

Testimony of the California Dental Association for the  
Little Hoover Commission Hearing on Denti-Cal on September 24, 2015

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The California Dental Association (CDA) is pleased that the Little Hoover Commission is evaluating the operations and outcomes of the state's Denti-Cal program. As an engaged stakeholder in the Denti-Cal program on behalf of our members and their patients, CDA is very interested in seeing program improvements which will enhance access to oral health care for the millions of children and adults who are Denti-Cal beneficiaries.

Dental disease is one of the most common childhood illnesses in the United States. While it is easily treatable when children have access to dental care, it is more prevalent than asthma and obesity combined, can lead to other medical conditions such as ear and sinus infections and affects school attendance and performance. Children with poor oral health are nearly three times more likely than their counterparts to miss school as a result of dental pain and California students miss an estimated 874,000 school days annually due to dental problems. Additionally, it greatly affects the overall health and employability of adults and can have detrimental impacts on effectively treating older adults with chronic illnesses.

Denti-Cal is a small fraction (about 1 percent) of the overall budget for the Medi-Cal program, but oral health has a tremendous impact on Medi-Cal beneficiaries' overall health, and we appreciate the focus on it today.

There are now over 12 million Medi-Cal beneficiaries with dental benefits in California. As pointed out in the State Auditor's report of December 2014, less than half of the children enrolled in the Denti-Cal program in 2013 were able to access basic dental care. Recent estimates from the Department of Health Care Services (DHCS) indicate that only one in four adults enrolled in the Denti-Cal program

accessed any dental treatment during 2014 once adult benefits were partially restored.

Addressing the deficiencies of this complicated program will take a multi-faceted approach. We talk about it as a three-legged stool: Reimbursement rates, provider network improvements, and administrative barriers in the program.

These three elements include targeted provider reimbursement increases coupled with programmatic improvements in treatment delivery, streamlining the time-consuming and overly burdensome provider enrollment process and finally, simplifying the complicated administrative hurdles needed for reimbursement of covered services. Addressing all three of these issues would result in more dentists able to participate in the network, therefore improving access to care for beneficiaries.

### **Reimbursement Rates**

The Medi-Cal Dental Services Rate Review Report released by the department in July found that California's 2014 reimbursement rates for the 25 most common Medicaid dental services were well below those in the comparable states of New York, Texas and Florida. Additionally, the review states that California's Denti-Cal

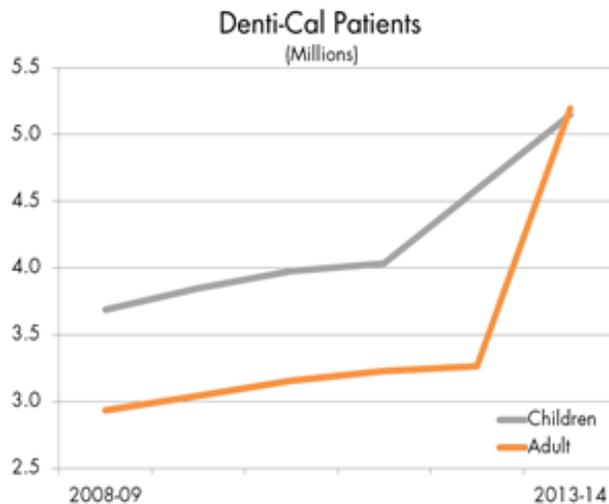


*How CA rates compare to other states & commercial average*

reimbursement rates are only 31 percent of the national average for commercial insurance.

These exceptionally low reimbursement rates come at a time when the number of people who are covered by the Medi-Cal program is growing exponentially. Since

2008, there has been a 77 percent increase in the number of adults enrolled and a 40 percent increase in children enrolled as a result of the Medi-Cal eligibility expansion, the Healthy Families transition and the partial restoration of adult benefits. Meanwhile, the number of dentists participating in the Denti-Cal program has dropped by nearly 15 percent during that time.



Documented experiences in several states during the past decade have illustrated that Medicaid reforms, coupled with improved reimbursement rates, are directly tied to dentists' ability to participate in the Medicaid program and substantially increased access to dental care for enrollees.

Increasing reimbursement rates to providers has led to increases in utilization and provider network size in a number of other states. Maryland provided targeted rate increases and saw a rise in the number of children receiving access to dental care from 44 percent to 64 percent. The state also saw a 62 percent increase in provider participation. Similarly, Virginia increased its provider rates by 28 percent and the percentage of children accessing dental services increased from 24 percent to 56 percent. Virginia also saw a 145 percent rise in dentists participating in the network.

Recent analysis by the state and other entities indicate that this is true of California dentists as well. Dentists indicated they would be more inclined to either begin participating as a Denti-Cal provider or increase the number of Denti-Cal patients treated in their practices if reimbursement rates were increased.

While the reversal of the AB 97 10 percent rate reduction as approved in the 2015-16 state budget is an important first step in rebuilding Denti-Cal, as noted in recent

reports from the department, a great amount of work remains to ensure access to care for California's beneficiaries.

### **Targeted Program Improvements with Provider Incentives**

CDA believes it is necessary to make substantive program improvements to ensure access to high quality dental care for California's beneficiaries. Targeted program improvements and rate increases that would incentivize providers to join the Denti-Cal network and the provision of cost-effective preventive services to young children and older adults can lead to great success.

Focused changes should improve access to prevention and basic dental care treatment services for at-risk children by implementing a proven program that targets care to that population and provides enhanced reimbursement rates for key services.

In the Access to Baby and Child Dentistry (ABCD) program in Washington State and the Healthy Kids Healthy Teeth program in Alameda County, Medicaid works with community agencies, like Head Start and WIC, to refer children age 0 to 5 to dentists who are certified participants in the program and, therefore, receive an enhanced reimbursement rate for certain prevention and basic treatment services.

Implemented statewide, local community health workers would be used to identify vulnerable children enrolled in the Medicaid program less than five years old, and link to a network of dental providers who are uniquely trained to treat these younger and more difficult-to-treat beneficiaries.

By augmenting current reimbursement rates for certain key services, which include cleanings, fluoride application and basic restorations, when provided by a select group of providers uniquely trained to care for very young children, the state can begin to transform its program to one that improves access to important treatment, sets children up for a lifetime of better oral health and improves access to care by encouraging provider participation in the program. This program design has a

proven record of increased access to care, improved oral health outcomes, recruitment of dentists to the program and reduced per capita costs to the state.

To incentivize providers to enroll and serve this population, the state should provide an enhanced reimbursement to dentists who either: (1) enroll and participate in a California version of the ABCD training program; (2) complete training in a streamlined Pediatric Oral Health Access Program (POHAP®) or (3) are board- certified pediatric dentists.

Additionally, the state will have to take action to authorize and reimburse for one of the services instrumental in the success of this program: Family Oral Health Counseling. Family oral health education allows the dental practitioner to provide a comprehensive counseling session to parents and children on the need and best methods for ensuring good oral health. This consultation includes education as well as demonstrations to parents of proper hygiene techniques, dietary consultation, and fluoride supplement prescriptions, if appropriate. It is essential to provide education about the value and methods for establishing a proper oral hygiene routine for children early in life to help ensure the development of strong and healthy teeth. Parents, as consistent role models, are key to setting a daily routine and making children understand the importance of good oral hygiene. This is a foundational element of this program's success.

To accomplish the goal of implementing this innovative care model, some programmatic changes and additional support are needed within the Department of Public Health.

### **Training to Increase Pediatric Dental Workforce**

As referenced previously, the POHAP® helps expand the network of general dentists trained to treat young children. This can improve access to care for the youngest beneficiaries, creating a lifetime of improved oral health while increasing long-term savings for the state. Funding through the Oral Health Program in the

Department of Public Health could provide this training to 1,000 general dentists a year to increase dentist capacity and encourage participation in the proposed California ABCD program. In addition to the long-term cost savings of providing preventive care for children, it should be considered as part of the fiscal analysis that general dentists who participate in the POHAP® training will be trained in child behavior management techniques that could alleviate the need to treat as many children using different forms of sedation and anesthesia, including general anesthesia in more expensive health care settings such as surgery centers and hospitals.

**Invest in care coordinators/community outreach workers dedicated to dental beneficiary and provider engagement**

Proven successful in similar programs, having public health staff at the local level dedicated to identifying and supporting beneficiaries' access to dental care and informing and recruiting dentists to join the program's network of providers is a critical and much needed addition to California's oral health system of care. A dedicated staff person in each county's Children's Health and Disability Prevention (CHDP) Program could be charged with:

- Conducting an aggressive outreach campaign to recruit families of children ages 0-5 in Medicaid into the ABCD-like program;
- Orienting enrollees on dental treatment expectations and responsibilities, helping to resolve barriers to access (addressing missed patient appointments, informing beneficiaries of transportation policies), and providing case management services, including linking families with participating providers; and
- Recruiting dental providers into the program and linking them to educational components on child management, caries risk assessment, family education, and use of preventive treatments.

Building upon the readily available infrastructure in local CDHP programs is an efficient way to effectively provide the support both families and providers need to ensure the program's success.

### **Expanding Access through Virtual Dental Homes**

Leveraging teledentistry programs will help address the state's need to provide more comprehensive care in rural and underserved areas effectively and efficiently, particularly the older adult population and school-aged youth.

The Virtual Dental Home (VDH) model allows dental hygienists in community settings (e.g., community clinics, nursing homes, preschools) to provide basic care for patients under the direction of a dentist using tele-health technology. A VDH grant program using public and private funds would expand the model into the state's greatest areas of need. One-time funding of several million dollars phased in over three years would provide start-up elements such as training, equipment and technical support to help advance the VDH model in underserved areas.

### **Dental School Clinic Support**

There are six dental schools in California. Dental school clinics represent a win-win endeavor for Denti-Cal, as the Denti-Cal patient population looks to the universities as reliable sources for quality care and provides future dentists with a broad scope of experience in a high volume setting to refine their skills and develop a social awareness of the needs the Medicaid population. Operating a dental school clinic carries the burden of additional costs that come with educating students and necessary faculty oversight of treatment, but the clinics also bring significant value to the community and patients they serve. The lack of adequate Denti-Cal reimbursement is creating a financial hardship for dental school clinics which can affect tuition costs result in students shouldering the burden with increased student loan debt to offset the costs of providing care to Denti-Cal beneficiaries in the

community. Dental schools should be carved out of the Denti-Cal fee schedule and reimbursed at rates established for the pre-doctoral clinics.

### **Provider Incentives**

In addition to the work noted above that can be done through the state budget and administrative processes, the administration is in the midst of negotiating a Medicaid waiver with the federal government and there are opportunities to make some critical changes to the program.

One example of program enhancements the state should explore includes provider incentive programs similar to one recently approved for Colorado's Medicaid dental program. To increase provider participation in the state's dental program, Colorado Medicaid includes supplemental incentive payments to providers who either increase the number of Denti-Cal patients in their practice or begin participating as Denti-Cal providers. Colorado's Medicaid recently received Centers for Medicare and Medicaid Services (CMS) approval for a state plan amendment that will pay qualifying dentists supplemental Medicaid payments upon providing two services to a new Medicaid patient receiving dental services for the first time. New and existing dental providers will be eligible for the supplemental payment, which could earn any single dentist a maximum performance payment of \$3,000.

### **Provider Network Engagement**

To ensure patients have accurate information about the dentists who are part of the provider network and there is a sufficient network of providers able to see patients, the state needs to ensure it has accurate information regarding the number of providers and capacity of those providers, as well as simplify its enrollment process. This is the second leg of the stool.

### **Accurate Provider Network Information**

It has been well documented in several legislative hearings that the department's referral list of Denti-Cal providers is woefully out of date. This creates time-

consuming and frustrating barriers to care for patients with coverage who are trying to see a dentist. The department needs to determine which providers in their network are active, taking new patients, and how many Denti-Cal patients the dentists on the state's list can see. This will tell them how many patient appointments are actually available each month on a county-by-county basis. Without this, we do not have a true handle on what access to care actually looks like for dental patients.

### **Provider Enrollment**

The provider enrollment and recertification process should not be so complex that it acts as a barrier by dissuading provider participation. The current process takes many hours, requires the submission of a lengthy paper application, and in most cases over 40 pages of attachments. The form is also designed for all health care providers and some of the questions may not apply to the dentist and when not answered completely can be rejected. One requirement of the form includes a copy of the original building lease agreement for the provider's dental practice, including all modifications. In one example CDA brought to the department's attention last year, a provider who had been serving Denti-Cal patients for more than 40 years in the same location had to renew his enrollment. His lease document and all modifications over the 40 years amounted to 26 pages that this long-standing Denti-Cal provider had to copy and fax to the department. There must be a better, more efficient way for the state to affirm a providers' operating location. We are aware of re-enrollments that have taken several months or even up to a year. The state needs to more efficiently and effectively work with its network and potential network of providers on enrolling in the program if we want a robust network and real access to care for patients.

### **Administrative Efficiencies**

While reimbursement rates and network support plays a critical role in enhancing provider participation, reducing burdensome administrative processes is the third leg of the three-legged stool.

The system and extensive paperwork that providers must go through to obtain reimbursement for the care they provide is exceptionally time-consuming and cumbersome. There are rules and processes in the state's program that do not exist within the commercial coverage system, which make it more difficult for dentists to incorporate Denti-Cal services into the rest of their practice. We hear from members that ambiguous criteria, delayed payments, inconsistent treatment authorizations and extensive documentation requirements provide additional barriers to provider participation in the program. Dentists have expressed dissatisfaction with the Medi-Cal program's increasingly more complicated processes and feel they are left without an engaged partner in the department to address these issues. Additionally, dentists have expressed the notion that the Denti-Cal administrators do not respect their professional judgment regarding patient care, creating a lack of positive provider sentiment in the program.

CDA and our members welcome the opportunity to work with new leadership within the department to address these kinds of concerns held by their dental providers. Addressing administrative barriers is an essential element to ensure increased access to care for beneficiaries.

### **Conclusion**

When you have a system of care that provides needed dental treatment to less than half of the children who are eligible for services and when studies show that the number of dental-related emergency room visits for adults continues to increase, it is clearly a serious problem that needs multiple strategies to address it.

This will take program improvements like streamlining the enrollment process and reducing the administrative burdens facing providers, and there is significant evidence available that the low provider rates are part of the access crisis.

We strongly encourage the state to provide additional resources for investments in the program and focus attention on developing program improvements. With smart investments of both time and money, the state can ensure an adequate network of providers are available to treat Denti-Cal beneficiaries.

We look forward to working with the Little Hoover Commission, the administration, and the legislature to continue the process of addressing these serious issues.