



policy brief

HUSKY A Dental Care: first in a series
January 2006

HUSKY A DENTAL CARE: NEW DIRECTIONS

SUMMARY FINDINGS

- The dental work force is declining in Connecticut.
- HUSKY A fees are below the 7th percentile of fees in New England.
- Safety net clinics are short of dental equipment and auxiliary staff.
- HUSKY A children have the lowest dental utilization rate in New England.
- Significant relief would be provided with better reimbursement, improvements in safety net auxiliary staff and equipment, and implementation of the hygiene team model.

In 2001, while more than 250,000 Connecticut children from low-income families were in HUSKY A dental plans, less than 30 percent of them received any dental services.

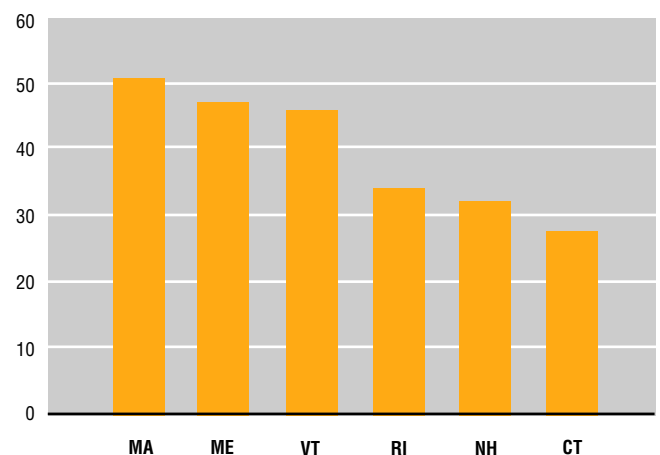


INTRODUCTION

The poor, medically disabled, and geographically isolated have difficulty accessing private sector dental care.¹ To address this problem, federal, state and municipal governments and voluntary sector organizations have established clinics that provide care to the non-institutionalized underserved. Collectively, these facilities are known as the “dental safety net.” In 2001, while more than 250,000 Connecticut children from low-income families were in HUSKY A (a Medicaid program for low-income children and families), less than 30 percent of them received any dental services. The dental utilization rate of these children is the lowest among New England states (Figure 1) and is less than half that of privately insured children (65 percent).

Figure 1

Dental Utilization Rate, 2001*
New England States



* Most recent year for which comparable data is available.

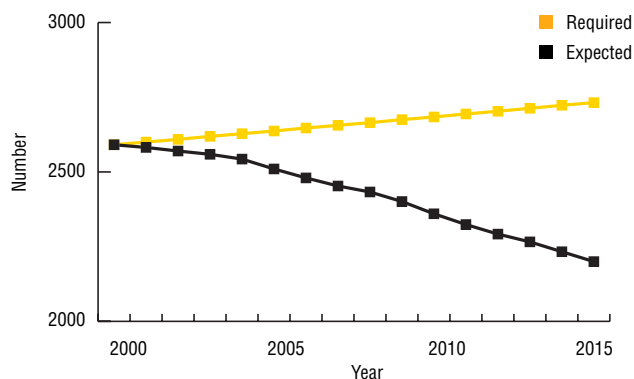


BARRIERS TO DENTAL CARE FOR LOW-INCOME CHILDREN

Diminishing dental work force: The number of dentists in Connecticut expected to retire will exceed the number of new dentists expected to enter practice during the period 2001 to 2015. By 2015 there will be a net loss of 391 dentists or approximately 15 percent of the current work force of 2,591 dentists.² To maintain the current dentist-to-population ratio (1 to 1,314) in 2015, given anticipated population growth, the required number of dentists is 2,732 — meaning a deficit of 532 dentists (Figure 2). Also, the distribution of dentists across Connecticut's 169 towns is uneven.

Figure 2

Expected and Required Number of Dentists



Low HUSKY A reimbursement rates: Less than 15 percent of Connecticut dentists participate in the HUSKY A program. Dental fees for HUSKY A enrollees were set in 1993 at the 80th percentile of prevailing fees and have not been adjusted since, even though the Consumer Price Index for dental services has increased by more than 60 percent. Connecticut's HUSKY A fees are now in the lower 1st to 7th percentiles of dental fees in New England states.

Limited dental safety net: Connecticut's dental safety net system provides services to about 10 percent of HUSKY A children annually. The safety net is made up of dental clinics owned and operated by public and voluntary sector organizations (Figure 3). These clinics provide services to both the Medicaid and non-Medicaid populations that have difficulty obtaining care in the private sector.

Figure 3

The Size and Composition of the Dental Safety Net in Connecticut, 2004

| Type of Facility | Dental Chairs | FTE Dentists | FTE Hygienists | Dental Assistants |
|---------------------------|---------------|--------------|----------------|-------------------|
| Community Dental Clinics* | 106 | 35 | 17 | 44 |
| Hospitals | 50 | 34 | 8 | 32 |
| Public Schools | 27 | 4 | 11 | 5 |
| Dental Schools | 38 | 38 | 2 | 14 |
| Total | 221 | 111 | 38 | 95 |

* FQHCs and CHCs

In 2004, Connecticut's safety net system included 111 full-time equivalent (FTE) dentists, 133 allied health personnel and 221 chairs. Most safety net care is delivered in community dental clinics (also known as federally qualified health centers or FQHCs) and community health centers (or CHCs). Other sources of safety net services are other community clinics, hospital clinics, the University of Connecticut School of Dental Medicine, and dental clinics located in public schools.³

Annually, FQHCs alone provide about 2,000 patient visits per dentist and treat 600 patients per dentist. The 111 FTE safety net dentists treat about 67,000 patients (children and adults) annually. The number of patient visits per safety net dentist is half that for private general dentists primarily because private dentists use more dental operatories and employ more allied dental staff.⁴

This suggests that with more operatories and staff, safety net clinics could significantly increase productivity.^{5,6} However, even with increased productivity, the safety net system is too small to meet the needs of the entire Medicaid population or the thousands of low-income children and adults not covered by Medicaid (Figure 4). Most (65 percent to 69 percent) HUSKY A children who receive care do so in private sector dental offices.

Broken appointments: Dentists cite broken appointments as another reason for their low participation in the Medicaid plan. Broken appointments cause idle practice time and loss of income.

Figure 4

Providers of Preventive and Restorative Dental Services for Ever Enrolled HUSKY A Recipients < 21 Years of Age in 2004

| Provider Type | Preventive Procedures | | | | Restorative Procedures | | | |
|-------------------|-----------------------|-------------|----------|-------------|------------------------|-------------|----------|-------------|
| | Visits | Percent (%) | Children | Percent (%) | Visits | Percent (%) | Children | Percent (%) |
| Safety Net | 36,352 | 37% | 27,654 | 35% | 21,623 | 28% | 13,046 | 31% |
| Private Practices | 62,568 | 63% | 50,310 | 65% | 55,759 | 72% | 29,134 | 69% |
| All Providers | 98,920 | 100% | 77,964 | 100% | 77,382 | 100% | 42,180 | 100% |

Source: Data provided by Connecticut Voices for Children with subsequent analysis by CHF and its consultants.

IMPROVING ACCESS TO DENTAL CARE

The goal is to double dental utilization rates among HUSKY A eligible children — close to the rate seen in privately insured children. Options include:

Increase fees and improve administration of Medicaid: Connecticut Medicaid fees are very low. In an experiment in 37 Michigan counties, the Medicaid program was turned over to a private insurer and dentists received the same fees as those paid by privately insured patients.⁷ Dental utilization increased after a year and is now approaching 60 percent.

Expand and improve the dental safety net: The Connecticut dental safety net system cares for 23,000 children annually, while private practices treat 46,000. To double utilization of eligible HUSKY A children solely through an expansion of the safety net, 70 more dentists, 84 hygienists and assistants, and 139 more dental operatories would be needed, if the expanded system operates similarly to the current one.

However, increasing auxiliary staff and operatories can significantly expand the capacity of the safety net by raising productivity of private practices and safety net clinics. Connecticut dentists are limited in their capacity to employ more hygienists by the current capacity of community colleges to train more dental hygienists.

Implement model dental program: Another option is a model plan where a dental hygiene team provides screening and preventive services to HUSKY A children in public schools and coordinates with private practices for any needed restorative and other care.⁸

The model is based on the fact that 76 percent of the services now used by HUSKY A children (Figure 5) can be provided by a hygiene team using portable equipment in a school. A dentist or hygienist does initial screening, and preventive services are provided by a hygienist, supported by a dental assistant, community aide, school aide, and driver.

The revenues generated could cover other expenses including the cost of transporting children requiring additional services to other offices and provide some additional financial incentives to participating dentists. Practitioner participation in the plan is expected because there are no broken appointments, scheduling can be convenient to the dentist, children are supervised, and dentists are compensated at a competitive rate.

Figure 5

Ever Enrolled HUSKY A Children Dental Service-Mix*

| Services | Number | Percent (%) | Cumulative Percent (%) |
|--------------|---------|-------------|------------------------|
| Examinations | 105,166 | 20.2% | 20.2% |
| Radiographs | 101,263 | 19.5% | 39.7% |
| Prophylaxes | 78,072 | 15% | 54.8% |
| Fluorides | 72,316 | 13.9% | 68.7% |
| Sealants | 38,514 | 7.4% | 76.1% |
| Restorations | 85,829 | 16.5% | 92.6% |
| Extractions | 15,453 | 3% | 95.6% |
| Other | 22,834 | 4.4% | 100% |
| Total | 519,447 | 100% | |

*Dental services provided to 267,949 ever enrolled HUSKY A recipients < 21 years of age in 2004. Source: Data provided by Connecticut Voices for Children with subsequent analysis by CHF and its consultants.



With this model, almost all participating children will receive basic dental care efficiently, the incidence of dental caries will be substantially reduced, time lost from school for dental visits will be reduced, relatively few dentists are needed to carry out the program, and adequate numbers of dentists are expected to participate.

Increase the number of dentists: For the next ten years, about 36 dentists per year are expected to enter practice in Connecticut. To maintain the current dentist to population ratio in 2015, an additional 315 dentists are needed. One option is to enroll more Connecticut residents in dental schools, since they are likely to practice in the state.⁹ However, just increasing the supply of dental services will have a limited impact on access to care for HUSKY A children, since new dentists are likely to follow established practice patterns. But with competitive HUSKY A fees, more dentists are an important part of the strategy for improving access.

CONCLUSION

A diminishing dental work force, cumbersome Medicaid administration imposing very low reimbursement fees, and a relatively small dental safety net have created a major access barrier for HUSKY A children in Connecticut. As a result, Connecticut has the lowest dental utilization rate in New England, even though it has the highest per capita income in the United States.

The above options could be combined to maximize dental care delivery for low-income children. HUSKY A fees for children's services would be raised to where an adequate number of private dentists participate in the program; the productivity of the dental safety net would be improved with the addition of more allied health personnel and dental operatories; and the model program can be implemented in several communities with large numbers of HUSKY A eligible children. These interventions will dramatically improve access to care and the oral health of low-income children in Connecticut.

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