

**Legislative Testimony  
Public Health Committee**

**AN ACT CONCERNING CERTIFICATION OF ADVANCED DENTAL HYGIENE  
PRACTITIONERS.**

**Wednesday, March 11, 2015  
William Nash, D.M.D.**

Senator Gerratana, Representative Ritter and members of the Public Health Committee, my name is Dr. William Nash. I have been practicing dentistry in for 37 years. My volunteer service to the citizens of our state includes Give Kids A Smile and CT-MOM. I am also a HUSKY/Medicaid provider. Currently I serve as President Elect of the Connecticut State Dental association. My testimony today is in opposition to H.B. 6275, An Act Concerning Certification of Advanced Dental Hygiene Practitioners

It has been stated that one rationale for creating ADHP in Connecticut is to increase access to dental care for Husky/Medicaid children. With over 1,900 participating dentists, the Connecticut Department of Social Services has reported for years that any Husky child patient can get an appointment for routine care within 10 days and an emergency appointment within 24 hours. It has also been reported that, dental practices call the Dept. of Social services on a regular basis, asking if they have any new patients needing services. Furthermore, reports from the Department of Social Services as well as the Connecticut Health Foundation (attached) indicate that current utilization for Husky patients in our state is at the same level as children with private insurance.

The Legislature has already weighed on the viability of the ADHP concept, as proposed bills have been submitted repeatedly for several years. The Public Health Committee has consistently refused to take action this unjustified topic. Nothing in the proposed bill has changed since the last time it was introduced, so why consider it now?

Furthermore, it is important to note that creating this new position will cost a significant amount of money for the State. The position must be defined, a curriculum has to be created and approved at the national level, testing of the applicants must be performed, and the practitioners must be supervised and monitored by an oversight body that currently does not exist in the state. In today's tight fiscal climate, should the State Government waste time and money creating an unnecessary provider?

I would like to sincerely thank you for your time and am in hopes that you will defeat H.B. 6275.

Respectfully Submitted,

William Nash, D.M.D.  
2157 Mill Plain Rd.  
Fairfield, CT 06824

**STATE OF CONNECTICUT**  
*DEPARTMENT OF SOCIAL SERVICES*  
25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

December 5, 2014

Jeffrey Berkley, DDS  
President  
Connecticut State Dental Association  
835 West Queen Street  
Southington, CT 06489

Dear Dr. Berkley,

I am writing in response to your request for information regarding the Connecticut Dental Health Partnership (CTDHP). We are the oral health program for state residents who receive their health care from the Department of Social Services (DSS) Medical Assistance Program (MAP), also called HUSKY Health. CTDHP serves more than 740,000 clients enrolled in HUSKY A (Medicaid for children/ parents/ relative caregivers/ pregnant women); HUSKY B (non-Medicaid Children's Health Insurance Program); HUSKY C (Medicaid for the Aged/Blind/Disabled, also known as Title 19 and including Long-Term Care services); and HUSKY D (Medicaid for Low-Income Adults). Approximately half are children.

The Partnership has made significant progress since it was established in September 2008.

- Utilization by children in the program has increased significantly:
  - In the Federal Fiscal Year (FFY) 2008 (10/1/07 - 9/30/08) the Connecticut's children's dental utilization rate was 36.7%.<sup>i</sup>
  - Data for FFY 2013 (10/1/12 - 9/30/13) shows a rate of 61.8%, an increase of 25 points (66% increase) from the FFY 2008 results.<sup>i</sup>
  - The rate compares favorably with the national rate for all children of 46.4%<sup>i</sup> in 2013. We understand that Connecticut has the highest children's dental utilization rate in the country.
- There are now more than 1,900 dental providers enrolled across the state:
  - Enrolled dental providers are easy to find, access is similar to commercial dental plans.
  - In a 2014 Secret Shopper Survey 92% of callers were able to get a routine dental appointment, in an average of 9.9 days and a median wait of 5 days.<sup>ii</sup>
  - In a 2012 Secret Shopper Survey 93% of callers were able to get a routine appointment in an average of 7.9 days and a median of 4 days.<sup>ii</sup>
  - A 2010 Secret Shopper Survey conducted by an independent consultant, 93% of 'clients' were able to secure a routine dental appointment (for offices reached - 95% of 418 called); average time for a routine appointment was 11.2 days.<sup>ii</sup>

- All clients (100%) are able to access care within 15 miles of their residence while over 99% are able to access two or more dentists within 10 miles of their place of residence. The contract standard is one dentist within 20 miles.
- Three quarters of the dental care provided to Medicaid enrollees today is through the private dental offices enrolled with CTDHP.
- We frequently receive request from provider offices for more client referrals.
- The oral health of children enrolled in Head Start programs across the state has significantly improved:
  - 92% have had their required dental exam according to reports filed by local programs to the Federal Government. <sup>iii</sup>
  - A 2012 study by the Connecticut Department of Public Health showed that untreated caries and rampant caries in Head Start children had dropped 50% since 2007. <sup>iv</sup>
  - Head Start staff frequently tell us that “dental is no longer a problem.”
- Connecticut was one of only three states that earned an “A” on the Pew Center for the States 2010 and 2011 children’s oral health report. <sup>v</sup>
- The Commonwealth Fund’s State Scorecard on Child Health System Performance <sup>vi</sup> found that Connecticut was in the top ten states overall and ranked fourth nationally for percent of children ages 1–17 with a preventive dental care visit in the past year. We also ranked ninth best for percent of children ages 1-17 without oral health problems.
- In a report of third grade students’ caries experience, Connecticut ranks best of 43 reporting states, that is the least percent of third graders with caries experience. <sup>vii</sup> About one-third of third graders in Connecticut are on HUSKY Health.

Clients can call **855-CT-DENTAL**, Monday through Friday, from 8:00 AM to 5:00 PM. The toll-free number is staffed by a bilingual team of CTDHP Customer Service Representatives. Referrals to dentists and clinics near the client’s home are provided. Since the program started, the representatives have answered more than 300,000 calls from clients. Ninety-seven percent of those calls are resolved and closed in the same day. Client satisfaction is our goal, even as we answer a large number of calls. In addition, clients can look up providers at [www.ctdhp.com](http://www.ctdhp.com).

While the increase in utilization was good, we want to further improve our performance. There is evidence that in order to make significant progress on utilization, the CTDHP will need to address a lack of understanding of the importance of oral health by a significant portion of our clients and the general population.

Since our inception we have conducted significant outreach across the state, focused on perinatal clients, non-utilizing clients, clients with special health care needs, clients who use the emergency room for dental issues and clients of the Department for Children and Families (DCF). These efforts have included hundreds of thousands of mailed materials and out-bound telephone calls.

In 2013 DSS received a four year grant from the Federal Department of Health and Human Services’ (HHS) Health Resources and Services Administration’s (HRSA) Maternal and Child Health Bureau to expand its efforts via CTDHP to increase dental utilization for perinatal women and infants. We were one of only three states that received an award after a national competition.

A team of nine Dental Health Care Specialists cover six regions of the state and work intensively with community agencies and providers to spread the word about our program and assist those organizations in informing and motivating our shared clients to get oral health care. They have made hundreds of visits to community agencies and providers as well as participation in dozens of collaborative efforts.

In addition DHCS work individually with clients referred or identified who have significant barriers to receiving dental care. One DHCS works exclusively with special needs clients.

The Department and CTDHP are looking at ways to educate and persuade clients that oral health is an important part of their overall well being. We are currently analyzing barriers to receiving care in order to determine the best strategies to increasing client interest in seeking care. The CTDHP's goal is to achieve long term results, which will achieve optimal oral health for clients within the design of the program. We believe it is important to do systematic analysis of the situation, not short-term fixes and strive to make long term productive changes to the program for the right reasons.

We look forward to working with the Connecticut State Dental Association and other oral health stakeholders. We thank you for your interest. If you have any additional questions about CTDHP, please feel free to contact me at any time.

Sincerely,



Donna L. Balaski, DMD  
Manager, Medical Care Administration  
Connecticut Department of Social Services  
860-424-5342  
[donna.balaski@ct.gov](mailto:donna.balaski@ct.gov)



Marty Milkovic, MSW  
Director of Care Coordination and Outreach  
Connecticut Dental Health Partnership  
860-507-2302  
[marty.milkovic@ctdhp.com](mailto:marty.milkovic@ctdhp.com)

<sup>i</sup> U.S. Department of Health & Human Services website, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>, accessed 12/5/2014

<sup>ii</sup> Secret Shopper surveys conducted by the United Way of Connecticut, under a contract with CTDHP.

<sup>iii</sup> From Program Information Reports (PIR) filed by local Head Start programs with the US Department of Health and Human Services. Obtained from the website <http://eclkc.ohs.acf.hhs.gov/hslc> on 12/5/2014, registration required.

<sup>iv</sup> Every Smile Counts reports, 2007 and 2012, Connecticut Department of Public Health, <http://www.ct.gov/dph/cwp/view.asp?a=3125&q=388872> accessed 12/5/2014.

<sup>v</sup> The Cost of Delay: State Factsheets, Pew Center on the States, 2010, <http://www.pewtrusts.org/en/research-and-analysis/reports/0001/01/01/the-state-of-childrens-dental-health> (accessed 12/5/2014)

<sup>vi</sup> S. K. H. How, A.-K. Fryer, D. McCarthy, C. Schoen, and E. L. Schor, Securing a Healthy Future: The Commonwealth Fund State Scorecard on Child Health System Performance, 2011, The Commonwealth Fund, Feb. 2011.

<sup>vii</sup> Percentage of 3rd Grade Students with Caries Experience (treated or untreated tooth decay), National Center for Chronic Disease Prevention and Health Promotion, accessed 12/5/2014  
<http://apps.nccd.cdc.gov/nohss/IndicatorV.asp?Indicator=2&OrderBy=2>

# Health Issues



Connecticut Health  
FOUNDATION

## IMPACT OF INCREASED DENTAL REIMBURSEMENT RATES ON HUSKY A-INSURED CHILDREN: 2006 – 2011

### OVERVIEW

Over the past few decades Connecticut children enrolled in HUSKY A (Healthcare for Uninsured Kids and Youth), the state's Medicaid program for low-income families, could not easily access dental health services for a variety of reasons including low private dentist participation. Many providers cited low reimbursement rates and cumbersome program administration as obstacles to treating children insured under Medicaid. Based on a 2008 lawsuit settlement agreement, program administration improved and reimbursement rates increased, moving closer to private insurance rates. An examination of Medicaid data between 2006 and 2011 will illustrate the impact of these changes on utilization rates, private dentist participation, and the relative contributions of private practices and dental safety net providers.

### FINDINGS

1. Higher Medicaid reimbursement rates and improved administrative structure encouraged many more private practice dentists to treat children insured under HUSKY A.
2. Utilization rates of children continuously enrolled in HUSKY A increased from 46 percent in 2006 to nearly 70 percent in 2011.
3. Nearly all of Connecticut's 169 cities and towns, including the ten with the greatest concentration of children on HUSKY A, experienced significant utilization rate increases.
4. Increased private dentist participation in the Medicaid program directly contributed to greater access to oral health services among low-income children.

### RECOMMENDATIONS

Children's access to dental care is linked to robust private provider participation in the Medicaid program and a strong dental safety net system. To ensure continued access to basic oral health services among low-income children insured under HUSKY A:

- Medicaid reimbursement rates must be periodically adjusted to mirror private insurance rates.
- The administrative structure and processes of the Medicaid dental program must remain streamlined.

### POINTS OF INTEREST:

The 2011 utilization rate among children continuously enrolled in HUSKY A is similar to the rate of 65 percent for children enrolled in private insurance plans.

Approximately half of all pediatric and general dental practitioners now provide care in the Medicaid dental program.

More than twice as many children received treatment services in 2011 than 2006.

*Continued on page 2*

**CONTEXT**

Well-established research illustrates the consequences of inadequate access to basic dental care: more oral disease, more pain and infection, and more days lost from school. Historically, Connecticut's low-income children have difficulty accessing dental care due, in large part, to low Medicaid reimbursement rates that discouraged private providers from program participation.

In 2000, Greater Hartford Legal Aid and Connecticut Legal Services brought a lawsuit on behalf of Connecticut children enrolled in HUSKY A who could not access basic dental services. In April 2008, thanks to the advocacy efforts of the Connecticut State Dental Association (CSDA), the Connecticut Dental Hygienists' Association (CDHA), the Connecticut Health Foundation (CT Health), and other community partners, the lawsuit settlement agreement included increasing dental reimbursement rates to the 70<sup>th</sup> percentile of 2005 private insurance fees (see Table 1).

In addition to increasing fees, the Connecticut Department of Social Services (DSS) simplified Medicaid dental program administration. Rather than four companies administering the program and accepting financial risk, dental services are now managed by a single administrative services organization (ASO) that has no financial risk. The department also initiated an outreach effort designed to increase dental program participation of both patients and providers.

In response to these positive changes, the CSDA also made a commitment to increase private sector providers participating in HUSKY A. Along with frequent membership communications designed to answer questions about administrative changes, CSDA worked with HUSKY A dental program representatives to guide new providers through streamlined processes. "Word of mouth" endorsements from new HUSKY A dental providers were a big factor in successful recruitment efforts statewide.<sup>1</sup>

Many states with low oral health reimbursement rates are interested in Connecticut's efforts to provide Medicaid-enrolled children adequate access to dental care. Some experts argue that even with fees competitive with those of private insurance, private dentists still may not participate in Medicaid. Others suggest that families on Medicaid may not seek dental care, even if available, because of non-economic barriers, such as education, language, culture, and transportation. The positive results from Connecticut suggest that these assumptions are not true.

Table 1  
**Reimbursement Fees for Selected Services**

Service	2006* Fees	2008 Fees
Initial exam	\$24	\$65
Cleaning	\$22	\$46
Two-surface amalgam (filling)	\$39	\$114
Stainless steel crown	\$88	\$230
Extraction (single tooth)	\$33	\$115

\*Prior to reimbursement rate increase

**METHODOLOGY**

Medicaid enrollment and encounter data, supplied by DSS, provides opportunities to compare utilization rates before (2006) and after (2009–2011) the reimbursement rate increase and implementation of the new administrative structure.

The year 2006 was chosen as the baseline because various administrative changes

occurred in 2007 and fee increases did not occur until mid-2008. The results include HUSKY A children enrolled in Medicaid for at least one day ("ever enrolled") and for at least 11 months and one day ("continuously enrolled") within a calendar year.

Between 30 percent and 42 percent of ever-enrolled HUSKY A children who are enrolled in

the Medicaid program for part of a full year have less time to access dental services. In contrast, most children covered under private insurance typically retain coverage for a full year. Therefore, data for children continuously enrolled in HUSKY A for a full year were examined to more accurately compare utilization rates of children insured under Medicaid to those insured under private insurance.

## IMPACT ON DENTAL SERVICE UTILIZATION

The number of children enrolled in the Medicaid program at least one day (ever enrolled) grew 18.1 percent between 2006 and 2011. Thirty-six and 59 percent of these children had at least one visit per year in 2006 and 2011, respectively (see Table 2).

Table 2  
Utilization Rates of Ever-Enrolled HUSKY A Children

Year	Number of Enrollees	Percent With Any Visit
2006*	265,114	35.9
2009	278,886	54.1
2010	303,941	58.5
2011	313,226	58.7

\*Prior to reimbursement rate increase



The number of children continuously enrolled in Medicaid grew nearly 37 percent between 2006 and 2011. In 2006, 46 percent of continuously enrolled children had at least one visit per year, compared with 69.5 percent in 2011 (see Table 3). The 2011 utilization rate among children continuously enrolled in HUSKY A is similar to the rate of 65 percent for children enrolled in private insurance plans.<sup>ii</sup>

The increase in utilization occurred across all three major service types (see Table 3): diagnostic (e.g., examinations and radiographs), preventive (e.g., cleanings, topical fluorides, and sealants), and treatment (e.g., fillings, root canals, extractions, and orthodontics).

Table 3  
Utilization Rates of Continuously Enrolled HUSKY A Children  
Before and After the Fee Increase by Service Type

Year	Number of Enrollees	Percent With Any Visit	Percent With Diagnostic Visit	Percent With Preventive Visit	Percent With Treatment Visit
2006*	160,070	46.0	42.1	39.2	20.2
2009	163,697	65.1	59.8	58.8	29.1
2010	203,158	69.1	64.7	63.7	31.5
2011	219,215	69.5	65.4	64.5	31.5

\*Prior to reimbursement rate increase

The utilization of treatment services is substantially lower than diagnostic and preventive services because not all children have caries or tooth decay. Even among those with caries, some may have previously received all required treatment. Data from national surveys show that approximately 30 percent of children at or below 100 percent of the federal poverty level (\$23,050 for a family of four) need dental caries treatment.<sup>iii</sup>

This suggests that among continuously enrolled children a large percentage of those needing treatment are receiving it.

Utilization rates among continuously enrolled children increased in 167 of Connecticut's 169 cities and towns. A total of 158 towns experienced double-digit increases between 2006 and 2011 (see Figure 1).

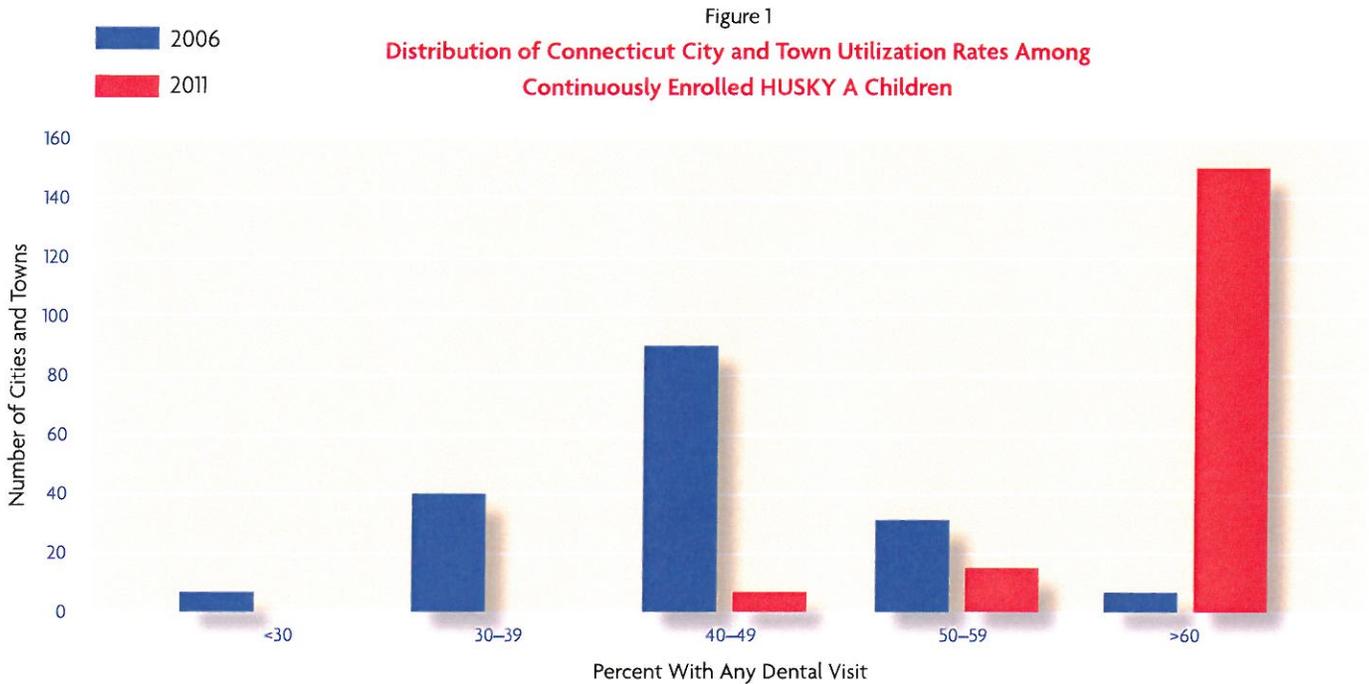


Table 4  
**Utilization Rates for Continuously Enrolled HUSKY A Children in 10 Connecticut Cities With Highest Concentration of HUSKY A Children**

*The ten cities with the highest concentration of HUSKY A children have the greatest need for dental services. In 2011, the utilization rates for continuously enrolled children averaged 70 percent across these cities, a rate higher than that of privately insured children (see Table 4).*

City	Percent With Any Dental Visit	
	2006*	2011
Hartford	54	75
New Britain	52	75
East Hartford	51	73
New London	50	73
Bridgeport	45	69
New Haven	44	69
Meriden	42	69
Waterbury	43	68
Windham	44	67
Norwich	50	66

\*Prior to reimbursement rate increase

## PRIVATE PROVIDER PARTICIPATION

Private dentist participation in the Medicaid program more than doubled between 2006 and 2010. A total of 416 private dentists submitted at least one Medicaid claim in 2006 versus 937 in 2010.<sup>iv</sup> The latter number represents approximately 38 percent of all (private and clinic) active practitioners (2,474) in Connecticut and about 50 percent of all active general and pediatric practitioners.

## PRIVATE PRACTICES AND SAFETY NET CLINICS

In addition to contributions made by private dentists, the dental safety net is an important source of care for children on HUSKY A. The dental safety net, which includes public and nonprofit clinics providing care to low-income patients, is located in hospitals, dental schools, Federally Qualified Health Centers (FQHCs) and other community health centers.

In 2006, private practices accounted for about 60 percent of Medicaid dental patients, visits, services, and expenditures. After the reimbursement rate increase, private dentists accounted for over 70 percent of patients and visits (see Table 5).

As expected, private sector providers accounted for most of the increases. The strong response of private dentists is most likely the result of increased Medicaid reimbursement rates. The contributions of Medicaid program administrative improvements, strong recruitment by the CSDA, and the economic recession also have contributed to the increase in private dentist participation.

The expansion in the number of safety net system patients and visits is mainly the result of increased capacity (e.g., new clinics, additional dentists and hygienists, and enhanced productivity). Increased rates did not positively affect a safety net system dominated by FQHCs that receive cost-based and annually adjusted reimbursement. These clinics typically operate at full capacity and continue to face excess demand.

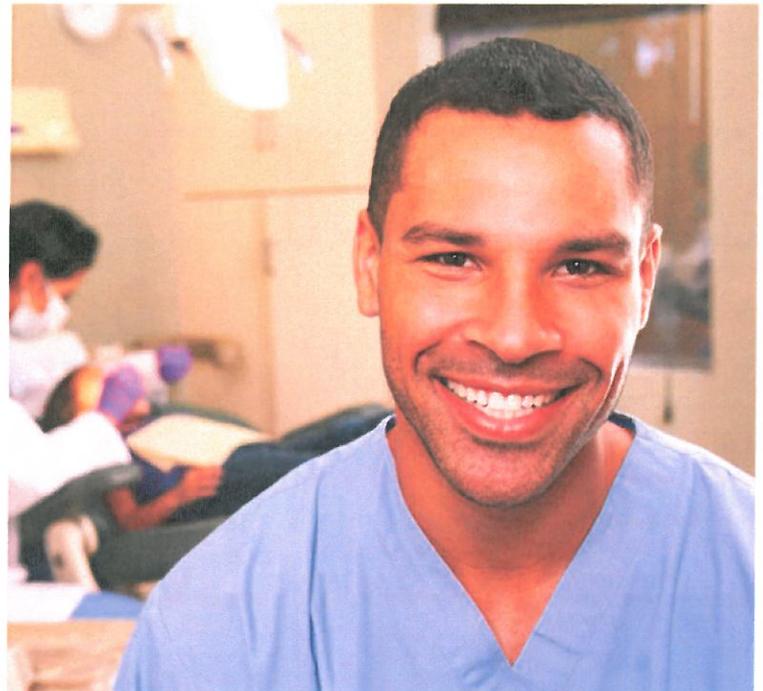


Table 5  
**Contribution of Private Practices and Dental Safety Net Dental Clinics  
 to Increase in Patients and Visits**

	Private Practices			Safety Net Clinics		
	2006*	2011	Percent Change	2006*	2011	Percent Change
Patients	58,645	142,592	143	41,959	59,593	42
Visits	124,617	385,827	210	83,510	131,012	57

\*Prior to reimbursement rate increase



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### IMPLICATIONS & RECOMMENDATIONS

The key provisions of the lawsuit settlement – increased reimbursement rates, improved program administration, and targeted provider recruitment – encouraged greater private dentist participation in the Medicaid program and reduced dental service access disparities. Children continuously enrolled under HUSKY A now have utilization rates – 65 percent to 70 percent – commonly seen in children enrolled in private dental insurance plans.

Three other states (Indiana, Michigan, and Tennessee) also have raised Medicaid reimbursement rates to a similar level. All reported a significant increase in utilization rates.<sup>v</sup> However, the increase in dentist participation and patient utilization in Connecticut exceeds that of these states, suggesting that program administration changes and strong state dental association recruitment efforts may have contributed to Connecticut's better results.

To maintain these utilization rates and ensure that low-income children continue to have access to oral health services, action is required:

- HUSKY A reimbursement rates must be increased periodically to offset the increasing cost of providing dental services. If HUSKY A reimbursement rates do not mirror those of private insurance, private providers may stop participating in the Medicaid program.
- Focus must be kept on removing administrative barriers to ensure that private providers continue to participate in HUSKY A.

### REFERENCES

<sup>i</sup> C. Dingeldey, email correspondence, Nov. 6, 2012.

<sup>ii</sup> Eklund, S. Pittman, J. and Clark, S. Michigan Medicaid's Healthy Kids Dental program: An assessment of the first 12 months. *J Am Dent Assoc* 134(11): 1509-15, 2003.

<sup>iii</sup> <http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/> Dec. 27, 2012.

<sup>iv</sup> The number of active general, pediatric and other dental practitioners in Connecticut was not available for the year 2011.

<sup>v</sup> Borchgrevink, A. Snyder, A. and Gehshan, S. The effects of Medicaid reimbursement rates on access to dental care. National Academy for State Health Policy, 2008.

### ABOUT THE AUTHORS

**Tryfon Beazoglou, PhD,**  
University of Connecticut School  
of Dental Medicine

**Veronica Myne-Joslin, BA,**  
University of Connecticut School  
of Dental Medicine

**Joanna Douglass, BDS, DDS,**  
University of Connecticut School  
of Dental Medicine

**Howard Bailit, DMD, PhD,**  
University of Connecticut School  
of Dental Medicine

**Credits:**  
Editor-in-Chief: Patricia Baker  
Project Consultant: Monette  
Goodrich  
Design: E.K. Weymouth Design  
Printer: Hitchcock Printing  
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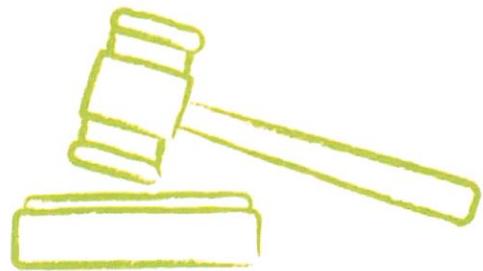
# SOMETHING TO SMILE ABOUT

SUCCESSFULLY REDUCING DENTAL ACCESS DISPARITIES\*

## MEDICAID CHILDREN FOUND TO BE UNDERSERVED



**In 1999, 71%**  
of children enrolled in  
HUSKY A, a Medicaid program,  
**received no  
dental visit.**



**In 2000, a lawsuit**  
determined the primary factors to be  
**low reimbursement  
levels & cumbersome  
program administration.**

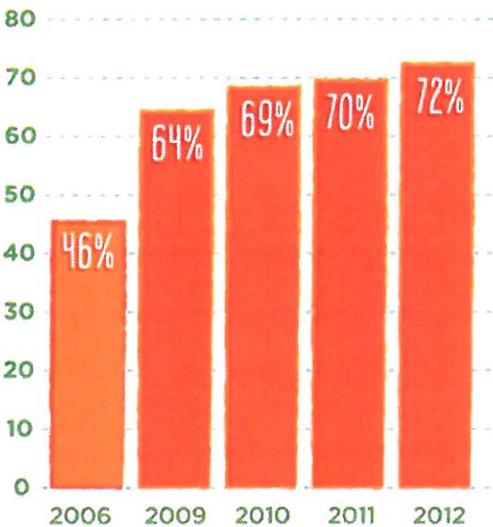
# REIMBURSEMENT RATES IMPROVED AFTER THE LAWSUIT SETTLEMENT



As part of the agreement in 2008, reimbursement rates increased to about the 70th percentile of 2005 market fees. The administration of Medicaid dental was also simplified.

## IMPACTS OF THE CHANGES

Utilization rates of continuously-enrolled Medicaid children under 21 years of age

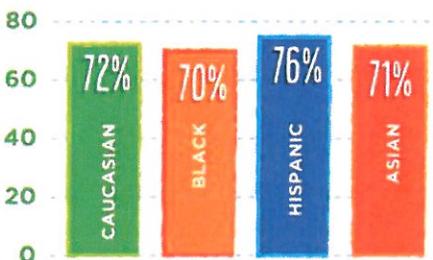


The 2012 utilization rate for Medicaid children is higher than the national average for privately insured children, which is 65%.\* In Connecticut, the percentage of privately insured children under the age of 21 who had a dental visit is 68%.

2012 utilization rates by gender



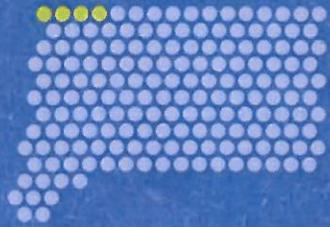
2012 utilization rates by race/ethnicity



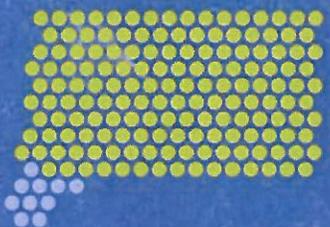
More children utilize dental services every year, regardless of age, gender, & race/ethnicity.



# FINDINGS:

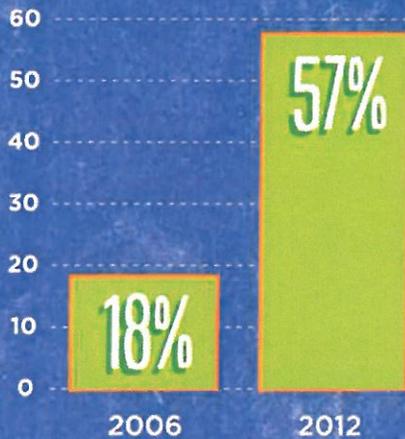


In 2006, only four Connecticut townships had a utilization rate of more than 60%.



By 2012, 156 of 169 of townships had dental utilization rates of 60% or greater.

UTILIZATION RATE FOR TWO-YEAR-OLDS



DENTIST PARTICIPATION



## WHAT CAN WE TAKE AWAY FROM THIS?

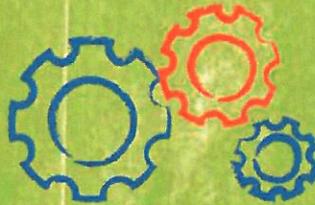


Children's access to dental care is linked to robust private provider participation in the Medicaid program and a strong dental safety net system.

# HOW CAN WE MAKE SURE LOW-INCOME CHILDREN CONTINUE TO RECEIVE EQUITABLE CARE?



Medicaid reimbursement rates should be adjusted periodically to mirror private insurance rates.



The administrative structure and processes of the Medicaid dental program must remain streamlined and easy for families to use.



Monitor utilization to inform policy recommendations around adjusting reimbursement rates or program administration.



Visit <http://www.cthealth.org/publication/impact-increased-dental-reimbursement-rates-husky-a-insured-children-2006-2011/> to read a related policy brief that was published in 2013.

These findings are from an analysis of 2012 Medicaid utilization data commissioned by the Connecticut Health Foundation and conducted by Tryfon Beazoglou, PhD, Independent Consultant, and Joanna Douglass, BDS, DDS, Howard Bailit, DMD, PhD, and Veronica Myne-Joslin, BA, of the University of Connecticut School of Dental Medicine, as part of regular monitoring of the impact of the children's dental reimbursement rate increase.

\*This figure comes from "Nasseh K, Aravamudhan K, Vujicic M, Grau B. American Dental Association.

\*This graphic is sharing monitoring and evaluation commissioned by The Connecticut Health Foundation.