



OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

**Medical Assistance
Payment Rates for
Dental Services**

MARCH 2013

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OFFICE OF THE LEGISLATIVE AUDITOR

STATE OF MINNESOTA • James Nobles, Legislative Auditor

March 2013

Members of the Legislative Audit Commission:

At your request, we evaluated the methods and practices the State of Minnesota has used to set payment rates for dental services provided through the Medical Assistance program. We also examined the impact the results have had on dentists' participation in the program and enrollees' access to dental care.

We found that Minnesota uses numerous methods and types of payments to reimburse dental providers, and we found that payment policies are inconsistently implemented across Medical Assistance programs. We also found that, historically, Minnesota's fee-for-service base rates for dental services have been low compared with rates of most other states, and Minnesota's rates are not based on the costs of current dental services.

We recommend that the Legislature and Department of Human Services better coordinate payment policies and rate-setting methods. We also recommend that the state increase fee-for-service rates and give particular attention to rates for services provided to individuals with special needs. Finally, we think that the Department of Human Services should more closely monitor recipient access to dental services, particularly for services provided through managed care organizations.

Our evaluation was conducted by Valerie Bombach (project manager) and Lang (Kate) Yang. The Department of Human Services cooperated fully with our evaluation.

Sincerely,

A handwritten signature in black ink that reads 'Jim Nobles'.

James Nobles
Legislative Auditor

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Summary

Minnesota's payment policies and methods to reimburse dental providers are poorly coordinated and inconsistently applied across Medical Assistance programs.

Key Facts and Findings:

- Minnesota provides more dental benefits in its state Medicaid program (called Medical Assistance, or MA) than required by federal law. Still, dental services represent just 3 percent of MA program expenditures. (pp. 11, 15)
- 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. (pp. 22-26)
- Minnesota's MA fee-for-service rates for paying dentists were lower in 2012 than in 2000, and lower than rates of most other states. In addition, the rates are based on an adjustment to 1989 dentist charges and not the costs of current dental services. (pp. 18, 27-32)
- Managed care organizations that contract with the state for MA often reimburse their dental providers more than the fee-for-service base rates, although the differences are sometimes small. (pp. 33-34)
- Although the share of Minnesota dentists participating in MA has been steady in recent years, many dentists report that they have limited or ceased treating MA enrollees due primarily to low state payments. (pp. 45, 48)

- Some low-income individuals—particularly those with special needs or located in sparsely populated areas—face challenges accessing MA dental providers. (pp. 52-56)

Key Recommendations:

- The Department of Human Services (DHS) should improve its information system, MN-ITS, to better support dental providers' inquiries of patient eligibility and state restrictions on benefits. (p. 39)
- DHS should ensure that service authorization criteria and benefit changes are more clearly defined and communicated to dental providers. (p. 42)
- The Legislature and DHS should better coordinate payment policies and rate-setting for Medical Assistance dental services. As part of this effort, the Legislature should increase fee-for-service payment rates for dental services. (p. 61)
- The Legislature and DHS should implement a separate benefit and payment structure for Minnesota's Medical Assistance population with special needs. (p. 61)
- DHS should more closely monitor Medical Assistance recipients' access to dental services. (p. 61)

Minnesota's fee-for-service dental payment rates rank relatively low among states.

Report Summary

Minnesota's Medicaid program—called Medical Assistance (MA)—is Minnesota's largest publicly funded health care program. It provided medical and dental services to 910,000 individuals in 2011. Federal Medicaid law requires dental services for children, but states can provide additional benefits. Minnesota requires that some limited dental services be made available to adults.

The state's 2011 expansion of MA eligibility to additional low-income individuals affected program costs. Spending for dental services totaled about \$131 million in 2011—a 9-percent annual increase since 2006. However, when considering changes in enrollment, average spending grew just 2 percent annually.

Like other MA health care services, MA dental services are provided through both fee-for-service and managed care programs. DHS administers dental services through fee-for-service, primarily for individuals who are disabled or have special needs. In 2012, DHS also contracted with eight managed care organizations (MCOs) to provide MA health care and dental services through several managed care programs.

Minnesota's fee-for-service dental rates are not based on the current costs and resources needed to provide dental care.

Federal law requires that MA payment rates be consistent with efficiency, economy, and quality of care. The rates also must be sufficient to enlist enough providers so that care and services are available to the extent that care and services

are available to the general population. The federal Centers for Medicare & Medicaid Services allows states some flexibility to determine how much to pay MA dentists. Minnesota's Legislature authorizes the method for setting MA fee-for-service base rates for dental services.

Minnesota's fee-for-service base rates for most dental procedures are based on how much dentists charged in 1989. (The most recent across-the-board rate increase was a 3-percent increase in 2000; however, the 2011 Legislature imposed a 22-month, 3-percent reduction in the rates.) In contrast, Minnesota uses Medicare cost-based reimbursement principals to determine and update payment rates for physicians and some other health care providers. Unlike dental fee-for-service rates, the Medicare-based rates are more closely related to the actual costs of providing care.

According to national research, Minnesota's fee-for-service rates have ranked in the lower one-third of all states, and Minnesota's rates today are lower than they were a decade ago. Minnesota's 2012 rates were mostly lower than those of neighboring states. For example, North Dakota paid an average of 185 percent of Minnesota's rates for select procedures, while Wisconsin paid an average of 104 percent.

Minnesota supplements its fee-for-service rates with other payments, but payment policies and eligibility criteria vary.

In lieu of increasing its fee-for-service base rates, Minnesota uses several types of targeted payments and other approaches to determining payment amounts. These payment policies and the related payment rates

**Minnesota’s
Medical
Assistance
payment policies
were not
systematically
developed to
ensure that MA
patients across
the state have
access to a dentist.**

were each independently developed through state or federal law, DHS policy, or negotiation between the managed care organizations and their dentists. That is, the state’s payment policies for dental services were not developed through a systematic, coordinated assessment of rates to achieve a goal of dentist participation and patient access statewide.

For example, the Legislature made one type of supplemental payment—“critical access” payments—available to dental providers in 2002. We estimated that about 17 percent of dentists worked for clinics that were eligible to receive critical access payments in 2011. DHS also pays all fee-for-service dentists an additional 2 percent of the fee-for-service rate (as reimbursement for Minnesota’s provider tax) and pays community clinics an additional 20 percent, but MCOs are not required to make similar payments. It is difficult to determine whether any of the state’s supplemental payments supplant rates otherwise negotiated between dentists and MCOs.

On average, dental payments by MCOs exceeded Minnesota’s fee-for-service rates, although the differences were sometimes small.

MCOs—and not DHS—determine how much they pay their dental providers. The MCOs often have used the fee-for-service rates as the starting point for setting rates, but MCOs often pay dentists in their network more. For example, the median MCO payment per dental procedure for the Prepaid Medical Assistance Program was 121 percent of the fee-for-service rates. On average, MCOs paid dentists more for the services they provided to MA enrollees with special needs. They also paid higher rates to specialists.

Historically, DHS has added “dental trend” increases into the payments made to MCOs to cover forecasted increases in the price of dental services. However, many dentists were sometimes reimbursed by MCOs at payment rates that were at or near the fee-for-service base rates, and the fee-for-service rates have not increased since 2000.

The share of dentists participating in MA has not changed much since 2006, due partly to newly licensed dentists enrolling in MA.

In Minnesota, dental providers have the option to participate in Medical Assistance and treat MA enrollees. State law requires that dentists who treat public employees must provide dental care to individuals who are enrolled in MA (or other public health care programs).

Between 2006 and 2011, about 65 percent of dentists licensed in Minnesota served at least one MA enrollee. However, dentists’ MA patient caseloads greatly varied and the proportion of dentists with large caseloads increased during this time period. On the other hand, 24 percent of dentists responding to our survey said they stopped serving MA patients after 2010.

Among all MA recipients, individuals with special needs and those in sparsely populated areas have had particular difficulties finding dental providers. According to dentists and other stakeholders, the scope of benefits and payment rates are inadequate relative to the amount of time and resources necessary to appropriately care for individuals with special needs.

Total payment rates for MA dental services varied considerably among dental providers.

Most dentists who limit or cease serving MA recipients do so because of insufficient payments.

Low payment rates were most often cited as the reason dentists have stopped treating MA patients, but there were other reasons, too. Recently imposed limits on MA dental benefits for non-pregnant adults mean there are fewer services for which dentists may be reimbursed. Dentists report that the payment is often insufficient relative to the amount of administrative work required to participate in MA. Administrative costs could be reduced if DHS would improve its automated information system (MN-ITS) to better facilitate provider inquiries about patients' treatment histories and eligibility for care. Without upgrades to MN-ITS, restrictions on benefits are likely to be poorly implemented.

DHS also should better communicate to dental providers the service authorization criteria and rationale for benefit changes and exclusion of dental coverage. The Dental Services Advisory Committee was established as a venue to address these and other issues; we think the department should make better use of this venue.

The Legislature and DHS should better coordinate payment policies and rate setting for Medical Assistance dental services.

Minnesota's array of payment policies and rate-setting practices for MA dental services has likely had opposing and negative outcomes for the state and its MA recipients. The state's approach of targeting higher payments to certain dental providers has likely improved access for many MA recipients in some parts of the state. However, not all dental

providers are eligible for higher payments, the cumulative payment rates vary, and many dentists are often reimbursed at the relatively low fee-for-service rates.

For more transparency and equity in payments, the Legislature should increase the fee-for-service base rates. Any increases should relate to the costs for providing services and should occur in a measured and incremental way, one that monitors the impact of rate increases on both dentist participation and MA recipient access. DHS also should coordinate these increases with other rate setting and payment policies—such as those applied through managed care—to ensure that the fee-for-service rate increases supplement and do not supplant other payments.

To address concerns about the impact of recent benefit restrictions on individuals with special needs (and long-term costs to the state), DHS should develop separate benefit coverage and payment rates for serving this population. Many of these individuals have limited ability to care for themselves and they often need more expensive, specialized dental care. Higher payments for treating these individuals should help facilitate their access to dental care.

Introduction

Minnesota reimburses medical and dental providers for the health care services they provide to individuals enrolled in Medical Assistance—Minnesota’s version of the federal Medicaid program. The Minnesota Legislature authorizes the scope of Medical Assistance benefits—within federal parameters—as well as the payment methods and rates for reimbursing providers. However, Minnesota’s payments for Medical Assistance dental services have been a longstanding concern among dentists, as many dentists say that the amounts are too low and are insufficient relative to their costs for providing dental care. National research also reports that low payment rates are why some dentists do not serve Medicaid enrollees, and that inadequate access to dental care is one reason for poor oral health among low-income populations.

In response to legislative concerns, the Legislative Audit Commission in March 2012 directed the Office of the Legislative Auditor to evaluate Medical Assistance payment rates for dental services. Our evaluation addressed the following questions:

- **Does Minnesota’s Medical Assistance program have reasonable payment rates for dentists? How have these rates changed, how do they compare with other states, and how do reimbursement practices for dentists compare with those for other health care professionals?**
- **To what extent do Minnesota dentists participate in Medical Assistance? To what extent do they serve Medical Assistance clients and how has this changed during recent years?**
- **What has been the impact of payment rates and supplemental payments on dentist participation in Medical Assistance? What has been the impact of Minnesota’s payment policies on Medical Assistance client access to dental services?**

Our evaluation focused on payments for dental services provided through Medical Assistance (MA) through July 2012, and did not include services provided through other publicly funded health programs, such as MinnesotaCare. We also did not examine changes that may have occurred as a result of Minnesota’s early expansion of MA in mid-2011 under the federal Patient Protection and Affordable Care Act. However, Medical Assistance payment rates provide the basis for reimbursement through some other health care programs; our findings and recommendations here may be useful for these programs. Finally, we did not evaluate the quality of MA dental services or identify what constitutes the “right” amount of dental care for MA enrollees.

To provide context for our evaluation, we reviewed current and historical laws regarding dental benefits covered under MA, fee-for-service payment rates, and other types of payments for dental services. We examined contracts between the

Department of Human Services (DHS) and managed care organizations for delivering MA services through managed care. We also reviewed DHS actuary reports on calculating capitation payments to managed care organizations and estimating funding for dental services.

We conducted numerous interviews to understand how payment rates for Medical Assistance are determined. We spoke with DHS staff about how Minnesota sets fee-for-service base rates for dental services and how this process differs from ones used to set rates for other medical services. We also contacted representatives from neighboring states about their reimbursement methods. For dental services provided through managed care programs, we interviewed managed care organizations regarding reimbursing dentists in their networks. We also spoke with dentists to better understand their payment arrangements with managed care organizations.

To determine how much dentists were reimbursed for MA dental services, we analyzed data from DHS on dental claims and payments through both fee-for-service and managed care programs. We also compared fee-for-service reimbursement rates with Medicaid payment rates in neighboring states and with amounts typically charged by dentists in the region.

To assess dentist participation in MA, we analyzed data from the Minnesota Board of Dentistry on all licensed dentists and data from DHS on dentists submitting MA claims for reimbursement. We interviewed dentists regarding factors affecting their participation in MA. We also surveyed a sample of all active, licensed dentists in Minnesota regarding their MA participation status, reasons for limiting their participation or for not serving MA recipients, and perceptions of MA payment rates and state policies on MA payments. Our response rate was 39 percent (516 respondents out of 1,327 surveyed).

To understand how payment rates may impact patient access to oral health care, we examined national literature and research on this issue. We also spoke with a wide range of Minnesota stakeholders, including DHS and Department of Health staff, dentists, managed care organization representatives, and representatives of facilities serving MA recipients with special needs. We analyzed data from DHS to understand the extent to which MA recipients received dental services between 2006 and 2011.

Chapter 1 of this report provides an overview of Minnesota's administrative structure for delivering MA dental services, MA dental benefits, and MA dental care funding and expenditures. In Chapter 2, we discuss the processes to set fee-for-service base payment rates and payment rates in managed care, and examine actual payments for dental services in fiscal year 2012. We also discuss several administrative issues pertaining to providing MA services. In Chapter 3, we present outcomes of MA dental service delivery, including the extent to which dentists participate in MA and MA recipients' access to MA dental care. We also make recommendations regarding Minnesota's payment policies and rates for MA dental services.

Background

Under federal law, Minnesota has some flexibility to determine the scope of benefits and payment policies for Medical Assistance dental services.

Medical Assistance (MA) is the largest of Minnesota’s publicly funded health care programs and provides medical and dental services to low-income individuals.¹ In this chapter, we provide background information on Minnesota’s approach for administering and funding Medical Assistance dental services. We also briefly describe the scope of Minnesota’s MA dental benefits, types of dental care and dental procedures, and Minnesota’s dental workforce. We address Medical Assistance payment rates and their impact on dentist participation and MA recipient access to dental services later in this report.

ADMINISTRATIVE STRUCTURE

The federal Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services oversees states’ Medicaid programs. Through CMS, states are allowed some flexibility to determine the scope of health care benefits (within federal parameters), how their services are administered and delivered, and provider payment methods and rates. CMS also reviews and approves each state’s approach for overseeing Medicaid services, including dental services.

At the state level,

- **Minnesota has a multi-layered administrative structure to deliver Medical Assistance dental services.**

The Minnesota Department of Human Services (DHS) oversees Minnesota’s Medical Assistance program, including supervising counties in their administration of Medical Assistance and enrollment of recipients. The department administers policies and procedures regarding the scope of health care benefits and the delivery of MA services. DHS can limit the types and frequency of dental services available under Medical Assistance, as well as the amount paid for these services.² The department administers a process for enrolling dentists (and other health care professionals) in Minnesota’s public health care programs.³ DHS also operates a service center to facilitate claims processing and respond to questions from health care providers and MA recipients.

¹ As of early 2013, MinnesotaCare was the second largest program. Other Minnesota publicly funded health care programs included Emergency Medical Assistance, Minnesota Family Planning Program, and home and community-based waiver programs, for example.

² *Minnesota Statutes* 2012, 256B.04, subd. 12. Such limits must be within the scope of services as specified in state statutes.

³ *Minnesota Rules* 2012, 9505.0195.

Like other Medical Assistance health care, dental services are provided through fee-for-service and managed care programs.

In 2009, the Dental Services Advisory Committee was established to advise DHS regarding dental coverage policy, evidence-based care, best practices, dental services delivery models, and services to be added or eliminated from the scope of dental benefits, among other issues.⁴ State law also requires the committee to provide feedback on changes to the state’s “critical access” dental provider program.⁵ The committee members include dental providers; health researchers; consumers; and county, public health, and health plan representatives. The DHS medical director serves as the committee administrator, and a representative from the Minnesota Department of Health serves as a member of the committee.

Like other Medical Assistance health care services, MA dental services are coordinated through two types of administrative arrangements: fee-for-service and managed care programs, as shown in Exhibit 1.1.⁶ DHS directly administers dental services provided through fee-for-service. Fee-for-service serves primarily individuals who are disabled or have special needs, many of whom are receiving other types of care. Other MA populations—including non-pregnant adults, families with children, and seniors—may initially receive MA services through fee-for-service before they transition into a managed care program. MA recipients enrolled in fee-for-service may seek services from any dental provider in the fee-for-service network. The dental provider then submits a claim for reimbursement to DHS for processing and payment.⁷

Minnesota also provides MA dental services through its managed care programs.⁸ In 2012, the state provided managed care services through several different programs that serve different populations, also shown in Exhibit 1.1. Each of these programs provides basic health care—including dental care—but some provide additional services.

⁴ *Minnesota Statutes* 2012, 256B.0625, subd. 3(c)(b).

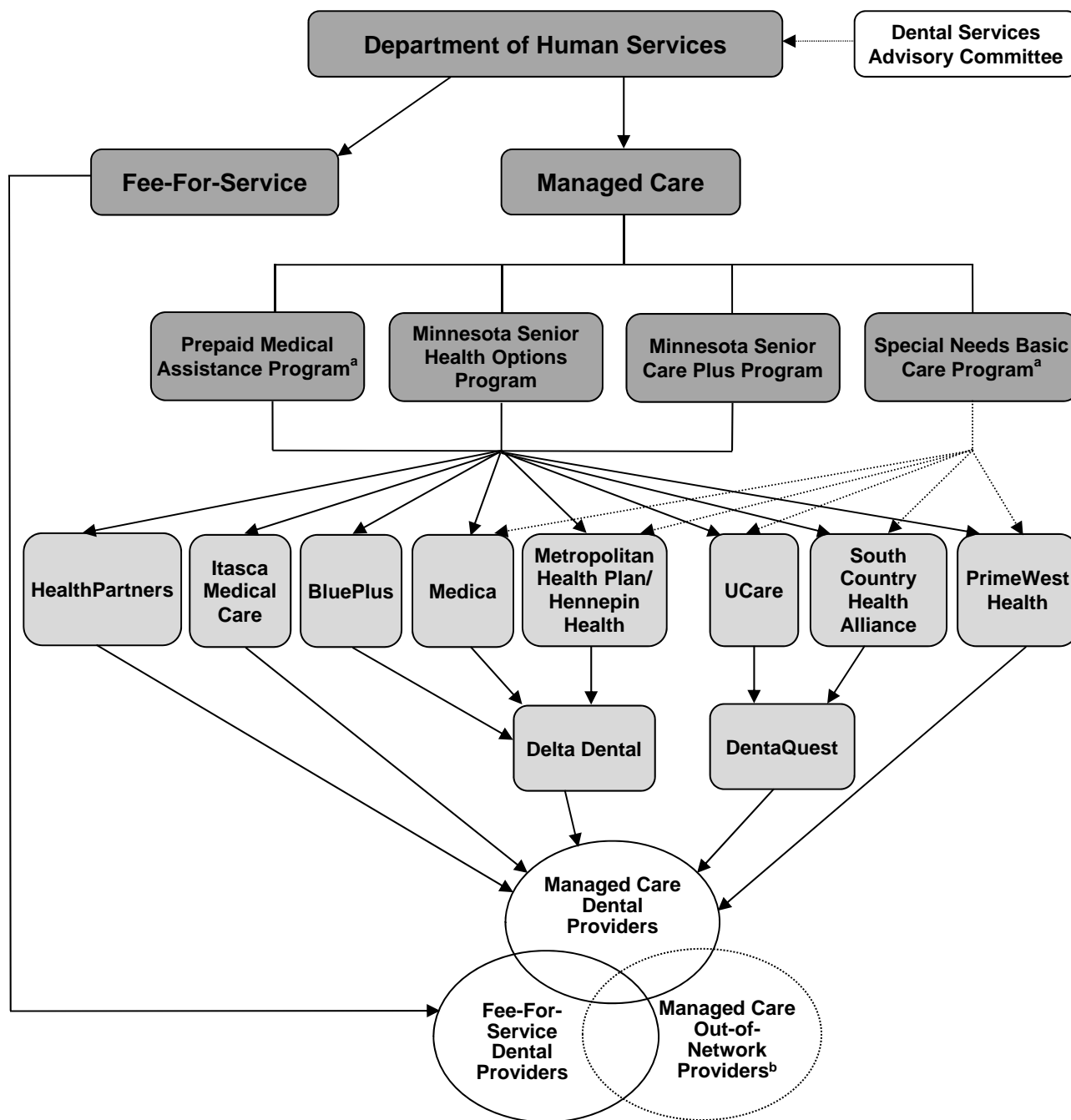
⁵ Under *Minnesota Statutes* 2012, 256B.76, subd. 4, eligible dental clinics and providers can receive additional reimbursement for their services. The law defines the reimbursement rate for “critical access” payments and the dental clinic/provider eligibility criteria for such payments. We discuss critical access payments in various sections of our report.

⁶ *Laws of Minnesota* 1993, First Special Session, chapter 1, art. 5, sec. 27. The law allowed the Department of Human Services to provide dental services through a prepaid program (the arrangement was initiated as a demonstration project similar to that conducted for Minnesota’s public health care programs). The commissioner was required to identify geographic areas where access to dental services was inadequate in which to conduct the demonstration project. Under *Minnesota Statutes* 2012, 256B.037, the provisions of this “demonstration project” for prepaid dental services are largely unchanged from the original law.

⁷ *Minnesota Statutes* 2012, 256B.041, requires the department to operate a statewide, centralized system for making payments to vendors.

⁸ For Medical Assistance dental services in Minnesota, managed care organizations must comply with federal requirements for comparable services and access relative to fee-for-service. Specifically, 42 *CFR* sec. 438.210 (2012) requires that Medicaid services provided through managed care organizations be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service. 42 *CFR* sec. 438.207 (2012) requires each managed care organization to offer an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area. Each MCO also must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. Any deviation from federal requirements must be approved by the Centers for Medicare & Medicaid services via a state’s request for managed care program waivers.

Exhibit 1.1: Minnesota’s Administrative Structure for Medical Assistance Dental Services, 2012



^a These programs also include a Preferred Integrated Network component that is implemented in only select counties.

^b An “out-of-network” provider does not have a contract with a managed care organization or its dental administrator to provide Medical Assistance dental services, but can agree to provide services to Medical Assistance patients on an ad hoc basis.

SOURCE: Office of the Legislative Auditor, summary of Department of Human Services’ 2012 contracts with managed care organizations and other documents.

Some managed care organizations hire a dental administrator to oversee dental services.

First, the Prepaid Medical Assistance Program (PMAP) serves families with children, pregnant women, and adults without children.⁹ Next, two programs serve MA recipients age 65 and over: Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO).¹⁰ These senior programs coordinate or integrate Medicaid with Medicare services together as a way to control costs and improve access to care. Minnesota Senior Care Plus provides the same services as PMAP and some additional benefits, such as limited nursing home care. Minnesota Senior Care Plus members must enroll in a separate federal Medicare plan and obtain separate Medicare prescription drug coverage. Minnesota Senior Health Options also provides coordinated Medicare and Medical Assistance health care services, but through a single, integrated health plan.¹¹ In the case of dental services, MSC+ and MSHO provide seniors with dental care that is not otherwise available through Medicare.

Finally, the Special Needs Basic Care (SNBC) program provides basic health care services to persons with disabilities or special needs who are eligible for both Medicaid and Medicare.¹² The SNBC program works through contracts with Medicare health plans to coordinate Medicaid and Medicare services; the program also provides some long-term care services to its enrollees. As part of the state’s PMAP and SNBC contracts with select managed care organizations, DHS has implemented Preferred Integrated Networks (PINs). The PINs effort involves integrating physical and mental health services within managed care organizations and coordinating this care with social services.¹³

Each year, the department determines which health plans and “county-based purchasing organizations” to contract with for managed care; we refer to these entities as managed care organizations (MCOs) throughout this report.¹⁴ Each MCO is responsible for maintaining and administering a network of dental providers and for providing claims processing, medical review, and other administrative services. Sometimes, MCOs do not handle all of these services directly and instead hire a vendor—or dental administrator—for these services. Each managed care organization determines how much it pays its dentists, although managed care organizations must provide at least the same scope of services and minimum payment rates that are available under fee-for-service.¹⁵

⁹ *Minnesota Statutes* 2012, 256B.69, subd. 4.

¹⁰ *Minnesota Statutes* 2012, 256B.69, subd. 23.

¹¹ The extent of care coordination and plan integration varies among managed care organizations.

¹² *Minnesota Statutes* 2012, 256B.69, subd. 28. Effective January 1, 2012, persons with disabilities are required to enroll in a special needs basic care plan with a managed care organization—rather than fee-for-service Medical Assistance—unless they affirmatively opt out of managed care.

¹³ *Minnesota Statutes* 2012, 245.4682, subd. 3.

¹⁴ Managed care organizations are often referred to as health maintenance organizations or “health plans.” These organizations have traditionally provided managed health care services according to a predetermined, fixed—or “capitated”—payment arrangement. In Minnesota, counties—through their governing boards—have the authority to purchase or provide health care services on behalf of enrollees in public programs. (See *Minnesota Statutes* 2012, 256B.692.) Similar to health plans, these “county-based purchasing organizations” are subject to state and federal laws and regulations pertaining to the administration of Minnesota’s Medical Assistance program.

¹⁵ 42 *CFR* sec. 438.2 (2012); *Minnesota Statutes* 2012, 256B.69, subd. 19; and 256B.76, subd.2 (e).

Dental providers can choose to participate in Medical Assistance.

Managed care enrollees may obtain dental services only through their managed care organization. Dental providers submit their claims for reimbursement to their managed care organization(s).

As shown above in Exhibit 1.1, DHS in 2012 contracted with five health plans and three county-based purchasing organizations to administer MA managed care services. Five of these managed care organizations subcontracted with a vendor to administer MA dental services: BluePlus, Medica, and Metropolitan Health Plan contracted with Delta Dental; and UCare and South Country Health Alliance contracted with DentaQuest. In many counties of the state, more than one MCO is available for MA recipients to select from and enroll with to receive services, as shown in Exhibit 1.2. Meanwhile, fee-for-service dental services are made available statewide to fee-for-service enrollees.

Two other state entities are involved in some aspects of dental services in Minnesota. First, the Minnesota Department of Health (MDH) works with the federal government on deploying initiatives to improve the health of populations in the community. MDH also monitors and reports to the federal government information on the number and availability of health care providers—including dentists—in Minnesota. Later in this chapter, we briefly describe supplemental funds made available to dental clinics serving low-income populations; MDH administers or facilitates some of these grant funds. Second, the Minnesota Board of Dentistry oversees the licensure of dentists in this state. The board is not involved in overseeing MA services; however, staff there field complaints about dental services in Minnesota—complaints that sometimes come from MA recipients who are unable to find a dentist willing to serve them.¹⁶

DENTAL PROVIDERS

However, providers must treat at least some MA recipients if they serve public employees.

Minnesota does not require all of its licensed dentists to participate in the Medical Assistance program. Rather, dental providers can choose to participate in Minnesota's public health care programs by enrolling with DHS for fee-for-service, with an MCO for managed care programs, or with both.¹⁷ However, state law requires that dentists that treat members of other state- or local-government sponsored health care programs—such as the health insurance program for state employees—*must* serve patients who are members of public health care programs.¹⁸ A dental provider meets this obligation when at least 10 percent of the provider's patients are covered by a Minnesota public health care program or the provider accepts new public health care program patients who are children with special health care needs.¹⁹ Providers must notify DHS when they have met their requirements and are limiting their participation in MA. Currently, no state entity monitors dentists' compliance with these statutory requirements.

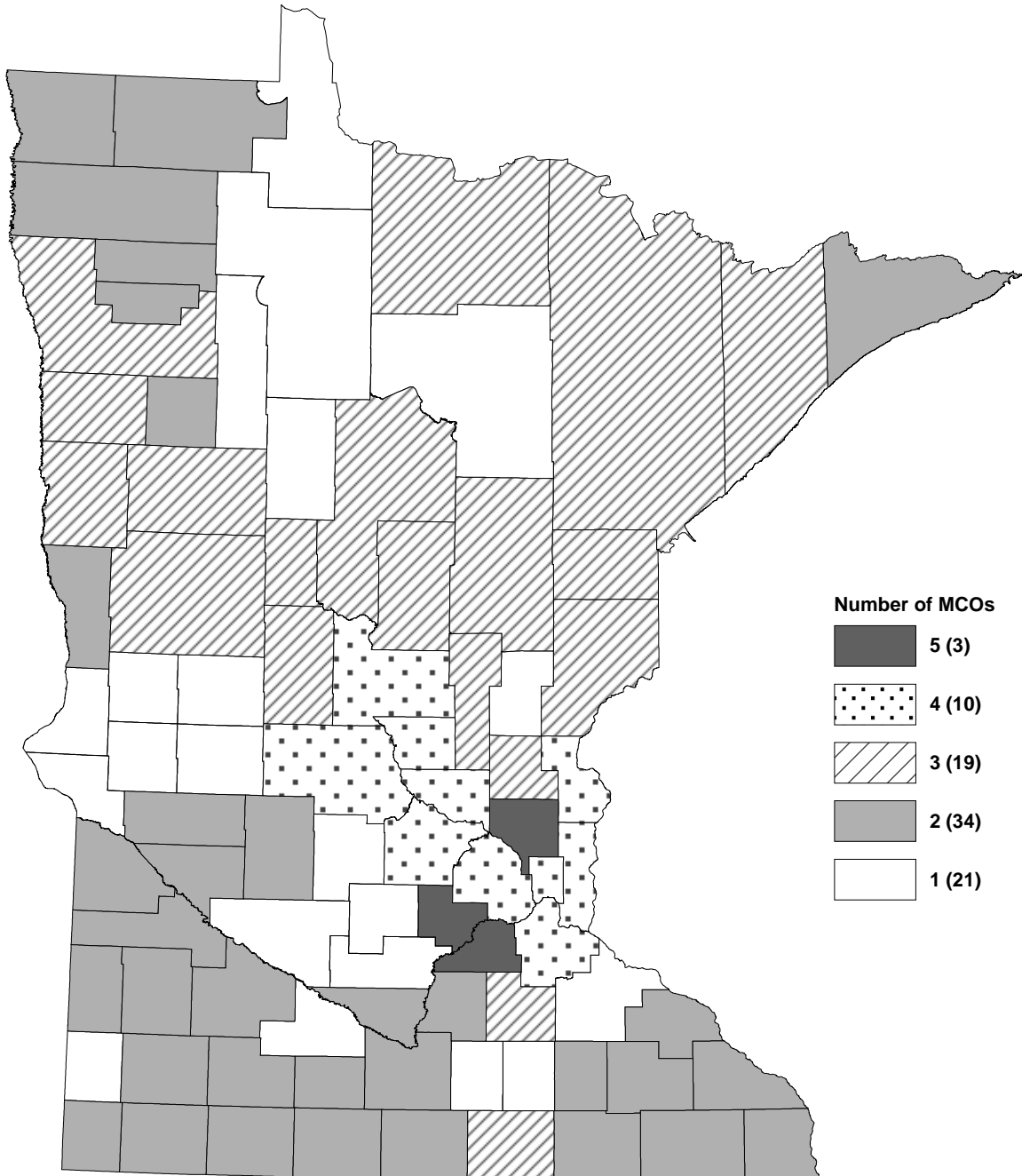
¹⁶ In cases where the Board receives such complaints, Board staff refer individuals to the managed care organization they are enrolled in to assist in their search for an MA dentist.

¹⁷ *Minnesota Rules* 2012, 9505.0195.

¹⁸ *Minnesota Statutes* 2012, 256B.0644. This requirement is often referred to as "Rule 101."

¹⁹ The 10 percent threshold for dentists is lower than the standard 20 percent threshold for other providers.

Exhibit 1.2: Number of Managed Care Organizations Providing Medical Assistance Dental Services, by Minnesota County, 2012



NOTES: Analysis includes all Medical Assistance managed care programs (Prepaid Medical Assistance Program, Special Needs Basic Care, Special Needs Basic Care Preferred Integrated Network, Minnesota Senior Health Options, and Minnesota Senior Care Plus). If a managed care organization (MCO) provides services through at least one Medical Assistance program in a county, it is considered to be serving that county. A total of 21 counties are served by only 1 MCO, 34 are served by 2 MCOs, 19 are served by 3 MCOs, 10 are served by 4 MCOs, and 3 are served by 5 MCOs. Fee-for-service dental services are provided statewide.

SOURCE: Department of Human Services, 2012 executed contracts with managed care organizations.

About 75 percent of licensed, actively practicing dentists in Minnesota were enrolled in Minnesota's public health care programs in 2012.

Dentists sometimes work in more than one type of practice setting.

In 2012, about 75 percent of all licensed, actively practicing dentists in Minnesota (2,561 of 3,396 dentists) were enrolled to participate in Minnesota's public health care programs. About 56 percent of licensed, actively practicing dentists were enrolled through fee-for-service in early 2012, and 65 percent appeared on an MCO provider roster. However, some dentists enrolled in Minnesota's public health care programs do not necessarily provide MA dental services or accept new Medical Assistance patients—an issue we discuss later in Chapter 3.²⁰

A health care provider's business setting for delivering services affects their overhead costs and, thus, is a factor in whether MA reimbursement rates are adequate. Dentists' services tend to be provided in small practice settings. In Minnesota, most dentists provide services through either a solo, private practice (44 percent of licensed dentists) or a small group practice of two to four dentists (37 percent).²¹ The small practice settings can mean that dentists have less opportunity to spread the overhead costs of doing business among many providers.²² Some Minnesota dentists provide services in a group business setting with other types of health care providers—for example, in Federally Qualified Health Centers or community health or public health clinics. We describe later in this chapter how additional state or federal funding is available for dental services provided through these types of clinics.

Dentists also may provide services in more than one clinic or type of practice setting, such as a private office, a community health clinic, an instructional clinic, or other type of clinic. Among the respondents to our survey of dentists, 83 percent of dentists reported that they worked in just one type of clinic, 15 percent worked in two types of clinics, and the remaining dentists reported that they worked in three or more types of clinics. Exhibit 1.3 shows that about 75 percent of our survey respondents worked exclusively in private offices or organizations, and about 4 percent worked exclusively in community health centers, Federally Qualified Health Centers, or other nonprofit organizations. The remaining dentists reported they worked in instructional settings, State-Operated Services clinics, or other types of settings.

²⁰ For example, some dentists may only provide dental care to MinnesotaCare enrollees.

²¹ The remaining 19 percent work in a school or community clinic, a higher education setting, a large group practices, or other setting. See *Fact Sheet: Minnesota's Dentist Workforce 2009-2010* (St. Paul: Minnesota Department of Health, 2011), <http://www.health.state.mn.us/divs/orhpc/pubs/workforce/dent10.pdf>, accessed January 15, 2013. Dentists tend to provide services through small practice settings more often than physicians, who are often affiliated with business settings that consolidate various types of physician services.

²² Some individuals we spoke with said that dentists have higher overhead costs per patient than other types of medical providers. For our study, we did not evaluate and compare dental providers' overhead costs with those of other medical providers.

Exhibit 1.3: Dentist Practice Settings Reported by Survey Respondents, 2012

Practice Setting	Percentage of Dentists Practicing Exclusively in This Setting ^a	Percentage of Dentists Practicing Primarily in This Setting ^b
Private office/organization	74.9%	89.6%
Community Health Center, Federally Qualified Health Center, Rural Health Center, or other nonprofit organization	4.2	4.2
Instructional clinic or setting	2.0	3.8
Nonprofit health maintenance organization	1.6	1.8
State-Operated Services dental clinic	0.4	0.6

NOTES: The survey question was: "Please estimate the percentage of time you spent providing dental services in each of the following practice settings in 2011. (*Your estimates should total 100 percent.*)" A total of 501 respondents provided a valid answer to the question: 416 reported they worked in only one type of practice setting and 85 worked in two or more types of settings.

^a Percentages do not sum to 100 because they represent the 416 dentists who reported they worked exclusively in one type of setting.

^b Percentages may not sum to 100 due to rounding. We define primary practice setting as the setting where a dentist reported to spend the most time practicing.

SOURCE: Office of the Legislative Auditor, survey of a sample of licensed dentists in Minnesota, 2012.

Most dentists practice "general dentistry," while others provide specialty dental care.

Dentists provide a variety of types of dental care. Most dentists practice general dentistry while others specialize in a particular type of dentistry. Exhibit 1.4 describes types of dental services; for example, "endodontics" involves diagnosing, preventing, and treating diseases and injuries of dental pulp and surrounding tissues, while "periodontics" involves diagnosing and treating diseases of gum tissues and bones supporting teeth. Some types of dentistry require additional medical training, such as oral and maxillofacial surgery. Among our survey respondents, about 81 percent reported they practiced general dentistry, and the remaining 19 percent reported they provided at least one type of specialty care.

In addition to dentists, there are other types of health care providers that can deliver limited dental services. For example, dental hygienists help with preventive dental care, such as teeth cleanings.²³ In Minnesota, dental therapists can provide some services that previously only dentists were allowed to provide, such as preparing teeth for filling cavities.²⁴ Dental therapists also may be paid amounts comparable to reimbursement rates for dentists when performing similar procedures. These types of dental providers are required to operate under the supervision of a dentist when delivering care. For purposes of our report, we focus mostly on dentists while acknowledging that other types of dental providers frequently assist in MA dental services.

²³ *Minnesota Statutes* 2012, 150A.05, subd. 1a.

²⁴ *Minnesota Statutes* 2012, 150A.105 and 150A.106.

Exhibit 1.4: Type of Dentistry Practiced by Dentist Survey Respondents, 2012

Type of Dentistry	Description	N	Percentage
General	Diagnosing and treating general oral health needs	416	81.3%
Orthodontics	Diagnosing, intercepting, and correcting dental and facial irregularities	24	4.7
Endodontics	Diagnosing, preventing, and treating diseases and injuries of dental pulp and surrounding tissues; performing root canals	21	4.1
Pediatric	Diagnosing and treating the oral health care needs of infants and children through adolescence	20	3.9
Oral and Maxillofacial Pathology/Surgery/Radiology	Diagnosing and managing diseases and disorders of mouth, teeth, and surrounding regions	18	3.5
Prosthodontics	Restoring natural teeth or replacing missing teeth or oral structures with artificial devices, such as dentures	14	2.7
Periodontics	Diagnosing and treating diseases of gum tissue and bones supporting teeth	10	2.0

NOTES: The survey question was: "Please indicate the type(s) of dentistry that best describes the primary focus of your dental services. (You may select up to two types.)" Percentages do not sum to 100 because survey respondents could select up to two types of dentistry. A total of 512 respondents answered the question. Among all respondents, 406 reported they practiced exclusively general dentistry, 10 reported one other type of dentistry—or specialty—besides general dentistry, and 96 reported they practiced exclusively specialty dentistry.

SOURCE: Office of the Legislative Auditor, survey of a sample of licensed dentists in Minnesota, 2012; and American Dental Association, *Dentists: Doctors of Oral Health* (Chicago: American Dental Association, 2012), <http://www.ada.org/4504.aspx>, accessed November 20, 2012.

SCOPE OF MEDICAL ASSISTANCE DENTAL BENEFITS

Federal law requires all states to offer at least basic health care services to certain low-income populations.²⁵ States can choose to provide more benefits and include additional low-income populations as part of their MA programs. In the case of dental services,

- **Minnesota provides more dental benefits in its Medicaid program than required by federal law.**

The federal Medicaid program requires dental services for children (up to age 21) but not adults.²⁶ However, Minnesota requires select dental services be available

²⁵ 42 U.S. Code, secs. 1396a(10) and 1396(d) (2012).

²⁶ 42 U.S. Code, secs. 1396a(10) and 1396d(r) (2012). 42 CFR sec. 441.56 (2012) requires that states provide minimum dental services for children, including: dental screening furnished by direct referral to a dentist beginning at 3 years of age; diagnostic and treatment as indicated by screening; and dental care for children of any age as needed for relief of pain and infection, restoration of teeth, and maintenance of dental health.

to both child and adult MA populations.²⁷ Generally, Minnesota MA dental benefits differ for children, pregnant women, and non-pregnant adults; a description of select benefits available for each of these populations in 2012 is outlined in Exhibit 1.5.

Exhibit 1.5: Dental Services Covered by Minnesota's Medical Assistance Program, 2012

Recipient Group	Service Type	Service Description
Non-Pregnant Adults	Diagnostic	Comprehensive exam once every five years
		Periodic exam once per year
		Limited exam
		Bitewing X-rays once per year
		Periapical X-rays
		Panoramic X-rays once every five years or two years under limited conditions
	Preventive	Cleaning once per year
		Application of fluoride varnish once per year
	Restorative	Filling
		Emergency treatment and sedative filling for relief of pain
Endodontic	Root canals on select areas	
Periodontic	Full-mouth debridement once every five years ^a	
Prosthodontic	Removable dentures once every six years	
Oral surgery	Extractions, biopsies, and incision and drainage of abscesses	
	Only through outpatient hospital or ambulatory surgery center	Periodontal scaling and root planing once every two years General anesthesia Full-mouth survey once every five years
Pregnant Women	All service types except orthodontics and sealant application	All medically necessary services ^b
Children Under the Age of 21	All service types ^c	All medically necessary services ^b

NOTES: Federal Medicaid laws require dental benefits for children, but states may choose to provide such benefits for adults. Dental services listed in the table are mandated by Minnesota statutes and covered under fee-for-service. A managed care organization can opt to provide additional services to Medical Assistance recipients enrolled in its managed care programs.

^a Full-mouth debridement is a teeth cleaning procedure applied when teeth have not been professionally cleaned and heavy bacterial colonies have built up.

^b *Minnesota Rules* 2012, 9505.0175, subp. 25, defines a "medically necessary" health service as one that is consistent with the recipient's diagnosis or condition and is: (a) recognized as the prevailing standard or current practice by the provider's peer group; and (b) provided in response to a life threatening condition or pain; to treat an injury, illness, or infection; to treat a condition that could result in physical or mental disability; to care for the mother and child through the maternity period; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or (c) a preventive health service (specified under separate state rules).

^c Certain dental services to children have frequency restrictions, such as application of sealants once every five years per permanent molar and application of fluoride varnish once every six months.

SOURCES: *Minnesota Statutes* 2012, 256B.0625, subd. 9; 42 *U.S. Code*, sec. 1396d(r)(3) (2012); and American Dental Association, *2011-2012 Current Dental Terminology: The ADA Practical Guide to Dental Procedure Codes* (Chicago, 2010), 5-77.

²⁷ *Minnesota Statutes* 2012, 256B.0625, subd. 9. As of 2008, only six other states did not provide any dental benefits to adults. Among states that did provide dental services, the scope of benefits greatly varied. For example, some only provided emergency dental care and others only provided services to adults with disabilities and the elderly.

Beginning in 2010, the Legislature placed limits on MA dental services for some populations.

Medical Assistance previously provided comprehensive dental benefits to all MA recipients. Beginning in 2010, the Minnesota Legislature placed limits on MA dental benefits, mostly for services provided to non-pregnant adult enrollees.²⁸ These benefit limits restrict the number, type, frequency, and location of some services for which dentists may be reimbursed by Medical Assistance. For example, Minnesota law limits periodic examinations for non-pregnant adults to one per year, but does not impose similar limits on examinations for children.²⁹ Currently, Minnesota does not provide different benefit coverage for individuals with special needs in its state Medicaid plan; that is, the reduced dental benefit coverage for non-pregnant adults also applies to non-pregnant individuals with special needs. In later chapters, we discuss concerns about the adequacy of MA dental coverage for the disabled population and the adequacy of reimbursement rates for treating these individuals.

For services that are not covered by Medical Assistance, MA recipients may still request and directly reimburse dentists for any additional care they are willing to pay for. For these additional services, DHS requires that dentists complete a services agreement signed by the recipient.³⁰ Later in this report, we discuss how limiting the number of reimbursable services has affected some dentists' participation in MA.

FUNDING

Medical Assistance is funded primarily through a mix of federal and state monies. The federal share is determined through a formula that takes into account the state's per capita income each year. Currently, the federal government pays about 50 percent of Minnesota's MA costs. The state's share is supported through General Fund appropriations and provider taxes imposed to fund Minnesota's Health Care Access Fund.³¹ Counties pay for a small share of overall costs.³² Some adult MA enrollees are also expected to pay monthly deductibles and copays for some services, unless they are unable to do so.³³

Medical Assistance dental services are also supported through other state and federal funding. For example, the Department of Human Services State-

²⁸ *Laws of Minnesota* 2009, chapter 79, art. 5, sec. 27.

²⁹ *Minnesota Statutes* 2012, 256B.0625, subd. 9.

³⁰ *Ibid.*, subd. 55.

³¹ *Minnesota Statutes* 2012, 16A.724. The Health Care Access Fund was initially established to exclusively fund MinnesotaCare, Minnesota's own public health care program, by a 2-percent tax on health care providers' gross receipts. Changes in the law allowed for transfers out of this fund to support other public health care programs.

³² In fiscal year 2012, Minnesota's total MA expenditures—including long-term care costs—were about \$8.1 billion; counties' MA expenditures represented about 1.2 percent of this amount.

³³ In fiscal year 2012, these cost-sharing requirements applied to non-pregnant adults and included: \$2.55 monthly deductible, \$3.00 copay for nonpreventive visits (excluding mental health visits), \$3.50 copay for nonemergency visits to an emergency room, and \$3.00 or \$1.00 copay for prescription drugs up to \$12.00 per month. Monthly copays and deductibles were also limited to 5 percent of family income for adults with income at or below 100 percent of federal poverty guidelines. Providers are required to serve enrollees who are unable to pay these costs.

Medical Assistance dental services are supported by state and federal funding, supplemental monies, and targeted grants.

Operated Services dental clinics are funded through dedicated revenues to cover their operating costs and to reimburse their dental providers more than the rate paid to fee-for-service providers.³⁴ Federally Qualified Health Centers and federal Rural Health Clinics—clinics that provide other health care services, too—are eligible to receive additional federal funds to help cover their overhead and administrative costs.³⁵ Since 2002, the state also has provided for separate “critical access payments” to qualifying dental clinics that serve low-income populations.³⁶

The state funds dental services provided through managed care programs by making “capitation payments” to the MCOs. That is, DHS pays the MCOs a predetermined monthly amount per enrollee to cover the entire costs of enrollees’ health care—including dental care. Historically, each MCO has been responsible for any costs that exceeded their capitation payments, and the MCO could keep any part of the monies that remained after paying for expenses. The capitated payments limit the state’s financial liability while providing an incentive to the MCOs to help control costs. Since 2011, the state has employed several cost-control mechanisms that modify this risk-based arrangement and limit the growth in payments to managed care organizations. For contract year 2011, the executive branch negotiated a 1-percent cap on the amount of leftover monies the MCOs could keep, and any excess monies over 1 percent of an MCO’s total revenue were returned to the state.³⁷ DHS also competitively bid contracts for the state’s public programs for 2012 and negotiated capitation payment rates so that spending through managed care in 2013 generally does not exceed 2012 levels.³⁸ The 2011 Legislature also imposed statutory limits in spending growth for the MCO contracts for 2013 through 2016.

Finally, MA dental services also are supported by various state-funded grants to clinics. Some of these grants are awarded and administered through the Minnesota Department of Health. For example, Clinical Education Innovations Grants and community clinic grants may be awarded to expand clinic services or improve their facilities. Between 2006 and 2011, total funding for grants to

³⁴ *Minnesota Statutes* 2012, 256B.76, subd. 2(f), specifies that State-Operated Services dental providers are paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. Beginning in fiscal year 2011, a supplemental state payment equal to the difference between (1) total cost-based interim payments to State-Operated Services dental clinics and (2) \$1,850,000 that is paid from the General Fund to State-Operated Services for the operation of the dental clinics. See *Minnesota Statutes* 2012, 256B.76, subd. 2(g).

³⁵ 42 *U.S. Code*, sec. 1396d(l) (2012); 42 *CFR* sec. 447.371 (2012); and *Minnesota Statutes* 2012, 256B.0625, subd. 30. Federally Qualified Health Centers are “safety net” providers that enhance the provision of primary care services in underserved urban and rural communities. Rural Health Clinics provide access to primary care services in rural areas. The payment methodology is set to cover 100 percent of costs as determined by the Medicare principals of reimbursement.

³⁶ *Minnesota Statutes* 2012, 256B.76, subd. 4.

³⁷ For the PMAP and MinnesotaCare programs, the managed care organizations returned about \$105.3 million.

³⁸ DHS staff report that they negotiated “flat capitation rates” for 2013 and that overall spending through managed care between 2012 and 2013 should not increase (assuming that the 2013 managed care population is the same as the 2012 population).

dental clinics ranged from about \$2.1 million in 2007 to \$1.2 million in other years. When compared with overall program costs,

- **Expenditures for dental services account for about 3 percent of total Medical Assistance spending.**

Exhibit 1.6 shows that total spending for MA dental services increased about 9 percent annually, from an estimated \$84.3 million in 2006 to \$130.8 million in 2011. Spending for dental services is largely affected by the number of individuals enrolled in Medical Assistance, where some recipients may be enrolled for long periods of time and others are enrolled sporadically or for a limited number of “member-months.”³⁹ For example, the total *number of individuals* ever enrolled in Medical Assistance during a calendar year increased an average of 7 percent annually between 2006 and 2011, as shown in Exhibit 1.6. Similarly, the total *number of months* that all recipients were ever enrolled in Medical Assistance—that is, the total member-months—also increased an average of 7 percent annually.

Exhibit 1.6: Medical Assistance (MA) Program Expenditures, 2006, 2009, and 2011

	2006	2009	2011	Average Annual Growth Rate
Expenditures (in thousands)				
Dental Services	\$ 77,664	\$ 109,964	\$ 121,999	
Critical Access Payments	<u>6,620</u>	<u>16,380</u>	<u>8,776</u>	
Total Dental Expenditures	84,285	126,344	130,775	9.2%
Total MA Expenditures	\$2,831,933	\$3,772,708	\$4,381,099	9.1%
Dental Expenditures as a Share of Total MA Expenditures	3.0%	3.4%	3.0%	
Enrollment (in thousands)				
Individuals Enrolled	648	736	910	7.0%
Member-Months	6,066	7,021	8,514	7.0%
Total MA Dental Expenditures per Member-Month	\$13.90	\$18.00	\$15.40	2.0%

NOTES: Totals may not sum due to rounding. Expenditure data include both federal and state shares for the Minnesota Medical Assistance program. Total MA Expenditures includes spending for MA basic care and excludes spending for long-term care services. MA dental expenditures reported here exclude DHS expenditures for administering MA dental services and include: total expenditures for State-Operated Services dental clinics; estimated expenditures for MA dental claims and administrative services through managed care organizations; and total expenditures for MA dental claims through fee-for-service.

SOURCES: Office of the Legislative Auditor, analysis of Department of Human Services MA expenditure data, managed care capitation rate setting documents, and MA enrollment data.

³⁹ One “member-month” represents a month of enrollment for one MA recipient.

When comparing spending for dental services with changes in MA enrollment, we found that:

- **On average, Medical Assistance dental services expenditures per member-month increased about 2 percent annually between 2006 and 2011.**

Minnesota's expansion of Medical Assistance has affected enrollment and costs.

Medical Assistance dental expenditures per member-month increased from about \$13.90 per member-month in 2006 up to \$18.00 in 2009, but then decreased to \$15.40 in 2011, also shown in Exhibit 1.6. The more recent decrease in expenditures per member-month may be due to benefit limits imposed on dental services for non-pregnant adults in 2010. The relatively higher enrollment in 2011 is partly due to Minnesota's early expansion of Medical Assistance under the federal Patient Protection and Affordable Care Act of 2010, where many more individuals are now eligible to receive MA services.⁴⁰ Some of these newer MA enrollees were adults previously enrolled in Minnesota's General Assistance Medical Program. We discuss the number and availability of dentists in Minnesota to treat the growing number of MA enrollees in Chapter 3. In the next chapter, we examine rate setting and MA payment rates for reimbursing dentists for treating MA recipients.

⁴⁰ *The Patient Protection and Affordable Care Act of 2010*, P. Law 111-148, March 23, 2010.

Rate Setting and Payments

Minnesota uses various types of payments to reimburse dentists for care provided to Medical Assistance (MA) enrollees. In this chapter, we discuss Minnesota’s approach for setting MA dental payment rates, focusing primarily on payments through fee-for-service and managed care organizations (MCOs). We then examine how much dentists are paid for treating MA recipients and compare Minnesota’s MA payment rates with those in other states. We also discuss several factors that affect the adequacy of payments for MA dental services, including administrative work required for providers. Later in Chapter 3, we discuss the relationship of payment rates to dentist participation in MA and patient access.

RATE-SETTING POLICIES AND PRACTICES

Minnesota uses various types of payments to reimburse Medical Assistance dentists.

In the delivery of health care services, dentists (and other providers) are reimbursed a predetermined amount—or rate—for a unique “procedure” or group of procedures. The corresponding codes for these procedures are most often developed through professional health care provider associations. In the case of dental services, the American Dental Association (ADA) developed the procedure codes, nomenclature, and descriptors used by dentists. Public health care programs use the ADA code structure when developing reimbursement rates for dental services.¹

States have some flexibility in determining which dental benefits are available under their Medicaid program and for which populations. These allowed benefits are typically defined in state laws and rules and, in Minnesota, Department of Human Services (DHS) staff translate which procedure codes correspond with each dental benefit. A payment “rate” is then assigned for each procedure code.² For example, state law currently allows payment for one “comprehensive dental examination” every five years for non-pregnant adults, and the 2012 DHS fee-for-service payment rate for such an examination was \$15.45.

¹ The ADA Current Dental Terminology code is designated by the federal government as the national terminology for reporting dental services.

² Some procedures are reimbursed by increments of time spent for a service—for example, a payment rate for a 15-minute increment of service. For other procedures, total reimbursement is determined on a case-by-case basis as explained in writing by the dentist (or “by report”). Payment for some services may depend on whether a procedure was provided concurrently, or “bundled,” with other procedures.

Medical Assistance recipients may need or request dental care beyond what is covered by Medical Assistance. For services that are not eligible for MA reimbursement but are requested by the MA enrollee, state law allows a dentist and the MA enrollee to negotiate their own agreement for services and payment rates.³ The MA enrollee must agree in writing to pay the dentist the negotiated amount. Payments for these additional services may be less than, similar to, or greater than the state's payment rates.

Fee-for-Service Rate Setting

Federal law requires that states' Medical Assistance payment rates be set 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."⁴ For purposes of our report, we refer to these rates as fee-for-service "base rates."

Federal law requires that MA payment rates be consistent with efficiency, economy, and quality of care.

Under federal Medicaid law, a state must document the policy and methods used for setting its payment rates.⁵ States may develop their fee-for-service rates based on (1) the cost of providing service, (2) a review of what commercial payers pay in the private market, or (3) a percentage of what Medicare pays for equivalent services, for example.⁶ These rates may be modified based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate. The federal Centers for Medicare & Medicaid Services must approve the state's rates and rate-setting methodology.⁷ In the interest of promoting transparency in public programs, a state may be required to hold public hearings if it seeks to change how it determines the rates.⁸ We found that:

- **Minnesota's approach for setting Medical Assistance fee-for-service rates for dental services differs from that used for some other providers' services and from methods used in some other states.**

Minnesota's Legislature authorizes the rate-setting methodology for determining the fee-for-service payment rates.⁹ Minnesota's current rates for most procedures

³ *Minnesota Statutes* 2012, 256B.0625, subd. 55.

⁴ *42 U.S. Code*, sec. 1396a(a)(30) (2012); and *42 CFR* sec. 447.200 (2012).

⁵ *42 CFR* sec. 447.201 (2012).

⁶ Centers for Medicare & Medicaid Services, "Medicaid Financing and Reimbursement," <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html>, accessed January 15, 2013.

⁷ *42 CFR* sec. 447.203 (2012). For example, states must record the following information for increases in payment rates for individual practitioner services: (1) an estimate of the percentile of the range of customary charges to which the revised payment structure equates and a description of the methods used to make the estimate, and (2) an estimate of the composite average percentage increase of the revised payment rates over the preceding rates.

⁸ *42 CFR* sec. 447.205 (2012).

⁹ *Minnesota Statutes* 2012, 256B.76, subd. 2.

Medical Assistance fee-for-service payment rates are based on dentists' 1989 charges, not the current cost of dental services.

are based on the median of 1989 usual and customary charges submitted by dentists in the region.¹⁰ For procedures for which there were no comparable 1989 charges, DHS applies an annual inflation-related adjustment—plus historical legislative reductions and increases—to estimate an equivalent 1989 rate as a percentage of the current year's price for services.¹¹

Since 1992, the Legislature has imposed several across-the-board gross adjustments to MA fee-for-service base rates for dental services.¹² These changes include:

- 1997: 5-percent increase in all rates,
- 1998: 3-percent increase in all rates,
- 1999: Increase rates for tooth sealant and fluoride procedures to 80 percent of median 1997 charges,
- 2000: 3-percent increase in all rates, and
- 2011: 3-percent reduction in all rates.

In addition, the Legislature increased the rates for diagnostic examinations and X-rays for children's services beginning in 2002.¹³ The most recent change to the fee-for-service rates—a 3-percent decrease effective September 2011 through June 2013—was imposed as a result of forecasted budget shortfalls and legislative limits on funding. Currently, fee-for-service rates for dental services are the same across all regions of the state.

Minnesota's payment rates for other types of health care providers have been subject to legislative adjustments as well. Typically, these rates have been increased or decreased by a specific percentage amount. However, the 2003 Legislature directed the Department of Human Services to implement a different, cost-based methodology similar to the approach used for the federal Medicare program to determine payment rates.¹⁴ In contrast with federal Medicaid laws—which create a relationship between payment rates and access to care—Medicare principles of reimbursement tie payment rates to the reasonable cost of providing services.¹⁵ Following a 2009 study by an independent consultant who evaluated Minnesota's fee-for-service rates, DHS implemented a Medicare "Resource-Based Relative Value Scale" (RBRVS) method to determine appropriate fee-for-

¹⁰ The rate for each procedure is calculated as the 50th percentile of the 1989 usual and customary charges, less 8.4 percent (or 91.6 percent). The law also requires that payments for dental services shall be paid at the lower of (1) submitted charges, or (2) 25 percent above the rate in effect on June 30, 1992.

¹¹ For example, when reimbursement is determined "by report" or a newly defined procedure is added to the benefit set.

¹² Some of these adjustments also applied to other state public health care programs and to other health care services.

¹³ *Minnesota Statutes* 2012, 256B.76, subd. 2(d).

¹⁴ *Laws of Minnesota* 2003, First Special Session, chapter 14, art. 12, sec. 67. The directive was to implement the payment system for all services provided after January 1, 2007.

¹⁵ 42 *CFR* secs. 413.1, 413.5, 413.9, 413.13, and 413.17 (2012).

DHS recently reviewed and modified rates for physicians and some other health care providers, but not dentists.

service rates for physicians and other health care professionals.¹⁶ This effort did not include adjusting fee-for-service rates for dental services. (In the case of dental services, Medicare covers very few dental procedures.) In an RBRVS approach, payments are determined according to the cost of resources needed to provide services, and the rates are adjusted for geographical differences.¹⁷ The results of implementing the RBRVS approach were that Minnesota’s fee-for-service rates for some health care services increased (such as primary care services) while others decreased (such as those provided by radiologists).¹⁸

Nationwide, other states set their payment rates using various approaches. Some states have used approaches similar to RBRVS to estimate the cost and value of dental services. For example, Montana uses “relative value units” (RVU) for determining its rates for Medicaid dental services. Each procedure is assigned a value as determined by the relative effort and costs expended for the procedure; the reimbursement rate is then calculated by applying a monetary conversion factor to the RVU for each procedure. Other states, such as Maryland and Louisiana, have more recently compared fee-for-service rates to current usual and customary charges in their region and adjusted their rates. Similar to Minnesota, other states have periodically applied a specific percentage increase or decrease to all fee-for-service base rates (North Dakota and South Dakota, for example).¹⁹

Various methods to determine payment rates, along with our survey respondents’ opinions on these methods, are described in Exhibit 2.1. When asked about the state’s approach for setting MA fee-for-service payment rates for dental services, 48 percent of respondents said the state should set the rates based on a fee survey of market rates, such as the annual survey conducted by the American Dental Association. Another 24 percent of respondents said the state should tie the rates to a percentage of dentists’ usual and customary charges, and 13 percent preferred a more comprehensive approach similar to the RBRVS used for other providers. Rate setting for the fee-for-service rates is just one component of the state’s strategy for deciding how much Minnesota dentists are paid for MA

¹⁶ DHS implemented this payment approach following a study by Burns & Associates, Inc., which said that Minnesota’s MA physician rates were losing ground to Medicare rates because of the absence of rate increases, and that the rates were significantly lower than the Medicaid rates of other selected states for physician services that enrollees of public health care programs tend to consume. The study also described Minnesota’s rate-setting mechanism—the lower of either charges or the 1989 median charge level—as “arbitrary and devoid of policy direction.” See Burns & Associates, Inc., *Report to the Legislature: Comparison of Minnesota Medicaid Fee-for-Service Physician Rates to Rates Paid by Medicare and Selected Other States* (Phoenix, 2009), 23.

¹⁷ The cost of providing each service is divided into three components: physician work, practice expense, and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor which is an amount that—for Medicare services—is determined by the Centers for Medicare & Medicaid Services.

¹⁸ For example, among the fee-for-service procedures for physicians’ services, the majority of rates increased. Across all physician procedures, the overall average change was a 29-percent increase.

¹⁹ According to a survey of other states regarding rate setting for MA dental services, 4 states increased their MA payment rates and 11 states decreased their payment rates in fiscal year 2011. Vernon Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder, *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends* (Washington, DC: Kaiser Family Foundation, 2011), 32.

services, however. Rate setting through managed care programs and for supplemental payments also affect overall reimbursement amounts, and we discuss these activities in the next sections.

Exhibit 2.1: Dentists’ Opinions on How Medical Assistance Payment Rates Should be Set for Dental Services, 2012

Please indicate which of the following rate-setting approaches you think Minnesota should use for reimbursing Medical Assistance (MA) dental services.

	N=452	Percentage
Set rates based on a survey of market rates, such as the annual survey of rates by the American Dental Association.	218	48.2%
Set MA payment rates based on a percentage of dentists’ usual and customary charges for specific services.	107	23.7
Use a comprehensive method, similar to the Resource-Based Relative Value Scale method, based on multiple factors. (For example, the Resource-Based Relative Value Scale takes into consideration practice expense, professional liability expense, and work associated with a procedure.)	59	13.1
Use a cost-based reimbursement method, where rates are based on the cost of such items as materials, operating expenses, and dentist services.	14	3.1
Use a capitated payment arrangement directly with provider groups, where the provider group is paid a lump sum per MA recipient to cover the total costs of care. The provider is responsible for any costs that exceed the capitated payment, but also may keep any unspent monies.	7	1.5
Other ^a	13	2.9
Don’t know	34	7.5

DHS administers payment policies for MA dental services.

NOTES: Percentages may not sum to 100 due to rounding. A total of 452 dentists responded to this survey question.

^a Other rate-setting approaches identified by the respondents include setting rates based on a percentage of individual dentist charges, based on the average charges of “preferred provider organizations,” or based on recommendations from an advisory group.

SOURCE: Office of the Legislative Auditor, survey of a sample of licensed dentists in Minnesota, 2012.

Coordinating Payment Policies

In Chapter 1, we briefly described how Minnesota pays for Medical Assistance dental services using a variety of state and federal revenue sources and payment methods. Exhibit 2.2 describes these methods, the authority for determining the amount of each type of payment, and the number of dentists who worked for clinics that received these payments in 2011. In general, the Department of Human Services is responsible for administering these payment policies as part of its authority for purchasing dental services for the Medical Assistance program. State law also requires the executive branch to consider ways to

The state's numerous payment methods and payment policies were developed through separate and independent processes.

equalize rates paid by different health care programs for the same service.²⁰ We think that:

- **Minnesota's myriad of methods and policies for reimbursing Medical Assistance dental providers is poorly coordinated.**

As shown in Exhibit 2.2, each type of payment for MA dental services was developed through separate and independent processes, and not through a systematic, coordinated assessment of appropriate payment rates to ensure dentist participation and patient access statewide. Payment rates and policies were determined through either state or federal law, DHS policy, or negotiation between the managed care organizations and their dental providers. Payment amounts are also determined using different cost factors or algorithms, and eligibility for some payments requires that the dental clinic operates as a nonprofit organization. For example, DHS fee-for-service rates are tied to dentists' charges in 1989.²¹ Meanwhile, reimbursement for dental services provided through Federally Qualified Health Centers is based on a federal algorithm tied to the overall encounter costs per patient per visit, including the clinic's administrative costs. For services provided through State-Operated Services dental clinics, payments are based on costs according to the Medicare principals of reimbursement. Critical access payments are based on a percentage of the rate *that would otherwise be paid to the provider*, and this percentage has changed frequently over the years, from 40 percent in 2002 to 20 percent in 2006 to a current rate of 30 percent set in 2010.²² Minnesota also pays supplemental monies to eligible institutions with MA-enrolled dentists that sponsor training for dental students.²³

²⁰ *Minnesota Statutes* 2012, 256B.038. The law requires the commissioner of Minnesota Management and Budget to include an inflationary adjustment in DHS annual budget proposals for dental and other services. The commissioner must increase Prepaid Medical Assistance Program capitation rates to reflect the rate increase, and consider proposing a schedule to equalize rates paid by different programs for the same service.

²¹ *Minnesota Statutes* 2012, 256B.76, subd. 2.

²² *Ibid.*, subd. 4. To be eligible for critical access payments, a clinic must: have specific nonprofit and tax-exempt status; be established to provide oral health services to low income, uninsured, special needs, and underserved populations; charge for services on a sliding fee scale; not restrict access or services because of a patient's financial limitations or public assistance status; and have free care available as needed, among other criteria. Other clinics that are eligible or may be designated by DHS as eligible include: Federally Qualified Health Centers, Rural Health Clinics, Public Health Clinics, and county-owned and operated hospital-based dental clinics; nonprofit clinics with more than 10,000 patient encounters per year with patients who are uninsured or through public health care programs; or a dental clinic owned and operated by the University of Minnesota or an institution within the Minnesota State Colleges and Universities system. DHS also may designate other clinics if they provide dental services to public program recipients at a level which significantly increases access to dental care in the service area.

²³ *Minnesota Statutes* 2012, 62J.692.

Exhibit 2.2: Types of Payments for Medical Assistance Dental Services, 2011

Payment Type	Description	Number of Dentists Who Provided MA Services	Number of Clinics that Provided MA Services ^c
Fee-for-Service (FFS) Base Rates	State law specifies that rates be based on median of 1989 charges by dentists ^a	1,780	1,160
Managed Care Organization (MCO) Payments	Rates are determined by each MCO and its dentists ^b	2,020	1,420
<i>Types Required Only through Fee-for-Service</i>			
Provider Tax Reimbursement	DHS policy to pay additional 2 percent of FFS rates, intended to offset the provider tax	1,780	1,160
Community/Public Health Clinics	1989 law provides for additional payment of 20 percent of FFS rates ^d	130	14
<i>Types Required through FFS and Managed Care</i>			
Critical Access Providers	Payment of an additional 30 percent of what would otherwise be paid ^e	378	73
Federally Qualified Health Centers	Interim payment and final payment based on a federal algorithm of overall encounter cost per patient per visit, including administrative costs ^f	97	16
Rural Health Centers	Interim payment and final payment based on federal algorithm of the overall encounter cost per patient per visit, including administrative costs ^f	1	1
<i>Other</i>			
State-Operated Services Dental Clinics	Cost-based interim payments are about 150 percent of FFS base rates. The state then pays DHS a year-end amount equal to the difference between all interim payments and a statutory cap. ^g	17	5
Medical Education Institutions	Institutions that sponsor training sites and serve public program enrollees may receive additional funds ^h	Not Available	Not Available

NOTES: Many clinics and dentists appear in more than one category and are eligible for multiple types of supplemental payments. For example, all Federally Qualified Health Centers and Rural Health Clinics are eligible for critical access payments for any dental services they provide. Some community/public health clinics are also designated as critical access clinics. The designation criteria for critical access clinics changed on September 1, 2011; this table covers services provided both prior to and after the change. Finally, many dentists and clinics reported here provided MA services through both fee-for-service and managed care in 2011.

^a *Minnesota Statutes* 2012, 256B.76, subd. 2.

^b MCO payment rates are based in part on fee-for-service rates. See *Minnesota Statutes* 2012, 256B.76, subd. 2(e).

^c We consider a "clinic" to be an organization with a unique National Provider Identifier that has received payments from MA in 2011.

^d *Laws of Minnesota* 1989, chapter 327, sec. 5, subd. 2(b).

^e *Minnesota Statutes* 2012, 256B.76, subd. 4.

^f 42 U.S. Code, sec. 1396d(l) (2012); 42 CFR sec. 447.371 (2012); and *Minnesota Statutes* 2012, 256B.0625, subd. 30.

^g *Minnesota Statutes* 2012, 256B.76, subd. 2(g).

^h *Minnesota Statutes* 2012, 62J.692.

SOURCES: Office of the Legislative Auditor, analysis of state and federal laws and DHS dental claims data and other documents.

DHS employs different approaches and policies for reimbursing dental providers through fee-for-service and managed care.

DHS also employs different approaches for reimbursing dental providers through fee-for-service and managed care. Specifically, each managed care organization—not DHS—oversees rate setting for payments to their dentists.²⁴ Generally, each of the managed care organizations, or its dental administrator, enters into negotiated payment arrangements with dentists that lay out provisions for reimbursement. For example, the agreement may specify that payments for each procedure will be 102 percent of the fee-for-service rates, or it may specify in a fee schedule the “maximum allowable amounts” per procedure. Managed care organizations also can pay dental providers outside of their network amounts comparable to those under the DHS fee-for-service arrangement.²⁵

When Minnesota first implemented managed care services for its public health care programs—including dental services—one expectation was that the approach would yield more cost-effective outcomes than a fee-for-service reimbursement system.²⁶ To achieve this goal, DHS initially used historical fee-for-service data to determine how much to pay managed care organizations for administering health care services, including dental services. The department still uses information about recipients’ use of services through fee-for-service—which serves primarily individuals with special needs—to help determine how much to pay managed care organizations for administering the Special Needs Basic Care Program. However, the department discontinued this practice for the Prepaid Medical Assistance Program (PMAP) as PMAP began to serve a very different population—mainly families with children—and the health care needs of PMAP enrollees and fee-for-service enrollees became less comparable. Instead, PMAP capitation payments are based partly on historical spending by the MCOs.

The department’s use of fee-for-service information to set managed care capitation payments is a useful way to compare trends in spending and the use of services, but the department’s approaches for setting rates for fee-for-service and managed care differ in other important ways. For example, state law requires the executive branch to include inflation-related increases for dental services in its budget requests to the Legislature, and to adjust payment rates to dentists if the requested increases are approved.²⁷ The department is also required to pass along these inflation-related increases in their capitation payments to managed care organizations. Until 2013, the department has not requested an across-the-board increase for fee-for-service dental rates for many years, nor have there been any inflation-related increases in the fee-for-service rates.

²⁴ Unless otherwise waived by the federal government, managed care organizations must comply with the same federal requirement that payments for services must be 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.

²⁵ *Minnesota Statutes* 2012, 256B.69, subd. 19.

²⁶ *Minnesota Statutes* 2012, 256B.037, subd. 2, specifies that the prepaid capitation payment rates shall not result in payments that exceed the per capita expenditures that would have been made for dental services by the programs under a fee-for-service reimbursement system. Federal law initially required comparability in payments between fee-for-service and managed care to ensure that managed care produced more cost-effective outcomes than a fee-for-service arrangement.

²⁷ *Minnesota Statutes* 2012, 256B.038.

However:

- **Unlike rate setting for fee-for-service, rate setting for capitation payments to managed care organizations has historically included annual increases to cover forecasted increases in the price of dental services.**

Historically, the DHS actuary has assumed that the overall price of dental services would increase for managed care organizations.

DHS, through its actuary, calculates the amount of each capitation payment to the MCOs using a complex method that includes analyzing historical health care services, costs, and client characteristics, and forecasting future trends.²⁸ To determine the dental services portion of each capitation payment, the DHS actuary separately analyzes historical changes in recipients' use of dental services (or "utilization"), costs for dental care, and payment rates. The actuary also analyzes other dental-related factors and incorporates the changes into the capitation payments to the MCOs. To do this, the actuary develops a "dental trend" factor that is based on forecasted changes in providers' charges, providers' costs, medical inflation, payment rates, and technological trends.²⁹ Historically, this "dental trend" factor has assumed that the price of dental services for managed care organizations would increase. For example, between 2007 and 2012, the average annual trend factor increase to the capitation payment (for dental services) was about 3.5 percent for the PMAP program. Consistent with the 2011 legislative directive to reduce MA payments for dental services by 3 percent, the DHS actuary incorporated a 3-percent reduction in the capitation payment amounts for 2012 dental services, but the actuary also included a 3-percent increase—the "dental trend" factor—for dental services to ensure that the capitation payments were "actuarially sound."³⁰ Managed care organizations are required to ensure services and payment rates that are at least comparable to fee-for-service, and MCOs are generally required to pass along any rate increases (or decreases) to their providers when specified in state law.³¹ However, DHS does not require the MCOs to pass along "dental trend" increases in their capitation payments to their providers.

In lieu of increasing fee-for-service rates across the board, the state has elected to use alternative payment approaches. The other types of supplemental payments

²⁸ Other factors used to adjust payments include the age, medical experience, and health risks of the populations served. These unique factors are applied for health care costs overall and not specifically for dental services. Capitation payment rates for Minnesota Senior Care Plus and Minnesota Senior Health Options are determined using historical data and are not risk-adjusted, since most of the services used to determine risk-adjustment values are covered by Medicare.

²⁹ This factor is different and separate from the factors used to address changes in utilization or health risks of particular populations served by each managed care organization.

³⁰ 42 U.S. Code, sec. 1396b(m) (2012); and 42 CFR sec. 438.6(c) (2012). We note that current Minnesota statutes for pre-paid dental services through MCOs reflect provisions in earlier federal law, where the capitation rate-setting process for dental services cannot result in dental payments that exceed the payments that would have been made under fee-for-service. (See *Minnesota Statutes* 2012, 256B.037, subd. 2.) However, the inflation-related increases are actuary estimates and are incorporated to meet the *current* federal requirement that capitation payments to managed care organizations are "actuarially sound." Minnesota law also requires the DHS commissioner to consult with an independent actuary to establish the prepayment rates, but the law states that the commissioner retains final authority over the methodology used to establish the rates.

³¹ 42 CFR sec. 438.2 (2012); *Minnesota Statutes* 2012, 256B.69, subd. 19, and 256B.76, subd. 2 (e).

It is difficult to determine whether, collectively, Minnesota’s payment methods ensure adequate provider participation and MA patient access statewide.

shown in Exhibit 2.2 are of varying amounts and are intended to maintain and facilitate dentist participation by helping cover their expenses, particularly for dentists that serve a relatively high number of MA and other low-income patients. For example, critical access payments are set at 30-percent above the reimbursement rate “that would otherwise be paid to the critical access provider.”³² (That is, the payment is intended to “supplement” and not replace—or “supplant”—any amounts that the provider has otherwise negotiated with managed care organizations.) Ultimately, the higher payments are intended to facilitate MA recipient access to dental care. It is worth noting that,

- **Some Minnesota dentists are eligible for only one type of supplemental payment, while others are eligible for multiple payment types. Further, some supplemental payment policies are applied inconsistently across Medical Assistance programs.**

For example, Exhibit 2.2 shows that many dentists participate in both fee-for-service and managed care (and some dentists participate with more than one MCO). DHS pays two types of supplemental payments to fee-for-service dentists, but does not require MCOs to make similar payments. First, fee-for-service dentists are paid an additional 2 percent of the fee-for-service rate as reimbursement for Minnesota’s tax on providers. These payments are not specified in state law or in the department’s contracts with MCOs.³³ Second, fee-for-service dentists working through community or public health clinics are also eligible to receive an additional payment equal to 20 percent of the fee-for-service rate; these payments were initially made available through 1989 legislative law.³⁴ DHS continues to carry out this payment policy today; however, the purpose and eligibility requirements are not specified in current state statutes. Meanwhile, the department’s contracts with managed care organizations only require MCOs to pay these clinics rates comparable to what they pay other providers.

When viewed collectively, it is difficult to determine whether the many different payment rates adequately address dentist participation—and MA recipient access—*around the state*. Because the rate factor for each type of payment in Exhibit 2.2 differs, the final payment rate to a provider can vary depending on the combination of payment add-ons. Further, some clinics, such as Federally Qualified Health Centers, are designated to receive additional funding to help ensure patient access, but these clinics serve relatively few MA recipients. We also estimated that in 2011 only 378 dentists (out of 2,212) worked for clinics that were eligible for critical access payments, but most of these clinics were located in the seven-county metropolitan area. Finally, it is difficult to determine whether any of these types of payments supplant rates otherwise negotiated between dentists and managed care organizations and, thus, reduces reimbursement amounts to be lower than what is intended.

³² *Minnesota Statutes* 2012, 256B.76, subd. 4.

³³ DHS staff assert that when Minnesota first implemented managed care, the department incorporated the 2-percent payments into the capitation payments to MCOs for their dentists. The department does not track the extent to which MCOs continue to pay this add-on to dentists.

³⁴ *Laws of Minnesota* 1989, chapter 327, sec. 5, subd. 2(b).

According to dentists, Minnesota’s multiple payment rates add unnecessary complexity to the MA program.

Many dentists we spoke with questioned the purpose behind the wide range of payment rates for each type of dental procedure. Some said these differences add unnecessary complexity to tracking and reconciling payments received—from Medical Assistance and other Minnesota public programs—thereby offsetting any amounts they are paid. Minnesota’s payment methods are one facet of reimbursing Medical Assistance providers. We discuss how the state’s payment policies are implemented and how much dentists are actually paid for MA services in the next section.

PAYMENTS FOR MEDICAL ASSISTANCE DENTAL SERVICES

Dentists who participate in Minnesota’s Medical Assistance program submit their claims for reimbursement to DHS (if the dental care was provided through fee-for-service) or to a managed care organization. However, the amount of payment by DHS or the managed care organizations is not necessarily the same as the fee charged by the dentist. Rather, the paid amount is based on a predetermined or “allowed amount” for each procedure, which is typically lower than a dentist’s charges. In the next sections, we provide information on how much dentists are reimbursed, and we compare fee-for-service rates with dentists’ usual and customary charges and with other states’ fee-for-service rates.

Fee-for-Service Base Rates

Minnesota has not increased its fee-for-service base rates since 2000, and the 2011 Legislature imposed a 3-percent reduction in payment rates through June 2013. We found that:

- **Minnesota’s fee-for-service base rates for Medical Assistance dental services have not kept up with the price of dental services, and the rates for most procedures were lower in 2012 than they were in 2000.**

Minnesota’s fee-for-service payment rates are lower today than in 2000.

Exhibit 2.3 illustrates a sample of dental procedures that Minnesota’s Medical Assistance program covered in 2012, along with the 2000 and 2012 fee-for-service base rates. For example, the fee-for-service rate for teeth cleaning for an adult was \$26.52 in 2000, and the rate decreased to \$25.72 in 2012. For any single dental visit, a Medical Assistance enrollee may receive one or several of these procedures, depending on the enrollee and the scope of benefits the enrollee is eligible to receive. The dentist then would be paid by DHS for each procedure that was provided and was eligible for MA reimbursement.

Dentists set their own charges—or price—for their services, and Minnesota’s 2012 fee-for-service rates were lower than what dentists in Minnesota and surrounding regions typically charged. For example, Minnesota’s 2012 fee-for-service payment rate for a periodic oral evaluation for a child was \$18.14 compared with a median charge of \$39.00 among dentists in Minnesota and some neighboring states, as shown in Exhibit 2.3. This comparison of actual payment rates to providers’ charges is referred to as the payment-to-charge ratio. Use of the payment-to-charge measure to assess the adequacy of fee-for-service

Exhibit 2.3: Examples of Dental Procedures, 2000 and 2012 Fee-for-Service Rates, and Dentists' Charges, 2011

Service Type	Procedure Description	Adult or Child Procedure	2000 FFS Base Rate	2012 FFS Base Rate ^a	2011 WNC Region Median Charge (Includes Minnesota) ^b	2011 ENC Region Median Charge ^c
Diagnostic	Periodic oral evaluation for established patient	Adult Child	\$12.22 12.22	\$11.85 18.14	\$ 39	\$ 42
	Problem focused, limited oral evaluation	Adult Child	15.93 15.93	15.45 23.91	55	61
	Comprehensive oral evaluation (once every five years)	Adult Child	15.93 15.93	15.45 24.74	58	66
	X-rays of the whole mouth	Adult Child	38.75 38.75	37.59 56.07	108	115
	Two-film X-rays of premolars and molars	Adult Child	11.20 11.20	10.86 16.49	36	38
Preventive	Cleaning	Adult Child	26.52 18.34	25.72 17.79	73 51	76 56
	Application of fluoride	Child	14.00	13.58	29	32
	Sealing enamel surface on a tooth to prevent decay	Both	17.30	16.78	40	44
Restorative	Two-surface filling using amalgam material	Both	41.65	40.40	130	138
	Two-surface filling using resin-based composite	Both	48.95	47.48	152	159
	Prefabricated stainless steel crown (excluding lab fees for the crown)	Child	76.51	74.21	202	240
Endodontic	Surgical removal of a portion of tissue in the tooth	Both	40.80	39.58	131	162
Oral Surgery	Extraction of erupted tooth	Both	44.70	43.36	125	136

NOTES: "Rate" represents Medical Assistance fee-for-service rates. "Charge" represents charges reported by dentists.

^a Reflects the 3-percent temporary payment rate reduction effective September 1, 2011, through June 30, 2013.

^b Based on responses from dentists in west north central region (including Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota) to the 2011 American Dental Association's survey regarding fees charged for select procedures. The regions cited here and in the survey are based on the U.S. Census Bureau's census regions.

^c Based on responses from dentists in east north central region (including Illinois, Indiana, Michigan, Ohio, and Wisconsin) to the 2011 American Dental Association's survey regarding fees charged for select procedures. The regions cited here and in the survey are based on the U.S. Census Bureau's census regions.

SOURCES: American Dental Association, *2011 Survey of Dental Fees* (Chicago, December 2011), 65-97; American Dental Association, *2011-2012 Current Dental Terminology: The ADA Practical Guide to Dental Procedure Codes* (Chicago, 2010), 5-77; and Minnesota Department of Human Services, "Minnesota Health Care Programs Fee Schedule" (St. Paul, 2012).

Relatively small shares of MA dentists are eligible to receive notable supplemental payments.

payment rates is controversial because the results depend on how much a provider charges—which can vary greatly—and dentists may not always get paid their full charges for privately insured patients, either.³⁵ With these limitations in mind, we looked at the payment-to-charge ratios for Minnesota’s dentists who participate in MA fee-for service.

Among 1,780 dentists submitting at least one MA claim through fee-for-service in 2011, the average payment-to-charge ratio was 32 percent when using the fee-for-service base rates only, shown in Exhibit 2.4 on the following page. However, DHS paid all fee-for-service providers an additional 2 percent of the fee-for-service rate as reimbursement for Minnesota’s 2-percent tax on providers. Including this add-on payment, the average 2011 fee-for-service payment-to-charge ratio was still just 32 percent.³⁶ On the other hand, a relatively small number of fee-for-service dentists (119 dentists) were also eligible to receive both critical access and community clinic payments in 2011, and their average payment-to-charge ratio was about 48 percent. Exhibit 2.4 also shows that, when compared with other providers, the average payment-to-charge ratio among all dentists was similar to those for chiropractors (38 percent) and audiologists (35 percent), but exceeded those for physicians overall (26 percent).

Without inflationary adjustments to the fee-for-service rates in over a decade, the payment-to-charge ratio for many dentists has eroded. For example, among all fee-for-service dentists, the average payment-to-charge ratio decreased from about 43 percent in 2006 to 32 percent in 2012. Among the fee-for-service dentists who received critical access and community health clinic payments, the average payment-to-charge ratio decreased from 58 percent in 2006 to 45 percent in 2012 (but still higher than the ratios for some other types of providers). We also found that:

- **Over the past decade, Minnesota has had relatively lower fee-for-service base rates than most other states.**

Minnesota has typically ranked in the lower one-third of all states on fee-for-service rates.

National research has found that Minnesota has typically ranked in the lower one-third of all states when comparing dental fee-for-service base rates. For example, a 2001 study ranked Minnesota 34th and 35th (out of 45 states) for a sample of dental procedures.³⁷ These findings did not change much over the

³⁵ Others reported concerns about the use of usual and customary charges—or “fee percentiles”—to assess payment rates. These concerns include dentists’ practice of submitting charges to MA that are equal to the amount MA currently pays, rather than their usual, higher charges through commercial programs or to private payers. See American Dental Association, *Medicaid Reimbursement for Mid-Atlantic Region –Using Marketplace Principles to Increase Access to Dental Services* (March 2004), 2.

³⁶ Among 1,780 dentists providing fee-for-service dental care in 2011, 1,480 were eligible to receive the additional 2-percent payment but not other supplemental payments.

³⁷ Joel Menges, *Comparing Physician and Dentist Fees Among Medicaid Programs* (The Lewin Group, June 2001), 23. See also Stephen Zuckerman, *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare* (California Health Care Foundation, April 2009), 15.

following decade; for example, a 2011 study found that Minnesota's 2008 fee-for-service rates for select procedures ranked at the bottom among all states, and that the 2008 rates were lower than the 2000 rates after adjusting for inflation.³⁸

We compared a sample of Minnesota's 2012 fee-for-service base rates for 18 procedures with those of neighboring states and found that Minnesota's rates were mostly lower, although the differences were sometimes small.³⁹

Exhibit 2.4: Fee-for-Service Payment-to-Charge Ratios, Select Provider Types, 2011

Fee-for-Service Provider Type	Total Charges Claimed (in millions)	Total State Payments (in millions)	Average 2011 Payment-to-Charge Ratio
All Dentists (N=1,780)			
Actual payment-to-charge, all payment types included	\$55.1	\$20.2	.34
Example: payment-to-charge for fee-for-service base rates only	55.1	17.6	.32
Dentists only eligible for fee-for-service base rates + 2% provider tax reimbursement (N=1,480)	30.3	9.7	.32
Dentists eligible for fee-for-service base rates, 2% provider tax reimbursement, and critical access and community health/public health clinic payments (N=119)	8.8	4.2	.48
Other			
Home and Community Service Provider	\$1,347.4	\$1,298.9	.96
Hospital	2,238.6	606.8	.27
Personal Care Provider	436.0	407.2	.93
Pharmacy	564.9	291.2	.52
Day Training and Habilitation Center	232.3	229.5	.99
County Reservations Service	206.1	196.1	.95
Physicians	557.5	145.9	.26
Nursing Facility	142.4	135.2	.95
Home Health Agency	175.7	115.4	.66
Chiropractor	2.4	.93	.38
Audiologist	1.1	.36	.35
Optometrist	.7	.38	.53

NOTE: Some types of "Other" providers receive other types of reimbursements, such as facility payments or drug rebates, to help defray their costs.

SOURCES: Office of the Legislative Auditor, analysis of Department of Human Services data on fee-for-service payments and payment-to-charge ratio of Medical Assistance health care services.

³⁸ Sandra L. Decker, *Journal of American Medical Association*, "Medicaid Payment Levels to Dentists and Access to Dental Care Among Children and Adolescents," July 13, 2011, vol. 306, no. 2: 189. See also The Pew Center on the States, *The State of Children's Dental Health: Making Coverage Matter* (Washington, DC: 2011), 25. For a regional comparison, see American Dental Association, *Medicaid Reimbursement—Using Marketplace Principles to Increase Access to Dental Services*, 23-27.

³⁹ These findings are similar to those of a 2009 study completed through DHS. The study found that Minnesota's fee-for-service dental rates were lower than the rates of six out of nine comparison states. Of the remaining three comparison states, only one state (Michigan) had lower rates for all 11 dental procedures used in the analysis. See Burns & Associates, Inc., *Report to the Legislature: Comparison of Minnesota Medicaid Fee-for-Service Physician Rates to Rates Paid by Medicare and Selected Other States*, 22.

Exhibit 2.5 shows that Minnesota’s fee-for-service rates for all 18 procedures averaged 44 percent lower than the published Medicaid rates for North Dakota

Exhibit 2.5: Medicaid Dental Payment Rates, Minnesota and Neighboring States, 2012

Service Type	Procedure Description	Minnesota 2012 Rate ^a	Neighboring States’ Payment Rates as a Percentage of Minnesota Fee-for-Service Rates			
			Iowa	North Dakota	South Dakota	Wisconsin
Diagnostic	Periodic oral evaluation for established patient	\$ 18.14	89%	145%	121%	88%
	Problem focused, limited oral evaluation	23.91	106	164	138	85
	Comprehensive oral evaluation (once every five years)	24.74	94	159	133	86
	X-rays of the whole mouth	56.07	90	147	123	82
	Two X-rays of premolars and molars	16.49	98	154	127	81
	X-ray taken from outside the mouth	45.35	101	140	119	89
Preventive	Cleaning	17.79	137	190	236	123
	Application of fluoride	13.58	104	170	133	95
	Application of fluoride for high cavity risk patients	13.58	104	166	133	95
	Sealing enamel surface on a tooth to prevent decay	16.78	121	161	143	102
Restorative	Two-surface filling using amalgam material	40.40	143	203	178	111
	Two-surface filling using resin-based composite	47.48	139	211	179	111
	Prefabricated stainless steel crown	74.21	137	186	167	119
	Prefabricated resin crown	84.14	139	309	155	139
Endodontic	Surgical removal of a portion of tissue in the tooth	39.58	149	217	167	121
	Root canal therapy on anterior tooth	173.19	146	220	182	121
	Root canal therapy on molar	263.26	148	218	187	126
Oral Surgery	Extraction of erupted tooth	43.36	117	170	150	97
Average percentage of Minnesota rates for select procedures			120%	185%	154%	104%
Average percentage below neighboring states’ rates for procedures where Minnesota rates are lower			-20%	-44%	-33%	-16%
Average percentage above neighboring states’ rates for procedures where Minnesota rates are higher			8%	NA ^b	NA ^b	13%

^a Rates reflect the 3-percent temporary payment rate reduction effective September 1, 2011 through June 30, 2013. For procedures for which both adults and children are eligible but there are different fee-for-service rates, the rates represent services provided to children.

^b Minnesota did not have a higher rate than the neighboring state for any of the procedures reviewed.

SOURCES: Minnesota Department of Human Services, “Minnesota Health Care Programs Fee Schedule” (St. Paul, 2012); American Dental Association, *2011-2012 Current Dental Terminology: The ADA Practical Guide to Dental Procedure Codes* (Chicago, 2010), 5-77; and published 2012 fee-for-service payment rate schedules from four neighboring states.

Minnesota’s fee-for-service rates were mostly lower than rates of neighboring states.

and 33 percent lower than South Dakota.⁴⁰ For example, North Dakota’s rate for a periodic oral examination was 145 percent of Minnesota’s rate. For 14 of 18 procedures, Minnesota’s rates were also lower than Iowa’s rates (on average 20 percent lower). For 9 of 18 procedures, Minnesota’s rates were on average 16 percent lower than Wisconsin’s rates; however, for the remaining 9 procedures, Minnesota’s rates were on average 13 percent higher. Our comparison here pertains to states’ published Medicaid fee-for-service rates only and does not include supplemental payments that Minnesota and other states may pay. For example, Wisconsin also pays its dental providers financial incentives for taking new Medicaid patients as part of the state’s effort to increase access.⁴¹

As part of our statewide survey of dentists, we asked for opinions about the sufficiency of Minnesota’s fee-for-service base rates. More than 79 percent of respondents said that the fee-for-service base rates were very insufficient or somewhat insufficient for treating MA patients, as shown in Exhibit 2.6.⁴² Survey respondents were slightly more likely to report that fee-for-service rates for treating adults were very insufficient (80 percent) compared with rates for treating children (71 percent), perhaps because dentists are paid higher rates for certain procedures for children. When asked whether the fee-for-service rates were adequate for treating MA recipients with special needs, about 80 percent of respondents said the rates were very insufficient or somewhat insufficient.

Exhibit 2.6: Dentists’ Opinions on Sufficiency of Fee-for-Service Base Rates for Dental Services, 2012

To what extent are the FFS base payment rates sufficient for treating the range of individuals enrolled in Medical Assistance? *Do not include critical access payments, community health clinic payments, or grants in your assessment.*

MA Recipient Type	N	Very Insufficient	Somewhat Insufficient	About Right	Somewhat Sufficient	Very Sufficient	Don’t Know
Children	493	70.8%	14.4%	0.8%	0.8%	0.6%	12.6%
Children with special needs	487	70.0	9.4	0.8	0.8	0.6	18.3
Adults/Seniors	489	80.4	6.1	0.4	0.2	0.6	12.3
Adults/Seniors with special needs	482	75.5	5.4	0.2	0.4	0.6	17.8

NOTE: Percentages may not sum to 100 due to rounding.

SOURCE: Office of the Legislative Auditor, survey of a sample of licensed dentists in Minnesota, 2012.

⁴⁰ For this analysis, we did not compare Minnesota’s scope of dental benefits and restrictions with those of other states.

⁴¹ The payment amounts vary and are based on a dentist’s U.S. postal zip code.

⁴² Among the respondents to this question, some dentists provided services exclusively through fee-for-service, some provided services exclusively through a managed care program, some provided services through both, and some did not participate in MA.

Managed care organizations determine payment rates through negotiations with dental providers.

Managed Care Organizations' Payment Rates

For MA dental services, DHS generally pays fee-for-service dental providers at least 102 percent of the fee-for-service base rate for each procedure; the additional 2-percent payment is to reimburse dentists for Minnesota's 2-percent provider tax. Managed care organizations determine their own payment rates through negotiations with their dental providers; in doing so, they must ensure that managed care dental services are available to the extent that they are available to fee-for-service enrollees. Among managed care organizations, standard payment rates have in the past ranged from 102 percent up to 140 percent of the fee-for-service base rate.⁴³ Some also pay higher rates to specialty dentists—such as endodontists—or dentists who treat MA enrollees with special needs.

We examined how much managed care organizations paid MA dental providers in fiscal year 2012 for a sample of dental procedures.⁴⁴ For our analysis, we used provider claims data collected and maintained by the managed care organizations and reported to DHS. It is worth noting that differences in recordkeeping among the MCOs—as well as anomalies in the claims data—allowed for only very limited analysis and comparison of dental payment rates.⁴⁵ In addition, Minnesota data practice laws further restrict our reporting and analysis.⁴⁶ With these caveats in mind, we found that:

- **On average, managed care organizations' payments for MA dental services in 2012 exceeded the state's fee-for-service base rates, although the differences were sometimes small.**

For the state's largest managed care program (PMAP), the median payment per procedure ranged from 110 percent to 131 percent of the fee-for-service rate, shown in Exhibit 2.7.⁴⁷ Across all procedures in our sample, the average median payment was 121 percent of the fee-for-service rate. Similarly, the median payment per procedure for programs serving seniors ranged from 105 percent of the fee-for-service rate up to 131 percent, with an average median of 116 percent of the fee-for-service rate. For managed care programs serving individuals with special needs, the median payment per procedure was slightly higher, ranging from 122 percent to 147 percent, with an average median payment of 125 percent of the fee-for-service rate.

⁴³ Minnesota Department of Human Services, *Provider Payment and Reimbursement Rates* (St. Paul, 2011), 14.

⁴⁴ We examined 28 dental procedures; a procedure with different rates for children and adults was counted as 2 procedures.

⁴⁵ For example, differences in recordkeeping did not allow for more comprehensive analysis of total payments to individual treating providers, by type of provider.

⁴⁶ *Minnesota Statutes* 2012, 256B.69, subd. 9c(b)(3)(iv).

⁴⁷ This analysis excludes critical access payments and payments made through State-Operated Services clinics.

Exhibit 2.7: Comparison of Minnesota Fee-for-Service and Managed Care Program Payment Rates, 2012

Service Type	Procedure Description	Adult or Child Procedure	Fee-for-Service 2012 Base Rate	Managed Care Organization Payments as a Percentage of Fee-for-Service Rate		
				PMAP Median Rate	MSHO, MSC+ Median Rate	SNBC, SNBC PIN Median Rate (Adults Only)
Diagnostic	Periodic oral evaluation for established patient	Adult	\$11.85	122%	112%	122%
		Child	18.14	122		
	Problem focused, limited oral evaluation	Adult	15.45	122	122	122
		Child	23.91	122		
	Comprehensive oral evaluation (once every five years)	Adult	15.45	131	131	147
		Child	24.74	121		
Two X-rays of premolars and molars	Adult	10.86	113	116	124	
	Child	16.49	122			
X-ray (panoramic) taken from outside the mouth	Adult	34.62	122	122	124	
	Child	45.35	122			
Preventive	Cleaning	Adult	25.72	113	113	124
		Child	17.79	110		
	Application of fluoride for child	Child	13.58	110	NC	NC
		Adult	13.58	110		
Application of fluoride for high cavity risk patients	Adult	13.58	110	105	113	
	Child	16.78	110			
Sealing enamel surface on a single tooth to prevent decay	Child	16.78	110	NC	NC	
	Adult	16.78	110			
Restorative	Two-surface filling using amalgam material	Adult	40.40	122	111	126
		Child	40.40	122		
	Two-surface filling using resin-based composite	Adult	47.48	119	119	126
		Child	47.48	119		
	Prefabricated stainless steel crown—primary tooth	Adult	74.21	—	NC	NC
		Child	74.21	122		
Prefabricated stainless steel crown—permanent tooth	Adult	79.16	—	NC	NC	
	Child	79.16	110			
Endodontic	Surgical removal of a portion of tissue in the tooth	Adult	39.58	—	NC	NC
		Child	39.58	123		
	Root canal therapy on anterior tooth (excludes final restoration)	Adult	173.19	110	113	126
		Child	173.19	110		
Root canal therapy on molar (excludes final restoration)	Adult	263.26	113	NC	NC	
	Child	263.26	116			
Oral Surgery	Extraction of erupted tooth	Adult	43.36	110	110	126
		Child	43.36	110		
Average Median of All Procedures				121%	116%	125%

NOTES: Analysis of median payment rates represents payments for services provided by a dentist in either a dental office or a skilled nursing facility between January 2012 and June 2012. Minnesota 2012 fee-for-service rates reflect the 3-percent rate reduction effective September 1, 2011 through June 30, 2013. PMAP (Prepaid Medical Assistance Program) is a managed care program for families with children and non-pregnant adults. MSHO (Minnesota Senior Health Options) and MSC+ (Minnesota Senior Care Plus) provide services for seniors. SNBC (Special Needs Basic Care) and SNBC PIN (Special Needs Basic Care Preferred Integrated Network) provide services for people with disabilities. Payment rates for the PMAP program represent payments for allowable services for children, pregnant women, and non-pregnant adults. Payment rates for the MSHO, MSC+, SNBC, and SNBC PIN represent payments for allowable services to non-pregnant adults; services not covered are noted as "NC."

SOURCES: Minnesota Department of Human Services, "Minnesota Health Care Programs Fee Schedule" (St. Paul, 2012); fiscal year 2012 data on managed care organizations' payments for dental services; and American Dental Association, *2011-2012 Current Dental Terminology: The ADA Practical Guide to Dental Procedure Codes* (Chicago, 2010), 5-77.

On average, managed care organizations paid higher rates than fee-for-service.

Earlier we described how the DHS actuary, as part of the annual rate-setting process, incorporates a “dental trend” factor into the state’s capitation payments to MCOs to reimburse them for any increases in the price of dental services. For example, the average annual “dental trend” factor for PMAP between 2007 and 2012 was 3.5 percent; during this time, there was no increase in the fee-for-service base rates. The “dental trend” factor is estimated and is intended to help cover each MCO’s dental costs, in aggregate. The MCOs are not required to pass along these increases in their payments to dentists. We found that:

- **Many dentists who provided services through managed care in 2011 did not always benefit from increases in the capitation payments to managed care organizations.**

Specifically, Minnesota’s fee-for-service rates have not increased in over a decade, and about 54 percent of dentists paid through managed care organizations were paid between 100 percent and 102 percent of the fee-for-service rates for at least one patient in 2011. Exhibit 2.8 shows that, among more than 1,380 dentists reimbursed by an MCO during a two-month period in 2011, only 46 percent were consistently paid more than what DHS typically pays through fee-for-service.⁴⁸

Exhibit 2.8: Percentage of Managed Care Dentists Reimbursed at 100 Percent to 102 Percent of Fee-for-Service Rates, July-August 2011

Still, many managed care dental providers were paid at or near the fee-for-service rates.

Number of MA Patients for Which Dentist was Paid 100% to 102% of Fee-for-Service Base Rate for All Procedures	Percentage of Managed Care Dentists (N=1,380)
26 or more MA patients	2%
6-25	10
2-5	20
1	22
0	<u>46</u>
	100%

NOTES: Analysis represents a conservative estimate of the number and share of dentists for which managed care organizations’ (MCOs) payments were between 100 percent and 102 percent of the 2011 fee-for-service base rate (i.e., the typical rate of reimbursement through fee-for service, excluding reductions or critical access or community clinic payments). Number of MA patients represents recipients for which all procedures provided by the dentist were paid between 100 percent and 102 percent of the fee-for-service base rate. Dentists include MCOs’ in-network and out-of-network dentists who submitted at least one MA claim between July 1, 2011 and August 31, 2011 to an MCO, and excludes services provided through State-Operated Services clinics, community health or public health clinics, or a Federally Qualified Health Center. Payments are for a sample of 18 procedures.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services and MCO data.

⁴⁸ For this analysis, we note that the percentage of dentists consistently paid *more than* the typical fee-for-service reimbursement decreases from 46 percent to 35 percent when looking at MA patients where payment *for at least one procedure* was between 100 percent and 102 percent of the fee-for-service base rate. That is, about 65 percent of dentists were paid between 100 percent and 102 percent of the fee-for-service rate for at least one procedure for one or more MA patients.

State law allows managed care organizations to pay fee-for-service rates to out-of-network providers.

Managed care organizations are not required to pay their providers more than the fee-for-service rates, and state law allows managed care organizations to pay the fee-for-service rate to providers that are not part of their standard provider network. It is possible that some of the dentists receiving payments between 100 percent and 102 percent of the fee-for-service rates were not within an MCO’s network. However, some of these dentists were reported by the MCOs as participating providers in earlier years. Our analysis here does not include payments for services through State-Operated Services clinics, Federally Qualified Health Centers, community health clinics, or critical access clinics. However, we estimated that only 18 percent of MA dentists were eligible to receive these supplemental payments in 2011. Thus, for many dentists participating in MA, their maximum reimbursement for some managed care patients was 102 percent of the fee-for-service rates or less.

Similar to our survey question about Minnesota’s fee-for-service base rates, we asked dentists to offer their opinion on the sufficiency of managed care organizations’ payment rates. More than 84 percent of dentists who contracted with a health plan in 2012 indicated that the payment rates were very insufficient or somewhat insufficient, as shown in Exhibit 2.9. These results are not significantly different than their opinions of the fee-for-service rates, shown previously in Exhibit 2.6.

Exhibit 2.9: Dentists’ Opinions on Sufficiency of Managed Care Organizations’ Payment Rates for Dental Services, 2012

To what extent are the health plans’ payment rates sufficient for treating the range of individuals enrolled in Medical Assistance? *Do not include critical access payments, community health clinic payments, or grants in your assessment.*

MA Recipient Type	N	Very Insufficient	Somewhat Insufficient	About Right	Somewhat Sufficient	Very Sufficient	Don't Know
Children	170	72.9%	15.3%	2.4%	1.8%	1.2%	6.5%
Children with special needs	166	75.3	10.2	1.2	1.2	1.2	10.8
Adults/Seniors	168	76.8	11.3	1.2	1.2	1.2	8.3
Adults/Seniors with special needs	164	77.4	6.7	0.6	1.2	1.2	12.8

NOTES: Analysis represents responses from 170 dentists who reported that they contracted with at least one health plan to provide Medical Assistance dental services in 2012. Percentages may not sum to 100 due to rounding.

SOURCE: Office of the Legislative Auditor, survey of a sample of licensed dentists in Minnesota, 2012.

Earlier we described the state’s use of other, targeted payments to supplement the fee-for-service rates and payments by managed care organizations. The following two examples illustrate how the use of multiple payment methods requires additional oversight, coordination, and clarification to administer the payment policies. First, many dentists whose clinic received critical access payments said that these additional monies were the determining factor as to whether they continued to participate in MA.

Minnesota's use of multiple payment methods requires additional oversight and coordination to administer.

However,

- **In 2012, 32 dental clinics did not receive timely critical access payments, primarily due to deficiencies in one dental administrator's information technology system.**

DHS reimburses critical access dental providers through two different processes. For fee-for-service dental providers, the department provides the 30-percent supplemental payment as part of each claim reimbursement. For dental services provided through managed care programs, each MCO or its dental administrator compiles and submits a critical access reimbursement report to DHS on a quarterly basis throughout the year. DHS then reviews the reports for accuracy, comparing the information to other data received from the MCOs. For payments that are approved, the department then sends funds to the MCOs to be forwarded to the critical access clinics.

For critical access services provided from January through June 2012, UCare, through its dental administrator DentaQuest, was unable to prepare an accurate payment report until mid-November 2012. The problem was primarily due to insufficient programming in the dental administrator's payment system—programming that should have been incorporated years earlier.⁴⁹ The department concluded that there were enough problems with the data to justify withholding all potential payments to UCare for these critical access providers until it could identify the source and the scope of the problem. As a result of these deficiencies, critical access payments totaling \$625,000 were held back from 32 clinic sites, and the amounts withheld from individual clinics ranged from \$15 to more than \$180,000. DHS eventually received a satisfactory report for dental services provided in 2012, and subsequent payments were not delayed.

Next, one DHS payment policy has not been consistently implemented through managed care organizations. Earlier we described how the department pays community health clinics an additional 20-percent above the fee-for-service rate. We found that,

- **DHS policies regarding supplemental payments to community health clinics are unclear and not consistently implemented through managed care organizations.**

The DHS payment policy is carried out in accordance with a 1989 session law, but the law is not codified in current state statutes, and the DHS contracts with the MCOs do not require the 20-percent supplemental payment.⁵⁰ We examined a sample of MCO claims for commonly provided dental procedures and found that the great majority of procedures provided through community clinics were reimbursed at least 120 percent of the fee-for-service rate. However, payments

⁴⁹ The reporting problems were first identified by DHS staff in their review of the health plans' quarterly critical access reports and aided by a review of the managed care organization's patient encounter and claims data.

⁵⁰ *Laws of Minnesota* 1989, chapter 327, sec. 5, subd. 2(b).

Dental providers do not receive separate reimbursement for their administrative activities.

for about 11 percent of procedures did not reflect the full 20-percent add-on.⁵¹ Unlike critical access payments which are passed through MCOs to clinics, MCOs pay community health clinic add-ons directly from their capitation monies, and DHS does not monitor payments of this type. It is worth noting that as fee-for-service patients were transitioned into managed care in the 1990s and 2000s, DHS incorporated amounts sufficient to support the 20-percent add-on for purposes of developing the capitation payments to the MCOs.

In the previous sections, we examined Minnesota’s various payment policies, rate setting, and how much MA dental providers are reimbursed for their services. Later in Chapter 3, we discuss the impact of payment rates on dentist participation and MA recipient access to services. We also make several recommendations regarding the state’s approach to purchasing dental services for the Medical Assistance program. But first, we address several administrative issues that dentists say impact the adequacy of MA payments.

ADMINISTRATIVE REQUIREMENTS

In Chapter 1, we observed how Minnesota provides MA dental services through a multi-layered administrative structure. Throughout our study, many dentists said this complex service arrangement poses significant and unreasonable difficulties in delivering what in many instances has become a minimal number of reimbursable services. Medical Assistance does not provide separate reimbursement for administrative activities necessary for participating in public health care programs; providers must rely on the reimbursement rate for each dental procedure to cover all related expenses, including business overhead, support staff, equipment and materials (such as composite for fillings), lab fees (for making crowns and dentures), and dental care. Among the many administrative tasks required to provide MA dental services, dentists identified two activities in particular—verifying patient eligibility and obtaining authorization for services—that, in their view, diminish the adequacy of MA payment rates.

Verifying Patient Eligibility

Prior to providing any services to an MA recipient, dental providers must first confirm the patient’s enrollment status and determine which benefits and procedures are eligible for MA reimbursement. To do this, dental providers must review and verify each patient’s dental history. These verification steps vary depending on whether the MA recipient is a new patient and enrolled in either fee-for-service or managed care.

⁵¹ Looking only at a sample of 18 commonly provided procedures, we estimated that the total number of procedures where the payment fell short was at least 8,000 annually. It is possible that some of the lower payments were because the procedures were provided by community clinics that were “out-of-network” providers—a practice allowed for in state law.

We found that:

- **The Department of Human Services’ information system used to verify patient eligibility and treatment history does not sufficiently support legal restrictions and providers’ inquiries on the number, type, and frequency of dental services.**

DHS’s online information system provides limited information on MA patients’ dental history.

Specifically, a provider must check DHS’s online information system called MN-ITS, a system that contains limited information about dental procedures provided to patients through fee-for-service and no information about patient encounters through a managed care organization. That is, MN-ITS often does not show the complete fee-for-service history of all procedures for which state law limits service frequency. Instead, for many procedures, the provider must call DHS directly to verify whether an MA recipient is eligible to receive a particular treatment or procedure. For recipients that are or have been enrolled in a managed care program, the provider then must contact the MCO directly to verify patient treatment history and/or obtain authorization for services.

There are other shortcomings in the functionality of MN-ITS. For example, MN-ITS does not accept dental procedure codes for certain queries and, thus, providers must enter and track alternative codes for claims purposes. For some queries, dental providers must bypass error messages to enter information into the system—a misleading process for someone unfamiliar with MN-ITS.

The deficiencies in MN-ITS for purposes of tracking patient treatment history and eligibility for care become more apparent when looking at the frequency with which individuals enroll in and drop out of MA, as well as how often they switch to a different managed care organization. A review of the 2011 “churn rate” shows that more than 55 percent of adults without children (or 66,000 adults) and 52 percent of parents and their children (or 305,000 recipients) were enrolled in both fee-for-service and managed care during the calendar year. Between 2007 and 2011, nearly 115,000 individuals were enrolled in two or more MCOs. Although a majority of MA recipients do not change MCOs during any given year, recipients do change dental clinics. For example, about 8 percent of MA adult recipients received services from three or more clinics during 2012.⁵²

RECOMMENDATION

The Department of Human Services should improve its information system, MN-ITS, to better support dental providers’ inquiries of patient eligibility and state restrictions on benefits.

When the 2009 Legislature imposed limits on dental benefits beginning in 2010, many individuals expressed concern about the ability of DHS’s information system to accurately support these benefit changes. According to DHS staff, the MA dental benefit set is administratively difficult to implement and some of the deficiencies in MN-ITS are due to challenges in programming discrete statutory

⁵² Represents services provided January through June 2012.

Due to the challenges verifying MA patients' complete dental history, legislative restrictions on benefits may be poorly implemented.

limits into the system.⁵³ Some of the deficiencies in the reported patient history also can be due to a delay by dentists in filing claims and, thus, the services are not reflected in MN-ITS in a timely manner. According to DHS staff, federal patient privacy requirements further restrict the department's ability to compile a complete patient treatment history from all MCOs for dentists to access.⁵⁴

Finally, DHS staff report that there are deficiencies in the encounter data (that is, records of MA recipients' treatments) reported by the MCOs to DHS, and that the data are not accurate enough to combine into individual, patient-based records. However, the department has attempted to address some of the concerns about verifying patient dental history across multiple MCOs. For example, DHS identifies patients that change MCOs frequently in seek of unreasonable use of services and restricts their ability to "plan hop."

Among its many purposes, MN-ITS was implemented as a cost savings tool to reduce administrative burden, to facilitate health care to MA recipients, and to expedite reimbursement to providers. More work on the functionality of the system is needed to achieve these goals or if the state intends to control costs by refining benefit coverage. Dentists may only check treatment history within the patient's current MCO network on a case-by-case basis, and doing so further erodes their MA reimbursement. In these instances, the legislative restrictions on benefits are likely to be poorly implemented.

Obtaining Authorization for Services

As a condition of participating in the federal Medicaid program, states must set up safeguards against unnecessary or inappropriate use of services, excess payments, and, in the case of prepaid health plans, underutilization of services.⁵⁵ For services not explicitly defined in state law—for example, those deemed "medically necessary"—state law requires that the Commissioner of Human Services determine whether services are reasonable and necessary, and publish the list of dental services that require authorization and related authorization criteria to its Web site.⁵⁶ As a resource for dentists and other providers, DHS also makes available additional information about service coverage and authorization criteria through its "provider manual" posted on the department's Web site. Finally, state law requires the department to have an electronic system

⁵³ For example, application of tooth sealant is covered once every five years per permanent molar for children only. According to DHS, programming MN-ITS to track treatment history for each tooth would be complicated and, for the data to be useful, would require more accurate reporting by providers.

⁵⁴ DHS staff cited federal laws and requirements under the Health Insurance Portability and Accountability Act (HIPAA) as restricting their ability to sufficiently address these issues. For example, dentists' access to patient data should be limited to be within their lawful scope of practice, a standard that is not easily programmed into an information system.

⁵⁵ 42 *U.S. Code*, sec. 1396a(a)(30) (2012); and 42 *CFR* sec. 438.240 (2012).

⁵⁶ *Minnesota Statutes* 2012, 256B.04, subd. 15, and 256B.0625, subd. 25. The law requires DHS to implement a utilization review program that includes both prepayment and postpayment reviews to determine whether the service(s) is medically necessary. In doing so, the commissioner shall make the determination of whether services are reasonable and necessary and that such a determination shall be made in consultation with a professional advisory group or health care consultant appointed by the commissioner.

to facilitate authorization requests for MA recipients' care and support providers' inquiries about the current status of their requests.⁵⁷

DHS contracts with a vendor to provide medical reviews of health and dental care and authorization of services provided through fee-for-service. Each MCO also must ensure similar services for their managed care programs. For services requiring prior approval, providers must submit authorization requests to the DHS vendor (or the appropriate medical reviewer for each MCO) and obtain approval to provide the dental care as a condition of payment.⁵⁸ The requests must be in writing and may be submitted via mail, facsimile, or the department's MN-ITS information system. According to MA dental providers:

- **Medical review and prior authorization decisions by DHS and managed care organizations are inconsistent and poorly communicated.**

Currently, DHS requires that initial medical reviews and authorization considerations be conducted in a way to ensure consistent application of review criteria, but does not require that the reviews be completed by a dental professional. Rather, a medical review must involve “a health care professional with appropriate clinical expertise in treating the MA enrollee’s condition,” but only if the request is denied or authorized for lesser care than what is requested.⁵⁹ A dentist does not review the request unless the health care professional is unwilling to authorize the service, or if the provider appeals the decision.⁶⁰ Dentists reported difficulties obtaining authorization from the DHS vendor providing medical review services, and some dental providers said that the vendor’s use of a nurse or dental hygienist—and not a dentist—required additional back-and-forth communication than what was necessary.⁶¹ They suggest that a dentist would have a better understanding of appropriate standards of dental care and necessary procedures.

Other concerns about MA medical review services involve communication by the DHS and MCO medical reviewers about what procedures and benefits are *not* eligible for reimbursement.⁶² State law allows for dental services when they are medically necessary—a standard open to differing opinions. Some dentists

Dental providers would like more input and information regarding changes in MA dental benefits.

⁵⁷ *Minnesota Statutes* 2012, 256B.0625, subd. 25(b). The law also specifies other requirements for system functionality; the system was required to be completed by March 2012.

⁵⁸ *Minnesota Rules* 2012, 9505.5010. The provider must submit materials, reports, progress notes, admission histories, and other information that substantiates that the service is medically necessary to treat the recipient.

⁵⁹ 42 *CFR* sec. 438.210(b) (2012).

⁶⁰ *Ibid.* DHS 2012 managed care contract for MA services for families with children, section 6.25.1, requires that requests be reviewed within 10 days of receipt and that decisions are communicated with MA enrollees or providers as expeditiously as possible.

⁶¹ According to DHS staff, the department’s medical review vendor had a registered nurse conduct medical reviews for dental services during a five-month period in 2012, and a dentist handled appeals of any decisions.

⁶² *Minnesota Rules* 2012, 9505.0270, subp. 10, identifies many items and procedures that are not reimbursable under MA.

Multiple entities review and authorize requests for dental services, which likely contributes to variation in authorization decisions.

questioned the medical reviewers' decisions about what procedures are medically necessary, suggesting that some denials of dental services do not conform with accepted standards of care, particularly as they pertain to individuals with special needs. For requests submitted through fee-for-service, DHS staff advised us that they had worked with providers to expedite and properly process their prior authorization requests. However, DHS staff assert that its vendor's use of a registered nurse and a dental hygienist for initial processing of requests has been appropriate, and that any appeals of the reviewer's decisions have been upheld by a licensed dentist.

To help guide policy decisions about dental services and benefits, the Legislature established the Dental Services Advisory Committee (DSAC).⁶³ However, we heard concerns that DSAC in recent years had focused mostly on pediatric dental issues and has had fewer communications with the dental community about policy and services for other populations, including recent legislative changes to MA benefits and payment rates. A DHS representative said that because the department does not have authority to modify the scope of dental coverage, the department has not sought formal input from DSAC on these changes.⁶⁴

RECOMMENDATION

The Department of Human Services should ensure that service authorization criteria and benefit changes are more clearly defined and communicated to dental providers.

The state, in purchasing and overseeing MA dental services, must balance "reasonable" and "necessary" with an acceptable standard of care. Differences over what services are appropriate or allowable—when not clearly specified in state law or rule—will likely always exist and require some subjective interpretation of need. However, there are currently six different entities providing utilization review services for MA dental services through DHS and the MCOs, thereby increasing the likelihood of variation in medical review determinations.⁶⁵ The Legislature recently changed the scope of MA dental benefits, primarily for non-pregnant adults. We think that DHS should more clearly communicate the rationale for excluding certain procedures and under what conditions they would be reimbursed, rather than relying on the medical review agents to convey this information on a case-by-case basis. We also think it reasonable that any medical reviewer of dental services have training and knowledge in dental services. We suggest that the state make better use of the

⁶³ *Minnesota Statutes* 2012, 256B.0625, subd. 3c(b). The committee's role is to advise the department on the critical access dental program, evidenced-based practices, best practices, dental delivery models, and proposed changes in service coverage; the commissioner may consider the committee's recommendations when developing changes in dental policy.

⁶⁴ DHS staff also assert that modifications to the critical access program that would impact the budget have not been brought to DSAC for review.

⁶⁵ Managed care organizations may provide dental services beyond that prescribed in state law. DHS staff report that the department does not pay for these services unless they are medically necessary. As of the release of this report, DHS did not have the technical capacity to remove MCO records of these additional services for purposes setting capitation payment rates.

Dental Services Advisory Committee to discuss what appear to be valid concerns among dentists about service coverage, recent benefit changes, and different standards of care, particularly for individuals with special needs.⁶⁶

In this chapter, we examined rate setting and payment rates for MA dental services. In the next chapter, we look at the impact of payment rates and other factors on dentist participation in MA and MA recipients' access to dental care. We also discuss several recommendations regarding Minnesota's approach for reimbursing MA dentists.

⁶⁶ For example, in its review of one request to authorize prescription toothpaste for an individual with special needs, the reviewer for one managed care organization communicated that poor dental care is a "lifestyle decision" and not medically necessary and, thus, denied coverage. As other examples, some dentists point to the lack of reimbursement for site visits to care facilities for the elderly and disabled as a poor decision and one that was not clearly communicated to dental providers when the change was implemented. Further, they question whether it is medically appropriate to force many of these recipients to travel for care—particularly when the state must still pay for patient transport—and they recommend that site visits to treat frail and disabled populations should still be covered.

Dentist Participation and Recipient Access

Minnesota has relatively low fee-for-service base rates for dental services when compared with other states and with dentists' usual and customary charges, although Minnesota supplements fee-for-service payments with notably higher reimbursement for some dentists. In this chapter, we examine the impact of low payment rates and other factors on dentist participation in Medical Assistance (MA) and MA recipient access to dental services. We also discuss several recommendations regarding Minnesota's MA payment rates, payment policies, and MA recipient access.

DENTIST PARTICIPATION

Dentists participate in the state's public health care programs by either enrolling directly with DHS for fee-for-service or contracting with a health plan or county-based purchasing organization that administers MA managed care programs. In any given year, a dentist may be enrolled but may not actually provide care to an MA recipient (or enrollee of other public health care programs). Throughout our study, dentists and others we spoke with said that many dentists have provided care to low-income individuals voluntarily and free of charge outside of the state's public programs—either through organized events or private clinics—and some have done so rather than incurring any additional administrative costs that come with being an MA provider. Our analysis of provider participation captures only MA dental care provided through DHS's fee-for-service or managed care programs and, thus, may not present a complete picture of the care Minnesota dentists provide to the poor and uninsured.

Many dentists provide care to low-income individuals outside of the state's public programs.

Participation Rates

To assess dentist participation in MA, we analyzed the extent to which dentists with active licenses in Minnesota submitted claims for MA reimbursement between 2006 and 2011. We also surveyed a sample of Minnesota dentists about their participation in MA. We found that:

- **The number and share of licensed dentists that participated in MA have not changed much since 2006.**

Among nearly 3,400 active, licensed dentists in Minnesota in 2011, about 75 percent were *enrolled* in the public health care programs, slightly more than the estimated 74 percent enrolled in 2006.¹ The *participation* rate of dentists—

¹ About 1,917 were enrolled in fee-for-service and 2,208 were enrolled through a managed care organization; among these dentists, about 1,564 were enrolled in both.

that is, the percentage of active, licensed dentists submitting at least one MA claim—has been somewhat lower.² Exhibit 3.1 shows that about 65 percent of all active, licensed dentists submitted at least one claim for MA payments in 2011, compared with 66 percent in 2006.³ The total number of participating dentists increased about 3.1 percent during this six-year period, from 2,146 in 2006 to 2,212 in 2011.

Exhibit 3.1: Dentists' Participation Rate and Distribution of Medical Assistance Patient Caseload, 2006, 2009, and 2011

Year	Participating Dentists		Percentage of Participating Dentists Treating:					
	Percentage of All Active, Licensed Dentists ^a	Number	1 or 2 Patients	3 to 20 Patients	21 to 100 Patients	101 to 250 Patients	251 to 1,000 Patients	More than 1,000 Patients
2006	65.7%	2,146	10.7%	30.1%	36.5%	12.9%	8.5%	1.4%
2009	66.0	2,205	8.3	26.9	33.7	14.5	13.6	3.0
2011	65.1	2,212	9.9	26.5	31.5	14.8	13.8	3.6 ^b

NOTES: Participating dentists are active Minnesota dentists who submitted at least one Medical Assistance claim during a calendar year to either managed care organizations or the Department of Human Services. Analysis represents an upper-bound estimate which may differ from the actual number of patients treated. Percentages may not sum to 100 due to rounding.

^a Based on data from the Minnesota Board of Dentistry and Minnesota Department of Health, we estimated that about 83 percent of all dentists with Minnesota licenses were actively practicing in Minnesota in a given year.

^b Some of these providers were but are no longer eligible for critical access payments, and they have stopped serving MA patients as of January 1, 2012.

SOURCE: Office of the Legislative Auditor, analysis of dentist claims data reported by the Department of Human Services.

The overall participation rate of dentists in Medical Assistance did not change much between 2006 and 2011.

The overall participation rate of Minnesota dentists did not change much in recent years, even though some dentists did stop serving MA recipients, perhaps for a single year or permanently. For example, about 65 percent of respondents to our survey of dentists said they treated at least one MA patient in 2010 and they continue to serve MA patients, or they started seeing MA patients after 2010. On the other hand, about 24 percent said they stopped serving MA recipients after 2010.⁴ One reason why the dentist participation rate has been fairly constant is because many dentists who are newly licensed enroll in MA and serve MA recipients. For example, 331 dentists who served MA recipients in 2011 did not serve any MA recipients in 2009; 128 of these dentists were newly licensed in Minnesota, and the remaining dentists had been licensed for a while

² Dentists with only licenses from other states can treat Minnesota MA recipients in their state or on Minnesota Indian reservations; we excluded these dentists from this analysis.

³ The analysis includes dental providers enrolled in fee-for-service, managed care, or both. In addition, these participation rates represent dental care provided to MA recipients only and exclude services provided to recipients of other public programs, such as MinnesotaCare. We note that it is possible that some dentists serve exclusively MinnesotaCare enrollees and, thus, the overall participation rate of dentists for all public programs may differ.

⁴ Among the remaining respondents, 8 percent said they have never treated an MA recipient and 3 percent selected "don't know."

However, dentist participation rates varied somewhat around the state.

but did not serve MA patients in 2009.⁵ Meanwhile, about 324 dentists who did serve MA recipients in 2009 did *not* serve any MA recipients in 2011.⁶ Overall, this represents a 15-percent turnover in dentists serving MA recipients during this two-year period.

Around the state, dentist participation rates in 2011 were somewhat higher in Greater Minnesota (about 77 percent) when compared with urban/suburban areas (61 percent). Among all dentists, a higher share was located in urban/suburban areas (about 68 percent compared with 32 percent in Greater Minnesota).⁷ On the other hand, survey respondents located in Greater Minnesota were also more likely to provide services in more than one county. For example, about 33 percent of survey respondents located in Greater Minnesota reported serving patients in three or more counties, compared with 21 percent of dentists in urban/suburban areas.⁸ These participation rates, however, do not mean that dental access is better in Greater Minnesota than elsewhere; we discuss MA recipient access further in the next section.

Among MA-participating dentists, the extent to which they accept and serve MA recipients varies. State law specifies minimum participation requirements for some, but not all, dentists enrolled as MA providers. For example, dentists must ensure that at least 10 percent of their patients are enrolled in a public health care program *if* they serve public employees.⁹ Dentists also can satisfy this requirement by providing care to children with special health care needs.¹⁰ We found that:

- **Among all MA dental providers, the number and share of dentists with large MA patient caseloads increased between 2006 and 2011.**

Exhibit 3.1 shows that in 2011, more than 17 percent of participating MA dentists served more than 250 MA recipients, up from 10 percent in 2006. The percentage of dentists treating more than 1,000 MA patients also increased, from

⁵ Analysis is based on dentists' claims for Medical Assistance reimbursement between 2006 and 2011 and Minnesota Board of Dentistry records.

⁶ Some of these dentists may have served MinnesotaCare enrollees during this period. Among the dentists that did not file any claims for MA reimbursement in 2011, about 58 percent appeared to have an active license in Minnesota and 42 percent no longer had an active Minnesota license.

⁷ Analysis is based on dentists' reported addresses to DHS and the Minnesota Board of Dentistry. Urban/suburban areas include counties in the Twin Cities metropolitan area and Olmstead, Sherburne, and Wright counties. Dentists from remaining counties and from neighboring states (and who serve Minnesota's MA population) are included in our analysis of Greater Minnesota.

⁸ In making this comparison, we recognize that many dentists travel around the state to serve recipients of public health care programs. Likewise, many recipients, particularly disabled or special needs populations, must travel out of their county to obtain dental services.

⁹ *Minnesota Statutes* 2012, 256B.0644. We did not examine the extent to which dentists comply with this requirement.

¹⁰ For patients served after July 1, 2007. *Laws of Minnesota* 2007, chapter 147, art. 5, sec. 22.

about 1.4 percent in 2006 to more than 3.6 percent in 2011.¹¹ Most of the dentists serving large numbers of MA recipients provided care through critical access, State-Operated Services, or community health clinics; these clinics either receive supplemental payments or reimburse their dentists at more than fee-for-service base rates. Meanwhile, we estimated that about 10 percent of participating dentists treated only 1 or 2 MA recipients in 2011.¹²

Factors Affecting Dentists' Participation

We surveyed dentists to better understand factors that affect their willingness or ability to serve MA enrollees. We also spoke with many dentists and other stakeholders around the state to obtain their perspectives on these issues. We found that:

- **Many Minnesota dentists have limited or discontinued their treatment of MA patients due to insufficient MA payments, as well as other factors.**

Many dentists reported that MA payment rates cover only a small portion of their costs.

Among our survey respondents, about 32 percent reported that they do not treat MA recipients or are not accepting new patients. More than 85 percent of these dentists indicated that insufficient payments were the primary reason, while a smaller percentage identified other factors, as shown in Exhibit 3.2.¹³ Many dentists reported that the payment rates cover only a small portion of their costs; for example, MA payments are less than the fees charged by laboratories to prepare dentures on behalf of the dentist. In addition, stakeholders we spoke with emphasized that low payment rates are not the only reason dentists decline to serve MA patients. In Chapter 2, we discussed dentists' concerns about administrative requirements and processes for the Medical Assistance program. Two other issues—inadequate standards of care due to restrictions on covered benefits and patients' failure to appear for appointments—were identified most frequently as disincentives to participate.

¹¹ Respondents to our survey reported similar changes in their MA patient caseload, where 36 percent said the number of recipients they treated has increased over the last five years, compared with 27 percent who said their caseload has decreased and 33 percent reported no change.

¹² We note that some of these smaller MA patient caseloads may be for dentists in sparsely populated areas, where there may be fewer MA enrollees overall.

¹³ Our survey findings are similar to research findings elsewhere. National literature has observed that burdensome administrative hassles and missed appointments are key obstacles to more participation by dentists.

Exhibit 3.2: Dentists' Opinions on Reasons for Not Treating Patients or Not Accepting New Patients in Medical Assistance, 2012

Reason	Percentage of Respondents Identifying this Reason for Not Treating MA Patients ^a (N=163)	Percentage of Respondents Identifying this Reason for Not Accepting New MA Patients ^b (N=144)
Insufficient payments for services	84.7%	89.6%
The scope of covered services under MA does not allow for an acceptable standard of care	27.6	36.1
Patient's failure to appear for appointments	23.9	18.1
Administrative work required to treat MA patients	23.3	18.1
Work associated with processing claims and obtaining payments	11.7	5.6
My practice is currently operating at full capacity	2.5	6.9
Not comfortable or interested in treating MA patients	1.8	4.2
Interruption in patient eligibility for MA services or changes in health plan enrollment	1.8	3.5
Patient's noncompliance with health care directives	1.2	1.4
Other reasons	8.6	6.9

NOTES: Percentages in each column do not sum to 100 because respondents could select up to two reasons. Respondents also could select "Other reasons" for not treating MA patients or accepting new MA patients; we do not describe the other reasons here.

^a The survey question was: "Please indicate the primary reason(s) that you do not accept or provide services to Medical Assistance recipients. (You may select up to two reasons.)" A total of 164 out of 509 respondents (32.2 percent) reported that they do not accept or provide services to MA recipients.

^b The survey question was: "Please indicate the primary reason(s) that you are currently not accepting new Medical Assistance patients. (You may select up to two reasons.)" A total of 149 out of 330 respondents that are currently serving MA patients (45.2 percent) reported that they do not accept new MA patients.

SOURCE: Office of the Legislative Auditor, survey of a sample of licensed dentists in Minnesota, 2012.

Dentists expressed concern about the impact of recent dental benefit restrictions on the health of some MA patients.

More specifically, many dentists emphasized that the recent restrictions on dental benefits for non-pregnant adults mean that there are fewer services for which they may be reimbursed by Medical Assistance. This means that the dentist may be asked to either provide less care than what is needed or asked for by the recipient, or to provide care for which they will not be reimbursed.¹⁴ Dentists also may not necessarily be reimbursed for initial examinations if the examination recently had been provided somewhere else. Some providers told us they are reluctant to serve a new patient without first clearly determining the recipient's overall dental condition.

Dentists expressed particular concern about how such limits on preventive and periodontal care will impact the overall health of adults—particularly those with special needs—as well as the costs to the state.¹⁵ For example, for non-pregnant adults, "planing and scaling" of teeth is allowed once every two years and "full-mouth debridement" is allowed once every five years. Many MA recipients with

¹⁴ As we described in earlier chapters, dentists can negotiate payment for dental care outside the scope of MA benefits.

¹⁵ Research has found that there is an association between untreated oral disease and an exacerbation of chronic conditions such as diabetes, heart disease, and stroke. Mary McGinn-Shapiro, "Medicaid Coverage of Adult Dental Services," State Health Policy Monitor, National Academy for State Health Policy (October 2008), 2.

special needs have limited ability to care for themselves, and dentists reported that there is often advanced deterioration in their oral health by the time they present for dental care. Among some general dentists that said they are able to treat these patients, they reported that the MA reimbursement is insufficient for the additional time and resources required to provide an appropriate level of care. General dentists also said they often must refer recipients with special needs to a dental specialist (and, it is worth noting that in managed care programs specialists are often paid higher rates than general dentists). For patients requiring anesthesia for this type of care, the services must be provided in a certified ambulatory surgical center, and not in a dentist's office.

In recent years, the Legislature and DHS have made key changes to MA dental services and payments. These changes were due partly to budget constraints, but also to bring about greater uniformity in the delivery of dental services. We found that:

- **Frequent changes in MA payment policies for dental services, combined with inconsistent payment practices and rates among fee-for-service and managed care programs, have eroded some dentists' participation in public health care programs.**

Instability in supplemental critical access payments present challenges for MA dentists.

Since 2002, the Legislature has provided funding to support critical access payments. However, the amount of these supplemental payments has changed five times over the last decade, including one point where payments were stopped for a three-month period in 2010.¹⁶ Some critical access dentists said that instability in these supplemental payments creates challenges for them in managing the size of their MA patient caseload, particularly since the fee-for-service rates alone do not cover their costs. Concurrent with critical access rate changes, many dentists and clinics stopped receiving critical access payments altogether in 2010 due to changes in the eligibility criteria.¹⁷ Dentists from several clinics that became ineligible advised us they greatly cut back or no longer provide care to MA patients, and some clinics closed their business operations altogether. For example, one clinic located in the southeast part of the state closed shortly after it became ineligible for critical access payments. Staff there directly cited the state's low reimbursement rates as the reason the clinic stopped serving an estimated 6,000 MA patients at the end of 2011.¹⁸ Thus, in some regions of the state, many MA recipients have had to locate a new dental provider.

In Chapter 2, we explained that the 2011 Legislature imposed a 22-month temporary reduction in fee-for-service rates, and that the rates were lower in 2012 than they were during the previous decade. We also described the various types of payments and how much dentists are paid for Medical Assistance services, and we found that many dentists are not consistently paid some types of

¹⁶ Since critical access payments were first funded in 2002, the rate factor has been: 40 percent (effective January 2002); 20 percent (January 2006); 38 percent (October 2006); 30 percent (July 2007); 0 percent (April 2010 through June 2010); and 30 percent (July 2010).

¹⁷ Among 2,212 dentists treating MA patients in 2011, 378 worked for clinics that received critical access payments, compared with 466 dentists (out of 2,205) in 2009.

¹⁸ The estimate represents services over a two-year period.

supplemental payments. Many dentists have questioned the state’s rationale for using multiple payment rates for the state’s public programs. They reported that tracking numerous fee schedules and reconciling varying payments through fee-for-service and multiple managed care organizations—both within MA and across all public health care programs—has added to their administrative costs and is a disincentive to participate in MA.

IMPACT ON ACCESS TO SERVICES

Inadequacies in access to oral health care, particularly for children, have been an increasing concern in recent years. For example, national research has found that poor children are more likely than other children to suffer from untreated dental disease.¹⁹ Medicaid and the State Children’s Health Insurance Program (SCHIP) provide a venue for improving oral health for children and others.

Federal laws lay out general requirements for MA patients’ access to care, specifying that payment rates must be set to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that comparable care and services are available for the MA population as that available for others in the geographic area.²⁰ Federal law also sets forth general goals for state Medicaid programs to improve children’s access to dental services, but allows states to develop their own benchmarks for service. States must report to the Centers for Medicare & Medicaid Services (CMS) the results of Early and Periodic Screening, Diagnosis, and Treatment measures regarding dental care for individuals under 21 years of age. In Minnesota, these measures are referred to as Child and Teen Checkups (C&TC). For example, one C&TC measure looks at the extent to which eligible MA children receive or “utilize” dental services, including whether they receive preventive or restorative dental care.²¹ For dental care in Minnesota, transport time from a recipient’s location to a dental provider must not exceed 60 minutes, appointment wait time must not exceed 60 days for regular care or 48 hours for urgent care, and emergency care must be available on a 24-hour basis.²²

Precisely measuring and comparing MA patient access to dental services to determine the sufficiency of payment rates is challenging, and federal law does not prescribe how states should do so. For example, in Minnesota, differences in dental benefits and population characteristics make it difficult to compare access for the fee-for-service disabled population with that for the general population. Individuals also have different interpretations of “access.” Some may consider a

Precisely measuring the impact of payment rates on access is difficult.

¹⁹ The Kaiser Commission on Medicaid and the Uninsured, *Filling an Urgent Need: Improving Children’s Access to Dental Care in Medicaid and SCHIP* (Washington, DC, 2008), 3; and United States Government Accountability Office, *State and Federal Actions Have Been Taken to Improve Children’s Access to Dental Services, but Gaps Remain* (Washington, DC, 2000), 1.

²⁰ 42 CFR sec. 447.204 (2012); and 42 U.S. Code, sec. 1396a (a)(30).

²¹ Centers for Medicare & Medicaid Services, *CMS Oral Health Strategy* (Washington, DC: CMS, 2011), <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf>. CMS evaluates states based on their reported data for various measures through Form 416.

²² We did not evaluate the extent to which managed care organizations comply with this requirement.

The federal government expressed concern about the impact of recent Minnesota rate reductions on patient access.

30-day wait for an appointment a problem, while others may consider it normal. A recent effort by the federal Medicaid and CHIP Payment and Access Commission (MACPAC) provides some guidance on assessing the adequacy of payment policies, payment rates, and access to services. In early 2011, MACPAC recommended that states employ a three-part analysis that examines (1) enrollee characteristics and health needs, (2) availability of care and providers, and (3) utilization of services.²³

As one approach to measure access, the Minnesota Department of Health (MDH) periodically assesses whether there is a sufficient health care provider workforce, including the number and location of dentists around Minnesota, to provide care to low-income populations.²⁴ MDH uses the federal government's criteria for identifying whether a region or county may be designated as a federal Health Professional Shortage Area (HPSA).²⁵ Facilities serving a large number of low-income individuals in HPSA may benefit from services provided by dentists in a federal student loan forgiveness program.²⁶ In the following sections, we discuss the extent to which Minnesota's MA enrollees obtain dental services and factors likely affecting their access.

MA Recipients' Use of Dental Services

The Centers for Medicare & Medicaid Services (CMS) requires states to report at least once every five years on the sufficiency of their payment rates for ensuring MA recipient access. States also must justify how they will continue to comply with federal access goals when they change their rates or modify their rate-setting methodology. For example, in response to Minnesota's 3-percent reduction in dental rates in 2011, CMS expressed concern that MA recipient access could be negatively impacted and it requested information on dentist participation and other factors. These factors included trends in "utilization rates," that is, the proportion of eligible MA recipients that received any dental care in a given time period. We looked at annual utilization rates for the Minnesota MA population between 2006 and 2011 and found that:

- **Some MA populations in Minnesota may face challenges to obtaining access to dental care.**

²³ Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (March 2011), 126-141.

²⁴ See 42 U.S. Code, sec. 254e (2012).

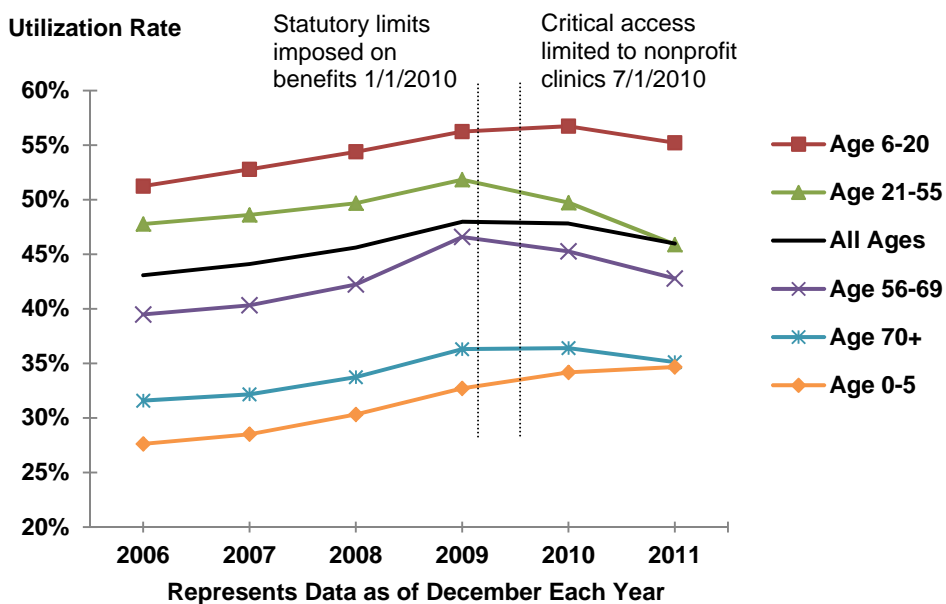
²⁵ Federal law allows for three types of HPSA designations: by geographic area, by population group within a "rational area," and for a public or nonprofit private medical facility that has been determined to have a shortage of providers. MDH's current methodology involves using multiple criteria to identify provider shortages. For example, 4,000 Medicaid claims equal one FTE dentist in a "rational service area." If the ratio of the number of low-income population and number of FTE dentists in the area is greater than 4,000 to 1, the low-income population in the area is likely to be considered having a dentist shortage. Minnesota currently uses individual counties as the base for measuring rational service areas.

²⁶ MDH staff caution that there are limitations to the data and methodology used for HPSA designations. As of 2012, there were 112 areas in 67 Minnesota counties that were designated as a dental HPSA. The HPSA designations for clinics serving low-income populations do not necessarily mean that the individuals with higher incomes in the region *do* have adequate access to dental services.

Minnesota’s MA population generally had lower dental care utilization rates than rates for the general population.

In Minnesota in 2010, the MA adult population had a lower utilization rate than that for the general adult population (about 47 percent compared with 79 percent).²⁷ Exhibit 3.3 shows that dental care utilization for all Minnesota MA recipients increased from 43 percent in 2006 to 48 percent in 2009, but subsequently decreased or remained flat for most age groups after the Legislature imposed restrictions on MA dental benefits for non-pregnant adults. However, among children age 5 years and younger, utilization rates consistently increased, from 28 percent in 2006 to 35 percent in 2011.²⁸ These rates were still short of Minnesota’s Child and Teen Checkup goal that *all* children receive examinations and care at 1 year and 3 years of age. Overall, children 5-years-old and younger and seniors age 70 and older appear to see the dentist less often than other MA recipients; their utilization rates in 2011 were each about 35 percent.

Exhibit 3.3: Dental Service Utilization Rates among Medical Assistance Recipients, by Age Group, 2006-2011



NOTES: Utilization rates are defined as the proportion of Medical Assistance (MA) enrollees that were continuously enrolled and received at least one dental service during a given calendar year. A “continuously enrolled” recipient is a person enrolled in MA for all 12 months during a calendar year. Age groups include enrollees of fee-for-service and all managed care programs.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services’ Medical Assistance dental services utilization data.

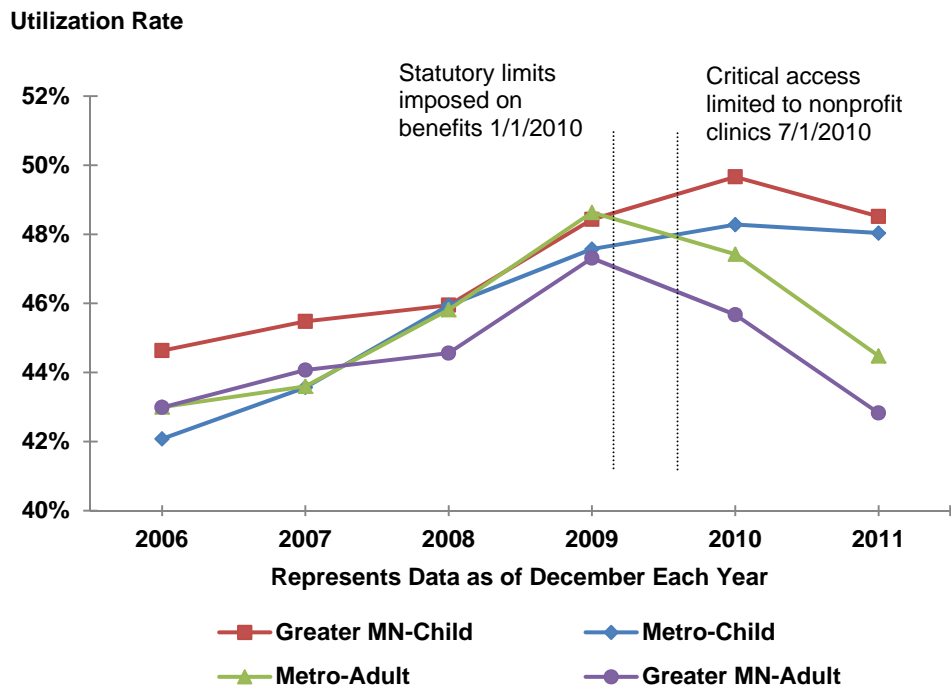
²⁷ Comparable data were not available for children. See Kaiser Family Foundation, *Percentage of Adults Who Visited the Dentist or Dental Clinic within the Past Year, 2010*, <http://statehealthfacts.org/comparetable.jsp?ind=108&cat=2&sub=30&yr=138&typ=2&sort=a>, accessed January 15, 2013.

²⁸ DHS contracts with counties for outreach services to ensure children receive the recommended C&TC dental exams and services. MCOs also employ initiatives to improve children’s access to dental care and their oral health. These efforts have likely had a positive impact on young children’s utilization rates.

Children receiving Medical Assistance in Minnesota had higher rates of dental care than did children in other states' Medicaid programs.

A 2011 national review of Minnesota's dental services for children ranked Minnesota's 2009 utilization rates for all Medicaid children above the national average for all states (42 percent compared with 38 percent nationwide).²⁹ Among dentists and other stakeholders we spoke with, we heard mixed opinions about the adequacy of children's access to dental care in Minnesota. For example, some said that access to pediatric dental care in Greater Minnesota was good in their area, while others said it was a great concern. Exhibit 3.4 shows that in 2006 and 2010, utilization rates for children in Greater Minnesota were just slightly higher than utilization rates for children in urban/suburban areas; however, their rates were about the same in 2011—about 48 percent. Meanwhile, utilization rates for adults and seniors in urban/suburban areas have been slightly higher than for adults and seniors in Greater Minnesota, but statewide were much lower than rates for children in 2011.

Exhibit 3.4: Dental Service Utilization Rates among Medical Assistance Recipients, by Age Group and Region, 2006-2011



NOTES: Utilization rates are defined as the proportion of Medical Assistance (MA) enrollees that were continuously enrolled and received at least one dental service during a given calendar year. A "continuously enrolled" recipient is a person enrolled in MA for all 12 months during a calendar year. In our definition, metro areas included the following counties: Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, Sherburne, Washington, and Wright; the remaining 77 Minnesota counties were considered Greater Minnesota areas. Child enrollees are individuals less than 21 years old.

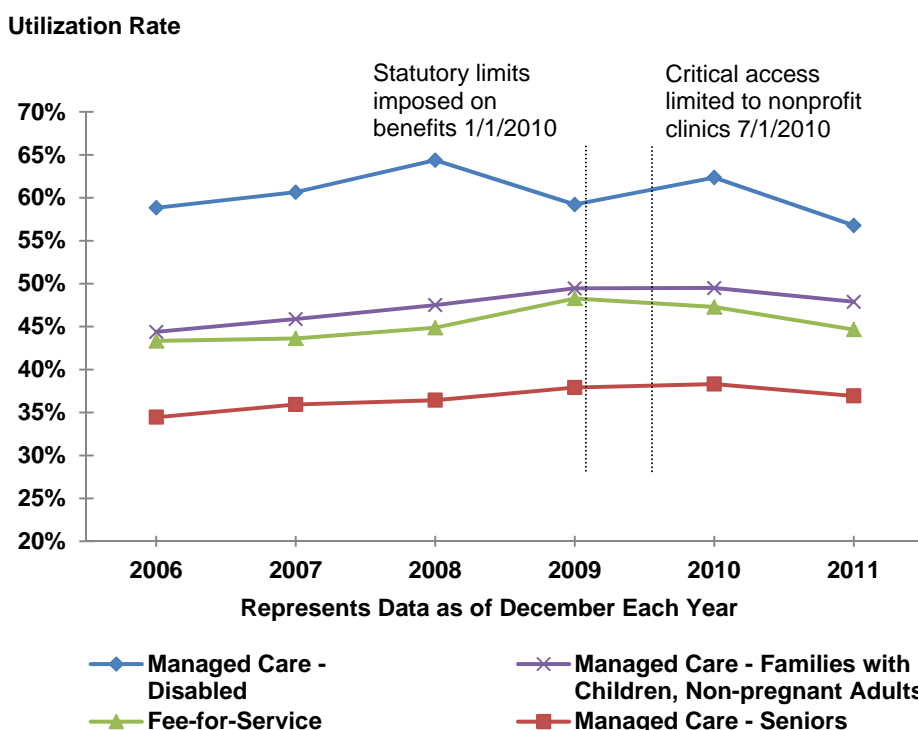
SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services' Medical Assistance dental services utilization data.

²⁹ The Pew Center on the States, *The State of Children's Dental Health*, 22.

When comparing fee-for-service and managed care programs, dental utilization rates for the continuously enrolled fee-for-service population (comprised mostly of individuals with special needs) were much lower than rates for the special needs population served through managed care.³⁰ Exhibit 3.5 shows that managed care special needs programs had the highest utilization rates among all programs—59 percent in 2006 and 57 percent in 2011—compared with the lower fee-for-service utilization rates of 43 percent in 2006 and 45 percent in 2011.

Individuals with special needs had higher dental utilization rates through managed care than through fee-for-service.

Exhibit 3.5: Dental Service Utilization Rates among Medical Assistance Recipients, by Fee-for-Service and Managed Care Program, 2006-2011



NOTES: Utilization rates are defined as the proportion of Medical Assistance (MA) enrollees that were continuously enrolled and received at least one dental service during a given calendar year. A “continuously enrolled” recipient is a person enrolled in MA for all 12 months during a calendar year. MA programs for the disabled include three managed care programs: Minnesota Disability Health Options (discontinued after 2010), Special Needs Basic Care (started in 2008), and Special Needs Basic Care Preferred Integrated Network (started in 2009). Minnesota Senior Health Options and Minnesota Senior Care Plus serve seniors. Prepaid Medical Assistance Program serves families with children and non-pregnant adults. Fee-for-Service is administered by the Department of Human Services and serves primarily individuals who are disabled or have special needs.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services’ Medical Assistance dental services utilization data.

³⁰ 42 CFR sec. 438.206 (2012) requires that all services covered under the state plan are available and accessible to enrollees of managed care organizations. That is, managed care enrollees must have at least the same level of access to services as enrollees through fee-for-service. 42 CFR sec. 438.207 (2012) also requires that each managed care organization require its providers to meet state standards for timely access to care and services.

Managed care organizations serving the special needs population reported that they invest additional resources—including patient transportation and direct contact with dentists—to facilitate patient access to dental care.

Other indicators suggest problems with MA dental utilization rates and MA recipient access. For example, enrollees unable to find a provider willing to see them can call the DHS member help desk, the DHS Office of the Ombudsman, or their managed care organization, and the number of such calls provides another indicator of access. According to data from DHS, the number of calls from MA recipients with concerns about access to dental services has increased in recent years and has exceeded complaints about access to other types of health care services. Among other individuals and stakeholders we spoke with, access to dentists has been a longstanding concern, particularly in sparsely-populated areas and more so than other types of providers.³¹

Factors Affecting MA Recipient Access

In Minnesota, the relationship among MA payment rates, dentist participation, and patient access to care is mixed and complicated. Earlier we described how some providers have limited or ceased serving MA recipients due to low reimbursement rates. We also found that:

- **Higher reimbursement rates have sometimes facilitated MA recipients' access to dental services.**

The relationship among MA payment rates, dentist participation, and patient access is complicated.

For example, representatives from managed care organizations reported that they have had to pay higher rates to some providers in order for the dentist to treat a particular patient.³² Further, although many dentists reported they have limited their participation in the MA program—in part due to low payment rates—a number of clinics have taken in many more patients (shown previously in Exhibit 3.1). Most, but not all, of the clinics serving a large number of MA recipients received some form of supplemental funding.³³ Among clinics receiving these supplemental funds in 2011, the median caseload was 332 MA recipients per dentist, compared with 31 MA recipients per dentist among all other dentists. Among the dentists that did not receive supplemental payments, they may have received payment amounts that greatly exceeded the fee-for-service rate, perhaps through their agreements with managed care organizations. Our comparison here is only to illustrate that payments that are consistently greater than the fee-for-service rates likely have improved access for some patients.

³¹ These findings are similar to those of a 2009 study completed through DHS. The study found that only 54 percent of fee-for-service Medicaid members surveyed reported *no* difficulty finding a dentist, compared with 80 percent of respondents that indicated no difficulty finding a personal doctor or nurse. When analyzed at the regional level, the difficulty in finding a dentist was concentrated in the northern and central parts of the state. See Burns & Associates, Inc., *Final Report to the Legislature: Compilation of Findings on Provider Rate Evaluations and Availability of Services in the Medicaid Fee-for-Service Program* (Phoenix, 2009), iv.

³² The individuals did not specify a precise amount, only that the payments were higher than the fee-for-service base rates.

³³ These additional reimbursements included payments for critical access clinics, community health or public health clinics, State-Operated Services clinics, or Federally Qualified Health Centers.

One factor that may be affecting patient access pertains to the size and location of Minnesota’s dental workforce relative to the number of MA enrollees. We found that:

- **In recent years, the growth in Minnesota’s MA population has exceeded the growth in dentists participating in MA.**

Between 2006 and 2011, the total number of individuals enrolled in MA increased about 41 percent. Nearly one-half of this increase occurred after March 2011 due to Minnesota’s early expansion of Medicaid to cover childless adults under the federal Patient Protection and Affordable Care Act.³⁴ Meanwhile, the total number of participating dentists—those serving at least one recipient—increased about 5.8 percent.³⁵ Thus, the total number of MA enrollees per dentist increased about 33 percent, from 292 per dentist in 2006 to 388 per dentist in 2011, shown in Exhibit 3.6. Similarly, the number of continuously enrolled MA recipients—that is, enrolled for 12 continuous months—grew about 42 percent.

Exhibit 3.6: Ratio of Medical Assistance Enrollees and Dentists Serving MA Patients, 2006, 2009, and 2011

Year	Number of Dentists Submitting at Least One MA Claim ^a	Ever Enrolled ^b		Continuously Enrolled ^c	
		Number of Enrollees	Number of Enrollees per Participating Dentist	Number of Enrollees	Number of Enrollees per Participating Dentist
2006	2,215	647,571	292	371,178	168
2009	2,279	736,325	323	438,915	193
2011	2,344	910,035	388	526,636	225

^a We include dentists who submitted at least one MA claim during a calendar year to either managed care organizations or to DHS, regardless of whether they were licensed only in other states or were not actively practicing in Minnesota that year. (We note that a dentist has up to a year to submit an MA claim and the dentist only needs to be licensed at the time of service provision; therefore, a claim submitted in 2011 may be for services provided prior to 2011.) Because we did not restrict participating dentists to active, licensed Minnesota dentists, numbers in this column may be different from numbers of participating dentists shown elsewhere in the report.

^b An “ever enrolled” recipient is a person enrolled in MA at any point during a calendar year.

^c A “continuously enrolled” recipient is a person enrolled in MA for all 12 months during a calendar year.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services’ dentist claims data and dental service utilization data.

It is worth noting that dentists from outside of Minnesota also provide dental services to Minnesota’s MA population. Typically, these dentists are licensed in other states but provide care to American Indian communities in Minnesota or they practice in communities located in other states but near Minnesota’s border. We estimated that about 1 percent of all MA dental patients in 2011 were treated

³⁴ Medical Assistance coverage was expanded to include about 119,000 low-income childless adults who were not previously eligible for MA, many of whom were previously enrolled in Minnesota’s General Assistance Medical Care program.

³⁵ We included all dentists who submitted at least one MA claim in 2011.

Recent limits on the scope of MA dental benefits for non-pregnant adults have likely contributed to a decrease in the use of dental services.

by these dentists, who comprised about 2 percent of all dentists who were paid for MA services.

Minnesota may be experiencing a dentist workforce shortage in some parts of the state, and this may be affecting access for MA recipients.³⁶ Among individuals we spoke with from around the state, some reported that their area was “provider-rich,” while others said the number of dentists in their area was just adequate. However, accessing a dentist may become more challenging for some in the near future. According to a 2011 MDH report, almost half of all Minnesota dentists were age 55 or older in 2009 and, thus, were nearing retirement age. The median age of dentists in Minnesota in small, rural areas was 57 years, compared with 53 years in urban areas.

In general, low payment rates appear to have contributed to access issues around the state. However, we cannot precisely measure the magnitude of this relationship, nor can we separate low payment rates from other possible factors. It is worth noting that:

- **Beyond payment rates, dentist participation rates, and workforce shortages, there are other factors that may affect recipient access to dental services.**

For example, lack of transportation, limitations on coverage, or parents’ willingness or ability to bring children in for dental care may also affect utilization rates.³⁷ Minnesota recently limited the scope of benefits available for non-pregnant adults, and this has likely contributed to a decrease in adult utilization (shown previously in Exhibit 3.4). According to some dentists and other individuals we spoke with, these adults may be less likely to bring their children in for dental care if they are not also eligible to receive services. The declining fee-for-service utilization rates for individuals with special needs may also be due to providers’ reluctance to travel to facilities to treat these patients since they are no longer compensated for site visits.

Among the various MA populations in Minnesota, individuals with special needs enrolled in fee-for-service and the elderly may be experiencing greater challenges accessing dental care.³⁸ These adult recipients have the same MA dental coverage as other adult enrollees, although they often have greater dental needs or more complex medical conditions.³⁹ Representatives from organizations serving these individuals said that locating a dentist has become increasingly

³⁶ See The Pew Center on the States, *Two Kinds of Dental Shortages Fuel One Major Access Problem*, Issue Brief (February 2011), 2. The report stated that less than 10 percent of Minnesota’s population is unable to find a dentist, but that even for states with relatively low percentages of unserved residents, dentist shortages could hinder efforts to improve access.

³⁷ See Inyang A. Isong, et al., “Association Between Parents’ Use and Children’s Use of Oral Health Services,” *Pediatrics* 2010, v. 125, 502-508. The study found that parents who did not obtain dental care for themselves were less likely to bring their children in for dental care.

³⁸ Our conclusions are based on utilization data and anecdotal information about the additional effort that these individuals must undertake to obtain dental services, and not an analysis of whether MA dental service delivery complies with the 60 day/60 minute requirements.

³⁹ Mary McGinn-Shapiro, *Medicaid Coverage of Adult Dental Services*, 2.

difficult in the past two years, and that they often have to make numerous phone calls or request the assistance of DHS, MCOs, or their MCO's dental administrator. In addition, they have had to transport their clients longer distances to connect with a dentist—particularly specialty dentists—willing to treat them. (Some MCOs reported that their transportation costs have increased for this reason, too.) Finally, the data we present here do not provide information about the adequacy or amount of dental services that MA patients received.

DISCUSSION AND RECOMMENDATIONS

National research has observed that a core cause of inadequate access to dental care—particularly for children in Medicaid—is dentists limiting their participation in the program.⁴⁰ Further, the key reason for dentists not accepting more Medicaid patients in Minnesota and elsewhere is low payment rates.

In lieu of increasing fee-for-service rates, the state has used targeted payments to select clinics and providers.

In Minnesota, the Legislature and the executive branch have attempted to address these issues over the years. In lieu of increasing Medical Assistance fee-for-service base rates for all dentists, the Legislature and DHS have targeted additional monies for critical access, community health, public health, and State-Operated Services clinics. DHS, MDH, and some managed care organizations also have made available special funding and grants for dental clinics. If low payment rates have reduced dentist participation and affected recipients' ability to locate a provider willing to serve them, then these additional monies have likely improved dentist participation and MA recipient access. However,

- **Minnesota's array of payment policies and rate-setting practices for MA dental services has likely had opposing and negative outcomes for the state and its MA recipients.**

In Chapter 2, we described how the rate factor for each of these payment types differs—individually and when paid in combination with other types of payments—and that not all payment types are based on either some measure of dentists' costs for providing services or an established, appropriate payment threshold. Some clinics are eligible for only one type of payment, while others are eligible for multiple payment types. When viewed collectively, it is not clear whether the multiple payment policies adequately address dentist participation and, thus, MA recipient access around the state. Finally, it is difficult to determine whether any of these types of payments supplant rates that would otherwise be negotiated between dentists and managed care organizations.

State law requires DHS to consider ways to equalize MA rates paid by different health care programs for the same service.⁴¹ Some payment policies are

⁴⁰ The Kaiser Commission on Medicaid and the Uninsured, *Filling an Urgent Need*, 5-6; and National Conference of State Legislatures, *Increasing Dentists' Participation in Medicaid and SCHIP* (Washington, DC, 2001), 2.

⁴¹ *Minnesota Statutes* 2012, 256B.038. The law requires the commissioner of Minnesota Management and Budget to include an annual inflationary adjustment in payment rates for dental and other services as a budget change request. If the request is approved, DHS must increase prepaid medical assistance program capitation payment rates to reflect the rate increase, and consider proposing a schedule to equalize rates paid by different programs for the same service.

The state’s targeted approach to funding dental services has likely had some unintended fiscal consequences.

implemented through fee-for-service but are not consistently implemented through managed care. For example, the 2011 Legislature decreased the fee-for-service base rates by 3 percent from September 2011 through June 2013.⁴² These reductions have been implemented through fee-for-service, but some MCOs did not decrease rates paid to dentists out of concern that their dentists would drop out of the Medical Assistance program. Since 1989, DHS also has supplemented its fee-for-service payments to qualified community health clinics by paying an additional 20 percent of the fee-for-service rates. However, managed care organizations do not always provide comparable, *additional* payments to these dental clinics—despite receiving funds at one time to do so—nor are they required to do so in their contracts with DHS.

The state’s rate-setting policies for fee-for-service and managed care also differ in important ways. Specifically, DHS, through its actuary, has incorporated annual “trend” increases specific to dental services into the managed care capitation payments.⁴³ That is, the payments include a factor to account for anticipated increases in the price of dental services for the health plans and county-based purchasing organizations. DHS has not required the MCOs to pass along these increases in payments to their dentists; rather, each managed care organization is allowed to decide how it distributes any increases to its providers. Meanwhile, there have been no inflation-related increases, “dental trend” increases, or other increases to the fee-for-service dental rates in over a decade.

We recognize that a capitated payment arrangement is by definition risk-based and less transparent than a direct payment or fee-for-service approach, and that it allows for greater flexibility in determining reimbursement to providers. The managed care approach has helped manage dental costs for the state.⁴⁴ Managed care organizations often provide higher reimbursement to encourage provider participation and, thus, may have positively impacted access in some areas of the state. However, many dentists providing services through managed care organizations are sometimes paid rates at or near the fee-for-service base rates (a finding we discuss in Chapter 2), and some have stopped participating in managed care because of low reimbursement.

The state’s targeted approach to funding MA dental services through certain clinics also has had some unintended fiscal consequences for the MA program. Because some dentists are reluctant to participate in MA, some MA recipients have had to travel greater distances to access a dentist willing to see them. In particular, representatives from MCOs and long-term care facilities serving patients with special needs said that access is a problem for these patients around the state. Some said that costs for transporting special needs patients (and others) for dental care have increased in the past two years. Another example of this

⁴² *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 67.

⁴³ The actuary develops a “dental trend” factor that is based on forecasted changes in providers’ charges, their costs, payment rates, medical inflation, and technological trends. Historically, this “dental trend” factor has predicted an increase in the price of dental services for managed care organizations. This factor is different and separate from the factors used to address changes in utilization or health risks of particular populations served by each managed care organization.

⁴⁴ For example, the managed care organizations assist with monitoring overutilization of services and with the recapture of improper payments to dental providers.

Dentists had differing opinions on how to reimburse MA providers for dental services.

cost-shifting occurs through the increased use of hospital emergency rooms—a more costly alternative to dental office visits—by MA patients who are unable to access a dentist. Research has found that hospital emergency room visits by individuals seeking dental care in Minnesota and elsewhere have greatly increased in recent years, and that many of these visits were preventable.⁴⁵ (In contrast, individuals with commercial dental insurance rarely used hospital ERs for dental problems.)

In our report, we observed that Minnesota’s fee-for-service rates were low compared with fee-for-service rates in other states and with dentists’ usual and customary charges. We also observed that fee-for-service rates and benefits for non-pregnant adults are the same for both the general population and for individuals with special needs, and that dentist and other stakeholders expressed concern about this approach. When asked about the potential ways the state should administer MA payment rates for dental services, 96 percent of the respondents to our survey agreed on one approach: increase the base payment rates for all dentists who serve MA patients, shown in Exhibit 3.7 on the following page. On the other hand, survey respondents were divided on the state’s use of targeted funding. For example, about 65 percent of respondents said the state should increase payment rates for dentists that serve MA patients in designated underserved areas; about 53 percent said the state should rely more on pay incentives to encourage quality dental services. However, respondents were mostly opposed to increasing rates *exclusively* for certain dentists. For example, 74 percent were opposed to increased rates *only* for dentists that increase the number of MA recipients they serve annually. About 46 percent disagreed with stopping critical access payments, while 28 percent said they did not know whether the state should continue these payments.

RECOMMENDATIONS

- *The Legislature and the Department of Human Services should better coordinate payment policies and rate setting for Medical Assistance dental services. As part of this effort, the Legislature should increase fee-for-service payment rates for dental providers.*
 - *The Legislature and the Department of Human Services should implement a separate benefit and payment structure for Minnesota’s Medical Assistance population with special needs.*
 - *The Department of Human Services should more closely monitor Medical Assistance recipients’ access to dental services.*
-

⁴⁵ The Pew Center on the States, *A Costly Destination: Hospital Care Means States Pay Dearly* (Washington, DC, 2012), 1. In one Minnesota study, most of the emergency room visits were charged to public programs and reimbursed at about 50 percent of emergency room visit charges. Elizabeth Davis, Amos Deinard, and Eugenie Maiga, “Doctor, My Tooth Hurts: The Costs of Incomplete Dental Care in the Emergency Room,” *Journal of Public Health Dentistry* 70 (2010): 1. See also Washington State Hospital Association, *Emergency Room Use* (October 2010), 8-12.

Exhibit 3.7: Dentists' Opinions on State Payment Policies, 2012

	<i>N</i>	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree	Don't Know
The state should discontinue critical access payments.	471	5.9%	4.9%	15.5%	12.1%	33.8%	27.8%
The state should increase payment rates only for dentists who serve a disproportionately large number of MA patients.	472	11.4	9.7	8.5	15.5	50.8	4.0
The state should increase payment rates only for dentists that increase the number of MA recipients they serve annually.	464	4.7	7.5	10.6	17.5	56.3	3.4
The state should rely more on pay incentives to encourage quality dental services.	468	32.5	20.5	14.1	6.6	16.7	9.6
When appropriate, the state should direct MA recipients to allied dental professionals and pay them the current base rates.	469	10.0	17.9	18.8	10.9	28.1	14.3
The state should increase payment rates for dentists that serve MA patients in designated underserved areas.	467	40.5	24.2	10.7	4.7	15.8	4.1
The state should increase the base payment rates for all dentists who serve MA patients.	481	89.8	6.2	0.8	0.4	0.8	1.9

NOTES: Analysis includes responses from participating and non-participating dentists. Percentages may not total 100 due to rounding.

SOURCE: Office of the Legislative Auditor, survey of a sample of licensed dentists in Minnesota, 2012.

The state's approach of targeting higher, supplemental payments to certain dental providers appears to have improved access for many MA recipients. These providers tended to have much higher MA caseloads than dentists who did not receive supplemental payments. On the other hand, not all dental providers are eligible to receive notably higher payments, the cumulative payment rates vary, and many dentists are often reimbursed at the relatively low fee-for-service rates. We suggest that more work is needed to refine how the Legislature and Department of Human Services purchase MA dental services. To improve dentist participation and MA recipient access, we suggest that the Legislature consider other payment approaches. These options include (1) creating separate benefit coverage and reimbursement rates for MA recipients with special needs, and (2) increasing the fee-for-service base rates.

First, the Legislature should consider developing a separate benefit and rate structure for MA enrollees with special needs. The federal Medicaid and CHIP Payment and Access Commission recommends considering enrollee characteristics and needs when evaluating the impact of payment approaches on access to services. Minnesota's current fee-for-service rates may be negatively impacting the special needs population's access to dental care. Further, many

**Minnesota's
fee-for-service
payment rates do
not adequately
consider the needs
of some MA
enrollees.**

dentists and others suggest that the state's current coverage and rates do not adequately recognize this population's oral health care needs. Disabled individuals who were served through fee-for-service have had notably lower utilization rates than rates for similar populations served through managed care (and MCOs paid higher average rates to treat this population). Minnesota currently has separate payment rates for select procedures for children as part of its effort to improve children's oral health. Federal law also allows for separate dental benefits and reimbursement rates for individuals who are medically needy or have special needs, and other states employ this approach.⁴⁶ DHS staff caution that (1) creating a separate benefit and rate structure for this population would be challenging and add complexity to providing MA dental services, and (2) not all disabled individuals have a need for additional dental services. However, we also heard compelling arguments that expanding coverage of certain procedures—such as offering more frequent periodontal care—for these enrollees may prove to be cost-effective for the state in the long run. For our recommendation, we emphasize that any such changes be made in consultation with dental professionals, representatives of this recipient population, and other stakeholders, and that these changes should adequately balance accepted industry practices with limitations in state resources.

Second, we think there is sufficient evidence that other MA enrollees around the state face challenges finding a dentist willing to see them, and that low reimbursement rates are one reason. Some of the reported access issues may be temporary due to a combination of recent factors, including the 2011 reduction in payment rates, restrictions in eligibility for critical access payments, and the expansion of the MA program accompanied by increased enrollment. However, Minnesota's fee-for-service base rates are low when compared with dentists' usual and customary charges—on average, about 38 percent when compared with dentists' charges around Minnesota and regionally. Many clinics are consistently reimbursed much more than the fee-for-service rates, but many are not.⁴⁷ There are some areas of the state—particularly sparsely populated regions—where the dental providers do not qualify for supplemental funding beyond the fee-for-service rates, but must deliver care to MA enrollees to comply with the provisions of *Minnesota Statutes 256B.0644*.⁴⁸ Increasing the fee-for-service rates—and requiring managed care organizations to pay, at a minimum, the revised fee-for-service rates—has the potential to improve recipient access to

⁴⁶ For example, North Dakota uses this approach for individuals with developmental disabilities. See also Mary McGinn-Shapiro, *Medicaid Coverage of Adult Dental Services*, 4-5.

⁴⁷ For example, we estimated that about 18 percent of MA dentists qualified for supplemental payments in 2011, and that 54 percent of dentists paid through a managed care organization were paid the fee-for-service rates for at least one of their MA patients.

⁴⁸ Dentists who serve public employees must also provide services to a specified number of enrollees in the state's MA or other public health care programs.

The Legislature and DHS should better coordinate Medical Assistance payment policies for dental services.

dental care in these areas.⁴⁹ Doing so also will ensure more transparency and equity in payments and would help offset dentists' administrative costs.

It is possible that increasing the fee-for-service rates for all dental procedures would increase the overall costs of dental services for the state. The Governor's budget proposal for the 2014-2015 biennium recommends a 5 percent increase in the DHS budget to increase the MA fee-for-service rates, with an estimated cost of \$2.8 million.⁵⁰ We support this initiative as it may broaden the network of participating dentists. It is also possible that some of the increased costs would be offset by reduced emergency room costs for MA patients and costs for transporting MA patients in some parts of the state. In 2009, DHS evaluated the payment rates for physician and other health care provider services using the Medicare-based value system. This effort required that any changes to the rates had a neutral impact on the budget, and the result was that rates for some procedures decreased while others increased. We think that a similar approach could be considered for dental rates.

We also emphasize that the Legislature and DHS should better coordinate payment policies for dental services and that any adjustments to the rates should be made within the context of all types of dental payments, such as critical access payments. DHS also would need to appropriately coordinate any fee-for-service rate increases with "dental trend" increases made by its actuary to capitation payments in order to avoid over-estimating capitation payments to managed care organizations. Further, if DHS continues to pay an additional 20 percent to community clinics participating in fee-for-service, it should clarify whether managed care organizations must make comparable payments to their dentists.

In making these recommendations, we note that the Centers for Medicare & Medicaid Services approved Minnesota's current fee-for-service rates, including the temporary 3-percent reduction imposed in 2011. We do not prescribe what the fee-for-service rates should be or which procedures merit higher reimbursement; however, some studies suggest that reimbursement rates should be high enough to at least cover the costs of care.⁵¹ In Chapter 1, we observed that dentists tend to practice in small practice settings—rather than consolidated business settings with other providers—and, thus, have fewer opportunities to spread their overhead costs. For the Medical Assistance program, a benchmark that ties rates to the costs of an efficiently managed dental office would support ongoing efforts to control health care costs and comply with the federal requirement that payment rates be consistent with efficiency and economy of care.

⁴⁹ Sandra L. Decker, "Medicaid Payment Levels to Dentists and Access to Dental Care among Children and Adolescents," *Journal of American Medical Association*, vol. 306, no. 2 (July 2011): 187. See also California Healthcare Foundation, *Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?* (Oakland, 2008), 3. The authors analyzed Medicaid payment reforms in five states and found that both dentists' participation and the number of Medicaid patients served increased following increases in payment rates and administrative reforms.

⁵⁰ The estimate is for increasing rates through fee-for-service and PMAP.

⁵¹ Alison Borchgrevink, Andrew Snyder, and Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care* (Washington, DC: National Academy for State Health Policy, 2008), vi; and The Pew Center on the States, *A Costly Dental Destination*, 10.

To improve dentist participation and MA patient access, Minnesota should increase the fee-for-service rates for dental services in a measured and incremental way.

To help determine payment rates, we suggest that DHS staff (1) assess the actual costs for dental materials and services in Minnesota, by procedure, (2) compile more consistent managed care payment data and compare historical payments through managed care and private insurance, and (3) identify procedures that are high priority for rate increases and for *improving access*. Any changes to the rates should be implemented in a measured and incremental way, one that monitors the impact of rate increases on both dentist participation and MA recipient access.⁵² This work should include input and consideration from the Dental Services Advisory Committee, legislative staff, and possibly representatives from other stakeholder groups. We caution that other factors, including patients' failure to appear for appointments and extensive administrative work, are strong disincentives for some providers. Thus, increasing the payment rates, by any amount, is unlikely to entice some dentists to serve recipients of public health care programs.⁵³

One important consideration regarding the state's use of managed care programs and MA patient access pertains to the recent controversy over excess profit levels and employee bonuses paid within the MCOs that administer the state's public health care programs.⁵⁴ During our study, many dentists and other stakeholders questioned why executives within the managed care organizations were receiving sizeable bonuses when the fee-for-service rates were reduced. In our view, the state's attempt to control costs and coordinate dental services with other health care provided through managed care organizations is a reasonable approach, as long as it does not adversely affect access. Throughout this evaluation, however, we heard of many dentists that will or have discontinued serving recipients of public programs because the state has not addressed what they view as insufficient reimbursement, particularly when compared with the profits of the managed care organizations. For this reason, DHS should very closely monitor the adequacy of MA recipient access to dental services in the future.

⁵² We note that other states' experience with raising rates and the impact on dentist participation has been mixed. See Borchgrevink et al., *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, 25; and Michelle Mayer, Sally Stearns, Edward Norton, and R. Gary Rozier, "The Effects of Medicaid Expansions and Reimbursement Increases on Dentists' Participation," *Inquiry* 37 (Spring 2000): 39.

⁵³ A 2002 DHS report found that the relationship between payment rates and participation was complex and that raising fees would likely increase access but not as much as some might expect. For example, among Minnesota dentists reporting a "low commitment" to serve public program enrollees, only 25 percent said that increased fees would lead to their participation. Meanwhile, a higher proportion of those with moderate or high commitments said that they would participate if fees were higher, although they were already participating at levels lower than what might be achieved with higher fees. Minnesota Department of Human Services, *Perspectives of Dentists and Enrollees on Dental Care under Minnesota Health Care Programs* (St. Paul, 2002), 15.

⁵⁴ The controversy was in response to health plans' reported financial information to the Minnesota Department of Health for 2010 and 2011. Regarding concerns about excess profit levels by the MCOs, the executive branch in 2011 renegotiated the 2011 contracts with MCOs to require a 1-percent cap on their profits; any surplus in excess of 1 percent had to be returned to the state. As of December 10, 2012, four MCOs returned a total of \$105.3 million. Some providers and others questioned how the MCOs were able to compile their surplus, asserting that many providers have not received increases in their reimbursement rates for many years.

List of Recommendations

- The Department of Human Services should improve its information system, MN-ITS, to better support dental providers' inquiries of patient eligibility and state restrictions on benefits. (p. 39)
- The Department of Human Services should ensure that service authorization criteria and benefit changes are more clearly defined and communicated to dental providers. (p. 42)
- The Legislature and the Department of Human Services should better coordinate payment policies and rate setting for Medical Assistance dental services. As part of this effort, the Legislature should increase fee-for-service payment rates for dental providers. (p. 61)
- The Legislature and the Department of Human Services should implement a separate benefit and payment structure for Minnesota's Medical Assistance population with special needs. (p. 61)
- The Department of Human Services should more closely monitor Medical Assistance recipients' access to dental services. (p. 61)



Minnesota Department of **Human Services**

March 4, 2013

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to the recommendations in the draft audit report titled "Medical Assistance Payment Rates for Dental Services." The Department of Human Services (DHS) appreciates the Legislative Auditor's time and effort in reviewing the structure of rates for dental services and the relationship of these rates to the provision of dental services for the clients we serve.

DHS supports the key recommendations of the report. We understand that the rate structure for dental services has changed frequently and that clarity in these structures will be important as we manage dental services for our participants. We also understand that dental providers continue to be concerned about the adequacy of these rates. We have begun to address these issues by creating a new position "chief rates officer" and by including dental services in a rate increase proposed in the Governor's biennial budget. This chief rates officer will address all rates, including those for dental services and will specifically consider the relationship of rates to adequate access in both the fee-for-service and managed care program.

We appreciate that rates are a crucial factor in providing adequate access to dental services. Other factors (such as professional shortages, patient adherence to treatment plans) also may impact access to services. DHS is proud to support the use of advanced dental therapists and community health workers to advance new models to people enrolled in public programs. We support the need to monitor the impact of all of these efforts on access to services.

Thank you again for your work in conducting this evaluation and addressing the issue of rates for dental services in a thorough and balanced manner.

Sincerely,

Scott Leitz
Assistant Commissioner

Department of Human Services
Response to the Legislative Audit Report titled
Medical Assistance Payment Rates for Dental Services

Audit Recommendation #1

The Department of Human Services should improve its information system MN-ITS to better support dental providers' inquiries of patient eligibility and state restrictions on benefits.

Agency Response to Recommendation #1

The Department supports this recommendation, recognizing that systems limitations and uniform transaction standards exist. However, the Department will explore whether there are potential solutions to provide additional information in order to improve coordination and communication of benefit limits and utilization.

Person Responsible: Julie Marquardt, PSD Deputy Director, and Chandra Breen, Manager MC Contracting and Service Implementation

Estimated Completion Date: Analysis completed by September, 2013.

Audit Recommendation #2

The Department of Human Services should ensure that service authorization criteria and benefit changes are more clearly defined and communicated to dental providers.

Agency Response to Recommendation #2

The Agency agrees with this recommendation and will ensure information is clear and communicated to providers.

Person Responsible: Julie Marquardt, PSD Deputy Director, and Chandra Breen, Manager MC Contracting and Service Implementation

Estimated Completion Date: June, 2013

Audit Recommendation #3

The Legislature and Department of Human Services should better coordinate payment policies and rate-setting for Medical Assistance dental services. As part of this effort, the Legislature should increase fee-for-service payment rates for dental providers.

Agency Response to Recommendation #3

The Department agrees with this recommendation and has included a 5% increase to the FFS and MCO dental services base rate in the Governor's budget proposals. In addition, the agency has recently restructured its rates unit; including establishing a Chief Rates Officer position to ensure that rates are appropriate and methodologies are transparent.

Person Responsible: Mark Hudson, Chief Rates Officer

Estimated Completion Date: Legislative proposal has been completed, July, 2014 for additional analysis and potential recommendations for future changes.

Department of Human Services
Response to the Legislative Audit Report titled
Medical Assistance Payment Rates for Dental Services

Audit Recommendation #4

The Legislature and the Department of Human Services should implement a separate benefit and payment structure for Minnesota's Medical Assistance population with special needs.

Agency Response to Recommendation #4

The Department supports this recommendation. Agency staff have already made improvements in coordination related to technical assistance and analysis of proposed legislation related to dental services. The agency will work with stakeholders and the Dental Services Advisory Committee to inform recommendations to ensure dental benefits are appropriate to serve those recipients with special needs.

Person Responsible: Jeff Schiff, Medical Director

Estimated Completion Date: Fall, 2013

Audit Recommendation #5

- *The Department of Human Services should more closely monitor Medical Assistance recipients access to dental services.*

Agency Response to Recommendation #5

The Department agrees with this recommendation and will establish improved methods for monitoring access to dental services.

Person Responsible: Julie Marquardt, PSD Deputy Director, and Chandra Breen, Manager MC
Contracting and Service Implementation

Estimated Completion Date: Fall, 2013

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Watershed Management, January 2007

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Misclassification of Employees as Independent Contractors, November 2007
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Governance of Transit in the Twin Cities Region, January 2011
State Highways and Bridges, February 2008
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