Medi-Cal Children's Health Advisory Panel

Pediatric Dental Subcommittee

Denti-Cal Policy and Programmatic Recommendations
January 27, 2016

The goal of the Medi-Cal Children's Health Advisory Panel Pediatric Dental Subcommittee is to identify and propose recommendations to the Department of Health Care Services regarding the health and well-being of children and families served and to be served by the Medi-Cal Dental Program

Background

Dental disease – commonly referred to as dental decay or dental cavities --- is the most prevalent chronic illness affecting California's childhood population. While it is largely preventable and easily treated when children have access to dental care, over half of California children at school entrance have experienced dental decay, almost 30% in elementary school have untreated tooth decay, and about 4% of elementary school students at any one time are in urgent need of dental care because of pain or infection. These problems are not distributed equally across economic strata, but are found disproportionately in low-income households including the Medi-Cal population. Approximately 51% of children in California (5.7 million) in 2015 were eligible for Medi-Cal dental services and that figure will increase this year with the addition of full-scope benefits for undocumented children. Prior to the year 2000, Denti-Cal accounted for 2.7% of Medi-Cal spending. That figure is now 1.4% ($1.3 billion of a $94 billion Medi-Cal budget). While Denti-Cal is but a small fraction of Medi-Cal spending, oral health has a tremendous impact on children's overall health, comfort and school-readiness. A 2014 report by the Office of the State Auditor found less than half of the children enrolled in the Denti-Cal program in 2013 received even a single dental service (dental visit) and for infants and toddlers that figure was only about one in four. Additionally, the report concluded that half of all counties had either no providers or an insufficient number of providers willing to participate in the Denti-Cal program. Low reimbursement rates were identified specifically as one of the primary reasons for a lack of providers and access to dental services.

Recommendations

1. **Increase provider reimbursement by targeted changes in the Schedule of Maximum Allowances (SMA) in the fee-for-service program 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 state budget restores provider payments to that of year 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 that paid on a 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 are now spent on preventive care.
- The *Access to Baby and Child Dentistry* (ABCD) Medicaid dental program in Washington state, established in 1995, is one example of a targeted initiative focusing on expanding access to preventive and restorative dental services to Medicaid eligible children from birth through age five, with emphasis on enrollment by age one. The program provides enhanced reimbursement to dentists who have received ABCD training and provide specified services to infants and young children.

2. **Simplify and streamline the Denti-Cal provider enrollment application and recertification process to more closely mirror that of commercial benefit carrier provider contracting.**
    - 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 20 to 50 pages of supporting documentation and to experience delays of six or more months for enrollment to be successfully completed. Newly licensed dentists are particularly challenged in navigating the enrollment process, which uses the same standardized application as that required of pharmacies and providers of durable medical goods.
    - It is recommended that the Department evaluate on a line-by-line basis the necessity for each item in the application required to comply with federal and state regulations and their own needs, and eliminate all unnecessary elements. From this process the Department should develop an application for enrollment and recertification unique to Medi-Cal dental providers.
    - The Department is further encouraged to establish a provider enrollment and recertification process utilizing the unique Medi-Cal dental application which can be completed and submitted online.

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. This is particularly vexing for providers in light of significantly reduced reimbursement. More complex documentation and reporting requirements also make it more difficult for dentists to integrate the Denti-Cal program into their practice routines.

- Dentists further report that inconsistent applications of ambiguous criteria complicate the Denti-Cal claims and pre-authorization process.
- 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 subjective 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) due to a lack of enrolled providers. As currently constructed, the survey asks only about existing volume and fails to assess provider's future capacity or willingness to treat Denti-Cal enrollees over the next month, quarter, half-year or year. Expanding the survey to a greater number of providers, as well as adding questions directly related to future capacity is recommended. Also recommended is additional probing as what programmatic or administrative issues would need to be addressed prior to enrolled dentists increasing the number of Denti-Cal beneficiaries treated in their practices. This would provide a much more accurate portrait of provider capacity than merely measuring current volume.
- 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. While Connecticut and Texas Medicaid dental programs achieved a near 65% annual enrollee utilization, and the national Medicaid average was 48%, using the same criteria, California fell below the national norm. In the same time period, annual dental utilization by children in California covered by commercial dental benefit plans was about 65%. While methodology to determine the eligible pool (children continuously eligible for at least 11 of the previous 12 months of the reporting period, the Healthcare Effectiveness Data and Information Set [HEDIS] standard; the number child beneficiaries during any one month anytime during the previous 12 month reporting period, that used by the State Auditor's Office; or children continuously enrolled in Medicaid for at least 90 days anytime during the previous fiscal year, that reported on the CMS Form 416), the Department should set published beneficiary utilization goals achievable in Medicaid and commercial sectors of approximately 65% and report annually on the progress and methods being employed to meet these goals. This is consistent with the equal access provisions of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of federal law.

5. **Engage within the Department of Health Care Services transparency and opportunities for stakeholder participation in the planning and implementation of the Dental Transformation Initiative within the Medi-Cal 2020 CMS Federal Section 1115 Continuation Waiver**
    - On October 31, the Centers for Medicare and Medicaid Services (CMS) approved California's request for a five-year extension of the Medi-Cal "Bridge to Reform" Demonstration Project, which will now 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 neglected and underfunded dental program has received such a substantial federal investment in reform, and is unprecedented in other state Medicaid dental programs. While this limited short term funding does not provide for comprehensive program transformation, it delivers a framework for dental investments: incentives for early, preventive care; implementation of a caries risk assessment and disease management pilot program; bonus payments to providers for continuity of care; and a competitive grant program to fund local initiatives that address these three areas in innovative ways.
    - The Department 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.

6. **Retract the Medi-Cal Department of Health Care Services All Plan Letter 15-012 (Revised 8/21/15) and the Denti-Cal Provider Bulletin Vol 31, No 12 (August 2015) regarding modified General Anesthesia and IV Sedation policies.**
    - The modified general anesthesia and intravenous sedation policies effective 11/1/15 concerning preauthorization requirements for general anesthesia and intravenous conscious sedation when dental services are provided, while well-intended to assure that patients treated under these modalities are appropriately chosen, have proven problematic for both providers and patients. Medical managed care plans have implemented inconsistent review criteria and some have denied requests for general anesthesia for all but the most severely developmentally disabled regardless of the patient's age, extent of treatment, psycho-social status, or cognitive maturity. Appeal of these decisions, still often denied, delays necessary treatment and results in patient suffering and worsening of their dental conditions.
    - In addition, dentists report that required treatment authorization requests submitted directly to the DHCS create four to six week delays before patients can be scheduled for necessary procedures.
    - The desire to provide clarity and alignment between medical and dental plans for the provision of sedation and general anesthesia is understandable, as is the objective of avoiding overutilization of these services. However, the policies in place have created unintended undesirable consequences and should be replaced with policies better thought-out and implemented.

7. **Establish and utilize the expertise of an independent *Medi-Cal Dental Program Evidence-Based Policy Advisory Committee,* the purpose of which would be to assess and make recommendations to the DHCS regarding the delivery of Denti-Cal services.**
    - This Advisory Committee to the DHCS would be comprised of a panel of subject experts outside the Department and its contractors and would include practicing dentists and dental specialists, dental school faculty, and oral health scientists and researchers. The panel would evaluate and prioritize Denti-Cal services, programs, policies, and best practices, as well as the evidence-based outcomes of each and the strength of the evidence behind each recommendation. The purpose of the panel would be to provide unbiased, unfettered, clear scientific information on which to base policy decisions.
    - This level of oversight is desirable to maximize the quality, effectiveness, efficiencies, and oral health outcomes of Denti-Cal services and programs and to meet the expectations and requirements of CMS, HRSA and the Health People 2020 objectives.

8. **Provide increased case management services to Denti-Cal beneficiaries and their families to overcome obstacles of limited oral health literacy, cultural attitudes and beliefs, transportation challenges, appointment compliance, follow-through with professional recommendations, and other barriers to good oral health.**
    - Proven successful in similar public programs in medicine and dentistry, having dedicated public health support staff available and working at the local level is a critical and much-needed addition to California's system of oral health care.
    - A Community Dental Health Coordinator in each county's *Child Health and Disability Prevention (CHDP) Program* could:
        - Conduct an aggressive targeted outreach campaign to bring Medi-Cal enrollees five years of age and under who have not accessed Medicaid dental services into the dental delivery system for the first time.
        - Educate Medi-Cal beneficiaries and their families on the importance of infant and childhood oral health and help orient enrollees on dental treatment expectations and responsibilities, including appointment compliance and follow-through with professional treatment recommendations.
        - Provide direct case management services, including linking families with participating providers and helping solve transportation and other access issues.
        - Recruit and support Denti-Cal providers as needed at the local level, taking into account practice location, office hours, linguistic competencies, and willingness and ability to treat infants and young children, as well as special needs populations. As needed or requested, link local providers to educational opportunities on such areas of care as child behavior guidance, caries-risk assessment, treatment of Early Childhood Caries, pharmacologic pediatric anxiety management, motivational interviewing and family oral health interventions, and effective use of preventive agents and strategies.
    - Building upon the existing and readily available infrastructure in county CHDP programs is an effective and efficient way to maximize current resources and reach Medicaid children not currently accessing dental care. Funding of this infrastructure, as with all EPSDT/CHDP non-clinical administrative services designed either to enroll Medicaid eligible children and, for children already enrolled, to access and utilize program benefits (such as dental services), can be matched with federal funds.

9. **Dismantle or completely replace the current managed dental care model in Sacramento and Los Angeles counties with a redesigned system.**
    - The failed *Geographic Managed Care* experiment in Sacramento has long been criticized for low utilization rates by beneficiaries (especially 0 – 5 years of age), long wait times for appointments, and a lower proportion of expenditures going to direct patient care (i.e. higher administrative overhead). In 2010, fewer than one-third of Sacramento Medi-Cal enrolled children visited a dentist, compared with a rate slightly under 50% in the fee-for-service program across the state.
    - A recent independent analysis prepared for the Sacramento Board of Supervisors found that in spite of 2012 reforms, the situation has barely changed, and Sacramento dental managed care still lags behind the fee-for-service delivery system. The report was especially critical of the lack of providers in the Denti-Cal managed care network.
    - At the very least, automatic mandatory enrollment in dental managed care in Sacramento (with a very limited opt-out provision) should be changed to a voluntary opt-in structure such as that which exists in Los Angeles county.

Respectfully submitted,

Medi-Cal Children's Health Advisory Panel Pediatric Dental Subcommittee
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