TO: Wisconsin State Legislators

FROM: Dr. Patrick Tepe, President, Wisconsin Dental Association
Dr. William K. Lobb, DDS, MS, MPH, Dean, Marquette University School of Dentistry

Dear Legislators,

We write to you today as your partners in providing oral healthcare, and in educating future dentists at Wisconsin’s only dental school. We know that you have heard from individuals and groups making the case that dental therapy is a “no-lose policy option” and “without cost”. In fact, there are real consequences behind significant policy shifts of this nature and significant hidden costs to pursuing this concept. Furthermore, the bill before you – in Wisconsin – is nothing like the program in Minnesota.

We both bring important personal perspectives to this debate. Dr. Tepe is a graduate of the University of Minnesota School of Dentistry, a veteran of the US Army Reserve, volunteers his time regularly at low-income clinics in the Madison area and sees special needs patients in his private practice in Verona.

Dr. Lobb has been with Marquette since 1994, and as Dean since 1997. An orthodontist by trade, he is a well-respected leader in the dental community, and has served in a variety of positions, including multiple stints with the Commission on Dental Accreditation. In addition to his duties as dean, he is active in the clinic with students and patients on a weekly basis. Perhaps most importantly in this context, Dr. Lobb is a native of Canada and has firsthand experience working with dental therapists.

That is why, today, as experienced clinicians and leaders in dentistry, we are writing to you to cut through the noise and provide you with facts from those who know what it means to educate future dentists and practice in an incredibly rewarding profession. There are several important principles we will address:

- The education of a dental therapist is nothing like that of a physician’s assistant or a nurse practitioner;
- The legislation in front of you contains no requirement for dental therapists to see Medicaid patients or practice in underserved areas, ostensibly the goal of this profession;
- Professionals of all types will continue to avoid rural and underserved areas unless incentivized, including dental therapists;
- Despite assurances to the contrary, this program will cost taxpayer money;
• Any suggestion that this will save taxpayer money comes from a fundamental misunderstanding of how providers bill Medicaid;
• Wisconsin has an existing, well-trained dental workforce that can be utilized without creating an entirely new profession.

**Training Standards**

Wisconsin is, and should be, proud of all of its universities and technical colleges. This state turns out high-quality, ethical professionals of all stripes, which is why the design of any new program must match that tradition. A dental therapist has been commonly compared to a nurse practitioner or a physician’s assistant, and on the surface it is an easy comparison to make. Unfortunately, it is a deeply misleading one.

APRN’s or PA’s are required to complete the following, in order:

• Bachelor’s degrees with science prerequisites;
• Between 1-3 years of hands-on patient care;
• A three year masters program;
• A licensing exam.

These highly-trained professionals can take up to a decade to graduate, and still have supervision requirements. By contrast, a dental therapist as proposed under the bill before us in Wisconsin could:

• Graduate from a three-year tech college program;
• Without any requirement that they have any background even in dental hygiene;
• Be sent anywhere in Wisconsin without a dentist being anywhere nearby, to perform a variety of procedures including drilling and extracting teeth. These procedures could be performed without the patient even having been examined by dentist.

Comparing a dental therapist to a PA or an APRN insults the time and talent that these professionals must invest in order to earn their titles.

More importantly, there is not a single accredited dental therapy program in the United States. **Not one.** Not in Minnesota (despite having a program for 10 years), not in Vermont, not anywhere else. Passing a dental therapy bill does not mean that a state has established a program. It simply means that the law is on the books, and nothing more.

Building programs like these takes time—and money. Despite telling the Vermont legislature that they had no plans to ask for funding, Vermont Technical College remained unable to start a dental therapy program until receiving a $400,000 grant. Maine, whose law has been on the books for several years, has made no progress toward the development of a program due to a lack of any funding mechanism.
During the hearing on Senate Bill 89, we learned from one college that it would take several years and as much as $5 million to get a new program up and running, and the program would need endorsement from a local advisory committee and the Wisconsin Technical College System. Our point is not that the state shouldn’t invest in its oral health workforce—quite the opposite. That money should go toward those already providing services at a massive loss, as well as toward incentivizing existing professionals to locate outside of traditionally popular areas.

Further, the Marquette University School of Dentistry has no capacity or intention of educating and training dental therapists, in part, because the dental therapy model is not integrated into the dental practice model. As the state’s long-standing dental education partner, the Marquette University School of Dentistry does not believe that the track-record related to dental therapy programs will yield the results desired by the state.

**Dental Health Professional Shortage Areas (DHPSA)**

The federal designation of a Health Provider Shortage Area is a bit of a misnomer. While the calculation is designed to identify areas where the provider to population ratio needs improvement, the reality is that this designation is used primarily to qualify facilities within that HPSA for federal student loan relief. The designations are arbitrary and easy to manipulate, which is why an area of downtown Waukesha two blocks wide, containing a hospital and a dental clinic, qualifies as a HPSA, whereas the surrounding neighborhoods are miraculously well-served.

That said, the majority of DHPSA’s in Wisconsin do signal areas in need of improvement. It has been suggested that the addition of dental therapists in Wisconsin would help alleviate these shortage areas. However, just next door in Minnesota, this has proven not to be the case.

**Minnesota’s Own Data Tells the Story: The Dental Therapy Model Doesn’t Work**

Minnesota’s dental therapist workforce report shows that these professionals are not working in rural areas, ostensibly where they are needed most. According to the Minnesota Department of Health¹, in a report released in September 2019:

- **64% of Minnesota’s dental therapists work in the Twin Cities region;**
- **73% of Minnesota’s dental therapists work in an area classified as “Metropolitan”**
  - While this trend might mirror Minnesota’s population trends, it defeats the entire purpose of creating this new profession in the first place, as proponents of the legislation say the bill was introduced to address access in rural areas and for those on Medicaid.

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¹ [https://www.health.state.mn.us/data/workforce/oral/docs/2019dt.pdf](https://www.health.state.mn.us/data/workforce/oral/docs/2019dt.pdf)
Much has been made of the possibility of dental therapists reducing the number of Dental Health Provider Shortage Areas. However, after nearly a decade, this hasn’t been the case in Minnesota.

- 49 of Minnesota’s 87 counties are designated as DHPSA’s\(^2\)
  - This includes 30 of Minnesota’s 43 rural counties
- Despite Wisconsin’s population being greater than Minnesota’s by almost 200,000, there are more people living in a Dental Health Provider Shortage Area in Minnesota, than in Wisconsin.\(^3\)
  - Where the entire county is designated, over 1.1 million Minnesotans live in a DHPSA.
  - When partially-designated counties are included, over 1.3 million people live in a DHPSA.
- This situation continues even after dental therapists have practiced in Minnesota for nearly a decade, and despite a requirement that 50% of a dental therapist’s patient base be Medicaid patients.

So, how do we help solve Wisconsin’s provider distribution problem? There’s plenty of good news here.

- In 14 counties designated as DHPSA’s in Wisconsin, it would take just one or fewer dentists to remove the DHPSA designation.\(^4\)
- In a further 13 counties, two or fewer dentists would be enough to remove the designation.

Our citizens deserve the same level of comprehensive care regardless of ZIP code.

The more effective, cost-efficient way for Wisconsin to help solve this problem is to do what it already does for other professions in similar scenarios: invest in the existing workforce by incentivizing professionals to become long-term members of our rural and underserved communities. It has taken ten years for Minnesota to graduate more than 100 dental therapists; Wisconsin’s only dental school graduates 100 dentists annually. We have the dentists. Now, we need to get them to the right place.

**Tackling Medicaid**

Any discussion of dental care naturally includes Medicaid. One of the consistent arguments seen has been that dental therapists are a way to “stretch Medicaid dollars”, and will somehow save the state money. Again, while sounding good on its face, this argument is a fundamental misunderstanding of the way Medicaid actually works.

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\(^2\) [https://www.health.state.mn.us/facilities/underserved/docs/2018hpsadental.pdf](https://www.health.state.mn.us/facilities/underserved/docs/2018hpsadental.pdf)


\(^4\) [http://worh.org/sites/default/files/HPSA_Dental_Oct%202018_FTEsShort.pdf](http://worh.org/sites/default/files/HPSA_Dental_Oct%202018_FTEsShort.pdf)
Here’s the most important thing to understand: Medicaid bills by procedure—NOT by who performs the work. This means that regardless of whether a dentist, a dental therapist, or a hygienist is performing the work, the cost to the state is exactly the same. Each code, signifying a particular procedure, is attached to a dollar amount that does not change based on the person that performs it.

Using round numbers, if a particular procedure costs $100 and Medicaid pays $50 for that code, the state pays $50 whether a hygienist or the dentist does the work. The idea of “stretching Medicaid dollars” is simply false.

While a compelling argument, the idea that policymakers can legislate their way out of this problem without an additional investment is a false promise. Our Medicaid system is broken.

A real-life example of how Medicaid currently pays dentists:

- A BadgerCare patient comes to an office in Southeastern Wisconsin in need of work on several teeth. The dentist judges that one tooth needs to be extracted, and performs that procedure.
  - COST: $195
- Another tooth needs a four-surface filling
  - COST: $288
- Finally, the dentist judges that a third tooth could be extracted, but could also be saved. In order to keep the patient from having to lose another tooth, the dentist performs what is called a “pulp cap” in order to preserve the tooth. Despite being a cheaper option than an extraction, Medicaid does not cover pulp caps. They would rather the patient’s tooth be pulled, for simplicity.
  - COST: $88
- When the dentist receives their payment from the managed care organization, 5 weeks after seeing this patient, their payment was as follows:
  - Extraction
    - Cost: $195
    - Paid: $39.76
    - LOSS: $155.24
  - Filling
    - Cost: $288
    - Paid: $53.20
    - LOSS: $234.80
  - Pulp Cap
    - Cost: $88
    - Paid: $0
    - LOSS: $88
  - Total Work Performed
Cost: $571  
Paid: $92.96  
LOSS: $478.04  
Percentage of cost paid: 16%

- This is why the current system is unsustainable without further investment. No business owner, in any field, would survive getting paid for 16% of their work.
- It is also why creating a new profession will not solve the problem. Wisconsin must raise its rates to make it feasible for more dentists to see Medicaid patients, as they have for so many other providers in recent years.

**Using Our Existing Workforce**

As of October 9th of this year, there are 3,367 active, licensed dentists in Wisconsin. A further 784 dentists practice primarily in another state but hold an active Wisconsin license. This number has increased every year since 2010, and from a twenty-year low of 2,850 in 2005.

The number of dentists in Wisconsin is increasing every year. The primary question legislators should consider is how to best use their already well-trained workforce to serve all facets of the population.

Legislators should start by supporting Assembly Bill 258/Senate Bill 228, which would provide scholarship opportunities for dental students who agree to practice in Dental Health Professional Shortage Areas for a specified length of time after graduation. Similar programs exist for physicians, nurses, attorneys, and other professions. The state should apply this tried and true method for dentists as well.

During the next budget, legislators should finally tackle our woeful reimbursement rates, which are 48th in the country at $.27 for every dollar of service provided. Medicaid dental rates have not been increased across the board since 2008, when they were increased 1%. The increase prior to that was in 2002, also at 1%.

Oral health spending is roughly 1% of the Medicaid budget.

According to LFB, raising Medicaid rates to levels competitive with private insurance would result in a total GPR cost of $22 million annually. While not an insignificant amount, it would be a major step toward investing in quality oral health for all of our state’s citizens.

We greatly appreciate the increased attention being paid to oral health in Wisconsin. Regardless of our position in this debate, we can all agree that getting more people quality oral

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5 [https://dsps.wi.gov/Credentialing/General/LicenseCounts.pdf](https://dsps.wi.gov/Credentialing/General/LicenseCounts.pdf)
healthcare will require a multi-pronged approach, utilizing proven solutions. The Wisconsin Dental Association, representing over 3,000 dentists, and the Marquette University School of Dentistry, the state’s longstanding dental education partner, stand ready to work toward that goal.