCare.
(2) FFS figures are based on a sample selected for comparison with PPHP, which excludes persons not meeting PPHP eligibility criteria.
(3) County is eligible person's county of residence.
(4) Plans not reporting claims for services provided are excluded from computations.

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
061	All	FFS	0-20	590	5144	248	42.0	48.2
001	All	FFS	0-20	1244	10988	513	41.2	46.7
085	All	FFS	0-20	2148	18530	834	38.8	45.0
017	All	FFS	0-20	753	6450	287	38.1	44.5
050	All	FFS	0-20	2562	21710	950	37.1	43.8
007	All	FFS	0-20	2566	21729	946	36.9	43.5
023	All	FFS	0-20	1009	8718	368	36.5	42.2
049	All	FFS	0-20	2032	17886	729	35.9	40.8
028	All	FFS	0-20	791	6895	282	35.7	40.9
063	All	FFS	0-20	273	2344	97	35.5	41.4
021	All	FFS	0-20	1544	12773	547	35.4	42.8
077	All	FFS	0-20	1680	14897	583	34.7	39.1
018	All	FFS	0-20	3712	31797	1268	34.2	39.9
029	All	FFS	0-20	1292	10688	438	33.9	41.0
039	All	FFS	0-20	196	1562	65	33.2	41.6
051	All	FFS	0-20	354	2829	117	33.1	41.4
015	All	FFS	0-20	830	7155	274	33.0	38.3
037	All	FFS	0-20	429	3634	139	32.4	38.2
033	All	FFS	0-20	1127	9309	361	32.0	38.8
080	All	FFS	0-20	1185	10062	378	31.9	37.6
052	All	FFS	0-20	1105	8949	351	31.8	39.2
040	All	FFS	0-20	1255	9548	397	31.6	41.6
079	All	FFS	0-20	849	6763	265	31.2	39.2
055	All	FFS	0-20	5909	50036	1843	31.2	36.8
056	All	FFS	0-20	3150	25441	982	31.2	38.6
087	All	FFS	0-20	621	4673	193	31.1	41.3
013	All	FFS	0-20	1785	14349	548	30.7	38.2
076	All	FFS	0-20	694	5084	211	30.4	41.5
041	All	FFS	0-20	316	2606	96	30.4	36.8
020	All	FFS	0-20	822	6368	248	30.2	38.9
032	All	FFS	0-20	570	4517	171	30.0	37.9
081	All	FFS	0-20	970	7627	288	29.7	37.8
024	All	FFS	0-20	2006	16389	595	29.7	36.3
066	All	FFS	0-20	2412	19354	705	29.2	36.4
074	All	FFS	0-20	1754	14039	509	29.0	36.3
068	All	FFS	0-20	665	5002	192	28.9	38.4
003	All	FFS	0-20	2630	21374	737	28.0	34.5
011	All	FFS	0-20	2618	22737	730	27.9	32.1
008	All	FFS	0-20	1176	9285	323	27.5	34.8
006	All	FFS	0-20	344	2795	94	27.3	33.6
026	All	FFS	0-20	394	3339	107	27.2	32.0
034	All	FFS	0-20	3420	24335	926	27.1	38.1
075	All	FFS	0-20	344	2597	93	27.0	35.8
035	All	FFS	0-20	275	2118	73	26.5	34.5
047	All	FFS	0-20	1113	8791	295	26.5	33.6
030	All	FFS	0-20	1536	10284	404	26.3	39.3
057	All	FFS	0-20	936	7452	243	26.0	32.6

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
054	All	FFS	0-20	606	4578	157	25.9	34.3
053	All	FFS	0-20	1510	12163	391	25.9	32.1
059	All	FFS	0-20	609	5032	154	25.3	30.6
025	All	FFS	0-20	1508	12143	376	24.9	31.0
058	All	FFS	0-20	1901	15608	465	24.5	29.8
022	All	FFS	0-20	915	5240	223	24.4	42.6
083	All	FFS	0-20	998	7998	242	24.2	30.3
042	All	FFS	0-20	1505	11740	363	24.1	30.9
078	All	FFS	0-20	412	2999	99	24.0	33.0
046	All	FFS	0-20	1465	8168	350	23.9	42.9
012	All	FFS	0-20	891	6404	211	23.7	32.9
060	All	FFS	0-20	3135	23852	739	23.6	31.0
043	All	FFS	0-20	1416	10366	328	23.2	31.6
048	All	FFS	0-20	1573	13308	360	22.9	27.1
072	All	FFS	0-20	854	5671	195	22.8	34.4
064	All	FFS	0-20	872	6843	196	22.5	28.6
004	All	FFS	0-20	5253	48688	1180	22.5	24.2
045	All	FFS	0-20	666	4776	149	22.4	31.2
067	All	FFS	0-20	384	2936	82	21.4	27.9
031	All	FFS	0-20	1716	8571	359	20.9	41.9
086	All	FFS	0-20	3004	16594	619	20.6	37.3
014	All	FFS	0-20	4722	33216	800	16.9	24.1
065	All	FFS	0-20	1540	10093	254	16.5	25.2
044	All	FFS	0-20	747	6381	109	14.6	17.1
073	All	FFS	0-20	2575	9793	344	13.4	35.1
038	All	FFS	0-20	188	545	25	13.3	45.9
071	All	FFS	0-20	1181	4703	149	12.6	31.7
005	All	FFS	0-20	909	3803	114	12.5	30.0
002	All	FFS	0-20	6231	24346	766	12.3	31.5
069	All	FFS	0-20	6823	25593	822	12.0	32.1
084	All	FFS	0-20	632	3816	76	12.0	19.9
082	All	FFS	0-20	2199	8104	252	11.5	31.1
019	All	FFS	0-20	4412	16408	460	10.4	28.0
009	All	FFS	0-20	921	4179	93	10.1	22.3
070	All	FFS	0-20	1059	3933	104	9.8	26.4
010	All	FFS	0-20	720	2633	64	8.9	24.3
062	All	FFS	0-20	16374	56898	1380	8.4	24.3
016	All	FFS	0-20	144	677	12	8.3	17.7
036	All	FFS	0-20	348	935	29	8.3	31.0
027	All	FFS	0-20	29225	102228	1985	6.8	19.4
			0-20 Average				25.4	34.9
007	All	FFS	21-64	1427	10667	595	41.7	55.8
050	All	FFS	21-64	1494	11174	582	39.0	52.1
049	All	FFS	21-64	1066	8397	405	38.0	48.2
020	All	FFS	21-64	392	2725	148	37.8	54.3
001	All	FFS	21-64	814	6235	302	37.1	48.4
021	All	FFS	21-64	854	6106	316	37.0	51.8

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
079	All	FFS	21-64	430	2983	157	36.5	52.6
037	All	FFS	21-64	195	1432	71	36.4	49.6
052	All	FFS	21-64	594	4318	216	36.4	50.0
080	All	FFS	21-64	669	5123	243	36.3	47.4
061	All	FFS	21-64	295	2194	103	34.9	46.9
063	All	FFS	21-64	149	1162	52	34.9	44.8
032	All	FFS	21-64	275	1923	95	34.5	49.4
018	All	FFS	21-64	2108	15437	727	34.5	47.1
013	All	FFS	21-64	908	6479	312	34.4	48.2
024	All	FFS	21-64	1048	7781	357	34.1	45.9
076	All	FFS	21-64	330	2052	112	33.9	54.6
077	All	FFS	21-64	978	7758	330	33.7	42.5
023	All	FFS	21-64	567	4191	191	33.7	45.6
017	All	FFS	21-64	349	2728	117	33.5	42.9
085	All	FFS	21-64	1109	8251	370	33.4	44.8
087	All	FFS	21-64	273	1767	91	33.3	51.5
040	All	FFS	21-64	617	4000	203	32.9	50.8
029	All	FFS	21-64	750	5433	246	32.8	45.3
055	All	FFS	21-64	3598	25911	1165	32.4	45.0
066	All	FFS	21-64	1147	8043	370	32.3	46.0
074	All	FFS	21-64	844	5853	271	32.1	46.3
015	All	FFS	21-64	455	3532	144	31.6	40.8
012	All	FFS	21-64	372	2414	117	31.5	48.5
051	All	FFS	21-64	175	1208	55	31.4	45.5
028	All	FFS	21-64	398	3156	124	31.2	39.3
081	All	FFS	21-64	495	3308	153	30.9	46.3
057	All	FFS	21-64	504	3591	154	30.6	42.9
034	All	FFS	21-64	1590	9845	473	29.7	48.0
026	All	FFS	21-64	211	1541	62	29.4	40.2
041	All	FFS	21-64	160	1168	47	29.4	40.2
047	All	FFS	21-64	497	3322	145	29.2	43.6
056	All	FFS	21-64	1696	11460	493	29.1	43.0
006	All	FFS	21-64	185	1291	53	28.6	41.1
033	All	FFS	21-64	556	4111	159	28.6	38.7
008	All	FFS	21-64	587	3948	167	28.4	42.3
003	All	FFS	21-64	1597	11494	453	28.4	39.4
022	All	FFS	21-64	470	2381	133	28.3	55.9
025	All	FFS	21-64	807	5670	226	28.0	39.9
058	All	FFS	21-64	1052	7626	292	27.8	38.3
053	All	FFS	21-64	696	4910	189	27.2	38.5
083	All	FFS	21-64	361	2555	98	27.1	38.4
030	All	FFS	21-64	840	4927	228	27.1	46.3
068	All	FFS	21-64	277	1750	75	27.1	42.9
054	All	FFS	21-64	305	2003	82	26.9	40.9
035	All	FFS	21-64	132	946	35	26.5	37.0
011	All	FFS	21-64	1441	11059	380	26.4	34.4
048	All	FFS	21-64	889	6689	232	26.1	34.7

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
043	All	FFS	21-64	682	4158	177	26.0	42.6
059	All	FFS	21-64	278	1906	70	25.2	36.7
064	All	FFS	21-64	398	2633	100	25.1	38.0
004	All	FFS	21-64	2917	23869	720	24.7	30.2
075	All	FFS	21-64	203	1285	50	24.6	38.9
042	All	FFS	21-64	687	4543	169	24.6	37.2
046	All	FFS	21-64	787	3847	193	24.5	50.2
039	All	FFS	21-64	103	639	25	24.3	39.1
067	All	FFS	21-64	162	1102	38	23.5	34.5
045	All	FFS	21-64	316	1986	70	22.2	35.2
072	All	FFS	21-64	362	2166	80	22.1	36.9
014	All	FFS	21-64	2751	17309	606	22.0	35.0
078	All	FFS	21-64	208	1441	45	21.6	31.2
086	All	FFS	21-64	1549	7094	335	21.6	47.2
065	All	FFS	21-64	627	3326	130	20.7	39.1
060	All	FFS	21-64	1886	12706	378	20.0	29.7
044	All	FFS	21-64	376	2882	74	19.7	25.7
084	All	FFS	21-64	279	1498	47	16.8	31.4
031	All	FFS	21-64	1136	4299	188	16.5	43.7
073	All	FFS	21-64	1840	6050	275	14.9	45.5
069	All	FFS	21-64	5637	18253	830	14.7	45.5
002	All	FFS	21-64	3970	11819	551	13.9	46.6
082	All	FFS	21-64	1210	3863	167	13.8	43.2
009	All	FFS	21-64	682	2372	89	13.0	37.5
070	All	FFS	21-64	587	1860	76	12.9	40.9
071	All	FFS	21-64	660	2167	82	12.4	37.8
005	All	FFS	21-64	641	2224	74	11.5	33.3
019	All	FFS	21-64	2824	8437	326	11.5	38.6
027	All	FFS	21-64	22854	71623	2476	10.8	34.6
036	All	FFS	21-64	287	649	30	10.5	46.2
062	All	FFS	21-64	10287	30628	1074	10.4	35.1
016	All	FFS	21-64	118	410	12	10.2	29.3
010	All	FFS	21-64	425	1228	42	9.9	34.2
038	All	FFS	21-64	122	309	11	9.0	35.6
			21-64 Average				26.4	42.3
061	All	FFS	65 +	249	2385	140	56.2	58.7
085	All	FFS	65 +	565	5408	248	43.9	45.9
083	All	FFS	65 +	187	1814	82	43.9	45.2
065	All	FFS	65 +	282	2825	122	43.3	43.2
007	All	FFS	65 +	619	6218	267	43.1	42.9
068	All	FFS	65 +	239	2404	99	41.4	41.2
063	All	FFS	65 +	110	1042	44	40.0	42.2
078	All	FFS	65 +	141	1496	55	39.0	36.8
079	All	FFS	65 +	236	2329	88	37.3	37.8
030	All	FFS	65 +	318	2905	117	36.8	40.3
052	All	FFS	65 +	223	2145	82	36.8	38.2
013	All	FFS	65 +	314	2996	111	35.4	37.0

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
044	All	FFS	65 +	105	921	37	35.2	40.2
066	All	FFS	65 +	551	5178	194	35.2	37.5
040	All	FFS	65 +	291	2933	102	35.1	34.8
041	All	FFS	65 +	200	2019	70	35.0	34.7
015	All	FFS	65 +	271	2741	94	34.7	34.3
047	All	FFS	65 +	359	3513	124	34.5	35.3
060	All	FFS	65 +	699	6934	241	34.5	34.8
042	All	FFS	65 +	407	3881	140	34.4	36.1
058	All	FFS	65 +	323	3168	111	34.4	35.0
064	All	FFS	65 +	360	3515	120	33.3	34.1
014	All	FFS	65 +	555	5119	182	32.8	35.6
077	All	FFS	65 +	498	5104	161	32.3	31.5
016	All	FFS	65 +	31	183	10	32.3	54.6
006	All	FFS	65 +	165	1637	52	31.5	31.8
017	All	FFS	65 +	283	2913	88	31.1	30.2
034	All	FFS	65 +	611	5665	189	30.9	33.4
008	All	FFS	65 +	415	3956	126	30.4	31.9
035	All	FFS	65 +	161	1598	48	29.8	30.0
072	All	FFS	65 +	205	1923	59	28.8	30.7
043	All	FFS	65 +	382	3646	108	28.3	29.6
076	All	FFS	65 +	271	2385	76	28.0	31.9
049	All	FFS	65 +	543	5531	151	27.8	27.3
087	All	FFS	65 +	241	2447	66	27.4	27.0
037	All	FFS	65 +	231	2353	63	27.3	26.8
075	All	FFS	65 +	140	1460	38	27.1	26.0
011	All	FFS	65 +	452	4488	121	26.8	27.0
056	All	FFS	65 +	1069	10539	285	26.7	27.0
054	All	FFS	65 +	244	2506	65	26.6	25.9
024	All	FFS	65 +	499	4909	131	26.3	26.7
021	All	FFS	65 +	597	5871	155	26.0	26.4
055	All	FFS	65 +	1028	9835	266	25.9	27.0
012	All	FFS	65 +	257	2591	66	25.7	25.5
028	All	FFS	65 +	299	2937	75	25.1	25.5
062	All	FFS	65 +	2386	13611	585	24.5	43.0
080	All	FFS	65 +	360	3719	88	24.4	23.7
022	All	FFS	65 +	317	1807	77	24.3	42.6
020	All	FFS	65 +	190	1816	46	24.2	25.3
025	All	FFS	65 +	558	5550	135	24.2	24.3
074	All	FFS	65 +	283	2668	68	24.0	25.5
029	All	FFS	65 +	263	2609	63	24.0	24.1
084	All	FFS	65 +	114	1043	27	23.7	25.9
018	All	FFS	65 +	673	6518	157	23.3	24.1
003	All	FFS	65 +	529	4402	118	22.3	26.8
002	All	FFS	65 +	458	2343	102	22.3	43.5
050	All	FFS	65 +	635	5974	140	22.0	23.4
019	All	FFS	65 +	576	2755	126	21.9	45.7
027	All	FFS	65 +	4313	23388	934	21.7	39.9

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
057	All	FFS	65 +	245	2353	53	21.6	22.5
004	All	FFS	65 +	647	6232	134	20.7	21.5
036	All	FFS	65 +	59	190	12	20.3	63.2
082	All	FFS	65 +	315	1562	64	20.3	41.0
001	All	FFS	65 +	289	2806	58	20.1	20.7
048	All	FFS	65 +	390	3840	78	20.0	20.3
032	All	FFS	65 +	176	1711	35	19.9	20.5
086	All	FFS	65 +	603	3912	119	19.7	30.4
026	All	FFS	65 +	165	1720	32	19.4	18.6
045	All	FFS	65 +	150	1453	28	18.7	19.3
051	All	FFS	65 +	170	1644	31	18.2	18.9
023	All	FFS	65 +	483	4714	87	18.0	18.5
053	All	FFS	65 +	307	2922	54	17.6	18.5
046	All	FFS	65 +	365	2115	63	17.3	29.8
081	All	FFS	65 +	215	2127	37	17.2	17.4
010	All	FFS	65 +	125	520	21	16.8	40.4
033	All	FFS	65 +	150	1380	25	16.7	18.1
039	All	FFS	65 +	84	838	14	16.7	16.7
070	All	FFS	65 +	156	661	26	16.7	39.3
067	All	FFS	65 +	120	1179	17	14.2	14.4
059	All	FFS	65 +	232	2454	32	13.8	13.0
069	All	FFS	65 +	1168	5234	161	13.8	30.8
073	All	FFS	65 +	274	990	34	12.4	34.3
031	All	FFS	65 +	219	1008	26	11.9	25.8
071	All	FFS	65 +	133	537	15	11.3	27.9
005	All	FFS	65 +	140	471	15	10.7	31.8
038	All	FFS	65 +	38	90	4	10.5	44.4
009	All	FFS	65 +	155	586	16	10.3	27.3
			65 + Average				26.3	31.5
061	All	FFS	All	1123	9723	491	43.7	50.5
007	All	FFS	All	4572	38614	1807	39.5	46.8
085	All	FFS	All	3785	32189	1450	38.3	45.0
001	All	FFS	All	2331	20029	872	37.4	43.5
063	All	FFS	All	528	4548	193	36.6	42.4
050	All	FFS	All	4641	38858	1666	35.9	42.9
017	All	FFS	All	1375	12091	491	35.7	40.6
049	All	FFS	All	3618	31814	1283	35.5	40.3
021	All	FFS	All	2965	24750	1016	34.3	41.1
077	All	FFS	All	3136	27759	1073	34.2	38.7
052	All	FFS	All	1906	15412	647	33.9	42.0
079	All	FFS	All	1502	12075	509	33.9	42.2
018	All	FFS	All	6434	53752	2146	33.4	39.9
015	All	FFS	All	1538	13428	510	33.2	38.0
029	All	FFS	All	2292	18730	747	32.6	39.9
040	All	FFS	All	2151	16481	701	32.6	42.5
028	All	FFS	All	1478	12988	481	32.5	37.0
013	All	FFS	All	2983	23824	967	32.4	40.6

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
080	All	FFS	All	2189	18904	709	32.4	37.5
037	All	FFS	All	851	7419	271	31.8	36.5
020	All	FFS	All	1391	10909	442	31.8	40.5
041	All	FFS	All	673	5793	213	31.6	36.8
023	All	FFS	All	2039	17623	645	31.6	36.6
055	All	FFS	All	10438	85782	3264	31.3	38.0
068	All	FFS	All	1171	9156	364	31.1	39.8
076	All	FFS	All	1285	9521	399	31.1	41.9
066	All	FFS	All	4083	32575	1265	31.0	38.8
087	All	FFS	All	1130	8887	349	30.9	39.3
024	All	FFS	All	3529	29079	1083	30.7	37.2
056	All	FFS	All	5868	47440	1754	29.9	37.0
033	All	FFS	All	1825	14800	545	29.9	36.8
074	All	FFS	All	2854	22560	847	29.7	37.5
032	All	FFS	All	1015	8151	301	29.7	36.9
051	All	FFS	All	693	5681	202	29.1	35.6
006	All	FFS	All	686	5723	199	29.0	34.8
047	All	FFS	All	1956	15626	563	28.8	36.0
081	All	FFS	All	1664	13062	475	28.5	36.4
008	All	FFS	All	2159	17189	615	28.5	35.8
034	All	FFS	All	5590	39845	1586	28.4	39.8
030	All	FFS	All	2675	18116	746	27.9	41.2
003	All	FFS	All	4721	37270	1307	27.7	35.1
035	All	FFS	All	565	4662	156	27.6	33.5
011	All	FFS	All	4476	38284	1230	27.5	32.1
083	All	FFS	All	1537	12367	421	27.4	34.0
039	All	FFS	All	382	3039	104	27.2	34.2
057	All	FFS	All	1665	13396	449	27.0	33.5
058	All	FFS	All	3249	26402	864	26.6	32.7
075	All	FFS	All	678	5342	180	26.5	33.7
054	All	FFS	All	1147	9087	304	26.5	33.5
078	All	FFS	All	754	5936	198	26.3	33.4
026	All	FFS	All	766	6600	201	26.2	30.5
012	All	FFS	All	1509	11409	394	26.1	34.5
042	All	FFS	All	2578	20164	672	26.1	33.3
025	All	FFS	All	2855	23363	734	25.7	31.4
064	All	FFS	All	1623	12991	415	25.6	31.9
022	All	FFS	All	1696	9428	432	25.5	45.8
053	All	FFS	All	2500	19995	633	25.3	31.7
043	All	FFS	All	2457	18170	612	24.9	33.7
060	All	FFS	All	5683	43492	1358	23.9	31.2
072	All	FFS	All	1412	9760	334	23.7	34.2
048	All	FFS	All	2838	23837	670	23.6	28.1
004	All	FFS	All	8726	78789	2028	23.2	25.7
046	All	FFS	All	2605	14130	605	23.2	42.8
059	All	FFS	All	1116	9392	256	22.9	27.3
045	All	FFS	All	1129	8215	247	21.9	30.1

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
086	All	FFS	All	5133	27600	1073	20.9	38.9
065	All	FFS	All	2433	16244	506	20.8	31.1
067	All	FFS	All	665	5217	137	20.6	26.3
014	All	FFS	All	7961	55644	1584	19.9	28.5
031	All	FFS	All	3056	13878	573	18.8	41.3
044	All	FFS	All	1219	10184	220	18.0	21.6
084	All	FFS	All	1019	6357	150	14.7	23.6
073	All	FFS	All	4664	16833	652	14.0	38.7
069	All	FFS	All	13555	49080	1812	13.4	36.9
002	All	FFS	All	10617	38508	1419	13.4	36.8
082	All	FFS	All	3712	13529	482	13.0	35.6
071	All	FFS	All	1962	7407	246	12.5	33.2
005	All	FFS	All	1674	6498	203	12.1	31.2
019	All	FFS	All	7770	27600	910	11.7	33.0
038	All	FFS	All	347	944	40	11.5	42.4
070	All	FFS	All	1796	6454	206	11.5	31.9
016	All	FFS	All	290	1270	33	11.4	26.0
009	All	FFS	All	1755	7137	198	11.3	27.7
062	All	FFS	All	28928	101137	3033	10.5	30.0
036	All	FFS	All	692	1774	70	10.1	39.5
010	All	FFS	All	1265	4381	127	10.0	29.0
027	All	FFS	All	56113	197239	5386	9.6	27.3
			All Average				25.8	35.9
037	All	PPH	0-20	243	2403	166	68.3	69.1
078	All	PPH	0-20	151	1514	102	67.5	67.4
075	All	PPH	0-20	203	1951	128	63.1	65.6
061	All	PPH	0-20	416	3812	251	60.3	65.8
017	All	PPH	0-20	269	2606	161	59.9	61.8
006	All	PPH	0-20	286	2795	168	58.7	60.1
012	All	PPH	0-20	317	2973	186	58.7	62.6
080	All	PPH	0-20	592	5600	345	58.3	61.6
007	All	PPH	0-20	724	6391	419	57.9	65.6
085	All	PPH	0-20	633	5888	366	57.8	62.2
035	All	PPH	0-20	112	993	64	57.1	64.5
079	All	PPH	0-20	302	2536	169	56.0	66.6
040	All	PPH	0-20	338	2988	189	55.9	63.3
087	All	PPH	0-20	347	3333	194	55.9	58.2
021	All	PPH	0-20	880	8154	489	55.6	60.0
026	All	PPH	0-20	220	1968	122	55.5	62.0
072	All	PPH	0-20	220	1883	121	55.0	64.3
049	All	PPH	0-20	948	9078	520	54.9	57.3
066	All	PPH	0-20	566	5234	309	54.6	59.0
041	All	PPH	0-20	227	2310	123	54.2	53.2
068	All	PPH	0-20	299	2645	161	53.8	60.9
065	All	PPH	0-20	457	4128	246	53.8	59.6
064	All	PPH	0-20	411	3928	221	53.8	56.3
023	All	PPH	0-20	418	4033	223	53.3	55.3

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
052	All	PPH	0-20	304	2456	161	53.0	65.6
015	All	PPH	0-20	106	959	56	52.8	58.4
045	All	PPH	0-20	356	3313	188	52.8	56.7
020	All	PPH	0-20	258	2379	136	52.7	57.2
074	All	PPH	0-20	351	3062	185	52.7	60.4
083	All	PPH	0-20	222	2116	117	52.7	55.3
056	All	PPH	0-20	1516	14075	795	52.4	56.5
039	All	PPH	0-20	170	1573	89	52.4	56.6
081	All	PPH	0-20	228	2028	119	52.2	58.7
013	All	PPH	0-20	726	6493	376	51.8	57.9
032	All	PPH	0-20	226	2035	117	51.8	57.5
024	All	PPH	0-20	553	5065	285	51.5	56.3
053	All	PPH	0-20	365	3420	188	51.5	55.0
043	All	PPH	0-20	355	3031	180	50.7	59.4
029	All	PPH	0-20	609	5338	308	50.6	57.7
008	All	PPH	0-20	322	3128	159	49.4	50.8
050	All	PPH	0-20	601	5378	296	49.3	55.0
077	All	PPH	0-20	906	8413	443	48.9	52.7
004	All	PPH	0-20	779	7211	380	48.8	52.7
057	All	PPH	0-20	345	3191	168	48.7	52.6
084	All	PPH	0-20	101	996	49	48.5	49.2
047	All	PPH	0-20	512	4716	248	48.4	52.6
033	All	PPH	0-20	380	3462	184	48.4	53.1
055	All	PPH	0-20	1159	10389	558	48.1	53.7
001	All	PPH	0-20	542	5109	250	46.1	48.9
028	All	PPH	0-20	287	2679	132	46.0	49.3
058	All	PPH	0-20	705	6342	312	44.3	49.2
048	All	PPH	0-20	521	4775	228	43.8	47.7
051	All	PPH	0-20	225	1980	98	43.6	49.5
070	All	PPH	0-20	1636	12168	679	41.5	55.8
036	All	PPH	0-20	1216	10732	495	40.7	46.1
038	All	PPH	0-20	679	6131	274	40.4	44.7
018	All	PPH	0-20	1564	13980	631	40.3	45.1
067	All	PPH	0-20	201	1873	81	40.3	43.2
082	All	PPH	0-20	4462	36200	1773	39.7	49.0
042	All	PPH	0-20	494	4467	194	39.3	43.4
011	All	PPH	0-20	916	8306	354	38.6	42.6
076	All	PPH	0-20	730	4535	281	38.5	62.0
059	All	PPH	0-20	256	2598	98	38.3	37.7
063	All	PPH	0-20	218	2154	83	38.1	38.5
019	All	PPH	0-20	8615	69017	3252	37.7	47.1
009	All	PPH	0-20	2134	18585	802	37.6	43.2
002	All	PPH	0-20	12291	97053	4545	37.0	46.8
025	All	PPH	0-20	509	4191	185	36.3	44.1
010	All	PPH	0-20	1320	10633	475	36.0	44.7
069	All	PPH	0-20	14403	121363	5136	35.7	42.3
062	All	PPH	0-20	33729	296719	11932	35.4	40.2

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

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1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
086	All	PPH	0-20	2650	17253	915	34.5	53.0
030	All	PPH	0-20	1456	8971	481	33.0	53.6
034	All	PPH	0-20	2154	12187	705	32.7	57.8
005	All	PPH	0-20	1899	14153	605	31.9	42.7
071	All	PPH	0-20	2445	19103	778	31.8	40.7
022	All	PPH	0-20	936	5370	287	30.7	53.4
073	All	PPH	0-20	5436	43573	1654	30.4	38.0
027	All	PPH	0-20	64864	564069	18861	29.1	33.4
046	All	PPH	0-20	1459	8222	417	28.6	50.7
016	All	PPH	0-20	177	1304	48	27.1	36.8
060	All	PPH	0-20	828	7556	205	24.8	27.1
003	All	PPH	0-20	1129	7248	246	21.8	33.9
054	All	PPH	0-20	213	1999	35	16.4	17.5
044	All	PPH	0-20	202	1331	30	14.9	22.5
014	All	PPH	0-20	1503	5800	121	8.1	20.9
031	All	PPH	0-20	3929	34175	299	7.6	8.7
			0-20 Average				45.0	51.4
037	All	PPH	21-64	175	1692	74	42.3	43.7
074	All	PPH	21-64	293	2561	119	40.6	46.5
079	All	PPH	21-64	249	2086	99	39.8	47.5
070	All	PPH	21-64	960	6978	370	38.5	53.0
019	All	PPH	21-64	5143	39350	1964	38.2	49.9
085	All	PPH	21-64	553	4965	211	38.2	42.5
017	All	PPH	21-64	218	2011	81	37.2	40.3
081	All	PPH	21-64	212	1862	77	36.3	41.4
043	All	PPH	21-64	284	2436	103	36.3	42.3
065	All	PPH	21-64	308	2745	111	36.0	40.4
038	All	PPH	21-64	507	4376	182	35.9	41.6
012	All	PPH	21-64	233	2119	83	35.6	39.2
002	All	PPH	21-64	7526	56066	2661	35.4	47.5
078	All	PPH	21-64	105	1003	37	35.2	36.9
061	All	PPH	21-64	284	2587	99	34.9	38.3
021	All	PPH	21-64	732	6504	255	34.8	39.2
082	All	PPH	21-64	2591	20236	896	34.6	44.3
066	All	PPH	21-64	461	4123	159	34.5	38.6
064	All	PPH	21-64	302	2784	103	34.1	37.0
036	All	PPH	21-64	984	8164	332	33.7	40.7
075	All	PPH	21-64	165	1517	55	33.3	36.3
006	All	PPH	21-64	180	1639	59	32.8	36.0
010	All	PPH	21-64	791	6128	257	32.5	41.9
009	All	PPH	21-64	1670	13428	541	32.4	40.3
032	All	PPH	21-64	170	1547	55	32.4	35.6
013	All	PPH	21-64	554	4901	179	32.3	36.5
062	All	PPH	21-64	16989	133651	5448	32.1	40.8
072	All	PPH	21-64	181	1575	57	31.5	36.2
069	All	PPH	21-64	11729	92648	3673	31.3	39.6
027	All	PPH	21-64	37653	289255	11754	31.2	40.6

Dental Services Provision in Public Health Care Programs
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1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
007	All	PPH	21-64	618	5110	191	30.9	37.4
050	All	PPH	21-64	589	5274	182	30.9	34.5
080	All	PPH	21-64	506	4789	156	30.8	32.6
049	All	PPH	21-64	752	6994	231	30.7	33.0
035	All	PPH	21-64	88	828	27	30.7	32.6
020	All	PPH	21-64	190	1715	57	30.0	33.2
055	All	PPH	21-64	1078	8985	323	30.0	35.9
071	All	PPH	21-64	1398	10426	415	29.7	39.8
040	All	PPH	21-64	260	2272	77	29.6	33.9
023	All	PPH	21-64	381	3383	111	29.1	32.8
047	All	PPH	21-64	320	2875	93	29.1	32.3
053	All	PPH	21-64	280	2507	81	28.9	32.3
073	All	PPH	21-64	3499	25336	1003	28.7	39.6
087	All	PPH	21-64	242	2215	68	28.1	30.7
077	All	PPH	21-64	670	6273	188	28.1	30.0
005	All	PPH	21-64	1150	7767	318	27.7	40.9
045	All	PPH	21-64	283	2654	78	27.6	29.4
068	All	PPH	21-64	205	1841	56	27.3	30.4
086	All	PPH	21-64	1557	10449	421	27.0	40.3
052	All	PPH	21-64	256	2040	69	27.0	33.8
024	All	PPH	21-64	513	4522	138	26.9	30.5
056	All	PPH	21-64	1225	10993	324	26.4	29.5
076	All	PPH	21-64	395	2939	103	26.1	35.0
051	All	PPH	21-64	196	1810	51	26.0	28.2
026	All	PPH	21-64	194	1739	50	25.8	28.8
030	All	PPH	21-64	962	6630	246	25.6	37.1
034	All	PPH	21-64	1227	7932	308	25.1	38.8
033	All	PPH	21-64	310	2775	77	24.8	27.7
039	All	PPH	21-64	149	1374	37	24.8	26.9
083	All	PPH	21-64	133	1189	33	24.8	27.8
025	All	PPH	21-64	442	3623	107	24.2	29.5
001	All	PPH	21-64	592	5552	143	24.2	25.8
057	All	PPH	21-64	294	2568	70	23.8	27.3
048	All	PPH	21-64	429	3776	102	23.8	27.0
084	All	PPH	21-64	89	784	21	23.6	26.8
016	All	PPH	21-64	191	1422	45	23.6	31.6
029	All	PPH	21-64	582	4953	137	23.5	27.7
004	All	PPH	21-64	761	6723	178	23.4	26.5
058	All	PPH	21-64	640	5697	148	23.1	26.0
022	All	PPH	21-64	539	3582	124	23.0	34.6
046	All	PPH	21-64	826	4898	187	22.6	38.2
042	All	PPH	21-64	386	3320	87	22.5	26.2
059	All	PPH	21-64	194	1918	43	22.2	22.4
008	All	PPH	21-64	286	2611	62	21.7	23.7
028	All	PPH	21-64	205	1914	44	21.5	23.0
011	All	PPH	21-64	939	8737	199	21.2	22.8
041	All	PPH	21-64	190	1842	40	21.1	21.7

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
018	All	PPH	21-64	1482	13206	289	19.5	21.9
067	All	PPH	21-64	130	1125	23	17.7	20.4
015	All	PPH	21-64	120	1037	20	16.7	19.3
063	All	PPH	21-64	170	1683	27	15.9	16.0
003	All	PPH	21-64	858	5959	128	14.9	21.5
060	All	PPH	21-64	739	6745	96	13.0	14.2
054	All	PPH	21-64	194	1850	20	10.3	10.8
014	All	PPH	21-64	923	4266	75	8.1	17.6
044	All	PPH	21-64	147	1009	9	6.1	8.9
031	All	PPH	21-64	3042	25365	149	4.9	5.9
			21-64 Average				27.7	32.7
006	All	PPH	65 +	1	12	1	100.0	83.3
007	All	PPH	65 +	1	1	1	100.0	1000.0
016	All	PPH	65 +	39	379	28	71.8	73.9
082	All	PPH	65 +	595	5683	283	47.6	49.8
010	All	PPH	65 +	251	2383	105	41.8	44.1
040	All	PPH	65 +	5	29	2	40.0	69.0
038	All	PPH	65 +	143	1267	57	39.9	45.0
062	All	PPH	65 +	3324	31932	1260	37.9	39.5
070	All	PPH	65 +	361	3341	127	35.2	38.0
019	All	PPH	65 +	1101	10289	374	34.0	36.3
043	All	PPH	65 +	3	8	1	33.3	125.0
068	All	PPH	65 +	3	13	1	33.3	76.9
005	All	PPH	65 +	465	4511	151	32.5	33.5
069	All	PPH	65 +	2629	23899	825	31.4	34.5
027	All	PPH	65 +	8621	85588	2637	30.6	30.8
002	All	PPH	65 +	833	7607	243	29.2	31.9
086	All	PPH	65 +	478	1988	139	29.1	69.9
036	All	PPH	65 +	258	2583	74	28.7	28.6
071	All	PPH	65 +	397	3678	103	25.9	28.0
023	All	PPH	65 +	4	26	1	25.0	38.5
066	All	PPH	65 +	5	34	1	20.0	29.4
080	All	PPH	65 +	5	17	1	20.0	58.8
073	All	PPH	65 +	683	6476	136	19.9	21.0
009	All	PPH	65 +	427	3944	84	19.7	21.3
022	All	PPH	65 +	266	1295	49	18.4	37.8
011	All	PPH	65 +	11	73	2	18.2	27.4
047	All	PPH	65 +	6	15	1	16.7	66.7
046	All	PPH	65 +	296	1478	45	15.2	30.4
030	All	PPH	65 +	165	275	17	10.3	61.8
014	All	PPH	65 +	24	70	2	8.3	28.6
034	All	PPH	65 +	93	169	5	5.4	29.6
076	All	PPH	65 +	200	391	9	4.5	23.0
031	All	PPH	65 +	502	4707	6	1.2	1.3
003	All	PPH	65 +	316	929	3	0.9	3.2
			65 + Average				30.2	71.1
037	All	PPH	All	418	4095	240	57.4	58.6

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
078	All	PPH	All	256	2517	139	54.3	55.2
061	All	PPH	All	700	6399	350	50.0	54.7
017	All	PPH	All	487	4617	242	49.7	52.4
006	All	PPH	All	460	4446	228	49.6	51.3
075	All	PPH	All	368	3468	181	49.2	52.2
085	All	PPH	All	1186	10853	577	48.7	53.2
079	All	PPH	All	551	4622	268	48.6	58.0
012	All	PPH	All	550	5092	267	48.5	52.4
074	All	PPH	All	644	5623	303	47.0	53.9
065	All	PPH	All	765	6873	357	46.7	51.9
080	All	PPH	All	1085	10406	500	46.1	48.0
007	All	PPH	All	1326	11502	609	45.9	52.9
021	All	PPH	All	1612	14658	739	45.8	50.4
066	All	PPH	All	1024	9391	467	45.6	49.7
035	All	PPH	All	200	1821	91	45.5	50.0
064	All	PPH	All	713	6712	321	45.0	47.8
040	All	PPH	All	595	5289	267	44.9	50.5
043	All	PPH	All	634	5475	284	44.8	51.9
081	All	PPH	All	440	3890	196	44.5	50.4
072	All	PPH	All	401	3458	178	44.4	51.5
087	All	PPH	All	589	5548	261	44.3	47.0
049	All	PPH	All	1700	16072	749	44.1	46.6
068	All	PPH	All	499	4499	218	43.7	48.5
032	All	PPH	All	396	3582	172	43.4	48.0
013	All	PPH	All	1280	11394	555	43.4	48.7
020	All	PPH	All	448	4094	193	43.1	47.1
083	All	PPH	All	355	3305	150	42.3	45.4
023	All	PPH	All	798	7442	335	42.0	45.0
053	All	PPH	All	645	5927	269	41.7	45.4
045	All	PPH	All	639	5967	265	41.5	44.4
047	All	PPH	All	823	7606	341	41.4	44.8
026	All	PPH	All	414	3707	171	41.3	46.1
052	All	PPH	All	560	4496	229	40.9	50.9
056	All	PPH	All	2741	25068	1118	40.8	44.6
050	All	PPH	All	1190	10652	478	40.2	44.9
077	All	PPH	All	1576	14686	630	40.0	42.9
070	All	PPH	All	2940	22487	1175	40.0	52.3
024	All	PPH	All	1066	9587	423	39.7	44.1
039	All	PPH	All	319	2947	126	39.5	42.8
055	All	PPH	All	2237	19374	881	39.4	45.5
041	All	PPH	All	417	4152	163	39.1	39.3
038	All	PPH	All	1315	11774	512	38.9	43.5
082	All	PPH	All	7589	62119	2949	38.9	47.5
019	All	PPH	All	14711	118656	5575	37.9	47.0
033	All	PPH	All	690	6237	260	37.7	41.7
029	All	PPH	All	1191	10291	445	37.4	43.2
057	All	PPH	All	639	5759	238	37.2	41.3

Dental Services Provision in Public Health Care Programs
Comparison of Managed Care Utilization Rates to Fee-For-Service Utilization Rates

Year: 1997 **Service: All (Sorted by PaySys, Age Group, % Elig)**

1	2	3	4	5	6	7	8	9
County	Service Category	Payment System	Age Group	# Eligibles	# Eligibility Months	# Service Recipients	% Eligibles Who Received Service	# Recipients per 1,000 Eligibility Months
084	All	PPH	All	190	1780	70	36.8	39.3
036	All	PPH	All	2436	21479	896	36.8	41.7
008	All	PPH	All	608	5739	221	36.3	38.5
002	All	PPH	All	20477	160726	7437	36.3	46.3
004	All	PPH	All	1540	13934	557	36.2	40.0
028	All	PPH	All	492	4593	176	35.8	38.3
010	All	PPH	All	2349	19144	837	35.6	43.7
051	All	PPH	All	421	3790	148	35.2	39.1
048	All	PPH	All	950	8551	330	34.7	38.6
062	All	PPH	All	53602	462302	18610	34.7	40.3
001	All	PPH	All	1134	10661	392	34.6	36.8
058	All	PPH	All	1345	12039	460	34.2	38.2
009	All	PPH	All	4199	35957	1425	33.9	39.6
069	All	PPH	All	28472	237910	9608	33.7	40.4
015	All	PPH	All	226	1996	76	33.6	38.1
042	All	PPH	All	880	7787	280	31.8	36.0
086	All	PPH	All	4656	29690	1474	31.7	49.6
067	All	PPH	All	331	2998	104	31.4	34.7
059	All	PPH	All	450	4516	141	31.3	31.2
071	All	PPH	All	4213	33207	1294	30.7	39.0
025	All	PPH	All	951	7814	292	30.7	37.4
005	All	PPH	All	3494	26431	1072	30.7	40.6
018	All	PPH	All	3046	27186	918	30.1	33.8
027	All	PPH	All	110193	938912	33186	30.1	35.3
011	All	PPH	All	1843	17116	555	30.1	32.4
016	All	PPH	All	406	3105	121	29.8	39.0
076	All	PPH	All	1319	7865	393	29.8	50.0
034	All	PPH	All	3444	20288	1018	29.6	50.2
073	All	PPH	All	9528	75385	2790	29.3	37.0
030	All	PPH	All	2561	15876	743	29.0	46.8
063	All	PPH	All	388	3837	110	28.4	28.7
022	All	PPH	All	1728	10247	459	26.6	44.8
046	All	PPH	All	2570	14598	648	25.2	44.4
060	All	PPH	All	1567	14301	301	19.2	21.0
003	All	PPH	All	2282	14136	375	16.4	26.5
054	All	PPH	All	407	3849	54	13.3	14.0
044	All	PPH	All	349	2340	39	11.2	16.7
014	All	PPH	All	2431	10136	198	8.1	19.5
031	All	PPH	All	7405	64247	454	6.1	7.1
			All Average				37.3	43.0
			Grand Average				30.5	40.5

Table 2: CY98 Actively Enrolled Individual Dentists in FFS: Ratio to Average Number of Recipients

CY 98 Actively Enrolled Individual Dentists in FFS
Ratio to Average Number of Recipients

March 2, 1999

See narrative on page 27 of the Report

County Code	Name	Individual Providers	Avg # recips eligible per month	Ratio
001	AITKIN	3	1,342	1:447
002	ANOKA	94	6,154	1:65
003	BECKER	12	1,869	1:156
004	BELTRAMI	17	7,549	1:444
005	BENTON	9	1,062	1:118
006	BIG STONE	2	578	1:289
007	BLUE EARTH	37	3,968	1:107
008	BROWN	13	1,666	1:128
009	CARLTON	11	1,150	1:105
010	CARVER	12	879	1:73
011	CASS	6	3,502	1:584
012	CHIPPEWA	4	1,148	1:287
013	CHISAGO	8	1,224	1:153
014	CLAY	19	2,350	1:124
015	CLEARWATER	4	1,262	1:316
016	COOK	1	85	1:85
017	COTTONWOOD	7	1,163	1:166
018	CROW WING	30	4,951	1:165
019	DAKOTA	144	5,155	1:36
020	DODGE	3	1,013	1:338
021	DOUGLAS	15	2,460	1:164
022	FARIBAULT	7	495	1:71
023	FILLMORE	6	1,652	1:275
024	FREEBORN	9	2,689	1:299
025	GOODHUE	18	2,355	1:131
026	GRANT		651	0:651
027	HENNEPIN	676	39,483	1:58
028	HOUSTON	8	1,271	1:159
029	HUBBARD	6	1,726	1:288
030	ISANTI	11	818	1:74
031	ITASCA	23	1,966	1:85
032	JACKSON	3	772	1:257
033	KANABEC	6	1,302	1:217
034	KANDIYOHI	26	1,776	1:68
035	KITTSON	3	478	1:159
036	KOOCHICHING	8	438	1:55
037	LAC QUI PARLE	3	617	1:206
038	LAKE	3	236	1:79
039	LAKE OF THE WOODS	1	277	1:277
040	LESUEUR	12	1,545	1:129
041	LINCOLN	3	470	1:157
042	LYON	10	2,028	1:203
043	MCLEOD	18	1,820	1:101
044	MAHNOMEN	1	826	1:826
045	MARSHALL	2	833	1:417
046	MARTIN	10	750	1:75

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CY 98 Actively Enrolled Individual Dentists in FFS
Ratio to Average Number of Recipients

March 2, 1999

See narrative on page 27 of the Report

County Code	Name	Individual Providers	Avg # recips eligible per month	Ratio
047	MEEKER	6	1,498	1:250
048	MILLE LACS	6	2,273	1:379
049	MORRISON	9	2,800	1:311
050	MOWER	14	3,718	1:266
051	MURRAY	2	587	1:294
052	NICOLLET	15	1,488	1:99
053	NOBLES	8	2,012	1:252
054	NORMAN	4	379	1:95
055	OLMSTED	76	8,471	1:111
056	OTTER TAIL	21	4,752	1:226
057	PENNINGTON	6	1,252	1:209
058	PINE	4	2,469	1:617
059	PIPESTONE	3	861	1:287
060	POLK	13	4,097	1:315
061	POPE	4	937	1:234
062	RAMSEY	295	20,031	1:68
063	RED LAKE	1	403	1:403
064	REDWOOD	6	1,232	1:205
065	RENVILLE	7	1,613	1:230
066	RICE	27	3,354	1:124
067	ROCK	2	521	1:261
068	ROSEAU	6	870	1:145
069	ST LOUIS	138	7,749	1:56
070	SCOTT	31	1,064	1:34
071	SHERBURNE	13	1,041	1:80
072	SIBLEY	5	913	1:183
073	STEARNS	83	2,827	1:34
074	STEELE	22	2,350	1:107
075	STEVENS	4	616	1:154
076	SWIFT	4	383	1:96
077	TODD	7	2,561	1:366
078	TRAVERSE	1	532	1:532
079	WABASHA	10	1,120	1:112
080	WADENA	4	1,897	1:474
081	WASECA	8	1,307	1:163
082	WASHINGTON	77	2,328	1:30
083	WATONWAN	5	1,069	1:214
084	WILKIN	1	750	1:750
085	WINONA	24	3,116	1:130
086	WRIGHT	24	1,566	1:65
087	YELLOW MEDICINE	5	856	1:171
Total		**2,325**	**217,467**	**1:94**

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Cost of completing this report:

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

Staff time:	$20,000
Administrative costs:	3,000
Total:	$23,000