MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2213

2005 SENATE HUMAN SERVICES

SB 2213

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2213

Senate Human Services Committee

❑ Conference Committee

Hearing Date January 18, 2005

Tape Number	Side A	Side B	Meter #
1	x		00-6115
		x	00-6011
2	x		00-0150
Committee Clerk Signature			

Minutes:

Chairman Lee opened the hearing on SB 2213

Testimony in favor of SB 2213

Dr. Kristin Kenner, President of the North Dakota Dental Association

See written testimony (Attachment 1 through 3) Dr. Kristin also passed around four color photos of children with untreated dental treatments.

There was general discussion on oral health being linked with other health issues. Many times the cost of treating health issues due to lack of oral treatment is far greater than taking care of the oral problem.

Chairman Lee suggested there should be an intermediate level of dental professional--someone between a dentist and an hygienist to help in rural areas with screening where there might be a lack of dentists. Dr. Kenner said to the lay person, that might appear to be a good alternative, but in her opinion, dental expertise is so specialized that it would not work

Chairman Lee still believes it would be better to have someone look at children rather than no one and still feels strongly about a mid-level person doing this.

Gina Nolte: Executive Director of the Red River Valley Dental Access Project in Fargo.

See written testimony (Attachment 4)

Ms. Nolte also explained how volunteer urgent care works in the Fargo area (tape 1 side A meter 2675-3210)

Jon Larson, Executive director of Enable, Inc.

See written testimony (Attachment 5)

Neutral Testimony on SB 2213

David Zentner, Director of Medical Services for the Department of Human Services.

See written testimony (Attachment 6)

Mitch Vance, President of the board of Bridging the Dental Gap.

Mr. Vance explained the organization of his company. He wanted to clarify that they are a 501 C(3). It is a community owned clinic and provide services on a sliding fee schedule. Initial investment was about $650,000. They must pay their dentist and oral hygienist the going rate for salary. His board hasn't considered this bill, but reminded the committee that there are over 24,000 people in the area who need the reduced rate. They've already served about 900 patients.

No more testimony: in favor, neutral or opposition

Chairman Lee closed the public hearing

There was some general discussion on how rates are set and if there is an inflation factor. These issues did not directly relate to this bill.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2213

Senate Human Services Committee

❑ Conference Committee

Hearing Date January 26, 2005

Tape Number	Side A	Side B	Meter #
3	x		1565-4900
3		x	2920-3200
Committee Clerk Signature			

Minutes:

Chairman Lee opened further discussion on SB 2213.

Maggie Anderson, Medical Services

Passed out Attachment 1 and explained how the report was compiled and what the claims represented.

There was further discussion on this attachment, especially the differences in the reimbursement percentages

Chairman Lee thanked Ms. Anderson and asked **Joe Cichy, lobbyist for Dental Association,** to explain the amendment.

Cichy: The bill removes the 75th percentile and changes it to 85% of billed charges. Then if that appropriation were made, that would go to the Department and then they would take a look at the fees and adjust the ones that they felt improve access to services to children.

Sen. Dever: Are rates pretty standard from one dentist to another? Since we're looking at only 75% of billed services without any schedule.

Cichy: We haven't done any fee surveys because we can't . The federal trade commission says that's no allowed. But there is a range of fees, and things like location and overhead effect this. This would allow the Department to establish a fee to entice the majority of dentists to participate. Overhead is responsible for about 65% of a dentist's fee.

Sen. Dever: Are recipient liabilities not being paid?

Cichy: That's my understanding

Sen. Brown: That kind of throws in a whole different wrinkle.

There was discussion about appropriated money for reimbursement and how to measure access; and bad debts. Sen. Lyson couldn't remember any lawsuits involving dentists.

Chairman Lee: I think we all agree we need to see more appropriate reimbursement; our challenge is to see how do this without making a mess for Appropriations.

Sen. Dever: What would happen to the fiscal note at the 85% proposal?

Cichy: When we calculated that, we thought it would be about $1 million., $500,000 a year.

Chairman Lee: We have two options: one to figure out how we're going to set a number to work with and recommend to Appropriations and the other is to make it very clear to Appropriations that this access issue and the reimbursement issue are serious ones and ask them to give it special attention and try to work closely with them.

Senator Holmberg came into the room and Chairman Lee asked his opinion on the funding for this bill. He gave his opinion and said this isn't a new problem and when it goes to Appropriations it will get the appropriate attention.

Senator Warner moved DO PASS on amendment on SB 2213, seconded by Sen Dever.

Sen. Brown: For children, reimbursement is already 73%, rather than going to 85% why don't we go to 80%? It wouldn't be quite so expensive and we'd get our foot in the door.

Sen. Warner: Should I withdraw my amendment?

Chairman Lee: Not yet, lets see what the other members think.

Sen. Lyson; I don't have real heartburn either way, but if this is going to Appropriations anyway, they'll be adjusting too, so is there a reason to 80%?

Sen. Warner: We're sending a signal allowing for a hearing on the issue; I don't expect this bill to pass the legislature.

Vote: 5 yeas, 0 nays, 0 absent

Senator Warner moved DO PASS on amended bill, seconded by Sen. Dever.

Vote: 5 yeas, 0 nays, 0 absent Carrier: Sen. Dever

FISCAL NOTE

Requested by Legislative Council
03/17/2005

Amendment to: Engrossed SB 2213

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$917,395	$0	$929,898
Expenditures	$0	$0	$496,157	$917,395	$540,761	$929,898
Appropriations	$0	$0	$496,157	$917,395	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2003-2005 Biennium			2005-2007 Biennium			2007-2009 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would create and enact a new section to chapter 50-24.1 of the NDCC relating to dental medical assistance reimbursement. It would require that dental services be reimbursed for allowed services at 75 percent of billed covered services based upon a profile of fees submitted during 2004. The bill would also require that the department establish a fee reimbursement profile that would maximize access to care.

The fiscal impact would be on the department's regular appropriation in medical assistance grants.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The department would receive Title XIX funds at the FMAP in effect during each federal fiscal year of the biennium; for 2005-2007 revenue would equal $917,395 and for 2007-2009 revenue would equal $929,898.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The effect of this bill for 2005-2007 would be to increase expenditures in medical assistance grants by $1,413,552 in total; the increased expenditures would be funded by general funds of $496,157 and federal title XIX funds of $917,395. For 2007-2009, total expenditures in medical assistance grants would increase to $1,470,659 funded by general funds of $540,761 and $929,898 of federal title XIX funds.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The effect of this bill for 2005-2007 would be to increase medical assistance grants appropriations by $1,413,552 in total; the additional appropriation would be funded by general funds of $496,157 and federal title XIX funds of

$917,395.

Name:	Brenda Weisz	**Agency:**	Human Services
Phone Number:	328-2397	**Date Prepared:**	03/18/2005

FISCAL NOTE

Requested by Legislative Council
02/02/2005

Amendment to: SB 2213

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$2,140,792	$0	$2,169,968
Expenditures	$0	$0	$1,157,809	$2,140,792	$1,261,897	$2,169,968
Appropriations	$0	$0	$1,157,809	$2,140,792	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2003-2005 Biennium			2005-2007 Biennium			2007-2009 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would create and enact a new section to chapter 50-24.1 of the NDCC relating to dental medical assistance reimbursement. It would require that dental services be reimbursed for allowed services at 85 percent of billed covered services based upon a profile of fees submitted during 2004. The bill would also require that the department should establish a fee reimbursement profile that would maximize access to care.

The fiscal impact would be on the department's regular appropriation in medical assistance grants.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The department would receive Title XIX funds at the FMAP in effect during each federal fiscal year of the biennium; for 2005-2007 revenue would equal $2,140,792 and for 2007-2009 revenue would equal $2,169,968.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The effect of this bill for 2005-2007 would be to increase expenditures in medical assistance grants by $3,298,601 in total; the increased expenditures would be funded by general funds of $1,157,809 and federal title XIX funds of $2,140,792. For 2007-2009, total expenditures in medical assistance grants would increase to $3,431,865 funded by general funds of $1,261,897 and $2,169,968 of federal title XIX funds.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The effect of this bill for 2005-2007 would be to increase medical assistance grants appropriations by $3,298,601 in total; the additional appropriation would be funded by general funds of $1,157,809 and federal title XIX funds of $2,140,792.

Name:	Debra A. McDermott	**Agency:**	Human Services
Phone Number:	328-3695	**Date Prepared:**	02/04/2005

FISCAL NOTE

Requested by Legislative Council
01/14/2005

Bill/Resolution No.: SB 2213

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$1,309,766	$0	$3,155,042
Expenditures	$0	$0	$708,364	$1,309,766	$1,834,744	$3,155,042
Appropriations	$0	$0	$708,364	$1,309,766	$1,834,744	$3,155,042

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2003-2005 Biennium			2005-2007 Biennium			2007-2009 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would create and enact a new section to chapter 50-24.1 of the NDCC relating to dental medical assistance reimbursement. It would require that dental services be reimbursed at the 75th percentile of billed covered services, which would be determined as of September 30th of each even-numbered year. Because the first base year would be September 30, 2006, there would be only 10 months of reimbursement in the 2005-2007 biennium.

The fiscal impact would be on the department's regular appropriation in medical assistance grants.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The department would receive Title XIX funds at the FMAP in effect during each federal fiscal year of the biennia; for 2005-2007 revenue would equal $1,309,766 and for 2007-2009 revenue would equal $3,155,042.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The effect of this bill for 2005-2007 is to increase expenditures in medical assistance grants by $2,018,130 in total; the increased expenditures would be funded by general funds of $708,364 and federal title XIX funds of $1,309,766. For 2007-2009, total expenditures in medical assistance grants would increase to $4,989,786 funded by general funds of $1,834,744 and $3,155,042 of federal title XIX funds.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The effect of this bill for 2005-2007 is to increase medical assistance grants appropriations by $2,018,130 in total; the additional appropriation would be funded by general funds of $708,364 and federal title XIX funds of $1,309,766. For

2007-2009, total medical assistance grants appropriations required would be $4,989,786 funded by general funds of $1,834,744 and $3,155,042 of federal title XIX funds.

Name:	Brenda Weisz	**Agency:**	Human Services
Phone Number:	328-2397	**Date Prepared:**	01/17/2005

Date: 1-26-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2213

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass amend/grant

Motion Made By Warner Seconded By Sen Lyson Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No Ø

Absent _____

Floor Assignment Sen. Lee Dever

If the vote is on an amendment, briefly indicate intent:

Amendment

Date: 1-26-05
Roll Call Vote #: 2

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2213

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass as amended

Motion Made By Sen Warner Seconded By Sen Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen Dever

If the vote is on an amendment, briefly indicate intent:

Tom Stacy

Date: 1-26-05
Roll Call Vote #: 3

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2213

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Sen Warner Seconded By Sen Lyson

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No ϕ

Absent ϕ

Floor Assignment Sen Dever

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2213: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2213 was placed on the Sixth order on the calendar.

Page 1, line 2, after "reimbursement" insert "; and to provide an expiration date"

Page 1, line 7, replace "at the seventy-fifth percentile" with "for allowed services for the 2005-07 biennium at the rate of eighty-five percent"

Page 1, line 8, replace ". The seventy-fifth percentile of billed covered services must be determined as of" with "based upon a profile of fees submitted during 2004. The department, with the moneys appropriated, shall establish a fee reimbursement profile that maximizes access to care.

SECTION 2. EXPIRATION DATE. This Act is effective through June 30, 2007, and after that date is ineffective."

Page 1, remove line 9

Renumber accordingly

2005 SENATE APPROPRIATIONS

SB 2213

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2213

Senate Appropriations Committee

☐ Conference Committee

Hearing Date 02/08/05

Tape Number	Side A	Side B	Meter #
1	x		4,621
Committee Clerk Signature			

Minutes: **Chairman Holmberg** called meeting to order on SB 2213.

Sen. Mathern appeared in support of SB 2213. Sen. Mathern was a cosponsor of this bill.

Rep Hawken appeared in support of bill. Rep. Hawken feels that this is an important bill that will offer suport for seniors.

No questions were asked of Rep. Hawken.

Dr. Kristen Kenner, President, ND Dental Association appeared in support of SB 2213. Dr. Kenner stated to the committe that she is a practicing general dentist from Devils Lake, and due to her experiences with her practice and patients, she supports this bill. Written testimony was provided, see appendix I. Along with Dr. Kenner's testimony are two letters of support submitted from Todd Twogood, MD, ND American Academy of Pediatrics and Nola Storm, Social Worker.

Sen. Robinson: (2300) Have you been impacted my Meth?

Dr. Kenner I haven't, however, its out there and I know its coming.

Sen. Thane: (2686) Do Dentists specialize in testament for the disabled, if so will this improve the problem or will people still be reluctant to keep appointments?

Dr. Kenner (2828) Lack of funding is why dentists are not taking them. It takes longer to treat them, the reimbursement is also lower. Usually however they do keep appointments, because they have car givers to make sure of it.

Sen. Thane: Those pictures (see attached to Dr. Kenner's testimony) you passed around, is this the most extreme instances or does this happen a lot?

Dr. Kenner: It happens in Devils Lake all the time, there are instances when these children have to be admitted to the hospital for an IV flush.

Sen. Thane: Is it the parents fault?

Dr. Kenner: Its an education problem.

Questions were also asked regarding the **Access White Paper** attached to Dr. Kenner's Testimony, and how those numbers were compiled.

No further questions were asked of Dr. Kenner.

David Zentner, Director of Medical Services appeared in before the committee to provide information on the proposed legislation. Mr. Zentner Provided the committee with written testimony, see appendix II.

Sen Mathern: (4112) Do you agree the overhead expense for Dentists?

Mr.. Zentner: I don't think I am in a position to answer that, I am sure it varies.

Nancy Kopp, Lobbyist, ND Optometry Association appeared to have an amendment to include optometry services.

Chairman Holmberg closed meeting on SB 2213

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. 2213

Senate Appropriations Committee

❑ Conference Committee

Hearing Date February 11, 2005

Tape Number	Side A	Side B	Meter #
1		b	875
Committee Clerk Signature			

Minutes:

Chairman Holmberg reopened the vote on SB 2213 explaining what the vote was and that he wanted those absent to vote publicly.

The votes were reviewed and those absent voted. The bill was a DO PASS with 8 yes and 7 no votes. The carrier will be Senator Judy Lee.

The hearing on SB 2213 was closed.

Meeting

Date 2-11-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2213

Senate SENATE APPROPRIATIONS Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By M Seconded By Tallackson

open

Senators	Yes	No	Senators	Yes	No
CHAIRMAN HOLMBERG		✓	SENATOR KRAUTER	✓	
VICE CHAIRMAN BOWMAN		✓	SENATOR LINDAAS	✓	
VICE CHAIRMAN GRINDBERG	✓		SENATOR MATHERN	✓	
SENATOR ANDRIST		✓	SENATOR ROBINSON	✓	
SENATOR CHRISTMANN		✓	SEN. TALLACKSON	✓	
SENATOR FISCHER	✓				
SENATOR KILZER		✓			
SENATOR KRINGSTAD		✓			
SENATOR SCHOBINGER		✓			
SENATOR THANE	✓				

Total (Yes) 8 No 7

Absent 1 DF

Floor Assignment J Lee Mathern

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 11, 2005 4:17 p.m.

Module No: SR-28-2628
Carrier: J. Lee
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SB 2213, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (8 YEAS, 7 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2213 was placed on the Eleventh order on the calendar.

2005 HOUSE HUMAN SERVICES

SB 2213

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2213

House Human Services Committee

☐ Conference Committee

Hearing Date 3-14-05

Tape Number	Side A	Side B	Meter #
1	xx		18--4088
Committee Clerk Signature	Pam Dever		

Minutes: **Chair Price:** Let's open the hearing on SB 2213. Clerk read the title.

Sen. Tim Mathern, Dist. 4, Fargo: Here in support of this bill. This bill is to give attention to the rate of reimbursement for dental services in ND. Also, to set the rate for a two year period. I have some citizens who are raising questions about receiving care. I have never received a call from someone from Fargo regarding any services provided that they are not able to get because there is no Medicaid provider other than dental care. We have some dentists who don't want Medicaid patients because of the reinbursement level. The dentist who are willing to take those patients get more patients than is fair and take the burden for the community. We need to get that rate of reimbursements up. We need more dentists providing care.

Brent Holman, dentist, Fargo, ND: 303.0 here to support SB 2213. **(SEE ATTACHED #1)**

Rep. Nelson: I see in the original bill you did increase it to 75%. Why go to 85% in the engrossment?

Brent: The 85% based on 2004 utilization by code proved to be roughly the same in terms of

additional dollars as the 75%. Our concern was that they (legislators) did not understand the number very well. By definition, 75% means these are at a level that 75% of the dentists will get their full fee. Some people did not like that idea. Another way of looking at that is saying it was amended to say it was 85% of the global amount billed. What was billed may not be what the dentist normal fee is, because we know some dentist bill what they think they will get paid. Hard to know exactly what that number is. That's why we changed it.

Rep. Nelson: I will try a different approach. I don't quite understand your answer. Did the fiscal note change in the engrossed bill?

Chair Price: Yes there was and it did increase the cost quite a bit. We will get you a copy.

Rep. Porter: How many dentist in ND are providers?

Brent: I think we are around 290, maybe 300. 330 licensed dentists. 90% are listed as providers. You can be listed as a provider and see only emergencies. You can see only one patient a year or See only the patients of records you've seen before. Whole range of differences. You need to get Beyond just the exact numbers who are officially signed up as providers.

Rep. Porter: So you have participating providers that are not actively participating in the program. Correct? Would you have a problem with amending this to say that those dentists who aren't active don't reap the benefits, since they are part of the problem? I have a hard time increasing the amount of money when the problem is access. Everybody in health care has the same reimbursement problems. It's only fair that those who are active should share from the bigger pot.

Brent: I'd have a tough time making a judgment about whether or not that system would work.

How would it be administrated. Who's defined as active or not. Problem is nation wide. Most dentist are small business.

Rep. Porter: What do you tell the other providers who are significantly less than the 85% of billed charges? What do we tell the other providers in medical field? How do we say dentists are more important?

Brent: I am here representing the patients that we serve. I can't tell you how to do your job. I can only make the case for those who are not getting the care.

Rep. Potter: It's my understanding that the reimbursement at this point is 60%.

Brent: That's our best judgment. In 1997 we development a two-tier system with increasing for children. Medicaid has a high percent of no shows.

Rep. Devlin: (1895) How does the reimbursement compare to Blue Cross?

Brent: Blue has many dental plans. Their primary indemnity plan would have a 90% maximum. Most dentists are participants in Blue/Cross, Blue/Shield Dental Service Corp.

Chair Price: Thank you Dr. Holman. Anyone else to testify in favor? Any opposition?

David Zentner - Dir. of Medical Services, Human Services Dept.: Here in a neutral position.

(SEE ATTACHED #2) (2240)

Rep. Porter: Currently, who is highest provider group that is reimbursed by Medicaid?

David: Hearing aid dealers are over 90%. Audiologist are 80% and optometrists are 75%. Home Health agencies are around 81% and dentists are 68%. General hospitals are 41% and physicians At 45%. It does vary with ambulances the lowest.

Rep. Porter: When you are looking at reimbursements, the catch phrase "billed charges" and "cost" are always confusing. Every time I ask a provider what their cost is of doing business, they

don't know. This is what the Medicaid fee schedule says or what BS/BS says. Is there any information on your stuff, relating to dentists, that show us what their true cost of their services provided.

David: I don't have anything specific. I think the dental association collects information on that. I hear the number 70 to 75% as the average cost of the charges. Depends on a new Vs old dentist.

Rep. Porter: What % of claims are denied because the services are unnecessary?

David: I don't have a number. We have a dental consultant who reviews the need. Not high.

Rep. Porter: Has the department looked at any language that would assure, if this bill passes and the funding mechanism was put in place, assures that there is access? How will we tie this back to access?

David: We would have to rely on the promises of the dental community to jump back in.

Rep. Weisz: Why when the department got an increase did you not have an increase in usage?

David:(3250) In 1997, we had providers dropping out. This helped stop the dropping out. It's very difficult to find a dentist in certain areas. We are losing dentists in ND. No replacements. Our kids are 35 to 40% get in to see a dentist at least once a year. That's comparable to other states. The general public is around 60 to 70%.

Chair Price: What group in the Senate brought the amendment?

David: I believe it was the dental community that wanted the change.

Chair Price: Have you been able to do any analysis of what the ER charges are costing us for dental care?

David: Our numbers have gone down from 2004 and 2003.

Nancy Kopp - ND Optometric Assoc.: (3741) neutral on bill. Our group represents 115 of the

140 optometrists in ND, and only one is not a participating member with Medicaid. They are not making any money. Our reimbursement is $46.00 from Medicaid. If you pass this bill, all we ask is that you amend to include us also. Please try to equalize all provider groups.

Chair Price: Anyone else to testify? Hearing is now closed.

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. **SB 2213**

House Human Services Committee

❑ Conference Committee

Hearing Date **15 March 2005**

Tape Number	Side A	Side B	Meter #
1	X		600 - end
		X	89 - 838
Committee Clerk Signature			

Minutes:

Vice Chairman Kreidt opened discussion of SB 2213.

Rep. Devlin: My concern with this is all the other providers that are sitting out there that are to be treated the same way, how do chose this one?

Rep. Porter: I think part of the problem in a system this complicated is when you allow providers the ability to one at a time come in and cherry pick their network to be paid more than everybody else. It's never-ending, it's inconsistent and it's really the wrong policy for the state. We're basically the board of directors of an insurance company when you look at what we are doing here. When we look at this, it needs to be the whole picture. If this bill said that we needed to add a million dollars to the whole provider reimbursement pool to be equally divided out amongst providers because we think that everybody's too low, I'd be the first one to jump up and say "you're right." There's not a single provider group out there that is being reimbursed their cost of doing business. As providers they are all subsidizing the taxpayers of ND and

shifting costs to other patients in order to operate their business because the state has always under funded those providers and it's a systemwide problem. If anything, this should be a study to make everybody come in and sit at the table and say "these are what our costs are, this is what you're reimbursing us, it's not enough and we need more money." There is a huge concern not only with the dental but with other areas of access. At some point there's going to be enough of a concern that we're not meeting the minimum federal requirements for access because providers can't afford to shift any more costs because all of the other insurance companies have tightened the reins on them, from Medicare on down. I just don't see how you can take one provider and leap frog them up and over when the whole system needs to make a move not just one provider group.

Rep. Kreidt: We're looking at this pool of money. I can sit down and draft amendments to all of these entities and patch them on and we can divide that money up amongst all of them but I don't think that's the way we should go. I agree with Rep. Porter that this is not the way to go. I cannot support this bill.

Rep. Porter: Is there a comprehensive study in the system someplace about Medicaid reimbursement and access to services?

Rep. Nelson: Can you help me to understand this better. I'm guessing that looks at a perfect world. In these cases there isn't one. Do states around us struggle with this. Is there a comprehensive mechanism that is utilized in other states that we could draw from? Or do we piece meal across the region as well as in ND?

Chairman Price: From what I talk with people from other states about Medicaid, they are all struggling with it.

Rep. Porter: In other states like MN, their ambulance association successfully lobbied so that the Department of Human Services in MN had to pay at least the Medicare fee schedule. If that happened in ND that would be huge. Everybody across the board is different and it always comes back to the financial side of things. When you look at forcing the providers to accept what's paid out from this Medicaid pool, there's no balanced billing and then you get a "no show." I can understand the dentist's concern. Maybe we need to look at it from a different angle and say there is a minimum office charge reimbursable back to the dentist for documented "no shows." Maybe that will help their situation. To pick and choose provider groups without looking at the system as a whole, we're never going to get it right.

Rep. Weisz: Again, I would agree with Rep. Porter from the standpoint at least talking to my local dentist who does Medicaid. He's not complaining about the payment rate just the huge number of "no shows." He's booked 6-8 weeks out in advance and in his case probably 3/4 of his Medicaid clients don't show for their appointment. Frankly he will not take any new Medicaid cases.

Rep. Porter: If you look at just the basic office exam which is $19 if we put provision into the law that says "documented no shows within the Medicaid program are reimbursable at $10." Would that make a difference to him knowing that at least he didn't lose completely? Or is that not even enough to make a difference?

Rep. Weisz: I think it would help. What I sense is just the frustration of having to deal with the "no shows," trying to reschedule, trying to do these thing. It's just not worth it. Maybe the $10 would help. If we could get that "no show" to a reasonable level, I'd guess he would gladly take more Medicaid patients. It helps a little bit.

Rep. Porter: I certainly understand that. The $10 doesn't even come close to covering the loss if they would have any other patient booked at that time. At least it's something for the inconvenience and might start getting dentists to look at it and say that since the risk has been lowered start accepting a few more Medicaid patients. What everybody heard is that access is the problem but from the dental community we heard that "no shows" are the problem. I look at this bill as cost shifting those "no shows" into the "shows" so that they make more money off of the "shows" and then they can live with the "no shows." We should look at this from the other side and say we are going to help you with what you lose on the "no shows" by letting them bill it and be reimbursed at this rate. I'm not just looking at this from the standpoint of dental. Every provider group gets up and says the same thing. We can't pick one group and say your "no show" problem is greater. It's a problem systemwide.

Rep. Nelson: There are a couple of different methods to get around that issue. The message to clients is that they don't have to change their way of doing business and "no shows" will continue to be a big problem. Maybe we should approach it from a responsibility standpoint and set a block of time much like an emergency room for Medicaid patients and those that show up get served and those that don't, don't. Some may have to come back but they are the ones that cause the problem. I think we need to communicate to the people that are using the program that they have some responsibility as well.

Rep. Porter: You are still in the long run punishing only the providers because if the person fails to show and they have an abscess then they are going to the emergency room and get it treated there and it's going to cost us three times as much as it would have had they made their

appointment. It's a systemwide problem. When you have no ownership of your expenses in this system, it's difficult to make an incentive program work. That is the true problem.

Rep. Nelson: What would you get into if you double scheduled?

Nancy Kopp, representing the ND Optometric Association: We have approximately 20% "no show" rate for optometric services. Keep in mind that varies from different areas of the state.

Joe Cichy, representing the ND Dental Association: I've heard 40% "no shows." What I'm concerned with is the children. The parents have to bring the kids. When the parents fail, the children are the ones that suffer. I'm not sure how to get around that. I know the department has worked on facilitating these folks to get to their appointments. That doesn't seem to have helped a whole lot.

Rep. Porter: Maybe we need to look at it more from a block grant standpoint and say we're going to buy access into your practice. I'm just throwing that out because I don't think this bill is going anywhere in this committee. It's sad because there is problem and the problem is access and there is a problem and the problem is reimbursement systemwide through the Medicaid program and we're not addressing either of those by defeating this bill. We are not addressing either of those by passing this bill.

Rep. Potter: It doesn't look like we can revamp the system in this session. What we're going to either do is kill the bill or try to regenerate some how. The dentist reimbursement is either 60% or 68%. What would happen if we reduce the 85% figure since the other groups are not getting paid to make it not so non equitable. Let's say 75%. Until we change the system we are going to have to work with that.

Rep. Weisz: Just to be clear, the original bill was 75 percentile.

Rep. Kaldor: What they're currently getting?

Joe Cichy: It's 65% for children and 55% for adults. So an equal amount was 60%. As we got into the session they did some manipulating with the figures and it came up with closer to 70%, I think 68%.

Rep. Kaldor: If we don't do anything, the problem is going to be worse the next biennium. There will be less children getting access and fewer dentists will provide services. If there were some kind of compromise or middle ground in conjunction with some kind of analysis or study. I don't think all providers are equal. Not that one is worth more than the another except that the distribution of dentists compared to the distribution of doctors throughout the state of ND, it's probably quite a bit of variance and that's part of the problem. One reimbursement level or percentage doesn't necessarily fit all. The other issue is the ability to shift costs. I'm concerned if we don't do anything the problem will be much worse next time around and it will cost us more.

Rep. Weisz: There are a number of numbers being thrown around as far as "no shows." Do you have a number of what the actual "no shows" are?

Cichy: It varies by practice but I've heard 40%.

Rep. Kaldor: When dental office is making appointments for people they know are going to be Medicaid reimbursement, do they try to cover themselves with overbooking?

Cichy: I don't know that they do that. I think they disperse them through the day.

Rep. Kreidt: Do any of these "no shows" ever call and say they are not going to show?

Cichy: They don't.

Rep. Potter: I make a **motion to amend the bill to replace 85% with 75% on the engrossed version and have a study during the biennium.**

Rep. Kaldor: I second.

Rep. Devlin: You just lowered the problem, but we still have the problem. We have other providers at 40% and everywhere between 40% and 75%. I will resist the amendment because it doesn't fix the problem. It helps the dentists some but it certainly doesn't help any of the other providers in the same situation.

Rep. Kaldor: I would acknowledge that although I think with the study we are probably going to find this is like the free enterprise system where the demand and supply factors vary. The requirement for reimbursement is probably going to change as well. I don't know if that is true but I'm suspecting that if we go through a study we may find that.

Rep. Devlin: The other thing that comes up in my mind is that Dentists can turn this practice down very easily. Many other providers can't.

Rep. Devlin: Do we have any idea what the proposed amendment would do to the fiscal note of this bill? It's going to be higher than the original fiscal note.

Rep. Kaldor: That was only for 10 months. If you carry it out it would be over $1.5 million.

Rep. Potter: If we don't do something it continues the problem in the next biennium. We have seen that in other areas and what a problem that is. Trying to continue to catch up is difficult. I agree it doesn't address the other groups but the other groups aren't here either.

Rep. Uglem: I have the feeling this bill is going down and my concern is maybe we should be trying to save the study at least.

A roll call vote was taken on the amendment

Yes: 3, No: 7, Absent: 2 (Price, Sandvig) **The amendment failed.**

Rep. Weisz: We should remove Section 1 and Section 2, and pay 50% of schedule fee for a "no show" office visit. **I so move.**

Rep. Nelson: I second that.

Rep. Kaldor: I'm going to vote against that amendment just because I have a problem reimbursing. I know we are covering the cost but I have a problem reimbursing for nothing being done. I don't think that provides any incentive on anybody's part to get those patients to the dentist's office. Basically we are paying for no service being done. Realizing they have a cost when someone doesn't show up, I understand that. We are not reimbursing for a medical service at all. We are reimbursing for something that didn't happen.

Rep. Weisz: I can understand Rep. Kaldor's concern. We need to look at providing an incentive to provide to access. This does at least put it on the table to come up with some method to insure that this population shows up.

Rep. Nelson: I agree with Rep. Kaldor that this is not the best method of addressing this issue. I don't think we have a good method of addressing it. I do see an incentive for the provider in this case. If they didn't have an incentive to overbook they sure do now.

A roll call vote was taken.

Yes: 7, No: 3, Absent: 1 (Sandvig) The amendment passed.

Committee briefed arriving Chairman Price of meeting thus far.)

Rep. Weisz: We need to get 40% to 75%.

Rep. Kreidt: We have an amended bill. Is there a motion?

Rep. Devlin: We could further amend this bill to include any medical providers that have office calls.

Rep. Weisz: We need to treat all alike. Certainly they all have no shows.

Rep. Nelson: If equity among providers is an issue, obviously dentists are experiencing problems that are greater than other industries, maybe we should have trigger mechanism where that provision kicks if you scheduled "no show" list of 33%, 45%, whatever when this would kick in. That would only complicate the fiscal note but it would put every industry on that same level playing field.

Chairman Price: We have an amended bill. Do you wish to make a further amendment, Rep. Nelson?

Rep. Kaldor: For sake of discussion I agree with your thoughts Rep. Nelson. That would be difficult to put into law. There would have to be threshold level. I'm not sure how we would manage that. I have problems with the whole concept.

Rep. Weisz: I move Do Pass the amended bill and refer to Appropriations.

Rep. Nelson: I second.

A roll call vote was taken:

Yes: 5, No: 5, Absent: (Porter, Sandvig) The motion failed.

Rep. Potter: I propose we go back to the first engrossment and talk to Senator Lee and put it in HB 1459. I would **move an amendment to the first engrossment of SB 2213 on line 9 to remove 85% and make it 75%.**

Rep. Weisz: I second.

A voice vote was taken: Passed.

Chairman Price: We have an amended bill. What are your wishes?

Rep. Devlin: I **move do not pass.**

Rep. Damschen: I second.

A roll call vote was taken.

Yes: 6, No: 5, Absent: 1 (Sandvig)

The **Do not pass as amendment Carried.**

Rep. Kreidt will carry the bill.

Date: 3/15/05 Roll Call Vote #: 1

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2213

House Human Services **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Amd.

Motion Made By Rep Potter Seconded By Rep Kaldor

Representatives	Yes	No	Representatives	Yes	No
Chairman C.S.**Price**	AB	.	Rep.L. **Kaldor**	✓	
V Chrm.G. **Kreidt**		✓	Rep.L. **Potter**	✓	
Rep. V. **Pietsch**		✓	Rep.S. **Sandvig**	AB	
Rep.J.O. **Nelson**	✓				
Rep.W.R. **Devlin**		✓			
Rep.T. **Porter**		✓			
Rep.G. **Uglem**		✓			
Rep C. **Damschen**		✓			
Rep.R. **Weisz**		✓			

Total (10) 3 yes **No** 7

Absent 2 AB Price - Sandvig (Failed)

Floor Assignment _____

on an amendment, briefly indicate intent:

Heard 3/7/05
Action No

Date: 3/15/05 Roll Call Vote #: 2

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2213

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken motion Amd #2

Motion Made By Rep Weisz Seconded By Rep Porter

Representatives	Yes	No	Representatives	Yes	No
Chairman C.S.Price		↘	Rep.L. Kaldor		↘
V Chrm.G. Kreidt	↘		Rep.L. Potter	↘	
Rep. V. Pietsch	↘		Rep.S. Sandvig	AB	
Rep.J.O. Nelson	↘				
Rep.W.R. Devlin		↘			
Rep.T. Porter	↘				
Rep.G. Uglem	↘				
Rep C. Damschen	↘				
Rep.R. Weisz	↘				

Total (10) yes 7 No 3

Absent _____

Floor Assignment _____

on an amendment, briefly indicate intent:

Reimb no shows at 50% sched. fee

Date: 3/15/05 Roll Call Vote #: 3

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2213

House Human Services **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as Amend - R. Ref to Approp.

Motion Made By Rep Weisz Seconded By Rep Nelson

Representatives	Yes	No	Representatives	Yes	No
Chairman C.S. **Price**		↘	Rep.L. **Kaldor**		↘
V Chrm.G. **Kreidt**	↘		Rep.L. **Potter**	↘	
Rep. V. **Pietsch**	↘		Rep.S. **Sandvig**	AB	
Rep.J.O. **Nelson**	↘				
Rep.W.R. **Devlin**		↘			
Rep.T. **Porter**	AB				
Rep.G. **Uglem**		↘			
Rep C. **Damschen**		↘			
Rep.R. **Weisz**	↘				

Total (10) 5 yes **No** 5

Absent 2 - Sandvig - Porter

Floor Assignment (failed)

on an amendment, briefly indicate intent:

Date: 3/15/05 Roll Call Vote #: 4

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2213

House Human Services **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass as amd

Motion Made By Rep Devlin Seconded By Rep Damschen

Representatives	Yes	No	Representatives	Yes	No
Chairman C.S. **Price**		✓	Rep.L. **Kaldor**		✓
V Chrm.G. **Kreidt**	✓		Rep.L. **Potter**		✓
Rep. V. **Pietsch**		✓	Rep.S. **Sandvig**	AB	
Rep.J.O. **Nelson**		✓			
Rep.W.R. **Devlin**	✓				
Rep.T. **Porter**	✓				
Rep.G. **Uglem**	✓				
Rep C. **Damschen**	✓				
Rep.R. **Weisz**	✓				

Total (11) 6 yes **No** 5

Absent 1 - Sandvig

Floor Assignment Rep Kreidt

on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2213, as engrossed: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (6 YEAS, 5 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2213 was placed on the Sixth order on the calendar.

Page 1, line 9, replace "eighty-five" with "seventy-five"

Renumber accordingly

2005 TESTIMONY

SB 2213

Attachment 1

January 18, 2005

Testimony before the Senate Human Services Committee
Red River Room
Senator Judy Lee, Chair

Senate Bill 2213 – Relating to Dental Medical Assistance Reimbursement

Chairperson Lee and members of the Committee, my name is Dr. Kristin Kenner. I am a practicing general dentist from Devils Lake, North Dakota and President of the North Dakota Dental Association. I present this testimony in support of Senate Bill 2213.

The North Dakota Dental Association has been working to address the dental access issues in our state. One success is the Donated Dental Services program, through which volunteer dentists have donated nearly one quarter of a million dollars in dental care to over 100 people in the past two fiscal years. This program is designed to help the elderly and people with developmental disabilities who are unable to access care through other programs and unable to afford the care. The NDDA also participates in the national Give Kids A Smile program, which is designed to screen, educate, and treat children who are otherwise unable to access dental care. Dentists in Fargo have set up an urgent care clinic, which provides voluntary services to people with acute dental needs. This urgent care clinic prevents what would eventually become a considerably more expensive and less productive trip to a hospital emergency room. Grand Forks dentists also provide access to urgent care through partnership with the Third Street Clinic. In Bismarck, Bridging the Dental Gap started this fall and is seeing low-income patients. Additionally, dentists on their own provide free or discounted dental services daily in their private offices to those who may not have the means to cover the costs of the care. As great as these programs are, more must be done.

The medical assistance budget for the biennium is approximately $12 million, including both state and federal dollars. I understand that this covers about 60% of billed

charges. That means that dentists, during the biennium, contributed approximately $8 million worth of dental care to this program. That is considerably more than the state's share, which is around $4 million. Charity cannot be the cornerstone of an effective dental care delivery system.

We are asking in this bill that dental medical assistance reimbursement be set at the 75th percentile of billed charges. This level of reimbursement has proven effective in many states. (See attachment.) The attached letter of support from the American Academy of Pediatric Dentists cites the American Dental Association's **Access White Paper**, which identifies ways to improve access. This paper shows the success states have had using the market approach the ADA used to arrive at the 75th percentile. States that have established reimbursement at that level have seen dramatic increases in provider participation. In Wyoming, as of July 2004, dentists are being reimbursed at the 75th percentile. In the 2005-2006 fiscal year, the reimbursement will increase to the 80th percentile.

Based upon a survey at our annual meeting in September, increasing reimbursement would provide additional dental access to the Medicaid population. While the NDDA has taken the lead on this issue, we have the support of 17 other groups that are like-minded. (See attached resolution.) These groups represent our most vulnerable and compromised population in North Dakota, such as the elderly, individuals with physical and mental disabilities, and children. This legislation is necessary to ensure adequate dental access for the Medicaid population.

The principle reason for this bill is to open the doors of more dental offices to the children you see in these pictures that are circulating among the committee members. Regular preventative dental care could easily prevent many of the conditions experienced by these children. If these suffering children had a regular dentist, and acute problems

did occur, they would be able to access care more quickly due to their established relationship with a dentist. This would minimize the pain and resolve the problem. The effects on children with oral disease who lack access to dental care are devastating. The children experience considerable pain, which can affect their eating habits and growth. They are also more likely to get sick and miss school, and their ability to concentrate in school is affected.

Medical assistance patients seeking dental treatment often visit hospital emergency rooms, and the already high costs of these visits increased in North Dakota by 40% from July 2003 to 2004. Unfortunately, many trips to the hospital will not provide the necessary treatment needed to eliminate the chief complaint of the patient. Access to regular dental care also prevents costly treatment by specialists in the future, which becomes necessary due to the rapid deterioration of dental health.

I have attached to my testimony a **Dental Medicaid in North Dakota Fact Sheet** for your review. I would like to highlight a few of those facts. (See attachment.)

This legislation is another step by the dental community, and by others interested in providing care to our underserved population, to create an environment that provides access to quality dental care to these citizens. We, as dentists, have a moral obligation to advocate for the underserved population. North Dakota's dental community has improved access to care through programs such as Donated Dental Services, Give Kids A Smile, urgent care clinics, and gratis work provided daily in private offices. However, we cannot solve this problem alone. We need dental access to be a joint effort with the state of North Dakota. The NDDA asks you to support this bill with a do pass recommendation.

RESOLUTION
Regarding Dental Access

WHEREAS, oral health is essential to overall health, especially for children, patients with complicating medical conditions, elderly patients, and people with developmental disabilities; and

WHEREAS, access to dental care in North Dakota is a growing problem, particularly for indigent children, the elderly, and people with developmental disabilities; and

WHEREAS, vulnerable patients in need of dental care increasingly must access hospital emergency rooms for treatment of dental problems, or need to travel great distances to access care, resulting in greater cost to the state and its associated agencies; and

WHEREAS, the percentage of dentists in North Dakota willing to see new Medicaid patients fell from 77% in 1992 to 34% in 2002, below federal definitions of adequate access; and

WHEREAS, dental care is provided predominantly in private practice dental offices in North Dakota for Medicaid-eligible patients and current Medicaid fee reimbursement to dentists is below the cost of providing that care; and

WHEREAS, administrative complexity and limitations on covered services are deterrents to provider participation; and

WHEREAS, market-based rates of dental reimbursement and administrative dental Medicaid reform, often including outsourcing administration to a non-government third party, have significantly improved access to dental care in other states;

NOW THEREFORE, BE IT RESOLVED, we urge the North Dakota Legislative Assembly in 2005 to improve access to dental care for our most vulnerable citizens by increasing funding and administratively reforming dental Medicaid.

Endorsing Organizations:

Red River Valley Dental Access Project
Freedom Resource Center for Independent Living
North Dakota Association of Community Facilities
Dental Service Corporation of North Dakota
The Arc of North Dakota
North Dakota Long Term Care Association
Fargo Cass Board of Health
North Dakota Association for the Disabled
North Dakota Dental Hygienists Association
The North Dakota Center for Persons with Disabilities at Minot State University

Children's Caucus
The North Dakota Head Start Association
North Dakota State Council on Developmental Disabilities
North Dakota Dental Lab Association
North Dakota Family to Family Network
Grand Forks Board of Health
Grand Forks Dental Access Committee

DENTAL MEDICAID IN NORTH DAKOTA
FACT SHEET-2005

- Oral health is essential to overall health, especially for children, developmentally-delayed patients, elderly, and medically-compromised individuals.
- Low-income preschoolers are twice as likely to have dental decay as children from more affluent families, have twice the pain, yet visit the dentist only half as often.
- Children with oral disease who lack access to dental care have significant pain, which can affect their eating habits and growth, makes them more likely to get sick and miss school, and even affects their ability to concentrate in school (Frameworks Institute, Wash DC).
- North Dakota received a "D+" in overall access to dental care by the Oral Health America Grading Project 2003.
- Seventeen North Dakota organizations have signed the North Dakota Dental Access Resolution urging the ND Legislature to improve access to care for Medicaid eligibles.
- Of about 35,000 Medicaid-eligible children in ND, only a third receives a dental service in any given year (ND State Department of Health).
- As access to care deteriorates, Medicaid patients increasingly show up at Emergency Rooms for dental problems where no definitive treatment can be provided. The number of ER visits by Medicaid patients for dental problems in ND increased by 27% and the amount paid for these visits increased by 40% through July 2004 as compared to 2003 (ND Department of Human Services).
- Low Medicaid fee reimbursement is the number one reason that dentists limit their participation in Medicaid. Poor patient compliance, failed appointments, and limitations in allowed treatment are other reasons that dentists limit participation.
- Federal courts have determined that adequate access exists for Medicaid patients when at least 50% of dentists see any and all Medicaid patients presenting for treatment. In ND, only 10% of dentists see any and all Medicaid patients that present for treatment (UND Center for Rural Health). This percentage was 49% in 1992.
- ND Dental Medicaid reimburses dentists below the cost of providing dental services to Medicaid patients (ND Department of Human Services).
- The majority of participating dentists can afford to do relatively little Medicaid. In 2003, only 20% of the participating dentists performed the majority of the Medicaid services provided in the state.
- Four states (Georgia, Tennessee, Indiana, and South Carolina) have increased fees to the 75th percentile (75% of dentists receive their usual fee) and subsequently saw significant increases in dentist participation.
- The 12.1 million dollar ND dental Medicaid appropriation for this biennium is only 2% of the entire Medicaid budget (ND Dept of Human Services).
- Increasing fees in ND Medicaid to the 75th percentile would increase the budget for the next biennium by about 4.8 million dollars. With the expected 35.32% state share of the federally matched funds, the increase in state dollars would be about 1.7 million for the biennium.
- Adequate dentist reimbursement, along with efficient claims submission and payment, will improve access to care for North Dakota's most vulnerable citizens, reduce costly and inappropriate Emergency Room treatment, and prevent more expensive specialty care for this population. Care for the most vulnerable population must be a shared responsibility between dentists and the state of North Dakota.

AMERICAN ACADEMY OF PEDIATRIC DENTISTRY
211 East Chicago Avenue - Suite 700, Chicago, IL 60611-2663
Phone: 312-337-2169 Fax: 312-337-6329
Web Site: www.aapd.org

January 14, 2005

Brent L. Holman, DDS
2538 S. University Drive #A
Fargo, ND 58103

Dear Brent:

The American Academy of Pediatric Dentistry[1] (AAPD) writes you in strong support of SB 2213, legislation recently introduced in the state of North Dakota that would raise Medicaid dental fees to the 75th percentile of regional dental fees. We applaud the North Dakota Association of Pediatric Dentists for its advocacy on this issue.

Evidence is compelling that similar efforts in other states have yielded impressive results in increasing the number of dentists participating in Medicaid, and expanding patient utilization and preventive visits. As you know, the American Dental Association (ADA) has documented these findings in its recent *Access White Paper* entitled "State and Community Models for Improving Access to Dental Care for the Underserved." The state examples described below are from the ADA's March 2004 policy paper on "Increasing Access to Medicaid Dental Services for Children Through Collaborative Partnership." We have highlighted the patient care impact in **bold**.

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[1] The AAPD is the membership organization representing the specialty of pediatric dentistry. Our members are the "front line", providers of oral health care to America's children and educators of health professionals about children's oral health. The AAPD represents not only the nation's pediatric dentists, but also general dentists who treat significant numbers of children in their practices. Our 6,000 members serve as primary care providers for millions of children from infancy through adolescence; provide advanced, specialty-level care for infants, children, adolescents, and patients with special health care needs in private offices, clinics, and hospital settings; and are the primary contributors to professional education programs and scholarly works concerning dental care for children. Individuals trained in pediatric dentistry learn advanced, diagnostic, and surgical procedures; child psychology and clinical management; oral pathology; pharmacology related to the child; radiology; child development; management of oral-facial trauma; caring for patients with special health care needs; conscious sedation; and general anesthesia. Since children's oral health is an important part of overall health, pediatric dentists often work with pediatricians, other physicians, and dental specialists.

Excerpt from "Increasing Access to Medicaid Dental Services for Children Through Collaborative Partnership," © 2004 American Dental Association

"Examples from Selected States

Several states have engaged in significant efforts to improve access to dental services for individuals covered by Medicaid. The following selected examples highlight the variety and importance of sustained collaboration among program officials and dental providers in those efforts.

Alabama
Faced with increasing Medicaid enrollments and declining provider participation, Alabama Medicaid officials sought to remedy what was viewed as a 'dental crisis' beginning in 1997. One of the first steps was to seek assistance from the dental provider community through the creation of a Dental Task Force. The task force determined the major issues surrounding the dental program; made recommendations concerning program administration, covered services and reimbursement levels; and subsequently worked to address these issues. Alabama Medicaid also formed an Outreach Work Group to recruit new Medicaid providers. Alabama subsequently was selected for participation in the National Governors Association (NGA) Oral Health Policy Academy, which allowed further development of a state-level strategic plan and action plan on dental access issues. These efforts were augmented by funding from the Robert Wood Johnson Foundation to increase the Medicaid dental provider base and educate the public about the importance of good oral health. The Dental Task Force continues to meet quarterly to monitor program performance and provide input on policy and program changes. Alabama also has held a series of dental Medicaid summits to sustain attention to the issue and focus on ways to remove access barriers. More recently, an Oral Health Coalition, consisting of three workgroups, has been formed to:

√ Assist the state in disseminating information and building public awareness;
√ Advise in the development, implementation and completion of the strategic oral health plan; and
√ Create and reinforce relationships between key stakeholders to ensure the success of state efforts in improving oral health care in Alabama.

These combined and sustained efforts have resulted in significant increases in provider participation and utilization of services by Medicaid enrollees in Alabama. In fiscal year (FY) 2002, approximately 50,000 more Alabama Medicaid-enrolled children received dental services than in FY 2000. Overall, FY 2002 utilization rates were three times the levels reported in FY 1998.

Delaware
Extremely low levels of Medicaid participation by private dentists spurred Delaware's Medicaid officials to develop a partnership with the provider community. Steps taken to address access issues included development of a state access report in 1997, followed by the formation of a Dental Access Improvement Committee in 1998. State officials and

representatives of practicing dentists also participated in the development of a state-level strategic plan and action plan through the NGA Oral Health Policy Academy. These efforts culminated in significant program changes involving claims submission, a new Medicaid Provider Manual, implementation of an innovative approach for enhanced Medicaid dental reimbursement, and a dentist recruitment campaign organized by the state dental association. **Results included the participation of more than 100 new dentist providers in Medicaid and a doubling of the number of children receiving dental services between FY 1998 and FY 2001.**

Indiana, South Carolina and Georgia

Substantial Medicaid program changes in 1997 that were viewed as unduly burdensome by Indiana dentists resulted in an exodus of participating providers and a public outcry for efforts to restore access to services. A Dental Advisory Panel was formed to provide input on policy and payment issues. Prominent ensuing changes included a 'carve out' of dental benefits from Medicaid managed care and rate increases to the 75th percentile of prevailing market fees. Also notable is the involvement of practicing dentists in helping state officials review Medicaid dental expenditures and identify areas where program savings could be achieved without sacrificing essential benefits. **Results included an increase of more than 50 percent in dentist participation in Medicaid and a tripling of the number of children receiving dental services between FY 1998 and FY 2001.** Similar collaborative partnerships in South Carolina and Georgia have yielded comparable results. In South Carolina and Georgia, the partnership also has been effective in stimulating provider recruitment - dental recruitment campaigns being organized by the state dental associations. In recent years, both states also have succeeded in preserving core program enhancements in the face of declining state revenues and growing Medicaid budget pressures.

Michigan

Michigan has implemented a highly successful alternative to its traditional state-administered Medicaid program that relies on contracting out dental Medicaid benefits under a popular commercial dental benefits plan administered by Delta Dental in 37 counties. The Healthy Kids Dental (HKD) program began in 2000, although the state's effort to address Medicaid dental access issues began in 1995 with the development of a Dental Medicaid Task Force, and went on to include efforts to engage political support among key stakeholders both within and outside of dentistry, and strategic action involving the media, public and key legislators. **Results include an increase of nearly 40 percent in utilization among continuously enrolled Medicaid children, substantial increases in dentists' participation, more comprehensive services to beneficiaries, and services being delivered closer to where enrolled children live.**

Tennessee

Substantial revisions to Tennessee's Medicaid dental program in 2002 include 'carving out' dental benefits from the state's Medicaid managed care program and contracting with a single commercial vendor (Doral Dental) to administer dental Medicaid benefits under an arrangement that reimburses at the 75th percentile of market-based fees. Prominent steps leading up to this fundamental change include participation by key

stakeholders in a 2000 NGA Oral Health Policy Academy, development of a comprehensive children's oral health plan, formation of a Dental Advisory Committee, and promotion of the new program by the Tennessee Dental Association. **While the program is relatively new, it has already achieved substantial increases in dentist participation and utilization of services."**

If you have any questions concerning this letter or there is anything else that the AAPD can do to support your efforts on this legislation, please contact C. Scott Litch, AAPD Deputy Executive Director and General Counsel, at 312-337-2169 or slitch@aapd.org.

Sincerely yours,

Neophytos L. Savide, DDS
AAPD President

John S. Rutkauskas, DDA, MBA, CAE
AAPD Executive Director

STATE	Adjustments Made to Medicaid Rates (Market-based Benchmarks)	Changes in Dentists' Participation in Medicaid Following Rate Increases	Intervals (mos.) Between Rate Increases and Changes in Provider Participation
Alabama	100% of Blue Cross rates	+39%	24
Delaware	85% of each dentist's submitted charges	From 1 private dentist to 108 (of 302 licensed dentists)	48
Georgia	75th percentile of dentists' fees	+546% (to 1,674 of 4,000)	27
Indiana	75th percentile of dentists' fees	+58%	54
Michigan (Healthy Kids Dental Program)	100% of Delta Dental Premier rates	+300%	12
South Carolina	75th percentile of dentists' fees	+73%	36
Tennessee	75th percentile of dentists' fees	+60%	4

Comparison of ND Medicaid Rates with Regional and National Benchmark Rates

Procedure Code	Procedure Description	ND Medicaid Rates	WNC Region 2001 Avg. Fees	WNC Region 2001 75th %-ile Fees	ND Medicaid vs WNC Region Fees (percentile)	National 2001 Avg. Fees	ND Medicaid vs National Fees (percentile)
Diagnostic							
D0120	Periodic Oral Exam	$19.70	$ 25.13	$ 28	16th	$ 28.14	13th
D0150	Initial/Comprehensive Oral Exam	$29.75	$ 36.91	$ 42	27th	$ 43.85	16th
D0210	Complete X-rays, with Bitewings	$56.85	$ 71.80	$ 80	13th	$ 79.45	7th
D0272	Bitewing X-rays – 2 Films	$18.60	$ 23.41	$ 26	18th	$ 26.04	12th
D0330	Panoramic X-ray Film	$48.40	$ 62.45	$ 70	9th	$ 68.43	4th
Preventive							
D1120	Prophylaxis (cleaning)-Child	$25.55	$ 34.10	$ 39	8th	$ 42.48	3rd
D1203	Topical Fluoride (excluding prophylaxis).	$17.05	$ 19.97	$ 23	30th	$ 22.88	24th
D1351	Dental Sealant	$20.25	$ 26.74	$ 30	7th	$ 31.89	6th
Restorative							
D2150	Amalgam, 2 surfaces, permanent tooth	$58.50	$ 79.26	$ 92	7th	$ 91.11	4th
D2331	Resin , 2 surfaces, anterior tooth	$69.65	$ 99.87	$ 111	8th	$ 111.51	5th
D2751	Crown, porcelain fused to base metal	NL	$ 566.55	$ 622		$ 630.20	
D2930	Prefabricated Steel Crown, primary tooth	$97.90	$ 141.51	$ 175	12th	$ 152.64	9th
Endodontics							
D3220	Removal of tooth pulp	$63.80	$ 85.02	$ 99	27th	$ 101.19	12th
D3310	Anterior Endodontic Therapy	$284.15	$ 358.66	$ 402	13th	$ 411.87	6th
Oral Surgery							
D7110	Extraction, single tooth	$52.15	$ 76.36	$ 88	7th	$ 87.76	4th

WNC Region = IA, KS, MN, MO, NE, ND, SD

Attachment 1A

NORTH DAKOTA DENTAL ASSOCIATION

January 24, 2005

Senator Judy Lee,
Chair, Senate Human Services Committee

Senator Lee,

We met with Dave Zentner and Maggie Anderson of the Department of Human Services and asked them to clarify the discrepancies between the paid/billed percentages that were given to your committee last week (as a comparison to other providers) and the comprehensive service breakdown for the first 11 months of 2003 that was given to us a year ago by the Department. The additional clarification from The Dept of Human Services did not clear up the variance as their latest run shows a reimbursement rate for children at about 74% as compared to the earlier information we were provided of approximately 64%. Whatever the reimbursement percent calculated by the department is, the system is not working.

In response to concerns that your committee members had about paid vs. billed dental Medicaid services, particularly as it relates to other professional providers, please consider a couple of additional points.

1. National studies repeatedly show that appointment "no-show" rates for dental Medicaid patients average about 30-50%. The "Bridging the Dental Gap Clinic" in Bismarck and the Family HealthCare Center Dental Clinic in Fargo-Moorhead (clinics that primarily see low-income patients) anecdotally report similarly high no-show rates for this population. Obviously, this means that if a dentist is reimbursed at say 60% of their fee, one "no-show" for a particular patient means that the fee they will get for the patients' next visit will really be 30%. Hence, please exercise caution interpreting reimbursement percentages, as they relate to real-world decisions that dentists make about their ability to see these patients.

2. As your provider reimbursement comparisons table shows, there is quite a range of fee reimbursement percentages among different provider groups. It's important to remember that there are also significant differences between these groups in regards to their practice overhead costs. Dental practice overhead is high (60-65%) and the majority of dentists practice solo, with little ability to cost-shift.

3. Ultimately, the issue is not about dentists...it is about the vulnerable patients that currently cannot access care. The North Dakota Dental Association is trying improve this situation for these patients by encouraging dentists to continue their very significant participation in volunteer access programs around the state, and partner with you in the Legislature to improve reimbursement.....and improve it in a way that will be meaningful enough to enlist a significant number of dentists to reassess their resistance to participate.

Please add this information to our previous testimony and thanks for you consideration of this additional information.

Sincerely,

Dr Kristin Kenner
President, North Dakota Dental Association

cc: Senator Tony Grindberg
Senator Tom Fischer
Senator David Nething
Senator Tim Mathern
Rep Clara Sue Price
Rep Kathy Hawken
Rep Jeff Delzer

P.O. Box 1332 • Bismarck, ND 58502
Phone: 701/223-8870 • Email: ndda@olsoncichy.com • www.nddental.com

Attachment 2

January 14, 2005

Honorable Tim Mathern
State Senator
N.D. Legislative Assembly
Bismarck, North Dakota 58505

Dear Senator Mathern:

I was happy to learn that I am in your District 11, and so I am writing to you in behalf of my Down Syndrome son, David, who is in need of on-going dental care for protection of his teeth from periodontal disease. I have found that the amount of money provided by Medicare here in North Dakota is not sufficient to cover on-going protection to pay for the dentists David needs.

It is now known that there is a larger link between the overall health of a patient and periodontal disease than previously thought in the past.

David does not have the ability to physically clean the areas in the back part of his teeth that the dentists can successfully do with their lights, gloves and other treatment to preserve his gums. I know of a young man of David's age who was taken to Bismarck along with others in his group home and had all his teeth pulled. I know that could save the State a lot of money, but I am horrified to think that could happen to David.

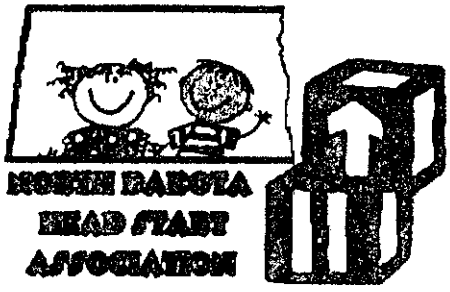
Many dentists here in Fargo won't take Medicare patients. Dr. Brent Holman has been David's dentist from the beginning and continues to treat David. Dr. Holman's practice is limited to Pediatric dentistry and he does take Medicare. David was also under the care of Dr. Robert Kline, a periodontist, recently deceased, who did take Medicare. It is recommended that David see a dentist every two months. None of the three periodontists here in Fargo take Medicare and charge $122.00+ for a visit.

I would appreciate your help and advice in knowing if there are any funds available to increase the funding of the dental care for the developmentally disabled in North Dakota.

Respectfully yours,

Katherine Moe

Attachment 3



SENATE BILL 2213
DENTAL MEDICAL ASSISTANCE REIMBURSEMENT

Tuesday, January 18, 2005

Good Morning Chairperson Lee and members of the Senate Human Services Committee,

My name is Allison Dybing, President of the North Dakota Head Start Association, providing a voice for over 3500 low-income children, prenatal to age five and their families, served in ND Head Start and Early Head Start. We support Senate Bill 2213 to increase dental medical assistance reimbursement. Increase Medicaid dental reimbursement to the 75 percentile. Adequate dentist reimbursement, along with efficient claims submission and payment, will improve access to care for North Dakota's most vulnerable citizens.

Of the 35,000 Medicaid-eligible children in North Dakota, only a third receives a dental service in any given year (ND State Department of Health). Many dentists choose not to participate in Medicaid primarily due to low provider payment rates and burdensome paperwork. Children who cannot see dentists either utilize costly emergency rooms or go untreated which leads to facial swelling, discomfort and pain.

Due to the historically low payment rates for dental services under Medicaid, many states are increasing reimbursement levels for dentists to make them more comparable to commercial rates. Several of the steps to improve access to care have stemmed from lawsuits. California, Maine, New Jersey, New York, and West Virginia increased provider reimbursement rates because of lawsuits. Minnesota's Medicaid Provider Mandate was enacted in 1994 to require dentists and other providers to treat Medicaid beneficiaries as a condition of participation in health insurance programs for state employees. (Children's Defense Fund)

The proposed $12.1 million North Dakota dental Medicaid appropriations for this biennium are only 2% of the entire Medicaid budget. Dentists collectively write off about $4 million annually or about $13,300 for every dentist in the state. In this biennium, the amount that dentists write off exceeds the amount that the state of North Dakota provides to dental Medicaid in general funds.

Barriers to dental care for children must be removed so children can be free of untreated dental pain and receive regular preventative check-ups and treatment when needed. Children from low-income families should not be denied treatment due to cost and provider access issues. Each child has the basic human right to reach or develop their full potential.

Respectfully Submitted,
Allison Dybing
President of North Dakota Head Start Association

Attachment 4

Testimony in Support of
SB 2213

01-18-05

Chairman Lee, and members of the committee, my name is Gina Nolte, Executive Director of the Red River Valley Dental Access Project located in Fargo. The Red River Valley Dental Access Project is a 501 (c) (3) non-profit, non-governmental organization, which was formed to address the critical and growing problem of access to oral health care especially for low-income, uninsured and those who have Medical Assistance. I also co-chair a "Dental Access Committee" for the Greater Grand Forks area.

The Red River Valley Dental Access Project supports SB 2213. You have before you the *Fact Sheet* provided by the North Dakota Dental Association. As you can see accessing dental care is complex and a multifaceted issue, and affects many. To highlight, only about a third of children have a dental visit a year, experience twice as much decay, and only about 20% of the participating dentists perform the majority of dental services to those with Medicaid. Children and all vulnerable populations served through Medical Assistance are experiencing great difficulty in accessing dental care. And there are many more people who do not meet MA criteria and cannot afford dental care.

Community Action Associations in North Dakota conduct regular needs assessments. In 2003, 7 of the 8 regions of North Dakota reported that dental care was either the first or second basic need that was unmet – the other need

SB 2213

reported in 7 of the regions was food. Region IV Children's Services Coordinating Committee recently conducted a needs assessment (2004) and accessing dental care went from #10 most significant problem in 2001 to #3 most significant problem in 2004 as reported by key informants in the Grand Forks region.

Oral healthcare is a part of overall health. A sample of situations that I have encountered include children who couldn't focus in school because they were in pain, elderly who cannot find someone to even align or repair their dentures and have difficulty eating, a 36 year old man who had recent heart surgery and whose face was swollen from an abscess and could not find care, a woman who could not find a dentist, but needed an oral health evaluation before she could start radiation for a oral cancer, a nursing home who cannot find a dentist to take their patients, providers and family members who struggle to find dental care for their clients who have disabilities; developmentally, emotionally and/or physically.

While we know there is no simple solution to this problem, it is highly unlikely that any progress can be made without the support and passage of this bill. I urge you to vote to pass SB 2213. It is only with your leadership that residents in North Dakota will have improved access to oral healthcare. We thank you for your consideration of this very important legislative action.

Current Red River Valley Dental Access Project Board of Directors:

Sherlyn Dahl	Family HealthCare Center	President (2005)
David Manning	Prairie Oral Surgery	Vice President
Stacy Goodwill, DDS	Family HealthCare Center	Sec/Treasurer
James Lichtsinn, DDS	Moorhead	Past President (03-04)
Brent Holman, DDS	Fargo	Past President (00-02)
Kathy McKay	Clay County Public Health	
Fowzia Addie	Representative from Refugee Community	
Joan Altenbernd	Migrant Health	
Maija Beyer	North Dakota Department of Health, Oral Health Program	
Dan Boedigheimer, DDS	Apple Tree Dental	
Mary Kay Herrmann	Fargo Cass Public Health	
John Hicks, DDS	Dakota Clinic/Dakota Medical Foundation	
James McDonald, DDS	Fargo	
Heather Skari, DDS	Fargo	
Carol Steidl	MN State Community and Technical College	
Bob Syverson	ND Protection and Advocacy	
Judy Vorachek	Fargo Dental Hygienist	

Literature Review on Low Income Access to Dental Services

This literature review focuses on the access of low income respondents to dental services. The primary source includes a series of needs assessment studies conducted for the Community Action Associates in North Dakota. In addition, a secondary source includes a *Children's Oral Health Maternal and Child Health Fact Sheet*, published by the North Dakota Department of Health.

North Dakota Statewide Data

This section of the literature review focuses on a series of needs assessment studies of low income individuals in North Dakota. Table 1 presents data for studies conducted in 1996, 1998, and 2003.

TABLE 1
STATEWIDE THREE YEAR COMPARISON
RANKING OF NEEDS THAT ARE BASIC TO WELL-BEING

Needs	*1996**	*1998*	*2003*
Food	67.4%	54.8% (-12.6)	54.3% (-0.5)
Dental Health Care	48.3%	48.0% (-0.3)	44.3% (-3.7)
Clothing	31.1%	35.0% (+3.9)	39.9% (+4.9)
Employment	25.3%	33.3% (+8.0)	38.6% (+5.3)
General Health Care	50.6%	38.2% (-12.4)	37.9% (-0.3)
Referrals/Info about available assistance	25.9%	31.9% (+6.0)	32.7% (+0.8)
Housing/Shelter	44.2%	27.6% (-16.6)	32.0% (+4.4)
Education	23.7%	27.2% (+3.5)	31.3% (+4.1)
Transportation	31.6%	26.7% (-4.9)	29.2% (+2.5)
Budgeting Skills Training	14.5%	25.4% (+10.9)	27.0% (+1.6)
Child Care Services	27.0%	24.5% (-2.5)	24.5% (0.0)
Legal Services	18.2%	19.0% (+0.8)	21.7% (+2.7)
Family or individual counseling	18.1%	20.2% (+2.1)	21.2% (+1.0)
Immediate/Crisis Assistance	16.2%	18.3% (+2.1)	20.8% (+2.5)
Income Tax Preparation	N/A	14.9%	16.1% (+1.2)

**Question for 1996 was different in wording compared to 1998 and 2003.*

As shown in Table 1, the top ranked need in 2003 was food as indicated by 54.3% of the respondents. The second rated need was dental health care as indicated by 44.3%. Clothing was third at 39.9%. In 1998 a similar study of 1,450 low income respondents was conducted for the North Dakota Community Action Association by the North Dakota State Data Center. This study also found food to be the top rated need among respondents as 54.8% mentioned it followed by dental health care at 48.0%, with general health care third at 38.2%. In 1996 a similar study found Dental Health Care to be a basic need according to 48.3% of the low income respondents.

The data in Table 1 show that Dental Health Care is one of the most serious health issues facing low income North Dakotans over the past eight to nine years. Statewide it was the third most important need in 1996 and has been the second most important need in 1998 and 2003. The relative stability of the percentage of respondents indicating that is a need shows the persistence of the problem of dental health care.

Table 2 provides data from the same question but focuses only on the top two needs for the eight regions in North Dakota from the 2003 needs assessment survey.

TABLE 2

EIGHT REGION OVERVIEW

	Williston Region 1	*Minot Region 2*	*Devils Lake Region 3*	*Grand Forks Region 4*	*Fargo Region 5*	*Jamestown Region 6*	*Bismarck Region 7*	*Dickinson Region 8*
Top Rated Basic Need	Food 50.6%	Food 44.2%	Food 57.6%	Food 57.6%	Dental 58.2%	Food 42.7%	Food 73.9%	Dental 36.7%
Second Rated Basic Need	Dental 46.5%	Employ 32.3%	Dental 45.0%	Dental 49.8%	Food 55.4%	Dental 35.3%	Dental 52.9%	Food 32.9%

The data in Table 2 show that Dental Care is a consistent need across the state of North Dakota and is not simply skewed in one or more counties. The results show that Dental Care needs are top rated in two counties, including Region 5 (Fargo Area) and Region 8 (Dickinson Area). In addition, Dental Care is a second rated need in five of the remaining six regional areas. In the Minot Region Dental Care was rated fourth at 27.8%.

REGION 5 DATA

The 2003 statewide needs assessment conducted by Danielson and Associates also provided separate reports for eight regions of North Dakota. The Southeast North Dakota Community Action Association based in Fargo, and includes Steele, Traill, Cass, Ransom, Sargent, and Richland counties, had a separate regional report that indicated Dental Health Care was the top rated need for low income respondents as 58.2% checked it as a need. Food was second at 55.4% followed by General Health Care at 50.7%. The 1998 study conducted by the

North Dakota State Data Center also showed that Dental Health Care was the top rated need as 47.6% listed that need. Food was second at 40.7% and General Health Care was third at 31.9%. Table 3 presents the data from the Region 5 report.

TABLE 3

RANKING OF NEEDS THAT ARE BASIC TO WELL-BEING: REGION 5

Needs	*1996**	*1998*	*2003*
Dental Health Care	55.3%	47.6% (-7.7)	58.2% (+10.6)
Food	64.7%	40.7% (-24.0)	55.4% (+14.7)
General Health Care	57.1%	31.9% (-25.2)	50.7% (+18.8)
Referrals/Info about available assistance	27.6%	22.5% (-5.1)	40.8% (+18.3)
Child Care Services	35.3%	31.0% (-4.3)	39.6% (+8.6)
Employment	36.5%	22.8% (-13.7)	37.7% (+14.9)
Education	28.8%	24.8% (-4.0)	37.1% (+12.3)
Clothing	37.1%	27.8% (-9.3)	35.7% (+7.9)
Housing/Shelter	50.0%	14.8% (-35.2)	35.4% (+20.6)
Budgeting Skills Training	19.4%	16.3% (-3.1)	33.3% (+17.0)
Immediate/Crisis Assistance	18.8%	10.9% (-7.9)	31.9% (+21.0)
Legal Services	19.4%	18.9% (-0.5)	25.0% (+6.1)
Family or individual counseling	21.8%	22.4% (+0.6)	24.9% (+2.5)
Transportation	28.8%	17.9% (-10.9)	24.9% (+7.0)
Income Tax Preparation	N/A	9.0%	16.5% (+7.5)

**Question for 1996 was different in wording compared to 1998 and 2003.*

Table 3 shows that Dental Care needs are very high in the most populated region of the state. A total of 58.2% of those surveyed indicate the need for dental care and the need has grown by 10% from 1998.

SPECIAL POPULATIONS AND DENTAL CARE NEEDS

The previous sections have detailed the general needs for Dental Care among the general population of low income individuals and families. In addition, several special population groups are under served in terms of dental health needs.

Children from Low Income Families

According to the *Children's Oral Health Maternal and Child Health Fact Sheet*, published by the North Dakota Department of Health, "In North Dakota between 1997 and 1999,

fewer than one in three Medicaid-eligible children received dental services, as compared to nine in ten who received medical services." In addition, the fact sheet reports the following:

- In 1995, 10 percent of children ages 3 through 5 suffered from baby bottle tooth decay. Among Native American children, the rate was three times higher (29 percent).

- In 1994, more than one-half (51 percent) of 8 year olds and nearly three-fourths (70 percent) of 15 year olds experienced tooth decay. One-fourth (25 percent) of children suffered from untreated tooth decay.

- In 1999, nearly one-fourth (22.5 percent) of students in grades nine through 12 did not brush their teeth daily, and a similar percentage (23.4 percent) either had not visited the dentist within the past year or had never gone to the dentist.

Although these data are from the mid and late 1990's, they are consistent with the more current findings gathered for the Community Action Partnership from adults about their families in 2003.

Attachment 5

Testimony on HB 2213
Senate Human Services Committee
January 18, 2005

Chairman Lee and members of the committee, my name is Jon Larson. I am the executive Director of Enable, Inc, a licensed service provider for people with developmental disabilities in Bismarck and Mandan. I am also here today to testify on behalf of the North Dakota Association of Community Facilities (NDACF). I am here today in support of SB 2213.

Access to appropriate dental care has become a serious issue for people receiving medical assistance in North Dakota. Many people with developmental disabilities are forced to travel outside their home communities for dental care because of a shortage of dentists willing to serve people on medical assistance. We are very appreciative of the Dentists who are willing to accept individuals receiving medical assistance and feel that they should be reimbursed adequately for the services they provide. We are also hopeful that if reimbursement improves more Dentists will be encouraged to provide these needed services.

Thank-you for this opportunity to testify today.

Jon Larson, Executive Director Enable, Inc.
North Dakota Association of Community Facilities

Attachment 6

TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE

REGARDING SENATE BILL 2213

JANUARY 18, 2005

Chairman Lee, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding this proposed legislation.

Dental services are one of the optional services that are made available to recipients of the North Dakota Medicaid program. North Dakota has chosen to cover this service for all individuals eligible for the Medicaid program. Payments for dental services are based on a fee for service rate schedule. Fee increases are granted only when the Legislature provides funds for that purpose.

During the 1997 session, the Legislature did provide for a substantial increase in dental fees of about $2 million. At that time the Department established a separate fee schedule for adults and children. Services for children are paid at a higher rate to encourage dentists to provide services to our youngest citizens. The fee increase did result in stabilizing the number of dentists who were willing to remain in the program, but did not result in any substantial increase in the utilization of dental services for Medicaid recipients.

Subsequent to that increase, the Legislature provided inflationary increases of about 2 percent per year until 2002. During the 2001-2003 biennium the Department experienced a budget shortfall that included a deficit of about $13.2 million in general funds. We were unable to grant any fee increases for any providers in the last year of that biennium. In addition, the Legislature did not provide any funds during the current biennium to provide fee increases for any providers except nursing facilities, basic care facilities, in-patient hospital and physician services.

This bill would require the Department to calculate a new fee schedule every two years based on the 75th percentile of billed charges. This method takes the usual and customary charges for each dental service, and calculates at what fee at least 75 percent of all dentists would receive 100% of their billed charges. It would require the Department to recalculate these rates every two years, based on the 75th percentile methodology.

The bill would establish in state law how to pay dentists for services, and would require the Legislature to appropriate adequate funds to support this payment process. At the present time no other provider group has this type of language in state law except for nursing facilities. Most of the professional provider groups and hospitals have payment rates comparable or lower than dentists.

The Department does recognize that there is an access problem for some Medicaid recipients who cannot find a dentist who will treat them. If this bill becomes law I would hope that the dental community would make the commitment, and that dental access would become available for all recipients who seek that service.

The proposed budget for dental services in the 2005-2007 biennium is $13.1 million, of which $4.6 million is general funds. The proposed law indicates that the calculation would occur on September 30th of even numbered years. Based on this language the new fee would go into affect on October 1, 2006, and would be effective for about 10 months of the new biennium. The fiscal note for this bill totals $2.0 million of which about $.7 million is general funds. This bill would increase dental fees within the Medicaid program by about 37% above what other professional providers are scheduled to receive under the proposed appropriation for the next biennium and beyond.

I would be happy to respond to any questions you may have.

Billed to Paid Percentage by Provider Type

Provider Type	Amount Billed	Amount Paid	% of Paid to Billed Amount
General Hospital - Outpatient	$40,297,099.07	$24,309,477.30	60.33%
General Hospital - Inpatient	$81,890,489.93	$33,767,313.55	41.23%
Mental Hospital - Outpatient	$1,840,999.29	$883,946.86	48.01%
Mental Hospital - Inpatient	$6,016,062.25	$3,008,667.50	50.01%
Rehab Hospital - Outpatient	$420,367.49	$229,907.06	54.69%
Rehab Hospital - Inpatient	$378,978.50	$211,728.00	55.87%
Physician	$1,508,057.88	$688,019.00	45.62%
Chiropractor	$439,071.59	$166,954.16	38.02%
Psychologist	$357,863.18	$235,122.04	65.70%
Podiatrist	$55,813.29	$32,322.22	57.91%
Optometrist	$836,496.71	$633,981.26	75.79%
Audiologist	$130,811.40	$107,123.96	81.89%
Dentist	$8,894,684.69	$6,086,112.67	68.42%
Independent Clinic	$55,926,845.60	$23,937,521.16	42.80%
Home Health Agency/Hospice	$3,385,699.39	$2,766,768.38	81.72%
Hearing Aid Dealer	$263,673.89	$251,726.08	95.47%
Medical Equipment Supplier	$2,227,508.52	$1,557,273.44	69.91%
Nurse Practitioner	$2,012.85	$832.91	41.38%
Independent Laboratory	$1,029,688.03	$402,181.05	39.06%
Independent x-ray Service	$1,249,935.38	$425,367.99	34.03%
Ambulance	$2,773,656.54	$845,948.14	30.50%

* Using Dates of Service 07/01/2003 to 06/30/2004

Proposed amendments to SB 2213

Page 1, line 7, after "reimbursed" delete "at the seventy-fifth percentile" and insert "for allowed services for the 2005-2007 biennium at the rate of eighty-five percent"

Page 1, line 8, after "services" delete ". The seventy-fifth percentile of billed covered services must be determined as of September thirtieth of each even-numbered year." and insert "based upon a profile of fees submitted during 2004. The department, with the moneys appropriated, must establish a fee reimbursement profile that maximizes access to care."

Renumber accordingly

Fifty-ninth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2213

Introduced by

A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to dental Medicaid reimbursement.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Dental Medicaid Reimbursement. Dental services through the medical assistance program must be reimbursed for allowed services for the 2005-2007 biennium at a rate of eighty-five percent of billed covered services based upon a profile of fees submitted during 2004. The department, with the moneys appropriated, must establish a fee reimbursement profile that maximizes access to care.

PROPOSED AMENDED VERSION 1/23/05

II

TESTIMONY BEFORE THE SENATE APPROPRIATIONS COMMITTEE

REGARDING SENATE BILL 2213

FEBRUARY 8, 2005

Chairman Holmberg, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding this proposed legislation.

Dental services are one of the optional services that are made available to recipients of the North Dakota Medicaid program. North Dakota has chosen to cover this service for all individuals eligible for the Medicaid program. Payments for dental services are based on a fee for service rate schedule. Fee increases are granted only when the Legislature provides funds for that purpose.

During the 1997 session, the Legislature did provide for a substantial increase in dental fees of about $2 million. At that time the Department established a separate fee schedule for adults and children. Services for children are paid at a higher rate to encourage dentists to provide services to our youngest citizens. The fee increase did result in stabilizing the number of dentists who were willing to remain in the program, but did not result in any substantial increase in the utilization of dental services for Medicaid recipients.

Subsequent to that increase, the Legislature provided inflationary increases of about 2 percent per year until 2002. During the 2001-2003 biennium the Department experienced a budget shortfall that included a deficit of about $13.2 million in general funds. We were unable to grant any fee increases for any providers in the last year of that biennium. In addition, the Legislature did not provide any funds during the current biennium to provide fee increases for any providers except nursing facilities, basic care facilities, in-patient hospital and physician services.

This amended bill would require the Department to calculate the funds available for payment to dental providers based on 85 percent of billed covered charges during 2004. We would then establish a fee schedule that would maximize access to care. Based on payment data for 2004 the proposed change in payment methodology would require an additional $3.2 million, of which $1.2 million is general funds, in order to fund this fee increase in the 2005-2007 biennium.

The bill would establish in state law how to pay dentists for services, and would require the Legislature to appropriate adequate funds to support this payment process. At the present time no other provider group has this type of language in state law except for nursing facilities. Most of the professional provider groups and hospitals have payment rates comparable or lower than dentists.

The Department does recognize that there is an access problem for some Medicaid recipients who cannot find a dentist who will treat them. If this bill becomes law I would hope that the dental community would make the commitment to provide access for recipients who seek needed dental care.

The proposed budget for dental services in the 2005-2007 biennium is $13.1 million, of which $4.6 million is general funds. The additional funds in the fiscal note have not been included in the Executive budget.

I would be happy to respond to any questions you may have.

(1)

March 14, 2005

Testimony before the House Human Services Committee
Fort Union Room
Representative Clara Sue Price, Chairperson

Senate Bill 2213 – Relating to Dental Medical Assistance Reimbursement

Chairperson Price and members of the Committee, my name is Dr. Brent Holman. I am a practicing pediatric dentist from Fargo, North Dakota and Past President of the North Dakota Dental Association. I present this testimony in support of Senate Bill 2213.

The North Dakota Dental Association has been working to address the dental access issues in our state. One success is the Donated Dental Services program, through which volunteer dentists have donated nearly one quarter of a million dollars in dental care to over 100 people in the past two fiscal years. This program is designed to help the elderly and people with developmental disabilities who are unable to access care through other programs and unable to afford the care. The NDDA also participates in the national Give Kids A Smile program, which is designed to screen, educate, and treat children who are otherwise unable to access dental care. Dentists in Fargo have set up an urgent care clinic, which provides voluntary services to people with acute dental needs. This urgent care clinic prevents what would eventually become a considerably more expensive and less productive trip to a hospital emergency room. Grand Forks dentists also provide access to urgent care through partnership with the Third Street Clinic. In Bismarck, Bridging the Dental Gap started this fall and is seeing low-income patients. Additionally, dentists on their own provide free or discounted dental services daily in their private offices to those who may not have the means to cover the costs of the care. As great as these programs are, more must be done.

The medical assistance budget for the biennium is approximately $12 million, including both state and federal dollars. Based on a 60% reimbursement rate during the biennium, dentists contributed approximately $8 million worth of dental care to this program. That is considerably

more than the state's share, which is around $4 million. Charity cannot be the cornerstone of an effective dental care delivery system.

We are asking the committee to increase dental medical assistance reimbursement to 85% of billed charges. This level of reimbursement has proven effective in many states. (See attachment.) The attached letter of support from the American Academy of Pediatric Dentists cites the American Dental Association's **Access White Paper**, which identifies ways to improve access. This paper shows the success states have had where meaningful increases in reimbursement, similar to the 85% level, have occurred. States that have established reimbursement at similar levels have seen dramatic increases in provider participation.

The higher reimbursement is necessary to somewhat balance the issue of no-shows. The Medicaid population has a no-show rate of over 30% for scheduled dental visits. Dentists can't fill these vacancies, thus losing production time. A higher reimbursement is necessary to partially offset this loss and encourage dentists to participate.

Based upon a survey at our annual meeting in September, increasing reimbursement would provide additional dental access to the Medicaid population. While the NDDA has taken the lead on this issue; we have the support of 18 other groups that represent children and the elderly. (See attached resolution.) These groups represent our most vulnerable and compromised population in North Dakota; the elderly, individuals with physical and mental disabilities, and children. This legislation is necessary to ensure adequate dental access for this population.

Legislators are sometimes swayed by calls and letters supporting a certain piece of legislation. It is virtually impossible to mobilize this population to participate in the legislative process. Thus the NDDA and the 18 supporting groups are requesting this legislation for those that are unable to do so themselves.

The principle reason for this increase is to open the doors of more dental offices to the children you see in these pictures that are circulating among the committee members. Regular preventative dental care could easily prevent many of the conditions experienced by these children. If these suffering children had a regular dentist, and acute problems did occur, they would be able to access care more quickly due to their established relationship with a dentist. This would minimize the pain and resolve the problem. The effects on children with oral disease who lack access to dental care are devastating. The children experience considerable pain, which can affect their eating habits and growth. They are also more likely to get sick and miss school, and their ability to concentrate in school is affected.

Medical assistance patients seeking dental treatment often visit hospital emergency rooms, and the already high costs of these visits increased in North Dakota by 40% from July 2003 to 2004. Unfortunately, many trips to the hospital will not provide the necessary treatment needed to eliminate the chief complaint of the patient. Access to regular dental care also prevents costly treatment by specialists in the future, which becomes necessary due to the rapid deterioration of dental health. Attached to this testimony is summary of the cost savings to the state, entitled **North Dakota Cost Savings with Improvement in Dental Medicaid Access to Care.**

I have also attached to my testimony a **Dental Medicaid in North Dakota Fact Sheet** for your review. I would like to highlight a few of those facts. (See attachment.)

Increasing reimbursement is another step by the legislature, the dental community, and by others interested in providing care to our underserved population, to create an environment that provides access to quality dental care to these citizens. The last significant fee increase in the dental program was in 1997. We, as dentists, have a moral obligation to advocate for the underserved population.

This issue is not about dentists. It is about the vulnerable patients who currently cannot access care. The North Dakota Dental Association is trying to improve this situation for these patients by encouraging dentists to continue their very significant participation in volunteer access programs around the state, and partner with you in the Legislature to improve reimbursement in a way that will be meaningful enough to enlist a significant number of dentists to reassess their resistance to participate.

North Dakota's dental community has improved access to care through Donated Dental Services, Give Kids A Smile, urgent care clinics, and gratis work provided daily in private offices. However, we cannot solve this problem alone. We need dental access to be a joint effort with the state of North Dakota. The NDDA asks you to support this requested increase.

North Dakota Cost Savings with Improvement in Dental Medicaid Access to Care

1. As access to care deteriorates, Medicaid patients increasingly show up at Emergency Rooms and Walk-in Clinics where treatment is costly and rarely definitive. The number of ER visits by MA patients for dental problems in ND increased by 27% and the amount paid for these visits increased by 40% through July 2004 compared to 2003 (ND Department of Human Services). A study in Texas showed that the costs of managing dental problems in an in-patient medical setting were about 10 times more than that to provide care in a dental office (Pettinato, Webb, Seale, Pediatric Dentistry 2000:22(6)).

2. Future dental costs for children who receive regular preventive visits early in life are 50% lower than costs for children who receive care after years of neglect (Children's Dental Health Project Brief, February 2005).

3. In 2003, only 11,638 of the 38,494 kids that were eligible for Medicaid through EPSDT received a dental visit (ND Department of Human Services). These low-income children typically have 2-3 times the amount of dental disease than other children. As the dental disease becomes more severe, these children many times require treatment by a specialist under general anesthesia in a hospital setting where medical costs in North Dakota can run as high as $3,000-$4,000 per child.

4. Early access to dental care for low-income children allows better access to preventive education and treatment. Adequate access to fluoride supplementation from birth reduces decay by 60% over a lifetime. Sealants in permanent molars for high-risk children prevent decay completely over 5-7 years on average (CDHP Policy Brief, Feb 2005).

5. Elderly Medicaid patients many times have dental infection that impacts their overall health and due to the severity of their problems and/or medical diagnoses require specialized treatment by oral surgeons in a hospital setting.....a setting that involves as much as $5,000-$6,000 in additional medical costs that are billed to the state.

6. For each additional dollar of state Medicaid spending, 3.77 additional dollars of goods and services are provided in the state (Families USA, May 2004).

7. The proposed increase to 85% of billed services for dental Medicaid involves only an additional 1.15 million dollars of state spending over the next biennium with a federal match of about 2.14 million. The dental budget is only about 1% of the total Human Service budget in ND.....money spent on this program may have a much more significant effect than a comparative amount of money spent in other parts of the Human Service budget.

I

February 8, 2005

Testimony before the Senate Appropriations Committee
Harvest Room
Senator Ray Holmberg, Chairman

Senate Bill 2213 – Relating to Dental Medical Assistance Reimbursement

Chairman Holmberg and members of the Committee, my name is Dr. Kristin Kenner. I am a practicing general dentist from Devils Lake, North Dakota and President of the North Dakota Dental Association. I present this testimony in support of Senate Bill 2213.

The North Dakota Dental Association has been working to address the dental access issues in our state. One success is the Donated Dental Services program, through which volunteer dentists have donated nearly one quarter of a million dollars in dental care to over 100 people in the past two fiscal years. This program is designed to help the elderly and people with developmental disabilities who are unable to access care through other programs and unable to afford the care. The NDDA also participates in the national Give Kids A Smile program, which is designed to screen, educate, and treat children who are otherwise unable to access dental care. Dentists in Fargo have set up an urgent care clinic, which provides voluntary services to people with acute dental needs. This urgent care clinic prevents what would eventually become a considerably more expensive and less productive trip to a hospital emergency room. Grand Forks dentists also provide access to urgent care through partnership with the Third Street Clinic. In Bismarck, Bridging the Dental Gap started this fall and is seeing low-income patients. Additionally, dentists on their own provide free or discounted dental services daily in their private offices to those who may not have the means to cover the costs of the care. As great as these programs are, more must be done.

The medical assistance budget for the biennium is approximately $12 million, including both state and federal dollars. Based on a 60% reimbursement rate during the biennium, dentists contributed approximately $8 million worth of dental care to this program. That is considerably more than the state's share, which is around $4 million. Charity cannot be the cornerstone of an effective dental care delivery system.

We are asking the committee to increase dental medical assistance reimbursement to 85% of billed charges, which equates to the 75th percentile of billed charges. This level of reimbursement has proven effective in many states. (See attachment.) The attached letter of support from the American Academy of Pediatric Dentists cites the American Dental Association's **Access White Paper**, which identifies ways to improve access. This paper shows the success states have had using the market approach the ADA used to arrive at the 75th percentile. States that have established reimbursement at that level have seen dramatic increases in provider participation.

The higher reimbursement is necessary to somewhat balance the issue of no-shows. The Medicaid population has a no-show rate of over 30% for scheduled dental visits. Dentists can't fill these vacancies, thus losing production time. A higher reimbursement is necessary to partially offset this loss and encourage dentists to participate.

Based upon a survey at our annual meeting in September, increasing reimbursement would provide additional dental access to the Medicaid population. While the NDDA has taken the lead on this issue, we have the support of 18 other groups that represent children and the elderly. (See attached resolution.) These groups represent our most vulnerable and compromised population in North Dakota; the elderly, individuals with physical and mental disabilities, and children. This legislation is necessary to ensure adequate dental access for this population.

Legislators are sometimes swayed by calls and letters supporting a certain piece of legislation. It is virtually impossible to mobilize this population to participate in the legislative process. Thus the NDDA and the 18 supporting groups are requesting this legislation for those that are unable to do so themselves.

The principle reason for this increase is to open the doors of more dental offices to the children you see in these pictures that are circulating among the committee members. Regular preventative dental care could easily prevent many of the conditions experienced by these children. If these suffering children had a regular dentist, and acute problems did occur, they would be able to access care more quickly due to their established relationship with a dentist. This would minimize the pain and resolve the problem. The effects on children with oral disease who lack access to dental care are devastating. The children experience considerable pain, which can affect their eating habits and growth. They are also more likely to get sick and miss school, and their ability to concentrate in school is affected.

Medical assistance patients seeking dental treatment often visit hospital emergency rooms, and the already high costs of these visits increased in North Dakota by 40% from July 2003 to 2004. Unfortunately, many trips to the hospital will not provide the necessary treatment needed to eliminate the chief complaint of the patient. Access to regular dental care also prevents costly treatment by specialists in the future, which becomes necessary due to the rapid deterioration of dental health.

I have attached to my testimony a **Dental Medicaid in North Dakota Fact Sheet** for your review. I would like to highlight a few of those facts. (See attachment.)

Increasing reimbursement is another step by the legislature, the dental community, and by others interested in providing care to our underserved population, to

create an environment that provides access to quality dental care to these citizens. We, as dentists, have a moral obligation to advocate for the underserved population.

This issue is not about dentists. It is about the vulnerable patients who currently cannot access care. The North Dakota Dental Association is trying to improve this situation for these patients by encouraging dentists to continue their very significant participation in volunteer access programs around the state, and partner with you in the Legislature to improve reimbursement in a way that will be meaningful enough to enlist a significant number of dentists to reassess their resistance to participate.

North Dakota's dental community has improved access to care through Donated Dental Services, Give Kids A Smile, urgent care clinics, and gratis work provided daily in private offices. However, we cannot solve this problem alone. We need dental access to be a joint effort with the state of North Dakota. The NDDA asks you to support this requested increase.

January 18, 2005

Senate Bill 2213:

In support of

Representing: North Dakota Chapter of the American Academy of Pediatrics (NDAAP)

As a voice for the children of North Dakota, our organization has a strong tradition in advocacy for children and their needs. The needs of the children span from health, social services, prevention and ongoing access to the people and professionals they need. The access to dentists in our state is diminishing, and especially for our kids. There is a responsibility that aligns with care for our children and that is fair access. Currently there is a very underserved population of children in our state when it comes to dentistry services, and that is the group of children under the medicaid insurance plan. The problem is that dentists seem to not want and accept medicaid patients because the reimbursement is so low- and in doing so access is terrible for those children and their families.

The plan to increase dental reimbursement for medicaid would improve access to dental care for the kids of North Dakota, and we support that.

Todd Twogood M.D., FAAP
President Elect and Chair of the Legislative Committee

Thank you.

January 22, 2005

Nola J. Storm
Social Worker
10308 6th St. S.
Fargo ND 58104

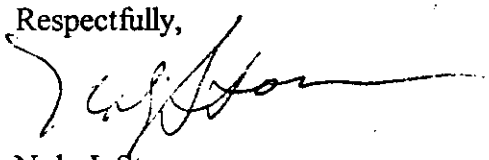
Honorable Legislators,

I would like to ask that you would support SB 2213. As a social worker working with family literacy, and English as a Second Language programs in Fargo I am in contact with families who are participants in the Medical Assistance program. I occasionally receive phone calls from teachers regarding dental problems their students are experiencing. One time I particularly remember a teacher called me with concern because she had a little girl who was experiencing great pain in one of her teeth. The teacher said that the little girl would eventually fall asleep in class to shut out the pain. Because so few dentists are currently taking Medical Assistance patients it can be difficult helping families obtain timely appointments. I was able to get this family in contact with the Dental Access program in Moorhead Minnesota, but they are limited to doing extractions, temporary pain relief, and referrals. These referrals are to the already over-burdened few dental clinics willing to take Medical Assistance clients.

Like any other business dental businesses want to make a profit. They shouldn't have to choose between giving their employees raises and training, and upgrading equipment, or providing dental care to Medical Assistance patients. Currently, to do so more often than not means doing so at a financial loss.

By increasing the Medical Assistance reimbursement you will make it less of a financial burden on those who currently accept these patients, and make it more likely that others will step in and begin opening their doors.

Respectfully,



Nola J. Storm

(2)

TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE

REGARDING SENATE BILL 2213

MARCH 14, 2005

Chairman Price, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding this proposed legislation.

Dental services are one of the optional services that are made available to recipients of the North Dakota Medicaid program. North Dakota has chosen to cover this service for all individuals eligible for the Medicaid program. Payments for dental services are based on a fee for service rate schedule. Fee increases are granted when the Legislature provides funds for that purpose.

During the 1997 session, the Legislature did provide for a substantial increase in dental fees of about $2 million. At that time the Department established a separate fee schedule for adults and children. Services for children are paid at a higher rate to encourage dentists to provide services to our youngest citizens. The fee increase did result in stabilizing the number of dentists who were willing to remain in the program, but did not result in any substantial increase in the utilization of dental services for Medicaid recipients.

Subsequent to that increase, the Legislature provided inflationary increases of about 2 percent per year until 2002. During the 2001-2003 biennium the Department experienced a budget shortfall that included a deficit of about $13.2 million in general funds. We were unable to grant any fee increases for any providers in the last year of that biennium. In addition, the Legislature did not provide any funds during the current biennium to provide fee increases for any providers except nursing facilities, basic care facilities, in-patient hospital and physician services.

This amended bill would require the Department to calculate the funds available for payment to dental providers based on 85 percent of billed covered charges during 2004. We would then establish a fee schedule that would maximize access to care. Based on payment data for 2004, the proposed change in payment methodology would require an additional $3.2 million, of which $1.2 million is general funds, in order to fund this fee increase in the 2005-2007 biennium.

The bill would establish in state law how to pay dentists for services, and would require the Legislature to appropriate adequate funds to support this payment process for the next biennium. At the present time no other provider group has this type of language in state law except for nursing facilities. Most of the professional provider groups and hospitals have payment rates comparable or lower than dentists.

The Department does recognize that there is an access problem for some Medicaid recipients who cannot find a dentist who will treat them. If this bill becomes law I would hope that the dental community would make the commitment to provide access for recipients who seek needed dental care.

The proposed budget for dental services in the 2005-2007 biennium is $13.1 million, of which $4.6 million is general funds. The additional funds in the fiscal note have not been included in the Executive budget. If this bill becomes law we request that the necessary funds be added to the appropriation as indicated by the language on line 10 of the bill.

I would be happy to respond to any questions you may have.

Red River Valley

Dental Access Project

Progress and Participation Report: The First Four Years 2000 - 2004

Mission

The Red River Valley Dental Access Project is an oral health coalition that is committed to improve access to oral health care through advocacy, education, expanding and developing the workforce, assuring services and creating unified strategies to improve access.

History

The Red River Region Community Dental Access Committee was formed in 1997 to address the critical and growing problem of access to oral health care especially for low-income, uninsured or Medical Assistance eligible individuals and their families. In 1998, through the support of Dakota Medical Foundation, the committee solicited the help of Oral Health of America to facilitate a conference with regional stakeholders. In November 1999, a follow-up meeting was held for strategic planning which set the stage for a grant that was awarded by Dakota Medical Foundation in 2000 for the development of the Red River Valley Dental Access Project (RRVDAP). RRVDAP is now a non-profit, non-governmental, 501-(c)(3) organization lead by a board of committed individuals, agencies, health and dental (public and private) professionals and legislators.

364-5364
www.rrdentalaccess.com

Programs

Advocacy

- Resource and referral
- Collect and disseminate regional and national dental access data
- Activities to increase awareness of oral healthcare issues and effect on underserved populations
- Participation and collaboration with organizations, programs and communities to develop strategies to improve oral healthcare

Education/Prevention

"Healthy Smiles for the Red River Valley " education/prevention project program

3 components:

- "Healthy Smiles for the Red River Valley"; HRSA- Healthy Tomorrows Partnership for Children Program grant, targeting low-income children and families.
- "Healthy Smiles for the Red River Valley – Special Populations"; ND Oral Health Grant Allocation, targeting special populations and their caretakers such as nursing homes, Developmentally Delayed, residential programs, child care and others.
- "Healthy Smiles for the Red River Valley – Celebrating Diversity"; F-M Area Foundation grant, geared towards education activities and activities that increase understanding planned for 2004.

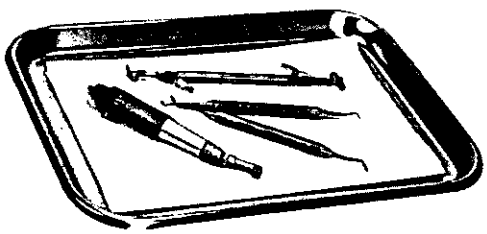
Education/Prevention Activities

Activities in 14 counties of North Dakota and 11 Counties in Minnesota:

- United Way: School Supply Drive, Holiday Clearing Program
- WIC Programs: Fargo/Cass, Richland, Grand Forks Counties
- Head Start/Early Head Start Programs: Clay-Wilkin Opportunity Council, Otter Tail-Wadena Community Action Council, Tri-Valley Opportunity Council, West Central Minnesota Communities Action, Mahube Community Council, Mayville State University Child Development Programs, Grand Forks Head Start Community Action, Region VI Head Start, SENDCAA Head Start Program
- Child Care Providers, Daily Discoveries Classroom, Dickey County Child Care Association, Midwest Kids Fest, Child Resource & Referral
- Health Fairs: Wal Mart, Kindred High School, MSUM, NDSU, Concordia
- American Dental Association "Give Kids a Smile Day" Program
- CHARISM, Madison and Jefferson YMCA School Programs
- ECFE projects, Partners in Parenting – Detroit Lakes, Park Rapids, Parkers Prairie

- Fargo Schools ELL, Refugee Activities, Center for New Americans
- Romkey Park Parent's Resource Fair and Centro Cultural Fall Fiesta
- Migrant Health: East Grand Forks, Hillsboro, Moorhead, Grafton, Manvel
- Developmental Disability Programs: Friendship, Friendship ISAL, Fraser, Svee Home, DWAC, Community Living Services, Northern Plains Conference on Aging/Disabilities
- ShareHouse, Dakota Boys Ranch, Ruth Meiers
- Mental Health Association – Social Club, The Social Connextion of Moorhead
- Long Term Care: Northwood Nursing Home, Sheyenne Health Care Center, Roseadele Nursing Home, Hillsboro Medical Center, Northwood Nursing Home, Luther Memorial Home, Lakota Good Samaritan, Bethany, Valley Eldercare, Woodside Village Nursing, Waterford, St Gerard's Nursing Home, Four Seasons Health Care, Hatton-TriCounty Nursing Home, Evergreens, Good Samaritan Home, St. Anne's Guest House, McVille Care Center, MeritCare Home Care
- Public Health: Richland County, Southeast Counties Nurse group, Clay County, Fargo/Cass County
- Family HealthCare Center: Homeless Clinics
- Workshop for Area Case Managers

Our thanks to the many partners who have collaborated with us on these activities, including dental hygiene and assisting students from both MN State Community and Technical College and ND State College of Science, Apple Tree Dental, and the CHARISM Center as well as members of our Advisory Committee.



Expanding and Developing the Workforce

Listed below are the Partners and Members of the RRVDAP that work to develop increased opportunities for improved oral health care:

Organizations whose missions focus on serving underserved populations:

- Apple Tree Dental
- Family HealthCare Center
- Migrant Health Dental Program
- MNSCTC and NDSCS Dental Hygiene and Assisting Programs
- National Foundation for Dentistry for the Handicapped, Donated Dental Services Program

Initiatives formed to develop strategies for improved oral healthcare for underserved:

- Grand Forks Dental Access Committee
- MN Oral Health Solutions Project
- ND Oral Health Coalition
- University of Minnesota Mobile Dental Clinic, sponsored by Medica in March 2002, to serve Medical Population in Clay County
- American Dental Association's annual Give Kids A Smile Day

Legislative Initiatives:

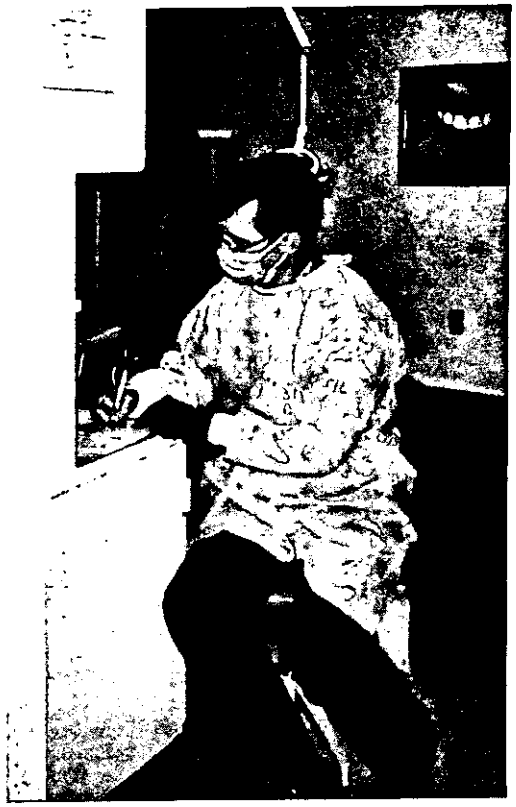
- MN Legislative activities include: dental access grants, incentive-based reimbursement, dental advisory committee, student loan forgiveness program, licensed foreign trained dentists, expanded role of dental auxiliaries, increased reimbursement rates/selected areas, retired dentist program, and in 2002, guest licensure, Donated Dental Services Program, Volunteer Health Care Provider Program
- ND Legislative loan repayment program, Donated Dental Services

Give Kids A Smile Program Participating Dentists:

Dr. Paul Abrahamson
Dr. Richard Callender
Dr. Brad Clark
Dr. Nick Dorsher
Dr. Darin Edeen
Dr. Tom Fellman
Dr. Stephanie Gruchalla
Dr. Melinda Harr
Dr. Dennis Hetland
Dr. Chris Hieb
Dr. William Hunter
Dr. Brent Holman
Dr. Mark Jung
Dr. Michael Keim
Dr. William Kranzler
Dr. James Lancaster
Dr. Fred Lundstrom
Dr. James Lichtsinn
Dr. Dan Lysne
Dr. Brian Mathison
Dr. Ed May
Dr. Lynne Olson
Dr. John Pollard
Dr. Robert Saunders
Dr. Heather Skari
Dr. David Rostad
Dr. Paul Tronsgard
Dr. David Vogelsang
Dr. Robert Toutges

Assuring Services:

An Urgent Care/Walk In Dental Clinic for low-income, uninsured or Medicaid eligible individuals began in June 2002. This program is a collaborative effort between the local private dentists, oral surgeons, dental specialists and Family HealthCare Center. The program which is open on Tuesday nights and two Fridays a month during the school year has served nearly 1,600 patients from over 80 communities in our region. This clinic has been successful because of the dedication of all these partners, especially dentists who have volunteered their time and services:



Participating Dentists

Dr. Paul Abrahamson
Dr. Geoffrey Bentley
Dr. Byrum Cartwright
Dr. Gary Cornforth
Dr. Nicholas Dorsher
Dr. Tom Fellman
Dr. Dennis Hetland
Dr. William Hunter (Peds)
Dr. Charles Klemz
Dr. James Lancaster
Dr. Dan Lysne
Dr. James McDonald
Dr. Lynne Olson
Dr. David Rostad
Dr. Heather Skari
Dr. William Stearns
Dr. David Tranby
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Dr. Charles Crago
Dr. Paul Iverson
Dr. John Hicks (Oral Pathology)
Dr. Mitchell Magid
Dr. Edward May
Dr. Gary Lindemoen
Dr. Scott Preisler

Financial Information

The Funding for all programs and activities sponsored by RRVDAP for FY 03-04:

Dakota Medical Foundation 51%

All other Grants 38%

Fundraising/ Contributions 5%

Revenues from Urgent Care 5%

Other 1%

Grants

- American Academy of Pediatrics CATCH Grant - collaboration
- American Dental Association Foundation Grant in Honor of Dr. Brent Holman receiving the E. Bud Tarrson Access to Oral Healthcare Award
- Dakota Medical Foundation - 3-year seed grant, 2003 - extended grant
- Dakota Medical Foundation Matching Program
- Dakota Medical Foundation Board Member Discretionary Grant
- Delta Dental Plan of Minnesota
- Fargo-Moorhead Area Foundation
- Foundation for Dental Health Education
- Healthy Tomorrows Partnership for Children Program (Maternal Child - HRSA, DHHS)
- Minnesota Department of Human Services
- North Dakota Oral Health Department
- Otto Bremer Foundation

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(Accumulated Contributions)

Grand Access Champion
$5,000 plus

- Swanson Health Products
- Anonymous Donor

Access Champion
$1,000 - $5,000

- Corwin-Wilson, Mgmt, LLP
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- Dental Service Corporation of ND/Blue Cross Blue Shield
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Red River Valley **Dental Access** Project

To learn how you can further support this effort call 364-5364 or visit www.rrdentalaccess.com.

Have you had trouble getting dental care?
Listed below and inside are options
to help you and your family
get the dental care you need!

Dental Clinics

Family HealthCare Center

Fargo: (701) 271-3332
306 4th St. N. (lower level)

Moorhead: (218) 299-7830
715 11th St. N., Suite 106B

Services for all ages:
- Routine restorative care
- Urgent care (extractions, sedative fillings, pain relief)
- Preventative (cleaning, exam, x-ray)

Generally accepted payers *(verification of eligibility required)*:
- North Dakota and Minnesota Medical Assistance
- Minnesota plans (BluePlus, Medica, Ucare)
- North Dakota and Minnesota state assistance programs
- Sliding fee scale based on eligibility
- Other specialized programs; for example, Homeless Health Services, special grants and contracts
- Minimum co-pay and self-pay amounts are due at visits.

Apple Tree Dental

Hawley: (218) 483-1038
520 Main Street

Services for all ages:
- Routine restorative care
- Urgent care (extractions, sedative fillings, pain relief)
- Preventative (cleaning, exam, x-ray)
- Dentures
- Root canals
- Crowns

Generally accepted payers *(verification of eligibility required)*:
- North Dakota & Minnesota Medical Assistance
- Minnesota plans (BluePlus, Medica, Ucare)
- North Dakota and Minnesota state assistance programs
- Self pay
- Payment plans
- Minimum co-pay and self-pay amounts are due at visits.

Bridging the Dental Gap

Bismarck, ND: (701) 221-0518
1223 South 12th Street, Suite #1

Services for all ages:
- Routine restorative care
- Urgent care (extractions, sedative fillings, pain relief)
- Preventative (cleaning, exam, x-ray)
- Limited to residents within 50 miles

Generally accepted payers *(verification of eligibility required)*:
- North Dakota Medical Assistance
- Sliding fee scale based on eligibility
- Minimum co-pay of $20 per visit & self-pay amounts are due at visits.

We are very fortunate to have two excellent dental hygiene/dental assisting programs at our technical colleges. Staff and students welcome participation by the public as "teaching cases." Services for children and adults may occur as part of an educational activity.

Minn. State Community and Technical College

Moorhead: (218) 299-6560
1900 28th Ave. S.

Services:

- Examination by a staff dentist
- X-rays
- Cleaning
- Fluoride treatment
- Sealant placement
- Oral hygiene education
- Charges apply for the above services.
- All forms of insurance plans are accepted, including Minnesota Health Care, UCare, Medica, Blue Plus and Minnesota and North Dakota Medical Assistance.

N.D. State College of Science

Wahpeton: 1-800-342-4325 ext. 2333 or (701) 671-2333
800 6th St. N.

Services:

- Examination by a staff dentist
- Radiographs (X-rays)
- Prophylaxis (Cleaning)
- Fluoride treatment
- Sealant placement
- Oral hygiene education
- Charges apply for the above services.
- All forms of insurance plans are accepted, including Minnesota Health Care, UCare, Medica, Blue Plus, PrimeWest, and North Dakota Medical Assistance.

Donated Dental Service

The Donated Dental Service (DDS) program, a program of the National Foundation for Dentistry for the Handicapped, provides extensive treatment, for those who cannot afford needed dental treatment and have no other way of getting help. Applicants must be disabled, chronically ill (physically or mentally) or elderly. Qualified applicants will be matched with an area participating dentist who will provide services in their office. An extended waiting period may occur for this program. For more information call:

Minnesota Residents:
(651) 454-6290 or **1-866-242-6290**

North Dakota Residents:
(303) 534-5299 or **1-888-471-6334**

Urgent Care/Walk In Dental Clinic is for people who:

- Have urgent dental pain
- Do not have a dentist
- Low income and uninsured (may have Medical Assistance or CHIP)
- All minors must be accompanied by a parent/guardian
- No residency requirements

Services:

- Immediate relief of pain only. This may include:
  - Sedative fillings
  - Management of oral infections
  - Extractions
  - Other procedures to relieve pain

Cost: $20 per visit (paid at visit). No billing to other payers or Medical Assistance.

When: Walk-in, no appointments–first come, first served

- **Every Tuesday,** 5:30 p.m. to 7:45 p.m.
- **1st and 3rd Fridays,** 1 p.m. to 3:30 p.m. (Sept. – May only)
- (Closed holidays)

Where: Family HealthCare Center, Moorhead Dental Clinic
Family Service Center
715 North 11th Street, Suite 106B
Moorhead

Staff: Volunteer dentists

Please bring your own interpreter. Questions? Call **(701) 364-5364.**

A program coordinated by Red River Valley Dental Access Project

Grand Forks and Polk Counties

Urgent Dental Care for:

- Persons who are low income and uninsured
- Do not have a regular dentist
- Grand Forks County/Polk County Residents
- Experiencing pain

Service:

- Procedures for Immediate relief of pain only

Cost:

- No cost to those who qualify for the program

How:

- Screened and referred by Third Street Clinic
  Call: 701-772-1263 – Monday through Friday; 8:00 to 4:30

Where:

- Services provided in the offices of the participating Dentists

Private Practice Dentists

The private practice dentists provide a full range of services.

Please contact individual dentist offices to ask about services, accepted payment, scheduling appointments and more.

Plan ahead!

Getting dental appointments is difficult, even if you are having an urgent problem—especially if you are a new patient. Schedule routine care!

Plan ahead for yourself or your child's dental appointment:

- Make sure you have a ride.
- Be on time.
- If you must cancel, always call and let the dentist's office know as soon as you can.
- Keep your dentist's name and phone number handy.

Prevention is the key!

For Babies

- Prevent baby bottle tooth decay by *not* putting baby to sleep with a bottle, exposing baby to lots of sugary formula, juice or soda pop, or using bottle as a pacifier.
- Clean baby's gums and teeth after every feeding with a small, damp cloth or gauze pad—even before baby's teeth have come in!
- Start teaching baby to use a "sippy" or training cup around six months of age; after age one, always drink from a cup (training cup).
- Your child should have a first visit to the dentist around age one.

For Kids

- Limit drinks (especially juices and soda pop) and food high in sugar. Choose healthy snacks.
- Find out if your water supply has fluoride. If you drink bottled water, look for a brand that contains fluoride.
- Brush your children's teeth or, when they are able, have them brush with a soft-bristled toothbrush for about two minutes at least twice a day. Use a pea-size amount of toothpaste that smaller children won't swallow.
- Floss daily as soon as the child is able, around six years of age.
- Visit dentist at least once a year.

For Adults

- Brush at least twice daily and floss daily. Limit sugary foods and drinks.
- Visit the dentist at least once a year.
- Set an example for your children! Brush and floss!