

Submitted to CMS: December 2012

Revised: August 2014

Dental Action Plan
For Medicaid and CHIP Programs
August 2014

State: ARIZONA

Program (please designate): Medicaid ___ CHIP ___ Both X

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In an effort to increase the number of Medicaid and CHIP children who have access to dental care and receive preventive dental services, CMS is working with States to implement two national oral health goals. While some States have undertaken oral health improvement activities in recent years, additional activities are needed to increase access and prevention in order to meet children's needs and these goals. CMS will provide States with technical assistance and opportunities to share best practices to assist them in meeting these goals.

The purpose of this Action Plan is to identify what activities States intend to undertake in order to achieve these dental goals. CMS will share each State's plan by posting them on the CMS website, but CMS will omit posting proprietary dental provider payment data upon State request. In addition, States are asked to provide baseline information on their existing programs, and to identify access issues and barriers to care that they are currently facing so CMS can help address these issues with technical assistance. While CMS is interested in learning about efforts or activities States have already undertaken as well as successes of those efforts and lessons learned, development of the Action Plan will primarily serve to assist States in their efforts to document their current activities and collaborations to improve access and to inform States about where their resources could best be devoted to achieve the goals. This information will also be used to assist other States in their efforts to increase access.

Medicaid and CHIP Dental Health Goals:

- Increasing the proportion of children ages 1-20 enrolled in Medicaid or CHIP who received any preventive dental services by 10 percentage points over a five-year period.

To be phased-in:

- Increase the proportion of children ages 6-9 enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period.

Instructions & Next Steps:

- 1) Each State, including the District of Columbia, is to complete this Dental Action Plan Template in its entirety as a Word document. Please do not include graphics or charts in the Template itself, as these items are not compatible for posting on the CMS website. You may attach separate documentation if you want to submit additional information.

CMS encourages the Territories to complete a dental action plan but the Territories will not be included in the dental goal.

- 2) If you are undertaking State-wide oral health improvement activities that impact both programs, you may submit one combined dental action plan. Separate dental action plans should be submitted in States that are addressing oral health improvement activities separately in their Medicaid and separate CHIP programs.
- 3) Once you have completed the template, please e-mail this information to your CMS Regional Office within six months of the date of the State Health Official letter.
- 4) CMS Regional Office staff will review the information and send it to CMS Central Office for further review. Regional Office staff will contact you for additional information, if appropriate or necessary.
- 5) After reviewing and compiling this information, CMS plans to post this information on the CMS website.
- 6) CMS Regional Office staff will follow up with States on a regular basis to track the progress of the State Action Plans and achievement towards the goal(s).

If you have any questions when filling out this template, please contact your CMS Regional Office.

Oral Health Program (Background)

Provide information on your current oral health program for children under Medicaid and/or CHIP. Include information about your State's current delivery system(s) (e.g., fee-for-service, managed care, administrative service organization, etc.). If your State has changed delivery systems in recent years, explain the reason for the change and the impact on access to dental services. Also include information on provider participation rates (including dental specialists and other providers, such as physicians, dental hygienists and other newer model mid-level practitioners) and issues with access to oral health services in underserved areas. "Underserved areas" would include areas of your State that you know are rural, frontier or where it is difficult to recruit providers as well as designated Dental Health Professional Shortage Areas (DHPSAs).

- Access Issues/Barriers to Oral Health Services (please provide information on issues/barriers that you are aware of that impede access to providing oral health services to children through Medicaid or CHIP in your State generally, as well as in underserved areas, and any steps you have taken to address those issues or barriers):
- Current Dental Delivery System (e.g., fee for service, managed care, use of administrative service organization or combination dental programs). If you have a combination dental delivery system, provide the number of children served by each system:
- Provider (Dentist) Participation Rates (For the most recent year data is available, include the number of dentists licensed in your State, the number of Medicaid and/or CHIP participating dentists (any claims filed), and number of active dentists (billing \$10,000 or more in a year. Please specify the time period the data represents as well as the specialty of the dentist):
- Non-Dentist Provider Participation Rates: (Describe the participation of other providers, e.g., pediatricians, dental mid-level providers, dental hygienists, in your State to improve

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access to dental services for children. In addition, for the most recent year data is available (please specify), please provide the number of Medicaid and/or CHIP non-dentist providers, by provider type, participating in your Medicaid and/or CHIP programs. "Participating" is defined the same as for dentists (any claim filed).)

- Additional information about program (please provide any additional information that is relevant or that you would like to share about your dental program):

AHCCCS Background:

The Arizona Health Care Cost Containment System was implemented on October 1, 1982, as the nation's first statewide indigent health care program designed to provide services to eligible persons primarily through a prepaid capitated managed care system. Operating as a demonstration project under the federal Medicaid program, AHCCCS receives federal, state and county funds to operate, plus some monies from Arizona's tobacco tax. The Arizona Long Term Care System (ALTCS) was implemented December 19, 1988 for the developmentally disabled and on January 1, 1989, for the elderly and physically disabled. ALTCS provides institutional care and home and community based services to individuals who meet financial eligibility requirements and are at risk of institutionalization.

AHCCCS enrolls most eligible persons with Acute-care and long term care Program Contractors (Contractors). The Contractors assume responsibility for the provision of all covered Acute-care services to enrolled recipients. ALTCS Contractors responsible for providing and managing acute, behavioral health and long term care services for eligible recipients from the prior period coverage (PPC) time frame throughout the time of the members enrollment with the Contractor.

In addition to the managed care populations, AHCCCS has a small fee-for-service (FFS) population. The fee-for-service population includes the following groups:

- Recipients in the Federal Emergency Services (FES) program
- Recipients enrolled in Indian Health Services (IHS)
- On-reservation Native Americans enrolled with the AHCCCS-operated American Indian Health Plan (AIHP)

The primary role of providers is to render medically necessary services to AHCCCS recipients. Prior to billing for services, the provider must be an active registered provider with AHCCCS. Providers may elect to only provide services to AHCCCS fee-for-service recipients or may subcontract with one or more contractors to provide services to enrolled recipients. However, the provider must be registered with AHCCCS in order to receive payment for services provided from either AHCCCS or a Contractor.

AHCCCS covers medically necessary oral health services for Medicaid-eligible children through age 20 as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Oral health services also are covered for children enrolled in KidsCare, the State Child Health Insurance Program (SCHIP), through 18 years of age. Both Medicaid and KidsCare populations are jointly served by Acute-care Contractors; interventions and planned improvements are implemented jointly to both populations.

AHCCCS-covered oral health services for children and adolescents include dental screening in the Primary Care Provider’s (PCP’s) office; preventive dental services, such as application of topical fluorides and dental sealants; and therapeutic and emergency dental services, such as crowns and tooth extractions. According to AHCCCS medical policy, PCPs should refer children for routine dental visits at least once a year, beginning at 6 months of age. Members under the age of 21 may see a dentist without a referral.

The Arizona State Board of Dental Examiners reports there were 3,694 licensed dentists throughout the state as of FY 2013. AHCCCS has 1,327 participating dentists; 921 of which bill a minimum of \$10,000 annually as of September 2013. Please see the following table for additional information.

Active AHCCCS Dental Providers

Dental Provider Specialty Types	Provider Counts	Provider Counts, who bill \$10,000+ Annually	% of Providers Who Bill \$10,000+ Annually, by Specialty
General Dentist	1080	736	68.1%
Pediatric Dentist	156	139	89.1%
Endodontist	45	29	64.4%
Orthodontist	36	13	36.1%
Oral Surgeon	41	28	68.3%
Surgery, Oral and Maxillofacial	30	22	73.3%
Anesthesiologist	25	20	80.0%
Periodontist	11	4	36.4%
Prosthodontist	9	6	66.7%
Public Health	2	2	100.0%
TOTAL:	1327	921	69.4%

The overall total is reflective of a distinct count. Specialties may include duplicate dentists as a minimal number of dentists identify more than one specialty type.

AHCCCS Access Issues/Barriers

Dentists cite these disincentives for contracting with AHCCCS:

- Poor reimbursement rates
- High appointment no-show
- Excessive paperwork

Contractors cite the following as the biggest issues or barriers:

- Caregivers do not remember or follow through with PCP’s recommendations for an annual dental visit
- Lack of awareness by case managers (re: importance of dental care)

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- Frequent changes in case managers, resulting in service receipt confusion (one Contractor)
- PCP's & dentists may forget importance of annual dental exam for children 0-3 years old

Additional barriers and issues that have been noted include:

- Limited preventive education/awareness
- Community events offering dental care – limited ability for Contractors to collect data
- Parent/Guardian disposition towards dental care impedes willingness to take children in for care.

Activities to Achieve Goal

Below are activities that have been implemented or are being considered for implementation in order to achieve the new dental goals. It is anticipated that additional activities will be developed as the Dental Workgroup reviews current data and continues meeting (see first bullet point below).

- Development of a Dental Work Group which consists of AHCCCS Quality Improvement staff, Contractor Quality Improvement staff and Dental/Oral Health Directors.

This work group meets bi-monthly in order to continuously work cohesively in identifying barriers and developing strategies and the results of the implementation of them.

- Potential barriers include: schedule coordination (AHCCCS has addressed this barrier by limiting the work group to two participants per Contractor)
- Collaboration with dental schools - Ongoing conversations on ways to build partnerships with dental schools are underway; however, there has been some resistance on the schools' part to work with AHCCCS members.
 - Potential barriers: To be determined
- Education/outreach to dentists, dental hygienists, and State/National dental associations
 - Potential barriers: None noted at this time
- Education/outreach to pediatricians, family practitioners, and State/national medical associations
 - Potential barriers: None noted at this time
- Education/outreach to beneficiaries - Extensive focus is placed on Long Term Care members as they have a lower participation rate than acute members. Regardless of line of business, the Contractors utilize newsletters, send mailings, and include additional information in the member handbooks so that members receive ongoing outreach and education related to dental. Another beneficiary-focused outreach includes identifying siblings of those participating within Head Start programs, which has mandatory dental requirements. The hope is that the family will take care of all members when completing the Head Start visit requirement.

- Potential barriers include: Transportation concerns (the service is available but not to siblings of the member, rendering the guardian unable to take the member to appointments); Beneficiary and/or guardian stigmas regarding dental care
- Undertaking administrative simplifications – This includes but is not limited to referral processes and/or documenting oral health concerns on the EPSDT provider forms
 - Potential barriers: Amount of documentation required of providers
- Using electronic health records and supporting Dental providers in their efforts to qualify for meaningful use incentive payments
 - Potential barriers: limited Electronic Health Record systems that meet dentists’ needs; inability to participate multiple years due to the Program requirements
- Incentive/Penalties
 - Added EPSDT dental participation as a statewide performance measure
 - Created payment reform which included dental performance measure; annual dental visit
- Policy changes
 - Allowing reimbursement to PCPs for the application of fluoride varnish
 - Assigning dental homes to members
- Reporting requirements
 - Added more oral health elements to Contractor quarterly reporting in order to track efforts
 - Require Contractors to submit a dental annual plan which includes; a program description, work plan for upcoming contract year and an evaluation on efforts from the previous contract year.

Additional Background: Provide additional information on your current oral health program for children under Medicaid and/or CHIP.

State Medicaid dental programs have been historically underfunded by state agencies and under-utilized by the members they serve. CMS has taken action to increase access to care and utilization for children enrolled in Medicaid over the past decade. In 2002, AHCCCS proactively implemented an Oral Health Performance Improvement Project (PIP) that required contracted health plans to improve utilization of dental services through interventions and activities, and then sustain the improvements. Some other dental program highlights include:

- January 2011- Arizona selected as one of eight (8) states for “Innovative State Practices for Improving the Provision of Medicaid Dental Services”. Specifically, Arizona showed innovation working with multiple managed care organizations (MCOs) improving access to children’s dental care.
- In 2009, CMS invited AHCCCS to speak at a Medicaid Oral Health Town Hall Meeting, addressing a national audience on the success of Arizona’s managed care dental program.

- The tables that show CMS-416 (EPSDT) dental utilization demonstrate very clearly that Arizona/AHCCCS through its managed care model have outperformed the majority of states in access to dental care a preventive dental services. In FFY 2012 nearly 50% of children enrolled for 90 continuous days in AHCCCS had a dental visit (CMS 416).
- Provider participation approaches one-half of the state's licensed dentists.
- Arizona has invested in the AHCCCS dental program. Dental reimbursement to dentists for dental services continues to be competitive in the market even with significant budgetary challenges.
- Arizona continues to participate in the CMS Learning Labs related to Oral Health, and was asked to present during one of the sessions on the topic of Maximizing Provider Participation.

Oral Health Improvement Initiatives: Has your State undertaken any initiatives within the last 5 years to increase the number of children covered under the Medicaid and CHIP program who receive access to oral health services? If so, please describe those activities.

- What impact did those initiatives have? Do you consider those activities to have been successful? If so, please describe.
- If the activities did not achieve the results that you had expected, please describe the lessons learned. These lessons can be a learning opportunity for other States.

To assist Contractors in improving performance, the AHCCCS Clinical Quality Management Unit synthesized research and literature on oral health initiatives from a variety of sources. The Chronic Care Model, developed by Wagner, et al, of the MacColl Institute for Healthcare Innovation at Group Health Cooperative, was adapted for use in organizing various interventions for improving oral health. The model identifies essential elements of a health care system that encourage high-quality care, and are likely to result in healthier patients, more satisfied providers, and cost savings. By using this model, AHCCCS and its contracted health plans could identify gaps in quality-improvement strategies and address those areas. Contractors maintained a consistent focus on improving performance and utilized a broad range of interventions, as listed in the table below. Over the course of this 5 year intervention period AHCCCS documented a relative increase of 25.3 percent

AHCCCS conducted a secret survey in 2012 of dental providers to research potential concerns on access to care for members. The two primary concerns were a delay in credentialing of dental providers and lack of dental providers accepting new patients, patients with special needs and patients that speak a foreign language exclusively. In order to gauge the availability of dentists in each Contractor's network, a random phone survey was conducted utilizing Contractor website listing for dental providers. Blocked calls were made requesting appointments for different scenarios. A total of 30 calls were made to each Contractor's dental providers, spread over geographic locations (urban vs rural) and urgent and routine appointment requests, language availability and capability to handle special needs members. Overall, 78 percent of dental providers were able to schedule an appointment within the timeframes established in AHCCCS contracts for both urgent and routine appointments. This number includes the providers that had disconnected numbers, did not speak Spanish, or had terminated contracts with the health plan or registration with AHCCCS. Removing those providers from the denominator, 85 percent of dental providers were able to meet the contractual timeframes for routine and urgent appointments. There were no differences noted in obtaining an appointment for either an urgent or routine appointment for oral health care. In most cases, when needs could not be met by the provider called, the caller was referred to another participating dentist. Several dental providers did not accept patients under the age of six years.

AHCCCS continues to work with Contractors and other stakeholders to ensure adequate provider capacity and utilization of services. In 2012, the Agency hired a new Dental Director to work with health plans, the ADHS OOH, the Arizona Dental Association and other stakeholders to continue collaborative efforts to ensure high-quality dental services are provided to AHCCCS members. AHCCCS has continued to review and update its dental periodicity schedule, which is incorporated into contracts with health plans to ensure children and adolescents receive oral health care at necessary intervals.

The following table includes interventions that one or more AHCCCS Contractor(s) are using or plan to implement in the near future to ensure children’s’ access to oral health services and improve rates of annual dental visits.

Community Linkages	Health Systems	Self-Management Support	Delivery System Design	Decision Support	Clinical Information System
<ul style="list-style-type: none"> • Tie in outreach efforts with related activities/events; e.g., National Children’s Dental Health Month, community health fairs • Collaborate with programs such as Head Start and WIC to assist in reaching members; educate these programs about oral health issues and AHCCCS-covered services • Utilize resources of the Arizona Department of Health 	<ul style="list-style-type: none"> • Utilize ”pay-for-performance” strategies to reward PCPs and/or dentists who met specific benchmarks for dental services • Utilize Health Plan staff dedicated to dental outreach and assisting families/members in making and keeping appointments 	<ul style="list-style-type: none"> • Mail annual reminders to parents about dental visit; send follow-up reminders to members who do not subsequently receive services • Reinforce education through newsletters, telephone hold messages, etc.) to members/parents/caregivers about: the importance of good oral health and its relationship to overall health, the positive outcomes of preventive dental care, importance of keeping 	<ul style="list-style-type: none"> • Work with programs that provide services in schools (ADHS, Healthy Kids Dental) and coordinated to follow up on member needs • Provide case management services to children in foster care or those with special health care needs/disabilities • Recruit additional dental providers to improve access 	<ul style="list-style-type: none"> • Educate Primary Care Providers (physicians, PAs, NPs) and office/clinic staff about: early detection of dental disease, EPSDT requirements/referral for treatment or preventive visits advising parents about the importance of regular dental care • Survey parents/caregivers or case managers on reasons dental care was not obtained and develop or enhance activities to address those reasons 	<ul style="list-style-type: none"> • Routinely monitor dental performance measure/utilization rates: overall by county/geographic area, by provider group • Utilize tracking systems to identify members with no dental services or those who missed appointments and attempt to contact and schedule or reschedule an appointment and arrange for transportation if needed • Incorporate medical and/or dental chart audits into the performance monitoring processes

Community Linkages	Health Systems	Self-Management Support	Delivery System Design	Decision Support	Clinical Information System
<p>Office of Oral Health (OOH) for provider and/or member education</p> <ul style="list-style-type: none"> Collaborate with the Arizona School of Dentistry and Oral Health to provide services and enhance training of dental professionals, especially in the care of special populations (e.g., individuals with disabilities) Use Health Plan staff and/or dental providers to make presentations in schools; provide educational materials and other items, such as toothbrushes, to take home 		<p>scheduled appointments</p> <ul style="list-style-type: none"> Offer incentives to members to encourage them to seek dental care Follow up with members who miss appointments and arrange for transportation when necessary Make or collaborate with organizations that make home visits to reinforce education about oral health and the importance of regular dental care 		<ul style="list-style-type: none"> Utilize dental consultants to review utilization patterns, practice guidelines and/or treatment plans for specific members Capture dental referral data from EPSDT Tracking Forms for follow up to ensure that appointment was completed 	<ul style="list-style-type: none"> Develop provider utilization profiles and send feedback to providers on visit rates or lists of specific members in need of service

Dental Data Measurement: Does your State compute or report the National Committee for Quality Assurance’s (NCQA) HEDIS dental measure or a modification of it? (Dental care: percentage of members 2 through 21 years of age who had at least one dental visit during the measurement year.”

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If yes, describe how that data compares with the data submitted on line 12.a of the CMS-416 and/or Section III, G.1.a. of the CHIP Annual Report (Total Enrollees Receiving Any Dental Services). If the HEDIS measure result differs from the result reported on CMS-416, line 12.a, or the CHIP Annual Report, Section III, G.1.a., please explain why you think there is a difference. If you use a modification of the HEDIS measure, please describe the modification. (NOTE: You are not required to report this data on the Template.)

AHCCCS has a HEDIS-like dental performance measure in place for Acute-care Contractors. AHCCCS measures Acute-care Contractor's performance dental performance of members aged 2-21 for the Medicaid population and 2-18 for the KidsCare (CHIP) population. The measurement period runs from October 1 (start of contract year) to September 30 of the next year (end of contract year). In addition, EPSDT Dental Participation (based on CMS 416 data) is also a performance measure for all Contractors as of CYE 2012. AHCCCS has historically tracked the CMS 416 data for federal reporting purposes; however, when planning on how to meet the goals set forth in this Action Plan, it was determined that formalizing a measure around the CMS 416 data would assist in driving up the preventive care rates.

The most recent AHCCCS data related to both measure types are shown below:

- Dental Performance Measure Rate, Medicaid: 61.8%
- CMS 416 Line 12.a, (all eligible members): 45.9%
- Dental Performance Measure Rate, KidsCare (CHIP): 77.9%
- CMS 416 Line 12.a, (CHIP-specific): 37.8%
- CMS 416 Preventive Rate (all eligible members): 45.5%
- CMS 416 Preventive Rate (CHIP-specific): 38.8%
- CMS 416 Dental Sealant Rate (All eligible members aged 6-9 years): 14.5%
- CMS 416 Dental Sealant Rate (All CHIP members aged 6-9 years): 13.3%

CHIP data should be interpreted with caution as the population was "unfrozen" in June 2012 and there was an influx of eligible members; many of which who were eligible during the reporting period but did not have a reasonable amount of time (90 days) to access services.

Reimbursement Strategies: What are your current reimbursement rates for the following 10 procedures for services provided to children eligible for Medicaid and CHIP?

Diagnostic: D0120 Periodic Oral Exam
D0140 Limited Oral Evaluation, problem focused
D0150 Comprehensive Oral Exam
D0210 Complete X-rays with Bitewings
D0272 Bitewing X-rays – 2 films
D0330 Panoramic X-ray film
Preventive: D1120 Prophylaxis (cleaning)
D1203 Topical Fluoride (excluding cleaning)
D1206 Topical Fluoride Varnish
D1351 Dental Sealant

Please describe any increases or decreases in these reimbursement rates that have occurred in the last five years.

Current AHCCCS reimbursement rates for the relevant codes; all were effective beginning 10/01/2011:

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Codes	Rates
D0120 Periodic Oral Exam	\$26.13
D0140 Limited Oral Evaluation, problem focused	\$34.51
D0150 Comprehensive Oral Exam	\$38.33
D0210 Complete X-rays with Bitewings	\$66.02
D0272 Bitewing X-rays – 2 films	\$21.71
D0330 Panoramic X-ray film	\$57.88
D1120 Prophylaxis (cleaning)	\$40.19
D1203 Topical Fluoride (excluding cleaning)	no longer covered, effective 10/1/2013
D1206 Topical Fluoride Varnish	\$18.58
D1351 Dental Sealant	\$25.24

Dental hygienists are the only AHCCCS-approved, non-dentist providers who are authorized to participate in comprehensive delivery of oral health care to members at this time. The following codes and rates are applicable for approved non-dentist providers:

Codes	Rates
D1120 Prophylaxis (cleaning)	\$32.15
D1203 Topical Fluoride (excluding cleaning)	no longer covered, effective 10/1/2013
D1206 Topical Fluoride Varnish	\$14.86
D1351 Sealant-Per Tooth	\$20.19

As of CYE 2014 (beginning 10/1/2013), the AHCCCS reimbursement rates for the dental codes were increased by 3 percent over the CYE 2013 rates.

Efforts Related to Dental Sealants: Do you encourage or plan to encourage dental providers in your State to provide dental sealants? If so, how do you communicate that information? Have you seen an increase in the number of children receiving sealants? Does your State support active school-based or school-linked dental sealant programs? If yes, how many Medicaid- or CHIP-enrolled children were served by these programs in the past year? How many sealants were placed in these programs in the past year? Are you continuing to see increases in the number of children served by these programs? Has funding from the Centers for Disease Control and Prevention [for oral health infrastructure development] contributed to these efforts? Please describe.

Ongoing analysis of data related to sealants is being conducted to determine the best course(s) of action to improve statewide sealant rates. AHCCCS promotes dental sealants to members through the Contractors and their interventions. Sealant data has been fairly consistent over the past two years, with no notable increases or decreases.

The Arizona Department of Health Services (ADHS) promotes the use of sealants by providing grant funds to support school-based sealant programs and by sharing the most current recommendations on the use of sealants. These programs are targeted to schools with a high percentage of enrolled students eligible for the state's Free and Reduced Price Meals Program. These programs are located in rural and urban areas where children have limited access to dental care.

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A barrier does exist, in that, the Contractors and/or AHCCCS is not always made aware of the procedures done for AHCCCS members via the School-Based program. AHCCCS promotes collaboration between the Contractors and ADHS, with ADHS having been invited to a recent Dental Workgroup meeting. The Contractors value collaborative approaches and continue to work with ADHS to ensure that services to Medicaid members are documented and that the loop is closed with the members' primary dental provider.

Collaboration with Dental Schools: Do you have a dental school or dental hygiene school in your State? If yes, do you have any arrangement with the dental school or dental hygiene school to treat Medicaid beneficiaries, serve in rural areas, provide educational opportunities, etc.? Please describe.

At this time, AHCCCS and the Contractors have limited collaboration with the dental schools. The Agency's new Dental Director has set up meetings with the State's two dental schools in order to discuss potential partnerships; however, the meetings have not yet occurred. AHCCCS will continue to pursue potential utilization of dental schools as an oral health care option for AHCCCS members.

Electronic Dental Records: Describe the use of electronic dental records in your State for your Medicaid and CHIP population. What is the take up rate by dental providers? Is the dental record integrated with the medical record? Will the State support dental provider efforts to qualify for meaningful use incentive payments?

Arizona opened the Adopt, Implement, and Upgrade (AIU) segment of the Electronic Health Record (EHR) Provider Incentive Program in late 2011. Meaningful Use (MU) attestations could be submitted for incentive payments as of November 1, 2012. To date, there have been 269 dentists (20.3% of all active AHCCCS dentists, up from 10.7% in 2012) who registered with the state. Of those, 233 have attested for at least one year. There have been 142 incentive payments issued to dentists. The remaining dentists who have attested are still being processed for payment.

AHCCCS is currently conducting an in-depth analysis of AHCCCS providers to determine who may be potentially eligible to participate in the EHR Program as well as the number of members that are served by participating providers. Once the data has been analyzed, AHCCCS will work with Agency stakeholders to outreach to providers who may be able to participate. In addition, AHCCCS will present the findings to the Dental Work Group and other stakeholder groups for discussion and planning of next steps. AHCCCS is committed to helping all eligible providers who are interested to participate in the EHR Incentive Program.