Miami-Dade County
Prepaid Dental Health Plan Demonstration:
Less Value for State Dollars

Analysis commissioned by
The Collins Center for Public Policy / Community Voices Miami

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*Less Value for State Dollars*

August 10, 2006

**SUMMARY**

Florida has embarked on a program of Medicaid reform using a variety of initiatives including the Miami-Dade County Prepaid Dental Health Plan. This two-year demonstration—now under consideration for continuation or expansion—studied the effect of managed care contracting combined with capitation payment to dentists. Analysis of best available data from the State and its managed care vendor suggest that this alternative method of purchasing dental care has resulted in lower quality and no cost savings.

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**Medicaid Experimentation**

States are today experiencing the most dynamic and fluid period in the 41 year history of Medicaid. Born out of the Johnson Administration’s Great Society in 1965, Medicaid has grown in size, cost, and complexity until it has become the first or second most costly item for states. Governors of both political parties now seek opportunities to reign in and redesign the program by calling for flexibility, cost sharing, increased beneficiary responsibility, and emulation of private markets. Recent changes in law, regulation, and administrative options coupled with federal innovation grants to states currently encourage major reform.

**Florida’s Dental Demonstration**

One example of Florida’s Medicaid reform effort is the Miami Dade County Prepaid Dental Health Plan for children referred to as the “demonstration” or “pilot.” This demonstration began on July 1, 2004 when Atlantic Dental Incorporated (ADI), a dental managed care vendor, assumed responsibility for the program from the state. Previously, Florida had contracted directly with dentists and paid them based on a fixed fee for each service (FFS) they provided to children. Under the demonstration, ADI developed a network of dentists and compensated them primarily through capitation, an approach well established in medicine but relatively rare in dentistry. Under capitation, dentists agree to be responsible for a panel of patients and their dental care needs and are paid a fixed dollar amount each month for each patient, whether or not the patient receives treatment.

**Purpose of This Analysis**

Experiments provide the basis for understanding what works and what doesn’t. Objective analysis allows policymakers to determine when to expand, continue, modify, or abandon a novel demonstration. The purpose of this analysis is to provide policymakers with the best available evidence on the demonstration’s performance in comparison with the pre-existing state-managed dental Medicaid program for children. Because of lag times in reporting data, this analysis utilized data from 2003 for the pre-pilot period and 2005 from the pilot period whenever possible.

**Quality Framework**

This analysis reports on value, the benefit to the state in terms of quality of care for Medicaid dollars expended. The National Academies of Science have proposed six measures of healthcare quality that are widely used by government and industry and are the basis for this evaluation. These are:

1. **Effectiveness**, a measure of achieving desired outcomes;
2. **Efficiency**, a measure of how outcomes relate to resources;
3. **Timeliness**, a measure of delay in receiving care;
4. **Safety**, a measure of actual or potential bodily harm;
5. **Patient Centeredness**, a measure of how well care meets patients’ needs and preferences;
6. **Equity**, a measure of the pilot’s ability to provide healthcare of equal quality to those who may differ in personal characteristics other than their clinical condition or preferences for care

### Best Available Data

This analysis utilizes the best available data from the State of Florida as reported by the University of Florida in its July 27th analysis by the Institute for Child Health Policy (“University of Florida Report”). It also utilizes data obtained from AHCA by the Collins Center for Public Policy and additional federal governmental data available to the public. When more than one value was reported for the same measure, the value most that most favorably reflected the program’s performance was utilized. Data sources are listed for each finding in the attached chart book and data chart.

Data obtained on the program both before and after the start of the demonstration may be flawed or difficult to interpret because of either over- or under-reporting by AHCA, the dental vendor ADI, participating dentists, or beneficiaries. In general, pre-pilot data is likely to reflect overtreatment because of perverse incentives created by deeply discounted fee schedules while pilot data are likely to understate care because of presumed poor reporting by dentists. Past studies suggest that findings from beneficiaries’ surveys tend to overstate findings of satisfaction and utilization.

### What Happened?

In short, costs stayed about the same (increased by 1%) while almost all measures of quality declined and the State of Florida lost value by paying the same amount for less care and less quality.

**COST:**

Aggregate costs increased by 1% (from $14.9 million to $15.1 million)

**QUALITY:**

1. **Effectiveness**

   **Children obtained less care**
   - The percent of children “continuously” enrolled in the program who received at least one dental visit declined by 42% (from 37% to 22%)
   - The percent of children enrolled for any period of time in the program who received at least one dental visit declined 45% (from 29% to 16%)

   **Children had fewer dental visits**
   - The average number of dental visits for “continuously” enrolled children decreased by 54% (from 1.0 to 0.47 visits).
   - The average number of dental visits per enrolled child decreased by 61% (from 0.60 visits to 0.24 visits)

   **Fewer dentists were available to children**
   - The number of Dade County dentists who provided services to at least one child declined 59% (from 669 dentists to 276 dentists.)
Fewer children had a dental prevention visit
Dental prophylaxis (tooth cleaning) is a sentinel marker for dental care of children because it is a routine procedure typically provided to all children and has a widely recommended frequency of twice annually.
- The number of dental cleanings provided to children declined by an estimated 59% (from 75,911 “prophylaxes” in 2003 to an annualized 31,106 in 2005)
- The percentage of children who had their teeth cleaned declined by an estimated 62% (from a 2003 Statewide rate reported by AHCA of 24% to an annualized 9% rate from ADI)

The majority of dentists reported seeing few of the children they contracted to care for.
- During the first half of 2005, only 18 of 191 dentists then listed in the pilot reported caring for a greater percentage of children than were cared for in the year prior to the demonstration. Taken together, these 18 practitioners provided a dental prophylaxis to 36% of their child patients while the remaining 173 dentists provided a cleaning to only 7% of their patients.
- During the first half of 2005, 10% of dentists did not report seeing any children for a prophylaxis, 79% reported seeing more than 1 but less than 20%, 8% reported seeing 20% or more but less than 50%, and only 2% (4 dentists) reported seeing more than 50%. Among dentists who reported providing any prophylaxes, the likelihood of a child getting a cleaning increases as panel size decreases. (The average panel size for dentists seeing less than 20% of children for prophylaxis is 993; the average for dentists seeing more than 20% but less than 50% is 652; and the average for dentists seeing more than 50% is 444.)

More children “had a dentist”
- The pilot assured that all children had a dentist of record by encouraging parents to select a dentist and by assigning dentists for those who had not done so. Of the 191 unique dental providers who participated in the program during the first half of calendar year 2005, the number of children enrolled in each office varied from 1 to 5,892. Of the 669 unique dental providers who participated in the program in the full year prior to the pilot, the number of children enrolled in each office varied from 1 to 1,940. The largest provider in the capitation program accepted responsibility for 3 times more children than the largest provider in the fee-for-service program.

Expenditures per child who obtained care decreased:
- The dollar value of services decreased 39% from $156 for each child who obtained care in the year prior to the pilot to $95 for each child who obtained care in the first year of the pilot based on Florida’s Medicaid fee schedule.
- Because Florida state Medicaid fees are 42% lower than regional dental fees, the commercial market value of services provided before and after the pilot declined from roughly $372 per utilizer to $226 per utilizer.

Purchasing power of Medicaid dollars decreased:
- The overall purchasing power of state dollars decreased by 68%:
  - Each pre-pilot dollar bought approximately 79 cents worth of dental care at Medicaid rates while each pilot dollar bought roughly 25 cents worth of care at Medicaid rates.
Each pre-pilot dollar bought approximately $1.89 worth of dental care at commercial rates while each pilot dollar bought roughly 60 cents worth of dental care at commercial rates.

2. Efficiency

Cost per beneficiary increased
- Dental care expenditures pro rated by number of beneficiaries increased by 14% (from $56 per enrollee per year to $64 per enrollee per year.)

Cost per utilizer increased
- Dental care expenditures pro rated by the number of children who received at least one dental service increased by 108% (from $192 per enrollee to $399 per enrollee per year.)

Cost per visit increased
- Dental care expenditures pro rated by the number of visits increased 188% (from $95 to $273.)

Cost per dentist increased
- Dental care expenditures pro rated by the number of dentists who provided one or more services increased 158% (from $22,317 to $57,609.)

3. Timeliness

Objectively, declines in care suggest loss of timeliness
- The 42% drop in utilization by continuously enrolled children and 45% drop in utilization for all enrolled children suggest a decrease in timeliness of care.
- The 54% drop in average numbers of visits for continuously enrolled children and 61% drop in numbers of visits for all enrolled children suggest a decrease in timeliness of care.

Subjectively, parent satisfaction was moderately high
- A very favorable 69% of families surveyed reported that they “always to usually” received a dental appointment for routine care as soon as they wanted.

4. Safety

There is no evidence to suggest any change in safety.

5. Patient centeredness

The University of Florida’s comprehensive survey suggests high levels of consumer satisfaction with the program.

6. Equity

Federal law established the Medicaid EPSDT program for children in 1967 to ensure equity between low-income children and children from non-poverty families in obtaining healthcare that meets their needs. The “equal access provision” of EPSDT legislation specifically calls for care that is as accessible for children in Medicaid as for their non-Medicaid peers in the same locale. Nationally 25% of low-income and Hispanic children, like the majority of those in the pilot, access dental care (comparable to Dade County’s pre-pilot performance of 29%) while 45% of children in families above the poverty level obtain dental examinations in a year. In the year prior to the demonstration, Florida fell 36% short of providing equitable access to dental care (29%
receiving care compared to benchmark of 45%). During the pilot this shortfall in equity increased to 64% (16% receiving care compared to benchmark of 45%).

**Explaining the Findings**

Whenever there is uncertainty, there is risk. In the case of Medicaid, what is uncertain is the cost of healthcare that will be used by the covered population. Since Medicaid is an individual entitlement, policymakers are always uncertain how much Medicaid will cost. This uncertainty makes it impossible to accurately predict and budget for Medicaid unless program costs can be fixed by passing financial risk to a vendor. During the past decade most states have shifted risk to vendors and changed their own roles from being “payers” of Medicaid healthcare to being “purchasers.” This dental demonstration is an example of this approach in which the vendor, in turn, has passed financial risk on to dental providers through capitation.

The relationship between risk and reward strongly influences behavior. “Risk” may explain changes in quality that occurred between the preexisting fee-for-service dental program and the capitation demonstration. When providers assumed the financial risk for delivering care to this population of pediatric Medicaid beneficiaries, the economic incentives to “under treat” appear to have led to far poorer quality of care. However, it is impossible to determine how much of decline in quality measured by this report resulted from underreporting by dental providers.
CHARTBOOK
2003 Dade County Total Claims" AHCA document received by Collins Center, July 2006; ADI quarterly financials provided to AHCA.

TOTAL PROGRAM COST

Pre-Pilot: $14,929,820
Pilot: $15,093,154

"2003 Dade County Total Claims" AHCA document received by Collins Center, July 2006; ADI quarterly financials provided to AHCA.
Quality Effectiveness Measure #1:

**UTILIZATION**

A.

Percent of Continuously Enrolled Children who Obtained One or More Dental Visits

<table>
<thead>
<tr>
<th></th>
<th>Pre-Pilot</th>
<th>Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>154,267</td>
<td>125,023</td>
</tr>
<tr>
<td>57,490</td>
<td>(37%)</td>
<td>27,027</td>
</tr>
</tbody>
</table>

42% Decrease

University of Florida Report Tables 6 (pre-pilot) and 7 (pilot).
Quality Effectiveness Measure #1: UTILIZATION continued

B.

Percent of Children Enrolled at Any Time Who Obtained One or More Dental Visits

<table>
<thead>
<tr>
<th></th>
<th>Pre-Pilot</th>
<th>Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td>264,321</td>
<td>247,785</td>
</tr>
<tr>
<td>77,839 (29%)</td>
<td></td>
<td>39,833 (16%)</td>
</tr>
</tbody>
</table>

University of Florida report Tables 8 and 10 (pre-pilot), 9 and 11 (pilot).

45% Decrease
Quality Effectiveness Measure #2:

A. VISITS

Number of Visits Prorated Across All Children Enrolled At Any Time

- Pre-Pilot: 0.60
- Pilot: 0.24

61% Decrease

University of Florida Report Tables 8 (pre-pilot) and 9 (pilot).
Quality Effectiveness Measure #2: VISITS continued

B.

University of Florida Report Tables 6 and 8 (pre-pilot), 7 and 9 (pilot).

54% Decrease
Quality Effectiveness Measure #3:

DENTISTS

Number of Dentists Providing Services to Children in Medicaid

- Pre-Pilot: 669
- Pilot: 276

59% Decrease

University of Florida Report Tables 13 (pre-pilot) and 15 (pilot).
Quality Effectiveness Measure #4:

PREVENTIVE CARE

A.

Number of Dental Cleanings Provided to Enrolled Children

Pre-Pilot

Pilot

75,119

31,106

59% Decrease

"2003 Dade County Total Claims" AHCA document received by Collins Center, July 2006; Child Preventive Dental Services Report received by Collins Center from AHCA in April 2006.
Quality Effectiveness Measure #4:
PREVENTIVE CARE, continued:

B.

"2003 Dade County Total Claims" AHCA document received by Collins Center, July 2006;
Child Preventive Dental Services Report received by Collins Center from AHCA in April 2006.
Quality Effectiveness Measure #5:

A. DENTISTS’ PERFORMANCE DURING THE PILOT

Percent of Dentists Providing Cleanings to Enrolled Children During the Pilot

- 79% of Dentists reported providing cleanings to 1-20% of enrolled children
- 2% of Dentists reported providing cleanings to more than 50% of their enrolled children
- 8% reported providing no cleanings
- 10% reported providing cleanings to 1 to 20% of enrolled children
- 1% reported providing cleanings to 20 to 50% of enrolled children

Percent of Enrolled Children to whom Dentists Provided Cleanings

Child Preventive Dental Services Report received by Collins Center from AHCA in April 2006.
Quality Effectiveness Measure #5: DENTISTS’ PERFORMANCE, continued

B.

Percent of Dentists Providing Cleanings to a Greater Percent of Children Than Were Served in the Pre-Pilot Year

- 92% provided cleanings to LESS than 24% of Children enrolled in their practices
- 8% of dentists provided cleanings to MORE than 24% of Children enrolled in their practices

Child Preventive Dental Services Report received by Collins Center from AHCA in April 2006.
Quality Effectiveness Measure #6:

**DENTISTS OF RECORD**

Each figure represents 1000 children

**Pre-Pilot**
- 1 Dental Office
- Served between 1 and 1940 Children

**Pilot**
- 1 Dental Office
- Assumed responsibility for 1 to 5892 Children

University of Florida report, page 13; Child Preventive Dental Services Report received by Collins Center from AHCA in April 2006.
Quality Effectiveness Measure #7:

EXPENDITURES PER CHILD

Dollar Value of Total Services Purchased Per Child Served

<table>
<thead>
<tr>
<th>Pre-Pilot</th>
<th>Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Rate</td>
<td>Commercial Rate</td>
</tr>
<tr>
<td>$156.36</td>
<td>$95.04</td>
</tr>
<tr>
<td>$372.29</td>
<td>$226.29</td>
</tr>
</tbody>
</table>

The Medicaid rate and the Commercial rate show a **39% DECREASE** in the Dollar Value of Total Services

University of Florida Report, Tables 10 (pre-pilot) and 11 (pilot); "2003 Dade County Total Claims" AHCA document received by Collins Center, July 2006
Quality Effectiveness Measure #8:

PURCHASING POWER OF MEDICAID DOLLARS

A.

Purchasing Power of Each Medicaid Dollar Expended

Pre-Pilot: $0.79

Pilot: $0.25

Payment rates show a 68% DECREASE in Purchasing Power per Dollar Expended

University of Florida report Table 11; "2003 Dade County Total Claims" AHCA document received by Collins Center, July 2006; Quarterly Financials Provided by ADI to AHCA obtained from Collins Center.
Quality Efficiency Measure #1:

**COST PER BENEFICIARY**

State Expenditure Per Enrolled Child

- **Pre-Pilot**: $56.48*
- **Pilot**: $64.17**

*Average Cost, based on 264,321 Enrolled Children (Pre-Pilot)

** Average Cost, based on 247,785 Enrolled Children (Pilot)

14% Cost Increase

University of Florida Tables 10 (pre-pilot) and 11(pilot).
Quality Efficiency Measure #2:

**COST PER UTILIZER**

State Expenditure Per Enrolled Child Who Obtained at One or More Dental Visits

- **Pre-Pilot**: $191.80*
- **Pilot**: $399.17**

*Average Cost, based on 77,839 Enrolled Children Who Received at Least One Dental Visit (Pre-Pilot)

**Average Cost, based on 39,833 Enrolled Children Who Received At Least One Dental Visit (Pilot)

University of Florida Tables 10 (pre-pilot) and 11(pilot).
Quality Efficiency Measure #3:

**COST PER VISIT**

State Expenditure Per Dental Visit

- **Pre-Pilot**: $94.65 *
- **Pilot**: $272.55 **

*Average cost per visit, based on 157,735 Dental Visits (Pre-Pilot)

** Average Cost, based on 58,337 Dental Visits (Pilot)

University of Florida Tables 8 (pre-pilot) and 9 (pilot).
Quality Efficiency Measures 1, 2, & 3 combined:

Comparison of State Expenditures Based on Enrollees, Enrollees Receiving At Least One Visit, and Dental Visits

University of Florida Tables 8, 9, 10 and 11.
Quality Efficiency Measure #4:

**COST PER PARTICIPATING DENTIST**

State Expenditure Per Participating Dentist

- **Pre-Pilot**: $22,316.62 *
- **Pilot**: $57,608.70 **

*Average cost, based on 669 Participating Dentists (Pre-Pilot)

**Average Cost, based on 276 Participating Dentists (Pilot)

- **59%** Fewer Participating Dentists
- **158%** Higher Cost

University of Florida report Tables 13 (pre-pilot) and 15 (pilot).
Quality Timeliness Measure:

A. **OBJECTIVE MEASURE OF TIMELINESS**

University of Florida Report Tables 6, 7, 8 and 9.

42% Drop in Utilization and 54% Drop in Visits for Continuously Enrolled Children Suggest a Loss of Timeliness of Care
B. SUBJECTIVE MEASURE OF TIMELINESS

Parents' Survey Response Regarding Timeliness

69% of Parents surveyed reported that routine care was "Always or Usually" available when wanted.

University of Florida Report page 17.
Quality Equity Measure:

Florida Medicaid Utilization Pre-pilot and Pilot in Comparison to Federal Benchmark

University of Florida Tables 8 and 10 (pre-pilot); 9 and 11 (pilot).
### Cost

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot Fee For Service State Program</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot Fee For Service State Program</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Program Cost</td>
<td>$14,909,820</td>
<td>$15,093,154</td>
<td>1%</td>
<td>&quot;2003 Dade County Total Claims&quot; AHCA document received by Collins Center, July 2006</td>
<td>Quarterly Financials Provided by ADI to AHCA obtained from Collins Center</td>
<td></td>
</tr>
</tbody>
</table>

### Quality Effectiveness Measure #1: Utilization

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Percent of Continuously Enrolled Children who Obtained One or More Dental Visits</td>
<td>37.3%</td>
<td>57,490</td>
<td>154,267</td>
<td>21.6%</td>
<td>27,027</td>
<td>125,023</td>
</tr>
<tr>
<td></td>
<td>Percent of Children Enrolled At Any Time With One or More Dental Visits</td>
<td>29.4%</td>
<td>77,839</td>
<td>264,321</td>
<td>16.1%</td>
<td>39,883</td>
<td>247,785</td>
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### Quality Effectiveness Measure #2: Visits

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Visits Prorated Across All Children Enrolled At Any Time</td>
<td>1.02</td>
<td>157,735</td>
<td>154,267</td>
<td>0.47</td>
<td>58,337</td>
<td>125,023</td>
</tr>
<tr>
<td></td>
<td>Number of Visits Prorated Across Children Who Obtained One or More Dental Visits</td>
<td>1.02</td>
<td>157,735</td>
<td>154,267</td>
<td>0.47</td>
<td>58,337</td>
<td>125,023</td>
</tr>
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### Quality Effectiveness Measure #3: Dentists

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number of Dentists Providing Services to Children in Medicaid</td>
<td>Total</td>
<td>680</td>
<td>Total</td>
<td>276</td>
<td>-58.7%</td>
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### Quality Effectiveness Measure #4: Preventive Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Dental Cleanings Provided to Continuously Enrolled Children</td>
<td>75911</td>
<td>31106</td>
<td>-59.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of Children Enrolled At Any Time Who Obtained A Dental Cleaning</td>
<td>24%</td>
<td>75911</td>
<td>322,400</td>
<td>9%</td>
<td>15553</td>
<td>171,364</td>
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### Quality Effectiveness Measure #5: Dentists' Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
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<tbody>
<tr>
<td></td>
<td>Percent of Dentists Providing Cleanings to Enrolled Children</td>
<td>10%</td>
<td>75911</td>
<td>322,400</td>
<td>24%</td>
<td>15553</td>
<td>171,364</td>
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### Quality Effectiveness Measure #6: Dentist of Record

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number of Children Per Dental Provider</td>
<td>range: 1 to 1940</td>
<td>range: 1 to 5892</td>
<td>Same as above calculation inflated by 42% to compensate for discounted fees</td>
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</table>

### Quality Effectiveness Measure #7: Expenditures Per Child

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dollar Value of Services Per Child Served</td>
<td>Medicaid Payment Rates</td>
<td>$13.03</td>
<td>$156.36</td>
<td>$7.92</td>
<td>$95.04</td>
<td>-39.2%</td>
</tr>
<tr>
<td></td>
<td>Dollar Value of Services Per Child Served</td>
<td>Commercial Payment Rates</td>
<td>$372.29</td>
<td>$226.29</td>
<td>$372.29</td>
<td>$226.29</td>
<td>-39.2%</td>
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### Quality Effectiveness Measure #8: Purchasing Power of Medicaid Dollars

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
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<tbody>
<tr>
<td></td>
<td>Purchasing Power of Each Medicaid Dollar Expended</td>
<td>Medicaid Payment Rates</td>
<td>$14,909,820</td>
<td>$15,093,154</td>
<td>1%</td>
<td>&quot;2003 Dade County Total Claims&quot; AHCA document received by Collins Center, July 2006</td>
<td>Quarterly financials provided by ADI to AHCA obtained from Collins Center</td>
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<td></td>
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<td>$13.03</td>
<td>$156.36</td>
<td>$7.92</td>
<td>$95.04</td>
<td>-39.2%</td>
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</table>

### Quality Efficiency Measure #1: Cost per Utilizer

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicaid dollar purchasing power at Medicaid payment rates</td>
<td>$0.79</td>
<td>$0.25</td>
<td>-48.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #2: Cost per Visits

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial dollar value purchased</td>
<td>$372.29</td>
<td>$226.29</td>
<td>-39.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #3: Cost per Visit

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commercial dollar value purchased</td>
<td>$372.29</td>
<td>$226.29</td>
<td>-39.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #4: Cost per Participating Dentist

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State Expenditure Per Participating Dentist</td>
<td>$264,211</td>
<td>$58,48</td>
<td>$247,785</td>
<td>$64.17</td>
<td>UF Table 10</td>
<td>UF Table 11</td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #5: Cost per Beneficiary

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State Expenditure Per Enrolled Child</td>
<td>$73,639</td>
<td>$191,80</td>
<td>$398,33</td>
<td>$399.17</td>
<td>108.1%</td>
<td>UF Table 10</td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #6: Cost per Visit

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State Expenditure Per Dental Visit</td>
<td>$157,735</td>
<td>$94,65</td>
<td>$583,37</td>
<td>$272.55</td>
<td>188.0%</td>
<td>UF Table 10</td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #7: Objective Measures of Timeliness

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Objective Measures of Timeliness</td>
<td>no data available</td>
<td>42% Drop In Utilization and 54% Drop in Visits For Continuously Enrolled Children Suggests a Loss of Timeliness of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #8: Subjective Measure of Timeliness

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subjective Measure of Timeliness</td>
<td>69% of Parents Surveyed Reported That Routine Care was &quot;Always or Usually&quot; Available When Wanted</td>
<td>From above calculations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #9: Quality Equity Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Equity standard is dental utilization rate for US non-poor children from federal MEPS survey: 45%</td>
<td>0.29%</td>
<td>short of target: -36%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality Efficiency Measure #10: Quality Efficiency Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Percent Change</th>
<th>Pre-Pilot</th>
<th>Pilot Capitation ADI Program</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Utilization rate</td>
<td>16%</td>
<td>short of target: -64%</td>
<td>UF Tables 8 and 10</td>
<td>UF Tables 9 and 11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See quality effectiveness measure #1 above