



## Appendix:

### **Research Methodology for COHI's report: [A Medicaid Gap Analysis of Oral Health Care for Adults in Connecticut \(August 2022\)](#)**

COHI's report "A Medicaid Gap Analysis of Oral Health Care for Adults in Connecticut (August 2022)" is based on analysis of data from three sources which are combined to offer recommendations. These three sources of data address different questions discussed in the report.

1. Data from the State of Connecticut on Medicaid/HUSKY and dental provider claims to examine changes in claims as a result of the introduction of a \$1000 annual cap on reimbursements in 2018, and other delays in reimbursement that could affect quality of care.
2. Data from COHI's 2021-2022 in-depth interviews and focused group conversations with adults enrolled in Medicaid/HUSKY and dental providers on their experiences and challenges in utilizing Medicaid/HUSKY to obtain or provide access to oral health treatments.
3. Geolocation data on dental offices and Medicaid/HUSKY recipients in Connecticut to examine locational barrier to treatment

This appendix summarizes the approaches utilized in analyzing these data.

#### **1. Data from the State of Connecticut on Medicaid/HUSKY and dental provider claims.**

Dental provider claims records were provided by the Connecticut Department of Social Services to provide the basis for examining the question of whether the maximum benefit ceiling of \$1,000 had an impact on claims and services. The data covered the period from 2016 to 2020 and included the number of Medicaid/HUSKY enrollees each year, number of claims each year, number of claims requiring prior approval, average turnaround time for referrals, number and type of denials, reasons for denials, and number of claims in dollar categories from 0 (no claims) to over \$1000. To understand the implications of the gap, we first graphed the number of pre-approved claims in



relation to HUSKY enrollment for adults and children by number and percentage (Chart 1). We then used counts of procedures denied to adults over the five year period to determine whether patterns of claims denial changed from 2018 on. Next we extracted the 80 most frequent denials and graphed them for 2020 to identify the most common reasons for rejecting a claim (Chart 3). Next we grouped claim costs into four groupings across the five years of the study: 0 claims, \$1 to \$499; \$500 - \$999, and \$1000 and above (chart 4). Finally we considered the number of clients whose claims were over \$1000 over the five year period, to identify any pattern of change during the post cap period 2018-2020.

## **2. Data from COHI's 2021-2022 interview and focused group conversations of experiences utilizing Medicaid for oral health access**

From November 2021 to May 2022, COHI conducted individual interviews and focused group conversations to collect information about the experiences of adults currently or recently enrolled in Medicaid within the State of Connecticut. The study team included the COHI Community Engagement Specialist and community researcher, a Dental Hygienist interning with COHI as part of her UCONN Public Health Master's Degree program, an experienced community based research/oral health methodologist and anthropologist, and a visiting public health dentist and researcher from Sri Lanka.

20 in-depth interviews were conducted with individuals enrolled or recently in Medicaid/HUSKY and 7 focused group conversations were conducted with a total of over 50 participants. Both in-depth and focused group interviews were widely distributed across the state, and included participants diverse in age, race/ethnicity, gender and experience with dental treatment systems. Three expert interviews with providers were also conducted about their experiences with Medicaid/HUSKY reimbursement and treatment options.

Participants in the one-on-one interviews were aged 21-64 and were all current or recent enrollees of Medicaid/HUSKY. Of the twenty individuals, seventeen identified as female and three as male. Sixteen people identified as a person of color: Black, Latinx, Hispanic/Latinx, multi-racial, or Pacific Islander. Four individuals identified as White. Seven out of twenty disclosed they had a disability. The individuals were located throughout the state with a concentration in New Haven, Hartford, Litchfield, and Fairfield Counties and represented both rural and urban/periurban areas. Towns included Bloomfield, Hartford, New Haven, Enfield, Ansonia, Meriden, Stratford, West Hartford, Derby, East Haven, Torrington, Brookfield, East Haddam and Vernon.



Seven group conversations were held, each with a minimum of 2 participants, a maximum of 25, almost all current or recent enrollees in the Medicaid/HUSKY program. The participants represented a diverse group of individuals. The groups included members of community advocacy groups, low-income workers in labor unions, and individuals seeking safety net services at locations including but not limited to community health centers and clinics, food pantries, homeless shelters, and kitchens. The participants were located throughout the state with a focus on Hartford, New Haven, Middlesex, New London, and Fairfield Counties.

All participant and focus group interviews followed a general interview guide prepared in advance in collaboration with an oral health mixed methods community research expert from the Institute for Community Research, that included open-ended questions on service utilization, affordability, satisfaction, quality, communications and access issues. Individual and group interviews were conducted virtually or in-person by COHI staff, usually with one or more of the study team in attendance. All interviewees were asked for their permission to conduct the interview and to record it. On completion, they received a 10-20-dollar gift card, oral health kit, and information to help navigate Medicaid/HUSKY dental services. Interviews were transcribed using a digital online transcription AI program, reviewed and uploaded into Dedoose, an online confidential software package for joint sharing and analysis of qualitative data. Data were coded utilizing a coding scheme derived from the study's prior understandings of issues surrounding the barriers to care, themes and subthemes that arose through the interviews with providers and HUSKY enrollees. The coding scheme evolved with the coding process. Data were coded by the COHI interviewer and coded quotations were reviewed and checked for accuracy and consistency by study team members. Coded text for main domains and secondary themes were extracted, examined for intra-group patterns and variations and results summarized and triangulated with other sources of data as appropriate.

The study has several limitations. First, in considering service access, gaps and limitations, it is important to note that this study took place during the COVID-19 pandemic, at a time when dental services were severely affected by COVID-19, limiting access to quality care. The qualitative, GIS and quantitative data all reflect gaps in service that are impacted by COVID-19. Only the Connecticut Department of Social Services data provide a snapshot of claims over time that provides some insight into whether or not the number and type of claims changed over time, and post the introduction of the \$1000 cap. A second limitation is that while the in-depth and focused group conversations are broadly demographically representative, they may have attracted people more likely to have had negative experiences with Medicaid/HUSKY. A



larger survey with a more representative sample of Medicaid/HUSKY enrollees is needed to fully understand the scope of the gaps represented in the qualitative data.

**3. Geolocation data on dental offices and Medicaid/HUSKY recipients in Connecticut.**

Methodology for this analysis data is included in the full report entitled Socio-Spatial Analysis Of Medicaid Private Providers Across The State, by Quinn Molloy, which is available at : <https://www.ctoralhealth.org/socio-spatial-analysis>.