I. Overview
   a. Goal of Medicaid: provide quality care at a predictable cost in a sustainable program.
   b. Medicaid is important bcs
      i. Major provider of programs and payment for dental treatment of "underserved" populations
      ii. Usually looked to for financial support of public programs, i.e., Pew report on mid level dental providers indicated Medicaid funding was vital means of support
      iii. As a very large sector of state budget, small changes in policy can have huge fiscal impact, especially for entitlement program beneficiaries
      iv. Medicaid programs have "halo effect" of supporting delivery of services to those ineligible for direct services, i.e., income from children's dental services pay overhead to support delivery of services to adults
      v. Because Medicaid $$ are limited, important to consider
         1. fiscal impact of policy decisions
         2. Most efficient use of Medicaid $$s
         3. Opportunity costs of any decision, i.e., if you do one thing, there isn't going to be funding to do something else

II. Successes
   a. Our experience over last 12 years shows that when reimbursement is adequate, administrative burden is low, and Medicaid patients are supported in overcoming barriers to care, we have rising access.
   b. NH Medicaid dental services are provided
      i. in private dental offices, so our biggest safety net providers are private practitioners
      ii. FQHCs
      iii. Community programs
      iv. School based and linked programs

   c. All dental services are fee for service. No managed care contracts for dental services
   d. Review report of Medicaid 2003-2012

III. Challenges: Supply of dental services and Demand for the services that are supplied
   a. Supply
      i. Most private dental offices, FQHC and community dental programs supply
         1. Preventive and routine treatment by appointment, with expectation of compliance
         2. Constraints on supply
            a. Expense to supply (dental practice very sensitive to no-shows)
            b. Administrative burden for claims, etc

c. Reimbursement sufficiency
d. Sense of doing good, being appreciated, feeling effective
3. Environmental limitations on supply
a. Specialties: oral surgery, pediatric specialty treatment, endo(root canals)
b. Unreimbursed care for adults
c. Ability to treat Medicaid patients just as others are treated (language, transportation, compliance, special health care needs, etc.)

b. Demand
i. Easiest to satisfy: Demand for preventive, routine treatment by appointment, services adequately reimbursed by Medicaid or other third party payer
ii. Hard to satisfy: emergency treatment, extensive treatment needed due to deferred care, no means of reimbursement, specialty services such as oral surgery, root canals, and pediatric dentists, need for case management
iii. Challenge is to educate and motivate people to demand preventive and routine care, while building supply of services to meet that demand.
iv. Most critical demand in underserved areas of the state are for oral surgery, periodontists, endodontists, pediatric dentists who are able to provide services to Medicaid clients (program and $$)

c. DHPSAs: do not reflect what we need to satisfy difficult to satisfy
d. ADA materials showing flagging rates and lack of ability to compete with surrounding states

IV. Other States
a. MN and Alaska: very different from NH

V. My point of view
a. Carefully choose our path, as any one choice excludes ability and $$ to do others
b. Be mindful of exactly the problems we are trying to solve
i. Understand what services are needed/demanded
ii. Develop programs, funding and recruitment of services that are needed/demanded
1. Support adult Medicaid benefit
2. Support the improvement of Medicaid systems that make costs more predictable and sustainable while assuring quality
iii. Capture the services that are needed at the least possible cost (i.e., capture existing capacity rather than create new programs that will need additional resources to administer, regulate and fund)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**Summary: Annual Dental Access for NH Medicaid Under Age 21**													
2	Author:	Margaret Snow, DMD												
3	Date:	24-Oct-12												
4	Source	ad1557ms for 2012												
5		**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**		**Increase: 2002 to 2012**
6	**Total Enrolled Providers Treating Medicaid Patients Under Age 21**	294	300	322	352	370	378	388	388	375	**366**	**388**	**Increase Since 2002 in Providers Treating Medicaid Patients**	**94**
7	**% Increase Over Previous Year Enrolled Providers**		2%	7%	9%	5%	2%	3%	0%	-3%	**-2%**	**6%**	**Overall Increase Since 2002 In Enrolled Providers**	**32%**
8	**Enrolled Providers Treating 100 or More Under Age 21**	57	56	74	94	100	107	114	114	120	**127**	117	**Increase Over 2002 in Enrolled Providers Treating >100**	**60**
9	**% Increase Over Previous Year in Providers Treating Over 100**		-2%	32%	27%	6%	7%	7%	0%	5%	**6%**	**-8%**	**% Increase Since 2002 in Providers Treating Over 100 Patients/Yr**	**105%**
10	**Total Medicaid Enrolled Children Receiving Dental Treatment (Non Ortho)**	18457	18239	26871	33356	36171	38477	41365	46828	52104	**52986**	**54772**	**Increase Since 2002 in Total Medicaid Enrolled Children Receiving Dental Treatment (Non Ortho)**	**36315**
11	**% Increase Over Previous Year Children With Dental Access (Non-Ortho)**		-1%	47%	24%	8%	6%	8%	13%	11%	**2%**	**3.4%**	**% Increase Since 2002 in Children With Dental Access (Non-Ortho)**	**197%**
12	**Average Number of Medicaid Enrolled Children Cared For By Each Provider in Top-Performing 10%**	379	391	551	636	653	691	756	1038	1000	**1019**	**1023**	**Increase Since 2002 in Average Number of Medicaid Enrolled Children Treated Per Provider Among Top 10%**	**644**
13	**% Increase Over Previous Year In Avg Children Treated Per Provider Among Top 10% of Providers**		3%	41%	15%	3%	6%	9%	37%	-4%	**2%**	**0.4%**	**% Increase Since 2002 In Avg Children Treated Per Provider Among Top 10% of Providers**	**164%**
14	**Total Medicaid Dental Provider Payments for All Patients Under Age 21**	$6.3 M ($4.4 M Medicaid FFS + $1.9M NEDD Kids)	$7.8 M ($4.0 M Medicaid FFS + $3.8 M NEDD Kids)	$8,400,000	$12,800,000	$13,700,000	$14,200,000	$16,100,000	$18,473,000	$20,285,626	**$20,269,732**	**$20,384,236**	**Increase Since 2002 in Total Medicaid Dental Provider Payments for Patients 0-21yrs**	**$14,084,236**
15	**% Increase In Cost Over Previous Year**		**24%**	8%	52%	7%	4%	13%	15%	10%	**-0.1%**	**0.6%**	**% Increase In Cost Since 2002**	**224%**
16														
17	% Medicaid Eligible Children with Paid Medicaid Claims for Dental Treatment		25%	35%	39%	42%	43%	49%	50%	58%	57%	57%		

NH Medicaid Dental Access for Children (Birth to 21 Years)
State Fiscal Years 2002 Through 2012

This report is generated from claims-data and provider enrollment-data provided to NH Medicaid by its fiscal agent, Hewlett Packard.

In this report, the following terms mean:

- Provider = A billing entity enrolled to provide dental services; thus, each "provider" may be a solo dental practice or a group practice with more than one dentist providing dental treatment
- Medicaid enrolled children = numbers of non-duplicated children for whom dental treatment claims were paid in the period indicated
- Children = Medicaid eligible individuals between birth and 21st birthday

The data in this report are presented in a table and a graph. The table compares data year-to-year from State Fiscal Year (SFY) 2002 through SFY 2012. Overall change from SFY 2002 through SFY 2012 is summarized on the right side of the table. Change year-over-year and the summary of overall changes from 2002 through 2012 are shown in actual numbers in each category of information as well as a percent change, to make comparison of different units more meaningful. The graph on the second page shows changes in three important aspects of dental capacity for providing access to Medicaid dental treatment for children.

By reading the data entries from left to right on the table, one may see trends in changes in certain aspects of children's access to dental treatment in NH Medicaid:

Lines 6 & 7 show an increase in "Total Enrolled Providers Treating Medicaid Patients...". Because this number counts as "providers" any practice with one or more dentists, and does not reflect individual dentists, it is not a precise count of willing dentists. Nonetheless, enrolled providers are counted in the same way each year, so the overall trend is an accurate representation of the trend in dentist participation. Reading left to right, one can observe that the number of treating providers became flat or decreasing in the period from 2009 through 2011, then the decrease in SFY 2011 slowed compared to SFY 2010, and there was a 6% increase in SFY 2012. No statistical tests were performed to measure the significance of these changes. **It seems safe to conclude that there has not been a significant change in the number of active dental providers in the period from 2009 through 2012.**

Lines 8 & 9 show an apparent 8% decrease in the number of providers treating more than 100 children during SFY 2012. Although the Department welcomes and appreciates the value of dentists providing treatment for even a small number of Medicaid eligible children, increasing the number of "high-volume" providers is thought to improve quality assurance and standardization of care for the children, and also improves the quality of provider support for dentists. The Dental Director interprets increases in the number of "high-volume" providers as an indirect measure of provider

satisfaction with the program, which is a high priority goal of the program. For these reasons, **the apparent decrease in number of high volume providers is of concern.**

Lines 10 & 11 show the number of Medicaid eligible children receiving the benefit of dental treatment excluding orthodontic treatment, and the percent increase over the previous year. These figures reflect the number of children receiving care, and not the percent of all Medicaid eligible children who received dental care. **The rate of increase in Medicaid enrollment in SFY 2012 greatly exceeded the slight increase in the number of Medicaid eligible children who received dental care in 2012; therefore, the percentage of all Medicaid eligible children with dental care is declining. The rate of that decline is not reflected on this chart.**

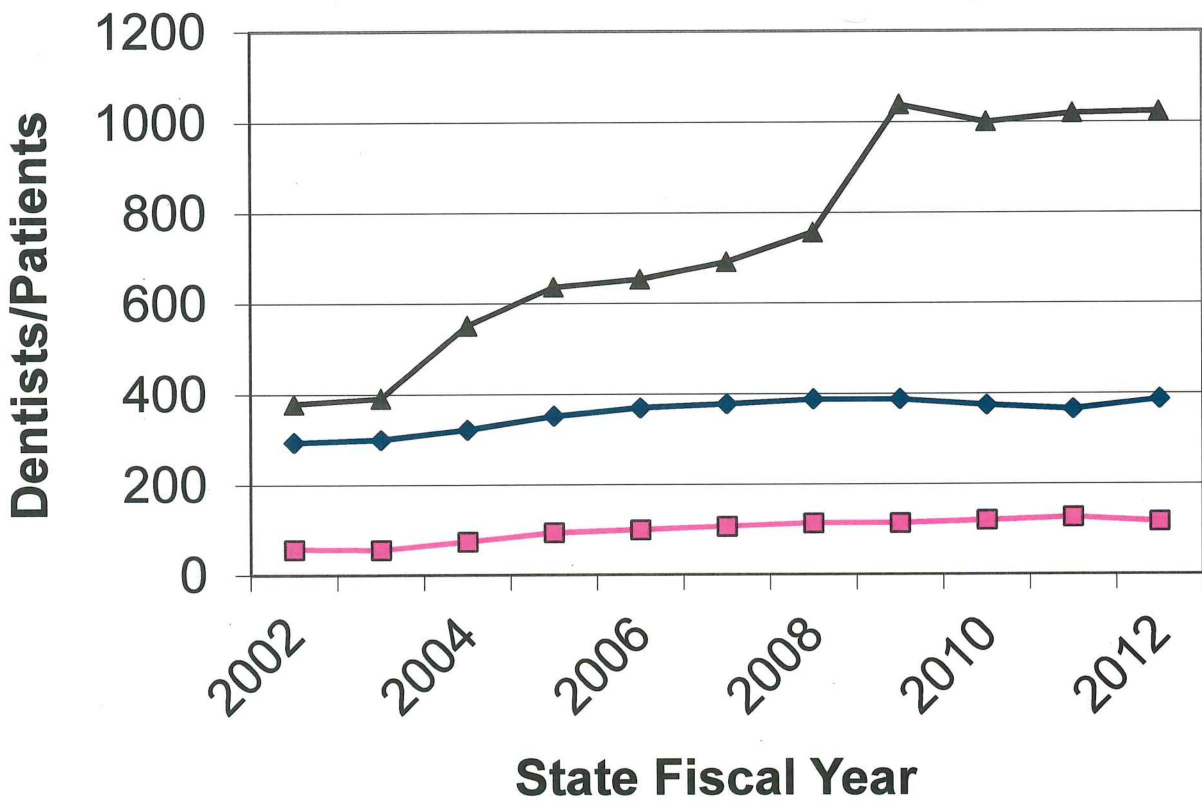
Lines 12 & 13 show the average number of Medicaid eligible children treated by each of the dentists who are included among the top performing 10% of providers, based on numbers of patients treated. Since there were 388 enrolled providers treating Medicaid eligible patients, the top 10% of performers equals 39 dentists. The average number of Medicaid patients treated by each of those 39 dentists was 1023 in SFY 2012, up .4% over the previous year. **The information in Lines 12 & 13 appears to reflect stability in the access provided by Medicaid's most productive providers.**

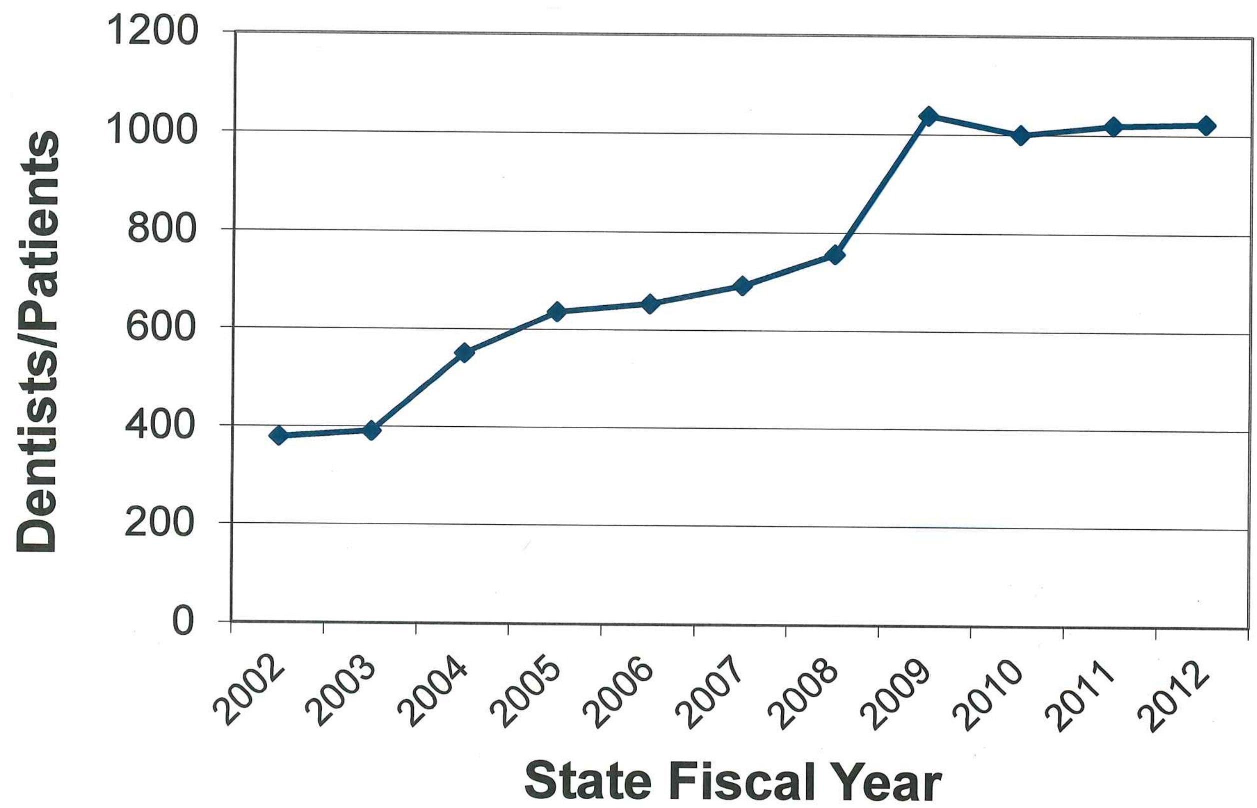
Lines 14 & 15 show the change in overall payment for all dental claims (including ortho) in SFY 2012 and shows the percent increase in payments over SFY 2011. **The rate of increase in costs is much less, at .6% increase, than the rate of increase in access to care, at 4%.** Several changes in policy seem to have caused a rate of increase in costs in SFY 2012 compared with SFY2011, for example, NH Medicaid no longer covers routine extraction of third molars and orthodontic criteria for coverage has become more stringent.
Totals in Column L indicate that there is a generalized slowing in growth in all measures of dental access for children in NH Medicaid.

Column N on the right hand side of the table, with highlights in warm colors, represents net change in the measures of access by comparing measures at the end of SFY 2012 with those of SFY 2002. Several observations that may be made include the following:

- Access to dental care has increased nearly threefold (18K to 55K children) with an increase in participating providers of only 32%
- About 80% of dental access for Medicaid eligible children (43K of the 54K children with access) is provided by only 40 providers, most of whom are pediatric dentists, along with one "big box" dental group

The graph on the last page of this report shows trends in three important measures of Medicaid Dental Capacity that provides access to dental care. The challenge for Medicaid is to capture capacity to provide for the increasingly complex needs of children who do not yet have access to oral health care.


Medicaid Dental Capacity
Dentists/Patients
1200
1000
800
600
400
200
0
2002
2004
2006
2008
2010
2012
State Fiscal Year
Total Enrolled Providers Treating Medicaid Patients Under Age 21
Enrolled Providers Treating 100 or More Under Age 21
Average Number of Medicaid Enrolled Children Cared For By Each Provider in Top-Performing 10%


Medicaid Dental Capacity
Dentists/Patients
1200
1000
800
600
400
200
0
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
State Fiscal Year
Average Number of Medicaid Enrolled Children Cared For By Each Provider in Top-Performing 10%

Comparison of Proposed NH Dental Mid-Level Provider With Those in Minnesota and Alaska

	A	B	C	D	E
1		Proposed NH	MN DT	MN ADT	AK DHAT
2					
3					
4	Educational/Credential Requirements	*Current Dental hygienist license in NH *Completion of a dental hygiene practitioner education program with : +a minimum of 18 months worth of curriculum +Consistent with model curriculum adopted from AAPHD or successor organization +Administered by an institution accredited to educate dentists or dental hygienists *Dental board approved comprehensive exam administered independently from educaional institution *a minimum of 500 hours clinical practice with direct supervision	*Bachelor's degree in dental therapy (28 month post-high school program requiring 10 prerequisite courses) *Students work alongside dental and hygiene students in the School of Dentistry patient clinics *Competency and licensure exam *Jurisprudence exam	*Dental therapist license *Master's degree in advanced dental therapy (26 month program requiring a bachelor's degree in dental hygiene or 28 month program requiring a bachelor's degree and 10 prerequisite courses) *2000 hours of clinical practice *Certification exam for advanced practice	*24 month program in partnership with Otago University in New Zealand *400 hours of clinical practice in a tribal location under direct supervision of a dentist
5					
6	Scope of Practice	*A licensed dental hygiene practitioner can perform specified services under the supervision of a licensed dentist, subject to limitations and requirements of a written practice agreement.	*A licensed dental therapist may perform certain dental services under "indirect supervision". *A dental therapist may perform additional services under "general supervision" unless restricted or prohibited from doing so in the collaborative management agreement. *A dental therapist may also dispense certain medications and supervise up to 4 dental assistants.	*An advanced dental therapist certified by the Board of Dentistry may perform the following services and procedures, pursuant to a written collaborative management agreement (and any limitations therein): +All services a dental therapist provides +Oral evaluation and assessment +Treatment plan formulation +Routine, nonsurgical extractions of certain diseased teeth.	*DHAT's practice under a standing order of a dentist who is also their point of contact *DHAT connected to dentist located at a hub by telehealth/telemedicine network
7					

Margaret Snow, DMD
NH DHHS Dental Director
2/11/2015

Comparison of Proposed NH Dental Mid-Level Provider With Those in Minnesota and Alaska

	A	B	C	D	E
8	Level of Supervision	Practices under the supervision of a currently licensed dentist with a written practice agreement. The dentist does not have to examine the patient first unless the standing protocol requires it. The written practice agreement may limit the dental hygiene practitioner's scope of practice.	Practices under the supervision of a dentist, with whom they must have a collaborative management agreement. Some dental therapy services can be provided under "indirect supervision" (the dentist is on-site and authorizes procedures) and others under "general supervision" (the dentist is not necessarily on-site during procedure but does authorize performance).	Like a dental therapist, the advanced dental therapist practices under the supervision of a dentist, with whom they must have a collaborative agreement, but all advanced dental therapy services can be provided under "general supervision." The dentist does not need to see the patient first or be on-site during procedure.	Practice under the general supervision of a dentist, perform procedures according to standing orders issued by supervising dentist.
9					
10	Additional Requirements	None	The underserved population must make up at least 50% of the DT's patients.	The underserved population must make up at least 50% of the ADT's patients.	Part of the Community Health Aide Program authorized by the federal Indian Health Care Improvement Act; must be employed by the Indian Health Service or by a tribe or tribal organization.

Margaret Snow, DMD
NH DHHS Dental Director
2/11/2015

Comparison of Procedures Allowed ("Scope of Practice")

	A	B	C	D	E	F	G
1		Proposed NH DHP		MN DT		MN ADT	AK
2	General Supervision		General Supervision		General Supervision		
3		OH instruction, disease prevention education, nutritional counseling, dietary analysis		OH instruction, disease prevention education, nutritional counseling, dietary analysis		All procedures allowed for DT under general and indirect supervision are allowed for ADT.	Examinations
4		dental charting, periodontal screening		preliminary charting		oral evaluation and assessment	radiographs
5		radiographs		radiographs		Treatment plan formulation	prophylaxis
6		dental prophylaxis, removal of visible calculus				Routine, nonsurgical extractions of certain diseased teeth	apply fluoride varnish and sealants
7		mechanical polishing		mechanical polishing			cavity preparation
8		application of topical preventive or prophylactic agents including fl varnish, antimicrobial agents, pit and fissure sealants		application of topical preventive or prophylactic agents including fl varnish, pit and fissure sealants			restoration of primary and permanent teeth
9		pulp vitality testing		pulp vitality testing			placement of temporary stainless steel crowns
10		application of desensitizing medication or resin		application of desensitizing medication or resin			perform pulpotomies
11		fabrication of athletic mouthguards		fabrication of athletic mouthguards			Nonsurgical extraction of primary and permanent teeth
12		placement of temporary restorations		placement of temporary restorations			
13		fabrication of soft occlusal guards		fabrication of soft occlusal guards			
14		tissue conditioning and soft reline		tissue conditioning and soft reline			
15		placement of interim therapeutic restorations		atraumatic restorative therapy			
16		periodontal dressing changes		dressing changes			
17		tooth reimplantation and stabilization		tooth reimplantation			
18		administration of local anesthetic		administration of local anesthetic			
19		oral evaluation and assessment of dental disease		administration of nitrous oxide			
20		treatment plan including DHP scope services and those requiring referral for services outside that scope	Indirect supervision				
21		extraction of primary teeth		emergency palliative treatment of dental pain			

Margaret Snow, DMD
NH DHHS Dental Director
2/11/2015

	A	B	C	D	E	F	G
22		nonsurgical extraction of permanent teeth except unerupted, impacted, fractured or requiring sectioning		placement and removal of space maintainers			
23		emergency palliative treatment of dental pain		cavity preparation			
24		placement and removal of space maintainers		restoration of primary and permanent teeth			
25		cavity preparation		placement of temporary crowns			
26		restoration of primary and permanent teeth with amalgam and composite		preparation and placement of preformed crowns			
27		placement of temporary crowns		pulpotomies on primary teeth			
28		preparation and placement of preformed crowns		indirect and direct pulp capping on primary and permanent teeth			
29		pulpotomies on primary teeth		stabilization of reimplanted teeth			
30		indirect and direct pulp capping on primary and permanent teeth		extractions of primary teeth			
31		suture removal		suture removal			
32		brush biopsies		brush biopsies			
33		repair of defective prosthetic devices		repair of defective prosthetic devices			
34		recement permanent crowns		recementing of permanent crowns			
35							
36	Dispensing/administration of drugs	written practice agreement includes protocols for which medications may be dispensed and administered		within the collaborative management agreement parameters may dispense and administer analgesics, anti-inflammatories, and antibiotics		within the collaborative management agreement parameters may dispense and administer analgesics, anti-inflammatories, and antibiotics	N/A
37	Supervision of dental assistants	no specifications		limited to supervision of no more than four licensed or unlicensed dental assistants		statute does not include this restriction for ADT	N/A

Margaret Snow, DMD
NH DHHS Dental Director
2/11/2015

Comparison of Required Collaborative Agreements to Provide Dentist Supervision for Mid Level Dental Providers

	A	B	C	D	E
1		Proposed NH DHP	MN DT	MN ADT	AK DHAT
2					
3		DHP practices under the supervision of a New Hampshire licensed dentist with a written practice agreement.	DT practices under the supervision of a Minnesota-licensed dentist in addition to a written collaborative management agreement.	ADT practices under a written collaborative management agreement with a Minnesota-licensed dentist.	DHAT practices under the general supervision of a dentist who is responsible for writing standing orders and being the point of contact for the DHAT.
4		A collaborating dentist may enter into an unlimited number of written practice agreements at any given time.	A collaborating dentist is limited to entering into a collaborative agreement with no more than five DT's or ADT's at any given time.	A collaborating dentist is limited to entering into a collaborative agreement with no more than five DT's or ADT's at any given time.	A collaborating dentist is limited to entering into a collaborative agreement with no more than five DT's or ADT's at any given time.
5		Written practice agreement outlines the functions, agreed upon by the dentist and DHP, that the DHP is authorized to provide within the scope of practice in the applicable statute.	Written practice agreement outlines the functions, agreed upon by the dentist and DT, that the DT is authorized to provide within the scope of practice in the applicable statute.	Written practice agreement outlines the functions, agreed upon by the dentist and ADT, that the ADT is authorized to provide within the scope of practice in the applicable statute.	Supervising dentist issues written standing orders.
6		DHP services may be provided without the patient first seeing the dentist for an examination, diagnosis, or treatment plan if the DHP has written authorization and standing protocols for the services and the dentist reviews DHP patient records once in a 12 month period. The supervising dentist will examine the patient face to face or via teledentistry, for those cases that standing protocols require.	Collaborative management agreements must be signed and maintained by the collaborating dentist and the dental therapist. Agreements must be reviewed, updated, and submitted to the board on an annual basis.	Collaborative management agreements must be signed and maintained by the collaborating dentist and the dental therapist. Agreements must be reviewed, updated, and submitted to the board on an annual basis.	
7		The written practice agreement may limit the DHP's scope of practice set forth in statutes.	The written collaborative management agreement may limit the DT's scope of practice set forth in statutes.	The written collaborative management agreement may limit the ADT's scope of practice set forth in statutes.	Supervising dentist issues written standing orders.

Margaret Snow, DMD
NH DHHS Dental Director
February 13, 2015

	A	B	C	D	E
8		Written practice agreement will include, at a minimum, the following: 1.any limitations on DHP services or procedures otherwise authorized by statute, 2. practice settings where services and procedures may be provided, 3.age and procedure-specific practice protocols, including case selection criteria, assessment guidelines, and imaging frequency, 4. a procedure for obtaining informed consent, and for creating and maintaining dental records for patients treated by the DHP, 5. a plan for review of DHP patient records by the supervising dentist	Written collaborative agreement will include: 1. practice settings where services may be provided and the populations to be served, 2. any limitations on the services that may be provided by the DT, including level of supervision required by the collaborating dentist, 3.age and procedure-specific practice protocols, including case selection criteria, assessment guidelines, and imaging frequency, 4.procedure for creating and maintaining dental records for patients treated by the DT, 5. a plan to manage medical emergencies in each practice setting where the DT provides care,	Written collaborative agreement will include: 1. practice settings where services may be provided and the populations to be served, 2. any limitations on the services that may be provided by the ADT, including level of supervision required by the collaborating dentist, 3.age and procedure-specific practice protocols, including case selection criteria, assessment guidelines, and imaging frequency, 4.procedure for creating and maintaining dental records for patients treated by the ADT, 5. a plan to manage medical emergencies in each practice setting where the ADT provides care,	

Margaret Snow, DMD
NH DHHS Dental Director
February 13, 2015

	A	B	C	D	E
9		6. a plan to manage medical emergencies in each practice setting where the DHP provides care, 7. a quality assurance plan for monitoring care provided by the DHP, including patient care review, referral follow-up, and a quality assurance chart review, 8. protocols for administering and dispensing medications, including specific circumstances under which these medications will be dispensed and administered, 9. criteria for care for patients with specific medical conditions or complex medical histories, including consultation prior to initiation of care, and 10. specific protocol, including a plan for provision of clinical resources and/or referrals when a patient requires treatment exceeding the DHP scope of practice or capabilities.	6. a quality assurance plan for monitoring care provided by the DT, including patient care review, referral follow-up, and a quality assurance chart review, 7. protocols for administering and dispensing medications, including specific circumstances under which these medications will be dispensed and administered, 8. criteria for care for patients with specific medical conditions or complex medical histories, including consultation prior to initiation of care, 9. supervision criteria of dental assistants, and 10. a plan for provision of clinical resources and referrals in situations which are beyond the capabilities of the DT.	6. a quality assurance plan for monitoring care provided by the ADT, including patient care review, referral follow-up, and a quality assurance chart review, 7. protocols for administering and dispensing medications, including specific circumstances under which these medications will be dispensed and administered, 8. criteria for care for patients with specific medical conditions or complex medical histories, including consultation prior to initiation of care, 9. supervision criteria of dental assistants, and 10. a plan for provision of clinical resources and referrals in situations which are beyond the scope of practice of the ADT. **The collaborating dentist must ensure that a dentist is available to the ADT for timely consultation during treatment and must provide or arrange for necessary treatment by another dentist or specialist to provide for treatment beyond the treatment the ADT is authorized to provide.**	
10					
11		The supervising dentist is responsible for all authorized services and procedures performed by the DHP pursuant to the written practice agreement.	The collaborating dentist is responsible for all services authorized and performed by the dental therapist persuant to the management agreement.	The collaborating dentist is responsible for all services authorized and performed by the dental therapist persuant to the management agreement.	

Margaret Snow, DMD
NH DHHS Dental Director
February 13, 2015

Comparison of Required Collaborative Agreements to Provide Dentist Supervision for Mid Level Dental Providers

	A	B	C	D	E
12		New and/or revised written practice agreements shall be signed and maintained by the supervising dentist and the DHP, provided to patients upon request, and filed with the Board of Dental Examiners.	Collaborative management agreements must be signed and maintained by the collaborating dentist and the DT. Agreements must be reviewed, updated, and submitted to the dental board on an annual basis.	Collaborative management agreements must be signed and maintained by the collaborating dentist and the ADT. Agreements must be reviewed, updated, and submitted to the dental board on an annual basis.	

Margaret Snow, DMD
NH DHHS Dental Director
February 13, 2015

MINNESOTA COMMUNITY HEALTH BOARDS

Public Health Practice Section
Health Partnerships Division
651-201-3880 | health.ophp@state.mn.us

Learn more:
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How do I contact my community health board?

QUIN COUNTY
NORTH COUNTRY
AITKIN-ITASCA-KOOCHICHING
CARLTON-COOK-LAKE-ST LOUIS
POLK-NORMAN-MAHNOMEN
CASS
PARTNERSHIP-4HEALTH
CROW WING
KANABEC-PINE
MORRISON-TODD-WADENA
ISANTI-MILLE LACS
HORIZON
BEN-TON
STEARNS
SHER-BURNE
CHISAGO
ANOKA
WRIGHT
WASHINGTON
COUNTRYSIDE
HENN
SEE RIGHT
KANDIYOHI-RENVILLE
CARVER
MEEKER-McLEOD-SIBLEY
SCOTT
DAKOTA
LE SUEUR-WASECA
BROWN-NICOLLET
RICE
GOOD-HUE
WABASHA
SWHHS
WATON-WAN
BLUE EARTH
DODGE-STEELE
OLM-STED
WINONA
DES MOINES VALLEY
NOBLES
FARIBAULT-MARTIN
FREE-BORN
MOWER
FILLMORE-HOUSTON

1. MINNEAPOLIS
2. ST PAUL-RAMSEY
3. EDINA
4. RICHFIELD
5. BLOOMINGTON

1/1/2015

Dental Care Health Professional Shortage Areas (HPSAs)

Location	Total Dental Care HPSA Designations	Percent of Need Met	Practitioners Needed to Remove HPSA Designation	State Population 2014 estimate US Census Bureau
Alaska	57	68.77%	9	736,732
Minnesota	124	47.78%	94	5.42 million
New Hampshire	22	61.96%	4	1.323 million
Sources				
Bureau of Clinician Recruitment and Service, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, HRSA Data Warehouse: Designated Health Professional Shortage Areas Statistics, as of April 28, 2014.				

Margaret Snow, DMD
NH DHHS Dental Director
2/11/2015

HPI Health Policy Institute

ADA American Dental Association®

Research Brief

A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services

Authors: Kamyar Nasseh, Ph.D.; Marko Vujicic, Ph.D.; Cassandra Yarbrough, M.P.P.

The Health Policy Institute (HPI) is a thought leader and trusted source for policy knowledge on critical issues affecting the U.S. dental care system. HPI strives to generate, synthesize, and disseminate innovative research for policy makers, oral health advocates, and dental care providers.

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Key Messages

- *In 2013, the average Medicaid fee-for-service reimbursement rate was 48.8 percent of commercial dental insurance charges for pediatric dental care services.*
- *In 2014, the average Medicaid fee-for-service reimbursement rate was 40.7 percent of commercial dental insurance charges for adult dental care services in states that provide at least limited adult dental benefits in their Medicaid program.*
- *From 2003 to 2013, for pediatric dental care services, Medicaid fee-for-service reimbursement relative to commercial dental insurance charges fell in 39 states and rose in seven states and the District of Columbia.*
- *The available evidence strongly suggests that increasing Medicaid reimbursement rates for dental care services, in conjunction with other reforms, increases provider participation and access to dental care for Medicaid enrollees.*

Introduction

Recent years have brought significant changes in dental care use patterns for low-income Americans. In 47 out of 50 states plus the District of Columbia (DC), dental care utilization among Medicaid-enrolled children increased during the past decade.[1,2] In contrast, dental care use among low-income adults has declined steadily.[3] As a result, the gap in dental care utilization between low-income and high-income children has narrowed,[4] while it has widened for adults.[5]

Low-income children and adults are subject to different dental safety nets. Medicaid and the Children's Health Insurance Program (CHIP) must provide dental benefits for children, but states have the option of providing dental benefits for adults in Medicaid.[6] In fact, increased

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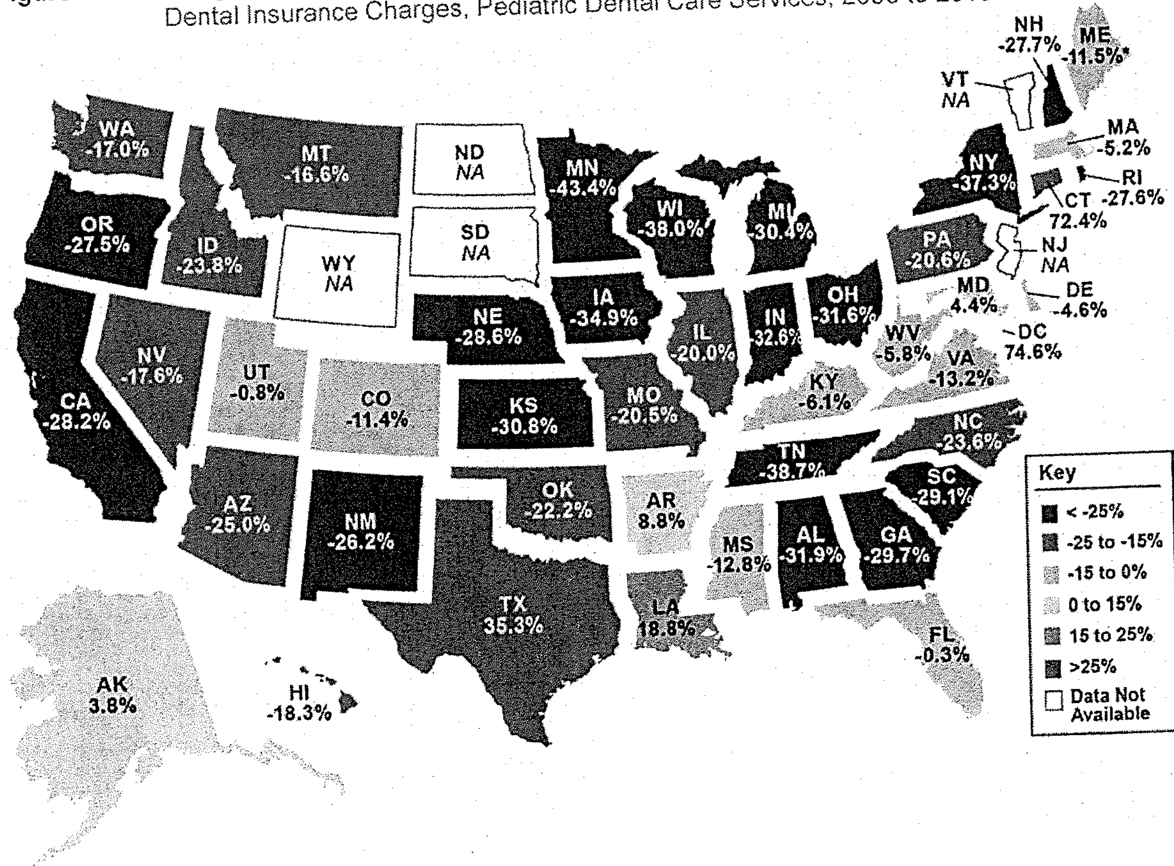
Table 3: Medicaid Fee-for-Service Reimbursement as a Percentage of Commercial Dental Insurance Charges, Pediatric Dental Care Services, 2003 and 2013

State	2003	2013	% change
Alabama	78.7%	53.6%	-31.9%
Alaska	59.2%	61.5%	3.8%
Arizona	72.9%	54.7%	-25.0%
Arkansas	61.8%	67.2%	8.8%
California	40.4%	29.0%	-28.2%
Colorado	50.9%	45.1%	-11.4%
Connecticut	38.7%	66.8%	72.4%
Delaware	85.0%	81.1%	-4.6%
District of Columbia**	33.4%	58.4%	74.6%
Florida**	36.7%	36.6%	-0.3%
Georgia**	76.8%	54.0%	-29.7%
Hawaii	57.6%	47.1%	-18.3%
Idaho**	58.8%	44.8%	-23.8%
Illinois	40.6%	32.5%	-20.0%
Indiana	82.6%	55.7%	-32.6%
Iowa	64.1%	41.8%	-34.9%
Kansas	68.2%	47.2%	-30.8%
Kentucky**	46.8%	44.0%	-6.1%
Louisiana**	51.3%	61.0%	18.8%
Maine*	NA	43.6%	-11.5%*
Maryland	45.7%	47.8%	4.4%
Massachusetts	61.1%	57.9%	-5.2%
Michigan**	46.8%	32.5%	-30.4%
Minnesota**	47.3%	26.7%	-43.4%
Mississippi	54.6%	47.6%	-12.8%
Missouri	50.5%	40.2%	-20.5%
Montana	63.4%	52.9%	-16.6%
Nebraska	60.2%	43.0%	-28.6%
Nevada**	58.7%	48.4%	-17.6%
New Hampshire	54.7%	39.5%	-27.7%
New Jersey**	NA	68.8%	NA
New Mexico**	66.8%	49.3%	-26.2%
New York**	59.1%	37.1%	-37.3%
North Carolina	63.1%	48.2%	-23.6%
North Dakota	NA	62.7%	NA
Ohio**	59.2%	40.5%	-31.6%
Oklahoma	70.1%	54.5%	-22.2%
Oregon**	44.9%	32.6%	-27.5%
Pennsylvania	53.9%	42.8%	-20.6%
Rhode Island**	38.6%	27.9%	-27.6%
South Carolina	74.1%	52.5%	-29.1%
South Dakota	NA	51.3%	NA
Tennessee**	88.0%	53.9%	-38.7%
Texas**	44.0%	59.5%	35.3%
Utah	42.8%	42.5%	-0.8%
Vermont**	NA	49.7%	NA
Virginia	54.6%	47.4%	-13.2%
Washington	49.3%	40.9%	-17.0%
West Virginia**	74.2%	69.9%	-5.8%
Wisconsin	50.8%	31.5%	-38.0%
Wyoming	NA	61.2%	NA

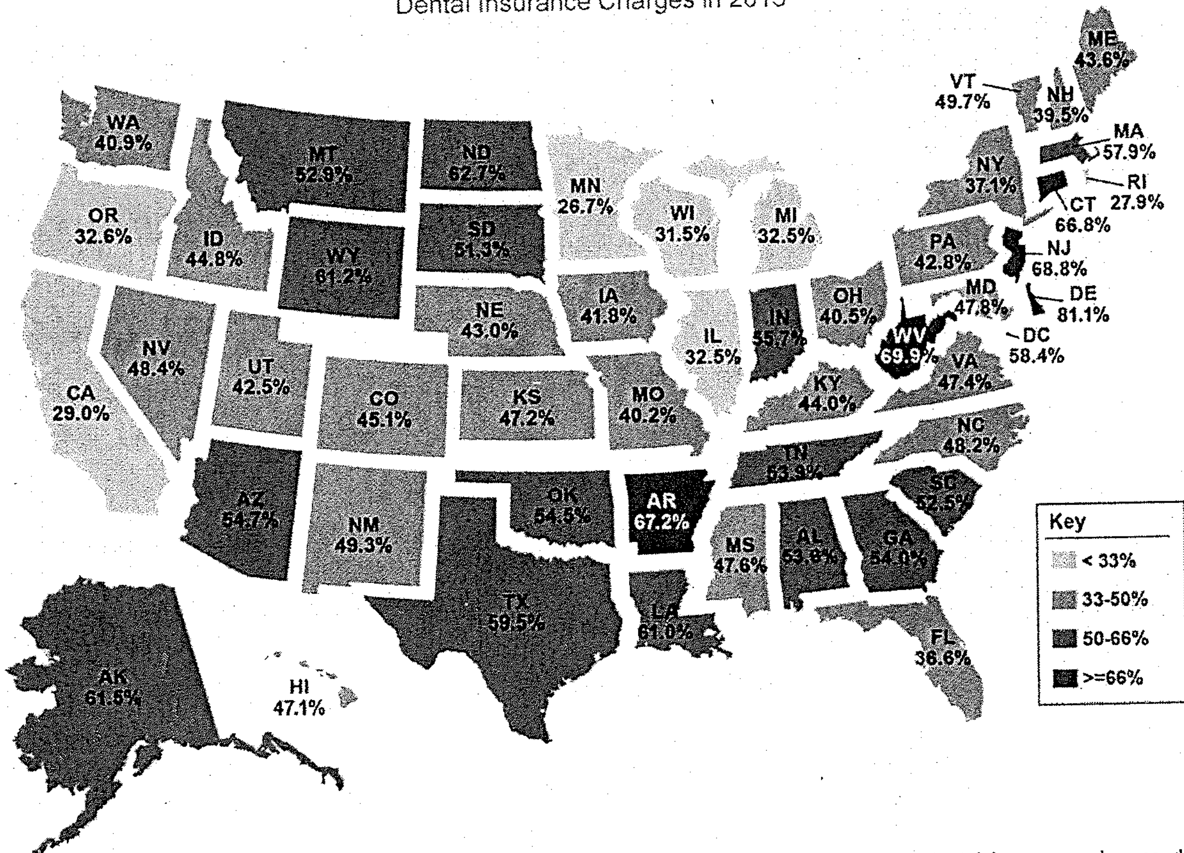
Source: Medicaid FFS reimbursement data collected from state Medicaid agencies. Commercial dental insurance charges data collected from FAIR Health. **Notes:** 2003 Medicaid FFS data for pediatric dental care services were not available for ME, ND, SD, VT and WY. *For Maine, the percentage change in the ratio of Medicaid FFS to commercial dental insurance charges for pediatric dental care services was calculated from 2004 through 2013. **These states enroll the majority of their Medicaid beneficiaries in managed care programs for dental services; for these states, the data shown in this table may not be representative of typical dentist reimbursement in Medicaid.

Figure 2: Percentage Change in the Ratio of Medicaid Fee-for-Service Reimbursement to Commercial Dental Insurance Charges, Pediatric Dental Care Services, 2003 to 2013



Source: Medicaid FFS reimbursement data collected from state Medicaid agencies. Commercial dental insurance charges data collected from FAIR Health. **Notes:** 2003 Medicaid FFS data for pediatric services were not available for Maine, North Dakota, South Dakota, Vermont and Wyoming. For Maine, the percentage change in the relative Medicaid FFS to commercial insurance charges rate for pediatric dental services was calculated from 2004 through 2013. The following states contract the majority of their Medicaid enrollees to managed care programs for dental services: DC, FL, GA, ID, KY, LA, MI, MN, NJ, NM, NV, NY, OH, OR, RI, TN, TX, VT and WV. For these states, the percentage change from 2003 through 2013 in relative reimbursement rates shown in this figure may not be representative of changes in typical dentist reimbursement in Medicaid.

Figure 1: Pediatric Dental Medicaid Fee-for-Service Reimbursement as a Percentage of Commercial Dental Insurance Charges in 2013



Source: Medicaid FFS reimbursement data collected from state Medicaid agencies. Commercial dental insurance charges data collected from FAIR Health. **Notes:** The following states contract the majority of their Medicaid enrollees to managed care programs for dental services: DC, FL, GA, ID, KY, LA, MI, MN, NJ, NM, NV, NY, OH, OR, RI, TN, TX, VT and WV. The relative fee rates shown in this figure for these states, therefore, may not be representative of typical dentist reimbursement in Medicaid.