

RECEIVED

JUN 22 2001

LEGISLATIVE REFERENCE LIBRARY
STATE OFFICE BUILDING
ST. PAUL, MN 55155

Minnesota Department of Human Services Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

A report to the 2001 Minnesota Legislature as required
by Laws of Minnesota 1999
Chapter 245, Article 4, Section 113

Dental Access for Minnesota Health Care Programs Beneficiaries: Supplemental Report to the 2001 Minnesota Legislature on the Evaluation of the Effects of the 1999 Dental Initiatives

Cost of completing this report:

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

Staff time: \$2,900

Administrative costs: 150

Total: \$3,050

Table of Contents

Executive Summary	i
Introduction	1
Dental services payment rate increase	1
Payment rate increase for preventive services	2
Dental hygienist demonstration projects	4
Dental access project start-up grants	5
Northwestern Minnesota dental access grant	10
Recommendations	12
Appendix A: 1999 Dental Access Initiatives Legislation	14
Appendix B: Dental Access Grants - Summary of Awards	16
Appendix C: DHS Dental Access Advisory Committee Membership	17

Dental Access for Minnesota Health Care Programs Beneficiaries: Supplemental Report to the 2001 Minnesota Legislature on the Evaluation of the Effects of the 1999 Dental Initiatives

May 2001

Executive Summary

The 1999 Legislature passed several initiatives addressing the Minnesota Health Care Programs (MHCP) dental access problem. The legislation required the Minnesota Department of Human Services (DHS) to evaluate the impact of these initiatives on dental access. That evaluation is the focus of this report.

The same legislation also required DHS to study the dental access problem and make recommendations to the Legislature for improving access. DHS previously released a report focusing on this requirement: *Dental Access for Minnesota Health Care Programs Beneficiaries: Report to the 2001 Minnesota Legislature*.

Methodology

DHS conducted its review by examining utilization data and grantees' reports. As required by statute, DHS sought the input of the Dental Access Advisory Committee, composed of key stakeholders. The findings and conclusions were limited based on the availability of utilization data; complete data was available for only one quarter (first quarter, CY 2000).

1999 Legislative Initiatives: Findings and Conclusions

The Legislature appropriated an across-the-board 3 percent payment rate increase for all MHCP dental services.

This increase did not appear to improve access to dental care. Utilization continued to decline at about the same rate as it had over the previous two years. Minnesota's results may change as additional data becomes available. However, a recent study of state dental payment rate increases, by the U.S. General Accounting Office, indicates that an increase of 3 percent is unlikely to improve access.

The Legislature appropriated a payment rate increase of approximately 43 percent for tooth sealants and fluoride treatments.

This increase appears to have had no impact on the utilization of these two important preventive dental care services. The Dental Access Advisory Committee recommends that if rate increases are targeted to specific services, the increases should be targeted at those services which are more likely to "get the patient into the office", i.e., oral exams and x-rays.

The Legislature granted DHS authority to approve dental hygienist demonstration projects.

An inability amongst the key stakeholders to reach consensus on the fundamental parameters of the practices of dentistry and dental hygiene prevented the development of workable models.

The Legislature appropriated \$600,000 for dental access start-up project grants.

The eight projects funded by these grants largely improved dental access, expanded the infrastructure, and garnered additional non-state funds. The dental manpower shortage forced some grantees to alter their plans or to operate on a reduced scale. The full impact of the grants will become more apparent as the infrastructure created by the projects reaches capacity and utilization data for additional quarters becomes available.

The Legislature appropriated a \$75,000 grant to a dental clinic serving northwestern Minnesota.

The northwestern Minnesota dental clinic grant allowed its recipient to restructure its finances, allowing the recipient to continue to provide dental services. This clinic remains an important, permanent part of the service delivery system in an area of the state with some of the lowest levels of MHCP dental access.

Recommendations

DHS Recognizes that funding for dental access initiatives may be limited for the 2002-2003 biennium. Based on an evaluation of the 1999 initiatives, should funding become available, DHS recommends:

1. Grant funds should be targeted at proven methods of improving dental access for MHCP beneficiaries.

Based on the outcomes of the eight 1999 dental access start-up project grants, the Legislature should consider this type of grant to be an effective tool to improve dental access for MHCP beneficiaries. Most grant projects made services available to patients who otherwise did not access dental care services.

- Contracts for future grant projects should include performance measures and provisions that would allow funds to be moved among grantees depending on their performance.
- To allow sufficient lead time for potential grantees to develop their concepts and line up matching resources, future appropriations for grants should be made with realistic time frames.

2. Provider payment increases should be large enough to motivate provider participation. Increases should be targeted at critical services and providers to ensure the most efficient use of available funds.

To better ensure improved access, future payment rate increases should be of sufficient magnitude to address the administrative considerations of individual practices. To mitigate the cost of payment rate increases, DHS should continually review its purchasing and coverage policies, seeking new cost-effective ways to deliver dental services to MHCP beneficiaries. As a purchaser of dental services, DHS should stay current with the research on “evidence-based” dentistry and consider adjusting its policies as the efficacy of this concept emerges.

3. *Continue to identify new ways of using dental hygienists, other dental auxiliaries and other health professionals to improve dental access.*

The 1999 dental hygienist demonstration project was unsuccessful due to a lack of consensus among key stakeholders over the model specified in the legislation. However, around the nation there are several successful examples of employing dental auxiliaries in creative ways. Minnesota should continue its efforts to identify new models for which the stakeholders can reach consensus. Equal consideration should be given to the interests of the affected professions, as well as to the needs of Minnesotans for access, quality and safety.

4. *Address dental workforce issues.*

The declining number of dental school graduates, and tight labor markets for dental hygienists and dental assistants thwart many efforts to improve dental access for underserved populations. The issue is particularly acute in rural areas of Minnesota because fewer dentists locate their practices in towns where dentists retire. In both rural and urban areas, community clinics find themselves outbid by the private sector as they try to recruit dentists. Efforts to improve infrastructure and equipment, as well as payment rate increases, are more likely to produce results if an adequate workforce is available.

Dental Access for Minnesota Health Care Programs Beneficiaries: Supplemental Report to the 2001 Minnesota Legislature on the Evaluation of the Effects of the 1999 Dental Initiatives

April 2001

Introduction

The 1999 Legislature passed several initiatives addressing the Minnesota Health Care Programs (MHCP) dental access problem. These initiatives included the requirement for the Minnesota Department of Human Services (DHS) to conduct a study of the dental access problem and make recommendations to the Legislature that would improve access. In addition, these initiatives appropriated funds for start-up project grants, provided for dental hygienist demonstration projects, increased payment rates, and required an evaluation of the impact of these initiatives on dental access. See Appendix A for the legislation.

This report evaluates the impact of the grants, demonstration projects and payment rate increases on the access to dental care for MHCP recipients and enrollees. DHS previously released a companion report, *Dental Access for Minnesota Health Care Programs Beneficiaries: Report to the 2001 Minnesota Legislature*¹, that focuses on the study of the dental access problem and recommendations for improvement.

Methodology

DHS gathered and reviewed outcome data on each of the initiatives. This data included utilization data as well as data from the quarterly and final reports required of the nine grantees. The DHS Dental Access Advisory Committee, composed of representatives of the state's major dental stakeholders (see Appendix C), advised DHS in this evaluation.

Dental services payment rate increase

The Legislature appropriated \$561,000 for the 1999-2001 biennium to increase payment rates for all covered dental services by 3 percent over the rates in effect on December 31, 1999. DHS adjusted fee-for-service rates and prepaid managed care rates effective January 1, 2000.

The purpose of this initiative was to give a financial incentive for dentists to provide more services to MHCP recipients and enrollees. To measure the impact of the rate increase, DHS compared utilization data for the latest complete quarter (first quarter, CY 2000) with

¹ Minnesota Department of Human Services, "Dental Access for Minnesota Health Care Programs Beneficiaries: Report to the 2001 Minnesota Legislature," January 2001. This report is available on the web at <http://www.dhs.state.mn.us/HlthCare/PDF/2001DentalAccessreport.pdf>

comparable quarters from the immediately previous two years. Data for both fee-for-service recipients and enrollees, and for managed care recipients and enrollees (Table 1) was examined.

		FFS	FFS	Managed	Managed care		Total	Visits/1000
		distinct	eligible	care	eligible	Total	Eligible	member
CY	Q	visits	months	distinct visits	months	distinct visits	months	months
1998	1	55,636	678,134	74,749	864,220	130,385	1,542,354	84.5
1999	1	46,427	594,740	94,630	907,678	141,057	1,502,418	93.9
2000	-1	45,381	579,291	78,043	935,882	123,424	1,515,173	81.5

Discussion: Evaluation of this increase was limited by the availability of complete data from only one quarter during which the payment rate increase was in effect. However, dental utilization for MHCP beneficiaries has declined each year for the period of 1997 to 1999², despite similar rate increases granted by the Legislature during those years (5 percent for MA and GAMC and 15 percent for MinnesotaCare in 1997; 3 percent for all three programs in 1998). In contrast, the average dental claim submitted to the largest payer of dental claims for MHCP prepaid enrollees was 10 percent higher in 1999 than in 1998³. The U.S. Government Accounting Office studied 40 states which raised their Medicaid dental payment rates over a recent 3-year period and found that those which saw increases in utilization were those which raised their rates to at least 2/3 of the regional usual and customary fee.⁴

Conclusion: The size of this rate increase was too small to have an effect on improving dental access.

Payment rate increase for preventive services

The Legislature appropriated funds to increase payment rates for two key preventive services, fluoride treatments and tooth sealants. Rates for both services were raised to 80 percent of 1997 median charges. Payment rates for these services were approximately 56 percent of median charges in 1997, so these increases effectively represented approximately a 43 percent raise. The purpose of this initiative was to give dentists an incentive to provide two key dental services that can have a significant impact on the oral health of children.

DHS raised fee-for-service rates effective October 1, 1999 and adjusted prepaid managed care capitation rates effective January 1, 2000. To measure the impact of these rate increases, DHS compared utilization data for the latest complete quarter (first quarter, CY 2000) with

² Ibid., page 3.

³ Walsh, M., Delta Dental Plan of Minnesota, letter to "Delta Dental Customer", October 17, 2000.

⁴ United States General Accounting Office, "Factors Contributing to Low Use of Dental Services by Low-Income Populations", September 2000.

comparable quarters from the immediately previous two years (Tables 1 and 2). Data for both fee-for-service patients and for managed care patients was examined.

Table 2. Fluoride Visits for Recipients < Age 18, Minnesota Health Care Programs								
<i>(includes procedure code D1201, topical application of fluoride including prophylaxis and D1203, topical application of fluoride not including prophylaxis)</i>								
		FFS		Managed care				Visits/1000
		distinct	Eligible	Managed care	Eligible	Total	Eligible	member
CY	Q	visits	months	distinct visits	months	distinct visits	months	months
1998	1	6,474	277,198	15,610	458,996	22,084	736,194	30.0
1999	1	4,895	231,944	18,519	473,476	23,414	705,420	33.2
2000	1	4,200	216,362	14,558	476,531	18,758	692,893	27.0

Table 3. Sealant Visits for Recipients < Age 18, Minnesota Health Care Programs								
<i>(includes procedure code D1201, topical application of fluoride including prophylaxis and D1203, topical application of fluoride not including prophylaxis)</i>								
		FFS		Managed care				Visits/1000
		distinct	Eligible	Managed care	Eligible	Total	Eligible	member
CY	Q	visits	months	distinct visits	months	distinct visits	months	months
1998	1	4,596	277,198	10,501	458,996	15,097	736,194	20.5
1999	1	3,198	231,944	13,113	473,476	16,311	705,420	23.1
2000	1	2,950	216,362	9,950	476,531	12,900	692,893	18.6

Discussion: As with the analysis of the overall payment rate increase, analysis of the effects of these increases was hampered by the limited availability of usable data. Tables 2 and 3 indicate that visits for the two services actually decreased from the previous two years.

While the magnitude of this increase was much greater than the overall payment rate increase, the Dental Access Advisory Committee believes that targeting increases to these particular services is not an effective way to improve access. They advise that if rate increases are targeted to specific services, the increases should be targeted at those services which are more likely to “get the patient into the office”, i.e., oral exams and x-rays. They speculate that increased reimbursement for two preventive services is not a large enough incentive for a dentist to accept a MHCP child as a new patient.

Members of the Dental Access Advisory Committee observed that not all children need sealants or fluorides. They suggested that for these services, MHCP children would ideally be screened, with application of fluorides or sealants made for those determined to be most at risk. The Committee believes this approach would be preferable to the payment rates-based approach to increasing utilization, as it would target children most in need as well as be more cost-effective for the State.

Conclusion: Substantial, overall payment rate increases may be most effective in improving access, but if alternatively specific services are targeted for increases, the services should be the more commonly used ones. In the future, as strides are made in “evidence-based” dentistry DHS should investigate the more targeted approach to providing dental services suggested by the Committee.

Dental hygienist demonstration projects

Effective July 1, 1999, the Legislature authorized DHS to approve projects that extend access to the services of dental hygienists by allowing the provision of dental hygiene services outside traditional dental offices, without the patient having first be seen by a dentist. The services would still be authorized by a licensed dentist. These projects are permitted to serve patients who have "limited access" to dental care. Limited access is defined as unable to receive regular dental services in a dental office due to age, disability or geographic location. The purpose of this initiative was to enable dental auxiliary personnel to provide dental services to MHCP patients that the patients would probably not have otherwise received.

DHS published a request for proposals (RFP) on August 9, 1999 and reissued it on March 20, 2000. The concept was also promoted to its members by the Minnesota Dental Hygienists Association. By January 2001, DHS had received approximately 30 inquiries from all areas of the state. However, only two formal proposals were submitted. The proposed projects would extend dental hygienist services to nursing facility residents, to children in Head Start programs, and to children in elementary school settings. DHS granted authorization for both proposals. One was later withdrawn. The remaining project that was approved, submitted by the Amherst H. Wilder Foundation, also received a dental access project start up grant.

The Wilder project proposed to establish a school-based pediatric dentistry program to serve 1,200 public school children in grades K-8 at two elementary schools in medically under-served areas of St. Paul. Incorporated into their model was a dental hygienist demonstration project whereby the hygienists would provide teeth cleaning (prophylaxis), apply topical fluoride, perform screenings, risk assessment and education.

Discussion: The Wilder project was successful in increasing dental access for low income children, but did so without exercising the provisions of the demonstration project statutory language. The project staff met with the state Board of Dentistry three times during the course of the project. While the Board members were supportive of many aspects of the project activities, they expressed considerable skepticism as to the efficacy of the demonstration project activities (i.e., application of fluoride treatments and providing services when a dentist is not physically present on site). The Dental Board observed that the legislation that passed in 1999 was "contradictory".

While the hygienist employed by the Wilder project did not practice under the 1999 demonstration project language, during the course of the project staff initiated potentially productive conversations with one of the participating health plans. Discussions were begun with HealthPartners and the University of Minnesota Dental Hygiene Program about the initiation of an agreement whereby a U of M dental hygienist would apply sealants and fluorides for children at Monroe school who are enrolled in HealthPartners, with off-site supervision by a HealthPartners dentist.

Conclusion: Using dental hygienists to improve dental access is a highly controversial issue in

Minnesota's dental community. The absence of single successful project emerging to take full advantage of the 1999 legislation demonstrates the lack of support from organized dentistry for this particular approach. Because other states and the federal government have demonstrated successful models of serving patients by employing dental auxiliaries in non-traditional ways, Minnesota should continue to develop alternative models that can be supported by the auxiliaries and the dentists.

Dental access project start-up grants

The Legislature appropriated \$600,000 for the state fiscal year July 1, 1999 - June 30, 2000 to fund start up costs of dental access projects. Grantees were required to match grant funds on a dollar-per-dollar basis with non-state funds. DHS was required to award grants to entities with a demonstrated ability to provide dental services effectively to public programs beneficiaries. The purpose of this initiative was to encourage local projects that would improve access to dental services in their communities.

DHS issued an RFP on August 9, 1999. Sixteen proposals were received, requesting a total of \$1.48 million. DHS empaneled a committee which reviewed the proposals and made award recommendations. The committee found merit in most of the 16 proposals reviewed, but the limitations of the funding required the committee to prioritize and limit the number of proposals recommended for funding. Some of the approved proposals were not recommended for the full amount sought, not because their concept was deemed unacceptable but because the committee attempted to maximize the number of projects funded. DHS awarded the \$600,000 appropriation to eight of the proposals. Appendix B summarizes the eight grant projects as they were finally approved and funded.

To further leverage the grant funds, DHS asked Patterson Dental, one of the state's largest dental supply firms, for discounts for the equipment purchases of the grantees. The company responded with generous discounts available to each of the eight grantees. These discounts extended the purchasing power of the funds appropriated by the Legislature, as well as the matching funds put up by the grantees. Patterson Dental's involvement with this initiative is an excellent example of the kind of partnership between the private sector and government that is needed to effectively address the dental access problem.

Following are summaries and discussion of each of the approved grant projects.

Amherst Wilder Foundation. This grantee received funds to establish a school-based pediatric dentistry program to serve 1,200 public school children in grades K-8 at two elementary schools in medically under-served areas of St. Paul. A different model was employed at each site.

At Monroe School, the project employed a dental hygienist to do screening, risk assessments and education. A total of 97 children received these services. Children determined to be at high risk for dental disease who did not have dental insurance were given funds to obtain the needed services. Fourteen children received such funds. In addition, the project provided for language translators, transportation and family health advocates. Families were connected to health

advocates who visited 200 homes, providing information on oral health.

At Dayton's Bluff School, Wilder arranged for Children's Dental Services to provide screenings and treatment. Children's screened 503 children and treated 95 of those determined to be at high risk. The project supplied funds to 44 high risk children who did not have dental insurance and supplied translators and family health advocates.

This project allowed many children to be seen by a dentist who otherwise did not have dental care. Both project sites demonstrated that using health advocates to follow up with families improved access for this hard-to-reach population. At the Monroe site, the project officers felt that requiring parents to be present at the treatment site allowed them to do more effective oral health education. Competing demands of the school day was an issue at both sites-- school officials did not permit the clinics to operate during the school day at Monroe, and restricted clinics to non-academic time at Dayton's Bluff. Because of this, project staff felt that fewer families participated than otherwise would have. They observe that, had the clinic been allowed to operate during the school day, the amount of time a child would be pulled out of class would be less than the time the child would be out of class to go to a dentist in the community (assuming one would be available). At the Dayton's Bluff site, out-of-class time was minimized because a dentist was available on site.

Apple Tree Dental. This grant was authorized for the purchase of mobile dental vehicles, the expansion of the grantee's existing clinics, manpower recruitment, and the purchase of computer and x-ray equipment. The grantee's programs serve MHCP eligibles, other low income persons, and Head Start children in 13 counties in northwestern Minnesota and in 11 counties in the Metro and adjacent areas.

The grantee reported increased access to care using several measures, comparing their latest fiscal year with the previous one:

- increased total dental visits from 22,198 to 27,756 (25 percent)
- increased the number of emergency services visits from 695 to 1,123 (61 percent)
- increased the number of visits by special needs patients from 15,689 to 18,707 (19 percent)

The grantee proposed to increase the number of dentists for their Twin Cities operation by one; they successfully recruited two. They proposed to attract an additional dentist to their Hawley Clinic; they were unable to do so. They proposed to expand the number of hygienists employed by one at their Twin Cities operations, and by two at their Hawley operation; they were able to attract one for each. They proposed to expand the number of dental assistants by one each in the Twin Cities and in Hawley; they were successful at both sites. The grantee proposed to increase the total number of satellite sites from 84 to 121; they were able to increase the number to 92.

This grantee has a long track record of seeking and receiving support from the private sector. They attribute to their state grant assistance in securing a total of \$840,000 in contributions from four different private foundations.

Children's Dental Services. The original proposal was for a new dental clinic in the Midway, an under-served area of St. Paul. The grantee was unable to find suitable clinic space in the target area, so the contract was amended to fund the grantee to provide services at a school based site on the city's East Side. In addition, funds were authorized for the purchase of new equipment for the grantee's Minneapolis clinic.

The grantee trained two chair-side assistants to be dental screeners at the school-based clinic. The screeners were trained to use the American Association of State and Territorial Directors' dental screening criteria. All children in the school were screened in May 2000. The grantee also purchased monitoring, anesthesia and emergency equipment for their main clinic in Minneapolis to perform intravenous sedation on patients whose behavior cannot be managed by other means. In addition, they have started using intravenous sedation with developmentally disabled adults. The alternative to sedation for these patients would be general anesthesia in a hospital or day surgery center, which would be much more costly.

The grantee reports that the grant enabled their annual production to increase by 28 percent. The \$100,000 state grant resulted in \$197,000 in new services and an investment in more modern equipment.

Clay County Public Health. This grant was awarded to develop new capacity in an area of the state with very low utilization of dental services by MHCP patients. Grant funds were used to remodel space in a county public health building to accommodate three new dental operatories, and to purchase the necessary equipment for the operatories. The grantee obtained matching funds from a private medical foundation to staff the clinic and purchase other dental equipment not covered by the state grant.

Constructing and equipping the new clinic space went more slowly than the grantee had originally scheduled. By the end of the grant period, work on the clinic was not yet complete and efforts to recruit a dentist had not yet come to fruition. The grantee was projecting that the clinic would be complete by August 2000, and was developing a contingency plan to hire temporary dental staff and secure the services of local dentists on a volunteer basis to assure that the clinic would be utilized immediately upon completion.

Fremont Community Health Services. This project would increase dental access for MHCP and uninsured patients in an under-served area of the inner city through the direct provision of dental services. Fremont Clinic does not have a dental component, so they have contracted with a mobile dental service to bring services to the community they serve. Grant funds were used to purchase additional hours of service from the contractor, adding dental clinic capacity.

In the six months prior to the grant, the clinic offered 11 days of dental care, serving a total of 86 patients at the rate of 7.8 patients per day. During the eight months of the grant period, the clinic provided 22 days of dental services at the rate of 8.6 patients per day. During the last three months of the grant, the clinic stepped up dental services to a weekly schedule, raising the rate to 9.4 visits per day. Project staff attribute this increase to a reduced appointment fail rate resulting from more frequent availability of service.

The Dental Access Committee noted that while dental access was increased through this project, it appears this increase was sustained only during the grant period. No permanent capacity was created, and the average cost per visit of approximately \$250 was much greater than typical costs for similar visits.

Hennepin Care - South Clinic. This clinic sought to improve dental access through improved efficiency of production. Grant funds were used to purchase a new Panorex x-ray machine. The clinic serves MHCP and other low income patients largely from the surrounding area, but due to the presence of Spanish speaking staff, draws Spanish speaking patients from almost a 100 mile radius.

The new machine was not installed until the last quarter of the grant period, so no increase in access was documented.

Uptown Community Clinic. This grantee sought to impact dental access for uninsured people by replacing some of its worn and outdated equipment, specifically a dental chair and hand pieces. The clinic is staffed largely by volunteer dentists, so clinic administrators felt that reliable, updated equipment would help them recruit volunteers.

Recruitment of volunteers proved to be difficult. The clinic may resort to hiring a part-time, paid contracted dentist until their volunteer base increases. They are collaborating with the Minneapolis District Dental Society and believe the new equipment represents important groundwork in working with the society to attract future volunteers. Table 4 summarizes the project results.

Table 4. Uptown Community Clinic Dental Access Grant Project Results

	Q3 1999	Q4 1999	Q1 2000	Q2 2000
Volunteer hours	78	90	108	103
Clinic sessions	69	93	93	103
Visits	158	198	203	227
Hygiene procedures	87	111	124	141
Other preventive procedures	21	16	7	21
Exams	35	40	44	48
Operative procedures	40	52	45	51
Oral surgery procedures	5	9	9	7

West Side Community Health Services. The purpose of this project was to extend dental outreach to under-served people in this clinic's service area. Those covered included MHCP eligibles, uninsured persons, homeless individuals, and public housing residents. Grant funds

were used to hire a .6 FTE dental hygienist, and in June, a .8 FTE dentist. Also purchased were educational materials. Hygienist services were made available 1 ½ days per week at 2 different public housing projects and one day a week at a clinic in a homeless shelter for families.

Project staff completed 277 outreach visits during a 5 ½ month period. Sixty percent of those seen were referred for follow-up. The outreach clinics did not have a dentist on site; referrals were made to West Side's main dental clinic. Only 10 percent of those referred kept their appointments.

West Side has continued its dental outreach program beyond the termination of the grant funds. They are experimenting with including a dental hygienist contact at well child exams in their medical clinics.

Discussion: Timing issues presented many obstacles to DHS, the grant applicants and the grantees. Because the funds were appropriated for a single fiscal year and couldn't be carried over, DHS was forced to impose a short deadline on the RFP, allowing potential applicants little time to fully develop their concepts. Several weeks were required for the administrative procedures necessary to issue the RFP, evaluate the proposals, award the grants, and negotiate contracts with the eight grantees. In some cases this resulted in project delays until late 1999, despite the readiness of the awardee. In many instances, grantees ran into unforeseen obstacles that could have been avoided if they had more planning time. Several of the grantees were unable to begin their projects until the end of the second quarter of the grant year, and some of those who were purchasing equipment had delays in ordering, receiving, and installing the equipment so their projects did not start until the third quarter.

Because of these timing issues, the project results shown at the end of the grant period may not tell the full story. For those grants that developed infrastructure, full results will not be apparent until several months after June 30, 2000, the end of the grant year and date on which their final report was due.

A common obstacle encountered by several of the grantees was the dental workforce shortage. While these grants enabled the grantees to purchase infrastructure, most did not use the funds for hiring additional dental professionals. Those who did were at best only partially successful in recruiting dental professionals in their nonprofit clinics at a time when demand for all types of dental professionals is extremely high. In some cases, grantees developed new infrastructure but were unable to operate their projects at full capacity due to limited manpower.

The offer of the equipment discount from Patterson Dental Supply proved to be an unforeseen positive for the grantees and the State. The discounts allowed the grantees to stretch their funds further. In addition, some of the grantees were successful at using their state grant funds to leverage substantial amounts of funding through grants from other sources. Again, this development brought more value to the grantees and to the State.

Conclusion: The dental access project start-up grants did achieve improved access for MHCP

patients. Some of the improvement was limited to the period when the grant money was available, while some was a net gain in capacity. Other positive outcomes included expansion of the knowledge base for future strategies.

DHS and the Dental Access Advisory Committee believe that the future appropriation of funds for dental access grants should be seriously considered. If adjustments are made in timing and careful scrutiny is paid toward outcomes, with the ability to move money across fiscal years and to take money from underperforming grantees and award it to others with more potential, this type of grant can be a valuable means of improving dental access for MHCP patients.

Northwestern Minnesota dental access grant

The Legislature appropriated \$75,000 for FY 2000 for a grant to a nonprofit dental provider group in Clay County to increase access for MHCP beneficiaries in northwestern Minnesota. The purpose of this initiative was to assure the continued operation of a recently opened dental clinic after a key contract was canceled. The clinic serves a large volume of MHCP patients from a wide area.

DHS issued an RFP in August 1999. In response, DHS received one proposal, from Apple Tree Dental, which operates a dental clinic in Hawley, Minnesota. The grant was awarded to Apple Tree. Per their contract, Apple Tree paid off three outstanding bridge loans they had obtained when their contract with another organization was canceled. Apple Tree attributes the receipt of this grant to their ability to leverage over \$500,000 in additional grants from other sources. During the grant period, the clinic expanded their capacity to accept emergency patients five days per week, and increased the number of visits by 38 percent over the previous four quarters.

Discussion: The state grant allowed the Apple Tree Hawley clinic to continue operations in an area of the state in which MHCP dental access is among the lowest. The clinic's difficulty in recruiting a dentist is an obstacle that is preventing this clinic from offering more access to this area. As in many rural areas of the state, the dental workforce shortage has proven to be a particularly challenging aspect of improving dental access to under-served populations in northwestern Minnesota.

Conclusion: Resources to increase infrastructure are well-spent in rural areas, but they represent only part of the equation: workforce resources are the other essential component.

Recommendations

DHS recognizes that funding for dental access initiatives may be limited for the 2002-2003 biennium. Based on an evaluation of the 1999 initiatives, should funding become available, DHS recommends:

1. *Grant funds should be targeted at proven methods of improving dental access for MHCP beneficiaries.*

Based on the outcomes of the eight 1999 dental access start-up project grants, the Legislature should consider this type of grant to be an effective tool to improve dental access for MHCP beneficiaries. Most grant projects made services available to patients who otherwise did not have access to dental care services.

- Contracts for future grant projects should include performance measures and provisions that would allow funds to be moved among grantees depending on their performance.
- To allow sufficient lead time for potential grantees to develop their concepts and line up matching resources, future appropriations for grants should be made with realistic time frames.

2. *Provider payment increases should be large enough to motivate provider participation. Increases should be targeted at critical services and providers to ensure the most efficient use of available funds.*

To better ensure improved access, future payment rate increases should be of sufficient magnitude to address the administrative considerations of individual practices. To mitigate the cost of payment rate increases, DHS should continually review its purchasing and coverage policies, seeking new cost-effective ways to deliver dental services to MHCP beneficiaries. As a purchaser of dental services, DHS should stay current with the research on "evidence-based" dentistry and consider adjusting its policies as the efficacy of this concept emerges.

3. *Continue to identify new ways of using dental hygienists, other dental auxiliaries and other health professionals to improve dental access.*

The 1999 dental hygienist demonstration project was unsuccessful due to a lack of consensus among key stakeholders over the model specified in the legislation. However, around the nation there are several successful examples of employing dental auxiliaries in creative ways. Minnesota should continue its efforts to identify new models for which the stakeholders can reach consensus. Equal consideration should be given to the interests of the affected professions, as well as to the needs of Minnesotans for access, quality and safety.

4. *Address dental workforce issues.*

The declining number of dental school graduates, and tight labor markets for dental hygienists and dental assistants thwart many efforts to improve dental access for underserved populations. The issue is particularly acute in rural areas of Minnesota because fewer dentists locate their practices in towns where dentists retire. In both rural and urban areas, community clinics find themselves outbid by the private sector as they try to recruit dentists. Efforts to improve infrastructure and equipment, as well as payment rate increases, are more likely to produce results if an adequate workforce is available.

Appendix A: 1999 Dental Access Initiatives Legislation

Payment Rate Increases

Laws of Minnesota, Chapter 245, Article 4, Section 78

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges; and

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care.

Access Grants

Laws of Minnesota, Chapter 245, Article 4, Section 78

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants: (i) potential to successfully increase access to an underserved population; (ii) the ability to raise matching funds; (iii) the long-term viability of the project to improve access beyond the period of initial funding; (iv) the efficiency in the use of the funding; and (v) the experience of the proposers in providing services to the target population. The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following: (i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas; (ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and (iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals.

Laws of Minnesota, Chapter 245, Article 1, Sec. 2, Subd. 5.

[COMMUNITY DENTAL CLINICS.] Of this appropriation, \$600,000 in fiscal year 2000 is for the commissioner to provide start-up grants to establish community dental clinics under Minnesota Statutes, section 256B.76, paragraph (b), clause (5). The commissioner shall award grants and shall require grant recipients to match the state grant with nonstate funding on a one-to-one basis. This is a one-time appropriation and shall not become part of base level funding for this activity for the 2002-2003 biennium

Laws of Minnesota, Chapter 245, Article 1, Sec. 2, Subd. 5.

[DENTAL ACCESS GRANT.] Of this appropriation, \$75,000 is from the general fund to the commissioner in fiscal year 2000 for a grant to a nonprofit dental provider group operating a dental clinic in Clay county. The grant must be used to increase access to dental services for recipients of medical assistance, general assistance medical care, and the MinnesotaCare program in the northwest area of the state. This appropriation is available the day following final enactment.

Dental Hygienist Demonstration Projects

Laws of Minnesota, Chapter 245, Article 4, Sec. 118.

[DENTAL HYGIENIST DEMONSTRATION PROJECT.] (a) The commissioner of human services may develop demonstration projects utilizing dental hygienists outside a traditional dental office to provide dental hygiene services to limited access patients. Notwithstanding Minnesota Statutes, section 150A.10, subdivision 1, a licensed dental hygienist may provide screening services, education, prophylaxis, and application of topical fluorides under general supervision as defined in Minnesota Rules, part 3100.0100, subpart 21, without the patient being first examined by a licensed dentist. Services under this section must be authorized by a licensed dentist and must be performed by a licensed dental hygienist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist. For purposes of this section, "limited access patient" means a patient who the commissioner determines is unable to receive regular dental services in a dental office due to age, disability, or geographic location. (b) The commissioner shall report to the legislature by January 15, 2001, on whether this demonstration project has been effective in improving access to dental services for limited access patients.

Appendix B: Dental Access Grants - Summary of Awards

A. Start-Up Grants				
Grantee	Project summary	Target population	Geographic area served	Amount awarded
Amherst Wilder Foundation St. Paul	Establish a school-based pediatric dentistry program	1,200 public school children, grades K-8	2 medically under-served areas in St. Paul	\$38,000
Apple Tree Dental Minneapolis	Purchase mobile dental vehicles, expand existing clinics, manpower recruitment, purchase computer & x-ray equipment	Minnesota Health Care Program (MHCP) eligibles, low income, Head Start	13 counties in NW MN; 11 Metro & adjacent counties	\$174,000
Children's Dental Services Minneapolis	Purchase equipment and repair equipment to expand services	MHCP eligibles, uninsured	Minneapolis and St. Paul areas	\$100,000
Clay County Public Health Moorhead	Develop a community dental clinic and establish a dental hygienist demo project	MHCP eligibles, uninsured	10 counties in NW MN	\$180,000
Fremont Community Health Services Minneapolis	Increase clinic hours through an extended contract with a service provider	MHCP eligibles, uninsured	Designated medically under-served areas in N. & NE Mpls.	\$25,000
Hennepin Care-South Clinic Richfield	Increase clinic efficiency through the purchase of a new x-ray machine	MHCP eligibles; including Spanish speaking	Metro area & Albert Lea to Zimmerman	\$8,000
Uptown Community Clinic Minneapolis	Replace dental chair and hand pieces	Uninsured	City of Minneapolis	\$25,000
West Side Community Health Services St. Paul	Increase clinic manpower, extend outreach	MHCP eligibles, uninsured; homeless, public housing residents.	Inner city St. Paul	\$50,000
Total:				\$600,000
B. NW Minnesota Dental Access Grant				
Grantee	Proposal summary	Target population	Geographic area served	Amount awarded
Apple Tree Dental Minneapolis	Pay debt on new clinic serving public programs patients	MHCP eligibles	Northwestern MN	\$75,000

Appendix C: DHS Dental Access Advisory Committee Membership

DHS Dental Access Advisory Committee Members

Nita Aasen, Director, Nicollet County Public Health

Karla Abdo, Paralegal, Legal Services of Northwest Minnesota

Craig Amundson, D.D.S., Dental Director, HealthPartners

Jonathon Babcock, D.D.S., Chairman, Minnesota Association of Community Dentistry

Carrie Benson, R.D.H., Minnesota Dental Hygienists' Association

Doug Britton, Director of Planning and Contracts, St. Louis County Social Service Department

Lazette Chang-Yit, Medica Health Plan, representing Minnesota Council of Health Plans

Tarryl Clark, Executive Director, Minnesota Community Action Association

Rhonda Degelau, J.D., Executive Director, Minnesota Primary Care Association

Amos Deinard, M.D., M.P.H., Associate Professor, Department of Pediatrics, University of Minnesota School of Medicine

Richard Diercks, Executive Director, Minnesota Dental Association

Carl Ebert, D.D.S., Assistant Director, Apple Tree Dental

Patricia H. Glasrud, Executive Director, Minnesota Board of Dentistry

Kathy McDonough, Staff Attorney, Legal Services Advocacy Project

Chuck Neil, P.H.N., Health Manager, Arrowhead Head Start, representing Minnesota Head Start Association

Vacharee Peterson, D.D.S., Peterson and Peterson Dental

Mildred Roesch, R.D.H., M.P.H., State Dental Coordinator, Minnesota Department of Health

Ann Rogers, Government Programs Manager, Delta Dental of Minnesota

Dan Rose, D.D.S., School of Dentistry, University of Minnesota

Mark Schoenbaum, Planning Grants Administrator, Minnesota Department of Health, Office of Rural Health and Primary Care

Betty Windom-Kirsch, Administrator, Clay County Public Health

