CONNECTICUT VOICES FOR CHILDREN

Dental Services for Adults in the HUSKY Program: Utilization Before and After Major Program Changes in 2008

September 2012

KEY FINDINGS

In 2008, Connecticut made significant changes in the HUSKY Program that were designed to improve access to dental care for children. Increased provider reimbursement, provider network expansion and enhanced customer services adopted for children also affected dental care for adults.

Results of this study show that adult dental care utilization increased, continuing a long-term trend in utilization evident prior to program changes. However, just one of every three adults received preventive care in 2009 and 2010. Dental treatment rates improved, perhaps because the greatest percentage increase in provider reimbursement was for treatment services. Key findings:

- About 50 percent of adults in HUSKY A (Medicaid) received any dental care, including about 32 percent with preventive care and 33 percent with treatment;
- Adult dental care utilization rates for preventive care were far lower than rates for children, while treatment rates were similar;
- As in previous years, dental care utilization rates were highest for Hispanic adults and adults of other non-Hispanic racial/ethnic groups (mainly Asian); utilization rate differences associated with race/ethnicity have not narrowed appreciably over time.

INTRODUCTION

Good oral health is essential for well-being and good physical health for persons of all ages.[1] In the United States however, not everyone enjoys optimal oral health. In fact, one of every four adults 18 to 64 report fair to poor oral health, a rate that varies by race/ethnicity, education, income, and insurance status.[2] 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. Clearly, poor oral health affects overall health, social functioning, employability, and quality of life.

Dental insurance is strongly associated with access to oral health services.[3] In 2007, about 60 percent of US adults 21 to 64 were insured for dental expenditures.[4] In Connecticut, results of a household survey showed that 74 percent of Connecticut residents had dental insurance coverage in 2004, including 80 percent of children, 72 percent of adults under 65, and less than one-third of adults over 65.[5]

In fact, many adults do not have access to dental coverage and could not afford the out-of-pocket costs if they did.[6] Poor adults are less likely than higher income adults to have dental coverage. While federal law requires Medicaid and Children's Health Insurance (CHIP) programs to cover dental care for children, states have the option of providing coverage to the low income adults in the Medicaid program. The National Academy of State Health Policy reported that in 2008, 16 states, including Connecticut, covered all dental service categories for adults in their Medicaid programs, and an additional 13 states covered some services (typically emergency services only).[7] In recent years however, some states have reduced or eliminated adult dental coverage as a means of cutting Medicaid spending.[8, 9]

Access to care for Medicaid beneficiaries is dependent on safety net providers and participation by dentists in private practice. In 2008, Connecticut took steps to improve access to care for children by increasing provider participation in the program.[10] The State increased provider reimbursement for 60 children's services (effective April 1, 2008) and carved-out dental care from the Medicaid managed care contracts (effective September 1, 2008). Since provider reimbursement for adult services is tied to fees for children's services, reimbursement for care of adults also increased significantly. Other changes, including provider network expansion and enhanced customer service, also affected access to dental care for adults.

Table 1. Provider Reimbursement for Selected Dental Services, 2005 and 2011

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

[a] Fees for adult services set at 55% of child fees in 2005 and earlier.

[b] In 2008, fees for adult services were set at 52% of child fee.

PURPOSE

- To describe adult dental care utilization in the HUSKY Program and compare to child utilization;

- To determine whether adult dental care utilization increased after 2008 when provider reimbursement increased, the provider network expanded, and administrative services were enhanced, compared with utilization when the dental services were part of risk-based managed care.

METHODS

Using a retrospective cohort design, we described adults' dental care utilization in the HUSKY Program in 2009 and 2010, post-program changes. For investigation of trends, utilization was compared to rates under managed care going back to 2005. In addition, we compared utilization rates for adults and changes overtime to children's dental care utilization.

This report on adult dental care utilization is the first from Connecticut Voices for Children. However, this report follows from monitoring of children's dental care since 1997 by Connecticut Voices and its performance monitoring predecessor, the Children's Health Council. This report on adult dental care utilization builds on many years of state-funded independent performance monitoring in the HUSKY Program, Connecticut's publicly funded health insurance program for children, parents, and pregnant women.[11]

In HUSKY A, parents and relative caregivers are currently eligible for Medicaid coverage if living in households with income under 185 percent of the federal poverty level (FPL). This income eligibility threshold was increased from 150 percent FPL, effective July 1, 2007. Pregnant women are eligible for coverage if living in households with income less than 250 percent FPL, up from 185 percent FPL prior to January 1, 2008. These income eligibility changes occurred prior to the changes in the dental program and have had the effect of increasing the number of people eligible for care, compared with earlier years.

Data and Analytic Approach

This report is based on analyses of the most recent HUSKY Program data obtained by Connecticut Voices directly from the Department of Social Services for independent performance monitoring.[12]

Using HUSKY A enrollment data, adults age 21 and over who were continuously enrolled in the HUSKY Program between January 1 and December 31 in 2009 and in 2010 were identified.[13] Those few adults who were enrolled in Primary Care Case Management, an alternative to managed care enrollment in 2009 and 2010, were counted with all other adults in enrolled in HUSKY A managed care health plans.[14]

Dental services encounter data and claims were obtained from the Department of Social Services for utilization analyses. Dental services data for adults in HUSKY A were searched for claims with selected procedure codes corresponding to dental care received by adults 21 and over.[15] The procedure code set is the same as that used for analyses of children's dental care utilization.[16] Rates for adults are shown by other factors that may be associated with utilization, such as age (21-39, 40 and over), race/ethnicity (White, Black, Hispanic, all other racial/ethnic groups), primary language (English, Spanish, all other languages), and residence (Bridgeport, Hartford, New Haven, all other towns). Rates for 2009 and 2010 (after the fee increases and major program changes) are compared to previous years. To date, the Department of Social Services has not reported to the legislature's oversight council or the plaintiffs' attorneys on adult dental care utilization.

The results are reported in terms of unadjusted utilization rates, calculated by comparing the numbers of continuously enrolled adults with care to the numbers who were continuously enrolled during the time periods.

Differences between 2009 or 2010 and utilization in earlier years were determined by comparing utilization rates for services (rate ratios); differences that were highly significant ($p<.001$) are reported as either higher or lower than rates for previous years. Because the sample size is so large, relatively small rate changes can be statistically significant, so those differences that were both statistically significant and meaningful in program terms are highlighted in the discussion section.

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 the methods (i.e., continuously enrolled v. ever enrolled, calendar year v. federal fiscal year) and/or when the dataset was created by the Department for the analyses. It was not possible to determine which if any of the adults had other dental services that were covered by third party payers or delivered by providers who did not submit claims. The experience of adults who were continuously enrolled may not be representative of all adults who were enrolled for just part of the year. At the time that these analyses were conducted, encounter data for dental emergency visits to hospitals were unavailable. Despite these limitations, the findings provide policy makers, agency staff, and health advocates with data for assessing the effect of program changes on access to dental care and utilization.

RESULTS

The findings in this report are based on utilization of health services by adults who were continuously enrolled in the HUSKY Program in 2009 and 2010 (79,122 and 92,629 age 21 and over, respectively). In recent years, the percent of ever enrolled adults who were continuously enrolled has increased from a low of just over 50 percent in 2006 to just over 60 percent in 2010. Thus, for utilization rates to increase, the program and provider network must serve many more adults. Access to care is likely to be better for those who maintain continuous coverage.

Utilization Trends

Overall, utilization of dental services has increased steadily in recent years, even prior to program changes (Figure 1). In 2009 and 2010, the percentages of adults who had any dental care, preventive care, and treatment were statistically significantly higher than rates for 2008 and earlier years, though the rate change for preventive care was relatively modest (about 4 to 5 percentage points) (Table 1).

Figure 1. Percentage of Adults with Dental Care: 2005-2010

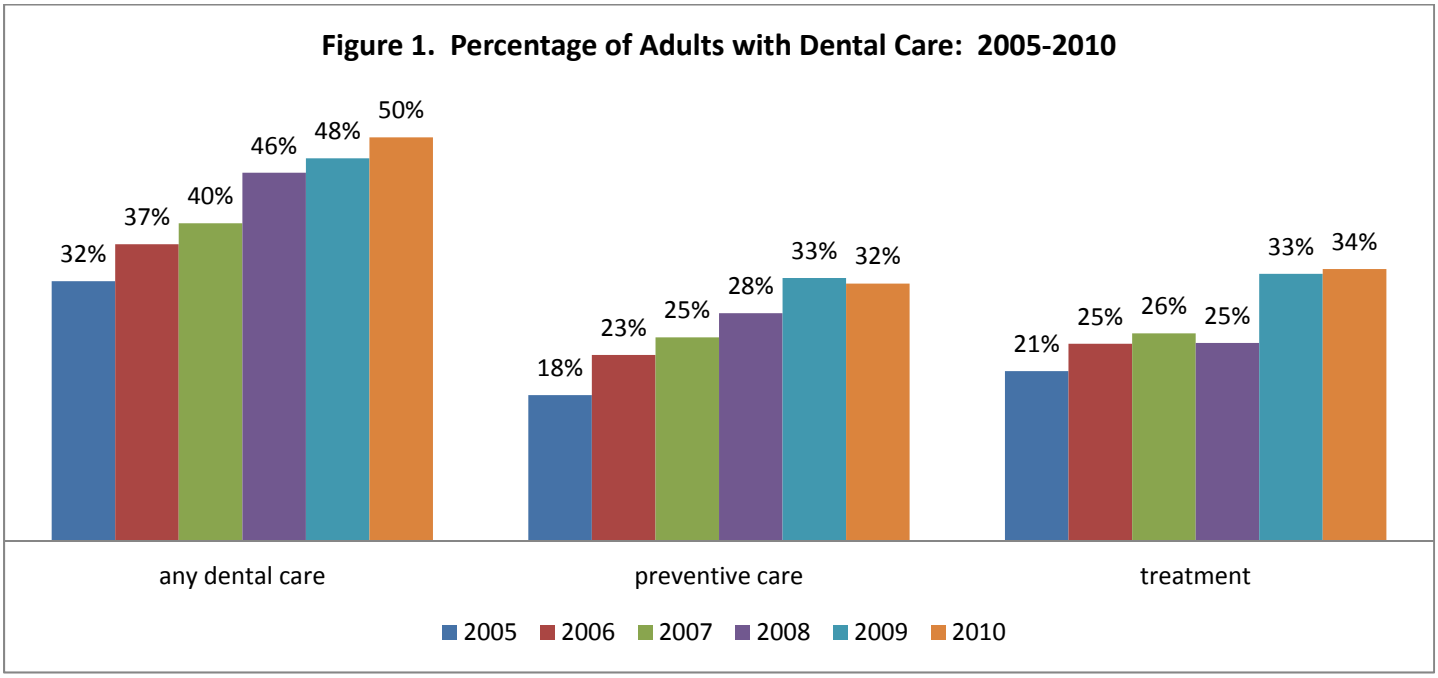


Table 1. Adult Dental Services in HUSKY A, 2005 to 2010

	Adults 21 and Over with Dental Care[a]					
	2010	2009	2008	2007 [b]	2006	2005
Any dental care	46,556 50.3%*	37,726 47.7%*	32,705 45.9%	24,509 39.6%	21,384 37.0%	20,215 32.4%
Preventive care	29,765 32.1%*	25,913 32.8%*	20,256 28.4%	15,745 25.4%	13,388 23.2%	11,325 18.2%
Dental treatment	31,442 33.9%*	26,360 33.3%*	17,622 24.7%	16,043 25.9%	14,180 24.6%	13,205 21.2%

[a] Percent of continuously enrolled adults who had at least one service or visit.

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

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

Dental care utilization rates for adult subgroups in 2010 are shown in Table 2.[17] Hispanic adults and Spanish-speaking adults were most likely to have had any dental care. Utilization of dental care increased for adults of all ages and both genders, and for every racial/ethnic, language and residence group in 2009 and 2010, compared with 2008 (data not shown).

Table 2. Adult Dental Services in HUSKY A, 2010

		Adults with Care by Type of Dental Services[a]		
	Number	Any Care	Preventive	Treatment
Total	92,629	50.3%	32.1%	33.9%
Age				
21-29	62,389	50.6%	31.9%	34.4%
40 and over	30,240	49.5%	32.7%	32.9%
Gender				
Female	72,590	52.0%	33.1%	35.1%
Male	20,039	44.1%	28.6%	29.6%
Race/ethnicity				
White non-Hispanic	41,133	47.6%	31.0%	31.7%
Black non-Hispanic	18,662	49.9%	29.0%	34.2%
Other non-Hispanic	4,121	54.2%	38.3%	33.5%
Hispanic	28,713	53.8%	35.0%	37.0%
Primary Language				
English	83,352	49.4%	31.4%	33.2%
Other	903	52.9%	35.1%	37.1%
Spanish	8,374	58.6%	39.3%	41.0%
Residence				
Bridgeport	7,711	52.3%	29.8%	36.8%
Hartford	9,253	51.3%	32.0%	35.6%
New Haven	6,632	49.6%	27.3%	34.2%
All other towns	69,033	50.0%	32.9%	33.4%

[a] Percent of continuously enrolled adults who had at least one visit.

Utilization by Adults Compared with Children

In both 2009 and 2010, utilization rates for any dental care and for preventive care were significantly lower for adults, compared with children (Table 3). For adults, rates for preventive care and treatment were similar (32.1% and 33.9% respectively in 2010), in contrast to the greater likelihood that children received preventive services (59.2%) rather than treatment (33.3%).

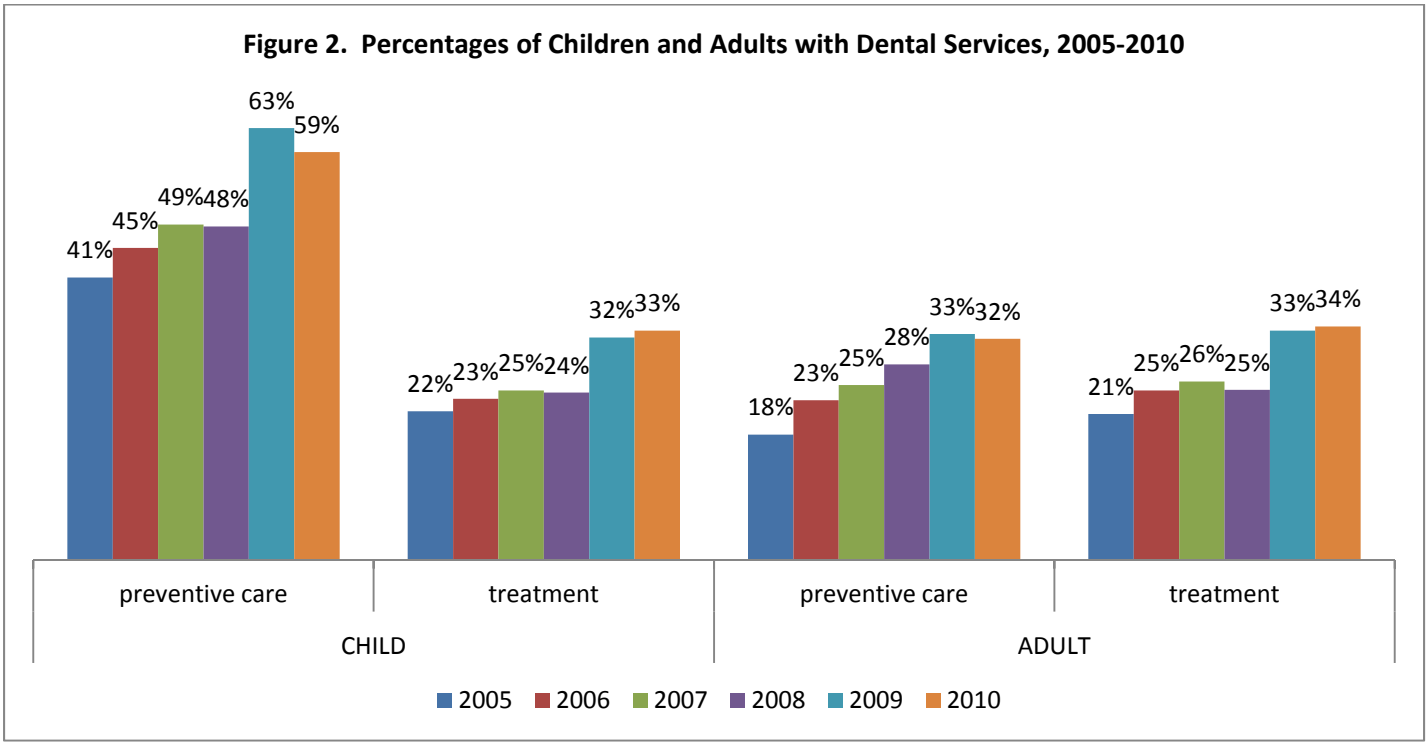
Table 3. Comparison of Adult and Child Dental Utilization in HUSKY A, 2009 and 2010

	Persons with Dental Care[a]			
	2010		2009	
	Adults	Children	Adults	Children
Any dental care	50.3%*	68.1%	47.7%*	68.0%*
Preventive care	32.1%*	59.2%	32.8%*	62.7%*
Dental treatment	33.9%	33.3%	33.3%	32.3%

[a]Percent of continuously enrolled adults or children who had at least one visit.
*Rate for adults in 2009 or 2010 is significantly lower than the rate for children in HUSKY A (p<.001).

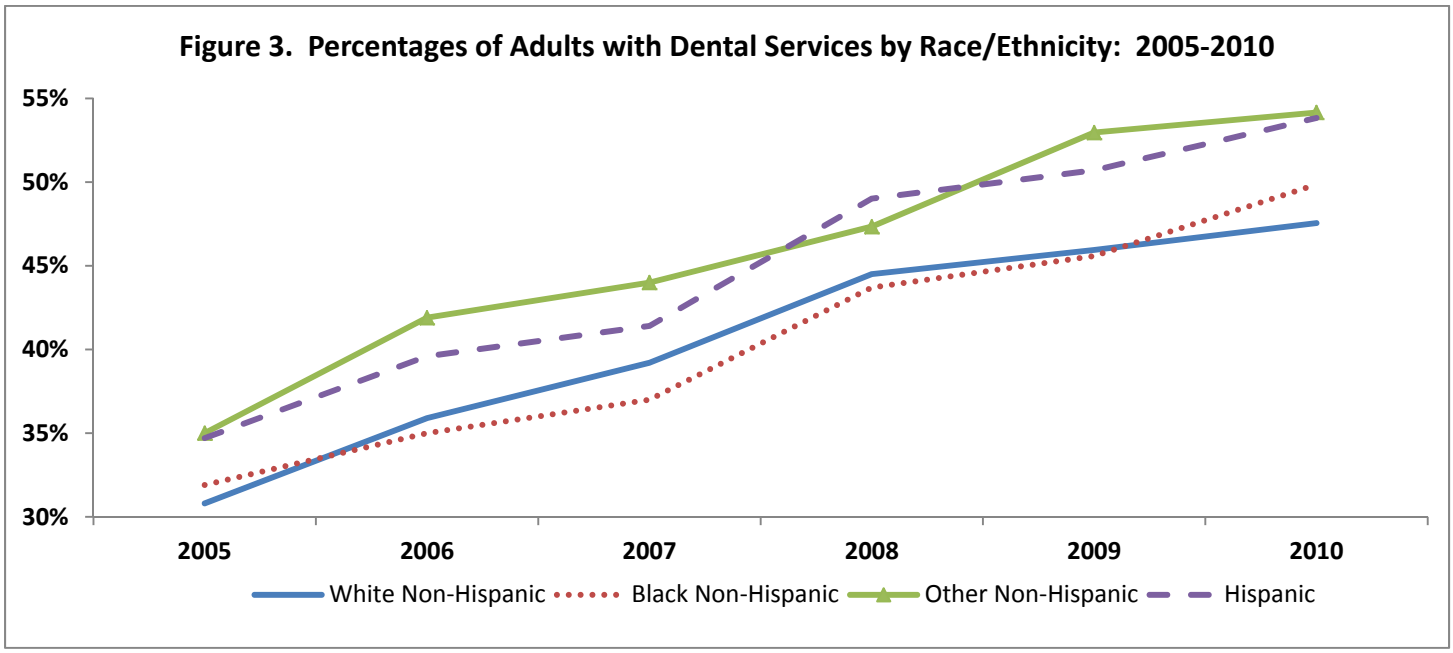
After program changes, dental care utilization improved most noticeably for children's preventive care (about 11 percentage points increase) (Figure 2). Treatment rates for adults and children increased as well (about 9 percentage points).

Figure 2. Percentages of Children and Adults with Dental Services, 2005-2010



The average number of visits for preventive care for adults with any preventive care increased only very slightly since the program changes took effect, from 1.17 preventive care visits (2005 to 2007) to 1.24 (2008 and 2009) and 1.28 (2010). The average number of visits for treatment was just over two per adult with any dental treatment, except for 2009 when the average number of treatment visits increased to 2.45.

Racial/ethnic differences in utilization of needed health care suggest disparities in access to care for adults. The lowest and highest rates for any care varied consistently by three to seven percentage points (Figure 3). Each year between 2005 and 2010, Hispanic adults and the mainly Asian adults who were non-Hispanic had utilization rates that were higher than the rates for White non-Hispanic and Black non-Hispanic adults.



DISCUSSION

Results of these analyses show that efforts to improve access to dental care for children in the HUSKY Program may have contributed to increased access for adults as well. However, just one of every three adults received preventive care. Dental treatment rates improved, perhaps because the greatest percentage increase in provider reimbursement was for treatment services. The Department took steps to prevent over-treatment by ensuring that all treatment is necessary and appropriate for each patient and in compliance with medical services policies. Beginning in February 2010, the Department began requiring prior authorization for selected procedures (for adults, root canals, dentures, crowns, and extractions of impacted teeth). Following this administrative change, the number of single crowns, endodontic treatments, surgical extractions, and dentures (full and partial) dropped off considerably for all adults in Medicaid (including the elderly and disabled for whom data were not available for this analysis). [18]

Since 2008, the Department and the Connecticut Dental Health Partnership have focused their efforts on provider network development. Currently, there are over 1,500 participating dental practitioners (general dentists, pediatric dentists, dental hygienists, endodontists, and oral surgeons), up from less than 800 in 2009.[19] The Department and the Connecticut Dental Health Partnership monitor geographic proximity to providers, appointment wait time, and closed panels (providers who will not accept new patients). [20] Currently, general dentists who are unwilling to serve adults cannot enroll in the provider network. [21] Dentists who do participate are asked to provide care at least for parents of children in their caseloads, if not for other adults in the Medicaid program.

Several findings warrant further investigation and monitoring. Utilization of preventive care is still quite low; understanding why is important. It is possible that many adults in Medicaid have had regular preventive care, but are unable to afford treatment until they obtain coverage. It is also possible that the higher preventive care rate for children, compared to adults, is largely attributable to a robust safety net, including school-based dental clinics. More information about provider participation is needed to understand the extent to which office-based providers and safety nets clinics serve adults in the HUSKY Program. Another area for investigation and monitoring is the persistence of disparities associated with race and ethnicity. Utilization rates should be monitored to determine whether the differences narrow over time as access to care improves for everyone. The fact that utilization by Hispanic adults (and children) is consistently higher than utilization by adults in other racial/ethnic groups runs counter to national data and should be explored. Emergency care for dental conditions before and after program changes should be investigated and monitored going forward. Finally, the effect of special initiatives, like follow-up with adult non-utilizers and targeted outreach to pregnant women, should be investigated.

Conclusion

Changes in the HUSKY program may have had a generally positive effect on adult dental care utilization. To the extent that the oral health needs of adults are met, their families' oral health will improve too with better oral hygiene, decreased prevalence and transmission of bacteria that cause dental caries, and increased likelihood that all their dental care needs will be met in a timely and appropriate manner.

The Affordable Care Act (ACA) will go a long way toward ensuring access to oral health care for adults in Connecticut's HUSKY Program and nationwide.[22] First and foremost, states can expand Medicaid coverage to low income childless adults up to 133 percent of the federal poverty level. An estimated 155,000 Connecticut residents who are currently uninsured (mainly childless adults) would qualify for Medicaid coverage, including dental services, in 2014.[23] In addition, the ACA takes steps to improve the nation's oral health by:

- Commissioning a national oral health campaign targeting children, pregnant women, parents, the elderly, the disabled, and persons in racial/ethnic minority groups;
- Authorizing grant funding for dental training programs, including financial assistance for professional education and loan repayment;
- Providing funding for expanding dental care facilities at community health centers; and
- Creating a special national commission to study workforce issues focused on education and training.

The ACA will help Connecticut build on its long-standing commitment to the oral health care needs of low income adults.

ACKNOWLEDGEMENTS

This report was prepared by Connecticut Voices for Children under a contract between the Department of Social Services and the Hartford Foundation for Public Giving, with a grant from the Hartford Foundation to Connecticut Voices for Children. This report was prepared by Mary Alice Lee, Ph.D., Senior Policy Fellow. Amanda Learned of MAXIMUS Health Services, Inc. conducted the data analyses. Sharon Langer, J.D., Senior Policy Fellow, critiqued the brief and provided important background information. 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.

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[11] Independent performance monitoring is state-funded in the line item "Children's Health Council" in the Department of Social Services budget. This label is a clear reference to the state-funded, Hartford Foundation-sponsored oversight council that monitored program performance from 1995 to 2003. In 2004, state-funding and independent performance monitoring resumed under a new contract between the Department of Social Services and the Hartford Foundation, with a grant to Connecticut Voices for Children.
[12] Contract #064HFP-HUO-03/10DSS1001ME-A1between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving, April 1, 2010 to June 30, 2013. With 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, asthma prevalence and asthma care, and births to mothers with HUSKY Program or Medicaid coverage can be found at www.ctkidslink.org.
[13] This report is based on health services utilization by continuously enrolled v. ever enrolled adults for the following reasons: 1) all adults had uniform periods of observation, 2) the utilization measure (percentage of adults with care) is relatively simple to calculate and easy to communicate to policy makers, 3) HUSKY Program and participating managed care plans can be held accountable for adults who were enrolled for one entire calendar year and not those who may have lost coverage for part of the year or changed plans. Utilization rates for continuously enrolled adults are likely to be higher than rates for adults with part-year coverage, especially those with unintended gaps in coverage.
[14] Beginning in February 2009, families had the option of enrolling in Primary Care Case Management (PCCM) (v. insurance company-run managed care), depending on where the family resided. Enrollment in PCCM grew to 515 persons statewide by January 1, 2011, including 384 in New Haven County (mainly in the Waterbury area).
[15] 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 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.
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[17] Summary data for earlier years is available upon request.
[18] Connecticut Department of Social Services report to the Medical Assistance Program Oversight Council, September 17, 2010. Available at: www.cga.ct.gov/ph/Medicaid under minutes for the meeting September 17, 2010. NOTE: As its portfolio changed over the years since it was established in 1995, this oversight council has been known as "Medicaid Managed Care Council," "Medicaid Care Management Oversight Council," "Medicaid Medical Assistance Program Oversight Council," and currently, "Council on Medical Assistance Program Oversight."
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