Review of the California Medi-Cal Dental Program
Testimony to the Little Hoover Commission
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Background

I am a professor at the University of the Pacific School of Dentistry and have been involved for more than 40 years in supporting, developing, and testing dental care systems for the large number of people in California who face tremendous barriers to accessing dental care. I was also a member of the Institute of Medicine's (IOM) Committee that produced the 2011 IOM report on *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*.

I also had the opportunity to provide testimony at the November 19, 2015 hearing of the Little Hoover Commission. The April 2016 Report #230 of the Commission on Fixing Denti-Cal incorporated several recommendations I made.

Among the innovations in oral health care that I addressed in my 2015 testimony, was the development of a system for improving oral health we call the Virtual Dental Home (VDH).[1] That system has received widespread interest and has continued to expand. The VDH system was incorporated in the approved applications from 8 of the 15 Local Dental Pilot Projects (LDPP) funded under California's CMS 1115 Waiver Dental Transformation Initiative (DTI).

In addition, despite efforts to increase utilization rates in the Medi-Cal dental program, it is well known to the Commission that the majority of Denti-Cal beneficiaries do not receive dental services, as measured by the "annual dental visit". Data from the DHCS dashboard indicates that in 2016-17, in the fee-for-services system, only 45.9% of children ages 0-20 had a dental

1. The Pacific Center for Special Care at the University of the Pacific School of Dentistry. http:/www.virtualdentalhome.org.

visit. In 2016, in the managed care system, only 38.1% of children had a dental visit. The data for adults are far worse.[2,3]

Because of these developments, I have been asked to address several points at the Commission hearing scheduled for March 22, 2018. These are:

- Developments in dental science that support new strategies for improving the oral health of Medi-Cal beneficiaries,
- The oversight of California's Denti-Cal program,
- The Dental Transformation Initiative, in particular the application process, structure, and plans for evaluation of the Local Dental Pilot Projects, and
- Other related topics

Developments in Oral Health Prevention and Therapeutic Sciences

As additional background to my recommendations, I am including here a brief summary of developments in oral health prevention and therapeutic sciences. These advances have brought us to an era where there is declining need for dental surgical interventions, i.e. use of the dental drill and extraction and replacement of teeth. There are now many circumstances where effective disease prevention and early therapeutic interventions can be accomplished by allied dental personnel in community settings. Unfortunately, many of these new techniques and strategies are underutilized because of inadequate policy support and outright policy barriers.

There is a large base of scientific literature in this area which will not be included here. A brief listing and explanation of some strategies and techniques that have important policy implications include:

- Recognition of relation between oral health and general health: There is growing recognition of the influence of oral health and disease on general health and on specific systemic diseases. For example, there is evidence that better diabetes control and lower costs for diabetes care can be obtained when people with diabetes have good oral health. Health care systems where oral and general health activities are integrated have better results in managing certain medical conditions. There is currently no support for these types of integrated health care systems or approaches in the Medi-Cal dental program.
- Dental Diseases as Chronic Diseases: There is growing recognition that the major diseases addressed by the oral health system, dental caries and periodontal disease, are both chronic diseases. For example, when a dentist places a filling in a hole in a tooth (the "cavity") this does not cure or stop the disease that caused the hole to be there.

2. DHCS. Dental Data Reports. FFS Statewide Performance Measures Reports. FFS SFY 2016 - 17 Report. http://www.dhcs.ca.gov/services/Documents/MDSD/Fee%20For%20Service%20Performance%20Measures/Copy_of_FFS_FY_16-17_PM_Report.xls.
3. DHCS. Dental Data Reports. Pediatric Sealants, Annual Dental Visits & Preventive Services Performance Measures (Calendar Years 2013 - 2016). http://www.dhcs.ca.gov/services/Documents/MDSD/Dental%20Data%20Reporting/Pediatric_Sealants,Annual_Dental_Visits_and_Preventitive_Services_Performance_Measures_CY2013-2016.xls.

This is because the dental caries "disease" is caused by bacteria producing tooth dissolving acid in the presence of sugar. This disease is not stopped by the filling. The same is true for periodontal (gum) disease. Scaling and surgical interventions can address the consequences of the disease but do not cure the disease. This means that an effective program of "disease management" must include strategies and techniques to address and manage the underlying disease over an extended period of time. The Medi-Cal dental program does not recognize or incentivize long term management systems.

- Fluoride and fluoride containing products: This includes optimal levels of fluoridation of public water systems. There are still many communities in California with no or inadequate levels of fluoride in the public water system. Fluoride containing products can also be placed directly on teeth in various forms. One form, fluoride varnish, has good evidence that it can reverse the early dissolution of the enamel surface of teeth. Fluoride varnish can be applied quickly and easily by allied dental personnel and even non-dental professionals such as medical assistants and pediatricians both in the provider's office, and in community locations such as pre-schools, schools, and community centers.
- Dental Sealants: Dental sealants are among the oral health interventions with the best evidence of effectiveness and have been found to be highly cost-effective. Sealants can be placed effectively by allied dental personnel in community locations like pre-schools, schools, and community centers. However dental sealants have been found to be widely under-utilized.
- Caries Arresting Medications: There are medications that can be applied to beginning caries lesions (tooth decay) that can stop the progression of the decay. One medication, approved for use recently in the United States is silver diamine fluoride (SDF). This medication is being widely adopted and used by dentists in dental offices to stop decay progression although it is not a covered procedure under the Denti-Cal program. Efforts are underway to acknowledge its effectiveness and have it covered. As with some of the other interventions described above, SDF can be effectively applied by allied dental personnel in community locations such as pre-schools, schools, and community centers.
- Interim Therapeutic Restorations: Interim Therapeutic Restorations (ITR) are small fillings that be placed in certain circumstances with no local anesthetic (no shots) and no drilling. Soft material is removed from the tooth using hand instruments and a tooth colored, fluoride releasing filling material is bonded into place. This is a procedure gaining wide use in dental practices. We conducted a pilot project where we tested the ability of allied personnel to place these fillings.[4] We found that in more than 1000 placements, they all met correct placement criteria and there were no adverse consequences. Subsequently California Legislation, AB1174, 2014, added these procedures to the scope of practice of specified allied dental personnel.

4. OSHPD. Health Workforce Pilot Project # 172: Report and Evaluation. May 12, 1013. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwiD697aqtPZAhVS92MKHSXmBZwQFggwMAE&url=http%3A%2F%2Fwww.dental.pacific.edu%2FDocuments%2Fdepartments%2Fpcsc%2FVirtualDentalHome_HWPP_Evaluation_2013_04_051213.pdf&usg=AOvVaw08hkOVc5hgA-bC7U9p7gZz

- Social Determinants of Health and Daily Mouth Care: There is growing recognition that "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life," collectively referred to as the "social determinants of health" have a significant impact on people's health.[5] In fact there is evidence that these factors have a significantly larger impact on people's oral health than any procedures performed by oral health professionals. There is also growing understand that bringing oral health services into community settings and integrating oral health activities with the activities of social, educational, and general health systems, can impact people's daily habits such as daily mouth care (tooth brushing and use of fluoride toothpaste) and adoption of tooth healthy diets (reduced consumption and frequency of sugary drinks and foods).

Collectively, these strategies have a far greater potential for improving the health of underserved people than does repair of disease by oral health professionals after it has occurred. However, the Medi-Cal dental program is largely organized around a "disease care model" with most of the resources going to the repair of disease and far fewer going to support the strategies listed here.

Oversight of the Denti-Cal program

The California Medi-Cal dental program is largely based on a sixty-year-old model of "dental insurance" that is based on a several hundred-year-old "disease care" model with an emphasis on repair of disease once it has occurred. With the advent of evidence, strategies, and techniques for prevention, early intervention, community delivered services, and integration of oral health services with social, educational, and general health systems described in the previous section, it is time to re-examine the program.

In my previous testimony to the Commission I recommended that California should form an evidence-based advisory committee to review the structure and fees of the Medi-Cal dental program and make recommendations to allow the State to deliver better return, in terms of oral health, on its investment in oral health care.

In making that recommendation I had envisioned a group with structure and function similar to the Institute of Medicine's (IOM) 2011 report on *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*[6]. The committee was composed of members chosen for their educational background and expertise in the subject matter and did not include political appointees or individual's representing professional or other organizations. The committee was staffed adequately to be able to meet its charge of "assessing the current oral health care delivery system; exploring its strengths, limitations, and future challenges; and describing a vision for the delivery of oral health care to vulnerable and underserved

5. World Health Organization (WHO). 2016. Social Determinants of Health. Available at: "http://www.who.int/social_determinants/sdh_definition/en/".
6. IOM (Institute of Medicine) and NRC (National Research Council). 2011. Improving access to oral health care for vulnerable and underserved populations. Washington, DC: The National Academies Press.

populations." The IOM was renamed in 2016 to the Health and Medicine Division (HMD) of the National Academies of Sciences, Engineering, and Medicine. This report was prepared by the IOM Committee on Oral Health Access to Services. I was privileged to be a member of that committee.

I had envisioned a similar process for California. A commission or committee with similar composition and structure, charged with a comprehensive review of the Medi-Cal dental program. The commission or committee would make recommendations to the Legislature for structure, fees, rules, and processes for the Medi-Cal dental program that would allow California to achieve optimal oral health outcomes for the investment it makes in publicly funded oral health care.

The California Department of Health Care Services (DHCS) has numerous advisory committees and activities. These include the DHCS Stakeholder Advisory Committee (SAC), charged with providing input on the Department's current 1115 Waiver.[7] There is a Medi-Cal Children's Health Advisory Panel (MCHAP) that advises DHCS on policy and operational issues that affect children in Medi-Cal.[8] There is a Managed Care Advisory Group (MCAG) established to facilitate active communication between the Managed Care program and all interested parties and stakeholders.[9] In addition, DHCS holds numerous stakeholder meetings to solicit input. Finally, there are local advisory groups such as the Sacramento Medi-Cal Dental Advisory Committee (MCDAC) which provides oversight and guidance to improve Medi-Cal dental program utilization rates, the delivery of dental care services, including prevention and education services in Sacramento County.[10] Unfortunately, most of these groups, while they may include a representative from the dental industry, do not have dental care as a primary focus. Even those that do have dental care as a primary focus are not structured and staffed in a manner that would allow the kind of broad analysis and recommendations produced by the IOM group.

There are legislative proposals that would form an advisory group with a charge similar to what is envisioned here. However, the proposed groups are primarily composed of representatives from stakeholder groups, and may not have the structure, funding, subject matter expertise, and ability to perform a broad analysis of the Medi-Cal dental program, consider developments and trends in oral health science, and make recommendations based on this analysis for re-structure of the Medi-Cal dental program.

Finally, it would be useful to consider the relationship between the oral health care activities of the DHCS Medi-Cal dental program and those of the Oral Health Program in the Department of Public Health (DPH). Following 2003 recommendations of the Little Hoover Commission, the California Department of Public Health's (CDPH) was spun off from its predecessor Department

7. DHCS Stakeholder Advisory Committee. http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx.
8. Medi-Cal Children's Health Advisory Panel. http://www.dhcs.ca.gov/services/Pages/Medi-Cal_Childrens_Health_Advisory_Panel.aspx.
9. Managed Care Advisory Group. http://www.dhcs.ca.gov/services/Pages/ManagedCareAdvisoryGroup.aspx.
10. Medi-Cal Dental Advisory Committee – Sacramento County. http://www.first5sacramento.net/Meetings/Pages/Medi-CalDentalAdvisoryComm.aspx

of Health Services (DHS) in 2007 as a direct response to the terrorist attacks of September 11, 2001.[11] While there are advantages to separating direct care and public health activities for the purpose of coordinating responses to public emergencies, this arrangement may have contributed to an unfavorable separation of direct dental care activities in DHCS and non-emergency public health activities of DPH. In an era where significant attention is turning to focusing public health care spending on improving population health outcomes, a closer integration of individual health care activities and measures and population-based activities and outcomes is essential.

RECOMMENDATION: **Create a commission or committee composed of individuals with background and expertise in the subject matter, that is staffed and adequately funded to be able to perform a broad analysis of the Medi-Cal dental program, consider evidence, developments and trends in oral health science and population-based oral health outcomes, and make recommendations based on this analysis for program reforms that both improve beneficiary and provider participation and facilitate integration with public health activities in order to improve population oral health outcomes . The goal of this activity would be to allow California to achieve optimal oral health outcomes for the investment it makes in publicly funded oral health activities.**

Dental Transformation Initiative (DTI)

California included the Dental Transformation Initiative (DTI) in the Medi-Cal 2020 Waiver in recognition of "the importance of oral health to the overall health of an individual." My involvement with the DTI has been primarily through the Local Dental Pilot Project (LDPP) portion of the initiative. Of the 15 approved LDPP applications, 8 included a component for incorporating the Virtual Dental Home (VDH) system we developed. It now appears that 6 of the 8 will conduct a project that includes the VDH system.

As indicated in my testimony to the Commission in 2015, the VDH is a system that deploys allied dental personnel, such as dental hygienists, in urban and rural community in sites such as pre-schools, elementary schools, community centers serving low income communities, residential facilities for people with disabilities, and nursing homes for dependent older adults. The allied personnel (dental hygienists and assistants) collect diagnostic records that are reviewed by dentists from their office or clinics. The allied personnel in the community provide preventive dental services as well as protective interim restorations. Most importantly, they interact with staff in these community locations to integrate oral health with other systems and services and improve the knowledge and individual oral health preventive practices that are critical for maintaining oral health.

The DTI has the potential to provide valuable information that can help inform future reform of the Denti-Cal system. I was asked to comment specifically on two aspects of the LDPP process, application and evaluation.

11. To Protect and Prevent: Rebuilding California's Public Health System. Little Hoover Commission Report #170, April 2003. http://www.lhc.ca.gov/report/protect-and-prevent-rebuilding-californias-public-health-system.

I understand the considerable burden that the DTI LDPP application and grant administration process placed on DHCS staff. Administering a large grant program is not the usual business of the Department and many systems and processes had to be developed to administer this application process. There was also the need for the Department to obtain CMS approval for various aspects of the program and to follow CMS guidelines and conditions. In addition, some aspects of the application process were still being developed or changed after the application process started. The result, despite considerable efforts of numerous people within the Department, was that there were difficulties faced by applicant agencies and partner organizations. These can be summarized here:

- The required steps and processes to be followed in the application process were not always clear. In some instances, there was contradictory information presented, different applicant organizations received different responses to the same questions, and instructions changed over time.
- There did not seem to be adequate recognition of the significant time, effort, and flexibility required to establish a fundamentally different system of care such as the VDH system.

There are organizations within state government and in philanthropic organizations with infrastructure and experience administering grant programs. Had one of these organizations been involved, some of these difficulties might have been avoided.

Recommendation: For future state grant making activities, consider engaging resources with infrastructure and experience administering grant programs.

Another aspect of the DTI that I was asked to comment on is the evaluation process. While the DTI will provide increased oral health services to children who might not have received those services otherwise, clearly, the major benefit of the program will be to learn from the experience and develop ideas for improving the Medi-Cal dental program. To that end the evaluation of the program is critical. It is especially critical for the LDPPs where innovative approaches are being tested.

DHCS has developed an evaluation plan for the DTI.[12] DHCS has indicated that they will engage and external evaluation organization to conduct the evaluation or portions of it. The plan is focused on the outcomes of DTI Domains 1, 2, and 3. The indicated measures are primarily process measures, based on claims data with a "quality" component consisting of surveys of providers and other stakeholders. These measures will provide valuable information. However, there are other potentially valuable kinds of information that will not be collected using these methodologies. Some of these are presented here:

12. DHCS. Medi-Cal Waiver Evaluation. Evaluation Plan for the Dental Transformation Initiative. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKEwjt9s3jy9PZAhVD2mMKHSSbClsQFggxMAE&url=http%3A%2F%2Fwww.dhcs.ca.gov%2Fprovgovpart%2FDocuments%2FDTIFinalEvalDesign.pdf&usg=AOvVaw3oa1hQyQljoQlH8_VqV20U

- Health outcomes improvement: Pacific has developed a set of measures of health outcomes that are being collected in various implementation sites of the Virtual Dental Home system. Improved oral health outcomes and lowered cost per person are the ultimate goal of health system reform in general and need to be considered in the structure of the Medi-Cal dental program.
- Use of ER and OR for dental care: The DHCS plan describes a proposal to compare ER and OR (use of general anesthesia [GA}) use and costs between counties in Domains 2 and non-Domain 2 counties. However, the described methodology, based on county-wide data will not produce meaningful results unless many children in the county actually receive the enhanced Domain 2 services. Data showing improvements in ER and OR use by a comparatively small number of users will be obscured by the total county data. Similarly, the LDPP projects may produce significant improvement in ER and OR (GA) usage, which would not be detectible in county wide data. DHCS needs to develop a system for providing data about the use of ER and OR (GA) services for the group of beneficiaries participating in a specific intervention. This could be done by producing de-identified, summary data for those beneficiaries participating in a specific intervention based on receiving a list of their Medi-Cal ID numbers.
- Locally collected data and conclusions: DHCS has discouraged LDPP lead entities from conducting their own evaluations of their pilot projects. While the state evaluation plan will produce valuable data and conclusions, locally collected data and analysis could contribute to the lessons learned from the DTI and help inform future policy decisions for improving the Denti-Cal system. DHCS should actively support and encourage LDPP lead entities and partner organizations to collect, analyze and report locally collected data and conclusions.

Recommendation: DHCS needs to develop a system for providing data about the use of ER and OR (general anesthesia) services for the specific group of beneficiaries participating in a specific intervention, particularly the LDPP pilots. This could be done by producing de-identified, summary data for those beneficiaries participating in these specific interventions based on receiving a list of their Medi-Cal numbers.

Recommendation: DHCS should actively support and encourage LDPP lead entities and partner organizations to collect, analyze and report locally collected data and conclusions.

Diversity in Conditions and Needs of the Medi-Cal population

Among the reasons that the utilization rate for dental services among Medi-Cal dental program beneficiaries is so low is that many Medi-Cal beneficiaries have significant social bariers or chronic medical, physical, mental, behavioral, or developmental conditions or other disabilities. These conditions complicate their dental care or require the dental provider to provide additional expertise, actions, and resources to provide dental care. The Medi-Cal dental program is generally a “one-size-fits-all” system where payment is for procedures or visits and where there is no allowance for the variation in individuals that require more time, expertise, and resources to complete those procedures or visits compared to other individuals. Combined

with the extremely low reimbursement rates compared to the cost of delivering care, the result is a strong dis-incentive for providers to treat individuals with significant social barriers conditions or chronic medical, physical, mental, behavioral, or developmental conditions or other disabilities.

DHCS has recognized the value of case management services in assisting providers to contact individuals who may have trouble contacting or coming to their offices and to follow-up on appointments and other follow-up activities. Resources for case management have been included in some of the DTI LDPPs. However, these services are not generally available in the Medi-Cal dental program, not available at all for adults, and do not directly address the additional time and expertise it takes to serve people with chronic medical, physical, mental, behavioral, or developmental conditions or other disabilities where these conditions complicate their dental care or require the dental provider to provide additional expertise, actions, and resources to provide dental care. People with these conditions who develop advanced oral health problems often require more, and more expensive treatment to address these late stage problems than do people without these conditions.

Recommendation: DHCS should institute a system to identify individuals with chronic medical, physical, mental, behavioral, or developmental conditions or other disabilities where these conditions complicate their dental care or require the dental provider to provide additional expertise, actions, and resources to provide dental care and provide a mechanism to pay providers for the additional expertise, actions, and resources needed.

Lack of Regulatory Clarity

Given that California is a large state with large regulatory agencies, it is not uncommon that laws are adopted and subsequent regulations issued that do not completely ensure the application of the law. There are numerous instances where providers and other stakeholders are unsure about what is allowed or what process to follow and have difficulty getting definitive answers to their questions.

One current example that is inhibiting the adoption of the VDH system of care is the application of AB 1174 for health centers. AB 1174 was the bill adopted in 2014 that declared in part that that “face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, and teledentistry by store and forward.” Although provider bulletins explaining billing circumstances and procedures related to this legislation have been issued for fee-for-service system, this has not taken place for the health center system. Stakeholder groups have developed guidelines and resources to help providers in health centers operate and bill for services when using a system like the Virtual Dental Home which incorporates store-and-forward teledentistry. However, DHCS has not endorsed these guidelines and there is no system to obtain endorsement. This leads to uncertainty among health centers and reluctance to adopt this methodology.

In addition, various DHCS employees, contractors, auditors are not always well informed about new laws, regulations, and procedures. We have experienced numerous instances where providers have been given wrong information from someone they perceive to be in a position of authority. Without written documentation with DHCS approval it is hard for providers to decide whether to proceed or not in these circumstances.

While DHCS is reluctant to take actions that can be construed as issuing "underground regulations", it would be helpful if there was a straightforward method for getting clarification from a knowledgeable and authoritative source about questions related to Medi-Cal dental program rules and processes.

Recommendation: DHCS should develop a method to easily and definitively clarify provider questions related to payment and process questions. This could include working with stakeholder groups to develop and approve guideline documents.

Systems of Care

The Medi-Cal dental program is primarily structured to reimburse for isolated episodes of care. These are specific procedures in the fee-for-service system or visits in the encounter-based reimbursement model. However, there is widespread interest and activity in developing systems of care that can improve the ability of health care systems to produce better health outcomes, improve the experiences of care for individuals and providers, and lower the per-capita costs of care – the Quadruple Aim. While DHCS is supporting tests of some system-based models in the DTI, it could be more active in developing, testing, and supporting innovative systems of care. In parallel with developments across the health care industries and the dental industry in particular, DHCS could be working with stakeholders on identification and designation of effective systems of care supported by value-based reimbursement models and their application to the Medi-Cal dental program. Systems of care are developing or possible that integrate multiple heath care systems and workers, emphasize activities coordinated over time, and focus on long term health improvement.

One example of system support that I proposed in my 2015 testimony is this:

Given the value of community-delivered services that emphasize prevention and early intervention, structure the Medi-Cal dental program to support systems that deliver dental services in community locations and emphasize prevention and early intervention. This could be accomplished by establishing a system for designating special "Community Access and Prevention Systems."

- Criteria to qualify as a "Community Access and Prevention System" would include having structures and processes that result in reaching people in community sites, emphasizing prevention and early intervention procedures, and having an effective system of case management and health literacy improvement.
- Payment would be based on outcome measures tied to these criteria.

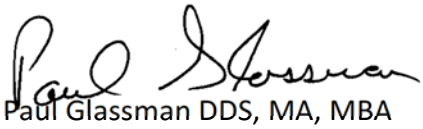
- Payment could include adjusting the fee schedule to increase payment for prevention and early intervention procedures, adjusting periodicity limits, including payment for case management and health literacy improvement, and/or directly rewarding providers for achieving better oral health in the populations they are serving.

Recommendation: In addition to and separate from the DTI, DHCS should be working with stakeholders on identification and designation of effective Systems of Care supported by value-based reimbursement models and their application to the Medi-Cal dental program.

Conclusions

Leaders and policy makers in the U.S. health care and oral health care systems are increasingly interested in the movement toward population health approaches and achieving the Quadruple Aim. There is also increasing interest in public health care programs taking steps to maximize the health impact of public spending on health care services. I have offered some ideas here for moving the Medi-Cal dental program in this direction.

Thank you for the opportunity to express these ideas. I would be happy to provide further background or explanation about any of the points contained herein with members or staff of the Little Hoover Commission.



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