2025 HOUSE HUMAN SERVICES

HB 1567

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1567
1/27/2025

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities; and to provide an appropriation.

9:00 a.m. Chairman M. Ruby opened the hearing.

Members Present: Chairman Ruby, Vice-Chairman Frelich, Representatives Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Holle, Kiefert, Rios, Rohr

Members Absent: Representative Hendrix

Discussion Topics:

- Comparison to other states
- Dental student rotations
- Barriers to oral healthcare
- Disparities between groups

9:01 a.m. Representative Schneider, District 21, introduced the bill and submitted testimony, #31585.

9:10 a.m. William Sherwin, Executive Director of the North Dakota Dental Association, testified in favor and submitted testimony, #31713, #31714.

9:23 a.m. Tammy King, Executive Director of Bridging the Dental Gap, testified in favor and submitted testimony, #31594.

9:30 a.m. Kim Kuhlman, Policy & Partnership Manager of the Community HealthCare Association of the Dakotas, testified in favor and submitted testimony, #31567, #31568, #31569.

9:45 a.m. Maurice Hardy, Director of the Dakota Central Human Service Zone, testified in favor and submitted testimony, #31552.

9:49 a.m. Micah Olson testified on behalf of Brenda Rheul, Director Program Services of Protection & Advocacy, in favor and submitted testimony, #31521.

9:53 a.m. Representative Finley-DeVille, District 4a, testified in favor and submitted testimony, #31674.

9:54 a.m. Representative Davis, District 9, testified in favor and submitted testimony, #31635.

Additional written testimony:
Sargianna Wutzke submitted testimony in favor, #31595.
Kristin Dvorak, Executive Director of The Arc of North Dakota, submitted testimony in favor, #31592.
Barbara Frydenlund, Administrator, Registered Nurse, Rolette County Public Health, submitted testimony in favor, #31577.
Jackie Nord, Dental Student Program Manager of Family HealthCare, submitted testimony in favor, #31321.

9:58 a.m. Vice-Chairman Frelich closed the hearing.

Jackson Toman, Committee Clerk

FAMILY HealthCare

University of Minnesota 4th Year Dental Students

Family HealthCare hosts three dental students in their 4th year of dental school for 4-5 weeks on a year-round basis. The staff, the students and the patients all benefit from the care rendered during these weeks of intense education with a very small faculty to student ratio. The students have helped with access to care enormously, seeing nearly 1000 medical assistant patient encounters from April through December 2024 and providing $391,943 worth of dental care. The program goals are introducing dental students to a community health center, recruiting dentists to North Dakota and helping with access to dental care in the underserved. Family HealthCare partners with the University of North Dakota School of Medicine & Health Sciences for data collection and reporting purposes.

The students are housed in a local extended stay hotel during this time. A Memo of Understanding with the University of Minnesota also requires the students to get reimbursed for travel and Family HealthCare pays a fee to the University for each day the students are at their clinic.

Hotels: one room per student
Miles: one round trip of 467 miles per student
Fee to school: The University charges outreach sites $179 per day per student in the clinic

Actual costs

Hotels: $2100 x 3 students = $6300

Miles: $350 x 3 students = $1050

Fee to school: $179 x 25 days x 3 students = $13425

Additional dental assistants: 2 DA x $20/hr x 40 hours x 5 weeks = $8000

Total cost of one University of Minnesota rotation: $28,775

Family Healthcare hosts 10 rotations each year.

In the past, we have been fortunate enough to rely on the North Dakota Oral Health Program's HRSA grant to help with the expenses of the program. A stable partnership for the future of this program would be amazing!

Our current students had this to say about their time at Family HealthCare:

"My time at Family HealthCare has been the best rotation experience yet. We get to see a full schedule of patients so there's lots of opportunities to increase our speed, learn four-handed dentistry, and learn from some of the best faculty. The clinic runs super efficiently so I really have felt that my weeks here has been hugely impactful on my dental education. It's an experience I won't forget!"

FAMILY
HealthCare

"Rotating through Family HealthCare has been the best part of my dental education thus far. We are able to get a glimpse of what working in the real world is like while being able to give back to an underserved community. It is evident how much the team here wants to not only help our patients but help us grow as dentists. I feel that I have learned so much in just a short time and will certainly be sad to leave, but I know that the connections I have made here will be with me for the rest of my professional career!"

Thank you,

Dr. Jackie Nord
Family HealthCare

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Human Services Committee
House Bill 1567 – January 27, 2025
Testimony of Brenda Ruehl, P&A Director Program Services

Greetings Chairman Ruby and members of the Human Services Committee. My name is Brenda Ruehl and I'm a Program Services Director at the North Dakota Protection and Advocacy Project (P&A). P&A is an independent state agency established in 1977 to assert and advance the human, civil, and legal rights of people with disabilities. The agency's programs and services seek to make positive changes for people with disabilities where we live, learn, work and play.

P&A supports HB 1567 to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities.

Individuals with disabilities suffer significant barriers and disparities in access to dental healthcare.

Individuals with disabilities continue to run into complex physical, behavioral, or multidimensional barriers in accessing dental services. This is related to multifactorial causes related to the disability itself, side effects of medications, and a lack of accessibility to dental and oral services. Much of the time substantial dental complications turn into anxiety and cooperation problems, mainly because of the individual's physical limitations, mental disabilities, or behavioral management needs. For the dentist and oral hygiene staff, these factors may cause dental examination and treatment to be more challenging.

Individuals, parents, guardians, legal custodians, community-based providers, foster parents and anyone caring for children and adults with disabilities struggle to find dental and oral health care providers in their communities. There are very few dentists available to meet the dental care of people with disabilities across North Dakota. People must travel many hours to access care which often includes finding transportation, gas, an overnight stay in a hotel, meals and time missed from work or school. These would be barriers for anyone but certainly for low-income people.

Poor dental and oral health care has serious consequences, including problems with nutrition, speech, pain and systemic health conditions. Poor dental and oral health care can have a significant effect on

overall health. It can lead to infections of the respiratory tract, such as aspiration pneumonia. Consequences of poor oral health go beyond immediate physical impacts to severe social integration and quality of life associated with bad breath and speech deficits that has negative impact on self-image and self-esteem. It can also affect one's ability to obtain and maintain employment.

Poor dental and oral health is largely preventable through regular dental and oral healthcare. Good dental and oral healthcare are dependent on adequate oral hygiene and regular access to a dental clinic or hospital. People with disabilities are statically more likely to experience more frequent and serious health care needs that people without disabilities. Poor dental and oral healthcare can further impact the health and wellbeing of people with disabilities. Poor dental and oral healthcare especially in low-income populations including people with disabilities, result in higher medical costs including hospitalizations and institutionalizations. Access to dental and oral care throughout one's lifetime can reduce the cost of medical care, healthier lifestyles and keep people living in the community.

P&A requests that you give a "Do Pass" on HB 1567.

Thank you for your time and consideration.

Brenda Ruehl
Director Program Services
bruehl@nd.gov

Testimony Prepared for the
House Human Services Committee
January 27, 2025
Maurice Hardy; LBSW, MRC, Dakota Central Human Service Zone

RE: HB 1567 A Bill for an Act to provide for a legislative management study relation to dental and oral health care status among Medicaid recipients.

Chairman Ruby, and members of the House Human Service Committee, I am Maurice Hardy, Director of Dakota Central Human Service Zone, which includes the counties of McLean, Mercer, Oliver and Sheridan. In addition, I am a member of the North Dakota Human Service Zone Director Association. I am here to provide testimony in support of studying dental and oral health care status among Medicaid recipients.

When a child comes into foster care and legal custody is provided to a human service zone director, human service zones are required, by statue and policy, to meet the needs of the child including their dental and oral health care. Foster children are covered under North Dakota Medicaid. Human Service Zones are finding this to become more difficult as time goes on. Fewer dental professionals are not accepting Medicaid or have long waiting lists to see foster children. Many times, when children enter foster care, they have not had routine dental care and it is key to their overall health to receive dental services. In some instances when the foster child could not wait and no provider would see the foster child, who needed immediate care, the zone needed to use general funds within their budgets and pay out of pocket to obtain the necessary care.

Most zones are finding that they do not have a dental professional, within their boundaries that accept Medicaid. This results in zone team members needing to transport a foster child for up to 2 hours one way, for required dental care and see a Medicaid provider. That is a minimum of five hours of time for the zone employee to meet the foster children's needs. More importantly for some foster children, this is a full day of educational instruction lost. If follow-up appointments are needed, even more days are lost. Factoring in lost instructional days, zone wages, benefits, mileage, and time away from other cases this has significant time and financial impact.

In the general population, a low-income family seeking dental care on North Dakota Medicaid also results in often having to travel considerable distances and which would require reliable transportation. Their limited finances are often impacted by travel costs and lost wages from and hourly wage job. This poses a real burden. That is if they can find a provider that has openings and accepts Medicaid.

I have consulted with four dentists I know personally, to find the reasons that dental professionals do not sign up to be a Medicaid provider. The reasons were not unexpected and all echoed the same reasons.

1. **Inadequate Reimbursement:** North Dakota Medicaid reimbursement seldom covers the procedure and does not cover any office overhead that is needed to provide care.
2. **No Compensation for no-shows:** Should a Medicaid patient be a no-show, there is no monetary compensation for that lost revenue. This results in loss of procedural reimbursement.
3. **Negative Perceptions in Dental Education:** One who graduated from dental school in the last 10 years, indicated dental schools are implying being a Medicaid provider is a financially losing proposition. With the cost of higher education this is easy to understand.
4. **Administrative Burden:** Another zone was told by one of their providers that both the process to become a provider (paperwork) and the billing is cumbersome and not easy to complete creating a barrier to complete.

We believe the study will highlight these reasons for lack of providers, and it is a start to identify and address the issues facing North Dakota Medicaid patients, including foster youth, and service providers. The Human Service Zone Directors support HB 1567 and respectfully ask for do pass recommendation.

Thank you for your time and I will stand for questions.

DENTAL STUDENT ROTATIONS AT COMMUNITY HEALTH CENTERS IN NORTH DAKOTA

Increasing the Dental Workforce and Serving Community

North Dakota has no dental school. Recognizing the need to address dental workforce shortages, and barriers to recruiting new dental professionals to the state, the North Dakota Department of Health & Human Services Oral Health Program (OHP) and the North Dakota Area Health Education Center financially support dental rotations at three community health centers in North Dakota.

SPECTRA HEALTH

Spectra Health is a federally qualified health center in Grand Forks, N.D. The group has been in operation since 2004 and strives to ensure that high-quality and affordable services are available to everyone in the community. Dental services provided at Spectra Health include dental cleanings, sealants, filings, extractions, composites, night guards, selective root canals, child-safe nitrous-gas, urgent dental care, restorative crowns, and partial dentures. Spectra Health began hosting dental rotations in 2018.

> "I've told my friends I love outreach and I don't want to go back to school."

FAMILY HEALTHCARE

Family HealthCare, with locations in Fargo, N.D., and Moorehead, Minn., has been providing primary care for residents of Fargo and Moorhead for over 30 years. Dental services include comprehensive dental exams and cleanings, fluoride treatments and sealants, x-rays, cavity fillings, extractions, emergency/walk-in dental care, denture care, bridges, and restorative care. Family HealthCare began hosting dental rotations in 2024.

BRIDGING THE DENTAL GAP

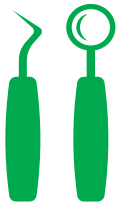
Bridging the Dental Gap (BDG), located in Bismarck, N.D., is a non–profit 501(c)3 community dental clinic with a mission to improve access to dental care for persons in their community who are uninsured, under–insured, low-income, and/or covered by Medicaid. Dental services include exams and x-rays, cleanings, fillings, extractions, root planning, sealants and fluoride, root canals and crowns, and partial and full dentures. Bridging began hosting dental rotations in 2023.

COMMUNITY AND STUDENT IMPACT

Beginning in 2017, Spectra Health began to host dental student rotations. Reliable data collection began in 2018. Most recently, in 2023, both BDG and Family HealthCare joined the OHP to also coordinate and host dental students.

JANUARY 2019 THROUGH MAY 2024

3
participating health centers



33
dental students

2,430
preventive services

2,070
restorative services

2,296
MA patients served

$435,213
total MA services billed

CARE PROVIDED BY DENTAL STUDENTS

Dental student rotations have proven to be advantageous for the students, but also provide the health center the opportunity to complete additional services and reduce wait times for patients seeking preventive care. The table highlights the number of services provided by students during their respective dental rotations. Most patients who received care from the dental students were covered by medical assistance (MA). Student rotation lengths vary from ten days to six weeks.

DENTAL STUDENT PROCEDURE REPORT

Year	Dental Students	Restorative Services	Dental Exams	Preventive Services	Extractions	MA Patients	Total MA Billed
Spectra Health							
2018	3	128	22	21	49	NA	NA
2019	4	358	86	62	68	394	$61,035
2020	2	161	41	102	18	282	$35,649
2021	3	220	19	203	31	208	$23,409
2022	4	273	45	440	101	310	$37,193
2023	4	321	49	751	50	400	$80,125
2024[a]	6	297	53	518	33	219	$77,878
Bridging the Dental Gap							
2023-24[b]	7	158	152	25	60	200	$83,424
Family HealthCare							
2024[c]	3	282	–	329	64	283	$87,559

a. As of August 2024; b. Date range 9/1/2023 – 5/22/2024; c. April 2024 – May 2024

> "I really enjoyed being able to do so much dentistry in a day and working with real assistants."

Students traditionally reported a greater number of restorative services than preventive. However, following the COVID-19 pandemic (beginning in 2020), dental students began to contribute to reducing the backlog of pediatric patients in need of preventive dental care. In 2018 and 2019, preventive services were only 10% and 11%, respectively, of the care provided by students; by 2022, 51% of dental student services were preventive. In the most recent year, dental students have returned to practicing a greater number of restorative services.

DENTAL STUDENT EXPERIENCES

The program provides housing, dinners, and networking opportunities with private practice dentists. The students spoke positively about their dental professional role, functioning as a lead dental provider, overseeing other dental professionals, and providing patient care as a colleague and member of the care team. Students enjoyed the staff, understood the billing, and learned about loan repayment and other professional topics. Students who rotated at BDG shared that their biggest motivator for attending this rotation was helping the community they grew up in.

> "Every preceptor was so willing to teach and they were all very patient with me as I was getting used to working at a faster pace and seeing more than two patients a day. I loved working with the dental assistants."

Contact the author and program evaluator:
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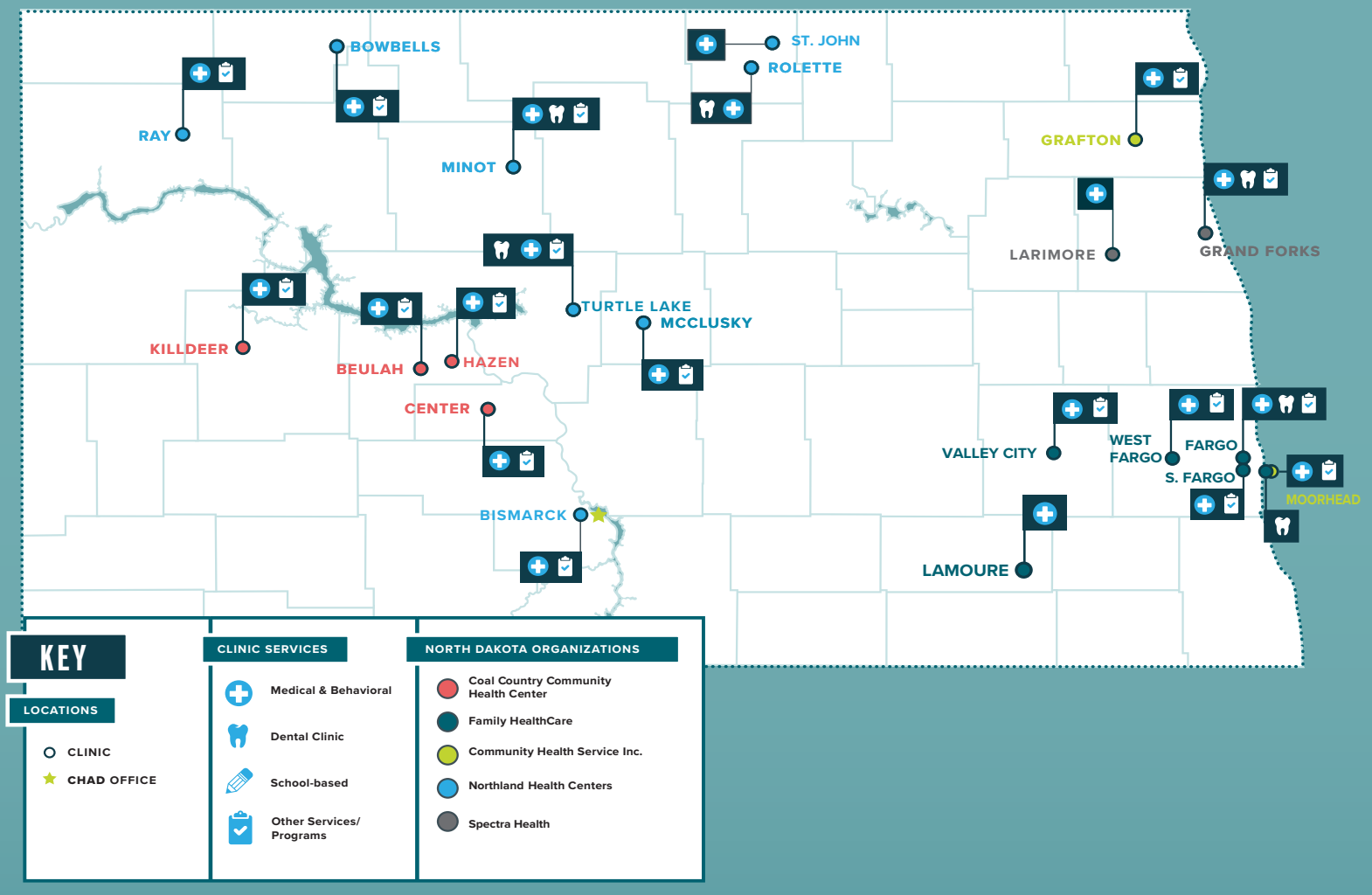
North Dakota Oral Health Program | hhs.nd.gov/health/oral-health-program

UND School of Medicine & Health Sciences
University of North Dakota

CHAD

WHAT IS A COMMUNITY HEALTH CENTER?

Community health centers (CHCs) are non-profit, community-driven primary care clinics that provide high-quality primary and preventive care to all individuals, regardless of their insurance status or ability to pay. Health centers are located in underserved and low-income urban and rural areas across North Dakota, providing access to affordable, quality health care for those who need it most. The centers serve as essential medical homes where patients can receive a wide array of services including medical, behavioral, and dental care along with help with transportation, interpretation, and other case management and care coordination services. In rural communities, health centers support a community's ability to retain local health care options, supporting access to health care where rural Dakotans live and work. North Dakota's network of five health center organizations provides care to over 36,000 patients each year at 22 locations in 20 communities across North Dakota.



NORTH DAKOTA PATIENTS

Source: 2023 UDS Preliminary Reports

PATIENTS BY POVERTY LEVEL

- < 100%: 42.4%
- 101%-150%: 13.6%
- 151%-200%: 8.4%
- > 200%: 35.6%

This represents a distribution of patients for whom income is known. Income is unknown for 47.0% of patients.

TOTAL PATIENTS 36,376

37.9% of total patients served are people of color

PATIENTS BY PAYOR SOURCE

- MEDICAID: 39.5%
- MEDICARE: 13.1%
- UNINSURED: 16.1%
- PRIVATE: 31.2%

ECONOMIC VIABLILITY

Source: Calculations based on 2023 UDS Reports

In addition to the actual dollars that flow to local communities through health centers, their role in maintaining access to health care can have an enormous impact on the long-term economic viability of rural and urban communities throughout North Dakota. For our smaller communities, access to local health care is crucial to a town's ability to recruit new companies and maintain a healthy workforce without long out-of-town trips to the doctors or to pick up prescriptions. When a small town is able to retain access to health care, it can serve as a main street anchor, keeping other small businesses viable. Across rural and urban communities, CHCs keep health care affordable by providing health care services regardless of ability to pay and by helping patients find health coverage options that are right for them.

STATEWIDE IMPACT

North Dakota CHCs had a total annual economic impact on the state of

$101,966,207 IN 2023

NORTH DAKOTA CHCs DIRECTLY GENERATED:

387 full-time jobs

AND SUPPORTED AN ADDITIONAL

229 jobs in other business

616 total jobs

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Community HealthCare Association of the Dakotas

Testimony
House Bill No. 1567
House Human Services Committee
Representative Matthew Ruby, Chair
January 27, 2025

Chairman Ruby, Vice Chairman Frelich and honorable members of the House Human Services Committee:

I am Kim Kuhlmann, the Policy and Partnership Manager in North Dakota for Community HealthCare Association of the Dakotas (CHAD). On behalf of CHAD and our member health centers, I am here today to support House Bill 1567.

In my position at CHAD, I also facilitate the North Dakota Oral Health Coalition, which has over sixty member organizations who are working collaboratively to address access to oral health care in North Dakota, especially for underserved populations.

CHAD is a non-profit membership organization that serves as the Primary Care Association for North Dakota and South Dakota, supporting community health centers across both states in their efforts to provide health care to underserved and low-income populations. The heath centers we represent have locations in both urban and rural communities.

Community health centers (CHCs) are non-profit, community-based primary care clinics that serve all individuals, regardless of their insurance status or ability to pay. The community health center integrated care model includes primary care, mental health and substance use treatment, dental care, pharmacy services, and a range of case management services that can include help with transportation, finding community resources, or assistance with insurance and financial enrollments.

North Dakota is home to five community health center organizations that provide comprehensive, integrated care to more than 36,000 individuals at 22 locations in 20 communities across the state. Sixteen percent of those patients are uninsured and about 40 percent earn incomes below the federal poverty level. Three health centers in North Dakota provide dental care at seven locations, with a new urgent dental clinic opening in Ray in February. Health centers served 11,912 dental patients with over 25,000 visits in 2023.

Community HealthCare Association of the Dakotas

North Dakota is Facing an Oral Health Crisis

North Dakota is facing an oral health crisis, and it is impacting children, adults, and the aging population. These are just a few statistics which illustrate the unmet dental needs in our state:

- One of every two kindergarteners have experienced tooth decay;
- More than half of adults who are Indigenous reported no dental visit in the past 5 or more years;
- Nearly 1 in 3 adults who are not Indigenous reported no dental visit in the past 5 or more years; and
- 1 in 4 long term care residents in our state have untreated tooth decay.

We know that oral health impacts a variety of chronic disease outcomes, including diabetes, heart disease, and respiratory disease. In North Dakota, over twice as many adults with diabetes have lost 6 or more teeth due to tooth decay or gum disease compared to those without diabetes. According to the Centers for Disease Control, treating gum disease significantly improves blood sugar level among people with diabetes. Access to routine preventive dental care is a much less costly – and more healthy – way to help manage associated chronic diseases.

According to the North Dakota Department of Health and Human Services, our state has seen a significant rise in the number of emergency room and urgent care clinic visits related to tooth pain over the last 5 years. From 2020 to 2024, the number of tooth pain related visits, including visits to emergency rooms, primary care clinics, and urgent care, increased from 2,625 to 4,715, nearly doubling in just 5 years.

These oral health related emergencies are costing the healthcare system, the Medicaid program, and patients additional money in emergency visits. And they don't even include the additional costs of the complications for patients with heart disease and diabetes that is caused by poor oral health. In addition, individuals who report dental care affordability concerns miss more hours of work for unplanned dental care. Better oral health results in better overall health outcomes, improved productivity, and leads to better quality of life.

Coverage and Workforce Challenges at Health Centers

Let me share how the coverage numbers shape up for North Dakota health centers. Currently

around 40 percent of our patients are Medicaid beneficiaries, and those covered by Medicaid Expansion have no dental coverage. 13 percent are served by Medicare (which lacks dental coverage), 16 percent are uninsured, and 31 percent have private insurance coverage. When put together, that adds up nearly half of those we see lacking dental coverage. This makes it difficult to pay competitive wages and build our dental programs enough to meet community needs. The North Dakota Department of Health and Human Services reports that only 44 percent of the need for dental providers across the state is being met. North Dakota has 20 counties that are geographical dental care health professional shortage areas (HPSAs) and two counties that are considered low-income population dental HPSAs. Geographical shortage areas means a shortage of providers within a defined geographic area. The low-income population indicates there is a sub-population of individuals living in a defined geography that has insufficient access to care. These designations indicate a gap between the healthcare needs of the population and the available resources. Rural citizens, patients with urgent dental care needs, and patients with Medicaid coverage are more adversely affected by a dental provider shortages.

Given that health centers serve underserved populations and communities where there are likely to be even fewer providers than the state average, that gap looms large. Mara Jiran, CEO of Spectra Health, one of the state's community health centers that provides dental care, says, "Every week, hundreds of people attempt to schedule dental visits at our clinic. The demand far outweighs our current capacity." This is a challenge we hear from other health centers providing dental care as well.

Health centers are continuously looking for opportunities to innovate and expand access to dental care, and we would welcome the opportunity to collaborate and provide information for a legislative study on this topic. We were glad to see that HB 1567 includes consideration of the expansion or promotion of programs that offer support for on-the-job training and apprenticeships for dental assistants. At CHAD, we have developed an on-the-job training toolkit for health centers to offer dental assistant apprenticeships and are finding this to be a promising model for bringing homegrown talent into a dental career path. Further studying the application of this model in North Dakota, and resources needed to enable its success, would be incredibly valuable. In Ray, Northland Health Centers is preparing to open an urgent care dental clinic. At this time they will only be operating one day a week and only for emergency dental services because they cannot find a full time dentist. The long-term hope is to expand the care being provided at that location. The Ray clinic is the result of a multi-year, multi-partner collaborative project team committed to establishing a new dental clinic to address disparities for low-income,

uninsured, or Medicaid-eligible individuals in the northwest region of the state. This area is one of the largest areas with lack of dental access in the state. The clinic will be sustained as part of Northland Health Centers operations in Ray.

Dental Student Rotations & Recruitment

Currently, North Dakota does not have a dental school. In an effort to address dental workforce shortages, the North Dakota Department of Health and Human Services Oral Health Program (OHP) is helping to offset some costs associated with hosting dental student rotations, currently at two non-profit organizations in North Dakota. These sites are working cooperatively with dental schools from surrounding states to provide fourth year dental student rotations.

Dr. Jacki Nord, a dentist at Family HealthCare in Fargo, submitted testimony about the program she oversees at Family HealthCare including the costs associated with hosting students. Tammy King is here today to share information about the dental student rotations at Bridging the Dental Gap in Bismarck. These organizations provide valuable experiences in public health dentistry for dental students and bringing dental students to North Dakota.

The impact of this program is two-fold. During their rotations, dental students provide additional services and help reduce wait times for patients seeking preventive care. In other words, they help to address immediate needs. In addition, these rotations expose dental students to career paths within North Dakota, with some students choosing to begin their career in North Dakota.
We would appreciate your support for additional funding to sustain these programs and possibly expand to additional sites. Again, one of the biggest challenges to expanding the program is the additional staff needed to administer the programs.

Conclusion

Today, I've shared about the significant barriers to oral health care in the state. While we are proud of the ways that CHAD and community health centers are creatively working to address the limited rural oral health infrastructure and the limited options for our lower-income neighbors in need, we remain deeply concerned by the level of unmet need that persists. A legislative management study of oral health care could identify ways to strengthen an oral health system in which we are facing a real crisis in access to care. CHAD and our member health centers would welcome the opportunity to provide information and collaborate throughout

the study, and we can also serve as a liaison by inviting members of the Oral Health Coalition to participate.

I ask for your support on behalf of our member health centers to recommend a do pass on HB 1567 to provide for a legislative management study of dental care in North Dakota and provide for an appropriation for dental student rotations and dental student recruitment. I am happy to answer any questions you have. Thank you!

Kim Kuhlmann
Policy and Partnership Manager, ND
Community HealthCare Association of the Dakotas (CHAD)

Testimony
House Bill 1567
House Human Service Committee,
Monday, January 27, 2025
Rolette County Public Health District

Good morning, Chairman Ruby and members of the Human Services Committee.
My name is Barbara Frydenlund, I am a Registered Nurse and the administrator of Rolette County Public Health.

House Bill 1567 is very dear to my heart, and I encourage action on this bill.

Rolette County Public Health District has historically had the largest Medicaid Health Tracks program in North Dakota. Access to dental care for children and adults on Medicaid is at a critical level within our service area and the state of North Dakota. Our staff directly assists families in making dental appointments for children that we see in our Health Tracks program and all too often we fail because of lack of providers willing to accept Medicaid clients or restrict greatly the number of Medicaid clients that they will accept into their practice.

During 2024, 48% of the children participating in our Health Tracks program had an immediate need to see a dentist or do not have a dental home. We are extremely limited in local dental appointment availability and the waiting time for Indian Health Service Dental is extreme and complicated for families. If we are lucky, we may be able to seek appointments in a larger city such as Bismarck or Minot, but the wait is long, and transportation often is a barrier to getting to appointments resulting in the child not obtaining the service and often restricted from further appointments with that clinic. Many of the children we see in our clinic need a pediatric dentist who can provide anesthesia as the magnitude of the dental care needed is beyond what can be completed in a dental chair. Most of our Health Tracks participants are American Indian.

The staff of Rolette County Public Health offers fluoride varnish to all our clients with the consent of the parent/guardian. We average 80-90% uptake on the varnish application. The 10-20% that decline the service state that the child received the varnish at a recent dental appointment. We also apply fluoride varnish to school age children in the school setting, again with consent. The fluoride varnish strengthens the existing teeth making them more decay resistant, slows the progression of existing cavities and eases some of the pain that maybe present.

Dental caries can be a serious health threat to both children and adults. Many of our children have as many cavities as they have teeth. These very large cavities cause pain, causing problems with eating, speaking, playing and learning. A child with tooth pain is not going to be attentive in school, leading to learning and behavioral concerns. If the cavity reaches the nerve an abscess can form, and the infection can be spread throughout the body. Oral health of an individual is considered indicative of the overall health.

We understand that the Ronald McDonald Dental Mobile can't begin to serve the number of children in need of dental services.

Rolette County Public Health has three suggestions for the improvement of the dental crisis that we are facing.

1. Mid-level dental providers. *Equivalent to Physician Assistances and Nurse Practitioners who with our rural health care would be even a greater disparity.*
2. The opportunity for Dental Hygienists to work independently from a dentist, to provide cleanings, sealants and fluoride varnish in public health offices and schools-----funding would be required for this option
3. Increase in mobile dental services

In 2021 we purchased a 38-foot mobile clinic, complete with two exam rooms. The purpose of our mobile clinic is to provide public health services in locations within our county where we do not have physical public health office space.

As we look locally for solutions to the dental access crisis, Rolette County Public Health would like to propose that as a pilot project, the North Dakota legislature provide funding to transform one exam room of our mobile clinic into a dental suite to provide preventive dental services and simple fillings and extractions. In addition to the mobile clinic transformation, we would need state funding to cover the costs of this venture, including staff members. Our suggestion would be to start with very young children, with the goal of preventing the dental disasters that we are now seeing.

I thank you greatly for looking into the dental crisis for the most vulnerable citizens of our state. Please keep in mind that this includes both children and adults.

Sincerely,

Barbara Frydenlund, RN
Rolette County Public Health District
Administrator
bfrydenlund@nd.gov

INTRODUCTION

By Representative Mary Schneider

HB 1567-Study relating to dental and oral health care status among Medicaid recipients

House Human Services Committee, Matt Ruby, Chairman

January 27, 2025

Chairman Ruby and members of the Human Services Committee, I'm Mary Schneider and I proudly represent the people of District 21, central Fargo and West Fargo. HB 1567 is a request for an interim study on the unmet dental and oral health needs of low-income children, Native American children, and individuals with disabilities. There are some things we already know, and they're not good.

- ✓ The number of children in Head Start, kindergarten, and third grade who need dental treatment--just those little clusters, would fill 115 school buses.
- ✓ Only 44 percent of the need for dental providers in North Dakota is being met. For Medicaid recipients, the percentage is much, much lower.
- ✓ There are 69 dental health care practitioner shortage areas (HPSAs) designated in the state. The population of those areas is 153,291.
- ✓ 19 of our 53 counties had ZERO dentists.
- ✓ 80 percent of those on Medicaid DID NOT receive dental care.
- ✓ North Dakota has the 6th highest Native American population and the dental data for nearly all categories is shockingly worse for them.

There are some things we still don't know, even though we've studied the problem in the past. Some things just need updating and the study will help in these areas. Some of the components of the study include:

- The dental and oral health care status of low income and Native American children, and persons with disabilities;
- The impacts, consequences, complications, and expanded future costs from not receiving care and services;
- The regulations, policies, and procedures limiting Dentists' enrollment in Medicaid;
- The availability of and access to medical facilities needed for complex dental work for people with disabilities and others who might require anesthesia or critical care;
- A review of reimbursement rates, comparing other states, private payors, and actual costs;

- Consideration of the need to expand or promote dental support services, and programs using dental students, volunteer and charitable dental programs, and nonprofit dental services;
- Ways to improve accessibility to dental services for low income and Native American children and individuals with disabilities, both on and off reservations;
- Exploring partnerships between state programs and tribal health providers;
- Recruitment and retention programs and incentives, such as expanded loan forgiveness, free professional education, and other reinforcers for practice in underserved communities or in complex cases; and
- So important, the study calls for an action plan to address the findings, including goals, objectives, costs, legislation and timetables for remediation of this pervasive, persistent, pernicious, and perpetual problem we desperately need to address.

It's both shocking and shameful that after the attention from past studies, and admissions of unmet needs, we haven't addressed the problem of dental access in a permanent and meaningful way that solves the problem for Medicaid recipients. We say dental care is covered by Medicaid, but is it really? The stories of parents and providers calling dentist after dentist on behalf of a child or disabled person in pain to be told "we don't take Medicaid," or "we're not taking any more Medicaid patients," or "we don't have access to hospital facilities you need for dental surgery" is heart-wrenching. One mother I know about started sobbing when she was turned down or away from every dental office she called. And the geographic barriers are very real, too. For a low-income parent to take a day off work or drive an unreliable car 200 miles to get help for their crying child with an abscessed tooth or be forced to wait for one of a few "charitable" days, also far away, is disgraceful.

We legislators all have good insurance, but, really, how would we feel if our policies said we had coverage for a critical procedure, but we couldn't find anyone to do it? If we had to phone, and beg, until we finally gave up and suffered the consequences of not getting help? How would we feel if being turned down, shut down, and sent off was for our children or grandchildren?

Oral health is health. We have countless dental practitioners working hard to serve those who need them. We have amazing dental assistants, hygienists, dental students, and others giving of their skills and services, trying to meet dental needs, some without payment. But we need more dental service providers if we don't want our promises of access to care to be false or fictitious. Let's approve this study with its limited appropriation to expand the dental student program. It can address the barriers, and recommend ways to ensure enough providers, and better ways to recruit, retain, remunerate, and appreciate them. It will help develop partners, programs, resources, and services that work for our kids and people with disabilities. In a state of rich resources and good people, that's what we should be, and must be, doing. HB 1567 is being

presented to you with a do pass request to help us work together to make true dental access happen.

House Human Services
HB 1567
January 27, 2025

Chairperson Rep. Ruby and Members of the Committee,

I am Kirsten Dvorak, executive director of The Arc of North Dakota, writing to express our support for House Bill 1567. For 65 years, The Arc has been advocating for the rights of individuals with intellectual and developmental disabilities (IDD) in North Dakota, working to ensure they have access to the services and support necessary to lead meaningful and independent lives.

The Arc of North Dakota strongly supports House Bill 1567, which aims to address the critical issue of dental care access for individuals with developmental disabilities by creating a study to evaluate current challenges and identify solutions. Individuals with disabilities face significant barriers to dental care, such as transportation challenges, a shortage of trained providers, and inadequate Medicaid reimbursement rates.

This study is an essential step toward understanding and addressing these barriers. It will help explore solutions like improved reimbursement rates, enhanced provider education, and telehealth options, which are vital for ensuring access to essential dental care for all North Dakotans, including those with developmental disabilities.
We urge the committee to support HB 1567 and this crucial effort to improve oral health care for individuals with developmental disabilities.

Kirsten Dvorak
Executive Director
The Arc of North Dakota
701-222-1854

HB 1567
Hearing Date: Monday, January 27, 2025
ND House Human Services Committee

Providing Testimony:
Tammy King, Executive Director
Bridging the Dental Gap
Bismarck ND

Position: In support of HB 1567

Chair Ruby and honorable members of the House Human Service Committee

My name is Tammy King and I am the Executive Director of Bridging the Dental Gap (BDG). I am here in support of House Bill 1567.

I am going to provide you with just a little information on what Bridging the Dental Gap is doing to assist with access to dental care in the state. We also have Federally Qualified Health Centers, the ND Oral Health Coalition, the ND Dental Association, the ND Dental Foundation, Community HealthCare Association of the Dakotas, the ND Dental Board, state agencies, private dental clinics, and others all working together to improve dental care access to the people of North Dakota.

BDG is a non-profit stand-alone dental clinic located in Bismarck ND. BDG is not a free clinic and does not receive any state or federal funding. All funding comes from the revenue received from insurance reimbursement and payments from patients along with funding raised from grants and fundraising events. All staff are paid, and we do not have any volunteer dentists.

The clinic was established 21 years ago. The mission of BDG is to improve access to dental care for those receiving ND Medicaid benefits, those who are uninsured and under-insured and for low-income members of the community. What started out as a clinic providing dental services to people living within a 50-mile radius from Bismarck in 2004 is now providing dental care to people across the entire state of North Dakota. Individuals without ND Medicaid or other dental insurance can qualify for a sliding scale discount based on their income and family size. BDG provides dental care in an 8-operatory clinic as well as outreach to long-term care facilities in Bismarck.

Currently, there is a huge shortage of dentists in the state who are accepting new patients with ND Medicaid. As of January 1, 2025, BDG has patients in every county in the state of North Dakota, with the exception of four counties. We have multiple people calling daily saying they have been calling dentists around the state and BDG is the only dental clinic accepting new Medicaid patients. In the past we were always fortunate to have pediatric dentists in the Bismarck-Mandan area accept our referrals. In the past year we found that that was no longer the case, and they were no longer accepting new

Medicaid patients. We were extremely fortunate to be able to add a part-time pediatric dentist to our staff so we are able to provide some dental care to children now.

Fifty-five percent of BDG patients receive ND Medicaid and 15% receive some other form of insurance which is mostly Medicare supplemental insurances. The remaining 30% of patients are at or below 200% of the Federal Poverty Guidelines and qualify for a sliding fee scale discount. Our patients consist of people of all ages, from all walks of life, with various degrees of limitations and barriers and for almost all, no place else to go for dental care.

BDG provides clinical rotations for fourth year dental students through Creighton University in Omaha, Nebraska. Rotations are scheduled for a two-week time period and usually consist of 2 students at a time. Hosting these students has allowed us to see additional patients while they are here and for the students to learn and experience the area of public health. In addition to these benefits, BDG uses the opportunity as a recruitment tool to educate each student about employment opportunities, state loan repayment programs, the benefits of Bismarck-Mandan and the entire state of North Dakota. These dental students are responsible for paying for their own housing while they complete their rotations. BDG has been fortunate to receive some funding through the State Oral Health Program to cover housing costs for students, but this funding is not guaranteed in the future. Most of the time, paying for housing is what brings the students to our clinic. We are working with the University of Minnesota to possibly start additional dental student rotations in the fall of 2025. Without funding, it would be very difficult for BDG to cover these housing costs or to expand this program.

In addition to providing rotations for dental students, BDG is committed to host high school and college students for job shadowing and volunteering opportunities. BDG has a history of training our own dental assistants and have had several who have completed the required hours at the clinic and pass their qualifications to become a Qualified Dental Assistant as well as Registered Dental Assistants.

I am one of five other team members who are involved in a yearly trip for the purpose of recruiting fourth year dental students to work in North Dakota. We travel to the University of Minnesota, the University of Nebraska in Lincoln and Creighton University in Omaha to provide them with information regarding the employment opportunities, loan repayment options and other information about the benefits of working and living in North Dakota.

While we are doing many good things in the state to help provide access to dental care, I feel we are just touching the surface. This proposed study is very essential to discovering how much more can be done and what should be addressed to increase access to dental care in the state of North Dakota, which is why I fully support HB 1567.

Thank you for your time.

Senator Ruby and members of the House Human Services Committee.

I am writing in support of HB 1567. I have worked in the Human Services field for over twenty years specifically with individuals with developmental disabilities. My biggest concern regarding healthcare for this population is specifically in the field of dental care. There are very few dental offices in the state that accept Medicaid. Thus, leaving many families with children with developmental disabilities having to drive two hours or more one way each time a dental visit is necessary for their child. It also takes a significant amount of time to get into a dentist due to so few accepting Medicaid.

Individuals with disabilities often have significant dental needs and these needs are often untreated. In fact, as early as 1979 the National Conference on Dental Care for Handicapped Americans reported that the number one unmet health need for this population was adequate dental care.

According to the National Institute of Dental and Craniofacial Research (2009), although accessible dental care is essential for the general population, it is particularly important for people with disabilities due to the additional health concerns they face, as certain health conditions may make it difficult to maintain good oral hygiene, yet poor oral health may make it harder for an individual to manage—or could exacerbate—other health conditions. For instance, individuals with epilepsy may suffer from increased tooth trauma occurring during a seizure and many children with autism grind their teeth for self-stimulation or may take medications that worsen oral health. Oral problems such as gingivitis and periodontal disease have been shown to make it more difficult to manage blood glucose— critical for patients with diabetes— and problems such as muscular abnormalities or oral malformations can make it difficult to maintain a nutritional diet and good oral hygiene.

I think the study that is proposed is essential to be able to realize the problem that greatly impacts children with developmental disabilities but also low-income children as well as Native American children. I also think it is crucial that there is an exploration into solutions to the problem at hand and by reviewing the bill it seems the study is aimed at doing this as well.

Again, I am in support of HB 1567, and I think this look into lack of dental care is long overdue.

Sargianna Wutzke, Bismarck ND

Legislative Assembly

North Dakota House of Representatives

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600 EAST BOULEVARD
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COMMITTEES:
Human Services
Political Subdivisions

January 27, 2025

Testimony in Support of House Bill 1567
House Human Services Committee

Good Morning Chairman Ruby and members of the committee. For the record my name is Jayme Davis and I represent District 9, and I am honored to speak as a cosponsor of House Bill 1567. This legislation addresses a critical need within our state—access to dental and oral health care services for underserved populations, including Native American children, individuals with disabilities, and low-income families.

Access to dental care is not a luxury. My mother worked in the dental field for over 30 years and stressed that it is a necessity that impacts every aspect of our well-being, from physical health to educational and economic outcomes. Yet, for far too long, members of our tribal communities and other underserved groups have faced significant barriers to receiving these essential services. These barriers—whether related to geographic isolation, financial limitations, or lack of provider availability—create inequities that harm our families and hinder their futures.

This bill is particularly significant to our tribal nations. Oral health disparities among Native Americans are well-documented. Many of our people suffer from preventable dental issues at disproportionately high rates due to limited access to regular care. Children miss school, adults miss work, and elders endure unnecessary pain—all due to a system that fails to meet their needs.

House Bill 1567 takes meaningful steps to address these disparities by:

1. **Studying barriers to access**: The legislative management study will provide valuable insights into the unmet needs of Native American children and other Medicaid recipients, both on and off reservations.
2. **Investing in workforce solutions**: By promoting education, training, and recruitment for dental providers, this bill lays the groundwork for a more sustainable, inclusive dental workforce.
3. **Expanding access through partnerships**: Encouraging collaboration between state programs and tribal health organizations ensures culturally appropriate care that respects the sovereignty and unique needs of our nations.

Additionally, the appropriation of $97,000 to support dental student rotations across the state is a critical investment in building long-term capacity, particularly in areas serving Native American populations. This funding not only supports students but also inspires a pipeline of providers dedicated to serving underserved communities. By passing this bill, you are affirming that every child, elder, and family in North Dakota deserves access to care. You are acknowledging the challenges faced by our tribal people and showing your commitment to partnering with us in finding solutions.

In closing, I urge you to vote in favor of HB 1567 and to prioritize oral health equity for all North Dakotans. Thank you for your consideration of this vital legislation. I am happy to answer any questions you may have.

Sincerely,
Jayme Davis
Representative, District 9

Testimony of Representative Lisa Finley-DeVille

In support of House bill 1567

Chairman Ruby and members of the House Human Services committee my name is Representative Lisa Finley- DeVille, representing District 4 A, which includes the MHA Nation. I'm here to testify in support for of House Bill 1567, relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities.

As a co-sponsor of HB 1567, I am committed to ensuring that all individuals, particularly our most vulnerable populations, have access to the essential dental care they need. During the 2025-26 interim, this study will focus on understanding and addressing the unmet dental and oral health care needs of low-income children, Native American children, and individuals with disabilities. By examining the specific barriers they face, we can work toward creating solutions that will significantly improve their health outcomes and quality of life.

In rural communities, there are often fewer dental professionals, making it harder for residents to access regular care. In fact, nearly 60% of rural areas in the U.S. are designated as dental shortage areas, meaning that access to essential oral health care is limited or non-existent for many families. For low-income children and Native American children, these barriers are even more pronounced. A recent study found that children in low-income households are more likely to have untreated cavities, and Native American children experience dental disease at rates significantly higher than the general population. These disparities underscore the need for a targeted focus on improving access to dental care in underserved areas.

The study will include a thorough overview of the dental and oral health care status of Medicaid recipients. This critical analysis will shed light on the current gaps in care and help us understand where improvements are most urgently needed. Additionally, this study will evaluate the importance of receiving dental and oral health care services and the far-reaching consequences of not receiving timely care. From general health complications to the expanded costs of future care, we need to understand the full scope of the impacts that insufficient dental care can have on these individuals, especially in terms of long-term health outcomes.

The study will also review state and federal regulations, policies, and procedures that may be limiting or perceived as limiting dentist provider enrollment in Medicaid. Issues such as impediments to enrollment, prior authorizations, attachments, appeals, and delayed payments must be addressed to ensure that dental providers are able to serve Medicaid recipients effectively. I am confident that this study will provide a valuable framework for addressing these systemic challenges and improving access to dental care for those who need it most. As we move forward, I look forward to collaborating with my colleagues and stakeholders to bring about meaningful changes that will ensure equitable access to dental and oral health care for all.

I urge you to give House Bill 1567a do pass. Thank you for your time and consideration.

North Dakota DENTAL ASSOCIATION

Physical Address: 1720 Burnt Boat Drive, Suite 201
Mailing Address: PO Box 1332, Bismarck ND 58502
T: 701-223-8870

M E D I C A I D
SOLUTIONS, RESOURCES, & SUGGESTIONS

PRIMARY MESSAGES

Strengthening Medicaid programs to include Comprehensive dental coverage for adults will:

- Prevent costly and often debilitating advanced dental disease.
- Improve overall patient health by improving their oral health.
- Reduce the high cost to taxpayers of dental care sought in emergency rooms.
- Provide essential healthcare to low-income people, people with disabilities, and seniors.
- Improve Medicaid participants' ability to secure and maintain employment.

MEDICAID SHOULD COVER ADULT DENTAL CARE

Medicaid dental benefits save states money.

- There are more than 2 million hospital emergency room visits a year for dental pain. States with adult dental Medicaid coverage have decreased unnecessary emergency room visits, significantly lowering the cost to the public for this uncompensated care.
    - A limited adult dental Medicaid benefit in Missouri has cut emergency room visits for nontraumatic conditions by 38%.[1]
    - Massachusetts partially restored coverage in 2013 and saw emergency room dental visits fall 15% in the first five months.[2]
    - Conversely, when California eliminated its comprehensive coverage in 2009, 1,800 more people visited the ER for dental emergencies each year, and the cost of this emergency care rose 68%.[3]
- Covering dental care through Medicaid reduces the overwhelming cost to taxpayers of uncompensated care sought in emergency rooms, which totals $2.7 billion nationwide each year.

Medicaid dental benefits allow low-income citizens to secure and maintain employment.

- Poor oral health harms adults' ability to work.
    - Americans miss more than 92.4 million hours of work or school each year for emergency dental care.[4]
    - Ten percent of low-income patients say they must miss work very often or occasionally for dental problems.[5]
    - In states without an adult Medicaid dental benefit, 60% of Medicaid-enrolled adults report that their ability to interview for a job is impacted by the appearance of their teeth or mouth.[6]

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[1]. Good reasons for states to preserve or expand Medicaid adult dental benefits: A toolkit for advocates. CareQuest Institute for Oral Health. December 2020

[2] Changes in Dental Benefits and Use of Emergency Departments for Nontraumatic Dental Conditions in Massachusetts. Public Health Reports. Health Affairs. September 2020.

[3] Eliminating Medicaid adult dental coverage in California led to increased dental emergency visits and associated costs. Health Affairs. May 2015.

[4] Hours Lost to Planned and Unplanned Dental Visits Among US Adults. Centers for Disease Control and Prevention. 2018.

[5] Oral health and well-being in the United States American Dental Association. Health Policy Institute Infographic. May 2016.

[6]Oral Health and Well-Being Among Medicaid Adults by Type of Medicaid Dental Benefit. American Dental Association. Health Policy Institute Infographic. May 2018.

Oral health and well-being in the United States American Dental Association. Health Policy Institute Infographic. May 2016.

- Access to oral health care empowers Medicaid participants to work and move toward economic self-sufficiency.

Dentists' priority is always to enhance the oral health of patients, and we support public policy that empowers dental teams to do that.

- Dentists donate hundreds of thousands of hours providing care each year in their own offices and through events like Mission of Mercy, Give Kids A Smile and Give Veterans a Smile.
- However, charity is not a sufficient or sustainable way to protect individual and public health.
- Solid investments in people's health through Medicaid will ensure vulnerable patients, including seniors and people with disabilities, get the care they need but can't otherwise afford.

Inability to access dental care can have significant health consequences.

- Medicaid serves low-income parents and other adults, people with disabilities, and seniors.
- Without dental care, people will suffer from irreversible oral health conditions such as cavities, severe gum disease, pain, and tooth loss.
- Untreated oral health conditions negatively affect a person's overall health. For example, gum disease is linked to diabetes, heart disease, strokes, kidney disease, Alzheimer's disease, poor pregnancy outcomes, and even mental illness.

Providing adult dental coverage through Medicaid consistently would improve access to dental care for low-income adults, people with disabilities, and seniors. It would reduce racial disparities in chronic disease prevalence and maternal health while improving employment opportunity and economic mobility.

- Underserved communities and people with disabilities stand to benefit most from comprehensive dental coverage in Medicaid.
- While oral health has generally improved in recent decades, not all groups have benefited equally. Black and Hispanic adults face cost barriers to dental care to a greater degree than their White and Asian peers. As a result, these patient groups are more likely to have outcomes like untreated cavities and severe gum disease.
- Policymakers should prioritize strengthening Medicaid to reduce health disparities.

ADULT DENTAL MEDICAID BENEFITS SHOULD BE COMPREHENSIVE AND ADEQUATELY REIMBURSED

States should ensure their Medicaid programs provide comprehensive adult dental coverage, which enhances patients' overall health.

- Comprehensive care, including preventive and corrective care, are without a doubt the best approach to achieve benefits such as decreased emergency room visits and improved work-readiness.
- Comprehensive coverage should include not just emergency care – which most states already offer – but also routine preventive care like x-rays, fluoride treatments, and oral hygiene instruction.
- Prosthodontics to replace missing teeth or treatments to address dental decay, or other medically necessary treatments should be covered too. These are important services people need to maintain or regain their oral health.

Dentists want to be able to accept Medicaid to reach vulnerable patients, but Medicaid needs to sustainably reimburse for dental care before that becomes viable for many dental practices.

- Most dental practices are small businesses. They need to be sustainably reimbursed in order to pay their employees and sustain their business.
- Reimbursement to traditional medical providers is already low, but the rate for dental care is even lower, far below the cost of delivering care.
    - The average Medicaid reimbursement among states providing limited or extensive adult dental services was 53.3% of private insurance reimbursement in 2020.[7]

[7] Reimbursement Rates for Child and Adult Dental Services in Medicaid by State. American Dental Association. Health Policy Institute Infographic. October 2021.

    - Medicaid reimbursement as a percentage of private insurance reimbursement for adult dental services varies between 30.5% in Minnesota to 86.8% in California. [8]
    - It is important to note that private insurance reimbursements reduce dentists' normal fees 20%, so comparing Medicaid fees to private insurance fees represents a discount on top of a discount.
- In many cases, treating Medicaid patients is *more expensive* for dental practices than receiving no compensation for care provided care due to the time and resources it takes to navigate the Medicaid system coupled with a low reimbursement rate.
- It is not a question of desire to treat Medicaid patients; rather, it is a question of economic reality. Many dental practices simply cannot afford to accept Medicaid patients, making it difficult for patients to find a dentist.

ACCOUNTABILITY FOR MANAGED CARE ORGANIZATIONS

Many states use managed care for their Medicaid programs and could do so for a dental benefit. States are motivated to adopt managed care models to make spending on these programs more efficient and predictable, but the evidence on managed care's effectiveness when it comes to access and cost is limited.

- A 2011 survey of state Medicaid programs found that over two-thirds of responding states with managed care organizations (MCOs) reported that Medicaid beneficiaries enrolled in MCOs sometimes experience access problems, including access to dental care.[i]
- While MCOs may have both benefits and risks, one way to protect their effectiveness and the tax dollars entrusted to them is through fair and binding accountability measures.

States that choose to contract out their dental program to a managed care organization (MCO) should establish accountability measures to make sure the program runs efficiently and improves the quality of care for patients.

- States should establish a Medical Loss Ratio requirement, in which there is a minimum percentage of revenue for the MCO that must go directly toward patient care, to ensure that state dollars are used efficiently.
- MCOs should actively work to help patients improve their dental care and prevent emergencies by helping patients find a dentist and establish a dental home, and by offering case management services.
- States should evaluate MCOs by how well they provide oral healthcare to Medicaid patients. For example, by tracking the percentage of enrollees who have at least a comprehensive exam and preventive care each year.
- States can track the program's success by requiring the MCO to track and report metrics including:
    - Network size
    - Average time to make payment of claims
    - Accuracy of paid claims
    - Response time (call wait time) and missed calls in call centers
    - Accuracy of dentist directory
    - Grievance and appeals resolution
    - Credentialing times

States should specify how the MCO will work with dentists to ensure patients can get the care they need.

- Dental coverage through Medicaid should be reliable, predictable and efficient for patients and their dentists.
    - When administrative burdens in Medicaid are unnecessarily high, fewer dentists can viably treat Medicaid patients. Meanwhile, those that do accept Medicaid patients have fewer available patient appointments due to the additional hours required for navigating bureaucratic red tape.
    - Worst of all, patients suffer ongoing decay and pain during lengthy waits for prior authorization approvals.

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[8] Reimbursement Rates for Child and Adult Dental Services in Medicaid by State. American Dental Association. Health Policy Institute Infographic. October 2021.

- The MCO should employ a dentist licensed in North Dakota to review prior authorization requests and reply to these requests promptly.
- Administrative barriers and impacts on patient care significantly increase by unclear or changing policies. The MCO should keep an up-to-date member handbook for dentists and give at least 60 days written notice before changing fee schedules or processing policies.

LEGISLATURES ACROSS THE COUNTRY ARE ADOPTING MEDICAID ENHANCEMENTS

Several states have recently passed or enacted improvements to their Medicaid programs' dental coverage and reimbursement rates due to the many benefits to state budgets, patient health, and work readiness. Some of the changes passed since 2021 include:

- Kansas extended adult dental coverage from emergency-only to more comprehensive care.
- Louisiana extended dental coverage for adults with developmental disabilities in intermediate care facilities.
- Nebraska eliminated their annual per-person spending limit for adult enrollee dental services.
- Tennessee and Maryland, which previously had no dental benefits for adult Medicaid enrollees, each created a new, comprehensive dental benefit covering preventive, corrective, and emergency care.
- Missouri, Nebraska, South Dakota, Connecticut, Vermont and Virginia increased dental Medicaid reimbursement rates.

QUESTIONS & ANSWERS

WHAT DENTISTS ARE DOING

Q. Do you accept Medicaid patients? Why or why not?

A. Often our member dentist say I do, because ensuring that all patients have access to dental care is a priority for me. I must share, however, that it is challenging given the low reimbursement rates and administrative burdens. Raising these rates and relieving these burdens would allow more dentists to accept more Medicaid patients, giving patients better access.

Some of our member dentists say no, unfortunately, the costs associated with providing care, such as equipment and labor, are not set by dentists. What Medicaid pays for patients in the program makes accepting Medicaid unsustainable for my practice. We need to raise reimbursement rates so more dentists can afford to see Medicaid patients and give patients better access.

Q. Why do so many dentists refuse to accept Medicaid patients?

A. Dentists want to accept Medicaid patients. However, the administrative burdens like excessive paperwork, credentialing delays and program integrity compliance requirements – matched with low reimbursement rates – make it hard or impossible for most dentists to manage patient care in a population vulnerable to greater disease burden while navigating the requirements of the Medicaid program.

Q. Why don't dentists just lower their costs for low-income patients?

A. Under the current system, dentists enrolled in Medicaid programs accept much lower rates to treat Medicaid patients, including low-income patients, people with disabilities, and seniors. Some states report that dentists are reimbursed as low as 30% of what private insurance would pay. Many others reimburse dentists at less than 50% of the private insurance rates, which are already discounted from normal fees. Dentists want to provide care for low-income patients, but these low rates do not allow dentists to cover their overhead and pay their staff.

Q. What are dentists doing to try to reach adult Medicaid enrollees with insufficient dental coverage?

A. Dentists have established numerous programs to reach vulnerable patients. For example, the Community Dental Health Coordinator program trains individuals to help patients navigate the oral healthcare system from inside the communities they serve.

North Dakota DENTAL ASSOCIATION

COST & FINANCIAL IMPACT

Q. It would be nice for everyone to have dental care, but can our state/country really afford it?

A. Yes. Providing a Medicaid dental benefit would actually save taxpayers money by preventing expensive dental emergencies for a relatively modest investment. Providing regular, preventative care in a dental office has holistic health and economic benefits which are not realized when treating dental problems in emergency rooms, which is what happens now.

Q. I agree that adults on Medicaid should have dental care. But there are so many problems that need addressing, and limited resources. Why should this be a higher priority than those other needs?

A. Providing a Medicaid dental benefit is an investment in Medicaid participants' future overall health. It also saves money by preventing expensive dental emergencies. Covering comprehensive dental care with adequate reimbursement rates is a relatively modest investment that pays big dividends.

MEDICAID BASICS

Q. What is Medicaid?

A. Medicaid is a public insurance program for low-income people, people with disabilities, seniors, pregnant women, and other groups. Medicaid is administered by states, and jointly funded by states and the federal government.

Q. Why is Medicaid coverage different for dental and medical care?

A. There is a long history of dental care being separated from care for the rest of the body. Dentists and physicians are trained separately, care for dental and medical is billed separately, and Medicaid programs for dental and medical are administered separately. States are not required to provide dental benefits for adults, so coverage varies from state to state. Oral health is necessary for overall health, but the payment systems operate differently necessitating a unique focus on covering the costs for oral health care.

Q. Does Medicaid cover dental care for kids?

A. Yes. All states must cover dental care for Medicaid patients under 21. Medicaid coverage for children has worked very well to improve health and reduce disparities among children. Current federal policy suggests that the importance of oral health expires upon reaching adulthood, which we know is completely false. Adult dental coverage also benefits children. In states that provide adult benefits, children of Medicaid patients are more likely to have visited the dentist in the last year, and they are less likely to defer care.

Q. How many states currently cover dental care for adults in Medicaid?

A. Forty-nine states provide some kind of dental coverage, but this coverage varies widely. Only about half of states have comprehensive benefits that cover both preventive care and treatment of disease. Others provide limited coverage or coverage for emergencies only.

Q. Medicaid is a federal program. Why do Medicaid reimbursement rates vary so widely by state and age?

A. Medicaid is funded at the federal and state levels but is administered by states. States can determine whether they provide adult dental coverage, which services are covered, and how much providers are reimbursed for their services. This results in a patchwork of coverage across the country.

Q. What role should managed care organizations (MCOs) play in adult dental Medicaid benefits?

A. Many states use managed care for their Medicaid programs and could do so for a dental benefit. States are motivated to work with an MCO to make spending on these programs more predictable, but the evidence on managed care's effectiveness when it comes to access and cost is limited. If a state selects an MCO to manage their adult dental benefit, we suggest that states retain their policy-setting power and establish a timeline, perhaps 4 or 5 years, for reviewing the MCO and measure utilization. It is important that the MCO

also reimburses providers at a reasonable rate; we recommend that the rate be at least as high as in the state's fee-for-service plan.

SEEKING CARE

Q. Can community health centers solve the problem of access to dental care?

A. Community health centers and clinics can play a role in helping patients get care, and many do by offering dental services. But they simply don't have the capacity to meet all of the needs of patients who don't have dental benefits without the systemic solution of Medicaid benefits.

Q. Where should patients go if they don't have dental coverage?

A. Patients can look for dental care through community health centers, dental clinics and sometimes dental schools in their communities. Ultimately, to meet all of the needs of low-income people, Medicaid needs to improve oral health care coverage.

Q. What do you recommend patients do if they have Medicaid dental benefits but can't find a provider?

A. Having dental coverage is not enough if you can't find a provider who can take your coverage. Patients shouldn't have to travel long distances or wait months to see a dentist. Unfortunately, this is very common. We need to raise reimbursement rates so more dentists can participate in the program and care for Medicaid patients in their communities.

Q. What changes are needed to Medicaid that would allow more patients to access care?

A. Congress should reduce administrative burdens and require adult dental Medicaid coverage for all states, defining what kinds of services are necessary for states to provide comprehensive coverage. At the state level, we need to raise reimbursement rates so dentists can provide care to Medicaid patients without a financial loss to their practice.

Q. How would you define comprehensive coverage? What benefits or services should be included?

A. We would like to see all states offer coverage that enhances patients' overall health. That would include coverage for emergency care – which most states already offer – as well as the routine preventative care like x-rays, fluoride treatments, and oral hygiene instruction. And for patients who need prosthodontics to replace missing teeth or treatments to address dental decay, or other medically necessary treatments, those services should be covered too. These are the basic things all people need to maintain or regain their oral health.

TOUGH QUESTIONS

Q. If people want dental coverage, why shouldn't they just get a better job?

A. What we know is that people with some form of dental coverage are more likely to go to the dentist; however, not all jobs offer the full spectrum of health care coverage that includes dental benefits. Our goal is to expand dental coverage, and thereby expand access. Having some form of dependable and meaningful dental coverage should not be solely tethered to a job. For example, most entrepreneurs are required to purchase their own health coverage. The point is that all patients must have a reliable source of oral health care coverage so they can see a dentist and get the care they need to stay healthy. A strong Medicaid system can help do that.

Q. It sounds like you are putting the burden of receiving care on patients and a government program. Is that true?

A. Comprehensive coverage through Medicaid is the only way to provide oral health care for all low-income patients. Dentists want to provide care to all patients, especially the vulnerable, but they can't take on this responsibility alone.

Q. How can you ask for higher Medicaid reimbursements after opposing a proposal in Congress that would have brought a Medicare dental benefit to all seniors? Why did you oppose that proposal?

A. The American Dental Association did support a Medicare dental benefit for those seniors who are most in need, similar to how we support strengthening Medicaid to help low-income people ages 18-64. The bottom line is dentists want to be able to reach as many patients as possible to improve oral health. We will look closely at any policy at the state or federal level that will help us accomplish that.

North Dakota DENTAL ASSOCIATION

Physical Address: 1720 Burnt Boat Drive, Suite 201
Mailing Address: PO Box 1332, Bismarck ND 58502
T: 701-223-8870

OTHER PRIMARY MESSAGES

Strengthening Medicaid programs to include comprehensive dental coverage for adults will:

- Improve patient health.
- Help decrease health disparities.
- Reduce the costs of dental care sought in emergency rooms.
- Improve Medicaid participants' ability to secure and maintain employment.

MEDICAID SHOULD COVER ADULT DENTAL CARE

If we want to improve health equity, improving access to dental care is an important factor.

- Providing adult dental coverage through Medicaid would reduce racial disparities and inequities in chronic disease prevalence and maternal health**.**
- Underserved communities and people with disabilities stand to benefit most from comprehensive dental coverage in Medicaid.
- Black and Hispanic adults face cost barriers to dental care to a greater degree than their White and Asian peers. As a result, these patient groups are more likely to have outcomes like untreated cavities and severe gum disease. Recent improvements in oral health have not benefited all groups equally.
- Policymakers who want to reduce health disparities should prioritize strengthening Medicaid.

Strong dental Medicaid programs have shown numerous societal benefits.

- Access to dental care for poor Americans helps maintain a high quality of life, keep kids in school, keep adults at work and reduces unnecessary emergency room visits.
- While policymakers face many competing priorities, covering comprehensive dental care with adequate reimbursement rates is a relatively modest investment that pays big dividends.

Lack of focus on adult oral health care by federal and state governments has created a patchwork of dental coverage in state Medicaid programs.

- Medicaid was created to help low-income Americans, people with disabilities, and seniors receive healthcare, but programs often neglect certain services for entire populations.
    - Twenty-one states and the District of Columbia provide extensive adult dental Medicaid benefits. Sixteen states provide limited benefits, nine provide emergency-only benefits, three provide no benefits, and one has a dental benefit under development.[1]
    - All states are required to comply with the Early and Periodic Screening, Diagnostic and Treatment benefit to provide preventive and medically necessary comprehensive health care services for children under 21. This includes dental care.
- The inconsistency in adult dental Medicaid coverage results in spotty access for kids too. In states with adult dental benefits, children of Medicaid patients are more likely to visit the dentist and are less likely to defer care.

ADULT DENTAL MEDICAID BENEFITS SHOULD BE COMPREHENSIVE AND ADEQUATELY REIMBURSED

When dentists can't afford to accept Medicaid, patient access suffers.

- In many cases, treating Medicaid patients is *more expensive* for dental practices than receiving no compensation for care provided care due to the time and resources it takes to navigate the Medicaid system, matched with a low reimbursement rate.

- As a result, many dental practices do not accept Medicaid, or severely restrict the number of Medicaid patients they take. This makes it hard for patients to find a dentist who will see them.
- Without a dentist willing to treat them, simply having dental benefits does not actually help patients.

Improving patient and dentist participation requires Medicaid programs to reduce administrative barriers and fairly reimburse for dental care.

- Reimbursement to traditional medical providers is already too low, but the rate for dental care is even lower, far below the cost of delivering care.
    - The average Medicaid reimbursement among states providing limited or extensive adult dental services was 53.3% of private insurance reimbursement in 2020.[2]
    - Medicaid reimbursement as a percentage of private insurance reimbursement for adult dental services varied between 30.5% in Minnesota to 86.8% in California. [3]
- Dentists donate hundreds of thousands of dollars in care each year in their own offices and through events like Mission of Mercy, Give Kids A Smile and Veterans Stand Down so vulnerable people can get the care they desperately need.
- Though dentists are doing their part to meet the need, charity care is not a healthcare system and patients deserve more reliable, consistent dental coverage through Medicaid.

ACCOUNTABILITY FOR MANAGED CARE ORGANIZATIONS

Many states choose to contract part or all of their Medicaid program to managed care organizations (MCO).

- MCOs promise policymakers that they will administer the program and save the state money.
- As private organizations, MCOs are focused on the bottom line. The more they save on patient care, the more money they can keep as profit.
- In some instances, this profit motive can lead MCOs to decline coverage for necessary care.
- States need accountability measures for MCOs to make sure they are delivering the care they have promised to provide.

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[i] https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/

North Dakota DENTAL ASSOCIATION

Physical Address: 1720 Burnt Boat Drive, Suite 201
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T: 701-223-8870

RESULTS OF DENTAL MEDICAID FUNDING IMPROVEMENTS

It is well-established that a multifaceted approach to dental Medicaid improvements vastly increases the chances for greater utilization and improved oral health for Medicaid enrollees. It is common knowledge that improving investment in dental Medicaid funding is the key component to ensuring enrollees get the care they need when they need it.

To prove funding improvements have an impact, consider the reports from past improvements and research performed:

Connecticut – 2008 children's dental fees set to 70th percentile of dental market fees in 2005. [1]

- *"For children continuously enrolled in Medicaid, utilization rates increased from 45.9% in 2006 to 71.6% in 2012."*
- *"These increased utilization rates eliminated the disparities in access to dental services between children with private insurance and children receiving Medicaid benefits. Children enrolled in Medicaid now have utilization rates that are similar to or higher than privately insured children."*
- *"Expenditures increased $62 million; this represents less than 1% of 2012 State Medicaid expenditures."*
- *"Dentist participation increased by 72%."*
- *"These results suggest that dentists will participate in the Medicaid program if adequately compensated, and low-income families will seek dental services."*
- *"One solution to the substantial disparities in access to dental care is to increase Medicaid fees to competitive levels."*

Indiana – 1998 fees increased to 100 percent of the 75th percentile of usual and customary fees. [2]

- *"The number of dentists seeing a Medicaid-enrolled child increased from 770 in fiscal year (FY) 1997 to 1,096 in FY 2000.*
- *The number of Medicaid-enrolled children with any dental visit increased from 68,717 (18 percent) to 147,878 (32 percent), with little difference between children enrolled through the Medicaid-SCHIP and traditional Medicaid programs by FY 2000.*

[1] Tryfon Beazoglou, Joanna Douglass, Veronica Myne-Joslin, Patricia Baker, Howard Bailit, Impact of fee increases on dental utilization rates for children living in Connecticut and enrolled in Medicaid, The Journal of the American Dental Association, Volume 146, Issue 1, 2015, Pages 52-60, ISSN 0002-8177, https://doi.org/10.1016/j.adaj.2014.11.001.

[2] Hughes RJ, Damiano PC, Kanellis MJ, Kuthy R, Slayton R. Dentists' participation and children's use of services in the Indiana dental Medicaid program and SCHIP: assessing the impact of increased fees and administrative changes. J Am Dent Assoc. 2005 Apr;136(4):517-23. doi: 10.14219/jada.archive.2005.0209. PMID: 15884323.

- *The mean number of visits per child per year and the mean number of procedures per child per year remained relatively constant. The cost per enrolled child increased from $1.70 to $6.70 per month, while the cost per child with a visit increased from $9 to $21 per month.*

- *The increase in fees and changes in administration of the Indiana dental Medicaid program were positively associated with improved dentist participation and children's use of dental services*

National Association of State Health Policy – Research [3]

- *Survey research, available literature, and interviews with key stakeholders in six study states indicate that higher fees positively influence: (1) dentists' willingness to accept new Medicaid-enrolled patients; and (2) Medicaid patients' access to and utilization of needed oral health care.*

- *The study states all enjoyed improvements in the percentage of children utilizing dental services (even in a period of expanding Medicaid enrollment), although they have not yet reached the utilization levels of privately insured children. The changes that these states made did mean they substantially increased their spending on dental services, but even so, dental spending is still only a small piece of total Medicaid expenditures.*

California Health Care Foundation – Research [4]

- *Survey research, academic literature, and interviews with key stakeholders in six states indicate that higher fees positively influence both dentists' willingness to participate in state Medicaid programs and Medicaid patients' access to oral health care.*

- *However, a majority of experts interviewed felt that while adequate reimbursement rates were necessary for improving access to Medicaid dental services, they were not sufficient on their own. Higher rates must be combined with efforts to address administrative concerns and strengthen the state's relationships with community dentists.*

American Journal of Public Health [5]

- *Reimbursement rates and access to dental care were directly related at the state level, but no evidence indicated that higher reimbursement rates resulted in overuse of dental services for those who had access. The relation between reimbursement rates and access to care was moderated by dentist density and dentist participation in Medicaid. We estimate that more than 1.8 million additional children would have had access to dental care if reimbursement rates were higher in states with low rates.*

- *Children who access the dental care system receive care, but reimbursement may significantly affect access. States with low dentist density and low dentist participation in Medicaid may be able to improve access to dental services significantly by increasing reimbursement rates.*

The Impact of Medicaid Reform on Children's Dental Care Utilization in Connecticut, Maryland & Texas [6]

- *Increasing Medicaid dental fees closer to private insurance fee levels has a significant impact on dental care utilization and unmet dental need among Medicaid-eligible children.*

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[3] The Effects of Medicaid Reimbursement Rates on Access to Dental Care; National Academy for State Health Policy 2008

[4] Increasing Access to Dental Care in Medicaid: Does Rasing Provider Rates Work? Californai Healthcare Foundation, 2008

[5] Chalmers NI, Compton RD. Children's Access to Dental Care Affected by Reimbursement Rates, Dentist Density, and Dentist Participation in Medicaid. Am J Public Health. 2017 Oct;107(10):1612-1614. doi: 10.2105/AJPH.2017.303962. Epub 2017 Aug 17. PMID: 28817336; PMCID: PMC5607675.

[6] Nasseh K, Vujicic M. The Impact of Medicaid Reform on Children's Dental Care Utilization in Connecticut, Maryland, and Texas. Health Serv Res. 2015 Aug;50(4):1236-49. doi: 10.1111/1475-6773.12265. Epub 2014 Dec 7. PMID: 25483733; PMCID: PMC4545356.

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1567
2/5/2025

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities; and to provide an appropriation.

5:52 p.m. Chairman M. Ruby opened the meeting.

Members Present: Chairman Ruby, Vice-Chairman Frelich, Representatives Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Kiefert, Rios, Rohr

Members Absent: Representative Holle

Discussion Topics:

- Committee work
- Amendments relating to dental insurance reform

5:59 p.m. Representative Davis moved to adopt the amendment LC# 25.1142.02001.

6:00 p.m. Representative Rohr seconded the motion.

6:00 p.m. Voice Vote passed.

6:00 p.m. Representative Rohr moved a Do Pass as amended.

6:00 p.m Representative Davis seconded the motion.

Representatives	Vote
Representative Matthew Ruby	N
Representative Kathy Frelich	Y
Representative Karen Anderson	Y
Representative Mike Beltz	Y
Representative Macy Bolinske	N
Representative Jayme Davis	Y
Representative Gretchen Dobervich	Y
Representative Cleyton Fegley	Y
Representative Jared Hendrix	Y
Representative Dawson Holle	AB
Representative Dwight Kiefert	N
Representative Nico Rios	Y
Representative Karen Rohr	Y

6:02 p.m. Motion passed 9-3-1.

Representative Davis will carry the bill.

6:10 p.m. Chairman M. Ruby adjourned the meeting.

Jackson Toman, Committee Clerk

Bill further amended on 02/18/25.

25.1142.02001
Title.03000

Prepared by the Legislative Council staff for Representative Rohr
February 4, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

2-5-25
HB 1093

HOUSE BILL NO. 1567

Introduced by

Representatives Schneider, Brown, Davis, Finley-DeVille, McLeod, Mitskog, Nelson, Hager

Senators Bekkedahl, Hogan

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCESS TO DENTAL AND ORAL HEALTH CARE SERVICES FOR LOW-INCOME CHILDREN, NATIVE AMERICAN CHILDREN, AND INDIVIDUALS WITH DISABILITIES.

1. During the 2025-26 interim, the legislative management shall consider studying the unmet dental and oral health care needs of low-income children, Native American children, and individuals with disabilities. The study must include:
   a. An overview of the dental and oral health care status of Medicaid recipients, including low-income children, Native American children, and individuals with disabilities, both on and off reservations;
   b. Evaluation of the importance of receiving dental and oral health care services, the impacts and outcomes of not receiving services, general health consequences, complications, and expanded costs of future care;
   c. Review of state and federal regulations, policies, and procedures limiting or perceived as limiting dentist provider enrollment in Medicaid, including

HB 2003

impediments to enrollment, prior authorizations, attachments, appeals, and timely payments;

d. Availability of, and access or barriers to, complex dental services for Medicaid recipients with disabilities or dental conditions which might require anesthesia or critical care;

e. Review of Medicaid dental reimbursement rates for a selection of preventative and treatment services in this state compared to other states, private payers, and in comparison to real cost for dental teams to determine potential need to increase reimbursement rates;

f. Review of barriers and opportunities relating to expanding education for dentists and dental staff, including consideration of a new dental school in this state, long-term partnership with regional dental schools, and increased dental student residencies located in this state;

g. Consideration of the expansion or promotion of programs that offer support and resources to enable on-the-job training and apprenticeships for dental assistants, including the visibility of providing state and federal resources to support providers offering such training;

h. Consideration of expansion or creation of volunteer and charitable dental programs and nonprofit services;

i. Evaluation of ways to improve accessibility to dental and oral health care services for Medicaid recipients, including low-income children, Native American children, and individuals with disabilities, both on and off reservations;

j. Exploration of the feasibility of partnerships between state programs and tribal health organizations to enhance delivery;

k. Review of programs designed to recruit and retain dental health providers, such as loan forgiveness or incentives for dentists working in underserved communities, including tribal communities; ~~and~~

l. Exploration of the use of telehealth solutions to reach rural areas, including tribal communities;

m. Review of compensation for dental professionals including dentists, dental hygienists, and dental assistants as compared to other states and the nation;

JB 3 of 3

n. Review of cost and profit margins for dental providers as compared to other states and the nation;

o. Review of dental provider participation with dental insurers, including the percentage of dental providers in-network and out-of-network for the largest dental insurers; and

p. Review of charges covered by dental benefit plans and out-of-pocket costs for dental care.

2. The study may include broader considerations of unmet needs for dental services for all Medicaid recipients, data for those recipients, and any current for remediation with goals, objectives, projected costs, and implementation timetables.

3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

SECTION 2. APPROPRIATION - DEPARTMENT OF HEALTH AND HUMAN SERVICES - ORAL HEALTH PROGRAM STUDENT ROTATION EXPANSION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $97,000, or so much of the sum as may be necessary, to the department of health and human services for the purpose of supporting the department's oral health program student rotations across the state, including community health centers serving Native American populations, and for dental student recruitment efforts, for the biennium beginning July 1, 2025, and ending June 30, 2027.

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1567
2/17/2025

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities; and to provide an appropriation.

4:14 p.m. Chairman M. Ruby opened the meeting.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives K. Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- Committee action
- Proposed amendments relating to the cost of dental insurance

4:14 p.m. Representative Holle moved to reconsider the bill.

4:14 p.m. Representative Rios seconded the motion.

4:15 p.m. Voice Vote passed.

4:16 p.m. Representative Rohr introduced amendments LC#25.1142.02000, #44924.

4:18 p.m. Chairman M. Ruby closed the meeting.

Jackson Toman, Committee Clerk

25.1142.02000

Sixty-ninth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1567

Introduced by

Representatives Schneider, Brown, Davis, Finley-DeVille, McLeod, Mitskog, Nelson, Hager

Senators Bekkedahl, Hogan

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCESS TO DENTAL AND ORAL HEALTH CARE SERVICES FOR LOW-INCOME CHILDREN, NATIVE AMERICAN CHILDREN, AND INDIVIDUALS WITH DISABILITIES.

1. During the 2025-26 interim, the legislative management shall consider studying the unmet dental and oral health care needs of low-income children, Native American children, and individuals with disabilities. The study must include:
   a. An overview of the dental and oral health care status of Medicaid recipients, including low-income children, Native American children, and individuals with disabilities, both on and off reservations;
   b. Evaluation of the importance of receiving dental and oral health care services, the impacts and outcomes of not receiving services, general health consequences, complications, and expanded costs of future care;
   c. Review of state and federal regulations, policies, and procedures limiting or perceived as limiting dentist provider enrollment in Medicaid, including impediments to enrollment, prior authorizations, attachments, appeals, and timely payments;
   d. Availability of, and access or barriers to, complex dental services for Medicaid recipients with disabilities or dental conditions which might require anesthesia or critical care;

e. Review Medicaid dental reimbursement rates for a selection of preventative and treatment services in this state compared to other states, private payers, and in comparison to real cost for dental teams to determine potential need to increase reimbursement rates;

f. Review barriers and opportunities relating to expanding education for dentists and dental staff, including consideration of a new dental school in this state, long-term partnership with regional dental schools, and increased dental student residencies located in this state;

g. Consideration of the expansion or promotion of programs that offer support and resources to enable on-the-job training and apprenticeships for dental assistants, including the visibility of providing state and federal resources to support providers offering such training;

h. Consideration of expansion or creation of volunteer and charitable dental programs and nonprofit services;

i. Evaluation of ways to improve accessibility to dental and oral health care services for Medicaid recipients, including low-income children, Native American children, and individuals with disabilities, both on and off reservations;

j. Exploration of the feasibility of partnerships between state programs and tribal health organizations to enhance delivery;

k. Review of programs designed to recruit and retain dental health providers, such as loan forgiveness or incentives for dentists working in underserved communities, including tribal communities; and

l. Exploration of the use of telehealth solutions to reach rural areas, including tribal communities.

2. The study may include broader considerations of unmet needs for dental services for all Medicaid recipients, data for those recipients, and any current for remediation with goals, objectives, projected costs, and implementation timetables.

3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

SECTION 2. APPROPRIATION - DEPARTMENT OF HEALTH AND HUMAN SERVICES - ORAL HEALTH PROGRAM STUDENT ROTATION EXPANSION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $97,000, or so much of the sum as may be necessary, to the department of health and human services for the purpose of supporting the department's oral health program student rotations across the state, including community health centers serving Native American populations, and for dental student recruitment efforts, for the biennium beginning July 1, 2025, and ending June 30, 2027.

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1567
2/18/2025

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities; and to provide an appropriation.

10:38 a.m. Chairman M. Ruby opened the meeting.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives K. Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- Committee action
- Amendments relating to dental costs
- Amendments relating to the appropriation

10:39 a.m. Chairman M. Ruby introduced proposed amendments relating to dental costs.

10:41 a.m. Representative K. Anderson moved to adopt the amendments removing sub m and n from pages 2 and 3.

10:41 a.m. Representative Holle seconded the motion.

10:43 a.m. Voice vote passed.

10:45 a.m. Representative Holle moved a Do Pass as amended.

10:45 a.m. Representative Fegley seconded the motion.

Representatives	Vote
Representative Matthew Ruby	N
Representative Kathy Frelich	N
Representative Karen Anderson	N
Representative Mike Beltz	Y
Representative Macy Bolinske	N
Representative Jayme Davis	AB
Representative Gretchen Dobervich	Y
Representative Cleyton Fegley	Y
Representative Jared Hendrix	Y
Representative Dawson Holle	Y
Representative Dwight Kiefert	N
Representative Nico Rios	N
Representative Karen Rohr	N

10:46 a.m. Motion failed 5-7-1.

10:49 a.m. Vice-Chairman Frelich moved to amend the bill relating to the appropriation.

10:49 a.m. Representative K. Anderson seconded the motion.

Representatives	Vote
Representative Matthew Ruby	Y
Representative Kathy Frelich	Y
Representative Karen Anderson	Y
Representative Mike Beltz	Y
Representative Macy Bolinske	Y
Representative Jayme Davis	AB
Representative Gretchen Dobervich	N
Representative Cleyton Fegley	Y
Representative Jared Hendrix	N
Representative Dawson Holle	N
Representative Dwight Kiefert	Y
Representative Nico Rios	N
Representative Karen Rohr	Y

10:49 a.m. Motion passed 8-4-1.

10:49 a.m. Representative Dobervich moved a Do Pass as twice amended.

10:50 a.m. Representative Holle seconded the motion.

Representatives	Vote
Representative Matthew Ruby	Y
Representative Kathy Frelich	Y
Representative Karen Anderson	Y
Representative Mike Beltz	Y
Representative Macy Bolinske	Y
Representative Jayme Davis	AB
Representative Gretchen Dobervich	Y
Representative Cleyton Fegley	Y
Representative Jared Hendrix	Y
Representative Dawson Holle	Y
Representative Dwight Kiefert	Y
Representative Nico Rios	Y
Representative Karen Rohr	Y

10:50 a.m. Motion passed 12-0-1.

Representative Davis will carry the bill.

10:51 a.m. Representative Dobervich moved to place the bill on the consent calendar.

10:51 a.m. Representative Holle seconded the motion.

10:52 a.m. Voice vote passed.

10:52 a.m. Chairman M. Ruby adjourned the meeting.

Jackson Toman, Committee Clerk

BV 2/18/25

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25.1142.02003
Title.03000

Adopted by the Human Services Committee
February 18, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1567

Introduced by

Representatives Schneider, Brown, Davis, Finley-DeVille, McLeod, Mitskog, Nelson, Hager

Senators Bekkedahl, Hogan

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities~~; and to provide an appropriation.~~

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCESS TO DENTAL AND ORAL HEALTH CARE SERVICES FOR LOW-INCOME CHILDREN, NATIVE AMERICAN CHILDREN, AND INDIVIDUALS WITH DISABILITIES.

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   b. Evaluation of the importance of receiving dental and oral health care services, the impacts and outcomes of not receiving services, general health consequences, complications, and expanded costs of future care;
   c. Review of state and federal regulations, policies, and procedures limiting or perceived as limiting dentist provider enrollment in Medicaid, including impediments to enrollment, length of credentialing and recredentialing, reasons

for provider termination, prior authorizations, attachments, appeals, and timely payments;

d. Availability of, and access or barriers to, complex dental services for Medicaid recipients with disabilities or dental conditions which might require anesthesia or critical care;

e. Review of Medicaid dental reimbursement rates for a selection of preventative and treatment services in this state compared to other states, private payers, and in comparison to real cost for dental teams to determine potential need to increase reimbursement rates;

f. Review of barriers and opportunities relating to expanding education for dentists and dental staff, including consideration of a new dental school in this state, long-term partnership with regional dental schools, and increased dental student residencies located in this state;

g. Consideration of the expansion or promotion of programs that offer support and resources to enable on-the-job training and apprenticeships for dental assistants, including the visibility of providing state and federal resources to support providers offering such training;

h. Consideration of expansion or creation of volunteer and charitable dental programs and nonprofit services;

i. Evaluation of ways to improve accessibility to dental and oral health care services for Medicaid recipients, including low-income children, Native American children, and individuals with disabilities, both on and off reservations;

j. Exploration of the feasibility of partnerships between state programs and tribal health organizations to enhance delivery;

k. Review of programs designed to recruit and retain dental health providers, such as loan forgiveness or incentives for dentists working in underserved communities, including tribal communities; ~~and~~

l. Exploration of the use of telehealth solutions to reach rural areas, including tribal communities;

m. Review of dental provider participation with dental insurers, including the percentage of dental providers in-network and out-of-network for the largest dental insurers;

n. Review of charges covered by dental benefit plans and out-of-pocket costs for dental care;

o. Review of dental program preauthorization and service coverage in adherence to clinical guidelines of the American dental association and the American academy of pediatric dentistry;

p. Review of the provider relations program for answering questions from providers and staff, online and in-person education and training to providers and staff to promote efficiency and effectiveness;

q. Consideration of program staff credentials for appropriate oversight of clinical care for claim preauthorizations and approvals;

r. Consideration of the administrative system addressing grievances and appeals of submitted claims and preauthorizations to assess the system's responsiveness and review the ability to submit additional documentation, such as x-rays and photos using an online portal;

s. Review of parity in the submission of claims between private offices, nonprofit dental clinics, and federally qualified health centers;

t. Consideration of the potential effects of dental Medicaid expansion and increase in adult Medicaid-eligible enrollees on access to dental care, administrative efficiency, and participation of dentists in the Medicaid program;

u. Review of dental claims administration including the percentage of preauthorizations and denials;

v. Review of call center management including the number of calls, average hold time, and caller satisfaction;

w. Review of cases and decisions by a program administration related to audits and claims review to determine what percentage were completed with a peer review committee that includes a licensed dentist and a licensed dentist of a specialty;

x. Review the quality improvement system that assists providers in providing clinically appropriate care in accordance with the guidelines of the American

dental association and the American academy of pediatric dentistry clinical guidelines;

y. Analysis of the information required by centers for Medicare and Medicaid form 416, in compliance with Medicaid early and periodic screening, diagnostic, and treatment, including the percentage of eligible children receiving any dental service, preventative service, or sealants;

z. Analysis of provider participation and recredentialing of dental providers with Medicaid, the average benefit paid per user and beneficiary, the geographical distribution of active providers with active recipients in the state, and provider participation surveys; and

aa. Review of ambulatory surgery and hospital facility claims for dental rehabilitation procedures that require monitored anesthesia for children to compare with other medical providers providing similar same-day surgical services.

2. The study may include broader considerations of unmet needs for dental services for all Medicaid recipients, data for those recipients, and any current for remediation with goals, objectives, projected costs, and implementation timetables.

3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

~~**SECTION 2. APPROPRIATION - DEPARTMENT OF HEALTH AND HUMAN SERVICES - ORAL HEALTH PROGRAM STUDENT ROTATION EXPANSION.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $97,000, or so much of the sum as may be necessary, to the department of health and human services for the purpose of supporting the department's oral health program student rotations across the state, including community health centers serving Native American populations, and for dental student recruitment efforts, for the biennium beginning July 1, 2025, and ending June 30, 2027.~~

REPORT OF STANDING COMMITTEE
HB 1567

Human Services Committee (Rep. M. Ruby, Chairman) recommends **AMENDMENTS (25.1142.02003)** and when so amended, recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (12 YEAS, 0 NAYS, 1 ABSENT OR EXCUSED AND NOT VOTING). HB 1567 was placed on the Sixth order on the calendar.

2025 SENATE HUMAN SERVICES

HB 1567

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1567
3/18/2025

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities.

9:00 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

Discussion Topics:

- Economically Disadvantaged Population
- Dental student recruitment
- Medicaid reimbursement
- Training Opportunities

9:00 a.m. Representative Mary Schneider introduced the bill and submitted testimony in favor #42795 and #425796.

9:14 a.m. Kim Kuhlmann, Policy & Partnership Manager with Community HealthCare Association of the Dakotas, testified in favor and submitted testimony #42816 and #42670.

9:33 a.m. William R. Sherwin, Executive Director with The North Dakota Dental Association, testified in favor and submitted testimony #42632 and #42633.

9:36 a.m. Brent Kleinjan, Ronald McDonald House Charities of Bismarck ND, testified in favor and submitted testimony #41608, #41609, #41610 and #41611.

9:38 a.m. Barbara Frydenlund, Public Health Administrator with Rolette Co Public Health, testified in favor and submitted testimony #42066.

9:46 a.m. Kimberly K. Jacobson, Director of Agassiz Valley Human Service Zone, testified in favor and submitted testimony #42635.

9:53 a.m. Micah Olson, PNA, testified in favor and submitted testimony #42815.

Additional written testimony:

Representative Lisa Finley-DeVille submitted written testimony in favor #42715.

Dori Leslie, President of CHI Friendship, submitted written testimony in favor #41812.

Sarganna Wutzke submitted written testimony in favor #42321.

Kirsten Dvorak, Executive Director The Arc of ND, submitted written testimony in favor #42681.

Kendra Vander Wal, Executive Director of Designer Genes of ND, submitted written testimony in favor #42730.

9:57 a.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

Ronald McDonald House Charities
Bismarck, ND
Keeping families close

Ronald McDonald Care Mobile Service Delivery Summary
January – December 2023 (12th Year of Service)

Aggregate Data :
Number of Sites: 46 (46 in 2022)
Total number of children seen: 1183 (962 in 2022)
Total number of visits/encounters: 1,679 (1988 in 2022)
Total number of services provided: 9160 (7145 in 2022)
Total value of treatment provided: $698,772 ($532,860 in 2022)

Individual Data:

Average cost per child to deliver RMCM services: $590.67 ($530.92 in 2022)
Average number of visits per child: 1.41 (1.75 in 2022)
Average number of services per child: 7.74 (7.43 in 2022)

Detail of Services provided:

Diagnostic	Number Provided		Preventive	Number Provided		Restorative/Surgical	Number Provided	
Exams	915		Oral health education	799		Fillings	1265	
X-rays	1414		Cleanings	795		Stainless Steel Crowns	9	
Caries Risk Assess	933		Fluoride Treatments	790		Extractions	240	
Referrals	10		Sealants	2643		Pulpotomies	67	
						Other	212	

Demographics:

Race/Ethnicity
Caucasian 27%
Native American 51%
African American 7%
Hispanic 8%
Asian 1%
Mixed Race/Other 3%

Gender
Males 51%
Females 49%

Grade
Pre-K 6%
K-6 71%
7-9 11%
10-12 6%
13+ 1%
NA 5%

Age
0-2 2%
3-5 14%
6-8 34%
9-11 28%
12-14 8%
15-17 8%
18-21 6%

Service delivery sites: 46
Service delivery days: 172

Payor Source:
35% Medicaid
3% Private insurance
62% Uninsured

Communities Served:
Belcourt/Dunseith
Bismarck
Cannon Ball/Solen
Dickinson
Fort Yates
Hebron
Mandan
Minot
New England
New Town
Selfridge
United Tribes
Mott/Regent
Hazelton MB
Parshall
Selfridge

2025 RMCM Schedule				
Month	***Date***	***Location***	***Site***	***Notes***
January	1st-3rd	Bismarck	No Oper	School resumes in Bismarck Jan 2
January	6th-10th	Bismarck	Moses	
January	13th-17th	Bismarck	Myhre	
January	20th-24th	Bismarck	Roosevelt	No School in Bismarck 20th & 21st
January/February	27th-31st	Bismarck	TJES	
February	3rd-7th	Bismarck	Will Moore	
February	10th-14th	Bismarck	Pioneer	
February	17th-21rd	Bismarck	Make-up	No School Feb 17th in Bismarck
February	24-28	Mandan	Lakewood	
March	3rd-7th	Bismarck	Murphy	
March	10th-14th	Bismarck	Grimsrud	March 14th-No School unless needed M-U
March	17th-21rd	Bismarck	No Oper	No School March 17th in Bismarck
March	24th-28th	Bismarck	Miller	
March/April	31st-3	Bismarck	Northridge	No School in Bismarck April 4
April	7th-11th	Minot	Washington	
April	14th-18th	Bismarck	Make-up	
April	21st-25th	Dickinson	Heart R iver	
April/May	28th-2nd	Hebron	Hebron	
May	5th-9th	Minot	Sunnyside	
May	12th-16th	Mandan	Middle	
May	19th-23rd	Bismarck	No Oper	
May/June	26th-31st	Bismarck	No Oper	26th Memorial Day
June	2nd-6th	Cannon B	Cannon B	
June	9th-13th	Bismarck	C. Kids	
June	16th-20th	Bismarck	C. Kids	
June	23rd-27th	Bismarck	C. Kids	
June /July	30th-4th	Bismarck	No Oper	
July	7th-11th	Belcourt	I H S	
July	14h-18th	Bismarck	No Oper	
July	21st-25th	Belcourt	I H S	
July/August	28th-1st	Bismarck	No Oper	
August	4th-8th	Bismarck	C. Kids	
August	11th-15th	Bismarck	No Oper	
August	18th-22rdN	Bismarck	No Oper	
Au/September	25th-29th	Minot	Roosevelt	
September	1st-5th	Minot	Longfellow	Labor Day September 1
September	8th-12th	Selfridge	Selfridge	
September	15th-19th	New ENg	New Eng	
September	22nd-26th	Solen	Solen	
September/October	29th-3rd	Newtown	Early Child	
October	6th-10th	Cannon B	Cannon B	
October	13th-17th	Bismarck	No Oper	Teachers Convention
October	20st-24th	St. John	St. John	
October	27th-31st	Fort Yates	SRCS	
November	3th-7th	Dickinson	Middle	
November	10th-14th	Ft. Yates	SRCS	
November	17th-21nd	Fort Yates	St. Bernard	
November	24th-28th	Bismarck	No Oper	
December	1st-5th	Mandan	Mary Stark	
December	8th-12th	Mandan	Custer	
December	15th-19th	Bismarck	Make-up	
December	23rd-27th	Home	Home	
				12/5/2024

Ronald McDonald House Charities
Bismarck, ND
Keeping families close

Ronald McDonald Care Mobile Service Delivery Summary
January – December 2024 (13th Year of Service)

Aggregate Data:
Number of Sites: 43 (46 in 2023)
Total number of children seen: 1057 (1183 in 2023)
Total number of visits/encounters: 1799 (1679 in 2023)
Total number of services provided: 8166 (9160 in 2023)
Total value of treatment provided: $638,906 ($698,772 in 2023)

Individual Data:

Average cost per child to deliver RMCM services: $604.45 ($590.67 in 2023)
Average number of visits per child: 1.70 (1.41 in 2023)
Average number of services per child: 7.72 (7.74 in 2023)

Detail of Services provided:

Diagnostic	Number Provided		Preventive	Number Provided		Restorative/Surgical	Number Provided	
Exams	804		Oral health education	743		Fillings	1142	
X-rays	1425		Cleanings	744		Stainless Steel Crowns	24	
Caries Risk Assess	727		Fluoride Treatments	743		Extractions	234	
Referrals	17		Sealants	1989		Pulpotomies	75	
						Other	251	

Demographics:

Race/Ethnicity	
Caucasian	27%
Native American	51%
African American	7%
Hispanic	8%
Asian	1%
Mixed Race/Other	3%

Grade	
Pre-K	3%
K-6	70%
7-9	15%
10-12	7 %
13+	1%
NA	4%

Age	
0-2	2%
3-5	11%
6-8	37%
9-11	26%
12-14	12%
15-17	9 %
18-21	3%

Gender	
Males	52%
Females	48%

Service delivery sites: 43
Service delivery days: 152

Payor Source:
37% Medicaid
3% Private insurance
60% Uninsured

Communities Served:
Belcourt/Dunseith
Bismarck
Cannon Ball/Solen
Dickinson
Fort Yates
Hebron
Mandan
Minot
New England
New Town
Selfridge
United Tribes
Mott/Regent
Hazelton MB
St. John

Ronald McDonald House Charities
Bismarck, ND
Keeping families close

Senate Human Services Committee
Chair Judy Lee

3-14-2025

Chair Lee and Members of the Committee,

I appreciate the opportunity to provide testimony in support of a legislative management study on oral health, particularly as it relates to children, Native Americans, and individuals with disabilities. Oral health is a critical component of overall well-being, yet many individuals in North Dakota face significant barriers to accessing essential dental care. These disparities are especially pronounced among vulnerable populations, including children, Native American communities, and individuals with disabilities.

The Ronald McDonald Care Mobile (RMCM) of North Dakota has been a vital resource in addressing these disparities by delivering comprehensive mobile dental care to underserved communities. In 2024 alone, the RMCM provided services at 43 sites across the state, offering critical oral health care to 1,057 children. This program ensures that children who may otherwise lack access to preventive and restorative treatments receive necessary care, improving their long-term health outcomes.

Key findings from RMCM's 2024 service delivery summary include:

- **Total visits/encounters:** 1,799
- **Total number of services provided:** 8,166
- **Total value of treatment provided:** $638,906
- **Demographics:** 51% of children served were Native American, with 60% uninsured and 37% covered by Medicaid.

The services provided through RMCM include diagnostic, preventive, and restorative treatments such as exams (804), X-rays (1,425), fluoride treatments (743), sealants (1,989), fillings (1,142), and extractions (234). These numbers underscore the significant need for oral health services in our state, particularly for those who face financial, geographic, and systemic barriers to care.

Many of the communities served by RMCM, including Belcourt, Dunseith, Cannon Ball, Fort Yates, and New Town, have high populations of Native American residents who experience disproportionately high rates of dental disease. Additionally, the mobile unit

reaches rural and remote areas where dental care providers are scarce, ensuring that children receive the preventive and emergency dental services they need.

Given the documented need for expanded access to oral health care, I strongly urge the committee to support a legislative management study on oral health. Such a study would help identify gaps in services, evaluate current programs, and explore policy solutions to improve access to care for children, Native Americans, and individuals with disabilities. Investing in oral health today will reduce long-term healthcare costs and improve the quality of life for many North Dakotans.

Thank you for your time and consideration. I welcome any questions from the committee.

Sincerely,

Brent Kleinjan
Executive Director
RMHC Bismarck
701-471-0348 (cell)
brent@rmhcbismarck.org

HOUSE HUMAN SERVICES COMMITTEE
HB 1567
TESTIMONY OF DORI LESLIE, CHI FRIENDSHIP (NDACP MEMBER)
JANUARY 26, 2025

Good morning members of the Human Resources committee. I am Dori Leslie, Executive Director of CHI Friendship, and I am grateful for the opportunity to share with you my thoughts on additional resources needed for dental and oral health care services for low-income, Native American children and individuals with disabilities in North Dakota. CHI Friendship has been providing services to people with disabilities in the Fargo and Grafton/Park River areas since 1974. Today we serve over 200 clients and have about 350 staff. Our major areas of service to people with developmental disabilities are in group homes, apartments, and in vocational/employment settings.

As a state, North Dakota can and should take great pride in the outstanding services it has provided over the years to people with disabilities. Among the reasons North Dakota has been recognized as such a strong leader in this field is because of the outstanding leadership from the Department of Human Services, the quality of care from providers, and the important ongoing support of our state legislators. Thank you.

I stand before you today to passionately advocate for significant improvements to dental care access and quality, particularly for underserved communities. As a leader in the Developmental Disability field for close to 35 years, I have witnessed firsthand the devastating consequences of inadequate dental care, impacting not only oral health but overall well-being and systemic health.

According to insurekidsnow.gov there are six dental providers within a 50 mile radius of Fargo that are currently approved to accept ND Medicaid and who are able to support patients with "special healthcare needs". Due to the limited number of dental providers in our area, NDMA recipients have had to seek services over 250 miles away and sometimes out of state. Goebel Pediatric Dentistry is the only dental provider in the entire state of North Dakota that offers dental services under general anesthesia, they are located in Bismarck.

At CHI Friendship, there are currently 38 individuals that travel to Bismarck for their routine dental care or require the use of general anesthesia to complete a thorough dental exam, cleaning or restoration service. Goebel Pediatric Dentistry schedules one to two days each month that they identify as "special needs days". These days are reserved for North Dakota Medicaid recipients. They have two doctors and 12 staff on shift and see on average, 120 patients each day. Unfortunately, they only expect about half of each visit to be paid for by insurance.

Dental providers in the Fargo/Moorhead area have shared that they have to limit the number of patients insured by North Dakota Medicaid due to inadequate reimbursement for time, services rendered and delayed payment on submitted claims. Several dental offices report that they end up having to write off many NDMA claims, due to denial of coverage, lengthy prior authorizations, or claims being consistently denied. Each of these cases result in zero payment to a dental office, they are essentially donating their time and services.

In October of 2022, one of the Minnesota dental providers decided to no longer accept NDMA due to the previously mentioned concerns. According to AppleTree Dental, this left over 1,000 patients (children and adults) seeking a new dental provider that would accept North Dakota Medicaid insurance. AppleTree Dental provided a compassionate and gentle approach in the care they provided. They took time to get to know each patient. Patients were encouraged to go to the office without appointments to become familiar with the location (exposure therapy) and if anxiety was a concern, patients were able to schedule multiple appointments to complete their dental work in small steps. In speaking with a representative at AppleTree, they shared that NDMA would not reimburse claims due to the title variations of their assistant/hygienist in the notes that were submitted for payment.

There continues to be a significant shortage of dental providers willing to accept North Dakota Medicaid. Oral health and hygiene affects the entire body; weight, diet, airway, energy, cardiovascular and metabolic disorders, etc. In order to continue supporting people to have their best possible health, we ask for your support by completing a Legislative Management Study regarding access to improved dental and oral care for low-income, Native American children and individuals with disabilities in North Dakota.

Thank you!

Testimony
House Bill 1567
Senate Human Service Committee,
Tuesday March 18, 2025
Rolette County Public Health District

Good morning, Chairman Lee and members of the Senate Human Services Committee.

My name is Barbara Frydenlund, I am a Registered Nurse and the administrator of Rolette County Public Health. Rolette County Public Health District serves Rolette County located in District 9.

House Bill 1567 is very dear to my heart, and I encourage favorable action on this bill.

Rolette County Public Health District has historically had the largest Medicaid Health Tracks program in North Dakota. Access to dental care for children and adults on Medicaid is at a critical level within our service area and the state of North Dakota. Our staff directly assists families in making dental appointments for children that we see in our Health Tracks program and all too often we fail because of lack of providers willing to accept Medicaid clients or restrict greatly the number of Medicaid clients that they will accept into their practice.

During 2024, 48% of the children participating in our Health Tracks program had an immediate need to see a dentist or do not have a dental home. We are extremely limited in local dental appointment availability and the waiting time for Indian Health Service Dental is extreme and complicated for families. If we are lucky, we may be able to seek appointments in a larger city such as Bismarck or Minot, but the wait is long, and transportation often is a barrier to getting to appointments resulting in the child not obtaining the

service and often restricted from further appointments with that clinic. Many of the children we see in our clinic need a pediatric dentist who can provide anesthesia as the magnitude of the dental care needed is beyond what can be completed in a dental chair. Most of our Health Tracks participants are American Indian and or under served.

Oral health care is essential to the overall health of the individual, regardless of age. Dental care should not be a luxury, as has become in my service area and many other areas within North Dakota and the nation.

The staff of Rolette County Public Health offers fluoride varnish to all our clients with the consent of the parent/guardian. We average 80-90% uptake on the varnish application. The 10-20% that decline the service state that the child received the varnish at a recent dental appointment. We also apply fluoride varnish to school age children in the school setting, again with consent. The fluoride varnish strengthens the existing teeth making them more decay resistant, slows the progression of existing cavities and eases some of the pain that maybe present.

Dental caries can be a serious health threat to both children and adults. Many of our children have as many cavities as they have teeth. These very large cavities cause pain, causing problems with eating, speaking, playing and learning. A child with tooth pain is not going to be attentive in school, leading to learning and behavioral concerns. If the cavity reaches the nerve an abscess can form, and the infection can be spread throughout the body. Again, oral health of an individual is considered indicative of the overall health.

We understand that the Ronald McDonald Dental Mobile can’t begin to serve the number of children in need of dental services.

Rolette County Public Health has three suggestions for the improvement of the dental crisis that we are facing.

1. Mid-level dental providers. *Equivalent to Physician Assistances and Nurse Practitioners who without, our rural health care would be even a greater disparity.*

2. The opportunity for Dental Hygienists to work independently from a dentist, to provide cleanings, sealants and fluoride varnish in public health offices and schools-----funding would be required for this option.

3. Increase in mobile dental services

In 2021 we purchased a 38-foot mobile clinic, complete with two exam rooms. The purpose of our mobile clinic is to provide public health services in locations within our county where we do not have physical public health infrastructure.

As we look locally for solutions to the dental access crisis, Rolette County Public Health would like to propose that as a pilot project, the North Dakota legislature provide funding to transform one exam room of our mobile clinic into a dental suite to provide preventive dental services and simple fillings and extractions.

In addition to the mobile clinic transformation, we would need state funding to cover the costs of this venture, including staff members.

Our suggestion would be to start with very young children, with the goal of preventing the dental disasters that we are now seeing. We do not feel that this service would in any way decrease the local

dental business as most children with Medicaid in our county do not have a dental home.

I thank you greatly for looking into the dental crisis for the most vulnerable citizens of our state. Please keep in mind that this includes both children and adults.

Sincerely,

Barbara Frydenlund, RN
Rolette County Public Health District
Administrator
bfrydenlund@nd.gov

Senator Lee and members of the Senate Human Services Committee,

I am writing in support of HB 1567. I have worked in the Human Services field for over twenty years specifically with individuals with developmental disabilities. My biggest concern regarding healthcare for this population is specifically in the field of dental care. There are very few dental offices in the state that accept Medicaid. Thus, leaving many individuals having to travel two hours or more one way each time a dental visit is necessary. It also takes a significant amount of time to get into a dentist due to so few accepting Medicaid.

Individuals with disabilities often have significant dental needs and these needs are often untreated. In fact, as early as 1979 the National Conference on Dental Care for Handicapped Americans reported that the number one unmet health need for this population was adequate dental care.

According to the National Institute of Dental and Craniofacial Research (2009), although accessible dental care is essential for the general population, it is particularly important for people with disabilities due to the additional health concerns they face, as certain health conditions may make it difficult to maintain good oral hygiene, yet poor oral health may make it harder for an individual to manage—or could exacerbate—other health conditions. For instance, individuals with epilepsy may suffer from increased tooth trauma occurring during a seizure and many children with autism grind their teeth for self-stimulation or may take medications that worsen oral health. Oral problems such as gingivitis and periodontal disease have been shown to make it more difficult to manage blood glucose— critical for patients with diabetes— and problems such as muscular abnormalities or oral malformations can make it difficult to maintain a nutritional diet and good oral hygiene.

I think the study that is proposed is essential to be able to realize the problem that greatly impacts individuals with developmental disabilities but also low-income children as well as Native American children. I also think it is crucial that there is an exploration into solutions to the problem at hand and by reviewing the bill it seems the study is aimed at doing this as well. Again, I am in support of HB 1567, and I think this look into lack of dental care is long overdue.

Sargianna Wutzke

Bismarck ND

North Dakota DENTAL ASSOCIATION

Physical Address: 1720 Burnt Boat Drive, Suite 201
Mailing Address: PO Box 1332, Bismarck ND 58502
T: 701-223-8870

MEDICAID
SOLUTIONS, RESOURCES, & SUGGESTIONS

PRIMARY MESSAGES

Strengthening Medicaid programs to include Comprehensive dental coverage for adults will:

- Prevent costly and often debilitating advanced dental disease.
- Improve overall patient health by improving their oral health.
- Reduce the high cost to taxpayers of dental care sought in emergency rooms.
- Provide essential healthcare to low-income people, people with disabilities, and seniors.
- Improve Medicaid participants' ability to secure and maintain employment.

MEDICAID SHOULD COVER ADULT DENTAL CARE

Medicaid dental benefits save states money.

- There are more than 2 million hospital emergency room visits a year for dental pain. States with adult dental Medicaid coverage have decreased unnecessary emergency room visits, significantly lowering the cost to the public for this uncompensated care.
    - A limited adult dental Medicaid benefit in Missouri has cut emergency room visits for nontraumatic conditions by 38%.[1]
    - Massachusetts partially restored coverage in 2013 and saw emergency room dental visits fall 15% in the first five months.[2]
    - Conversely, when California eliminated its comprehensive coverage in 2009, 1,800 more people visited the ER for dental emergencies each year, and the cost of this emergency care rose 68%.[3]
- Covering dental care through Medicaid reduces the overwhelming cost to taxpayers of uncompensated care sought in emergency rooms, which totals $2.7 billion nationwide each year.

Medicaid dental benefits allow low-income citizens to secure and maintain employment.

- Poor oral health harms adults' ability to work.
    - Americans miss more than 92.4 million hours of work or school each year for emergency dental care.[4]
    - Ten percent of low-income patients say they must miss work very often or occasionally for dental problems.[5]
    - In states without an adult Medicaid dental benefit, 60% of Medicaid-enrolled adults report that their ability to interview for a job is impacted by the appearance of their teeth or mouth.[6]

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[1]. Good reasons for states to preserve or expand Medicaid adult dental benefits: A toolkit for advocates. CareQuest Institute for Oral Health. December 2020

[2] Changes in Dental Benefits and Use of Emergency Departments for Nontraumatic Dental Conditions in Massachusetts. Public Health Reports. Health Affairs. September 2020.

[3] Eliminating Medicaid adult dental coverage in California led to increased dental emergency visits and associated costs. Health Affairs. May 2015.

[4] Hours Lost to Planned and Unplanned Dental Visits Among US Adults. Centers for Disease Control and Prevention. 2018.

[5] Oral health and well-being in the United States American Dental Association. Health Policy Institute Infographic. May 2016.

[6]Oral Health and Well-Being Among Medicaid Adults by Type of Medicaid Dental Benefit. American Dental Association. Health Policy Institute Infographic. May 2018.

Oral health and well-being in the United States American Dental Association. Health Policy Institute Infographic. May 2016.

- Access to oral health care empowers Medicaid participants to work and move toward economic self-sufficiency.

Dentists' priority is always to enhance the oral health of patients, and we support public policy that empowers dental teams to do that.

- Dentists donate hundreds of thousands of hours providing care each year in their own offices and through events like Mission of Mercy, Give Kids A Smile and Give Veterans a Smile.
- However, charity is not a sufficient or sustainable way to protect individual and public health.
- Solid investments in people's health through Medicaid will ensure vulnerable patients, including seniors and people with disabilities, get the care they need but can't otherwise afford.

Inability to access dental care can have significant health consequences.

- Medicaid serves low-income parents and other adults, people with disabilities, and seniors.
- Without dental care, people will suffer from irreversible oral health conditions such as cavities, severe gum disease, pain, and tooth loss.
- Untreated oral health conditions negatively affect a person's overall health. For example, gum disease is linked to diabetes, heart disease, strokes, kidney disease, Alzheimer's disease, poor pregnancy outcomes, and even mental illness.

Providing adult dental coverage through Medicaid consistently would improve access to dental care for low-income adults, people with disabilities, and seniors. It would reduce racial disparities in chronic disease prevalence and maternal health while improving employment opportunity and economic mobility.

- Underserved communities and people with disabilities stand to benefit most from comprehensive dental coverage in Medicaid.
- While oral health has generally improved in recent decades, not all groups have benefited equally. Black and Hispanic adults face cost barriers to dental care to a greater degree than their White and Asian peers. As a result, these patient groups are more likely to have outcomes like untreated cavities and severe gum disease.
- Policymakers should prioritize strengthening Medicaid to reduce health disparities.

ADULT DENTAL MEDICAID BENEFITS SHOULD BE COMPREHENSIVE AND ADEQUATELY REIMBURSED

States should ensure their Medicaid programs provide comprehensive adult dental coverage, which enhances patients' overall health.

- Comprehensive care, including preventive and corrective care, are without a doubt the best approach to achieve benefits such as decreased emergency room visits and improved work-readiness.
- Comprehensive coverage should include not just emergency care – which most states already offer – but also routine preventive care like x-rays, fluoride treatments, and oral hygiene instruction.
- Prosthodontics to replace missing teeth or treatments to address dental decay, or other medically necessary treatments should be covered too. These are important services people need to maintain or regain their oral health.

Dentists want to be able to accept Medicaid to reach vulnerable patients, but Medicaid needs to sustainably reimburse for dental care before that becomes viable for many dental practices.

- Most dental practices are small businesses. They need to be sustainably reimbursed in order to pay their employees and sustain their business.
- Reimbursement to traditional medical providers is already low, but the rate for dental care is even lower, far below the cost of delivering care.
    - The average Medicaid reimbursement among states providing limited or extensive adult dental services was 53.3% of private insurance reimbursement in 2020.[7]

[7] Reimbursement Rates for Child and Adult Dental Services in Medicaid by State. American Dental Association. Health Policy Institute Infographic. October 2021.

    - Medicaid reimbursement as a percentage of private insurance reimbursement for adult dental services varies between 30.5% in Minnesota to 86.8% in California. [8]
    - It is important to note that private insurance reimbursements reduce dentists' normal fees 20%, so comparing Medicaid fees to private insurance fees represents a discount on top of a discount.
- In many cases, treating Medicaid patients is *more expensive* for dental practices than receiving no compensation for care provided care due to the time and resources it takes to navigate the Medicaid system coupled with a low reimbursement rate.
- It is not a question of desire to treat Medicaid patients; rather, it is a question of economic reality. Many dental practices simply cannot afford to accept Medicaid patients, making it difficult for patients to find a dentist.

ACCOUNTABILITY FOR MANAGED CARE ORGANIZATIONS

Many states use managed care for their Medicaid programs and could do so for a dental benefit. States are motivated to adopt managed care models to make spending on these programs more efficient and predictable, but the evidence on managed care's effectiveness when it comes to access and cost is limited.

- A 2011 survey of state Medicaid programs found that over two-thirds of responding states with managed care organizations (MCOs) reported that Medicaid beneficiaries enrolled in MCOs sometimes experience access problems, including access to dental care.[i]
- While MCOs may have both benefits and risks, one way to protect their effectiveness and the tax dollars entrusted to them is through fair and binding accountability measures.

States that choose to contract out their dental program to a managed care organization (MCO) should establish accountability measures to make sure the program runs efficiently and improves the quality of care for patients.

- States should establish a Medical Loss Ratio requirement, in which there is a minimum percentage of revenue for the MCO that must go directly toward patient care, to ensure that state dollars are used efficiently.
- MCOs should actively work to help patients improve their dental care and prevent emergencies by helping patients find a dentist and establish a dental home, and by offering case management services.
- States should evaluate MCOs by how well they provide oral healthcare to Medicaid patients. For example, by tracking the percentage of enrollees who have at least a comprehensive exam and preventive care each year.
- States can track the program's success by requiring the MCO to track and report metrics including:
    - Network size
    - Average time to make payment of claims
    - Accuracy of paid claims
    - Response time (call wait time) and missed calls in call centers
    - Accuracy of dentist directory
    - Grievance and appeals resolution
    - Credentialing times

States should specify how the MCO will work with dentists to ensure patients can get the care they need.

- Dental coverage through Medicaid should be reliable, predictable and efficient for patients and their dentists.
    - When administrative burdens in Medicaid are unnecessarily high, fewer dentists can viably treat Medicaid patients. Meanwhile, those that do accept Medicaid patients have fewer available patient appointments due to the additional hours required for navigating bureaucratic red tape.
    - Worst of all, patients suffer ongoing decay and pain during lengthy waits for prior authorization approvals.

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[8] Reimbursement Rates for Child and Adult Dental Services in Medicaid by State. American Dental Association. Health Policy Institute Infographic. October 2021.

- The MCO should employ a dentist licensed in North Dakota to review prior authorization requests and reply to these requests promptly.
- Administrative barriers and impacts on patient care significantly increase by unclear or changing policies. The MCO should keep an up-to-date member handbook for dentists and give at least 60 days written notice before changing fee schedules or processing policies.

LEGISLATURES ACROSS THE COUNTRY ARE ADOPTING MEDICAID ENHANCEMENTS

Several states have recently passed or enacted improvements to their Medicaid programs' dental coverage and reimbursement rates due to the many benefits to state budgets, patient health, and work readiness. Some of the changes passed since 2021 include:

- Kansas extended adult dental coverage from emergency-only to more comprehensive care.
- Louisiana extended dental coverage for adults with developmental disabilities in intermediate care facilities.
- Nebraska eliminated their annual per-person spending limit for adult enrollee dental services.
- Tennessee and Maryland, which previously had no dental benefits for adult Medicaid enrollees, each created a new, comprehensive dental benefit covering preventive, corrective, and emergency care.
- Missouri, Nebraska, South Dakota, Connecticut, Vermont and Virginia increased dental Medicaid reimbursement rates.

QUESTIONS & ANSWERS

WHAT DENTISTS ARE DOING

Q. Do you accept Medicaid patients? Why or why not?

A. Often our member dentist say I do, because ensuring that all patients have access to dental care is a priority for me. I must share, however, that it is challenging given the low reimbursement rates and administrative burdens. Raising these rates and relieving these burdens would allow more dentists to accept more Medicaid patients, giving patients better access.

Some of our member dentists say no, unfortunately, the costs associated with providing care, such as equipment and labor, are not set by dentists. What Medicaid pays for patients in the program makes accepting Medicaid unsustainable for my practice. We need to raise reimbursement rates so more dentists can afford to see Medicaid patients and give patients better access.

Q. Why do so many dentists refuse to accept Medicaid patients?

A. Dentists want to accept Medicaid patients. However, the administrative burdens like excessive paperwork, credentialing delays and program integrity compliance requirements – matched with low reimbursement rates – make it hard or impossible for most dentists to manage patient care in a population vulnerable to greater disease burden while navigating the requirements of the Medicaid program.

Q. Why don't dentists just lower their costs for low-income patients?

A. Under the current system, dentists enrolled in Medicaid programs accept much lower rates to treat Medicaid patients, including low-income patients, people with disabilities, and seniors. Some states report that dentists are reimbursed as low as 30% of what private insurance would pay. Many others reimburse dentists at less than 50% of the private insurance rates, which are already discounted from normal fees. Dentists want to provide care for low-income patients, but these low rates do not allow dentists to cover their overhead and pay their staff.

Q. What are dentists doing to try to reach adult Medicaid enrollees with insufficient dental coverage?

A. Dentists have established numerous programs to reach vulnerable patients. For example, the Community Dental Health Coordinator program trains individuals to help patients navigate the oral healthcare system from inside the communities they serve.

North Dakota DENTAL ASSOCIATION

COST & FINANCIAL IMPACT

Q. It would be nice for everyone to have dental care, but can our state/country really afford it?

A. Yes. Providing a Medicaid dental benefit would actually save taxpayers money by preventing expensive dental emergencies for a relatively modest investment. Providing regular, preventative care in a dental office has holistic health and economic benefits which are not realized when treating dental problems in emergency rooms, which is what happens now.

Q. I agree that adults on Medicaid should have dental care. But there are so many problems that need addressing, and limited resources. Why should this be a higher priority than those other needs?

A. Providing a Medicaid dental benefit is an investment in Medicaid participants' future overall health. It also saves money by preventing expensive dental emergencies. Covering comprehensive dental care with adequate reimbursement rates is a relatively modest investment that pays big dividends.

MEDICAID BASICS

Q. What is Medicaid?

A. Medicaid is a public insurance program for low-income people, people with disabilities, seniors, pregnant women, and other groups. Medicaid is administered by states, and jointly funded by states and the federal government.

Q. Why is Medicaid coverage different for dental and medical care?

A. There is a long history of dental care being separated from care for the rest of the body. Dentists and physicians are trained separately, care for dental and medical is billed separately, and Medicaid programs for dental and medical are administered separately. States are not required to provide dental benefits for adults, so coverage varies from state to state. Oral health is necessary for overall health, but the payment systems operate differently necessitating a unique focus on covering the costs for oral health care.

Q. Does Medicaid cover dental care for kids?

A. Yes. All states must cover dental care for Medicaid patients under 21. Medicaid coverage for children has worked very well to improve health and reduce disparities among children. Current federal policy suggests that the importance of oral health expires upon reaching adulthood, which we know is completely false. Adult dental coverage also benefits children. In states that provide adult benefits, children of Medicaid patients are more likely to have visited the dentist in the last year, and they are less likely to defer care.

Q. How many states currently cover dental care for adults in Medicaid?

A. Forty-nine states provide some kind of dental coverage, but this coverage varies widely. Only about half of states have comprehensive benefits that cover both preventive care and treatment of disease. Others provide limited coverage or coverage for emergencies only.

Q. Medicaid is a federal program. Why do Medicaid reimbursement rates vary so widely by state and age?

A. Medicaid is funded at the federal and state levels but is administered by states. States can determine whether they provide adult dental coverage, which services are covered, and how much providers are reimbursed for their services. This results in a patchwork of coverage across the country.

Q. What role should managed care organizations (MCOs) play in adult dental Medicaid benefits?

A. Many states use managed care for their Medicaid programs and could do so for a dental benefit. States are motivated to work with an MCO to make spending on these programs more predictable, but the evidence on managed care's effectiveness when it comes to access and cost is limited. If a state selects an MCO to manage their adult dental benefit, we suggest that states retain their policy-setting power and establish a timeline, perhaps 4 or 5 years, for reviewing the MCO and measure utilization. It is important that the MCO

also reimburses providers at a reasonable rate; we recommend that the rate be at least as high as in the state's fee-for-service plan.

SEEKING CARE

Q. Can community health centers solve the problem of access to dental care?

A. Community health centers and clinics can play a role in helping patients get care, and many do by offering dental services. But they simply don't have the capacity to meet all of the needs of patients who don't have dental benefits without the systemic solution of Medicaid benefits.

Q. Where should patients go if they don't have dental coverage?

A. Patients can look for dental care through community health centers, dental clinics and sometimes dental schools in their communities. Ultimately, to meet all of the needs of low-income people, Medicaid needs to improve oral health care coverage.

Q. What do you recommend patients do if they have Medicaid dental benefits but can't find a provider?

A. Having dental coverage is not enough if you can't find a provider who can take your coverage. Patients shouldn't have to travel long distances or wait months to see a dentist. Unfortunately, this is very common. We need to raise reimbursement rates so more dentists can participate in the program and care for Medicaid patients in their communities.

Q. What changes are needed to Medicaid that would allow more patients to access care?

A. Congress should reduce administrative burdens and require adult dental Medicaid coverage for all states, defining what kinds of services are necessary for states to provide comprehensive coverage. At the state level, we need to raise reimbursement rates so dentists can provide care to Medicaid patients without a financial loss to their practice.

Q. How would you define comprehensive coverage? What benefits or services should be included?

A. We would like to see all states offer coverage that enhances patients' overall health. That would include coverage for emergency care – which most states already offer – as well as the routine preventative care like x-rays, fluoride treatments, and oral hygiene instruction. And for patients who need prosthodontics to replace missing teeth or treatments to address dental decay, or other medically necessary treatments, those services should be covered too. These are the basic things all people need to maintain or regain their oral health.

TOUGH QUESTIONS

Q. If people want dental coverage, why shouldn't they just get a better job?

A. What we know is that people with some form of dental coverage are more likely to go to the dentist; however, not all jobs offer the full spectrum of health care coverage that includes dental benefits. Our goal is to expand dental coverage, and thereby expand access. Having some form of dependable and meaningful dental coverage should not be solely tethered to a job. For example, most entrepreneurs are required to purchase their own health coverage. The point is that all patients must have a reliable source of oral health care coverage so they can see a dentist and get the care they need to stay healthy. A strong Medicaid system can help do that.

Q. It sounds like you are putting the burden of receiving care on patients and a government program. Is that true?

A. Comprehensive coverage through Medicaid is the only way to provide oral health care for all low-income patients. Dentists want to provide care to all patients, especially the vulnerable, but they can't take on this responsibility alone.

Q. How can you ask for higher Medicaid reimbursements after opposing a proposal in Congress that would have brought a Medicare dental benefit to all seniors? Why did you oppose that proposal?

A. The American Dental Association did support a Medicare dental benefit for those seniors who are most in need, similar to how we support strengthening Medicaid to help low-income people ages 18-64. The bottom line is dentists want to be able to reach as many patients as possible to improve oral health. We will look closely at any policy at the state or federal level that will help us accomplish that.

North Dakota DENTAL ASSOCIATION

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OTHER PRIMARY MESSAGES

Strengthening Medicaid programs to include comprehensive dental coverage for adults will:

- Improve patient health.
- Help decrease health disparities.
- Reduce the costs of dental care sought in emergency rooms.
- Improve Medicaid participants' ability to secure and maintain employment.

MEDICAID SHOULD COVER ADULT DENTAL CARE

If we want to improve health equity, improving access to dental care is an important factor.

- Providing adult dental coverage through Medicaid would reduce racial disparities and inequities in chronic disease prevalence and maternal health**.**
- Underserved communities and people with disabilities stand to benefit most from comprehensive dental coverage in Medicaid.
- Black and Hispanic adults face cost barriers to dental care to a greater degree than their White and Asian peers. As a result, these patient groups are more likely to have outcomes like untreated cavities and severe gum disease. Recent improvements in oral health have not benefited all groups equally.
- Policymakers who want to reduce health disparities should prioritize strengthening Medicaid.

Strong dental Medicaid programs have shown numerous societal benefits.

- Access to dental care for poor Americans helps maintain a high quality of life, keep kids in school, keep adults at work and reduces unnecessary emergency room visits.
- While policymakers face many competing priorities, covering comprehensive dental care with adequate reimbursement rates is a relatively modest investment that pays big dividends.

Lack of focus on adult oral health care by federal and state governments has created a patchwork of dental coverage in state Medicaid programs.

- Medicaid was created to help low-income Americans, people with disabilities, and seniors receive healthcare, but programs often neglect certain services for entire populations.
    - Twenty-one states and the District of Columbia provide extensive adult dental Medicaid benefits. Sixteen states provide limited benefits, nine provide emergency-only benefits, three provide no benefits, and one has a dental benefit under development.[1]
    - All states are required to comply with the Early and Periodic Screening, Diagnostic and Treatment benefit to provide preventive and medically necessary comprehensive health care services for children under 21. This includes dental care.
- The inconsistency in adult dental Medicaid coverage results in spotty access for kids too. In states with adult dental benefits, children of Medicaid patients are more likely to visit the dentist and are less likely to defer care.

ADULT DENTAL MEDICAID BENEFITS SHOULD BE COMPREHENSIVE AND ADEQUATELY REIMBURSED

When dentists can't afford to accept Medicaid, patient access suffers.

- In many cases, treating Medicaid patients is *more expensive* for dental practices than receiving no compensation for care provided care due to the time and resources it takes to navigate the Medicaid system, matched with a low reimbursement rate.

- As a result, many dental practices do not accept Medicaid, or severely restrict the number of Medicaid patients they take. This makes it hard for patients to find a dentist who will see them.
- Without a dentist willing to treat them, simply having dental benefits does not actually help patients.

Improving patient and dentist participation requires Medicaid programs to reduce administrative barriers and fairly reimburse for dental care.

- Reimbursement to traditional medical providers is already too low, but the rate for dental care is even lower, far below the cost of delivering care.
    - The average Medicaid reimbursement among states providing limited or extensive adult dental services was 53.3% of private insurance reimbursement in 2020.[2]
    - Medicaid reimbursement as a percentage of private insurance reimbursement for adult dental services varied between 30.5% in Minnesota to 86.8% in California. [3]
- Dentists donate hundreds of thousands of dollars in care each year in their own offices and through events like Mission of Mercy, Give Kids A Smile and Veterans Stand Down so vulnerable people can get the care they desperately need.
- Though dentists are doing their part to meet the need, charity care is not a healthcare system and patients deserve more reliable, consistent dental coverage through Medicaid.

ACCOUNTABILITY FOR MANAGED CARE ORGANIZATIONS

Many states choose to contract part or all of their Medicaid program to managed care organizations (MCO).

- MCOs promise policymakers that they will administer the program and save the state money.
- As private organizations, MCOs are focused on the bottom line. The more they save on patient care, the more money they can keep as profit.
- In some instances, this profit motive can lead MCOs to decline coverage for necessary care.
- States need accountability measures for MCOs to make sure they are delivering the care they have promised to provide.

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[i] https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/

North Dakota DENTAL ASSOCIATION

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RESULTS OF DENTAL MEDICAID FUNDING IMPROVEMENTS

It is well-established that a multifaceted approach to dental Medicaid improvements vastly increases the chances for greater utilization and improved oral health for Medicaid enrollees. It is common knowledge that improving investment in dental Medicaid funding is the key component to ensuring enrollees get the care they need when they need it.

To prove funding improvements have an impact, consider the reports from past improvements and research performed:

Connecticut – 2008 children's dental fees set to 70th percentile of dental market fees in 2005. [1]

- *"For children continuously enrolled in Medicaid, utilization rates increased from 45.9% in 2006 to 71.6% in 2012."*
- *"These increased utilization rates eliminated the disparities in access to dental services between children with private insurance and children receiving Medicaid benefits. Children enrolled in Medicaid now have utilization rates that are similar to or higher than privately insured children."*
- *"Expenditures increased $62 million; this represents less than 1% of 2012 State Medicaid expenditures."*
- *"Dentist participation increased by 72%."*
- *"These results suggest that dentists will participate in the Medicaid program if adequately compensated, and low-income families will seek dental services."*
- *"One solution to the substantial disparities in access to dental care is to increase Medicaid fees to competitive levels."*

Indiana – 1998 fees increased to 100 percent of the 75th percentile of usual and customary fees. [2]

- *"The number of dentists seeing a Medicaid-enrolled child increased from 770 in fiscal year (FY) 1997 to 1,096 in FY 2000.*
- *The number of Medicaid-enrolled children with any dental visit increased from 68,717 (18 percent) to 147,878 (32 percent), with little difference between children enrolled through the Medicaid-SCHIP and traditional Medicaid programs by FY 2000.*

[1] Tryfon Beazoglou, Joanna Douglass, Veronica Myne-Joslin, Patricia Baker, Howard Bailit, Impact of fee increases on dental utilization rates for children living in Connecticut and enrolled in Medicaid, The Journal of the American Dental Association, Volume 146, Issue 1, 2015, Pages 52-60, ISSN 0002-8177, https://doi.org/10.1016/j.adaj.2014.11.001.

[2] Hughes RJ, Damiano PC, Kanellis MJ, Kuthy R, Slayton R. Dentists' participation and children's use of services in the Indiana dental Medicaid program and SCHIP: assessing the impact of increased fees and administrative changes. J Am Dent Assoc. 2005 Apr;136(4):517-23. doi: 10.14219/jada.archive.2005.0209. PMID: 15884323.

- *The mean number of visits per child per year and the mean number of procedures per child per year remained relatively constant. The cost per enrolled child increased from $1.70 to $6.70 per month, while the cost per child with a visit increased from $9 to $21 per month.*

- *The increase in fees and changes in administration of the Indiana dental Medicaid program were positively associated with improved dentist participation and children's use of dental services*

National Association of State Health Policy – Research [3]

- *Survey research, available literature, and interviews with key stakeholders in six study states indicate that higher fees positively influence: (1) dentists' willingness to accept new Medicaid-enrolled patients; and (2) Medicaid patients' access to and utilization of needed oral health care.*

- *The study states all enjoyed improvements in the percentage of children utilizing dental services (even in a period of expanding Medicaid enrollment), although they have not yet reached the utilization levels of privately insured children. The changes that these states made did mean they substantially increased their spending on dental services, but even so, dental spending is still only a small piece of total Medicaid expenditures.*

California Health Care Foundation – Research [4]

- *Survey research, academic literature, and interviews with key stakeholders in six states indicate that higher fees positively influence both dentists' willingness to participate in state Medicaid programs and Medicaid patients' access to oral health care.*

- *However, a majority of experts interviewed felt that while adequate reimbursement rates were necessary for improving access to Medicaid dental services, they were not sufficient on their own. Higher rates must be combined with efforts to address administrative concerns and strengthen the state's relationships with community dentists.*

American Journal of Public Health [5]

- *Reimbursement rates and access to dental care were directly related at the state level, but no evidence indicated that higher reimbursement rates resulted in overuse of dental services for those who had access. The relation between reimbursement rates and access to care was moderated by dentist density and dentist participation in Medicaid. We estimate that more than 1.8 million additional children would have had access to dental care if reimbursement rates were higher in states with low rates.*

- *Children who access the dental care system receive care, but reimbursement may significantly affect access. States with low dentist density and low dentist participation in Medicaid may be able to improve access to dental services significantly by increasing reimbursement rates.*

The Impact of Medicaid Reform on Children's Dental Care Utilization in Connecticut, Maryland & Texas [6]

- *Increasing Medicaid dental fees closer to private insurance fee levels has a significant impact on dental care utilization and unmet dental need among Medicaid-eligible children.*

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[3] The Effects of Medicaid Reimbursement Rates on Access to Dental Care; National Academy for State Health Policy 2008

[4] Increasing Access to Dental Care in Medicaid: Does Rasing Provider Rates Work? Californai Healthcare Foundation, 2008

[5] Chalmers NI, Compton RD. Children's Access to Dental Care Affected by Reimbursement Rates, Dentist Density, and Dentist Participation in Medicaid. Am J Public Health. 2017 Oct;107(10):1612-1614. doi: 10.2105/AJPH.2017.303962. Epub 2017 Aug 17. PMID: 28817336; PMCID: PMC5607675.

[6] Nasseh K, Vujicic M. The Impact of Medicaid Reform on Children's Dental Care Utilization in Connecticut, Maryland, and Texas. Health Serv Res. 2015 Aug;50(4):1236-49. doi: 10.1111/1475-6773.12265. Epub 2014 Dec 7. PMID: 25483733; PMCID: PMC4545356.

NDHSZDA
NORTH DAKOTA HUMAN SERVICE ZONE DIRECTOR ASSOCIATION

Testimony prepared for the Senate Human Services Committee
HB 1567 – Related to Study of Dental/Oral Health Care among Medicaid Recipients
Kim Jacobson, Agassiz Valley Human Service Zone Director
March 18, 2025

Chair Lee, and members of the Senate Human Services Committee, my name is Kim Jacobson. I serve as the Director of Agassiz Valley Human Service Zone, which includes the counties of Traill and Steele, and as President of the North Dakota Human Service Zone Director Association. I am here to testify in support of HB 1567.

Access to dental care is one of the top legislative priorities of the North Dakota Human Service Zone Director Association. Many North Dakota dental providers do not accept North Dakota Medicaid and there is a shortage of dental providers in our state, especially in rural communities. As human service zones touch every community across North Dakota, we frequently hear the challenges our citizens face in accessing dental services. This is particularly challenging for low-income individuals, those with disabilities, and for foster children.

Children in our public foster care system are eligible for North Dakota Medicaid. As the child's legal custodian, it is our responsibility to ensure the child's medical needs are met, including dental and oral health care. Frequently, children who enter foster care have not had routine dental care. This poses both a medical and quality of life concern.

Many human service zones find that they do not have a dental professional, within their boundaries that accept Medicaid. This results in zone team members needing to transport a foster child, two or more hours, one-way, to receive necessary care. This is costly from many perspectives. The child may miss up to a full day of school. A case manager or aide must spend time out of the office to transport and escort the child to their appointment. This along with the travel expenses impact zone budgets. North Dakota dental providers who do accept Medicaid do not always accept new patients, including foster children. Even when they do, provider wait lists can be months long. And if a human service zone cannot gain access to a dental provider that accepts Medicaid, and the child's need is urgent, zones often have no alternative but to use zone funding to pay for out-of-pocket dental services.

In the general population, a low-income family seeking dental care on North Dakota Medicaid must often travel considerable distances. Just like case managers, adults must take time away from work to see a dentist. The further someone must travel to an in-network dentist, the more time they must take off. Reliable transportation is often a common barrier. The household's limited finances are often adversely impacted by both travel costs and lost wages. This poses a significant burden if they

can even locate a provider that has openings who accepts Medicaid. If follow-up appointments are needed, there is an increased impact on both the general population and foster children.

Even our climate can be a compounding factor in dental care access. If someone cannot afford to put good tires on their vehicle – or if their vehicle is not designed to manage snow drift, ice, and high winds – then traveling for dental care may be impossible between November and April.

Likewise, dental care providers face barriers to accepting Medicaid. Local dentists have shared the following challenges with human service zones:

- **Inadequate Reimbursement:** North Dakota Medicaid is insufficient to cover the cost of dental procedures, and it fails to recognize related costs that are required to operate the practice and provide care.
- **Lost Income for No-Shows:** When a Medicaid patient misses a dental appointment, or cancels it without proper notice, there is no monetary compensation for that lost revenue. (Conversely, dentists can charge a "no show" fee when a patient with private insurance misses an appointment.) Providers have reported that Medicaid patients have a higher no-show rate than the general population.
- **Negative Perceptions in Dental Education:** A North Dakota dentist who graduated from dental school in the last ten years shared that dental students are told that they will "go broke" if they accept Medicaid. A dental degree is a significant financial investment, which increases hesitancy to offer reduced reimbursement services.
- **Administrative Burden:** Providers have shared that the complexity processes required to enroll and bill as a Medicaid provider drives administrative overhead.

Our Association believes that the proposed study would equip our state to offer data-driven solutions to dental care access barriers. Increased coverage might seem like a logical outcome of this study, but likely, the data will point to the need for diverse solutioning. This could include Medicaid myth-busting for dentists, promoting patient accountability regarding appointments, and/or workforce development projects that help our state attract and retain dental care talent. The value of this study is that it will help take the guesswork out of solutioning so that we can make informed decisions that lead to tangible results.

Dental care is such an important part of a person's health and wellbeing. We urge the committee to issue a "do pass" vote on HB 1567. Thank you for your consideration. I stand for questions from the committee.

Community HealthCare Association of the Dakotas

Testimony
House Bill No. 1567
Senate Human Services Committee
Senator Judy Lee, Chair
March 18, 2025

Chair Lee, Vice Chair Weston and honorable members of the Senate Human Services Committee:

I am Kim Kuhlmann, the Policy and Partnership Manager in North Dakota for Community HealthCare Association of the Dakotas (CHAD). On behalf of CHAD and our member health centers, I am here today to support House Bill 1567.

In my position at CHAD, I also facilitate the North Dakota Oral Health Coalition, which has over sixty member organizations who are working collaboratively to address access to oral health care in North Dakota, especially for underserved populations.

CHAD is a non-profit membership organization that serves as the Primary Care Association for North Dakota and South Dakota, supporting community health centers across both states in their efforts to provide health care to underserved and low-income populations. The heath centers we represent have locations in both urban and rural communities.

Community health centers (CHCs) are non-profit, community-based primary care clinics that serve all individuals, regardless of their insurance status or ability to pay. The community health center integrated care model includes primary care, mental health and substance use treatment, dental care, pharmacy services, and a range of case management services that can include help with transportation, finding community resources, or assistance with insurance and financial enrollments.

North Dakota is home to five community health center organizations that provide comprehensive, integrated care to more than 36,000 individuals at 22 locations in 20 communities across the state. Sixteen percent of those patients are uninsured and about 40 percent earn incomes below the federal poverty level. Three health centers in North Dakota provide dental care at eight locations, with a new urgent dental clinic that just opened in Ray in February. Health centers served 11,912 dental patients with over 25,000 visits in 2023.

Community HealthCare Association of the Dakotas

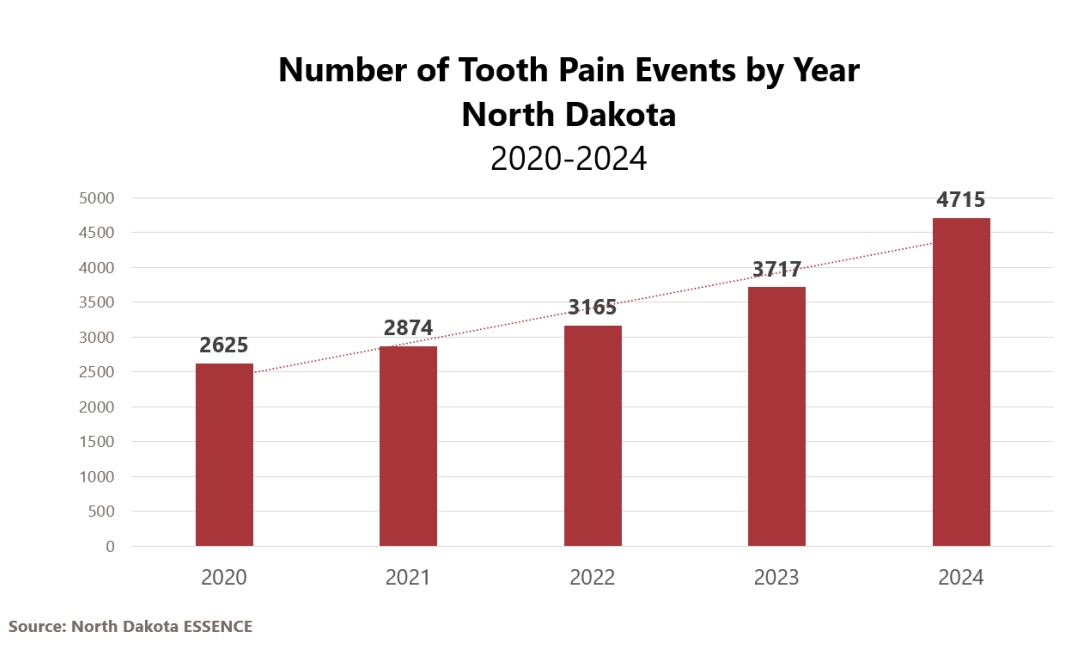
North Dakota is Facing an Oral Health Crisis

North Dakota is facing an oral health crisis, and it is impacting children, adults, and the aging population. These are just a few statistics which illustrate the unmet dental needs in our state:

- One of every two kindergarteners have experienced tooth decay;
- More than half of adults who are Indigenous reported no dental visit in the past 5 or more years;
- Nearly 1 in 3 adults who are not Indigenous reported no dental visit in the past 5 or more years; and
- 1 in 4 long term care residents in our state have untreated tooth decay.

We know that oral health impacts a variety of chronic disease outcomes, including diabetes, heart disease, and respiratory disease. In North Dakota, over twice as many adults with diabetes have lost 6 or more teeth due to tooth decay or gum disease compared to those without diabetes. According to the Centers for Disease Control, treating gum disease significantly improves blood sugar level among people with diabetes. Access to routine preventive dental care is a much less costly – and more healthy – way to help manage associated chronic diseases.

According to the North Dakota Department of Health and Human Services ESSENCE data, our state has seen a significant rise in the number of emergency room and urgent care clinic visits related to tooth pain over the last 5 years. From 2020 to 2024, the number of tooth pain related visits, including visits to emergency rooms, primary care clinics, and urgent care, increased from 2,625 to 4,715, nearly doubling in just 5 years. (See chart on next page).



These oral health related emergencies are costing the healthcare system, the Medicaid program, and patients additional money in emergency visits. And they don't even include the additional costs of the complications for patients with heart disease and diabetes that is caused by poor oral health. In addition, individuals who report dental care affordability concerns miss more hours of work for unplanned dental care. Better oral health results in better overall health outcomes, improved productivity, and leads to better quality of life.

Coverage and Workforce Challenges at Health Centers

Let me share how the coverage numbers shape up for North Dakota health centers. Currently around 40 percent of our patients are Medicaid beneficiaries, and those covered by Medicaid Expansion have no dental coverage. 13 percent are served by Medicare (which lacks dental coverage), 16 percent are uninsured, and 31 percent have private insurance coverage. When put together, that adds up nearly half of those we see lacking dental coverage. This makes it difficult to pay competitive wages and build our dental programs enough to meet community needs.

The North Dakota Department of Health and Human Services reports that only 44 percent of the need for dental providers across the state is being met. North Dakota has 20 counties that are geographical dental care health professional shortage areas (HPSAs) and two counties that are considered low-income population dental HPSAs. Geographical shortage areas means a shortage

of providers within a defined geographic area. The low-income population indicates there is a sub-population of individuals living in a defined geography that has insufficient access to care. These designations indicate a gap between the healthcare needs of the population and the available resources. Rural citizens, patients with urgent dental care needs, and patients with Medicaid coverage are more adversely affected by a dental provider shortages.

Given that health centers serve underserved populations and communities where there are likely to be even fewer providers than the state average, that gap looms large. Mara Jiran, CEO of Spectra Health, one of the state's community health centers that provides dental care, says, "Every week, hundreds of people attempt to schedule dental visits at our clinic. The demand far outweighs our current capacity." This is a challenge we hear from other health centers providing dental care as well.

Health centers are continuously looking for opportunities to innovate and expand access to dental care, and we would welcome the opportunity to collaborate and provide information for a legislative study on this topic. We were glad to see that HB 1567 includes consideration of the expansion or promotion of programs that offer support for on-the-job training and apprenticeships for dental assistants. At CHAD, we have developed an on-the-job training toolkit for health centers to offer dental assistant apprenticeships and are finding this to be a promising model for bringing homegrown talent into a dental career path. Further studying the application of this model in North Dakota, and resources needed to enable its success, would be incredibly valuable.

In Ray, Northland Health Centers just opened an urgent care dental clinic in February. At this time they will only be operating two days a week and only for emergency dental services because they cannot find a full time dentist. The long-term hope is to expand the care being provided at that location. The Ray clinic is the result of a multi-year, multi-partner collaborative project team committed to establishing a new dental clinic to address disparities for low-income, uninsured, or Medicaid-eligible individuals in the northwest region of the state. This area is one of the largest areas with lack of dental access in the state. The clinic will be sustained as part of Northland Health Centers operations in Ray.

Dental Student Rotations & Recruitment

The study originally included an appropriation of $97,000 for supporting dental student rotations

and dental student recruitment in North Dakota. The bill was amended in the House to remove the appropriation, but I would like to share the information we provided on those programs.

Currently, North Dakota does not have a dental school. In an effort to address dental workforce shortages, the North Dakota Department of Health and Human Services Oral Health Program (OHP) is helping to offset some costs associated with hosting dental student rotations, currently at two non-profit organizations in North Dakota. These sites are working cooperatively with dental schools from surrounding states to provide fourth year dental student rotations.

Dr. Jacki Nord, a dentist at Family HealthCare in Fargo, submitted testimony in the House Human Services Committee about the program she oversees at Family HealthCare including the costs associated with hosting students. Tammy King also shared information about the dental student rotations at Bridging the Dental Gap in Bismarck and the dental student recruitment trips taking place, the next one is coming up in April. These organizations provide valuable experiences in public health dentistry for dental students and bringing dental students to North Dakota.

The impact of this program is two-fold. During their rotations, dental students provide additional services and help reduce wait times for patients seeking preventive care. In other words, they help to address immediate needs. In addition, these rotations expose dental students to career paths within North Dakota, with some students choosing to begin their career in North Dakota.
We would appreciate your support for additional funding to sustain these programs and possibly expand to additional sites. Again, one of the biggest challenges to expanding the program is the additional staff needed to administer the programs.

Conclusion

Today, I've shared about the significant barriers to oral health care in the state. While we are proud of the ways that CHAD and community health centers and are partners are creatively working to address the limited rural oral health infrastructure and the limited options for our lower-income neighbors in need, we remain deeply concerned by the level of unmet need that persists. A legislative management study of oral health care could identify ways to strengthen an oral health system in which we are facing a real crisis in access to care. CHAD and our member health centers would welcome the opportunity to provide information and collaborate throughout the study, and we can also serve as a liaison by inviting members of the Oral Health Coalition to participate.

Community HealthCare Association of the Dakotas

I ask for your support on behalf of our member health centers to recommend a do pass on HB 1567 to provide for a legislative management study of dental care in North Dakota. I am happy to answer any questions you have. Thank you!

Kim Kuhlmann
Policy and Partnership Manager, ND
Community HealthCare Association of the Dakotas (CHAD)

The Arc
North Dakota

Senate House Human Services
HB 1567
March 18. 2025

I am Kirsten Dvorak, executive director of The Arc of North Dakota, writing to express our support for House Bill 1567. For 65 years, The Arc has been advocating for the rights of individuals with intellectual and developmental disabilities (IDD) in North Dakota, working to ensure they have access to the services and support necessary to lead meaningful and independent lives.

The Arc of North Dakota strongly supports House Bill 1567, which aims to address the critical issue of dental care access for individuals with developmental disabilities by creating a study to evaluate current challenges and identify solutions. Individuals with disabilities face significant barriers to dental care, such as transportation challenges, a shortage of trained providers, and inadequate Medicaid reimbursement rates.

This study is an essential step toward understanding and addressing these barriers. It will help explore solutions like improved reimbursement rates, enhanced provider education, and telehealth options, which are vital for ensuring access to essential dental care for all North Dakotans, including those with developmental disabilities.
We urge the committee to support HB 1567 and this crucial effort to improve oral health care for individuals with developmental disabilities.

Kirsten Dvorak
Executive Director
The Arc of North Dakota
701-222-1854

Testimony of Representative Lisa Finley-DeVille

In support of House bill 1567

Chair Lee and members of the Senate Human Services committee my name is Representative Lisa Finley- DeVille, representing District 4 A, which includes the MHA Nation. I'm here to testify in support for of House Bill 1567, relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities.

As a co-sponsor of HB 1567, I am committed to ensuring that all individuals, particularly our most vulnerable populations, have access to the essential dental care they need. During the 2025-26 interim, this study will focus on understanding and addressing the unmet dental and oral health care needs of low-income children, Native American children, and individuals with disabilities. By examining the specific barriers they face, we can work toward creating solutions that will significantly improve their health outcomes and quality of life.

In rural communities, there are often fewer dental professionals, making it harder for residents to access regular care. In fact, nearly 60% of rural areas in the U.S. are designated as dental shortage areas, meaning that access to essential oral health care is limited or non-existent for many families. For low-income children and Native American children, these barriers are even more pronounced. A recent study found that children in low-income households are more likely to have untreated cavities, and Native American children experience dental disease at rates significantly higher than the general population. These disparities underscore the need for a targeted focus on improving access to dental care in underserved areas.

The study will include a thorough overview of the dental and oral health care status of Medicaid recipients. This critical analysis will shed light on the current gaps in care and help us understand where improvements are most urgently needed. Additionally, this study will evaluate the importance of receiving dental and oral health care services and the far-reaching consequences of not receiving timely care. From general health complications to the expanded costs of future care, we need to understand the full scope of the impacts that insufficient dental care can have on these individuals, especially in terms of long-term health outcomes.

The study will also review state and federal regulations, policies, and procedures that may be limiting or perceived as limiting dentist provider enrollment in Medicaid. Issues such as impediments to enrollment, prior authorizations, attachments, appeals, and delayed payments must be addressed to ensure that dental providers are able to serve Medicaid recipients effectively. I am confident that this study will provide a valuable framework for addressing these systemic challenges and improving access to dental care for those who need it most. As we move forward, I look forward to collaborating with my colleagues and stakeholders to bring about meaningful changes that will ensure equitable access to dental and oral health care for all.

I urge you to give House Bill 1567a do pass. Thank you for your time and consideration.

HB 1567 - Senate Human Services Committee
Tuesday, March 18, 2025

Chairman Lee and members of the Senate Human Services Committee,

My name is Kendra Vander Wal and I am the Executive Director for Designer Genes of ND, Inc. Designer Genes' mission is to support individuals with Down syndrome and those who support them to earn, learn, and belong across our state. At Designer Genes we estimate that there are over 270 individuals with Down syndrome living in North Dakota.

I appreciate the opportunity to share on the need for a comprehensive study of dental and oral health care access for individuals with disabilities. The Department of Health and Human Services tracks oral health data for North Dakota, and the findings are concerning. Results showed North Dakota has only 52 dentists per 100,000 residents, compared to 61 nationally. In addition, testimony by Sarah Aker, our North Dakota Medical Services Director, indicated that our state ranks 47th in the nation for this outcome measure for children on Medicaid, even though the dental payment rate for oral evaluations for children is 11th in the nation. Moreover, a March 2022 report from the National Council on Disability highlighted the ongoing lack of dental providers willing to accept Medicaid. Given that Medicaid is a common insurance source for many individuals with Down syndrome in our state, this shortage is challenging to our community. Although North Dakota includes Medicaid dental benefits as an optional State Plan, our dentist-to-patient ratio remains significantly lower than the national average.

The study will provide an understanding to barriers to accessing complex dental services, explore solutions to reimbursement rates, analyze consequences of unmet dental needs which includes health and financial burdens, learn more about obstacles to dental enrollment in Medicaid, and enhance provider education to name a few.

In closing, I encourage you to move forward with support of HB 1567. Dental care has a large impact on individuals with disabilities and that is true to individuals with Down syndrome. With data and clear recommendations, we can work towards improving access to services but also ensures the highest quality of dental care. I welcome the opportunity to further discuss insights and lived experiences of those we serve. Thank you for your time and for your commitment to improving the dental and oral health outcomes for individuals with disabilities in our state.

Kendra Vander Wal
Designer Genes of ND, Inc.
701-751-2071

kendra@designergenesnd.com

HB 1567 AMENDMENT REQUEST:

y. Analysis of the information required by centers for Medicare and Medicaid form 416, in compliance with Medicaid early and periodic screening, diagnostic, and treatment, including the percentage of eligible children receiving any dental service, preventative service, or sealants;

z. Analysis of provider participation and recredentialing of dental providers with Medicaid, the average benefit paid per user and beneficiary, the geographical distribution of active providers with active recipients in the state, and provider participation surveys; and

aa. Review of ambulatory surgery and hospital facility claims for dental rehabilitation procedures that require monitored anesthesia for children to compare with other medical providers providing similar same-day surgical services.

2. The study may include broader considerations of unmet needs for dental services for all Medicaid recipients, data for those recipients, and any current plans for remediation with goals, objectives, projected costs, and implementation timetables.

3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

INTRODUCTION

By Representative Mary Schneider

HB 1567-Study Relating to Dental and Oral Healthcare Status Among Medicaid Recipients

Senate Human Services Committee

Senator Judy Lee, Chairman, and Senator Kent Weston, Vice Chairman

March 18, 2025

Chairman Lee, Vice Chairman Weston, and distinguished members of the Senate Human Services Committee, I'm Mary Schneider and I proudly represent the people of District 21, central Fargo and West Fargo. HB 1567 is a request for an interim study on the unmet dental and oral health needs of low-income children, Native American children, and individuals with disabilities. There are some things we already know, and they're not good.

- The number of children in Head Start, kindergarten, and third grade who need dental treatment--just those 3 little clusters, would fill 115 school buses.
- Only 44 percent of the need for dental providers in North Dakota is being met. For Medicaid recipients, the percentage is much, much lower.
- There are 69 dental health care practitioner shortage areas (HPSAs) designated in the state. The population of those areas is 153,291.
- 19 of our 53 counties had ZERO dentists.
- 80 percent of those on Medicaid DID NOT receive dental care.
- North Dakota has the 6th highest Native American population and the dental data for nearly all categories is shockingly worse for them.

There are some things we still don't know, even though we've studied the problem in the past. Some things just need updating and the study will help in these areas. Some of the components of the study include:

- The dental and oral health care status of low income and Native American children, and persons with disabilities;
- The impacts, consequences, complications, and expanded future costs from not receiving care and services;
- The regulations, policies, and procedures limiting Dentists' enrollment in Medicaid;
- The availability of and access to medical facilities needed for complex dental work for people with disabilities and others who might require anesthesia or critical care;

- A review of reimbursement rates, comparing other states, private payors, and actual costs;
- Consideration of the need to expand or promote dental support services, and programs using dental students, volunteer and charitable dental programs, and nonprofit dental services;
- Ways to improve accessibility to dental services for low income and Native American children and individuals with disabilities, both on and off reservations;
- Exploring partnerships between state programs and tribal health providers;
- Recruitment and retention programs and incentives, such as expanded loan forgiveness, free professional education, and other reinforcers for practice in underserved communities or in complex cases;

Amendments in the House Human Services Committee added other provisions to the study bill, letters m through z and aa. Some of the additional study requirements include:

- Insurance and benefit plan charges and out-of-pocket costs;
- Review of pre-authorizations, claims administration, and percentage of denials;
- Review of provider relations programs, and call center management;
- Consideration of staff credentials for appropriate oversight, and the administrative system addressing grievances and appeals of submitted claims and pre-authorizations--and its responsiveness;
- Consideration of the impacts of dental Medicaid expansion;
- Review of complex dental procedures which might require anesthesia, and comparisons of same day surgery practices; and really many more and more specific components that impact dental services and delivery of them.

So important, the study calls for plans to address the findings, including goals, objectives, costs, legislation and timetables for remediation of this pervasive, persistent, pernicious, and perpetual problem we desperately need to address.

It's both shocking and shameful that after the attention from past studies, and admissions of unmet needs, we haven't addressed the problem of dental access in a permanent and meaningful way that solves the problem for Medicaid recipients.

We say dental care is covered by Medicaid, but is it really? The stories of parents and providers calling dentist after dentist on behalf of a child or disabled person in pain to be told "we don't take Medicaid," or "we're not taking any more Medicaid patients," or "we don't have access to hospital facilities you need for dental surgery" is heart-wrenching. One mother I know about started sobbing when she was turned down or away from every dental office she called.

And the geographic barriers are very real, too. For a low-income parent to take a day off work or drive an unreliable car 200 miles to get help for their crying child with an abscessed tooth or be forced to wait for one of a few "charitable" days, also far away, is disgraceful.

We legislators all have good insurance, but, really, how would we feel if our policies said we had coverage for a critical procedure, but we couldn't find anyone to do it? If we had to phone, and beg, until we finally gave up and suffered the consequences of not getting help? How would we feel if being turned down, shut down, and sent off was for our children or grandchildren?

Oral health is health. We have countless dental practitioners working hard to serve those who need them. We have amazing dental assistants, hygienists, dental students, and others giving of their skills and services, trying to meet dental needs, some without payment. But we need more dental service providers if we don't want our promises of access to care to be false or fictitious.

Let's approve this study to expand the dental student program. It can address the barriers, and recommend ways to ensure enough providers, and better ways to recruit, retain, remunerate, and appreciate them. It will help develop partners, programs, resources, and services that work for our kids and people with disabilities.

In a state of rich resources and good people, that's what we should be, and must be, doing. HB 1567 is being presented to you with a do pass request to help us work together to make true dental access happen.

Protection & Advocacy Project
400 E. Broadway, Suite 409
Bismarck, ND 58501
701-328-2950
1-800-472-2670
TTY: 711
www.ndpanda.org

Senate Human Services Committee
House Bill 1567 - March 18, 2025
Testimony of Brenda Ruehl, P&A Director Program Services

Greetings Chairman Lee and members of the Human Services Committee. My name is Brenda Ruehl and I'm a Program Services Director at the North Dakota Protection and Advocacy Project (P&A). P&A is an independent state agency established in 1977 to assert and advance the human, civil, and legal rights of people with disabilities. The agency's programs and services seek to make positive changes for people with disabilities where we live, learn, work and play.

P&A supports HB 1567 to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities.

Individuals with disabilities suffer significant barriers and disparities in access to dental healthcare.

Individuals with disabilities continue to run into complex physical, behavioral, or multidimensional barriers in accessing dental services. This is due to multifactorial causes related to the disability itself, side effects of medications, and a lack of accessibility to dental and oral services. Much of the time substantial dental complications turn into anxiety and cooperation problems, mainly because of the individual's physical limitations, mental disabilities, or behavioral management needs. For the dentist and oral hygiene staff, these factors may cause dental examination and treatment to be more challenging.

Individuals, parents, guardians, legal custodians, community-based providers, foster parents and anyone caring for children and adults with disabilities struggle to find dental and oral health care providers in their communities. There are very few dentists available to meet the dental care needs of people with disabilities across North Dakota. People must travel many hours to access care which often includes finding transportation, gas, an overnight stay in a hotel, meals and time missed from work or school. These would be barriers for anyone but certainly for people with disabilities, many of whom are low-income.

Poor dental and oral health care has serious consequences, including problems with nutrition, speech,

pain and systemic health conditions. Poor dental and oral health care can have a significant effect on overall health. It can lead to infections of the respiratory tract, such as aspiration pneumonia. Consequences of poor oral health go beyond immediate physical impacts to severe social integration and quality of life associated with bad breath and speech deficits that has negative impact on self-image and self-esteem. It can also affect one's ability to obtain and maintain employment.

Poor dental and oral health are largely preventable through regular dental and oral healthcare. Good dental and oral healthcare are dependent on adequate oral hygiene and regular access to a dental clinic. People with disabilities are statistically more likely to experience frequent and serious health care needs than people without disabilities. Poor dental and oral healthcare can further impact the health and wellbeing of people with disabilities. Poor dental and oral healthcare especially in low-income populations including people with disabilities, result in higher medical costs including hospitalizations and institutionalizations. Access to dental and oral care throughout one's lifetime can reduce the cost of medical care, promote healthier lifestyles and keep people living in the community.

P&A requests that you give a "Do Pass" on HB 1567.

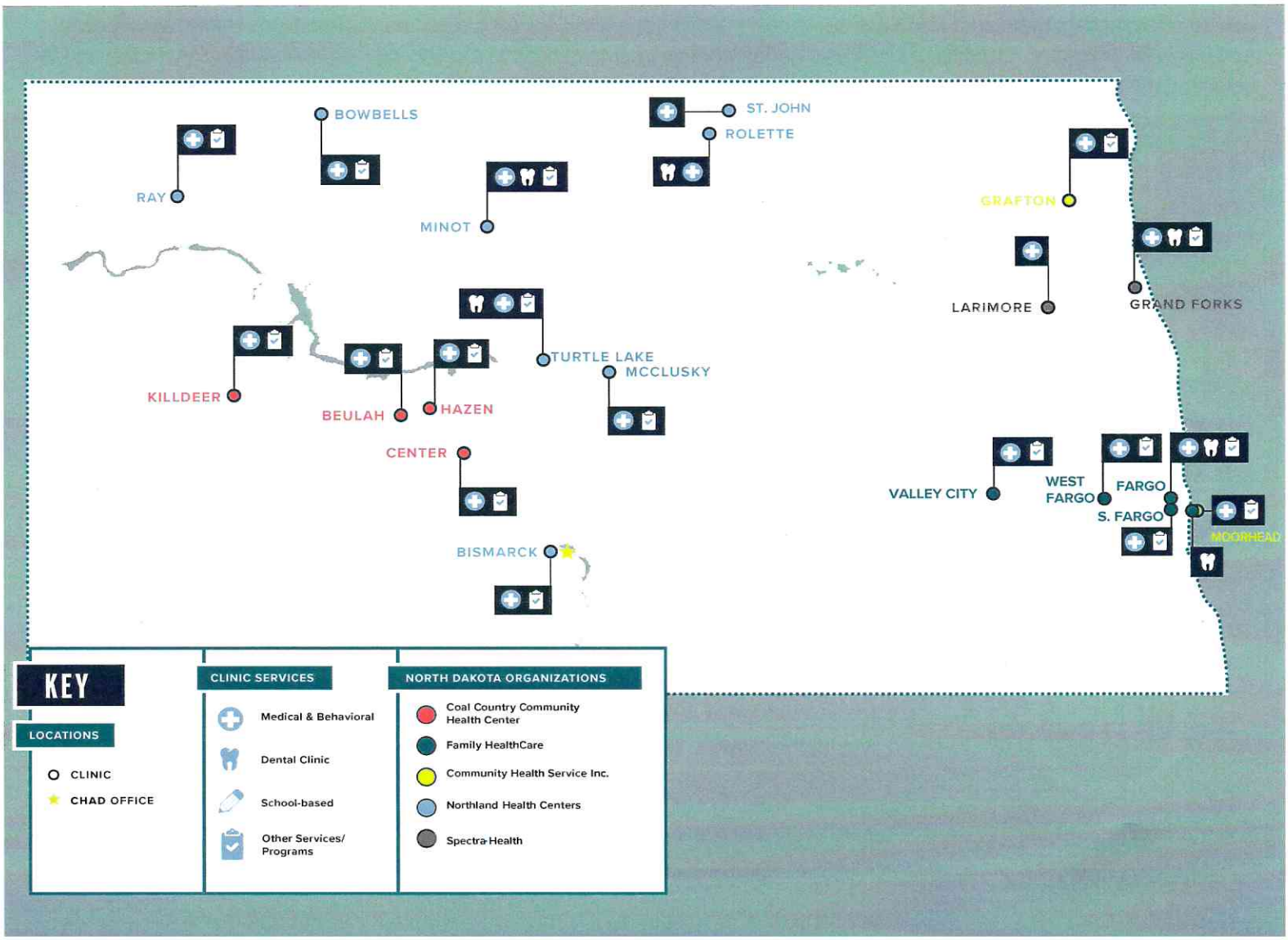
Thank you for your time and consideration.

Brenda Ruehl
Director Program Services
bruehl@nd.gov

CHAD

WHAT IS A COMMUNITY HEALTH CENTER?

Community health centers (CHCs) are non-profit, community-driven primary care clinics that provide high-quality primary and preventive care to all individuals, regardless of their insurance status or ability to pay. Health centers are located in underserved and low-income urban and rural areas across North Dakota, providing access to affordable, quality health care for those who need it most. The centers serve as essential medical homes where patients can receive a wide array of services including medical, behavioral, and dental care along with help with transportation, interpretation, and other case management and care coordination services. In rural communities, health centers support a community's ability to retain local health care options, supporting access to health care where rural Dakotans live and work. North Dakota's network of five health center organizations provides care to over 34,000 patients each year at 21 locations in 19 communities across North Dakota.



NORTH DAKOTA PATIENTS

Source: 2022 UDS Preliminary Reports

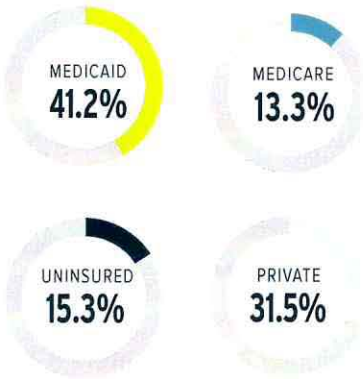
PATIENTS BY INCOME LEVELS

This represents a distribution of patients for whom income is known. Income is unknown for 47.0% of patients.

TOTAL PATIENTS 34, 576

32.9% of total patients served are of racial/ethnic minority

PATIENTS BY PAYOR SOURCE



ECONOMIC VIABLILITY

Source: Calculations based on 2021 UDS Reports

In addition to the actual dollars that flow to local communities through health centers, their role in maintaining access to health care can have an enormous impact on the long-term economic viability of rural and urban communities throughout North Dakota. For our smaller communities, access to local health care is crucial to a town's ability to recruit new companies and maintain a healthy workforce without long out-of-town trips to the doctors or to pick up prescriptions. When a small town is able to retain access to health care, it can serve as a main street anchor, keeping other small businesses viable. Across rural and urban communities, CHCs keep health care affordable by providing health care services regardless of ability to pay and by helping patients find health coverage options that are right for them.

STATEWIDE IMPACT

North Dakota CHCs had a total annual economic impact on the state of

$90,907,553 IN 2021

NORTH DAKOTA CHCs DIRECTLY GENERATED:

369 full-time jobs

AND SUPPORTED AN ADDITIONAL

228 jobs in other business

597 total jobs

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2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1567
3/24/2025

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities.

9:37 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

Discussion Topics:

- Minnesota's Implementation
- Reimbursement Request

9:38 a.m. William Sherwin, Executive Director of ND Dental Board, answered committee questions.

9:39 a.m. Senator Hogan moved amendment LC#25.1142.04001.

9:39 a.m. Senator Roers seconded the motion.

Senators	Vote
Senator Judy Lee	Y
Senator Kent Weston	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Desiree Van Oosting	Y

Motion passed 6-0-0.

9:51 a.m. Senator Hogan moved Do Pass as amended.

9:51 a.m. Senator Weston seconded the motion.

Senators	Vote
Senator Judy Lee	Y
Senator Kent Weston	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Desiree Van Oosting	Y

Motion passed 6-0-0.

Senator Weston will carry the bill.

9:55 a.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

CO 3/24/25 1 of 4

25.1142.04001
Title.05000

Adopted by the Senate Human Services Committee
March 24, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1567

Introduced by

Representatives Schneider, Brown, Davis, Finley-DeVille, McLeod, Mitskog, Nelson, Hager

Senators Bekkedahl, Hogan

A BILL for an Act to provide for a legislative management study relating to dental and oral health care status among Medicaid recipients and workforce support to improve access for low-income children, Native American children, and individuals with disabilities.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCESS TO DENTAL AND ORAL HEALTH CARE SERVICES FOR LOW-INCOME CHILDREN, NATIVE AMERICAN CHILDREN, AND INDIVIDUALS WITH DISABILITIES.

1. During the 2025-26 interim, the legislative management shall consider studying the unmet dental and oral health care needs of low-income children, Native American children, and individuals with disabilities. The study must include:
   a. An overview of the dental and oral health care status of Medicaid recipients, including low-income children, Native American children, and individuals with disabilities, both on and off reservations;
   b. Evaluation of the importance of receiving dental and oral health care services, the impacts and outcomes of not receiving services, general health consequences, complications, and expanded costs of future care;
   c. Review of state and federal regulations, policies, and procedures limiting or perceived as limiting dentist provider enrollment in Medicaid, including impediments to enrollment, length of credentialing and recredentialing, reasons

for provider termination, prior authorizations, attachments, appeals, and timely payments;

d. Availability of, and access or barriers to, complex dental services for Medicaid recipients with disabilities or dental conditions which might require anesthesia or critical care;

e. Review of Medicaid dental reimbursement rates for a selection of preventative and treatment services in this state compared to other states, private payers, and in comparison to real cost for dental teams to determine potential need to increase reimbursement rates;

f. Review of barriers and opportunities relating to expanding education for dentists and dental staff, including consideration of a new dental school in this state, long-term partnership with regional dental schools, and increased dental student residencies located in this state;

g. Consideration of the expansion or promotion of programs that offer support and resources to enable on-the-job training and apprenticeships for dental assistants, including the visibility of providing state and federal resources to support providers offering such training;

h. Consideration of expansion or creation of volunteer and charitable dental programs and nonprofit services;

i. Evaluation of ways to improve accessibility to dental and oral health care services for Medicaid recipients, including low-income children, Native American children, and individuals with disabilities, both on and off reservations;

j. Exploration of the feasibility of partnerships between state programs and tribal health organizations to enhance delivery;

k. Review of programs designed to recruit and retain dental health providers, such as loan forgiveness or incentives for dentists working in underserved communities, including tribal communities;

l. Exploration of the use of telehealth solutions to reach rural areas, including tribal communities;

m. Review of dental provider participation with dental insurers, including the percentage of dental providers in-network and out-of-network for the largest dental insurers;

n. Review of charges covered by dental benefit plans and out-of-pocket costs for dental care;

o. Review of dental program preauthorization and service coverage in adherence to clinical guidelines of the American dental association and the American academy of pediatric dentistry;

p. Review of the provider relations program for answering questions from providers and staff, online and in-person education and training to providers and staff to promote efficiency and effectiveness;

q. Consideration of program staff credentials for appropriate oversight of clinical care for claim preauthorizations and approvals;

r. Consideration of the administrative system addressing grievances and appeals of submitted claims and preauthorizations to assess the system's responsiveness and review the ability to submit additional documentation, such as x-rays and photos using an online portal;

s. Review of parity in the submission of claims between private offices, nonprofit dental clinics, and federally qualified health centers;

t. Consideration of the potential effects of dental Medicaid expansion and increase in adult Medicaid-eligible enrollees on access to dental care, administrative efficiency, and participation of dentists in the Medicaid program;

u. Review of dental claims administration including the percentage of preauthorizations and denials;

v. Review of call center management including the number of calls, average hold time, and caller satisfaction;

w. Review of cases and decisions by a program administration related to audits and claims review to determine what percentage were completed with a peer review committee that includes a licensed dentist and a licensed dentist of a specialty;

x. Review the quality improvement system that assists providers in providing clinically appropriate care in accordance with the guidelines of the American

dental association and the American academy of pediatric dentistry clinical guidelines;

y. Analysis of the information required by centers for Medicare and Medicaid form 416, in compliance with Medicaid early and periodic screening, diagnostic, and treatment, including the percentage of eligible children receiving any dental service, preventative service, or sealants;

z. Analysis of provider participation and recredentialing of dental providers with Medicaid, the average benefit paid per user and beneficiary, the geographical distribution of active providers with active recipients in the state, and provider participation surveys; and

aa. Review of ambulatory surgery and hospital facility claims for dental rehabilitation procedures that require monitored anesthesia for children to compare with other medical providers providing similar same-day surgical services.

2. The study may include broader considerations of unmet needs for dental services for all Medicaid recipients, data for those recipients, and any current plans for remediation with goals, objectives, projected costs, and implementation timetables.

3. The study may include a focus on solutions to identified needs including a review of scope of practice and additional providers and provider types.

4. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

REPORT OF STANDING COMMITTEE
ENGROSSED HB 1567

Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS (25.1142.04001)** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). HB 1567 was placed on the Sixth order on the calendar. This bill does not affect workforce development.