Revised May 1, 2016

Jennifer Kent
Director, Department of Health Care Services
State of California
1500 Capitol Avenue
Sacramento, CA 95814

Dear Director Kent:

The Medi-Cal Children's Health Advisory Panel (MCHAP) is an independent, statewide advisory board, legislatively authorized to advise the Department of Health Care Services (DHCS) on matters relevant to all children enrolled in Medi-Cal and their families, including, but not limited to, emerging trends in the care of children, quality measurements, communications between DHCS and Medi-Cal families, provider network issues and Medi-Cal enrollment issues.

To carry out this legislative charge, MCHAP organized a number of workgroups to develop recommendations for improving systems and services for low-income children. This letter and recommendations report on MCHAP's initial review of children's dental services.

Ensuring access to quality dental services for Medi-Cal eligible children has been a long-standing challenge for California. As part of its analysis, MCHAP had conversations over many months and reviewed a number of reports[1],[2] detailing the barriers in California, as well as current and proposed efforts by DHCS to overcoming these challenges. Dr. Paul Reggiardo, a pediatric dentist and member of MCHAP, provided invaluable information and perspective to the Panel as it discussed these important issues.

The following recommendations are forwarded in the interest of ongoing collaboration between MCHAP and DHCS to improve dental services to children enrolled in Medi-Cal. MCHAP actively supports current efforts by DHCS such as changes to the provider application process and targeted incentive payments through the Medi-Cal 2020 waiver. MCHAP recommendations propose that DHCS expand its efforts to improve dental access and quality through a number of additional initiatives.

1. **Increase provider reimbursement through targeted changes in the Medi-Cal fee-for-service Schedule of Maximum Allowances (SMA) to incentivize provider participation and retention in the Denti-Cal program.**
    - While the reversal of the earlier 10% rate reduction contained in the 2015-2016

[1]The following reports were reviewed as background: 1) California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care, Report 2013-125.
2) Department of Health and Human Services, OFFICE OF INSPECTOR GENERAL MOST CHILDREN WITH MEDICAID IN FOUR STATES ARE NOT RECEIVING REQUIRED DENTAL SERVICES, Suzanne Murrin Deputy Inspector General for Evaluation and Inspections January 2016 OEI-02-14-00490.
3) Medi-Cal Dental Services Rate Review, July 1, 2015: Submitted by the California Department of Health Care Services In Fulfillment of the Requirements of Welfare & Institutions Code §14079.
4) American Dental Association: Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrows, Remains Large for Adults.
5) American Dental Association. A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services.
6) Request letter sent April 6, 2015 by Senator and Dr. Richard Pan to the Little Hoover Commission requesting they examine California's Denti-Cal program.

[2] *Fixing Denti-Cal,* Little Hoover Commission report #230 was issued after the MCHAP recommendation was adopted. http://www.lhc.ca.gov/studies/230/Report230.pdf

state budget restores provider payments to 2000 levels, Denti-Cal reimbursement remains inadequate for program sustainability. The Department's own *Medi-Cal Dental Services Rate Review,* released in July 2015, reported a 44% increase in children enrolled in Medi-Cal since 2008 while, in the same time period, there was a 15% decrease in enrolled Denti-Cal providers. The review also determined that California's 2014 SMA for the 25 most common dental services were well below those in the comparable states of New York, Texas and Florida and only 31% of the national average for commercial benefit (insurance) programs.

- These findings were essentially identical to those of the State Auditor, which reported reimbursement rates paid to Denti-Cal providers amounted to only 35% of the national average.
- Targeted rate increases make sense to enhance access and the provision of care to defined underserved populations (such as the developmentally disabled), dental provider shortage areas, age-related services (especially for infants and children age 6 and under), and to amplify preventive treatment. Less than 15% of all Denti-Cal expenditures now are spent on preventive care.

2. **Simplify and streamline the Denti-Cal provider enrollment application and recertification process.**
    - The current Denti-Cal enrollment and recertification procedure is complex, difficult to maneuver, and discourages and delays provider participation. It is not uncommon for providers to be required to submit many pages of supporting documentation and to experience delays of more than 6 months for enrollment to be successfully completed.
    - The Provider Application and Validation for Enrollment (PAVE) provider enrollment system is being implemented by DHCS to move from a manual, paper-based process to a web-based portal for providers to complete and submit applications, verifications, and report changes. PAVE offers providers on-line instructions; secure log-in; increased accuracy; application fee payment; document uploading capability; electronic signature; application progress tracking; and reduced processing time. MCHAP encourages DHCS to pursue the rapid expansion of those improvements to the dental program and its providers.
    - The MCHAP offers its active support to these efforts underway by DHCS to simplify and streamline provider enrollment. The MCHAP would like to work with DHCS as changes are made and continue to monitor improvements to the provider enrollment application and recertification process.

3. **Reduce unnecessary administrative claim payment and treatment authorization requirements so that the Medi-Cal dental program more closely resembles that of commercial benefit carriers.**
    - The Denti-Cal documentation and reporting requirements, as well as the pre-authorization criteria for the provision of services, is much more extensive, expensive, and time-consuming than that required by commercial dental plans. More complex documentation and reporting requirements also make it more difficult for dentists to integrate the Denti-Cal program into their practice routines.
    - The prevention of fraudulent billing and delivery of unnecessary or inappropriate care is not unique to a public program. The Department should determine where those policies, internal procedures, and constraints utilized by commercial benefit carriers could be successfully substituted for current administrative practices.

4. **Assess and report on actual network capacity and set beneficiary utilization goals**
    - The Department's initial *Dental Provider Network Capacity Survey,* a self-reported data collection, released in 2015, found a large majority of providers were willing to

accept new child beneficiaries and were willing to see patients age three and under (despite reporting longer wait times for appointments). The survey, however, was limited in scope and failed to include responses from 11 counties (almost 20% of counties in the state). Expanding the survey to a greater number of providers, as well as adding questions directly related to future capacity is recommended.

- MCHAP also recommends the provider survey include the opportunity for input about programmatic or administrative issues respondents suggest should be addressed to increase the number of Denti-Cal beneficiaries accepted into care.
- In addition, in 2015 the *American Dental Association Health Policy Institute* analyzed annual dental utilization rates (percentage of covered children receiving a single dental service in the reporting period), obtained from CMS Form 416 reporting data, by Medicaid enrollees and, through a commercial research database, by those with private dental benefits. California fell below the national norm. MCHAP recommends that DHCS develop a methodology to track dental utilization among children, report on utilization annually and develop approaches to increasing utilization throughout the state. We certainly anticipate that the Medi-Cal 2020 Dental Transformation Initiative will support changes in utilization and are pleased that the DTI was included in the 1115 waiver renewal.

5. **Create additional opportunities for stakeholder participation and transparency in planning and implementing the Dental Transformation Initiative of the Medi-Cal 2020 Section 1115 Waiver**
   - On December 30, the Centers for Medicare and Medicaid Services (CMS) approved California's Medi-Cal 2020 1115 waiver, which will provide an additional $740 million to California's Medi-Cal dental program over the next five years. This is the first time the state's dental program has received such a substantial federal investment and it is unprecedented in other state Medicaid dental programs. MCHAP applauds DHCS for these efforts.
   - DHCS should employ a robust stakeholder process in setting and evaluating project benchmarks to determine mission success and/or course correction in meeting the goals and objectives of the initiative and should report out in sufficient detail for independent periodic progress evaluation.
   - MCHAP requests that one of its members be engaged as a member of the stakeholder process.

ADDITIONAL RECOMMENDATIONS WILL BE INSERTED AFTER MAY 11, 2016 MEETING

Thank you for your efforts to date to improve dental care for California's children. We greatly appreciate the active engagement and dialog with DHCS as MCHAP continues to develop recommendations. We look forward to continuing to work with you.

Respectfully,

Ellen Beck, M.D.

Chair, Medi-Cal Child Health Advisory Panel