

RESEARCH REPORT

Room to Grow

**An Analysis of Dental and Health Care Claims in
Medicaid-Enrolled Children in Arizona**

SUGGESTED CITATION:

CareQuest Institute for Oral Health, Arizona Oral Health Coalition, and Arizona Children's Action Alliance. *Room to Grow: An Analysis of Dental and Health Care Claims in Medicaid-Enrolled Children in Arizona*. Boston, MA: June 2022. DOI: 10.35565/CQI.2022.04

Copyright ©2022 CareQuest Institute for Oral Health, Inc.



Executive Summary

- This study examined Arizona Health Care Cost Containment System (AHCCCS) health claims data to determine patterns of use of well-child medical visits and dental services in Arizona children enrolled in Medicaid from April 2016 to March 2020.
- Results of this study show that recommendations for a dental visit by the age of 1 are not being met in Arizona, and that racial disparities exist in access to health care services.
- Most children in the sample (82.3%) had at least one health care claim (well-child, dental, or other visit) during the study period. More children had a well-child visit (43.6%) than a dental visit (39.5%).
- Nearly all claims for children up to the age of 1 year were for well-child visits (95.9%); claims were much lower for dental visits (0.9%).
- Compared to claims for children up to the age of 1, the percentage of claims for well-child visits decreased for children aged 1–3 years (55.6%) and the percentage of claims for dental visits increased for this age group (26.7%).
- Claims for preventive care (cleanings, examinations) were most common in the 0–3 age group (38.1%) and least common in the 19–21 age group (20.2%). The youngest age group (0–3 years) also had the greatest percentage of major restorative care (large fillings; 8.9%) of all the age groups.
- American Indian or Alaska Native (AI/AN) children were least likely to have a claim (48.4%), while children identifying as Asian were the most likely to have at least one claim (86.9%). AI/AN children also traveled longer distances to receive health care than children from racial backgrounds other than AI/AN.
- Less than 1% of children had a dental claim before the age of 1, and only about one in four Arizona children aged 1–3 years had a dental claim. (The American Academy of Pediatric Dentists and the AHCCCS recommend that children see a dentist by their first birthday.)

Introduction

Medicaid-enrolled children experience more oral health problems and have fewer dental visits than children with private dental insurance.¹⁻³ The American Academy of Pediatric Dentists (AAPD) recommends that all children see a dentist by the age of 1.⁴ Prior research shows that children who see a dentist for a preventive visit by the age of 1 are more likely to have additional preventive visits, but are not more likely to have visits for restorative or emergency treatment.⁵ Other studies have found that children who first see a dentist at 3 or 4 years old are significantly more likely to have dental caries (tooth decay) and need restorative treatment (fillings) than children who see a dentist for the first time at the first year of age.^{6,7}

Studies have shown that incorporating anticipatory oral health guidance into a well-child visit increases the likelihood that a child will have a subsequent dental visit.^{8,9} The American Academy of Pediatrics (AAP) recommends that pediatricians conduct oral health assessments, including referrals to dental providers, as part of well-child visits.¹⁰ Medicaid, which provides health care coverage for children from low-income families, requires that children covered by Medicaid receive regular medical and dental visits according to the schedule set for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.¹¹ Inclusion of both medical and dental requirements for this benefit affirms the importance of early dental visits.

The Medicaid program in the state of Arizona, called the Arizona Health Care Cost Containment System (AHCCCS), provides comprehensive dental care under the EPSDT requirement for children under 21 whose families' incomes fall below a certain threshold.¹² KidsCare is a Children's Health Insurance Program (CHIP) in Arizona that offers coverage to eligible children under the age of 19 who do not qualify for other AHCCCS insurance.¹³ Additionally, the AHCCCS American Indian Health program provides dental services for eligible children under the age of 21 who identify as American Indian or Alaska Native (AI/AN) and includes coverage for examinations, sealants, emergency dental services, and "all medically necessary therapeutic dental services, including fillings."¹⁴ However, even with a comprehensive dental care benefit that includes assigning all Medicaid-enrolled children to a dental home,¹² Arizona lags behind the nation when it comes to children's oral health.¹⁵ The Arizona Healthy Smiles Healthy Bodies Survey, a survey of a representative sample of public elementary schools in non-reservation communities in Arizona,

estimated that more than half (52%) of Arizona's kindergarten children have experienced tooth decay, which is a higher rate than that of 5-year-old children nationally (36%).¹⁵ Further evidence from that survey indicates that nearly two thirds of Arizona's third-grade children (64%) have a history of tooth decay, higher than the rate of third-grade children nationally (52%).¹⁵

The goal of this study was to examine, through AHCCCS health claims data, patterns of use of medical (well-child visit) and dental services in Arizona children enrolled in Medicaid. We also examined health services use considering demographic variables as well as type of dental services provided, distance traveled for care, and how many days had passed since a health care benefit was used.

Medicaid-enrolled children experience more oral health problems and have fewer dental visits than children with private dental insurance.

Methods

Data source and study population

Data for this study was obtained from the AHCCCS health claims data source.¹⁶ This dataset includes subject identification numbers and claim identifiers, as well as individuals' demographic data on gender, year of birth, race and ethnicity, income, tribal affiliation, days enrolled in Medicaid, days since the last benefit was used, and distance in miles driven to the last appointment. Each claim includes information on fiscal year, visit type, procedure code, primary care association, health care provider group, a flag to indicate care at a federal qualified health center (FQHC), and flags for primary care physician (PCP) and pediatric dentist to indicate the provider performing the procedure. Data on distance driven to the last visit were available only in the first two years of data.

Children were included in the analysis if they were aged 0–21 at the time of service, living in the state of Arizona, and enrolled in Medicaid for at least 90 days (about three months). The data span from April 1, 2016 to March 31, 2020.

Outcome variables

The primary outcome variable was the presence of at least one health care claim during the study period. We also examined whether claims were for a dental visit, well-child visit, or if no visit type was reported.

Other variables

We collected data on enrollees' gender (male or female), age (categorized in years as 0–3, 4–6, 7–9, 10–12, 13–15, 16–18, or 19–21), and race (AI/AN, Asian, Black, Hispanic, Native Hawaiian or other Pacific Islander, white, or other). Within dental visit claims, we determined what type of service was provided (diagnostic, imaging, preventive, minor restorative, major restorative, scaling and root planing, other periodontic treatment, orthodontic, prosthodontic, oral surgery, general anesthesia, other anesthesia, or adjunctive general treatment). We also collected data on how many days had passed since a health care benefit had been used, and how many miles each enrollee traveled to access health care. Finally, we determined how each enrollee accessed dental care (through PCP, pediatric dentist, or an FQHC).

Statistical Analyses

Descriptive analyses examined the percentage of the sample with at least one health care claim, as well as the type of visit (dental, well-child, no type noted) by gender, age, and race. Descriptive analyses were also used to examine the length of time since the last benefit was used and distance traveled for a health care visit by gender, age, and race. Type of dental service provided by age group and access points to dental care by race were examined using descriptive statistics. A logistic regression analysis was conducted to determine predictors of having at least one health care claim during the study period.

Results

Table 1 presents demographic data of the study sample (N=1,250,668) by presence of at least one claim and type of claim (dental, well-child, no type listed). Most individuals in the sample (82.3%) had one or more claims during the study period. The percentage of males and females with at least one visit were similar (82.7% versus 82%, respectively). Younger children were more likely to have any type of claim than older children. For example, while 91.4% of children up

to age 1 and 88.4% of children aged 1–3 had at least one claim, those percentages dropped to 71.9% and 43.8% for individuals aged 16–18 and 19–21, respectively. Less than half of children identifying as American Indian or Alaska Native (AI/AN) had at least one claim (48.4%), while children identifying as Asian were the most likely to have at least one claim (86.9%). Most children identifying as white (86.2%) had at least one claim.

Table 1. Descriptive statistics (N (%)) of study sample (N=1,250,668)

	No claims (220,829 (17.7))	One or more claims (1,029,839 (82.3))		
		Dental Visit 406,867 (39.5)	Well-Child Visit 449,029 (43.6)	No type listed 173,943 (16.9)
Gender				
Male (n=620,583 (49.6))	107,242 (17.3)	39.2%	44.1%	16.7%
Female (n=630,085 (50.4))	113,587 (18.0)	39.8%	43.1%	17.0%
Race/ethnicity				
AI/AN	59,696 (51.6)	45.6%	26.5%	27.8%
Asian	2,225 (13.1)	36.8%	46.8%	16.3%
Black	19,911 (15.1)	34.4%	46.4%	19.2%
Hispanic	27,119 (14.7)	50.5%	33.7%	15.8%
NHPI	748 (14.7)	36.6%	43.4%	20.0%
Other	18,301 (14.8)	14.8%	76.7%	8.4%
White	92,060 (13.8)	41.5%	41.3%	17.3%
Age in years				
0	17,206 (8.6)	0.9%	95.9%	3.2%
1–3	20,680 (11.6)	26.7%	55.6%	17.7%
4–6	16,923 (10.5)	51.6%	30.1%	18.2%
7–9	18,099 (10.8)	58.2%	23.0%	18.7%
10–12	19,740 (12.4)	52.7%	28.0%	19.3%
13–15	22,676 (16.0)	50.2%	27.9%	21.9%
16–18	35,596 (28.1)	50.4%	26.0%	23.5%
19–21	57,353 (56.2)	49.6%	24.9%	25.4%
Year				
2016	156,904 (16.6)	45.7%	35.6%	18.6%
2017	21,797 (17.8)	20.2%	63.3%	16.6%
2018	19,598 (18.8)	17.6%	69.9%	12.5%
2019	22,530 (28.2)	20.3%	79.7%	0%

AI/AN = American Indian/Alaska Native; NHPI = Native Hawaiian/Pacific Islander

More enrollees had a well-child visit (43.6%) than a dental visit (39.5%) overall. The percentages for males and females were similar for dental visits (39.2% and 39.8%) and for well-child visits (44.1% and 43.1%, respectively). Nearly all claims for children up to the age of 1 year were for well-child visits (95.9%) rather than for dental visits (0.9%). In contrast, compared to claims for children up to the age of 1, the percentage of claims for well-child visits decreased for children aged 1–3 years (55.6%) and the percentage of claims for dental visits increased for this age group (26.7%). After the age of 4, the percentage of claims for dental visits exceeds that of claims for well-child visits. By the ages of 19–21, nearly half (49.6%) of claims are for dental visits, while less than a quarter (24.9%) are for well-child visits. Across most racial categories, there were more claims for well-child than for dental visits. However, dental claims were nearly twice that of well-child visit claims for AI/AN children (45.6% versus 26.5%), and for Hispanic children, the number of well-child visit claims was about two-thirds that of the percentage of claims for dental visits (33.7% versus 50.5%). In

2016, for all patients, there were more claims for dental visits (45.7%) than for well-child visits (35.6%). Beginning in 2017 and continuing through 2019, however, the percentage of claims for well-child visits exceeded that for dental claims.

Regarding the median number of days since a medical or dental benefit was used, males (78 days) were similar to females (74 days; Table 2). Older children had much longer periods since using their last benefit compared to younger children. For example, individuals aged 19–21 had last used a benefit nearly one year previously (median=351 days; 25th percentile=67; 75th=781), while children up to 1 year old had last used a benefit just over two months previously (median=66 days; 25th=25; 75th=257). Hispanic children had the longest median time since their last benefit was used (median=182 days; 25th=39; 75th=827), while children identifying as an “other” racial category had last used a benefit just under three months previously (median=84 days; 25th=25, 75th=226) and Asian children had a median period of 86 days (25th=29, 75th=776) since their last benefit was used.

Table 2. Days since last benefit used

	N	Mean	SD	Median	25th Percentile	75th Percentile
Type of visit						
Dental	808,300	238	331	78	25	302
Well-Child Visit	865,934	228	320	75	24	285
Gender						
Male						
Female						
Race						
AI/AN	115,768	388	502	86	29	776
Asian	16,953	335	416	125	33	522
Black	131,687	332	399	138	39	827
Hispanic	184,719	430	468	182	39	827
NHPI	5,087	330	382	147	42	537
Other	123,812	287	376	84	25	446
White	665,010	305	387	110	28	471
Ethnicity						
Hispanic or Latino	500,845	269	349	99	29	384
Not Hispanic or Latino	741,860	370	446	130	29	657
Unknown	7,963	869	488	1,043	497	1,281
Age in years						
0–3	324,275	224	332	66	25	257
4–6	257,590	185	286	62	22	188
7–9	250,952	187	287	64	22	193
10–12	245,451	188	284	67	21	202
13–15	210,050	196	288	70	20	228
16–18	162,649	265	338	109	22	386
19–21	81,651	453	407	351	67	781

SD = Standard deviation; AI/AN = American Indian/Alaska Native; NHPI = Native Hawaiian/Pacific Islander

The number of miles traveled for a health care visit was available for 30% of the sample (Table 3). Within that cohort, males and females traveled a similar distance (median of 9 miles versus 7). The median number of miles was similar across age groups (range of 7–9) and across

most racial categories (range of 7–8 miles). AI/AN children, however, traveled longer distances than children from racial backgrounds other than AI/AN (median=15 miles, 25th=5, 75th=98).

Table 3. Distance traveled in miles to health care visit (available for 30% of claims)

	N	Mean	SD	Median	25th Percentile	75th Percentile
Type of visit						
Dental	194,013	38	73	9	7	30
Well-Child Visit	201,659	44	220	7	3	14
Gender						
Male						
Female						
Race						
AI/AN	18,736	61	130	15	5	98
Asian	4,845	39	179	7	3	16
Black	33,752	37	157	8	4	18
Hispanic	63,916	41	180	7	3	16
NHPI	1,438	34	141	7	3	20
Other	18,775	55	246	8	3	18
White	215,163	42	167	8	3	22
Ethnicity						
Hispanic or Latino	164,346	46	194	8	3	19
Not Hispanic or Latino	193,217	40	150	8	3	23
Unknown	1,940	56	272	6	3	15
Age in years						
0–3	103,056	54	237	8	3	20
4–6	62,383	40	137	8	4	23
7–9	60,796	41	133	9	4	25
10–12	55,334	36	134	8	3	20
13–15	46,312	34	131	7	3	19
16–18	34,583	35	135	7	3	19
19–21	15,244	31	116	7	3	18

SD = Standard deviation; AI/AN = American Indian/Alaska Native; NHPI = Native Hawaiian/Pacific Islander

Figure 1 shows procedure groupings by age groups. Preventive claims were most common in the 0–3 age group (38.1%) and least common in the 19–21 age group (20.2%). Conversely, minor restorative claims were most common in the 19–21 age group (20.1%) and least common in the 0–3 age group (8.1%). However, the youngest age group also had the greatest percentage of major restorative care (8.9%) of all the age groups. Children aged 4–6 and 7–9 had the largest percentage of claims for “other anesthesia” compared to other age groups (4.6% and 4.8%, respectively). Diagnostic and imaging claims (4.6% and 4.8%, respectively). Diagnostic and imaging claims

combined generally increased with age; these categories represented 38.8% of claims among 0- to 3-year-olds and 47.8% of claims for 19- to 21-year-olds.

Figure 1 shows procedure codes by age group, with each differently colored portion of a vertical bar (age grouping) representing a different procedure code. All bars total to 100%. For example, among 0- to 3-year-olds, 38.1% of procedures fell in the preventive (orange) category, while this percentage drops to 20.2% among 19- to 21-year-olds.

Figure 1. Procedure groupings by age groups

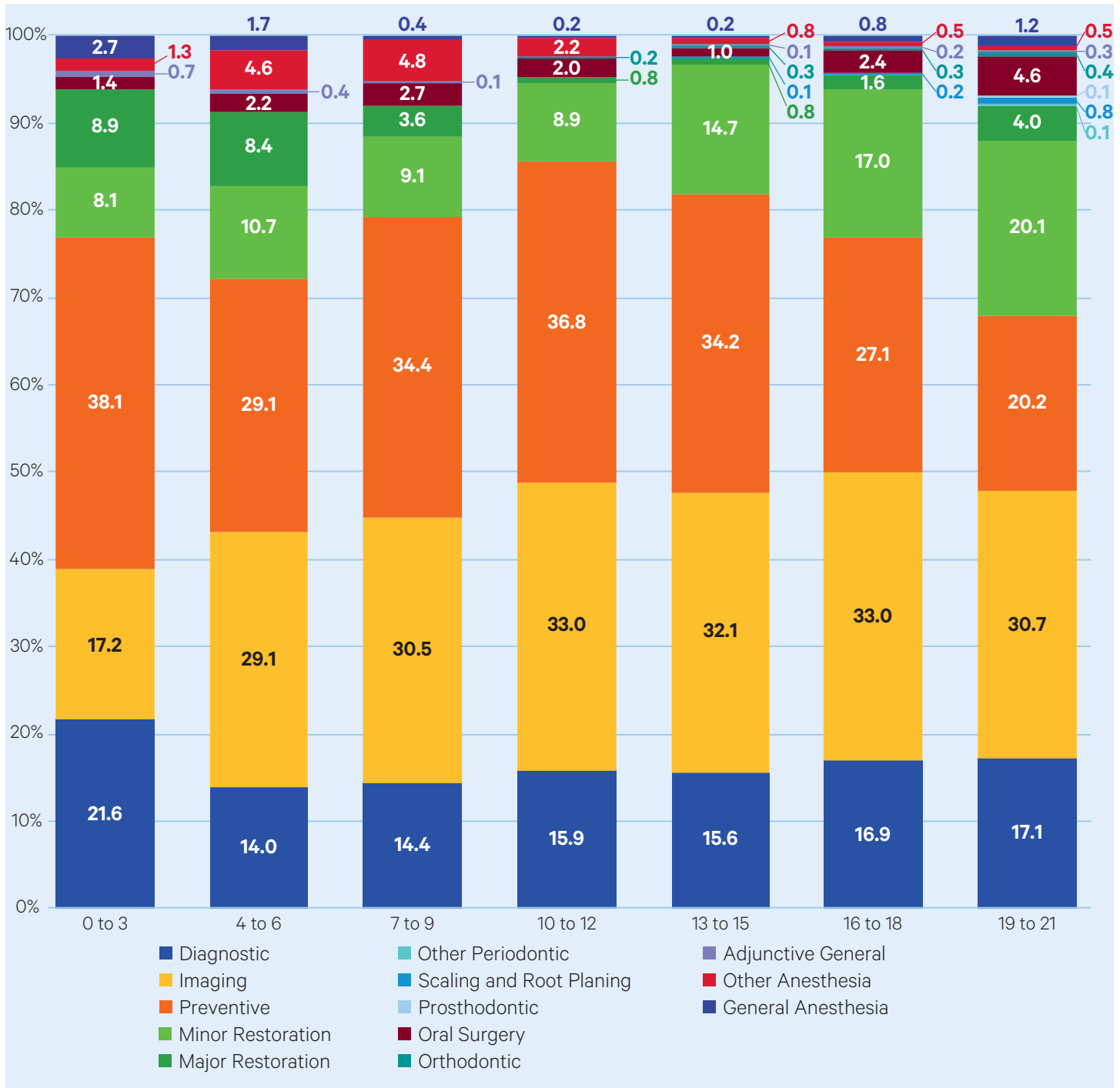
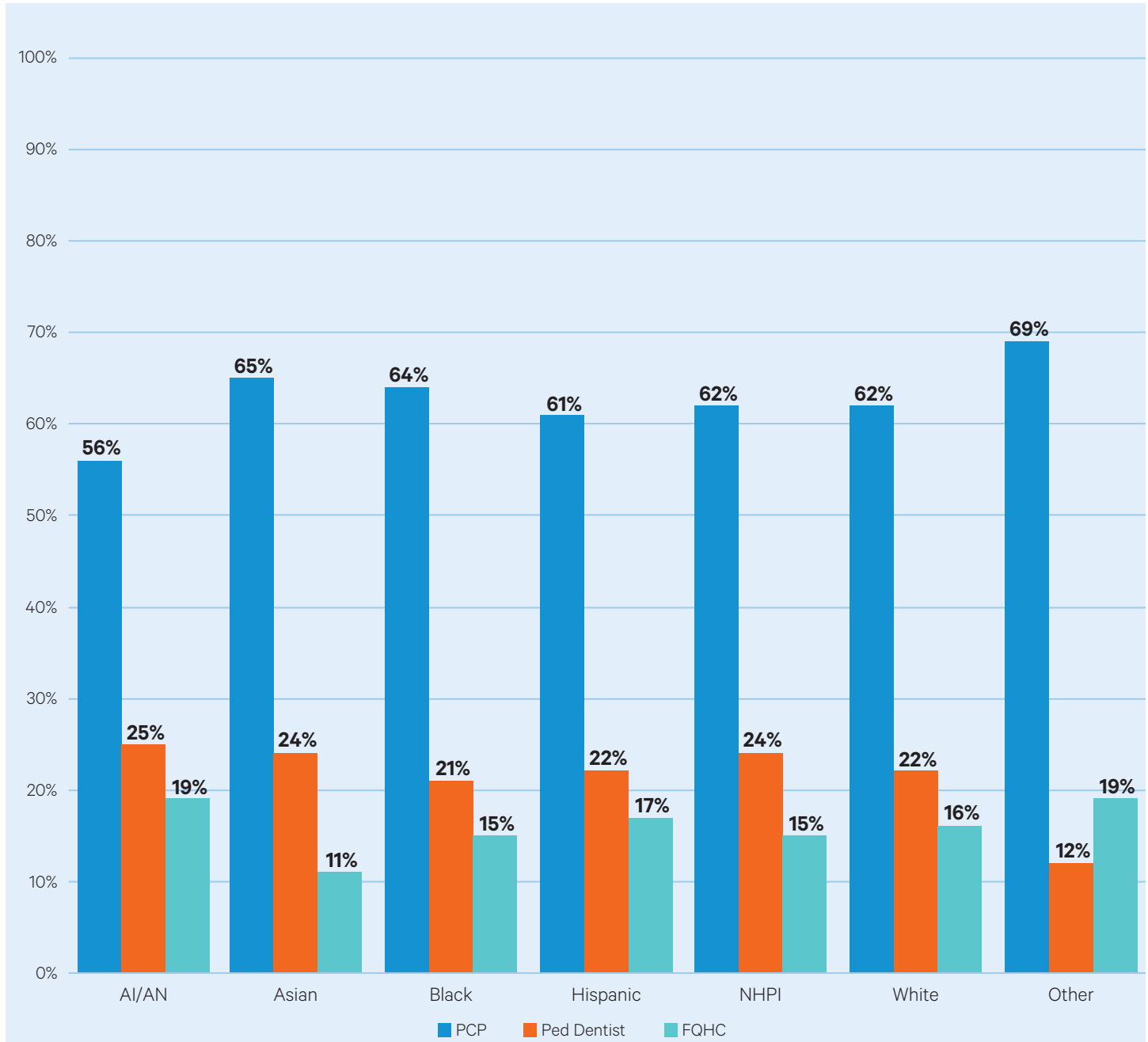


Figure 2 presents access points to dental care by racial categories. Children identified as an “other” racial category were most likely to access dental care through their primary care physician (PCP; 69%). While AI/AN children were least

likely to access dental care through their PCP (56%), they were most likely to access dental care through a pediatric dentist (25%) or an FQHC (19%).

Figure 2. Access points to dental care by race



AI/AN = American Indian/Alaska Native; NHPI = Native Hawaiian/Pacific Islander

Table 4 presents the results of the logistic regression model with the presence of one or more claims as the dependent variable. Females were significantly more likely than males to have at least one claim (Odds Ratio (OR)=1.21, 95% Confidence Interval (CI)=1.20–1.21, p<0.0001). Children aged 4 and above were significantly more likely to have one or more claims compared with children aged 0–3 (p’s<0.0001). Hispanic and

Asian children were significantly more likely to have at least one claim compared with white children (Hispanic OR=1.22, 95% CI=1.21–1.24, p<0.0001; Asian OR=1.14, 95% CI=1.10–1.18, p<0.0001). Enrollees in all other racial categories were significantly less likely than white beneficiaries to have at least one claim (p’s<0.0001).

Table 4. Care Utilization Model with presence of 1+ claims as outcome variable

Variable of Interest	OR	95% Wald Confidence Limits	
Age in years			
0 (reference)			
1–3	1.04	1.02	1.06
4–6	1.83	1.796	1.866
7–9	1.713	1.68	1.746
10–12	1.318	1.294	1.344
13–15	0.873	0.857	0.889
16–18	0.392	0.385	0.399
19–20	0.089	0.087	0.09
Race			
White (ref)			
AI/AN	0.315	0.312	0.319
Asian	1.14	1.104	1.177
Black	0.735	0.727	0.743
Hispanic	1.224	1.212	1.236
NHPI	0.738	0.701	0.777
Other	0.549	0.542	0.557
Gender			
Male (ref)			
Female	1.206	1.198	1.213
Effect	OR	95% Wald Confidence Limits	
Health Plan enrollment			
Serious Mental Illness (SMI) (ref)			
American Indian Health Program (AIHP)	0.05	0.046	0.054
Acute Managed Care Organization (MCO)	1.14	1.05	1.237
Comprehensive Medical and Dental Program (CMDP)*	3.576	3.264	3.917
Department of Economic Security, Division of Developmental Disabilities (DES/DD)	1.143	1.051	1.244
Integrated Care	1.968	1.802	2.15
Long-Term Care (LTC)	0.785	0.691	0.891
Other	0.027	0.024	0.029
Fiscal year of data			
Year 4 (ref)			
Year 1	0.589	0.584	0.595
Year 2	0.663	0.657	0.669
Year 3	0.793	0.786	0.8

*Effective April 1, 2021, Comprehensive Medical and Dental Program (CMDP) is known as Comprehensive Health Plan (CHP) ([AHCCCS Medical Policy Manual \(AMPM\)](https://www.azahcccs.gov/AMPM) ([azahcccs.gov](https://www.azahcccs.gov/)))



Discussion

This study found that while most Medicaid-enrolled children had at least one health care claim during the study period, there were differences by age, race, and ethnicity in use of health services. The youngest children in the study were the most likely to have a health care claim, while less than half of children in late adolescence (19–21) had a claim for any type of health service. Younger children were also more likely to have a well-child visit than a dental visit, while this pattern was reversed for older age groups. The AAPD recommends that children see a dentist by their first birthday, and the AHCCCS also issues this recommendation.^{4,17} However, less than 1% of children had a dental claim before the age of 1, and only about one in four Arizona children aged 1–3 years had a dental claim.

Differences by age were also seen regarding the type of dental services provided. Preventive services were most often used by the youngest children and least by the oldest children, while this pattern was reversed for minor restorative claims, with children aged 19–21 having the highest percentage of minor restorative claims. Interestingly, the youngest age group (0–3 years) had the greatest percentage of major restorative care of all the age groups. As noted prior, children in Arizona have higher rates of dental decay than the national average.¹⁵ The results of this study suggest that the youngest Medicaid-enrolled children either have higher rates of decay than older children or are more likely to receive treatment than other age groups.

Differences in dental claims by race and ethnicity also emerged from this data. While less than half of children identifying as AI/AN had at least one health care claim during the study, AI/AN children were more likely to have a dental claim than a well-child visit claim during this same period. The AHCCCS American Indian Health program provides dental services for eligible children under the age of 21 and includes coverage for examinations, sealants, emergency dental services, and “all medically necessary therapeutic dental services, including fillings.”¹⁴ However, Arizona has substantial disparities in oral health, with low-income children as well as AI/AN and Hispanic/Latino children having the highest prevalence of tooth decay in 2014–2015.¹⁵

Our study also found that AI/AN children traveled the longest distances of children in any racial group to receive health care. Arizona struggles with recruiting and sustaining dentists, particularly in rural and low-income areas. A recent analysis by Arizona State University researchers and Children’s Action Alliance found four Arizona counties without an AHCCCS-enrolled pediatric dentist. Care offered through FQHCs and other free or low-cost dental programs is critical, but additional resources and payment supports are needed.¹⁸



Conclusion

Most Medicaid-enrolled children in Arizona had at least one health care claim from 2016 to 2020. Well-child visits were more common than dental visits in younger age groups, although dental visits became more common in older age groups. Younger children had more preventive and major restorative visits, while older children had more minor restorative services. Children who identified as AI/AN were less likely to have any health care claim than other children, but their claims were more often for dental visits than for well-child visits. These results show that recommendations from the AAP and AAPD for a dental visit by the age of 1 are not being met in Arizona, and that racial disparities exist in access to health care services.

These results show that recommendations from the AAP and AAPD for a dental visit by the age of 1 are not being met in Arizona, and that racial disparities exist in access to health care services.

References

1. Jaffer A. Shariff and Burton L. Edelstein, "Medicaid Meets Its Equal Access Requirement for Dental Care, but Oral Health Disparities Remain," *Health Affairs* (Millwood) 35, no. 12 (December 2016): 2259–2267.
2. Ashley M. Kranz, Isaac M. Opper, Ingrid Estrada-Darley, Evan Goldstein, Bradley D. Stein, and Andrew W. Dick, "Outcomes Associated with State Policies Enabling Provision of Oral Health Services in Medical Offices among Medicaid-enrolled Children," *Medical Care* 59, no. 6 (June 2021): 513–518.
3. Zhou J. Yu, Maryam Elyasi, and Maryam Amin, "Associations among Dental Insurance, Dental Visits, and Unmet Needs of US Children," *Journal of the American Dental Association* 148, no. 2 (February 2017): 92–99.
4. "Perinatal and Infant Oral Health Care," *Pediatric Dentistry* 40, no. 6 (October 2018): 216–220.
5. Matthew F. Savage, Jessica Y. Lee, Jonathan B. Kotch, and William F. Vann, Jr., "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs," *Pediatrics* 114, no. 4 (October 2004): e418–423.
6. Imram Ahmed, Sean McGivern, Matthew R. Beymer, Ilya Okunev, Eric P. Tranby, Julie Frantsve-Hawley, C. H. Tseng, and Francisco Ramos-Gomez. "Age of First Oral Health Examination and Dental Treatment Needs of Medicaid-Enrolled Children," *Journal of Dental Research Clinical and Translational Research* (December 2021): 23800844211057793.
7. Sean McGivern, Imran Ahmed, Matthew R. Beymer, Ilya Okunev, Eric P. Tranby, Julie Frantsve-Hawley, and Francisco Ramos-Gomez, "Association between first oral examination characteristics and dental treatment needs in privately insured children: A claims data analysis," *Journal of the American Dental Association* 152, no. 11 (September 2021): 936–42.
8. Tamanna Tiwari, Jennie Marinucci, Eric P. Tranby, and Julie Frantsve-Hawley, "The Effect of Well Child Visit Location on Preventative Dental Visit," *Children* (Basel) 8, no. 3 (2021): 191.
9. Tamanna Tiwari, Nayanjot Rai, Avery Brow, Eric P. Tranby, and Sean G. Boynes, "Association Between Medical Well-Child Visits and Dental Preventive Visits: A Big Data Report," *Journal of Dental Research Clinical & Translational Research* 4, no. 3 (July 2019): 239–245.
10. "Maintaining and Improving the Oral Health of Young Children," *Pediatrics* 134, no. 6 (2014): 1224–1229.
11. United States Department of Health & Human Services (DHHS). *Ensuring Children Are Up to Date on Oral Health Services 2021*, updated November 12, 2021. <https://eclkc.ohs.acf.hhs.gov/oral-health/brush-oral-health/ensuring-children-are-date-oral-health-services>.
12. Arizona Health Care Cost Containment System (AHCCCS). *AHCCCS Members under 21 Years of Age Have Dental Coverage*. <https://www.azahcccs.gov/AHCCCS/Downloads/DentalCoverage.pdf>.
13. Arizona Health Care Cost Containment System " (AHCCCS). KidsCare — Arizona's Children's Health Insurance Program (CHIP)." <https://www.azahcccs.gov/Members/GetCovered/Categories/KidsCare.html>.
14. Arizona Health Care Cost Containment System (AHCCCS). *The Handbook for Members of the American Indian Health Program and/or the Tribal Regional Behavioral Health Authorities*, February 2019. https://www.azahcccs.gov/AmericanIndians/Downloads/AHCCCS_AIHP_Guide.pdf.
15. Arizona Department of Health Services. Healthy Smiles Healthy Bodies Survey 2015: *The Oral Health of Arizona's Kindergarten and Third Grade Children*, December 2015. <https://www.astdd.org/www/docs/az-healthy-smiles-healthy-bodies-data-brief-2015.pdf>.
16. Arizona Health Care Cost Containment System (AHCCCS). Data Access. <https://www.azahcccs.gov/PlansProviders/ISDresources.html>.
17. Arizona Health Care Cost Containment System (AHCCCS). *Recommendations for Preventive Pediatric Oral Health Care 2018* [updated June 7, 2018; cited February 1, 2022]. https://healthchoicewiz.com/wp-content/uploads/mdocs/431_ATT_A.pdf.
18. Swapna Reddy, Matthew Speer, Mary Saxon, Madison Ziegler, Zaida Dedolph, and Siman Qaasim, "Evaluating Network Adequacy of Oral Health Services for Children on Medicaid in Arizona," *AIMS Public Health* 9, no. 1 (2022): 53–61.

CareQuest Institute for Oral Health

CareQuest Institute for Oral Health® is a national nonprofit championing a more equitable future where every person can reach their full potential through excellent health. We do this through our work in grantmaking, research, health improvement programs, policy and advocacy, and education as well as our leadership in dental benefits and innovation advancements. We collaborate with thought leaders, health care providers, patients, and local, state, and federal stakeholders to accelerate oral health care transformation and create a system designed for everyone. To learn more, visit carequest.org.

Arizona Oral Health Coalition

Arizona Oral Health Coalition is a nonprofit unincorporated Association and is a sponsored project of Children's Action Alliance (CAA). AZOHC envisions a world of opportunities for every person and community by virtue of good health; in that oral health is fundamental to overall health.

Children's Action Alliance

Children's Action Alliance (CAA) is a 501(c)3 nonprofit organization and an independent voice for Arizona children at the state capitol and in the community. By identifying and eliminating barriers to well-being, by creating partnership opportunities, and by promoting equitable policy solutions, Children's Action Alliance is building an Arizona where children and families can thrive.

This report and others are available at carequest.org.