To: Members of the Minnesota House Health Finance and Policy Committee
Re: HF4401 (Reyer)
From: Dawn D. Bly
Date: April 12, 2026

Chair Bierman and Members of the Committee,

Thank you for the opportunity to submit testimony in support of **HF4401**, which addresses Medical Assistance (MA) reimbursement rates for dental services and critical access dental providers. I am writing to share a real experience that illustrates why this bill is urgently needed.

David is an adult Minnesotan enrolled in Medical Assistance. He goes to the dentist every three months for cleanings and does what he can to manage his oral health. Despite this, in December he required **three dental extractions, one crown, and seventeen fillings**—all completed during one procedure.

This level of dental intervention did not happen because of neglect. It happened because of **systemic barriers** in MA dental care that delay diagnosis, restrict preventive access, and discourage provider participation.

In David's case, it had been **three and a half years since his last outpatient x-rays and thorough cleaning**. We knew there were issues, but we had no idea how severe they had become until it was too late. By the time diagnostic care was available, the damage was extensive and irreversible. The waiting list across the state prohibits adequate care. After his procedure I spoke with his provider and it was explained to me that there are only have a dozen or so facilities that will allow them to use facilities for this work, and then they can only schedule 4 clients. For one facility that is at most 48 clients a year. Facilities aren't reimbursed enough to allow the dentists who are willing to work with these clients to schedule more day. Something needs to change.

Like many MA recipients, David has additional challenges. Due to medical and behavioral needs, **sedation is required for him to safely receive dental treatment**. However, under current MA policy, sedation for dental care is only covered **once every five years**. That meant everything had to be done at once—years of delayed care compressed into a single traumatic appointment—rather than being addressed earlier and more gradually.

This approach is not humane, not preventative, and not cost-effective.

Low reimbursement rates under Medical Assistance make it extremely difficult for dental clinics—especially in rural or underserved areas—to accept MA patients, invest in preventive services, or provide timely diagnostic care. As a result, problems are caught late, when treatment is more invasive, more expensive, and more painful for the patient.

Oral health is not optional health care. Poor dental health affects nutrition, heart disease, diabetes, mental health, employability, and overall quality of life. When MA reimbursement rates are too low, patients lose access—and delayed care ultimately costs the system far more.

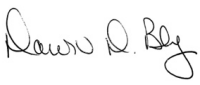
HF4401 takes an important step toward correcting this by improving reimbursement rates and strengthening support for **critical access dental providers** who serve our most vulnerable communities. This bill recognizes that fair payment is necessary to maintain access, expand provider participation, and prevent the kind of dental crises David experienced.

David's story is not unique. It is a clear example of what happens when preventive dental care under Medical Assistance is limited by reimbursement and policy restrictions instead of guided by medical need.

I urge you to support HF4401 and to continue working toward a Medical Assistance dental system that prioritizes **prevention, timely diagnosis, dignity, and true health equity**.

Thank you for your time and consideration.

Respectfully,



Dawn D. Bly
On behalf of my 30-year-old son

David Bly
Fosston, MN