COHI
Connecticut Oral Health Initiative

OCTOBER 2022

A MEDICAID GAP ANALYSIS OF ORAL HEALTH CARE FOR ADULTS IN CONNECTICUT

FUNDED BY

CareQuest Institute for Oral Health
&
Connecticut Health Foundation

ACKNOWLEDGMENTS

The Connecticut Oral Health Initiative (COHI) would like to thank the CareQuest Institute for Oral Health and Connecticut Health Foundation for funding this project and the staff and volunteers who contributed. We would also like to thank the numerous community partners for helping to organize the group conversations and the individual participants for their courage and insights in sharing their oral health experiences.

About COHI

COHI is a 501c3 organization founded in 2001, focused on strengthening and safeguarding access to quality, affordable oral health services for all Connecticut residents. COHI does this work by advocating for statewide policy changes, communicating the impact of structural and social factors on oral health, and promoting the necessity of good oral health for overall health and well-being. COHI envisions a Connecticut where residents achieve equal opportunity, regardless of race, ethnicity, or socioeconomic status, to the services needed to maintain good oral health.

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EXECUTIVE SUMMARY

Over 500,000 adults in Connecticut are enrolled in Medicaid,[1] yet more than half may not be utilizing any of their dental benefits in a given year. COHI conducted a comprehensive study from 2021-2022 to investigate potential barriers causing gaps in oral health access and quality care, and to identify solutions to achieving better outcomes. The study focused on understanding Medicaid service utilization data, the impact of the annual maximum benefits cap initiated in 2018, identifying gaps in provider networks across the state, and understanding the experiences of providers and enrollees.

The results showed that although the benefits cap (the limit on annual Medicaid payment for oral health care, absent a waiver) can impose significant limits on treatment, it affects a relatively small number of people. Other barriers affect many more Medicaid recipients. Some of them include an inadequate active Medicaid provider network in some regions of the state, difficulties and delays in making dental appointments, lack of trust in providers, possible discrimination against enrollees, denials of covered benefits, the inability to obtain medically necessary uncovered benefits, enrollees limited knowledge of Medicaid dental benefits, and difficulties accessing Medicaid assistance.

Changes in policy and front-line care are needed to reduce these gaps. Enrollee search tools should be based on up-to-date information on the Medicaid provider network. Providers should be helped to create and maintain websites that inform and engage Medicaid recipients and help to build communication with patients that addresses dental anxiety and builds trust. The state should expand coverage for essential services such as periodontal treatment, exempt certain vital service categories from the annual maximum benefit cap, and invest in expanded educational outreach to improve participant understanding and use of their Medicaid benefits.

COHI recommends additional research be conducted, especially in the areas of:

- Identifying additional factors that contribute to the underutilization of dental benefits for over 60% of enrollees of Medicaid.
- Evaluating the impact of the recent increase in provider reimbursement rates on provider participation and exhaustion of benefits under the annual cap.
- Exploring the acceptability of and barriers to developing a dental therapy workforce in Connecticut to help close access and quality of care gaps.

More details, appendices, and references can be found at: www.ctoralhealth.org/medicaid-gap-analysis-report-2022.

INTRODUCTION

Connecticut is one of only 21 states that offer comprehensive dental benefits for adults covered by Medicaid.[2] It was one of the first states in the nation to expand its Medicaid coverage after the passage of the Federal Affordable Care Act. Adult dental benefits are optional under Medicaid, while comprehensive dental care for children is required under the Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.[3] Currently, over 900,000 Connecticut residents, approximately 24% of the state's population, are enrolled in Medicaid, with more than half being adults aged 21-64.[4]

Although Connecticut's oral health Medicaid benefits (HUSKY Dental Health) are considered extensive by national standards, it is also among the states with the largest health disparities. Stark segregation, a large wealth gap, and persistently inequitable health outcomes are masked in statewide averages, contributing to persistent gaps in dental treatment and service utilization.[5]

Connecticut's benefits, though better than some other states, still leave numerous gaps in the oral health safety net. Certain procedures that are key to achieving and maintaining oral health are not covered benefits,[6] and provider reimbursement rates for services may be inadequate. Other procedures are challenging to obtain because of a lack of accessible specialty providers.[7] Further, as a state cost-saving measure, a $1,000 annual maximum dental benefits cap was implemented in 2018 for all adult enrollees aged 21 and over. Finally, most Connecticut providers do not accept Medicaid, and only a small percentage see at least one hundred or more enrollees a year, according to the American Dental Association Health Policy Institute,[8] making it difficult to find timely care.

In 2020, COHI explored these gaps through several community conversations in which Medicaid enrollees described their difficulties with access and quality of care, such as having to travel across the state to find a provider and feeling they were being steered toward dental extractions rather than restorative alternatives. Some individuals suggested that the newly implemented $1,000 annual maximum benefit cap was increasing the pressure to have teeth pulled rather than restored.

Following up on these community-based messages, COHI focused its further research on:

- Collecting and analyzing utilization claims and claim denials in relation to the annual cap.
- Mapping providers and transportation options to identify areas with localized access problems.
- Hearing perspectives and experiences through in-depth individual interviews and focused discussion groups with enrollees of Medicaid, providers, and grassroots community leaders.

ANALYSIS OF MEDICAID CLAIMS DATA

In 2018, Connecticut instituted an annual adult (21+) dental benefit maximum of $1,000. Once the cap is met in a calendar year, the HUSKY Dental Health program stops paying all dental services except for emergencies or medically necessary services that are prior authorized. For example, dentures may be covered even if they exceed the cap over the yearly maximum with prior approval. When the change was enacted, The Connecticut Dental Health Partnership expected that only a small number of individuals would ever reach the cap in a given year.[9] To help determine the impact of the cap on the access and quality of care, COHI analyzed claims data obtained from the Connecticut Department of Social Services for the years 2016 to 2020.

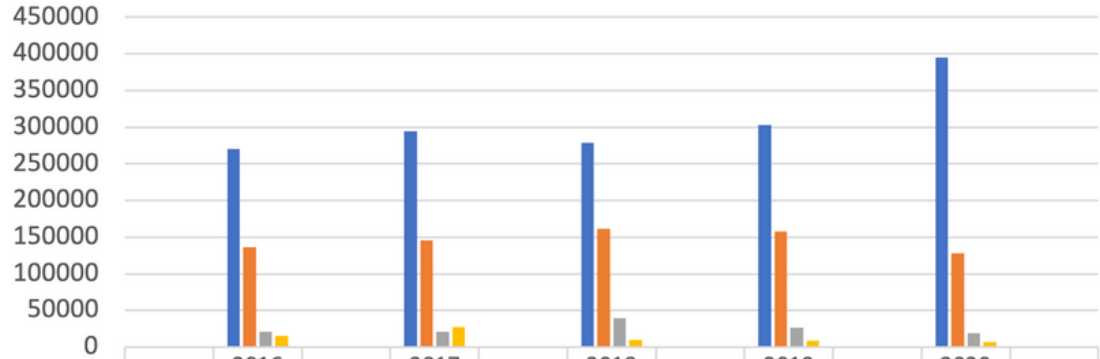
Findings

Medicaid adult enrollment went up every year from 2016 to 2020. However, a majority of enrollees have no claims submitted on their behalf in a single year, as shown in chart 1, and are likely not receiving any dental services through Medicaid, likely suggesting unmet needs. The same pattern of underutilization was found across all five years. The problem was exacerbated in the later years because of a reduction in services available at the height of COVID-19.

It is also noteworthy that claims between $500 and $1,000 have been very low across the last five years, and most participants receive under $500 in oral health benefits per year. It will be important to understand whether the predominance of low-level claims is: 1) because there is no need for more care, 2) because the reimbursement for restorative and reconstructive dental services exceeds the cap, 3) because the providers' recommended treatment is not covered under Medicaid, 4) or for other reasons.

Chart 1: Changes in Number of Adult Claims Over Five Years by Amount

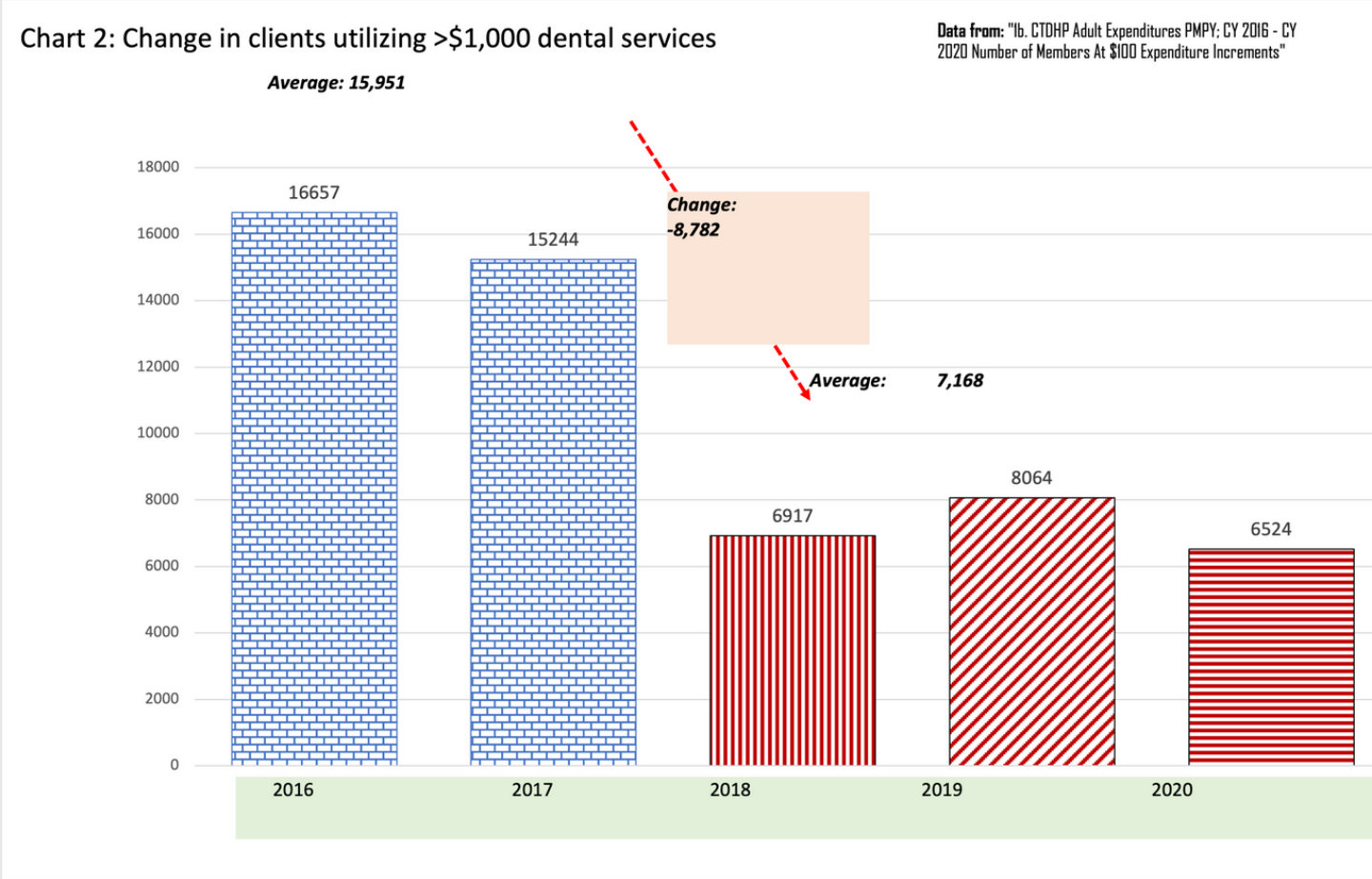
Annual Trends: 2016-2022
Adult Benefit Utilization, Appeals, Service Volumes & Utilization Management Activities
Year over Year Adult Benefit Usage Trends



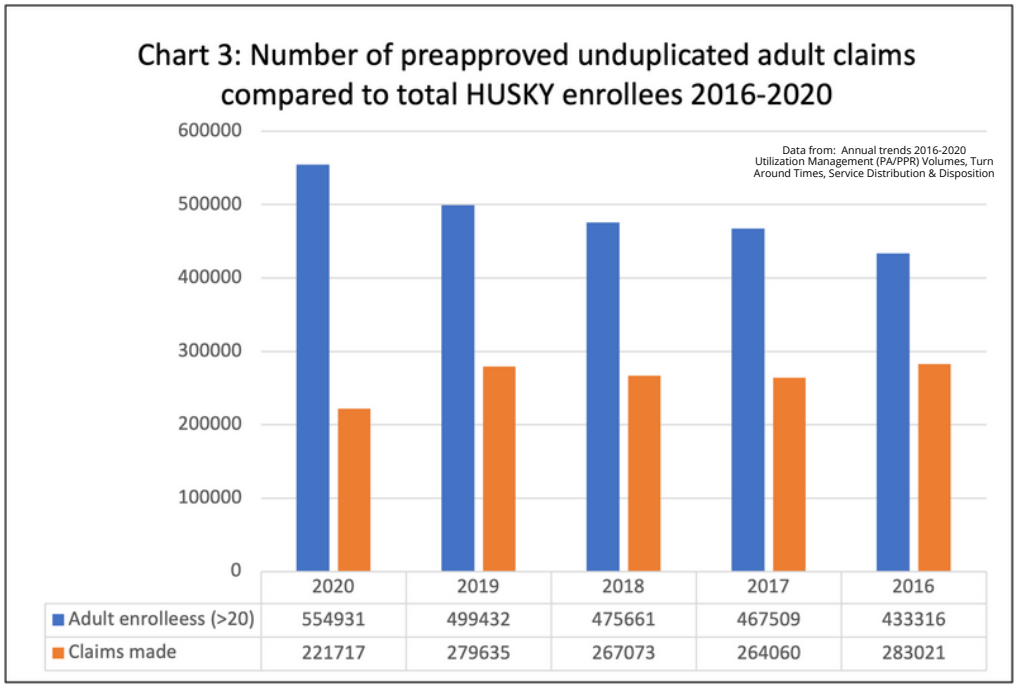
	2016		2017		2018		2019		2020	
No Claims	270160	60.4	294191	60.1	278443	59.3	303119	61.1	394883	71.9
Claims of $1 - 499	136472	30.5	145791	29.8	161493	34.4	157559	31.7	127672	23.3
Claims of $500-$999	20649	4.6	21337	4.7	39223	4.1	26590	5.4	18984	3.5
Claims $1000/above	15704	4.4	27970	5.7	10206	2.1	8645	1.7	7394	1.4

After the cap was initiated in 2018, as chart 2 shows, there was a steep drop in claims approved over the $1,000 annual maximum benefit amount. Because of the overall underutilization of benefits, the cap affects only a tiny proportion (1 - 2%) of adult enrollees. But for these adults, the cap may be significant, causing delays or denials of care, with a potential prolonged state of pain and other adverse effects on oral and overall health.

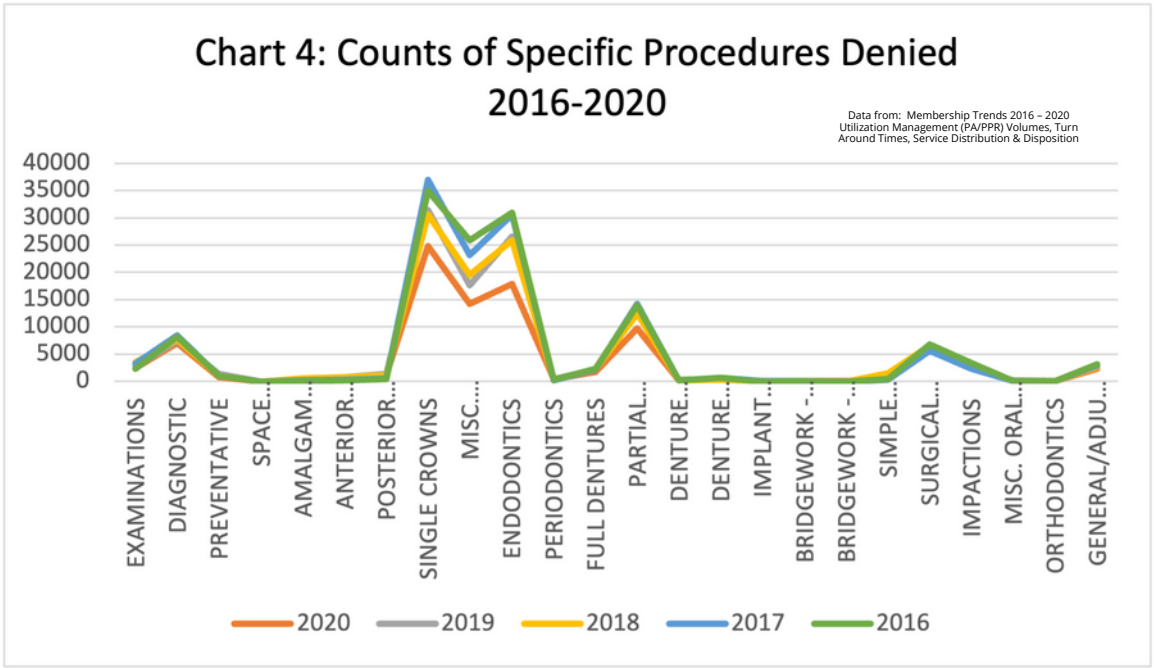
The reasons for the drop in claims over the $1,000 level are not known but could relate to perceived administrative costs to challenge denials or request authorization above the cap, the disproportionate cost of allowable non-routine procedures that exceed the cap, or a gap in communication between providers and patients that interferes with effective utilization of available benefits over time.



The data also shows that more than 40% of requests for services requiring pre-approval are denied for reasons coded, for example, as "duplicate claims," "calls for more information," or "inappropriate," (the last presumably either because they do not require prior approval or because they are covered benefits not requiring pre-approval).



The main procedures denied were single crowns, other restorative procedures, endodontics, full and partial dentures, denture adjustments, and surgical as opposed to “simple” extractions, as shown in chart 4. Many of the reasons for denials are correctable and preventable with more education and guidance to help save providers and enrollees time and money.



To help determine existing geographical Medicaid access gaps and potential barriers to oral health care in the state, COHI evaluated the network adequacy of Medicaid providers by conducting a geographic assessment of providers in relation to transportation options and population density. Three key factors were location, transportation, and supply/demand, but there are other less obvious factors that also inhibit access both in terms of location, and physical, and internet presence.

Data were derived from a base dataset of dental facilities, geocoded using the ArcGIS address geolocator, and manually refined. Due to a lack of publicly available data provided by the state of Connecticut, manual data collection via research and digitization were used to supplement existing data sources, creating a database as of 2022. Researchers mirrored the process an individual might embark on to find appropriate dental care, via a rigorous, systematic search of geographic areas.

Findings

There were 1,385 total active dentist offices confirmed, and 32.4% are believed to currently accept Medicaid (Figure 1). Of the total active offices, 60.5% can be reached by public transit, whereas only 21.5% of offices that accept Medicaid can be reached by public transit.

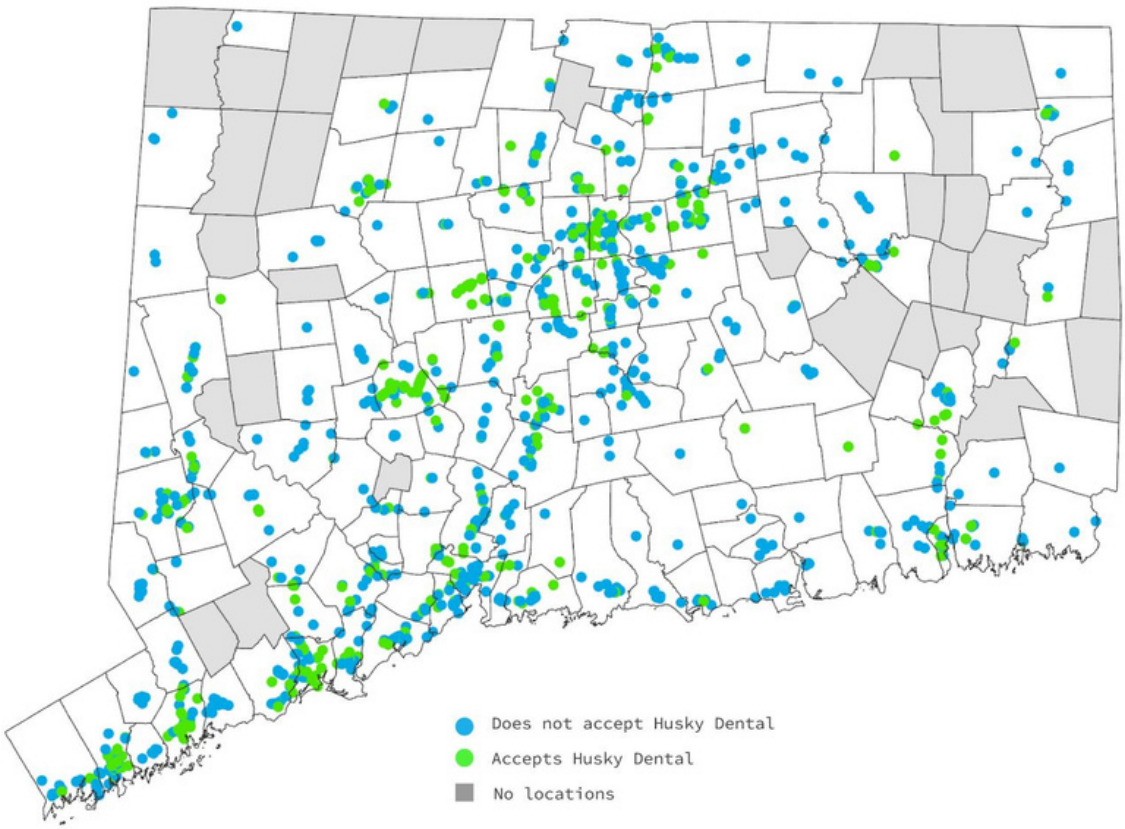


Figure 1 - General Provider Locations

Office density is highest along Interstate 91, the main north-south route through CT. This localized provider density does not necessarily result in increased access as the density of eligible adults in the area is greater than the density of providers (Figure 2A). A floating catchment area analysis reveals that suburban towns, such as the municipalities of central Fairfield County and those along the I-91 corridor between Hartford have better access relative to their more urban or rural counterparts. (Figure 2B).

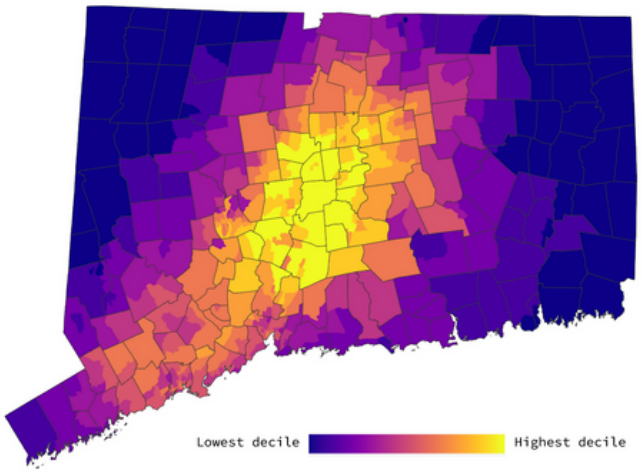


Figure 2A - Provider Location Saturation

Areas with low population may have high dental saturation in concentrated strip malls without local residential development. This may not serve dispersed populations without regular access to cars.

Rural areas are substantially underserved compared to their more urban counterparts even when population is controlled. Cities outside of the I-91/I-95 corridor, like New London, New Milford, Danbury, Windham, and Killingly, also experience low levels of provider access and high levels of poverty. Only 89 of 169 municipalities have at least one or more provider offices that accept Medicaid. Within those towns, only 35% are reachable by a 15-minute walk of a transit station.

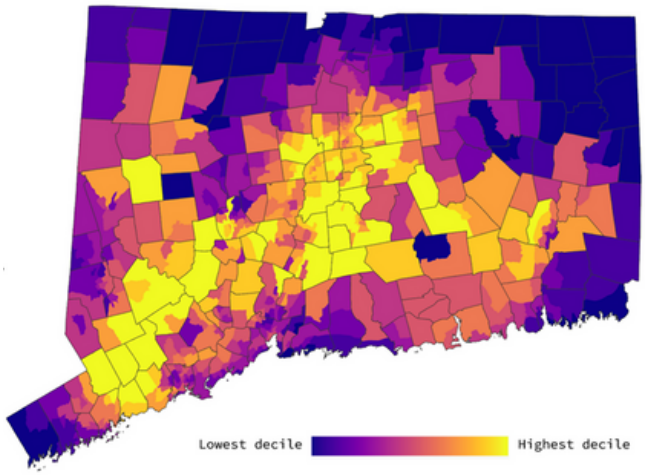


Figure 2B - Location Saturation by Service Area Congestion

There are areas of the state where there may not be enough providers participating in Medicaid (HUSKY) to care for the population (shown in light pink), and other areas where there are a high number of providers who accept Medicaid compared to the households living in poverty (shown in light blue). The maroon areas are comparatively well-matched, representing places with a high number of dentists who accept Medicaid (HUSKY) and high poverty rates (Figure 3).

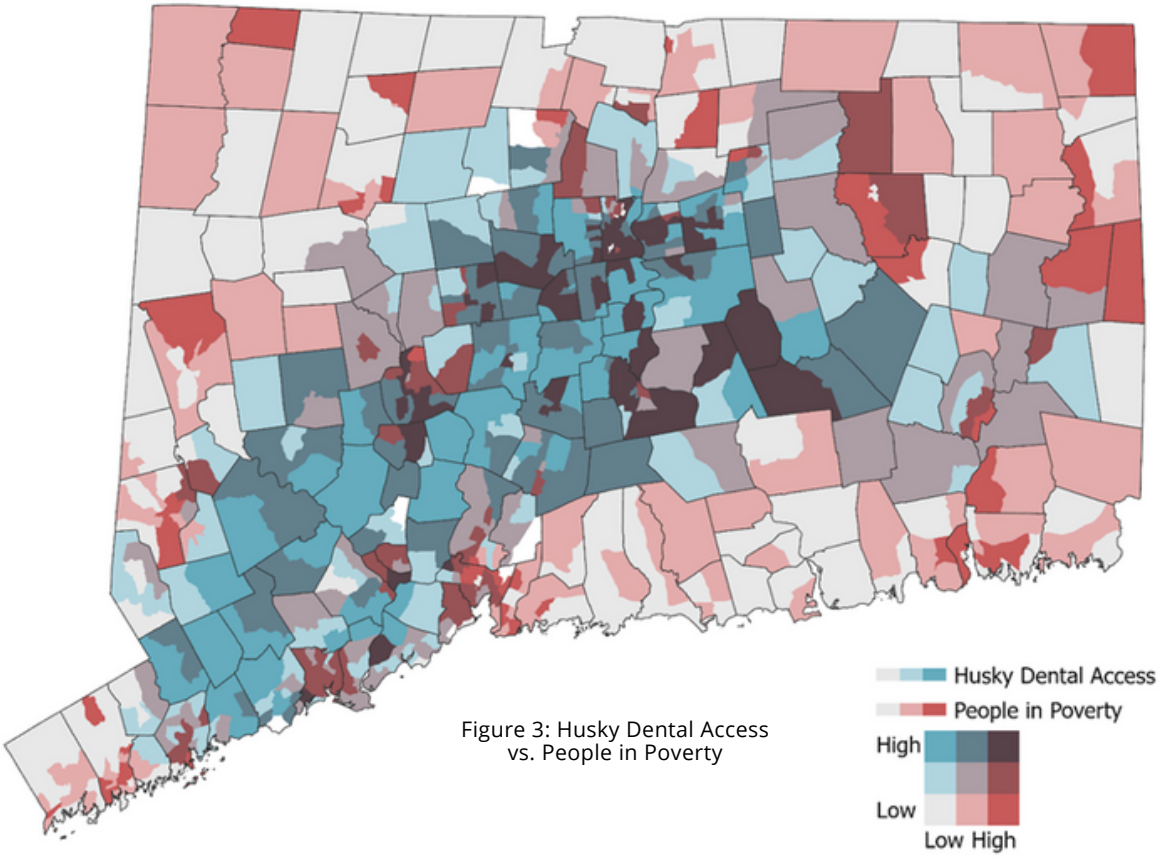


Figure 3: Husky Dental Access vs. People in Poverty

Several other barriers to access apart from transportation were found during the analysis. These data were collected through the direct examination of websites and physical locations via Google street view imagery, which considered factors that could dissuade users from accessing a location. These included:

- **Digital accessibility:** Lack of current active web presence and/or active phone number; missing information about Medicaid acceptance, other insurance, and range of services provided; and lack of Spanish language use on the website or in office. This could lead to a loss of time and transportation costs as clients search for offices that may be closed or unable to serve them, or avoidance of offices that offer unlisted services.

- **Physical accessibility and facility limitation:** Site isolation; lack of ramps, rails, and elevators; clustering in areas of low population concentration; physical environmental dangers such as missing curb cuts/ramps (breaks in the sidewalks), and steep stairs; and unclear signage.

- **Location isolation and built environment:** Zoning laws prioritizing single-use zones and construction of the built environment and transportation options to favor automobile transportation make it difficult for rural and suburban residents, especially those with limited resources, to access dentist offices.

ENROLLEE AND PROVIDER EXPERIENCES

From December 2021 through April 2022, COHI conducted a series of in-depth interviews and focused group conversations with current or recent enrollees who were enrolled in Medicaid during the past year, conversations with community organizers who advocate for individuals and dental providers, to collect information about experienced or witnessed gaps to dental treatment access and quality oral health care.

Twenty individual in-depth interviews and seven focused group conversations were conducted with a total of over 50 participants. Both In-depth and focused group conversations were widely distributed across Connecticut and included adult participants diverse in age, race/ethnicity, gender, ability, and experience with dental treatment systems. Four providers were interviewed about their experiences with Medicaid reimbursement and treatment options.

This section of the report is organized around the main issues associated with gaps in Medicaid oral health, including access to care, quality of care, cost of care, and knowledge and awareness of Medicaid and oral health. Selected quotes are used to illustrate main points, from among a group of similar quotes. Some quotes have been shortened, but the meaning of the quotations has not been altered.

All provider and patient interviews followed a general interview guide prepared in advance in collaboration with an oral health mixed methods community research expert from the Institute for Community Research. The guide included open-ended questions on service utilization, affordability, satisfaction, quality, communications, and access issues.

Access to Care

Access to care is multifaceted. Overall, from the patient perspective, challenges in access include difficulties identifying a dentist that accepts Medicaid, long wait times, distance to the dentist, problems in accessing emergency care and follow-up, and reductions in service related to COVID-19.

Participants commented that finding a dentist who would accept Medicaid was very challenging. They complained about wait time when seeking a referral to a Medicaid provider. Participants also complained about having to spend hours on the phone calling dentist offices themselves to find the few that accepted Medicaid and were accessible either by car or public transportation.

> *I did have an appointment to have the extraction. The dentist was busy that day, now I have to wait another month which I don't mind because it's becoming harder to find a ride 45 minutes away.*
> *(Community Center in New London group participant)*

ENROLLEE AND PROVIDER EXPERIENCES

Finding providers offering specialized dental care such as endodontics, especially those within easy traveling distance, was also reported as a challenge. This is unsurprising since there are few providers willing to provide specialized treatment to those enrolled in Medicaid.

> *I do have four fractured teeth from clenching and grinding. I have been told I need a night guard, and I need to have some restorative work done. I think I have a couple caries, and I live in Brookfield. There's not a lot of places that take HUSKY [Medicaid]. (White female, age 35-40)*

COVID-19 highlighted and exacerbated existing problems in dental treatment and access by causing delays in necessary treatment, limiting already existing access to Medicaid services, and reducing the quality of care. A number of people noted that the offices they usually used prior to the onset of COVID-19 had either lost significant staff, closed, or were no longer accepting Medicaid patients.

Convenience is a major factor in accessing care both in terms of availability of time, and costs associated with having to take time away from work to meet the schedules of available dentist offices. Dentist office hours can limit or increase access. If offices are open only during weekdays, working adults may have to lose working hours for scheduled appointments. Participants were positive about the availability of appointments on weekends and negative about appointments only during working hours.

> *It's good because they work on Saturdays, so it's very convenient. Since I work during the week, it's easy for me to get my appointments on the weekends. (Hispanic female, age 41-50)*

> *I woke up like my whole face is swollen. I had an abscess. They gave me antibiotics to take down the swelling, and then they gave me like a three-month date. Had two different teeth on the same side that needed to be pulled. Within a week, my face is swollen again. By the time my waiting came over, I was already in a different town, homeless. (Community Center in New London group participant)*

Obtaining services for children as well as adults on Medicaid was important to participants. The ability of adult enrollees on Medicaid to schedule appointments for themselves and their children offered them the opportunity to save time, and cost of travel, and avoid the cost of childcare.

Obtaining appropriate follow-up care is an issue with respect to continuing pain, problems, unresolved issues, and regular monitoring of specific treatments, including prescribed antibiotics.

Quality of Care Gaps

Perceptions about the quality of care, and general satisfaction with care are important in ensuring regular and follow-up dental visits and avoiding the need for emergency treatment or unwanted procedures like tooth extraction.

A number of participants complained that they received inadequate services and procedures, such as a lack of thorough prophylaxis (cleanings) and exams. Several mentioned that, as patients, they were rushed, there was not a lot of attention to detail, and their teeth did not feel clean afterward.

> *They don't really clean my teeth as well as I'd hoped. There's a lot of plaque that they just left there and I told them to like really like scrape it all off because I only get one cleaning a year. (White male, age 31-40)*

Several mentioned their concern that the provider was more focused on extractions rather than procedures to save their teeth. They also said that they did not believe they had many options with Medicaid.

> *Another thing that happens frequently is that instead of just doing all the work, the dentist might say you know what, you better pull it out. And some people got a whole bunch of teeth pulled out just so they don't have to do it [the work]. (Multi-racial female, age 61-70)*

Participants expressed the desire to build trusting relationships with their oral health providers and staff. Good communication and trust were key for some participants in reassuring them that they were receiving quality care. Provider and staff turnover was an impediment to building this trust. Some participants also mentioned the importance of the provider's positive "chairside manner."

Many participants did have positive experiences and were satisfied with their care when they believed their provider spent extra time explaining a procedure and making them feel comfortable, thus reducing anxiety. Also, important was feeling that the provider's focus was promoting their oral health, helping them keep their teeth, and being responsive to their individual needs, such as pain management.

> *He's very gentle and seems to be very thorough…He tells you what he's gonna do and that's it…I find him to have a very light hand. (Hispanic female, age 63)*

> *Someone with HUSKY [Medicaid] would go in and they would wait for two hours in the waiting room where somebody with private insurance would come in and they wait 10 minutes. (Black Faith Leaders group participant)*

Some participants did express the belief that they had experienced discrimination based on their skin color, ethnicity, or gender. However, far more people felt discriminated against because they were an enrollee of Medicaid. They reported receiving negative attitudes, longer wait times than patients on private insurance, and fewer quality restorative care services.

Costs, Benefits, and Coverage Gaps

Despite Connecticut's Medicaid broad coverage compared to states that provide limited emergency-only benefits, there are still numerous non-cosmetic procedures and treatments that Connecticut limits or does not cover except for rare exceptions. Interviews with participants revealed several common cost/coverage gaps.

> *I go to a Health Center, they work with providers…who do root canals. However, most of them don't take Medicaid. So I have to make a decision. Now that's going to be between $800- $1500 to cap a tooth or do the full root canal. (Black Faith Leaders group participant)*

> *I needed the mouth guard because I grind my teeth really bad. Because I've got severe cervical stenosis, and that wreaks havoc on TMJ and other parts. They denied that. I still have not gotten one, and we've tried to appeal it three times. (Personal Care Assistants group participant)*

Participants reported out-of-pocket costs for necessary procedures when they could not find a provider that accepted Medicaid or could not travel the distance required. In some cases, a procedure is not approved, even though the provider says it is medically necessary, such as a mouth guard to treat temporomandibular joint dysfunction (TMJ), which is reimbursable with preapproval.

Many participants reported that they required a procedure that was not covered by Medicaid. These included periodontal treatments (surgery or scaling), new dentures or modifications before the time allowance, and a second annual prophylaxis cleaning. Often participants stated that their need for periodontal services was so great that their dentist told them that prophylaxis cleanings were not possible. As a result, these individuals had few options to save their teeth and were told that they would eventually need full mouth extractions.

> *I got told that I had a degenerative bone disease. The only way to slow down tooth decay would be to get deep cleanings once a year. That's $800. Because the state doesn't cover it, I know that by the time I'm 32, 16 of my teeth on the bottom will all be ripped out. (Community Center in New London group participant)*

Almost all participants interviewed said they would take advantage of second annual prophylaxis if covered. The Connecticut Department of Social Services recently expanded coverage for a second annual cleaning to enrollees with certain health conditions. However, many participants are not aware of this recent policy change. The inability to obtain coverage for needed services essential to dental/oral health results in frustration, stress, and anger and can have long-term physical and mental consequences.

CRITICAL ORAL HEALTH LITERACY

Critical oral health literacy refers to patient knowledge of oral health and hygiene and the ability to make and advocate for appropriate decisions for themselves and others. COHI sought to learn about participants' oral literacy, as well as their knowledge of and ability to act on their rights under Medicaid. We also explored participants' knowledge of the $1,000 annual maximum benefit cap and how it might be affecting their care.

> *There's a lack of transparency, it seems arbitrary as to what is allowed and what is not. You can see the [HUSKY Dental] website there, it doesn't really tell you anything, which is very frustrating. (Personal Care Assistant group participant)*

Enrollees have certain rights, and systems exist for them to express violations and complaints. Understanding the program, its benefits coverage, and how to seek help are essential to advocating for one's health care needs. The enrollees we spoke to had varying degrees of knowledge of their rights, limiting their ability to advocate for themselves and appropriately utilize their oral health care benefits.

In general, participants were very anxious to have more information on the importance of oral health, provider relationships, and hygiene best practices. They wanted HUSKY Dental Health to provide more resources and outreach. Some enrollees complained about a lack of transparency, making it difficult for them to understand what is covered, which creates hesitancy to seek care.

> *People that I know with HUSKY [Medicaid] do not go to the dentist until there's a problem. I think we need more education around the importance of caring for your teeth and your oral hygiene. (Black Faith Leaders Group participant)*

> *I needed the crown, and it was at the end of the year. So they were like, let's hurry up and get it done before the end of the year, so you don't lose that money or something. I didn't really understand. (Hispanic Health Workers group participant)*

A majority of participants were not aware of the $1,000 annual maximum benefits cap. Others had heard of it, but were not well informed and were concerned that the cap was too low and would be reached too quickly. Only a handful had been fully informed by their providers, and/or were keeping track of their dental “allowance.” Some participants claimed their dentists urged them to schedule treatment with consideration of the benefit year and annual maximum benefit policy, helping them to navigate the best use of the cap.

Provider Responses

COHI conducted several interviews with providers who currently or previously accepted Medicaid to gain insight into their experience with the HUSKY program. Those conversations surfaced several common themes.

The providers reported that the Medicaid fee-for-service reimbursement rates for adults are too low to act as an incentive to accept a large number of enrollees. In some cases, a practice can lose money if certain procedures are performed, because of high uncovered overhead costs. They noted that it is difficult to find specialty providers accepting Medicaid, so they cannot refer patients who need care outside their expertise.

One provider who formerly worked for a large dental chain said that in their opinion, the quality of care was less for Medicaid patients because of lower reimbursement rates. Appointments were shorter, and providers were sometimes double-booked because of a high level of enrollee no-shows.

Another provider mentioned that he saw a lot of anxiety from enrollees of Medicaid because of their negative experiences with past providers. A provider also believed that some individuals are not educated about their oral health, and there was a tendency to cancel appointments or not show up. These providers also were concerned that the $1,000 maximum benefit cap on adults might be too low, especially since many enrollees who have gone without care for years may need extensive immediate work.

The providers noted that the coverage of benefits is lacking in some areas, (such as periodontal treatment for gum disease), and does not always cover what a provider feels is necessary for the best care of the patient, especially in preventative care, such as additional cleanings. They commented that the authorization process also takes too long at times. In some cases, a patient may wait several weeks in pain before approval of a procedure, and sometimes the delay may last for months when there are multiple stages in treatment needed*. The providers did find the Connecticut Dental Health Partnership to be helpful when they needed assistance.

*Prior authorization *wait times have significantly decreased from an average of over 20 days in 2016 to under 7 days in 2020*.

RECOMMENDATIONS

This study revealed existing or potential gaps in oral health care access, coverage, and quality. It provides the basis for COHI's recommendations to Connecticut policymakers, oral health providers, and other stakeholders for improvements to close the gaps.

Recommendation 1: Reduce Access to Care Gaps

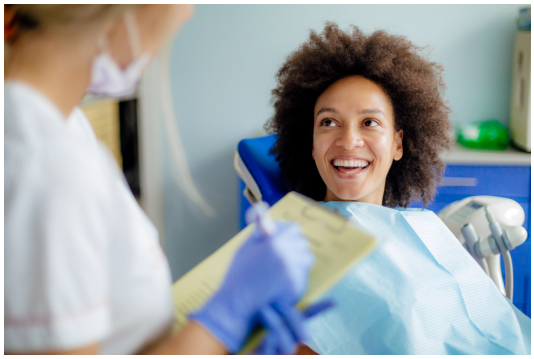
Increase network and accessibility of oral health providers, provide greater assistance for obtaining appointments, and identify policy changes that can help increase access by:

- Expanding oral health provider networks in both urban dense population areas where there is increased demand and remote rural areas that have limited public transportation options. This may necessitate more mobile care units, increased fee-for-service reimbursement rates to provide greater incentives, and licensing dental therapists.

- Developing a more accessible, easily searchable, real-time database system for enrollees and advocates on what providers are currently accepting Medicaid, appointment wait times, services provided, and languages spoken.

- Offering guidance to oral health providers to maintain and update websites that achieve American Disability Act (ADA) compliance, as well as requiring providers to display information on their Medicaid participation, process to make an appointment, and their hours of operation.

- Expanding provider availability for appointments outside of traditional business (9am-5pm weekday) operating hours.



- Automatically assign every enrollee a general dentist while allowing them the option to select their own from a list of participating providers.

- Increase efficiency and lower costs by allowing providers to perform at the top of their scope.

- Improving zoning laws and regulations to augment more dispersed dentist office subsidies for new office construction in underserved areas. Promote mixed-use development where possible; density alone is insufficient.

- Conducting extensive grassroots outreach and targeted marketing campaigns on accessing HUSKY Dental's phone and web services when needing assistance in finding providers, especially in emergency situations.

Recommendation 2: Reduce Benefit Coverage Gaps

Expand coverage to additional procedures and treatments that are medically necessary to an individual's oral health and overall health and may require high out-of-pocket costs, such as, but not limited to:

- Periodontal (gum disease) treatments
- Dental Debridement (the removal of plaque and tartar that would interfere with the dentist's ability to perform a comprehensive oral exam)
- Second annual prophylaxis cleanings for all adults
- Prosthetics replacement at reduced timeframes for individuals with reduced quality of life such as pain and difficulty eating
- Occlusal guard or "night guard" (currently covered after prior approval but cited as often denied by interview participants)

Recommendation 3: Reduce Quality of Care Gaps

Improve the patient care experience and evaluate alternative policies that incentivize increased quality by:

- Providing additional training to direct care providers and front office staff on how to build trusting relationships and communication with enrollees, especially those who may be traumatized, discriminated against, and/or have increased dental anxiety due to poor past experiences.
- Improving the standards for treatment plan explanation from providers, so enrollees of Medicaid have more understanding and increased comfort level with respect to their oral health treatment needs and are fully informed about reasons for and possible alternatives to extractions.
- Further integrating medical and dental care through oral health's inclusion in the Health Information Exchange (HIE).
- Exploring and piloting a value-based payment model for Medicaid dental services provided.

Recommendation 4: Reduce Oral Health Literacy Gaps

Invest in educational outreach and better incorporate oral health with primary care to increase literacy by:

- Conducting grassroots educational outreach to enrollees on their Medicaid benefits to better understand coverage limitations, avoid out-of-pocket costs, and maximize utilization with the annual maximum benefits cap.

- Creating an extensive educational campaign targeted to enrollees to promote greater use of preventative care through annual cleanings and exams, proper at-home oral hygiene, proactive restorative work, and other proactive dental restorative care.

- Integrating primary medical care with oral health by conducting oral screenings by primary care providers (PCPs) and requiring PCPs to provide encouragement to patients and referrals to seek dental care.

Recommendation 5: Adjust the Annual $1,000 Maximum Benefits Cap

Adjust the cap amount limit, exempt specific service categories, and educate enrollees by:

- Exempting preventative and diagnostic services from the cap limit to encourage routine care and remove perceived barriers.

- Adjusting the cap amount to account for increases in provider reimbursement rates passed in the Connecticut FY 2023 Budget Adjustment bill, especially for endodontic care.

- Providing further education to enrollees on their benefits, including information on the cap and available care navigation support services through the CT Dental Health Partnership.

- Exempting persons with special needs who receive dental services in an operating room setting from the cap, as service needs are often not known until the patient is sedated.

NEXT STEPS IN RESEARCH

COHI believes there are numerous additional areas for research and investigation based on the findings and recommendations in this report to help find policy solutions and promote systematic change to improve the oral health of all of Connecticut's residents. For immediate impact, the following should be considered:

- Supporting a statewide oral health status and treatment utilization survey with Medicaid recipients conducted for the following purposes:
  - Track changes and improvements in oral health status, treatment access, payment levels, and utilization for adults on Medicaid disaggregated by sociodemographic, geographic, and other relevant differentiating factors.
  - Identify factors that contribute to the annual approximately 60% non-utilization rate among adult Medicaid enrollees.
  - Examine the differences in consequences of oral health status (mental health, employment status, quality of life, housing, etc.) in association with treatment access and utilization.
  - Explore the factors contributing to tooth extraction rather than other options to assess excess extractions and to determine whether removing restrictions on the cap or procedures such as periodontal (gum disease) care would help to remedy this problem.

- Exploring the acceptability of and barriers to developing a dental therapy workforce in Connecticut to reduce gaps in treatment access and culturally and linguistically appropriate care, such as where travel is more difficult to find a provider and in areas where large racial/ethnic disparities exist.

- Exploring further the communication gaps between providers and patients, especially where there are ethnic/racial/gender differences between them, as the basis for developing needed education programs for students, dentists, hygienists, and other oral health staff to improve patient experiences and reduce patient anxiety.

- Conducting an evaluation of the impact of the recent 25% increase in reimbursement rates for services provided to adults enrolled in Medicaid to determine any increases in provider enrollment or increases in Medicaid patient loads of the current providers.

- Working with the Connecticut Department of Social Services to track the pattern of claims, denials, and appeals in the $500 to $1000, and over $1000 categories, to identify whether services provided before the annual maximum benefits cap in these groupings were different from those provided when the cap was initiated.

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