



# North Dakota Legislative Council

Prepared for the Health Care Committee  
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## UNMET DENTAL AND ORAL HEALTH CARE NEEDS - BACKGROUND MEMORANDUM

### INTRODUCTION

Section 1 of House Bill No. 1567 (2025) ([Appendix A](#)) directs the Legislative Management to study the unmet dental and oral health care needs of low-income children, Native American children, and individuals with disabilities, and assess dental provider workforce capacity and support strategies to improve access for these populations. The study must involve a comprehensive review of access to, and quality of, dental care, including:

- 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;
- 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 increased costs of future care;
- Review of federal and state regulations, policies, and procedures that may limit dentist provider enrollment in Medicaid, including impediments to enrollment, length of credentialing and recredentialing, reasons for provider termination, prior authorizations, attachments, appeals, availability of Medicaid program staff to answer questions from providers, and timely payments;
- Availability of, and access or barriers to, complex dental services;
- Review of Medicaid dental reimbursement rates, charges covered by dental benefit plans, and out-of-pocket costs for care;
- Review of barriers and opportunities relating to expanding education for dentists and dental staff, including expansion or promotion of programs that offer support and resources to enable on-the-job training and apprenticeships for staff, consideration of the establishment of a new dental school, and programs designed to retain and recruit providers;
- Consideration of expansion or creation of volunteer and charitable dental programs and nonprofit services;
- Review of dental provider participation with dental insurers; and
- Evaluation of ways to improve access to dental and oral health care services.

### BACKGROUND

As introduced, House Bill No. 1567 (2025) provided funding to support the Department of Health and Human Services (DHHS) Oral Health Program's student rotations for dental student recruitment efforts. The bill also included a compressed version of this study. The bill was amended to remove the appropriation to DHHS and expand the scope of the study to include a comprehensive review of the dental and oral health care needs of Native American children, low-income children, and individuals with disabilities, with a focus on Medicaid recipients and dental provider workforce challenges.

Testimony in support of the study indicated the need to examine access to, and outcomes of, dental and oral health care services in this state. Key concerns included the future costs for individuals not

receiving preventive dental care, particularly for underserved and hard-to-reach populations, as well as the need to improve accessibility for these populations.

Testimony from dental providers emphasized the need to review and evaluate the regulations, policies, and procedures governing dentists' enrollment in Medicaid. It was noted dental providers are generally small, private businesses, and understanding regulations for billing, coding, and payment for Medicaid is a larger burden for small businesses than it is for traditional large medical systems. Testimony also indicated the cost of care is the main reason dental care is deferred, regardless of whether the individual is covered by private insurance, Medicaid, or paying privately. Each dental office may set its dental fee scale, but providers may not discuss these rates among dental practices. Medicaid, however, sets its rates and dental providers may not bill above those rates for Medicaid patients. Providers also may not bill the difference to patients.

Testimony indicated dental insurance is not the same as traditional health insurance. Dental insurance is a limited benefit plan, which covers a restricted set of services or treatments up to a specified amount or for a limited period. General health insurance provides coverage for unexpected and catastrophic events, while dental insurance provides basic preventative care. Testimony indicated unlike typical major medical insurance with a maximum out-of-pocket cost that has adjusted for inflation, dental insurance covers a lower threshold that has largely not been adjusted. According to the United States Health Resource Administration, in 1973 the most common annual maximum threshold for individual dental insurance benefits was \$1,000, while the most common family maximum ranged between \$1,000 and \$1,999.<sup>1</sup> These amounts remain largely unchanged today, with many dental benefit plans offering annual maximum benefits ranging from \$1,000 to \$2,000, depending on the plan type.<sup>2</sup>

Testimony from providers also described the need for recruitment and retention programs, professional education, and incentives for practitioners providing services in underserved communities and for complex cases. Providers described workforce saturation for dentists as adequate, but indicated staff workforce was drastically insufficient by approximately 1,000 to 2,000 dental assistants and hygienists. A dentist may rotate between operatories within a dental clinic; however, if there is only one staff member, a dentist's ability to treat additional patients is limited. Testimony indicated the workforce shortage could be alleviated in the next 18 to 36 months, as students complete dental education programs at the two new additional schools within the state.

## **NORTH DAKOTA Provider Education**

### **Dentists**

To become a licensed dentist in North Dakota, an individual must first complete a bachelor's degree with specific prerequisite courses, generally in biology and chemistry, followed by 4 years of dental school to earn a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine degree. After graduation, the individual also must complete the Integrated National Board Dental Examination, the North Dakota State Board of Dentistry clinical examination, a cardiopulmonary resuscitation (CPR) certification, a nitrous oxide inhalation course if not received during dental school, the mandatory jurisprudence and ethics examination, and a background check. Once licensed, a dentist must complete 32 hours of continuing education classes every 2 years.<sup>3</sup> This must include 2 hours of ethics, 2 hours of infection control, a CPR course, and two additional requirements for sedation and anesthesia permitholders. A maximum of 2 hours may be related to administrative aspects and a maximum of 16 hours may be self-study.

Additional education and training beyond dental school generally are necessary for dental specialties. The American Dental Association (ADA) recognizes 12 dental specialties: dental anesthesiology, dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and

<sup>1</sup> United States Health Resource Administration Division of Dentistry, Survey of dental benefit plans, 1973 (p. 62, 1979).

<sup>2</sup> Delta Dental Plans Association, What is a dental insurance annual maximum?

<sup>3</sup> North Dakota Administrative Code (NDAC) Section 20-02-01-06.

maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, and prosthodontics.<sup>4</sup> The American Dental Education Association indicates dental anesthesiology requires an additional 3 years of education, dental public health an average of 14 additional months, endodontics an average of 26 months, oral and maxillofacial pathology an additional 3 years, oral and maxillofacial radiology an additional 2 to 3 years, oral and maxillofacial surgery an additional 4 to 6 years, oral medicine an additional 2 to 3 years, orofacial pain an additional 1 to 3 years, orthodontics and dentofacial orthopedics an additional 2 to 3 years, pediatric dentistry an additional 2 to 3 years, periodontics an additional 3 years, and prosthodontics an additional 3 years.

According to the ADA, there are 77 accredited dental schools in the United States and 10 in Canada. There are no dental schools in North Dakota. The closest programs are in Colorado, at the University of Colorado School of Dental Medicine in Aurora; Iowa, at the University of Iowa College of Dentistry and Dental Clinics in Iowa City; Wisconsin, at Marquette University School of Dentistry in Milwaukee; Nebraska, at Creighton University School of Dentistry in Omaha and the University of Nebraska Medical Center College of Dentistry in Lincoln; and Minnesota, at the University of Minnesota School of Dentistry in Minneapolis. Most North Dakota dentists graduated from dental school in Minnesota (42 percent of all practicing North Dakota dentists in 2016) or Nebraska (22 percent in 2016).<sup>5</sup> The University of Minnesota has reciprocity agreements for tuition with Wisconsin, North Dakota, and Manitoba. However, the reciprocity agreement does not apply for the DDS program.

For academic year 2024-25, the national average 1<sup>st</sup> year cost of dental school at public institutions (including tuition and mandatory general fees) was \$46,865 for students who were in-state residents and \$76,060 for nonresidents in public programs.<sup>6</sup> The average 1<sup>st</sup> year cost of private dental school programs was \$87,078.<sup>7</sup> According to a study by the American Dental Education Association, the average dental school debt was \$297,800 for 2024 graduates, which is an increase from a previous peak debt of \$284,200 in 2020.<sup>8</sup> The average total debt for 2024 dental school graduates, which includes other education debt, was \$312,700.<sup>9</sup> On average, graduates financed just over two-thirds of their dental education through debt (67 percent), financial support from family and friends (17 percent), and grants and scholarships (11 percent). A smaller portion of the educational costs of graduates were funded through savings (3 percent), part-time employment (1.2 percent), and other sources (0.8 percent). Eighty-five percent of 2024 graduates who used loans for dental school used federal direct unsubsidized loans.<sup>10</sup>

### Dental Hygienists and Assistants

To become a registered dental assistant (RDA) in North Dakota, the State Board of Dental Examiners requires an individual to:

- Complete an accredited dental assisting program within 1 year of application;
- Complete the dental assisting national board within 2 years before application with 16 hours of continuing education and proof the applicant was gainfully employed in the time before the application;
- Complete an accredited dental assisting program within 2 years before application with 16 hours of continuing education;

<sup>4</sup> National Commission on Recognition of Dental Specialties and Certifying Boards, Definitions of the recognized dental specialties.

<sup>5</sup> Center For Rural Health, Educating the Oral Healthcare Workforce in North Dakota Factsheet, (Sept. 2016).

<sup>6</sup> ADA, CODA Survey of Dental Education Series, Report 2 Tuition, Admission, and Attrition, 2024-25, Figure 1.

<sup>7</sup> *Id.*

<sup>8</sup> American Dental Education Association, Dentists of Tomorrow 2024: An Analysis of the Results of the 2024 ADEA Survey of U.S. Dental School Seniors Summary Report, (Dec. 2024).

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

- Complete the examination administered by the Joint Commission on National Dental Examinations or Dental Hygiene Certification Board of Canada and complete, within 2 years of the application, 16 hours of continuing education; or
- Be licensed in good standing in a jurisdiction with similar requirements.

In addition, the applicant must pass a written examination on the laws governing the practice of dentistry in North Dakota within 1 year of the application and complete a CPR course within 2 years.<sup>11</sup>

The State Board of Dental Examiners may grant registration as a qualified dental assistant (QDA) to an applicant who:

- Has passed the National Entry Level Dental Assistant certification and completed 300 hours of on-the-job training within 1 year of application;
- Has passed the National Entry Level Dental Assistant certification, completed 300 hours of on-the-job clinical training, and within 2 years before application, completed 16 hours of continuing education;
- Has passed the National Entry Level Dental Assistant certification and completed the Department of Career and Technical Education Dental Assisting Education Program association;
- Has completed a board-approved equivalent course within 1 year of application; or
- Is licensed in good standing in a jurisdiction with similar requirements.

In addition, the applicant must pass a written examination on the laws governing the practice of dentistry in North Dakota within 1 year of the application and complete a CPR course within 2 years.<sup>12</sup>

A qualified dental assistant-limited radiology registrant must, within 2 years of a registration application, obtain the Dental Assisting National Board's Radiation Health and Safety certificate or complete a radiation health and safety course approved by the board and complete a CPR course.<sup>13</sup>

To become a dental hygienist, an applicant must pass a clinical competency examination, complete a CPR course, complete the jurisprudence and ethics examination on the laws governing the practice of dentistry in this state, and complete a dental hygienist education program, which is generally a 2-year program. Once licensed, a dental hygienist must complete 16 hours of continuing education within a 2-year cycle. This must include 2 hours of ethics, 2 hours of infection control, and a CPR course.<sup>14</sup> Dental assistants must complete 16 hours of continuing education within a 2-year cycle.<sup>15</sup>

Until recently, the North Dakota State College of Science (NDSCS) was the only institution in the state offering education for dental assistants and dental hygienists. The college provides a certificate in dental assisting, an associate degree in applied science for dental assisting, and an associate degree in applied science for dental hygiene. Both the dental assistant certificate and dental assistant associate degree curriculum include content in general studies, biodental sciences, dental sciences, clinical sciences, and clinical practice. In addition to courses taken on campus, students in both programs receive more than 300 hours of clinical experience in community and regional dental offices. The Dental Assisting Certificate Program is 41 credit-hours and the associate degree is 61 credit-hours. The Dental Hygiene Program consists of classroom, laboratory, and clinical experiences emphasizing skill development, self-assessment, and professionalism offered over five continuous semesters. Most clinical experience takes place in the college's dental clinic. Students also are assigned to off-campus affiliation sites. The Dental Hygiene Program requires 72 credit-hours.

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<sup>11</sup> NDAC § 20-03-01-05.

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> NDAC § 20-04-01-08.

<sup>15</sup> NDAC § 20-03-01-06.

Dakota College at Bottineau recently started a new Dental Education Program in Minot. The Dental Assisting Certificate Program is a 10-month, 45-credit program that includes lectures, supervised labs, clinical instruction, and over 300 hours of clinical affiliation in dental practices. Admission to the program requires the completion of four prerequisite courses. The Dental Assisting Program accepts 12 students each year. Students also may choose the Associate in Applied Science Degree program, a 64-credit program completed over 2 academic years.

The Dental Hygiene Program requires 35 credits of prerequisite courses. These courses must be completed before applying and being accepted into the Dental Hygiene Program. The Dental Hygiene Program includes 64 credits and takes 2 academic years, plus one summer session, to complete. The program includes lectures, supervised labs, and clinics. Students also participate in service-learning opportunities. Graduates earn an Associate of Applied Science Degree in Dental Hygiene. The Dental Hygiene Program accepts 10 students each year.

In 2024, the State Board of Higher Education approved Bismarck State College to offer programs in dental assisting, dental hygiene, and a certificate in dental careers awareness, with a target date to start the programs in the fall of 2025. The qualified Dental Assistant Program includes didactic, self-paced online learning of up to 144 hours and a 300-hour chairside clinical experience to be completed within a 1-year period. The Department of Commerce awarded Bismarck State College a technical skills training grant of \$44,000 to provide full scholarships to more than 20 students for the new qualified Dental Assistant Program.

Bismarck State College established Mystic Smiles Dental Clinic, a nonprofit clinic designed to function as a teaching dental practice, integrating clinical education with community service, and specializing in pediatric dental care for children through age 13. Mystic Smiles opened in May 2025, and recently received a \$75,000 grant to support the purchase of imaging equipment and sterilization technology.<sup>16</sup>

### Workforce

According to the DHHS Oral Health Program, in 2022, only 44 percent of the state's need for dental providers was being met. At that time, there were 69 dental care health practitioner shortage areas with a service area that reached 153,291 individuals.<sup>17</sup> Nineteen of the 53 counties had no dentists.<sup>18</sup> In 2024, due to staffing shortages, more than 80 percent of dentists in this state attempted to hire staff and most were unsuccessful.<sup>19</sup>

According to the State Board of Dental Examiners, as of July 2025, there are 425 DDSs, 737 registered dental hygienists (RDH), and 704 RDAs and QDAs with in-state addresses.<sup>20</sup> The following table provides a history of the number of dental providers in the state from 2020 through 2025:

<sup>16</sup> Bismarck State College, \$75,000 grant advances BSC Mystic Smiles dental clinic and dental career programs, (Sept. 10, 2025).

<sup>17</sup> Connor, et al., DHHS, Oral Health In North Dakota: Opportunities and need to promote oral health equity, p. 17, (2022).

<sup>18</sup> *Id.*

<sup>19</sup> Bismarck State College, \$75,000 grant advances BSC Mystic Smiles dental clinic and dental career programs, (Sept. 10, 2025).

<sup>20</sup> Data from the ADA reflects North Dakota has 21 oral and maxillofacial surgeons, 19 orthodontics and dentofacial orthopedists, 17 pediatric dentists, 11 endodontists, 3 periodontists, and 4 other specialists. See KFF, Professionally Active Dentists by Specialty Field, (2004).

Year	DDS			RDH			RDA/QDA	
	In-State	Total Including Out-of-State	Inactive DDS	In-State	Total Including Out-of-State	Inactive RDH	In-State	Total Including Out-of-State
2020	426	473	26	694	843	47	687	811
2021	431	486	17	708	852	35	595	722
2022	414	463	23	684	822	45	696	813
2023	430	500	17	713	899	33	725	810
2024	409	485	29	707	860	46	790	894
2025*	425	520	18	737	899	44	704	840

\*This data is accurate as of July 28, 2025.

Dental providers, including RDHs, RDAs, and QDAs, may perform different tasks at varying levels of supervision.<sup>21</sup> The State Board of Dental Examiners provides a comprehensive list of procedures each position may perform and the required level of supervision. See North Dakota Board of Dental Examiners, RDH/RDA/QDA/DA - Duties Chart.<sup>22</sup>

Dentists generally practice within independent, small businesses, and unlike traditional medicine, dentists may incur high costs to establish a practice, including purchasing equipment.<sup>23</sup> Dentists also must hire staff, lease space, understand regulatory framework, file required forms, and arrange payments for employees.

**Retention Programs**

In Senate Bill No. 2152 (2007), the Legislative Assembly created the Dental Practice Grant Program for new practices. The program allowed a dentist who graduated from an accredited dental school within the previous 5 years and was licensed to practice in North Dakota to apply for a grant to establish a new dental practice in North Dakota cities with populations of 7,500 or less. The maximum grant amount was \$50,000, to be distributed in equal amounts over 5 years, and the dentist was required to practice in the community for a minimum of 5 years. Only two grants could be awarded per year, and the community was required to provide a 50 percent match for the grant. The grant could be used only for buildings, equipment, and operating expenses. The grant program was modified by Senate Bill No. 2146 (2011) to permit the community to provide an in-kind or dollar match. The program was discontinued and repealed by Senate Bill No. 2205 (2015).

The North Dakota Dental Loan Repayment Program, administered by DHHS, provides loan repayment for selected dentists who serve in a public health clinic, practice with a focus on underserved populations, or practice in a nonprofit clinic. Providers must serve in areas of the state with a defined need for such services. Each dentist selected may receive up to \$100,000 to repay educational loans and must sign a contract to practice full time for 5 years in an area that has a defined need for dental services. Applicants must accept Medicare and Medicaid patients. The department reviews all applicants in consultation with the North Dakota Dental Association. The applicants are reviewed and prioritized based on personal statements, letters of recommendation, and the need for dental services in the applicant's practice area.

The North Dakota Federal Loan Repayment Program also is available for dentists and dental hygienists who practice in eligible public and nonprofit sites. Applicants must accept patients covered by Medicare, Medicaid, and the Children's Health Insurance Program. Applicants must agree to practice in a selected area for 2 years. Award recipients may receive up to \$50,000 for a 2 year, full-time service commitment. Full time is a minimum of 32 hours per week of direct patient care with 8 hours of administrative time allowed. Part time is a minimum of 16 hours per week of direct patient care with 4 hours of administrative time allowed.

<sup>21</sup> North Dakota Century Code (NDCC) Section 43-20-01.1.

<sup>22</sup> North Dakota Board of Dental Examiners, Meeting Agenda, Attachment B: Quantity of Licensees and Registrants, (Aug. 1, 2025).

<sup>23</sup> Shelly Gehshan, Paetra Hauck, and Julie Scales, National Conference of State Legislatures, Increasing Dentists' Participation in Medicaid and SCHIP, (2001).

### Low-income Children and Children with Disabilities

Children in lower-income households are at an increased risk for oral health disparities. Nationally, 60 percent of children ages 6 to 9 years from lower-income households have cavities compared to 40 percent from higher-income households.<sup>24</sup> Untreated cavities for children ages 12 to 19 years are more common for lower-income children, at 14 percent, compared to 8 percent for higher-income children.<sup>25</sup> According to the federal Centers for Disease Control and Prevention, children at 100 percent below the federal poverty level have a prevalence of untreated tooth decay in primary (also known as deciduous or baby) teeth at 18 percent, while children at 200 percent above the federal poverty level have a prevalence of untreated tooth decay in primary teeth of over 6 percent.<sup>26</sup> In permanent teeth, these impoverished children had a prevalence of tooth decay of over 26 percent, while high-income children's prevalence of tooth decay was 10 percent.<sup>27</sup>

Studies indicate children with intellectual or developmental disabilities are at an increased risk for developing gingivitis, dental caries, defective enamel, and pathological periodontal pockets.<sup>28</sup> In addition to increased risk for oral health problems, children with disabilities also face barriers to care. Even when nondevelopmentally disabled children and developmentally disabled children are equally likely to have seen a dentist, developmentally disabled children are more likely to not receive dental treatments due to cost.<sup>29</sup> Parents of developmentally disabled children from the lowest income bracket were nearly twice as likely to identify costs as a barrier to dental care than parents of nondevelopmentally disabled children with the same income.<sup>30</sup> Families of children with disabilities identify lack of information, insurance, and financial resources as barriers to care.<sup>31</sup> Finding an appropriate provider also is a barrier, as some dentists report not being prepared to treat children with disabilities, in part due to a lack of clinical experiences during dental school.<sup>32</sup>

### Native Americans

North Dakota has the sixth highest Native American population in the United States. Native Americans face more oral health challenges than other populations. More than two times as many students in kindergarten who are indigenous have rampant decay compared to their peers.<sup>33</sup> Nine in 10 Native American and American Indian students in kindergarten through 3rd grade have experienced tooth decay.<sup>34</sup> Preventative dental visits are a way to prevent oral disease; however, many Native Americans go without regular dental cleanings. Fifty-one percent of indigenous adults have not seen a dentist in 5 or more years, compared to 31 percent who are nonindigenous.<sup>35</sup>

Barriers to receiving care and risk factors are higher for Native American children and families. Barriers include limited access to care, lack of culturally representative care, and socioeconomic challenges. Many Native Americans live in areas considered medical deserts, or in vast areas without providers and must travel long distances to see a provider. Over one-third of North Dakota counties do not have a dentist.<sup>36</sup> In a study rating the ease of receiving dental care based on place of residence, 39 percent of

<sup>24</sup> Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services, Health Disparities in Oral Health, (May 15, 2024).

<sup>25</sup> *Id.*

<sup>26</sup> Centers for Disease Control and Prevention, U.S. Dept. of Health and Human Services, Oral Health Surveillance Report: Dental Caries, Tooth Retention, and Edentulism, United States, 2017–March 2020, (2024).

<sup>27</sup> *Id.*

<sup>28</sup> Donald Chi, et. al, Preventative Dental Utilization for Medicaid-Enrolled Children in Iowa Identified with Intellectual and/or Developmental Disability, J. Pub. Health Dent. (2010).

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> Connor, et. al, DHHS, Oral Health in North Dakota: Opportunities and need to promote oral health equity, (2022).

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

Native Americans reported receiving dental care would be extremely to moderately difficult as compared to 24.3 percent of non-Native American adults.<sup>37</sup> Native Americans also may have unmet needs for culturally representative care, as only 0.3 percent of dental providers in the United States are Native American or American Indian.<sup>38</sup> This number is unlikely to change due to low dental school application rates among Native Americans. A record high of 92 Native Americans applied to dental school in the United States in 2006, while only 16 applied in 2021.<sup>39</sup>

Additional oral health challenges faced by Native Americans include a lack of access to high-quality water and fluoridation. Nearly half of community water systems lacking fluoride are in counties with an Indian reservation.<sup>40</sup> Native American communities are often food deserts as well as medical deserts, with less readily available access to large grocery stores, which increases the prevalence of shopping at convenience stores or smaller stores with limited offerings of fresh and healthy foods.<sup>41</sup> In North Dakota, 89 percent of indigenous students in kindergarten drink soda daily.<sup>42</sup> Food programs like the Food Distribution Program on Indian Reservations sponsored by the United States Department of Agriculture historically offered items like sugar, sugared juices, processed meats, and other "poor-quality, high calorie foods with inadequate nutritional value" that may contribute to poor oral and overall health.<sup>43</sup> In addition to a lack of healthy options, economics creates further barriers to care. In the United States, more than one in four Native American families with children live in poverty.<sup>44</sup> Native Americans also experience job and housing insecurity at higher percentages, making oral health less likely to be a priority.

### **Tribal Health Providers**

Tribes in North Dakota have a variety of affiliated dental providers and programs. Medical and dental care provided at an Indian Health Service (IHS) or tribal health care facility is called direct care. The Purchased and Referred Care (PRC) Program through IHS is for members of federally recognized tribes who reside on or near the reservation in geographic areas called contract health service delivery areas. Eligibility for PRC is more stringent than for receiving direct care. If IHS is requested to pay for PRC, a patient must first meet requirements related to tribal affiliation, residency, notification, medical priority, and use of alternate resources requirements. A member of a federally recognized tribe may obtain care at any IHS hospital or clinic if the facility has the staff and ability to provide care. Patients generally must reside on the reservation to receive PRC. Most PRC is for urgent or emergency needs and requires prior approval for nonemergencies or notification within a certain time of emergency care occurring. Some tribally operated hospitals or clinics restrict services to tribal members.

### **Three Affiliated Tribes of the Fort Berthold Reservation**

The Elbowoods Memorial Health Center serves the members of the Three Affiliated Tribes. The main clinic is located four miles west of New Town. The center is an outpatient facility with specialty and dental clinics. In June 2025, a grand opening was held for the Dental and Optometry Clinic at the Elbowoods Memorial Health Campus.<sup>45</sup> The new clinic has 10 dental bays, 1 dental surgical room, and 21 dental staff.<sup>46</sup> In 2022, the White Shield Medical Clinic was opened to provide services for the eastern segment

<sup>37</sup> CareQuest, Disproportionate Burden of Oral Disease.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> Connor, et. al, DHHS, Oral health in North Dakota: Opportunities and need to promote oral health equity, (2022).

<sup>41</sup> Michelle Saksena and Phillip Kaufman, United States Dept. of Agriculture, Native Americans Living in Tribal Areas Face Longer Trips to the Grocery Store, (April 6, 2015).

<sup>42</sup> Connor, et. al, DHHS, Oral health In North Dakota: Opportunities and need to promote oral health equity, (2022).

<sup>43</sup> Donald Warne and Denise Lajimodiere, Social and Personality Psychology Compass, American Indian Health Disparities: Psychosocial influences, (2015).

<sup>44</sup> CareQuest, Disproportionate Burden of Oral Disease.

<sup>45</sup> Kyona Rivera, KFYZ, Elbowoods Memorial Health Center Celebrates new dental, eye care facility in New Town, (June 13, 2025).

<sup>46</sup> *Id.*

of the reservation.<sup>47</sup> The facility houses a pharmacy; examination rooms for primary care, dental care, optical, pediatrics, women's health, and radiology; behavioral health offices; physical therapy space; laboratory services; administrative offices; and an ambulance bay. Three field clinics also serve the Three Affiliated Tribes of the Fort Berthold Reservation in Mandaree, Parshall, and Twin Buttes.

The Three Affiliated Tribes of the Fort Berthold Reservation offers Tribal Health Insurance for enrolled members who do not have other medical insurance coverage, which includes dental and vision coverage. The Three Affiliated Tribes also has a dental assistance policy for enrolled tribal members through which financial assistance is available to pay for dental procedures as approved by the Tribal Business Council in the dental assistance policy. The policy provides if the patient has coverage for dental services like private insurance, IHS, or Medicaid, the patient must work with the coverage provider before requesting financial assistance from the tribe for dental care. The policy provides if the tribal member has private insurance, the tribal member must go to a dentist who accepts the insurance and request at least two treatment plan options with a breakdown of what insurance will cover for each option.

If the member is covered by IHS or PRC, the tribal member must go to the Elbowoods Memorial Health Center dental clinic and follow the referral process. Purchased and Referred Care will pay only for services within the referral. For other services not stated in the referral, two treatment plans are needed from the outside dental provider. Medical necessity must be met and requires a determination by a dentist at the Elbowoods dental clinic which indicates the procedure is medically necessary. Typically, implants are viewed as cosmetic procedures, but rare cases for patients with a history of jaw malformation, cancer, or developmental disabilities may be deemed a medical necessity under the policy.

The maximum allowable lifetime amount is \$10,000 per tribal member for dental implant services and is available for tribal members ages 18 to 70. The maximum allowable lifetime amount is \$5,000 per member for orthodontics. The maximum allowable lifetime amount is \$10,000 per tribal member for other dental services.

Patients may bring their dental assistance request and treatment plan information to the MHA Nation Grants and Donations Department, which will provide the request information to the Tribal Health Insurance Department. The Tribal Health Insurance Department will then verify the required treatment plans were completed, medical necessity requirements have been met, and all other resources have been exhausted. The patient must provide all requested information to the Tribal Health Insurance Department. The Tribal Health Insurance Department will provide verification to the MHA Nation Grants and Donations Department, which processes the assistance request and tracks the amounts per patient to ensure lifetime limits are not exceeded.

### **Standing Rock Sioux Tribe**

The Standing Rock Service Unit of IHS consists of Fort Yates Hospital, which has inpatient care and an emergency department, and McLaughlin Health Center, which is an outpatient medical clinic with an urgent care department. The dental program consists of two outpatient clinics, which are both five operatories in size. There are two dental providers at the Fort Yates site and one dental provider at the McLaughlin, South Dakota site. Referrals are made for oral surgery and pediatric services.

Outgoing Chair of the Standing Rock Sioux Tribe, Janet Alkire, was working to secure a mobile dental unit.<sup>48</sup> The tribe also has partnered with Boger Dental, a Minneapolis based dental practice. The providers spent two 3-day-long visits in the fall of 2024 and spring of 2025 and provided free dental cleanings to 432 children. The providers also taught dental education. In the fall of 2024, the tribe collaborated with Smile Network to provide dental services to two schools in South Dakota, McLaughlin, and Rock Creek.

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<sup>47</sup> Grace Kraemer, KFYP, New medical facility in White Shield sparks hope for future healthcare in the area, (June 22, 2022).

<sup>48</sup> Peyton Haug, Fargo Forum, Outgoing chair leaves legacy of 'truth and compassion' on Standing Rock Sioux Tribe, (Aug. 27, 2025).

### **Turtle Mountain Band of Chippewa Indians**

According to IHS, the Quentin N. Burdick Memorial Health Care Facility in Belcourt has a 14-chair dental clinic and a 2-chair satellite clinic in Dunseith and serves 8,500 active patients. The clinic has nine staff, full clinic digital radiography with digital panoramic, electronic dental health records, new dental chairs and stools, and computers with dual screens in each unit. Referrals are made for oral surgery and pediatric services.

The Trenton Indian Service Area provides services for the Turtle Mountain tribal members in the Trenton, North Dakota area. The Trenton Community Dental Program provides cleanings, examinations, fillings, extractions, dentures, and sealants.

### **Spirit Lake Tribe**

According to IHS, the Spirit Lake Service Unit contains the Spirit Lake Health Center, an ambulatory, or outpatient, care facility. The Spirit Lake Health Center has a dental clinic that provides a range of dental services to patients, including same-day emergency appointments. The dental clinic focuses on prevention and encourages regular dental examinations and cleanings.

### **Sisseton-Wahpeton Oyate of the Lake Traverse Reservation**

The Sisseton Service Unit of IHS operates outpatient and dental clinics in Sisseton, South Dakota at the Woodrow Wilson Keeble Memorial Health Care Center. In 2007, the dental clinic was moved to a new site with 16 dental operatories equipped with digital radiography with plans for electronic dental records.

## **Dental Care Programs**

### **Medicaid**

Medicaid is an assistance program for eligible individuals without health insurance or for those whose health insurance does not cover all of their needs. Medicaid provides limited dental care services, and copayments may apply for certain recipients.

### **Community Health Centers**

Community health centers are nonprofit, community-based primary care clinics, that serve individuals regardless of their insurance status or ability to pay.<sup>49</sup> The integrated care model includes dental care. Three health care centers in North Dakota provide dental care. Approximately 40 percent of health center patients are Medicaid recipients, and those covered by Medicaid Expansion have no dental coverage; 13 percent are served by Medicare, which lacks dental coverage.<sup>50</sup> Additionally, 16 percent of health center patients are uninsured, and 31 percent have private insurance coverage.<sup>51</sup> Nearly half of the patients seen by community health centers lack dental coverage.<sup>52</sup> Serving patients who lack coverage makes it difficult for community health centers to pay competitive wages to staff and build dental programs to meet community needs. The following community health centers operate in the state:

- **Bridging the Dental Gap** is a nonprofit standalone clinic in Bismarck. The clinic is funded by revenue received from insurance reimbursements, patient payments, grant funds, and fundraising. The clinic does not receive any state or federal funding.<sup>53</sup> The clinic was started in 2004 to improve access to care for those on Medicaid, those who are uninsured and underinsured, and low-income members of the community. The clinic initially provided care to individuals within a 50-mile radius of Bismarck, but now provides care for individuals across the state. Individuals without Medicaid can qualify for a sliding scale discount based on income and family size. Fifty-five percent of the clinic's patients receive Medicaid and 15 percent receive some other form of insurance, mostly

<sup>49</sup> Testimony of Kim Kuhlmann, Policy and Partnership Manager in North Dakota for Community HealthCare Association of the Dakotas, Hearing on House Bill No. 1567 (2025), (January 27, 2025).

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> Testimony of Tammy King, Executive Director of Bridging the Dental Gap, Hearing on House Bill No. 1567 (2025), (January 27, 2025).

Medicare supplemental insurance. The remaining 30 percent of patients are at or below 200 percent of the federal poverty guidelines and qualify for a sliding fee scale discount. The clinic provides clinical rotations for 4<sup>th</sup> year dental students through Creighton University in Omaha, Nebraska. Rotations are scheduled for 2 weeks and consist of two students at a time.<sup>54</sup>

- **Spectra Health** is a community health center with locations in Grand Forks and Larimore. The Grand Forks location has a dental clinic that was established in 2007.<sup>55</sup> The location specializes in general dentistry and accepts most insurance, including Medicaid. The SpectraPlan, a sliding fee discount program, is available based on family size and income.<sup>56</sup> Spectra began hosting dental rotations in 2018. The North Dakota Area Health Education Center and the Center for Rural Health have worked with Spectra Health to host dental student rotations with two and four rotations annually.<sup>57</sup>
- **Family HealthCare** has locations in Fargo and Moorhead, Minnesota, and has been providing care for over 30 years. In addition to accepting insurance, Family HealthCare has a financial assistance discount program called Access Plan, which provides a sliding fee discount based on household size and income. Family HealthCare began hosting dental rotations in 2024.<sup>58</sup>

### Children's Health Insurance Program

The state Children's Health Insurance Program provides premium-free health coverage to uninsured children in qualifying families. It is intended to help meet the health care needs of children from working families that earn too much to qualify for full Medicaid coverage but not enough to afford private insurance. Covered services include some dental services.

### Well-Child Visits

Formerly called Health Tracks and also known as early periodic screening diagnosis and treatment benefits, North Dakota Well-Child Visits is a preventative health program for children up to age 20 who are eligible for Medicaid. The program provides initial and periodic health checkups, including dental care, braces, and fluoride varnish.

### Mobile Dental Care Services

North Dakota has some of the most rural areas in the nation. Several providers use mobile units to provide both medical and dental care in rural areas. Mobile units may visit schools to provide preventative dental care services. Use of the mobile units may be limited due to staff availability.

The Ronald McDonald Care Mobile is a mobile dental clinic on wheels which delivers dental care to underserved children ages 0 through 21. The 40-foot mobile dental clinic is owned and operated by Ronald McDonald House Charities of Bismarck and is partnered with Bridging the Dental Gap. The clinic provides oral health education, referrals, and basic dental services, including examinations, x-rays, caries risk assessment, cleanings, fluoride treatments, sealants, fillings pulpotomies, and simple extractions.

### Smiles for Life

Smiles for Life is a free online oral health training curriculum that is designed to enhance the role of primary care clinicians in the promotion of oral health for all age groups. Smiles for Life online training includes nine courses: The Relationship of Oral to Systemic Health, Child Oral Health, Adult Oral Health, Acute Dental Problems, Oral Health and the Pregnant Patient, Caries Risk Assessment, Fluoride Varnish and Counseling, The Oral Examination, and Geriatric Oral Health.

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<sup>54</sup> *Id.*

<sup>55</sup> Spectra Health, Dental Services.

<sup>56</sup> Spectra Health, SpectraPlan.

<sup>57</sup> Connor, et. al, DHHS, Oral Health in North Dakota: Opportunities and need to promote oral health equity, (2022).

<sup>58</sup> Shawnda Schroeder, University of North Dakota, Fact Sheet: Dental Student Rotations at Community Health Centers in North Dakota: Increasing the Dental Workforce and Serving Community, (Sept. 2024).

### **North Dakota Dental Foundation**

The North Dakota Dental Foundation is a Section 501(c)(3) organization established to foster and promote dental health. The foundation offers grant opportunities and in-kind services for programs that focus on making improvements to access to care, education, and workforce. Programs include:

- **Missions of Mercy** - A 2-day, volunteer-staffed clinic providing free dental care to people in need. Community events strive to provide treatment for patients experiencing barriers to oral health care.
- **Kids Without Cavities** - A program to improve access to free dental resources to help parents and children from birth to age 8 build positive brushing habits, prevent long-term decay, and understand the importance of dietary habits.
- **1 Million Brushes** - A program to distribute toothbrushes and dental kits to children in need. The program has provided nearly 250,000 toothbrushes and dental kits since 2017 to local high schools, Head Start programs, and others in need in North Dakota.
- **Smiles for Vets** - A 1-day volunteer event to provide free dental services to North Dakota veterans.

### **Medical-Dental Integration**

Medical-dental integration is an approach to care that integrates and coordinates dental medicine into primary care and behavioral health to support individual and population health. Primary care, health centers, dental teams, and others interested in developing a model of medical-dental integration can work with the DHHS Oral Health Program.

### **Community Water Fluoridation**

Fluoride has been added to public water supplies to bring fluoride levels up to the amount necessary to help prevent tooth decay. Studies indicate water fluoridation continues to help prevent tooth decay by at least 25 percent in children and adults, even with fluoride available from other sources, such as toothpaste. In North Dakota, 96.5 percent of the state population is served by fluoridated community water systems.

### **Seal! ND**

A school-based fluoride varnish and sealant program administered by the DHHS Oral Health Program. Under a standing order of a dentist, dental hygienists visit schools two times each year and provide direct preventive services that include oral health education, dental screenings, dental sealant, and fluoride varnish application.

### **North Dakota Oral Health Surveillance System**

The DHHS Oral Health Program's Oral Health Surveillance System reports on annual oral health workforce data, conducts and reports the results of oral health basic screening surveys among specific subpopulations of the state, reports annual oral health data provided through Medicaid, and annually updates and tracks public-use data on oral health. The program also monitors the burden of oral disease, the use of the oral health care delivery system, and the status of community water fluoridation at a state level.

### **Give Kids a Smile Program**

The Give Kids a Smile Program is a national program by the ADA to provide underserved children with free oral health care. It is designed to provide oral health education and free screening, treatment, and preventive and restorative services to children in need. Providers in the state can use the program to create education, screening, or treatment events.

## North Dakota Medicaid

### Coverage

Untreated oral health conditions can lead to other health complications.<sup>59</sup> Heart disease, clogged arteries, and strokes may be linked to oral inflammation.<sup>60</sup> Gum disease in pregnant women is linked to premature birth and low birth weights.<sup>61</sup> Diabetes is linked to poor dental health.<sup>62</sup> Preventative dental care may negate or minimize these health complications. Medicaid enrolled adults and children who use early preventative dental visits are more likely to receive cleanings and tooth saving procedures, need fewer extractions, and experience better oral health outcomes in the future.<sup>63</sup> Nationally, the average adult Medicaid enrollee with 5 continuous years of preventative care required 43 percent lower costs than individuals who received no preventative care.<sup>64</sup> Additionally, a Medicaid enrollee with no preventative dental visits was eight times more likely to have an emergency room visit for a nontraumatic dental condition, seven times more likely to have oral surgery, and six times more likely to receive opioids for dental prescriptions compared to those who had 5 years of dental prevention visits.<sup>65</sup>

In addition to improving oral health outcomes, preventative care can provide cost-savings. Medicaid expenditures for children are lower for children who receive topical fluoride and sealants before caries develop than other children who do not.<sup>66</sup> In a study of nearly 10,000 Medicaid-enrolled children in Alabama, children without sealants were four times more likely to have subsequent restorative care claims than those who did not.<sup>67</sup> A study in North Carolina found fluoride varnish applied to Medicaid-enrolled children created a 32 percent probability of future cost-savings.<sup>68</sup> In a study across six states, cost-savings from preventative treatment of topical fluoride and sealants varied, but savings ranged from 1 million per year in Mississippi to over 12 million per year in Texas.<sup>69</sup>

In North Dakota, Medicaid dental coverage may have limits or requirements based on patient age or other dental needs, but generally includes two examinations and cleanings per year; crowns (with prior authorization); dentures or partial dentures (with prior authorization); fillings and tooth removals; fluoride varnish (for children only); night guards, splints for oral surgery, anesthesia, and followup visits; root canal treatments (front teeth for adults only); and x-rays.

When filing claims with the Medicaid program, the provider agrees to accept Medicaid payment as payment in full. The provider may not bill the recipient for any part of the bill unless the remittance advice indicates a recipient liability applies to the services, or it is a noncovered service. Medicaid does not enroll nor reimburse services rendered by advanced dental therapists. Dental screening and assessment services are considered inclusive when performed in conjunction with any dental examination or evaluation on the same date of service. Supervision rules apply to dental hygiene services per the supervising dentist's diagnosis and treatment plan by statute.<sup>70</sup> An encounter is billable when dental hygiene only services are performed in accordance with the supervising dentist's diagnosis and treatment plan.

Individuals with a developmental disability may require an extra amount of time and a greater number of personnel to provide routine dental care. Additional compensation may be provided to dentists who

<sup>59</sup> Kelley Griffin, National Conference of State Legislatures, Offering Medicaid Dental Care for Adults Now Can Yield Savings Later, (July 21, 2025).

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> Ilya Okunev, et. al, The impact of underutilization of preventative dental care by adult Medicaid participants, J. Pub. Health Dent., (2021).

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> Ilban Lee, et. al, Health Services Research, Estimating the Cost Savings of Preventative Dental Services Delivered to Medicaid-Enrolled Children in Six Southeastern States, (2017).

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> N.D.C.C. § 43-20-03.

treat individuals who require extra care. However, when the dentist provides a service to an individual with a developmental disability who requires extra time, the dental provider must submit the Request for Extra Time Individuals with Developmental Disabilities form (SFN 64) to DHHS.

Dental Case Management is a program designed for Medicaid members with mental, physical, or behavioral health care needs who are unable to schedule or coordinate complex treatment plans involving one or more medical or dental providers. Dental Case Management may involve addressing appointment compliance barriers, care coordination, motivational interviewing, patient education, and addressing special health care needs. Medicaid allows a limit of two dental case management services per calendar year. Additional services may be submitted through a service authorization request with documentation to support the previous dental case management services provided.

A service authorization must be obtained for certain procedures for Medicaid-eligible recipients before services commence. The department will refuse payment for any covered service or procedure for which a service authorization is required but not obtained. Retroactive service authorizations may be submitted for consideration up to 90 days from the date of service. However, the dental provider must demonstrate good cause for the failure to secure the required service authorization request before the date services were rendered. The submission of a retroactive service authorization request does not guarantee the approval of the service authorization or payment of the claim.

For reimbursement, records must be complete, legible, and include the patient's name and demographic information, medical and dental history including prescription history, progress and treatment notes, diagnostic records and radiographs, treatment plans, and patient complaints and resolutions. Information must be dated and signed by the provider of the service, either handwritten in pen or electronic signatures in particular formats. If a signature is not included, claims will be denied for lack of signature. Appropriate risk factors must be identified, and patient progress, changes, and revision of diagnoses should be documented. The treating dentist ultimately is responsible for the patient chart. Late entries, corrections, or addendums may be added if it bears the current date of the entry and is signed by the person making the addition or change and does not overwrite or destroy the original record.

Medicaid does not reimburse limited or comprehensive orthodontic treatment unless referred by Well-Child Visits (Health Tracks or Early and Periodic Screening, Diagnostic, and Treatment) or the referring dentist. A service authorization is required for all orthodontic transfer cases. Medicaid will prorate the payment if another orthodontist becomes involved with the service due to the member relocating in- or out-of-state while treatment is in progress. This process may include recouping (from the current treating dental office) a prorated percentage representing the uncompleted treatment of the original payment made to the current treating dental office.

## **Billing**

Medicaid sets fee schedules for services and categorizes services using billing codes. There are 12 categories of billing codes, and the inclusion or exclusion of a code does not necessarily mean coverage or reimbursement will occur. Certain services may require service authorizations before beginning treatment. Other services may not be performed on the same day, such as full mouth debridement and comprehensive periodontal evaluations. Some services, like local anesthesia, may not be billed separately. (See [Appendix B](#) for a comparison of the billing codes and fee schedules for certain categories of service.)

Crowns for all Medicaid recipients, except stainless steel crowns, require service authorization. For children under age 21, crowns may be prior approved without endodontic therapy if medically necessary. Temporary crowns are not covered. Permanent crowns on primary (baby) teeth also are not covered. Service authorizations are required if restoration is needed on a functional supernumerary (extra) tooth. Radiographs and documentation must be submitted with the authorization request. Root canal therapy must be medically necessary and the most cost-effective treatment option for the patient. Supporting documentation may be required when multiple procedures are performed on the same day. Fixed prosthodontics require a service authorization for Medicaid recipients under age 21 and are not covered

for adults over age 21. Maxillofacial prosthetics also require a service authorization. Dental implants are a noncovered service, but implant supported removable dentures will be considered when documentation, which must include radiographs, supports medical necessity and the dental implants are existing. Implants, locator parts, and bone graphs, are not covered by Medicaid. If dental implants require removal, Medicaid will not cover the cost of replacement. Dental extractions that are attempted but are unable to be completed must be billed under a specific billing code, which requires a retroactive service authorization. Medicaid considers an extraction a once per lifetime per tooth procedure and all extractions must be medically necessary. Extraction of asymptomatic teeth are not covered.

The North Dakota Medicaid Automated Voice Response System permits enrolled providers to access information using a telephone. The Claims Call Center is available during regular business hours Monday through Friday. Available options include member inquiries, payment inquiries, service authorization inquiries, and claims status. Providers may use the system to access information about eligibility, coordinated service programs, service authorizations, remittance advice payment information, and claim information based upon the member number.

### **FEDERAL LAW**

The Health Resources and Services Administration provides grant funding to states for the State Loan Repayment Program (SLRP). States may develop their own loan repayment initiatives that work for their residents. The program supports primary medical, mental and behavioral health, and dental clinicians. These providers receive awards through SLRP-funded programs and agree to work in areas with provider shortages. In exchange for their service, the clinicians receive relief from their student debt.

The Federal Office of Rural Health Policy administers grant programs designed to build health care capacity at both the local and state levels. It also coordinates activities related to rural health care within DHHS and analyzes the possible effects of policy on residents of rural communities. The Center for Rural Health is also designated as the North Dakota State Office of Rural Health, a federal-state partnership that helps rural communities build their health care services through collaborations and initiatives with partners across the state.

### **ADJACENT STATES**

Adjacent states have a variety of programs and incentives for practice in underserved communities. Some services are shared across states and amongst tribes. For example, the Rosebud Service Unit Dental clinic in Aberdeen, South Dakota serves North Dakota, South Dakota, Iowa, and Nebraska.

#### **South Dakota**

The South Dakota SLRP is for primary care, mental health, and dental health providers practicing in rural and urban health professional shortage areas in South Dakota. The purpose of the South Dakota SLRP is to improve access to care by assisting underserved communities with recruitment and retention of health care professionals. The South Dakota SLRP provides funds for repayment of qualifying educational loans of up to \$30,000 annually for full-time dental, mental health, and primary care providers, and up to \$15,000 annually for half-time providers. In return for the loan repayment award, participants must complete a 2-year service obligation in eligible practice sites located in federally designated health professional shortage areas.

The South Dakota Recruitment Assistance Program provides incentive payments to dentists who enter a contract with the South Dakota Department of Health to provide services in an eligible community for at least 3 consecutive years. The maximum amount of the incentive payment for a qualifying physician or dentist is \$256,204.

In the private sector, loan repayment programs related to Medicaid also are available in South Dakota. Delta Dental of South Dakota administers the dental portion of the South Dakota Medicaid benefit through a contract with the South Dakota Department of Social Services. The Delta Dental of South Dakota Foundation was established in 1996 as a supporting charity to improve oral health and access to care in South Dakota. The foundation's primary focus is underserved children. Additional efforts support a robust

dental workforce in South Dakota and provide oral health education to the public. The foundation is most widely known for its mobile program, which provides preventive, diagnostic, and restorative care to children across the state, and dental hygienists and community health workers based on the state's Native American reservations. The foundation also offers a Loan Repayment for Service Program for dentists who agree to serve a selected percentage of Medicaid-insured patients in their practice. Loan balances must be part of the original student loan and not combined with other personal loans. Total loan repayments can range from \$75,000 to \$125,000, depending on the level of service commitment made by the dentist applicant. Loan recipients providing 1,000 or more Medicaid patient visits per year are eligible to receive an additional \$5,000 per year toward their loans.

South Dakota also has programs to help underserved populations. The South Dakota Donated Dental Services (SDDS) program was established in 1998 to help individuals who are disabled, elderly, or medically compromised. A dentist volunteering for SDDS donates services in the dentist's office. Dental laboratories also contribute services. Since the SDDS program was created, South Dakota dentists and dental labs have donated more than \$7 million of free, comprehensive dental treatment to those who cannot afford treatment due to financial limitations associated with their age or disabilities.

### Minnesota

The Minnesota Office of Rural Health and Primary Care (ORHPC) grants loan forgiveness to various health care professionals serving in high-need areas. Program eligibility requirements and benefits are established by state law.<sup>71</sup> This program is offered to dental students, residents, and licensed dentists who plan to serve or are serving at least 25 percent of their annual patient encounters to state public program enrollees or patients receiving a sliding fee schedule in Minnesota.

The Dentist Loan Forgiveness Program provides funds for repayment of qualified educational loans. Qualified educational loans include government, commercial, and foundation loans for actual costs paid for tuition, reasonable education, and living expenses related to the past graduate or undergraduate education of the dentist. Credit card debt or loans from family members and Parent PLUS loans do not qualify. The program requires a dentist to serve a minimum of 3 years, with a maximum of 4 years. Participants are required to practice for at least 30 hours per week, for at least 45 weeks per year. The ORHPC will make an annual payment to the participant in the amount of \$41,000, not to exceed \$164,000 total for the maximum 4-year period or the balance of the designated loan, whichever is less, subject to the availability of funds appropriated by the Minnesota Legislature for the program. Participants must live and work in Minnesota. Annually, ORHPC requires participants to verify continued employment and submit documentation that they have applied the loan forgiveness funds to their designated educational loans. This information will be verified before each annual disbursement. If a participant does not fulfill the minimum obligation of 3 years, or if the participant cannot verify that program funds were spent toward approved student loans, the participant will be required to repay the total amount ORHPC paid plus interest, at a rate established by statute.<sup>72</sup>

The ORHPC also provides for Rural Dental Therapist/Advanced Dental Therapist Loan Forgiveness. This program is offered to final year dental therapist or advanced dental therapist students, or licensed therapist or advanced dental therapist who plan to practice or are practicing in a designated rural area. Participants are required to practice for at least 30 hours per week, for at least 45 weeks per year, for a minimum of 3 years in a designated rural area. A designated rural area is defined by statute<sup>73</sup> as a statutory and home rule charter city or township that is outside the seven-county metropolitan area,<sup>74</sup> excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud. Participants are eligible to participate for up to 4 years in the program during which they serve in a designated rural area. The ORHPC will make an annual payment to the participant in the amount of up to \$15,000, not to exceed \$60,000 total for the maximum 4-year period or the balance of the designated loan, whichever is less, subject to fund availability.

<sup>71</sup> Minn. Stat. § 144.1501 (2025).

<sup>72</sup> Minn. Stat. § 270C.40 (2025).

<sup>73</sup> Minn. Stat. § 144.1501 (2025).

<sup>74</sup> Minn. Stat. § 473.121 (2025).

**Montana**

Montana has a similar loan program. The Montana SLRP is an incentive program for primary care providers working at approved National Health Service Corps or Montana SLRP sites in a health professional shortage area. The program is funded by the federal Health Resources and Services Administration and matched with state and community funds. Providers may receive up to \$25,000 per year to repay approved educational loan debt in exchange for a minimum of 2 years of full-time service at an approved practice site. Clinicians providing less than full-time service may be eligible for a part-time award. Award recipients may apply for a subsequent award for a maximum benefit of 4 years.

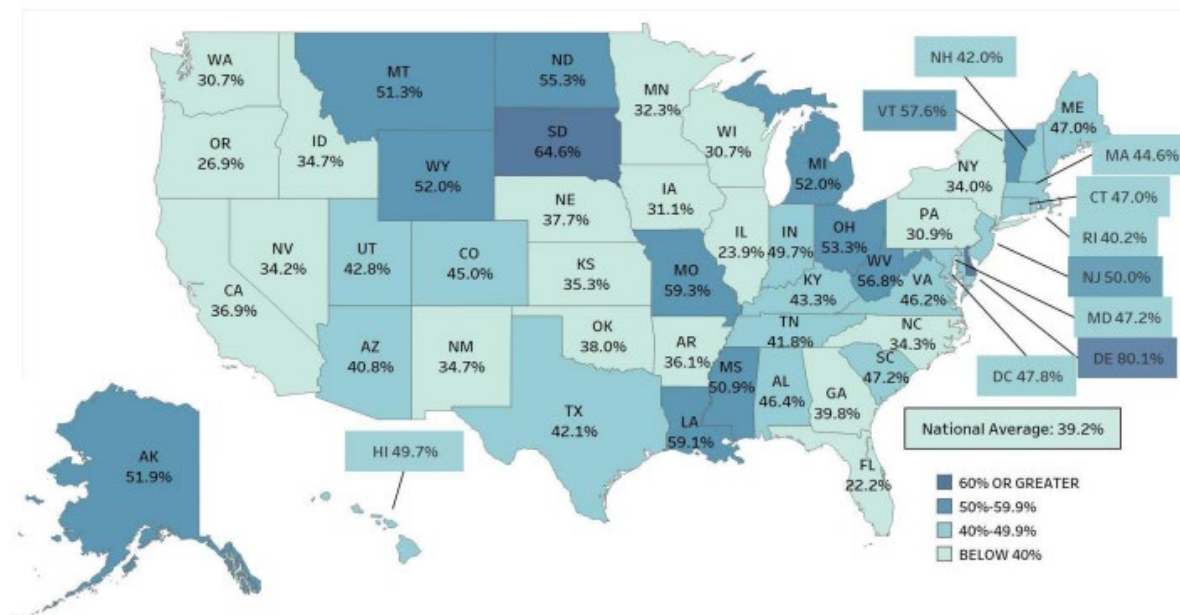
**OTHER STATES**

In states with fewer dentists in the population and low provider participation in Medicaid, relatively small increases in Medicaid reimbursement rates may yield large effects.<sup>75</sup> States with above average numbers of dentists also may see benefits from increasing reimbursement rates, whereas states with fewer dentists and high percentages already participating in Medicaid may not see any benefit from increasing reimbursement rates. Once children have access to the delivery system, clinicians tend to provide prevention services regardless of the reimbursement rate.<sup>76</sup>

Several states have increased Medicaid fees. In 2008, Connecticut increased its fee schedule for children's dental services to 70<sup>th</sup> percentile of dental market fees of 3 years prior. Studies in Maryland and Texas, after increasing Medicaid dental fees closer to private insurance fee levels, showed a positive impact on dental care utilization and unmet dental needs among Medicaid-eligible children.

North Dakota has one of the highest Medicaid reimbursement rates nationally. During the dental service study under Senate Concurrent Resolution No. 4004 (2015), the committee learned Medicaid fee-for-service reimbursement in North Dakota as a percentage of private dental benefit plan charges for child dental services was 68 percent, compared to 49 percent nationally. The committee learned North Dakota had one of the highest Medicaid reimbursement rates in the nation, but only 8 percent of the dental practices billing Medicaid in 2013 provided care to a majority (52 percent) of the Medicaid enrollees accessing dental services. North Dakota continues to have one of the highest reimbursement rates nationally, both in comparison to average charges from dental providers and as a percentage of average dental insurance payment rates.

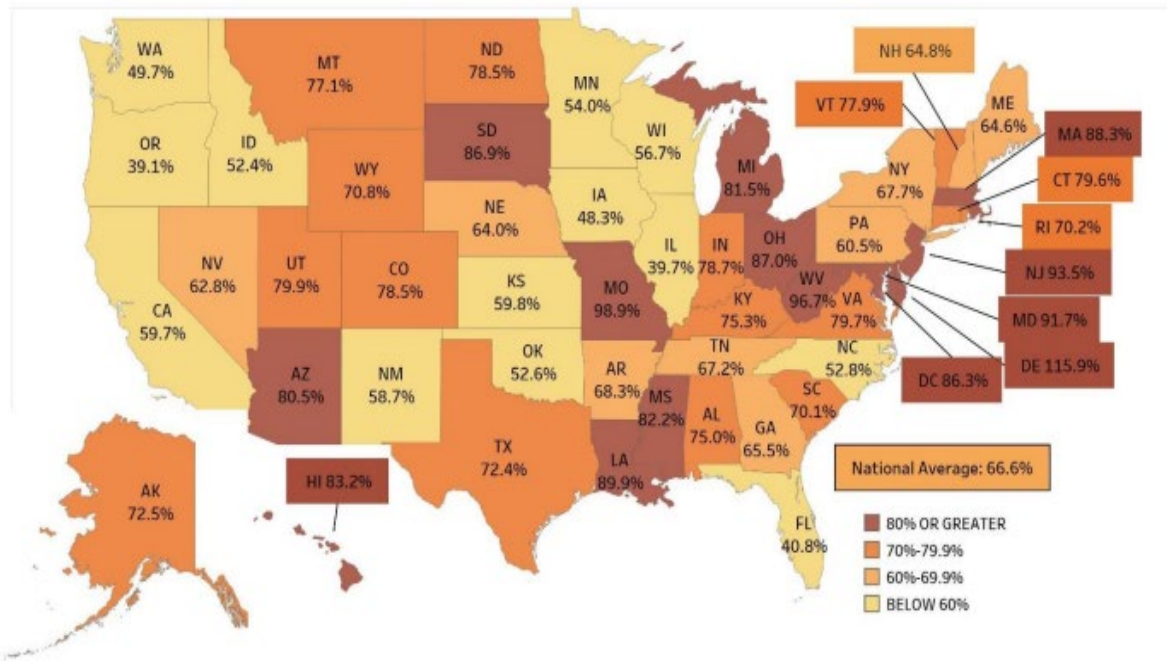
Medicaid FFS Reimbursement as a Percent of Average Dentist Charges, Child Dental Services, 2024



<sup>75</sup> Chalmers NI, Compton RD, Children's Access to Dental Care Affected by Reimbursement Rates, Dentist Density, and Dentist Participation in Medicaid, Am. J. Pub. Health., (Oct. 2017).

<sup>76</sup> *Id.*

Medicaid FFS Reimbursement as a Percent of Average Private Dental Insurance Payment Rates  
Child Dental Services, 2024



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### 2025 LEGISLATION

House Bill No. 1471 (2025) prohibits a preferred provider arrangement from including restrictions on methods of payment from a dental insurer or third-party payor vendor to the dental provider in which the only acceptable method is a credit card payment. The bill also requires a dental insurer or contracted vendor initiating or changing payments to a dental provider using electronic funds transfer payments to notify the provider if fees are associated with a payment method, advise of the available methods of payment and provide instructions on selecting an alternative payment method that does not impose fees, and notify the provider if the insurer is sharing a part of the profit of the fee charged by the credit card company to pay the claim. The bill restricts a dental provider or contracted vendor initiating or changing payments to a dental provider through the automated clearinghouse network from charging a fee solely to transmit the payment to the provider unless the provider has consented to the fee.

House Bill No. 1481 (2025) requires a dental insurer to file a dental loss ratio report with the Insurance Commissioner by April 30 of each year and requires the Commissioner to provide the information received in the dental loss ratio annual reports on the Insurance Department's website in a manner that allows the public to compare dental loss ratios among dental insurers by market type. The bill authorizes the Commissioner to deem a proposed plan rate of a dental insurer to be excessive and disapprove the rate if the dental insurer files a rate change and the administrative expense component increases from the previous year's rate filing by more than 4 percent, reported contribution to surplus exceeds 2 percent of total revenue, or the dental loss ratio for the plan is less than 75 percent. The bill requires a dental insurer with a dental benefit plan that has an annual dental loss ratio of less than 75 percent to refund the excess premium to covered individuals and groups.

Senate Bill No. 2375 (2025) provides dental providers and insurers may voluntarily enter joint non-fee-related negotiations as authorized by the Attorney General.

Senate Bill No. 2377 (2025) prohibits a preferred provider arrangement from restricting a covered person from receiving or paying for additional dental care services that were denied by the covered

<sup>77</sup> ADA, Health Policy Institute, Medicaid Fee-For-Service Reimbursement as a Percentage of Dentist Charges and Private Dental Insurance Reimbursement.

person's dental plan. The bill also prevents a provider from charging a covered person receiving or paying for additional services from being charged a rate in excess of the preferred provider arrangement's contracted rate, unless the rate was disclosed to the covered person before receiving dental care.

Senate Bill No. 2217 (2025) permits a volunteer license to be issued to a dentist or dental hygienist, revises the dentist licensure process for an out-of-state dentist, and permits a dental hygienist to administer a local anesthetic to a minor. The bill also clarifies grounds for disciplinary actions for dental hygienists and dentists, and permits the State Board of Dental Examiners to establish an alternative to discipline program.

### **PRIOR STUDIES**

Section 1 of House Bill No. 1454 (2013) provided for a study of how to improve access to dental services and ways to address dental service provider shortages. The study was assigned to the 2013-14 interim Health Services Committee. The committee reviewed previous studies and reports relating to access to dental services and ways to address dental service provider shortages, including a report received by the 2007-08 interim Human Services Committee on the status of medical assistance recipients' access to dental services. Medicaid dental-related expenditures totaled \$12.3 million for the 2005-07 biennium and \$14.5 million for the 2007-09 biennium. During the 2009-11 biennium, dental expenditures under Medicaid totaled \$23.5 million, a 62 percent increase from 2007-09 biennium expenditures. During the 2011-13 biennium and 2013-15 biennium, funding appropriated for Medicaid dental services totaled \$24 million and \$28.7 million, respectively.

The committee also reviewed state programs relating to dental care and received information regarding dental service provider programs. The committee reviewed North Dakota State College of Science dental programs and options to expand those programs. The committee received information regarding an environmental scan and contextual assessment of the oral health of North Dakota's residents completed in 2012 by the Center for Health Workforce Studies at the School of Public Health, University at Albany, New York. The report indicated oral health professionals are located mostly in urban areas of the state, and several counties are without a practicing dentist. A shortage of dentists willing to accept Medicaid patients resulted in a small number of dentists in the state treating the majority of children on Medicaid and limiting the availability of oral health services even in areas of the state where there was an adequate supply of dental professionals.

The committee recommended Senate Concurrent Resolution No. 4004 (2015), directing the Legislative Management to continue studying dental services in the state, including the effectiveness of case management services and the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state. The 2015 Legislative Assembly adopted the resolution and the study was assigned to the 2015-16 interim Health Services Committee.

The Health Services Committee concluded barriers to accessing oral health care include poverty, geography, workforce, an insufficient number of providers that accept Medicaid patients, lack of oral health education, language, cultural barriers, fear, and age, especially those in nursing homes. A shortage of dentists willing to accept Medicaid patients has resulted in a small number of dentists treating the majority of children on Medicaid and limiting the availability of oral health services, including in areas of the state where there was an adequate supply of dental professionals. The committee learned the North Dakota Dental Association supported Medicaid reimbursement for case management billing codes recently established nationally. The association also suggested current statutes and rules be amended to specifically allow teledentistry and the virtual dental home in outreach settings. The committee also learned limited reimbursement for more complex procedures makes those procedures less profitable and unless federally qualified health centers have several private pay or insured patients, the centers provide primarily basic procedures.

The committee recommended House Bill No. 1035 (2017) to change the Dental Loan Repayment Program to provide for a prorated payback of loan repayment funds if a dentist breaches the loan repayment contract.

### **STUDY APPROACH**

In conducting the study, the committee may wish to receive testimony from:

- Private insurance providers, regarding reimbursement rates;
- Dental providers, regarding concerns associated with Medicaid regulations and reimbursement rates, provider and staff retention, actual costs, and coverage levels of private insurance and Medicaid;
- The State Board of Dental Examiners, regarding dentists, specialists, and staff;
- DHHS, regarding the oral health of Native American children, low-income children, and persons with disabilities, and Medicaid policies and procedures including impediments to enrollment, length of credentialing and recredentialing, reasons for provider termination, prior authorizations, appeals, and payments;
- Tribal nations and dental and medical providers who provide dental services on reservations;
- The Society of American Indian Dentists, regarding Native American dental providers;
- Stakeholder groups and disability advocates, regarding access to receiving dental services; and
- The National Conference of State Legislatures, regarding what other states have done to address dental expenditures and staffing shortages.

ATTACH:2