

# Medicaid Contracting Strategies to Improve Children's Oral Health Care Access

By Stacey Chazin, Center for Health Care Strategies

## IN BRIEF

Despite the inclusion of oral health care in Medicaid's benefit for children, in a given year, less than half of children enrolled in Medicaid receive any dental service. States may be able to use their purchasing power to encourage better access, quality, and accountability in oral health care for children in Medicaid – particularly through contracting with dental plans. This brief explores contract-based options for improving access to oral health care for children enrolled in Medicaid. It describes how states with managed care delivery systems can use contracting mechanisms and incentives to engage plans and providers in improving access and outcomes in children's oral health care.

Less than half of the nation's 32 million children enrolled in Medicaid receive any dental service in a given year, and even fewer receive a preventive dental service.<sup>1</sup> These low rates persist even though oral health care is included in Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children. Low oral health care provider participation in Medicaid is a long-standing barrier to access – due largely to provider frustrations over reimbursement rates, administrative requirements, high appointment no-show rates, and poor compliance with follow-up.<sup>2</sup> The consequences of inadequate oral health care for children are numerous, and include progressive dental disease; costly emergency room and hospital use;<sup>3</sup> missed school days;<sup>4</sup> and low self-esteem from unhealthy looking teeth.<sup>5</sup> Children who lack proper preventive oral health care at a young age are also at greater risk of costly dental disease as adults, with risks related to systemic disease and employability.<sup>6</sup>

An additional 3.2 million children are expected to gain dental benefits via Medicaid expansion by 2018,<sup>7</sup> taxing Medicaid programs with an already inadequate supply of providers. Concurrently, dental costs continue to rise: Medicaid spending on dental services in 2012 was \$7.3 billion – 60 percent higher than five years prior.<sup>8</sup> Given this significant investment and expected beneficiary expansion, state Medicaid agencies have a critical need to improve access to lower-cost, preventive oral health care in order to stave off more costly treatment in the future. The purchasing power conferred by states' large investments in care suggests that state contracts with dental plans may be an effective channel for improving access. While states require contracted plans to provide access to oral health care for beneficiaries, many do not use contracts to hold them accountable – or reward them – for meeting measurable targets.

The Center for Health Care Strategies (CHCS) developed this brief to help states explore contract-based options for improving access to oral health care for children enrolled in Medicaid. It describes how states with managed care delivery systems can use contracting mechanisms and incentives to engage plans and providers in improving children's access to oral health care, advancing better oral health outcomes.

## Contracting Strategies to Improve Oral Health Care Access

State Medicaid agencies can use their purchasing clout to either mandate or incentivize contracted plans to ensure oral health care access for beneficiaries. Strategies can be rewarding or punitive; financial or administrative; and based on a plan’s individual performance relative to benchmarks, to its own historical performance, and/or to other plans contracted with the state. Following are five broad contracting strategies to promote improvements in oral health care access.

### 1. Offer Financial Incentives for Plan Performance

Plans will likely respond best to bottom-line rewards for performance. Below are key steps for designing a financial incentive structure that is meaningful to plans and is well-aligned with a state’s priority oral health performance measures and baseline measures of oral health care access.

#### **STEP ONE: Decide What Areas of Performance to Reward**

Consider which oral health care measures – such as annual dental visit, overall utilization of dental services, or treatment and prevention of caries – should be linked to incentives. Alternatively, consider linking incentives to broader ongoing care measures such as the establishment of dental homes<sup>9</sup> or lower rates of dental disease. Another option is to *weight* rewards for service delivery to priority populations, such as young children, as earlier preventive dental care is associated with up to 40 percent lower dental costs over a five-year period.<sup>10</sup> California holds its contracted plans accountable for meeting various benchmarks in 13 dental performance measures, addressing various aspects of prevention and treatment. The state withholds 10 percent of the monthly capitation payment to form a pool of incentive payments, and assigns points for meeting benchmarks in each measure. Plans can earn twice as many points for meeting benchmarks in children five years or younger.<sup>11</sup>

#### **STEP TWO: Determine Levels of Performance to Reward**

Once the specific measures are identified, decide what types and levels of achievement the incentive will reward. Exhibit 1 on the next page outlines four potential models, with pros and cons for each.

#### **Contracting Strategies to Improve Oral Health Access**

This section walks through the following key strategies:

1. Offer financial incentives for plan performance.
2. Establish *non*-financial incentives for plan performance.
3. Impose consequences on plans for failure to meet performance standards.
4. Reduce obstacles to oral health care provider participation in the Medicaid/CHIP network.
5. Engage health plans to promote oral health.

EXHIBIT 1: Overview of Financial Incentive Models

MODEL	PRO	CON	STATE EXAMPLES
<p><b>Model A</b> rewards plan for achieving a minimum standard on a given measure.</p> <p><i>For example, ABC Dental Plan receives a payment if at least 75 percent of enrolled children have an annual dental visit.</i></p>	<p>Rewards high-performing plans.</p>	<p>For plans with the minimum rate at baseline (e.g., 75 percent), there is no incentive to improve, unless payments increase for percentage points above the minimum, or the state increases the minimum rate annually.</p>	<ul style="list-style-type: none"> <li>• <b>Michigan</b> rewards plans relative to 22 benchmarks in the Healthcare Effectiveness Data and Information Set (HEDIS)<sup>12</sup> and the Consumer Assessment of Healthcare Providers and Systems (CAHPS).<sup>13</sup> <ul style="list-style-type: none"> <li>▪ Based on: achievement of the National Committee on Quality Assurance’s (NCQA) 50<sup>th</sup>, 75<sup>th</sup>, and 90<sup>th</sup> percentiles; accreditation status; and annual state-defined incentive measure.</li> <li>▪ Majority of plans receive an annual bonus.<sup>14</sup></li> </ul> </li> <li>• <b>Indiana</b> employs a bonus and premium withholding strategy.                     <ul style="list-style-type: none"> <li>▪ Bonus for performance above NCQA’s 50th percentile, with payments increasing at higher percentiles.</li> <li>▪ Participating plans reported its effectiveness.<sup>15</sup></li> </ul> </li> </ul>
<p><b>Model B</b> rewards plan for improvements over prior year’s performance.</p> <p><i>For example, increasing the percentage of children in ABC Dental Plan with an annual dental visit from 75 percent in 2010, to 80 percent in 2011, etc.<sup>16</sup></i></p>	<p>Rewards high- and low-performing plans, regardless of rates.</p>	<p>Rewarding low-performing plans sends the message that their performance is acceptable (establishing a minimum rate to qualify for an incentive would temper this shortcoming).</p>	<ul style="list-style-type: none"> <li>• <b>Pennsylvania</b> rewards plans for improvements over plan-specific historical performance.                     <ul style="list-style-type: none"> <li>▪ Progressive payments for improvements of more than 1, 2, 3, 4, and 5 percent, and performance on HEDIS measures above 50th, 75th, and 90th national percentiles (with greater weight on the latter).</li> <li>▪ State saw significant improvement in five of 11 targeted measures in the first three years.<sup>17</sup></li> </ul> </li> </ul>
<p><b>Model C</b> rewards plan relative to performance of the state’s set of contracted plans.</p> <p><i>For example, if the 2011 all-plan average rate for preventive service utilization was 60 percent, and ABC Dental Plan’s 2012 rate was 75 percent, ABC would receive an incentive payment.</i></p>	<p>Rewards high-performing plans for continuous improvements from year to year.</p>	<p>Little incentive for low-performing plans to improve, since they would need to rise to and then exceed the all-plan average.</p>	<ul style="list-style-type: none"> <li>• <b>New York</b> compares each plan’s performance to the statewide average on selected HEDIS and CAHPS measures.                     <ul style="list-style-type: none"> <li>▪ Bonus payments made to about two-thirds of contracted plans each year.<sup>18</sup></li> </ul> </li> </ul>
<p><b>Model D</b> is a hybrid incentive model that incorporates elements of the above three models.</p> <p><i>For example, this approach could establish a minimum rate for a plan to qualify for an incentive on a given measure; reward each plan for annual (or quarterly) increases in its own utilization rates for a given measure; and reward a plan for performance that is better than the “all-plan” average from the prior year.</i></p>	<p>Rewards both high- and low-performing plans.</p>	<p>Potentially dilutes incentive for improvement over own performance and over all-plan performance, if incentive money available is finite.</p>	<ul style="list-style-type: none"> <li>• <b>Arizona</b> withholds funds from plans to create an incentive pool built around adult and child performance measures, including children’s dental visits.                     <ul style="list-style-type: none"> <li>▪ Rewards each plan for performance relative to minimum standards around each measure.</li> <li>▪ Distributes balance of withheld funds to the plans based on their “performance rank score” – a pure ranking of the plan’s performance relative to all plans contracted with the state.<sup>19</sup></li> </ul> </li> </ul>

A state should choose the approach that is best-aligned with its quality improvement needs. If there is great disparity in performance among plans, a structure that rewards plans with high and low baseline rates (e.g., Model B) would likely be more effective at improving system-wide access. In contrast, if most or all plans are under-performing, an approach that requires achievement of a minimum rate for an incentive payment and rewards improvements over a plan's previous year's performance may be more appropriate.

### **STEP THREE: Consider the Payment Amount Needed to Spur Behavior Change**

To be effective, an incentive amount must be sufficient to resonate with contracted plans. The experiences of some states suggest that a rate between 0.5 and three percent of the per-member per-month (PMPM) payment is needed.

One study of pay-for-performance strategies used by state Medicaid and Children's Health Insurance Program (CHIP) agencies in medical managed care concluded that in order to affect program/policy efforts of managed care organizations (MCOs), financial incentives should be between 0.5 and one percent of the capitation rate they receive from the state and should be structured as a discrete percentage of the capitation rate or the annual rate increase.<sup>20</sup> Another found that bonuses and withheld payments range from less than one percent to five percent of the premium and are typically between one percent and three percent of the PMPM capitation payment.<sup>21</sup>

Texas withholds five percent of the premium payment from its Medicaid dental plans, and at the end of each rate period, assesses whether each plan has met agreed-upon performance benchmarks.<sup>22</sup> In contrast, in the first year of its incentive program, New York State offered bonuses of up to one percent of the PMPM payment to its Medicaid health plans (based on performance on HEDIS and CAHPS measures). However, the state later found that it needed to increase the bonus to three percent to motivate plans to action (subsequent budget challenges led to a decrease in that rate to 2.5 percent).<sup>23</sup>

### **STEP FOUR: Identify a Sustainable Source of Funding**

It is important to secure a *sustainable* source of incentive funding to allow sufficient time for change. In New York and Texas, such funds are Medicaid budget-line items.<sup>24,25</sup> More typically, budget constraints call for Medicaid agencies to either: (1) withhold a percentage of premium payments from plans; or (2) set aside funds from planned increases in payment rates to create an incentive pool.

## **2. Establish Non-Financial Incentives for Plan Performance**

States can also reward plans with non-financial incentives. One option is to assign new Medicaid beneficiaries to higher-performing plans using an algorithm that incorporates priority performance measures (e.g., preventive dental service utilization by young children). Several states have used such incentives with their Medicaid health plans, incorporating elements such as: (1) clinical quality measures aligned with financial incentive programs; (2) timeliness of encounter data submission; (3) the ratio of open primary care providers (PCPs) to plan capacity; and (4) the voluntary selection rate into competing plans in a service area.<sup>26</sup>

Michigan's Medicaid program uses a performance-based assignment algorithm with its health plans, incorporating: (1) clinical measures consistent with those in its financial incentive programs; (2)

measures of timely claims processing; (3) encounter data submission; and (4) provider capacity by region. The state applies this algorithm quarterly, adjusting new member assignments based on plan encounter data. In conjunction with financial incentives, this approach has improved HEDIS and CAHPS measures.<sup>27</sup>

New York’s performance-based auto-assignment algorithm is weighted by 75 percent to plans that qualify for bonus payments under the state’s financial incentive program. Medicaid-contracted plans reported that the state’s financial and auto-assignment incentives were sufficient to drive quality-improving practices.<sup>28</sup>

### 3. Impose Consequences on Plans for Failure to Meet Performance Standards

A state may also impose financial or non-financial penalties upon plans that do not meet minimum performance standards. The New York Medicaid program found that simply issuing statements of deficiency to health plans with poor access or inadequate provider networks was successful at driving change.<sup>29</sup> In Arizona, the Medicaid program requires plans that do not meet a given performance standard to develop a corrective action plan and face a financial penalty of up to \$100,000 for each deficient measure, an approach that was cited by the Centers for Medicare & Medicaid Services (CMS) as helpful in focusing health plan attention and resources on important areas for improvement.<sup>30</sup>

### 4. Reduce Obstacles to Oral Health Care Provider Participation in Medicaid/CHIP

To address provider Medicaid-participation barriers, Medicaid agencies can require or encourage administrative consistency (e.g., use of uniform reporting forms) across plans, as well as encourage plans to remove or agree to a common set of prior authorization requirements – another administrative deterrent to provider participation – for certain procedures. The latter can be designed as an incentive available to providers who achieve selected benchmarks. Another option is to offer providers centralized credentialing for participation in all plans in the Medicaid program, rather than individual credentialing with each.

Virginia undertook several of these approaches in 2005, eliminating pre-authorization for basic restorative care, and replacing multiple claim forms with a single form that mirrors one used by commercial payers. In conjunction with reimbursement increases, these changes led to a doubling of enrolled Medicaid dental providers by 2009 and significantly more annual dental visits by Medicaid-enrolled children.<sup>31,32</sup> While implemented in a fee-for-service delivery system in Virginia, this approach can be adapted in managed care states by Medicaid agencies’ requesting or requiring that contracted plans offer this incentive to providers.

Medicaid agencies in Virginia and Michigan reported that dentists prefer to work with a single entity rather than multiple plans with different administrative requirements. In its managed care delivery system, Arizona changed its plan contracts to promote procedural consistency (e.g., credentialing, reporting) across plans. Virginia, Michigan, and Arizona also require plans to support providers in addressing “no-show” rates. In turn, for example, Arizona’s plans send follow-up letters to patients who have missed appointments.<sup>33</sup>

The Alabama Medicaid agency worked to improve oral health care provider participation in its fee-for-service network by: (1) simplifying claims processing through a universal dental claim form and electronic claims filing; (2) updating provider manuals to clarify and update the claims process; and (3)

visiting non-participating dentists to encourage/facilitate enrollment in Medicaid.<sup>34,35</sup> States with managed care delivery systems may consider how this approach could be adapted with contracted plans.

## 5. Engage Health Plans to Promote Oral Health

While this brief focuses on contracting between Medicaid/CHIP agencies and *dental* plans, contract-based opportunities to advance oral health with *health* plans should not be overlooked. Oral health quality improvement programs across the country have begun to focus on the potential for health plans and PCPs to play a role in oral health education, screening, and referral provision for two key reasons.<sup>36</sup> First, PCPs interact more frequently with infants, young children, and families than do dentists,<sup>37</sup> giving them the opportunity and credibility to address oral health. Second, health plans face significant costs from unmet dental needs: treatment of severe dental disease in children often requires general anesthesia and hospitalization, costing over \$20,000 per case.<sup>38</sup>

Unfortunately, PCPs often struggle to find time during a well-visit to address oral health, and many health plans remain unconvinced by the business case to support that effort. A financial incentive to promote preventive dental service utilization can encourage providers and plans to prioritize the issue. A state may also require health and dental plans to give PCPs education and tools for oral health care referrals and subsequently reimburse them for referrals resulting in a dental visit.

Another option is to add fluoride varnish application as a covered health benefit provided through Medicaid/CHIP health plans. Through this mechanism, PCPs or trained office staff are reimbursed for applying fluoride varnish at the primary care site, a service that can reduce rates of tooth decay by one third. At least 44 state Medicaid programs reimburse PCPs for oral health services such as the application of fluoride varnish, paying between \$9 and \$57, depending on whether an exam with evaluation and counseling is included with the application.<sup>39</sup> For example:

- Through its *1st Look Program*, Alabama trains and reimburses PCPs to understand oral health screening guidelines, perform oral health assessments, apply fluoride varnish, and refer children to a dental home by their first birthday.<sup>40</sup>
- Texas educates medical providers about oral health screening and anticipatory guidance. Contracted health plans – including those that pay providers on a capitated basis – provide additional reimbursement for delivery of these services.<sup>41</sup>
- Since 2012, New Jersey has required contracted MCOs to reimburse PCPs for oral health screening and fluoride varnish application (reported in a single procedure code). As elsewhere, physicians must undergo training to be eligible for reimbursement.<sup>42</sup>

## Considerations for Planning and Implementation

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State experiences suggest a number of important considerations for those exploring Medicaid contracting strategies to improve children's oral health care access and outcomes:

### Engage Contracted Plans Early and Often

Including Medicaid-contracted plans in program design efforts is critical to ensuring feasibility, securing buy-in, and identifying necessary provisions. Plans can contribute to this by:

- **Identifying obstacles to program goals and objectives.** Dental plans may shed light on challenges around: (1) receiving complete and accurate data from providers, including use of electronic reporting; (2) recruiting dentists to undergo training to treat young children; and/or (3) recruiting/retaining network providers. In turn, health plans can share lessons from their efforts to incentivize oral health education, screening, and referral delivery in the primary care setting.
- **Determining target performance standards and other measures.** While the state should identify its priority oral health performance standards, plans should be consulted to determine the feasibility of specific benchmark rates and target improvements. Plans can also identify infrastructural or procedural support that could help them to meet these goals.
- **Informing network-development strategies.** Since plans, not the state, have direct relationships with providers, they can offer unique insights into obstacles to provider participation in Medicaid (e.g., high beneficiary no-show rates). Plan representatives can also offer feedback around the feasibility and likely effectiveness of administrative and other changes that may drive network development.
- **Raising any “red flags.”** Lastly, plans can alert the state to particular aspects of the contracting strategy that might impede their ability to continue as a contractor (e.g., premium withholds).

## Give Providers a Voice at the Table

While states with plan-based delivery systems contract with plans and not providers, the intent is for efforts to effect change in provider care delivery, thus engaging oral health care providers and PCPs in the planning process is noted by Medicaid leaders as critical to successful implementation.<sup>43,44</sup>

Providers can help the planning body to anticipate pushback from peers, such as resistance to weighting reimbursements in favor of certain services or populations. Dentists may object to PCPs’ application of fluoride varnish, a role that garners mixed support from the dental profession.<sup>45</sup> By anticipating resistance, the state can develop messaging or mitigating activities to smooth the way.

## Consider a Phased-In Approach to Implementation

It may not be feasible to implement all of the above-recommended contracting strategies at once or to implement several across a large geographic area. State budgetary constraints, concerns over requiring “too much change” at once, and administrative logistics may lead states to implement contract changes incrementally or to pilot changes with a subset of plans. A phased-in implementation approach can help address concerns, as well as inform potential modifications of tested strategies in subsequent roll-outs.

## Create Mechanisms for Providers to Report Access-Advancing Services

Challenges can arise when PCPs are asked to provide evidence of oral health care service delivery that is beyond EPSDT requirements, such as provision of a dental referral. It can also be challenging for dental plans to collect timely and accurate information from oral health care providers to demonstrate achievement of goals. That said, any contracting strategy must include effective reporting mechanisms.

For example, to be eligible for reimbursement under Alabama’s *1st Look Program*, PCPs must document in the child’s medical record: (1) the content of the anticipatory guidance given to parents; (2) results of the American Academy of Pediatric Dentistry Caries Risk Assessment Tool;<sup>46</sup> and (3) provision of a dental referral to children found to be high-risk. They then must submit two billing

codes – D0145 (oral exam < 3 years old, counseling) and D1206 (topical fluoride application) – to the health plan.<sup>47</sup>

A pilot project undertaken by Health Net's dental and health plans in California called for medical providers to send copies of completed dental visit referral forms to the dental plan to assist in scheduling each patient's appointment. Receipt of the form constituted proof that the PCP made the referral; the plan could then document completion of subsequent dental visits via claims data.<sup>48</sup>

## Determine How to Evaluate

States should evaluate both the effectiveness and return-on-investment of the above strategies. An assessment should include tangible measures (e.g., changes in provider behavior and dental service utilization rates), as well as changes in plan and provider satisfaction. Without this, a state cannot know the full extent of the impact achieved nor identify unintentional, adverse effects of the effort. The state of Texas, for example, evaluates its incentive structure annually with contracted dental plans and then makes modifications to “motivate, recognize, and reward dental contractors for superior performance.”<sup>49</sup>

States should also consider how often – if at all – targeted performance measures should be changed and whether the results of assessments will inform that process. Part of the buy-in process from plans ideally will include a mutually agreed-upon period of time for a quality-improvement initiative and the method for program evaluation. For example, while New York rotates the measures in its incentive program annually to address multiple services, plans cite the importance of keeping such measures constant, to allow plans to focus their efforts adequately.<sup>50</sup> Several implementation, outcomes, and impact measures for consideration include:

- **Degree of implementation.** Measures can assess the extent of quality improvement implementation (e.g., timely creation of an auto-assignment algorithm; incorporation of incentive clauses into contracts with dental plans; and plan compliance with data submission requirements).
- **Improvements in oral health care access.** Access can be measured in many ways, including increases in the willingness and capacity of providers to see additional Medicaid beneficiaries; shorter wait times to secure appointments; and increases in preventive dental service utilization. All states track utilization through CMS-416 data (most commonly, rates of receiving any dental service).<sup>51,52</sup> In addition, select states analyze claims/encounter data (23 states), consumer complaints (16), and surveys of beneficiary satisfaction (16) and children's oral health (7).<sup>53</sup>
- **Plan engagement and satisfaction.** These outcomes can be assessed via plan participation in the development of the quality improvement parameters; reports that the incentive structure is realistic and effective; and decisions to continue contracting with the state.
- **Provider participation.** Given the importance of network adequacy, states should not lose sight of how contracting strategies, including the reduction in administrative barriers, affect providers – including their willingness to accept Medicaid patients and the frequency of provider complaints.
- **Patient satisfaction.** Improvements in access can also be assessed via beneficiary satisfaction with benefits and services. Virginia and New York survey beneficiaries about wait times for dental visits, awareness of dental benefits, and/or satisfaction with the Medicaid program.<sup>54,55</sup>



- **Improvements in oral health status.** While improvements in oral health care access are the objectives of the strategies above, the ultimate impact goal is to improve oral *health* (e.g., the absence of caries). States should consider how to assess this goal, as plans/providers typically do not need to report such data.<sup>56</sup>
- **Impact on costs.** Keep in mind that any increase in preventive or other dental service utilization may increase short-term program costs, but should reduce longer-term dental disease and costs.

## Maintain a Long-Term Perspective

All of the above strategies call for a long-term perspective in terms of: (1) securing *sustainable* resources to support incentives (e.g., a designated funding pool); (2) maintaining consistent quality improvement targets; (3) engaging critical stakeholders to secure buy-in and input around continuous quality improvement; and (4) measuring consumer satisfaction and outcomes, as well as costs.

## Conclusion

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Across the country, state Medicaid agencies have undertaken a variety of approaches to improve access to oral health care for low-income children. Among those is a diverse set of contracting and other incentivizing strategies that can engage the oral health and primary care delivery systems in the critical effort to improve oral health access, outcomes, and costs for this high-risk, high-cost population.

## ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed health care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

Over the past 12 years, CHCS has worked with state Medicaid agencies, their contracted plans, and other oral health stakeholders to develop and implement strategies to improve oral health care access, quality, and outcomes for low-income children. For more information, visit [www.chcs.org](http://www.chcs.org).

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## ENDNOTES

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- <sup>9</sup> As defined by the American Academy of Pediatric Dentistry, a “dental home” is a source of comprehensive, continuously accessible, coordinated, and family-centered oral health care, beginning no later than age 1. See: [http://www.aapd.org/media/policies\\_guidelines/p\\_dentalhome.pdf](http://www.aapd.org/media/policies_guidelines/p_dentalhome.pdf).
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- <sup>11</sup> California Department of Health Care Services (March 2013). *Performance Measures and Benchmarks*. Provided by R. Isman, February 2014. Note that as of June 2014, the state was reassessing its current point-assignment structure.
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- <sup>13</sup> For more information about CAHPS, visit: <http://cahps.ahrq.gov/>.
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- <sup>15</sup> Ibid.
- <sup>16</sup> A state would need to decide whether additional improvements need to be incentivized once a plan reaches a certain level of utilization.
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- <sup>24</sup> Ibid.
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- <sup>27</sup> Bailit Health Purchasing, August 2009, op cit.
- <sup>28</sup> Ibid.
- <sup>29</sup> Anarella and Wehren, op cit.
- <sup>30</sup> Centers for Medicare & Medicaid Services (January 2011). "Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports." Available at: <https://www.cms.gov/MedicaidDentalCoverage/downloads/8staterrep2.pdf>.
- <sup>31</sup> Pew Center on the States (February 2010). "The Cost of Delay: State Dental Policies Fail One in Five Children." Available at: [http://www.pewtrusts.org/our\\_work\\_report\\_detail.aspx?id=57447](http://www.pewtrusts.org/our_work_report_detail.aspx?id=57447).
- <sup>32</sup> Centers for Medicare & Medicaid Services, op cit.
- <sup>33</sup> Health Management Associates, op cit.
- <sup>34</sup> Centers for Medicare & Medicaid Services, op cit.
- <sup>35</sup> Telephonic interview with S. Moore-Grimes and R. Rawls, Alabama Medicaid, July 12, 2012.
- <sup>36</sup> For examples, visit <http://www.dentaquestfoundation.org/programs/oral-health-2014>.
- <sup>37</sup> K.M. Pierce, R.G. Rozier, and W.F. Vann, Jr. "Accuracy of Pediatric Primary Care Providers' Screening and Referral for Early Childhood Caries." *Pediatrics*, 109: e82 (2002).
- <sup>38</sup> The California Society of Pediatric Dentistry. "The Consequences of Untreated Dental Disease in Children: Looking Closer at California's Children." Available at: <http://www.cspd.org/advocacy/#cudd>.
- <sup>39</sup> American Academy of Pediatrics (January 2013). "More State Medicaid Programs Pay for Children's Oral Health Prevention Services in Doctors' Offices." Available at: <http://www2.aap.org/oralhealth/docs/CelebratingOurWins.pdf>.
- <sup>40</sup> Alabama Medicaid Agency. *1<sup>st</sup> Look Program Specifics*. Available at: [http://medicaid.alabama.gov/CONTENT/4.0\\_Programs/4.4.0\\_Medical\\_Services/4.4.2.5\\_1st\\_Look.aspx](http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.2.5_1st_Look.aspx).
- <sup>41</sup> Gibson and Altenhoff, op cit.
- <sup>42</sup> Telephonic interview with B. Stanley, July 23, 2012, and e-mail communication, July 2, 2014. Note that New Jersey does not require PCPs to apply fluoride varnish, but does require its contracted plans to reimburse those PCPs who do.
- <sup>43</sup> Telephonic interview with D. Plain, Medicaid/CHIP Dental Program, Virginia Medicaid Agency, July 11, 2012.
- <sup>44</sup> Gibson and Altenhoff, op cit.
- <sup>45</sup> The AAPD does not support the application of fluoride varnish absent a comprehensive dental exam, but maintains that if an insurance program reimburses physicians for the service, guidelines for adequate physician training/education should apply. See: <http://www.aapd.org/assets/1/7/FluorideVarnishTalkingPoints.pdf>.
- <sup>46</sup> The AAPD's Caries Risk Assessment Tool is available at: [www.orthodontics.org/Caries-RiskAssesmentTool\(CAT\).pdf](http://www.orthodontics.org/Caries-RiskAssesmentTool(CAT).pdf).
- <sup>47</sup> Alabama Medicaid Agency, op cit.
- <sup>48</sup> Telephonic interview with E. McGee-Davidson, May 17, 2011, and July 8, 2014.
- <sup>49</sup> Texas Health & Human Services Commission, op cit.
- <sup>50</sup> Bailit Health Purchasing, LLC, op cit.
- <sup>51</sup> The CMS-416 is an annual report that states must submit to CMS to demonstrate statewide performance of the EPSDT benefit. The CMS-416 form is available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Form-CMS-416-PDF.pdf>.
- <sup>52</sup> A. Borchgrevink, A. Snyder, and S. Gehshan, National Academy for State Health Policy (March 2008). "The Effects of Medicaid Reimbursement Rates on Access to Dental Care." Available at: [http://nashp.org/sites/default/files/CHCF\\_dental\\_rates.pdf?q=Files/CHCF\\_dental\\_rates.pdf](http://nashp.org/sites/default/files/CHCF_dental_rates.pdf?q=Files/CHCF_dental_rates.pdf).
- <sup>53</sup> T.P. Wall, American Dental Association Health Policy Resources Center (2012). "Dental Medicaid – 2012." Available at: <http://www.ada.org/news/7092.aspx>.
- <sup>54</sup> Plain, op cit.
- <sup>55</sup> Anarella and Wehren, op cit.
- <sup>56</sup> State-specific longitudinal data are available from the National Oral Health Surveillance System on the percentages of third-grade students with: (1) caries experience, including treated and untreated tooth decay; or (2) untreated tooth decay. See: <http://www.cdc.gov/nohss/>.