Dental Services for Children and Parents in the HUSKY Program: Utilization Continues to Increase Since Program Improvements in 2008

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July 2013
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KEY FINDINGS

Connecticut’s multi-faceted approach to expanding access to oral health care in the HUSKY health insurance program continues to have measurable and positive effects on access to care and utilization for children and parents. The number and percentage of children and parents who received dental services in 2011 increased for the third consecutive year since program reforms were implemented in 2008. These reforms included increased provider reimbursements and structural changes to the way dental benefits are administered and reimbursed. Key findings:

- The number of very young children under 3 who received any care in 2011 nearly doubled and the percent with preventive care (37%) was nearly three times higher than rates for 2008.
- The number and percent of children 3 to 19 with preventive care increased in HUSKY A (Medicaid) and HUSKY B (Children’s Health Insurance Program), to 69% and 73% respectively.
- Just 37 percent of parents received preventive care, up from the previous year, but considerably less than the 2011 rate for children in HUSKY A.
- Differences associated with race and ethnicity persist: Hispanics were most likely and Black/African Americans were least likely to have received preventive care.

The program is clearly headed in the right direction in terms of expanding access to oral health care for children and parents in the HUSKY Program. Moreover, parents of children in HUSKY will continue to have access to dental care, despite threats to eligibility for HUSKY parent coverage during state budget negotiations. This report recommends ongoing monitoring of the use of dental care and special studies of differences in access to care and utilization among racial/ethnic and age groups.

INTRODUCTION

Good oral health is essential for well-being and good physical health for persons of all ages. Poor oral health results in dental disease such as dental caries, periodontal disease, and tooth loss; exacerbates chronic physical illnesses such as diabetes and health disease; and contributes to adverse pregnancy outcomes. Depending on severity, dental disease can affect nutrition, speech, and physical appearance, and may be accompanied by chronic debilitating pain. Across the life span, poor oral health affects overall health, physical growth and development in childhood, school attendance and learning, social functioning, employability, and quality of life.

Access to preventive dental care and treatment is a problem for many low income families. Even with coverage, ensuring access to dental care is a long-standing challenge in Medicaid programs all across the country. All states are required under federal law to cover dental care for children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP); however, coverage for adults is a state option. The most recent comprehensive survey of states showed that in 2008, Connecticut and 15 other states and the District of Columbia covered all dental service categories for adults in Medicaid. Twenty-two states covered emergency care only or did not cover dental care for adults. Since that time, several states have dropped coverage for some or all adult dental services.
In 2008, the State of Connecticut took steps to improve access to dental care for children in its HUSKY Program. The State increased provider reimbursement for 60 children’s services (effective April 1, 2008) (Table 1). Dental services were carved-out of the HUSKY Program’s risk-based managed care contracts (effective September 1, 2008). All children and parents in HUSKY A (Medicaid) and children in HUSKY B (Children’s Health Insurance Program) now obtain dental services through the Connecticut Dental Health Partnership, a managed fee-for-service approach to paying claims while providing customer support, targeted outreach, provider relations, and care coordination. Dental care providers are reimbursed directly by the Medicaid agency. These program enhancements were designed to increase the number of providers willing to participate in the HUSKY Program and to increase the number of children who obtain dental care. Since reimbursement rates for adults in HUSKY A (parents, caregiver relatives, and pregnant women) are pegged to rates for children, provider reimbursement for adult dental services increased as well.

Table 1. Provider Reimbursement for Selected Dental Services in the HUSKY Program, 2005 and 2011

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Procedure</th>
<th>Fees for Children’s Services</th>
<th>Fees for Adult Services *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2005</td>
<td>2011</td>
</tr>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation</td>
<td>$18.80</td>
<td>$35.00</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited evaluation-- problem</td>
<td>$20.80</td>
<td>$48.00</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation</td>
<td>$24.58</td>
<td>$65.00</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings (2 views)</td>
<td>$16.54</td>
<td>$32.00</td>
</tr>
<tr>
<td>D2140</td>
<td>Amalgam(1 surface)</td>
<td>$30.82</td>
<td>$95.00</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam(2 surfaces)</td>
<td>$39.14</td>
<td>$114.00</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction-erupted tooth</td>
<td>$34.44</td>
<td>$115.00</td>
</tr>
</tbody>
</table>

*In 2005 and earlier years, fees for adult services were set at 55% of child fees. In 2008, fees for adult services were set at 52% of child fees.

METHODS

Using a retrospective cohort design, we described child and adult dental care utilization in the HUSKY Program in 2011. For investigation of trends, utilization in 2011 was compared to utilization in 2008 and earlier under risk-based managed care. Rates for 2009 and 2010 (previously reported) are also shown. In addition, we compared utilization rates for children in HUSKY A with utilization rates for children in HUSKY B.

This report from Connecticut Voices for Children is the third in a series of reports on the impact of the program changes that occurred in 2008. It is the thirteenth annual report on children’s dental care. Connecticut Voices has reported on adult dental care since 2005. Each year, the results are based on analyses of the most recent enrollment and claims data provided by the Department of Social Services for independent performance monitoring in the HUSKY Program.
Data and Analytic Approach

Using HUSKY A and B enrollment data, we identified children and adults who were continuously enrolled in the HUSKY Program between January 1 and December 31, 2011. To ensure comparability with rates we reported in previous years, dental service utilization rates were determined separately for the following age groups (age as of December 31):

- **Children:**
  - **Very young children:** Utilization rates in HUSKY A have been low in the past for children under 3, compared with older children and adolescents. In recent years, HUSKY Program- and foundation-sponsored initiatives have focused on increasing access to care and utilization for very young children.
  - **Children and adolescents:** Utilization rates for pre-school, school-aged children and adolescents, ages 3 to 19, are reported by age group for HUSKY A and B. Rates for 20 year olds (not previously reported) are shown separately.

- **Parents:**
  - **Parents 21 and over:** Utilization rates are reported for the adults in HUSKY A who are parents and caregiver relatives of children in HUSKY A or pregnant women (referred to as “parents” throughout the report). Adults 21 and over are not covered by Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) requirements for timely preventive care.

Children and parents who were enrolled in HUSKY A for 12 months and children who were in HUSKY B for 12 months were included in the sample. The few children who changed between A and B at any time during the calendar year were not included in the sample.

Dental services claim data were obtained from the Department of Social Services for utilization analyses. The methods used to determine utilization rates in 2011 were the same as methods used by Connecticut Voices to report on dental care each year since 2000. Dental service records for children and parents in HUSKY A and children in HUSKY B were searched for claims with selected procedure codes corresponding to any dental care, preventive care, sealants, or treatment received by program participants in 2011. The procedure code set is the same as that used by state Medicaid agencies to report annually by age group to the Centers for Medicare and Medicaid Services (CMS). The results we report include far more detail about additional factors associated with utilization (race/ethnicity, primary household language, residence) than the data reported by the Department to CMS (CMS 416 annual report) or to the legislature’s oversight council. In addition, annual reporting on dental care allows for detecting utilization changes over time, including trends that pre-date the program changes.

The results are reported in terms of unadjusted utilization rates, calculated by comparing the numbers of children or parents with care to the numbers who were continuously enrolled during the period. Differences between 2011 and 2008 (last year before program changes were fully implemented) were determined by comparing utilization rates for services (rate ratios); differences that were highly significant (p<.001) are reported as either higher or lower. Because the sample size is so large, only those differences that were both statistically significant and meaningful in program terms are highlighted in the results section. Differences in utilization rates associated with race or ethnicity over time are shown graphically for children and parents in HUSKY A and reported in terms of the number of percentage points between the highest and lowest rates. The numbers of children and parents who obtained care in 2008-2011 are shown by type of service in the data tables that are appended to this report.
This report is focused on determining over time the number and percentage of HUSKY Program members who had dental services in one-year periods of continuous enrollment in the program. These are the people for whom the program had ample time to conduct outreach and oral health education, to link individuals with providers, and to reach out to those with special dental care needs (pregnant women, children with chronic health conditions, families with language barriers, etc.). The report does not include counts of ever-enrolled children and parents who had services nor does it include a count all services delivered in the one-year periods. The results do not include a cost analysis for all services rendered. Utilization rates are based on individuals who were continuously enrolled for one year and received care. These individuals may not be representative of all those who were ever enrolled that year, including those who experienced gaps or lost coverage. This utilization report does not include dental care rates for other adults in Connecticut’s Medicaid program (HUSKY C --elderly or disabled adults; HUSKY D --very low income childless adults).

In addition, the findings are subject to certain limitations associated with secondary analysis of administrative data and availability of data for this study: The data were not audited for completeness or accuracy. To the extent that the counts and rates reported herein might differ from counts and rates in other reports, the differences may be due to methods (i.e., continuously enrolled v. ever enrolled, calendar year v. federal fiscal year) and/or when or how the datasets were created by the Department for the respective analyses. It was not possible to determine which if any of the HUSKY enrollees in our sample had dental services that were covered by third party payers or delivered by providers who did not submit claims. Finally, the Department’s methods for categorizing race and ethnicity may have changed in 2011; the results do not align perfectly with previous years when “unknown” was apparently not an option for applicants. Despite these limitations, the findings can provide state agency staff and contractors, policy makers, providers, foundations, and health advocates with data for assessing the effect of program changes on access to dental care and utilization.

RESULTS

Utilization Trends for Very Young Children in HUSKY A

Historically, utilization of dental services by children under 3 has been low, despite the EPSDT schedule in the HUSKY Program that calls for an initial dental visit at age 1 to 2. Beginning in 2009, utilization increased significantly (Table 1). In 2011, over 10,000 very young children had any dental care, more than twice the number of very young children seen in 2008 (4,667). Overall, the preventive care rate was nearly three times higher in 2011 than in 2008. Among children who were two years of age, over 50 percent had preventive care. The number and percentage of very young children who had dental treatment was down from 2010, but remained significantly higher than the rate for 2008.

Table 1. Dental Utilization by Very Young Children in HUSKY A, 2008-2011

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any dental care</td>
<td>41.6%*</td>
<td>37.3%*</td>
<td>29.3%*</td>
<td>21.1%</td>
</tr>
<tr>
<td>Preventive dental care</td>
<td>37.0%*</td>
<td>32.3%*</td>
<td>24.1%*</td>
<td>13.7%</td>
</tr>
<tr>
<td>Treatment</td>
<td>2.4%*</td>
<td>3.3%*</td>
<td>2.6%*</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

*Percent of continuously enrolled children under 3 who had at least one dental service or visit by service type.
*Rate in 2009, 2010 or 2011 is significantly higher than the rate in 2008 (p<.001).
Utilization Trends for Children and Adolescents in HUSKY A

After years of steady but largely unremarkable improvement since performance monitoring began, the number and percentage of children with dental care increased substantially after 2008 (Figure 1). Over 57,000 more continuously enrolled children had preventive care and nearly 31,000 more had treatment in 2011, compared with 2008. In fact, while the number of continuously enrolled children 3 to 19 increased over 26 percent, the number of children with preventive care increased 80 percent and the number with treatment increased 85 percent.

![Figure 1. Dental Care for Children and Adolescents in HUSKY A: 2000-2011](image)


In 2011, the number and percentage of children and adolescents who had any dental care, preventive care, and/or treatment were higher than rates for 2010 and significantly higher than rates for 2008 prior to the program changes (Table 2). Utilization of preventive care and treatment increased in every age group, every racial/ethnic group, and every language group, compared with 2010 and with 2008 before the program changes. Utilization increased for children living in Bridgeport, Hartford, New Haven, and all other towns. As in previous years, the highest preventive care rates were for school-aged children age 6 to 8 (76.9% with care) and 9 to 11 (75.0%), and for Hispanic children (73.2%), relative to other racial/ethnic groups (68.2%). The percentage of children with any care who had sealants placed increased significantly.

In 2011, the dental care utilization rate for 20 year olds in HUSKY A was considerably lower than rates for younger children and adolescents. Just 47.9 percent of 20 year olds had any dental care, including 36.8 percent that had preventive care and 31.6 percent that had treatment. Rates for previous years are not available for comparison.
Table 2. Dental Services for Children and Adolescents in HUSKY A, 2006-2011

<table>
<thead>
<tr>
<th>Children and Adolescents with Dental Care(^a)</th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
<th>2007(^b)</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any dental care</td>
<td>73.8(^*)</td>
<td>68.1(^*)</td>
<td>68.0(^*)</td>
<td>56.3%</td>
<td>55.7%</td>
<td>51.9%</td>
</tr>
<tr>
<td>Preventive care</td>
<td>68.9(^*)</td>
<td>59.2(^*)</td>
<td>62.7(^*)</td>
<td>48.4%</td>
<td>48.7%</td>
<td>45.3%</td>
</tr>
<tr>
<td>Dental treatment</td>
<td>35.7(^*)</td>
<td>33.3(^*)</td>
<td>32.3(^*)</td>
<td>24.3%</td>
<td>24.6%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Sealants(^c)</td>
<td>23.5(^*)</td>
<td>22.1(^*)</td>
<td>22.9(^*)</td>
<td>17.6%</td>
<td>16.3%</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

\(^a\) Percent of continuously enrolled children 3 to 19 who had at least one dental service or visit by service type.

\(^b\) Encounter records for 2007 were incomplete for HUSKY members enrolled in BlueCare Family Plan.

\(^c\) Percent of those with any dental care who had sealants placed.

\(^*\) Rate in 2009, 2010 or 2011 is significantly higher than the rate in 2008 (p<.001).


Comparison of Utilization in HUSKY A and HUSKY B

HUSKY B data were available for independent analyses beginning in 2009, allowing for comparison with utilization by children in HUSKY A. In 2011, as in the two previous years, rates for preventive care were significantly higher for children in HUSKY B than the corresponding utilization rates for children in HUSKY A (Table 3). In 2011, children in HUSKY B were less likely than children in HUSKY A to get dental treatment. On average, children in HUSKY B in 2011 were the same age as children in HUSKY A.\(^16\)

Table 3. Comparison of Dental Care Utilization in HUSKY A and B: 2009-2011

<table>
<thead>
<tr>
<th>Children and Adolescents with Dental Care(^a)</th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>HUSKY A</td>
<td>HUSKY B</td>
<td>HUSKY A</td>
<td>HUSKY B</td>
</tr>
<tr>
<td>Any dental care</td>
<td>73.5%</td>
<td>75.3%</td>
<td>68.1%</td>
</tr>
<tr>
<td>Preventive care</td>
<td>68.9%</td>
<td>72.8(^*)</td>
<td>59.2%</td>
</tr>
<tr>
<td>Treatment</td>
<td>35.7%</td>
<td>32.1(^*)</td>
<td>33.3%</td>
</tr>
<tr>
<td>Sealants(^b)</td>
<td>23.5%</td>
<td>22.0%</td>
<td>22.1%</td>
</tr>
</tbody>
</table>

\(^a\) Percent of continuously enrolled children 3 to 19 who had at least one dental service or visit by service type.

\(^b\) Percent of those with any dental care who had sealants placed.

\(^*\) Rate for children in HUSKY B in 2009, 2010 or 2011 is significantly higher (or lower, as in the case of 2011 treatment rate) than the rate for children in HUSKY A that year (p<.001).


Pediatric and dental care professionals recommend that children have dental exams every 6 months (two exams per year). In 2011, children in HUSKY A were more likely to have had two or more visits for preventive care than they were in previous years (Table 4). The rates for recommended care in HUSKY B were significantly higher than rates for children in HUSKY A.
Table 4. Children with Recommended Preventive Care, HUSKY A and B: 2006-2011

<table>
<thead>
<tr>
<th>Children and Adolescents with Two or More Visits for Preventive Dental Care&lt;sup&gt;a&lt;/sup&gt;</th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
<th>2008</th>
<th>2007&lt;sup&gt;b&lt;/sup&gt;</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>HUSKY A</td>
<td>50.1%&lt;sup&gt;*&lt;/sup&gt;</td>
<td>39.6%&lt;sup&gt;*&lt;/sup&gt;</td>
<td>44.7%&lt;sup&gt;*&lt;/sup&gt;</td>
<td>30.9%</td>
<td>30.3%</td>
<td>31.0%</td>
</tr>
<tr>
<td>HUSKY B</td>
<td>59.5% †</td>
<td>57.0% †</td>
<td>53.9% †</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

<sup>a</sup>Percent of children 3 to 19 with any dental care who had two or more preventive visits.  <sup>b</sup>Encounter records for 2007 were incomplete for HUSKY members enrolled in BlueCare Family Plan.

†Rate in HUSKY A in 2009, 2010 or 2011 was significantly higher than the rate in 2008 (p<.001).
†Rate for children in HUSKY B was significantly higher than the rate for children in HUSKY A (p<.001).
NA: data not available.


Dental professionals recommend placement of sealants to protect the biting surfaces of permanent molars from decay. To achieve the greatest benefit, sealants should be applied soon after the teeth have erupted, at age 6 or so and around age 12, before the teeth decay. Overall, the percentages of children in HUSKY A that had sealants applied increased significantly after the program changes in 2008, but have not changed since then (refer back to Table 1). A comparison of age-specific rates shows that children 9 to 11 in HUSKY A were more likely than children in HUSKY B to have had sealants applied in 2011 (Table 5).

Table 5. Sealants for Children in HUSKY A and B, 2009-2011

<table>
<thead>
<tr>
<th>Age:</th>
<th>2011</th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 to 8</td>
<td>33.1%</td>
<td>30.8%</td>
<td>31.2%</td>
</tr>
<tr>
<td>9 to 11</td>
<td>34.2%&lt;sup&gt;*&lt;/sup&gt;</td>
<td>28.5%</td>
<td>32.4%</td>
</tr>
<tr>
<td>12 to 14</td>
<td>36.9%</td>
<td>32.8%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

<sup>*</sup>Percent of children with any dental care who had at least one sealant placed.


Utilization Trends for Parents in HUSKY A

Overall, utilization of dental services by parents in the HUSKY A increased steadily in over time, even prior to program changes in 2008 (Figure 1). In 2011, the percentages of parents who had any dental care, preventive care, and treatment were statistically significantly higher than rates for 2008 and earlier years (Table 6). As in the previous year, 2011 utilization rates for children were greater than rates for parents (any dental care: 73.8% v. 50.2%; preventive care: 68.9% v. 36.6%).
Table 6. Dental Care Utilization by Parents in HUSKY A, 2005 to 2011

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any dental care</td>
<td>50.2% *</td>
<td>50.3% *</td>
<td>47.7% *</td>
<td>45.90%</td>
<td>39.60%</td>
<td>37.00%</td>
<td>32.40%</td>
</tr>
<tr>
<td>Preventive care</td>
<td>36.6% *</td>
<td>32.1% *</td>
<td>32.8% *</td>
<td>28.40%</td>
<td>25.40%</td>
<td>23.20%</td>
<td>18.20%</td>
</tr>
<tr>
<td>Treatment</td>
<td>32.8% *</td>
<td>33.9% *</td>
<td>33.3% *</td>
<td>24.70%</td>
<td>25.90%</td>
<td>24.60%</td>
<td>21.20%</td>
</tr>
</tbody>
</table>

* Percent of continuously enrolled adults 21 and over who had at least one service or visit.

b Encounter records for 2007 were incomplete for HUSKY members enrolled in BlueCare Family Plan.

* Rate in 2009, 2010, or 2011 is significantly higher than the rate in 2008 (p<.001).


Racial/ Ethnic Differences in HUSKY Dental Utilization

Racial/ethnic differences in utilization of needed health care suggest disparities in access to care. Dental care utilization differences are evident and persistent in HUSKY A. Preventive care utilization rates for children in HUSKY A are consistently highest for Hispanics and lowest for Blacks/African Americans. The rate difference has narrowed somewhat from 9.4 percentage points in 2008 to 7.9 percentage points in 2011 (Figure 4). In recent years, the gap between Black/African American children and White children has nearly disappeared (1.4 percentage points in 2011).
As in previous years, Hispanic and other non-Hispanic (mainly Asian) parents were most likely to receive any dental care (Figure 5). Utilization rates for Black/African-American parents and White parents were essentially the same in 2011 (<1.0 percentage point different). However, the gap between high and low utilization ethnic groups has actually grown in recent years.

**Figure 4. Effect of Race or Ethnicity on Children’s Utilization in HUSKY A**

![Figure 4](image)


**Figure 5. Effect of Race or Ethnicity on Parent’s Utilization of Preventive Care HUSKY A**

![Figure 5](image)

DISCUSSION

In recent years, the Institute of Medicine convened a committee of experts to develop strategies for improving oral health care nationwide, especially care for vulnerable and underserved populations. Based on the principle that “good health requires good oral health,” the Committee recommended that states strive to increase provider participation in publicly-funded programs by setting Medicaid and CHIP reimbursement rates high enough to enhance provider participation, by streamlining administrative processes, and by supporting case management services. A study of the effect of Medicaid reimbursement rates on access to dental care, conducted by the National Academy for State Health Policy, led researchers to conclude that “rate increases are necessary—but not sufficient on their own—to improve access to dental care.”

Connecticut’s multi-faceted approach to expanding access to oral health care is consistent with these recommendations. The state invested $80 million over four years to increase provider reimbursement for child dental services, the first fee increase since 1993. Fees for adult services also increased. The state Medicaid agency contracted for administrative services, including customer service and provider network development, on a non-risk basis. The agency established a Dental Advisory Committee, with representation from key stakeholder groups. An additional $4.5 million funding was awarded on a one-time basis to school-based and non-FQHC community-based dental clinics. In its reports to the legislature’s oversight council, the state Medicaid agency has shown that provider outreach and recruitment resulted in a three-fold increase in dental practitioner participation in the Medicaid program. Less than ten percent of providers report closed panels (not accepting new patients). Nearly every HUSKY A and HUSKY B client has access to at least two providers within 10 miles of where they live. The average wait time for an appointment has decreased steadily and is now less than 13 days. The state agency also reported that a telephone mystery shopper survey in 2010 showed that nearly 90 percent of calls resulted in appointments for routine care in less than four weeks (11 days on average). The administrative services contractor ramped up outreach to newly enrolled children, community groups, pregnant women, and families whose children have special health care needs.

The program changes adopted in 2008 had immediate, measurable and positive effects on access to care and utilization for children and parents in the HUSKY Program. Very young children are also more likely to receive care from dental care providers in recent years. Despite utilization trends that are headed in the right direction however, almost one of every three children did not receive preventive dental care in 2011. Differences in utilization associated with race and ethnicity persist. There is clearly room for further improvement in access to oral health care.

Several findings warrant further investigation. The persistence of utilization differences associated with race and ethnicity are troubling and should be investigated to identify the underlying features of the oral health delivery system that can be modified to reduce disparities. The effect of targeted outreach on special populations, such as pregnant women and children with special health care needs, should be evaluated. Trends in utilization of emergency departments for treatment of dental conditions should be investigated. The impact of primary care provider training on access to oral health care for very young children should be evaluated. Records for families could be linked to investigate whether children whose parents get care are themselves more likely to get dental care.

Connecticut’s experience is instructive for other states. The combination of significant state investment in provider fee increases and fundamental changes to the way dental benefits are administered resulted in increased utilization of preventive care and treatment. In the current fiscal environment however, some states are finding it fiscally and politically difficult to continue investing the public dollars needed to ensure access to dental care for adults in Medicaid.
Recently, the Connecticut General Assembly rejected the Governor’s proposal to cut back on Medicaid eligibility for over 35,000 parents in Medicaid, a change that would have put access to dental care at risk. While these parents would have been eligible to purchase subsidized medical insurance through Connecticut’s health insurance exchange beginning in January 2014, many of them would not have been able to afford unsubsidized dental insurance premiums and out-of-pocket expenses for dental care. Cutting back Medicaid coverage for parents who currently depend on the HUSKY Program would have been a significant step backwards from Connecticut’s long-standing commitment to good oral health for families.

RECOMMENDATIONS

The Department of Social Services, working with partners in the Connecticut General Assembly and its Medicaid oversight council, the Department of Public Health, professional dental care provider organizations, and other key stakeholders should study and report on:

- Factors that contribute to persistent racial and ethnic differences in access to care and utilization;
- Factors that contribute to utilization of preventive care by parents, including pregnant women, in HUSKY A.

ACKNOWLEDGEMENTS

This report was prepared by Connecticut Voices for Children under a contract between the Department of Social Services and the Hartford Foundation for Public Giving, with a grant from the Hartford Foundation to Connecticut Voices for Children. This report was prepared by Mary Alice Lee, Ph.D., Senior Policy Fellow, and Kenny Feder, Policy Fellow, at Connecticut Voices. Amanda Learned of MAXIMUS, Inc. conducted the data analyses. This publication does not express the views of the Department of Social Services or the State of Connecticut. The views and opinions expressed are those of the authors.

2 Preventive dental services and treatment are guaranteed for children under federal law in Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program [42 U.S.C. §§ 1396D(r)(3)].
4 Email communication with Andrew Snyder, National Academy for State Health Policy, April 22, 2013.
5 The changes came about as part of the settlement agreement in the case of Carr v. Wilton-Coker, No. 3:00CV1050 (D.Conn., Aug. 26, 2008). This case was brought in 1999 by Greater Hartford Legal Assistance on behalf of children in the Medicaid program who were unable to obtain the preventive dental services and treatment guaranteed to them under federal law in Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program [42 U.S.C. §§ 1396D(r)(3)]. The settlement agreement expired in August 2012, but the program changes are still in effect.
6 The Connecticut Dental Health Partnership is run by Benecare, Inc., under a contract with the Department of Social Services for administrative services.
7 In 2011, children in HUSKY A and B and adults in HUSKY A obtained medical services from one of three participating managed care companies or from a participating primary care case management provider.
9 Since 1995, independent performance monitoring has been conducted under a contract between the Department of Social Services and the Hartford Foundation for Public Giving (Contract #064HFP-HUO-03/10DSS1001ME-A1). Under a grant from the Hartford Foundation, Connecticut Voices for Children conducts the HUSKY Program performance monitoring described in this state-funded contract. Annual reports on enrollment, preventive care (well-child and dental), emergency care, and births to mothers with HUSKY Program or Medicaid coverage can be found at www.ctvoices.org.
10 Utilization estimates are based on the experience of continuously enrolled (v. ever enrolled) persons for the following reasons: 1) all persons had uniform periods of observation, 2) utilization measures (percentage of children or adults with care) are relatively simple to calculate and easy to communicate to policy makers, 3) the HUSKY Program can best be held accountable for persons who were enrolled for one entire calendar year and not those who may have lost coverage for part of the year or changed programs. Utilization rates for continuously enrolled adults and children are likely to be higher than rates for adults and children with part-year coverage, especially those with unintended gaps in coverage.

11 In October 1998, the EPSDT periodicity schedule in Connecticut was changed to include an initial dental exam at age 2 (v. age 3). In 2009, when Connecticut adopted the American Academy of Pediatrics Bright Futures periodicity schedule for the HUSKY Program, the first visit dental visit was moved up to one to two years of age. According to the CMS-416 reports submitted to the Center for Medicare and Medicaid Services, 8.5% of ever enrolled young children 1 to 2 received preventive dental care in FFY08. Following the program changes, the percentage of very young children with preventive care grew steadily, from 15.9% in FFY09 to 26.8% in FFY10 to 31.2% in FFY11.

12 In order to compare utilization rates for comparable age groups in HUSKY A and B, children who were 19 as of December 31 were included in both groups. Technically, children who are otherwise qualified are eligible for HUSKY B only until they turn 19; however, some children are still enrolled in HUSKY B after they turn 19: in HUSKY B, 23 of 43 continuously enrolled 19 year olds in HUSKY B (0.7% of all continuously enrolled children 3 to 19), compared with HUSKY A, 1,560 of 3,216 (1.7% of all continuously enrolled children 3 to 19). The percentages of 19 year olds who had any dental care (48.5% in HUSKY A; 53.5% in HUSKY B) were not statistically significantly different.

13 A recent analysis of 2010 enrollment data showed that very few children change between HUSKY A and B: Among 247,476 children enrolled in HUSKY A or B in January 2010, just 139 changed programs during the balance of the one year period. Source: Unpublished data, available from the author.

14 **Preventive dental care**: Encounter records with a HCFA Common Procedure Coding (HCPC) system code ranging from D1000 through D1999 or ADA codes 01000 – 01999. **Dental treatment**: Encounter records with a HCPC code ranging from D2000 through D9999 or ADA codes 02000-09999. **Any dental care**: Encounter records with a HCPC code ranging from D100 through D9999 or ADA codes 0100-09999. This definition for “any care” includes all preventive dental care and dental treatment codes outlined above plus additional HCPC codes between D0100 and D0999 or ADA codes 0100-0999 and T1015 codes for clinic visits. **Dental sealants**: Encounter records with ADA code 01351 or state codes D1351 or 1351D (sealant-per tooth).


16 In 2011, children 3 to 19 were 11.0 years of age on average in HUSKY B and 10.2 years of age on average in HUSKY A.


19 These grants to school-based health centers and non-FQHC clinics ended September 30, 2010.

20 Connecticut Department of Social Services report to the Medicaid Care Management Oversight Council, April 8, 2011. Available at: www.cga.ct.gov/ph/Medicaid under minutes for the meeting April 8, 2011.

21 Connecticut Department of Social Services report to Medical Assistance Oversight Council, September 17, 2010. Available at: www.cga.ct.gov/ph/Medicaid under minutes for the meeting September 17, 2010.

22 Basic oral health services for very young children are also provided by trained pediatric care providers who are reimbursed by Medicaid for these services. According to Joanna Douglass BDS, DDS, Associate Professor at the UCONN School of Dental Medicine and Oral Health Consultant to the Connecticut Health Foundation, about 160 Medicaid pediatric care providers were trained prior to April 2010 to provide oral health care for very young children; a few more were trained in 2011 and an additional 89 Medicaid providers were trained in 2012. In 2011, about 61 pediatric primary care providers in about 35 sites statewide conducted 3600 exams, applied fluoride varnish, and billed for these services. Only trained medical care providers can bill for dental services for very young children. Email communication May 2, 2013.
APPENDICES

- Dental Care Utilization by Children 3 to 19 in HUSKY A: 2008-2011 (data table)
- Dental Care Utilization by Children 3 to 19 in HUSKY B: 2009-11 (data table)
- Dental Care Utilization by Adults 21+ in HUSKY A: 2008-2011 (data table)
### Dental Care Utilization by Children 3 to 19 in HUSKY A: 2008 - 2011

#### Calendar Year 2011

<table>
<thead>
<tr>
<th>HUSKY A Child Dental Care</th>
<th>Population</th>
<th>Any Dental Care</th>
<th>Preventive Care</th>
<th>Treatment</th>
<th>Population</th>
<th>Any Dental Care</th>
<th>Preventive Care</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>186,903</td>
<td>137,863</td>
<td>73.6%</td>
<td>66,731</td>
<td>35.1%</td>
<td>175,668</td>
<td>119,669</td>
<td>66.1%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 - 5</td>
<td>39,181</td>
<td>29,231</td>
<td>74.6%</td>
<td>28,078</td>
<td>71.7%</td>
<td>3,831</td>
<td>21.2%</td>
<td>21,656</td>
</tr>
<tr>
<td>6 - 8</td>
<td>36,399</td>
<td>24,977</td>
<td>70.2%</td>
<td>27,968</td>
<td>76.9%</td>
<td>13,935</td>
<td>38.3%</td>
<td>20,478</td>
</tr>
<tr>
<td>9 - 11</td>
<td>34,922</td>
<td>27,468</td>
<td>78.7%</td>
<td>26,178</td>
<td>75.0%</td>
<td>13,636</td>
<td>38.8%</td>
<td>27,235</td>
</tr>
<tr>
<td>12 - 14</td>
<td>33,510</td>
<td>24,850</td>
<td>74.2%</td>
<td>22,831</td>
<td>68.1%</td>
<td>13,991</td>
<td>41.8%</td>
<td>21,742</td>
</tr>
<tr>
<td>15 - 19</td>
<td>42,931</td>
<td>23,717</td>
<td>63.2%</td>
<td>23,723</td>
<td>55.3%</td>
<td>16,958</td>
<td>39.5%</td>
<td>18,621</td>
</tr>
<tr>
<td>Total</td>
<td>186,903</td>
<td>137,863</td>
<td>73.6%</td>
<td>66,731</td>
<td>35.1%</td>
<td>175,668</td>
<td>119,669</td>
<td>66.1%</td>
</tr>
</tbody>
</table>

#### Gender

| Female                    | 91,643     | 68,871          | 75.2%           | 64,207    | 70.1%      | 34,106         | 37.2%          | 86,315     |
| Male                      | 95,053     | 68,845          | 72.4%           | 64,427    | 67.8%      | 32,559         | 34.3%          | 93,349     |
| Unknown                   | 207        | 147             | 71.0%           | 144       | 69.6%      | 66            | 31.9%          | 0          |

#### Race/Ethnicity

| White Non-Hispanic        | 105,553    | 75,983          | 72.9%           | 70,200    | 63.5%      | 56,047         | 43.6%          | 77,232     |
| Black Non-Hispanic        | 64,064     | 48,964          | 71.1%           | 45,941    | 62.3%      | 23,004         | 33.4%          | 54,115     |
| Other Non-Hispanic        | 6,342      | 4,771           | 75.2%           | 4,482     | 70.7%      | 2,503          | 39.5%          | 3,761      |
| Hispanic                  | 69,924     | 54,658          | 78.2%           | 51,162    | 73.2%      | 27,242         | 39.0%          | 45,673     |

#### Language

| English                   | 165,763    | 120,892         | 72.9%           | 112,878   | 68.1%      | 57,983         | 35.0%          | 157,309    |
| Other/Unknown             | 2,791      | 2,029           | 72.7%           | 1,878     | 68.3%      | 1,064          | 37.2%          | 1,277      |

#### Population

| Town                      | 16,263     | 11,854          | 72.9%           | 10,903    | 63.0%      | 6,234          | 38.3%          | 16,035     |
| Hartford                  | 19,032     | 14,899          | 78.3%           | 13,215    | 69.4%      | 7,023          | 36.9%          | 18,588     |
| New Haven                 | 14,472     | 10,588          | 73.2%           | 10,075    | 62.6%      | 5,265          | 36.4%          | 14,500     |
| All Other Towns           | 137,134    | 100,512         | 73.3%           | 93,485    | 69.0%      | 48,209         | 35.2%          | 126,535    |

#### Retirement

| Bridgeport                | 16,263     | 11,854          | 72.9%           | 10,903    | 63.0%      | 6,234          | 38.3%          | 16,035     |
| Hartford                  | 19,032     | 14,899          | 78.3%           | 13,215    | 69.4%      | 7,023          | 36.9%          | 18,588     |
| New Haven                 | 14,472     | 10,588          | 73.2%           | 10,075    | 62.6%      | 5,265          | 36.4%          | 14,500     |
| All Other Towns           | 137,134    | 100,512         | 73.3%           | 93,485    | 69.0%      | 48,209         | 35.2%          | 126,535    |

#### Race/Ethnicity

| White Non-Hispanic        | 105,553    | 75,983          | 72.9%           | 70,200    | 63.5%      | 56,047         | 43.6%          | 77,232     |
| Black Non-Hispanic        | 64,064     | 48,964          | 71.1%           | 45,941    | 62.3%      | 23,004         | 33.4%          | 54,115     |
| Other Non-Hispanic        | 6,342      | 4,771           | 75.2%           | 4,482     | 70.7%      | 2,503          | 39.5%          | 3,761      |
| Hispanic                  | 69,924     | 54,658          | 78.2%           | 51,162    | 73.2%      | 27,242         | 39.0%          | 45,673     |
| Other/Unknown             | 2,791      | 2,029           | 72.7%           | 1,878     | 68.3%      | 1,064          | 37.2%          | 1,277      |

#### Codes:

- Preventive dental care: Encounter records with a HCFA Common Procedure Coding (HCPC) system code ranging from D1000 through D1999 or ADA codes 01000 – 01999.
- Dental treatment: Encounter records with a HCPC code ranging from D2000 through D9999 or ADA codes 02000-09999.
- Any dental care: Encounter records with a HCPC code ranging from D100 through D999 or ADA codes 0100-09999. This definition for "any care" includes all preventive dental care and dental treatment codes outlined above plus additional HCPC codes between D1000 and D9999 and ADA codes 0100-09999 and T1015 codes for clinic visits.

#### Note:

Utilization rates are shown for children 3 to 19 who were continuously enrolled in HUSKY A (Medicaid) for the calendar year.

#### Source:

Analysis of HUSKY Program data, obtained from the Connecticut Department of Social Services for independent performance monitoring by Connecticut Voices for Children

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Connecticut Voices for Children

July 2013
Preventive dental care: Encounter records with a HCFA Common Procedure Coding (HCPC) system code ranging from D1000 through D1999 or ADA codes 01000 – 01999.

Dental treatment: Encounter records with a HCPC code ranging from D2000 through D9999 or ADA codes 02000-09999.

Note: Utilization rates are shown for children 3 to 19 who were continuously enrolled in HUSKY B (CHIP) for the calendar year.

Source: Analysis of HUSKY Program data, obtained from the Connecticut Department of Social Services for independent performance monitoring by Connecticut Voices for Children.
## Connecticut Voices for Children July 2013

**Dental Care Utilization by Parents in HUSKY A: 2008 - 2011**

### Calendar Year 2011

<table>
<thead>
<tr>
<th>HUSKY A Adult Dental Care</th>
<th>Population</th>
<th>Any Dental Care</th>
<th>Preventive Care</th>
<th>Treatment</th>
<th>Population</th>
<th>Any Dental Care</th>
<th>Preventive Care</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>98,495</td>
<td>49,486</td>
<td>30,306</td>
<td>36,632</td>
<td>32,324</td>
<td>32,324</td>
<td>32,324</td>
<td>32,324</td>
</tr>
<tr>
<td>21 - 39</td>
<td>65,015</td>
<td>66.0%</td>
<td>32,829</td>
<td>50.5%</td>
<td>23,558</td>
<td>36.2%</td>
<td>21,709</td>
<td>33.4%</td>
</tr>
<tr>
<td>&gt;= 40</td>
<td>33,480</td>
<td>34.0%</td>
<td>16,657</td>
<td>49.8%</td>
<td>12,526</td>
<td>37.4%</td>
<td>10,615</td>
<td>31.7%</td>
</tr>
<tr>
<td>Total</td>
<td>98,495</td>
<td>100.0%</td>
<td>49,486</td>
<td>36,632</td>
<td>32,324</td>
<td>32,324</td>
<td>32,324</td>
<td>32,324</td>
</tr>
</tbody>
</table>

### Calendar Year 2010

<table>
<thead>
<tr>
<th>HUSKY A Adult Dental Care</th>
<th>Population</th>
<th>Any Dental Care</th>
<th>Preventive Care</th>
<th>Treatment</th>
<th>Population</th>
<th>Any Dental Care</th>
<th>Preventive Care</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>92,629</td>
<td>46,556</td>
<td>36,632</td>
<td>32,324</td>
<td>32,324</td>
<td>32,324</td>
<td>32,324</td>
<td>32,324</td>
</tr>
</tbody>
</table>

### Gender

#### Male

- 22,220 (22.6%) 9,745 (43.9%) 7,112 (32.0%) 6,292 (28.3%)
- 20,039 (21.6%) 8,843 (44.1%) 5,724 (28.8%) 5,993 (30.9%)

#### Female

- 76,263 (77.4%) 39,733 (52.1%) 28,966 (38.0%) 26,026 (34.1%)
- 72,590 (78.4%) 37,713 (52.0%) 24,041 (33%) 25,510 (35%)

### Residence

#### Non-urban

- 75,537 (76.7%) 37,631 (49.8%) 28,010 (37.1%) 24,498 (32.2%)
- 69,033 (74.5%) 34,487 (50.0%) 22,690 (33%) 23,043 (33%)

#### Urban

- 22,958 (23.3%) 11,855 (51.6%) 8,074 (35.2%) 8,026 (35.0%)
- 23,596 (25.5%) 12,069 (51.1%) 7,075 (30%) 8,399 (36%)

### Primary Language

#### English

- 88,004 (89.3%) 43,481 (49.4%) 31,536 (35.8%) 28,317 (32.2%)
- 83,352 (90.0%) 41,173 (49.6%) 24,168 (31%) 27,674 (33%)

#### Spanish

- 8,415 (8.5%) 4,954 (58.9%) 3,763 (43.4%) 3,314 (39.4%)
- 8,374 (9.4%) 4,905 (58.6%) 3,290 (39%) 3,433 (41%)

### Town

#### Bridgeport

- 7,339 (7.5%) 3,838 (52.3%) 2,543 (34.7%) 2,618 (35.7%)
- 7,711 (8.3%) 4,032 (52.3%) 2,300 (30%) 2,840 (37%)

#### Hartford

- 9,289 (9.4%) 4,980 (53.6%) 3,544 (38.2%) 3,361 (36.2%)
- 9,253 (10.0%) 4,749 (51.3%) 2,964 (32%) 3,294 (36%)

#### New Haven

- 6,330 (6.4%) 3,037 (48.0%) 1,987 (31.4%) 2,047 (32.3%)
- 6,632 (7.2%) 3,288 (49.6%) 1,811 (27%) 2,265 (34%)

#### All Other Towns

- 75,537 (76.7%) 37,631 (49.8%) 28,010 (37.1%) 24,498 (32.2%)
- 69,033 (74.5%) 34,487 (50.0%) 22,690 (33%) 23,043 (33%)

### Race Roll Up

#### White Non-Hispanic

- 44,214 (44.9%) 20,878 (47.2%) 15,391 (34.8%) 13,448 (30.4%)
- 41,133 (44.4%) 19,561 (46.7%) 12,739 (31%) 13,059 (32.9%)

#### Black Non-Hispanic

- 24,051 (24.6%) 6,543 (42.3%) 3,427 (21.2%) 3,624 (22.1%)
- 22,682 (20.5%) 3,905 (44.9%) 2,540 (28.9%) 6,391 (34.1%)

#### Other Non-Hispanic

- 4,064 (4.1%) 2,195 (54.0%) 1,737 (42.7%) 1,275 (31.4%)
- 4,121 (4.4%) 2,232 (54.2%) 1,579 (38%) 1,379 (33.7%)

#### Hispanic

- 30,101 (30.6%) 16,420 (54.5%) 10,080 (40.2%) 10,414 (36.0%)
- 28,713 (31.0%) 15,458 (53.8%) 10,073 (35%) 10,613 (37%)

#### Other/Unknown

- 1,004 (1.0%) 472 (47.0%) 325 (32.4%) 336 (33.5%)
- 0.0% 0.0% 0.0% 0.0%

### Codes

**Preventive dental care:** Encounter records with a HCFA Common Procedure Coding (HCPC) system code ranging from D1000 through D1999 or ADA codes 01000 – 01999.

**Dental treatment:** Encounter records with a HCPC code ranging from D2000 through D9999 or ADA codes 02000-09999.

**Any dental care:** Encounter records with a HCPC coding range from D100 through D9999 or ADA codes 0100-09999. This definition for "any care" includes all preventive dental care and dental treatment codes outlined above plus additional HCPC codes between D0100 and D0999 or ADA codes 0100-09999 and T1015 codes for clinic visits.

**Note:** Utilization rates are shown for adults 21 and over (parents, pregnant women) who were continuously enrolled in HUSKY A (Medicaid) for the calendar year.

**Source:** Analysis of HUSKY Program data, obtained from the Connecticut Department of Social Services for independent performance monitoring by Connecticut Voices for Children.

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**Connecticut Voices for Children**

July 2013