

**Health Services Committee  
Chairman: Senator Judy Lee  
Presented by Dr. Murray Greer  
October 30, 2013**

RE: Interim Study Hearing – HB 1454

Good morning Chairman Lee and members of the Health Services Committee. My name is Murray Greer and I am the President of the North Dakota Dental Association (NDDA). I have a general dental practice in Minot where I have practiced for the past twenty six years.

Recently, there has been some concern that there is a shortage of dentists in our state. I am here today representing the North Dakota Dental Association and over 330 members. We do not have a dentist shortage. There may be a maldistribution of dentists in our state, but we do not believe there is a shortage now or will be one in the foreseeable future.

Currently, we have 400 dentists licensed in our state which has a total population of around 700,000 (see attachment A – County by County dentist numbers). The ratio of dentists to population is approximately one dentist per 1,750 residents. South Dakota has a ratio of one dentist per 1,890 residents, Iowa has a ratio of one dentist per 1,825 residents, and Minnesota has a ratio of one dentist per 1,630 residents. Studies show the national ratio in the US is one dentist per 1,612 residents. During the 2011 Denta Quest Study, North Dakota's dentist/population was said to be "adequate". North Dakota has had a steady increase in the number of dentists in the past few years. The Board of Dental Examiners (BODE) issued 34 licenses in 2013 and 37 in 2012. Before 2012 the number of new dentists licensed was in the 20s. Dentists are choosing to practice in our state because of the growing economy. According to the Health Resources and Services Administration (HRSA) study from January 2013 of Health Professional Shortage Areas (HPSA), North Dakota was only 7 dentists short statewide. It is likely that ND no longer has a perceived shortage because of the newly licensed dentists.

We have provided a map today (see Attachment B) which shows where dental offices are located throughout our state. Keep in mind, the chart shows dental practices, not dentists. Some dentists operate satellite clinics to bring dentistry closer to their patients. This map shows that with perhaps a few exceptions, the delivery of dental care is available to nearly all ND residents within 25 miles or less of their home. In a rural state like North Dakota, for the most part we choose how far we live from work and how far we travel for various amenities such as shopping, entertainment, and other services--including healthcare.

The NDDA believes the dental loan repayment programs that help place dentists in rural areas of our state and promote dentists to work in our safety net clinics have been very successful. More programs of this type and keeping these current programs funded are keys to improving access to dental care in rural areas. Our safety net clinics see a large

portion of Medicaid patients, so it would make sense to expand these type clinics and continue to support them.

There are numerous barriers that negatively impact the oral health of North Dakotans, but a dentist or hygienist workforce shortage is not one of them. Expanding the duties of dental assistants and hygienists which would improve the efficiency of dentists are now being considered by the BODE. Education and prevention are still key issues to help reduce the need for restorative dentistry. Please review the testimony presented at your last meeting from Dr. Alison Fallgatter and Dr. Brent Holman. These testimonies provide essential information from the dental perspective that I have tried not to duplicate today.

To improve access to the Medicaid population provider reimbursement needs to be improved. I understand that will be discussed at a future meeting of this committee, but it is the linchpin to the improvement of access along with creating a community dental health coordinator. This coordinator would be a person from the community who would help navigate the Medicaid patient and ensure compliance with appointments and provide oral health education. We can not drill and fill our way out of this problem. Education and prevention are the keys to turning the tide toward this population.

Attachment C is provided for your review and is part of a report from the American Dental Association that discusses the HPSA methodology regarding the supply of dentists in the US and ND, age breakdown of dentists in the US & ND and the busyness of dentists and leveraging the unused capacity available in the dental care system.

Thank you, I would be happy to answer any questions.

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### Dentists and Population by County

Total Licensed Dentists: 400  
Total Population: 700,000  
Average Population per dentist 1750

<b>County</b>	<b>Dentists</b>	<b>Total Population</b>
<a href="#">Cass</a>	121	149,778
<a href="#">Burleigh</a>	69	81,308
<a href="#">Grand Forks</a>	39	66,861
<a href="#">Ward</a>	38	61,675
<a href="#">Morton</a>	9	27,471
<a href="#">Stark</a>	10	24,199
<a href="#">Stutsman</a>	12	21,100
<a href="#">Williams</a>	20	22,398
<a href="#">Richland</a>	8	16,888
<a href="#">Rolette</a>	1 + IHS	13,973
<a href="#">Walsh</a>	8	11,362
<a href="#">Ramsey</a>	7	11,267
<a href="#">Barnes</a>	5	10,955
<a href="#">McLean</a>	3	8,962
<a href="#">Mercer</a>	5	8,234
<a href="#">Traill</a>	2	8,178
<a href="#">Pembina</a>	1	7,906
<a href="#">Benson</a>	0 - IHS	6,997
<a href="#">Bottineau</a>	2	6,650
<a href="#">Mountrail</a>	5	7,673
<a href="#">McKenzie</a>	3	6,360
<a href="#">Ransom</a>	3	5,457

<u>McHenry</u>	1		5,429
<u>Dickey</u>	2		5,398
<u>Wells</u>	3		4,432
<u>Sioux</u>	0 - IHS		4,282
<u>LaMoure</u>	0		4,262
<u>Pierce</u>	2		4,221
<u>Sargent</u>	1		4,198
<u>Cavalier</u>	1		4,099
<u>Emmons</u>	1		3,645
<u>Foster</u>	2		3,583
<u>Dunn</u>	0		3,536
<u>Nelson</u>	0		3,289
<u>Bowman</u>	3		3,151
<u>McIntosh</u>	1		2,956
<u>Grant</u>	1		2,588
<u>Hettinger</u>	1		2,564
<u>Eddy</u>	3		2,502
<u>Griggs</u>	1		2,456
<u>Kidder</u>	0		2,453
<u>Renville</u>	1		2,425
<u>Towner</u>	0		2,417
<u>Adams</u>	1		2,332
<u>Divide</u>	0 -Satellite		2,092
<u>Logan</u>	0		1,999
<u>Burke</u>	0 -Satellite		1,947
<u>Steele</u>	0		1,943
<u>Oliver</u>	1		1,808
<u>Golden Valley</u>	0 -Satellite		1,691
<u>Sheridan</u>	0		1,408
<u>Billings</u>	0		829
<u>Slope</u>	0		713

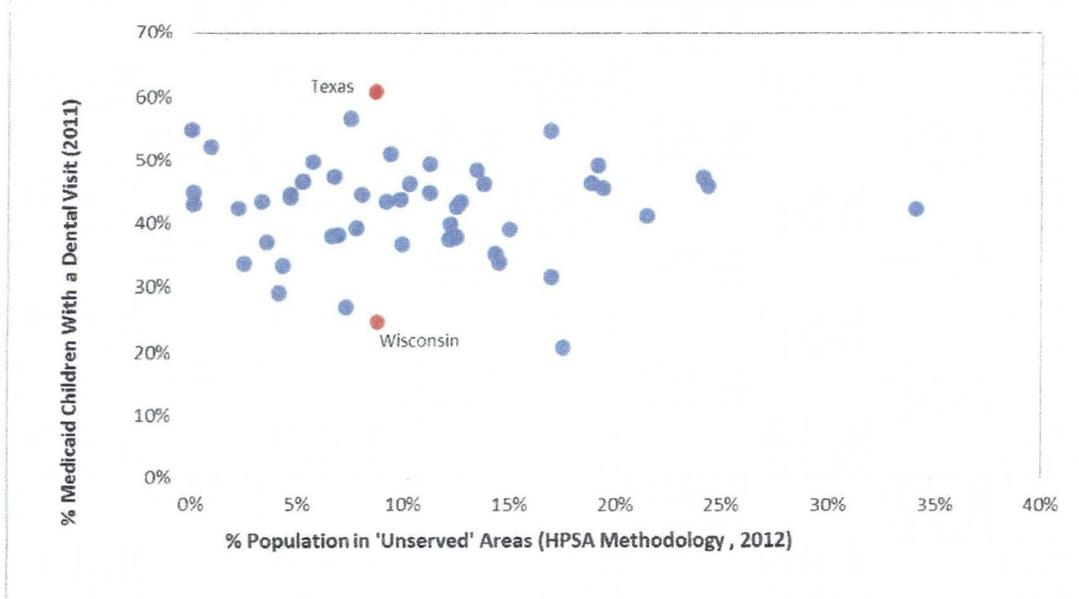
Counties w/o private dentists	Population	Nearest office
Billings	829	Dickinson/Beach
Sheridan	1408	Harvey/Turtle Lake
Steele	1943	Cooperstown
Logan	1999	Wishek/Linton
Kidder	2453	Bismarck/Jamestown
Nelson	3289	Devils Lake
Dunn	3443	Dickinson
La Moure	4262	Jamestown/Oakes
Slope	713	Bowman/Dickinson
Benson	6997	Harvey/Devils Lake
Towner	2417	Devils Lake/Langdon
Sioux	4282	IHS Standing Rock

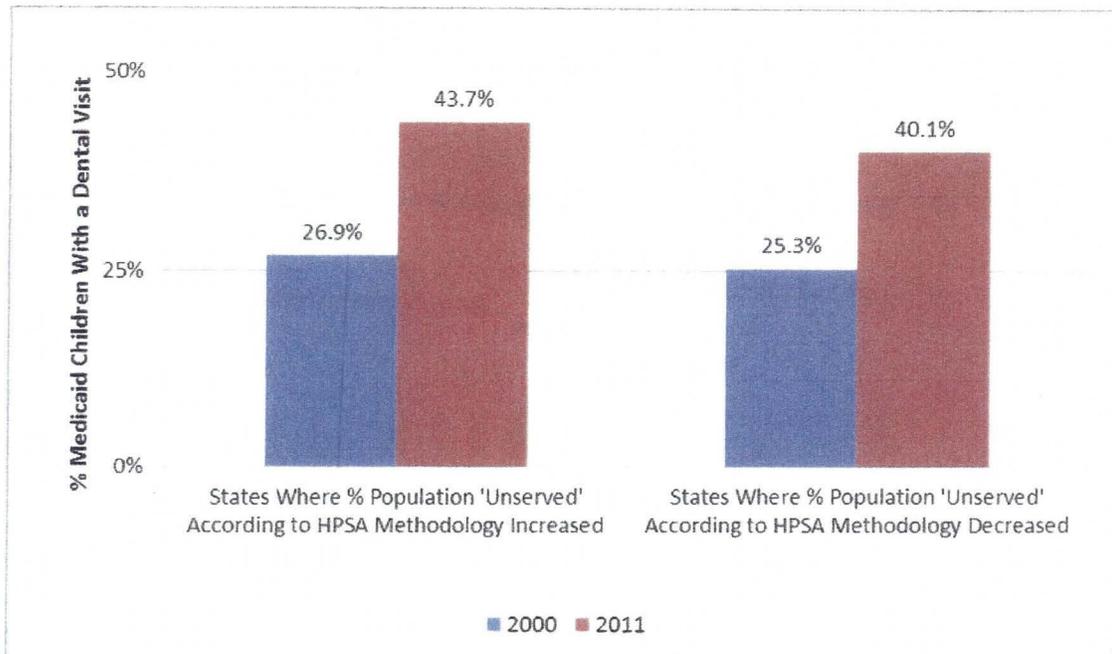
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**The commonly used HPSA methodology is seriously flawed as a measure of dentist shortages and access to dental care.**

- According to HRSA, there are 30 million people who are 'unserved' by a dentist and, therefore, lacking access to dental care. This measure is based on, among other things, population to provider ratio thresholds. HRSA estimates that an additional 6,300 dentists are needed in the United States to improve access to dental care. (HRSA data).
- The HRSA shortage area methodology should not be used as a measure of access to dental care for several reasons.
- *Conceptually*, provider to population ratios are too simplistic. They do not capture rational service areas and instead rely on county or other political boundaries. They do not capture effective demand for services, which in the case of dental care is influenced heavily by insurance coverage, education levels, and household income. The thresholds are also fairly arbitrary.
- *Empirically*, there is absolutely no relationship between the percent of the population living in unserved areas and access to dental care for Medicaid children. Wisconsin and Texas both have about 9% of the population classified as unserved for dental care according to the HPSA method. However, 61% of Medicaid children in Texas had a dental visit in 2011 (the highest of any state) while in Wisconsin the rate was only 25% (one of the lowest of any state). Mississippi has the highest percent of the population without access to a dentist according to the HPSA methodology but it ranks well above average (17<sup>th</sup>) in terms of improvements in access to dental care for Medicaid children (43% in 2011 versus 22% in 2000).
- Underscoring the potentially misleading conclusions from the HPSA methodology, states that decreased their dental shortages had no better outcomes than those that did not. The opposite is true, in fact – dental care utilization went up a bit faster in states that experienced an increase in dental shortages according to the HPSA definition.



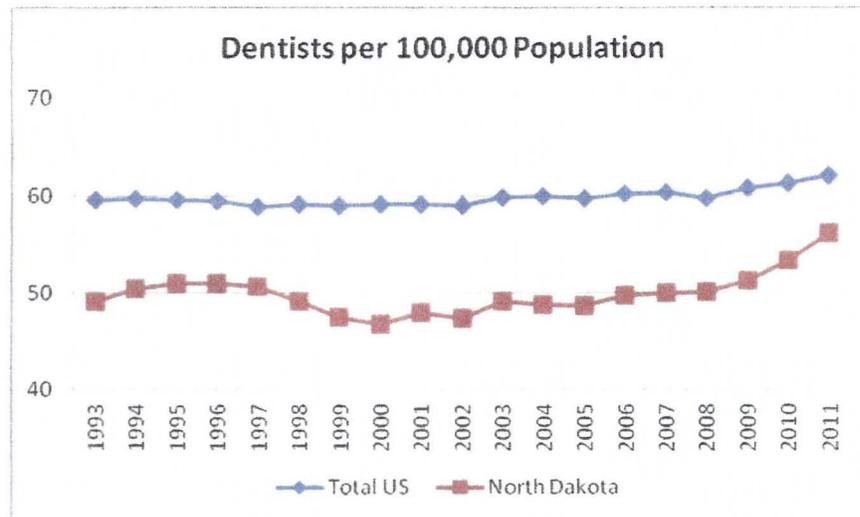


**Even according to the flawed HPSA methodology, the percent of the population living in underserved areas in the U.S. is declining.**

- In 2012, only 9.4% of the US population was designated as living in underserved areas in terms of access to dental care. This is down from 10.1% in 2000. (HRSA data)
- In North Dakota in 2012, 7.2% lived in an underserved dental shortage area.
- There are more people designated as underserved for medical care than dental care. In 2012, 10.6% of the population lived in areas designated as medically underserved.
- Comparing 2012 to 2010, the majority of states (31) managed to reduce the percent of the population designated as underserved for dental care.

**The supply of dentists is increasing both in the U.S. and in North Dakota.**

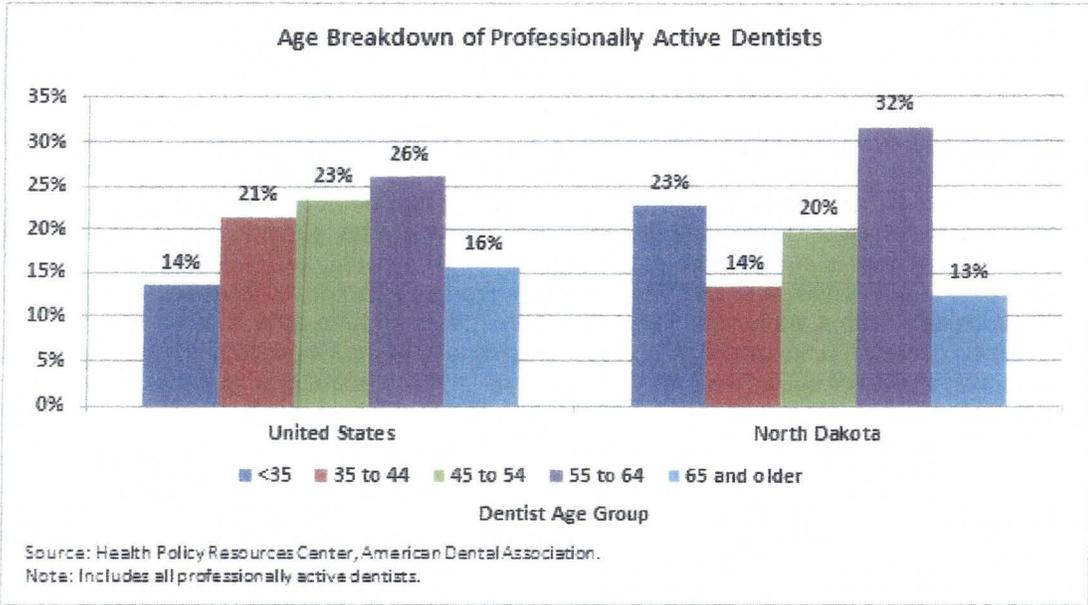
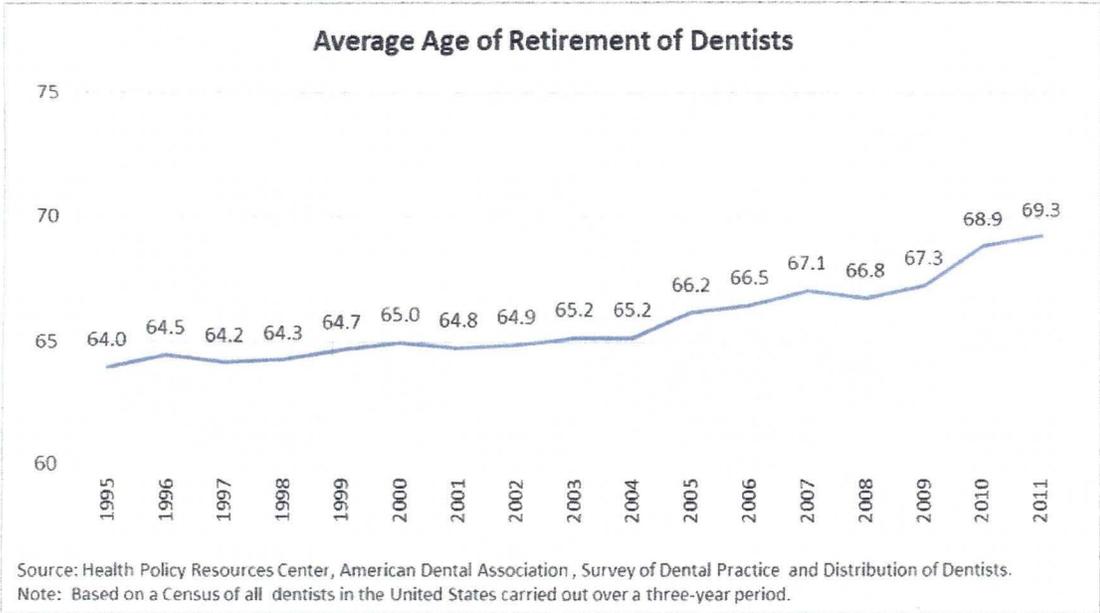
- Recent years have brought an uptick in the number of professionally active dentists per capita in most states. In fact, between 2000 and 2011, only 7 states experienced a decrease in the number of professionally active dentists per capita.
- In North Dakota, the number of professionally active dentists increased from 46.7 per 100,000 population in 2000 to 56.2 in 2011. This is a reversal of the slow decline in preceding years.



Source: Health Policy Resources Center, American Dental Association; Census Bureau. Note: Includes all dentists who are professionally active.

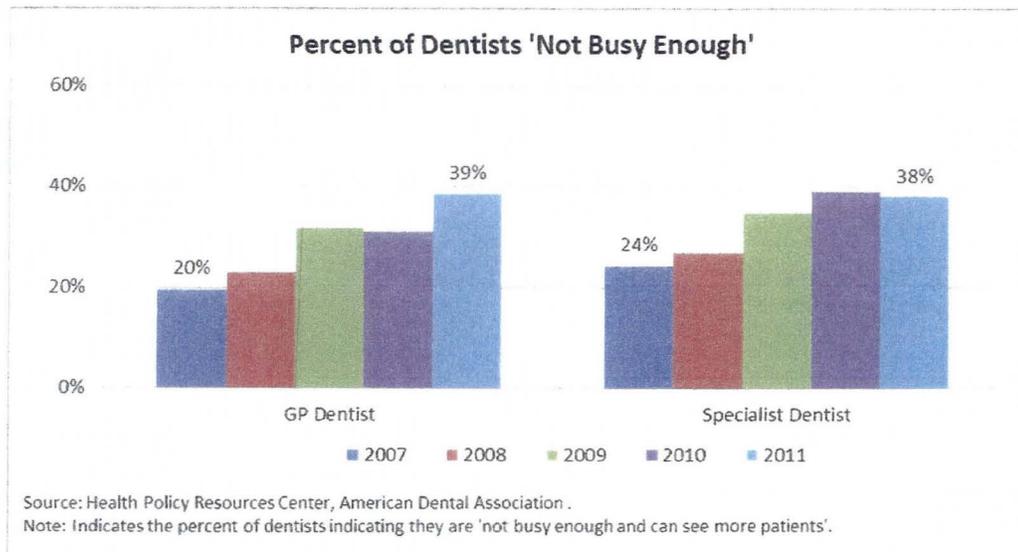
**The increase in the supply of dentists is being driven by two main factors, but more analysis is needed.**

- There has been a substantial increase in dental school enrolment and graduates in the past few years. This trend will continue as dental school capacity continues to expand rapidly.
- There has been a steady, smooth increase in the average retirement age of dentists. According to the most recent data, the average age of retirement for dentists in 2001 was 64.8 and has increased to 69.3 in 2011. This increase has been steady and does not appear to be related to cyclical fluctuations in the economy.
- Compared to the age distribution of dentists across the entire country, North Dakota has a bi-modal age distribution. Relative to the national average, North Dakota has more dentists under age 35 and more dentists ages 55 to 64.



**There is substantial unused capacity within the dental care delivery system.**

- In 2011, almost 2 out of 5 dentists indicated they are 'not busy enough and can see more patients' according to the nationally representative Survey of Dental Practice administered by the ADA Health Policy Resources Center.
- There has been a significant increase in the level of 'non-busyness' in the past few years in the U.S. among both GP and specialist dentists.



**The unused capacity in the dental care system can be leveraged with appropriate policies, and many states provide success stories.**

In [Maryland](#), the state with the largest increase in dental care utilization among Medicaid children, the state government used a multi-pronged strategy. This included using a single vendor dental provider program, carving out Medicaid dental services, streamlining administrative processes, increasing dental reimbursement rates, establishing a public health level dental hygienist to provide services without a dentist present, systematically providing dental screenings in public schools, and establishing a dental home for children. The percent of Medicaid children with a dental visit increased from 11% in 2000 to 50% in 2011. Over this same period of remarkable progress in access to dental care for Medicaid children, the supply of dentists actually decreased from 75.3 dentists per 100,000 population to 74.7. This demonstrates that significant progress is possible with the existing dental workforce if policies are put in place that improve the delivery system and leverage existing capacity.

In both [Virginia](#) and [Connecticut](#) the evidence is very clear that significant gains in access to dental care for vulnerable children are possible with targeted reforms that address bottlenecks in the delivery system. Both states implemented reforms that streamlined administrative processes and increased dental reimbursement rates, leading to increased utilization among children eligible for Medicaid. Virginia ranked fourth in terms of progress. The percent of Medicaid children with a dental visit increasing from 19% in 2000 to 45% in 2011. Connecticut was also well above the national average in terms of gains, with utilization increasing from 31% in 2000 to 57% in 2011. This is even more remarkable given that Connecticut started at a utilization rate that was well above the national average.

One of the main bottlenecks is low reimbursement for dental care services within Medicaid programs. This is one of the key factors contributing to [low dentists participation](#). This issue is not unique to dental care. Medicaid reimbursement levels have historically been low for medical services as well. However, the Affordable Care Act explicitly addresses the bottleneck of

medical payment issue by mandating increases in Medicaid fees to a level on par with Medicare. As a result, Medicaid reimbursement rates to many primary care physicians are expected to increase by about 73%. Despite the fact that pediatric dental care is one of ten essential health benefits mandated by the ACA, no such reimbursement adjustment has been mandated for dental care services within Medicaid.

In North Dakota, Medicaid fees for dental services are approximately 61.6% of commercial fees.