Department of Health Care Services

Medi-Cal Children's Dental Utilization

Report to the Legislature

January 2018

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Executive Summary

The Department of Health Care Services (DHCS) is providing information regarding the progress made towards the goal of raising the Denti-Cal utilization rate among eligible child beneficiaries pursuant to Welfare and Institutions Code Section 14005.276, which states the following:

> *(a) By October 1, 2017, the department shall report to the Legislature on progress towards the goal of raising the Denti-Cal utilization rate among eligible child beneficiaries to 60 percent or greater and identify a date by which the department projects this utilization goal will be met. The department may include in the report any recommendations for legislative consideration that would assist the department in meeting the goal by the specified date, and, if applicable, shall engage relevant stakeholders in the development of those recommendations.*

The proposed utilization goal of 60 percent or greater is consistent with the Little Hoover Commission's recommendation in their April 2016 report, *Fixing Denti-Cal.* DHCS shares this goal of reaching 60 percent annual utilization among Medi-Cal enrolled children and is committed to using efforts authorized under state law and approved by the federal government to make progress toward that goal and beyond. DHCS aims to administer a program that allows individuals to receive the medically necessary services they are entitled to and this is consistent with the DHCS mission to provide eligible Californians with access to affordable, integrated, high-quality health care.

DHCS acknowledges there have been historical challenges to increasing dental utilization among children enrolled in Medi-Cal. The most recent data for calendar year (CY) 2016 shows that children's dental utilization for ages 0-20 was 44.5 percent. As shown in Figure 1 below, children's dental utilization has been stable since 2013. For preventive dental services, based on the federal Center for Medicare and Medicaid Services' (CMS') tracking, in California, for Federal Fiscal Year (FFY) 2011, children's dental utilization, age 1-20, was 37 percent[1] and in FFY 2015 it was also 37 percent, meaning that over four years, California's preventive service utilization for this population did not improve.

During CY 2016, DHCS performed a variety of outreach efforts to increase children's dental utilization and overall provider participation. A large part of this effort was focused on the Dental Transformation Initiative (DTI) targeting Medi-Cal children age one through 20, with the goal of increasing preventive service utilization for this population by 10 percentage points across five years – moving from 37.84 percent in FFY 2014 to 47.84 percent in CY 2020[2].

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[1] Percent of Children Ages 1-20 Enrolled in Medicaid for at Least 90 Continuous Days Receiving A Preventive Dental Service: FFY 2011 Baselines, FFY 2012, FFY 2013, FFY 2014 and FFY 2015 Progress, Revised August 3, 2016. https://www.medicaid.gov/medicaid/benefits/downloads/ohi-baselines-progress-goals.pdf

[2] Current Medi-Cal 2020 Special Terms and Conditions (STCs) (See STCs 108-113 [p. 81-94] and Attachment JJ [p. 457-479] for information relevant to the DTI.) http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs12-22-17.pdf

Also, on November 8, 2016, California voters approved the California Healthcare, Research and Prevention Tobacco Tax Act (commonly known as Prop. 56) to increase the excise tax rate on cigarettes and tobacco products. Under Prop. 56, a specified portion of the tobacco tax revenue is allocated to DHCS for use as the nonfederal share of health care expenditures and during the 2017 Budget process $140 million was allocated to be matched with federal funds to provide supplemental provider payments to dental providers as a means to improve dental provider participation.

Furthermore, there have been a variety of administrative efforts to improve dental utilization and increase provider participation such as changing the structure of our fiscal intermediary (FI) and Administrative Services Organization (ASO) contracts, outreach campaigns via mailers/robo calls, rigorous oversight of dental managed care plans, and implementation of a streamlined provider application which has reduced new provider enrollment processing times and has assisted in increasing overall provider enrollment.

DHCS has also partnered with the Department of Public Health Oral Health Program, various stakeholders, such as the California Dental Association, California Primary Care Association, Dental Hygiene Committee of California, Medi-Cal Dental Advisory Committee, and Medi-Cal Dental Los Angeles Stakeholder groups, inclusive of children's advocacy groups, to enhance beneficiary and provider awareness regarding eligibility, participation, and billing practices for the Medi-Cal dental program and associated initiatives.

DHCS has initiated more transparency on statewide performance by creating a Medi-Cal dental data reports webpage as part of the larger DHCS website, which includes dental Fee-For-Service (FFS) and Dental Managed Care (DMC) reports. By having this information readily accessible to beneficiaries, providers, and stakeholders, DHCS is supporting a more informed public with the goal of increasing awareness of services, providing information on where and how to access those services, and reporting statewide Medi-Cal dental performance in the dental FFS and DMC delivery systems in order to better understand the impact of policy interventions and facilitate discussion on where improvements can be made. However, DHCS does acknowledge that it is not possible to collect and analyze data in real time due to the nature of claiming and reimbursement. Data is often not complete enough for analysis for up to a year after the measurement period, since claims can be submitted up to one year from the date of service, which means the impact of policies currently being implemented will not be known until further into the future.

DHCS is committed to using these efforts to improve children's dental utilization in order to reach a 60 percent utilization rate and beyond. Given that DHCS is currently implementing a variety of policies to improve children's dental utilization and the impact of those policies is not currently measureable due to the data challenges mentioned, it is difficult to determine to what degree utilization trends are changing and therefore

when DHCS will reach the 60 percent utilization goal. Assuming a modest two percentage point increase occurs every year from CY 2016, DHCS would see a 60 percent utilization in CY 2024. However, this timeline is preliminary as the impacts of current efforts to increase utilization and provider participation materialize and are further analyzed.

Children's Dental Utilization

This section analyzes Medi-Cal Children Dental Utilization in multiple perspectives including age, county and ethnicity. Data is based on dental claims or encounters submitted to the DHCS data warehouse (MIS/DSS). CY 2013 to CY 2015 data is available at California Health and Human Services Agency (CHHS) Open Data Portal[3]. CY 2016 data is pending internal review and approval within DHCS for publishing in the Open Data Portal.

Overall

Dental utilization, measured by Annual Dental Visit (ADV), for children has been stable since CY 2013 (Figure 1), hovering around 44 percent. The Medi-Cal child population increased from 5.18 million in CY 2013 to 6.06 million in CY 2016. Utilization remaining constant at 44 percent demonstrates DHCS has continued to keep pace with the population growth and has provided more dental services to meet the needs of this population (Table 1).

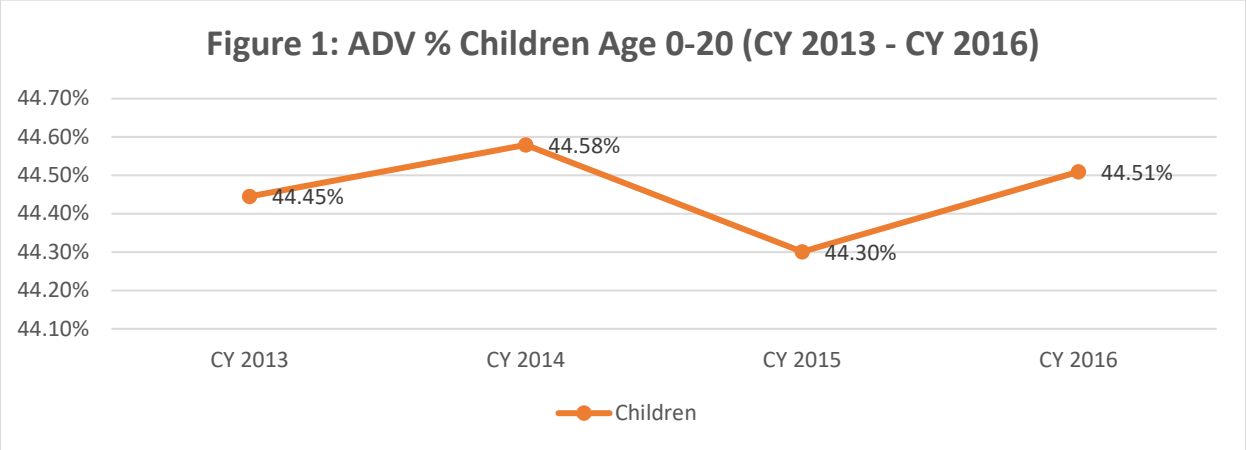


Table 1 Eligible Medi-Cal Beneficiary Population in Millions

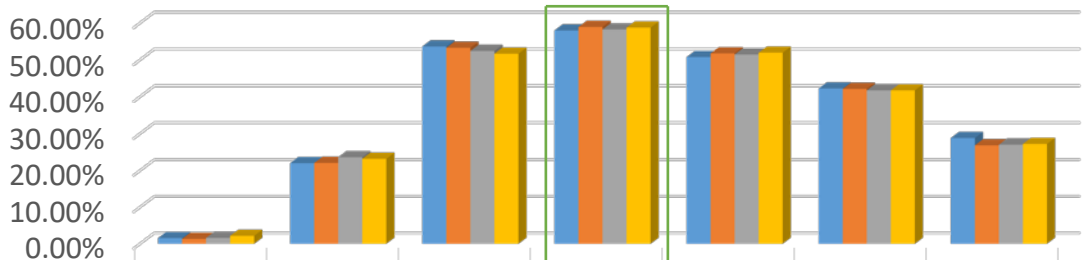
Eligible Beneficiary Population (Millions)	CY 2013	CY 2014	CY 2015	CY 2016
Children (Age 0-20)	5.18	5.53	5.72	6.06

Utilization by Age

Child beneficiaries age 6-9 have the highest dental utilization in any CY of the comparison period. (Figure 2).

[3] https://data.chhs.ca.gov/dataset?q=dental

Figure 2: ADV % by Age (2013-2016)

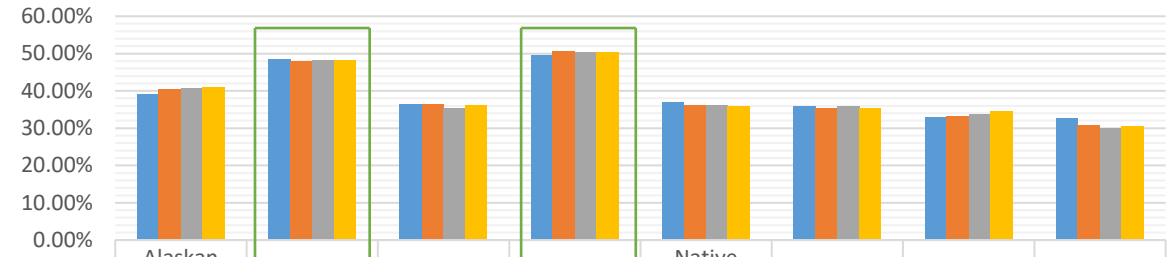


	Age <1	Age 1-2	Age 3-5	Age 6-9	Age 10-14	Age 15-18	Age 19-20
CY 2013	1.56%	22.02%	53.63%	57.97%	50.76%	42.26%	28.82%
CY 2014	1.33%	22.07%	53.28%	58.94%	51.77%	42.14%	26.85%
CY 2015	1.61%	23.61%	52.41%	58.24%	51.45%	41.74%	27.01%
CY 2016	2.18%	23.18%	51.68%	58.76%	51.95%	41.74%	27.21%

Utilization by Ethnicity

For child beneficiaries, Hispanic and Asian beneficiaries have higher dental utilization than other ethnicities (Figure 3). This aligns with Preventive Dental Services Utilization for children age 1-20 by ethnicity. (Figure 6).

Figure 3: Children ADV % by Ethnicity (2013-2016)



	Alaskan Native or American Indian	Asian	Black	Hispanic	Native Hawaiian or Pacific Islander	White	Other	Invalid/Unknown
CY 2013	39.13%	48.46%	36.27%	49.63%	36.94%	35.90%	32.98%	32.62%
CY 2014	40.31%	47.86%	36.53%	50.60%	36.02%	35.40%	33.16%	30.77%
CY 2015	40.79%	48.20%	35.37%	50.43%	35.98%	35.69%	33.58%	30.10%
CY 2016	41.04%	48.13%	35.97%	50.31%	35.81%	35.34%	34.49%	30.39%

Utilization by County

Medi-Cal children's dental utilization, by county, increased from 2014 to 2016, especially in rural counties including: Del Norte, Siskiyou, Modoc, Inyo and Tulare counties. (Figure 4a and 4b).

Figure 4a (CY 2014)

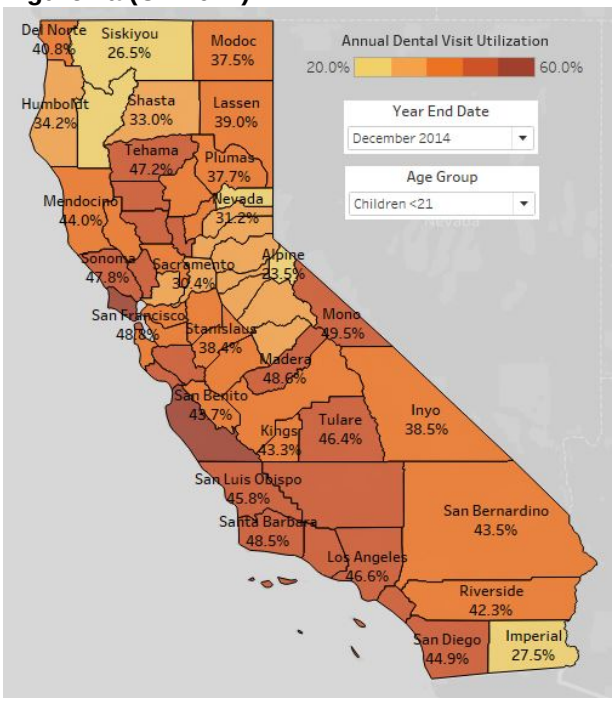
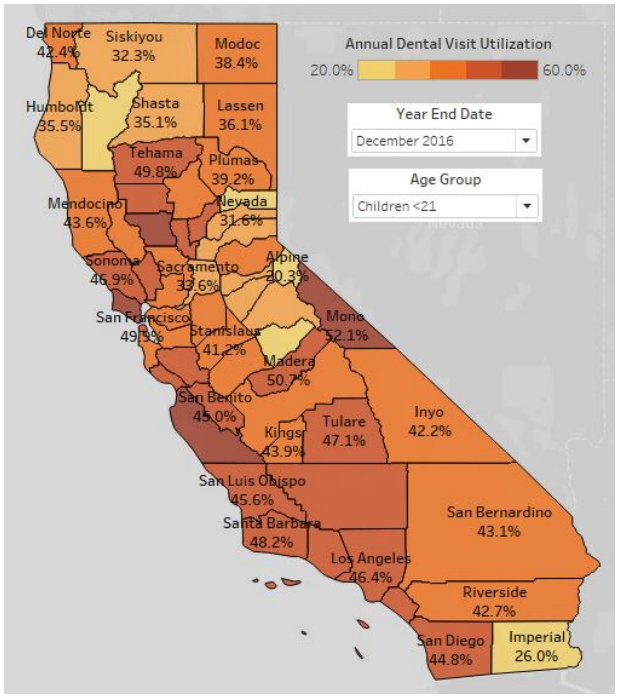


Figure 4b (CY 2016)



As reported in overall utilization, dental utilization for children has been stable since 2013. DHCS has provided more dental services to meet the needs of the growing population. Children beneficiaries age 6-9 have the highest dental utilization. Hispanic and Asian child beneficiaries have higher dental utilization than other ethnicities. Medi-Cal children's dental utilization, by county, increased, especially in rural counties including: Del Norte, Siskiyou, Modoc, Inyo and Tulare counties. However, DHCS acknowledges there is room for improvement for all ages, races, and counties. Most notably for children under age 2, African-American, Pacific Islander/Hawaiian, and white children, and children in rural counties.

Dental Transformation Initiative

Approved as part of California's 1115 Waiver (Medi-Cal 2020 Waiver), the Dental Transformation Initiative (DTI) represents a critical mechanism to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this strategy aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children. There are four project areas, referred to as domains, with funding up to $150 million per year for five years that are being tested to improve utilization.

Domain 1: Increase Preventive Services Utilization for Children

DTI, Domain 1 is a statewide initiative that aims to increase the statewide proportion of children ages 1-20 enrolled in Medi-Cal who receive a preventive dental service in a given year. DHCS' goal, as part of the 1115 Waiver Special Terms and Conditions, is to increase preventive service utilization among children by at least ten percentage points over a five-year period. The amount of funding allocated over five program years for Domain 1 is $259,121,730.86. The following are a few of the latest progress updates based on the DTI Annual Report for Program Year 1[4]:

- Preventive service utilization rate for children increased by 4.67 percentage points from CY 2014 to CY 2016 (See Table 2 below).
- The number of Medi-Cal dentists providing preventive dental services to at least ten children increased by 6.07 percent from CY 2014 to CY 2016.
- The number of treatment[5] services increased by approximately 3.4 percent from CY 2014 to CY 2016 while the number of preventive dental services increased by 19.0 percent during that same period.

Table 2: Percent of beneficiaries ages 1-20 statewide who received any preventive dental service during the measurement period[6]

	Baseline Year: CY 2014	PY 1: CY 2016
Numerator[1]	1,997,190	2,466,173
Denominator[2]	5,279,035	5,807,169
Preventive Service Utilization	**37.80%**	**42.47%**[3]

[1] Numerator: Eligible beneficiaries who received any preventive dental service (D1000-D1999 or a Safety Net Clinics (SNC) dental encounter with ICD 10: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810) in the identified year.
[2] Denominator: Number of beneficiaries ages one through 20 enrolled in Medi-Cal Program for at least 90 continuous days in the same dental plan during the identified year.
[3] The reporting period of this report (CY) is different from the reporting period of CMS 416 report (FFY).

[4] PY 1 Final Report for January-December 2016 (Submitted to CMS on December 22, 2017 and pending CMS' final review and approval)
[5] Treatment means dental treatment service (D2000-D9999 or a SNC dental encounter with certain ICD 10 codes specified in DTI Annual Report Program Year 1 Appendix 2 List A) ICD 10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems.
[6] Source: MISDSS Dental Dashboards

Preventive Dental Service Utilization Age 1-20 by County

Utilization of preventive dental services by county increased from CY 2014 to CY 2016, especially in rural counties with a 40 percent or more increase in utilization rates including: Glenn, Inyo, Marin, Mono and Tehama counties. (Figure 5a, Figure 5b).

Figure 5a (CY 2014)

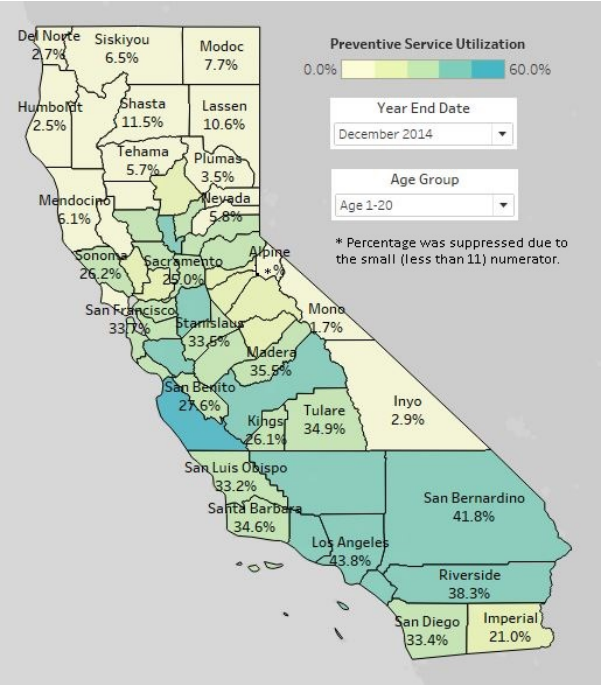
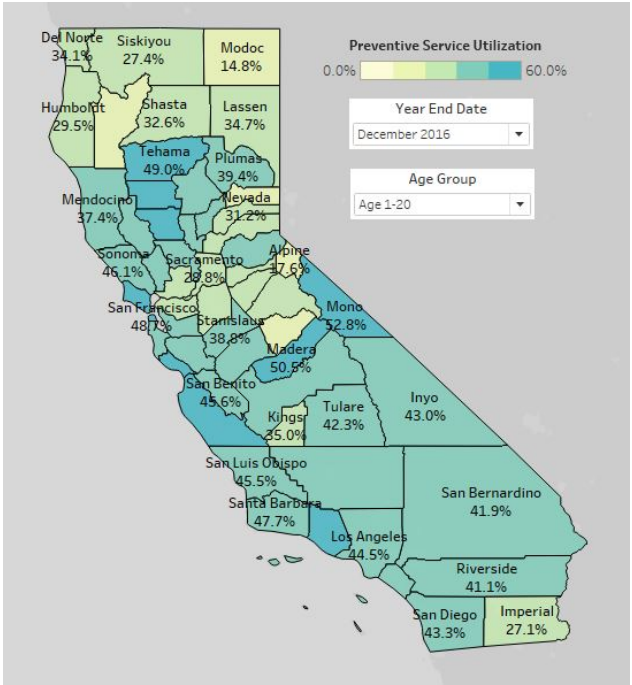


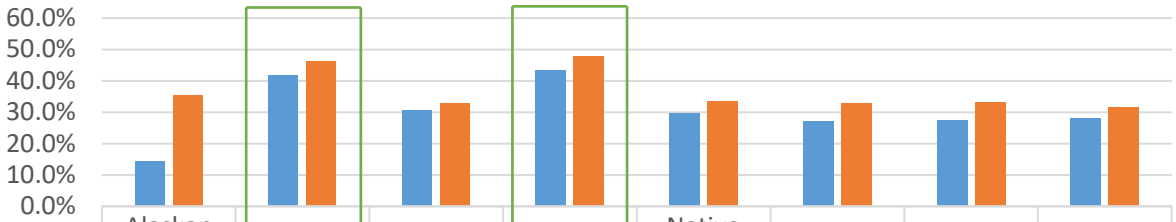
Figure 5b (CY 2016)



Preventive Dental Services Utilization Age 1-20 by Ethnicity

Preventive dental service utilization for children statewide, age 1-20, across all ethnicities has increased from CY 2014 to CY 2016, with the greatest increase demonstrated in Alaskan Native or American Indian children moving from a 14.5 percent utilization rate in 2014 to more than doubling to 35.4 percent in 2016. In this age grouping of preventive dental services, as well as in age 0-20 of ADV reported earlier, Hispanic and Asian child beneficiaries continue to have higher preventive dental services utilization rates than other ethnicities (Figure 6).

Figure 6: Children Age 1-20 Preventive Dental Services Utilization Statewide by Ethnicity (2014 vs 2016)



	Alaskan Native or American Indian	Asian	Black	Hispanic	Native Hawaiian or Pacific Islander	White	Others	Invalid/Unknown
2014	14.5%	41.7%	30.8%	43.3%	29.6%	27.4%	27.6%	28.2%
2016	35.4%	46.4%	32.9%	48.0%	33.4%	32.9%	33.3%	31.5%

Domain 2: Caries Risk Assessment and Disease Management Pilot

DTI, Domain 2 is a four year domain that commenced in 2017 and includes 11 pilot counties that may be expanded to additional counties. This initiative aims to assess caries risk and manage the disease of caries using preventive services and non-invasive treatment approaches and is only available for services performed on children age six and under. The amount of funding allocated over four program years for Domain 2 is $111,543,313.85. The following are some of the latest progress updates taken from claims data reports that track the Domain 2 progress on a weekly basis

- As of January 17, 2018 143 providers have opted-in for Domain 2 participation.
- In November 2017, DHCS issued approximately 400 provider outreach letters to non-participating providers in the 11 eligible counties.
- A Denti-Cal provider bulletin was released November 2017, which included clarification directed towards providers and a detailed breakdown of the Domain 2 billing process.
- The Dental Fiscal Intermediary (FI), Delta Dental, continued in-person outreach to providers and is ongoing, with a targeted focus on Kings, Glenn, Plumas, and Lassen counties, where no providers had opted into Domain 2.
- Future office visits are planned for Mendocino, Humboldt, and Lassen counties; and follow-up phone calls to Kings, Glenn, Plumas, and Yuba counties to garner more participation.

Domain 3: Increase Continuity of Care

DTI, Domain 3 aims to improve continuity of care for Medi-Cal children ages 20 and under by establishing and incentivizing an ongoing relationship between beneficiaries and dental providers in 17 pilot counties. Incentive payments are made to dental service office locations who have maintained continuity of care by providing qualifying examinations to beneficiaries ages 20 and under for two, three, four, five, and six continuous year periods. The amount of funding allocated over five program years for Domain 2 is $186,619,224.18. The following are some of the latest progress updates:

- From CY 2015 to CY 2016, across 17 pilot counties, the percentage of children receiving continuity of care from the same service office location increased by 2.6 percentage points.
- From CY 2014 to CY 2016 utilization of preventive dental services increased 7.46 percent in Domain 3 counties, and 3.74 percent in non-Domain 3 counties.
- Among the 17 counties in Domain 3, those counties with higher continuity of care between CY 2015 and CY 2016 also had higher utilization of preventive dental services in CY 2016.
- From CY 2014 to CY 2016, DHCS observed a 22.9 percent increase in the number of preventive dental services performed and only a 6.5 percent increase in treatment[7] services during that period.

Domain 4: Local Dental Pilot Programs (LDPPs)

DTI, Domain 4 aims to address one or more of the goals of three domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships. DHCS required local pilots to have broad-based provider and community support and collaboration including Tribal and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of DHCS in any of the domains specified above. The amount of funding allocated over four program years for Domain 4 is $146,726,707.00. The following are some of the latest progress updates as of January 17, 2018:

- Currently, 13 of 14 LDPPs have been executed and began implementation of their programs.
- DHCS expects the remaining LDPP to be executed by February 2018.
- DHCS is excited to track these LDPPs through 2020 for insight and impact on the above mentioned goals.
- DHCS is projected to pay $36 million to the LDPPs in FY 2017-18

Proposition 56

On November 8, 2016, California voters approved the California Healthcare, Research and Prevention Tobacco Tax Act (commonly known as Prop. 56) to increase taxes imposed on cigarettes and tobacco products. Assembly Bill 120 (Statutes of 17, Chapter 22, §3, Item 4260-101-3305) amended the Budget Act of 2017 to appropriate Prop. 56 funds for specific DHCS health care expenditures during the 2017-18 state fiscal year, including up to $140M for supplemental payments on select dental services for providers who bill the Dental Fiscal Intermediary or DMC plans.

Prop. 56 funds will be utilized to provide supplemental payments in addition to the current dental Schedule of Maximum Allowances (SMA) for specific dental procedures, targeted to increase provider participation and access which should help utilization, particularly in underserved areas. Services within the following categories – restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, visits and diagnostic

[7] Treatment means dental treatment service (D2000-D9999 or a SNC dental encounter with certain ICD 10 codes specified in DTI Annual Report Program Year 1 Appendix 2 List A)

services – will receive a supplemental payment at a rate equal to 40 percent of the SMA for the specified codes for the dates of service during the period of July 1, 2017 through June 30, 2018.

DHCS received State Plan Amendment (SPA) approval from CMS for SPA17-031 on November 22, 2017, enabling DHCS to implement the Prop. 56 supplemental payments for dental services. To reduce administrative burden to the providers, all retroactive payments for claims submitted prior to November 29, 2017, with dates of service (DOS) July 1, 2017 – November 29, 2017, will be completed systematically through an Erroneous Payment Correction (EPC) and systematically re-processed to include the supplemental payment for the applicable procedures. No provider action is required to receive the retroactive payment for services rendered; however, due to the large volume of claims, the retroactive payment process may take up to six months to complete. All claims submitted after November 29, 2017 with DOS July 1, 2017 and after, will include the supplemental payment. The first supplemental payments were mailed out on December 7, 2017.

DHCS expects to achieve a five percent utilization increase due to the supplemental payments. DHCS also anticipates receipt of the first invoice from the dental FI for Prop. 56 payments in January 2018. The first Prop. 56 disbursement to the dental FI is expected to be approximately $16.2 million and will be paid in February 2018.

Other Efforts

New Contract Procurements

DHCS recently procured two contracts simultaneously to replace the existing single FI contract with Delta Dental of California (Delta). Awarding two separate contracts, a Dental Administrative Services Organization (ASO) and a Dental FI contract, was part of DHCS' long term plan to transition from a capitated, at-risk contract to a true fee-for-service contract model. This transition was intended to create a competitive environment incentivizing Dental ASO vendors to submit bids with aggressive pricing and enhanced services. This allows the Dental ASO to be more program-focused on areas such as provider and beneficiary outreach to improve utilization in underserved areas and also eliminates the financial incentive for the ASO to minimize utilization.

Streamlined Dental Provider Application

DHCS remains committed and focused on increasing the satisfaction of both beneficiaries and providers in utilizing Medi-Cal dental benefits as well as rendering them. DHCS appreciates and values stakeholder input and where possible, translates recommendations into program improvements. One such effort for program improvement was the implementation of a streamlined provider enrollment application. In January 2017, DHCS implemented a dental specific provider application, Form 5300 as described on the Provider Bulletin Volume 32 Number 20 for both individual and group dental offices enrolling as new providers or for revalidation of enrollment. With the implementation of a streamlined provider application, the application processing time has been reduced because the new applications are arriving with fewer errors and

requiring less remediation from the providers. In a comparison of a one-year period, provider enrollment processing timelines for both new and revalidation applications decreased from 99 days to 34 days and 324 days to 147 days, respectively. New enrollment also doubled from 34 to 78 new applications. DHCS has also seen an increase in active service office locations rendering dental services to Medi-Cal beneficiaries – growing from 5,487 active dental service office locations in 2014 to 5,622 in 2017 – an increase of 135 locations rendering dental services to Medi-Cal beneficiaries.

Figure 7

Provider Application Approval Timeframes - New & Revalidation: From Date Received* to Enrollment								
Month-Year	Total # New Apps	Shortest # Days to Enroll	Longest # Days to Enroll	Average # Days to Enroll	Total # Revalidation Apps	Shortest # Days to Re-Enroll	Longest # Days to Re-Enroll	Average # Days to Re-Enroll
October-16	34	3	99	19	37	3	324	64
October-17	78	4	34	14	10	5	147	41

*Note: date received = the date a complete application is received.

Provider and Beneficiary Outreach

Provider outreach efforts continue on a monthly basis via dental provider bulletins and e-mail communications to keep providers informed on current and upcoming efforts or changes within the Medi-Cal dental program. Additionally, DHCS continues to refine and improve materials offered at regularly scheduled provider training seminars held throughout the state. The seminars are held on a regular basis throughout the year and are scheduled in all regions of California so that current and prospective dental providers, across all dental delivery systems, have reasonable access to attend.

The Dental FI (and soon to be ASO) performs ongoing beneficiary outreach through various activities identified in an annual beneficiary outreach plan that is developed by the FI and approved by DHCS. The intent is to increase awareness of the Medi-Cal Dental Program for covered beneficiaries to encourage them to fully utilize their Medi-Cal dental benefits. The focus of the beneficiary outreach plan is on beneficiary populations within identified underutilizing counties and through targeted outreach efforts, with a goal towards reducing access and utilization barriers.

Teledentistry (Virtual Dental Home)

Another DHCS effort is the Virtual Dental Home (VDH) which is a community-based oral health delivery system in which beneficiaries receive preventive and simple therapeutic services in community settings. VDH utilizes the Teledentistry technology to facilitate the diagnosis, consultation, and treatment of a beneficiary's dental health care by their primary care dentists and allied professionals. The VDH demonstration was conducted from 2010 to 2016. Approximately 27 funders provided over $5.5 million to support this

demonstration in 11 communities and approximately 50 sites across California, including sites in Sacramento and Los Angeles counties.

Medical-Dental Collaboration Pilot Project

In an ongoing effort to increase children's utilization of dental services, DHCS participated in projects such as the Medical-Dental Collaboration which is a pilot project with Children Now to strengthen medical and dental collaboration in Los Angeles County in order to increase preventive dental service utilization among children from ages 1-6, who are currently enrolled in Medi-Cal and have not had a dental visit within the past 12 months. DHCS has been involved in this project since its inception, along with Children Now, the DMC plans, Medi-Cal Managed Care Plans and Dental FI, work collaboratively toward the implementation of this pilot project to improve dental utilization for the designated population in Los Angeles County. Federally Qualified Health Centers (FQHC) have been utilized in 2016 for improving the oral health quality for publicly insured children in Los Angeles County through medical and dental integration.

Quality Improvement Projects – Dental Managed Care

As part of the DMC contracts, DMC plans are contractually obligated to conduct and/or participate in two DHCS-approved Quality Improvement Projects (QIP) per year. One QIP must be DHCS-designated, while the second may be proposed by the plans. The QIPs began August 1, 2014, and continued through July 1, 2017. One of the DMC plans, Access Dental, QIP study sought to identify baseline population statistics related to differences in utilization within the enrolled population based on race/ethnicity and to identify intervention strategies, including educational activities. The findings show that from 2013-2016 there was minimal change in utilization and an overall decrease in the use of sealants. In order to mitigate the overall decline of sealants, fluoride, and preventive services utilization, Access implemented a preventive bonus for providers and updated member materials for outreach. The other two DMC plans, LIBERTY Dental and Health Net, collaborated on their QIP submission to reflect the CMS goals to: 1) increase by four percentage points over a five-year period, the proportion of children ages 1-20 enrolled in a Medicaid program for at least 90 consecutive days, who receive a preventive dental service, and 2) increase by four percentage points over a two-year period, the proportion of children ages 6-9 enrolled in Medicaid program for at least 90 consecutive days, who receive a dental sealant on a permanent molar tooth. Their findings: Utilization for 2016 preventive dental services, for most plans has improved from their 2014 baseline percentage and all plans have improved on their 2015 percentage. For dental sealants, LIBERTY PHP shows a 3.3 percentage point increase from 2014 to 2016. Other plans show no more than a 0.2 percentage point decrease, but all plans improved on their 2015 percentage. Both plans are involved in multiple outreach programs in efforts to improve utilization, and study results are not yet finalized. One factor reflected in the data is the significant increase in the numerators and denominators for all measures based on the substantial growth of the Medi-Cal population since 2014, meaning many more patients are being seen, many of which are new to the program.

Restoration of Adult Dental Benefits

Effective January 1, 2018, DHCS restored adult optional dental benefits for beneficiaries 21 and older with full-scope dental coverage. Senate Bill 97 (Chapter 52, Statutes of 2017) amended Welfare and Institutions Code, Section 14131.10 and required full restoration of optional adult dental benefits that were not restored in May 2014. Restored benefits include, for example, laboratory processed crowns, posterior root canal therapy, periodontal services, and partial dentures, including denture adjustments, repairs, and relines.

DHCS submitted SPA 17-027 on November 8, 2017 and remains under review by the federal government. As part of the SPA submission process, both tribal and public notices were posted and no comments were received.

Outreach efforts to provide beneficiaries and providers awareness of the restored benefits include notices mailed to all Medi-Cal heads of household from October 2017 – December 2017 as well as posted the notice in 16 threshold languages to the Denti-Cal website. The dental FI has also sent provider bulletins every month from November 2017 through January 2018, including a Benefits Quick Reference Guide – 2018, informing providers of the restoration and their ability to render, bill, and be reimbursed for restored adult dental benefits effective January 1, 2018. DMC plans also received All Plan Letter 17-009 to inform them of the restored adult dental benefits. Corresponding Medi-Cal Dental Program handbooks are also in the process of being updated to reflect the adult restoration benefits. While this restoration is specific to adults, DHCS is hopeful that access to these benefits and outreach and education efforts associated with this benefit restoration will have a residual impact on children's dental utilization as their parents are now able to seek additional dental benefits.

DHCS Dental Partnerships and Data Transparency

Additional DHCS efforts to increase utilization for children include continuing to work with stakeholders, such as the California Dental Association, California Primary Care Association, Dental Hygiene Committee of California, Sacramento District Dental Society, Medi-Cal Dental Advisory Committee, and Medi-Cal Dental Los Angeles Stakeholder groups, inclusive of children's advocacy groups – Children Now, First 5 California, The Children's Partnership and more – to enhance beneficiary and provider awareness regarding eligibility, participation, and billing practices for the Medi-Cal dental program and associated initiatives. DHCS and its dental FI are collaborating with the California Department of Public Health's Oral Health Program to increase access to oral health services for high risk populations, develop oral health materials, a provider toolkit, and assist local health jurisdictions with their objectives to increase the oral health status of all Californians. In addition, DHCS convenes a number of policy and program specific stakeholder meetings to discuss enhancing the delivery of oral health care to Medi-Cal beneficiaries. The DHCS Medi-Cal Dental Program webpage host a magnitude of useful information and resources, including the DHCS Medi-Cal Dental Stakeholders page that provides stakeholders with information regarding previous and

upcoming meetings/webinars[8], program developments, resources, and other important announcements[9]. Particularly for DTI, stakeholder engagement is reported in the DTI Annual Report[10] and the DHCS Medi-Cal Dental DTI page[11].

DHCS has initiated more transparency on statewide performance by creating a Medi-Cal dental data reports webpage as part of the larger DHCS website, which includes dental FFS and DMC reports, available at http://www.dhcs.ca.gov/services/Pages/DentalReports.aspx.

The Dental Performance Measures are reported every quarter for FFS and from each DMC plan with age breakdowns aligned with CMS 416 report. There are 11 measures across a variety of performance areas, including ADV, Preventive Dental Services Utilization, Use of Sealants, and Continuity of Care. DHCS is also actively adding dental information to the California Health and Human Services Agency Open Data Portal, available at https://data.chhs.ca.gov/, to enable the public to manipulate DHCS dental program data for their own trending and analysis purposes.

The Dental Performance Measures are also published on the Open Data Portal and are broken down by 1) age, 2) ethnicity, 3) county, and 4) ethnicity and county combined for CY 2013, 2014 and 2015. The CY data will be updated annually; CY 2016 data is currently pending DHCS approval to be uploaded. By having this information readily accessible to beneficiaries, providers, and stakeholders, DHCS is supporting a more informed public with the goal of increasing awareness of services, providing information on where and how to access those services, and demonstrating statewide Medi-Cal dental performance in the dental FFS and DMC delivery systems. DHCS is committed to program transparency through increased and ongoing public reporting, as required by the DTI evaluation process as well as through AB 2207 (Wood, Chapter 613, Statutes of 2016).

Conclusion

The key highlights of the data collection referenced in this report include:

- Population of children age 0-20 has increased every year since 2013.
- Children dental utilization for age 0-20 has been stable since CY 2013.
- Children dental utilization of Hispanic and Asian beneficiaries at age 0-20 are higher than other ethnicities.

[8] All Stakeholders: www.dhcs.ca.gov/provgovpart/denti-cal/Pages/AllDentalStakeholder.aspx Sacramento: http://www.first5sacramento.net/Meetings/Pages/Medi-CalDentalAdvisoryComm.aspx and LA: www.dhcs.ca.gov/provgovpart/denti-cal/Pages/la_pastmeeting.aspx

[9] Proposition 56 Supplemental Payments and Restoration of Adult Dental Services Announcement http://www.dhcs.ca.gov/services/Pages/MediCalDental.aspx

[10] PY 1 Final Report for January-December 2016 (Submitted to CMS on December 22, 2017 and pending CMS' final review and approval)

[11] DHCS Medi-Cal Dental Program DTI home page www.dhcs.ca.gov/provgovpart/Pages/dti.aspx

- The statewide preventive dental services utilization for children age 1-20 has increased by 4.67 percentage points from CY 2014 to CY 2016.
- The preventive dental services utilizations of all ethnicities for children age 1-20 statewide have increased from 2014 to 2016, especially Alaskan Native or American Indian children beneficiaries.

DHCS' mission is to provide Californians with access to affordable, high-quality health care, including dental services. DHCS believes our current program efforts, along with the DTI, Prop 56 supplemental payments, and targeted outreach for beneficiary education and provider participation, will help DHCS achieve the desired impact of generating higher overall dental utilization among Medi-Cal children. These efforts remain a high priority for DHCS as it constantly seeks to improve services and promote patient-centered, coordinated care for Medi-Cal members. As utilization data becomes available that incorporates the impact of the various policies and efforts described in this report, DHCS will make that data available and engage in ongoing policy discussions with stakeholders on the future of the program. DHCS acknowledges that improving child dental utilization has been historically challenging, but is committed to working with stakeholders and implementing those policies authorized under law to continue striving toward the goal of 60 percent annual child dental utilization and beyond.