Children in low-income families suffer disproportionately from dental disease, in large part due to lack of access to dental services. Dental care access problems were reported by virtually every Medicaid program recently surveyed by the American Public Human Services Association.

**State reports on dental care**
Over the last two years, the number of children enrolled in HUSKY Part A (Medicaid managed care) has increased. At the same time, the percentage of children and youth under 21 receiving preventive dental services has decreased, according to the Department of Social Service’s annual report to the federal government (see chart).

- During federal fiscal year 1999, just 28% of eligible children received any type of dental services (preventive or treatment). Only 12% of eligible children received dental treatment services.
- Use of preventive care utilization based on age, region, ethnicity, and health plan were evident. Use of preventive services was
  - highest among children 6 to 11 years of age (47%) and lowest among teens aged 15 to 19 (25%)
  - highest in Hartford (47%), Litchfield (44%), and New London (45%) counties and lowest in Fairfield (34%) and Tolland (33%) counties
  - greater among children enrolled in BlueCare (45%) than members of Physicians Health Services (37%) or Preferred One (38%)
  - higher among Hispanic children (44%) than African-American children (38%)
- Use of dental treatment was
  - higher among children 6 to 14 years of age (25%) than preschool children (17%)
  - greater among Hispanic children (26%) than African American children (20%)
  - higher in Hartford county (26%) than in Fairfield (20%), Middlesex (20%), and Tolland (17%) counties
  - greater among children enrolled in Blue Care (26%) than members of PHS (19%) and Preferred One (20%).

These differences based on race/ethnicity, age, region, and health plan indicate that some populations need special attention to increase their use of dental services.
Recent Initiatives on Dental Access

Connecticut Community Oral Health Systems Development Project: In 1997, the Connecticut Department of Public Health received a four-year federal grant to develop oral health initiatives at the local level. These local projects have resulted in an expansion of the capacity for dental care in several communities, including the development of clinics and mobile vans in Groton, New Haven, Stamford, East Hartford, Manchester, and Rockville.

Other communities, including those comprising the Northeastern Connecticut Health District and the city of Bridgeport, are also planning projects intended to increase the capacity for dental care.ii

Medicaid reimbursement of dental hygienists: The Department of Social Services authorized direct reimbursement for dental screenings and preventive procedures performed by dental hygienists within their scope of practice. As a result, the managed care organizations participating in the HUSKY program have begun to credential dental hygienists as providers in their health plans. The impact of this change has not yet been evaluated in terms of its effect on access, utilization, costs, and provider participation.

Litigation on dental access: In June 2000, three families enrolled in the HUSKY Part A program filed a lawsuit against the Department of Social Services claiming that they have been denied access to dental services in violation of federal law. The families brought the lawsuit as a class action seeking to represent all families enrolled in the HUSKY Part A program. They are asking that the court order DSS to increase dental reimbursement rates, to improve administration of the Medicaid dental program, and to do whatever else is necessary to recruit an adequate number of qualified dental providers throughout the state.

Legislative action: In June 2000, the General Assembly created two provisions affecting dental access in Public Act 00-2. One provision directs the Departments of Public Health and Social Services and the UCONN Health Center to establish a pilot program for the delivery of dental services to children in low-income families in two regions of the state. The second provision establishes a dental advisory council, which will review fees in the Medicaid program, make recommendations for the modification of the fees, monitor the effect of any fee increases, evaluate pilot programs, and enhance public and provider awareness of dental access issues. An interim report is due to the General Assembly no later than April 15, 2001, with a final report due by January 1, 2002.

Summary and Recommendations

Dental access has been a problem for children and families in the Medicaid/HUSKY A program for many years. The barriers to dental access are not new, either. However, over the last several years the problem has received far more attention and study at both the federal and state levels. In addition, there has been far greater recognition of the consequences that result from dental disease, including the effect on children’s ability to grow and learn.

The complex and seemingly intractable problem of inadequate dental access for children enrolled in the HUSKY Part A program requires a multi-faceted approach. Strategies should be aimed at enabling provider participation, enhancing the public dental infrastructure, and involving other health and education professionals in oral health promotion. The Council’s recommendations include:

- Raise Medicaid dental fees for selected dental procedures for adults and children;
- Reduce administrative burdens on dental providers who participate in Medicaid managed care;
- Increase the ability of pediatric primary care providers to screen for dental caries in very young children;
- Increase the ability of general dentists to treat dental caries in very young children;
- Systematically monitor dental access and utilization so that program changes and initiatives can be evaluated.
- Develop demonstration projects with innovative approaches that increase comprehensive dental care for children on Medicaid.

Two additional recommendations from the US Surgeon General should also be included in Connecticut’s approach:

- Incorporate and integrate education and outreach efforts designed to enhance oral health in other initiatives such as WIC, Head Start, and HUSKY outreach.
- Enhance the public dental infrastructure through public/private partnerships that can utilize increased fees to sustain programs established with private funding.

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