



## Dental Services for Children and Parents in the HUSKY Program in 2012: Utilization Is Improved Over 2008 but Unchanged from 2011

August 2014

### 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 improved, with increased provider reimbursement and operational changes to the way dental benefits are administered and reimbursed. For the fourth consecutive year, the number and percentage of children and parents who received dental services in 2012 were significantly higher than in 2008 when program reforms were implemented. Key findings for 2012:

- **Utilization trends:** Preventive care and treatment rates in 2012 were the same or lower than 2011.
  - The percentages of children under 3 and ages 3 to 19 who had preventive care, treatment, and sealants remained well above the utilization rates reported for 2008 (prior to program changes) but were largely unchanged or less than rates for 2011;
  - The percentage of adults 21 and over in HUSKY A that had preventive care or treatment in 2012 remained well above the rates reported for 2008, but significantly lower than the rates reported for 2011.
- **Racial/ethnic disparities:** Differences associated with race and ethnicity persist: Children of Hispanic origin were most likely to have received preventive care; the gap between rates for White and Black/African American children narrowed to where they are essentially equally likely to receive preventive care. Preventive care rates for White adults and Black/African American adults declined and the difference in the rates narrowed.
- **Coverage continuity:** In every age group, the longer HUSKY A children and adults were enrolled, the more likely they were to have had preventive dental care and treatment. In fact, there was a *10-fold difference* between those enrolled less than 3 months and those enrolled 11 to 12 months.

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, compared with 2011, suggests that additional strategies may be needed to reach the hardest-to-reach families. Further improvements in dental utilization may depend on targeted initiatives and on keeping eligible children and their parents enrolled for long enough to link them with dental providers.

## INTRODUCTION

Good oral health is essential for well-being and good physical health for persons of all ages.<sup>1</sup> 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.

Children should have periodic preventive dental care and treatment for dental disease when needed. 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, access to preventive dental care and treatment is a long-standing problem for many low income families in Medicaid programs across the country. This problem was brought to national attention in 2007 when Diamonte Driver, a 12-year old boy from the Baltimore area, died from a brain abscess that began with an abscessed tooth. The Washington Post and The New York Times reported that when he developed a toothache weeks earlier, his mother tried to find a dentist who would accept Medicaid, only to be told that his Medicaid coverage had lapsed.<sup>2</sup> Diamonte Driver’s death stirred a sense of outrage that brought together state and federal policy makers and providers, children’s health advocates and experts, Medicaid and public health professionals to address Medicaid’s failure to fulfill its promise to low income families.

In 2008, the State of Connecticut took steps to improve access to dental care for children in its HUSKY Program.<sup>3</sup> 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.<sup>4</sup> Dental care providers are reimbursed directly by the Medicaid agency.<sup>5</sup> 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**

Billing Code	Procedure	Fees for Children’s Services			Fees for Adult Services <sup>a</sup>		
		2005	Effective 2008	Increase	2005	Effective 2008	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%

<sup>a</sup> 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 2012 and 2014 are the same as those adopted 2008 under terms of the settlement of *Carr v. Wilson-Coker*.

This report from Connecticut Voices for Children is the fourth in a series of reports on the impact of the program changes that occurred in 2008.<sup>6</sup> It is the fourteenth 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 2012. For investigation of trends, utilization in 2012 was compared to utilization in 2008 and earlier under risk-based managed care. Rates for 2009 thru 2011 (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.<sup>7</sup>

### 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, 2012, and the subset who were continuously enrolled for the entire year.<sup>8</sup> 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.<sup>9</sup> 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).<sup>10</sup> 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 2012 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 2012.<sup>11</sup> The procedure code set is the same as that used by state Medicaid agencies to report by federal fiscal year age group to the Centers for Medicare and Medicaid Services (CMS).<sup>12</sup> 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 2012 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 2008-2012 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 2012 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 2012; 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 2012, there were 334,252 children and 178,774 adults ever enrolled in HUSKY A for a month or more. About 72 percent of children and 66 percent of adults were continuously enrolled for 12 months during the calendar year. In HUSKY B, 21,692 children under 19 were ever enrolled, including just 7,895 (36.4%) who were continuously enrolled. Compared with HUSKY Program enrollment in 2008, the number of continuously enrolled children ages 3 to 19 increased 42 percent and the number of continuously enrolled adults increased by 65 percent.

### 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).

**Table 1. Dental Services for Very Young Children in HUSKY A, 2008-2012**

	Children under 3 with dental care <sup>a</sup>				
	2012	2011	2010	2009	2008
<b>Any dental care</b>	42.9%*	41.6%*	37.3%*	29.3%*	21.1%
<b>Preventive dental care</b>	38.2%*	37.0%*	32.3%*	24.1%*	13.7%
<b>Treatment</b>	2.1%	2.4%*	3.3%*	2.6%*	1.5%

<sup>a</sup> Percent of continuously enrolled children under 3 (age as of 12/31) who had at least one dental service or visit by service type.

\*Rate in 2009, 2010, 2011 and 2012 is significantly higher than the rate in 2008 ( $p < .001$ ).

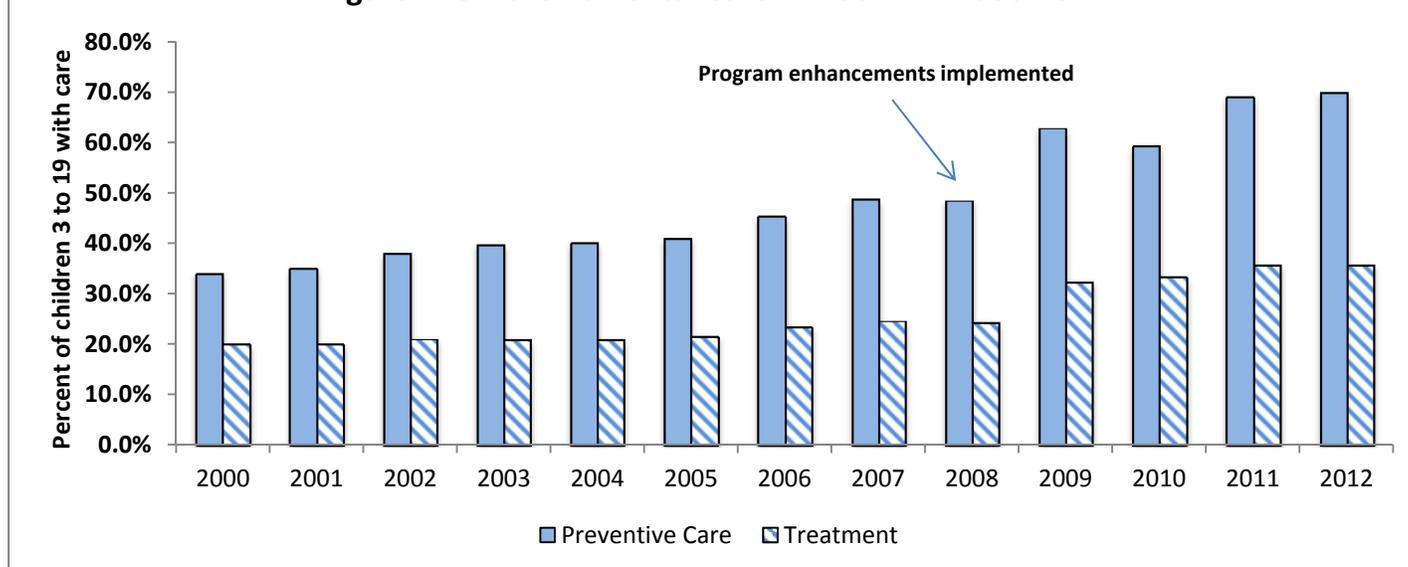
**Source:** Analysis of HUSKY Program data by Connecticut Voices for Children, 2014.

In 2012, over 12,000 very young children in HUSKY A had any dental care. The number and percentage of very young children seen were about three times the number and rate in 2008. Children under 1 were least likely to have had care, while nearly 54 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 2012, the percentage of very young children in HUSKY A with preventive care (38.2 %) was slightly higher (but not significantly different) than rates for children in HUSKY B (32.2%) and children who changed between A and B (35.4%).

### 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 2012, over 146,000 continuously enrolled children had preventive care, up from 72,000 in 2008; 75,000 children had treatment in 2012, up nearly 39,000 children compared with 2008. In fact, while the number of continuously enrolled children 3 to 19 increased 42 percent, the number of children with preventive care and with treatment increased over 100 percent.

**Figure 1. Children's Dental Care in HUSKY A: 2000-2012**



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2014.

In 2012, 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 2011 (Table 2). As in previous years, the highest preventive care rates were for school-aged children age 6 to 8 (77.0% with care) and 9 to 11 (75.7%), and for Hispanic children (74.1%) relative to children in other racial/ethnic groups (67.2%). Overall, the percentage of children with any care who had sealants placed remained above the rate for 2008 but was essentially unchanged from 2011.

**Table 2. Dental Services for Children and Adolescents in HUSKY A, 2006-2012**

	Children and Adolescents with Dental Care <sup>a</sup>						
	2012	2011	2010	2009	2008	2007 <sup>b</sup>	2006
<b>Any dental care</b>	74.4%*	73.8%*	68.1%*	68.0%*	56.3%	55.7%	51.9%
<b>Preventive care</b>	69.8%*	68.9%*	59.2%*	62.7%*	48.4%	48.7%	45.3%
<b>Dental treatment</b>	35.7%*	35.7%*	33.3%*	32.3%*	24.3%	24.6%	23.4%
<b>Sealants<sup>c</sup></b>	22.9%*	23.5%*	22.1%*	22.9%*	17.6%	16.3%	16.1%

<sup>a</sup> 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.

<sup>b</sup> Encounter records for 2007 were incomplete for HUSKY members enrolled in BlueCare Family Plan.

<sup>c</sup> Percent of children with any dental care who had sealants placed.

\*Rate in 2009, 2010, 2011 and 2012 is significantly higher than the rate in 2008 ( $p < .001$ ).

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2014.

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 49.9 percent of 20 year olds had any dental care, including 39.6 percent that had preventive care and 33.2 percent with treatment, rates that are virtually unchanged from 2011.<sup>13</sup>

## 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 2012, there were 210,233 children in HUSKY A, many fewer children in HUSKY B (7,417 children), and fewer still who changed programs without a break in coverage (3,234 children). On average, children in HUSKY B in 2012 were about one year older than children in HUSKY A.<sup>14</sup>

In 2012, as in the two previous years, rates for preventive care were significantly higher for children in HUSKY B compared with children in HUSKY A (Table 3). However, children in HUSKY B are less likely than children in HUSKY A to get dental treatment. As in 2011, children in HUSKY B in 2012 were less likely than children in HUSKY A to get dental treatment.

**Table 3. Comparison of Dental Care Utilization in HUSKY A and B: 2009-2012**

	Children and Adolescents with Dental Care <sup>a</sup>							
	2012		2011		2010		2009	
	HUSKY A	HUSKY B	HUSKY A	HUSKY B	HUSKY A	HUSKY B	HUSKY A	HUSKY B
<b>Any dental care</b>	74.4%	75.4%	73.5%	75.3%	68.1%	72.8%*	68.0%	69.8%*
<b>Preventive care</b>	69.8%	72.3%*	68.9%	72.8%*	59.2%	69.8%*	62.7%	68.9%*
<b>Treatment</b>	35.7%	31.9%*	35.7%	32.1%*	33.3%	31.5%	32.3%	32.2%
<b>Sealants<sup>b</sup></b>	22.9%	21.4%	23.5%	22.0%	22.1%	23.6%	22.9%	24.2%

<sup>a</sup> 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.

<sup>b</sup> Percent of children with any dental care who had sealants placed.

\*Rate for children in HUSKY B in 2009, 2010, 2011 and 2012 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, 2014.

Pediatric and dental care professionals recommend that children have dental exams every 6 months (two exams per year). In 2012, 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: 2006-2012**

	Children and Adolescents with Two+ Visits for Preventive Care <sup>a</sup>						
	2012	2011	2010	2009	2008	2007 <sup>b</sup>	2006
<b>HUSKY A</b>	53.2%*	50.1%*	39.6%*	44.7%*	30.9%	30.3%	31.0%
<b>HUSKY B</b>	61.5%†	59.5%†	57.0%†	53.9%†	NA	NA	NA

<sup>a</sup> Percent of children 3 to 19 (age as of 12/31) with any dental care who had two or more preventive visits.

<sup>b</sup> Encounter records for 2007 were incomplete for HUSKY members enrolled in BlueCare Family Plan.

\*Rate in HUSKY A in 2009, 2010, 2011 and 2012 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, 2014.

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 2012 (Table 5).

**Table 5. Sealants for School-age Children and Young Adolescents in HUSKY A and B, 2009-2012**

Age:	Children with Sealants <sup>a</sup>							
	2012		2011		2010		2009	
	HUSKY A	HUSKY B	HUSKY A	HUSKY B	HUSKY A	HUSKY B	HUSKY A	HUSKY B
<b>6 to 8</b>	26.0%	25.8%	33.1%	30.8%	31.2%	32.2%	32.6%	36.7%
<b>9 to 11</b>	26.5%*	20.9%	34.2%*	28.5%	32.4%	27.8%	33.0%	31.6%
<b>12 to 14</b>	27.2%	24.9%	36.9%	32.8%	33.3%	35.7%	34.6%	29.2%

<sup>a</sup> Percent of children with any dental care who had at least one sealant placed. Age as of 12/31.

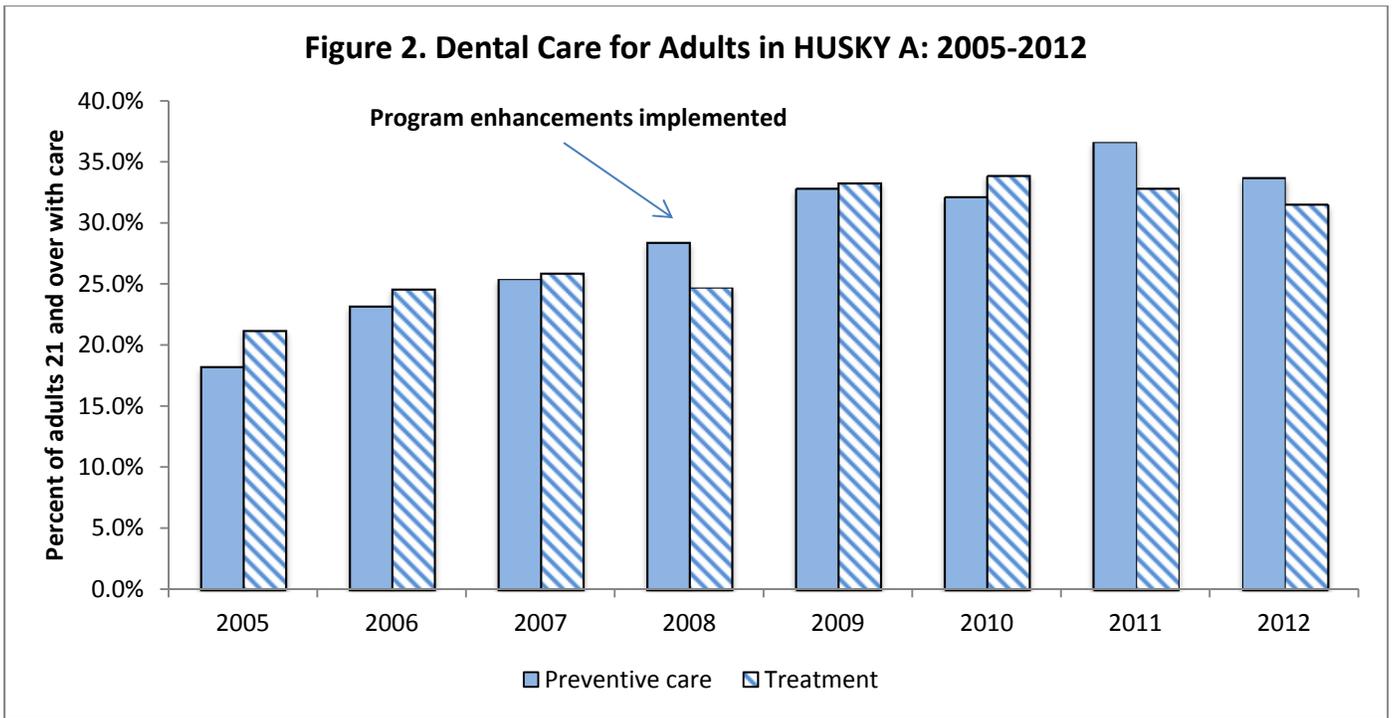
\* Age-specific rate for children in HUSKY A is greater than the rate for children in HUSKY B (p<.001).

**Source:** Analysis of HUSKY Program data by Connecticut Voices for Children, 2014.

### 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 declined significantly in 2012 compared with 2011 (Figure 2). In 2012, 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, 2012 utilization rates for adults were lower than rates for children in HUSKY A, especially for preventive care (33.7% v. 69.8% for children).

**Figure 2. Dental Care for Adults in HUSKY A: 2005-2012**



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2014.

**Table 6. Dental Care Utilization by Parents in HUSKY A, 2005 to 2012**

	Parents with Dental Care <sup>a</sup>							
	2012	2011	2010	2009	2008	2007 <sup>b</sup>	2006	2005
<b>Any dental care</b>	48.6%*†	50.2%*	50.3%*	47.7%*	45.90%	39.60%	37.00%	32.40%
<b>Preventive care</b>	33.7%*†	36.6%*	32.1%*	32.8%*	28.40%	25.40%	23.20%	18.20%
<b>Treatment</b>	31.5%*†	32.8%*	33.9%*	33.3%*	24.70%	25.90%	24.60%	21.20%

<sup>a</sup> Percent of continuously enrolled adults 21 and over (age as of 12/31) who had at least one service or visit.

<sup>b</sup> Encounter records for 2007 were incomplete for HUSKY members enrolled in BlueCare Family Plan.

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

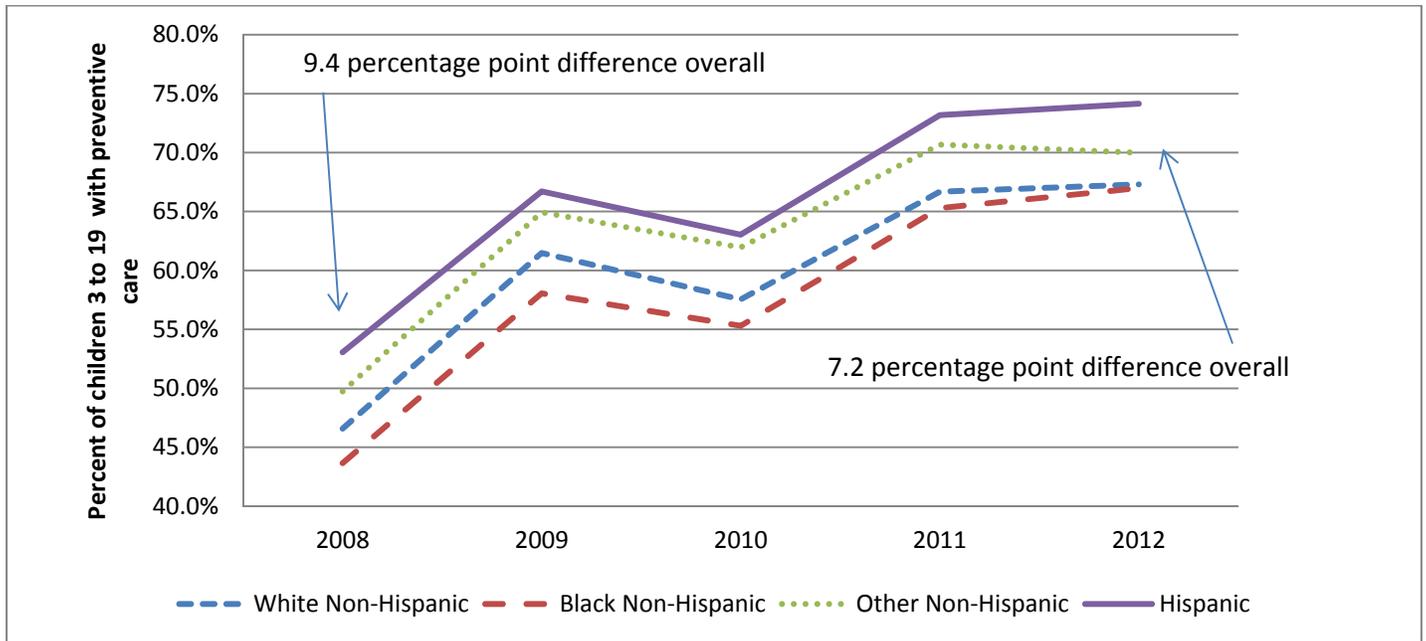
†Rate in 2012 is significantly lower than in 2011 (p<.001).

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2014.

### 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 7.2 percentage points in 2012 (Figure 3). In recent years, the gap between Black/African American children and White children has nearly disappeared (<1.0 percentage points difference in 2012).

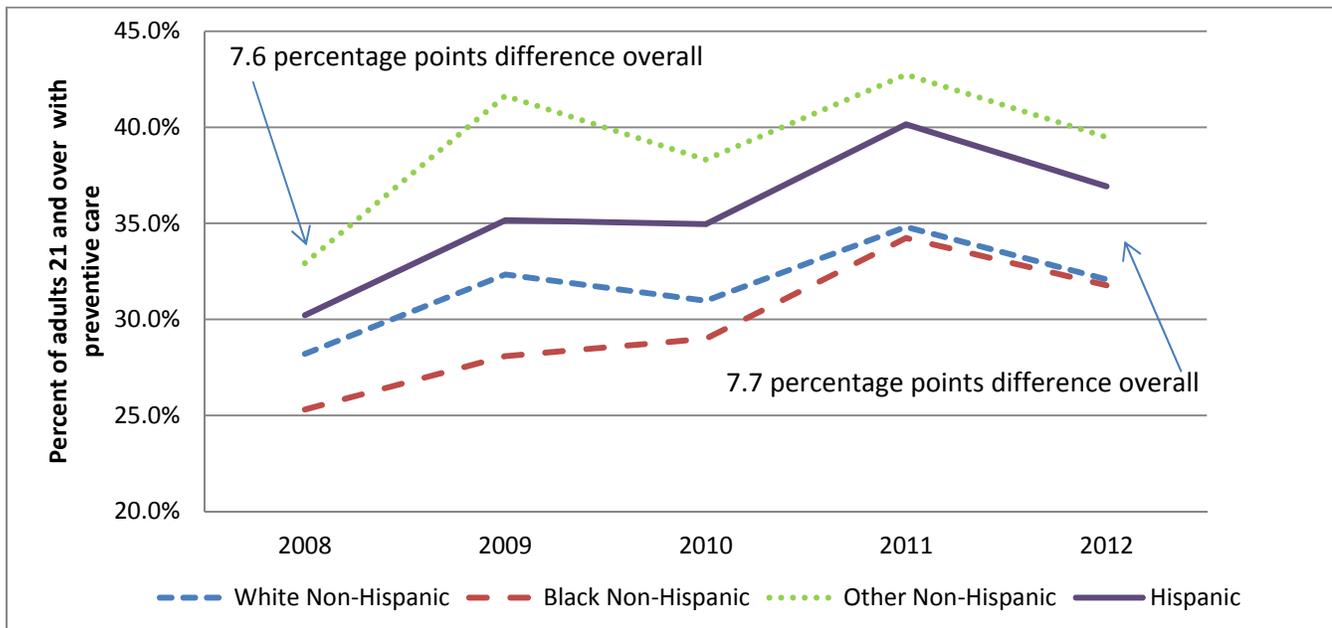
**Figure 3. Effect of Race or Ethnicity on Children’s Utilization in HUSKY A**



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2014.

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 2012 (<1.0 percentage point difference). However, the gap between high and low utilization ethnic groups has actually grown in recent years.

**Figure 4. 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, 2014.

## Effect of Enrollment on Utilization

In 2012, we investigated the effect of enrollment in HUSKY A on utilization. Previous analyses had focused only on those who were continuously enrolled, a subset of those who were ever enrolled for a year or less in the HUSKY Program.

In 2012, 72 percent of children 20 and under were continuously enrolled and 66 percent of adults 21 and over were continuously enrolled for 12 months.

In every age group, the longer HUSKY A children and adults were covered during the calendar year, the more likely they were to have had preventive dental care (Table 7). There was a *10-fold difference* between those enrolled less than 3 months and those enrolled 11 to 12 months. The same relationship between enrollment and treatment was evident.<sup>15</sup>

**Table 7. Enrollment and Preventive Care Utilization by Age Group, 2012**

Enrolled in HUSKY A:	HUSKY A Children and Adults with Preventive Care						
	3 - 5	6 - 8	9 - 11	12 - 14	15 - 19	20	21+
Less than 3 months	5.9%	6.6%	6.6%	5.2%	5.9%	6.0%	2.6%
3 to 5 months	24.0%	28.9%	27.3%	25.2%	19.5%	14.6%	12.5%
6 to 8 months	41.9%	47.3%	44.7%	39.7%	31.8%	23.0%	20.2%
9 to 10 months	51.7%	58.3%	56.1%	52.8%	41.2%	32.9%	24.9%
11 to 12 months	72.0%	76.6%	75.3%	68.6%	56.0%	39.4%	33.4%

**Note:** Months of enrollment in 2012 may not be continuous.

**Source:** Analysis of HUSKY Program data by Connecticut Voices for Children, 2014.

## DISCUSSION

In 2013, the Centers for Medicare and Medicaid Services (CMS) reported that access to care for children in Medicaid has improved in many states in recent years.<sup>16</sup> State-specific data from the CMS-416 report show that *Connecticut leads the nation in improving the proportion of Medicaid children with preventive dental care.*<sup>17</sup> Other states that showed significant improvement included Arkansas, Louisiana, District of Columbia, and Maryland (Diamonte Driver’s home state). CMS works with states and a variety of stakeholders to improve access to preventive care by increasing provider participation and increasing awareness of the need for good oral health and health care.<sup>18</sup>

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.”<sup>19</sup> Strategies recommended by CMS include:

- Improving state Medicaid program performance through policy changes;
- Maximizing provider participation in Medicaid;
- Directly addressing children and families; and
- Partnering with oral health stakeholders.<sup>20</sup>

Connecticut’s has done all of this and more. 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.

In a recent report to the legislative oversight council, the Connecticut Dental Health Partnership (Department of Social Services and its administrative services contractor) described program changes since the end of risk-based managed care in 2008.<sup>21</sup> Instead of four, there is now just one provider network, one fee schedule, one benefit package, and one set of administrative rules. In 2013, the number of participating dentists was over 1,800, up from just 349 in 2008. One hundred percent of the 700,000 HUSKY Program members have access to a participating provider within 15 miles or less. The average wait time for an appointment is less than seven days on average. The Connecticut Dental Health Partnership (CT DHP) conducts targeted outreach, sends reminders, and provides appointment scheduling assistance. CT DHP Dental Care Specialists work with community-based organizations, pediatricians, obstetrician-gynecologists, and emergency department directors to reach families through the health care providers they rely on. CT DHP staff work with the medical and behavioral health services administrators to coordinate care for those with intensive needs. Reportedly, the cost per member per month has declined from about \$31 to about \$27.<sup>22</sup> The largest portion of Medicaid spending for dental care was attributable to children's services and preventive services, compared with restorative, orthodontic, or other dental procedures. The Department of Social Services and CT DHP are active participants in program and policy deliberations with other key stakeholders.

The results of this study suggest, 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 2012 than rates reported for 2011. Moreover, we show the persistence of utilization differences associated with race/ethnicity and differences associated with length of coverage in the program.<sup>23</sup>

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 has not increased since April 1, 2008.
- The administration of the HUSKY Program and enrollment 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.<sup>24</sup> 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.

The impact of these program changes has yet to be determined.

Finally, these results show that 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. 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.<sup>25</sup> Our results agree and also show that enrollment affects care for adults as well. Thus, the oral health of entire families is dependent in part on the Medicaid program's capacity for timely, error-free application processing and renewal. In order to sustain significant improvements in access to dental care and utilization, Connecticut and other states may need to 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 tailored to reach those who lose coverage or return after a coverage gap.

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<sup>1</sup> 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.

<sup>2</sup> Gilbert CB. Child dies for lack of dental care. *The Washington Post*, 2/28/07. Herbert B. Young, Ill and Uninsured. *The New York Times*, May 19, 2007. Herbert B. The divide in caring for our kids. *The New York Times*, June 12, 2007. Diamonte's name is also spelled "Deamonte" in press coverage and other documents.

<sup>3</sup>The 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.

<sup>4</sup>The 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.

<sup>5</sup>In 2012, Connecticut ended its risk-based HUSKY Program and entered into a contract for administrative services for medical care. This action brought to a close 17 years of capitated payments for managed care, making the entire program of benefits (medical, behavioral health, and dental) available in an administered fee-for-services program.

<sup>6</sup>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>.

<sup>7</sup>Since 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](http://www.ctvoices.org).

<sup>8</sup>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.

<sup>9</sup>In 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.

<sup>10</sup>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.

<sup>11</sup>**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).

<sup>12</sup>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](http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage).

<sup>13</sup>Data for 2008 are not available for comparison.

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<sup>14</sup> In 2012, continuously enrolled children 3 to 19 were 10.2 years of age on average in HUSKY A and 11.1 years of age on average in HUSKY B.

<sup>15</sup> Data available upon request.

<sup>16</sup> Centers for Medicare and Medicaid Services. CMS Oral Health Initiative and other Dental-related Items. CMCS Informational Bulletin, April 18, 2013. Available at: [cms.hhs.gov](http://cms.hhs.gov).

<sup>17</sup> CMS reported that data from Connecticut showed a 23 percentage point increase between FFY2007 and FFY2011 in the proportion of children under 21 who were continuously enrolled in Medicaid for at least 90 days and received preventive dental services.

<sup>18</sup> Centers for Medicare and Medicaid Services. CMS Oral Health Strategy: Improving access to and utilization of oral health services for children in Medicaid and CHIP programs. April 11, 2011. This strategy is continuing to evolve; for the latest information, contact Laurie Norris ([laurie.norris@cms.hhs.gov](mailto:laurie.norris@cms.hhs.gov)).

<sup>19</sup> Centers for Medicare and Medicaid Services. Keep kids smiling: Promoting oral health through the Medicaid benefit for children & adolescents. September 2013. p.1. Available at: <http://www.medicaid.gov/Medicaid-DHIP-Program-Information/By-Topics/Benefits/Dental-Care.html>.

<sup>20</sup> Ibid.

<sup>21</sup> Connecticut Department of Social Services. Improving the oral health of HUSKY members (presentation). June 13, 2014. Available at: <http://www.cga.ct.gov/med/mh-meetings.asp?sYear=2014>.

<sup>22</sup> It is not clear whether the reduced cost per member is cost per member who actually used services or cost averaged over many more HUSKY enrollees or a change in case mix. The overall cost for dental services was not reported by the CT Dental Health Partnership.

<sup>23</sup> The Connecticut Health Foundation has provided Connecticut Voices with grant funding to investigate the effect of coverage continuity and parents' care on utilization of oral health services.

<sup>24</sup> Count of individuals in HUSKY C (disabled, elderly adults) and HUSKY D (low income adults without dependent children) as of January 2012.

<sup>25</sup> Bouchery E. Utilization of dental services among Medicaid-enrolled children. Medicare & Medicaid Research Review, 2013: 3(3), 1-8. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3983737/>.