

Study of Alternative Dental Providers Five-State Comparison Summary Report

April 9, 2012



TABLE OF CONTENTS

	<u>Page</u>
I. Executive Summary.....	1
II. Introduction.....	5
III. Approach.....	9
IV. Results – The Economic Viability of Alternative Providers.....	13
V. Conclusion.....	18

I. Executive Summary

ECG Management Consultants, Inc., was engaged by the American Dental Association (ADA) to assist in assessing the economic viability of alternative mid-level provider models for the provision of dental care to the underserved in five selected states – Connecticut, Kansas, Maine, New Hampshire, and Washington. The three alternative mid-level providers were dental therapists (DTs), dental health aide therapists (DHATs), and advanced dental hygiene providers (ADHPs) based on existing models and those in proposed legislation. The assessment of these mid-level provider types included evaluating compensation levels, cost of training, operating expenses, estimated productivity, and potential revenue. The feasibility of each alternative provider was evaluated for three payor mix scenarios. See Table 1 below for the composition of each payor mix. Furthermore, the attractiveness of the career was evaluated through an analysis of educational debt levels relative to compensation levels.

Table 1 – Payor Mix Composition

Payor Mix	Public Fee Schedule	Sliding Fee Schedule	Private Fee Schedule
A	75%	25%	0%
B	50%	25%	25%
C	50%	0%	50%

To prepare these analyses in each state, ECG obtained data from the ADA, each state’s dental association (e.g., Washington State Dental Association was contacted for specific information in Washington, the Connecticut State Dental Association was contacted in Connecticut), tertiary dental educational programs, community dental health centers, and online sources. ECG also interviewed dental association leaders, dentists in public practice clinics and clinic administrators, and representatives from dentist and dental provider educational institutions familiar with tuition and program finances.

As shown in Table 2 below, across all five states, none of the three alternative mid-level provider models are economically viable under Payor Mixes A and B. That is, the additional revenue generated does not exceed the additional expenses incurred. Under Payor Mix C, the DHAT model is economically viable in four out of five states, and the percentage by which revenue exceeds expenses ranges from 17 percent in Connecticut to 4 percent in Kansas. The DT model is economically viable only in Connecticut, and revenue exceeds expenses by 4 percent. The ADHP model is not economically viable in any state under any payor mix, primarily due to significantly higher expenses (higher provider salaries).

Integrating mid-level providers into an existing clinic would lower equipment, finance, and rent expenses. However, when this scenario is modeled, the overall results do not change, with few exceptions (notably, the DHAT provider is net positive in Payor Mix C in all states except Washington; the DT provider is net positive in Connecticut only in Payor Mix C).

Table 2 – Practice Economics – Annual Income
(in thousands of dollars)

Connecticut

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
Total Revenue	\$ 162	\$199	\$256	\$ 166	\$199	\$256	\$ 157	\$ 195	\$ 253
Total Expenses	<u>218</u>	<u>218</u>	<u>218</u>	<u>245</u>	<u>245</u>	<u>245</u>	<u>263</u>	<u>263</u>	<u>263</u>
Net Income/(Loss)	\$(56)	\$(19)	\$ 38	\$(79)	\$(46)	\$ 11	\$(106)	\$(68)	\$(10)

Kansas

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
Total Revenue	\$103	\$150	\$201	\$ 105	\$151	\$203	\$ 102	\$149	\$201
Total Expenses	<u>193</u>	<u>193</u>	<u>193</u>	<u>225</u>	<u>225</u>	<u>225</u>	<u>238</u>	<u>238</u>	<u>238</u>
Net Income/(Loss)	\$(90)	\$(43)	\$ 8	\$(120)	\$(74)	\$(22)	\$(136)	\$(89)	\$(37)

Maine

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
Total Revenue	\$ 136	\$181	\$239	\$ 128	\$174	\$231	\$ 124	\$ 173	\$ 231
Total Expenses	<u>212</u>	<u>212</u>	<u>212</u>	<u>261</u>	<u>261</u>	<u>261</u>	<u>267</u>	<u>267</u>	<u>267</u>
Net Income/(Loss)	\$(76)	\$(31)	\$ 27	\$(133)	\$(87)	\$(30)	\$(143)	\$(94)	\$(36)

New Hampshire

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
Total Revenue	\$ 139	\$183	\$241	\$ 134	\$178	\$235	\$ 134	\$ 180	\$ 238
Total Expenses	<u>214</u>	<u>214</u>	<u>214</u>	<u>265</u>	<u>265</u>	<u>265</u>	<u>287</u>	<u>287</u>	<u>287</u>
Net Income/(Loss)	\$(75)	\$(31)	\$ 27	\$(131)	\$(87)	\$(30)	\$(153)	\$(107)	\$(49)

Washington

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
Total Revenue	\$ 100	\$161	\$221	\$ 102	\$160	\$219	\$ 98	\$ 159	\$218
Total Expenses	<u>222</u>	<u>222</u>	<u>222</u>	<u>258</u>	<u>258</u>	<u>258</u>	<u>274</u>	<u>274</u>	<u>274</u>
Net Income/(Loss)	\$(122)	\$(61)	\$ (1)	\$(156)	\$(98)	\$(39)	\$(176)	\$(115)	\$(56)

Table 3 below indicates that the debt burden for the DHAT provider model is close to the sustainable range of a 15 percent debt load.¹ This suggests that there is likely to be sufficient interest in this occupation to attract applicants. The debt for both the DT and ADHP is much larger than for the DHAT, due to a longer duration of training. This clearly indicates that in order for both the DT and ADHP models to be sustainable, significant tuition subsidies or loan repayment programs would be necessary.

Table 3 – Mid-Level Provider Economics – Debt Burden

Connecticut

	DHAT	DT	ADHP
Provider Salary	\$65,000	\$85,000	\$101,000
Educational Debt (Annual, Over 25 Years)	\$12,000	\$24,000	\$30,000
Debt as a Percentage of Salary	18%	28%	30%

Kansas

	DHAT	DT	ADHP
Provider Salary	\$51,000	\$76,000	\$90,000
Educational Debt (Annual, Over 25 Years)	\$11,000	\$22,000	\$27,000
Debt as a Percentage of Salary	22%	29%	30%

Maine

	DHAT	DT	ADHP
Provider Salary	\$54,000	\$93,000	\$110,000
Educational Debt (Annual, Over 25 Years)	\$11,000	\$22,000	\$28,000
Debt as a Percentage of Salary	20%	24%	25%

New Hampshire

	DHAT	DT	ADHP
Provider Salary	\$61,000	\$101,000	\$120,000
Educational Debt (Annual, Over 25 Years)	\$13,000	\$25,000	\$33,000
Debt as a Percentage of Salary	21%	25%	28%

¹ U.S. Department of Education, Federal Student Aid, Administrative Wage Garnishment. Available at: www2.ed.gov/offices/OSFAP/DCS/awg.html.

Washington

	DHAT	DT	ADHP
Provider Salary	\$66,000	\$95,000	\$113,000
Educational Debt (Annual, Over 25 Years)	\$11,000	\$22,000	\$28,000
Debt as a Percentage of Salary	17%	23%	25%

The analysis for all five states suggests that the DHAT model is economically viable only in settings where at least 50 percent of patients pay market-based fees. For all other payor mixes, none of the models are economically viable. Moreover, even under the generous payor mix of 50 percent private-pay patients, the DT and ADHP models are not economically viable.

The inadequacy of current public reimbursement levels for dental providers is highlighted by these results. If serving patients at the public reimbursement level is not economically feasible for mid-level providers (where DHAT and DT salaries are below 50 percent of the dentist salaries, and ADHP salaries range from 54 to 60 percent of private dentist salaries and 78 to 90 percent of public dentist salaries), then one of the limitations of greater access to dental treatment is clearly that existing fee schedules in public settings do not cover the cost of treating patients. Conversely, the introduction of additional providers is likely to do little to address this issue.

The educational debt burden for DHATs relative to projected salaries was within acceptable ranges only in Connecticut and Washington (and even in these two states, the debt burden exceeded the 15 percent recommended threshold of debt burden), but the debt burden for DTs and ADHPs was found to be unsustainable at the projected salaries in all states.

II. Introduction

Oral health is vital to the general health and well-being of all Americans. As stated in the 2011 Institute of Medicine report, “In recent decades, advances in oral health science broadened understanding not just of healthy teeth but of the health of the entire craniofacial-oral dental complex and its relation to overall health.”² The nation’s overall oral health is improving (as shown by decreases in caries prevalence and edentulism, as well as increases in the delivery of preventive services such as sealants), and the U.S. population’s access to dental care is excellent. Most Americans today receive the oral health care services that they need and want. Near-term and long-term outlooks for the affordability and accessibility of dental care for the majority of Americans remain excellent, a situation due in no small part to dentistry’s outstanding record of prevention, efficiency, and cost-control.³

Amidst an abundance of dental services for the huge majority of Americans, pockets of our citizens do not access dental services commensurate with the overall population. For individuals with meager incomes, especially those who live in areas with few dental personnel, access is more difficult. For individuals who have disabilities and other special problems, access to care can be exceedingly difficult.^{2,3} There are many components to attempt to address the oral healthcare needs of the economically disadvantaged: charity care provided by private practice dentists, the dental safety net system, and Medicaid.

Results of these efforts have shown some success. For example, national estimates from the Centers for Medicare and Medicaid Services (CMS)⁴ show that the percentage of children enrolled in Medicaid with a dental visit during the past year rose from 27 percent in 2000 to 40 percent in 2009. The national trends, however, mask significant variation in progress among states. Table 4 summarizes the difference in Medicaid utilization rates for children and adults in 2000 and 2010 in the five states where ECG studied the financial feasibility of alternative dental programs.

² Institute of Medicine of the National Academies, “Advancing Oral Health in America,” The National Academies Press, Washington, D.C., 2011.

³ L.J. Brown, *Adequacy of Current and Future Dental Workforce: Theory and Analysis*, Chicago, ADA, Health Policy Resources Center; 2005.

⁴ CMS. Available at: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html.

Table 4 – Medicaid Utilization Rates for Children and Adults in 2000 and 2010

Medicaid Utilization	Connecticut	Kansas	Maine	New Hampshire	Washington
Children 2000 ⁵	31%	20%	35%	31%	43%
Children 2010	39%	40%	37%	50%	48%
Adults 2010 ⁶	82%	73%	69%	77%	72%

In all states, the utilization rate for Medicaid children⁴ increased from 2000 to 2010. However, in all states, private utilization exceeded Medicaid utilization for children. Private insurance utilization for children was 52 percent for children in 2000⁷ and 57 percent in 2010. Among adults, there is a different experience in that Medicaid utilization generally exceeds the 2010 private utilization rate of 69.7 percent in the U.S. as a whole.⁸

As part of their efforts to improve the oral health of the economically disadvantaged population, some states are considering the addition of a mid-level provider to the dental workforce. Efforts to add a mid-level provider are taking place during a time when several new dental schools have opened and the number of dental school graduates has dramatically increased.

When assessing various policy options, it is important to perform a cost-benefit analysis of any proposed solution.

ECG was engaged by the ADA to conduct a study to explore the economics of three types of mid-level currently being considered in several states: Connecticut, Kansas, Maine, New Hampshire and Washington. This economic feasibility assessment consists of two elements:

- Whether the DHAT, DT, and ADHP are financially viable in practice conditions that enhance dental care access to the underserved.
- Estimation of whether provider compensation can sustain the debt load associated with the cost of training programs.

This report summarizes the results for the five individual states and, therefore, provides a comparative analysis among these five states.

⁵ U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS). Available at: <http://meps.ahrq.gov/mepsweb/>.

⁶ Centers for Disease Control and Prevention; Office of Surveillance, Epidemiology, and Laboratory Services; Behavioral Risk Factor Surveillance System (RFSS). Available at: <http://apps.nccd.cdc.gov/nohss/ListV.asp?qkey=5&DataSet=2>.

⁷ U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, MEPS. Available at: <http://meps.ahrq.gov/mepsweb/>.

⁸ Centers for Disease Control and Prevention; Office of Surveillance, Epidemiology, and Laboratory Services; Behavioral RFSS. Available at: <http://apps.nccd.cdc.gov/nohss/ListV.asp?qkey=5&DataSet=2>.

Table 5 below lists the general characteristics of the DHAT, DT, and ADHP as they have been introduced into legislation to provide increased access to dental care for the underserved, as well as locations where a similar model is currently deployed.

Table 5 – Comparison of Provider Models

Characteristic	DHAT	DT	ADHP
Currently Active	Alaska.	Minnesota.	No states.
Prerequisite	High school.	High school.	Bachelor’s degree in dental hygiene.
Education/Training	An 18- to 24-month community college/ technical school program and preceptorship. Modeled as a 24-month program.	A 48-month university-based program after high school.	A 24-month university-based master’s degree program that follows a 48-month university-based bachelor’s degree program in dental hygiene.
Practice Setting	Predominantly public health setting.	Predominantly public health setting.	Predominantly public health setting.
Billing Practice	Procedural-based billing (done by employing entity).	Procedural-based billing (done by employing entity).	Procedural-based billing. Can bill independently (may be done by employing entity).
Dental Supervision	Dental supervision on site or remotely using teledentistry technology.	Dental supervision on site or remotely using teledentistry technology.	Not required.
Expected Patient Population Served	Underserved children and adults (50% or more of the patients are on public insurance or are uninsured).	Underserved children and adults (50% or more of the patients are on public insurance or are uninsured).	Underserved children and adults (50% or more of the patients are on public insurance or are uninsured).

Table 6 broadly defines the scope of practice for each mid-level provider. Note that there are differences in scope within each procedure category for the various providers. The DHAT is the most limited in scope, and the ADHP has the broadest scope of practice of the three models examined.

Table 6 – Scope of Practice for Provider Models

Procedure Category	DHAT	DT	ADHP
Diagnostic	None	None	Moderate
Radiographs	Extensive	Limited Interpretation	Extensive
Preventive	Limited	Extensive	Extensive
Restorative	Some	Extensive Direct Restorations	Extensive Direct Restorations

Procedure Category	DHAT	DT	ADHP
Endodontics	Limited	Limited	Limited
Periodontics	None	None	Nonsurgical
Prosthodontics	None	Limited	Limited

III. Approach

Economic viability is determined by modeling expected revenues and expenses in the simplest practice model – one chair and a dental assistant (DA). This approach ensures the greatest flexibility to provide dental care in underserved settings and applicability of results, whether the setting is school-based, rural, mobile, or a larger dental and/or medical clinic. A detailed approach overview can be seen in Appendix A of the individual state reports.

Revenue is based on the three key elements illustrated in the figure below. Each state report includes Appendices B through E, with state-specific detailed calculations of revenue as described below.

- Blended procedural-based reimbursement scenarios from 0 percent of private payor fee schedules to a maximum of 50 percent of the ADA *Survey of Dental Fees*. See Table 1 for the exact composition of each payor mix. The sliding fee is calculated as 30 percent of the private fee schedule. The public reimbursement source is the most recent fee schedule available, based on each state's health care authority fee schedule. Please refer to Appendices F through G in the individual state reports for more detail.
- Volumes derived from estimated time to perform procedures in a public health clinic setting and adjusted for productivity in the one operatory setting. Please refer to Appendix H in each state report for more details.
- Procedure and patient mix based on an average public dental clinic and within each provider's scope of practice. Please refer to Appendices I through L of each state report for more detail.

As a result of using procedures performed in a generic public health clinic, the results are not biased by available coverage and more accurately represent the care that would be provided to the underserved. To ensure that reimbursement is recorded for all work, when a procedure is within the scope of practice and not covered, the sliding fee schedule is applied.

Figure – Derivation of Provider Revenues

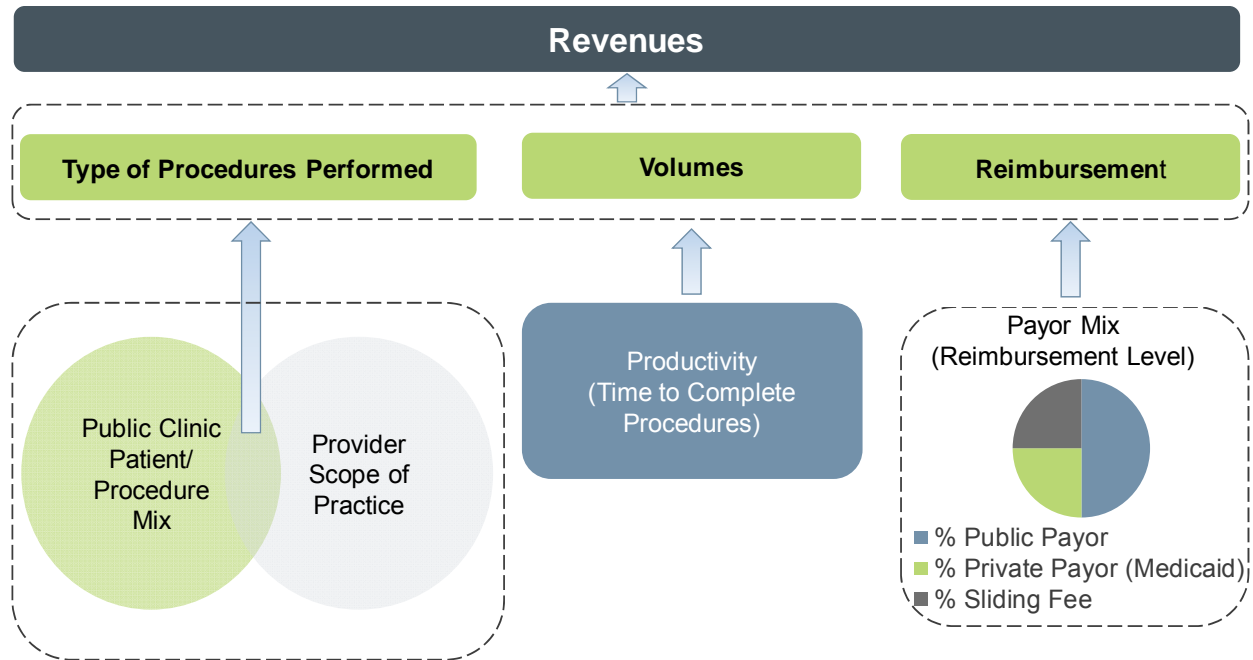


Table 7 – Payor Mix Composition

Payor Mix	Public Fee Schedule	Sliding Fee Schedule	Private Fee Schedule
A	75%	25%	0%
B	50%	25%	25%
C	50%	0%	50%

The following expenses are included in the income statement for the public dental practice:

- *Provider Salary* – The salary for each provider is derived from actual salaries paid to the Alaska DHAT and Minnesota DT, as well as a projected salary for an ADHP, and is adjusted for income differentials between those states and the respective state in each state’s report. Please refer to Appendix M for more detail.
- *Staff Salary* – Based on the average salary of a DA in a public dental clinic, which varies by state. ECG assumed that the staff assisting the mid-level provider is a DA. Please refer to Appendix M for more detail.
- *Benefits* – A 27.5 percent benefits rate is applied to all providers, except for dental supervision below. Please refer to Appendix M for more detail.
- *Dentist Compensation* – This is a salary estimate to meet the supervision requirement for the DHAT and DT only. It assumes 15 minutes a day for oversight. Please refer to Appendix N for more detail.

- *Depreciation (Computer and Equipment)* – Depreciation based on the purchase of new, low-end operatory equipment to permit practicing independent of a larger clinic setting. In addition to basic operatory equipment to practice, this requires sterilization, lab, X-ray, and other machinery. Equipment cost includes a laptop. These expenses are identical for all providers, with the exception of intraoral cameras to be used for teledentistry and supervision excluded from the ADHP costs. Please refer to Appendices O and P in the state reports for more detail.
- *Finance Expense* – Financing of the previously described equipment at current market rates for 10 years. Please refer to Appendix Q of the individual state reports for more detail.
- *Rent/Lease* – Rent costs are based on square footage required for the operatory and equipment. Other areas are omitted, as they are not required in a mobile setting or common to a larger facility, such as a school or clinic setting. Please refer to Appendix R of the individual state reports for more detail.
- *Operating Expenses* – Operating expenses include dental supplies and maintenance costs, lab services, office supplies, and other miscellaneous expenses for cleaning and so forth and are based on average practice expenses from multiple public dental clinics normalized for provider FTEs and productivity. Please refer to Appendix S of the individual state reports for more detail.

The economic sustainability of a career as a DHAT, DT, or ADHP is determined by the cost of training (noted in Appendix T of the individual state reports) and associated debt load relative to the expected earnings in the context of other alternatives. In addition to the salary derivation described above, the cost of training was calculated using unsubsidized tuition and the average cost of living (e.g., room, board, books, transportation, personal expenses) (noted in Appendices U and V of the individual state reports) for the respective program durations (see Table 5). To determine the annual debt expense of each provider, standard student loan terms and current interest rates were applied. Please refer to Appendix W of the individual state reports for more detail.

There are three key features of this approach:

1. Identifying the unsubsidized or actual program cost per student provides decision makers with the true cost of the training per provider.
2. Including post-high school training costs for all providers:
 - Ensures an equal basis for comparison of educational costs.
 - Permits assessment of the cost of increasing the supply of providers rather than poaching from existing dental workers that may pursue additional training.
3. Assuming that 100 percent of the educational costs are borrowed, this approach ensures that the analysis is not biased by the socioeconomic limitations of potential applicants. It

represents the full cost of the education, unsubsidized by the financial means available to some candidates.

Unsubsidized tuition is based on the actual training cost of the Alaska DHAT students for a class size of 30 – approximately \$51,000 per year. It is expected that annual educational expenses for the other programs would be similar, as they require the same clinical equipment, facilities, and salary level for educators. Costs specific to the Alaska setting were excluded.

IV. Results – The Economic Viability of Alternative Providers

Estimated revenue for each provider and for each payor mix is detailed in EXHIBIT I, which is provided for each state. As expected, Payor Mix C produces the highest revenue, due to a larger percentage (50 percent) of privately insured beneficiaries. Comparing across the providers, revenues are similar, with a variability across providers of approximately \$2,000 within a given payor mix. This indicates that for the same expected productivity level, the procedural mix/scope of practice has little impact on revenues.

The practice variability has little effect on the expenses – the DHAT and DT only differ in their salaries. In addition to the salary differential, the ADHP has no costs associated with supervision requirements such as dentist compensation and teledentistry equipment. This results in \$5,000 less in expenses. Salaries are the primary driver of the varying practice expense.

The resulting margins show a net loss for each provider model in a public health practice setting, regardless of payor mix. Only the DHAT's practice nearly breaks even, with a \$1,000 loss at 50 percent private payor reimbursement. Even assuming that the equipment is paid off, thereby reducing annual costs by approximately \$32,000, none of the other practices and payor mixes generate a positive net income. This demonstrates that subsidies would be necessary to sustain any of these models.

The magnitude of the practice loss for each margin is large and, with the exception of an increase in reimbursement, few realistic scenarios would change this considerably. However, two scenarios should be considered.

The first scenario is to vary reimbursement. This model assumes that all mid-level providers are reimbursed, similar to a dentist, at 100 percent of the fee schedule for all procedures within their scope of practice. However, there is precedent for reimbursement to be a percentage of dentists' reimbursement, similar to how physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) are currently reimbursed by some payors. For example, PAs are reimbursed at either 75 or 85 percent (depending on the service) of the Medicare Physician Fee Schedule, and ARNPs are reimbursed at 85 percent of the Medicare Physician Fee Schedule.⁹ Were this to be the case for dental care, the loss per practice would be far greater than modeled in this study.

The second scenario is to vary equipment expenses. DTs, DHATs, and ADHPs are expected to practice in public health settings. These can either be freestanding or integrated clinics. Integrated into an existing clinic, the equipment expenses could be reduced by approximately half, as the mechanical, lab, and sterilization equipment could be shared. Furthermore, this would reduce rent/lease costs equivalent to the space required for this equipment. The operating expenses vary by state. However, in all states, varying the operating expenses in the ranges tested would be insufficient to change the outcome of the analysis.

⁹ CMS, *Medicare Claims Processing Manual*.

AMERICAN DENTAL ASSOCIATION
STUDY OF ALTERNATIVE DENTAL PROVIDERS

INCOME STATEMENT – PRACTICE
Connecticut

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
REVENUE									
Clinic Revenue ^{1,2,3}	\$ 162,000	\$ 199,000	\$ 256,000	\$ 166,000	\$ 199,000	\$ 256,000	\$ 157,000	\$ 195,000	\$ 253,000
Total Revenue	\$ 162,000	\$ 199,000	\$ 256,000	\$ 166,000	\$ 199,000	\$ 256,000	\$ 157,000	\$ 195,000	\$ 253,000
EXPENSES									
Practitioner Salary & Benefits ⁴	\$ 82,000	\$ 82,000	\$ 82,000	\$ 109,000	\$ 109,000	\$ 109,000	\$ 129,000	\$ 129,000	\$ 129,000
Staff Salaries & Benefits ^{4,5}	51,000	51,000	51,000	51,000	51,000	51,000	51,000	51,000	51,000
Dentist Compensation ⁶	-	-	-	-	-	-	-	-	-
Depreciation (Computer & Equipment) ⁷	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Finance Expense ⁸	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Rent/Lease ⁹	\$ 7,000	\$ 7,000	\$ 7,000	\$ 7,000	\$ 7,000	\$ 7,000	\$ 7,000	\$ 7,000	\$ 7,000
Operating Expenses ¹⁰	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000
Total Expenses	\$ 218,000	\$ 218,000	\$ 218,000	\$ 245,000	\$ 245,000	\$ 245,000	\$ 263,000	\$ 263,000	\$ 263,000
NET INCOME/(LOSS)	\$ (56,000)	\$ (19,000)	\$ 38,000	\$ (79,000)	\$ (46,000)	\$ 11,000	\$ (106,000)	\$ (68,000)	\$ (10,000)
Expenses as a Percentage of Clinical Revenue	135%	110%	85%	148%	123%	96%	168%	135%	104%

NOTE: Totals have been rounded to the nearest thousand.

¹ Payor Mix A: 75% Public Fee Schedule, 25% Sliding Fee Schedule, and 0% Private Fee Schedule.

² Payor Mix B: 50% Public Fee Schedule, 25% Sliding Fee Schedule, and 25% Private Fee Schedule.

³ Payor Mix C: 50% Public Fee Schedule, 0% Sliding Fee Schedule, and 50% Private Fee Schedule.

⁴ Salary and benefit estimates based on data from Alaska DHAT program, public dental clinic in Minnesota, and U.S. Bureau of Labor Statistics.

⁵ Salary based on average annual compensation for a dental assistant. Source: U.S. Bureau of Labor Statistics. Benefits are applied at a rate of 27.5%

⁶ This includes a salary for supervision. Salary based on dentist in public health setting.

⁷ Depreciation cost in Year 1. In accordance with IRS Publication 946, computer depreciation is based on a 5-year useful life, and office equipment and other nonspecified equipment depreciation is based on a 7-year useful life. Furthermore, the straight-line depreciation method is applied.

⁸ Annual financing payment based on an interest rate of 7.5% for a 10-year term.

⁹ Based on an average square foot estimate of 397 based on a mix of locations from Ms. Charmen Brummer, Patterson Dental. Includes space for sterilization, laboratory, gas storage, X-ray, and other areas.

¹⁰ Operating expenses include dental supplies and maintenance costs, any contractual services, office supplies, and other miscellaneous expenses.

AMERICAN DENTAL ASSOCIATION
STUDY OF ALTERNATIVE DENTAL PROVIDERS

INCOME STATEMENT – PRACTICE
Kansas

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
REVENUE									
Clinic Revenue ^{1,2,3}	\$ 103,000	\$ 150,000	\$ 201,000	\$ 105,000	\$ 151,000	\$ 203,000	\$ 102,000	\$ 149,000	\$ 201,000
Total Revenue	\$ 103,000	\$ 150,000	\$ 201,000	\$ 105,000	\$ 151,000	\$ 203,000	\$ 102,000	\$ 149,000	\$ 201,000
EXPENSES									
Practitioner Salary & Benefits ⁴	\$ 65,000	\$ 65,000	\$ 65,000	\$ 97,000	\$ 97,000	\$ 97,000	\$ 115,000	\$ 115,000	\$ 115,000
Staff Salaries & Benefits ^{4,5}	41,000	41,000	41,000	41,000	41,000	41,000	41,000	41,000	41,000
Dentist Compensation ⁶	3,000	3,000	3,000	3,000	3,000	3,000	-	-	-
Depreciation (Computer & Equipment) ⁷	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Finance Expense ⁸	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Rent/Lease ⁹	\$ 6,000	\$ 6,000	\$ 6,000	\$ 6,000	\$ 6,000	\$ 6,000	\$ 6,000	\$ 6,000	\$ 6,000
Operating Expenses ¹⁰	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000
Total Expenses	\$ 193,000	\$ 193,000	\$ 193,000	\$ 225,000	\$ 225,000	\$ 225,000	\$ 238,000	\$ 238,000	\$ 238,000
NET INCOME/(LOSS)	\$ (90,000)	\$ (43,000)	\$ 8,000	\$ (120,000)	\$ (74,000)	\$ (22,000)	\$ (136,000)	\$ (89,000)	\$ (37,000)
Expenses as a Percentage of Clinical Revenue	187%	129%	96%	214%	149%	111%	233%	160%	118%

NOTE: Totals have been rounded to the nearest thousand.

¹ Payor Mix A: 75% Public Fee Schedule, 25% Sliding Fee Schedule, and 0% Private Fee Schedule.

² Payor Mix B: 50% Public Fee Schedule, 25% Sliding Fee Schedule, and 25% Private Fee Schedule.

³ Payor Mix C: 50% Public Fee Schedule, 0% Sliding Fee Schedule, and 50% Private Fee Schedule.

⁴ Salary and benefit estimates based on data from Alaska DHAT program, public dental clinic in Minnesota, and U.S. Bureau of Labor Statistics.

⁵ Salary based on average annual compensation for a dental assistant. Source: U.S. Bureau of Labor Statistics. Benefits are applied at a rate of 27.5%

⁶ This includes a salary for supervision. Salary based on dentist in public health setting.

⁷ Depreciation cost in Year 1. In accordance with IRS Publication 946, computer depreciation is based on a 5-year useful life, and office equipment and other nonspecified equipment depreciation is based on a 7-year useful life. Furthermore, the straight-line depreciation method is applied.

⁸ Annual financing payment based on an interest rate of 7.5% for a 10-year term.

⁹ Based on an average square foot estimate of 397 based on a mix of locations from Ms. Charmen Brummer, Patterson Dental. Includes space for sterilization, laboratory, gas storage, X-ray, and other areas.

¹⁰ Operating expenses include dental supplies and maintenance costs, any contractual services, office supplies, and other miscellaneous expenses.

AMERICAN DENTAL ASSOCIATION
STUDY OF ALTERNATIVE DENTAL PROVIDERS

INCOME STATEMENT – PRACTICE

Maine

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
REVENUE									
Clinic Revenue ^{1,2,3}	\$ 136,000	\$ 181,000	\$ 239,000	\$ 128,000	\$ 174,000	\$ 231,000	\$ 124,000	\$ 173,000	\$ 231,000
Total Revenue	\$ 136,000	\$ 181,000	\$ 239,000	\$ 128,000	\$ 174,000	\$ 231,000	\$ 124,000	\$ 173,000	\$ 231,000
EXPENSES									
Practitioner Salary & Benefits ⁴	\$ 69,000	\$ 69,000	\$ 69,000	\$ 118,000	\$ 118,000	\$ 118,000	\$ 141,000	\$ 141,000	\$ 141,000
Staff Salaries & Benefits ^{4,5}	45,000	45,000	45,000	45,000	45,000	45,000	45,000	45,000	45,000
Dentist Compensation ⁶	15,000	15,000	15,000	15,000	15,000	15,000	-	-	-
Depreciation (Computer & Equipment) ⁷	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Finance Expense ⁸	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Rent/Lease ⁹	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000
Operating Expenses ¹⁰	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000
Total Expenses	\$ 212,000	\$ 212,000	\$ 212,000	\$ 261,000	\$ 261,000	\$ 261,000	\$ 267,000	\$ 267,000	\$ 267,000
NET INCOME/(LOSS)	\$ (76,000)	\$ (31,000)	\$ 27,000	\$ (133,000)	\$ (87,000)	\$ (30,000)	\$ (143,000)	\$ (94,000)	\$ (36,000)
Expenses as a Percentage of Clinical Revenue	156%	117%	89%	204%	150%	113%	215%	154%	116%

NOTE: Totals have been rounded to the nearest thousand.

¹ Payor Mix A: 75% Public Fee Schedule, 25% Sliding Fee Schedule, and 0% Private Fee Schedule.

² Payor Mix B: 50% Public Fee Schedule, 25% Sliding Fee Schedule, and 25% Private Fee Schedule.

³ Payor Mix C: 50% Public Fee Schedule, 0% Sliding Fee Schedule, and 50% Private Fee Schedule.

⁴ Salary and benefit estimates based on data from Alaska DHAT program, public dental clinic in Minnesota, and U.S. Bureau of Labor Statistics.

⁵ Salary based on average annual compensation for a dental assistant. Source: U.S. Bureau of Labor Statistics. Benefits are applied at a rate of 27.5%

⁶ This includes a salary for supervision. Salary based on dentist in public health setting.

⁷ Depreciation cost in Year 1. In accordance with IRS Publication 946, computer depreciation is based on a 5-year useful life, and office equipment and other nonspecified equipment depreciation is based on a 7-year useful life. Furthermore, the straight-line depreciation method is applied.

⁸ Annual financing payment based on an interest rate of 7.5% for a 10-year term.

⁹ Based on an average square foot estimate of 397 based on a mix of locations from Ms. Charmen Brummer, Patterson Dental. Includes space for sterilization, laboratory, gas storage, X-ray, and other areas.

¹⁰ Operating expenses include dental supplies and maintenance costs, any contractual services, office supplies, and other miscellaneous expenses.

AMERICAN DENTAL ASSOCIATION
STUDY OF ALTERNATIVE DENTAL PROVIDERS

INCOME STATEMENT – PRACTICE

New Hampshire

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
REVENUE									
Clinic Revenue ^{1,2,3}	\$ 139,000	\$ 183,000	\$ 241,000	\$ 134,000	\$ 178,000	\$ 235,000	\$ 134,000	\$ 180,000	\$ 238,000
Total Revenue	\$ 139,000	\$ 183,000	\$ 241,000	\$ 134,000	\$ 178,000	\$ 235,000	\$ 134,000	\$ 180,000	\$ 238,000
EXPENSES									
Practitioner Salary & Benefits ⁴	\$ 78,000	\$ 78,000	\$ 78,000	\$ 129,000	\$ 129,000	\$ 129,000	\$ 153,000	\$ 153,000	\$ 153,000
Staff Salaries & Benefits ^{4,5}	53,000	53,000	53,000	53,000	53,000	53,000	53,000	53,000	53,000
Dentist Compensation ⁶	-	-	-	-	-	-	-	-	-
Depreciation (Computer & Equipment) ⁷	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Finance Expense ⁸	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Rent/Lease ⁹	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000
Operating Expenses ¹⁰	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000
Total Expenses	\$ 214,000	\$ 214,000	\$ 214,000	\$ 265,000	\$ 265,000	\$ 265,000	\$ 287,000	\$ 287,000	\$ 287,000
NET INCOME/(LOSS)	\$ (75,000)	\$ (31,000)	\$ 27,000	\$ (131,000)	\$ (87,000)	\$ (30,000)	\$ (153,000)	\$ (107,000)	\$ (49,000)
Expenses as a Percentage of Clinical Revenue	154%	117%	89%	198%	149%	113%	214%	159%	121%

NOTE: Totals have been rounded to the nearest thousand.

¹ Payor Mix A: 75% Public Fee Schedule, 25% Sliding Fee Schedule, and 0% Private Fee Schedule.

² Payor Mix B: 50% Public Fee Schedule, 25% Sliding Fee Schedule, and 25% Private Fee Schedule.

³ Payor Mix C: 50% Public Fee Schedule, 0% Sliding Fee Schedule, and 50% Private Fee Schedule.

⁴ Salary and benefit estimates based on data from Alaska DHAT program, public dental clinic in Minnesota, and U.S. Bureau of Labor Statistics.

⁵ Salary based on average annual compensation for a dental assistant. Source: U.S. Bureau of Labor Statistics. Benefits are applied at a rate of 27.5%

⁶ This includes a salary for supervision. Salary based on dentist in public health setting.

⁷ Depreciation cost in Year 1. In accordance with IRS Publication 946, computer depreciation is based on a 5-year useful life, and office equipment and other nonspecified equipment depreciation is based on a 7-year useful life. Furthermore, the straight-line depreciation method is applied.

⁸ Annual financing payment based on an interest rate of 7.5% for a 10-year term.

⁹ Based on an average square foot estimate of 397 based on a mix of locations from Ms. Charmen Brummer, Patterson Dental. Includes space for sterilization, laboratory, gas storage, X-ray, and other areas.

¹⁰ Operating expenses include dental supplies and maintenance costs, any contractual services, office supplies, and other miscellaneous expenses.

AMERICAN DENTAL ASSOCIATION
STUDY OF ALTERNATIVE DENTAL PROVIDERS

INCOME STATEMENT – PRACTICE
Washington

Payor Mix	DHAT			DT			ADHP		
	A	B	C	A	B	C	A	B	C
REVENUE									
Clinic Revenue ^{1,2,3}	\$ 100,000	\$ 161,000	\$ 221,000	\$ 102,000	\$ 160,000	\$ 219,000	\$ 98,000	\$ 159,000	\$ 218,000
Total Revenue	\$ 100,000	\$ 161,000	\$ 221,000	\$ 102,000	\$ 160,000	\$ 219,000	\$ 98,000	\$ 159,000	\$ 218,000
EXPENSES									
Practitioner Salary and Benefits ⁴	\$ 85,000	\$ 85,000	\$ 85,000	\$ 121,000	\$ 121,000	\$ 121,000	\$ 143,000	\$ 143,000	\$ 143,000
Staff Salaries and Benefits ^{4,5}	49,000	49,000	49,000	49,000	49,000	49,000	49,000	49,000	49,000
Supervision ⁶	4,000	4,000	4,000	4,000	4,000	4,000	-	-	-
Depreciation (Computer and Equipment) ⁷	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Finance Expense ⁸	16,000	16,000	16,000	16,000	16,000	16,000	15,000	15,000	15,000
Rent/Lease ⁹	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000
Operating Expenses ¹⁰	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000	46,000
Total Expenses	\$ 222,000	\$ 222,000	\$ 222,000	\$ 258,000	\$ 258,000	\$ 258,000	\$ 274,000	\$ 274,000	\$ 274,000
NET INCOME/(LOSS)	\$ (122,000)	\$ (61,000)	\$ (1,000)	\$ (156,000)	\$ (98,000)	\$ (39,000)	\$ (176,000)	\$ (115,000)	\$ (56,000)
Expenses as a Percent of Clinical Revenues	222%	138%	100%	253%	161%	118%	280%	172%	126%

NOTE: Totals have been rounded to the nearest thousand.

¹ Payor Mix A: 75% Public Fee Schedule, 25% Sliding Fee Schedule, and 0% Private Fee Schedule.

² Payor Mix B: 50% Public Fee Schedule, 25% Sliding Fee Schedule, and 25% Private Fee Schedule.

³ Payor Mix C: 50% Public Fee Schedule, 0% Sliding Fee Schedule, and 50% Private Fee Schedule.

⁴ Salary and benefit estimates based on data from Alaska DHAT program, public dental clinic in Minnesota, and U.S. Bureau of Labor Statistics.

⁵ Salary based on average annual compensation for a dental assistant. Source: U.S. Bureau of Labor Statistics. Benefits are applied at a rate of 27.5%.

⁶ This includes a salary for supervision. Salary based on dentist in public health setting.

⁷ Depreciation cost in Year 1. In accordance with IRS Publication 946, computer depreciation is based on a 5-year useful life, and office equipment and other nonspecified equipment depreciation is based on a 7-year useful life. Furthermore, the straight-line depreciation method is applied.

⁸ Annual financing payment based on an interest rate of 7.5% for a 10-year term.

⁹ Based on an average square foot estimate of 397 based on a mix of locations from Ms. Charmen Brummer, Patterson Dental. Includes space for sterilization, laboratory, gas storage, X-ray, and other areas.

¹⁰ Operating expenses include dental supplies and maintenance costs, any contractual services, office supplies, and other miscellaneous expenses.

As a first test of appeal, the alternative provider compensation has to be greater than that of existing providers with similar education levels. All pass this test.

Table 8 – Salary Comparison

Connecticut

Salary	DA	DH	DHAT	DT	ADHP	Dentist
Public	\$34,500	\$70,000	\$64,627	\$85,204	\$101,433	\$119,500
Private	\$40,180	\$82,390				\$168,180

Kansas

Salary	DA	DH	DHAT	DT	ADHP	Dentist
Public	\$22,880	\$58,500	\$50,892	\$75,717	\$90,139	\$115,000
Private	\$32,210	\$64,310				\$158,360

Maine

Salary	DA	DH	DHAT	DT	ADHP	Dentist
Public	\$29,120	\$55,120	\$54,483	\$92,733	\$110,396	\$122,720
Private	\$35,670	\$67,660				\$205,050

New Hampshire

Salary	DA	DH	DHAT	DT	ADHP	Dentist
Public	\$34,122	\$70,273	\$60,984	\$100,951	\$120,180	\$143,208
Private	\$41,640	\$74,020				\$222,860

Washington

Salary	DA	DH	DHAT	DT	ADHP	Dentist
Public	\$27,200	\$66,173	\$66,170	\$94,513	\$112,585	\$140,000
Private	\$38,220	\$87,810				\$190,170

Based on debt levels, both the DT and the ADHP are less attractive career options than the DHAT. As shown in Table 3, the debt burden for the DT is 23 percent and for the ADHP is 25 percent, both of which exceed the 15 percent of salary threshold considered sustainable for educational loans.¹⁰ Here again, no state is within 15 percent or less of a debt burden from tuition, although Connecticut and Washington come close at 18 percent and 17 percent, respectively, for DHAT only. The DT and ADHP were not close to the 15 percent debt burden threshold across the five states studied.

¹⁰ U.S. Department of Education, Federal Student Aid, Administrative Wage Garnishment. Available at: www2.ed.gov/offices/OSFAP/DCS/awg.html.

Now that the emerging Minnesota providers have established earning expectations, students are unlikely to choose DT or ADHP as careers unless salaries increase or their tuition cost is subsidized, as at the University of Minnesota.

To achieve a 15 percent debt-to-salary ratio, the DHAT, DT, and ADHP will require the tuition subsidies shown in Table 9 for each state. This subsidy ranges by provider type (DHAT, DT, and ADHP, with ADHP requiring the largest subsidy in all states and DHAT requiring the least). The total supplemental tuition funding for the program’s duration also ranges by state, with ADHP requiring the largest subsidy in all states, primarily driven by the lengthiest educational program duration. Appendix X in each state’s report contains more detailed calculations that support the summary by state shown in Table 9 below.

Table 9 – Tuition Subsidy Required to Maintain 15 Percent Debt-to-Salary Ratio

Connecticut

	DHAT	DT	ADHP
Debt-to-Salary Ratio and Salary Required			
Provider Salary	\$65,000	\$ 85,000	\$101,000
Annual Debt Expense (Actual)	<u>12,000</u>	<u>24,000</u>	<u>30,000</u>
Debt Percentage of Salary (Actual)	18%	28%	30%
Salary Required Each Year of Loan for 15% Ratio	\$80,000	\$160,000	\$200,000
Tuition Subsidy Required			
Total Loan Amount	\$119,000	\$154,000	\$178,000
Average Annual Unsubsidized Tuition (Per Student)	51,000	51,000	41,000
Required Tuition to Meet Debt Ratio (Annual)	<u>41,000</u>	<u>20,000</u>	<u>11,000</u>
Tuition Subsidy (Annual Per Student)	<u>\$ 10,000</u>	<u>\$ 31,000</u>	<u>\$ 30,000</u>
Total Subsidy for Duration of Training (Per Student)	<u>\$ 20,000</u>	<u>\$124,000</u>	<u>\$180,000</u>

Kansas

	DHAT	DT	ADHP
Debt-to-Salary Ratio and Salary Required			
Provider Salary	\$51,000	\$ 76,000	\$ 90,000
Annual Debt Expense (Actual)	<u>11,000</u>	<u>22,000</u>	<u>27,000</u>
Debt Percentage of Salary (Actual)	22%	29%	30%
Salary Required Each Year of Loan for 15% Ratio	\$73,000	\$147,000	\$180,000

	DHAT	DT	ADHP
Tuition Subsidy Required			
Total Loan Amount	\$ 95,000	\$131,000	\$166,000
Average Annual Unsubsidized Tuition (Per Student)	51,000	51,000	41,000
Required Tuition to Meet Debt Ratio (Annual)	<u>35,000</u>	<u>20,000</u>	<u>15,000</u>
Tuition Subsidy (Annual Per Student)	<u>\$ 16,000</u>	<u>\$ 31,000</u>	<u>\$ 26,000</u>
Total Subsidy for Duration of Training (Per Student)	\$ 32,000	\$124,000	\$156,000

Maine

	DHAT	DT	ADHP
Debt-to-Salary Ratio and Salary Required			
Provider Salary	\$54,000	\$ 93,000	\$110,000
Annual Debt Expense (Actual)	<u>11,000</u>	<u>22,000</u>	<u>28,000</u>
Debt Percentage of Salary (Actual)	20%	24%	25%
Salary Required Each Year of Loan for 15% Ratio	\$73,000	\$147,000	\$187,000
Tuition Subsidy Required			
Total Loan Amount	\$95,000	\$166,000	\$202,000
Average Annual Unsubsidized Tuition (Per Student)	51,000	51,000	41,000
Required Tuition to Meet Debt Ratio (Annual)	<u>34,000</u>	<u>28,000</u>	<u>20,000</u>
Tuition Subsidy (Annual Per Student)	<u>\$17,000</u>	<u>\$ 23,000</u>	<u>\$ 21,000</u>
Total Subsidy for Duration of Training (Per Student)	<u>\$34,000</u>	<u>\$ 92,000</u>	<u>\$126,000</u>

New Hampshire

	DHAT	DT	ADHP
Debt-to-Salary Ratio and Salary Required			
Provider Salary	\$61,000	\$101,000	\$120,000
Annual Debt Expense (Actual)	<u>13,000</u>	<u>25,000</u>	<u>33,000</u>
Debt Percentage of Salary (Actual)	21%	25%	28%
Salary Required Each Year of Loan for 15% Ratio	\$87,000	\$167,000	\$220,000
Tuition Subsidy Required			
Total Loan Amount	\$107,000	\$178,000	\$214,000
Average Annual Unsubsidized Tuition (Per Student)	51,000	51,000	41,000
Required Tuition to Meet Debt Ratio (Annual)	<u>30,000</u>	<u>21,000</u>	<u>12,000</u>
Tuition Subsidy (Annual Per Student)	<u>\$ 21,000</u>	<u>\$ 30,000</u>	<u>\$ 29,000</u>
Total Subsidy for Duration of Training (Per Student)	<u>\$ 42,000</u>	<u>\$120,000</u>	<u>\$174,000</u>

Washington

	DHAT	DT	ADHP
Debt-to-Salary Ratio and Salary Required			
Provider Salary	\$66,000	\$ 95,000	\$113,000
Annual Debt Expense (Actual)	<u>11,000</u>	<u>22,000</u>	<u>33,000</u>
Debt Percentage of Salary (Actual)	17%	23%	25%
Salary Required Each Year of Loan for 15% Ratio	\$73,000	\$147,000	\$187,000
Tuition Subsidy Required			
Total Loan Amount	\$119,000	\$166,000	\$202,000
Average Annual Unsubsidized Tuition (Per Student)	51,000	51,000	41,000
Required Tuition to Meet Debt Ratio (Annual)	<u>45,000</u>	<u>27,000</u>	<u>19,000</u>
Tuition Subsidy (Annual Per Student)	<u>\$ 6,000</u>	<u>\$ 24,000</u>	<u>\$ 22,000</u>
Total Subsidy for Duration of Training (Per Student)	<u>\$ 12,000</u>	<u>\$ 96,000</u>	<u>\$132,000</u>

V. Conclusion

Financially, none of the mid-level provider models are independently sustainable in the sense that they are both economically feasible from a practice operations perspective and are within reasonable debt burden limits for the required training and education. Addressing the access issue will require more public subsidies for practices as a result of the following factors:

1. Dental care in Dental Health Professional Shortage Areas (DHPSAs) is impacted by the economics of remote locations and small populations. Bringing care into these areas is less efficient. Costs increase when practices must be small scale because the population cannot support the more productive large clinic-based multi-operator and provider model.
2. Public procedural-based reimbursement and sliding fees are too low. Although mid-level providers are likely to require lower salaries than dentists, available reimbursement through Medicaid is insufficient. At a 75 percent minimum, Medicaid patient mix reimbursement does not cover salary and benefits for any of the mid-level provider types. Medicaid and sliding fee payments are insufficient to cover direct salaries, benefits and operating expenses. These are covered only for the DHAT and DT and assuming a 50 percent private payor patient mix (Payor Mix C) and no overhead for administrative salaries or lease.

Based on an analysis for all states, there are a few circumstances where the DHAT provider is economically viable from a practice operations perspective in one of the payor mixes modeled; however, most of the alternative providers are not economically feasible in the payor mix ranges that were considered. The educational debt burden for DHATs relative to projected salaries was within acceptable ranges, but the debt burden for DTs and ADHPs was found to be unsustainable at the projected salaries. The DT and the ADHP would not be viable without considerable tuition subsidies. However, it is important to note that this analysis is based on the very lean expense structure of the Alaska DHAT program.

Does the introduction of these providers increase access?

Introduction of the DHAT provider will attract candidates and, within a larger dental practice and an adequate mix of private payor patients, the DHAT may be financially feasible. However, this alone will not solve the access issue and may lead to unintended consequences.

The inadequacy of current public payor and indigent reimbursement levels for dental providers is highlighted by the results of the practice economics. If serving patients at the public reimbursement level is not economically feasible for providers with salaries below 50 percent of the dentists', then one of the limitations of greater access to dental treatment is clearly that existing fee schedules do not cover the cost of treating these patients. The introduction of additional providers does nothing to address this issue.