

**TESTIMONY IN SUPPORT OF SENATE BILL 1, AN ACT CONCERNING  
INCREASING ACCESS TO AFFORDABLE, QUALITY HEALTH CARE**

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Good morning. I am Dr. Joanna Douglass, a pediatric dentist and associate professor at the University of Connecticut. I have directed the UCONN-Burgdorf Pediatric Dental Clinic, a large facility serving Medicaid children, and worked throughout the state to increase access to oral health care. I am here today in support of Senate Bill 1, *An Act Concerning Increasing Access To Affordable, Quality Health Care*.

In an effort to improve access to oral health care among Medicaid or HUSKY children, I have authored two policy briefs. The briefs, which were commissioned by the Connecticut Health Foundation, are attached to my written testimony.

Oral health is part of overall health and contributes to our ability to function well at school, at work and in social settings. Poor oral health has been linked to pre-term births and poor diabetic control, as well as the inability to concentrate and learn at school. Any measure to improve overall health must include oral health. And, any effort to expand health care coverage must include real access to providers. Without adequate access to providers, expanded coverage will not solve our health care dilemma.

One-quarter of children in Connecticut are insured under HUSKY. While oral health coverage under HUSKY is adequate, access to oral health providers is in crisis. In Connecticut, the percent of HUSKY children able to see a dentist is the lowest among ALL New England states. Less than one-half of those requiring treatment actually receive it. In a recent "mystery shopper" survey, only around 27 percent of those who inquired were able to secure a dental appointment.

National studies cite low reimbursement rates as the biggest reason for low provider participation in Medicaid. Connecticut's reimbursement fees are one of the lowest in New England. In other words, each time dentists see Medicaid patients, they lose money. To put the issue in perspective, the state pays \$22 per person per month for dental insurance for state employees and their children, yet only pays \$7 per person per month for HUSKY children. It is hardly surprising that families cannot locate dentists willing to see their children insured under HUSKY.

While Connecticut's oral health safety net is trying to meet ever-expanding needs, community and school health clinics provide only about one-third of the dental care that HUSKY children receive. Private dentists, on the other hand, provide two-thirds of the care.

The attached table illustrates that private providers will participate in Medicaid in significant numbers if fees are increased to the 70<sup>th</sup> percentile, meaning that 70 percent of Connecticut's private dentists charge this fee or less as their normal and customary fee. A recent survey in Connecticut revealed that 270 new dentists will join the Medicaid program if fees were raised to this level.

I support Senate Bill 1 as it clearly recognizes the importance of oral health in overall health and addresses the issue that insurance coverage without real access does not improve health. The bill also clearly identifies that any plan must provide realistic reimbursement rates to doctors and dentists to ensure adequate participation in the HUSKY program.

Thank you for your time. I will be happy to answer any questions.

### Increase in Provider Rates Among States That Have Increased Fees to Market Rates

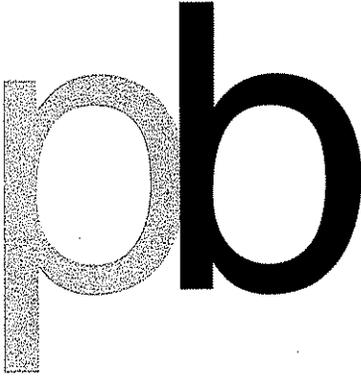
State Year of Change	New Rates	Approx. # Dentists in State	Numerical Increase in Participating Providers*	% Increase in Participating Providers
Alabama 2000 <sup>4, 6, 7</sup>	100% of Blue Cross rates <sup>4, 6, 7</sup>	1,912 <sup>7, 8</sup>	308 to 456 <sup>7</sup>	48%
Delaware 1998 <sup>4</sup>	85% of dentists normal submitted charges <sup>4</sup>	302 <sup>8, 9</sup>	1 to 108 <sup>9</sup>	
Georgia 2000 <sup>4</sup>	75 to 85% of UCR <sup>4</sup>	4,000 <sup>4</sup>	259 to 1,355 <sup>4</sup>	423%
Indiana 1998 <sup>4, 9</sup>	75 <sup>th</sup> percentile <sup>4, 10</sup>	3,583 <sup>10</sup>	770 to 1,096 <sup>10</sup>	42%
Michigan (Select Counties) 2000 <sup>9</sup>	100% of Delta Dental Premier Rates <sup>10</sup>		115 to 351 <sup>10</sup>	205%
Nebraska 1998 <sup>4</sup>	85% of UCR <sup>4</sup>	1,077 <sup>8</sup>	798 to 964 <sup>12</sup> 231 to 387 <sup>** 12</sup>	21% 68% **
North Carolina 2003 <sup>13</sup>	73% of University Faculty rates <sup>13</sup>	3,500 <sup>13</sup>	644 to 855 <sup>** 14</sup>	33% **
South Carolina 2000 <sup>4, 15</sup>	75 <sup>th</sup> percentile <sup>4, 15</sup>	1,561 <sup>8</sup>	619 to 886 <sup>4</sup>	43%
Tennessee 2002 <sup>4, 16</sup>	75 <sup>th</sup> percentile <sup>4, 16</sup>	2,861 <sup>8</sup>	380 to 700 <sup>16</sup>	84%

\*Change reported after a period of 2-3 years from the rate increase except for Delaware which was 5 years.

\*\*Providers billing greater than \$10,000 per annum.

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## HUSKY A DENTAL CARE: FINANCIAL STRATEGIES

### SUMMARY FINDINGS

- Raising Medicaid reimbursement is one key component to increasing access to dental care for children on Medicaid.
- Increasing fees to the 70th percentile in other states has resulted in increased utilization.
- In the first year, raising all fees except orthodontics to the 70th percentile will cost an additional \$21 million, which would be eligible for a federal match.
- Any increase in fees must be accompanied by ongoing cost of living adjustments.

In Connecticut multiple barriers exist to providing dental care for children on Medicaid, including a diminishing work force, limited capacity of the “dental safety net” clinics and low Medicaid reimbursement rates. Reimbursement rates are currently in the lower 1st to 7th percentiles of dental fees in New England resulting in less than 15 percent of Connecticut dentists participating in Medicaid. Raising reimbursement fees to a level at which an adequate number of providers participate in the Medicaid program will substantially enhance access to care for Connecticut’s children.

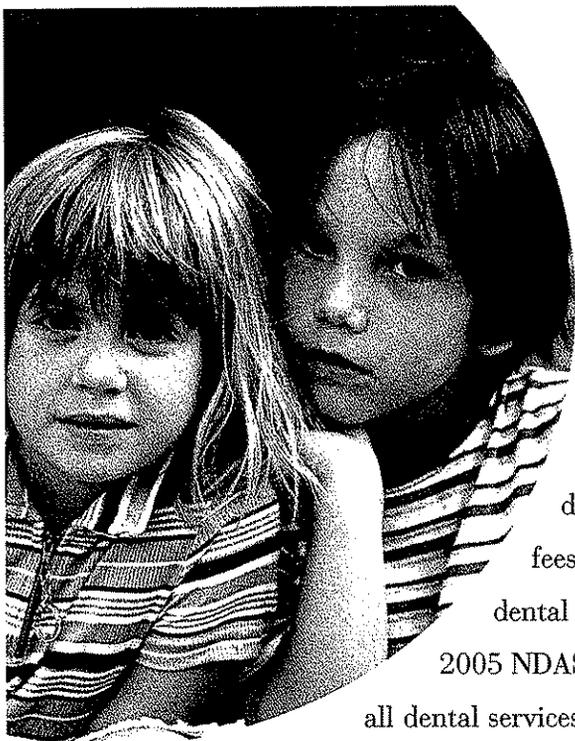


### CURRENT ENROLLMENT, UTILIZATION AND EXPENSES

In 2004 there were 267,949 enrolled individuals under the HUSKY A state dental plan.<sup>1</sup> Of these individuals 170,937 were continuously enrolled for the entire year while 97,012 were enrolled for part of the year. Among those continuously enrolled for the entire year 42.2 percent had at least one dental visit compared to only 17.4 percent for those enrolled for part of the year. Overall, 33.2 percent had at least one dental visit.

Using the frequency of dental services utilized by HUSKY A individuals and current Medicaid fees [as obtained from the Connecticut Department of Social Services (DSS) website for fee-for-service clients] the current total dental expenses for HUSKY A individuals were estimated. They amounted to \$16,360,526. The annual dental expenses per enrollee amounted to \$61.06 (about \$5 per month per enrollee); the annual dental expense per user was \$184.08. Assuming the number of enrolled individuals and their utilization of services did not change since 2004 the dental expenses for 2005 would remain the same.

*Reimbursement rates are currently  
in the lower 1st to 7th percentile of  
dental fees in New England.*



## NEW FEES, UTILIZATION AND EXPENSES:

The actual fees charged by Connecticut providers in 2005 are not available hence the 2005 National Dental Advisory Service, Comprehensive Fee Report (NDAS) was used as the fee schedule for dental procedures provided in Connecticut.<sup>2</sup> The NDAS report provides fees for the 40th, 70th, and 95th percentile of dental providers. Using the dental service experience of HUSKY A enrolled individuals in 2004 and the 2005 NDAS fee schedule we estimated the dental expenses for these percentiles for all dental services covered by the HUSKY A dental plan.

Selecting a fee schedule based on a percentile helps determine the level of access afforded to HUSKY individuals. The 70th percentile has been suggested as the level at which fees have to be set to increase provider participation in Medicaid. If the fee schedule is based on the 70th percentile it can be expected that HUSKY individuals will have access to 70 percent of the providers in Connecticut. The 70th percentile indicates that 70 percent of providers charge this fee or less as their normal and customary fee.

If the distribution of provider's fees is distributed uniformly the estimated expenses at the 70th percentile may be higher than the true expenses by nearly 10 percent. Therefore these estimates are upper bound estimates for 2005 provided that the number of HUSKY A individuals and their dental service utilization have not changed since 2004 and participating dentists continue to charge their usual and customary fees.

Table 1

Sample Fee Increase

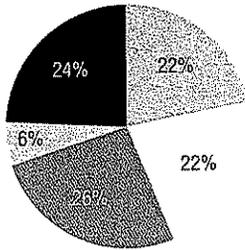
DESCRIPTION	CURRENT HUSKY A FEES	2005 NDAS FEES AT 70TH PERCENTILE
Pediodic oral exam	\$18	\$37
Initial exam	\$24	\$65
Bitewing x rays	\$16	\$35
Cleaning	\$22	\$52
Fluoride treatment	\$15	\$29
Sealant	\$18	\$42
Amalgam - 2 surface	\$38	\$126
Resin - 2 surface	\$46	\$147
Stainless steel crown	\$85	\$207
Pulpotomy	\$45	\$150
Anterior root canal	\$200	\$539
Extraction single tooth	\$33	\$122

Source: CT Department of Social Services and National Dental Advisory Service.

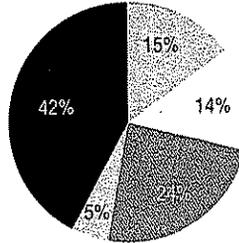
Adjusting Medicaid fees to 2005 levels, regardless of the chosen percentile, will result in significant cost increases as dental fees have not been adjusted since 1993.<sup>3</sup> In addition the fee increases change the distribution of the costs. Of note, the percentage of the costs attributed to orthodontics will increase from 24 percent to 42 percent (Figure 1), a disproportionate increase given that orthodontic services are provided to less than 5,000 of the 267,949 individuals on Medicaid annually. If the costs for the two most common orthodontic procedures were to remain constant at their present 2004 level this cost proportion would drop to 11 percent. Therefore, if fees for all services except orthodontics were increased to the 70th percentile, it

Figure 1

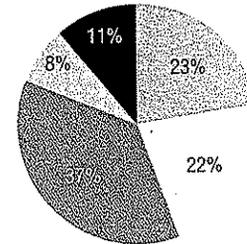
**Distribution of Costs for Current Fees**



**Distribution of Costs if All Fees Raised**



**Distribution of Costs if All Fees Except Orthodontics Raised**



Diagnostic Services  
 Prevention  
 Fillings and Root Canals  
 Other  
 Orthodontics

*Analysis based on data from the CT Department of Social Services, Connecticut Voices for Children, and National Dental Advisory Service.*

would cost an additional \$21 million, which is eligible for matching dollars from the federal Medicaid program. In contrast, if fees were increased for all services including orthodontics, total costs would increase by \$40 million (Table 2), which also is eligible for a federal match.

The increase in fees is expected to lead to an increase in the dental utilization of HUSKY A individuals as the number of Medicaid providers increases. Currently less than 15 percent of providers participate. Although projected utilization is difficult to estimate the range is expected to lie between the present dental utilization rate (33.2 percent) and the utilization rate of non-poor individuals (65 percent). As a result, we provide additional estimates of total dental expenditures for an overall dental utilization rate of 50 percent. This range should not be considered as low. If we were to assume that the ratio of dental utilization between continuously and non-continuously enrolled children remains constant the overall dental utilization of 50 percent is equivalent to 64 percent for children enrolled in HUSKY A for 12 months con-

tinuously. This is consistent with Michigan's experience after Medicaid fees were increased.<sup>4</sup> However, it will take considerable time and effort to achieve an overall utilization of 50 percent after the new fees are implemented. Additional federal matching dollars can be expected in future years to offset increased costs.

All estimates are in 2005 dollars. No attempt has been made to adjust expenses for future increases in dental fees. Ongoing adjustments to account for cost-of-inflation are essential for improving and maintaining access to dental care for HUSKY A individuals and to prevent the erosion of access that has occurred since fees were last adjusted in 1993.

*The increase in fees is expected to lead to an increase in the dental utilization of HUSKY A individuals.*



Table 2

**Current and Projected Costs of HUSKY A Children's Dental Services for All Services and Modified Services**

	Total Program Cost: All Fees Raised		Total Program Cost: All Fees Except Orthodontics Raised*	
	Current Utilization (33%)	Projected Rates (50%)	Current Utilization (33%)	Projected Rates (50%)
<b>Number of Children Receiving Services</b>	88,876	133,974	88,876	133,974
<b>Current HUSKY A Fees</b>	\$16,360,526	\$24,639,346	\$16,360,526	\$24,639,346
<b>2005 NDAS Fees at 40th Percentile</b>	\$49,346,870	\$74,317,575	\$32,599,095	\$49,095,023
<b>2005 NDAS Fees at 70th Percentile</b>	<b>\$56,678,137</b>	<b>\$85,358,640</b>	<b>\$37,092,983</b>	<b>\$55,862,926</b>
<b>2005 NDAS Fees at 95th Percentile</b>	\$71,292,608	\$107,368,386	\$46,214,566	\$69,600,250

\*Fees of two orthodontic procedures (8080 and 8670) maintained at 2004 HUSKY A levels. Analysis based on data from the CT Department of Social Services, Connecticut Voices for Children, and National Dental Advisory Service.

**CONCLUSION**

Adjusting Medicaid fees to prevailing fees is long overdue and necessary if the current level of access is not to decline. Arguing in favor of a particular set of fees is less critical. The set of fees corresponding to the 70th percentile seems to be a reasonable upper bound set of fees. These fees will improve access significantly. Adapting a provision to adjust fees periodically (preferably annually) is an essential element of any plan to increase access and utilization.

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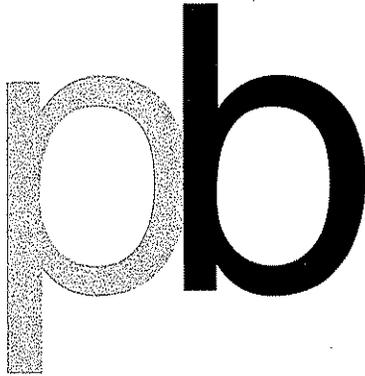


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policy brief

## 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.*

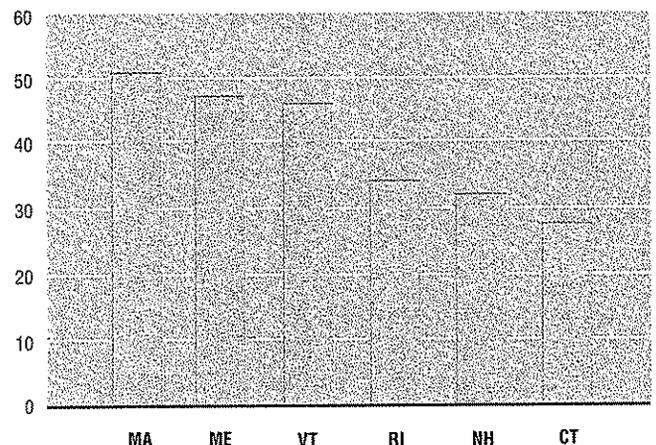


### INTRODUCTION

The poor, medically disabled, and geographically isolated have difficulty accessing private sector dental care.<sup>1</sup> 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.<sup>2</sup> 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**

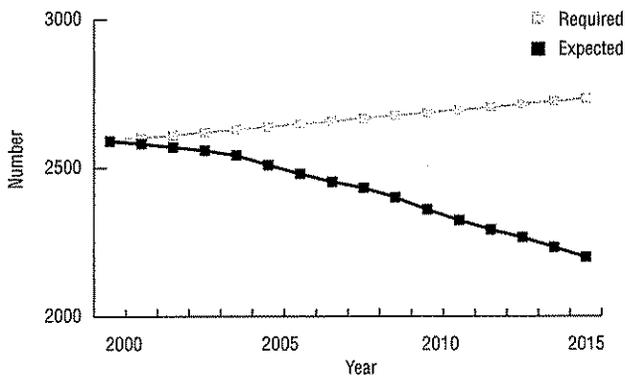


Figure 3

**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
<b>Total</b>	<b>221</b>	<b>111</b>	<b>38</b>	<b>95</b>

\* FQHCs and CHCs

**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.

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.<sup>3</sup>

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.<sup>4</sup>

This suggests that with more operatories and staff, safety net clinics could significantly increase productivity.<sup>5,6</sup> 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.<sup>7</sup> 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.<sup>8</sup>

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.

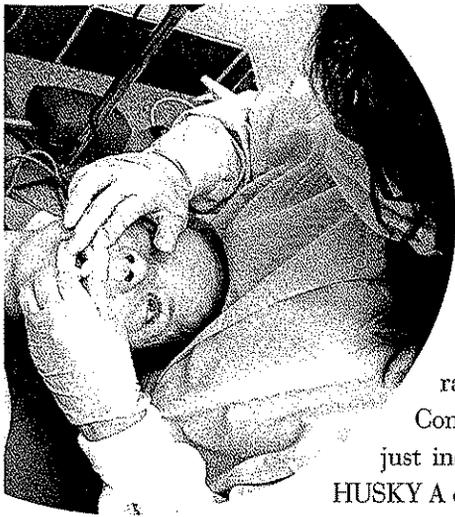
The revenues generated could cover other expenses including the cost of transporting children requiring additional services to other offices and provide some additional financial incentives to participating dentists. Practitioner participation in the plan is expected because there are no broken appointments, 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%
<b>Total</b>	<b>519,447</b>	<b>100%</b>	

\*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.<sup>9</sup> 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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