Dental Therapy: Opponents' arguments don't hold up

Opponents SAY: Dental therapists have not increased access to care where they are working

Facts:

- A 2014 report released by Minnesota dental board and health department reported the following about clinics that were employing dental therapists:[i]
    - Over 1.5 years, dental therapists working in 14 clinics saw more than 6,300 new patients; more than 80% of these new patients were publicly insured;
    - Some patients had shorter travel times and nearly 1/3 saw decreased wait times;
- Minnesota dental therapists provided ***more than 175,000 patient visits*** since 2017.[ii]
- Dental Health Aide Therapists (DHATs) were launched in Alaska to provide regular care to Alaska Natives living in remote villages that dentists were visiting only sporadically. DHATs have provided regular access to dental care to more than 45,000 Alaska Natives in 80 communities.[iii]

Opponents SAY: DTs in Minnesota are not improving children's access to care, as evidenced by the declining percent of Medicaid children receiving dental care in Minnesota

Facts:

- Between 2011 and 2016, the actual number of Medicaid children in Minnesota receiving dental care increased by more than 40,000, even though the percentage receiving care did not increase. This is because the state's overall child enrollment in Medicaid spiked.[iv]
- Still, the number of DTs in Minnesota is tiny compared to the dentist population – about 90 versus over 4,000.[v] Such a small cohort "cannot yet produce statistically valid changes in statewide or regional access," to quote a letter from Minnesota Health Department officials to Wisconsin legislators.[vi] But the evidence is clear that DTs are making a difference in the Minnesota communities where they work.

Opponents SAY: In Minnesota dental therapists have been concentrated in the Twin Cities instead of the rural areas they are intended to serve.

Facts:

- In Minnesota, just under 30% of the state's dental shortage areas– home to more than 260,000 Minnesotans -- are in the Twin Cities area.[vii] Dental therapists in these urban areas are fulfilling their mission of treating low-income and underserved populations.
- Dental therapists are geographically distributed in proportion to the state's population:
    - 55% of Minnesotans live in the Twin Cities metro area, where 59% of working dental therapists are employed;
    - 45% of Minnesotans live outside the Metro area, where 41% of working dental therapists are employed.[viii]

Opponents SAY: Wisconsin doesn't need dental therapists. Dentists can solve the access problem if the state only increased Medicaid reimbursement rates

Facts:

- Increasing Medicaid payment rates does nothing for the 1.2 million Wisconsin residents who live in dentist shortage areas, where they already have trouble finding a dentist.

- Raising Medicaid reimbursement rates is ***an important but insufficient strategy*** to solve the access problem. A National Bureau of Economic Research study found that raising Medicaid child dental payments from 52% to 85% of average dentists' fees would only yield a 9% increase in utilization, or an average of .12 extra visits per child per year.[ix]

- Raising Medicaid payment rates to perpetuate a system where only dentists – the highest paid member of the dental team -- provide routine care is a highly inefficient use of Medicaid dollars. With labor costs one-third to one-half of starting dentists[x], DTs can help practices serve more Medicaid patients with government dollars. Practices will also find it more affordable to defray the transportation and equipment costs of sending providers to locations such as schools and nursing homes to provide care.

Opponents SAY: Training dental therapists will be a drain on the state budget

Facts:

- Neither of the Minnesota dental therapy education programs received any additional state support. Both run their training programs with existing general funding and contributions from nongovernment sources and from student tuition.[xi]

- Wisconsin has given Marquette University about $25 million for capital projects for the dental school[xii]; apart from the millions it appropriates to subsidize dental school tuition.[xiii] In 2016, state and local government funding to dental schools across the US totaled more than $445 million.[xiv] States do this because they want to ensure an adequate supply of dentists for their residents. For this same reason, Wisconsin may choose to support the operating costs of DT training programs.

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[i] Minnesota Department of Health, Minnesota Board of Dentistry, "Early Impacts of Dental Therapists in Minnesota: Report to the Legislature, 2014" (February 2014) http://www.health.state.mn.us/divs/orhpc/workforce/oral/dtlegisrpt.pdf

[ii] Data provided by Michael Scandrett, MS Strategies research group to Jane Koppelman, Pew Dental Campaign on January 29, 2019.

[iii] "DHAT: Alaska and Beyond!" Presentation to the National Indian Health Board, June 8, 2017, https://www.nihb.org/docs/07182017_tphs/thursday/DHAT%27s%20Improving%20Both%20Oral%20Health%20Outcomes%20&%20Access-%20New%20Research%20from%20Alaska%20&%20New%20Policies.pdf

[iv] Pew analysis based on EDSDT utilization, MN Children (1-20 eligible for 90 days) who received dental care went from 183,773 in 2011 to 228,148 in 2016.

[v] Minnesota Department of Health, *Minnesota's Dentists Workforce, 2014-2015*, at http://www.health.state.mn.us/divs/orhpc/workforce/oral/2016dentists.pdf

[vi] Letter from Diane Rydrych, and Prasida Khana, Minnesota Dept. of Health, to Wisconsin legislators, January 31, 2018.

vii Pew Charitable Trusts analysis using DHPSA data by county, accessed January 24, 2019, https://data.hrsa.gov/hdw/tools/DataByGeography.aspx . Using Minnesota counties in the 33460 Minneapolis-St. Paul-Bloomington, MN-WI Metropolitan Statistical Area. Population in Twin-City area DHPSAs using federal HRSA data of DHPSAs by county, based on same Minnesota counties in the 33460 Minneapolis-St. Paul-Bloomington, MN-WI Metro Area. Population count based on population-group designated HPSAs only. Population designations in Mille Lacs County excluded due to their rural and partial-rural designations.

[viii] Minnesota Department of Health and the Minnesota Board of Dentistry, "Dental Therapy in Minnesota, Issue Brief, 2018, http://www.health.state.mn.us/divs/orhpc/workforce/oral/2018dtbrief.pdf

[ix] Buchmueller, T. et. Al., "THE EFFECT OF MEDICAID PAYMENT RATES ON ACCESS TO DENTAL CARE AMONG CHILDREN," NBER Working Paper 19218 (July, 2013). Available at https://www.nber.org/papers/w19218.pdf

[x] Minnesota Department of Health, Minnesota Department of Human Services, and Health Reform Minnesota, "Dental Therapy Toolkit: A Resource for Potential Employers," February 2017, http://www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/2017dttool.pdf

xi Email correspondence from Michael Scandrett, J.D., MS Strategies to Jane Koppelman, Pew Dental Campaign on January 3, 2018.

[xii] Wisconsin Capital Budget Funding for Marquette School of Dentistry Expansion https://legis.wisconsin.gov/lab/media/1162/13-13full.pdf https://www.bizjournals.com/milwaukee/news/2015/04/14/gov-walker-provides-2m-for-marquette-dental-school.html

[xiii] See https://legis.wisconsin.gov/lab/reports/11-dentaleducationcontract_ltr.pdf

xiv American Dental Association, "Dental Education, Report 3: Finances, Table 1 a. Fiscal Statistics for All Dental Schools, FYE 2006 to 2016," accessed January 24, 2019, https://www.ada.org/en/science-research/health-policy-institute/data-center/dental-education .