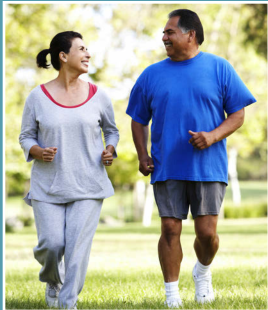
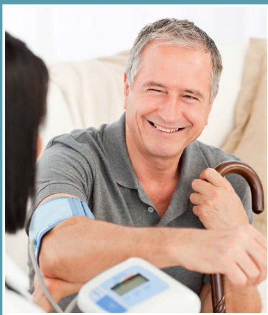

Dental and Oral Health Services in Medicaid and CHIP

February 2016

Centers for Medicare & Medicaid Services

Medicaid/CHIP

Health Care Quality Measures

ABOUT THIS SERIES OF REPORTS

This report is part of a series of domain-specific reports about the quality of health care delivered to children and adults enrolled in Medicaid and the Children's Health Insurance Program (CHIP). The five domain-specific reports include: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, (4) behavioral health care, and (5) dental and oral health services.

The Secretary of the Department of Health and Human Services (HHS) is required to measure and report annually on the quality of health care delivered to children and adults in Medicaid and CHIP. To standardize the measurement of health care quality for these children and adults, the Secretary of HHS established a set of health care quality measures (referred to as the Child Core Set and the Adult Core Set, respectively). The Centers for Medicare & Medicaid Services (CMS), the HHS agency responsible for promoting quality health care for children and adults enrolled in Medicaid and CHIP, works collaboratively with states to strengthen systems for voluntarily collecting and reporting the Child and Adult Core Set measures, and using the measures to drive quality improvement.

Another vehicle for driving quality improvement is the annual External Quality Review (EQR) of care furnished to children and adults in managed care. States that contract with managed care organizations are required to submit an EQR technical report on the strategies used to improve the quality of care for children and adults in Medicaid and CHIP.

The 2015 Secretary's Reports on the quality of care for children and adults present information on the status of quality measurement and reporting efforts using the 2014 Child and Adult Core Sets and summarize information on managed care quality reported in the EQR technical reports. This report on dental and oral health services in Medicaid and CHIP supplements information presented in the 2015 Secretary's Reports. For additional information, please refer to the 2015 Secretary's Reports at the following links:

- 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-sec-rept.pdf.
- 2015 Annual Report on the Quality of Care for Adults in Medicaid: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-sec-rept.pdf.
- 2015 Domain-Specific Reports: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

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Introduction

Together, Medicaid and the Children's Health Insurance Program (CHIP) served more than 43 million children in federal fiscal year (FFY) 2014, representing more than 1 in 3 children in the United States.[1,2] All children enrolled in Medicaid and CHIP have coverage for dental and oral health services. Children's oral health is important to their overall health, both in childhood, and later in adulthood. Improving children's access to oral health care in Medicaid and CHIP continues to be a focus of federal and state efforts.

This report provides state-specific findings on children's use of dental services in Medicaid. It includes state-specific performance data for two Child Core Set measures: (1) Preventive Dental Services (PDENT-CH) and (2) Dental Treatment Services (TDENT-CH).[3] For a measure to be publicly reported, data must be provided to CMS by at least 25 states and meet internal standards for quality. This report also summarizes information on managed care quality monitoring and improvement efforts related to oral health care that were reported in states' External Quality Review (EQR) technical reports.

Efforts to Improve Children's Access to Oral Health Care in Medicaid

Over the past several years, the Centers for Medicare & Medicaid Services (CMS) has worked with federal and state partners, the dental and medical provider communities, and other stakeholders to continue to improve children's access to dental care. Launched in April 2010, CMS's Oral Health Initiative has two goals: (1) increase by 10 percentage points the proportion of Medicaid and CHIP children ages 1 to 20 who receive a preventive dental service; and (2) increase by 10 percentage points the proportion of Medicaid and CHIP children ages 6 to 9 who receive a sealant on a permanent molar. In April 2013, CMS set state-specific baselines, based on data reported by states on the federal fiscal year (FFY) 2011 Form CMS-416, along with FFY 2015 goals for children's use of preventive dental services.[4]

States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid. The percentage of children receiving any dental care (including preventive and treatment) increased by nearly 20 percentage points, from 29 percent in FFY 2000 to 48 percent in FFY 2012.[5] Children's use of preventive care increased at a similar pace, from 23 percent in FFY 2000 to 42 percent in FFY 2012.

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[1] http://medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf.

[2] http://kff.org/other/state-indicator/children-0-18/.

[3] More information about CMS's Child Core Set is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html. The Dental Treatment Services (TDENT) measure will be retired after this year and will not be a part of the Child Core Set for FFY 2015 reporting.

[4] See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/OHIBaselineGoals.pdf.

[5] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/dental-trends-2000-to-2012.pdf.

Between FFY 2007 and FFY 2011, almost half of all states achieved at least a 10 percentage-point increase in the proportion of enrolled children who received a preventive dental service during the reporting year.[6] Between FFY 2011 and FFY 2012, 15 states achieved at least an additional 2 percentage-point improvement.[7] But despite considerable progress in improving the use of oral health services in recent years, tooth decay remains one of the most common chronic diseases among children. As such, children's oral health continues to be a primary focus of improvement efforts in both Medicaid and CHIP.

As part of the Children's Oral Health Initiative, CMS invited Medicaid agencies to develop State Oral Health Action Plans (SOHAPs) as a roadmap to achieving these goals.[8] CMS offers technical assistance to states to develop and implement their SOHAPs. To date, 26 states have submitted SOHAPs to support their efforts to achieve the goals of the Oral Health Initiative.

CMS also supports state planning through other efforts including:

- CMS hosts a series of webinars entitled The CMS Learning Lab: Improving Oral Health Through Access.[9]
- CMS provides oral health education materials available for order at no cost.[10]
- CMS produced three issue briefs for state policymakers and program managers on reducing early childhood tooth decay, including an overview, leading steps, and strategies.[11]
- In September 2013, CMS released a strategy guide, *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents*, which describes effective approaches for state Medicaid programs.[12]

State-Specific Findings on Children's Use of Dental Services

State performance related to children's use of dental services is evaluated through two measures in the Child Core Set.[13] The measures are as follows:

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[6] See http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-04-18-13.pdf.

[7] See http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-10-2014.pdf.

[8] Information on the Children's Oral Health Initiative, including a link to state Oral Health Action Plans, is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/dental-care.html.

[9] Information on the CMS Learning Lab is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html.

[10] These materials are available at http://www.insurekidsnow.gov/professionals/dental/index.html.

[11] The three issue briefs are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/dental-care.html.

[12] The strategy guide is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf.

[13] To streamline reporting and reduce burden on states, in FFY 2012, CMS began calculating the two Child Core Set dental measures on behalf of states using data from Form CMS-416. The measures are calculated using data from lines 1b, 12b, and 12c of the Form CMS-416.

- Preventive Dental Services (PDENT-CH)
- Dental Treatment Services (TDENT-CH)

This section presents an overview of state performance on these measures based on state reporting for FFY 2014. Appendix A presents snapshots of state-specific performance on the two measures. See Appendix B for state-specific data on the measures.

Children's access to dental services in FFY 2014 was similar to patterns observed in previous years. Among children ages 1 to 20 enrolled in Medicaid and CHIP Medicaid Expansion programs (those eligible for Early and Periodic Screening, Diagnostic, and Treatment [EPSDT]), a median of 48 percent received a preventive dental service (such as cleanings, application of topical fluoride, or dental sealants) in FFY 2014. A median of 22 percent of children received a dental treatment service (such as dental fillings) in FFY 2014. The 75th percentile is an indicator of the performance of higher-performing states. For preventive dental services, the top quartile achieved a rate of 50.6 percent or higher in FFY 2014, and for dental treatment services, the top quartile was 25.2 percent or higher.

The rate for use of preventive dental services increased slightly from 45.5 percent in FFY 2012 to 47.6 percent in FFY 2014 (51 states reporting in both years). The rate for use of dental treatment services did not change substantially from the rate reported in FFY 2012 (22.8 percent in FFY 2012 versus 22.3 percent in FFY 2014).

These results highlight the need for continued federal and state efforts to reach the Oral Health Initiative goals of expanding access to and use of dental services in Medicaid/CHIP, and in particular, achieving a 10 percentage-point increase in the use of preventive dental services.

Monitoring and Improving Managed Care Quality

In FFY 2014, about 70 percent of children enrolled in Medicaid and CHIP obtained their care through managed care plans.[14] Regardless of the enrollment rate, states using a managed care delivery system must comply with certain federal requirements, including standards to assess and monitor the quality of care provided by contracted managed care plans. This section summarizes state activities related to monitoring and improving dental care for children in managed care.[15]

Of the 41 states[16] that contracted with managed care organizations (MCOs) or prepaid inpatient health plans (PIHPs) during the 2014–2015 reporting cycle, 38 states submitted EQR technical

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[14] CMS analysis of FFY 2014 Statistical Enrollment Data System (SEDS) data.

[15] Federal regulations require an annual external quality review (EQR) of MCOs and PIHPs. Some dental health managed care plans are structured as prepaid ambulatory health plans (PAHPs), which are not currently subject to these regulations. Information about the EQR process is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[16] For purposes of EQR technical reports, the term "states" includes the 50 states, the District of Columbia, and the territories.

reports to CMS.[17] These states contracted with 15 different External Quality Review Organizations (EQROs) to conduct the annual EQR, and five EQROs conducted reviews for multiple states during the 2014–2015 reporting cycle.[18]

CMS conducted detailed abstractions of EQR technical reporting on performance measures and performance improvement projects (PIPs) related to oral health care. Among the 38 states submitting EQR technical reports for the 2014–2015 reporting cycle, 13 included performance measures related to oral health care. Eight states reported a combined total of 32 PIPs aimed at improving oral health care. Two of the eight states, Georgia and Missouri, mandated this topic (these states also mandated PIPs on this topic for the 2011–2012, 2012–2013, and 2013–2014 reporting cycles).

Analysis of the PIPs indicates that states are using a diverse set of interventions to improve the quality of oral health care (see Appendix C).[19] This report highlights an example of a state improvement project related to improving oral health care. Criteria for selecting states to highlight in the domain-specific reports included whether the EQR technical report contained some information on interventions and outcomes, and an interest in ensuring geographic diversity of the states profiled.

Missouri required its three MCOs to implement an improvement project aimed at increasing the number of children ages 2 to 20 who had an annual dental visit. (Each of the three MCOs subcontracts with the same dental contractor to provide dental services to children enrolled in their MCO.) The state set annual performance improvement targets for the MCOs to increase the state's aggregate annual dental visit rate by 3 percentage points each year and by 10 percentage points by the end of 2016. One MCO took a leadership role in the development and implementation of the statewide PIP. The MCO conducted a variety of activities to improve performance, including establishing a PIP team to work with the dental subcontractor to ensure that all interventions and improvement strategies were implemented. The MCO also conducted targeted outreach to members, including contacting parents whose children have not seen a dental provider and referring members who sought emergency oral health care to community oral health providers. The MCO has taken several steps to expand access to oral health care, including contracting with a mobile dental provider to provide care in the community;

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[17] Of the 41 states that contracted with MCOs or PIHPs, three (Indiana, Puerto Rico, and Texas) did not submit an EQR technical report before April 30, 2015 for inclusion in this analysis, and one (Delaware) submitted readiness reviews only. North Dakota's managed care program was limited to the Children's Health Insurance Program (CHIP) population during the 2014–2015 reporting cycle. Alabama, Alaska, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, Oklahoma, South Dakota, the Virgin Islands, and Wyoming do not have MCOs or PIHPs that enroll children covered by Medicaid or CHIP. While Vermont is required to conduct an EQR under the terms of its Section 1115 demonstration, its managed care entity is neither an MCO nor a PIHP and therefore is excluded from this analysis.

[18] For a list of EQROs with current state Medicaid contracts in 2015, see EQR Table CH-1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2014-2015.zip.

[19] Information on "Findings from EQR Technical Reports, 2014–2015," including the detailed PIP abstractions related to oral health care, is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2014-2015.zip.

contracting with dentists who rotate through rural areas; coordinating with schools to provide care; and working with dentists to provide after-hours and weekend appointments. The MCO increased the percentage of children with a dental visit in the past year from 35 percent in 2009 (the year the PIP was implemented) to 51 percent in 2013.

The two other participating MCOs in Missouri conducted member, community, and provider outreach activities, and they both contracted with dental vans to improve access to care. Both MCOs demonstrated improvement on the rate of annual dental visits, and one met the statewide annual goal of a 3 percentage-point improvement in 2013. The EQRO noted that although the two MCOs did not meet the requirements of the PIP validation process, the interventions and barrier analyses conducted by one of the MCOs indicated a commitment to the statewide PIP project goals. The EQRO plans to provide feedback to the other MCO in order to improve the quality of reporting.

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APPENDIX A

SNAPSHOTS OF STATE-SPECIFIC PERFORMANCE

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PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)

Measure Steward: Centers for Medicare & Medicaid Services (CMS)

Tooth decay, or dental caries, is one of the most common chronic diseases of children. It is a growing problem: among children ages 2 to 5, the prevalence of early childhood caries increased 15 percent between 1988–1994 and 1999–2004.[1] Untreated tooth decay affects 19.5 percent of 2-to-5 year olds and 22.9 percent of 6-to-9 year olds.[2] The disease is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services.

Measure Description

- The percentage of children ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible for the Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] benefit), enrolled for at least 90 continuous days, that received preventive dental services during the reporting period.[3]
- The EPSDT benefit provides comprehensive and preventive health care services, including dental services, for children under age 21 who are enrolled in Medicaid.[4]

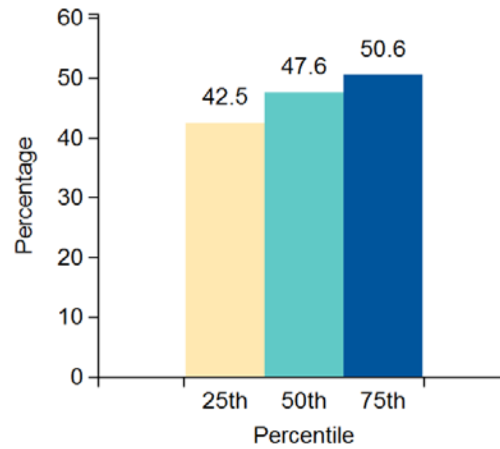
Overview of State Reporting

- The number of states reporting the measure remained constant with 51 states reporting for FFY 2012, FFY 2013 and FFY 2014.[5]
- To reduce state reporting burden and have a single information source, in FFY 2012, CMS formally began calculating this measure on behalf of states based on data submitted as part of the Form CMS-416.

State Performance

- Among the 51 states reporting the measure for FFY 2014, the median rate was 48 percent, with an 8-point spread between the 25th and 75th percentiles (Exhibit PDENT-CH.1).
- Performance on this measure ranged from 25 to 62 percent among states, with considerable geographic variation across states (Exhibit PDENT-CH.3, next page).

Exhibit PDENT-CH.1. Preventive Dental Services, FFY 2014 (n = 51 states)



Source: Mathematica analysis of FFY 2014 Form CMS-416 reports as of September 29, 2015.

Trends

- Among the 51 states reporting data for this measure for all three years, the median rate increased by more than 2 percentage points, from 45.5 percent for FFY 2012 to 47.6 percent for FFY 2014 (Exhibit PDENT-CH.2, next page).
- The 25th percentile for states showed a gain of over 4 percentage points from FFY 2012 to FFY 2014, while the 75th percentile remained about the same.

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[1] http://www.cdc.gov/nchs/data/series/sr_11/sr11_248.pdf.

[2] http://www.cdc.gov/features/dsuntreatedcavitieskids/.

[3] This measure is calculated using the administrative method (claims/encounter data).

[4] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

[5] The term "states" includes the 50 states and the District of Columbia.

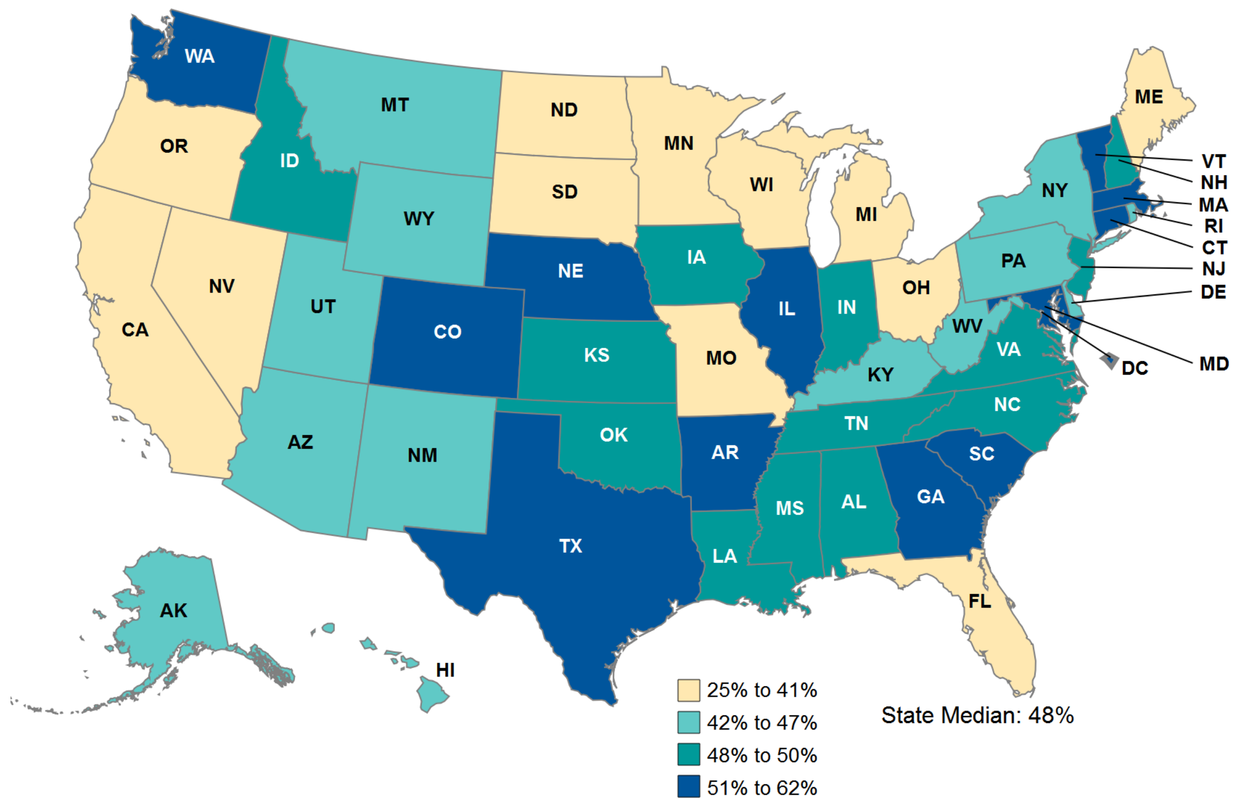
Exhibit PDENT-CH.2. Trends in the Use of Preventive Dental Services, FFY 2012–2014 (n = 51 states)

Rate	FFY 2012	FFY 2013	FFY 2014
Mean	44.1	45.4	45.6
Median	45.5	47.0	47.6
25th Percentile	38.4	40.8	42.5
75th Percentile	50.5	51.4	50.6

Source: Mathematica analysis of FFY 2012, 2013, and 2014 Form CMS-416 reports as of September 29, 2015.

Note: This table includes 51 states that reported the measure using Form CMS-416 for all three years.

Exhibit PDENT-CH.3. Geographic Variation in the Use of Preventive Dental Services, FFY 2014 (n = 51 states)



Source: Mathematica analysis of FFY 2014 Form CMS-416 reports as of September 29, 2015.

Notes: When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used.

To view state-specific data for this measure, please see Table PDENT-CH at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/performance-on-the-child-core-set-measures-ffy-2014.zip.

PERCENTAGE OF ELIGIBLES WHO RECEIVED DENTAL TREATMENT SERVICES (TDENT-CH)

Measure Steward: Centers for Medicare & Medicaid Services (CMS)

Tooth decay, or dental caries (cavities), is one of the most common chronic diseases of children. If left untreated, tooth decay can negatively affect a child's physical and social development and school performance. The prevalence of untreated tooth decay among children ages 2 to 5 increased 7 percent between 1988–1994 and 1999–2004.[1] Over 19 percent of children ages 2–19 had untreated tooth decay in 2001–2004.[2] Children in families with incomes below 100 percent of the federal poverty level (FPL) had higher rates of untreated tooth decay than children from higher income families.

Measure Description

- The percentage of children ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible for the Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] benefit), enrolled for at least 90 continuous days, that received at least one dental treatment service during the reporting period.[3]
- The EPSDT benefit provides comprehensive and preventive health care services, including dental services, for children under age 21 who are enrolled in Medicaid.[4]

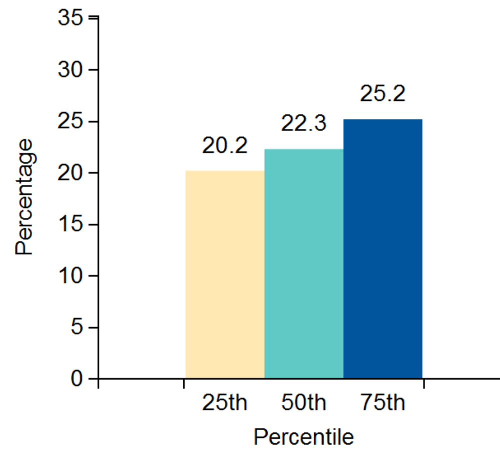
Overview of State Reporting

- The number of states reporting the measure remained constant with 51 states reporting for FFY 2012, FFY 2013 and FFY 2014.[5]
- To reduce state reporting burden and have a single information source, in FFY 2012, CMS formally began calculating this measure on behalf of states based on data submitted as part of the Form CMS-416.

State Performance

- Among the 51 states reporting the measure for FFY 2014, the median rate was 22 percent, with a 5-point spread between the 25th and 75th percentiles (Exhibit TDENT-CH.1).
- Performance on this measure ranged from 11 to 52 percent among states, with considerable geographic variation across states (Exhibit TDENT-CH.3, next page).

Exhibit TDENT-CH.1. Dental Treatment Services, FFY 2014 (n = 51 states)



Source: Mathematica analysis of FFY 2014 Form CMS-416 reports as of September 29, 2015.

Trends

- Among the 51 states reporting data for this measure on the Form CMS-416 for all three years, the median rate decreased slightly, from 22.8 percent in FFY 2012 to 20.2 percent in FFY 2014 (Exhibit TDENT-CH.2, next page).

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[1] http://www.cdc.gov/nchs/data/series/sr_11/sr11_248.pdf.

[2] http://www.cdc.gov/features/dsuntreatedcavitieskids/.

[3] This measure is calculated using the administrative method (claims/encounter data).

[4] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

[5] The term "states" includes the 50 states and the District of Columbia.

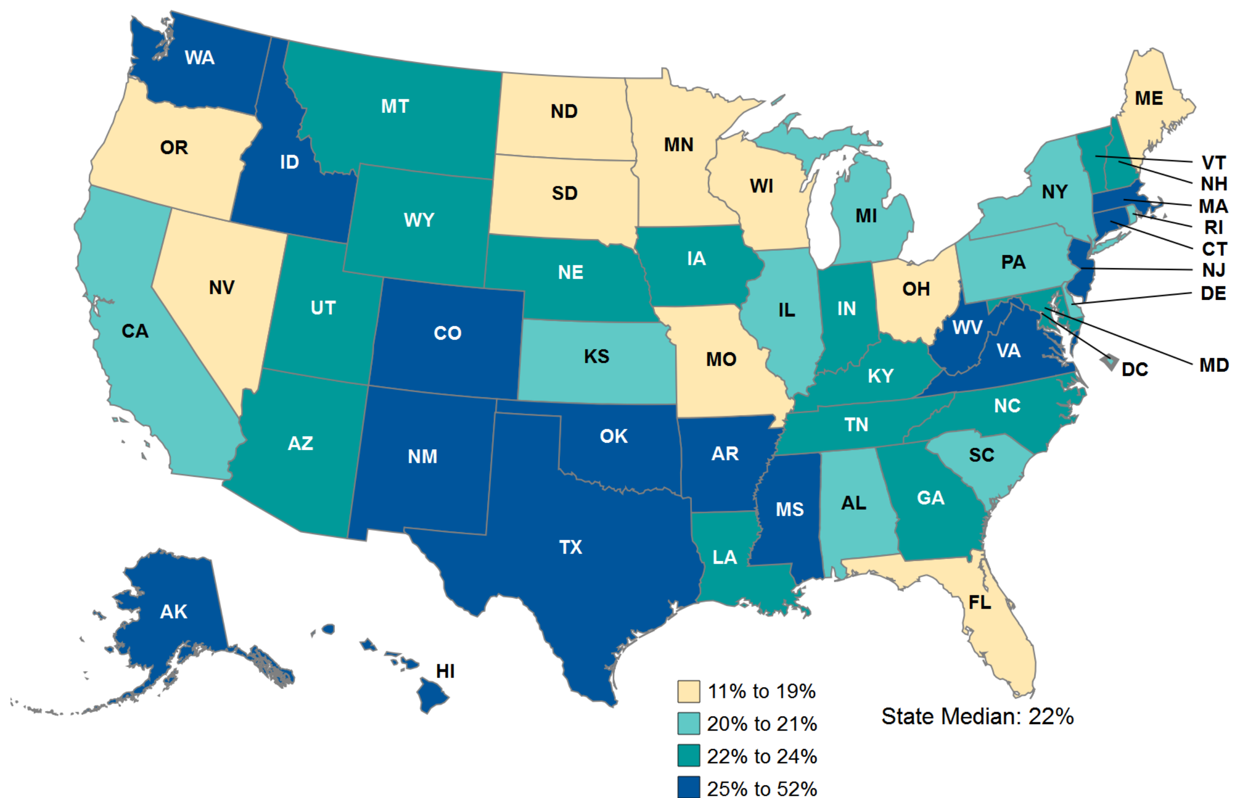
Exhibit TDENT-CH.2. Trends in the Use of Dental Treatment Services, FFY 2012–2014 (n = 51 states)

Rate	FFY 2012	FFY 2013	FFY 2014
Mean	23.7	24.1	23.5
Median	22.8	22.7	22.3
25th Percentile	19.6	19.6	20.2
75th Percentile	26.0	26.9	25.2

Source: Mathematica analysis of FFY 2012, 2013, and 2014 Form CMS-416 reports as of September 29, 2015.

Note: This table includes 51 states that reported the measure using Form CMS-416 for all three years.

Exhibit TDENT-CH.3. Geographic Variation in the Use of Dental Treatment Services, FFY 2014 (n = 51 states)



Source: Mathematica analysis of FFY 2014 Form CMS-416 reports as of September 29, 2015.

Notes: When a state reported separate rates for its Medicaid and CHIP populations, the rate for the larger measure-eligible population was used.

To view state-specific data for this measure, please see Table TDENT-CH at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/performance-on-the-child-core-set-measures-ffy-2014.zip.

APPENDIX B

MEASURE-SPECIFIC TABLES OF STATE PERFORMANCE

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Table PDENT-CH. Percentage of Eligibles Who Received Preventive Dental Services, as Submitted by States for the FFY 2014 Form CMS-416 Report (n = 51 states)

State	Denominator	Rate
State Mean		45.6
State Median		47.6
Alabama	597,603	49.6
Alaska	85,245	45.6
Arizona	727,378	45.7
Arkansas	383,297	51.1
California	5,304,181	37.8
Colorado	525,019	50.9
Connecticut	331,838	59.6
Delaware	106,995	47.3
Dist. of Col.	90,323	53.0
Florida	2,128,391	27.1
Georgia	1,150,273	50.7
Hawaii	148,837	44.5
Idaho	185,523	49.9
Illinois	1,547,301	51.5
Indiana	714,901	47.6
Iowa	294,737	48.6
Kansas	245,554	48.5
Kentucky	512,983	42.8
Louisiana	756,903	47.8
Maine	132,301	39.6
Maryland	636,122	53.0
Massachusetts	586,356	52.9
Michigan	1,109,026	40.3
Minnesota	477,244	38.0
Mississippi	377,505	49.6
Missouri	575,966	35.1
Montana	94,227	42.9
Nebraska	176,959	52.1
Nevada	275,906	36.6
New Hampshire	102,179	50.4
New Jersey	717,576	47.6
New Mexico	360,127	47.3
New York	2,233,538	43.3
North Carolina	1,151,387	49.3
North Dakota	45,929	28.9
Ohio	1,334,528	33.3
Oklahoma	545,459	48.2
Oregon	403,948	35.0
Pennsylvania	1,151,659	42.5
Rhode Island	113,824	44.4

Table PDENT-CH (continued)

State	Denominator	Rate
South Carolina	657,382	50.6
South Dakota	80,315	39.6
Tennessee	739,198	48.1
Texas	3,290,322	52.6
Utah	216,125	47.1
Vermont	55,861	61.6
Virginia	635,019	49.3
Washington	789,549	55.2
West Virginia	215,102	45.4
Wisconsin	527,253	25.1
Wyoming	50,526	43.4

Source: Mathematica analysis of FFY 2014 Form CMS-416 Reports (annual EPSDT report), Lines 1b and 12b, as of September 29, 2015.

Note: The term "states" includes the 50 states and the District of Columbia.

Table TDENT-CH. Percentage of Eligibles Who Received Dental Treatment Services, as Submitted by States for the FFY 2014 Form CMS-416 Report (n = 51 states)

State	Denominator	Rate
State Mean		23.5
State Median		22.3
Alabama	597,603	20.2
Alaska	85,245	28.1
Arizona	727,378	22.1
Arkansas	383,297	27.0
California	5,304,181	21.0
Colorado	525,019	26.4
Connecticut	331,838	29.0
Delaware	106,995	20.2
Dist. of Col.	90,323	20.6
Florida	2,128,391	12.1
Georgia	1,150,273	22.7
Hawaii	148,837	33.7
Idaho	185,523	24.5
Illinois	1,547,301	20.6
Indiana	714,901	21.5
Iowa	294,737	22.3
Kansas	245,554	20.1
Kentucky	512,983	21.5
Louisiana	756,903	23.3
Maine	132,301	17.7
Maryland	636,122	24.1
Massachusetts	586,356	30.1
Michigan	1,109,026	21.5
Minnesota	477,244	17.8
Mississippi	377,505	24.7
Missouri	575,966	16.8
Montana	94,227	23.5
Nebraska	176,959	23.5
Nevada	275,906	19.3
New Hampshire	102,179	21.8
New Jersey	717,576	25.2
New Mexico	360,127	52.1
New York	2,233,538	20.7
North Carolina	1,151,387	24.1
North Dakota	45,929	14.2
Ohio	1,334,528	14.8
Oklahoma	545,459	26.1
Oregon	403,948	16.1
Pennsylvania	1,151,659	21.3
Rhode Island	113,824	19.8

Table TDENT-CH (continued)

State	Denominator	Rate
South Carolina	657,382	21.4
South Dakota	80,315	16.5
Tennessee	739,198	23.4
Texas	3,290,322	29.7
Utah	216,125	22.8
Vermont	55,861	23.1
Virginia	635,019	27.6
Washington	789,549	35.1
West Virginia	215,102	50.7
Wisconsin	527,253	10.8
Wyoming	50,526	24.1

Source: Mathematica analysis of FFY 2014 Form CMS-416 Reports (annual EPSDT report), Lines 1b and 12c, as of September 29, 2015.

Note: The term “states” includes the 50 states and the District of Columbia.

APPENDIX C

PROGRESS ON ORAL HEALTH (CHILDREN) PERFORMANCE IMPROVEMENT PROJECTS (PIPS), AS REPORTED IN EXTERNAL QUALITY REVIEW (EQR) TECHNICAL REPORTS, 2014–2015 REPORTING CYCLE

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Table C.1. Progress on Oral Health (Children) Performance Improvement Projects (PIPs), as Reported in External Quality Review (EQR) Technical Reports, 2014–2015 Reporting Cycle

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Florida: DentaQuest of Florida	PIP aims to improve performance on the percentage of eligible enrollees ages 2 to 21 who had at least one dental visit during the measurement year. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach/education: sent automated telephone calls, postcards, emails, and text messages reminding enrollees to schedule a dental visit; scripted outbound calls to enrollees in the past 12 months to determine reason(s) for lack of visit and provide education on importance of regular dental visits. Community outreach/education: developed partnership with dental and health care providers to host community dental events; distributed dental health flyers; provided on-site dental hygienist educator to explain the importance of dental visits and proper dental hygiene at home. System change: developed member services software system alert that lets member services representative on inbound calls know when the enrollee is due for a dental visit.	Not met	The validation performance suggests a need for additional training on the PIP process and PIP documentation requirements. Recommendations: The MCO should ensure that the PIP study population represents the population identified in the study question and aligns with the study indicators.
Florida: MCNA of Florida	PIP aims to improve performance on the percentage of eligible enrollees ages 2 to 21 who had at least one dental visit during the measurement year. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	Member outreach/education: automated telephone calls, postcards, emails, and text messages reminding enrollees to schedule a dental visit; scripted outbound calls to enrollees in the past 12 months to determine reason(s) for lack of visit and provide education on importance of regular dental visits. Community outreach/education: developed partnership with dental and health care providers to host community dental events; distributed dental health flyers; provided on-site dental hygienist educator to explain the important of dental visits and proper dental hygiene at home. System change: developed member services software system that lets member services representative on inbound calls know when the enrollee is due for a dental visit.	Not met	The validation performance suggests a need for additional training on the PIP process and PIP documentation requirements. Recommendations: The MCO should ensure that the PIP study population represents the population identified in the study question and aligns with the study indicators.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Florida: AMERIGROUP Community Care Better Health Children's Medical Services CoventryCare of Florida First Coast Advantage Humana Family Integral Quality Care Molina Healthcare Preferred Medical Plan Prestige Health Choice Simply Healthcare Plans South Florida Community Care Network Sunshine State Health Plan Staywell Health UnitedHealthcare	PIPs aim to improve performance on the percentage of enrollees ages 1 to 20 who had at least one preventive dental service during the measurement year. The PIPs were in the planning and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Met: 7 MCOs[b] Partially met: 5 MCOs Not met: 3 MCOs	None reported

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Georgia: Amerigroup	PIP demonstrated statistically significant improvement in performance on the percentage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)-eligible members ages 1 to 20 who received any dental services during the measurement period (54.2 percent at baseline versus 56.6 percent at first remeasurement). PIP demonstrated statistically significant improvement in performance on the percentage of EPSDT-eligible members ages 6 to 9 who received preventive dental visits during the measurement period (22.4 percent at baseline versus 26. 9 percent at first remeasurement). PIP demonstrated a statistically significant decrease in performance on the percentage of EPSDT-eligible members ages 1 to 20 who received preventive dental services during the measurement period (51.1 percent at baseline versus 49.5 percent at first remeasurement).	Member outreach/education: deployed mobile dental units accompanied by member outreach; conducted robotic calls to members and text messaging. Provider outreach/education: health promotion coordinator visits with providers to support referrals for annual dental services.	Not met	The MCO did not document any revision of improvement strategies to address the statistically significant decrease by one of the three performance indicators. Recommendations: The MCO should conduct a drill-down analysis to determine why one indicator decreased, while the other two indicators improved. The MCO should document follow-up analyses and implement new or revised interventions to address the performance decrease.
Georgia: Peach State Health Plan	PIP demonstrated a statistically significant decrease in performance on the percentage of EPSDT-eligible members ages 1 to 20 who received any dental services during the measurement period (48.8 percent at baseline versus 48.2 percent at first remeasurement). PIP demonstrated a statistically significant decrease in performance on the percentage of EPSDT-eligible members ages 6 to 9 who received preventive dental visits during the measurement period (15.7 percent at baseline versus 14.9 percent at first remeasurement). PIP demonstrated a statistically significant improvement in performance on the percentage of EPSDT-eligible members ages 1 to 20 who received preventive dental services during the measurement period (44.5 percent at baseline versus 45.0 percent at first remeasurement).	Member outreach/education: implemented a care gap alert system that notified member services and other internal staff when a member was due or past-due for a preventive dental visit. Provider outreach/education: targeted "Preventistry Provider Sealant Program" to changing provider practices of delaying the application of sealants and providing preventive and restorative care without applying sealants. System change: implemented a secure member web portal to improve member awareness of due/past-due preventive dental services.	Not met	The mixed indicator results illustrate the importance of evaluating the impact of interventions on each indicator. The MCO documented evaluations of effectiveness for some interventions but not others. Recommendations: The MCO should document the evaluation of effectiveness of each intervention, and the link between evaluation results and decisions to continue, revise, or discontinue implementation should be documented.
Georgia: WellCare of Georgia, Inc.	PIP demonstrated a statistically significant improvement in performance on the percentage of EPSDT-eligible members ages 1 to 20 who received any dental services during the measurement period (63.8 percent at baseline versus 64.7 percent at first remeasurement). PIP demonstrated a statistically significant decrease in performance on the percentage of EPSDT-eligible members ages 1 to 20 who received preventive dental services during the measurement period (59.6 percent at baseline versus 45.4 percent at first remeasurement). PIP demonstrated a statistically significant decrease in performance on the percentage of EPSDT-eligible members ages 6 to 9 who received preventive dental visits during the measurement period (16.7 percent at baseline versus 16.1 percent at first remeasurement).	Member outreach/education: mailed member reminders. Community outreach: developed a community outreach program. Provider outreach/education: mailed lists of noncompliant members to providers. System change: implemented case manager program.	Not met	Recommendations: It is critical that the MCO implement and document processes to evaluate the effectiveness of each intervention. To address the mixed indicator results, the MCO should examine each intervention to determine whether it is affecting some of the indicators but not others.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Kentucky: Passport Health Plan	PIP demonstrated no change in performance on the percentage of children with special health care needs with annual dental visit (52.0 percent at baseline versus 51.2 percent at second remeasurement).	Member education/outreach: attended scheduled in-school physical exam visits to obtain information on oral health and identify members who needed a dental exam. Provider education/outreach: provided on-site provider education and training regarding appropriate health care for members who have language access issues; conducted an EPSDT provider compliance audit. Community outreach/education: participated in community events to educate the public regarding dental exams and transportation services available through Medicaid. System change: integrated preventive dental care into the treatment plans of members currently enrolled in coordination; implemented Cultural and Linguistic Support (CLS) program activities; upgraded member documentation systems for better collection of member demographic data.	Not reported	The MCO chose to address a significant health issue, particularly for disadvantaged populations. Recommendations: The following barriers should be addressed: lack of complete race, ethnicity, and language data for members; lack of member knowledge regarding the importance of dental care; lack of provider knowledge regarding EPSDT standards for dental care and CLS requirements; lack of available dental care information in the primary care provider (PCP) record; and lack of member knowledge regarding transportation and dental benefits.
Minnesota: Metropolitan Health Plan	PIP aims to improve performance on the percentage of members who received an annual preventive and/or diagnostic dental service. The PIP has been initiated, but the technical report did not include performance rates.	None reported	Not reported	None reported
Missouri (statewide): Healthcare USA	PIP demonstrated a statistically significant improvement in performance on the percentage of children ages 2 to 20 who had an annual dental visit and state met the goal of 3 percent improvement (35 percent at baseline versus 51 percent in 2013).	Member outreach/education: made outreach telephone calls to members who have not yet seen a dental provider. Community outreach/education: supplied current DentaQuest provider lists for several back-to-school fairs; continued to sponsor Doc Bear Days at dental provider locations. System change: relied on floating dentists; partnered with community advocates and events; collaborated with schools/nurses; implemented after-hours/weekend scheduling; partnered with DentaQuest on the Smiling Stork initiative; collaborated with the Reach Out Dental Van to coordinate events targeting noncompliant members for preventive care and sealant applications.	Met	The MCO has efforts in place to collaborate with its subcontractor and to address children's oral health needs with the MCO's staff. The MCO has incorporated successful strategies as part of its normal work activities and continues to devise new initiatives to ensure that the outcomes achieved to date continue. Recommendations: Analysis of regional differences would benefit the project evaluation and guide further interventions.

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
Missouri (statewide): Home State Health Plan	PIP demonstrated statistically significant improvement in performance on the percentage of children ages 2 to 20 who had an annual dental visit (19.7 percent at baseline versus 42.3 percent at first remeasurement).	Member outreach/education: mailed birthday cards to members; conducted outreach to noncompliant members; directed DentaQuest to contact any member seen in an emergency room for dental care; automated outreach calls to all members each month who needed a dental visit. Provider outreach/education: provided education to EPSDT coordinators; distributed prescription pads with reminders to high-volume PCPs and pediatricians; distributed lists of noncompliant members to PCPs. System change: deployed dental vans and mobile dentistry services in areas of high volume and low access.	Met	The MCO included all available data to inform the PIP process. The MCO received technical assistance during the EQRO's on-site review to enhance the study design. Recommendations: The MCO should request technical assistance, as needed, in PIP development. The MCO should ensure that improvement focuses on enhancing member services. The MCO should continue its involvement with the statewide PIP planning group.
Missouri (statewide): Missouri Care Health Plan	PIP demonstrated improvement in performance on the percentage of children ages 2 to 20 who had an annual dental visit (27.4 percent in 2008 versus 31.4 percent in 2013).	Provider outreach/education: distributed dental education flyers, developed HEDIS provider toolkit. Community outreach/education: expanded Dental Month Campaign-Show Me Smiles; used "I Will" campaign flyers at health fairs and in magazines and newspapers. System change: added seven new dental vans in the central region.	Partially met	Although the MCO made improvements earlier in the statewide initiative, it has not achieved the statewide goals. The MCO continues to implement new interventions. The MCO claims that it tracks and trends initiatives so additional improvement can be achieved. However, there is no evidence of this type of analysis for the 2013 PIP. The MCO has used the PIP process as a method to obtain improved performance, but it did not include results of its analysis of 2013 outcomes in the submission.
New Jersey: Amerigroup	PIP aims to improve performance on dental visits for children ages 1 to 2. The EQR technical report did not include performance rates.	None reported	Not reported	None reported
New Jersey: Amerigroup	PIP aims to improve performance on the rate of dental visits among pregnant enrollees. The EQR technical report did not include performance rates.	None reported	Not reported	None reported
New Jersey: HealthFirst Health Plan of New Jersey	PIP aims to improve oral health for enrollees ages 2 to 3. The EQR technical report did not include performance rates.	None reported	Not reported	None reported
New Jersey: Horizon New Jersey Health	PIP aims to improve performance on the Physician's Oral Health Initiative. The EQR technical report did not include performance rates.	None reported	Not reported	None reported

Table C.1 (continued)

MCO/PIHP	Summary of Performance	PIP Interventions and Activities	EQR Validation Rating[a]	EQR Discussion and Recommendations
New Jersey: UnitedHealthCare Community Plan	PIP aims to improve performance on annual dental care. The EQR technical report did not include performance rates.	None reported	Not reported	None reported
New Mexico: Molina Healthcare	PIP demonstrated improvement in performance on the percentage of enrolled members ages 2 to 20 who received at least one preventive dental service (62.8 percent at baseline versus 71.5 percent at second remeasurement).	Provider education/outreach: sent information to the parents of 222 member children in Santa Fe County who missed services and encouraged completion of the EPSDT well-child checkup, including annual dental services; offered a $20 gift card incentive coupon for Rewards for Healthy Choices program. Community education/outreach: sponsored Family Appreciation Day, including dental health education. System change: initiated a partnership with dental delegate DentalQuest to begin receiving lists of member children who had missed services.	Met	None reported
North Dakota: Delta Dental	PIP aims to improve performance on children's preventive dental services. The PIP was in the planning and implementation phase, and the EQR technical report does not include any data on performance.	None reported	Met	None reported

Source: EQR technical reports submitted to CMS for the 2014–2015 reporting cycle, as of April 30, 2015. Analysis includes PIPs targeting children or pregnant women from the submitted EQR technical reports.

Notes: During the 2014–2015 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. ID recently implemented an MCO for its dual eligible population; it has not yet produced an EQR report. In addition, IN, PR, and TX did not submit an EQR technical report before April 30, 2015 for inclusion in this analysis. While VT is required to conduct an EQR under the terms of its section 1115 demonstration, its managed care entity is neither an MCO nor PIHP and therefore is excluded from this analysis. EQR technical reports for DE and NY did not include any information about PIPs.

Information about the EQR process is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

A statewide PIP mandates that all MCOs or PIHPs in the state develop and operate a PIP in the specific topic area. Collaborative PIPs are those state-mandated PIPs that MCOs across a state worked together to implement and operate.

[a] EQR validation rating is the overall validation rating assigned to the PIP in the EQR technical report. EQROs used different rating systems in the validation process. EQRO discussion and recommendations are summarized from the EQR technical report's discussion of the validation results for each PIP, including strengths, limitations, and recommendations for improvement.

[b] The following MCOs had a validation rating of "Met": AMERIGROUP Community Care; Better Health; Integral Quality Care; Preferred Medical Plan; Prestige Health Choice; Sunshine State Health Plan; and UnitedHealthcare of Florida. The following MCOs had a validation rating of "Partially met": CoventryCare of Florida; First Coast Advantage; Humana Family; Molina Healthcare; and Staywell Health. The following MCOs had a validation rating of "Not met": Children's Medical Services; Simply Healthcare Plans; and South Florida Community Care Network.