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Dental Services for Children and Parents in the HUSKY Program: An Update for 2014

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KEY FINDINGS

This report on dental care in Connecticut's HUSKY Program suggests that the positive effects of major program changes in 2008 may have run their course. For the first time in recent years, utilization of preventive services and treatment has declined among children who were enrolled in the HUSKY Program for the year.

- **Utilization trends:** For most children and for adults, preventive care and treatment rates in 2014 were lower than 2013.
 - The percentage of **children under 3** who had preventive care declined; however, the rate was still well above the utilization rates reported for 2008 (prior to program changes);
 - The percentages of **children 3 to 19** who had preventive care, treatment, and sealants declined in every age group; however the rates were significantly higher than utilization rates in 2008;
 - Utilization of preventive care by **children in HUSKY B** dropped precipitously in 2014 to a rate well below that for children in HUSKY A;
 - The percentage of **adults 21 and over** in HUSKY A who had preventive care or treatment in 2014 was essentially unchanged from rates for 2012 and 2013 and still well above the rates reported for 2008.
- **Racial/ethnic disparities:** Differences associated with race and ethnicity persist: After years of utilization at the highest rate among children, preventive care utilization fell off for Hispanic children. The difference between utilization rates for adults widened slightly.

These trends are troublesome, especially in view of upcoming coverage changes and cuts to provider reimbursement. Precipitous changes to utilization among Hispanic children are also worrisome. The Department of Social Services and its dental services administrator should conduct additional studies of provider network adequacy, appointment availability, provider willingness, and demand for care. 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 access to 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 dental care 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 ^a			
		2005	Effective 2008	2005-2008 Increase	2017	2005	Effective 2008	2005-2008 Increase	2017
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.

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

In 2016, the Connecticut General Assembly adopted a budget calling for a 5 percent cut in provider reimbursement for dental care. After a period for public comment, the Department of Social Services reported consideration of a plan for a 2 percent across the board reduction in fees plus changes in selected benefits.⁴

Connecticut's HUSKY Program provides comprehensive dental care for children and parents and pregnant women.⁵ The following services are covered (no charge for children and adults in HUSKY A; 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).⁶

This report from Connecticut Voices for Children is the sixth and final report in a series on the impact of the program changes that occurred in 2008.⁷ It is the sixteenth 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 2014. For investigation of trends, utilization in 2014 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.⁸ Claims data for 2015 were not provided by the Department for this report.

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, 2014, and the subset who were continuously enrolled for the entire year.⁹ The vast majority of children were enrolled in HUSKY A (Medicaid) (more than 95% as of yearend 2014), 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.¹⁰ 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). Children under 21 are covered by Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) requirements for timely preventive care. Rates for 20 year olds in HUSKY A 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 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. In 2014, there were 336,124 children under 19 and 222,823 adults 19 and over who were ever enrolled in HUSKY A for a month or more. About 70 percent of children and 62 percent of adults were

continuously enrolled for 12 months that year, down from the previous year. There were 21,329 children under 19 ever enrolled in HUSKY B; 35 percent of them were continuously enrolled in 2014, down from the previous year. Among children ages 3 to 19 who were continuously enrolled in 2014, there were 236,954 in HUSKY A and far fewer children in HUSKY B (7,511) and fewer still who changed programs without a break in coverage (5,507 children).

Dental services claim data were obtained from the Department of Social Services for utilization analyses. The methods used to determine utilization rates in 2014 were the same as methods used by Connecticut Voices to report on dental care each year since 2000. HUSKY B data have been available for independent analyses since 2009, allowing for comparison with utilization by children in HUSKY A. 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 2014.¹¹ 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).¹² 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. Because the sample size is so large, only those differences and changes over time that were meaningful in programmatic 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 2008-2014 are shown by type of service in the detailed data tables that are posted with this report.

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); data were unavailable for analyses. 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

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. In 2014, following years of remarkable increasing rates, utilization of dental care, including preventive care and treatment, fell off considerably (Table 1).

Table 1. Dental Services for Very Young Children in HUSKY A, 2008-2014

	Children under 3 with dental care						
	2014	2013	2012	2011	2010	2009	2008
Any dental care	37.2%	44.8%	42.9%	41.6%	37.3%	29.3%	21.1%
Preventive dental care	33.6%	40.4%	38.2%	37.0%	32.3%	24.1%	13.7%
Treatment	1.4%	1.9%	2.1%	2.4%	3.3%	2.6%	1.5%

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

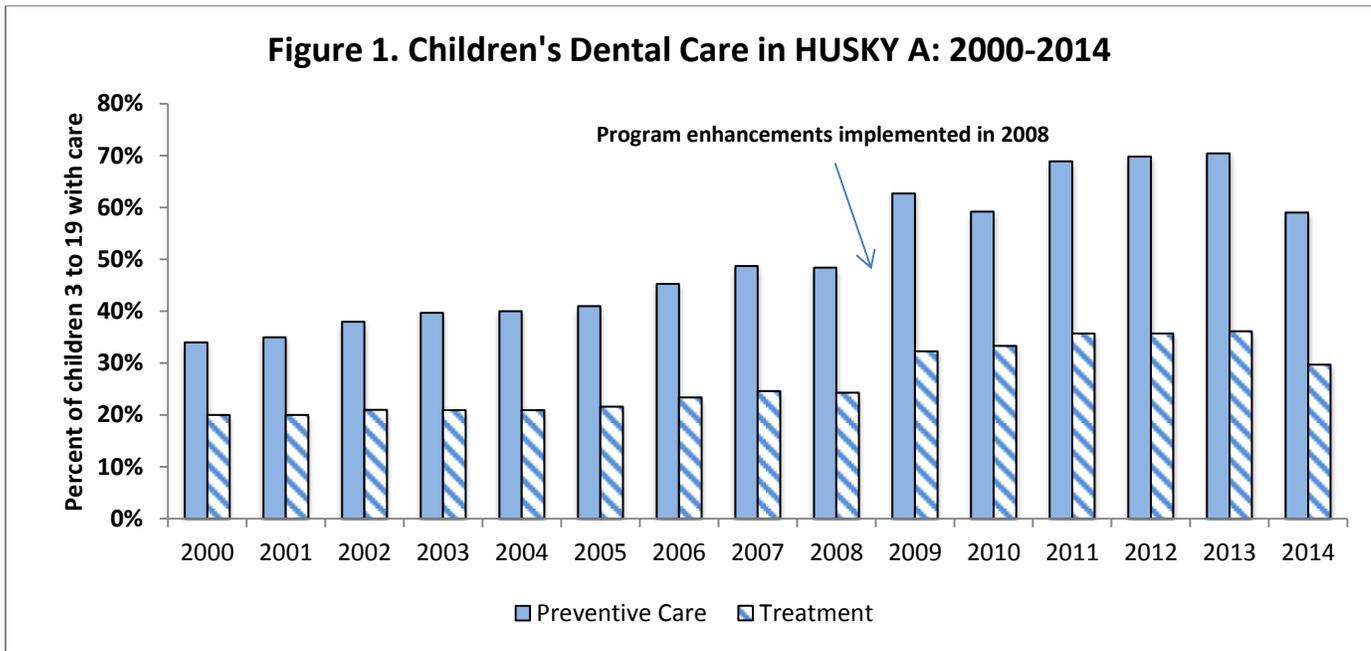
Utilization Trends for Children and Adolescents in HUSKY A

After years of remarkable improvement in dental care utilization since the end of risk-based managed care in 2008, the percentage of children ages 3 to 19 with preventive care and treatment declined in 2014 (Figure 1). The number of continuously enrolled children who had preventive care in 2014 also declined, to less than 140,000 children compared with over 150,000 in 2013.

In 2014, the percentages of children and adolescents in HUSKY A who had any dental care, preventive care, and/or treatment were below utilization rates seen since 2009 (though higher than in 2008) (Table 2). As in previous years, the highest preventive care rates were for school-aged children ages 6 to 8 (65.5% with care) and 9 to 11 (65.0%). Overall, the percentage of children age 6 to 19 with any care who had sealants placed (18.1%) declined to near the 2008 level.

Medicaid EPSDT program requirements for dental care apply to HUSKY A enrollees age 20. However in 2014, the dental care utilization rate for 20 year olds in HUSKY A was considerably lower than the rate for younger children and adolescents. Just 30.9 percent of 20 year olds had any dental care, including 24.3 percent who had preventive care and 19.4 percent with treatment, rates that are considerably lower than rates in 2012.¹³

Figure 1. Children's Dental Care in HUSKY A: 2000-2014



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

Table 2. Dental Services for Children and Adolescents in HUSKY A, 2008-2014

	Children and Adolescents with Dental Care						
	2014	2013	2012	2011	2010	2009	2008
Any dental care	63.6%	75.0%	74.4%	73.8%	68.1%	68.0%	56.3%
Preventive care	59.0%	70.4%	69.8%	68.9%	59.2%	62.7%	48.4%
Dental treatment	29.7%	36.1%	35.7%	35.7%	33.3%	32.3%	24.3%
Sealants^a	18.1%	21.8%	22.9%	23.5%	22.1%	22.9%	17.6%

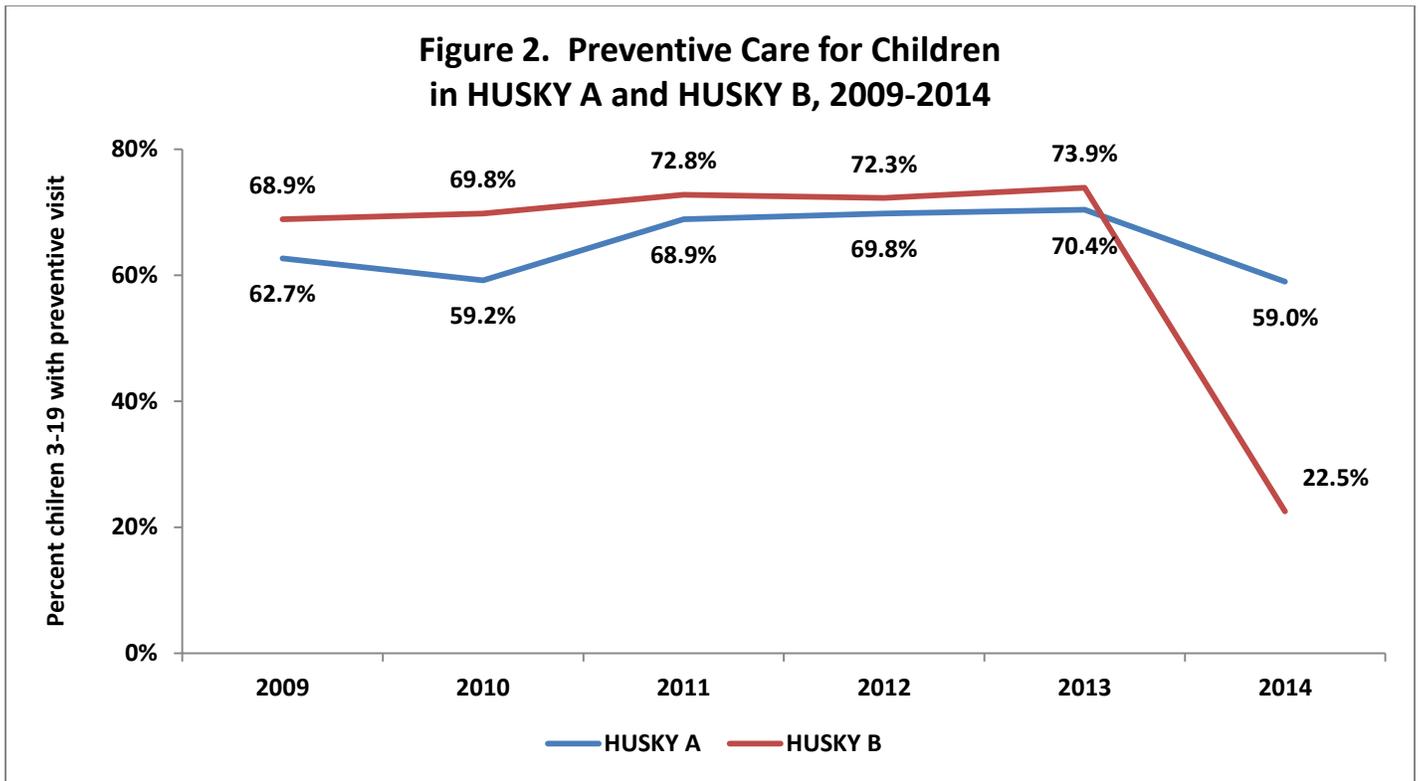
^a Percent of children 6 to 19 with any dental care who had sealants placed.

Note: In 2014, 61.6% of continuously enrolled children who changed between HUSKY A and B (5,507 children) had any dental care, 57.2% had preventive care, and 25.5% were treated for dental conditions.

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

Comparison of Utilization for Children in HUSKY A and HUSKY B

In 2014, children in HUSKY B were *far less likely* than children in HUSKY A to get preventive care (Figure 2). In every previous year for which data were available, children in HUSKY B were *more* likely to get preventive care. Whereas treatment rates had been essentially the same in past years, in 2014 children in HUSKY B were far less likely than children in HUSKY A to get dental treatment (9.0% v. 29.7%). Likewise, children 6 to 19 in HUSKY B were less likely to get sealants in 2014 (5.2% v. 18.1%) after years of rates that were not remarkably different from HUSKY A. Among children who changed from HUSKY A to B or B to A in 2014, rates for preventive care and treatment were similar to rates for children continuously enrolled in HUSKY A and far higher than rates for children in HUSKY B.



Note: In 2014, 57.2% of continuously enrolled children who changed between HUSKY A and B (5,507 children) had preventive care.
Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

Pediatric and dental care professionals recommend that children have dental exams every six months (two exams per year). In 2014, children in HUSKY A were less likely to have had two or more visits for preventive care than they were in recent years (Table 3). However, the recommended visit rate in HUSKY A exceeded the rate for children in HUSKY B in 2014 for the first time since monitoring began.

Table 3. Children with Recommended Preventive Dental Care, HUSKY A and B: 2006-2013

	Children and Adolescents with Two or More Visits for Preventive Care					
	2014	2013	2012	2011	2010	2009
HUSKY A	50.3%	53.9%	53.2%	50.1%	39.6%	44.7%
HUSKY B	40.6%	61.5%	61.5%	59.5%	57.0%	53.9%

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

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 dropped in 2014 to pre-2009 levels (refer back to Table 1). In 2014, few children in HUSKY B received sealants in comparison to previous years and to rates for children in HUSKY A (Table 4).

Table 4. Sealants for School-age Children and Young Adolescents in HUSKY A and B, 2009-2014

	Children with Sealants											
	2014		2013		2012		2011		2010		2009	
	A	B	A	B	A	B	A	B	A	B	A	B
Age:												
6-8	21.4%	6.5%	25.9%	24.2%	26.0%	25.8%	33.1%	30.8%	31.2%	32.2%	32.6%	36.7%
9-11	22.6%	5.7%	26.8%	22.6%	26.5%	20.9%	34.2%	28.5%	32.4%	27.8%	33.0%	31.6%
12-14	24.7%	7.6%	28.9%	25.1%	27.2%	24.9%	36.9%	32.8%	33.3%	35.7%	34.6%	29.2%

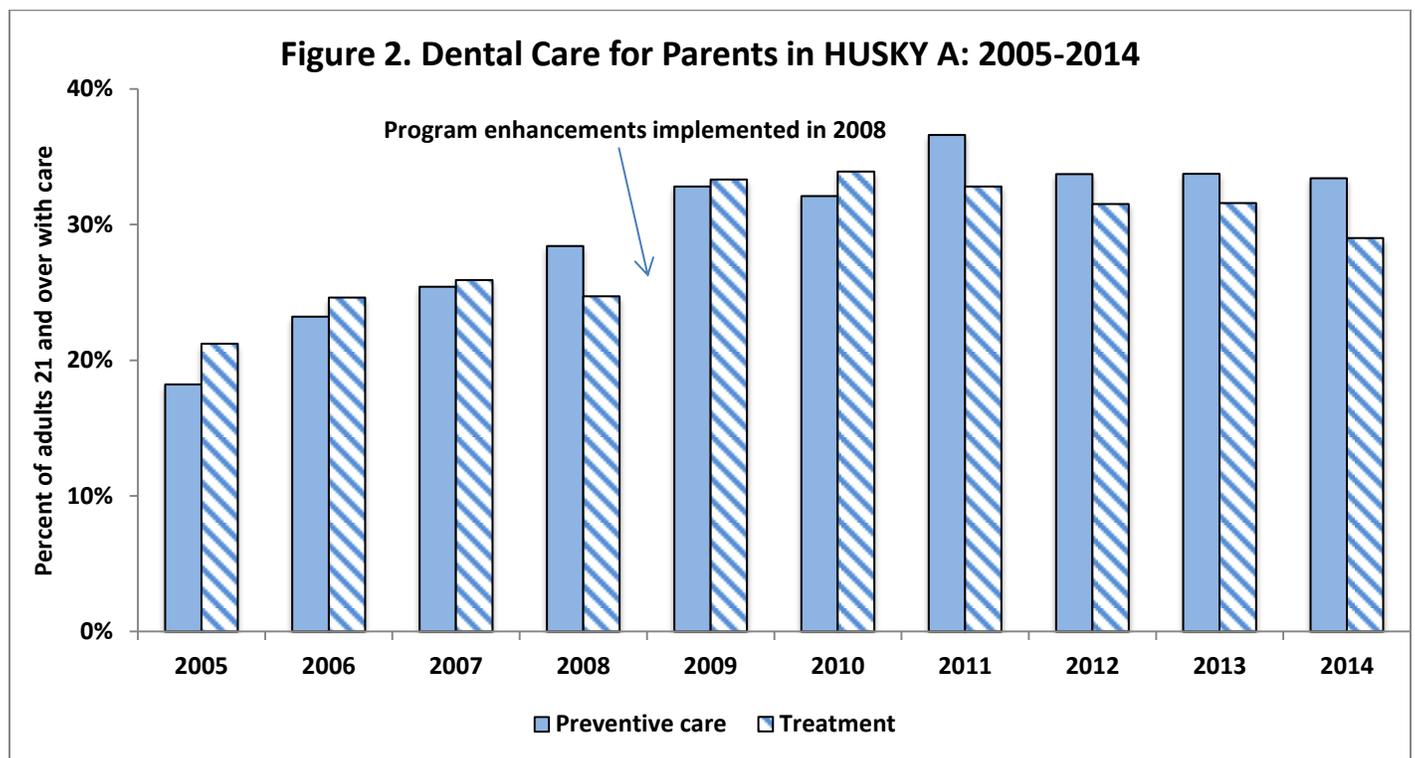
Note: Percent of children with any dental care who had at least one sealant placed. Age as of 12/31.

Note: In 2014, 17.2% of continuously enrolled children who changed between HUSKY A and B (5,507 children) received sealants.

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

Utilization Trends for Parents in HUSKY A

Overall, utilization of dental services by parents in the HUSKY A increased steadily until 2011, beginning prior to program changes in 2008 (Figure 2). However, both preventive care and treatment rates have been essentially unchanged since 2012. In 2014, the percentages of parents who had any dental care, preventive care, and treatment were higher than rates for 2008 and earlier years (Table 5). As in the previous year, 2014 utilization rates for adults were lower than rates for children in HUSKY A, especially for preventive care (33.4% v. 59.0% for children).



Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

Table 5. Dental Care Utilization by Adults in HUSKY A, 2005 to 2014

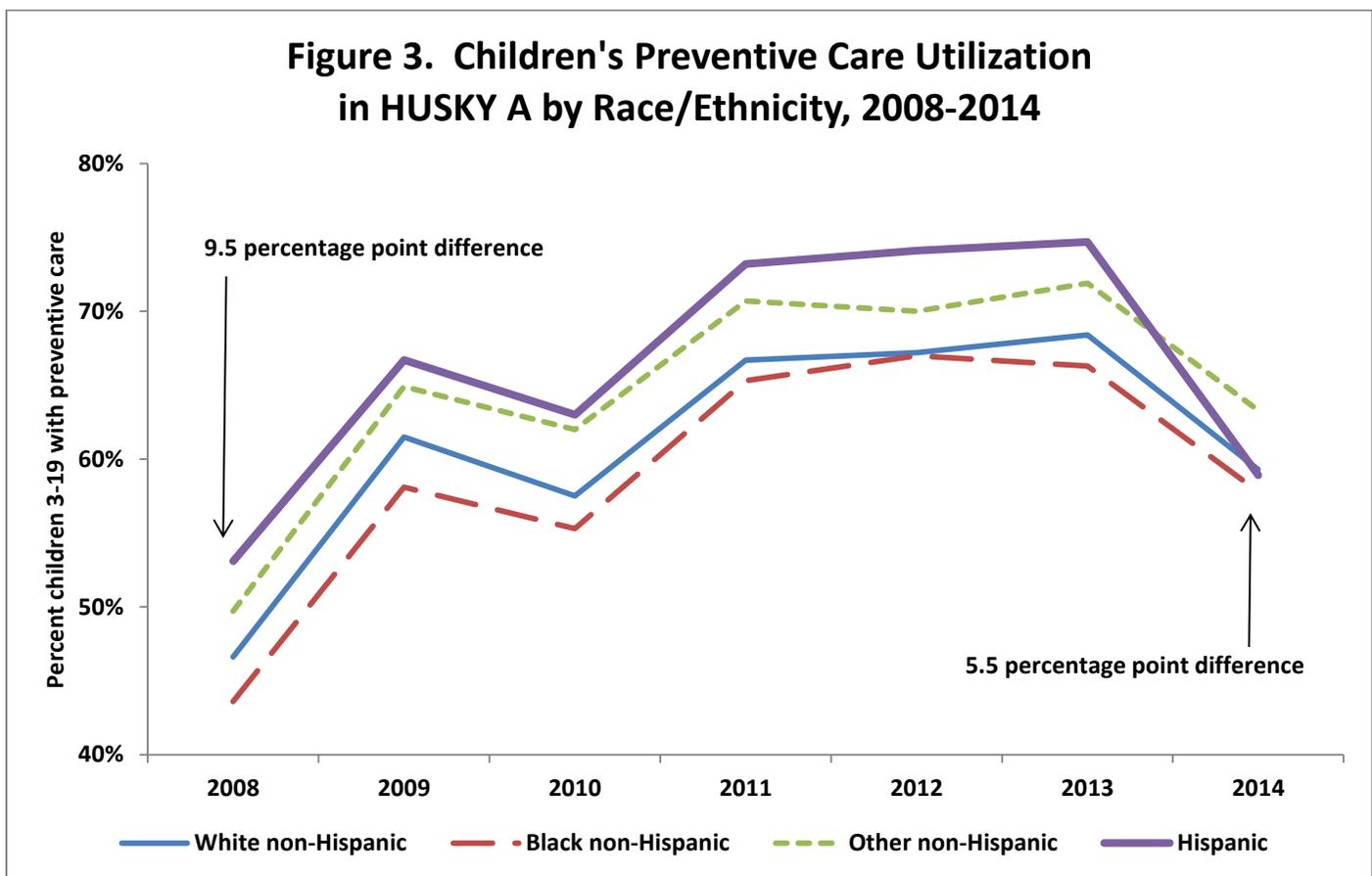
	Adults with Dental Care						
	2014	2013	2012	2011	2010	2009	2008
Any dental care	46.7%	48.6%	48.6%	50.2%	50.3%	47.7%	45.9%
Preventive care	33.4%	33.7%	33.7%	36.6%	32.1%	32.8%	28.4%
Treatment	29.0%	31.6%	31.5%	32.8%	33.9%	33.3%	24.7%

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

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

Racial/ Ethnic Differences in HUSKY A Dental Utilization

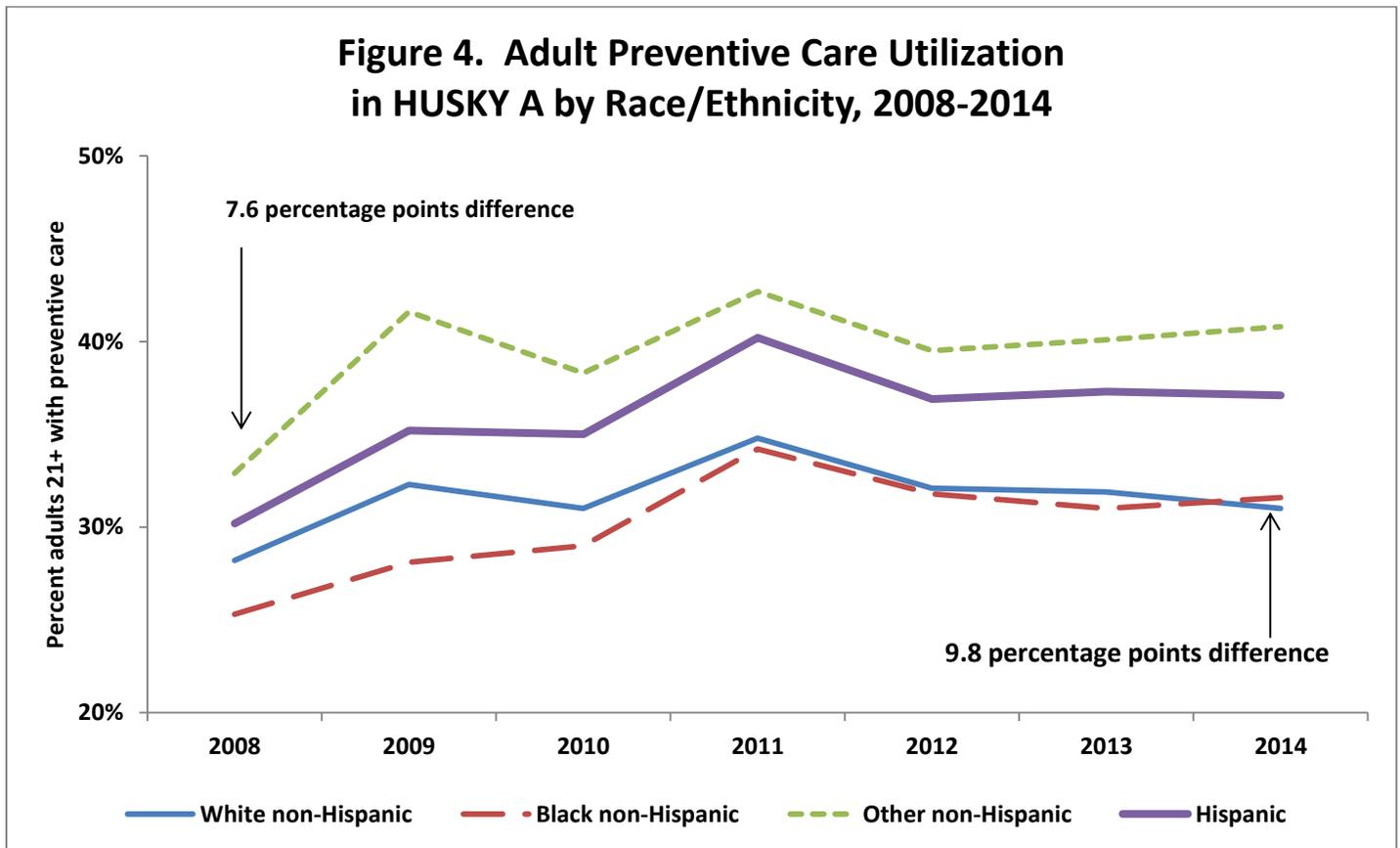
Racial/ethnic differences in utilization of needed health care suggest disparities in access to care. Dental care utilization differences are evident and persistent in HUSKY A. Until 2014, preventive dental care utilization rates for children in HUSKY A were consistently highest for Hispanics and lowest for Blacks/African Americans; however, the utilization rate for Hispanic children fell off sharply in 2014 (Figure 3). This drop off caused the overall rate difference to narrow considerably.



Note: Vertical axis re-scaled so that utilization differences and trends are more readily apparent.

Source: Analysis of HUSKY A data by Connecticut Voices for Children, 2016.

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 and 2014 (<1.0 percentage point difference). However, the gap between high and low utilization by race/ethnic group has grown in recent years.



Note: Vertical axis re-scaled so that utilization differences and trends are more readily apparent.

Source: Analysis of HUSKY Program data by Connecticut Voices for Children, 2016.

DISCUSSION

The American Dental Association’s Health Policy Institute recently reported that Connecticut has the highest dental care rate for children in the nation (64% of children had a visit in the past 12 months in 2013).¹⁴ Among adults, the rate is 4th highest in the nation (48% with a dental visit in the past 12 months in 2013). In a recent report to the legislature’s Council on Medical Assistance Program Oversight, the Connecticut Dental Health Partnership In 2014, results of a mystery shopper survey showed that 92 percent of callers got a routine appointment within about 10 days on average. Essentially all HUSKY enrollees have at least two primary care dentists within 10 miles of their home, far exceeding the contract standard for the provider network. Child utilization rates increased after outreach began in the new program in 2008. The Connecticut Dental Health Partnership reported that costs per client are declining.¹⁵

The results of this study show, however, a slowing in the gains realized since 2008 program changes. Based on our analyses, preventive care and treatment rates for nearly all age groups were lower in 2014 than rates reported in recent years. Moreover, we show the persistence of utilization differences associated with race/ethnicity and a sizable drop in utilization for Hispanic children. Rates for children in HUSKY B also dropped.

These findings warrant continued monitoring of utilization trends and closer attention to various program features that may affect these trends. Dental care provider reimbursement levels have not increased since April 1, 2008, and will decrease in 2017. Fewer children and adults have continuous coverage, a factor that may affect access to care and utilization when gaps in coverage interrupt relationships with providers or access to routine care.^{16 17}

ACKNOWLEDGEMENTS

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¹The 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.

³In 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.

⁴Report to Council for Medical Assistance Program Oversight, July 8, 2016.

⁵Other adults who qualify for Medicaid coverage (low income childless adults; aged, blind and disabled adults) also have comprehensive dental benefits.

⁶Connecticut 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**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).

¹²Centers 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.

¹³Data for 2013 are not available for comparison.

¹⁴American Dental Association Health Policy Institute. The oral health care system: a state-by-state analysis. 2015. Available at: <http://www.ada.org/en/science-research/health-policy-institute/oral-health-care-system/Connecticut-facts>.

¹⁵ Connecticut Dental Health Partnership. Report to Council on Medical Assistance Program Oversight, March 11, 2016.

¹⁶ 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/>.

¹⁷ Connecticut Voices for Children. Gaps or Loss of Coverage for Children in the HUSKY Program: An update. February 2015. Available at: www.ctvoices.org.