DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
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CMCS Informational Bulletin

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FROM: Calder Lynch, Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: CMS Oral Health Initiative and Dental Technical Support Opportunity

The Centers for Medicare & Medicaid Services (CMS) launched the Oral Health Initiative (OHI) in 2010 and set national and state-specific goals to improve Medicaid-enrolled children's use of preventive dental care. While the proportion of Medicaid-enrolled children receiving a preventive dental service has risen from 42 percent in federal fiscal year (FFY) 2011 to 48 percent in FFY 2018, the national target of 52 percent has not yet been met. This Informational Bulletin provides an update on state Medicaid agencies performance and progress on the OHI, announces the continuation of the OHI to support continued progress and drive further quality improvement, and provides an overview of technical assistance opportunities CMS will provide to states to support them in advancing preventive oral health services in order to reduce childhood tooth decay.

Background

Tooth decay is one of the most common chronic diseases of childhood, even though it can be prevented. Left untreated, dental disease can cause significant and long-lasting effects, including emergency room and operating room visits, and in rare cases, death. Tooth decay can have effects on other facets of life including children's healthy growth and development.[1] Prevalence of tooth decay is higher among low-income children, who are likely to be enrolled in Medicaid and the Children's Health Insurance Program (CHIP). In the period 2011-2016, 33.9 percent of two- to five-year-olds in households with incomes less than 100 percent of the Federal Poverty Level (FPL) had experienced tooth decay in their primary teeth, compared to 15.7 percent of children in households with income over 200 percent FPL. Likewise, 17.2 percent of two- to five-year-olds in households with incomes less than 100 percent of the FPL had untreated decay, compared to 6 percent of children in higher-income households. Among older children, 24.6 percent of children ages 6 to 11 had experienced tooth decay, and 8.1 percent had untreated decay in their permanent teeth, compared to children in households with income over 200 percent FPL, where 12 percent had experienced tooth decay, and 3.5 percent had untreated decay.[2]

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[1] Casamassimo, Paul et. al. "Beyond the DMFT: the human and economic cost of early childhood caries," *Journal of the American Dental Association* 2009 Jun;140(6):650-7.

[2] Centers for Disease Control and Prevention. Oral Health Surveillance Report: Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999-2004 to 2011-2016. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services, 2019. https://www.cdc.gov/oralhealth/publications/OHSR-2019-index.html.

Ensuring access to high quality dental care for children enrolled in Medicaid and CHIP is a priority for CMS. For children enrolled in Medicaid, regardless of whether that coverage is funded through title XIX or title XXI Medicaid-expansion CHIP programs, states must provide medically necessary dental services, including relief of pain and infection, restoration of teeth, and maintenance of dental health.[3] For children enrolled in separate CHIP programs, states must provide dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.[4]

For these reasons, CMS launched the OHI in 2010 to work with states to improve Medicaid-enrolled children's use of appropriate dental and oral health services.[5] CMS' commitment to assuring children's access to dental and oral health services is further reflected in the Medicaid and CHIP Scorecard,[6] and the Medicaid and CHIP Child Core Set,[7] which both include a measure of the percentage of child beneficiaries receiving a preventive dental service as an indicator of state health system performance. Referred to as "PDENT," this measure tracks the proportion of children ages 1-20 continuously enrolled in Medicaid for at least 90 days and who have received at least one preventive dental service, as reported on the annual CMS-416 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) form.

OHI Performance and Progress to Date

To drive and monitor progress in addressing the goal of improving Medicaid-enrolled children's use of appropriate dental and oral health services, CMS challenged itself and each state to improve their performance on the PDENT measure by 10 percentage points by FFY 2018.

The OHI has supported a variety of activities to help states reach these goals, including:

- Supporting states' development of State Oral Health Action Plans,
- Hosting CMS Learning Labs, a series of webinars for state dental program managers on issues related to oral health access, including community partnerships, treatment modalities, and more,
- Hosting learning collaboratives to help states design dental Performance Improvement Projects in managed care delivery systems,[8]
- Developing the Think Teeth campaign of beneficiary outreach materials,[9]

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[3] Section 1905(r)(3) of the Social Security Act. See also CMS, *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents*, September 2013, available at https://www.medicaid.gov/medicaid/benefits/downloads/keep-kids-smiling.pdf.

[4] Section 2103(c)(5) of the Social Security Act.

[5] "Dental services" refers to services provided by or under the supervision of a dentist. "Oral health services" refers to services provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist.

[6] Information on the Medicaid and CHIP Scorecard is available at https://www.medicaid.gov/state-overviews/scorecard/index.html.

[7] Information on the Medicaid and CHIP Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

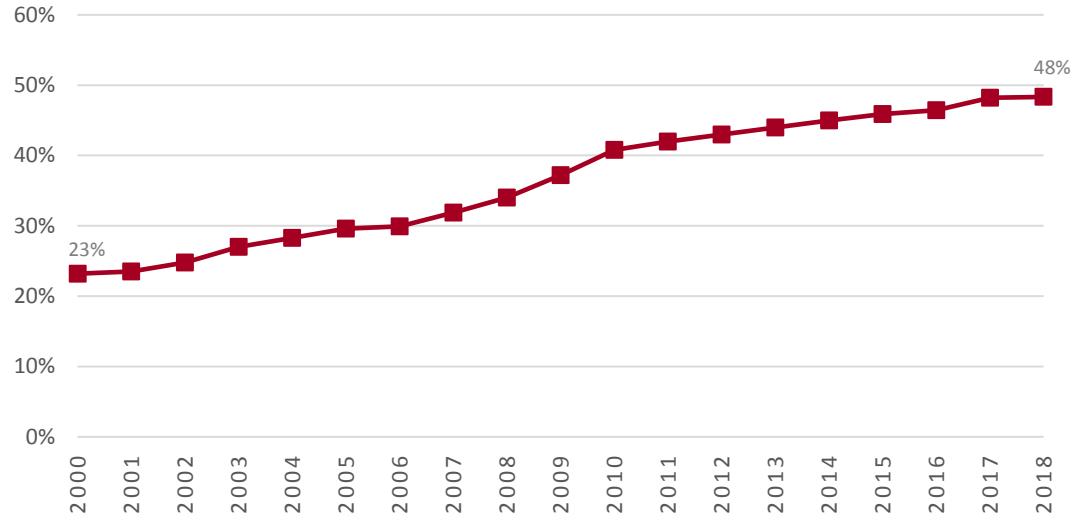
[8] Information on State Oral Health Action Plans, CMS Learning Labs, and dental Performance Improvement Projects is available on the Dental Benefits page of Medicaid.gov: https://www.medicaid.gov/medicaid/benefits/dental/index.html.

[9] Information is available on the Oral Health campaign page of insurekidsnow.gov: https://www.insurekidsnow.gov/initiatives/oral-health/index.html.

- Providing technical support through the Innovation Accelerator Program on developing value-based payment approaches in oral health,[10]
- Providing technical support on reporting key oral health data, and
- Engaging in intensive one-on-one work with targeted states, including work to help states refine elements of section 1115 demonstration projects related to dental and oral health services.

Through these efforts, CMS and states have made significant improvement in Medicaid-enrolled children's use of preventive dental care. Chart 1 below shows that the percentage of children ages 1-20 receiving at least one preventive dental service rose from 23 percent in FFY 2000 to 42 percent in FFY 2011 (the baseline year for OHI), to 48 percent in FFY 2018. Additionally, seven states have achieved their goal of ten percentage points of improvement: Florida, Indiana, Iowa, Montana, Pennsylvania, Texas, and Wisconsin. (See Appendix 1 for detailed information on state progress over the course of OHI.) Nevertheless, the national goal of 52 percent has not yet been met, and less than half of children enrolled in Medicaid are not receiving preventive dental care. Moreover, some states have experienced declines in performance relative to their FFY 2011 baseline.

Chart 1. Proportion of Children, Age 1-20, Enrolled in Medicaid for At Least 90 continuous Days Who Received Preventive Dental Health Services, FFY 2000 – FFY 2018



Source: Federal fiscal year (FFY) 2000-2018 Form CMS-416 reports, Lines 1b and 12b.
Note: FFY 2018 data reflect updates as of 10/2/2019. See Table 1 for details on individual state data excluded from certain years due to data quality issues.

[10] Information is available on the Innovation Accelerator Program, Value Based Payment and Financial Simulation page of Medicaid.gov: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/value-based-payment/index.html.

Next Phase of OHI, 2020-2022

CMS remains committed to ensuring that Medicaid-enrolled children receive appropriate oral health care.[11] For that reason, CMS is maintaining the 10 percentage point national and individual state performance targets for PDENT and extending OHI through 2022 (the FFY 2021 reporting year). We will continue to work intensively with states to drive improvement in delivery of appropriate dental and oral health services. CMS staff are available to work with states on strategies for improving utilization of oral health services; identifying State Plan or demonstration authorities that may be needed to advance policy changes; and refreshing or developing State Oral Health Action Plans to describe a state's delivery system and chart its goals for improvement.

CMS will also continue to help states identify best practices and drive improvement in their own circumstances. Below are several approaches that states have used to improve their Medicaid and CHIP dental programs for children and move toward their OHI goals.

Sharing Promising State Practices

Managed care contracting: An increasing number of states are administering Medicaid dental benefits through managed care contracts, both comprehensive managed care, and dental-specific prepaid ambulatory health plans. These contracts present opportunities to set priorities and establish enforceable targets for performance. **Pennsylvania** has made substantial improvements to their dental performance by setting strong goals and prioritizing oversight of dental services in comprehensive managed care contracts. [12] This includes:

- Designating (through 2019) access to pediatric preventive dental care as a required Performance Improvement Project topic for its comprehensive managed care plans.[13]
- Requiring each plan to have a dental director with an active Pennsylvania dental license.
- Conducting Quarterly Quality Review Meetings (QQRMs) with each plan to review their dental performance against stated goals, monitor progress of initiatives, and collaborate on improving performance and establishing new goals.
- Including a measure for annual dental visits in a quality improvement incentive program. Plans can earn payments of up to two percent of capitation revenue for demonstrating

[11] CMS is retiring the separate OHI improvement target related to placement of sealants on children ages 6-9 years old, originally announced in 2013. (CMCS Informational Bulletin, "CMS Oral Health Initiative and Other Dental-Related Items," April 18, 2013, available at https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-18-13.pdf) Individual state goals were never finalized due to methodological issues in setting targets for this measure. Sealant placement will still be captured in the calculation of PDENT, which includes the procedure code for sealants. In addition, a measure of sealant placement among children 6-9 years at elevated risk of tooth decay remains in the 2019 Medicaid and CHIP Child Core Set. Like other measures in the Core Sets, this measure is important for program monitoring, but does not have a discrete improvement target.

[12] National Academy for State Health Policy, "Webinar: A Conversation with State Officials on Medicaid Dental Managed Care," April 29, 2016. Recording and slides available at https://nashp.org/a-conversation-with-state-officials-on-medicaid-dental-managed-care/.

[13] Commonwealth of Pennsylvania Department of Human Services, *2018 External Quality Review Report: Statewide Medicaid Managed Care Annual Report*, May 2019. Page 28. https://www.dhs.pa.gov/docs/Publications/Documents/HealthChoices%20Behavioral%20Health%20Publications/c_290870.pdf.

quality improvement on twelve quality indicators. In fact, the state places extra emphasis on dental performance by counting the dental measure twice for purposes of determining plan performance.
- Requiring plans to develop pay-for-performance programs relating to dental service use. These programs must include payments to dental providers to increase provision of preventive dental services to new and established patients.
- Including dental services as a focus of plan requirements related to community-based care management.[14]

The state has exceeded its OHI improvement goal, achieving 11 percentage points of improvement (47 percent overall) on the PDENT measure between FFY 2011 and FFY 2018.

Section 1115 demonstrations: Section 1115 demonstration authority may provide states with the ability to test new approaches to providing dental care. **California** prioritized dental services in its Dental Transformation Initiative, implemented in 2016 as a part of the state's section 1115 demonstration. The initiative has been implemented across dental fee-for-service and dental managed care delivery systems, including safety net clinic providers such as Federally Qualified Health Centers. It includes activities in four domains:

- Making incentive payments to dental providers for increasing the number of child beneficiaries receiving preventive dental services year over year.
- Reimbursement for care aimed at reducing children's risk of dental disease and promoting disease management approaches in oral health, which requires completion of caries risk assessment (CRA) training and using a CRA tool to receive reimbursement for a bundle of services including silver diamine fluoride.
- Incentivizing the establishment of a dental home, by making incentive payments to dental providers when beneficiaries return to the same dental provider in subsequent years.
- Funding local dental pilot projects to foster innovative delivery mechanisms that apply the goals from one of the other three domains. [15]

The state has improved by nine percentage points since FFY 2011, from 37 to 46 percent in FFY 2018, and has almost met its OHI improvement goal.

Expanding settings of care: Several states have expanded access to preventive oral health services by expanding where and from whom Medicaid beneficiaries can receive them.

- **New Hampshire** received support from the Innovation Accelerator Program to develop a financial model to build on a local model that uses public health dental hygienists working in community Women, Infants and Children (WIC) clinics to deliver a set of preventive dental services to young children. This included dental screening, toothbrush prophylaxis, fluoride varnish, sealants, interim therapeutic restorations, silver diamine fluoride, and oral health education and anticipatory guidance. [16] Modeling tools were

[14] Commonwealth of Pennsylvania Department of Human Services, HealthChoices Physical Health Agreement effective January 1, 2019. http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf.
[15] California Department of Health Care Services, "Dental Transformation Initiative," https://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx.
[16] Medicaid Innovation Accelerator Program, "Value-Based Payment and Contracting Approaches for Caries Management: Implications for State Medicaid Programs," August 22, 2018. Slides available at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-

piloted with two local programs, and the state is considering next steps to implement the payment approach in its Medicaid program.

- CMS provided support to **Maine** to expand primary care medical providers' ability to engage in preventive oral health care. As part of a CHIPRA Quality Demonstration Grant, the state received support to train clinicians in primary care practices on oral health risk assessment and application of fluoride varnish for children under age 4, coaching on integrating oral health activities into office workflow, and assistance in making connections with local dentists willing to see young children.[17] The project resulted in approximately 2,000 more children under age 4 receiving fluoride varnish and oral health evaluations between 2012 and 2014.[18]

New Technical Support Opportunity for States: Advancing Prevention and Reducing Childhood Caries

To support states in their continued work toward their OHI improvement targets, CMS is announcing an Oral Health quality improvement learning collaborative on Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP. This technical assistance opportunity will support state oral health teams over two years to increase the delivery of oral health services outside of traditional dental office settings through improved and integrated systems of care. This will include improving pathways for referrals and co-management of oral health in medical and dental care settings.

This effort will also support state-to-state learning on best practices in the use of an emerging treatment modality, silver diamine fluoride, which arrests active decay, and is a promising intervention to improve children's oral health.[19]

The project will build state Medicaid oral health team knowledge and quality improvement (QI) skills through: working on a data-driven QI project; networking with peers; and developing and improving QI approaches. Information learned in this effort will be shared with all states through modalities including the monthly Oral Health Technical Advisory Group calls that CMS convenes with state Medicaid dental program managers, and a national webinar series to introduce key concepts that will be explored in the learning collaborative. More information on the learning collaborative, including information on how states can apply to participate, is available on Medicaid.gov.

Updating Performance Measurement

To align performance measurement with these delivery reform efforts, CMS is also planning to broaden the focus of our preventive services measure, in light of continuing work on the integration of oral health into overall health care, and in recognition of the important role of providers outside of dental offices in promoting oral health. In the pending renewal of the CMS-416 EPSDT form that is intended for release in mid-2020, CMS has proposed changing the

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areas/vbp-caries-management-webinar.pdf; transcript at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/vbp-caries-management-transcript.pdf.

[17] Information is available on the CHIPRA Quality Demonstration Grants Summary webpage, https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/chip-grants-summary/index.html.

[18] Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant final report (2010-2016), "Maine and Vermont," page 32.

[19] Seifo, N. et. al. "Silver diamine fluoride for managing carious lesions: an umbrella review," *BMC Oral Health*. 2019 Jul 12;19(1):145. https://www.ncbi.nlm.nih.gov/pubmed/31299955

definition of line 12g from a count of beneficiaries receiving any dental or oral health services to a count of beneficiaries receiving any preventive dental services or preventive oral health services provided by non-dentist providers, such as primary care medical providers and dental hygienists in states where a dentist's supervision is not required. This aligns with efforts across the health care system to broaden the venues for delivering preventive oral health care, such as the US Preventive Services Task Force recommendation that application of fluoride varnish by primary care medical staff should be a regular part of well-child care for children under age 6.[20]

This proposal was posted for public comment in the Federal Register in the fall of 2019. Should this change be finalized, CMS will adapt the PDENT measure in the Child Core Set to reflect this change as well.

Closing

Oral health is important and consequential to the overall health of Medicaid-enrolled children. CMS looks forward to continuing to work with states to improve children's access to needed oral health care. We encourage states to participate in the upcoming oral health learning collaborative, and we are ready to provide technical assistance to help states work toward their goals.

Please contact CMS OHI lead Andrew Snyder with any questions related to OHI at andrew.snyder@cms.hhs.gov.

[20] U.S. Preventive Services Task Force, "USPSTF A and B Recommendations," available at https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Appendix 1. Percentage of Children, Age 1-20, Enrolled in Medicaid for at Least 90 Continuous Days who Received a Preventive Dental Service: FFY 2011 Baselines, FFY 2012-FFY 2018 Progress, and FFY 2018 Goals, Revised October 2, 2019

State	Baseline (FFY 2011)	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	Goal (FFY 2018)
US TOTAL	**42%**[i]	**43%**[ii]	**44%**[iii]	**45%**[iv]	**46%**[v]	**47%**[vi]	**48%**[vii]	**48%**[viii]	**52%**
Alabama	51%	51%	52%	50%	49%	49%	49%	48%	61%
Alaska	43%	44%	42%	46%	46%	46%	46%	46%	53%
Arizona	46%	44%	45%	46%	47%	43%	48%	48%	56%
Arkansas	48%	49%	50%	51%	50%	48%	48%	38%	58%
California	37%	36%	37%	38%	37%	42%	45%	46%	47%
Colorado	51%	51%	50%	51%	49%	51%	51%	52%	61%
Connecticut	57%	NA[ix]	60%	60%	59%	63%	63%	62%	67%
Delaware	44%	46%	46%	47%	48%	48%	42%	48%	54%
District of Columbia	50%	48%	50%	53%	54%	53%	56%	56%	60%
Florida	--[x]	19%	25%	27%	33%	36%	37%	39%	29%
Georgia	48%	50%	50%	51%	52%	52%	52%	51%	58%
Hawaii	41%	41%	44%	44%	49%	63%	46%	45%	51%
Idaho	49%	53%	56%	50%	47%	59%	--[xi]	49%	59%
Illinois	49%	50%	52%	51%	45%	42%	45%	45%	59%
Indiana	29%	28%	38%	48%	48%	45%	45%	44%	39%
Iowa	40%	45%	49%	49%	50%	51%	52%	52%	50%
Kansas	41%	42%	46%	48%	47%	46%	46%	48%	51%
Kentucky	44%	38%	43%	43%	45%	47%	48%	48%	54%
Louisiana	47%	48%	48%	48%	47%	47%	49%	50%	57%
Maine	32%	34%	40%	40%	38%	38%	36%	35%	42%
Maryland	50%	52%	53%	53%	53%	54%	55%	55%	60%
Massachusetts	51%	53%	54%	53%	52%	55%	54%	54%	61%
Michigan	36%	37%	40%	40%	40%	42%	43%	41%	46%
Minnesota	38%	30%	38%	38%	37%	37%	37%	38%	48%
Mississippi	45%	47%	48%	50%	47%	50%	51%	52%	55%
Missouri	32%	34%	35%	35%	36%	34%	33%	32%	42%
Montana	36%	41%	47%	43%	40%	46%	53%	50%	46%
Nebraska	47%	48%	52%	52%	53%	54%	54%	53%	57%
Nevada	40%	38%	45%	37%	38%	43%	43%	38%	50%
New Hampshire	56%	55%	56%	50%	55%	55%	54%	55%	66%
New Jersey	43%	44%	47%	48%	48%	49%	50%	52%	53%
New Mexico	47%	51%	51%	47%	52%	53%	53%	54%	57%
New York	39%	39%	41%	43%	43%	44%	40%	40%	49%
North Carolina	45%	49%	49%	49%	50%	51%	51%	51%	55%
North Dakota	29%	29%	29%	29%	29%	26%	27%	18%	39%
Ohio	NA[xii]	37%	21%	33%	34%	35%	35%	36%	47%

State	Baseline (FFY 2011)	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	Goal (FFY 2018)
Oklahoma	44%	46%	47%	48%	48%	48%	49%	49%	54%
Oregon	39%	40%	40%	35%	37%	39%	41%	43%	49%
Pennsylvania	36%	37%	40%	43%	44%	46%	47%	47%	46%
Rhode Island	43%	43%	41%	44%	44%	47%	47%	47%	53%
South Carolina	53%	54%	51%	51%	48%	50%	50%	50%	63%
South Dakota	44%	45%	41%	40%	36%	45%	45%	48%	54%
Tennessee	47%	48%	49%	48%	48%	48%	47%	46%	57%
Texas	56%	54%	53%	53%	66%	67%	68%	68%	66%
Utah	48%	50%	52%	47%	53%	53%	50%	53%	58%
Vermont	58%	59%	59%	62%	54%	54%	55%	56%	68%
Virginia	47%	48%	48%	49%	50%	50%	53%	53%	57%
Washington	53%	54%	55%	55%	56%	56%	56%	56%	63%
West Virginia	42%	45%	46%	45%	47%	50%	48%	48%	52%
Wisconsin	25%	26%	25%	25%	27%	30%	39%	41%	35%
Wyoming	40%	40%	41%	43%	42%	47%	49%	49%	50%

[i] With the exception of FL and OH, the national FFY 2011 percentage used FFY 2011 data reported by states to CMS as of May 28, 2013. Due to errors in FL's FFY 2011 data that could not be corrected, the state's FFY 2012 data were used in the calculation of the FFY 2011 national percentage. As FFY 2011 data for OH were reported after May 28, 2013, these data were not included in the calculation of the FFY 2011 national percentage.

[ii] With the exception of CT and OH, the national FFY 2012 percentage used data reported by states to CMS as of April 10, 2014. FFY 2011 data for CT were used in the calculation of the FFY 2012 national percentage because final FFY 2012 data for CT were not available as of April 10, 2014. As FFY 2011 data for OH were not used in the calculation of the FFY 2011 national percentage, OH's FFY 2012 data were similarly excluded from the calculation of the FFY 2012 national percentage.

[iii] With the exception of OH, the national FFY 2013 percentage used data reported by states to CMS as of December 15, 2014. As FFY 2011 data for OH were not used in the calculation of the FFY 2011 national percentage, OH's FFY 2013 data were similarly excluded from the calculation of the FFY 2013 national percentage.

[iv] With the exception of OH, the national FFY 2014 percentage used data reported by states to CMS as of October 2, 2015. As FFY 2011 data for OH data were not used in the calculation of the FFY 2011 national percentage, OH's FFY 2014 data were similarly excluded from the calculation of the FFY 2014 national percentage.

[v] With the exception of OH, the national FFY 2015 percentage used data reported by states to CMS as of November 18, 2016. As FFY 2011 data for OH data were not used in the calculation of the FFY 2011 national percentage, FFY 2015 data were similarly excluded from the calculation of the FFY 2015 national percentage.

[vi] With the exception of OH, the national FFY 2016 percentage used data reported by states to CMS as of February 25, 2019. As FFY 2011 data for OH were not used in the FFY 2011 national percentage, OH's FFY 2016 data were similarly excluded from the FFY 2016 national percentage.

[vii] With the exception of ID and OH, the national FFY 2017 percentage used data reported by states to CMS as of February 25, 2019. As FFY 2011 data for OH were not used in the calculation of the FFY 2011 national percentage, OH's FFY 2017 data were similarly excluded from the calculation of the FFY 2016 national percentage. FFY 2016 data for ID were used in the calculation of the FFY 2017 national percentage because final FFY 2017 data for ID were not available as of February 25, 2019.

[viii] With the exception of OH, the national FFY 2018 percentage used data reported by states to CMS as of August 7, 2019. As FFY 2011 data for OH were not used in the FFY 2011 national percentage, OH's FFY 2018 data were similarly excluded from the FFY 2018 national percentage.
[ix] Final FFY 2012 data for CT were not available as of April 10, 2014, so the state's FFY 2011 data were substituted in the calculation of the FFY 2012 national percentage.
[x] For FL, the "--" in FFY 2011 signifies that there were errors in the state's FFY 2011 data that could not be corrected. As a result, FL's FFY 2018 goal is based on the state's FFY 2012 data, and the state's FFY 2012 data were used in the calculation of the FFY 2011 national percentage.
[xi] For ID, the "--" signifies that there were systems issues impacting the state's FFY 2017 reporting that could not be corrected before publishing data as of February 25, 2019. As such, FFY 2016 data for ID were used in the calculation of the FFY 2017 national percentage.
[xii] As FFY 2011 data for OH were reported after May 28, 2013, these data were not included in the state baselines, and thus were not used in the calculation of the FFY 2011 national percentage. As a result, OH's data were similarly excluded from the calculation of the FFY 2012-FFY 2017 national percentages. OH's FFY 2018 goal is based on the state's FFY 2012 data.