OHWRC
Oral Health Workforce Research Center

Trends in the Provision of Oral Health Services by FQHCs: Identification of Contributing Factors

Description and Policy Relevance: Federally Qualified Health Centers (FQHCs) are safety-net providers governed by Section 330 of the Public Health Service Act. In 2009, FQHCs provided oral health services to 3.4 million patients in the US[1] By 2014, FQHCs across the US reported providing oral health services to 4.8 million patients annually, a more than 40% increase over 5 years.[2] A number of factors have contributed to increased provision of oral health services by FQHCs, particularly Affordable Care Act (ACA) efforts to expand access to oral health services for children and Medicaid eligible adults as well as Health Resources and Services Administration's (HRSA) funding of oral health expansion at FQHCs.

While mandated to offer a comprehensive array of health services, FQHCs that provide access to oral health services can do so through a variety of configurations. They can provide general oral health services and some specialty oral health services directly to patients in fixed clinics or in affiliated mobile and portable oral health programs (especially in schools). They can also provide all oral health services or specialty oral health services through referrals or vouchers to local community dentists, who contract with or agree to see FQHC primary care patients. FQHCs may also use a combination of these approaches to provide different services to different types of patients, or they may provide dental care under only one of these models.

FQHC approaches to oral health service delivery depend on a variety of factors. Clearly, there are many financial barriers to the direct provision of oral health services at FQHCs, including the high cost of installing dental operatories and the expense of dental supplies, such as restorative and prosthetic materials. However, HRSA has provided substantial financial support to FQHCs interested in directly providing oral health services, awarding over $55 million in oral health expansion grants to date.[3] In 2016, HRSA will award an additional $100 million to FQHCs for expansion of oral health infrastructure.

There are a number of other factors that can influence FQHC decisions to provide oral health services directly including:

- Difficulties recruiting and retaining oral health professionals to work in safety net settings;
- State Medicaid reimbursement policy for the provision of oral health services;
- State scope of practice laws and regulations for oral health professionals.

[1] Institute of Medicine and National Research Council. Improving access to oral health care for vulnerable and underserved populations. 2011. Washington, DC. The National Academies Press.
[2] US Department of Health and Human Services. HRSA Health Center Program. 2014 Health Center Data. http://bphc.hrsa.gov/uds/datacenter.aspx

This study will examine trends in the direct provision of oral health services by FQHCs over time.

Hypotheses, Design, and Analysis: The hypotheses for this study include the following:

- HRSA's funding of oral health expansions at FQHCs has reduced financial barriers and increased the number of FQHCs that directly provide oral health services.
- State Medicaid reimbursement policies related to dental benefits for adults impact decisions by FQHCs regarding the direct provision of oral health services, ie, FQHCs located in states with limited Medicaid dental benefits for adults are less likely than FQHCs in states with more extensive adult Medicaid dental benefits to provide oral health services directly to patients.
- FQHCs in rural areas are more likely than FQHCs in urban areas to directly provide oral health services to patients.
- A state's regulatory climate for oral health professionals, particularly dental hygienists, impacts FQHCs' decisions to directly provide oral health services.

This study will examine factors that predict the likelihood of an FQHC providing direct general and/or specialty oral health services including:

- Medicaid coverage policy and reimbursement for FQHC oral health services;
- State workforce policies regarding the scope of practice laws for oral health professionals;
- Supply of oral health providers;
- Population need based on demographic indicators, socio-economic characteristics, geography.

The analyses will use both current and historical data to describe trends in direct provision of oral health services over recent years. The analyses will describe existing oral health service capacity in FQHCs and differences among health centers and across states in direct delivery of oral health services. The statistical analyses will incorporate population demographic and socio-economic variables, Medicaid eligibility rates, measures of rurality, supply of dentists and dental hygienists, numbers of Dental Health Professional Shortage Areas (DHPSAs) in a state, etc. The study will also examine geographic differences in FQHC engagement with direct delivery of oral health services.

Study implications:

- The results of this study will be useful for policymakers considering strategies to enable access to oral health services for underserved populations.
- This study will provide important contributions to the literature describing oral health services access barriers for the underserved.

Data Sources: Researchers will analyze Health Center Grantee Data in HRSA's Uniform Data System (UDS) as well as primary survey data collected by the OHWRC through a survey of FQHCs conducted in 2016. CHWS has been granted access to facility-level dental workforce data in UDS which was facilitated by project officers at HRSA. Other data elements will be gathered from a variety of sources including the annual survey of Medicaid providers from the Medicaid/Medicare/CHIP Services Dental Association, the American Community Survey and the Area Health Resource File. Literature describing barriers and facilitators to direct provision of oral health services in FQHCs will be reviewed and summarized.

Human Subjects Research: The project will be submitted to the New York State Department of Health Institutional Review Board for review.

Deliverables: Researchers will provide HRSA with a technical report and a research brief describing study findings. OHWRC staff will work with the Project Officer to determine whether the findings from this project merit the preparation of a peer-reviewed journal article.