Trends in the Provision of Oral Health Services by Federally Qualified Health Centers

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Objective: The objectives of this research project were to:

- Summarize trends in the direct provision of oral health services by federally qualified health centers (FQHC) in recent years,
- Determine factors that predict the likelihood of an FQHC providing direct general and/or specialty oral health services, and
- Analyze health service capacity in FQHCs, and differences among health centers and across states.

Design/Methods: This study is based on an analysis of Health Center Grantee Data in HRSA's Uniform Data System (UDS) from 2011 to 2014, as well as primary survey data collected by the Oral Health Workforce Research Center (OHWRC) through a survey of FQHCs conducted in 2016. Other data elements were gathered from a variety of sources, including the annual survey of Medicaid providers from the Medicaid/Medicare/Children's Health Insurance Program (CHIP) Services Dental Association, the American Community Survey, and the Area Health Resource File. Literature describing barriers and facilitators to the direct provision of oral health services by FQHCs was reviewed and summarized.

The statistical analyses incorporated population demographic and socioeconomic variables, Medicaid eligibility rates, measures of rurality, supply of dentists and dental hygienists, and Medicaid coverage of dental benefits for adults in a state, among other factors. The study also assessed geographic differences in FQHC engagement with direct delivery of oral health services. Analyses were conducted using SAS v9.4. Statistical significance was defined as $P<.05$ using 2-tailed tests.

Results: This study found a slight decline in the proportion of FQHCs nationwide that were directly providing oral health services from 2011 to 2014. However, this finding appears to be a regional issue. The proportion of FQHCs in the Midwest (+1.6% change), the Northeast (+6.6% change), and the West (+3.7% change) providing direct oral health services increased over the 4-year period. In contrast, there was a noticeable decline in the percentage of FQHCs providing direct dental services in the South (-14.8% change). One possible explanation for the decline in the South may be related to the presence or absence of an adult dental benefit in state Medicaid programs in the South. Among the 17 states in the South, 4 states offered no dental benefit and 6 states had an emergency-only dental benefit for adults eligible for Medicaid in 2014. Regression analysis supported the supposition that the quality of state Medicaid dental coverage affected the likelihood that FQHCs

provided direct dental services. The findings indicated that FQHCs were more likely to offer direct dental services in states with an extensive Medicaid dental benefit compared to those with a limited dental benefit, as well as in states with a limited dental benefit than in states with no benefit or emergency-only dental coverage. There was a noticeable increase in the proportion of FQHC patients in the Midwest (+27.5% change) and in the Northeast (+23.5% change) receiving direct oral health services. FQHCs in the West showed a positive trend but on a smaller scale (+2.7% change). In contrast, there was a notable decline in the proportion of FQHC patients in the South (-21.1% change) receiving any direct dental service over the 4-year period.

One of the most positive findings from this study was that the proportion of FQHC patients in the nation receiving preventive oral health services increased (+3.3% change) over the period between 2011 and 2014, while the proportion receiving restorative (-1.3% change), oral surgery (-7.4% change), and emergency dental (-11.7% change) services decreased. This positive trend was promising, although the changes in relative values were small. However, there were prominent differences by region in the types and proportion of patients receiving oral health services.

The study findings showed a significant positive association between provision of direct oral health services by FQHCs and percentages of patients with low incomes and percentages of children patients without insurance or on Medicaid/CHIP insurance. Percentages of patients with incomes at or below FPL and without insurance were the stronger positive predictors in the South region, while percentages of patients on Medicaid/CHIP insurance were the strongest positive predictors in the Northeast region. The proportion of FQHC patients accessing direct dental services was positively and significantly associated with oral health staffing ratios and capacity in FQHCs in all regions. One notable finding was that dental hygiene scope of practice in a state was positively and significantly associated with the likelihood of FQHCs providing direct dental care to patients (7% average increase for every 10-point increase in the dental hygiene scope-of-practice index). The funding from ACA Capital Development Grants, including School-Based Health Center Capital Grants, was also positively and significantly associated with the likelihood of FQHCs providing direct dental care to patients, particularly in the Midwest region.

Conclusions: The data analyzed for this study show that FQHC patients in the Midwest, the Northeast, and the West are increasingly accessing oral health services. Measures of regional differences in capacity to serve patients showed an overall decline among FQHCs in the South, in volume, workforce capacity, and ability to provide dental services. As a result, the region experienced lower levels of utilization of oral health services by patients. The analyses suggest promising impacts of recent federal funding initiatives to increase the infrastructure and workforce capacity of FQHCs to provide oral health services. It will be important to continue to track growth of dental service delivery to understand the effect of more recent investments by the federal government in oral health grants to these health centers.

Key Words: Federally Qualified Health Centers, Oral Health, Medicaid, Adult Dental Benefit

HWRC Website Link: