

Department of Health Care Services Medi-Cal Dental Services Division

Beneficiary Utilization Measurements Round 1: April 2nd Meeting Dental Stakeholder Feedback

1) Proposed performance measurements to be used in criteria for assessing beneficiary utilization:

- Annual Dental Visit
- Use of Preventive Services
- Use of Sealants
- Exams/Oral Health Evaluations
- Use of Dental Treatment Services

Stakeholder	Feedback
Alameda County Public Health Department	<p>The measures proposed here would benefit from the following additions and embellishments:</p> <ul style="list-style-type: none"> • Specify Use of Preventive Services • Specifying the Use of Sealants in terms of utilization of sealants for those who are eligible and can benefit from the service (including age and sealable surfaces); • Use the Dental Quality Alliance (DQA) measures to broaden and specify the language and details of performance measures ; • Adding FI Varnish Application: # of children aged 1-21 years who received at least 2 FI Varnish application in 12 months as this is the best practice standard in terms of health outcome benefit; • Continuity of Care: Percentage of Children and Adults enrolled in two consecutive years who received a comprehensive or periodic or other dental services in both years; • Include measures to reflect access rate by each <u>county</u> equivalent to utilization measures enjoyed by the general population there. This reflects the federal intent of access. Consider breaking it down by urban/rural, ethnicity and zip code. This will provide a fine comparison between utilization and provider participation • Include measures to reflect acceptability, frequency and continuity of care as well as the extent of overcoming access to care barriers for underserved populations; This could be measured through a survey and include waiting time at the office, language and cultural compatibility of the provider and the office staff, ethnicity measures; • Overall Utilization of dental services: Percentage continuously enrolled for 1, 2, and 3 years who received dental services during those periods and % who continued to receive oral examinations for 1, 2, and 3 consecutive years; • People with chronic diseases such as Diabetes: Percentage of people with diabetes who have a dental examination and or service within the reporting year • Pregnant women: Percentage of pregnant women who received a dental examination and/or a dental service during their pregnancy <p>Receiving complex dental care when needed (from a general practitioner or specialist) when needed. This includes RCT, Surgery, Sedation or General Anesthesia</p>

<p>California Dental Association</p>	<ul style="list-style-type: none"> • CDA strongly urges DHCS to explore adopting the performance measures for Prevention and Disease Management from the Dental Quality Alliance (DQA), which can be found at: http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/measure-sets • There are seven critical measures that should be adopted addressing overall utilization, oral exam access, use of fluoride varnish and sealants for critical age groups, and several measures related to emergency department use and follow up. • These standards reflect the current dental best practices for performance measures and will be more relevant and useful for the department to adopt moving forward. • These standards have been DQA tested and approved by the National Quality Forum. • As the field of health care quality management progresses, it will be important for performance measures to be adopted uniformly amongst all payer sources; to that end it is important to note that Covered California has invited the DQA to present these measures for their consideration and adoption for the dental benefits sold there. • In addition to these DQA measures, additional measures should be considered, including continuity of care measures that document the percentage of children and adults enrolled in two consecutive years who received a comprehensive exam or other dental services in both years. • Measures should be collected to reflect access to care using geo-mapping by county level, which can more finely account for community-based need and access to care. • As oral health care has a direct impact on overall health and has very clear relationship to the ability to effectively treat many chronic diseases such as diabetes; DHCS should measure the number of patients with diabetes and other chronic illnesses who have a dental examination or other treatment service within each calendar year. • Preventive dental work during pregnancy is critical to avoiding oral infections such as gum disease, which has been linked to preterm birth; therefore, DHCS should measure the number of pregnant patients who have a dental examination or other treatment service within each calendar year.
<p>Dental Surgery Center Coalition</p>	<p>Look like good measures. Would like to know what % of tx that is dx is completed. (Are providers doing all treatment, partial, just observing, etc.)</p>
<p>First 5 LA</p>	<p>Since CDHS is already reporting data on 0-3 and 4-5 for the 11 measures under state law, this should also be included in the assessment of utilization given the need to increase utilization of dental services by children 0-5 to improve children’s oral health. Also, recommend county-level information for counties where utilization has been identified as needing improvement (e.g. LA County).</p>
<p>First 5 Sacramento</p>	<ul style="list-style-type: none"> • Are these measures only for the children or are they also for adults? • Prevention Services and Dental Treatment Services should be broken down into more specific categories. Data on the specifics could be rolled up for the reporting but should be available to policy makers, stakeholders, etc., when requested. • Recommend collecting the more detailed data, as per the current utilization measures, while providing these 5 items as what is regularly reported. Provide a way for the more detailed data to be available by county (or smaller incremental unit) when requested. • Develop a way to break out the data into small than county increments (by zip code or group of zip codes – ask the larger counties what they need) to be able to provide more specific data. This will allow FI and stakeholders (counties, local First 5’s, other stakeholders) to utilize the data to better target client outreach efforts and provider recruitment efforts. • “Report quarterly” should be fine; an annual summary would also be great. • However, ‘report quarterly’ should also mean that data is posted on the DHCS website quarterly. A ‘disclaimer’ could be indicated that the data is raw when initially posted. When data is cleaned up and properly verified, then updated data could be posted with the proper ‘updated’ noted in the title/header of the document and a brief description as to why the data might be

	<p>different than originally reported.</p> <ul style="list-style-type: none"> • Waiting 9 to 12 to 15 months or more for data is not helpful to stakeholders and advocates that are actively working to secure resources to promote proper oral care, target specific areas of greatest need, and obtain services for Medi-Cal population. • Data collected should be available by age group (0-3; 4-5; 0-5subtotal; 6-20; total all). <p>All measures should be broken out by age: 0 to 3 4 to 5 Subtotal 6 to 20 TOTAL</p> <p>Collected information should be available to the public by the following quarter. If the data may change then just state that but the public needs to have access to the data.</p>
<p>Maternal and Child Health Access</p>	<ul style="list-style-type: none"> • For children, clinical oral examinations are available every six months and performance should be measured. • And under EPSDT, as needed. Please include EPSDT services provided.
<p>The Children’s Partnership/California Coverage and Health Initiatives</p>	<p>We propose the following changes to the proposed performance measures:</p> <ul style="list-style-type: none"> • Interim reporting (quarterly) on all of the proposed measures. Waiting 9 or 12 months or longer makes it difficult for stakeholders to support outreach efforts. • Reporting of proposed measures by race/ethnicity <p>Reporting of data for sub-county geographies in larger counties such as Los Angeles</p>
<p>PDI Surgery Center</p>	<p>Todd Gray, DDS in private practice and at PDI Surgery Center::</p> <p>Possible additional utilization measure:</p> <ul style="list-style-type: none"> • how many children under age 5 who qualify for care have been diagnosed with dental caries? • how many had those caries treated? <p>This would demonstrate whether or not utilization of care/access is actually working</p> <p>Identify WHICH kinds of treatment(s) were provided (not just a visual)</p>

2) The proposed parameters to attain the 5 revised performance measure categories:

- 90 continuous days of enrollment
- Full scope aid codes
- Age group stratification, when appropriate

Current parameters utilized to attain the current 11 performance measure categories:

- HEDIS-like (11 of 12 months continuous eligibility)
- Full scope aid codes
- Age group stratification, when appropriate

Stakeholder	Feedback
First 5 LA	Parameters are appropriate and as mentioned above, recommend age stratification for >5. Will children under 1 year be included as a result of the 90 continuous days of enrollment parameter? High-risk children may need to see a dentist at first tooth eruption (before age 1).
First 5 Sacramento	<ul style="list-style-type: none"> • Utilizing 90 continuous enrollments would be an improvement. • Age group stratification should be mandatory, not 'when appropriate'. Yes it is more work to get the data by age, but the age stratification information provides more accurate information to assist the FI and stakeholders in their efforts to target both clients and providers in outreach, enrollment, recruitment or other efforts. <p>See above for comments on age and data available to the public; same applies here ***Refer to First 5 Sacramento response under 1.) Proposed performance measurements to be used in criteria for assessing beneficiary utilization</p>
Maternal and Child Health Access	<ul style="list-style-type: none"> • Do not limit to full-scope aid codes, as ALL* pregnant women, regardless of aid code, receive ALL adult dental services necessary during pregnancy. *Denti-Cal provider bulletin: http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_30_Number_17.pdf • Please allow input on age group bands, before finalizing. What are the current bands? • Assess for pregnant women in addition to age groups. • Please demarcate if FFS or dental managed care.
The Children's Partnership/California Coverage and Health Initiatives	<ul style="list-style-type: none"> • Age group stratification should always be used as a parameter. • In addition, there should be stratification by county (and eventually, by MSSA), race/ethnicity, FFS vs. dental managed care.

Additional Comments for Beneficiary Utilization Measurements	
Stakeholder	Feedback
California Dental Association	<ul style="list-style-type: none"> The state needs to develop clear utilization benchmarks. Per the Clark v. Kizer lawsuit and federal law, the state should increase utilization of its Medi-Cal dental services, at a minimum, to the national average of utilization in the commercial market, which is 58.10% (American Dental Association, Health Policy Institute); however, the goal needs to be ensuring access to care is available to Medi-Cal recipients at least to the extent that such care and services are available to the general population in the same geographic area. This would be an adequate measure of California's compliance with federal Medicaid requirements.
Children Now	Children Now recommends collecting and reporting data by race/ethnicity to determine any disparities that could then inform outreach efforts to reach potentially underserved populations.
First 5 Sacramento	<ul style="list-style-type: none"> Data collection can be a hassle the everyone, including stakeholders and advocates, understands that. But the need for timely reported, detailed, age stratified data by county and zip code (or other smaller incremental count) is critical for targeted outreach efforts to increase client utilization of services and to recruit additional providers. Please maintain the highest level of detail possible to meet the needs of the legislature, counties, stakeholders, advocates, and auditors. Just because CMS doesn't ask for it, doesn't mean it isn't important to everyone else involved.
Maternal and Child Health Access	<ul style="list-style-type: none"> See below* – some comments may belong in the beneficiary section. <p>***Reviewed Provider Participation feedback and confirmed recommendations pertained to Provider Participation measures.</p>