# Table of Contents

**COMMENTARY** .......................................................... 3  
**KEY FINDINGS** ..................................................... 5  
**DATA & METHODS** .................................................. 7

**STATE FACT SHEETS**  
ALABAMA ........................................... 14  
ALASKA ........................................... 17  
ARIZONA .......................................... 20  
ARKANSAS ...................................................... 23  
CALIFORNIA ........................................... 26  
COLORADO ........................................... 29  
CONNECTICUT ............................................. 32  
DELAWARE .............................................. 35  
DISTRICT OF COLUMBIA ........................................ 38  
FLORIDA ................................................... 41  
GEORGIA .................................................. 44  
HAWAII .................................................... 47  
IDAHO ...................................................... 50  
ILLINOIS .................................................... 53  
INDIANA .................................................... 56  
IOWA ....................................................... 59  
KANSAS ..................................................... 62  
KENTUCKY .................................................. 65  
LOUISIANA ............................................... 68  
MAINE ..................................................... 71  
MARYLAND ............................................... 74  
MASSACHUSETTS ......................................... 77  
MICHIGAN ............................................... 80  
MINNESOTA ............................................... 83  
MISSISSIPPI ............................................... 86  
MISSOURI .................................................. 89  
MONTANA ................................................. 92  
NEBRASKA ............................................... 95  
NEVADA .................................................... 98  
NEW HAMPSHIRE ......................................... 101  
NEW JERSEY ............................................... 104  
NEW MEXICO ............................................... 107  
NEW YORK ............................................... 110  
NORTH CAROLINA ......................................... 113  
NORTH DAKOTA ........................................... 116  
OHIO ......................................................... 119  
OKLAHOMA ............................................... 122  
OREGON .................................................... 125  
PENNSYLVANIA ........................................... 128  
RHODE ISLAND ............................................ 131  
SOUTH CAROLINA ......................................... 134  
SOUTH DAKOTA ............................................ 137  
TENNESSEE ............................................... 140  
TEXAS ......................................................... 143  
UTAH ......................................................... 146  
VERMONT ................................................. 149  
VIRGINIA .................................................... 152  
WASHINGTON ............................................. 155  
WEST VIRGINIA ........................................... 158  
WISCONSIN ............................................... 161  
WYOMING .................................................. 164
“HEADLINES ARE IMPORTANT, BUT TREND LINES ARE MORE IMPORTANT.” This is how President Bill Clinton began his keynote address at the 154th Annual Meeting of the American Dental Association in 2013. It is not every day that you hear a politician, let alone a former president, emphasize the need to temper rhetoric with facts and to let evidence guide policy.

The American Dental Association’s Health Policy Institute (HPI) has compiled a first-of-its-kind comprehensive analysis of key aspects of the oral health care system in all 50 states and the District of Columbia. This multi-year effort brings together data and analysis in a way that helps inform policy decisions. And when it comes to oral health in America, indeed, many trend lines are important.

One major takeaway from this new analysis is that adults view oral health as very important. For example, 95 percent of adults say they value keeping their mouth healthy. Furthermore, routine dental care is seen as a key part of overall wellness, with 93 percent of adults agreeing that regular visits to the dentist “help keep me healthy.”

A second major takeaway is that there have been substantial gains in access to dental care among Medicaid children in recent years. Between 2000 and 2013, all but one state saw an increase in the percentage of Medicaid children who had at least one dental visit within the past year. Nationally, the rate increased from 29 percent to 48 percent, and in states such as Maryland, it increased fivefold. As a result, the gap in dental care use between Medicaid children and children with private dental benefits narrowed significantly over this same timeframe in the vast majority of states. In fact, in Texas, Medicaid children are actually more likely to visit a dentist than their privately insured counterparts.

A third major takeaway is that dental care use trends for adults are very different than the trends for children. Among adults with private dental benefits, dental care use is declining in most states. Additionally, other HPI analysis shows that the gap in dental care use between Medicaid and privately insured adults is much wider than it is for children.

Additional troubling statistics emerge when it comes to oral health among adults. More than one out of three low-income adults say they avoid smiling and 17 percent report difficulty doing usual activities because of the condition of their mouth and teeth. Nearly one out of four low-income adults and 14 percent of all adults report that their oral health issues have led them to reduce participation in social activities.
The facts are the facts. But what should policymakers think about doing to address some of these oral health challenges?

First, policymakers need to continue implementing evidence-based reforms in Medicaid. The states with the largest gains in access to dental care among Medicaid children are those that implemented comprehensive, multi-pronged reforms that work. For example, the experiences in Connecticut, Maryland and Texas have been well documented. The Medicaid programs in these states focused on provider and Medicaid beneficiary outreach, provider reimbursement increases, and streamlining administrative procedures. It is important to note that the remarkable gains in access to dental care in these three states, as well as others, did not involve any major increase in the number of dental care providers. In fact, there is strong evidence that there is significant excess capacity in the dental care system today. According to new HPI research, one out of three dentists in the U.S., and as high as one out of two in states like Florida, report they are not busy enough and can treat more patients. This further suggests that policymakers ought to focus on policies that leverage existing unused capacity rather than increasing the number of dental care providers.

Second, policymakers, and the oral health community more broadly, need to consider reinventing how oral health is defined and measured. The current focus of many government agency data collection efforts is to measure the presence and severity of dental disease and the frequency and type of dental care services people use. There is very little emphasis, in contrast, on measuring the contribution of oral health to physical, social and emotional wellbeing. These are the ultimate outcomes of interest that the oral health care system ought to be designed around. The new measures of oral health status developed by HPI are a significant advancement in this area but are meant to be a starting point for others, including the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality, to build upon. A robust oral health measurement system would also enable a shift toward outcomes-based delivery and reimbursement models, a critical aim of the Affordable Care Act.

Third, policymakers need to rethink how dental care for adults is handled in state and federal health care policy. Research shows that adults, particularly low-income adults, report cost as the number one reason for not visiting the dentist. Current policies are not helping. Under the Affordable Care Act, dental care for adults is not considered “essential” and thus, dental coverage is not part of the individual mandate. Within Medicaid, adult dental benefits are optional and most states provide only basic coverage. Implementing a comprehensive dental benefit for Medicaid adults in states that currently lack one is estimated to cost $1.4 billion to $1.6 billion per year. The estimated state portion of this bill translates to about 1 percent of total Medicaid spending. At the same time, an estimated $1.6 billion is spent each year on hospital emergency room visits for dental conditions, one-third of which is paid for by Medicaid. Additionally, while more and more private medical insurance plans in the health insurance marketplaces established by the Affordable Care Act are covering dental benefits for children, there are far fewer options for adults. This is despite the fact that dental care is a high priority among young adults who are shopping for health insurance.

As stated by a former U.S. surgeon general: “You can’t be healthy without good oral health.” There is emerging evidence that oral health is related to conditions outside of the mouth, like diabetes, pregnancy and even mental health. Health care policy in the United States clearly emphasizes oral health for children. It might be time to reconnect mouth and body for adults. Now there’s a headline.
Key Findings

Oral health is an integral component of whole body health. The American Dental Association’s Health Policy Institute (HPI) analyzed key aspects of the oral health care system in all 50 states and the District of Columbia. Topics include dental care utilization, self-reported oral health status, knowledge and attitude toward oral health, community water fluoridation, provider reimbursement rates and the supply of dentists.

The data sources, methodology, state-level fact sheets, as well as all of the underlying data used in the analysis are available for download at ADA.org/statefacts.

Key findings from the analysis are summarized below.

### Dental Care Utilization

Nationally, the percentage of Medicaid children who visited a dentist within the past year increased from 29 percent in 2000 to 48 percent in 2013. All but one state saw an increase in dental care utilization among Medicaid children. Dental care utilization among children with private dental benefits increased, as well, from 60 percent in 2005 to 64 percent in 2013. In contrast, utilization among adults with private dental benefits decreased slightly over the same timeframe, with the majority of states experiencing a decline.

In 2013, dental care utilization among children with Medicaid dental benefits was highest in Connecticut, while Massachusetts had the highest utilization rate among children with private dental benefits. Among adults with private dental benefits, dental care utilization was highest in Oregon.

### Sealants and Community Water Fluoridation

In 2013, 14 percent of Medicaid children ages 6 through 14 in the United States received a dental sealant on a permanent molar. This ranges from 6 percent in Ohio to 24 percent in Massachusetts.

In 2012, approximately 75 percent of Americans on a community water system received fluoridated drinking water. This ranges from 11 percent in Hawaii to 100 percent in the District of Columbia and Kentucky.

### Oral Health Status, Knowledge and Attitude

HPI developed a new, innovative composite measure of oral health status based on various self-reported measures. On an index of zero (frequent oral health problems) to ten (no oral health problems), the average oral health status rating for U.S. adults was 7.9 in 2015. This ranges from 7.2 in Alaska to 8.6 in Illinois. High-income adults had an average score of 8.2 compared to 7.2 for low-income adults. The widest gap between high- and low-income adults was in Arizona, while the narrowest gap was in California.

HPI also developed a new, simplified measure of oral health knowledge. Nationally, 50 percent of adults were able to respond correctly to each of the eight general knowledge questions regarding oral health facts. This ranges from 42 percent in...
Key Findings

New Jersey to 60 percent in Colorado and from 44 percent among low-income adults to 52 percent among high-income adults nationwide.

HPI developed a new index measuring attitude toward oral health, and U.S. adults have a positive attitude overall toward oral health. On a scale of -10 to +10, with zero being neutral, the average score was 5.1 nationally. This ranges from 4.3 in Montana to 5.7 in Arizona.

Reimbursement, Supply of Dentists and Medicaid Participation

From 2003 to 2013, Medicaid fee-for-service reimbursement rates for child dental services decreased by 14 percent nationally. This ranges from a decrease of 41 percent in Minnesota to an increase of 82 percent in the District of Columbia. Over the same time period, private dental benefit plan charges increased, on average, by 1.2 percent nationally for child dental services. This ranges from a decrease of 13 percent in Hawaii to an increase of 14 percent in North Dakota. For adult dental services, private dental benefit plan charges decreased by 0.6 percent between 2003 and 2013, ranging from a decrease of 14 percent in Nevada to an increase of 12 percent in North Dakota.

The supply of dentists in the United States increased from 57.3 dentists per 100,000 population in 2001 to 60.5 in 2013. Nationally, 42 percent of dentists participate in Medicaid, with significant variation across states.
Data & Methods

Percentage with a Dental Visit in the Past 12 Months

To measure dental care utilization among adults and children with private dental benefits, we analyzed data from the Truven MarketScan® Research Database (Truven). Truven is based on a very large sample of enrollees with employer-sponsored health insurance and dental benefits and included 3.8 million individuals with private dental benefits in 2005 and 10.7 million in 2013. Based on the latest data from the 2012 Medical Expenditure Panel Survey (MEPS), we estimate that Truven captures about 7.6 percent of individuals with private dental benefits in the U.S.

In our utilization analysis, we focused on adults and children with at least 90 days of continuous enrollment in a private dental benefit plan. The 2005 Truven database included 2,497,278 adults ages 21 through 64 and 1,086,098 children ages 0 through 20 who were continuously enrolled in a private dental benefit plan for 90 days. The 2013 Truven database included 7,253,702 adults ages 21 through 64 and 2,923,720 children ages 0 through 20 who were continuously enrolled in a private dental benefit plan for 90 days. We substituted 2011 data for Montana as the sample sizes in 2012 and 2013 were not sufficient.

We measured dental care utilization as the proportion of enrolled individuals who have at least one dental claim in a year.

The ADA Health Policy Institute (HPI) has Truven data from 2005 through 2013 and this is the period we chose to study.

To measure dental care utilization among children with Medicaid dental benefits, we analyzed data from the Centers for Medicare and Medicaid Services (CMS) Form 416 (CMS-416). The CMS-416 is a form that each state Medicaid program submits to CMS on an annual basis, and it includes children under age 21 eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Beginning in 2010, the dental care utilization rate is based on children ages 1 through 20 who had at least 90 days of continuous Medicaid enrollment during the fiscal year. Prior to 2010, the dental care utilization rate was based on children ages 0 through 20 who were enrolled in Medicaid at any time during the fiscal year.

We measured dental care utilization as the total number of children receiving any dental service (Line 12a) divided by the total number of children enrolled in Medicaid (Line 1b). It is important to note that because CMS changed its reporting methods beginning in 2010, we are not able to construct a consistent time series of dental care utilization. In other words, some component of the change in dental care utilization between 2000 and 2013 in the CMS-416 data will be due to the changes in how Medicaid enrollment is reported. There is no way to adjust for this in our analysis.

HPI has CMS data from 2000 through 2013 and this is the period we chose to study.

Officials from Ohio's Medicaid office indicated that 2013 CMS-416 data were not reliable. We substituted 2012 data for the 2013 Ohio utilization rate for children with Medicaid dental benefits. Maine's Medicaid program did not submit CMS-416 data for 2005, so we do not have a utilization rate for children with Medicaid dental benefits for that year.
Percentage of Medicaid Children Who Received a Sealant on a Permanent Molar in 2013

CMS began collecting data through the CMS-416 on the total number of children ages 6 through 14 receiving a sealant on a permanent molar in 2010. We define the sealant rate as the ratio of the total number of children ages 6 through 14 receiving a dental sealant (Line 12d) to the total number of children ages 6 through 14 enrolled in Medicaid (Line 1b). A dental sealant is an evidence-based service that prevents the onset of caries on healthy tooth surfaces. Data are available from 2010 through 2014. We analyze the data for 2013 because it is the most complete year of data available.

Oral Health Status, Knowledge and Attitude Index Among Adults in 2015

The HPI team developed a comprehensive index measure for oral health status, oral health knowledge and attitude toward oral health based on various self-reported items among adults. Data were collected through an online survey conducted by Harris Poll on behalf of HPI from June 23, 2015 through August 7, 2015. Harris Poll collected data from a nationally representative sample of 14,962 adults ages 18 and older across all 50 states and the District of Columbia. We analyzed responses to these survey questions by state and household income using appropriate survey weights.

We reported each index for both high-income and low-income adults. We defined high-income as adults with household incomes above 400 percent of the federal poverty level. We defined low-income as adults with household incomes at or below 138 percent of the federal poverty level.

The HPI oral health status index is reported using a 10-point scale where a score of 10 corresponds to excellent oral health (i.e. no oral health problems) and a score of 0 corresponds to poor oral health (i.e. frequent oral health problems). We report this index measure nationally and by state for both high-income and low-income adults.

The HPI oral health knowledge index is reported as the percentage of respondents who were able to answer each of eight general oral health knowledge questions correctly. We report this percentage nationally and by state for both high-income and low-income adults.

The HPI oral health attitude index is reported on a scale of –10 to +10, with negative values indicating negative attitudes toward oral health, zero indicating a neutral attitude, and positive values indicating positive attitudes toward oral health. We report these scores nationally and by state for both high-income and low-income adults.

For more information on these three measures, please see our detailed methodological description.
Data & Methods

Percentage of Population on Community Water Systems Receiving Fluoridated Water in 2012

Data on water fluoridation rates are from the Centers for Disease Control and Prevention (CDC). Estimates are based on data reported by each state to the CDC Water Fluoridation Reporting System as of December 31, 2012. The CDC utilized population estimates for 2012 from the U.S. Census Bureau.

Change in Private Dental Benefit Plan Charges Between 2003 and 2013

We drew on previous research to summarize changes in private dental benefit plan charges for adult and child dental services. We constructed separate price indices for 2003 and 2013 for each state and the District of Columbia using private dental benefits charges data from the FAIR Health Dental Benchmark Module. The full methodology on the construction of these indices is available in an earlier publication. In summary, we constructed a weighted average charge rate for a group of common dental procedures and used the Dental Services Consumer Price Index (CPI) to convert 2003 levels to 2013 dollars.

Our data source, FAIR Health, contains fees charged by providers before network discounts are applied. It does not contain data on actual reimbursement to providers. Based on anecdotal information, we feel that providers often submit fees they expect to be paid rather than their true non-discounted fees. However, we have no basis to evaluate this data limitation empirically.

HPI has FAIR Health data from 2003 through 2013 and this is the period we chose to study.

Medicaid Fee-for-Service Reimbursement as a Percentage of Private Dental Benefit Plan Charges for Child Dental Services

We drew on previous research to summarize changes in Medicaid dental reimbursement rates for child dental services. We constructed separate fee indices for each state and the District of Columbia based on fee-for-service (FFS) Medicaid reimbursement schedules for child dental services. These fee schedules were collected from each state’s Medicaid program webpage. We constructed an index that measures FFS reimbursement rates in Medicaid relative to commercial dental benefits charges. We feel this is a useful measure as it takes into account Medicaid reimbursement relative to “market” conditions. The full methodology on the construction of this index is available in an earlier publication. We tracked changes over time in inflation-adjusted Medicaid reimbursement using the Dental Services Consumer Price Index (CPI).
Data & Methods

Our analysis of reimbursement has important limitations that are outlined in previous work.10 A main limitation is that our Medicaid reimbursement data are based on FFS rates taken from state Medicaid fee schedules while a significant segment of the Medicaid population in many states may receive dental care through a managed care program. Managed care providers are not necessarily subject to established Medicaid FFS schedules and, as a result, our data may not necessarily capture typical fees paid to dental care providers.

Additionally, we were not able to obtain Medicaid reimbursement data for 2003 for six states: Maine, New Jersey, North Dakota, South Dakota, Vermont and Wyoming. For these states, therefore, we were unable to calculate the change in Medicaid reimbursement rates for child dental services between 2003 and 2013.

HPI has Medicaid reimbursement data from 2003 through 2013 and this is the period we chose to study.

Number of Dentists per 100,000 Population

To measure the supply of dentists, we analyzed the ADA Masterfile.12 The ADA Masterfile contains the most up-to-date information on dentists in the United States. The Masterfile is a database of all dentists, practicing and non-practicing, ADA members and non-members, and is updated through a variety of methods including reconciliation with state licensure databases, detailed records, various surveys and censuses of dentists carried out by the ADA. We only included professionally active dentists in our calculation (e.g. retirees are not included) and we used U.S. Census Bureau data for population counts.13, 14

HPI has comparable dentist supply data from 2001 through 2013 and this is the period we chose to study.

Percentage of Dentists Participating in Medicaid for Child Dental Services in 2014

To calculate the percentage of dentists participating in Medicaid for child dental services, we analyzed data from Insure Kids Now.15 Insure Kids Now is a website containing information about Medicaid and the Children’s Health Insurance Program (CHIP), including covered dental services for children and a dentist locator tool. The dentist locator tool is supported by a database of dental providers that are enrolled in the Medicaid program. It is overseen by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. One of the objectives of Insure Kids Now is to help families locate a dentist that accepts Medicaid and CHIP insurance. Additionally, Insure Kids Now is meant to connect interested organizations with the Connecting Kids to Coverage National Campaign.16

The Health Resources and Services Administration (HRSA) and CMS jointly provided HPI with Insure Kids Now provider rosters for the months of August, October and
November 2014. We combined these data, removed duplicate observations and then matched the Insure Kids Now data with the ADA’s roster of dentists who were professionally active as of October 30, 2014 based on the ADA Masterfile. Insure Kids Now providers who could not be matched were excluded. In situations where the Insure Kids Now database included an address only but no dentist information, we count all dentists practicing at that address as participating in the state’s Medicaid program. We recognize this could lead to an over-count of participating providers, depending on the extent of large group practices within a particular state. We cross-referenced practice addresses with a cotemporaneous list of Federally Qualified Health Centers (FQHCs) and included all dentists practicing at FQHCs as Medicaid participants irrespective of whether they are listed in the Insure Kids Now database. We count all dentists listed in Insure Kids Now as participating in Medicaid even if they indicated they were not accepting new patients. We divide the number of dentists who are Medicaid providers by the total number of professionally active dentists in each state, yielding our measure of the percentage of dentists participating in Medicaid in each state.

It is important to note that Insure Kids Now is limited to those dentists that treat children and may not accurately capture dentists that treat Medicaid adults.

HPI collaborated with HRSA and CMS to explore the accuracy and the validity of the Insure Kids Now data. HPI undertook two separate analyses in 2014. First, HPI selected a random sample of 398 dental offices included in the Insure Kids Now database and called each office to ascertain whether the dentist listed did in fact practice at that location and whether he or she did in fact accept Medicaid. Second, a random sample of 287 dental offices not included in the Insure Kids Now database were called to ascertain the same information – whether the dentist listed practiced at the location and whether he or she accepted Medicaid. These non-Insure Kids Now dentists were drawn from the ADA Masterfile.

HPI staff obtained responses from 156 of the 398 dental offices contacted (39 percent). Among respondents, the target dentist was reported to work at the office in only 52 percent of cases (81 of 156). During an initial round of calling these offices, when front office staff were asked whether the dentist accepted “Medicaid,” only 44 percent responded affirmatively. HPI staff subsequently re-contacted the offices which responded negatively and asked if the dentist accepted the specific Medicaid plan name listed in the Insure Kids Now database (e.g. Florida Healthy Kids Argus; Delta Dental; or Medicaid and CHIP United Healthcare). The vast majority of those re-surveyed indicated that the dentist did in fact accept the specified Medicaid plan, and the two groups – those initially responding affirmatively and those initially responding negatively but then responding affirmatively at the second call – were combined to yield an overall Medicaid acceptance rate of 95 percent. In other words, 95 percent of dentists who were practicing at the location listed in the Insure Kids Now database actually accepted Medicaid. In our view, this is a very high accuracy rate.
However, as noted, the Insure Kids Now database is less accurate in placing individual dentists in specific office locations. This could be for many reasons. For example, some large group practices list all dentists at all office locations in the Insure Kids Now database, even though it is unlikely that each dentist actually practices at multiple locations. This may be one reason why only 52 percent of dentists HPI contacted actually practiced at the office location listed in the Insure Kids Now database. We had no way of identifying if other dentists at the specific location we contacted accepted Medicaid. This was not part of our surveying protocol.

HPI also contacted a random sample of 287 dentists not listed in the Insure Kids Now database. We found that 11 percent of these dentists actually accepted Medicaid. Thus, there are dentists who are not listed on the Insure Kids Now roster who accept Medicaid.

Our vetting of the Insure Kids Now data indicated that dentists listed in the roster are often not actually present at the office they are listed under, but if they are, it is extremely likely that they do accept Medicaid patients. We also found, however, that there are dentists who are not included in Insure Kids Now who accept Medicaid patients. We also recognize that other research in this area has found that lists of Medicaid dental care providers often contain inaccuracies.17, 18

In 2015, HPI also worked directly with Medicaid officials in several states to further validate the Insure Kids Now data. Based on discussions with CMS, states administering their Medicaid dental program through managed care automatically include all participating dentists on the Insure Kids Now roster. However, CMS indicated that 18 state Medicaid programs administer the dental program directly. These states have some additional flexibility and may allow dentists to opt-out of being listed on Insure Kids Now, even though they participate in the Medicaid program. HPI contacted Medicaid officials in each of these 18 states to inquire about their opt-out procedures and to further validate the data. We found that four states allow providers to opt-out of being on publicly available lists, including Insure Kids Now: Alabama, New Hampshire, North Carolina and Oklahoma. At HPI’s request, Medicaid officials in these states provided data that included dentists who opted out of being listed in Insure Kids Now but participate in Medicaid and we used these data in our calculations. Medicaid officials in one other state, Maine, approached HPI and indicated the data submitted to CMS in 2014 were inaccurate and they were able to provide supplemental data that corrected inaccuracies. Due to inconsistencies in how data from Maine, New Hampshire and Oklahoma are handled in our data set, these three states are not included in our calculation of the national average.
Data & Methods


4. In 2010 the CMS Form 416 instructions for line 12a were changed as follows: Enter the unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one dental service by or under the supervision of a dentist.


Oral Health Care System: Mississippi

This fact sheet summarizes select data on the oral health care system as of 2015. Topics include dental care utilization; oral health status; attitudes and knowledge of oral health; fluoridation rates; reimbursement rates to providers and the supply of dentists.

For methods and data sources, please visit ADA.org/statefacts.

For more information on the ADA Health Policy Institute, please visit ADA.org/HPI.

Percentage with a Dental Visit in the Past 12 Months

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2005</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>28%</td>
<td>35%</td>
<td>48%</td>
</tr>
<tr>
<td>U.S.</td>
<td>52%</td>
<td>53%</td>
<td>50%</td>
</tr>
<tr>
<td>Children with Medicaid Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>52%</td>
<td>53%</td>
<td>53%</td>
</tr>
<tr>
<td>U.S.</td>
<td>50%</td>
<td>60%</td>
<td>64%</td>
</tr>
<tr>
<td>Adults with Private Dental Benefits Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>52%</td>
<td>45%</td>
<td>52%</td>
</tr>
<tr>
<td>U.S.</td>
<td>48%</td>
<td>50%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Percentage of Medicaid Children Who Received a Sealant on a Permanent Molar in 2013

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2005</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S.</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17% of Mississippi Medicaid children 6 through 14 years old received a sealant on a permanent molar in 2013, compared to 14% nationally.
Oral Health Care System: Mississippi

Oral Health Status Index Among Adults in 2015

<table>
<thead>
<tr>
<th>Mississippi</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>8.0</td>
</tr>
<tr>
<td>Very Good</td>
<td>8.2</td>
</tr>
<tr>
<td>Good</td>
<td>58%</td>
</tr>
<tr>
<td>Fair</td>
<td>23%</td>
</tr>
<tr>
<td>Poor</td>
<td>0%</td>
</tr>
</tbody>
</table>

Oral Health Knowledge Index Among Adults in 2015

- 45% of high-income Mississippi adults answered all of HPI's oral health knowledge survey questions correctly compared to 52% of high-income and 44% of low-income U.S. adults.
- 44% of low-income Mississippi adults answered all of HPI's oral health knowledge survey questions correctly.

Oral Health Attitude Index Among Adults in 2015

<table>
<thead>
<tr>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Income Adults</td>
<td>3.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Low-Income Adults</td>
<td>3.8</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Percentage of Population on Community Water Systems Receiving Fluoridated Water in 2012

- 58% of Mississippi's population on community water systems receive fluoridated water.

HPI Health Policy Institute

ADA American Dental Association*
Oral Health Care System: Mississippi

Change in Private Dental Benefit Plan Charges Between 2003 and 2013

<table>
<thead>
<tr>
<th></th>
<th>Child</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>2.6%</td>
<td>0.7%</td>
</tr>
<tr>
<td>U.S.</td>
<td>1.2%</td>
<td>-0.6%</td>
</tr>
</tbody>
</table>

Medicaid Fee-for-Service Reimbursement as a Percentage of Private Dental Benefit Plan Charges for Child Dental Services

- **Mississippi**: 48%
- **U.S.**: 49%

BETWEEN 2003 AND 2013: REIMBURSEMENT RATES FOR CHILD DENTAL SERVICES IN MEDICAID decreased 10.5% in Mississippi

Number of Dentists per 100,000 Population

- **Mississippi**: 57.3 in 2001, 60.5 in 2013
- **U.S.**: 39.2 in 2001, 42.6 in 2013

Percentage of Dentists Participating in Medicaid for Child Dental Services in 2014

- **Mississippi**: 55%
- **U.S.**: 42%

Health Policy Institute

*ADA American Dental Association*