Dental Services for Children and Parents in the HUSKY Program in 2013: Utilization Is Improved Over 2008 but Unchanged from 2012

April 2015

KEY FINDINGS

Connecticut’s approach to expanding access to oral health care in the HUSKY Program has led to measurable positive effects on access to care and utilization for children and parents. In 2008, the dental program was converted from risk-based managed care to an administered fee-for-service program. Provider reimbursement increased significantly and the provider network expanded to include two-thirds of active dentists in Connecticut. For the fifth consecutive year, the number and percentage of children and parents who received dental services in 2013 were significantly higher than in 2008 when program reforms were implemented; however, the initial gains appear to have leveled off.

- **Utilization trends:** For most children and for adults, preventive care and treatment rates in 2013 were the same or lower than 2012.
  - The percentage of children under 3 who had preventive care remained well above the utilization rates reported for 2008 (prior to program changes) and continued to increase;
  - The percentages of children 3 to 19 who had preventive care, treatment, and sealants were significantly higher than the rates for 2008, but essentially unchanged from 2011 and 2012;
  - The percentage of adults 21 and over in HUSKY A who had preventive care or treatment in 2013 remained well above the rates reported for 2008, but were about the same as in 2012 and lower than rates for 2011.

- **Racial/ethnic disparities:** Differences associated with race and ethnicity persist: Children of Hispanic origin were most likely to have received preventive care. After narrowing considerably by 2012, the gaps between rates for White and Black/African American children and adults widened slightly.

Since 2008, this program has been headed in the right direction in terms of expanding access to oral health care for children and parents in the HUSKY Program. The lack of improvement in 2012 and 2013, compared with previous years, suggests that as the impact of increased reimbursement diminishes, additional strategies may be needed to increase demand for dental services. These strategies should include raising awareness about HUSKY Program coverage for dental services and stressing the importance of oral health for overall health and well-being. In addition, the Department of Social Services, its contractors, and its community-based partners should work toward keeping eligible children and their parents continuously enrolled as a means of increasing utilization of preventive dental care.
INTRODUCTION

In 2008, the State of Connecticut took steps to improve access to dental care for children in its HUSKY Program.\(^1\) Under the terms of a lawsuit settlement agreement, Connecticut 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, an administered fee-for-service program with customer support, targeted outreach, provider relations, and care coordination.\(^2\) Dental care providers are reimbursed directly by the Medicaid agency.\(^3\) 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

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Procedure</th>
<th>Fees for Children’s Services</th>
<th>Fees for Adult Services(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2005</td>
<td>Effective</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>
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</table>

\(^a\)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.

Note: The dental service fees in 2013 were the same as those adopted 2008 under terms of the settlement of Carr v. Wilson-Coker.

Connecticut’s HUSKY Program provides comprehensive dental care for children and parents and pregnant women.\(^4\) The following services are covered (at no charge for children and adults in HUSKY A; with small co-payments for children in HUSKY B) when provided by a participating dentist:

- Oral exams (every 6 months for children under 21; annually for adults 21 and over);
- Topical fluoride application (twice a year for children under 21);
- Sealants (permanent molars and pre-molars for children 5 through 16);
- Cleanings (every six months for children under 21; annually for adults 21 and over);
- Restoration and other services, including spacers, fillings, x-rays, extractions, partial and full dentures, root canals, crowns, and oral surgery, subject to prior authorization and/or limits consistent with good dental practice); and
- Orthodontics (for children under 21 in HUSKY A to correct malocclusion; under 19 in HUSKY B).\(^5\)
The Connecticut Dental Health Partnership recently reported that two-thirds of all active dentists in Connecticut participate (over 1,800 participating providers, up from 349 in 2008). There are HUSKY dental providers within 10 miles of 99 percent of HUSKY Program members.

This report from Connecticut Voices for Children is the fifth in a series of reports on the impact of the program changes that occurred in 2008. It is the fifteenth annual report on children’s dental care in Connecticut’s Medicaid program. Connecticut Voices has reported on adult dental care since 2005.

METHODS

Using a retrospective cohort design, we described child and adult dental care utilization in the HUSKY Program in 2013. For investigation of trends, utilization in 2013 was compared to utilization in 2008 and earlier under risk-based managed care. Rates for 2009 thru 2012 (previously reported) are also shown. In addition, we compared utilization rates for children continuously enrolled in HUSKY A, with utilization rates for children continuously enrolled in HUSKY B, and those continuously enrolled who changed programs (HUSKY A to B, or HUSKY B to A). 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 ever enrolled in the HUSKY Program between January 1 and December 31, 2013, and the subset who were continuously enrolled for the entire year. The vast majority of children were enrolled in HUSKY A (Medicaid) (95% as of July 1 midpoint), with far fewer in HUSKY B. To ensure comparability with rates we reported in previous years, dental service utilization rates were determined separately for HUSKY A and B and for the following age groups (age as of December 31):

- **Children:**
  - **Very young children:** Utilization rates for very young children in HUSKY A and B are reported. 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 dental 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, and those who changed programs (HUSKY A to B or B to A). Rates for 20 year olds in HUSKY A are shown separately. Children under 21 are covered by Medicaid's Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) requirements for timely preventive care.

- **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 adult pregnant women (referred to as “parents” throughout the report). Adults 21 and over are not covered by Medicaid's EPSDT requirements for timely preventive care.

Children and parents who were continuously enrolled in HUSKY A for 12 months and children who were continuously enrolled in HUSKY B for 12 months were included in the sample. In addition, children who were continuously enrolled for 12 months but changed programs (HUSKY A to B or B to A) without a break in coverage are 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 2013 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 2013. The procedure code set is the same as that used by state Medicaid agencies to report by federal fiscal year and age group to the Centers for Medicare and Medicaid Services (CMS). The results we report include utilization data for HUSKY B and adults in HUSKY A, with 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 2013 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 race-specific rates. The numbers of children and parents who obtained care in 2008-2013 are shown by type of service in the data tables that are posted with this report.

In previous years, all analyses were based on the experience of children and adults who were continuously enrolled for 12 months in the calendar year. In addition, this report includes data on coverage continuity and utilization. Preventive care rates in 2013 were calculated for those enrolled less than a year by months enrolled and age group.

The rest of the 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 or disabling health conditions, families with language barriers, etc.). The report does not include a count of all services delivered in the one-year periods nor is there a cost analysis for all services rendered. Utilization rates are based on individuals who were continuously enrolled for one year and received care.

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 adults without dependent children). 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. continuously enrolled for just 90 days 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 other third party payers or delivered by providers who did not submit claims. In the absence of an all-payer-claims database for Connecticut, it was not possible to determine which if any of the HUSKY enrollees had care during gaps in coverage. Finally, the Department’s methods for categorizing race and ethnicity apparently changed in 2013; the results do not align perfectly with previous years when “unknown” was 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

Enrollment

In 2013, there were 320,806 children under 19 and 201,954 adults 19 and over ever enrolled in HUSKY A for a month of more. About 75 percent of children and 63 percent of adults were continuously enrolled for 12 months that year. There were 19,574 children under 19 ever enrolled in HUSKY B and 39 percent of them were continuously enrolled in 2013.

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. Since 2009, utilization of preventive care has increased steadily (Table 1).

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<tbody>
<tr>
<td>Any dental care</td>
<td>44.8%</td>
<td>42.9%</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>40.4%</td>
<td>38.2%</td>
<td>37.0%</td>
<td>32.3%</td>
<td>24.1%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Treatment</td>
<td>1.9%</td>
<td>2.1%</td>
<td>2.4%</td>
<td>3.3%</td>
<td>2.6%</td>
<td>1.5%</td>
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* Percent of continuously enrolled children under 3 (age as of 12/31) who had at least one dental service or visit by service type. 

In 2013, 12,986 very young children in HUSKY A had any dental care. The number and percentage of very young children with preventive care were more than three times the number and rate in 2008. Children under 1 were least likely to have had care, while 56 percent of children who were 2 years of age had preventive care. The percentage of very young children who had dental treatment was down from recent years and not significantly higher than the rate for 2008. In 2013, the percentage of very young children in HUSKY A with preventive care (40.4%) was slightly higher (but not significantly different) than rates for children in HUSKY B (38.5%) and children who changed between A and B (36.8%).

Utilization Trends for Children and Adolescents in HUSKY A

After years of steady but largely unremarkable improvement under managed care, the number and percentage of children with dental care increased substantially following program changes in 2008 (Figure 1). In 2013, over 151,000 continuously enrolled children in HUSKY A had preventive care, double the number who had preventive care in 2008.
In 2013, the number and percentage of children and adolescents who had any dental care, preventive care, and/or treatment were significantly higher than rates for 2008 prior to the program changes, but essentially unchanged from 2012 (Table 2). As in previous years, the highest preventive care rates were for school-aged children ages 6 to 8 (77.4% with care) and 9 to 11 (76.0%), and for Hispanic children (74.7%) relative to children in all other racial/ethnic groups (67.8%). Overall, the percentage of children age 6 to 19 with any care who had sealants placed remained above the rate for 2008 but was lower than 2012.

Table 2. Dental Services for Children and Adolescents in HUSKY A, 2006-2013

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<tbody>
<tr>
<td>Any dental care</td>
<td>75.0%*</td>
<td>74.4%*</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>70.4%*</td>
<td>69.8%*</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>36.1%*</td>
<td>35.7%*</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</td>
<td>21.8%*</td>
<td>22.9%*</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>
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</table>

* Percent of continuously enrolled children 3 to 19 (age as of 12/31) who had at least one dental service or visit by service type.

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

% Percent of children with any dental care who had sealants placed.

Rate in 2009, 2010, 2011, 2012, or 2013 is significantly higher than the rate in 2008 (p<.001).

Medicaid EPSDT program requirements for dental care apply to HUSKY A enrollees age 20. However in 2012, the dental care utilization rate for 20 year olds in HUSKY A was considerably lower than the rate for younger children and adolescents. Just 50.8 percent of 20 year olds had any dental care, including 41.7 percent that had preventive care and 31.5 percent with treatment, rates that are virtually unchanged from 2011.\textsuperscript{14}

**Comparison of Utilization for Children 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. Among children ages 3 to 19 who were continuously enrolled in 2013, there were 214,800 children in HUSKY A, many fewer children in HUSKY B (7,270 children), and fewer still who changed programs without a break in coverage (3,241 children). On average, children in HUSKY B in 2013 were about one year older than children in HUSKY A.\textsuperscript{15}

In 2013, children in HUSKY B were significantly more likely to have any dental care than children in HUSKY A. Every year since 2009, rates for preventive care have been significantly higher for children in HUSKY B, compared with children in HUSKY A (Table 3). Whereas treatment rates had been essentially the same in past years, in 2013 children in HUSKY B were less likely than children in HUSKY A to get dental treatment.

**Table 3. Comparison of Dental Care Utilization in HUSKY A and B: 2009-2013**

<table>
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<tbody>
<tr>
<td><strong>HUSKY A</strong></td>
<td>75.0%</td>
<td>76.8%*</td>
<td>74.4%</td>
<td>75.4%</td>
<td>73.5%</td>
</tr>
<tr>
<td><strong>HUSKY B</strong></td>
<td>70.4%</td>
<td>73.9%*</td>
<td>69.8%</td>
<td>72.3%*</td>
<td>68.9%</td>
</tr>
<tr>
<td><strong>Any dental care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>36.1%</td>
<td>33.3%*</td>
<td>35.7%</td>
<td>31.9%*</td>
<td>35.7%</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sealants\textsuperscript{b}</strong></td>
<td>21.8%</td>
<td>18.7%*</td>
<td>22.9%</td>
<td>21.4%</td>
<td>23.5%</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Percent of continuously enrolled children 3 to 19 (age as of 12/31) who had at least one dental service or visit by service type.

\textsuperscript{b} Percent of children age 6 – 19 with any dental care who had sealants placed.

*Rate for children in HUSKY B in 2009, 2010, 2011, 2012, or 2013 is significantly higher (or lower, as in the case of 2013 treatment and sealant rates) than the rate for children in HUSKY A that year (p<.001).

**Source:** Analysis of HUSKY Program data by Connecticut Voices for Children, 2015.

Pediatric and dental care professionals recommend that children have dental exams every 6 months (two exams per year). In 2013, 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). However, the rates for recommended care in HUSKY A were significantly lower than rates for children in HUSKY B.
Table 4. Children with Recommended Preventive Dental Care, HUSKY A and B: 2006-2013

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<tbody>
<tr>
<td><strong>HUSKY A</strong></td>
<td>53.9%*</td>
<td>53.2%*</td>
<td>50.1%*</td>
<td>39.6%*</td>
<td>44.7%*</td>
<td>30.9%</td>
<td>30.3%</td>
<td>31.0%</td>
</tr>
<tr>
<td><strong>HUSKY B</strong></td>
<td>61.5%†</td>
<td>61.5%†</td>
<td>59.5%†</td>
<td>57.0%†</td>
<td>53.9%†</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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</table>

*a Percent of children 3 to 19 (age as of 12/31) 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, 2011, 2012, or 2013 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 recently (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 2013 (Table 5).

Table 5. Sealants for School-age Children and Young Adolescents in HUSKY A and B, 2009-2013

<table>
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<tbody>
<tr>
<td><strong>HUSKY A</strong></td>
<td>25.9%</td>
<td>24.2%</td>
<td>26.0%</td>
<td>25.8%</td>
<td>33.1%</td>
</tr>
<tr>
<td><strong>HUSKY B</strong></td>
<td>26.0%</td>
<td>25.8%</td>
<td>33.1%</td>
<td>30.8%</td>
<td>31.2%</td>
</tr>
<tr>
<td><strong>HUSKY A</strong></td>
<td>26.5%</td>
<td>20.9%</td>
<td>34.2%</td>
<td>28.5%</td>
<td>32.4%</td>
</tr>
<tr>
<td><strong>HUSKY B</strong></td>
<td>34.2%</td>
<td>20.9%</td>
<td>34.2%</td>
<td>28.5%</td>
<td>32.4%</td>
</tr>
<tr>
<td><strong>HUSKY A</strong></td>
<td>27.2%</td>
<td>24.9%</td>
<td>36.9%</td>
<td>32.8%</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>HUSKY B</strong></td>
<td>24.9%</td>
<td>36.9%</td>
<td>32.8%</td>
<td>33.3%</td>
<td>35.7%</td>
</tr>
<tr>
<td><strong>HUSKY A</strong></td>
<td>25.1%</td>
<td>24.9%</td>
<td>36.9%</td>
<td>32.8%</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>HUSKY B</strong></td>
<td>24.9%</td>
<td>36.9%</td>
<td>32.8%</td>
<td>33.3%</td>
<td>35.7%</td>
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*Percent of children with any dental care who had at least one sealant placed. Age as of 12/31.

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


Utilization Trends for Parents in HUSKY A

Overall, utilization of dental services by parents in the HUSKY A increased steadily over time, even prior to program changes in 2008 (Figure 1); however, both preventive care and treatment rates essentially unchanged in 2013, compared with 2012, and lower than rates for 2011 (Figure 2). In 2013, the percentages of parents who had any dental care, preventive care, and treatment were still statistically significantly higher than rates for 2008 and earlier years (Table 6). As in the previous year, 2013 utilization rates for adults were lower than rates for children in HUSKY A, especially for preventive care (33.7% v. 70.4% for children).
Table 6. Dental Care Utilization by Adults in HUSKY A, 2005 to 2013

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<tbody>
<tr>
<td>Any dental care</td>
<td>48.6%*†</td>
<td>48.6%*†</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>33.7%*†</td>
<td>33.7%*†</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>31.6%*†</td>
<td>31.5%*†</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 (age as of 12/31) who had at least one service or visit.
*Encounter records for 2007 were incomplete for HUSKY members enrolled in BlueCare Family Plan.
* Rate in 2009, 2010, 2011, 2012 or 2013 is significantly higher than the rate in 2008 (p<.001).
† Rate in 2012, 2013 is significantly lower than in 2011 (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 8.4 percentage points in 2013, slightly greater than in 2012 (7.2 percentage points) (Figure 3). In recent years, the gap between Black/African American children and White children has nearly disappeared, although it widened slightly again in 2013 (to 2.0 percentage points difference in 2013).
As in previous years, Hispanic and other non-Hispanic (mainly Asian) parents were most likely to receive any dental care (Figure 4). Utilization rates for Black/African-American parents and White parents were essentially the same in 2013 (<1.0 percentage point difference). However, the gap between high and low utilization ethnic groups has grown in recent years.

**Figure 3. Effect of Race or Ethnicity on Children’s Utilization in HUSKY A**

![Figure 3. Effect of Race or Ethnicity on Children’s Utilization in HUSKY A](image)

**Source:** Analysis of HUSKY Program data by Connecticut Voices for Children, 2015.

**Figure 4. Effect of Race or Ethnicity on Parent’s Utilization of Preventive Care HUSKY A**

![Figure 4. Effect of Race or Ethnicity on Parent’s Utilization of Preventive Care HUSKY A](image)

**Source:** Analysis of HUSKY Program data by Connecticut Voices for Children, 2015.
DISCUSSION

Recently, CMS issued guidance for state Medicaid programs, reminding them that “dental coverage through Medicaid is a powerful tool that states can use to improve oral health for tens of millions of children and adolescents.”16 The following strategies were recommended by CMS and already implemented in Connecticut (✓):

- Improving state Medicaid program performance through policy changes;
- Maximizing provider participation in Medicaid;
- Directly addressing children and families; and
- Partnering with oral health stakeholders.17

The state’s experience is instructive for other states because the combination of significant state investment in provider fee increases and fundamental changes to the way dental benefits are administered has led to increased utilization of preventive care and treatment.

The results of this study show, however, a slowing in gains realized since 2008 program changes. Based on our analyses, preventive care and treatment rates for all age groups were essentially unchanged or lower in 2013 than rates reported for 2012. Moreover, we show the persistence of utilization differences associated with race/ethnicity.

The Connecticut Dental Health Partnership, in collaboration with other oral health stakeholders, is now focusing on increasing demand for oral health services.18 Strategies under consideration include use of social marketing tools to raise awareness of the importance of oral health and partnering with “trusted people,” i.e., community-based clinicians and social services providers who can promote good oral health and hygiene for their clients. Use of targeted, tailored outreach messages and special initiatives, coupled with repeated reminders, may prompt care-seeking even among those who were not moved by general outreach. This sort of approach is inherent in the Connecticut Dental Health Partnership’s initiative to increase care for pregnant women and infants.19

These findings warrant continued monitoring of utilization trends and closer attention to various program features that may affect these trends over time:

- Dental care provider reimbursement levels have not increased since April 1, 2008.

- The administration of medical benefits in the HUSKY Program changed significantly in January 2012:
  - Children and families were moved from risk-based managed care to an administered fee-for-service program, with responsibility for medical services under contract with Community Health Network of Connecticut.
  - Nearly 170,000 more adults, many with significant health needs, were moved from fee-for-service Medicaid to the HUSKY Program’s administered medical services.20 The Department and its administrative services contractors and key stakeholders appear to have shifted their focus and efforts away from children and families to managing the often complex needs of these adults.

- Methods for applying and renewing coverage changed significantly in the latter half of 2013, with the advent of ConnectCT, and in January 2014, with adoption of changes in forms, documentation requirements, timing, and income counting rules. Taken together, these changes may have had a very dramatic effect on coverage continuity and uninterrupted access to care.
National data and HUSKY data show that coverage affects the likelihood of getting dental care. An analysis of Medicaid data from nine other states showed that children who were enrolled less than a full year were far less likely to have received preventive dental care. Analyses of HUSKY Program data show that many children, even eligible children, experience gaps in coverage: 13.5% of all children enrolled in January 2013 had gaps in coverage, including 4% of likely-eligible children enrolled in January and December 2013 who lost coverage for 2 to 3 months on average. Gaps in coverage can disrupt ongoing care or relationships with providers. Further, the likelihood of getting preventive dental care increases the longer a child is enrolled: In every age group, children enrolled in the HUSKY program for 11 to 12 months in 2012 were 10 times more likely to get preventive dental care than children enrolled less than 3 months. Access to care is affected by coverage continuity, i.e. periods of uninterrupted coverage so that families can schedule and keep appointments for preventive care and treatment as needed. Thus, children’s oral health is dependent in part on the Medicaid program’s capacity for timely application processing and renewal. In order to sustain significant improvements in access to dental care and utilization, Connecticut must address coverage instability in the Medicaid program. In addition, outreach to new members and non-utilizers, undoubtedly a key component of the program’s success to date, may need to be intensified and tailored to include outreach to those who return after a coverage gap.

ACKNOWLEDGEMENTS

This report was prepared by Connecticut Voices for Children under a state-funded contract between the Connecticut 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.

3The 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.

2The Connecticut Dental Health Partnership is run by Dental Benefit Management, Inc., d.b.a. BeneCare Dental Plans under a contract with the Department of Social Services for administrative services.

4Other adults who qualify for Medicaid coverage (low income childless adults; aged, blind and disabled adults) also have comprehensive dental benefits.

5Connecticut Department of Social Services. Dental coverage limitations by program. Available at: https://www.ctdhp.com/documents/Dental_Coverage_By_Program-Client_version.pdf


7Past reports are available at: www.ctvoices.org.

8Since 1995, independent performance monitoring has been conducted under a contract between the Department of Social Services and the Hartford Foundation for Public Giving (current contract #064HFP-HUO-04/13DSS1001ME for July 1, 2013 – June 30, 2015). 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.

9Utilization 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.

10In October 1998, the EPSDT periodicity schedule in Connecticut was changed to include an initial dental exam at age 2 (v. age 3). Since 2009, when Connecticut adopted the American Academy of Pediatrics Bright Futures periodicity schedule for the HUSKY Program, the first visit dental visit has been recommended for children between one and two years of age. According to the CMS-416 report 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, to 36.2% of 1 to 2 year olds who were continuously enrolled at least 90 days in FFY13.

11 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. Not sure where this info came from, please update if needed.

12 **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).


14 Data for 2008 are not available for comparison.

15 In 2013, continuously enrolled children 3 to 19 were 10.25 years of age on average in HUSKY A and 11.11 years of age on average in HUSKY B.


17 Ibid.


19 The Perinatal and Infant Oral Health Quality Improvement Project is a four-year project funded by a grant from HHS Human Services and Resources Administration Maternal and Child Health Bureau. The project builds on local pilot projects implemented in 2009 and 2010.

20 Count of individuals in HUSKY C (disabled, elderly adults) and HUSKY D (low income adults without dependent children) as of January 2012.

