

PERSPECTIVES
OF DENTISTS AND ENROLLEES
ON DENTAL CARE
UNDER MINNESOTA HEALTH
CARE PROGRAMS

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EXECUTIVE SUMMARY

This report addresses certain facets of the problem of inadequate dental care for lower income children and adults in Minnesota. It reports the results of a survey of dentists on their experiences providing dental care to enrollees in Minnesota Health Care Programs (MHCP). MHCP consists of General Assistance Medical Care, Medical Assistance, and MinnesotaCare. The report also provides information obtained from a brief dental supplement to a survey of enrollees in these programs. Overall, the results of these surveys paint a picture of:

- many dentists being unwilling to provide care for payments that are much less than they deem acceptable,
- many enrollees failing to appreciate the value of preventive care,
- and many enrollees having difficulty getting care when they do perceive a need.

The survey of dentists, undertaken between November 2000 and February 2001, reveals that about 60% of dentists currently accept new MHCP patients. However, only one-fourth of these dentists accept — without restrictions — all MHCP patients who present for treatment. While 74% of dentists describe themselves as having enough time to grant appointments to all who request them, only 14% of dentists grant appointments to all MHCP enrollees who request them. Very few dentists have met the participation threshold set by Rule 101, which states that providers who treat state employees must agree to see MHCP enrollees until 20% of their practice consists of MHCP patients. In fact, there appears to be a category of dentists (about 20% of responding dentists) who exhibit a low commitment to MHCP patients. They see few, if any, MHCP patients and are unlikely to change their orientation. Fortunately, another 20% of dentists exhibit a high commitment to MHCP patients. The remaining 60% can be characterized as having a moderate commitment. The state would do well to concentrate on dentists with moderate or high commitments in its efforts to expand access.

The survey asked dentists about the importance of possible problems with MHCP. Low fees tops the list, with 93% of dentists reporting that it is a very significant problem. Broken or canceled appointments is second, with 82% reporting that it is very significant. The pattern of reported problems suggests a two-pronged solution. First, the structure of the program should be altered to alleviate dentists' concerns: such changes might involve increasing remuneration, moving toward greater continuity in enrollee's eligibility, and reducing and simplifying paperwork. Second, further efforts should be undertaken to increase the likelihood that enrollees will keep appointments when possible, notify the office if the appointment will be missed, and comply with dentists' advice. These efforts are apt to involve education about the benefits of preventive dental care and policies which facilitate access through means such as reminders about appointments and providing convenient child care.

The gap between what the state pays and what dentists want is large. The survey asked dentists for their usual fees for various procedures and what they would regard as acceptable payment for MHCP patients. Dentists are willing to give the state a 9% discount, but the current rates require one that is about 5 times that size. For most procedures, less than 1% of dentists are receiving fees that they consider acceptable.

Dentists view the problems as so serious that 81% of them have considered limiting their participation in MHCP. Unfortunately, a slight majority of even the committed dentists has done so. Increasing fees for this group is going to be essential for expanding and probably even maintaining access for MHCP patients. Since their loss to the program would be devastating, DHS has instituted a progressive payment schedule whereby dentists who see many MHCP patients will receive higher rates of remuneration.

The survey asked two questions about solutions to the problem of limited access. The first of these offered options which did not include rates of remuneration. The only item endorsed by more than half of the responding dentists is one that proposes

building a new clinic in their area for MHCP patients. Dentists were least supportive of measures which expanded the roles of others, such as dental hygienists, into the traditional province of dentists. Increasing fees was the most popular choice (60%) to the second question, which was open-ended. The second most frequent mention was establishing government clinics, but this was offered by only 8% of dentists. Dentists exhibit considerably greater consensus on problems with MHCP than on solutions, aside from increasing fees.

The survey of enrollees in MHCP, undertaken in the Spring of 2001, shows that as many as half did not accept the need for preventive dental care. About 80% of those who expressed a need for care were able to get it, but about one-third of them experienced difficulty finding a dentist. Of those who said that they needed but did not get care, the most frequently mentioned reason involved difficulty finding a dentist.

The patterns of responses given by members of racial and ethnic minorities is especially troubling. They are less likely to define themselves as needing care. Among those seeing a need for care, they are

less likely than others to obtain care. It seems likely that those who are unable to get care will become even less likely to define themselves as in need of it. Eliminating racial and ethnic disparities will necessitate breaking such reinforcing cycles. Educating enrollees about the importance of preventive care and ensuring access for those who seek it are obvious, if not necessarily easy, solutions.

Taken together, the results of these surveys indicate a need for education of MHCP enrollees about the benefits of preventive care, the importance of keeping appointments, and the importance of practicing the prescribed oral hygiene. However, these efforts are apt to be unproductive if the availability of dentists is limited. Increasing the availability of dentists will require increasing remuneration substantially, especially for dentists who exhibit moderate or high commitment to the program. Other strategies for maintaining dental access for MHCP patients include improving the provider relations departments of health plans and DHS, reducing denials of payment, and simplifying paperwork. These changes are especially critical in light of the shrinking supply of dentists in Minnesota.

INTRODUCTION

The former Surgeon General of the United States, David Satcher (U.S. Department of Health and Human Services 2000: vii), stated, "...there are profound and consequential disparities in the oral health of our citizens. Indeed, what amounts to a 'silent epidemic' of oral and dental diseases is affecting some population groups." These groups are the poor, especially children and the elderly, and members of racial and ethnic minorities. Furthermore, Satcher (U.S. Department of Health and Human Services 2000: 2) notes, "Medicaid has not been able to fill the gap in providing dental care to poor children." Not only do members of these groups suffer poorer oral and dental health, but resulting diseases further affect mental and physical health (National Institute of Dental and Craniofacial Research 2001).

How big are the gaps defined by ethnic and income groupings? Satcher reports that poor children suffer twice as many dental caries as do other children. Among poor children ages 2 to 9 nationwide, 71% of Mexican Americans, 67% of African Americans, and 57% of non-Hispanic whites have untreated decay in primary teeth (U.S. Department of Health and Human Services 2000). Manski, Moeller, and Maas (1999) note that nationally 53% of whites but 74% of blacks and Hispanics lacked a dental visit in the prior year. The income gap is similar: 76% of the poor but only 43% of people with high incomes lacked a visit. Fifty-six per cent of children with private insurance had at least one dental visit in the prior year; however, only 28% of children covered by Medicaid and 19% of children with no coverage had a dental visit during the same timeframe (Manski, Edelstein, and Moeller 2001). Thus, Medicaid is about half as effective as private insurance at giving children access to dental services. This result underscores Satcher's comment that Medicaid has failed to close the gap.

A report issued by the Minnesota Department of Human Services (1999) notes that the rates at the state level are only slightly better than national rates. Minnesota Health Care Programs (MHCP) consist of Medical Assistance, General Assistance Medical Care, and MinnesotaCare. In 1997, 37% of MHCP enrollees in managed care programs had a dental visit.

Only 26% of enrollees in the fee-for-service program had a dental visit. Worse yet, these rates actually declined by several percent by 1999 (DHS 2001). The fact that managed care served higher percentages does not necessarily mean that it does better at getting people in for visits, since enrollees in fee-for-service are more likely to have disabilities and face different barriers to access. The results do mean, though, that Minnesota has not solved the problem of dental access for the poor and the problem is worsening.

Nor has Minnesota done any better than the nation at eliminating racial and ethnic disparities. Looking at claims filed for services for children covered by MHCP, the DHS report to the legislature (2001) reports that 59% of whites, 61% of Asian Americans, 73% of American Indians and African Americans, and 76% of Hispanics lacked a dental visit in 1999. These numbers are almost identical to those reported by Manski et al. (1999) for the entire nation.

The local press has done its part to bring attention to the problem of dental access. For example, Howatt (2001) and Her (2001) wrote articles which helped to focus attention on the problem in the Minneapolis Star Tribune last year. Both do excellent jobs of putting a human face on the issue and reporting on attempts by DHS and others to improve the situation.

The Department (DHS 2001) submitted a report to the Minnesota Legislature which analyzed the problem, reported on potential ways of addressing it, and provided preliminary results from a survey of dentists which was underway. This paper provides a more complete report on the survey of providers and a report on a brief supplement about dental care to the Consumer Assessment of Health Plans Survey.

SURVEY OF DENTISTS

Methods

The instrument is a revised version of a questionnaire used by the State of Florida (Florida Agency for Health Care Administration 1998) to assess dentists' opinions of its dental program for Medicaid enrollees. Topics covered include problems with the program, support for various changes in the program, evaluation of the various health plans who contract with the state to operate MHCP, various features of the dentist's practice, and plans for future participation in MHCP.

DHS contracted with Wilder Research Center to help develop and administer the questionnaire, which was pretested with 10 dentists and revised accordingly. The Minnesota Board of Dentistry provided DHS and Wilder with a list of dentists who were actively practicing in Minnesota. Wilder employed a modified version of the method proposed by Dillman (1978) to reach the 2,892 licensed dentists who had not participated in the pretest. They sent each dentist a prenotification letter, the questionnaire, a reminder postcard, a second mailing of the questionnaire, and a final reminder postcard until they received a completed questionnaire, a refusal, or data collection ended. A total of 1,306 dentists returned completed questionnaires for a total response rate of 47.8%. Data were collected between November 2000 and February 2001.

Results

The analysis is presented in seven sections:

1. Characteristics of dentists and their practices,
2. Dentists' perceptions of problems with MHCP,
3. Possibility of limiting access,
4. Rating of the performance of DHS and health plans,
5. Reimbursement rates,
6. Possible improvements, and
7. Commitment to MHCP.

The general format of the second and subsequent sections is to first examine the overall response pattern and then to examine how responses vary by three important factors — tenure (experience), availability, and commitment. All of these factors are likely to influence participation in MHCP. Tenure is important in that dentists who enter the field in the next several years are more likely to mirror the attitudes and behaviors of dentists who entered the field recently. Availability is also important; if those dentists who are available are less likely than others to view the program as fraught with problems, they will tend to admit MHCP patients to their practices, thereby lessening problems of access. Similarly, if negative attitudes about MHCP are confined to those with little commitment to the program, expansion of the program is apt to be less difficult than if those with strong commitments see serious shortcomings.

Characteristics of dentists and their practices

Respondents have been practicing dentistry for a mean of 21 years. Most (85%) practice general dentistry, while orthodontics (5%) is the second most frequently mentioned area. Dentists report treating patients a mean of 34 hours per week. Most (82%) report doing at least some volunteer work. Almost all (96%) responding dentists work in a private practice or clinic, and 91% treat children under the age of 6. When asked to describe how busy they were in the 12 months prior to the survey (availability), 24% described themselves as, "too busy to treat all people requesting appointments," and 74% chose one of three options that indicated they were treating all who requested appointments. It is worth noting that dentists were responding in terms of time pressure and not in terms of their willingness to treat MHCP patients, since a much smaller percentage accepted all MHCP patients.

Payers. Those dentists who saw MHCP patients were asked, “From which of the following payers have you accepted ... [MHCP] patients in the past year?” Most dentists checked more than one payer. Their responses were:

84% checked DHS 26% checked HealthPartners
 67% checked Delta 2% checked Itasca
 47% checked Medica 2% checked Altru

All of the most frequent combinations of payers included DHS. DHS operates a fee-for-service program for those who are not eligible for managed care. The other plans are managed care organizations that offer care in various parts of the state.

Region of practice. Dentists also provided the county of their primary practice. Their responses are recoded into groups that correspond to the numbered Minnesota Planning regions and are named according to a prominent city or town in each. Table 1 presents the percentage of responding dentists in each region,

the percentage of the state’s dentists who practice in each region, and the percentage of the population in each region. These data show that dentists from the Twin Cities were less likely than others to respond to the survey and are underrepresented by 11%.

Comparing the percentage of the state’s dentists in a region with the percentage of the state’s population in that region shows whether the region has a disproportionate supply of dentists. There are 9% more dentists in the Twin Cities region than would be expected on the basis of its population. All other regions experience a deficit of less than 5%. The underrepresentation of dentists in Greater Minnesota is apt to be exacerbated in some areas by the low population densities which might require substantial travel to receive care. Furthermore, dentists tend to cluster in the urban areas within regions, so ease of access is apt to vary within regions, further inhibiting access for rural residents who live some distance from an urban area.

Table 1. Distribution of Respondents, Dentists and Population by Region.

Region	Respondents		Dentists ^a		Population ^b	
	n	%	n	%	n	%
(1) Grand Forks	19	1.5	36	1.2	88,472	1.8
(2) Bemidji	13	1.0	25	0.8	76,161	1.5
(3) Duluth	102	7.9	188	6.3	322,073	6.5
(4) Moorhead	56	4.3	86	2.9	210,059	4.3
(5) Brainerd	47	3.6	74	2.5	152,100	3.1
(6) Willmar	54	4.2	76	2.5	165,910	3.4
(7) St. Cloud	107	8.2	202	6.8	458,039	9.3
(8) Marshall	30	2.3	44	1.5	121,717	2.5
(9) Mankato	74	5.7	117	3.9	222,790	4.5
(10) Rochester	128	9.9	269	9.0	460,102	9.4
(11) Twin Cities	668	51.5	1,870	62.6	2,642,056	53.7
Total	1,298	100.0	2,987	100.0	4,919,479	100.0

^a Source: Minnesota Board of Dentistry

^b Source: Minnesota Planning Web Site

Participation in MHCP. Other questions ask about dentists' participation in MHCP. Almost all responding dentists (98%) have treated MHCP patients at some time, but only 88% did so at the time of the survey. Two questions ask about the percentage of dentists' patients and revenue that involve MHCP. The most frequent response to both questions is less than 10% (Figure 1). This corresponds nicely with data from the Minnesota Department of Revenue (DHS 2001). Clearly, most dentists do not rely heavily on MHCP for patients or revenue, and most have not met the minimum criterion of 20% set by Rule 101, at which point they can stop seeing additional MHCP patients. The proportion of revenue generated by MHCP is closely associated with the proportion of patients covered by MHCP, but there is a tendency for the proportion of revenue to be somewhat smaller than the proportion of patients, which is to be expected given that payment for services provided to MHCP patients are less than those received for services provided to other patients.

This fact is made even more forcefully by responses to the question, "When you compare your actual costs of providing treatment (i.e., overhead, including the costs of failed appointments) to your reimbursement from ... [MHCP], do you have a net profit, break even, or have a net loss?" Only 2% report a net profit, 13% report breaking even, and 85% report a net loss (Figure 2).

Examining responses to the question on financial consequences within categories of patients and revenue shows that it is not dentists with more patients or revenue from MHCP who are most likely to report a net loss. Rather it is dentists with the smallest proportions of patients or revenue from MHCP who are most likely to report a net loss. It is impossible to know from these data whether this results from dentists who experience losses limiting their participation in MHCP, or from economies of scale which develop with greater contact. It seems likely that both occur. This finding should provide some comfort for dentists who would like to increase their participation in MHCP but fear the financial consequences.

Figure 1. Percentages of dentists reporting that given portions of their practice come from MHCP

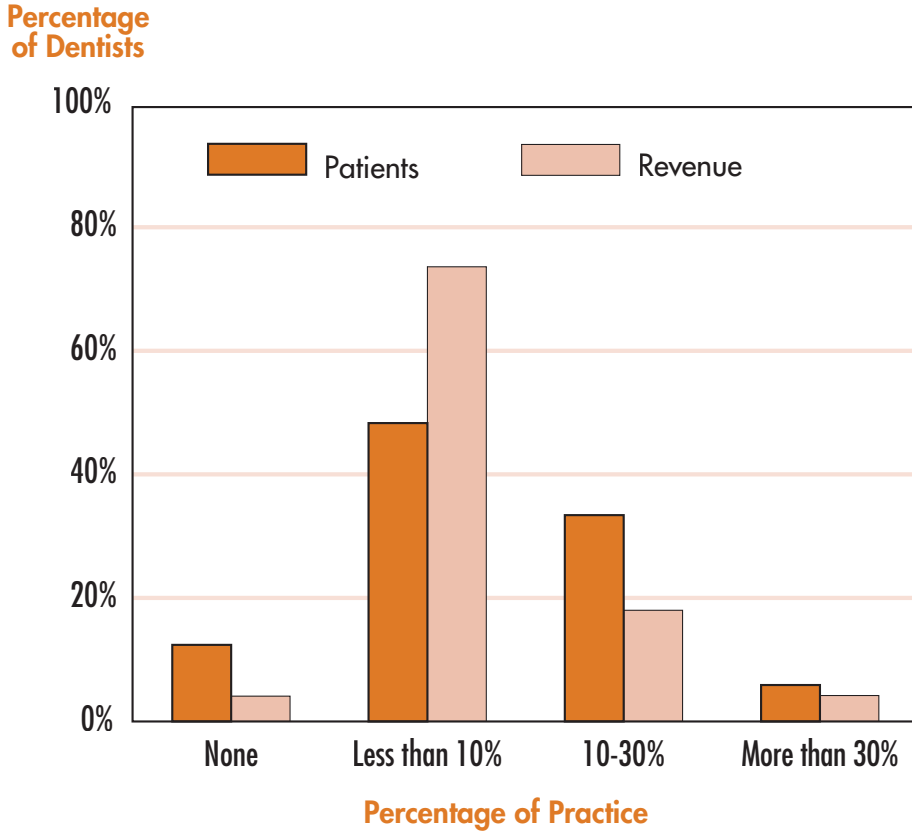
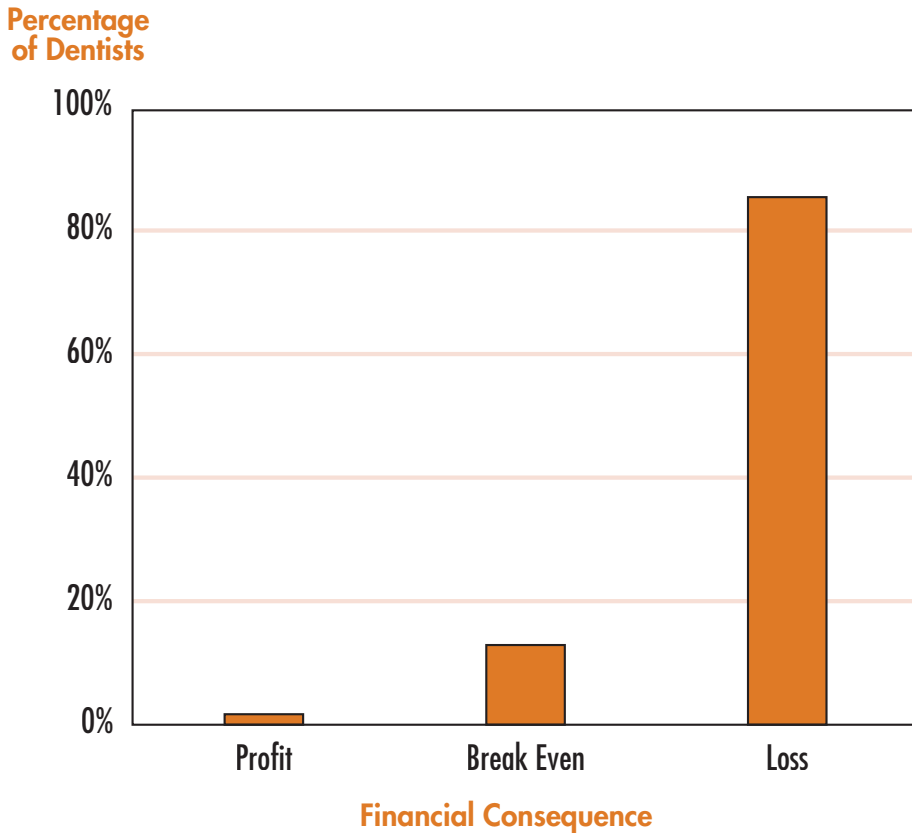
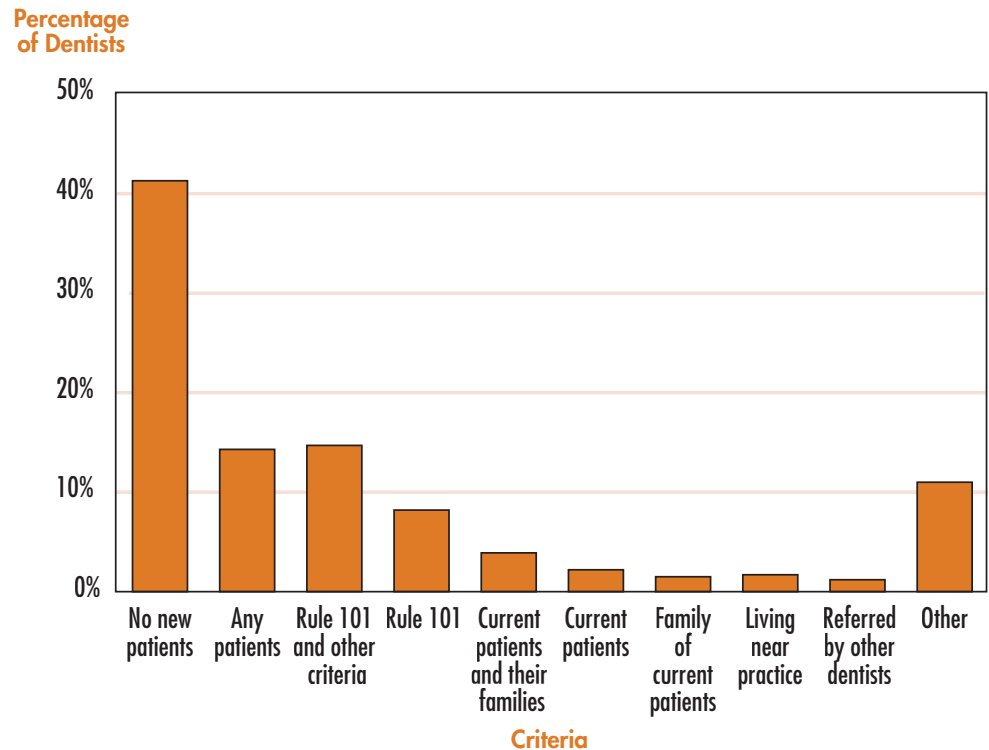


Figure 2. Percentages of dentists reporting various financial consequences of involvement in MHCP



Criteria for accepting new patients. Since an important goal of DHS is to expand access to dental care for MHCP patients, questions about accepting new patients are especially relevant. Although nearly 90% of dentists treat some MHCP patients, only 59% accept new MHCP patients. Dentists were asked what criteria they employ in accepting new MHCP patients. Respondents could choose any combination of eight options: (1) any patient, (2) the number of patients required by Rule 101, (3) existing patients who become eligible for MHCP, (4) family members of current patients, (5) referrals from other dentists or physicians, (6) patients from the area, (7) at restricted times, and (8) other. Respondents could and did choose several options. Responses are combined and recoded to yield the categories and frequencies shown in Figure 3. Forty-one percent do not accept new MHCP patients, 23% act in accord with Rule 101 (either alone or in combination with some other criteria), 22% use some other criteria to limit participation, and only 14% accept all MHCP patients.

Figure 3. Percentages of dentists reporting various criteria for accepting new MHCP patients



Examining the relationship of criteria with patients, which asks respondents to estimate the proportion of their patients who are covered by MHCP, is instructive. For this analysis, the categories of criteria are collapsed into no, some, and all patients accepted. The two variables are closely associated: 99% of dentists who currently see no MHCP patients respond that they will accept no such patients; conversely, 61% of dentists who report that more than 30% of their practice consists of MHCP patients respond that they accept any patients. It appears that there is a group of dentists in Minnesota who see few or no MHCP patients and have no plans to change this situation. At the other end of the continuum, there is a group of dentists with a strong commitment to serving MHCP patients.

A statistical analysis confirms this suspicion. Although dentists were not asked directly about their level of commitment, it can be inferred through a latent class analysis of criteria and patients. Latent class models posit one or more underlying dimensions which explain the associations among the observed variables (Goodman 1974 Clogg 1988). A model with three latent classes fits the cross-classification of criteria and patients quite nicely. The three latent classes vary in their commitment to serving MHCP patients and consist of those with weak, moderate, and strong commitments. The percentages of respondents in each of the classes are 19%, 63%, and 19%, respectively. Thus, this model suggests that about three-fifths of dentists have a moderate commitment to serving MHCP patients and the remainder are evenly split between those with weak and strong commitments. Policies which attempt to expand access by appealing to all three classes of dentists are apt to be much less efficient than those which appeal primarily to the 82% of dentists with moderate or strong commitments.

Dentists’ perceptions of problems with MHCP

This section examines various opinions that dentists have about MHCP. Respondents were presented with statements about MHCP with response options: (1) strongly disagree, (2) disagree, (3) neither agree nor disagree, (4) agree, and (5) strongly agree. Table 2 presents the means for these items. The means can vary from 1, which indicates strong disagreement, to 5, which indicates strong agreement; a value of 3 indicates that dentists are

evenly split. In this and similar tables, items are listed according to the size of the means. In Table 2, problems listed higher are seen by dentists as more problematic. The first four items listed have means above 3, suggesting that dentists tend to endorse the items. The first and third items attest to the fact that MHCP patients have more serious dental problems. Dentists’ open-ended comments to other questions suggest that some MHCP patients may also experience greater difficulty adhering to prescribed programs of dental hygiene.

Reasonable responses by the state to these concerns would involve educational and outreach campaigns to emphasize preventive care and the importance of regular dental hygiene. Another response would be to improve access, since enrollees who value preventive care but are unable to get it are apt to experience frustration rather than dental health. Concerns about managed care contracts could presumably be addressed legislatively by restricting managed care organizations from requiring dentists who treat MHCP patients to also treat their commercially insured patients. Such a change, however, might make MHCP contracts less desirable to some health plans. Alleviating fears about the fourth item — that dentists might have the only practice in the area that treats MHCP patients — is likely to be problematic. The most effective way is to involve many more dentists in the program, but evidence suggests that will be difficult. One possible approach is to emphasize that dentists with heavier involvement in MHCP are less likely than those with light involvement to suffer financial losses. Another, as

Table 2. Mean scores for items characterizing problems with MHCP.

Item	Mean*
Difficult to provide comprehensive treatment	4.49
Managed care contracts require treating commercially insured	3.98
MHCP patients are more difficult to treat than others	3.82
Worried about having the only practice that treats MHCP patients	3.64
MHCP patients make other patients uncomfortable	2.42
Dentists look unfavorably at dentists who treat MHCP patients	2.39

*A high score indicates agreement. Means can vary from 1 (strongly disagree) to 5 (strongly agree).

the Department’s report (DHS 2001) recommends, is to increase the rate of reimbursement as the dentist’s number of patients covered by MHCP increases. This would probably make the option of being the only dentists in the area serving MHCP patients more attractive.

Investigating the relations of tenure, availability, and commitment of dentists with opinions about MHCP provides some bad and good news. The bad news is that available dentists are more likely to agree that providing comprehensive treatment to MHCP patients is difficult. Also, committed dentists are more likely to worry about having the only practice that treats MHCP patients and that other dentists look unfavorably on those who treat MHCP patients.

The good news is that dentists who are more apt to be influential in the future (new, committed and available dentists) tend to view these problems as less serious. Dentists who are relatively new to the

field are less likely to believe that treating MHCP patients is difficult. New dentists are also less likely to avoid treating MHCP patients so as not to be obligated to treat commercially insured managed care patients. Dentists with higher levels of commitment are less likely to agree that providing comprehensive treatment to MHCP patients is difficult, less likely to agree that MHCP patients make other patients uncomfortable, and less likely to avoid treating MHCP patients so as not to be obligated to treat commercially insured managed care patients.

Another question asks respondents to assess the importance of various problems with MHCP, with response options (1) very insignificant, (2) somewhat insignificant, (3) neither significant or insignificant, (4) somewhat significant, and (5) very significant. Table 3 presents the mean scores for the 14 problems considered. The means can vary from 1, very insignificant, to 5, very significant. Not surprisingly,

Table 3. Mean scores for items assessing the importance of problems with MHCP.

Item	Mean*
Low fees	4.86
Broken or canceled appointments	4.74
Denial of payment	4.51
Managed care contracts	4.46
Patient non-compliance	4.38
Interruptions in eligibility	4.34
Slow payment	4.23
Need for prior authorizations	4.14
Complicated paperwork	4.13
Changes in regulations	4.07
Too few practices accepting MHCP patients	4.03
Collection of MNCare copayments	4.01
Rule 101 quota	3.99
MNCare patients don’t get support	3.10

* A high score indicates importance. Means can vary from 1 (very insignificant) to 5 (very significant).

low fees receives the highest score with a mean of 4.86. In fact, the top three scores are directly related to financial matters. Responding to these problems will involve increasing remuneration for dental services. Most of the means in this table are above 4.0, indicating that the respondents tend to think that these items are somewhat or very significant. The items in this table tend to refer to characteristics of the system of health care, whereas the items in Table 2 pertain more to characteristics of MHCP patients. Overall, issues related to the MHCP system (Table 3) are of greater concern to more dentists than are issues related to working with MHCP patients. This suggests that successfully addressing dentists' concerns is more likely to involve structural change in programs than changes in behaviors or characteristics of clients. It is worth noting that the response options differ for the items in these tables (although the number of options is the same) and that broken or cancelled appointments, an individualistic item, receives the

second highest endorsement in Table 3, surpassed only by low fees.

Overall, the pattern in Table 3, as in Table 2, suggests that a two-pronged approach would be most successful. First, the structure of the MHCP dental program should be altered wherever possible to alleviate dentists' concerns: such changes might involve increasing remuneration, moving toward greater continuity in enrollee's eligibility, and reducing and simplifying paperwork. Two items reflect the complexity of the problem: dentists dislike having payment denied, but they also dislike the need for prior authorizations, which reduces the likelihood of denials of payment. The appropriate solution is probably to attempt to reduce denials of payment, since dentists evaluate this as a more serious problem. The second prong of the approach is education of enrollees to keep appointments when possible, to notify the office if the appointment will be missed,

Table 4. Effects of tenure, availability, and commitment on assessments of the importance of various problems.*

Item	Tenure	Availability	Commitment
Low fees			—
Broken or canceled appointments			
Denial of payment			—
Managed care contracts		—	—
Patient non-compliance			—
Interruptions in eligibility	+		—
Slow payment	—		—
Need for prior authorizations			—
Complicated paperwork	+		—
Changes in regulations			—
Too few practices accepting MHCP patients		—	
Collection of MNCare copayments			—
Rule 101 quota			—
MNCare patients don't get support			

* "+" indicates that dentists with greater tenure, availability, or commitment exhibit higher means. A "—" indicates that dentists with less tenure, availability, or commitment exhibit higher means. A blank indicates that the relationship is absent or mixed.

and to comply with dentists' advice. Offering greater material support, such as reminders, transportation, and childcare, may also help to enable enrollees to keep appointments.

Table 4 summarizes the relations of the reported significance of these problems with tenure, availability, and commitment. A blank indicates that either the relationship is not statistically significant ($p > .05$) or difficult to interpret (e.g., nonlinear). A "+" indicates that those with greater tenure, availability, or commitment are more likely to see the problem as significant, and a "—" indicates that those with less tenure, availability, or commitment are more likely to see the problem as significant.

The news from the table is quite positive for the future of MHCP. Dentists with less experience are more likely to report that slow payments are a serious problem, but no other relationship suggests a dim future. Dentists who are newer to the field, who are more available, and who have greater commitment are less likely to report that a large number of the problems are serious. Conversely, dentists who are most likely to believe that these problems are serious are least likely to have an important impact on MHCP because they are nearer to retirement, less available, or less committed.

Possibility of limiting access

Dentists were asked, "Within the past year, have you seriously considered limiting your treatment of ... [MHCP] patients?" Eighty-one percent of dentists respond that they have considered such a limit. Dentists whose practice has less than 10% MHCP patients, those with smaller proportions of revenue deriving from MHCP, and those who report a net loss from participating in MHCP are the most likely to report that they have considered limiting their participation in MHCP.

Neither tenure nor availability are related to responses to this question. Dentists with a high commitment to MHCP are much less likely to say that they've considered limiting treatment of MHCP patients. Fifty-six percent of dentists with a high commitment and 87% of those with moderate or low commitments say that they have considered limiting their participation. It is worth noting that this difference is large, but it is also worth noting that a majority of dentists with a high commitment have

considered limiting their participation. These results suggest that without serious reform, MHCP patients who do not have a regular dentist are apt to face increasing difficulty finding one.

Ratings of the performance of DHS and the health plans

Another question asks respondents to rate the performance of the plans in which they participate, including DHS, on various dimensions. These dimensions are overall performance, the provider relations department, respect for the provider's judgement, opportunities for input, paperwork, credentialing, promptness of pay, and fee schedule. Figure 4 shows the mean ratings of overall performance, which is fairly typical of the evaluations of the other dimensions, and the 95% confidence intervals for the means. The size of the interval results largely from the number of respondents: more respondents lead to smaller confidence intervals and more precise estimates of the mean. Response options are (1) terrible, (2) poor, (3) fair, (4) good, and (5) excellent. Itasca obtains the highest overall rating, followed by Altru, Health Partners, Medica, Delta, and DHS. Comparing the confidence intervals for the evaluations reveals that Itasca, Altru, and HealthPartners cannot be reliably distinguished from each other; Medica is significantly lower than these three and significantly higher than DHS; Delta does not differ significantly from either Medica or DHS, but its mean is closer to that of DHS. Although a definitive explanation of this finding is unlikely, it is clear that larger organizations receive lower evaluations. Unfortunately, there is little that can be done about the size of DHS, but perhaps actions can be taken to make it feel less like a large, centralized bureaucracy to the dentists and their staff.

A statistical technique, multiple regression, can be used to shed light on the relative importance of the dimensions in forming the overall evaluation. Regressions are estimated within payers, averaged over payers, and adjusted for ease of understanding to yield the entries in Figure 5. These coefficients can be interpreted roughly as indicators of the unique contributions of the different dimensions to the overall evaluation. The largest and most consistent effects are those of the provider relations department. It appears, therefore, that having an effective provider relations department is an important issue in gaining the approval of participating dentists.

Figure 4. Confidence intervals and means for overall evaluations of payers

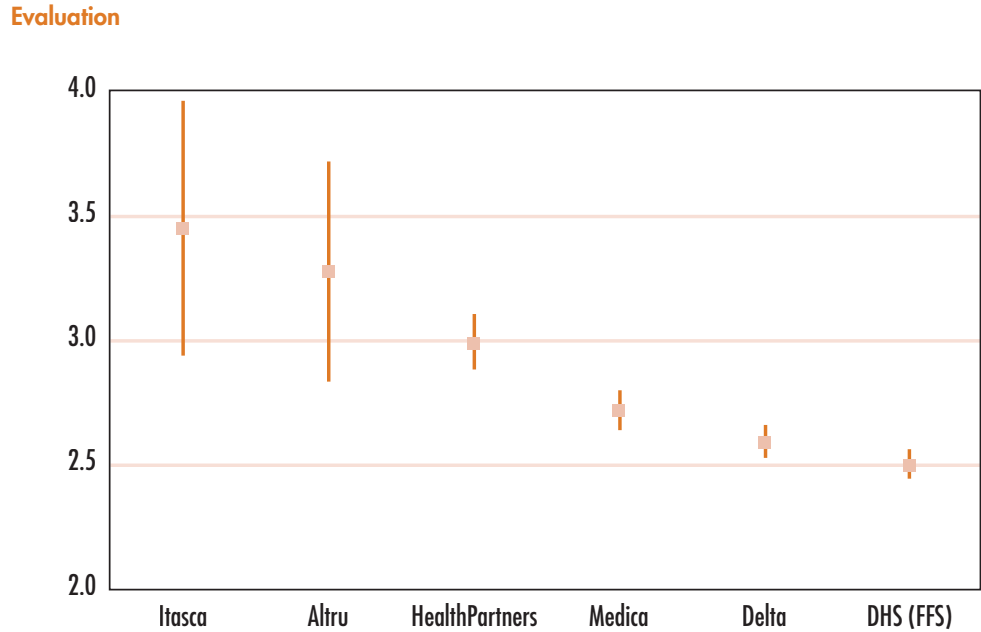
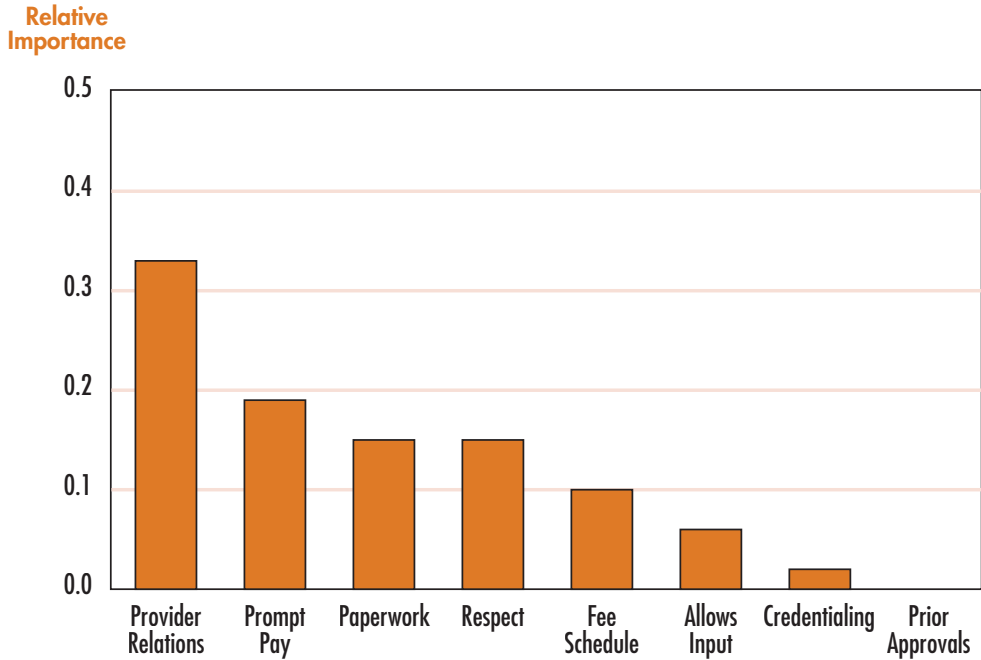


Figure 5. Relative importance of various dimensions for the overall evaluations of plans. (Values sum to 1.0)



Respecting dentists' judgements, simplifying paperwork, and paying promptly have significant effects for four of the payers. Of these, prompt payments seems to be the most important (as indicated by the size of the average standardized coefficient), followed by paperwork and respect. Fee schedule attains significance for Itasca, Delta, and DHS, allowing input only for DHS, and prior approvals only for Health Partners. Credentialing does not affect the overall evaluation for any of the payers, although this question was not asked about DHS, which does not have a credentialing process beyond state licensing requirements.

The ubiquitous effects of the provider relations department contrast sharply with the less frequent

effects of the fee schedule. Part of this is probably due to the greater variation of responses to the question about provider relations departments. While these results suggest that emphasizing provider relations would probably improve dentists' evaluations, doing so in lieu of increasing fees might result in very positive relations with a very small number of dentists. Nevertheless, trying to give provider relations a more personal feel would probably be a worthwhile endeavor.

The implications of the relations of the overall evaluations with tenure, availability, and commitment are mixed. Those with more tenure and less availability tend to provide more positive evaluations, but those with higher commitment also give more positive evaluations.

Table 5. Usual, acceptable, and DHS fees (in dollars) for various procedures.^a

Procedure	Usual	Acceptable	DHS ^b	Usual-Accept ^d	Accept-DHS ^e
Topical fluoride (child)	23	21	14	2	7
Bite wing X-rays (2)	26	23	c	3	
Periodic oral exam	27	24	12	3	12
Sealant (per tooth)	28	25	17	2	8
Prophylaxis (child)	36	32	18	3	14
Initial exam	37	33	c	4	
Comprehensive oral exam	40	36	16	4	20
Prophylaxis (adult)	53	48	27	4	22
Amalgam	63	58	29	6	29
Extraction	86	78	34	8	45
Complete upper denture	942	860	474	82	386
Mean	124	113	71	11	60

^a Values are expressed in dollars.

^b Fees paid by DHS in 2001 for fee-for-service Medicaid patients.

^c DHS no longer has a set fee for these services.

^d This is the difference between the usual and acceptable fees.

^e This is the difference between the fee that dentists would accept and what DHS pays.

Reimbursement rates

Dentists' loudest complaint about MHCP is the fee schedule. To investigate what dentists would regard as acceptable, they were asked, "What would you consider a reasonable fee from ...[MHCP] for the following procedures? Also, please list your usual and customary fee for each procedure in whole dollar amounts." Table 5 lists the mean values of the usual and acceptable fees for 11 procedures, the mean difference between them, the fee paid by DHS for fee-for-service Medicaid patients, and the mean difference between the DHS fee and dentist's acceptable fee. Inspecting the first three columns shows that dentists, on average, are willing to accept a bit less than their usual fee for MHCP patients but that the state expects a much deeper discount. The difference between the usual and acceptable fees, shown in the fourth column of the table, is about 9% of the usual fee, suggesting that dentists are willing to give the state a 9% discount. The state expects a much larger one. The entries in the fifth column, which show the difference between what the state pays and what dentists regard as acceptable, are much larger than those in the fourth column. In fact, the state wants a discount that is about five times larger than what dentists want to give. It is difficult to imagine how dental access for MHCP patients can be improved without substantially narrowing this gap.

Another way to see this is to calculate the proportion of dentists whose acceptable fee is equal to or less than the DHS fee. For seven of the nine items, this proportion is less than 1%; for the other two, it is between 1 and 5%. The vast majority of dentists are providing services for less than they consider acceptable.

The next question asks, "If program fees from ...[MHCP] would be set at levels you indicate as acceptable, would you participate in these programs?" The majority (62%) of dentists say yes, about a third (34%) say maybe, and only 4% say no.

The relationship of commitment with this question suggests even more strongly that there is a group of dentists in Minnesota who are very unlikely to serve MHCP enrollees. Only 25% of dentists who exhibit a weak commitment to MHCP patients say that they would participate if the fees were acceptable, whereas 64% of those with a moderate commitment and 87% of those with a strong commitment are willing to do so. Efforts to expand MHCP enrollees access to dental care would do well to recognize that the most fertile ground for expansion lies with the pool of dentists who already participate in MHCP, rather than with those who have resisted participating in the past. In fact, state policy (DHS 2001) is already moving in this direction: a recently instituted policy increases rates by 40% for dentists who provide substantial amounts of services to MHCP enrollees.

Neither tenure nor availability is associated with willingness to see MHCP patients.

Possible Improvements

Another question asks respondents to express their level of agreement with various ways of improving access to dental services, with response options: (1) strongly disagree, (2) disagree, (3) neither agree nor disagree, (4) agree, and (5) strongly agree. The mean scores, presented in Table 6, are considerably lower than those that assess the extent of problems in MHCP (Tables 2 and 3). This suggests considerably greater consensus on the problems facing MHCP than on solutions to the problem of increasing access, at least without a substantial infusion of money into the program. The only item endorsed by more than half of the responding dentists is one that proposes building a new clinic in their area for MHCP patients. However, only 33% of dentists would consider volunteering their time at such a clinic. Respondents were least supportive of measures which expanded the roles of others into the traditional province of dentists. This question did not ask about increased fees because the endorsement of that item by almost all, if not all, dentists is a foregone conclusion. Dentists' responses to open-ended questions indicate that the fee schedule is an overriding concern.

Table 6. Mean scores for proposed methods of improving access.

Item	Mean*
Support new clinic for MHCP patients	3.62
Would consider volunteering at clinic for MHCP patients	2.78
Would support creation of mid-level practitioner	2.31
Would support expansion of pediatrician’s role	2.20
Would support expansion of roles of other medical practitioners	2.09
Would support expansion of dental hygienist’s role	2.01

*A high score indicates agreement. Means can vary from 1 (strongly disagree) to 5 (strongly agree).

Table 7. Effects of tenure, availability, and commitment on proposed methods of improving access.*

Item	Tenure	Availability	Commitment
Support new clinic for MHCP patients		—	—
Consider volunteering at MHCP clinic	—		—
Support creation of mid-level practitioner		—	
Support expansion of pediatrician’s role			
Support expansion of other medical roles			
Support expansion of dental hygienist’s role		—	+

*A “+” indicates that dentists with greater tenure, availability, or commitment exhibit higher means. A “—” indicates that dentists with less tenure, availability, or commitment exhibit higher means. A blank indicates that the relationship is absent or mixed.

Table 7 summarizes relations of these potential improvements with tenure, availability, and commitment. Unfortunately, the only solution endorsed by a majority of respondents — opening new clinics for MHCP patients — is disproportionately endorsed by the unavailable and the uncommitted. However, this option is supported by a majority of dentists in all categories, including the available and the committed. The highly committed disproportionately favor expanding the roles of dental hygienists, but this change is not favored by a majority of dentists in any category. In fact, the lack of support for these options means that the associations can offer little guidance for action.

Respondents were given a brief explanation for Rule 101 and then asked, “If this requirement were rescinded, how could the State assure that dental access for these groups be preserved and expanded?” The question was open-ended, so respondents answered in their own words. By a wide margin, dentists reported that fees should be raised; 60% of dentists mentioned that higher fees would improve access. The next three most frequently offered responses were mentioned by less than 10% of respondents: establishing government clinics (8%), eliminating unfair treatment of dentists by DHS (7%), and eliminating red tape (5%).

These responses highlight how difficult improving access is likely to be. Raising fees is likely to increase access, but the effect is likely to be less than some might expect. Only 25 % of those with a low commitment said that increased fees would lead to their participation. While a much higher proportion of those with moderate or high commitments said that they would participate if fees were higher, they already are participating, although probably at levels lower than what might be achieved with higher fees.

Of the less frequently mentioned suggestions offered by at least 5% of respondents, establishing government clinics might be the most promising way to improve access. However, it has the potential disadvantage of explicitly creating a second tier of dentistry for MHCP patients. Eliminating “unfair treatment” of dentists by DHS is unlikely to improve access, since dentists are referring, at least in part, to laws and rules designed to compel them to treat MHCP patients for less than their usual fees. Eliminating such rules and laws might well improve the well-being of dentists and perhaps the supply of dentists in the long-term, but the short-term consequence is apt to be a decline in access. Complaints about red tape are common with all government programs, but eliminating the paperwork is unlikely. The form which dentists or their staff complete is simpler than the one that physicians file for medical care, and DHS has taken steps to simplify the process further through the use of electronic media. Any further simplification would be helpful.

Mentions of fees do vary by tenure and commitment but not availability. Dentists who have practiced less than 15 years are less likely than their older colleagues to mention fees (53% vs. 63%). The relationship with commitment is complex; 64% of those with a moderate commitment mention fees, while 53% of those with low and high commitments do so.

Commitment to MHCP

The previous section shows that the level of commitment is closely associated with various opinions and presumably behaviors involving MHCP. This section examines how commitment varies by other factors. Of special interest to the state is whether any geographic regions have a disproportionate number of dentists with low commitment. Such areas, especially those with low population density and a correspondingly low density of dentists, would face enormous problems if the dentists who practice in such areas exhibited low commitment. Fortunately, such is not the case. Dentists in the regions around Duluth and Willmar are more committed than elsewhere, and those in Grand Forks and St. Cloud tend to be moderately committed, avoiding both low and high levels of commitment.

Three other important considerations are tenure, availability and whether the dentist treats children. Fortunately, younger dentists are more likely than others to exhibit a high commitment; this suggests that new dentists will also be highly committed to serving MHCP patients. Dentists who are available and those who treat children are more likely than others to exhibit moderate commitment. Those with high and low commitments are roughly evenly split by availability and willingness to treat children. Although these relationships do not imply the best of futures for MHCP, neither do they imply the worst.

SURVEY OF CONSUMERS

Methods

Six questions on dental care within the prior six months were added to the Consumer Assessment of Health Plans (CAHPS) Medicaid Core Module, a widely used instrument for measuring the experiences of Medicaid enrollees with health care. The Minnesota Health Data Institute administered the survey via mail and telephone to enrollees in MHCP between March and May, 2001. The sample was stratified by program, health plan, region, and age. Response rates for the different MHCP programs vary between 42% and 52%. Separate but analogous questionnaires were sent for adults and children. The guardians of children (parents or others who are responsible for the children) completed their questionnaires. A total of 12,041 people responded to the survey. The Minnesota Health Data Institute (2001) provides a report on CAHPS and additional details on methodological matters.

Results

Need for care

Respondents were asked whether they or their selected child needed dental care in the previous six months. Less than half responded that they or their children needed care: 43% of adults reporting on their own experiences and 50% of guardians reporting for a child said there was a need for care. This is a difficult item to interpret, since guidelines for preventive care generally recommend a visit every six months. Since most respondents denied a need for care, they either do not accept the guidelines or they responded in terms of needing care for a specific problem. Either way, this highlights the need for education about the benefits of preventive care.

We examined how responses to this and other questions in the survey vary by region (the metropolitan Twin Cities area and Greater Minnesota), ethnicity (African American, American Indian, Asian American, and white), respondent's education (grade school, some high school, high school graduate, some college or trade school, college graduate, and post-graduate), and respondent's age

(18-64 and 65+). Adults in the Twin Cities report more need than do their counterparts in Greater Minnesota. African American guardians report less need for children than did those of other ethnicities, and Asian Americans and American Indians report less need for themselves than do those of other ethnicities. Reported need among both adults and children increases as education increases. Older adults report less need. Since we know that African Americans, American Indians, and those with less education tend to have more dental problems, it is clear that this question functions more as an indicator of acceptance of the norm of semi-annual dental visits than as an indicator of physical need for dental care. In that sense, little can be learned from this question about the prevalence of dental disease. What can be learned is that considerably more should be done to educate MHCP enrollees about the need for preventive dentistry.

Getting care

The next question asks if respondents or children who needed dental care were able to get it. Among those who expressed a need for care, whether preventive or restorative, 88% of children and 81% of adults were able to get it. From another perspective, though, one in five adults and one in ten children who identified a need for care did not get it.

Success does not vary by region but does vary by ethnicity, education, and age. American Indian children and African American adults are less likely than others to get care. Those with more education are more likely to get care for themselves and their children, and adults over the age of 64 are more likely than their younger counterparts to get care.

Members of ethnic minorities are less likely to define themselves as needing care; among those saying that they need care, they are less likely to get care. Together, these findings suggest a process with disastrous consequences for the health of these groups. They indicate a causal process in which serious dental disease is the only feedback loop operating to alter the cycle. Many members of minority groups do not recognize the need for care until there is a problem.

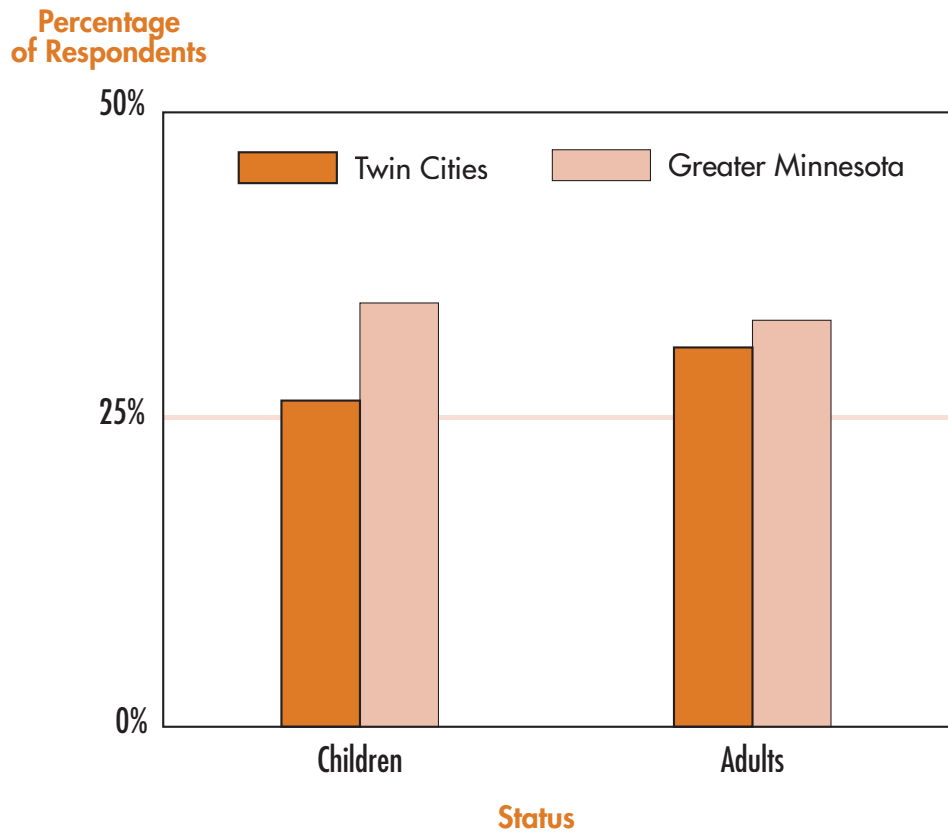
But when a problem surfaces, it is difficult for them to access care. Given the inability of the system to respond to their needs, they probably become even less likely to define themselves as in need of care, and the cycle continues until serious disease or some other factor intervenes. The state must interrupt this sort of spiraling process if it has any hope of reducing ethnic disparities in dental health.

Problems getting care

Those who got care were asked, “In the last six months, how much of a problem, if any, was it to find a convenient dental office/clinic to go to?” The response options were: a big problem, a small problem, and not a problem. Responses for adults and children are indistinguishable and show that 17% describe the problem as big and 14% describe it as small. Thus, about one in three MHCP enrollees who obtain dental care has some trouble finding a dentist.

The Department’s report (DHS 2001) notes that many rural counties face a severe crisis in access, since many counties with few dentists have even fewer who are willing and able to serve MHCP patients. The survey confirms that the problem is more prevalent in Greater Minnesota than in the Twin Cities, and this difference is larger for children than for adults (Figure 6). For both adults and children, Asian Americans are more likely and whites are less likely than others to report that this is a problem. This provides additional evidence for the negative causal loop for minorities discussed earlier. The effect of education

Figure 6. Percentage of those receiving care who had difficulty finding a convenient dentist.



is curvilinear and not significant for children; as education increases, the likelihood of reporting a problem increases, but those with college degrees are less likely than those with some college to report a problem. Adults over the age of 64 are less likely than their younger counterparts to report a problem.

Respondents who got care were asked, “In the last 6 months, how much of a problem, if any, was it to get an appointment with a dentist?” Responses for adults and children were indistinguishable and show that 17% describe the problem as big and 14% describe it as small. About one in three people who got care had trouble getting an appointment. Guardians of children in Greater Minnesota report more problems than do residents of the Twin Cities, but differences among adults are not significant. American Indians are more likely than others to report difficulty getting appointments for children, and Asian Americans are less likely than others to say that they had a big problem getting an appointment for themselves. Differences by educational level are not significant for children and nonlinear for adults; the pattern is very similar to that reported above for finding a dentist. Respondents over the age of 64 report less difficulty getting an appointment.

Evaluations of care

Respondents who got care were asked to rate it on a scale of 0 to 10, where 0 is the worst and 10 is the best care possible. Ratings of care are very positive. The mean for children is 8.0, and the mean for adults is 7.9. Ratings do not vary by region for adults or children or by ethnicity for children. In evaluating their own care, African Americans gave the highest evaluations, followed by whites and others, with Asian Americans giving the lowest evaluations. It seems likely that these differences reflect expectations as much as they do the quality of care. Differences by education are significant but show no clear pattern, other than that the evaluations of guardians with a grade school education are quite low. Evaluations of those over 64 are quite positive.

Barriers to care

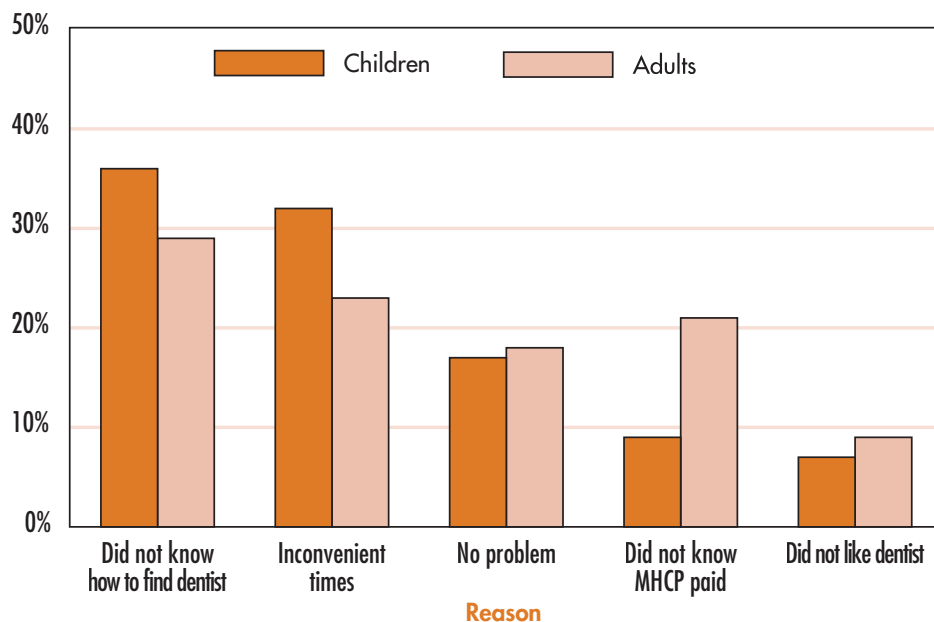
Those respondents who did not receive care in the prior six months were asked, “...what is the main reason you did not receive dental care for yourself?” Response options were (1) “I did not know my health plan paid for the dental services I needed,” (2) “I did

not know how to find a good dental office/clinic,” (3) “I only see a dentist when I have a problem with my teeth,” (4) “The dental office/clinic was not open at a convenient time,” (5) “The dental office/clinic did not have an appointment available at the time I could go,” (6) “I do not like the current dentist that I go to,” and (7) “I did get care from a dentist in the last 6 months.” Any classificatory scheme should satisfy at least two criteria: categories should be mutually exclusive and they should be exhaustive. The response options offered for this question are neither. The fourth and fifth categories overlap considerably, and any number of responses do not fit into a category. For example, respondents who forgot, who were too busy, or who visit the dentist annually do not have reasonable choices. These flaws severely limit the utility of this potentially useful question.

The most frequently chosen response was, “I only see a dentist when I have a problem with my teeth,” which was chosen by 39% of guardians and 63% of adults. This result seems to indicate that a high percentage of respondents see no need for preventive care. However, the numbers are probably too large because of the flawed design of the question. Some respondents might well have chosen this option because it came closest to their preferred response. In effect, the first question in this series asked, “Did you need care.” Those who said no were then asked “why didn’t you get care?” This option would probably be the closest approximation to their desired response, even though they might see benefit in preventive care.

To reduce the impact of this problem, we examined the responses of those who said that they needed but did not get care. Because the fourth and fifth options are so similar, we combined them into a category called “inconvenient times.” Figure 7 shows the distribution of responses. The most frequent response for children (36%) and adults (29%) is not knowing how to find a good dentist. Respondents also report considerable difficulty with inconvenient times (the hours of the clinic or the timing of appointments).

Figure 7. Reasons for not getting care among those who needed but did not get care



Regional differences are not significant for adults but show a pattern similar to that observed for children. The most frequent response for children in the Twin Cities is that there was not a problem meriting care. However, in Greater Minnesota, the most frequent response is that the respondent did not know how to find a dentist. This problem is undoubtedly a function of the limited supply of dentists rather than the respondents' faulty search procedures.

Ethnic differences also are significant for children and insignificant but similar for adults. African Americans are more likely to have problems with times, whites are more likely to have difficulty finding a dentist or clinic, and Asian Americans are more likely to report that they only seek help when there is a problem.

Educational differences are significant for adults but not children. Respondents with grade school educations are more likely to report that they only see a dentist when there is a problem, respondents with high school or some college are disproportionately unlikely to find a dentist, and respondents with college degrees or more tend to report difficulty with times.

Finally, adults over the age of 64 are more likely to report that they only see a dentist when there is a problem. This may reflect attitudes from an earlier era when preventive care received less emphasis.

Overall, these results underscore the importance of educating enrollees about the importance of preventive work and ensuring an adequate supply of dentists. As the Department's report (DHS 1999) notes, the issue is clearly one of supply and demand: both must be increased.

DISCUSSION

The results of these two surveys paint a picture of dentistry in Minnesota that is unlikely to solve the Surgeon General's crisis in the near future without a substantial infusion of funds, structural change, and educational efforts. Given that none of these is likely to occur, the crisis is apt to continue and Minnesota's attack on disparities in health is apt to fail, at least regarding dental health. As the Surgeon General makes clear, dental health profoundly affects all aspects of health.

This is not to say that the future outlook is entirely gloomy, because there are reasons for optimism. A substantial minority of dentists exhibit a high commitment to MHCP patients, and a majority exhibit a moderate commitment. Furthermore, younger dentists, who are more likely to resemble dentists just entering the field and are apt to have a larger impact on the future, are more likely to be highly committed and to hold attitudes that are favorable to MHCP.

Ultimately, it is likely that eliminating disparities depends on eliminating the underlying social and economic inequalities that give rise to the disparities (Link and Phelan 1995). This is unlikely, at least in the near future. Given that, the most obvious strategy to reduce disparities in health is to reduce disparities in the rewards offered for care. It probably is naive to expect that a portion of a dollar can buy the same dental health that a dollar buys. Dentists repeatedly tell us that it does not, and a substantial body of research provides every reason to believe that they are telling the truth. But the current political and economic climate probably precludes the type of spending that this solution implies. What then can be done?

The report to the Minnesota Legislature submitted by DHS (2001) contains many thoughtful suggestions that merit consideration. The recommendations of that report are included in the Appendix to this report. We note that solutions which acknowledge that some dentists show low levels of commitment to MHCP and which focus on those dentists with higher levels of commitment are more likely to achieve success efficiently.

The survey of dentists provides some insight about how the state might proceed. The assessments of

problems suggest that important areas to improve are reimbursement rates, broken appointments, denials of payment, and managed care contracts. The report to the Legislature by DHS (2001) discusses these problems, and the results of the survey highlight the importance of that discussion. The suggestion by DHS (2001) that fees increase as the number of MHCP patients seen increases seems especially appropriate.

Dentists' evaluations of payers suggest that improving the provider relations department would be a worthwhile exercise, since this is so central to the overall evaluations. It would be foolish to invest substantial resources which could be used to increase fees in this area, but some improvements could probably be made without large investments of resources. A study of the departments at payers which receive considerably higher ratings on this dimension would be useful and might identify practices that merit adoption.

The evaluations of consumers paint a picture that is both gloomy and positive. The gloomy aspects come mainly from the low proportion of respondents who saw a need for care, and the large proportion of those who saw a need for care but were unable to get it because they could not find a dentist. That members of minority groups were especially likely to be in both of these groups adds to the gloom. Educational efforts to convince participants in MHCP, especially minorities, that preventive care is a need are essential. Enhancing the supply of participating dentists so that interested enrollees can find a dentist will involve the sorts of structural changes suggested in the report to the legislature, especially increased payments to dentists.

On the bright side, the evaluations of care received were quite positive, and most respondents who defined themselves as in need of care were able to get it. Even on this issue, though, about one-third of those who were able to obtain care had difficulty finding a dentist.

Data from these two surveys show clearly that Surgeon General Satcher's crisis exists in Minnesota. Without the types of interventions recommended by DHS (2001), that crisis is likely to be with us for some time.

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APPENDIX

Recommendations from Dental Access for Minnesota Health Care Programs Beneficiaries: Report to the 2001 Minnesota Legislature

The author (Epstein 2000) of a recent comprehensive national study of states' approaches to improve dental access for Medicaid beneficiaries concludes:

“(States are using multiple approaches to increase Medicaid beneficiaries’ access to dental services, as each approach offers only a partial solution. At a minimum, all states should have Medicaid rates that are competitive with commercial rates.... However, rate increases alone are typically not sufficient to increase access. The best, most effective combination of approaches is contingent upon the historical, demographic, economic, political and technical conditions of each state, market and community.”

Based on its 1½ years of study, DHS concurs with this conclusion. With input from the Dental Access Advisory Committee, DHS has developed a single, overarching strategy to increase dental access in ways that best address the conditions unique to Minnesota.

Many of the recommendations are interdependent. While some individual recommendations may improve dental access marginally, DHS recommends that all be implemented in their entirety to achieve an increase in access that will make a significant improvement in the oral health of MHCP beneficiaries. Clearly, some strategies will have to be phased in as funding allows.

1. Improve financial incentives to dentists.

a. Restructure payment rates to cover overhead costs and reward providers who maintain or increase access.

The Legislature should fund the testing of whether access would be improved by increasing payment rates to cover dentists' overhead costs and provide additional financial incentives to providers who maintain or increase services to MHCP beneficiaries. Rates should reflect the facts that dentists find

MHCP beneficiaries more difficult to treat than commercially insured and cash-paying patients, and MHCP beneficiaries have higher appointment failure rates, yet dentists cannot recover the costs of these failures through billing the patient or third parties. Tests should be conducted in limited geographic areas. Consideration for expansion should be given only upon favorable, pre-established results. It is recognized that this increase is necessary but not sufficient by itself to significantly improve Minnesota dentists' participation in MHCP. Other strategies must be employed to achieve a meaningful increase in participation.

b. Evaluate the establishment of tax incentives for providers who treat MHCP patients

Many Minnesota dentists say they would find additional incentive to treat MHCP patients if they were able to take a tax credit. DHS should work with the Minnesota Department of Revenue to explore the feasibility of using tax incentives for dental providers, specifically through the individual income tax program, and the MinnesotaCare provider tax program. In addition, as an alternative to compensation for missed appointments through the MA program (which are prohibited by Medicaid regulations), tax write-offs should be explored.

c. Test the benefit of higher payment levels for high volume MHCP providers.

DHS should test one or more graduated incentive program models. These models would tie higher payments to providers' performance in increasing access. Consideration should be given to the two models proposed by the Advisory Committee work group, described in Appendix D. These models reward providers who provide significant amounts of services to MHCP patients. Tests should be conducted in limited geographic areas. Consideration for expansion should be given only upon favorable, pre-established results.

The primary hypothesis to be tested is that rewarding providers for doing more volume will gain additional access for MHCP beneficiaries.

d. Test the benefit of alternative ways of purchasing dental care

Currently, DHS employs two basic methods of purchasing dental services: contracting with risk-based health plans for dental services as part of comprehensive health plan benefits, and direct fee-for-service payments to dental providers. DHS should test one or more purchasing models that are substantially different from the current models. These models could include risk- and non-risk-based contracts with dental benefit organizations, direct contracts with providers, and modifications to the fee-for-service system. Models tested may include the enhanced payment concept described in Recommendation 1.a. Because data indicate that dental utilization is higher for MHCP beneficiaries enrolled in prepaid health plans than under fee-for-service, in any model where dental services are carved out of the managed care contracts, DHS should not consider returning these services to the existing fee-for-service system.

The tests should examine whether the model(s) increase access to care through such means as increased acceptance by providers, increased engagement of patients, new outreach methods, better care management models, etc. Evaluations of any models involving carve outs should include examination of the effects on the integration of health care and dental services.

In addition to exploring its own new ways of purchasing dental care, DHS should encourage and assist county-based purchasing projects to employ novel purchasing techniques and monitor their results for consideration for future state purchasing methods. In its current managed care contracts, DHS should experiment with additional contract provisions that would hold contractors more accountable in maintaining and expanding access to dental care for their enrollees.

e. Relieve administrative burden

DHS should continue its efforts to simplify MHCP requirements on providers. DHS should convene its health plan contractors and their dental subcontractors to identify administratively burdensome procedures and policies and seeking ways to mitigate their effect on provider participation in MHCP.

2. Preserve and expand the capacity of “safety-net” providers.

a. Maintain the level of reimbursement for Federally Qualified Health Clinics on a cost or other enhanced basis

The Legislature should reverse the negative financial impact of the Balanced Budget Act, which is phasing out cost-based reimbursement, with complete phase-out scheduled by 2004. The Legislature should do this by either:

- 1) appropriating state funds to reinstate payment levels to the pre-Balanced Budget Act (as modified by the Balanced Budget Refinement Act of 1999) level of 100% of reasonable costs; or
- 2) appropriating state funds and establishing a new prospective payment system that restores payments to approximate pre-Balanced Budget Act levels.

Stabilizing the funding for safety-net providers ensures the viability of FQHCs, whose dental operations are often the most financially fragile part of the clinic.

b. Establish mobile or other types of outreach clinics for underserved areas of the state

The Legislature should appropriate funds for purchasing equipment to establish mobile or other types of outreach clinics. Funds would be allocated as grants, targeted at areas with the greatest access problems. Ideally, these clinics should be operated by non-governmental entities.

Mobile clinics (and portable dentistry) are a solution that can be quickly implemented, particularly in areas where the number of dental practices are most rapidly declining. One unit could “circuit-ride” several

communities, allowing for continuity of care through regularly scheduled visits. This type of clinic is particularly advantageous for serving nursing home and non-ambulatory patients.

c. Explore the expansion of school-based dental clinics

Should state grant funds become available, DHS and MDH should determine whether the expansion of school-based clinics would improve access. Proponents believe these clinics would be effective because they have a “captive audience,” and would allow access to children who otherwise wouldn’t be seen in a dentist’s office due to the parent’s inability to get an appointment or lack of knowledge of the value of preventive dental care. These clinics may provide a logical venue for non-traditional providers to apply sealants and fluoride applications.

Models incorporating new ways of providing school-based dental screenings should be explored, including the provision of oral screenings (with referrals to dentists as necessary) by a dental auxiliary simultaneously with other types of screenings conducted in schools, such as hearing or vision.

d. Explore the development of a volunteer dental network

If grant funds become available for dental access projects, consideration should be given to awarding funds to establish a network of volunteer dentists to treat MHCP beneficiaries. Such programs have been established in several other states, and are further described elsewhere in this report.

e. Experiment with new ways to deliver dental care based on partnerships with local providers and public health agencies

The Legislature should appropriate funds to develop and implement one or more pilot projects to test new delivery models employing clinics integrating county public health agencies. The Dental Access Advisory Committee has proposed one such model, in which a clinic would be opened in a public health facility to serve one or more counties. Oral assessments and preventive services would

be provided to all patients where necessary, and for those needing restorative services, the clinic dentist would prepare a written treatment plan and refer the patient to a local dentist. County public health or human services would help assure patient compliance with keeping appointments and adhering to treatment plans through supporting the patient with transportation, interpretation, education, and case management. Local dentists may be more willing to see patients for restorative services knowing they are being supported by such a model.

Development of this model should occur through a partnership with the Local Public Health Association and the State Community Health Services Advisory Committee. Local collaborative funds and future receipt of federal Children’s Health Insurance Program (CHIP) funds may be the means of funding this demonstration. This model could be staffed using new models of practice described in Recommendation 3.b.

f. Initiate expedited payment for high volume MHCP providers

DHS and the health plans should create a means to expedite payment for those providers who see large volumes of MHCP patients to assure sufficient cash flow to maintain their level of services. This is particularly important because such providers often have no, or a much smaller privately insured or cash patient base, to offset outstanding payment for MHCP patients. This measure will help safety-net providers avoid cash flow problems that cause delayed payments to staff, suppliers, etc. Currently, some safety-net providers must obtain short-term bank loans to cover their obligations while awaiting payment for services already provided to MHCP patients. Much of this problem is attributed to the unique “settle-up” method of reimbursing Federally Qualified Health Clinics.

3. Expand the dental workforce.

a. Encourage the licensure of qualified foreign-trained dentists

The Legislature should direct the State Board of Dentistry to study the modification of licensure

standards to encourage recruitment and licensure of qualified dentists trained outside the United States or Canada. Regulations should protect the high quality standards of dentistry currently enjoyed by Minnesotans. More than a dozen states have similar provisions in their licensing standards.

This action will make “more hands” available to provide dental services to Minnesotans, including MHCP beneficiaries. These standards would apply to foreign-trained dentists now living in Minnesota, but also would be an incentive for more foreign-trained dentists to relocate here. Many foreign-trained dentists may be well equipped to meet linguistic and cultural needs of MHCP beneficiaries.

b. Evaluate ways of expanding the capacity of the dental workforce through new roles for dental practitioners

The legislature should direct the State Board of Dentistry, the U of M School of Dentistry, the state’s dental auxiliary training programs, MDH, and other relevant stakeholders to identify and evaluate if and how dental access could be improved by realigning the roles of dental practitioners. Concepts to be examined include the “mid-level dental practitioner,” and the expansion of the roles of the dental hygienist and/or the dental assistant, both of which are described elsewhere in this report.

It is imperative that scope of practice and employment issues that arose in previous such efforts are resolved prior to the establishment of any new training programs.

c. Designate additional dental Health Professional Shortage Areas

MDH should continue its pursuit of the designation of additional dental Health Professional Shortage Areas (HPSAs). Additional designations increase Minnesota’s opportunities for federal funds for dental education. This action would facilitate federal and state dental scholarship and loan forgiveness programs.

MDH and DHS should also lobby federal officials on the need for a new federal formula that factors in managed care and Medicaid in HPSA designation criteria.

d. Implement a state loan repayment/scholarship program to attract dentists willing to treat MHCP patients

The Legislature should appropriate funds for a state loan repayment and scholarship program as incentives to dental students who agree to serve MHCP beneficiaries and other low-income patients. MDH would administer the program. This Recommendation should be considered a long-term solution, and it must be recognized that new dental practices are by nature not as productive as established ones.

e. Establish a state-funded loan program to encourage new graduates to establish practices in underserved areas

The Legislature should appropriate funds for loans to be made to new dental graduates to open or acquire dental practices in areas of the state with low access. Qualifying dentists would agree to accept a substantial number of MHCP patients and other low-income patients. The rate of the loan would be set at lower than market.

f. Establish conditions for the receipt of Medical Education Research Committee (MERC) funds that promote improvements in dental access

DHS and MDH should explore the development of new conditions for acceptance for the schools which receive Medical Education Research Committee (MERC) funds. The new conditions would require those schools to use a portion of the funds for educational activities and programs that will improve dental access for MHCP beneficiaries.

g. Explore available grant funding for studies of the state dental workforce

DHS and MDH should explore the availability of grant funding from non-state sources to study the adequacy of Minnesota’s present and future dental workforce. Other states have examined their population trends and projections of dental school graduations and, like Minnesota’s Dental Access Advisory Committee, have concluded that if present trends continue dental services will become less available for all state residents. These states have conducted, or are conducting, studies and will use the results in planning their dental educational systems.

Upon the availability of funding, MDH, the State Board of Dentistry, the U of M School of Dentistry, and the educational institutions with dental auxiliary training programs should proceed by discussing Minnesota's anticipated long-term needs for dental professionals in relation to the present and projected supply.

b. Involve primary care medical clinics in the dental treatment and outreach process

DHS should bring together interested groups to identify new ways for pediatricians, family physicians and nurse practitioners who see children to become more involved in their patients' oral health needs. Examples include the provision of oral health screenings and certain preventive services (such as the application of fluoride varnishes) for MHCP children when they are seen by their medical providers. Educational materials would be produced and distributed to the state's physicians and nurse practitioners. The Minnesota Academy of Pediatrics, the Minnesota Academy of Family Practice, the nurse practitioners' association, and the Minnesota Dental Association would make recommendations to their members. For many children aged 1-3, frequent, periodic visits to a pediatrician is their primary contact with the health care system. This recommendation capitalizes on that contact.

4. Engage the responsibility of beneficiaries.

a. Convene focus groups of beneficiaries to better understand their issues

DHS should convene focus groups on the topic of oral health in urban and rural areas of the state, and among cultural groups who make up the MHCP population. The results could be instructive for DHS, county public health and human services, and contracted health plans in modifying purchasing and delivery systems to increase access and utilization for MHCP beneficiaries.

b. Promote educational programs on the infectious and transmissible nature of dental disease

The Legislature should appropriate funds for the compilation and/or development of educational materials on the infectious and

transmissible nature of pediatric dental diseases, and the link between dental disease and overall health status for all ages. These materials would be used both for public health outreach and professional education (pediatricians, family practice physicians, nurse practitioners, and other health professionals), and would stress the importance of prevention, improve outcomes, compliance and reduce appointment failures.

Understanding these relationships may lead to changes in patient behavior resulting in reduced levels of pathology and a reduced demand for restorative services.

c. Experiment with methods of eliminating/reducing appointment "no shows"

DHS should convene a work group and secure voluntary commitments among health plans and dental subcontractors, county public health nursing agencies, dental clinics and individual providers to identify and test methods of eliminating or reducing appointment failures. Methods could include case management and support, use of public health nurses, assignment of "dental homes," incentives for patients who keep their appointments and cooperate with treatment plans, etc.

Reducing appointment failures would address one of the dentists' most frequently expressed reasons for refusing MHCP patients.

5. Develop a comprehensive state MHCP dental policy addressing needs analysis, benefit coverage, administration, purchasing.

a. Establish a permanent Minnesota Health Care Programs dental advisory committee

The Dental Access Advisory Committee has found value in the regular meeting of diverse stakeholders in the dental access problem, and suggests that DHS continue this type of meeting permanently to oversee implementation of dental access initiatives, monitor dental access and coverage policy, and make future recommendations. This committee would have liberal opportunities for the participation of private, working dentists who see MHCP patients on a regular basis. The committee would perform continuous

review of dental services policy; resolution or avoidance of conflicts as they emerge, and would strive to keep policy current with the dental community standard.

DHS recommends that this committee sunset at the discretion of Legislature or of the Commissioner of Human Services after six years, based on continued need for the committee.

b. Establish goals for increasing dental utilization

DHS, in consultation with dental and public health experts, should establish goals for dental utilization for MHCP beneficiaries. A baseline would need to be established, and based on assessment of resources, periodic goals to advance utilization levels toward those of Minnesota's commercially insured population should be established. These goals should be the cornerstone for all contracting for dental services. The goals would help DHS and the general public assess whether the State's reimbursement, coverage and purchasing policies are effective in increasing access.

c. Conduct a statewide oral health survey

The Legislature should appropriate funds for, or direct state agencies to obtain grant funding, to conduct a statewide oral health survey. The survey would cover such areas as:

- identification of high risk individuals,
- identification of populations lacking access by geographic area,
- identification of needs for health promotion and education programs for patients and providers,
- establishment of a base line for charting future progress,
- identification of access barriers, including high risk behaviors, knowledge levels and beliefs about oral health,
- identification of why patients keep and fail to keep dental appointments, and why they comply and fail to comply with treatment plans, and
- exploration of dental providers' attitudes regarding care for low-income populations.

The survey would be conducted through local public and private dental clinics and overseen by MDH, the U of M School of Dentistry, Minnesota Primary Care Association and the Minnesota Association for Community Dentistry. Such a survey has never been conducted in Minnesota, although other states have done so with positive results. Survey results would help target efforts to increase dental access. It would assist policy makers to know the depth and breadth of the access problem and would help in allocating resources and setting goals.

d. Establish a state dental data and dental studies clearinghouse

MDH and the U of M School of Dentistry should establish a clearinghouse to maintain uniform data for baseline impact studies and accurate and easy to find Minnesota-specific oral health data. This data would be valuable for impact studies and program planning. Information would be disseminated via newsletter, web site and an annual conference. This activity could be accommodated within the existing organization of MDH and U of M; new personnel would not be required.