Recommendations for Improving Oral Health Services Delivery System

Health Care Administration
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Legislative Report

Minnesota Department of **Human Services**

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I. Executive Summary

In 2013 the Minnesota Legislature directed the Commissioner of the Department of Human Services to complete a study on dental access and reimbursement. They directed DHS to consult with dental providers enrolled in Minnesota Health Care Programs (MHCP) and submit recommendations for improvement.

Between September 2013 and December 2013, DHS and consultant researchers interviewed 57 providers and other stakeholders to gain their perspectives in nine topic areas. A major factor driving this study is reduced MHCP participant access to dental services. In 2010, for instance, less than half (47 percent) of adult MHCP participants had visited a dentist in the last year.

Among child MHCP participants in 2012, only 28 percent had received preventive dental services from a dental provider in the last year and only about 14 percent received treatment. This rate for children is a decrease from 2010 when the same measures were 37 percent and 19 percent, respectively. Unfortunately, the rates for children have been decreasing over the past three years, suggesting current policies and practices are not effective in ensuring MHCP recipients, particularly children, are receiving adequate dental care.

There are barriers to dental providers serving MHCP patients:

- low reimbursement rates,
- payment and administrative complexity, and
- a limited adult benefit set that providers at times find conflicting with adequate standards of care.

Other access challenges include

- variable access in different regions of the state,
- inadequate use of allied dental health professionals,
- special needs of some participants,
- a lack of coordination between oral health and other health services, and
- limited use of portable delivery systems and teledentistry.

Stakeholders overwhelmingly supported raising fee-for-service base rates to increase the number of providers serving MHCP participants. There was also strong support for simplifying administrative practices.

There was lack of consensus on other issues. Many stakeholders favored

- enhancing training and educational supports to attract dentists to serve in underserved areas,
- promoting innovative services, and
- developing standards of care.

Some of the elements stakeholders recommended are within DHS's scope, and some are not. After analysis of stakeholder and other state and national information, DHS staff agreed on three

recommendations to improve access and ensure cost-effective delivery of services. This report also describes the specific strategies associated with these recommendations.[*]

Recommendation 1: The legislature should increase base payment rates for dental services and refine the payment structure to encourage provider participation in Minnesota's Health Care Programs.

Recommendation 2: DHS should continue to collaborate with other entities to support an evidence-based, integrated service delivery system that uses preventive services, portable delivery systems, teledentistry, a comprehensive adult benefit set and an expanded workforce to increase access and enhance cost-effectiveness.

Recommendation 3: To improve administrative structures and processes, the state should adopt elements of the single administrator model that have been successful in other states – streamlining administrative processes and strengthening efforts to prevent fraud and abuse.

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[*] A summary of the recommendations and strategies appears in the conclusions.

II. Legislation

To address recent concerns about access, cost and financing, the 2013 Minnesota Legislature directed the DHS Commissioner to complete a study on dental access and reimbursement.[1]

The legislature required DHS to

- study the current oral health and dental services delivery system for state public health care programs to improve access and ensure cost-effective delivery of services.

- consult with dental providers who serve Minnesota Health Care Programs enrollees, including providers who serve substantial numbers of low-income and uninsured patients and are currently receiving enhanced Critical Access Dental (CAD) provider payments.

- make recommendations on modifying service delivery and reimbursement methods, including changes to the CAD provider payments under Minnesota Statutes, section 256B.76, subdivision 4.

DHS's Purchasing and Service Delivery division, Health Care Administration was responsible for completing the study. This resulting report provides recommendations in ten areas. The first nine areas were required by statute. DHS added the tenth area.

1. **Funding and access** "Targeting state funding and critical access dental payments to improve access to oral health services for individuals enrolled in Minnesota Health Care Programs who are not receiving timely and appropriate dental services;"

2. **Innovative service delivery** "Encouraging the use of cost-effective service delivery methods, workforce innovations and the delivery of preventive services, including, but not limited to, dental sealants that will reduce dental disease and future costs of treatment;"

3. **Geographic access** "Improving access in all geographic areas of the state;"

4. **Teledentistry and mobile dental equipment** "Encouraging the use of teledentistry and mobile dental equipment to serve underserved patients and communities;"

5. **Administrative model** "Evaluating the use of a single administrator delivery model;"

6. **Compensation related to disparities** "Compensating providers for the added costs of serving low-income and underserved patients and populations who experience the greatest oral health disparities in terms of incidence of oral health disease and access to and utilization of needed oral health services;"

7. **Coordination with other health services** "Encouraging coordination of oral health care with other health care services;"

8. **Preventing fraud** "Preventing overtreatment, fraud and abuse;" and

9. **Reducing administrative costs** "Reducing administrative costs for the state and for dental providers."

10. **Other recommendations for improving access.**

III. Introduction

The Minnesota Department of Human Services (DHS) provides an array of health care services to people with low incomes through its Minnesota Health Care Programs (MHCP). MHCP includes Medical Assistance (MA), MinnesotaCare and several smaller programs, such as the Minnesota HIV/AIDS program and programs for people who are dually eligible for Medicaid and Medicare.

The MA (Minnesota's Medicaid) program is by far the largest component of MHCP. Each state establishes and administers their own Medicaid programs and determines the type, amount, duration and scope of services within broad federal guidelines. For all MHCP enrollees, services, including dental services, must be medically necessary and meet community standards of care.[2]

The Centers for Medicare and Medicaid Services (CMS) manage Medicaid at the federal level and provide approximately half of the funding for MA services in Minnesota. Federal policy requires states to cover certain mandatory benefits; states may choose to provide other optional benefits.

Federal policy requires that states cover children's dental services and gives states the option of providing adult dental services. Like other states, Minnesota provides children's services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Pregnant women also receive comprehensive dental services.

Minnesota has elected to provide limited dental services to other adults with benefits outlined in statute. The provision of dental services reflects the important role that dental services and oral health play in a person's overall health.[3] Stakeholders have worked for decades to improve dental services and preserve a level of coverage for adults. During this time, Minnesota's dental services system has experienced many changes in program financing, benefits and service delivery.

This report follows up on many issues discussed in a March 2013 report of the Minnesota Office of the Legislative Auditor (OLA), *Medical Payment Rates for Dental Services*. OLA's comprehensive report

- described the state's dental rate setting system,

- identified payment rate and access problems and

- presented four broad recommendations for addressing these problems:

    1. improve administration and DHS-provider communication,

    2. coordinate payment and rate-setting policies

    3. increase rates and

4. create a new benefit and payment structure for people with special needs.[*]

DHS began working on several of these issues following the OLA report. Some key recommendations — such as increasing rates — are not within the purview of DHS. The legislature has set and defined rates and dental benefits in the statute.

Report Overview
This report addresses each of the ten recommendation areas the legislature and DHS identified.

- Section 1 includes legislative items one and six (funding and access and disparities).

- Section 2 examines innovative service delivery; geographic access; teledentistry and mobile equipment; and coordination with other health services.

- Section 3 considers an administrative model that reduces administrative costs and prevents fraud and abuse.

The report primarily presents recommendations related to DHS's role in the dental service system. However, if actions directly affect DHS's ability to carry out its recommendations and if collaborative efforts are called for, this report also makes recommendations to the legislature and other stakeholders. It should also be noted that for the purposes of this report, "oral health" and "dental services" are used interchangeably.

Methodology and Scope
DHS's Purchasing and Service Delivery (PSD) division asked Management Analysis & Development (MAD) to assist with interviewing stakeholders to obtain input across all topic areas and with responding to six of the study's topic areas.

DHS, in consultation with the Dental Services Advisory Committee (DSAC), prepared responses to items related to innovative service delivery. DHS is the owner and author of this report.

- The project began in September 2013. MAD consultants conducted limited background research and worked with DHS staff to develop a list of key people and organizations involved in oral health service provision, policy, research, administration and education.

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[*] OLA recommendations:
- DHS should improve its information system, MN-ITS, to better support dental providers' inquiries of patient eligibility and state restrictions on benefits.
- DHS should ensure that service authorization criteria and benefit changes are more clearly defined and communicated to dental providers.
- The Legislature and DHS should better coordinate payment policies and rate-setting for MA dental services.
- As part of this effort, the Legislature should increase fee-for-service payment rates for dental services.
- The Legislature and DHS should implement a separate benefit and payment structure for Minnesota's MA population with special needs.
- DHS should more closely monitor MA recipients' access to dental services.

- During September and October, MAD consultants interviewed 57 stakeholders representing all of the groups mentioned above.[*] DHS staff sat in on nearly all of the interviews. MAD conducted some interviews in person and some over the phone.

- In October and early November, MAD and DHS staff analyzed information.

- In mid-November, MAD and DHS staff completed a draft report.

- In January, DHS staff finalized the report.

- In February 2014, DHS presented the report to the legislature.

DHS' recommendations are based on

- capacity to increase MHCP recipients' access to oral health services;

- ability to improve the efficiency and effectiveness of DHS MHCP service delivery;

- support among stakeholders, as evidenced in the interviews; and

- support from the data and literature, which included a limited review of reports, statutes and research.

This project focused primarily on input from dental providers about each of the study's topic areas, as directed in the study legislation. It also focused on *recommendations*.[†] This study did not evaluate the quality of care, compare the effectiveness of different dental service providers and administrators or compare the value of fee for service (FFS) versus managed care dental services.[‡]

Access Overview
The MHCP population experiences one of the greatest contributors to disparities in access and oral health outcomes: low incomes and assets.

Low incomes are associated with higher rates of dental caries (cavities), for example, and less frequent service use.[4]

- In 2010, less than half (47 percent) of adult MHCP participants had visited a dentist in the last year.

- Among child MHCP participants, only 28 percent received preventive dental services

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[*] Appendix A contains a list of stakeholder interviewees.

[†] See the 2013 OLA report for an extensive review of challenges associated with MHCP payment policies and rates for dental services in March 2013. This DHS report is not intended to duplicate the OLA report. Rather, it expands the discussion of issues raised in the OLA report to focus on provider-informed recommendations and address the nine topic areas required by statute.

[‡] For information on FFS vs. MCO, see "PCG: Report on the Value of [MHCP] Managed Care, as Compared to Fee for Service" at http://www.leg.state.mn.us/docs/2013/mandated/130629.pdf.

from an enrolled dental provider in federal fiscal year 2012, and only about 14 percent received treatment.[*] On both these measures Minnesota is ranked well below the national average.[5]

- Statewide, 32 percent of FFS MHCP participants reported that finding a dentist was "a big problem" for them in 2009.[6]

Table 1 identifies MHCP-covered children's utilization from 2010 through 2012. The data, which includes children in both fee for service (FFS) and managed care, indicates a downward trend that has continued for the past three years and suggests that current policies and practices are not effective in maintaining or promoting access to dental services.

Table 1: Minnesota Indicators for Medicaid Participants (continuously enrolled for 90 days) Birth through Age 21[7]

Measure	FFY 2010 n=436,388	FFY 2011 n=453,536	FFY 2012 n=456,735
Percentage receiving any dental services	42	41	33
Percentage receiving at least one **preventive** dental service (by or under the supervision of a dentist)	37	37	28
Total receiving dental **treatment** services (by or under the supervision of a dentist)	19	18	14
Total eligible (age 6–9) receiving a sealant on a permanent molar tooth	17	15	11

*includes fluoride varnish treatment provided by non-dental providers

Many factors affect MHCP access:

- **Participants' inability to find a dentist who will accept MHCP patients** was a primary reason in 2002 that people did not visit a dentist.[8] In this study, stakeholders overwhelmingly blame low base payment rates for dental services as a barrier to providers participating in MHCP but cited other barriers such as the administrative complexity of the MHCP dental program, a restricted adult benefit set that sometimes conflicts with what the provider believes to be an adequate standard of care and too many cancelled appointments. These findings are consistent with research in other states.[9]

- **Participant perception of the need for care**. In a 2009 survey, the most common reason respondents gave for not visiting a dentist was that the respondents did not perceive they or their child needed care.[10]

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[*] Of children continuously enrolled at least 90 days.

- **No regular place of care**. Many MA patients are seen on a one-time or emergency basis rather than having an ongoing relationship with a dentist. Fidelity to a provider can be compounded by the fact that MA patients may move more frequently due to housing challenges or other factors.

- **The need to travel for care**. Residents of rural areas may have to travel long distances for dental care; rural and urban residents may live in areas with relatively few dental providers nearby, although the problem appears more common in many rural counties.

- **Participant challenges.** MHCP enrollees may experience access issues related to

    o disabilities,

    o language barriers,

    o difficulty navigating the MHCP or dental service system,

    o lack transportation or child care or

    o immediate health and living concerns that take precedence over dental care.[11]

Due to limited access to dentists, several stakeholders discussed the need to expand access to allied health professionals licensed in the state to provide dental services, particularly those who, as a requirement of licensing, must serve low-income and public-program patients.

The numbers reported in the table above also do not include any dental care that was not billed to MHCP, such as dental care provided free of charge by a provider through charity care. Such services would not be reported to DHS.

IV. Dental Services System Overview

Administrative Structure

Minnesota's structure for enrolling, monitoring and paying dentists has many layers. These include federal regulators, DHS, eight managed care organizations (MCOs) and multiple dental administrators. One MCO, HealthPartners, is both a health plan and a dental administrator.

- Dental services are provided through FFS and managed care.

- DHS directly administers dental services provided under FFS, paying according to a base FFS fee schedule.

- DHS provides capitated payments to the eight MCOs, who then enter into contracts with dentists for care provision.

    o Each MCO determines its administrative processes and the rates it pays through its contracts with dentists.

    o MCOs must at least provide the same service scope and payment as FFS.

    o Many MCOs subcontract with a vendor to administer dental services on their behalf.

Enrollees

In 2012, the total number of adults enrolled in the MHCP program for at least 90 continuous days was 547,260.

- Approximately 80 percent were enrolled in a dental MCO and 20 percent were enrolled in FFS.[12]

- Participants in the FFS system are primarily people with disabilities but also include other populations, such as American Indians and undocumented persons.

- Some people also receive services through FFS on a temporary basis because they are awaiting assignment to a MCO or may have temporarily lost their MCO enrollment (e.g., they did not pay their premium on time).

- Approximately 71 percent of all MHCP participants are families with children, 19 percent are people who have a disability or are blind and 10 percent are 65 and older.[13]

Providers

Minnesota had 3,396 licensed dentists in 2011. About 75 percent of them were enrolled as MHCP providers and approximately 65 percent were participating in the program (that is, had submitted at least one MA claim in the year). Eleven percent of participating dentists, as illustrated in Figure 1, saw only one or two patients during the year.

Figure 1: 2011 MHCP Patient Load—Participating Dentists
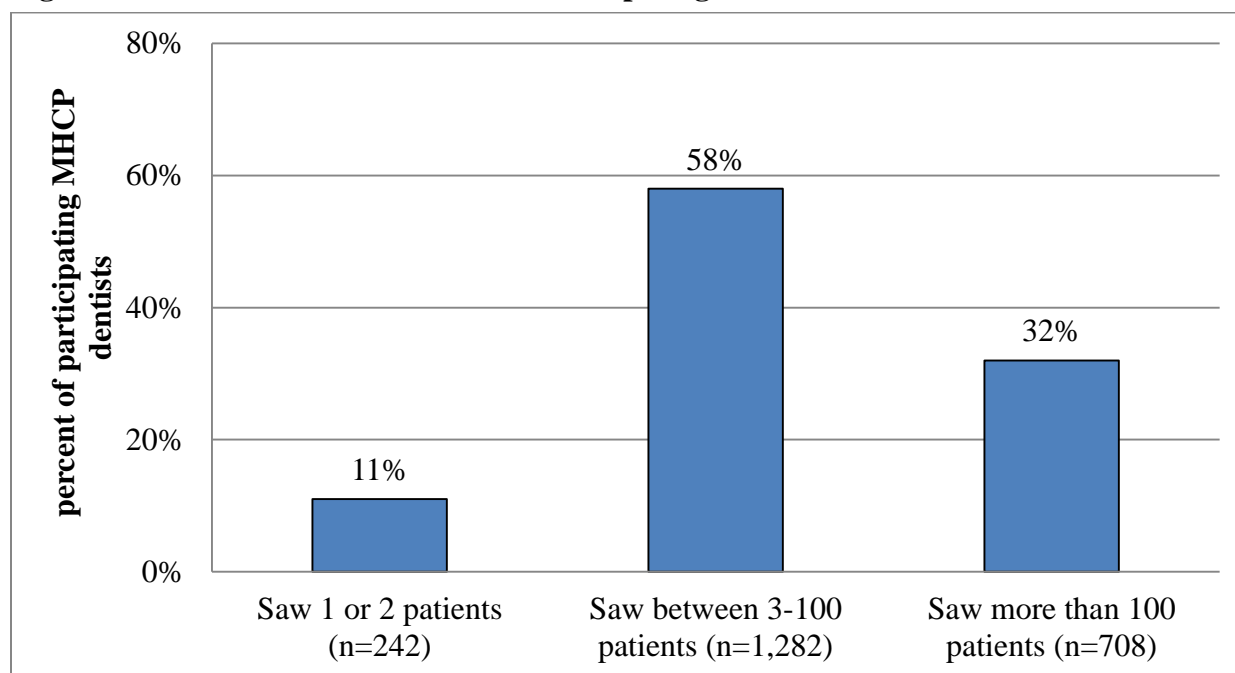
- Dentistry is usually practiced in small offices; nearly 90 percent of dentists provide care primarily through a private practice or organization.[14]

- The OLA reports that four percent provide care through community-based care for underserved populations, including community health centers, Federally Qualified Health Centers (FQHCs), rural health centers or other nonprofits.

- The remaining dentists practice in instructional settings or in one of the five state-operated dental clinics.

In addition to dentists, Minnesota has one of the largest number of allied professionals, including dental assistants, hygienists, dental therapists and advanced dental therapists (Alaska is the only other state with a dental therapist workforce). These allied practitioners each have a distinct scope of practice and different levels of autonomy to work outside of a traditional dental office model under the general supervision of a dentist.

Benefits and Costs
Nationally, dental benefits make up less than five percent of Medicaid payments.[15] In Minnesota, Medicaid dental costs are about three percent of the MHCP budget.

MHCP provides comprehensive services to children and pregnant women. Children's services include, for example, relief of pain and infections, restoration of teeth, maintenance of dental health, non-cosmetic orthodontic services and other medically necessary services. In addition, dentists must follow the CMS-required age-related standards for child and teen check-ups as part of EPSDT.

Adult dental services are limited to those services listed in statute.[*][16] Statutory specifications are detailed, such as how many teeth cleanings (prophylaxis) or x-rays a person may receive in a year. In the managed care system, each MCO must provide the minimum benefit set but may provide others, though DHS does not pay for additional benefits. DHS pays MCOs for dental care as part of the overall health services capitation rate for each MHCP participant; dental services are not separately capitated or carved out.

Access and Reimbursement Issues

Minnesota has taken many steps to address the sometimes-competing goals of improving access, controlling costs and encouraging providers to participate in MHCP. However, despite program changes, provider participant rates have remained constant.[17] As described in later report sections, these steps include

- **Adjustments to base FFS and MCO rates.**[18] Rates have fluctuated over time, with several three to five percent increases and three percent decease to FFS rates in the last decade. Most recently, the 2013 legislature approved a five percent increase to FFS base rates that was also applied to managed care.

- **Changes in adult services.** The legislature reduced the adult benefit set in the 2009 session, eliminating coverage of some services such as crowns.[†][19] In the 2013 session, the legislature expanded the non-pregnant adult benefit set to restore several areas of coverage. For example, coverage now includes on-site delivery in extended care facilities, additional staff time to accommodate patients with behavioral challenges and up to four additional cleanings under certain circumstances.[‡]DHS also conducted an in-depth legal review and interpretation of statute and rule that resulted in restoration of coverage for some services such as those related to dentures (denture relining, rebasing or repair).

- **Establishment of the Critical Access Dental (CAD) Payment Program.** The CAD payment program provides increased payment rates for specific providers who serve low-income and underserved populations and meet other criteria. Criteria for provider participation have changed over the years as part of state efforts to reduce costs or increase access.

- **Rule 101**. Rule 101 requires dental providers who serve members of other state-sponsored health care programs to participate in MHCP and accept, on a continuous basis, new patients who are MHCP recipients. Generally, a dentist may limit acceptance of new MHCP recipients if the MHCP recipient caseload is at least 10 percent of the provider's annual active caseload, compared to a 20 percent cap for other medical providers.[20]

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[*] See Appendix B for list of services.

[†] The National Academy for State Health Policy notes that because of its "optional" status, adult dental coverage is often one of the first areas states turn to when making Medicaid reductions.

[‡] For example, for patients "who are physically disabled or reside in a facility (including nursing homes) or group home setting" or "who have a medical condition that puts them at high risk for complications" or have "cognitive impairments that render cooperation with daily oral care challenging, with or without periodontal disease."

- **Management of DHS Direct Care and Treatment clinics.** Minnesota's five Direct Care and Treatment clinics (formerly State Operated Services) provide direct services to people with developmental disabilities, severe or persistent mental illness or brain injury who are unable to obtain care from other providers. Clinics are located in Brainerd, Cambridge, Faribault, Fergus Falls and Willmar.

- **Identification of barriers to access.** Minnesota and many other states have long generated lists of oral health access barriers, such as low reimbursement rates, low dentist participation in public programs, complicated administrative processes, cultural barriers and a lack of good data. Several people interviewed for this study said stakeholder lists of problems and solutions have been fairly consistent over the years.

- **Expanded services beyond dental offices.** The state has several initiatives to expand services in settings beyond dental offices through allied oral health professionals and other pilot projects and collaborations. For instance, DHS and the Minnesota Department of Health (MDH) participate in a *Medicaid Oral Health Learning Collaborative* to improve children's access and use of services within Medicaid programs.[21] MHCP also covers fluoride varnish treatments administered by non-dental providers. MHCP has covered dental therapist services since September 1, 2011.

State and DHS initiatives take place against a backdrop of DHS efforts to reform MHCP to provide services that are more person-centered, better coordinated across service settings, more effectively align financial incentives and have a stronger focus on evidence-based practices.[*]

Stakeholder Roles
A myriad of stakeholders are involved in establishing rates, shaping policy, administering the program and providing services.

- The legislature determines MHCP dental services payment rates and services, which also must be approved by CMS.

- DHS administers the program, as later described in some detail.

- Dentists and other providers deliver care.

- Counties and other community organizations provide outreach and support through their efforts to connect MHCP recipients with care they need.

- Many providers focus on MHCP participants or underserved subpopulations, such as community clinics and special MCO initiatives.

- MHCP participants and their behaviors are also a major element of the service system.

- DHS formally receives stakeholder input from the legislatively-mandated Dental Services

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[*] See list of recent DHS programs in Appendix C.

Advisory Committee (DSAC). This 13-member group, a subcommittee of the Health Services Advisory Council, consists of a variety of dental providers, representatives from health plans and public health, health researchers and a consumer. The role of this advisory committee is to provide clinical guidance to enhance the department's ability to design dental care benefits and coverage policies for MHCP. One of DSAC's stated purposes is to work with DHS to support evidence-based coverage policy so that decisions regarding services paid for by public programs are based on the best available quality of care and cost effectiveness research.

- Organizations involved in representing or monitoring dental providers include the Minnesota Dental Association and the Minnesota Board of Dentistry.

- Other Minnesota stakeholders include dental service administrators and managed care organizations (MCOs), the Minnesota Oral Health Coalition (MOHC),[*] non-traditional service sites (e.g., schools and nursing homes) and those involved in dental provider educational systems.

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[*] MOHC is a membership-based organization dedicated to promoting sound public oral health programs and policies in Minnesota. It was established in partnership with the MDH's Oral Health Program and helped produce the state's first-ever Oral Health Plan: Advancing Optimal Oral Health for All Minnesotans.

V. Section 1: Funding and Access

Background and Findings
This section focuses on ways to determine an appropriate reimbursement and payment structure that will encourage provider participation. The major finding of this section is that the legislature needs to raise base reimbursement rates to better compensate providers to incent them to participate in MHCP, thereby improving access. Increased rates are not the only way to improve access but are a fundamental step.

Dental Services Program Funding
MHCP dental programs are funded primarily through a mix of federal and state sources.

- The federal share is determined through a formula that takes into account the state's per capita income each year. The federal government currently pays 50 percent of MA costs in Minnesota.

- The state's share is supported through General Fund appropriations and a two percent provider tax imposed to fund the state's Health Care Access fund.[22]

- Additional funding comes from counties, enrollee monthly deductibles and copays and other state and federal funding, such as MDH grants.

Expenditures for dental services accounted for approximately three percent of total MA in 2011, or approximately $130.8 million in 2011.[23] Expenditures are largely impacted by the number of individuals enrolled in MHCP, the length of enrollment and the type and volume of services provided.

Provider Payment and Rate System
Federal law requires that state payment rates be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[24] States may develop their rates based on the cost of providing service, a review of what commercial payers pay in the private market or a percentage of what Medicare pays for equivalent services. CMS must approve the state's methodology. The dental services payment and rate system, like its administrative structure, is complex. There are various payment types and adjustments depending on the type of provider, whether the provider is in the FFS or MCO system and whether the legislature changed payment rates in a given year. Major aspects are described below.

- **FFS**
  In the FFS system, the state pays providers according to base FFS rates. Dentists bill the state, and the state reimburses them at a level determined by state law. Current state law requires that rates be based on the median of 1989 usual and customary charges submitted by dentists in the region.[*][25] Rate increases and decreases are achieved through legislation and have modified the originally calculated base rate over time.

  Dental FFS rates are the same across all regions of the state. Some FFS providers are also eligible for supplemental payments. For example, community clinics receive add-on payments of 20 percent of rates.[26] These clinics are nonprofit, tribal, Indian Health Service or publicly owned clinics established to provide health services to low income or rural population groups.[27] In 2011 DHS made payments to 130 community dentists and 14 clinics.

- **Managed Care**
  DHS pays the MCOs a predetermined monthly amount per enrollee (capitation) to cover the costs of the enrollees' health care. This includes dental care. The capitated payments are intended to limit the state's financial liability while providing an incentive to the MCOs to control costs.[†] The dentist bills the MCO and is reimbursed according to the dentist's contract with the MCO. In other words, DHS does not set or administer MCO rates to dentists; MCOs and dentists negotiate payment rates and enter into contracts. The OLA reported that in the state's larger managed care programs, the average MCO payment rate was 121 percent of the FFS rate. MCOs are also required by contract to ensure access to all services.

- **Critical Access Dental (CAD) program**
  The CAD program provides supplemental payments to approximately 375 dentists working in 75 clinics across the state. The program targets practices that serve a high number of MHCP participants and allocates increased reimbursement to them, bringing a provider's total payments closer in line with commercial market conditions.[28] CAD pays providers an additional 35 percent of what they would otherwise be paid under MA and 30 percent under MinnesotaCare.

  This program was created by the legislature in 2001 and applies to payments made through FFS and MC. The FFS add-on payment is made at the time the claim is

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[*] Dental services are paid for at the lower of (1) the submitted charge or (2) the prevailing charge. The prevailing charge is defined as a specified percentile of all customary charges statewide for a procedure during a base year. current prevailing charge for dental services is the 50th percentile of 1989 submitted charges, minus either 20 percent or 25 percent, depending upon the type of service. Since 1992, the legislature has imposed several across-the-board adjustments to the base rates for dental services that have increased or decreased rates, including a 3 percent decrease in all rates in 2011. State-operated dental clinics were exempt from this reduction.

[†] Whether MCOs or the FFS system is actually more cost effective is a subject beyond the scope of this report. However, see "PCG: Report on the Value of Minnesota Health Care Programs (MHCP) Managed care, as Compared to Fee-for-Services." Quality initiatives related to dental services appear to be far behind similar efforts in general health care services.

processed, while managed care payments are made on a quarterly basis calculated through reports provided to DHS by the MCOs. CAD payments primarily go to non-profit clinics, including community clinics (who also receive the 20 percent add-on payment) and other providers that serve thousands of the state's most vulnerable populations.

- Historically CAD providers had to have a non-profit status. Other entities were added in July 2013.[*] Despite the changes, the current CAD program leaves out many dental providers in private practice who are serving MHCP recipients in their communities but are unable to meet the qualifications of designation. Additionally, private practice dental clinics, as one criterion necessary for designation, must attest that at least 50 percent of their patients are MHCP recipients. However, this measure is not something that DHS can verify.

- **Other payment systems**
  A number of additional payment rate systems have been created, such as those for FQHCs, Rural Health Centers, community and public health clinics and dental trend payments. All of these payment rate systems are intend to increase access for dental services for underserved populations. As previously noted, the state also funds five state-operated dental clinics.

Major Issues

- **Multiple Payment Types**
  Each of Minnesota's many payment types was developed through "separate and independent processes rather than through a systematic, coordinated assessment of appropriate payment rates to ensure dentist participation and patient access statewide."[29] Payments fluctuate by year and different processes are used in determining and administrating each payment type.[†] As the OLA concluded in its 2013 report:

  > Minnesota uses a myriad of policies and methods to reimburse MA dental providers. These payment methods and policies are poorly coordinated and inconsistently applied across MA programs … The Legislature and DHS should better coordinate payment policies and rate-setting for [MA].[30]

  As noted earlier in this report, dental providers are paid under legislatively mandated FFS rates and negotiated MC rates. Providers may receive add- on payments if

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[*] Effective July 1, 2013, two additional dental practice types were made eligible for critical access provider status: city owned and operated hospital-based dental clinics and private practicing dentists who are enrolled with MHCP, as long as they meet certain criteria, such as private practicing dentists must be located within a Health Professional Shortage Area (HPSA) and more than 50 percent of the dentist's patient encounters must be with patients who are uninsured or covered by MA or MinnesotaCare.

[†] The dental services administrative structure and process as discussed in Section 3.

o they are a community health clinic

o they are CAD designated, with their FFS claim payments and quarterly payments from each MCO with whom they contract.

For many providers, these multiple streams of payment are difficult to track and challenging to predict. For example, MCOs make CAD quarterly; however, many providers receive a lump sum or have adjustments made through payment of future claims. As a result, it is difficult for providers to verify their CAD payments are correct and even more difficult to tie those payments back to specific patient encounters. Moreover, because the CAD payments in managed care are quarterly, payments are delayed. In addition, there have been instances where MCO reporting issues have caused all providers MCO CAD payments associated with that MCO to be delayed by up to nine months.

- **Impact of rate increases**
  Stakeholders overwhelmingly favored rate increases to improve provider participation and access. Although the legislature did increase the base rate for dental services by five percent in 2013, most stakeholders indicate this was not sufficient.

  o Research and interviews indicate that insufficient rates, plan complexity and administrative issues deter MHCP provider enrollment.[31]

  o Research also indicates that access increases as rates become closer to market rates, although results are somewhat mixed.

  o Some studies suggest that rate increases must be made in conjunction with other changes such as simplified administration including use of a single administrator model.[*]

  o When rate increases result in improved access, Medicaid claims and costs can rise; in some cases, increases have been substantial.[32]

An underlying issue in this balance between costs and improved access is whether the state considers dental care to be an essential part of health care services, "optional" or an unnecessary service.

Another element in rate increases is the Critical Access Dental (CAD) program. As noted, to incent providers serving a high volume of low income participants. CAD pays its providers substantially higher rates for procedures than are made to other providers rendering the same service, to incent providers serving a high volume of low income participants.

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* See Appendix D for more detail on studies on the impact of rate increases.

CAD payments and increases help sustain some safety-net providers who serve underserved populations.

- At the same time, DHS research and the OLA findings suggest that increased CAD funding and other rate increases have not improved rates of provider participation in MHCP, and data indicates fewer MHCP recipients, particularly children, are not receiving necessary dental services.

- In addition, the CAD payments are tied only to the business structure of the dental clinic (e.g., non-profit community health clinic) or the volume of MHCP patients served.

- Designation as a CAD clinic and CAD payments are not based on any quality of care measures. In fact, previous research and a few stakeholders also indicated that the program prompted some CAD providers to over-treat patients.[*][33]

- Stakeholders varied widely in their opinions of whether the CAD program was effective, and several stakeholders expressed concerns that approximately half of the current CAD payments go to one dental provider group.

- **Dental provider costs**
  Because dentists are not required to report on actual costs of care, very little data exists or has been reported regarding the actual costs of providing dental care to MHCP enrollees. Some stakeholders reported they knew what their monthly operating costs were, but they were unable to separate out these costs by procedure or indicate their break-even point or report administrative costs as a percent of operational costs. All agreed, however, that the current system does not adequately compensate them for the cost of care.

  One reason dentists are not required to document their costs is that the reimbursement system is based on usual and customary fees charged rather than costs or resources used.[†][34] The state's method of paying dentists based on charges is out of step with how MCHP pays for many other services. For example, DHS pays MHCP physicians several other MHCP FFS services using a version of the Resource-Based Relative Value Scale (RBRVS). Medicare began using RBRVS in 1992 for physician and other professional services. Payments are determined according to the cost of resources needed to provide services, and rates are adjusted for geographical differences. It has been adapted for Medicaid in many states, as well as for worker's compensation in Minnesota.[35]

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[*] Several respondents also indicated the problems with the HPSA designation which is a factor in CAD determination. For example, if a dental provider is located in a non-HPSA area that is on the border of a HPSA area and a majority of its clients from HPSA areas, this provider would not be eligible for CAD. Also, an existing provider serving a large number of underserved people in an area could be denied CAD because the provider's presence means the area is not a HPSA area; if the provider were a new provider coming in to the area, the provider would qualify for CAD, at least until the next review.

[†] Usual and customary charges are a dentist's regular, non-discounted charge for a service as listed on MHCP claims. The ADA defines as usual and customary payments as "the fee an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement."

- **Effectively targeting funding**
  Several stakeholders indicated that it is difficult for the state to target funding to improve access when there is no agreed-upon definition of access, no evidence-based set of adult benefits and no evidenced-based standards of care. What is an appropriate treatment for patients based on their diagnosis and needs? There appears to be little or no industry standards in this area, so practices vary widely. Moreover, because many people have no dental insurance or have commercial insurance with high deductibles and co-insurance, the patient's willingness to pay their cost-sharing portion heavily influences treatment decisions. Patients covered under MHCP do not have the same cost-sharing concerns as those with no dental insurance or high deductible and co-insurance commercial plans.

  Interviewees did appear to agree that the current limited adult benefit is too limited.[*] A few people said the current benefit set was established in haste based on budget concerns rather than practitioner consensus. Interviewees suggested these areas of expansion to the current adult benefit set:

  o Periodontics

  o Frequency of examinations and diagnostic testing (e.g., radiographs) are aligned with medical necessity for a given patient and evidence-based standards

  o Comprehensive benefit set. This would require the legislature and all other stakeholders to acknowledge that oral health is an essential part of health services and not an "optional" health service for adults.

- **Compensation Related to Disparities**

  o **Oral Health Disparities**
    In addition to general reimbursement issues, the legislature asked DHS to provide recommendations for compensating providers for any added costs of serving people experiencing oral health disparities. The legislative language for this study broadly refers to oral health disparities in terms of MHCP patients and populations who have a higher incidence of oral health disease and lower access and use of services. MHCP-specific data in this regard is limited. Table 2 shows utilization data based on the percentage of people who receive any dental service. Other stakeholders, DHS, MDH and national information sources have associated oral health disparities, such as incidence of dental caries, oral health disease and communication barriers with demographic and socio-economic factors such as age, race, income and educational levels.[36]

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[*] Issues associated with a lack of care standards are discussed in Section 2.

Table 2: Percentage of MHCP recipients who receive dental services by various factors, 2012

DESCRIPTION	PERCENTAGE
Race category	
White	38%
Black	38%
Hispanic	42%
Asian-Pacific Islander	39%
Native American	39%
Unknown	36%
Disability Status	
Not Disabled	38%
Disabled	44%
Blind	39%
Rural/Urban Status	
Urban	39%
Rural	37%
Unknown	43%
Managed Care vs. FFS	
Managed Care	42%
FFS	29%

- When asked to identify who experiences disparities, interviewees most frequently referred to people with disabilities. For example, some stakeholders and related research point to special access issues for some people who have developmental disabilities, are frail elders or have particularly complex conditions.[37] However, the utilization data does not corroborate that perception; more disabled recipients (42 percent) received a dental service in 2012 than non-disabled recipients (38 percent).

- Utilization data indicates no disparity between whites and non-whites on the measure of whether or not the person received a dental service in that year.

- Little difference was also noted between rural and urban areas; however, those in managed care (42 percent) were much more likely to receive a dental service in 2012 than those in FFS (29 percent).

o **Added costs**

There is little or no recent quantitative data about the "added costs" incurred by providers serving the MHCP population and subpopulations. However, stakeholders cited many examples of ways they believed it is more costly to serve people experiencing oral health disparities. For example, it can take extra time to:

- address high behavioral needs for some people (as noted, the 2013 legislation added coverage of behavior-related services for adults in addition to children).

- address complex oral health needs among people who have difficulty maintaining oral hygiene, do not see a dentist frequently or who are older and have years of accumulated needs and dental work.

- use interpretation or translation services. MHCP generally provides coverage for medical service language interpretation and translation. However, providers need to arrange for these services and cover the costs if an expected patient does not show up for an appointment where the provider has arranged for language services.

- communicate with clients. When an interpreter is involved, providers need to account for extra time required by the interpreting process during an appointment. Providers may need extended time with other patients to explain procedures or care, or counsel them regarding oral health behaviors.

- coordinate care. Providers noted the need to develop care plans and coordinate oral and other health services.

Recommendations and Strategies

Recommendation 1: The legislature should increase base payment rates for dental services and refine the payment structure to encourage provider participation in Minnesota's Health Care Programs.

All interviewees strongly encouraged the state to raise the base payment rates, so they at least cover overhead costs, which are estimated to comprise 60 to 65 percent of overhead cost and so dentists do not lose money through their participation in MHCP.[38]

- The current method of basing rates on 1989 charge data does not seem reasonable.

- Stakeholders and researchers indicate that current MA rates are often 30 to 50 percent of current usual and customary costs.

- Compared to other states, Minnesota pays lower rates.

- The OLA's extensive and recent research also concluded that Minnesota's rates are too low and the legislature should increase FFS rates.[39]

- In addition, the multiple and uncoordinated payments for dental services under MHCP should be simplified as was noted by the OLA and many interviewees.

Strategies
To increase reimbursement and simplify the payment system, DHS recommends that the legislature and dental stakeholders pursue the following strategies.

- **The legislature should give DHS the flexibility to tie rate increases to access or quality outcomes**.

  o The current dental payment system is based only on fees charged. Yet DHS has modified payment systems for several other services to link payment to outcomes.

  o For dental services, performance indicators might include utilization levels (such as percentage of MHCP participants receiving preventive care), changes in patient outcomes (such as a reduction in dental caries) or indicators of providers delivering comprehensive care (such as rates of preventive and restorative services by provider).

  o For providers unable to meet the expectations, DHS could provide support and create non-punitive corrective action plans.

  o An impediment to tying rate increases to performance indicators is that this adds a new

layer of complexity to the reimbursement system. However, some complexity is called for if the result is documented improvements in access and outcomes.[*]

- **The legislature should simplify and refine the payment system by incorporating the Critical Access Dental (CAD) payments into the overall rate structure.**

  o Stakeholders interviewed for this study and the OLA study called for a simplified payment system. The system for determining CAD eligibility and reimbursement is complicated and confusing, said some stakeholders, while others noted significant issues with the HPSA designation requirement for private practice dentists.[†]

  o Additionally, CAD designation is not based on quality of care or cost-effective care measures. Sufficiently raised rates can eliminate the need for a separate CAD program, especially because historical changes in the CAD rates have not affected access.

  o Increased, uniform rates may encourage private practice dental providers to participate in MHCP or increase the proportion of MHCP patients they see.

In the future:

- **DHS should lead discussions regarding ways in which the state could more similarly pay MHCP physicians and dentists** (i.e., incorporating components of a resource-based system in dental service payments).

  o There appears to be general agreement that oral and other health services should be better coordinated, yet payment systems remain completely separate, with different processes and bases of payment. Unlike MHCP physician services, for example, dental payments are based on fees charged. A fee-based system does not take into account whether the fees are related to efficient or effective care.

  o Consequently, more than three quarters of all public and private payers—including Medicaid programs—have changed their systems to adopt components of the Medicare Resource-Based Relative Value Scale (RBRVS) used to pay physicians.[40]

  o The state would need to better understand MHCP costs and resources and possible implications before moving in this direction. However, an RBRVS system could rationalize payments per the value and resources used in service provision and promote integration of oral health services with other services.

  o A resource-based system is likely to be quite unpopular with dentists. In a recent survey only 13 percent of Minnesota dentist respondents favored an RBRVS approach.[41]

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[*] See Section 2 for more on development of measures and standards of care.

[†] See discussion of HPSAs in Section 2

- **DHS, MDH and others should collaborate to assure that oral health disparity information is efficiently and effectively gathered**

  o More information is needed regarding oral health disparities. This includes better information regarding disparities experienced by MHCP subpopulations proposed interventions, including input from MHCP participants and local communities.

  o DHS and MDH have numerous health disparity initiatives, but oral health appears largely left out of these efforts. These efforts could be expanded to collect data on oral health issues.

  o Other projects are focused on oral health but do not include much MHCP information.

  o Many providers also have important health disparity information that has not been compiled and shared.

  o Examples of possible expanded collaborations include putting more emphasis on oral health in the DHS Annual Health Care Disparities report, expanding dental focus in ongoing Olmstead Plan[*] implementation and adding oral health indicators to DHS's "Measures that Matter" and the Managed Care Public Programs Consumer Satisfaction Survey.

  o A stronger focus on MHCP enrollee data could also be added to MDH Health Disparities Task Force activities and MDH oral health plans.

  o DHS coordination with other efforts and agencies would facilitate an efficient and broad-based look at disparities.

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[*] The state's Olmstead Plan for people with disabilities includes some information on dental services, including a plan for more data collection. The data timeline is 1) By December 31, 2014 establish baseline data for current care (medical, dental, chiropractic and mental health) of people with disability; develop an implementation plan to further assess, develop and respond. 2) By August 1, 2015 and biannually thereafter, measure how health care access and service are changing over time. Analyze the data to identify policy, practice and program changes that need to be made so that improvement happens more quickly; establish plans to make these changes.

VI. Section 2: Improving the Model of Service Delivery

Background and Findings
This section describes findings about how dentistry lags behind other health care systems in developing access and quality measures and developing standards of care. Although oral health is an integral part of overall health, dental and other health services are rarely integrated. Innovative approaches such as teledentistry and portable delivery systems and an expanded workforce with more experience in serving MHCP participants would help to increase MHCP participant access to care. Although some of these improvements are largely out of DHS's scope, DHS can continue to collaborate with other entities on overall efforts to develop an improved system. This system would be evidence-based, integrated and focused on prevention. It would also use innovations in service delivery (e.g., portable delivery systems and teledentistry) and an expanded workforce to increase access and enhance cost-effectiveness.

Access and Quality Measures and Standards of Care
A first step in improving access is developing consistent measures of access and standards of care, as several stakeholders noted. CMS, states, agencies and providers define access in various ways and have struggled to improve measurement. State efforts are driven in part by lawsuits claiming that Medicaid rates are insufficient. The Medicaid access requirement forces states to assure that payments are "sufficient to enlist enough providers so Medicaid participants have approximately the same access to care as people not using Medicaid.[*] Related to all health services, CMS reports that only a few states use data to determine if they meet the access requirement.

Within and outside of government, common access measures include utilization of services, availability of providers, prevalence of oral health disease and number of complaints or reported barriers (Table 2).

- CMS, for example, monitors states' dental services by whether children age six to nine receive any preventive care or have a sealant on a permanent molar.

- The Dental Quality Alliance (DQA) developed a set of services ("Measure Set 1") to evaluate children's use and access to certain services, as well as care continuity and per member per month costs.[†] These validated measures are categorized by utilization,

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[*] The Medicaid access requirement in 42 USC Sect. 1396(a) (30) (A) (also referred to as the equal access provision) requires states to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(I)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." CMS's proposed rule on states' measurement of access provides an overview of current access issues at www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf.

[†] In 2008, CMS asked the American Dental Association (ADA) to aid in the development and promotion of performance measurement as a means to improve oral health. The Dental Quality Alliance was convened in 2010 and endorsed a first measurement set 2013. This measurement set has had extensive scrutiny by academic research partners. DSAC recommended these measures for use in MHCP.

quality of care and cost measures. Quality measures focus on utilization (e.g., whether a child received certain treatments and examinations.)

Table 3 identifies some examples of access measures that could be used, likely in combination, as a proxy for access to dental care.

Table 3: Examples of Access Measures

Focus	Examples
Service utilization	• The rate of MHCP-enrolled children who receive *any* preventive dental service; number age six to nine who have a sealant on a permanent molar (two measures by which CMS is monitoring states' dental services) • Percent of people who receive any dental services or obtain atraumatic care in an ER • The percentage of enrolled children who received an oral evaluation, sealants and fluoride treatments in a year[*][42]
Geographic access	• The number and percent of dental providers in a geographic area, including current and new MHCP cases, providers who do not (or who no longer) accept MHCP patients and utilization and outcomes by rural/urban status.
Ability to obtain appropriate care	• Number of providers contacted until a participant finds a participating provider; quality of care; cultural measures
Disease and adverse events	• The prevalence of oral health disease and related factors, such as dental carries, periodontal disease, oral cancers, lost teeth and extracted teeth
30 minute/mile availability	• The availability of providers with within 30 minutes or 30 miles (this measure is often used by managed care organizations)
Health equity	• Access, disease and utilization measures by age, race, ethnicity, FFS/managed care, education status, disability, language used and others
Health Provider Service Area (HPSA) designations	• HPSA designations are based on factors such as geographic area, population groups and facilities. For instance, FTE dentist ratio to population, whether the population is a member of certain groups (e.g., Native American tribes) and whether the facility provides dental care services to an area or population group designed as having a dental HPSA.[43]

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[*] These examples are from the DQA's "Measure Set 1"

Patient satisfaction or complaints	The number of MHCP participant and advocacy complaints made to ombudsman offices, MCOs and other monitoring organizations.
Other dental measures	Whether the person has a usual source of care or continuity of care; per member per month costs; operating costs

As noted in the table above, CMS, as part of the Oral Health Initiative, has set a goal for all Medicaid programs to increase two utilization measures for children enrolled continuously for at least 90 days. Within the next four years, states should increase, by 10 percent each,

- the rate of children who receive at least one preventive dental service (by or under the supervision of a dentist) and

- the rate of children ages six to nine who have a sealant on at least one permanent molar.

As noted in Section 1 of this report, Minnesota has been losing ground on these measures over the past three years. Recommendations about changes to the MHCP dental program should take into consideration how such changes will improve these measures.

As DSAC and others have concluded, dentistry lags behind other medical fields in establishing quality measures and standards of care. Factors contributing to this are the sole practitioner business model, lack of diagnostic codes and lack of an electronic dental record.[44]

- The American Dental Association (ADA) has standards for informatics and dental products; however, standards of care, equivalent to those for other medical conditions, do not exist.

- In legal situations, a "standard of care" generally refers to the degree of care that a reasonable and prudent provider would exercise under the same or similar circumstances. This seems to apply to the dental industry's state of the art.

- In other medical fields, standards of care typically include quality statements and measures, objective clinical criteria and processes for managing the condition and providing care.

Integration of Oral and Other Health Care Services
One characteristic of the current system is that most dental care is provided in settings separate from medical care, without coordination between settings. Care is offered in traditional dental offices, each with its own care management system, billing system and administrative and record-keeping systems. Even newer electronic dental records are separate from the electronic medical record. The separation of dental from other services can adversely affect care outcomes. As the Institute of Medicine reported:

Evidence shows that decay and other oral health complications may be associated with adverse pregnancy outcomes, respiratory disease, cardiovascular disease and diabetes. While tooth decay is a highly preventable disease, individuals and many healthcare professionals remain unaware of the risk factors and preventive approaches for many oral diseases, and they do not fully appreciate how oral health affects overall health and well-being. The continued separation of oral health care from overall health care contributes to limited access to oral health care for many Americans.

The value of coordinating oral health care and overall health care is getting increased attention in Minnesota. For example, MDH's 2013 Oral Health Summit focused entirely on integrating oral health into broader health systems. Interviewees for this study indicated

- MHCP participants are seen at higher rates in medical settings than dental settings, which presents an opportunity for linking those visits to dental services. Care in integrated settings is more likely to include prevention and reduce oral disease. The system is likely to avoid the costs associated with treating preventable conditions.

- "One-stop" settings where MHCP recipients can receive multiple services, such as fluoride varnish and dental sealants during a well-child visit, increase access points and streamline the process of obtaining dental care for recipients.

- Delivering multiple services in one location can reduce administrative costs.

- Patients treated for chronic diseases, such as diabetes, are better served when oral health and medical health practitioners share information and complement each other's treatment protocols.

- Providing multiple entry points and referrals for dental care — at school, in the health clinic, at public health offices and in nursing homes— increases the likelihood that individuals will ultimately become patients of record in a full dental office.

Current approaches
As the value of coordination is more frequently realized, it is becoming more common. For instance, oral health screening is being offered to prenatal and diabetic patients; dental offices are providing blood pressure screenings and tobacco cessation referrals. Some medical providers, including FQHCs, have begun to co-locate dental offices in or alongside medical clinics, hospital emergency departments and public health clinics.
These settings

- can allow for non-dental staff to perform some procedures, such as applying fluoride varnish, with follow-up referral to a dentist for comprehensive care, or

- may include a full dental clinic on-site.

A few interviewees noted that children and seniors receiving MHCP are offered integrated care through Child and Teen Checkups and Minnesota Senior Health Options (MSHO), which specify

the need for early dental care, referral and anticipatory guidance, along with other health care services. The adult population between these age ranges does not have a comparable set of standard benefits integrating dental and health care.

Stakeholder recommendations for an improved system include

- **MCHP participants should have a regular source of dental care** rather than moving from dental clinic to dental clinic or using emergency rooms for non-emergency dental care. If access continues to be a challenge despite efforts to improve the system, DHS could consider expanding SOS dental clinics to serve a greater share of MHCP recipients.

- **Dental care should be integrated into new delivery systems,** particularly accountable care organizations (ACOs). ACOs have been developed to provide integrated care across many settings, but dental care is not included in their model.[*]

- **Facilities should be developed** that foster coordination of dental and medical care. For example, as some interviewees suggested, dental services could be expanded into local public health clinics and MCO-owned clinics. Communities could develop plans and partnerships to create new health centers with capacity to meet overall health care needs, including dental care.

- **The state's educational institutions** preparing the future medical and dental workforces should align their offerings with the state's need for professionals prepared to coordinate services across disciplines. With some exceptions, provider education is provided in separate medical and dental silos.

- **Rules and statutes should be changed to support the following:**

  o   Use of oral health access and quality measures as standards for ACOs/health homes.

  o   DHS/county referrals to help MHCP participants establish a regular source of care when participants contact public health and human services programs.

  o   Interoperability or integration of the electronic health and dental records.

  o   Establishment of quality and performance measures for coordinated care for practitioners to use in best practices for care coordination.

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[*] In 2010 the legislature mandated that DHS develop and implement a Health Care Delivery System (HCDS) demonstration, including ACOs. The goal of ACOs is to "ensure that every citizen of the state of Minnesota has the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long term care, and other services. (MDH. Health Reform in Minnesota. Accessed December 13, 2013, http://mn.gov/health-reform/health-reform-in-Minnesota/).The model will expand the current ACO model and include 15 accountable communities for health. These communities will develop and test models for integrating care. Jointly administered by MDH and DHS, the model is expected to save $111 million over three years and involve more than three million Minnesotans

o Possible extra reimbursement for patients who have co-occurring dental and medical diseases requiring coordination.

o Required dental check-up for school entry (similar to requirement for immunizations).

o Establishment of best practices and workflow process (from intake to the most complex care) to guide development of community-based entry points that lead to regular dental care.

Prevention

In addition to a more coordinated system, there is also a need for a system focused on prevention.

- DSAC and others have noted the importance of prevention in assuring MHCP participant access to appropriate services and in improving care. For example, school-based sealant programs were developed as an important way to reach children "where they are" throughout the state, especially in areas that have the lowest utilization of dental services.

- Sealants programs are a high priority for public health officials nationwide and in Minnesota. Along with public water fluoridation, sealants programs are one of two evidence-based recommendations of the US Department of Health and Human Services Community Preventive Services Task Force. In 2012, 11 percent of six to nine year olds had a sealant on a permanent molar tooth; this represents a drop from 15 percent in 2011 and 17 percent in 2010.

Teledentistry

Teledentistry is another delivery mechanism gaining traction in service delivery. Teledentistry is the use of telecommunications to provide dental services at a remote site. As DSAC has concluded, teledentistry may serve several functions.

- First, teledentistry may be a means for general dentists to consult with specialists. This practice provides timely and efficient dental care in rural areas where specialists are underrepresented. For example, a general dentist could transmit intraoral photographs and radiographs to an oral surgeon to develop a plan of care. This practice aligns with the current coverage of telemedicine.

- Second, teledentistry can also be used to provide dental examinations in the absence of an onsite dentist. This can facilitate the entrance to dental treatment and accurately identify those with the most acute needs.

Research has shown that oral examinations via teledentistry are comparable to in-person examinations. Pilot studies in Arizona,[45] California[46] and the Department of Defense[47] have all supported the use of teledentistry to increase access to dental care for underserved patients. In this approach, teledentistry requires the use of numerous technologies:

- A computer and secure internet connection
- An electronic dental record that facilitates the collection of necessary data
- Digital radiographs that can be acquired on site and interpreted remotely
- Intraoral photograph that allows the remote dentist to view the teeth and soft tissues

Allied dental personnel gather dental data and transmit it to a dentist for review. The Minnesota Board of Dentistry determines the scope of practice of each allied dental personnel. Under the general supervision of a dentist, various team members can expose radiographs, complete preliminary charting of the hard and soft tissue, expose intraoral photographs and take vital signs. It is the responsibility of the collaborating dentist to determine if the information is complete and of adequate quality to completely assess the oral health of the patient and develop a plan of treatment. According to some Minnesota interviewees, there are benefits, risks and barriers to teledentistry:

> Teledentistry has the potential to increase access to dental care. In underserved areas, bringing services to the patient rather than the patient to the dental office has been an effective strategy. The availability of specialty consultation may increase the number of general dentist in rural area. Utilizing dental auxiliaries to gather patient data is an efficient use of resources.

> In terms of risk, Minnesota Board of Dentistry or the Minnesota legislature has not addressed regulatory concerns.[*] Standards are needed for informed consent, standards for secure information transfer, and standards for communicating the results of the examination to the patient, monitoring for patient abandonment, and monitoring of continuity of patient care. A barrier to teledentistry is that current state regulations prevent billing for it.[48]

Teledentistry allows patient examinations without the physical presence of the dentist. This is of little value unless the patient also receives the necessary dental care, states DSAC: teledentistry service must be coupled with a commitment by the consulting dentist to provide care.

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[*] Other states, such as California, Alabama, Kentucky, Maine, Missouri and New Mexico, have addressed regulatory concerns.

Geographic Access

Another factor in providing oral health to MHCP enrollees is assuring access to services across all areas of the state. MHCP participants have uneven access to dental services, according to some interviewees and at least one measure of access, as identified in Table 4.

Table 4: Percent of MHCP recipients who received dental services for selected MSAs and non-MSA areas, 2012

Recipient MSA	
Minneapolis-St. Paul-Bloomington, MN-WI	40%
County not part of a metropolitan area	37%
Duluth, MN-WI	37%
St. Cloud, MN	39%
Rochester, MN	32%
Mankato-North Mankato, MN	39%
Fargo, ND-MN	37%
Grand Forks, ND-MN	38%
La Crosse-Onalaska, WI-MN	33%

Interviewees were most concerned about a lack of access in rural areas. As illustrated in Table 5, in nine percent of counties —all rural — only 24 to 29 percent of participants received any dental services. Across all counties, the percentage of participants who received services ranged from 24 percent to 49 percent.

Table 5: Percent of counties with lower, mid-range, and higher rates of MHCP dental services, 2012

County information	
Percent of counties with **24% to 29%** of MHCP enrollees receiving dental services	9%
Percent of counties with **30% to 39%** of MHCP enrollees receiving dental services	64%
Percent of counties with **40% to 49%** of MHCP enrollees receiving dental services	26%

- About two-thirds of the state's counties have been designated as a Health Professional Shortage Areas (HPSA) for dental care, most of them in rural areas. More than half of the dental HPSAs in Minnesota are low-income population designations.[*][49]

- However, a higher proportion of rural dentists accept MHCP patients than do in other areas. In 2011, 77 percent of dentists in Greater Minnesota participated in MA, compared to 61 percent in urban and suburban areas.[50]

- MHCP participants overall report having a "big problem" finding dentists.[†] Factors contributing to access problems in rural areas include fewer dentists in rural areas and the need to travel further to reach dental care.[51]

Contributors to Access Problems

Changes in the Critical Access Dental (CAD) program over the years have had a greater impact on rural MA participants than on their urban counterparts, said a few stakeholders. Several interviewees said that Minnesota's low reimbursement rates have a disproportionate effect on rural residents because many dentists with rural practices operate in a small, sole practitioner business model; they cannot share administrative and other overhead costs as they do in larger offices. A few stakeholders said the following issues also contributed to geographic access barriers:

- There are fewer dentists in rural areas.

- Some rural participants had to travel relatively far to reach care.

- Some areas have a greater number of dentists and allied professionals providing services in community settings, such as schools, nursing homes and public health clinics.

- Frequent changes in payment rates are an obstacle to enrolling and maintaining providers throughout the state. Also, until 2013, for-profit dental clinics were not eligible for CAD, which many interviewees said acted as a disincentive to accept MA patients.

- There is a lack of providers willing to serve MHCP residents in urban areas. Some HPSA designations include parts of the Twin Cities, and, as noted, dentist MHCP participation is lower in urban and suburban areas than in rural areas.

Improving Access

The Minnesota dental community and others have worked for years to improve geographic access and have identified ways to continue improvements. The most commonly mentioned strategies are using teledentistry, simplifying dental therapist credentialing, providing specialized dental training, expanding use of allied oral health professionals and supporting school-based

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[*] Appendix E provides HPSA maps including low-income information.
[†] A 2009 DHS survey of FFS MA recipients found that more people had difficulty finding a dentist than they did finding a personal doctor or nurse, especially in the northern and central parts of the state. Compared to a statewide rate of just under a third of respondents who said it was a "big problem" to find a dentist, about two-thirds of respondents in the northeast, northwest and the central region reported this difficulty.

sealant programs (these issues are discussed in other sections of this report). In addition, stakeholders gave examples of current or suggested approaches to meeting geographic needs including

- **Continue and expand coverage of volunteer dentistry services**

  o Minnesota dental providers and other agencies have collaborated to provide dental services to people experiencing barriers to access in different areas of the state. For example, community clinics, specialty clinics and programs, individual providers, some managed care plans and dental administrators provide or facilitate services to particularly underserved populations.

  o Other collaborations involve charitable organizations and volunteer dental providers, such as the dental program at the Salvation Army's Good Samaritan Health Clinic (Olmstead County), the Mission of Mercy in Bemidji and many other programs.[52]

  o Many of these organizations indicate that their organizations provide dentists, who may otherwise not wish to enroll as a MHCP provider, with opportunities to provide dental services to low-income individuals within their areas.

- **Restructure payment rates**

  - A few stakeholders recommended revising payment rates to support geographic access (e.g., replacing CAD with a rural/urban rate structure and allowing providers to perform as many needed procedures as may reasonably and safely be performed at one visit (to minimize return trips for patients who must travel long distances).

  - Many stakeholders suggest a base rate increase would persuade rural providers to participate in MHCP.

  - Another suggestion was for the state to find ways to make it feasible for small rural practitioners to participate in MHCP via a larger pool of providers, such as through county-based purchasing and multi-disciplinary health clinics (i.e., developing centers where various disciplines would gather to provide services in a common location on a regular basis, rather than trying to bring the patients to each individual practitioner.)

Workforce Issues
Behind all the issues and innovations stands the dental services workforce, including dentist and allied health professionals. State policymakers, educators, administrators, providers and others have led changes to improve the workforce and related client access.

- **Training and support**

  o One major approach to improvement is to provide training and other support to attract dentists to work with rural residents, people in other underserved areas or people with special needs. Specifically, dental providers can be encouraged through loan forgiveness programs, other funding supports, internships and enhanced training. Many stakeholders advocated this approach, noting the high cost of dental school and

the imminent retirement of dentists, especially in rural areas (an estimated 60 percent of Minnesota dentists may retire in the next 15 to 20 years).[53]

o MDH administers the competitive Dentist Loan Forgiveness Program using legislatively appropriated funds.[*][54] These competitive programs do not have adequate funding, and payments are taxed, which reduces their impact, said a few respondents.

o Stakeholders also noted that program restrictions limit participation, such as a requirement that dentists apply for the loan before setting up a practice. Stakeholders also recommended specialized training and internships, such as those at the University of Minnesota.

Other stakeholders suggested dentists and allied health professionals in training obtain experience working in rural areas or other underserved areas and with people with disabilities. Students must obtain community outreach experience as a condition of graduation from dental, dental therapy and dental hygiene programs.

- **Allied oral health professionals**
  In addition to encouraging more dentists to work with underserved populations, many people and organizations are working to expand the use of allied oral health professionals, including dental assistants, hygienists, dental therapists (DTs) and advanced DTs.

  o DTs positions and licensure requirements were created in 2010 and are increasingly viewed as helpful because of their capacity to expand access to underserved populations throughout the state, said several stakeholders. Statute requires DTs to practice in settings that serve low-income, uninsured and underserved patients or are located in dental HPSAs.[55]

  o Hygienists' scope of practice allows them to perform certain preventive and restorative procedures in settings outside a dental office, such as schools, group homes, community clinics and nursing homes.[†] Hygienists establish a collaborative agreement with a licensed dentist and work under her or his supervision. The dentist is not required to be present when the hygienist provides services, but must have prior knowledge of services being performed and give consent.

  o The 2012 Minnesota Oral Health Plan and many other sources support expanding use of allied health professionals as a way to both improve oral health in rural and underserved areas and to help accomplish other goals such as the integration of dental

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[*] The program provides funds for repayment of qualified educational loans for dentists working with low-income patients. Candidates must plan to practice for at least 30 hours per week for most of the year for a minimum of three years; a quarter of their annual patient encounters must include patients enrolled in state public programs; or the dentist must agree to receive a sliding fee.
[†] Since 2001, dental hygienists who establish a collaborative agreement with a licensed dentist have been allowed to perform certain preventive services in community settings under general supervision (Minnesota Statute § 150A.10, Subd. 1a).

services with other health care services and the delivery of cost-effective care:[56]

> By playing a role similar to nurse practitioners in the medical field, additional types of dental providers can expand the dental team's reach and help bring care to millions of people who live where dentists are scarce. Midlevel dental professionals also can make it financially feasible — and in some cases profitable — for private-practice dentists to serve more low-income patients. Because their salaries are significantly lower than dentists' salaries, alternative providers — who operate under the supervision of a dentist — also offer states a cost-effective approach to address the unmet need for care.[57]

o Under the current DHS FFS rates, allied professionals are reimbursed for a service at the same level as the dentist. This is different from medical settings where physician assistants' and nurse practitioners' rates are 10 percent less than the rate paid to a physician for the same service; physician extenders' rates are 35 percent less. Allied dental professionals can be cost effective for dental clinics and may encourage dental clinics to incorporate these professionals into their practices. Tension still exists, however, between the goal of increasing access by allowing allied professionals to be a first point of contact for underserved populations in the community and the goal of ensuring that only a qualified dentist diagnoses.

Recommendation and Strategies

Recommendation 2: DHS should continue to collaborate with other entities to support an evidence-based, integrated service delivery system that uses preventive services, portable delivery systems, teledentistry, a comprehensive adult benefit set and an expanded workforce to increase access and enhance cost-effectiveness.

A comprehensive approach to improving service delivery is needed. The more that state agencies and stakeholders can agree to setting overall goals for system development and work together toward them, the sooner MHCP participants and other Minnesotans will have expanded access and improved health outcomes. Strategies in each of the major areas are highlighted below. The findings of this study serve to emphasize the need for a system in which services

- are based on research regarding their effectiveness and integrated (or coordinated) across services settings;

- focus on prevention to avoid worse cost and care outcomes down the road;

- include innovative practices for assuring access and quality care (particularly portable delivery systems and teledentistry); and

- are provided by an expanded workforce able to meet the needs of MHCP participants.

Strategies to improve measurement and standard of care

The Institute of Medicine has stated "The only way to know whether the quality of care is improving is to measure performance." As Minnesota strives to improve the quality of its MHCP dental program, the state should begin with determining validated quality metrics. In the future, the dental community can work toward developing or adopting validated standards of care such as those found for among other health care providers.

It is difficult for the state to identify and fund those services that are most important in improving access and quality when there is no evidence-based benefit set or care standards. Standards have not yet been created for several reasons, including the state-of-the-art of dental measurement activities, a lack of agreement among stakeholders and stakeholder focus on rates or maintaining adult benefits. These barriers should not prevent stakeholders from moving ahead.

DHS, in consultation with DSAC, should work with the legislature to implement a revised benefit set for non-pregnant adults. Related standards of care should give policy makers, researchers, providers and MHCP enrollees a critical tool for monitoring and improving cost effectiveness and care effectiveness of services.

- **DHS should evaluate whether changes in the dental program contribute to improvement in the Dental Quality Alliance (DQA) Measure Set 1.** This helps ensure that changes made to the dental program are focused on improving outcomes for MHCP recipients.

- **DHS should continue to use DSAC expertise to assist DHS in developing access, outcome and performance measures.** DSAC's stated purpose is to support evidence-based coverage policy; DSAC focus on this area can offer vital assistance in continuous improvement in quality and standard development.

- **The dental benefit set for adults should be amended to include all medically necessary care.** DHS should have the authority to determine the benefit set with legislative restrictions appropriate to limit non-medically necessary care. DHS should collaborate with others in discussions of which services are most important and prioritize them in terms of their expected impact on access.

In the future:

- **DHS should continue to assess and adopt quality and performance measures and work through DSAC to develop an evidence-based benefit set and standards of care.** DSAC and others endorse use of the DQA's current measure set, a strong place to start. However, increasingly refined measures are necessary. The DQA's set relates only to children's services and does not include care and health outcome measures, patient satisfaction or other person-centered indicators. Advanced measures would also provide insight regarding how many people tried to access services (but could not) and did not see a need for services.

- **DHS is replete with quality initiatives across health care settings and has working relationships with the dental community**: there is no need to reinvent the wheel

advancing the development of refined measures. Stakeholders can help to prioritize measures and assure that Minnesota efforts are aligned with best practices in measurement and care delivery (e.g., include measures for coordinated care).

Strategies to support integrated models of care

DHS supports integration of dental health with other health services. Oral health is a part of physical health. In Medicaid and the Affordable Care Act, oral health is defined as essential for children. Oral health is also an essential benefit for adults. Ways that DHS can foster integration, in coordination or collaboration with others, include the following:

- **DHS should support the integration of oral health for all MHCP enrollees, for example ACO models that include dental care in the total cost of care**.

  o The ACO would be responsible for the delivery of physical, dental and behavioral health. ACOs and the Minnesota Health Care Delivery System (HCDS) reforms are changing the shape of Minnesota's health care system and integrating care across other systems with potential impacts on care and costs. These arrangements should include oral health care.

  o Quality metrics, including access, structural, process and outcome measures, should be used for cost sharing within these integrated dental delivery systems.

  o Alternatively, dental provider payments could be tied to outcomes and incorporate alternative payment methodologies for providers.

  o Pilot programs have been proposed and may demonstrate the efficacy of these payment models. Further support for such pilots may be warranted.

  o As ACO models mature and expand, determine viable methods to include dental services in the total cost of care and include dental care cost and quality outcomes under the ACO contracts.

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- **DHS should assist in the development or dissemination of best practices and consider other changes to policies and processes to support integration**.

  o DHS should

    ▪ provide MHCP participants with referrals when they contact DHS/counties to help them establish a continual source of care;

    ▪ support efforts to develop interoperability or integration of the electronic health record and electronic dental record; and

    ▪ consider paying additional reimbursement for patients with co-occurring dental and medical diseases requiring coordination.

o To the degree that it is in DHS's scope, DHS should also collaborate with others to help ensure that provider education includes more interdisciplinary curricula and residential opportunities.

o Other changes for possible future consideration include requiring a dental check-up for school entry (similar to requirement for immunizations) and establishing best practices for process flow from intake to the most complex care. Process flows could guide development of community-based entry points and lead to regular dental care.

Strategies related to prevention, portable systems of care and teledentistry
The expansion of teledentistry and portable delivery systems can promote fuller access to services for MHCP enrollees. Among other benefits, teledentistry and mobile clinics can meet people where they are, such as nursing homes, group homes and schools. DHS can support prevention programs by endorsing comprehensive, evidence-based programs like sealants and fluoride. In addition, pilot projects and legislative initiatives can advance the use of teledentistry as a vehicle for cost-effective, care-effective services.

- **DHS should coordinate with stakeholders in promoting a comprehensive prevention program for MHCP recipients comprising evidence-based strategies like sealants and fluoride.** Particularly important approaches that DHS could generally support when collaborating with other partners on system improvements include the following:

  o **Dental sealants** have been shown to prevent dental caries and reduce costs for dental care. School based sealant programs are endorsed by the Center for Disease Control, the American Dental Association and the Association of State and Territorial Dental Directors as effective public health interventions. The MDH promotes and provides consultative support for school based sealant programs. These programs are funded through various grants. School based sealant programs in every school with high risk children should be assured funding by the state.

  o **Fluoride varnish** is a proven preventive measure. This practice should be encouraged at well child visits with primary care medical providers to reduce early childhood caries. Efforts to promote the first dental visit by age 1, within 6 months of the eruption of the first tooth, can lead to increased prevention and reduced early childhood caries.

  o **School-based dental clinics** can improve timely service for children. Providing preventive and restorative treatment in schools allows for better care. Parents can consent to treatment, but avoid the barrier of travel and missed work to obtain dental care for their child. The use of midlevel providers may reduce cost and increase access.

  o **Dental Checkups** could be required for children enrolling in public and private schools. DHS, as a member of the Governor's Children's Cabinet should bring this concept forward for consideration by the Cabinet so that it can be analyzed collaboratively by the Departments of Human Services, Health, and Education.

- **DHS should endorse the use of portable delivery systems and teledentistry, understanding they must meet regulatory and quality assurance requirements, to improve access for care to MHCP participants.**

  o For example, DHS should support a two-year pilot of teledentistry and have a teledentistry policy that is not more restrictive than scope of practice laws and rules.

  o The use of mobile dental equipment is a strategy to increase access to underserved populations. All dental equipment can be contained in a van or brought into a site. These mobile dental clinics require onsite electrical and internet services. Portable dental equipment is transported and assembled on site.

  o Mobile systems bring the dental service to the patient, increase access and reduce the burden of transportation for the patient and caregiver. This practice facilitates timely treatment for children when parents cannot afford time from work to arrange dental care.

  o A risk to this approach is that the convenience of the mobile dentistry has a heightened potential for abuse when compared to fixed based operators. There are also concerns around continuity of care, provision of emergency care and informed consent. Many states such as California, Arizona, Massachusetts and Virginia have responded to this risk with increased oversight. These states require registration of mobile dental units with the Board of Dentistry, including plans to ensure quality of care. Minnesota should pursue similar regulations.

- **DHS should have a teledentistry policy that is not more restrictive than scope of practice laws and rules.** Further, DSAC recommends that a payment code or modifier be developed to allow for tracking of teledentistry examinations. These codes should be able to track the transmitting dental auxiliary provider as well as the examining dentist. Quality measures should be evaluated to assure that that teledentistry is effective in improving access to dental preventive or treatment services for the underserved.

- **DHS should allow a two-year pilot project in teledentistry. Payment for examinations conducted by teledentistry, once regulatory requirements are established, should be permitted.** Important questions that the Board of Dentistry can continue to address to facilitate such a pilot include

  o Who is accountable?

  o Who provides the care and who makes the recommendations?

  o Can the person making the recommendations be licensed in another state?

  o What are the standards of care?

Strategies related to workforce development

As it is within DHS's scope, DHS should collaborate with agencies and organizations, as appropriate, to help build a dental services workforce that improves access to services. Effective system-wide collaborations between DHS and others will help ensure statewide progress toward the common goal of enhanced access. Most of the strategies for enhancing the workforce contained in this section are largely or totally outside of DHS's purview (e.g., loan forgiveness programs, allied professionals scope of practice).[*] However, DHS can generally support dentists and allied health professionals by collaborating with other entities as appropriate in examining and developing workforce issues and strategies. Ongoing efforts where DHS may have varying degrees of influence include

- MDH and legislative strategies related to loan forgiveness and repayment programs (e.g., allowing applicants to retroactively apply for a loan once they have set up practice and providing matching grants to local communities for facilities and practices).

- Educational institution efforts to inform and encourage prospective and practicing dental providers to serve in underserved areas (e.g., new curricula and internship opportunities).

- Multiple partner strategies (e.g., MDH, education institutions, Board of Dentistry, Legislature, MDA, Minnesota Dental Hygiene Association) to support an allied workforce (e.g., education, financial incentives and supports, MDH sealant program and developing new arrangements under collaborative agreements (hygienists) and collaborative management agreements (DTs) with dentists).[†]

- Legislative efforts to

  o clarify or adjust the scopes of practice of allied professionals so they have clear authority to provide services in the community and refer patients to full dental practices for comprehensive exam and continuity of care and

  o bring dentists to non-office settings to partner with mid-level practitioners.

- Dental community efforts to develop standards of care to guide more uniform use of best practices across providers.

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[*] See also the administrative practices section for discussion of credentialing issues for allied health professionals.
[†] This may include addressing frequently asked questions such as: What services can be done in community settings (with variations for different settings and types of patients)? What is the optimal level of care that can be delivered in these settings? What supports need to be in place to ease time-of-service communications between mid-level providers and dentists working in a collaborative agreement model? How can referrals to comprehensive care be facilitated to move patients from entry points in the community into regular dental care? What record-keeping and communication technologies are needed to support the flow of information from setting to setting?

VII. Section 3: Administrative Structure and Processes

Background and Findings

This section describes the administrative complexity of the current system, outlines DHS administrative functions and discusses issues related to the option of implementing a single administrator model. It also considers ways to improve processes regardless of structural changes and provide strategies for preventing fraud and abuse.
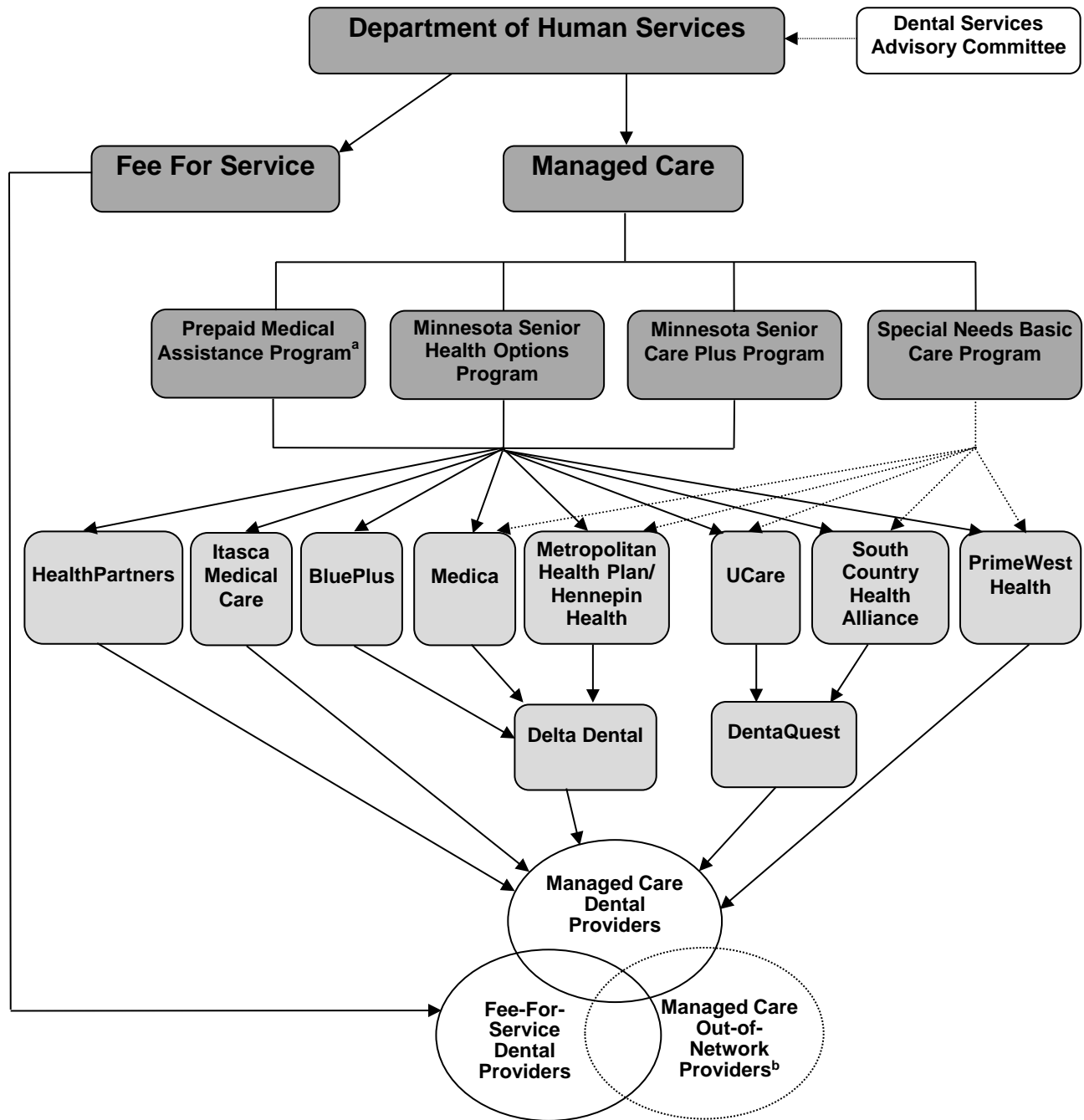
Administrative Complexity

Dental services under MHCP are currently administered under a variety of methods (Figure 2). One major factor is whether the recipient is enrolled in the fee-for service (FFS) program or enrolled in managed care.

- DHS administers benefits for MHCP participants.

- Dental benefits for recipients enrolled in one of the managed care organizations (MCO) contracting with DHS generally are administered by a dental administrator subcontracted with the MCO.

- There are three dental administrators each subcontracting with one or more MCOs that administer the dental benefit for the majority of managed care recipients.

The result, when including DHS as the FFS dental administrator, is essentially four to six methods under which dental benefits may be administered. The various administrators differ in how the functions and activities outlined above are carried out, generating a range of administrative accommodations that providers must support. In turn, recipients must also navigate the changes from one administrator to another if their enrollment changes.

Figure 2: Minnesota's Administrative Structure for Medical Assistance Dental Services, 2012[*][58]

Administrative Functions

With the overall administrative structure, DHS's administration of dental benefits involves operating several functions (Table 6). Functions include: benefit policy, provider management, payment rates, claims processing, authorization/utilization management, provider and recipient relations, program evaluation and program integrity activities.

Table 6: DHS Administration of Dental Benefits

Function	Components Include:
Benefit Policy	• Identify services covered by the benefit, including program differences and eligibility type differences (e.g. children, pregnant women, non-pregnant adults) • Establish parameters for coverage that may apply to services, such as providers, places of service, medical necessity determinations and cost-sharing (if applicable) • Maintain system policies, including billing codes and standards and utilization management criteria (e.g. annual limits, authorization requirements, etc.)
Provider Management	• Manage provider enrollment process: verify qualifications of providers and manage contracts/agreements with enrolled providers • Maintain provider system data
Payment Rates	• Manage fee schedule for dental services • Maintain rates system data
Claims Processing	• Maintain system that adjudicates claims; manage adjudication process • Implement coordination of benefits with other payers as appropriate • Implement recovery of overpayments
Authorization /Utilization management	• Manage authorization/utilization management processes • Apply clinical criteria to individual cases to verify medical necessity prior to payment or as part of post-payment review

Provider and Recipient Relations	• Maintain resources for recipients/members
	   o Recipient/member call center
	   o Written and electronic material related to benefits, network, cost-sharing, etc.
	• Maintain resource material for providers
	   o Provider call center
	   o Written and electronic material related to enrollment, coverage criteria, claims processing, etc.

Program Evaluation	• Analyze various program aspects such as: access to services, utilization trends, cost trends, patient satisfaction and quality of care metrics

Function	Components Include:
Program Integrity Activities	• Investigate complaints of fraud and abuse; establish proactive methods to identify potential fraud and abuse • Maintain methods to identify inappropriate service utilization • Coordinate with other DHS/state activities

Major Issues

There are major issues associated with both the *overall administrative structure* for providing dental services and for *individual system processes and components*. The discussion below first focuses on the burdens of the administrative structure and the option of a single administrative model. This is followed by an examination of administrative processes that could be improved regardless of whether a single administrative model is used.

Administrative Structure

- **Burdens of the Current Structure**

  o Nearly all providers expressed frustration with the administrative burden created by the current structure of dental benefits administration. Since many dental clinics are small businesses, they may lack the resources necessary to support the varying processes and requirements. Managing multiple processes around provider credentialing, billing, authorization and utilization management are quite costly, particularly to a small dental practice. The OLA reported that 75 percent of dentists practiced exclusively in small private practices in 2012 and 90 percent practiced primarily in this setting.[59]

  o Most providers interviewed support a transition to a single dental administrator. Under such a model, all providers and recipients would be under a single set of administrative requirements and processes. For providers, this eliminates the need to support multiple enrollment, billing, authorization, payment and utilization management methods. In addition, recipients would no longer experience changes in availability of providers or services based on administrative differences.

  o DHS also experiences difficulties related to the distributed administration of dental benefits. One example is the administration of the CAD program. Providers apply to DHS for designation.

    ▪ The add-on payments made to providers designated under the CAD program are administered entirely by DHS; however, the add-on payment is paid immediately with the FFS claim.

    ▪ For a managed care claim paid by a MCO (usually through their contracted dental administrator), the CAD add-on payment is received by the provider in the subsequent quarter. DHS makes payment to each MCO for the total value of the CAD add-on payments based on quarterly reports submitted by the MCOs of all

claims paid to CAD providers by them or by their dental administrator. The separation of the add-on payment from the claims adjudication creates a complex method of verifying eligible claims, making adjustments from quarter to quarter to payments based on reversed or modified claims reported by MCOs.

Once made, the payments are difficult for many clinics to reconcile back to the individual patient because the payment is received separately from the original claim. Thus, it is difficult for providers to determine whether they have been accurately paid. The process also requires the MCOs and their dental administrators to support a separate quarterly report and process separate quarterly payments. A few stakeholders reported that the CAD process was administratively burdensome, while a few others said it was no more burdensome that the processes involved with other insurers, indicating that large systems had the infrastructure to manage it.

- **Administrative structure best practices**
  In examining best practices and opportunities for improvement in service delivery, DHS, through consultation with the Center for Healthcare Strategies (the organization contracted to provide technical assistance to states participating in the Medicaid Oral Health Learning Collaborative), contacted states that have focused on practices and program innovations and successfully increased dental utilization in their states. DHS reviewed policies in Virginia, Tennessee, and Connecticut, and had telephone discussions with representatives from the state who were involved in management of the dental program in that state.

  o All of these states have a utilization rate above the national average, and they attribute this in great part to consolidating their dental benefit under one Dental Benefit Administrator (DBA). The DBA's role for the states discussed below is through an Administrative Services Only (ASO) contract for all their Medicaid recipients.

  o These states also faced lack of dental access especially critical among low-income children served by the Medicaid programs. Representatives from all three states indicated that the method of service delivery was central to the issue of poor access.

  o Most of these states moved their clients to MCOs as far back as 1994, and this move had resulted in some increased access to dental services. However, they continued to receive complaints from the dental provider community about the administrative burden associated with supporting varying administrative requirements among the contracted MCOs and from Medicaid enrollees who were having difficulty locating a dentist.

  o The dental communities within those states indicated that multiple payer contracts (i.e., multiple MCOs and the FFS program similar to Minnesota's current system) combined with the issue of low provider reimbursement deterred their participation in the state Medicaid program.

o Collaborative discussions between the Medicaid program and dental stakeholders of these states led to the recommendation that the Medicaid program carve dental services out of MCO contracts and consolidate dental services under a unified dental administrative arrangement. Each of the Medicaid programs embraced the idea of a single dental administrator system and began working with the DBA. The DBA's role and responsibilities includes expanding the Medicaid program's dental provider network, including recruiting; handling prior authorization requests; processing claims and submitting encounter data; promoting the new dental program; conducting provider and enrollee outreach activities; handling enrollee and provider services issues with the goal to increase access to and utilization of high quality dental care services through an expanded and adequate network of dental providers.

o Prior to implementing the DBA, all three states faced barriers accessing dental care across the states and had already identified causes of dentists' reluctance to participate in public programs. Barriers included: low Medicaid reimbursement rates that are often less than what it costs dentists to provide care, excessive paperwork and other billing and administrative complexities, high rates of broken appointments, movement of patients between MCOs or between MC and FFS, poor oral health literacy and awareness about the importance of oral health, and the uneven distribution or location of dentists within some states and local communities. The experiences of these states indicate that contracting with DBA helps reduce administrative costs, simplify the administrative process, and reduce the burden on providers. For example:

Virginia
Virginia moved to a single dental administrator in 2005 as part of a statewide focus on oral health for children.

- Prior to 2005, Virginia had only 660 dentists' statewide seeing Medicaid patients and only half of those were accepting new patients.

- In addition, providers had not had a fee schedule increase in approximately 20 years (fees were based on 1980 rates) and had to manage policies under five MCOs and a FFS program.

- Providers in the state wanted administrative costs and complexity reduced and reimbursement increased.

- The move to a single administrator was accompanied by an approximately 30 percent increase in rates (28 percent across all services and another two percent to preventive dental services for children).

- Within 1½ years of making these changes, Virginia's Medicaid program had doubled its provider network and today has 1,819 dental providers participating in their program. More importantly, the rate of children enrolled in Medicaid who received preventive dental services in a year increased from 29 percent in 2004 to over 60 percent today. Coupled with the improved access, state officials noted a significant decrease in

emergency department visits for dental pain.

- Virginia dental program representatives interviewed attribute at least half of their improvement to the movement to a single administrator.

- Through the administrator, the state is able to centralize a focus on oral health goals, to monitor providers better and to be more responsive to provider's needs. For instance, Virginia significantly reduced prior authorization complexity by simply moving from multiple methods to a single method.

- In addition, the administrator is helping providers reach out to those who miss their dental appointments, ensuring coordination with transportation to help reduce future missed appointments.

- These steps were viewed favorably by dental providers as reducing the burden on their office staff when working with Medicaid patients and improving their willingness to serve Medicaid patients.

- The state transferred all responsibilities for beneficiary outreach, patient education, provider outreach and enrollment and claims processing to the dental benefits administrator.

- Dentists were very receptive to the uniformity in process and felt that the single administrator de-stigmatized participation in Medicaid, helping providers in the network realize that seeing Medicaid patients would not necessarily be a negative experience.

- Virginia officials also estimate that the state's cost for administering the dental services have also decreased by approximately one-third.

Tennessee

- The Tennessee Medicaid program shifted to a single dental benefits administrator contract in 2002. Dental services prior to that were administered by 12 MCOs, all with different contracts and different provider manuals and requirements and all with low rates paid to providers.
- Those interviewed in Tennessee noted that although the fee schedule was increased for dental services in 2002 (and includes no differentiation for urban vs. rural providers), no further increases have occurred except a small adjustment for select procedures.
- Despite this, they continue to have more dentists willing to participate than they need to serve their Medicaid population. They credit the single administrator structure with easing the administrative burden and costs, making participating easier and less costly for providers
- They note that many dental providers want to treat members of their community and don't expect to make money off of Medicaid patients, but the administrative burden in the past was simply too great. Having to manage only one provider contract and one set of administrative rules have made the difference for providers.
- Under the Tennessee ASO contract, the state covers expenditures for benefit claims and

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the DBA is paid an administrative fee for managing dental benefits. The DBA is responsible for recruiting and maintaining a network of qualified dental providers adequate to make dental services available and accessible to beneficiaries. Providers are measured against several quality and performance benchmarks. According to the Tennessee officials, Medicaid dental providers are considered to be the best providers in the state and providers are seeking to be included in the state's dental network. In addition to conducting enrollee outreach and education activities, the DBA must also conduct statewide provider training programs annually. The DBA also manages data, provides mandatory reports, and conducts quality improvement programs and utilization review and management, as well as achieves specific performance requirements. As a result of the program changes, provider participation grew by more than 120 percent, and utilization of dental services by recipients' age three through 20 also increased from 36 percent to 51 percent annually.

- In 2013, Tennessee instituted its first risk-based contract with their dental benefits administrator. Under this arrangement, targets for utilization and costs are set and savings or costs will be shared between the state and the DBA depending on what targets are met or missed.

Connecticut:
The Connecticut model is similar to the DBA models in Virginia and Tennessee.

- Prior to 2006, their dental benefit administration was similar to Minnesota's current structure — FFS and 12 MCOs.

- In 2007, the state moved to a single dental administrator and reimbursement rates were increased to a rate equivalent to 90 percent of the 2007 commercial rate.

    o The single benefit administrator structure encouraged many more private practice dentists to treat children insured under Medicaid programs.

    o Utilization rates of preventive dental services for children continuously enrolled in Medicaid increased from around 35 percent to nearly 63 percent in 2011.

    o According to state officials, they went from one of the lowest performing states to second in the nation within two years of increasing rates and contracting with a single administrator.

    o Administrative requirements for providers have been eased, using more automated processes and a mixture of prior authorization, pre-payment, and post-procedure review to help identify quality issues and educate providers.

    o Officials note that with greater insight into provider performance, they have eased prior authorization requirements for providers who have long histories of high-quality services and few issues.

    o The DBA receives lists from the state of "non-utilizers" and reaches out to connect

them with dental services and also works with providers on methods to help ensure attendance of Medicaid enrollees who have missed dental appointments in the past.

- o In addition to the increased rates and decreased administrative burden, providers in Connecticut were pleased with the uniform fee structure.

- Nearly all of Connecticut's cities and towns, including areas with the greatest concentration of children, experienced significant increase in utilization rates. Increased private practice dentist participation in the Medicaid program directly contributed to greater access to oral health services among low-income children. Today, Medicaid enrollees in the rural corners of the state have access to two dental providers and in urban areas of the state a provider is available within two miles of each enrollee.

- State officials in Connecticut indicated that their MCOs were "happy to get rid of" administering dental services. They noted that the MCOs were all subcontracting dental services anyway, so moving to a single dental administrator provided the state increased influence over the administration of dental services and the quality of services enrollees receive. State officials have been so pleased with the single administrative approach that they now contract with single administrators for all services, including health care since 2010.

While each state is pleased with their results, a single administrator alone, while important to reducing administrative costs for providers, is often not the only step necessary to increasing provider participation. Rate increases in at least two of the states were also an important step.

Minnesota, unlike many state Medicaid programs, provides at least a limited adult dental benefit. Of the three states interviewed, only Connecticut provides coverage of limited dental services to adults. The other two states provide comprehensive services to children as required under federal law, but have not chosen to exercise the option of providing more than emergency dental services to adults. However, it is reasonable to assume that with similar measures taken, similar improvements could certainly be achieved in Minnesota for children, and it would be likely that improvements would also be seen for adults.

Stakeholder comments regarding a single administrative structure
Several people and groups in this study suggested that the state simplify administrative issues and reduce costs by moving to a system where there is a single administrator of MHCP dental benefits instead of the multiple administrators currently in the system.

- A single administrator, several stakeholders said, would mean one benefit set and one set of processes, instead of the many processes now in effect. Stakeholders who said they wanted a single administrator did not necessarily agree who that should be. Some people wanted DHS to be the administrator, some wanted a current administrator and some wanted to open the selection process to other non-profits.

- Stakeholders suggested or acknowledged that if a single administrator were selected, it would be selected through a RFP process with carefully chosen criteria. Some interviewees advised that stakeholders be involved in setting the criteria.

- A few stakeholders objected or were cautious about a possible move to a single administrator or dental carve out. They opined that this could undermine the goal of oral/other health integration (e.g., as is being done at HealthPartners). They also felt that single administrator proponents overestimate the administrative costs associated with billing multiple MCOs. They also preferred having options for administrative services, stating that competition lead to better administrator performance.

Administrative Processes and Components

For administrative processes in general, providers noted the most problems surrounding these functions:

- Enroll as an MHCP dental provider: This includes obtaining credentialing for self and, as applicable, allied dental health professional (dentists are the conduits for credentialing other providers)

- Verify the patients as MHCP enrollees and verify the scope of benefits covered for the individual: For many providers, this includes working with different verification processes established through DHS FFS and each MCO.

- Obtain prior authorization from the DHS-contracted medical review agency or MCO(s) for certain procedures, including the submission of patient histories, x-rays and related information.

- Submit claim forms to DHS and/or MCOs and receive payments. Claim forms and codes are not standardized across DHS and MCO dental insurance programs.

- Manage missed appointments which are reportedly more common among MHCP and Medicaid than other patients.

- Arrange for interpreters and pay for interpreters when there are missed appointments. MCHP pays for interpreters but providers must arrange for them.

- Address data privacy (HIPPA) and fraud and abuse regulations.

Several stakeholders emphasized the importance of improved processes. A study of eight states similarly found that "states and providers say these simplifications are extremely important to maintain and increasing provider participation."[60]

Previous Minnesota research shows mixed results. In a 2012 survey of providers, about 23 percent of dentists said administrative work was a reason for not treating MHCP patients or not accepting more; low fees, limited scope of benefits and missed appointments were deemed more important.[61] Earlier research similarly shows that low fees were the most important problem with MHCP, followed by broken or cancelled appointments and denial of payments.

Stakeholder recommended improvements
Stakeholder recommendations fell into five major areas, as discussed below, many of which were identified by stakeholders to be exacerbated by the administrative structure that currently exists.

1. **Develop a common benefit structure**
   Several interviewees said the existence of multiple benefit sets increases administrative costs. There are several variations on the statutory benefit set and several stakeholders stated that although the adult standard benefit set is listed in detail in statute, it remains open to interpretation. In addition, benefits frequently change over time. For example, adult benefits contracted in 2010 and expanded slightly in 2013. Several stakeholders suggested that the current benefit set is a product of budgetary discussions rather than clinical-based discussion or guidelines.

2. **Simplify credentialing, MHCP enrollment and benefit verification processes**
   Some states have developed a single set of rules and one provider agreement for credentialed providers. Other states have streamlined provider enrollment by publishing enrollment forms online and allowing dentists to enroll or update information online, while others have simplified their system by moving from multiple claims forms to a universal form.[62] Minnesota's efforts to do this seem to have stalled. Another suggestion from stakeholders was to use electronic fund transfers for payments. Apparently, despite electronic fund transfer requirements, some providers still submit paper claims or use dial-up internet. Several interviewees also said it was difficult to look up patient histories to determine if an individual was eligible for coverage. Some states have systems of automated beneficiary eligibility verification, which allows Medicaid dental providers to access eligibility information from beneficiary membership cards, automated voice response systems and computer software.[63] The OLA suggested that DHS make IT changes to better support providers' ability to look up inquiries of patient eligibility and state restrictions or benefits.

3. **Streamline preauthorization (PA) processes**
   Another suggestion made by several stakeholders in Minnesota and other states is for the state (and MCOs) to examine the necessity of all existing prior authorizations.[64] Options include reducing or eliminating prior authorizations except for the most costly services and streamlining the process "by ensuring that the requirements are publicized in a format that is easy to both access and comprehend."[65] Others have suggested the use of an electronic clearing house to submit x-rays, reducing the amount of information that providers must submit and simplifying the means of delivery (e.g., electronic submission).

4. **Address appointment "no shows"**
   Another administrative issue of access to some providers is missed appointments. A 2001 DHS report stated that "reducing appointment failures would address one of the dentists' most frequently expressed reasons" for refusing to see MHCP participants.[66] This rings true today for some providers, although there was also a comment that missed appointments should be seen as an opportunity; missed appointments free-up time for serving walk-ins or taking same-day appointments. Several interviewees reported

strategies they have effectively used to reduce the number of people with missed appointments. Their efforts include education to members and county case mangers regarding the importance of going to dental appointments and discussing transportation and child care issues. Increased participant health care literacy was also mentioned by some stakeholders as a way to reduce missed appointments and in incent providers to serve more MHCP participants.

5. **Other stakeholder advice**
   A few people gave advice for improving administrative processes that included:

   o Allow DHS to directly reimburse dental hygienists or pay under the dental therapist (DT) provider number (DTs are reimbursed under the dental provider number and dentists go through a separate credentialing process when hiring DTs).

   o Develop evidence-based standards of care for the benefit set (per section 2).

   o Improve contracts between dentists and MCOs (small dental offices do not have much leverage, said one person).

   o Improve the CAD process, because it is burdensome and lengthy.

   o Use the existing Administrative Uniformity Committee process to simply practices of the health plans and state public programs.

Processes for Preventing Fraud, Abuse and Overtreatment
As directed by the legislature, DHS's recommendations for improving administrative structure and processes include strategies for preventing fraud, abuse and overtreatment. Overtreatment, fraud and abuse fall under the broad category of "improper payments." Improper payments include inadvertent errors, such as duplicate payments and miscalculations; payments for unsupported or inadequately supported claims; payments for services not rendered; payments to ineligible beneficiaries; and payments resulting from outright fraud and abuse by program participant and/or program employees.[67]

Corrective Strategies
Improper payments can occur for many reasons, and preventing them requires a multi-pronged approach that includes prospective and reactive methodologies and multiple stakeholders. The risk of improper payments increases in programs that have complex criteria for computing payments, experience a significant volume of transactions or place an emphasis on expediting payments. Strategies to address improper payments can be classified as either *proactive* (those that identify overtreatment, fraud and abuse before payments are made) or *reactive* (those that identify the improper activity after it has occurred). Strategies generally fall into one or more of the following categories:

- **Risk assessment**—performing reviews and analyses of program operations to determine if risks exist and the nature and extent of those risks.

- **Control activities**—taking actions to address identified risk areas and ensure that management's decisions and plans are carried out and program objectives are met. These

actions can include data sharing, data mining and recovery auditing.

- **Information and communications**—using and sharing relevant, reliable and timely financial and nonfinancial information in managing improper payment-related activities.

- **Monitoring**—tracking improvement initiatives, over time and identifying additional actions needed to further improve program efficiency and effectiveness.[68]

DHS implements strategies for preventing improper payments through the Surveillance and Integrity Review (SIRS) unit and Purchasing and Service Delivery division. In addition, the Minnesota Board of Dentistry, the State Medicaid Fraud Control Unit (MFCU), and MCOS conduct their own activities.

- **DHS OIG SIRS Unit**
  Data from the DHS Office of Inspector General's (OIG) SIRS unit shows that between 2003 and 2012, SIRS conducted between 2 and 33 investigations each year, with total annual recoveries ranging from $0 to about $92,000. There was an average of 12 cases per year and an average of $1983 in recoveries per case.[*] Investigations were conducted largely as a result of complaints the DHS OIG received through the OIG complaint hotline or as the result of data mining activities they conducted using DHS and other claims data. The SIRS unit has limited resources to actively perform risk assessments and monitor MHCP dental program activity, with only part-time staff dedicated to this. The unit is in the process of hiring additional staff to devote additional time to responding to hotline complaints, bolstering data mining analytics and coordinating with stakeholders in follow up activities.

- **DHS Purchasing and Service Delivery (PSD) Division**
  In addition to conducting data mining work and responding to complaints of provider fraudulent or improper billing, the DHS OIG SIRS unit coordinates with the DHS Purchasing and Service Delivery division to identify improper billing practices and recommend potential prospective edit checks in the DHS billing system. These edit checks are a front-line, prospective approach to identifying and preventing reimbursement for fraudulent billing practices. The PSD division coordinates with its IT staff to implement the edit checks.

- **Minnesota Board of Dentistry and the State Medicaid Fraud Control Unit (MFCU)**
  The Minnesota Board of Dentistry also investigates complaints alleging fraudulent or improper billing activities. Over the past five years, the Board has investigated 67 complaints with fraudulent or improper billing as the primary allegation, resulting in ten disciplinary and two corrective actions that ranged from fines to license revocation. The State Attorney General's Office also has a Medicaid Fraud Control Unit (MFCU) MFCU coordinates with various entities (e.g., DHS OIG and the Minnesota Board of Dentistry) to investigate and prosecute fraud allegations. These actions are reactive and focused on confirming and prosecuting illegal activity.

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[*] See Appendix H for the number of cases and recoveries per year.

- **MCOs**
  MCOs use claims software that tracks utilization and coding patterns to proactively identify improper payments for dental and other services, MCOs use their own internal investigation units or contract with external organizations to conduct post-payment investigations. MCOs are required to report to MFCU and the SIRS unit the results of their internal investigations but not the results of the subcontractor and contractor investigations conducted by external organizations. However, beginning in January 2014, the DHS SIRS unit will require MCOs to send the monthly results of all improper payment investigations, including the subcontractor and contractor investigations.

Major Issues
Stakeholder comments reveal some of the underlying reasons, or root causes, behind fraudulent and abusive dental practices, including overtreatment.

- **Lack of treatment standards**
  One reported reason for potential improper payments was the dental community's lack of best practices and treatment standards. Providers have an inconsistent understanding of what constitutes appropriate treatment for patients. Several interviewees spoke about how multiple dentists could develop widely varied treatment plans for the same patient; this plan could be seen as excessive by one dentist, sufficient by another and inadequate by a third. The lack of industry standards leads to confusion and irregularity across the industry and makes it difficult for investigators to determine the extent of over or under treatment. If treatment standards were developed even for the most common procedures, this would reduce some confusion and give providers and investigators a more informed context for treatment decisions. Peer review by outside oral health professionals is one approach dental practices have taken to develop consensus on standards of care. A few interviewees suggested that the state develop incentives for practices that are regularly reviewed by peers or conduct reviews for others. Incentives could be funded out of the provider tax and be tied to any performance standards or measures that are adopted by DHS or other entities.

- **Need for a coordinated and multi-faceted monitoring approach**

  o Along with provider-based fraud and abuse concerns, another factor affecting fraudulent and abusive factors is the degree of coordination among the various entities monitoring this issue. Monitoring strategies include implementing edit checks in the DHS billing system, limited data mining activities conducted by the SIRs unit, more robust data mining activities conducted by the MCOs, and peer review processes adopted by some dental practices. Investigations into improper billing practices are also made by MCOs, the SIRS unit, the Attorney General's MFCU and the Board of Dentistry. While these approaches follow industry best practices, they are not coordinated and, in some cases, not applied on a consistent or robust basis. In addition, recipients seeking to receive services for which state regulations or policies limit the frequency with which a service can be provided, have moved between FFS and managed care or from one MCO to another to get around such limitations. Because information is not shared between the various administrators, MCOs and FFS, such activity is very difficult to detect and prevent.

o Coordinated activities can be combined with more multi-faceted approaches. For instance, more extensive data mining can be used to analyze data for relationships and target fraud and abuse investigations. The SIRS unit has previously conducted some analytics to identify fraudulent activity among dental providers, including those who submitted dental claims for services performed during extreme blizzard conditions. These efforts resulted in criminal prosecution and recoveries for fraudulent billing. Neural networking is another approach. A neural networking system analyzes associations and patterns among data elements, allowing it to find relationships that can result in new queries. Texas' Medicaid Fraud and Abuse Detection System used this system to identify fraudulent patterns from large volumes of medical claims and patient and provider data. Texas has developed models for physician and dental providers and has used data mining activities and neural networking reports to recover millions of dollars annually.[69] In addition, a single administrator may also improve the collection and coordination of information to identify patterns of utilization by recipients who may be engaging in inappropriate activity.

Recommendation and strategies

Recommendation 3: To improve administrative structures and processes, the state should adopt elements of the single administrator model that have been successful in other states – streamlining administrative processes and strengthening efforts to prevent fraud and abuse.

Strategies related to improving administrative structure and processes

- **Minnesota should adopt elements of the single administrator model that have been successful in other states.** A single point of contact for providers and their office staff reduces paperwork, creates consistency, and may improve the timeliness of reimbursement. States interviewed for this study say that these simplifications are extremely important to maintaining and increasing provider participation. There is no "one size fits all" solution to increasing dental access for Medicaid eligible recipients. However, there are certain elements of what other states have done and that are innovative and can be replicated here in Minnesota. While the issue of reimbursement remains a central issue, improved collaborations between state, stakeholders, and dental providers will help address the issues.

  While there are no simple answers to addressing the issue of improving access to dental care for Medicaid eligible recipients, these states have demonstrated innovative service delivery. Minnesota has continued to lose ground on important children's dental measures, and new efforts must be implemented in order to make the changes necessary to meet the requirements established by CMS. The shift to single administration in

conjunction with base rate increases certainly helped increase access in the states interviewed. Such a transition should take into consideration ideas to preserve the relationships and integration between medical and dental services that have been established within some programs, including whether limited carve-outs could be supported, provided they are able to achieve the administrative simplification without increasing administrative costs. Progress can be made by combining innovative ideas with support from providers, stakeholders and the state legislature.

- **DHS should improve administrative processes by enhancing communication regarding what benefits are covered, training and technical assistance to dental providers and by incorporating, wherever possible, best practices.**
  Benefits are specifically listed in statute and DHS has a provider manual and other communications. MCOs also have provider resources identifying clinical criteria for coverage of services. However, providers still report frustrations in understanding what is covered and how statutory language is interpreted. DHS could analyze prior authorization issues to ascertain which areas are of greatest confusion and which modes of information sharing are most effective. Communication vehicles could include webinars, formal training sessions, improved web sites and the use of social media. DHS could also review call center procedures to assure that dentists have quick access to someone with dental services expertise when needed.

Strategies related to strengthening efforts to prevent fraud and abuse

- **DHS should expand use of analytics, risk assessments and data mining to proactively and strategically identify and address fraud and abuse issues. Expand use of analytics, risk assessments and data mining to proactively and strategically identify and address fraud and abuse issues.**

  o The state needs to expand proactive approaches to systematically identify improper practices and over payments. DHS SIRS and others are planning to hire new staff and make greater use of risk assessments and data mining analytics to identify questionable patterns of coding, utilization, or other practices. Additional staff would allow SIRS to conduct a broader range of analytics and refine edit checks in the billing system. If SIRS resources do not allow for increased levels of chart reviews, they should consider contracting with appropriate organizations. Chart reviews can be an effective approach to detect improper billing—analytics provide a tool for doing them more strategically. DHS should consider including the MHCP dental program in its recovery audit contracting efforts, as this could provide another opportunity to identify potentially fraudulent post-payment claims. If feasible, the SIRS unit should also consider collaborating with the PSD and DHS IT divisions and other key parties to develop and implement neural networking, an advanced means of extracting and analyzing data. This tool could be used not just within the MHCP dental program, but in other areas as well.

  o **Leverage existing relationships to encourage best practices sharing, monitor the dental program, and allocate resources accordingly.** Much is already being done

to prevent improper payments by DHS Purchasing and Service Delivery, the Board of Dentistry, the State MFCU, the SIRS unit and MCOs. Prospective activities include DHS billing edit checks and MCO-developed analytics to identify utilization and coding patterns. Post-review actions such as investigations are conducted by the SIRS unit, the Board of Dentistry and the MFCUs in reaction to consumer complaints. While the SIRs unit may refer complaints to the Board of Dentistry or the MFCU (and vice-versa), many of these activities occur in isolation and best practices are not shared across organizations. Minimizing improper activity and improper payments often requires the exchange of relevant, reliable and timely information, not only between individuals and units within an organization, but also with external entities, particularly those with oversight and monitoring responsibilities.

VIII. Conclusion

A 2002 DHS report described many of the same issues contained in the current study and noted that these changes would require a substantial infusion of funds, structural change and educational efforts. It also concluded, "given that none of these is likely to occur, the crisis is apt to continue and Minnesota's attack on disparities in health is apt to fail, at least regarding dental health.

As the Surgeon General makes clear, dental health profoundly affects all aspects of health."[70] A few stakeholders opined that the issues talked about in 2002 are still the ones challenging the state today, such as the need to improve access, increase rates and extend the use of allied health professionals.

At present the state is in an excellent position to make progress in improving the dental services system. This report provides a basis for DHS to implement additional improvements in the system, in discussion and collaboration with other stakeholders. In summary, the major themes and recommendations of this report include the following:

Table 7: Summary of Recommendations and Strategies

Recommendation 1.The legislature should increase base payment rates for dental services and refine the payment structure to encourage provider participation in Minnesota's Health Care Programs.
• The legislature should give DHS the flexibility to tie rate increases to access or quality outcomes. • The legislature should simplify and refine the payment system by incorporating critical access payments into the overall rate structure • **DHS or others should discuss ways in which the state could create a similar payment method for paying both physicians and dentists** • **DHS, MDH and others should collaborate to assure that oral health disparity information is efficiently and effectively gathered**
Recommendation 2: DHS should continue to collaborate with other entities to support an evidence-based, integrated service delivery system that uses preventive services, portable delivery systems, teledentistry, a comprehensive adult benefit set and an expanded workforce to increase access and enhance cost-effectiveness.
Measurement and Standards of Care • DHS should evaluate whether changes in the dental program contribute to improvement in the DQA Measure Set #1. • DHS should continue to use DSAC expertise in assisting DHS in developing access, outcome and performance measures. • DHS should continue to assess and adopt quality and performance measures and provide a forum for creating an evidence-based benefit set and standards

Integration of oral health with other health services
- DHS should support the integration of oral health for all MHCP enrollees into ACO models, including dental care in the total cost of care.
- DHS should assist in the development or dissemination of best practices and consider other changes to policies and processes to support integration

Prevention, portable systems of care and teledentistry
- DHS should coordinate with stakeholder in promoting a comprehensive prevention program for MHCP recipients comprising evidence-based strategies like sealants and fluoride
- DHS should endorse the use of portable delivery systems and teledentistry to improve access for care to MHCP recipients; for example, DHS should support a two-year teledentistry and have a teledentistry policy that is not more restrictive than scope of practice laws and rules

Dental Workforce
- As it is within DHS' scope, DHS should collaborate with agencies and organizations, as appropriate, to help build a dental services workforce that improves access to services.

Recommendation 3: **To improve administrative structures and processes, the state should adopt elements of the single administrator model that have been successful in other states – streamlining administrative processes and strengthening efforts to prevent fraud and abuse.**

- Minnesota should adopt elements of the single administrator model that have been successful other states
- DHS should streamline, simplify administrative processes by improving communication with providers and disseminating best practices.
- DHS should expand data analytics, and leverage relationships to prevent fraud and abuse.

As DHS, the dental community and the legislature turn their attention to further improvements to the dental services system, they have strong assets upon which to build.

- Many hundreds of dentists, clinics, dental therapists, hygienists, managed care organizations, dental administrators and others provide excellent care to MHCP enrollees, conduct outreach activities to improve access, and target subpopulations of children, frail elders, people with disabilities, minorities and people in rural and urban areas who are homeless or have special problems accessing care.

- Stakeholders across many disciplines have years of experience in developing and improving policies to better address individual and systemic oral health needs.

- The legislature has maintained some level of dental services for adults and recently raised rates. It is critical to build upon this foundation to refine the payment, administrative, and service systems.

These refinements will help the state maintain a system that is both cost-effective and improves oral and overall health outcomes.

Appendixes

Appendix A: List of Stakeholder Interviewees

MAD staff interviewed 57 individual stakeholders either individually or as part of a group. They represented a range of perspectives, from providers to health plans to state agencies, and included:

- Eight managed care organizations (Blue Plus, HealthPartners, IMCare, MHP/HH, Medica, PrimeWest, South Country and UCare)
- Three dental administrators (DentaQuest, Delta Dental, HealthPartners)
- DHS State Operated Services
- Minnesota Dental Association
- Minnesota Dental Hygienists' Association
- Minnesota Board of Dentistry
- Apple Tree Dental
- Dental Services Advisory Committee
- Safety Net Coalition
- Minnesota Department of Health Oral Health Program
- Minnesota Department of Health Office of Rural Health and Primary Care
- Head Start
- Dental Associates
- University of Minnesota Dental School
- MnSCU-Metro State University
- Greater MN dental practices (three dentists)
- DHS Office of the Inspector General

Appendix B: Minnesota's non-pregnant adult dental services

Subd. 9. Dental services.

(a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for non-pregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planning once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

Appendix C: Selected DHS and MDH Initiatives

Initiative	Focus	DHS/MDH involvement
Accountable Health Model	Test new ways of delivering and paying for health care using the Minnesota Accountable Health Model (MAHM) framework. This model "expands patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services."[71]	DHS MDH
Health Care Homes[72]	HCHs are an approach to primary care to improve individual and population health and contain costs. Design principles "focus broadly on the continuum of 'health' and incorporate expectations for engagement of the patient, family and community." The model includes behavioral health homes and includes a focus on patient- and family-centered care.[73]	DHS MDH
Reform 2020[74]	Reform 2020 refers DHS efforts to reform Medical Assistance (MA) to increase people's independence and health, reduce reliance on institutional care and meet other goals. It includes: • Community First Services and Supports (CFSS), to replace the Personal Care Assistant benefit with expanded self-directed options. • Anoka Metro RTC Demonstration, to facilitate transition between community and inpatient settings. • Money Follows the Person (continued) to individualize care and/or reduce institutional care.	DHS
The MN Health Care Reform Task Force	This group was created to provide the state with advice on federal and state health reform implementation, the task force recommended new pay-for-value financial models and care models based on patient-centered care and evidence-based programs.[75]	MDH DHS
Advancing Health Equities activities and report	The Minnesota Legislature in 2013 directed MDH and its partners to complete a report about advancing health equity in Minnesota. The report will assess Minnesota's health disparities and recommend best practices, policies, processes, data strategies and other steps. The project launched October 22, 2013. The report is due to the Legislature February 1, 2014.[76]	MDH
Eliminating Health Disparities Initiative (EHDI)	EHDI works "to eliminate disparities by partnering with populations of color and American Indians to create their own healthy futures." MDH's work includes a focus on helping adults prevent and manage chronic conditions (e.g., diabetes and cancer).[77]	MDH

Initiative	Focus	DHS/MDH involvement
Olmstead State Plan	Two lawsuit outcomes (the federal Olmstead Ruling and the Minnesota Jensen Settlement) have resulted in the state's Olmstead Plan. An Olmstead Plan is a way for a government entity to document its plans to provide services to individuals with disabilities in the most integrated setting appropriate to the individual. The Governor's subcabinet developed the Olmstead plan in 2013.[78]	

Appendix D: Rate Increase Studies

Numerous studies have examined the role of increased rates on access. Although results are somewhat mixed, research suggests that where states have moved to increase Medicaid reimbursement levels to be more consistent with market rates, dentists participation in Medicaid increased. For example, in a study of the impact of increased rates in six states, provider participation increased by at least one-third and sometimes more than doubled in the first two years. There was also an increase in the number of patients treated. In fact, patients' access to care not only increased after new rates were implemented, enrollees in all six states encountered less difficulty finding care. The increased rates were usually directed at the procedure codes used most by the pediatric population. Importantly, the provider rate increases were implemented in conjunction with other changes such as simplified administrative procedures, partnerships with stakeholders and dental schools, and educating families.[79]

When Connecticut recently raised rates and simplified administrative procedures, researchers concluded that despite some experts who argued that rates competitive with those of private insurance wouldn't be enough to entice private dentists to participate in Medicaid, and despite others who suggested that families on Medicaid may not seek dental care due to non-economic barriers—such as education, language, culture and transportation, Connecticut's experience showed that "these assumptions are not true." In response to a lawsuit regarding impaired access to basic dental services, Connecticut:

- Increased dental reimbursement rates to the 70th percentile of 2005 private insurance fees.
- Simplified Medicaid dental program administration (services are now managed by a single administrative services organization that has no financial risk).
- Initiated an outreach effort to increase dental program participation of both patients and providers. A representative guides new providers through streamlined processes.[80]

Increases in rates, not surprisingly, results in higher state costs for Medicaid claims. In some cases, the increases were substantial. For instance, research of children's dental access found modest positive relationships between increased rates and utilization and number of providers who accept Medicaid. The researcher concludes that "increasing Medicaid payments to the level of private market fees would increase access to care, but the incremental cost of the additional visits induced would be very high."[81]

Appendix E: HPSA Maps

Figure 3: Statewide map of Health Professional Shortage Areas[82]

Health Professional Shortage Areas
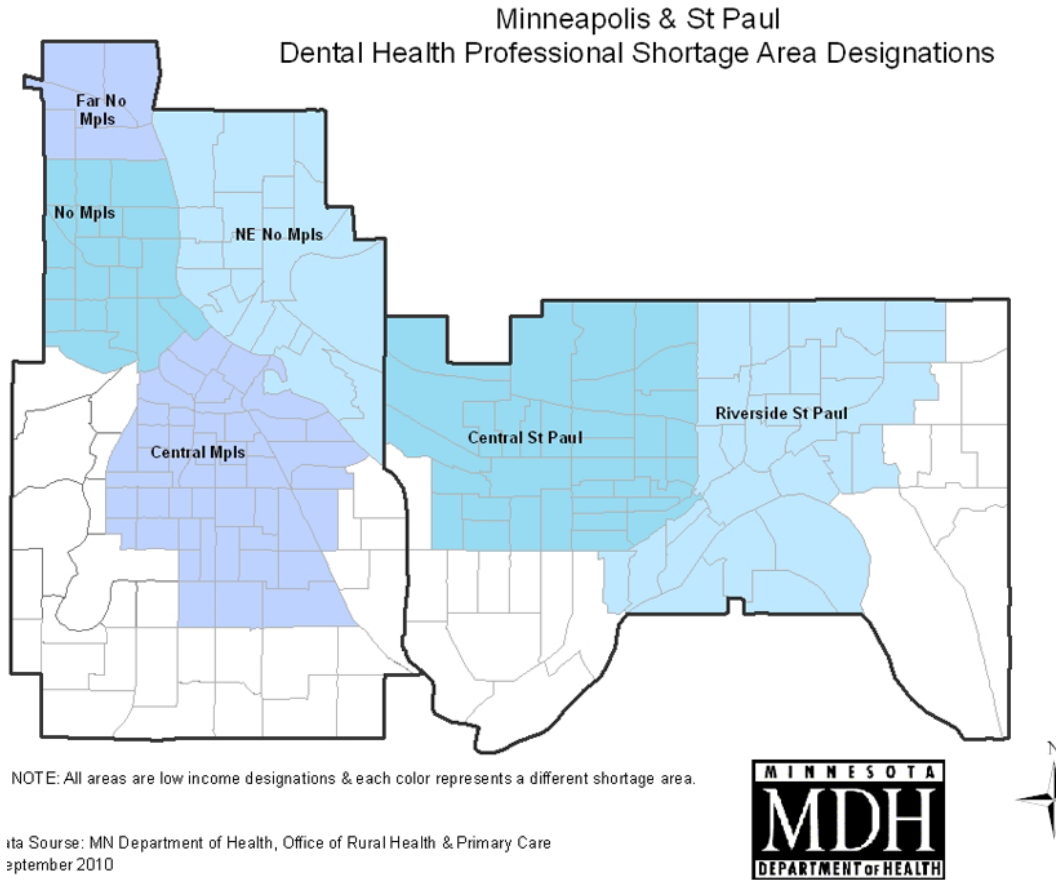Low Income Dental HPSA Designations
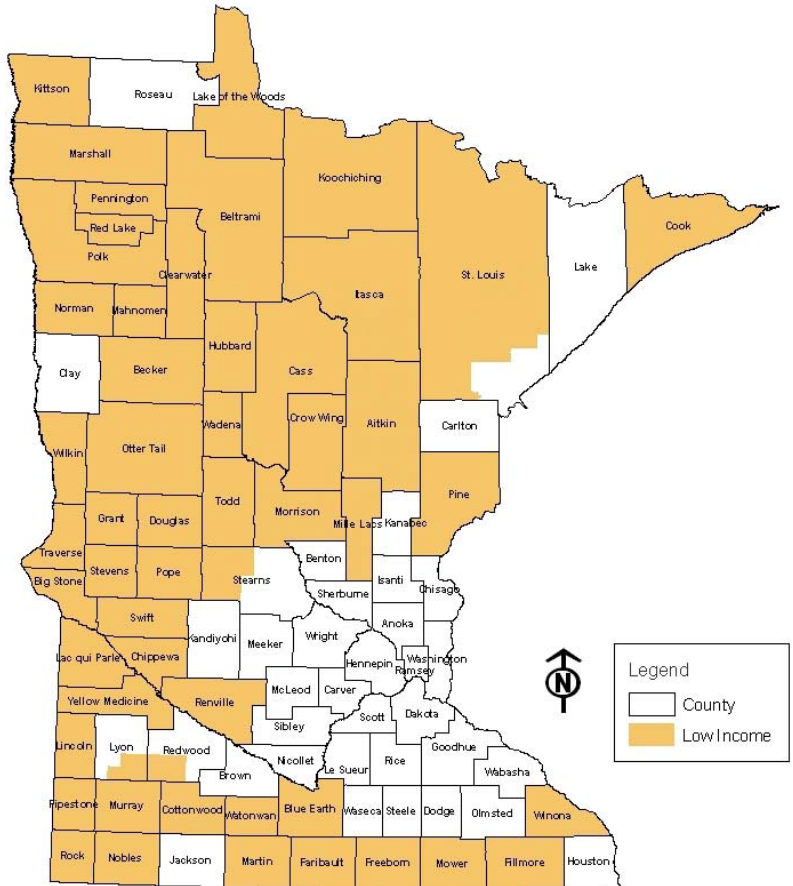
Data Source:
Minnesota Department of Health
Office of Rural Health and Primary Care
State DD HPSA Nov 2011.mxd

Figure 4: Health Professional Shortage Areas in Minneapolis and St. Paul[83]

Minneapolis & St Paul
Dental Health Professional Shortage Area Designations

NOTE: All areas are low income designations & each color represents a different shortage area.

Data Sourse: MN Department of Health, Office of Rural Health & Primary Care
September 2010

Note: Variances in blue designate neighborhood boundaries; all blue shaded areas are HPSAs.

Appendix F: DHS OIG Dental Provider Recoveries 2004–2012

Year	# of Cases	$ Recoveries
2003	3	0
2004	2	240
2005	5	5,000
2006	2	8,641
2007	33	9,705
2008	32	91,604
2009	29	39,039
2010	5	13,946
2011	5	61,322
2012	4	8,417
TOTAL	**120**	**$237,914**

Appendix G: Endnotes

[1] Laws of Minnesota 2013, chapter 108, article 6, section 35

[2] Minnesota Department of Human Services. "Dental Services Overview," MCHP Provider Manual. Accessed October 31, 2013, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008953.

[3] For example: National Academy of Sciences, Institute of Medicine. "Advancing Oral Health in America." 2013.

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[14] Minnesota Office of the Legislative Auditor (OLA), Program Evaluation Division. "Medical Assistance Payment Rates for Dental Services." St. Paul, 2013. *and* Department of Health and Human Services. 2010 Annual Report on the Quality of Care for Children in Medicaid and CHIP. December 2012. Accessed December 12, 2013, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf.

[15] Borchgrevink, Alison; Snyder, Andrew and Shelly Gehshan. "Effects of Medicaid Reimbursement Rates on Access to Dental Care." National Academy for State Health Policy. March 2008. http://www.nashp.org/publication/effects-medicaid-reimbursement-rates-access-dental-care.

[16] Minnesota Statutes 2010 § 256B.0625, Subd. 9.

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characteristics such as the population having "access barriers that prevent the population group from use of the area's dental providers." The state uses HPSA designations in researching needs and determining incentives to providers intended to increase access. The maps reflect DHS data on the distribution of dentists that accept at least one MA patient/year. See http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/dentalhpsaoverview.html for dental HPSA overview. For an example of perspectives on HPSA's limitations as access measure were, the president of the North Dakota Dental Association opined that: "The HPSA shortage area methodology should not be used as a measure of access to dental care for several reasons. *Conceptually,* provider to population ratios are too simplistic. They do not capture rational service areas and instead rely on county or other political boundaries. They do not capture effective demand for services…., *Empirically,* there is absolutely no relationship between the percent of the population living in unserved areas and access to dental care for Medicaid children…. Underscoring the potentially misleading conclusions from the HPSA methodology, states that decreased their dental shortages had no better outcomes than those that did not. See: Dr. Murray Greer, testimony at a October 20, 1013 North Dakota Health Services Committee meeting. Accessed December 13, 2013 at: http://www.legis.nd.gov/files/committees/63-2013nma/appendices/15_5038_02000appendixc.pdf?20131213080819

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