



Connecticut State Dental Association

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**Legislative Testimony
Raised Bill No. 7069
AAC Access to Oral Health Care
Dr. W. Fred Thal
Connecticut State Dental Association Board of Governors
Chairman, CSDA House Committee on Access to Oral Health Care
Chairman, Executive Committee, New Britain Oral Health Collaborative**

Good afternoon Representative Sayers, Senator Handley and Ladies and Gentlemen of the Public Health Committee:

First let me thank Representative Sayers and all of you for reintroducing this bill. It has been a frustrating experience for those of us who are concerned about access to oral health care to have seen this bill nearly passed in last year's legislative session, to have it withdrawn at the last hour based on an indication that the State was willing to settle the six year old class-action lawsuit, and then to see no resolution resulting.

I am a pediatric dentist, in private practice in New Britain. I, my partner, and my associate are all HUSKY providers. Together, we see over 700 HUSKY insured children as well as another 100 Medicaid fee for service insured patients. We, like other providers, continue to participate in the HUSKY plan because we see it as a community responsibility. In New Britain, there are approximately 16,000 school-aged children. Of these, nearly 10,000 are insured by the HUSKY plan. We, like other providers, find it necessary to limit the numbers of HUSKY insured patients we see. This is primarily because the fees we receive under the HUSKY plan are so low that they do not even cover our overhead. The typical dental office operates with an overhead of 60-70%. When HUSKY fees are only 30-40% of one's usual fees the dentist loses money on every HUSKY patient he sees. If we were to accept all the HUSKY insured patients who need and seek our services we would not be able to continue to pay our staff salaries, our rent, our taxes, etc. Many dentists in Connecticut have understandably opted for the easier alternative of complete non-participation with the HUSKY program.

The Connecticut State Dental Association, under the leadership of President Jack Mooney, in July, 2006, formed a Task Force to address the issue of Access to Care for the uninsured, underinsured, and HUSKY insured. A final report by this committee was received by a special session of our House of Delegates on February 7, 2007. This report identifies six basic strategies which can be used to resolve the problem of access to oral health care. They are: 1) Increase the number of dental providers serving the HUSKY population; 2) Explore and implement changes in the dental workforce; 3) Expand and improve the dental safety net; 4) Encourage school-based dental services; 5) Improve oral health education; and 6) Volunteerism. No single approach can be expected to solve the access problem. Private dentists currently provide about two-thirds of the care being provided to the HUSKY insured population. The dental safety net facilities, including UConn School of Dental Medicine, community health centers, school-based services, and other community clinics provide the other one-third. The safety net clinics are stretched to the limits of their finances, facilities and manpower. Only the private dentists have the capacity and flexibility to make a significant immediate impact on the access problem.

Bill 7069 calls for a significant increase in the fees paid to HUSKY providers. The current HUSKY fees are below the level that would be considered acceptable to fewer than 5% of the dentists in

Connecticut. Several other states (Michigan, Delaware, Indiana, Tennessee) have, in recent years increased their levels of reimbursement to the seventy-fifth percentile or higher. The result has been a significant increase in provider enrollment in their versions of the HUSKY plan. One of the concerns that the negotiators for the Department of Social Services has raised is that the dentists of Connecticut will not increase their participation even if fees are raised to the seventieth percentile. In response to that concern the CSDA has recently conducted an informal survey of its membership. Nearly 400 members responded that if fees were raised to the seventieth percentile they would participate as HUSKY providers. 300 of these would be dentists who are currently not participating in the HUSKY plan at any level. The other 100, who are current providers, have indicated that they would participate at a higher level if fees are increased. If the HUSKY and other Medicaid-based fees are increased to the 70th percentile the CSDA will actively work with DSS and the managed care organizations to recruit and credential dentists to become HUSKY providers. The CSDA has committed to assigning an employee specifically to facilitate this recruitment and credentialing process.

Fees should also be indexed to inflation or otherwise adjusted at regular intervals. The last adjustment to HUSKY fees was in 1993. If not adjusted for inflation, fees will erode in comparison to the current cost of health care. Dentists will again feel constrained financially and will gradually cease to participate as providers.

Fee increases must cover patients of all ages, children and adults. Dental Medicaid fee schedules for adults are unconscionably low, lower even than HUSKY fees for children. And many of these adults are the most vulnerable, most challenging patients we see (or don't see) in our offices. Often, the only time these medically and developmentally challenged adults are seen is when they have an emergency problem, a dental abscess, periodontal abscesses, etc. which require expensive emergency room treatment. The issue of access to oral health care for the elderly is only beginning to receive the attention which it needs.

Section 3 of Bill 7069 calls for "a regional oral health coordinator for up to six regions of the state... All regional oral health coordinators shall be dental hygienists ..." This is a very important part of the legislation because, in addition to the low fees, there are other barriers to access, barriers such as transportation and parent's employment commitments. However, this position does not need to be filled by dental hygienists. There is already a shortage of dental hygienists available to provide preventive services. Regional oral health coordinators do not require the clinical training of a dental hygienist. They should be trained as "care coordinators" or "care administrators." The oral health collaboratives which have been organized and funded by the Connecticut Health Foundation in recent years employ care coordinators, and the managed care organizations already employ such people. The Department of Public Health could build on their experience and expertise to develop a corps of regional coordinators skilled in outreach to the underserved and who would act as liaisons between the patients and providers.

I recognize that providing oral health care to all of Connecticut's citizens is an expensive proposition. Bill 7069 is a necessary first step. In the words of St. Francis of Assisi: "First do what is necessary, then do what is possible, and before long you will be doing the impossible."

Respectfully submitted,

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