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

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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.¹ 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.² 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.³ 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.⁴

In 2008, the State of Connecticut took steps to improve access to dental care for children in its HUSKY Program.⁵ 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.⁶ Dental care providers are reimbursed directly by the Medicaid agency.⁷ 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

Billing Code	Procedure	Fees for Children’s Services			Fees for Adult Services ^a		
		2005	2011	Increase	2005	2011	Increase
D0120	Periodic oral evaluation	\$18.80	\$35.00	86%	\$10.34	\$18.20	76%
D0140	Limited evaluation-- problem	\$20.80	\$48.00	131%	\$11.44	\$24.96	118%
D0150	Comprehensive oral evaluation	\$24.58	\$65.00	164%	\$13.52	\$33.80	150%
D0272	Bitewings (2 views)	\$16.54	\$32.00	94%	\$9.10	\$16.64	83%
D2140	Amalgam(1 surface)	\$30.82	\$95.00	208%	\$16.96	\$49.40	191%
D2150	Amalgam(2 surfaces)	\$39.14	\$114.00	191%	\$21.53	\$59.28	175%
D7140	Extraction-erupted tooth	\$34.44	\$115.00	234%	\$18.94	\$59.80	216%

^a 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 2008.⁸ 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.⁹

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, 2011.¹⁰ 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.¹¹ 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.¹² 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.¹³

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 2011.¹⁴ 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).¹⁵ 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

	Children under 3 with dental care ^a			
	2011	2010	2009	2008
Any dental care	41.6%*	37.3%*	29.3%*	21.1%
Preventive dental care	37.0%*	32.3%*	24.1%*	13.7%
Treatment	2.4%*	3.3%*	2.6%*	1.5%

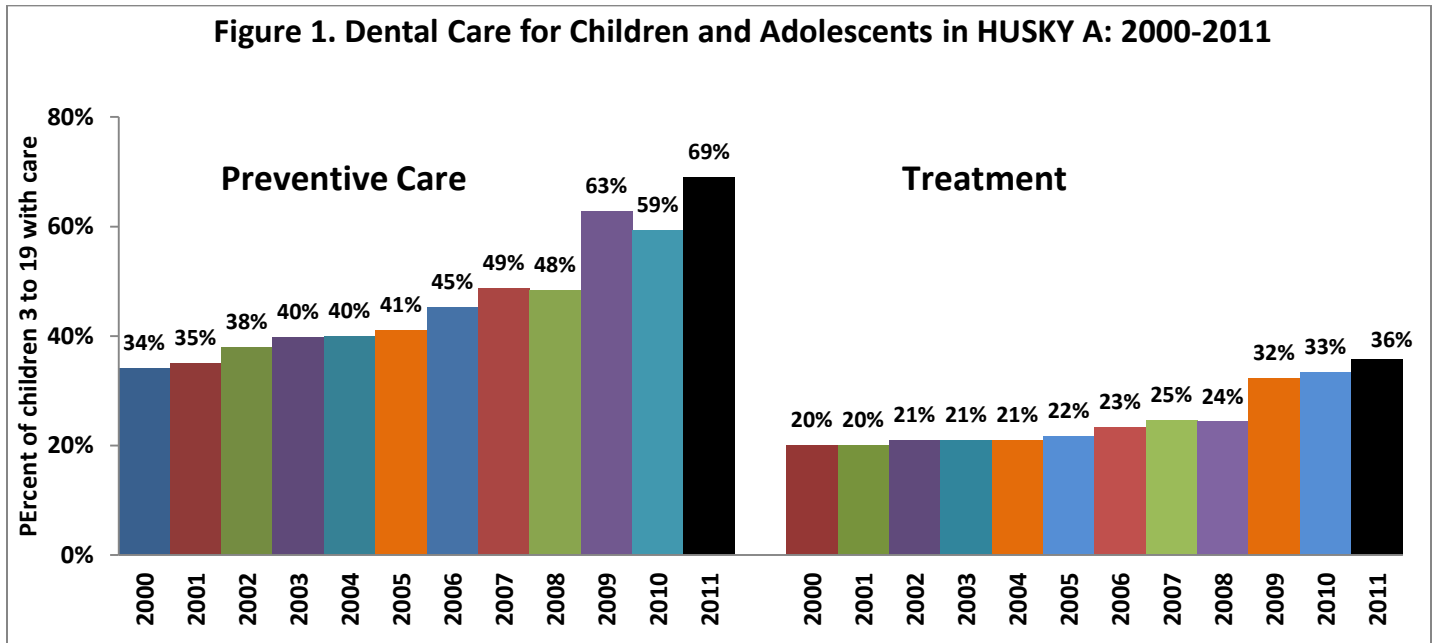
^a Percent of continuously enrolled children under 3 who had at least one dental service or visit by service type.

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

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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.



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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

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

^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 ($p < .001$).

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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

	Children and Adolescents with Dental Care ^a					
	2011		2010		2009	
	HUSKY A	HUSKY B	HUSKY A	HUSKY B	HUSKY A	HUSKY B
Any dental care	73.5%	75.3%	68.1%	72.8%*	68.0%	69.8%*
Preventive care	68.9%	72.8%*	59.2%	69.8%*	62.7%	68.9%*
Treatment	35.7%	32.1%*	33.3%	31.5%	32.3%	32.2%
Sealants^b	23.5%	22.0%	22.1%	23.6%	22.9%	24.2%

^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 ($p < .001$).

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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

	Children and Adolescents with Two or More Visits for Preventive Dental Care ^a					
	2011	2010	2009	2008	2007 ^b	2006
HUSKY A	50.1%*	39.6%*	44.7%*	30.9%	30.3%	31.0%
HUSKY B	59.5%†	57.0%†	53.9%†	NA	NA	NA

^a Percent of children 3 to 19 with any dental care who had two or more preventive visits. ^b 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.

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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

Age:	Children with Sealants ^a					
	2011		2010		2009	
	HUSKY A	HUSKY B	HUSKY A	HUSKY B	HUSKY A	HUSKY B
6 to 8	33.1%	30.8%	31.2%	32.2%	32.6%	36.7%
9 to 11	34.2%*	28.5%	32.4%	27.8%	33.0%	31.6%
12 to 14	36.9%	32.8%	33.3%	35.7%	34.6%	29.2%

^a Percent of children with any dental care who had at least one sealant placed.

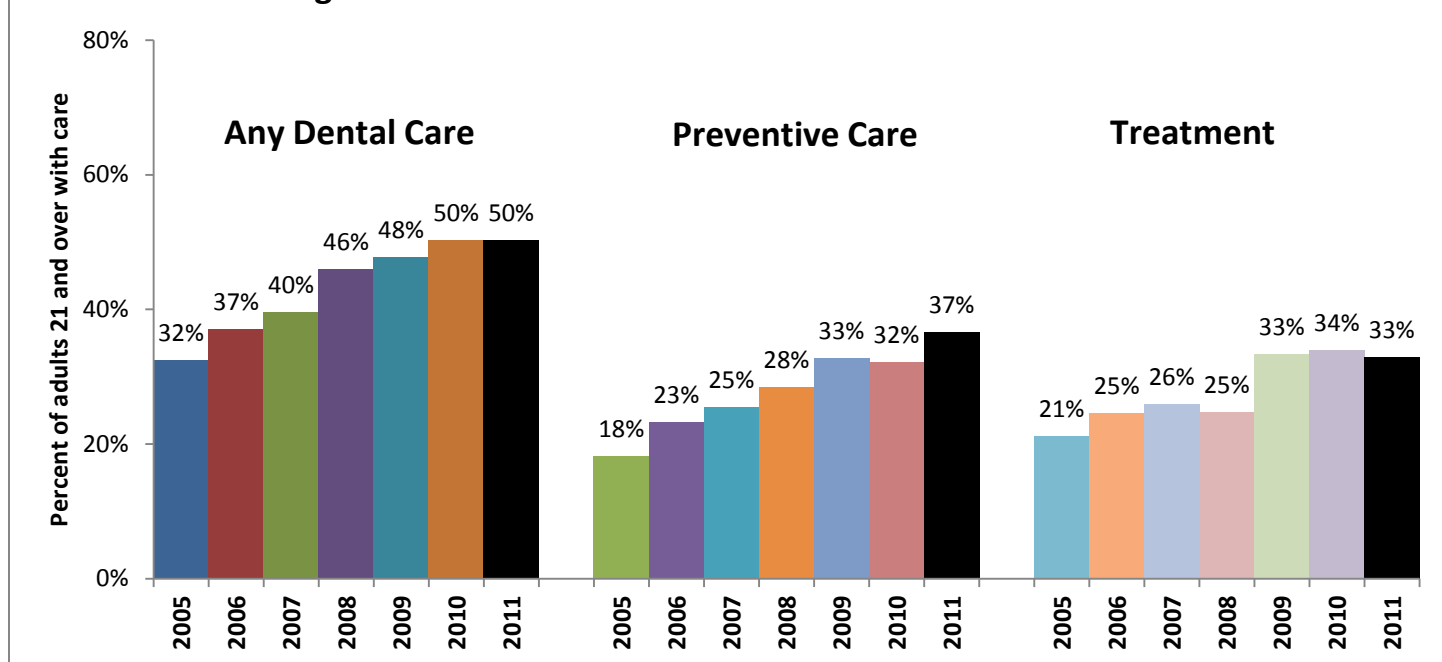
* Age-specific rate for children in HUSKY A is greater than the rate for children in HUSKY B (p<.001).

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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%).

Figure 2. Dental Care for Parents in HUSKY A: 2005-2011



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

Table 6. Dental Care Utilization by Parents in HUSKY A, 2005 to 2011

	Parents with Dental Care ^a						
	2011	2010	2009	2008	2007 ^b	2006	2005
Any dental care	50.2%*	50.3%*	47.7%*	45.90%	39.60%	37.00%	32.40%
Preventive care	36.6%*	32.1%*	32.8%*	28.40%	25.40%	23.20%	18.20%
Treatment	32.8%*	33.9%*	33.3%*	24.70%	25.90%	24.60%	21.20%

^a 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.

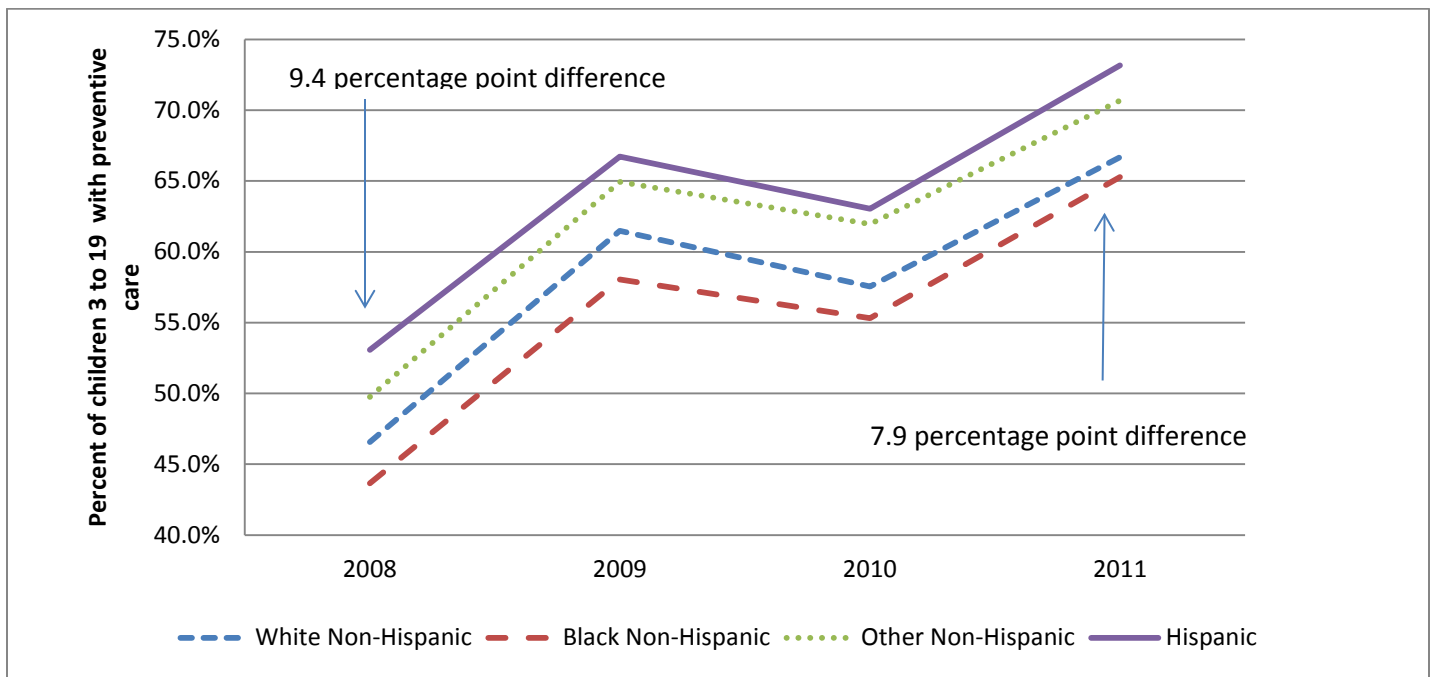
* Rate in 2009, 2010, or 2011 is significantly higher than the rate in 2008 ($p < .001$).

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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).

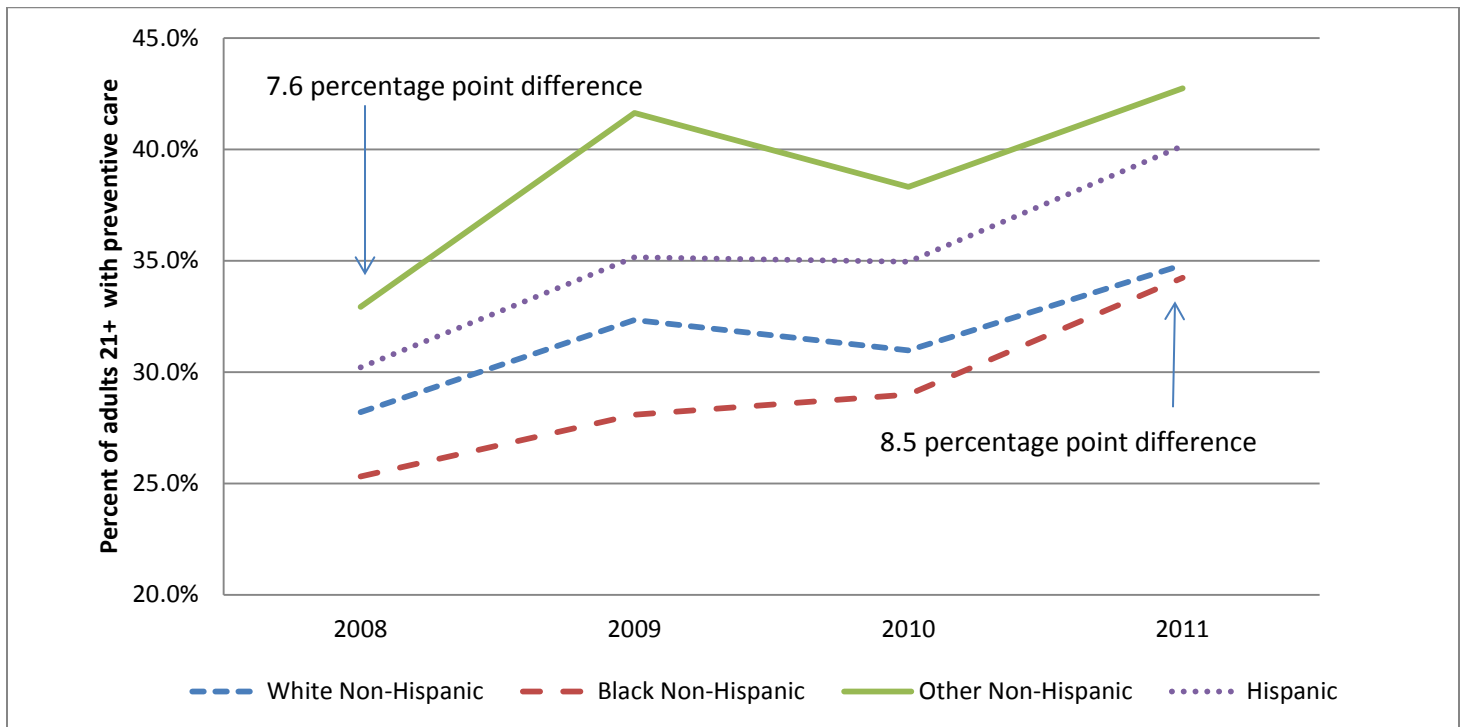
Figure 4. Effect of Race or Ethnicity on Children’s Utilization in HUSKY A



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2013.

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.¹⁷ 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.”¹⁸

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.¹⁹ 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.²⁰ 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.²¹

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.²² 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

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¹ US Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

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)].

³ McGinn-Shapiro M. Medicaid coverage of adult dental services. National Academy for State Health Policy: State Health Policy Monitor; October 2008. Available at: www.nashp.org/Files/shpmonitor_adental.pdf.

⁴ Email communication with Andrew Snyder, National Academy for State Health Policy, April 22, 2013.

⁵The changes came about as part of the settlement agreement in the case of *Carr v. Wilson-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.

⁸ Connecticut Voices for Children. Children’s Dental Services in the HUSKY Program: Program Improvements Led to Increased Utilization in 2009 and 2010. November 2011. Available at: <http://www.ctvoices.org/sites/default/files/h11dentalcare10.pdf>. Dental Services for Adults in the HUSKY Program: Utilization Before and After Major Program Changes in 2008. September 2012. Available at: <http://www.ctvoices.org/sites/default/files/h12adultdentalcare10.pdf>.

⁹Since 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).

¹⁵ Centers for Medicare and Medicaid Services. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416). Available at: http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage.

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.

¹⁷ Institute of Medicine Committee on Oral Health Access to Services. Improving access to oral health care for vulnerable and underserved populations (pre-publication copy). July 2011. Available free at: http://www.nap.edu/catalog.php?record_id=13116.

¹⁸ Borchegrevink A, Snyder A, Gehshan S. The effects of Medicaid reimbursement rates on access to dental care. March 2008. Available at: www.nashp.org/Files/CHCF_dental_rates.pdf.

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

HUSKY A Child Dental Care	Calendar Year 2011								Calendar Year 2010							
	Population		Any Dental Care		Preventive Care		Treatment		Population		Any Dental Care		Preventive Care		Treatment	
Total	186,903		137,863	73.8%	128,778	68.9%	66,731	35.7%	175,658		119,665	68.1%	104,051	59.2%	58,459	33.3%
Age																
3 - 5	39,181	21.0%	29,231	74.6%	28,078	71.7%	8,311	21.2%	37,272	21.2%	24,403	65.5%	21,656	58.1%	7,667	20.6%
6 - 8	36,359	19.5%	29,177	80.2%	27,968	76.9%	13,935	38.3%	33,885	19.3%	25,174	74.3%	22,679	66.9%	11,849	35.0%
9 - 11	34,922	18.7%	27,468	78.7%	26,178	75.0%	13,536	38.8%	33,339	19.0%	24,725	74.2%	22,360	67.1%	12,035	36.1%
12 - 14	33,510	17.9%	24,850	74.2%	22,831	68.1%	13,991	41.8%	31,062	17.7%	21,742	70.0%	18,712	60.2%	12,200	39.3%
15 - 19	42,931	23.0%	27,137	63.2%	23,723	55.3%	16,958	39.5%	40,100	22.8%	23,621	58.9%	18,644	46.5%	14,708	36.7%
Total	186,903	100.0%	137,863		128,778		66,731		175,658	100.0%	119,665		104,051		58,459	
Gender																
Female	91,643	49.0%	68,871	75.2%	64,207	70.1%	34,106	37.2%	86,315	49.1%	60,094	69.6%	52,064	60.3%	30,181	35.0%
Male	95,053	50.9%	68,845	72.4%	64,427	67.8%	32,559	34.3%	89,343	50.9%	59,571	66.7%	51,987	58.2%	28,278	31.7%
Unknown	207	0.1%	147	71.0%	144	69.6%	66	31.9%	-	0.0%	-	-	-	-	-	-
Total	186,903	100.0%	137,863		128,778		66,731		175,658	100.0%	119,665		104,051		58,459	
Residence																
Non-urban	137,136	73.4%	100,512	73.3%	94,585	69.0%	48,209	35.2%	126,535	72.0%	85,856	67.9%	75,366	59.6%	41,578	32.9%
Urban	49,767	26.6%	37,351	75.1%	34,193	68.7%	18,522	37.2%	49,123	28.0%	33,809	68.8%	28,685	58.4%	16,881	34.4%
Total	186,903	100.0%	137,863		128,778		66,731		175,658	100.0%	119,665		104,051		58,459	
Primary Language																
English	165,763	88.7%	120,892	72.9%	112,878	68.1%	57,983	35.0%	157,309	89.6%	105,848	67.3%	92,060	58.5%	51,305	32.6%
Other	2,791	1.5%	2,029	72.7%	1,878	67.3%	1,064	38.1%	1,279	0.7%	897	70.1%	782	61.1%	457	35.7%
Spanish	18,349	9.8%	14,942	81.4%	14,022	76.4%	7,684	41.9%	17,070	9.7%	12,920	75.7%	11,209	65.7%	6,697	39.2%
Total	186,903	100.0%	137,863		128,778		66,731		175,658	100.0%	119,665		104,051		58,459	
Town																
Bridgeport	16,263	8.7%	11,854	72.9%	10,903	67.0%	6,234	38.3%	16,035	9.1%	10,820	67.5%	9,175	57.2%	5,756	35.9%
Hartford	19,032	10.2%	14,899	78.3%	13,215	69.4%	7,023	36.9%	18,588	10.6%	13,348	71.8%	11,039	59.4%	6,395	34.4%
New Haven	14,472	7.7%	10,598	73.2%	10,075	69.6%	5,265	36.4%	14,500	8.3%	9,641	66.5%	8,471	58.4%	4,730	32.6%
All Other Towns	137,136	73.4%	100,512	73.3%	94,585	69.0%	48,209	35.2%	126,535	72.0%	85,856	67.9%	75,366	59.6%	41,578	32.9%
Total	186,903	100.0%	137,863		128,778		66,731		175,658	100.0%	119,665		104,051		58,459	
Race/Ethnicity																
White Non-Hispanic	68,892	36.9%	48,994	71.1%	45,941	66.7%	23,004	33.4%	64,428	36.7%	42,328	65.7%	37,072	57.5%	20,043	31.1%
Black Non-Hispanic	40,664	21.8%	28,749	70.7%	26,549	65.3%	13,620	33.5%	39,785	22.6%	25,849	65.0%	22,002	55.3%	12,430	31.2%
Other Non-Hispanic	6,342	3.4%	4,771	75.2%	4,482	70.7%	2,503	39.5%	5,681	3.2%	3,996	70.3%	3,520	62.0%	2,069	36.4%
Hispanic	69,924	37.4%	54,658	78.2%	51,162	73.2%	27,242	39.0%	65,764	37.4%	47,492	72.2%	41,457	63.0%	23,917	36.4%
Other/ Unkown	1,081	0.6%	691	0.5%	644	0.5%	362	0.5%	-	-	-	-	-	-	-	-
Total	186,903	100.0%	137,863		128,778		66,731		175,658	100.0%	119,665		104,051		58,459	

HUSKY A Child Dental Care	Calendar Year 2009								Calendar Year 2008							
	Population		Any Dental Care		Preventive Care		Treatment		Population		Any Dental Care		Preventive Care		Treatment	
Total	155,155		105,553	68.0%	97,357	62.7%	50,114	32.3%	147,872		83,224	56.3%	71,510	48.4%	35,987	24.3%
Age																
3 - 5	32,344	20.8%	22,095	68.3%	20,708	64.0%	6,419	19.8%	30,162	20.4%	16,318	54.1%	14,422	47.8%	4,441	14.7%
6 - 8	30,089	19.4%	22,912	76.1%	21,830	72.6%	10,887	36.2%	29,005	19.6%	18,508	63.8%	16,697	57.6%	8,007	27.6%
9 - 11	29,411	19.0%	21,779	74.1%	20,573	70.0%	10,603	36.1%	27,838	18.8%	17,065	61.3%	15,206	54.6%	7,407	26.6%
12 - 14	27,100	17.5%	18,231	67.3%	16,584	61.2%	9,878	36.5%	26,042	17.6%	14,702	56.5%	12,192	46.8%	7,328	28.1%
15 - 19	36,211	23.3%	20,536	56.7%	17,662	48.8%	12,327	34.0%	34,825	23.6%	16,631	47.8%	12,993	37.3%	8,804	25.3%
Total	155,155	100.0%	105,553		97,357		50,114		147,872	100.0%	83,224		71,510		35,987	
Gender																
Female	76,436	49.3%	52,906	69.2%	48,659	63.7%	25,227	33.5%	72,893	49.3%	41,686	57.2%	35,729	49.0%	18,456	25.3%
Male	78,719	50.7%	52,647	66.9%	48,698	61.9%	24,487	31.1%	74,930	50.7%	41,505	55.4%	35,752	47.7%	17,517	23.4%
Unknown	-	0.0%	-	-	-	-	-	-	49	0.0%	33	67.3%	29	59.2%	14	28.6%
Total	155,155	100.0%	105,553		97,357		50,114		147,872	100.0%	83,224		71,510		35,987	
Residence																
Non-urban	111,345	71.8%	75,983	68.2%	70,720	63.5%	35,925	32.3%	105,769	71.5%	58,967	55.8%	51,185	48.4%	25,219	23.8%
Urban	43,810	28.2%	29,570	67.5%	26,637	60.8%	14,189	32.4%	42,103	28.5%	24,257	57.6%	20,325	48.3%	10,768	25.6%
Total	155,155	100.0%	105,553		97,357		50,114		147,872	100.0%	83,224		71,510		35,987	
Primary Language																
English	139,080	89.6%	93,454	67.2%	86,195	62.0%	44,057	31.7%	133,186	90.1%	73,709	55.3%	63,297	47.5%	31,756	23.8%
Other	1,090	0.7%	743	68.2%	695	63.8%	357	32.8%	1,012	0.7%	593	58.6%	499	49.3%	260	25.7%
Spanish	14,985	9.7%	11,356	75.8%	10,467	69.8%	5,700	38.0%	13,674	9.2%	8,922	65.2%	7,714	56.4%	3,971	29.0%
Total	155,155	100.0%	105,553		97,357		50,114		147,872	100.0%	83,224		71,510		35,987	
Town																
Bridgeport	14,274	9.2%	8,907	62.4%	7,696	53.9%	4,368	30.6%	13,309	9.0%	7,043	52.9%	5,448	40.9%	3,231	24.3%
Hartford	16,509	10.6%	11,808	71.5%	10,692	64.8%	5,527	33.5%	16,071	10.9%	10,682	66.5%	9,086	56.5%	4,639	28.9%
New Haven	13,027	8.4%	8,855	68.0%	8,249	63.3%	4,294	33.0%	12,723	8.6%	6,532	51.3%	5,791	45.5%	2,898	22.8%
All Other Towns	111,345	71.8%	75,983	68.2%	70,720	63.5%	35,925	32.3%	105,769	71.5%	58,967	55.8%	51,185	48.4%	25,219	23.8%
Total	155,155	100.0%	105,553		97,357		50,114		147,872	100.0%	83,224		71,510		35,987	
Race/Ethnicity																
White Non-Hispanic	56,093	36.2%	36,945	65.9%	34,486	61.5%	17,439	31.1%	53,178	36.0%	28,577	53.7%	24,768	46.6%	12,432	23.4%
Black Non-Hispanic	36,189	23.3%	23,159	64.0%	21,008	58.1%	10,509	29.0%	35,740	24.2%	18,428	51.6%	15,600	43.6%	7,637	21.4%
Other Non-Hispanic	4,627	3.0%	3,223	69.7%	3,005	64.9%	1,672	36.1%	4,274	2.9%	2,477	58.0%	2,126	49.7%	1,243	29.1%
Hispanic	58,246	37.5%	42,226	72.5%	38,858	66.7%	20,494	35.2%	54,680	37.0%	33,742	61.7%	29,016	53.1%	14,675	26.8%
Other/ Unkown	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	155,155	100.0%	105,553		97,357		50,114		155,155	100.0%	105,553</					

Dental Care Utilization by Children 3 to 19 in HUSKY B: 2009 - 2011

HUSKY B Dental Care	Calendar Year 2011								Calendar Year 2010								Calendar Year 2009							
	Population	Any Dental Care		Preventive Care		Treatment			Population	Any Dental Care		Preventive Care		Treatment			Population	Any Dental Care		Preventive Care		Treatment		
Total	6,120	4,608	75.3%	4,456	72.8%	1,962	32.1%		6,043	4,402	72.8%	4,219	69.8%	1,903	31.5%		5,132	3,580	69.8%	3,537	68.9%	1,655	32.2%	
Age																								
3 - 5	877	14.3%	654	74.6%	637	72.6%	149	17.0%	862	14.3%	611	70.9%	600	69.6%	130	15.1%	887	17.3%	656	74.0%	645	72.7%	210	23.7%
6 - 8	1,088	17.8%	904	83.1%	884	81.3%	369	33.9%	1,122	18.6%	923	82.3%	905	80.7%	405	36.1%	1,007	19.6%	769	76.4%	765	76.0%	363	36.0%
9 - 11	1,211	19.8%	981	81.0%	951	78.5%	433	35.8%	1,175	19.4%	905	77.0%	873	74.3%	394	33.5%	1,073	20.9%	791	73.7%	781	72.8%	343	32.0%
12 - 14	1,240	20.3%	943	76.0%	914	73.7%	440	35.5%	1,246	20.6%	917	73.6%	874	70.1%	444	35.6%	1,104	21.5%	740	67.0%	735	66.6%	369	33.4%
15 - 19	1,704	27.8%	1,126	66.1%	1,070	62.8%	571	33.5%	1,638	27.1%	1,046	63.9%	967	59.0%	530	32.4%	1,061	20.7%	624	58.8%	611	57.6%	370	34.9%
Total	6,120	100.0%	4,608		4,456		1,962		6,043	100.0%	4,402		4,219		1,903		5,132	100.0%	3,580		3,537		1,655	
Gender																								
Female	2,914	47.6%	2,184	74.9%	2,119	72.7%	921	31.6%	2,900	48.0%	2,134	73.6%	2,027	69.9%	909	31.3%	2,458	47.9%	1,731	70.4%	1,708	69.5%	788	32.1%
Male	3,196	52.2%	2,415	75.6%	2,328	72.8%	1,034	32.4%	3,137	51.9%	2,262	72.1%	2,186	69.7%	990	31.6%	2,670	52.0%	1,847	69.2%	1,827	68.4%	865	32.4%
Unknown	10	0.2%	9	90.0%	9	90.0%	7	70.0%	6	0.1%	6	100.0%	6	100.0%	4	66.7%	4	0.1%	2	50.0%	2	50.0%	2	50.0%
Total	6,120	100.0%	4,608		4,456		1,962		6,043	100.0%	4,402		4,219		1,903		5,132	100.0%	3,580		3,537		1,655	
Residence																								
Non-urban	5,529	90.3%	4,142	74.9%	4,012	72.6%	1,765	31.9%	5,365	88.8%	3,876	72.2%	3,719	69.3%	1,670	31.1%	4,599	89.6%	3,213	69.9%	3,178	69.1%	1,465	31.9%
Urban	591	9.7%	466	78.8%	444	75.1%	197	33.3%	678	11.2%	526	77.6%	500	73.7%	233	34.4%	533	10.4%	367	68.9%	359	67.4%	190	35.6%
Total	6,120	100.0%	4,608		4,456		1,962		6,043	100.0%	4,402		4,219		1,903		5,132	100.0%	3,580		3,537		1,655	
Town																								
Bridgeport	300	4.9%	234	78.0%	226	75.3%	96	32.0%	308	5.1%	228	74.0%	220	71.4%	102	33.1%	254	4.9%	177	69.7%	175	68.9%	94	37.0%
Hartford	161	2.6%	123	76.4%	113	70.2%	43	26.7%	214	3.5%	172	80.4%	155	72.4%	73	34.1%	162	3.2%	118	72.8%	113	69.8%	63	38.9%
New Haven	130	2.1%	109	83.8%	105	80.8%	58	44.6%	156	2.6%	126	80.8%	125	80.1%	58	37.2%	117	2.3%	72	61.5%	71	60.7%	33	28.2%
All Other Towns	5,529	90.3%	4,142	74.9%	4,012	72.6%	1,765	31.9%	5,365	88.8%	3,876	72.2%	3,719	69.3%	1,670	31.1%	4,599	89.6%	3,213	69.9%	3,178	69.1%	1,465	31.9%
Total	6,120	100.0%	4,608		4,456		1,962		6,043	100.0%	4,402		4,219		1,903		5,132	100.0%	3,580		3,537		1,655	
Race/Ethnicity																								
White Non-Hispanic	3,675	60.0%	2,893	73.3%	2,611	71.0%	1,110	30.2%	3,658	60.5%	2,609	71.3%	2,509	68.6%	1,105	30.2%	3,195	62.3%	2,166	67.8%	2,149	67.3%	958	30.0%
Black Non-Hispanic	560	9.2%	431	77.0%	416	74.3%	178	31.8%	582	9.6%	432	74.2%	414	71.1%	183	31.4%	520	10.1%	349	67.1%	345	66.3%	167	32.1%
Other Non-Hispanic	467	7.6%	346	74.1%	332	71.1%	161	34.5%	318	5.3%	228	71.7%	218	68.6%	113	35.5%	259	5.0%	196	75.7%	193	74.5%	96	37.1%
Hispanic	1,265	20.7%	1,029	81.3%	991	78.3%	464	36.7%	1,257	20.8%	988	78.6%	937	74.5%	444	35.3%	1,070	20.8%	813	76.0%	794	74.2%	399	37.3%
Other/Unknown	153	2.5%	109	71.2%	106	69.3%	49	32.0%	228	3.8%	145	63.6%	141	61.8%	58	25.4%	88	1.7%	56	63.6%	56	63.6%	35	39.8%
Total	6,120	100.0%	4,608		4,456		1,962		6,043	100.0%	4,402		4,219		1,903		5,132	100.0%	3,580		3,537		1,655	

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 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

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

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

HUSKY A Adult Dental Care	Calendar Year 2011								Calendar Year 2010							
	Population		Any Dental Care		Preventive Care		Treatment		Population		Any Dental Care		Preventive Care		Treatment	
Total	98,495		49,486	50.2%	36,084	36.6%	32,324	32.8%	92,629		46,556	50.3%	29,765	32.1%	31,442	33.9%
Age																
21 - 39	65,015	66.0%	32,829	50.5%	23,558	36.2%	21,709	33.4%	62,389	67.4%	31,574	50.6%	19,885	32%	21,478	34%
>= 40	33,480	34.0%	16,657	49.8%	12,526	37.4%	10,615	31.7%	30,240	32.6%	14,982	49.5%	9,880	33%	9,964	33%
Total	98,495	100.0%	49,486		36,084		32,324		92,629	100.0%	46,556		29,765		31,442	
Gender																
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%
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	29%	5,932	30%
Unknown	12	0.0%	8	66.7%	6	50.0%	6	50.0%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
Total	98,495	100.0%	49,486		36,084		32,324		92,629	100.0%	46,556		29,765		31,442	
Residence																
Non-urban	75,537	76.7%	37,631	49.8%	28,010	37.1%	24,298	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%
Total	98,495	100.0%	49,486		36,084		32,324		92,629	100.0%	46,556		29,765		31,442	
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	49.4%	26,158	31%	27,674	33%
Other	2,076	2.1%	1,051	50.6%	785	37.8%	693	33.4%	903	1.0%	478	52.9%	317	35%	335	37%
Spanish	8,415	8.5%	4,954	58.9%	3,763	44.7%	3,314	39.4%	8,374	9.0%	4,905	58.6%	3,290	39%	3,433	41%
Total	98,495	100.0%	49,486		36,084		32,324		92,629	100.0%	46,556		29,765		31,442	
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%	24,298	32.2%	69,033	74.5%	34,487	50.0%	22,690	33%	23,043	33%
Total	98,495	100.0%	49,486		36,084		32,324		92,629	100.0%	46,556		29,765		31,442	
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	47.6%	12,739	31%	13,059	32%
Black Non-Hispanic	19,112	19.4%	9,521	49.8%	6,543	34.2%	6,424	33.6%	18,662	20.1%	9,305	49.9%	5,410	29%	6,391	34%
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%
Hispanic	30,101	30.6%	16,420	54.5%	12,088	40.2%	10,841	36.0%	28,713	31.0%	15,458	53.8%	10,037	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%
Total	98,495	100.0%	49,486		36,084		32,324		92,629	100.0%	46,556		29,765		31,442	

HUSKY A Adult Dental Care	Calendar Year 2009								Calendar Year 2008							
	Population		Any Dental Care		Preventive Care		Treatment		Population		Any Dental Care		Preventive Care		Treatment	
Total	79,122		37,726	47.7%	25,913	33%	26,360	33%	71,303		32,705	45.9%	20,256	28.4%	17,622	24.7%
Age																
21 - 39	54,498	69%	25,920	47.6%	17,523	32%	18,100	33%	49,621	69.6%	23,300	47%	14,641	30%	12,241	25%
>= 40	24,624	31%	11,806	47.9%	8,390	34%	8,260	34%	21,682	30.4%	9,405	43%	5,615	26%	5,381	25%
Total	79,122	100.0%	37,726		25,913		26,360		71,303	100.0%	32,705		20,256		17,622	
Gender																
Female	63,035	80%	30,788	48.8%	21,045	33%	21,474	34%	57,617	80.8%	27,639	48%	17,190	30%	14,568	25%
Male	16,087	20%	6,938	43.1%	4,868	30%	4,886	30%	13,683	19.2%	5,064	37%	3,064	22%	3,052	22%
Unknown	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	3	0.0%	2	67%	2	67%	2	67%
Total	79,122	100.0%	37,726		25,913		26,360		71,303	100.0%	32,705		20,256		17,622	
Residence																
Non-urban	58,343	74%	28,095	48.2%	19,837	34%	19,770	34%	52,266	73.3%	24,182	46%	15,264	29%	13,154	25%
Urban	20,779	26%	9,631	46.3%	6,076	29%	6,590	32%	19,037	26.7%	8,523	45%	4,992	26%	4,468	23%
Total	79,122	100.0%	37,726		25,913		26,360		71,303	100.0%	32,705		20,256		17,622	
Primary Language																
English	70,756	89%	33,131	46.8%	22,661	32%	23,201	33%	63,697	89.3%	28,874	45%	17,817	28%	15,466	24%
Other	780	1%	386	49.5%	261	33%	289	37%	754	1.1%	354	47%	216	29%	203	27%
Spanish	7,586	10%	4,209	55.5%	2,991	39%	2,870	38%	6,849	9.6%	3,477	51%	2,223	32%	1,953	29%
Total	79,122	100.0%	37,726		25,913		26,360		71,303	100.0%	32,705		20,256		17,622	
Town																
Bridgeport	6,817	9%	3,114	45.7%	1,758	26%	2,118	31%	5,953	8.3%	2,793	47%	1,416	24%	1,482	25%
Hartford	8,045	10%	3,813	47.4%	2,745	34%	2,605	32%	7,487	10.5%	3,584	48%	2,323	31%	1,886	25%
New Haven	5,917	7%	2,704	45.7%	1,573	27%	1,867	32%	5,597	7.8%	2,146	38%	1,253	22%	1,100	20%
All Other Towns	58,343	74%	28,095	48.2%	19,837	34%	19,770	34%	52,266	73.3%	24,182	46%	15,264	29%	13,154	25%
Total	79,122	100.0%	37,726		25,913		26,360		71,303	100.0%	32,705		20,256		17,622	
Race Roll Up																
White Non-Hispanic	34,396	43%	15,805	46.0%	11,121	32%	11,281	33%	30,631	43.0%	13,631	45%	8,638	28%	7,554	25%
Black Non-Hispanic	16,322	21%	7,440	45.6%	4,584	28%	5,177	32%	15,265	21.4%	6,670	44%	3,863	25%	3,403	22%
Other Non-Hispanic	3,425	4%	1,814	53.0%	1,426	42%	1,192	35%	2,913	4.1%	1,379	47%	959	33%	749	26%
Hispanic	24,979	32%	12,667	50.7%	8,782	35%	8,710	35%	22,494	31.5%	11,025	49%	6,796	30%	5,916	26%
Other/Unknown	-	0%	-	0.0%	-	0%	-	0%	-	0.0%	-	0%	-	0%	-	0%
Total	79,122	100.0%	37,726		25,913		26,360		71,303	100.0%	32,705		20,256		17,622	

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 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.

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.