State Medicaid and CHIP Experiences Promoting Children's Preventive Dental Visits

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Caitlyn Newhard:

I want to welcome you all to our third webinar in the *Promoting Children's Preventive Dental Visits* webinar series. My name is Caitlyn Newhard, and I am a Managing Consultant at Mathematica. We'll begin with an introduction from Shaelyn Hawkins with the Center for Medicare and Medicaid Services, who will discuss the importance of children's preventive dental and highlight some of CMS's quality improvement resources.

Then, I will provide an overview of current clinical recommendations and preventive dental service utilization trends, highlighting opportunities for state improvement. Then, we'll have two states, Idaho and New Jersey, showcase their work to promote children's preventive dental visits in Medicaid in their states. We'll have time at the end for Q&A and then close out by sharing information about upcoming opportunities in the series. Materials from today's webinar, including the recording, slides, and a transcript, will be posted to Medicaid.gov in the coming weeks. Next slide. And with that, I'll turn things over to Shaelyn Hawkins with CMS.

Shaelyn Hawkins:

Thanks, Caitlyn. Good afternoon, everyone, and thank you for joining us today. I'm Shaelyn Hawkins from the Division of Quality and Health Outcomes here at CMS. Next slide, please.

To provide some background, tooth decay is a common but preventable chronic disease among children in the U.S. Children and adolescents from low-income families, including those covered by Medicaid and CHIP, are roughly twice as likely to have untreated tooth decay as their higher-income peers. To address these gaps in children's oral health, we at CMS provide quality improvement technical assistance to support states in enhancing oral health care for children enrolled in Medicaid and CHIP. Next slide, please.

On Medicaid.gov, you can find a variety of oral health QI resources, including webinar recordings, state highlights from our previous affinity group, a video on how to get started with a QI project, and an example driver diagram and measurement strategy. Recordings and slides from this entire webinar series will also be posted there soon. Next slide, please.

Reflecting on our previous work in 2020, we launched a learning collaborative focused on increasing the delivery of oral health screening to children ages 0 to 5 years by primary care providers. The technical assistance included a webinar series that highlighted state Medicaid and CHIP strategies for improving children's oral health outcomes. Following the webinar series, we hosted the *Advancing Oral Health Prevention in Primary Care* Affinity Group, in which 14 states participated, as shown on the map on this slide. And you can find more information on this affinity group at the link provided. Next slide, please.

This current learning collaborative is really meant to build on the previous one by trying to help states improve systems to establish regular, ongoing care from dental providers, especially for kids who've been screened in primary care and referred to a dentist. Routine dental visits play a critical role in children's health by monitoring tooth and gum development, preventing tooth decay, establishing good oral hygiene habits, and enabling early identification and treatment of issues, all of which promote lifelong oral health. I'll now pass it back over to Caitlyn. Thank you.

Caitlyn Newhard:

Thanks, Shaelyn. Next slide. Next slide. Under federal law, state Medicaid programs must provide comprehensive oral health care to all beneficiaries under age 21 as part of the Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT benefit. Medicaid Expansion, M-CHIP, programs must provide the full EPSDT benefit, whereas separate CHIP programs are not subject to EPSDT requirements. However, the program must provide benchmark equivalent coverage, which includes coverage for dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

As part of the EPSDT requirements, all states must develop or adopt a dental periodicity schedule in consultation with recognized dental organizations involved in child health care, cover medically necessary dental services to correct or ameliorate dental conditions, and provide a referral to a dentist for every child in accordance with each state's periodicity schedule and at other intervals as medically necessary. Next slide.

The American Academy of Pediatric Dentistry, or AAPD, recommends that children have their first dental visit when the first tooth erupts and no later than age one. Follow-up exams every six months are recommended, though some children may need more frequent visits depending on their risk status. This table outlines the AAPD's recommended dental periodicity schedule, the timeline for when children should receive various dental services and screenings.

It shows how oral health needs evolve as children grow from infancy through adolescence. Core elements like clinical exams, fluoride treatments, and caries risk assessments are recommended at every age. As children get older, new services are added, such as sealants, periodontal assessments, and counseling for habits or risk behaviors. It is important to note that states are not required to use AAPD's dental periodicity schedule. States can establish another periodicity schedule in consultation with the appropriate professional organizations. Next slide.

Despite strong evidence supporting the importance of early and routine dental care, many children are not receiving timely dental visits. There is a persistent gap between privately and publicly insured children, which includes those covered by state Medicaid and CHIP programs. As shown in this graph, over the past 20 years, we have seen no signs of closing the gap, and children with private insurance have consistently received more dental visits than those with public insurance, with about a 20-percentage-point difference in 2022. Next slide.

There are three measures on the Child Core Set associated with services received during children's preventive dental visits: Oral Evaluation Dental Services, or OEV-CH; Topical Fluoride for Children, or TFL-CH; Sealant Recipient and Permanent First Molars, or SFM-CH. On the next slide, I will walk through OEV-CH in more detail, the measure of focus for this affinity group, and show recent data which underscores opportunities for improvement across states. Next slide.

OEV-CH examines the percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation as a dental service within the measurement year. It was first added to the 2022 Child Core Set and is a mandatory measure. When we look across state Medicaid programs, we see lots of opportunity for improvement. For 2024 Core Set reporting, which reflects calendar year 2023 data, the median value was 44.8% for this measure, with notable regional variation with reported rates ranging from 27% to 61%. Next slide.

Now, I'd like to introduce our first speaker, Wolf Tom from the Idaho Department of Health and Welfare. And Kendra Aracena from Managed Care North America, the state's Dental Benefits Administrator, who

will share their collaborative, data-informed QI efforts to improve children's utilization of preventative services.

Wolf Tom:

Idaho Medicaid provides comprehensive health coverage for low-income children. adults, pregnant women, and individuals with disabilities with various plan options like our Basic, Enhanced, and our Medicare and Medicaid Coordinated Plans, depending on the eligibility and the health needs of the individual. Our Basic Plan covers essential preventative medical, dental, and vision services. The Enhanced Plan includes those basic benefits, plus specialized services for those with disabilities or special health needs. Our Medicare and Medicaid Coordinated Plan is for individuals who have both Medicare and Medicaid, and it offers enhanced benefits and coordinated care through a managed care option. Next slide, please.

Idaho's Medicaid Dental Plan, which serves nearly 310,000 members, is known as Idaho Smiles. The Idaho Medicaid Children's Dental Plan serves over 160,000 members aged 0 to 20. And in 2016, MCNA, Managed Care North America, was selected as Idaho's managed care partner to administer the dental Medicaid benefits for our Idaho Smiles members. Next slide, please.

The Idaho Department of Health and Welfare has strategically included access and oral health improvement activities in our contract with MCNA, and those include the Sealant Program, which is aimed to increase the sealant application rates in children aged 6 to 14. Our Dental Home Program is aimed to increase the rate of children aged 0 to 3 who are actively receiving oral health care in a dental home. The Pregnancy Outreach Program is aimed to mitigate risk associated with the oral health literacy of pregnant members that can result in poor birth outcomes, and Bright Beginnings targets and educates them about the importance of proper oral hygiene during pregnancy and how to care for their new baby's oral health.

A quarterly access and oral health improvement report was implemented to inform Idaho Department of Health and Welfare of the progress on these targeted oral health outcomes, specifically the Dental Homes for Children aged 0 to 3, the Bright Beginnings for Pregnant Members, and the sealant Program for the 6-14-year-olds, and appropriate appointment assistance provided for children's services. The Access and Oral Health Improvement Activity Plan, utilized by MCNA to define newly proposed oral health initiatives, include expected outcomes and costs, and these contractual requirements have helped facilitate a strong collaborative relationship with MCNA and deliver improved oral health outcomes for Idaho Smiles members. Next slide, please.

And with this, I'm going to turn over to Kendra to delve a little bit more into how MCNA played an active role in this progress.

Kendra Aracena:

Thank you, Wolf. So, our QI program is designed to monitor and improve dental quality care and appropriateness. So, we're making sure that our members are receiving the right care at the right time. And a key part of our program is early identification, and that involves catching any issues and spotting opportunities for improvement before they become bigger problems. This proactive approach is what helps us maintain high standards of care. Another major focus is access, especially for our children. We want to continuously improve access to preventive dental services because we know that prevention is the foundation for not only good oral health, but also for our members' overall health. Everything that we do is aligned with state and federal regulations, accreditation standards, and Medicaid requirements from CMS as well as from IDHW. This ensures compliance and consistency across the board.

Our program also includes performance improvement projects, or PIPs, and our topics are including targeted initiatives that focus on utilizations to improve oral health outcomes. We also have our board of directors, and they have delegated authority to our Idaho Quality Improvement Committee, or QIC, to oversee and implement this program, and they play a really critical role in driving these efforts forward. And lastly, our QIC, it's designed for collaboration. So we have Idaho network providers, and then we also have our member advocate outreach specialist manager, who sits on our committee to provide that member feedback and make sure that our program is tailored to the communities that we're serving. Next slide, please.

So MCNA is built on the Institute of Healthcare Improvement's triple aim framework, which many of you are familiar with. But we've expanded that program to form our quadruple aim. And the quadruple aim adds a critical component, which is the dentist experience that we've included as a pillar, because we know that provider engagement and satisfaction directly impacts the quality of care that our members are receiving. And so, these four pillars, which are improved patient experience, patient outcomes, the dentist experience, and reduced cost of care, they guide everything that we do in preventive services. And by following this in framework, it ensures that our intervention strategies are in alignment with our members, providers, as well as nationally recognized standards of care. Next slide.

So, transitioning into how we develop and evaluate our interventions, here at MCNA, we start first by identifying any root causes. And we do that by both qualitative and quantitative barrier analyses. This helps us to understand what's preventing members from getting care and why. And to do this, we get feedback from two key sources. The first being our network providers through internal committees, such as our Dental Advisory Committee.

And then, like I mentioned before, they also are on our Quality Improvement Committee. And then we also get feedback from our members through outreach events and partnerships with community organizations. And this is really where our member advocate outreach specialists come in. And just a little background, our member advocates are MCNA staff members, and they serve as our boots on the ground, directly engaging with members during any outreach events and partnerships to collect any feedback. And then they bring that back to the QIC to share with our committee members.

And so, once we understand their barriers, we do use a rapid cycle approach to test our interventions on a small scale first, so that we can see what's working and then make any adjustments before rolling them out on a broader scale. And then once an intervention is adopted and implemented across all membership, we then monitor and track its performance using a software tool, Power BI, which we'll get into in the next few slides. Next slide, please.

So, within our QI program, we use key performance indicators, or KPIs, to track progress, especially for preventive services. And so, these KPIs can be established based on different factors. For example, it can be based on regulatory or contractual requirements. So, if we have anything from CMS or IDHW Medicaid, as well as URAC or NCQA accreditation standards, we will use those to set our KPIs. And then we also have evidence-based clinical guidelines.

We incorporate recommendations from organizations like the American Academy of Pediatric Dentistry, as well as the ADA, or American Dental Association, to ensure that our measures reflect the best practices in preventive dental care. And then we also look into past data to identify any areas where improvement is needed most. For example, we may look at sealant or fluoride application compliance. Another factor would be stakeholder input. So, we get feedback from providers and members and committees like our QIC and DAC that help us to prioritize the measures that matter most to our membership. And so, you see here, these are some examples of the KPIs that we track on an internal dashboard, as well as that are within our Power BI tool.

So, we're looking at percentage of targeted educational outreach events that our member advocates may have completed. And then we're also tracking percentage of members who are receiving a sealant on a permanent first molar by the age of 10, provider compliance with those AAPD and ADA preventive guidelines, and also percentage of members receiving the recommended twice annual fluoride applications. And so, once we've established our KPIs, we monitor them monthly at the leadership level. And then we do a deeper review during our quarterly QIC. So, this ensures accountability and continuous improvement. Next slide, please.

So here is a screenshot of a Power BI that we're using to track our interventions. And you can see in the upper left, we can select by plan because we have all of our markets built into Power BI. So, we can select specifically IDHW. And we also have all of our interventions loaded in here. So, this one specifically is looking at our text messages. And then going more to the right, you see it says visit type and it has a dropdown.

So, within that, I can also look to see from our text messages how many of our members had a preventive visit, how many of them had a sealant, how many had fluoride, or how many just accessed a dental provider period. And then going further to the right with the red font, I can track within the number of days. So, I can say within zero to 60 days of receiving a text message, 90 days, 120 days. And then I can also to the farthest right, I can filter by the age. And then we also can select the time period. I can select one specific year or I can select all years.

In this particular example, this is just looking at calendar year 2023. And we have it broken down by a quarterly basis that we can look at our results that will give a total. And so, it would give you a numerator, denominator, and then the overall rate. This specifically, since it's filtered on a visit type of preventive dental services, this would tell me how many percentage of members have received a preventive visit within 60 days of receiving a text message. Next slide.

So now let's take a look at some of the impacts of our interventions that we had last year. So, our dedicated outbound call team, Care Connections, made over 157,000 calls to members who were overdue for an oral eval. And of those members, 12% received an exam within 90 days of contact. And that's a significant number when you consider the scale of outreach that we did. We know that many members are not responsive to phone calls. So, we also sent preventive text messages to more than 7,700 members who haven't had a preventive service in the last six months. And the result for that is we had 11% complete a preventive service within 90 days.

And then we also have appointment assistance through our member hotline. So that's members calling in internally. They may be calling in for an ID card, but what's really great with our proprietary system dental track is, is that it will flag if a member is overdue for a checkup or for sealants or fluoride. And so, our Care Connections team will educate them on the importance of receiving those services and also assist with scheduling an appointment. And so, we had 470 members accept help, and 28% of those actually completed a preventive service within 90 days. That's the highest conversion rate among these interventions, which tells us that personalized assistance really works.

Finally, we also mail targeted outreach to over 153,000 members who haven't received an oral eval. And from that group, 11% received an exam within 90 days. So, you can see that by using the different ways to reach members, whether that was through calls, text messages, mailings, inbound calls, we were able to drive measurable improvement in access to care. Next slide, please.

This slide highlights some of the ways that we've addressed social determinants of health last year. The first thing that we did was we partnered with one of our network providers, Dr. Meshack-Hart and his team from Terry Reilly, to host a Van Day in Parma, Idaho. And just a little background on Terry Reilly,

they are a Federally Qualified Health Center of QHC, and they provide comprehensive medical, dental, and behavioral health services to underserved communities in Idaho.

They're also a trusted partner in improving access to care, especially in rural areas where resources are limited. And so, we did have our Van Day in Parma, which is a rural area, and tried to really target members who were overdue for a checkup and get them in. And so, it was a great example of meeting members of where they are and leveraging our community partnerships to close gaps. Second, we also coordinated over 1,700 in-office interpretation services with the top languages requested being Arabic, Dari, and Swahili.

We know that language access is critical for equitable care, and this helps us to remove any communication barriers that our members may be facing. And then finally, our member advocates visited schools that we identified to be low literacy counties, and we donated copies of our book, "Itty Bitty Baby Teeth." This is a book that our dental hygienist team created, and they delivered it to students that were in kindergarten through third grade. And so, this helps to promote oral health education early on, especially in communities where literacy challenges can impact health outcomes. Next slide, please.

So just like how I showed you on the previous slide, we use Power BI to track our interventions. We also use it to track our performance measures. So, this is an example of us tracking one of our performance measures. It has the market start date up at the left. It also has the last date that it was refreshed. We have a run chart at the top that has all of the years. So, in this case, it's going from 2017 all the way to 2025. You can see our performance year over year.

And then also at the bottom, we have the rates by month broken down for each of those years. And what's really great about it is I can see how we're trending in comparison, let's say, to the point in time last year. So, I can look at what our rate is for October of 2025 and see what it was October 2024, October 2023, and just to see how we're trending. And then that way, if we have any interventions or anything that we want to do to put in place to help drive utilization, especially if we have targets that we're trying to hit, then we can intervene and implement those interventions to close out those gaps. Next slide, please.

So, we've talked about our QI program design. We've talked about establishing and monitoring our KPIs, outreach initiatives and their outcomes. But now we're going to touch on the success that we actually saw in our performance measure outcomes last year. First, we increased the rate of members ages 0 to 20 who received a comprehensive or periodic exam by 11%. And that's been a big win for access to care.

Next, our preventive services improved, I'm sorry, across the board. For members ages 1 to 20, preventive services went up by 5%. For adults ages 21 and over, preventive service rates also increased by 11%. We saw progress in fluoride treatments. So twice annual fluoride applications for members ages 1 to 20 increased by 5%. Sealant rates, those improved as well. So, for permanent first molars by the 10th birthday, we saw a 2% increase for at least one molar sealed and then a 3% increase for all four molars sealed. Looking at our permanent second molars by the 15th birthday, we saw a 3% increase for at least one molar sealed and an impressive 8% increase for all four molars sealed. So, these numbers show that our interventions are working not just in outreach but in driving real improvement in preventive care. Next slide.

So, we certainly can't do all of this alone. We work very closely with our partners in Idaho. We have the Idaho Oral Health Program and the Idaho Oral Health Alliance to help us do that. We did partner with them in the past and we're also partnering with them this year. So, some of the things that we're doing with them this year is with the Idaho Department of Welfare, we have a Consortium for Oral Health Building State Capacity for Integration Learning Collaborative.

And within that group, we're targeting OB clinics and we're doing education for those providers who are dealing with pregnant members to educate them and get that referral over to a dental provider. Because we know that it's critical, especially for pregnant women, to seek dental care while they're pregnant. And it's important for their fetus and also for establishing those behaviors within them so that that can help their unborn child when they are coming in and having that first birthday, first checkup by the first birthday.

And then through the Idaho Oral Health Alliance, we're also active in their Healthy Me is Cavity-Free steering committee. Through that steering committee, there are three other subcommittees and we have leadership that's present on all three of those. This year has kind of just been us setting up our plan of what we're going to do, but we have some really great exciting things that are coming out of this group into next year. So, we're excited for that. Next slide, please.

So, as we wrap up, I just want to share some key lessons that we've learned through our quality improvement work. First, rapid cycle testing, it really makes a difference. Using PDSA cycles has allowed us to refine our interventions before scaling them up, which saved time and also improved outcomes. And then second, our QIC and dental advisory committees are essential. They help us identify any barriers, develop targeted interventions, and then they guide our efforts through provider and member feedback. And that collaboration is what keeps our program responsive and effective.

And then third, our Power BI tool. It's really a game changer. It helps us track the interventions and the quality measures, as you saw real-time. Also identify gaps, evaluate program effectiveness, and allows us to make those timely decisions. And then finally, the last key piece is engagement with the state and local oral health organizations. That's a really critical piece. These partnerships are what help to align our initiatives with the needs of the community, expand access to preventive care, and promote early intervention strategies. And that wraps up my slide, so I will pass it to Caitlyn.

Caitlyn Newhard:

Thanks, Kendra and Wolf. We appreciate you sharing those insights from Idaho. Next slide. Next, I'd like to introduce Dr. Donna Kurc, the Acting Dental Director for New Jersey FamilyCare, the state's Medicaid program, who will discuss how her state leveraged its managed care model to improve children's utilization of preventive dental services. Dr. Kurc, you now have the floor.

Donna Kurc:

Thank you very much, Caitlyn, and good afternoon, everybody. Next slide, please. We're going to start with an overview of New Jersey FamilyCare's enrollment. You'll see that our total enrollment is about 1.8 million, and almost 96% of that is in managed care. The remainder are in fee-for-service. 19.2% of New Jersey's population is enrolled in New Jersey FamilyCare, and about half of those enrolled in New Jersey FamilyCare are children.

The children who are being included on New Jersey's preventive dental service data that will be discussed in this presentation are shown as Medicaid children, which are about 36% of the members enrolled in New Jersey FamilyCare and are the group that are included on the CMS-416. New Jersey FamilyCare's managed care organization enrollment is highly asymmetric, with the largest MCOs having over 55% of total enrollment. The membership of the two highest performing MCOs approximate 74% of New Jersey FamilyCare's total enrollment. Next slide, please.

New Jersey FamilyCare utilizes five managed care organizations, or MCOs, as well as a fee-for-service program to administrate medical, dental, and behavioral health services. The dental benefit is comprehensive and uniform for both children and adult members. Each MCO utilizes a vendor to

administrate their dental benefit, and in this case it's either SkyGen or Liberty Dental Plan, has its own provider panel, must adhere to a single set of clinical criteria, age, and frequency limits for services, and this is determined by the state Medicaid agency. These criteria are reviewed and revised annually. And each MCO is required to employ a full-time dental director who is a licensed dentist in New Jersey.

New Jersey Medicaid conducts a comprehensive performance evaluation with each MCO twice annually. It includes their dental performance, which includes but is not limited to member appeals and grievances, preventive dental services utilization, and HEDIS and Core Set performance. The New Jersey FamilyCare Dental Director has regular meetings with the MCO Dental Directors to ensure contract compliance, improve service utilization, and access to care, and discuss program improvements. Next slide, please.

Dental service utilization declined sharply during the COVID public health emergency due to office closures and reduced provider participation in New Jersey FamilyCare among dentists and hygienists. So, in an effort to improve the oral health of all New Jersey FamilyCare enrolled children, the DMAHS Dental Unit set a uniform standard across all MCOs for the utilization of children's preventive services. The Dental Unit requires the MCOs to report utilization data for all enrolled children with subgroup reporting for children with intellectual and developmental disabilities. Once service utilization began to recover after the COVID-19 public health emergency, DMAHS set a minimum performance standard of 50% as measured by the Preventive Dental Services measure, or PDENT, and the MCOs that failed to meet this standard were subject to a corrective action plan, or CAP. Next slide, please.

To improve preventive service utilization, the three lowest-performing MCOs were placed on CAPs in early 2022 and were required to implement strategies to improve their performance. The CAP reporting was due to the Dental Unit on a quarterly basis and includes breakdown of the MCO's entire pediatric population. In this case, it includes both Medicaid and CHIP into low, medium, and high outreach priority based on their last preventive dental appointment.

For each quarter, the members in these categories receiving preventive services, the type and frequency of outreach by the MCO or the vendor, and narratives regarding activities specific to that MCO, such things as provider or member incentives or outreach programs that they might have in the community. The DMAHS Senior Management will review the progress of the MCO annually. That's under the CAP. And we have very active question and answer periods and suggestions for further improvements. They're very constructive. And all three MCOs continue to improve on their performance each year, but the progress has been gradual. And the CAP will be closed when an MCO achieves the contract's utilization threshold for that federal fiscal year. Next slide, please.

As previously mentioned, New Jersey uses the PDENT measure as a performance indicator for the MCOs. All MCOs are required to submit quarterly reporting on the cumulative PDENT value for its members, which we call the quarterly dental monitoring measure. And this measure, which was created internally, is based on PDENT as calculated from the CMS-416, and it allows both the MCO and New Jersey FamilyCare to track performance over the course of the year. Monetary sanctions are imposed based on final PDENT performance as calculated for the CMS-416. And as you see here, the line 12B, which is the numerator, is the children with unduplicated claims for HCPCS codes D1000 to D1999. And line 1B of the CMS-416 is the denominator, which are children ages 1 through 20 with continuous 90-day eligibility for EPSDT services. Next slide, please.

Okay, the MCOs that don't meet the utilization threshold specified in the managed care contract are subject to monetary sanctions. In federal fiscal year 2023, the threshold was 50%, with the penalties calculated as shown on the table on the left. In an effort to boost utilization in federal fiscal year 2024, the threshold was raised to 52%, and the penalties for each child were recalculated as shown in the table on the right. The utilization threshold for children's preventive dental services as included in the MCO contracts will continue to be revised upwards as an incentive for continual improvement, and only those

plans which meet the threshold will avoid monetary sanctions. Now let's have a look at MCO performance. Next slide, please.

The five MCOs' uneven preventive utilization performance was evident beginning in federal fiscal year 2019. And as previously mentioned, performance of each plan dropped significantly in federal fiscal year 2020 due to the public health emergency that began in March. Performance improved in federal fiscal year 2021, with the lagging three plans put on CAPs in the following year. The green dotted line in the upper right indicates the performance threshold that is in the managed care contract. In federal fiscal year 2023, four of the five MCOs were subject to sanctions. In federal fiscal year 2024, three of the five MCOs were subject to sanctions. So, we noticed an improvement. The sanctions appear to have motivated the MCOs. Two of the three MCOs involved in CAPs have also shown stronger improvement. And the two largest MCOs have consistently exhibited the strongest performance for children's preventive services. Next slide, please.

We also have other actions taken by New Jersey FamilyCare to improve preventive dental service utilizations, and these are mentioned in our managed care contract. The New Jersey Smiles program allows trained medical providers to provide oral health risk assessment, apply fluoride varnish, and provide anticipatory guidance and a dental referral for children through the age of five years old. The provider must submit an attestation of training for fluoride varnish application to qualify for reimbursement of the CDT code 99188 for fluoride varnish application. Up to four dental preventive visits are allowed for all members with special health care needs and/or intellectual and developmental disabilities without prior authorization. The MCOs have also been encouraged to include a "Find a Provider" function on their websites to help members locate a general dentist, specifically those who will accept members as young as one year of age. Next slide, please.

All right. Now, this should be familiar to everybody. I'm proud to say that New Jersey's performance was 50%, and we hope to continue to improve. And the reason for New Jersey's superior performance in this measure for oral evaluations is a collateral benefit of our recent focus on preventive service utilization. Since preventive services are often rendered on the same date of service as an oral evaluation, this would count as utilization in both categories. Next slide, please.

So, what worked well? Monetary sanctions have been effective in motivating the MCOs to improve member engagement and service utilization, and all members, or MCOs rather, who have been on a CAP have shown an improvement of utilization in every year they have been on the CAP. What we might have done differently would have been respond promptly once a trend in a dip in utilization has been noted. But, of course, COVID was a complicating factor there. Identifying and addressing lagging performance when first observed and establishing a performance threshold sooner. In fact, around the time when the lagging performance was noted, that's when it's a good idea to start thinking about, well, where do you want your performance standard to be? Next slide, please.

In addition to what I've already mentioned about dental CAPs and monetary sanctions, we have other initiatives in New Jersey to improve preventive service and oral evaluation utilization in children and adult populations. The utilization performance threshold to avoid monetary sanctions is expected to regularly be increased in the MCO contracts. The New Jersey Department of Health is conducting basic screening surveillance for oral health for third graders, middle school students, pregnant members, and seniors who are residing in long-term care. So we're looking forward to see what their screening surveillance turns up as far as the oral health population in our state. The DMAHS Behavioral Health Workgroup will have a new performance measure for dental preventive care utilization for members with substance use disorder. And the DMAHS Health Policy Workgroup will be conducting a regional health hub survey of adult oral health in four urban centers in 2026. Next slide, please.

For other states, especially those who utilize managed care, I'd like to make a few suggestions from, you know, what we've learned here in New Jersey, and that is to meet regularly with dental directors and establish a collegial relationship with them, not an adversarial one, because remember, you all have a common goal, which is healthier children in your state. Set and share performance goals. Make your state's objectives clear. Consider your own state's provider base and dental employment statistics when setting goals.

Be realistic. If you have workforce shortages, take this into consideration. Track your MCOs' performance early and often. Quarterly works for us. And consider including performance and reporting requirements in your MCO contract. Update them as necessary. And in addition to sanctions, you might also wish to consider things like payment withholds and bonuses to motivate your managed care plans. It doesn't have to be sanctions. There could be other solutions that could work better for you. So, I'd like to thank everyone for your attention. And back to you, Caitlyn.

Caitlyn Newhard:

Thank you, Dr. Kurc. We appreciate you taking the time to share your findings with us. Next slide. Now we'd like to open the floor up for question and discussion. Next slide, please.

As a reminder, you can submit a question using the Q&A panel located at the bottom right corner of the Webex window. Please be sure to select all panelists when submitting your question. Also, a reminder that materials from today will be available on Medicaid.gov in the coming weeks, which include the slides, recording, and a transcript. So go ahead and chat in those questions via the Q&A panel.

Alright, I will start with the first question here. This is going to be actually for Dr. Kurc in New Jersey. So can New Jersey share some best practices for interfacing with multiple MCOs with subcontracted dental vendors versus direct administration?

Donna Kurc:

Our dental directors, per the contract, are responsible for the oversight of their vendors. So, we track their performance, but it's really the responsibility to, for the dental director for that particular managed care plan to interact with their vendor and make sure that their vendor is performing. So, we'll have annual and sometimes more frequent meetings with the managed care companies. And they will tell us about, you know, how they're working with their vendor and specific programs that is being conducted through their vendor.

But if it doesn't, you know, if the statistics don't bear out that they're getting a positive performance out of this, we will discuss the statistics that they send to us and we will brainstorm about, well, if it isn't working, how are you going to go back to your vendor and insist that they create programs or better outreach techniques to improve your performance? So, it's really, we don't interact in contracts to Idaho, which has a beautiful program. But as they say, you know, if you've seen one Medicaid program, you've seen one Medicaid program. We don't work that closely with a dental vendor. That's really their responsibility. And this is also in our contract of the dental director for that plan to make sure that their vendor delivers. I hope that answered the question.

Caitlyn Newhard:

Thank you, Dr. Kurc. And then as a follow on to this question, Wolf, would you be able to speak to Idaho's experience working with a single dental prepaid ambulatory health plan, or PAHP?

Wolf Tom:

Yes, Idaho actually did do a little research on having multiple carriers, but found that working with one for our needs really did meet our expectations and the needs of our members. So we decided to stay with one. And like I said, working with MCNA has been great. They have so many resources. They are a very large organization and have been able to have experience in other states. So the experience that they earn from those other states brings what they know to Idaho to actually make our experience even better.

Donna Kurc:

Wolf, can I ask you a question?

Wolf Tom:

Certainly.

Donna Kurc:

Do you think that, you know, we're two very different sized states as far as population goes? Do you think not having such a large population as maybe some other states was an advantage in having one organization to work with? Was that a factor?

Wolf Tom:

Yes. Yes, it was. And being such a rural state as well, we're a large state with a lot of area, a lot of pockets with very little population. Finding the providers, we're seriously short on providers in Idaho.

Donna Kurc:

Yeah.

Wolf Tom:

So, dealing with that and trying to deal with another MCO or another vendor to try to compete with the limited resources we have for providers, it didn't make a lot of sense. You know, providers are struggling to make ends meet and not have to have so much overhead administrative burden that they would rather keep it simple as well. And that's what we found worked best for Idaho.

Donna Kurc:

Thank you.

Wolf Tom:

You're welcome.

Caitlyn Newhard:

Yeah, thanks, Wolf. Alright. Question for Kendra for MCNA. Is the Dental Provider Experience Committee for dental providers to share their experience, or patients to share their experience with dental providers?

Kendra Aracena:

I'm assuming you're referring to the Dental Advisory Committee. And within that committee, the providers will share their experience, any barriers that they're encountering, and also any barriers that maybe they've identified that their members are also experiencing. And then that also translates into our Quality Improvement Committee that meets quarterly. We share any feedback that comes out of that committee.

It rolls up into our QIC on a broader platform and gets shared within that committee. So, we're looking at everything. We're looking at their providers' experience, their experience with the member, anything the member's encountering. And then because we also have our member advocate outreach specialist manager who is out there in the community with our members and working closely with the organizations, they're also providing member experience of barriers.

Caitlyn Newhard:

Thanks, Kendra. Alright. And another question for Dr. Kurc. Dr. Kurc, how is New Jersey determining when to adjust the utilization threshold associated with the financial sanctions?

Donna Kurc:

We have increased it basically over time because we see that if we insist on a certain level of performance, it serves as an incentive to motivate the managed care plans. So, as we consider, you know, continually raise it, they are incentivized to meet the challenge. And basically, their performance has been improving. So that is really what we're basing it on. It's like we really would like to get beyond 52%. We have set the standard for federal fiscal year 2026 for 53%. So, we continue to raise the bar and the plans continue to strive for it.

Caitlyn Newhard:

So how did you all decide to raise it to 53%? Is it just based on whether or not a sufficient number of MCOs are hitting the threshold, the existing threshold, I should say?

Donna Kurc:

Sure. In the chart that I showed about the preventive service utilization, you'll see that the two largest plans meet the threshold. And when you look at the two largest plans, you're talking about, about 75% of the kids in New Jersey FamilyCare. So, a lot of those children are in plans that can meet that challenge. And we're trying to work, and we are working with, the other plans to get them to also be able to meet their challenge through their CAPs.

Caitlyn Newhard:

Great. Thank you.

Stephanie Reyna:

So, for both states, we got a question. Do you face challenges with having an adequate network of dentists accepting Medicaid beneficiaries? And if so, could you speak to what your state is doing to address that?

Wolf Tom:

I can go first. Idaho, as other states, always faces a shortage of providers. We do our best to do what we can. And I have asked MCNA on a quarterly basis to reach out to 25% of the providers that are not Medicaid enrollees to invite them to participate in the network. Every quarter they do reach out and we still haven't had much success, but it is an effort that we are using and utilizing to try and grow that network as best we can.

Donna Kurc:

Okay. In New Jersey, in our managed care contract, we have specific requirements for network adequacy as far as geo access, distance traveled, whether it's an urban or a non-urban area. And although New Jersey is probably often thought of as being a pretty urban state, we do have some counties that are much more rural and have fewer dental providers than we would like to see. So, there are contract provisions that have to be met as far as the number of providers that are available.

The MCOs all have to meet those requirements, and there are penalties for those MCOs who cannot meet the requirements in the contract for provider access. It's really up to the MCOs to reach out to the providers who are in their panels and incentivize them to be providers, be more active providers. And if they are lacking providers in certain areas of the state, to go out and get more providers who may not previously be on their panels to join. So that's a responsibility that's really pretty squarely in the lap of the MCOs to provide the provider panels and the network adequacy that they're contractually bound to do.

Stephanie Reyna:

Thank you so much for both of you answering that question. I think with that, we'll close out our question and discussion section. Special thank you to our state presenters and to all of our attendees for sending in your questions. Move us on to the next slide.

So, to build on topics discussed in the webinar series, CMS is launching an affinity group focused on promoting children's preventive dental visits. The affinity group will begin in early 2026 and run for 21 months. An informational webinar was held on December 3rd and materials will be available on Medicaid.gov soon. All webinar series registrants will receive an email when those materials are posted. Interested states must submit an expression of interest form to participate in the affinity group. Those forms are due on January 9th. The expression of interest form is available at the link shown on the slide. And the link was also provided to you in the chat. If you have any questions about the affinity group or expression of interest process, please email the CMS mailbox at MedicaidCHIPQI@cms.hhs.gov. This is also available in the chat.

Thank you for your participation in today's event and another special thank you to all of our state presenters. We ask that you please complete the evaluation as you exit the webinar. We appreciate your feedback and the information gathered will be used to improve future webinar series. Thank you for joining us and have a great rest of your day.