March 7, 2018

Pedro Nava, Chairman
Little Hoover Commission
925 L Street, Suite 805
Sacramento, CA 95814
via email: tamar.lazarus@lhc.ca.gov

Dear Chairman Nava,

Since the Commission's 2015 hearings and the subsequent *Fixing Denti-Cal* report released in 2016, there have been several changes and new initiatives within the program. It is too early to say whether these efforts have or will remarkably improve the program, but each of these changes demonstrates a heightened awareness of the challenges within the Denti-Cal program and CDA is hopeful that we are building towards an improved program. There is no magic bullet and Denti-Cal is far from "fixed." To move towards that point, the state must maintain its renewed commitment to addressing program challenges and optimizing opportunities.

**Program stability and sustainable funding**:

The state's funding of Denti-Cal ebbs and flows with the boom and bust nature of the budget cycle and changing priorities. Nothing wreaks more havoc on a program than lack of stability. To wit, the state cut reimbursement rates by 10 percent in 2011, restored the 10 percent rate cut in 2015, and then after the passage of Proposition 56, provided supplemental provider payments in 2017 - approved for only for one year. What's more, the state eliminated adult dental benefits in 2009, partially restored those benefits in 2014 and then restored the remaining benefits as of January 1, 2018.

Prior to the recent supplemental rate increases, Denti-Cal had not seen a provider rate increase in nearly 20 years. Research in several states during the past decade has illustrated that Medicaid reforms, coupled with improved reimbursement rates, increase dentists' ability to participate in the Medicaid program and result in substantial increases in access to dental care for enrollees. After repeated attempts to convince the legislature to make similar investments in California's program, CDA co-sponsored Proposition 56 in 2016. Through increased tobacco tax revenue, this initiative sought not only to fund tobacco prevention efforts and other important health initiatives, but provide the resources necessary to improve access to dental care for California's 13.5 million Medi-Cal enrollees.

A compromise struck in the Budget Act of 2017 achieved a one-year 40 percent supplemental payment increase for certain services provided under the Denti-Cal program. Though retroactive to July 1, 2017, supplemental payments did not commence until December 1, 2017 – *five-months*

*later*. This was due to the need for the Department of Health Care Services (DHCS) to select the dental procedures for adjustment and to submit a State Plan Amendment (SPA) to the federal government for necessary approvals. Due to the manner in which the legislature approved this funding, the SPA, which is necessary to receive federal funding, is only effective for one year, ending on June 30, 2018.

The governor's proposed 2018-19 budget provides an estimated $164 million (Proposition 56 funds) for Denti-Cal. Of this amount, approximately $94 million is expected to continue to fund the 2017-18 supplemental payments. However, with the existing SPA ending on June 30, 2018, it is very likely the supplemental payments to providers for 2018-19 will be disrupted for several months while a new SPA is submitted and approved.

**Recommendation: The state must find a budget solution that maintains continuity for the Proposition 56 provider supplemental payments approved last year and should appropriate ongoing (rather than annual) increases to ensure stability and provide confidence for providers that the state is committed to sustaining and improving the Denti-Cal program.**

**In the long-term, the state must be a good business partner with dental providers who are committed to caring for their communities. The state should pursue stability in base reimbursement rates over inconsistent, drastic shifts in reimbursement, benefits or eligibility, thereby reducing the confusion for beneficiaries while enabling providers to make sound business decisions that allow them to serve the Denti-Cal population.**

**Administrative Improvements and Data Transparency:**

In addition to the need for consistent reimbursement and benefits, administrative burdens also contribute to the challenges of Denti-Cal provider participation. CDA has long advocated for streamlining the Denti-Cal provider enrollment application and expediting the department's review and approval process. Last year, we provided feedback to DHCS during the development of the new streamlined application that drastically reduces the amount of paperwork required to apply to become a new Denti-Cal provider. In addition, AB 2207 (Wood, 2016) afforded DHCS the ability to reduce some of the administrative barriers for provider enrollment which were previously causing significant delays in application processing.

As an interim step while the department works to include dental provider enrollment in the Provider Application and Validation for Enrollment (PAVE) online enrollment system, the department implemented a new streamlined Denti-Cal provider paper application in early 2017. CDA appreciates this incremental step toward reducing the administrative burden to enroll dentists and looks forward to PAVE implementation for dental providers in the near future.

Initial data from the Department indicates that new applications are being approved more quickly than previous years. 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 applications also doubled from 34 in October 2016 to 78 new applications in October 2017. This is a promising trend.

Additionally, over the course of this past year, DHCS has made improvements to data transparency by overhauling their public reporting of dental quality measures, making it easier to find and easier compare publicly available data on their website. The Department has published more consistent, comparable, and usable data on their new Dental Data Reports website and has begun to add dental data to the state's Health and Human Services Open Data Portal, allowing stakeholders improved methods of monitoring and analyzing oral health of beneficiaries and utilization of services.

**Recommendation: The Department continue to work toward streamlined and supported provider enrollment processes and be forthcoming and transparent with program data. This will support adjustments and improvements in multiple oral health program activities, including local health department oral health programs (Prop 56 funding), Local Dental Pilot Projects (DTI funding), provider and beneficiary outreach activities, program benefit design and more.**

**Program benefit priorities**:

The additional resources available to the program as a result of Proposition 56 funding provides a somewhat unique opportunity for the program to look carefully at its priorities and make adjustments in policies that support improved health and lower health care costs overall. CDA understands that an analysis of this kind may have been considered a luxury in the past, where program resources were scarce, but we submit that now is exactly the right time to do this.

We also understand that the requirements and timelines for the first year implementation of supplemental payments necessitated quick action. CDA appreciates that quick response and understands the department's decision at the outset to apply the supplemental rates evenly across a wide range of dental procedures. However, as we move forward into year two, CDA believes now is the opportunity to apply these resources in better alignment with the goal to reduce dental disease and lower overall costs to the healthcare system.

Prevention is at the core of effectively managing dental disease and reducing the cost burden of severe conditions. Supporting prevention for children and adults should always be a high priority within the healthcare system. Dental disease is highly preventable, yet California has some of the highest dental disease rates in the nation. We must do more to prevent disease onset and apply chronic disease management principles to control its progression and severity across the lifespan – a goal that is clearly articulated in California's recently released state oral health plan.

In this regard, CDA applauds DHCS' decision to pilot the use of silver diamine fluoride (SDF) in DTI's Domain 2. SDF is gaining rapid recognition as a useful and effective tool to manage tooth decay in populations that have difficulty receiving traditional dental treatment services, such as very

young children, frail elders, and people with developmental disabilities. CDA believes that while DHCS continues to collect Domain 2 data and evaluate the effectiveness of the suite of services offered in that Domain, SDF should be made available now to all dentists and enrollees as an option to control the progression of dental disease. To that end, CDA is sponsoring, and Senator Richard Pan is authoring, SB 1148 as a means to quickly move this policy forward.

In addition, periodontal services are essential to improving the general health of the adult population, and may reduce state expenditures on medical services, especially for beneficiaries with chronic diseases affected by systemic inflammation, like diabetes and heart disease. Periodontal services were part of last year's full restoration of adult benefits but were excluded from the Proposition 56 supplemental payments and are being paid at the pre- elimination 2009 rates. Because of the elimination, there is currently a backlog of untreated disease for many adults and that often includes the need for periodontal services. CDA anticipates that with the January 2018 restoration of these services, data will soon be available to project future costs and include supplemental rate increases for periodontal services in the next SPA.

**Recommendation: The rates for all services need to be set high enough to cover the cost of care and support increased access. Given the importance of preventive and periodontal care, the potential long-term cost savings to the state, and the significant additional resources proposed by the Governor's budget for this program, CDA urges the Department to include preventive and periodontal services in the next iteration of supplemental payments. CDA also urges the Department to support the inclusion of SDF in Denti-Cal as a treatment option for dental caries.**

**Opportunities:**

State Oral Health Program funding

Proposition 56 included a $30 million ongoing allocation to the state dental director's office; funding that CDA expects will serve as a "game changer" for the state's oral health program. This is a tenfold funding increase and the first time the program has ever had a dedicated revenue source. These funds will support implementation of the state oral health plan through various means, including supporting local oral health programs, strengthening oral health surveillance and evaluation capacity, launching communication and health literacy initiatives and providing training and technical assistance. Specifically, funding awards totaling $18 million of the $30 million has allocated to local health departments or jurisdictions for both the 2017-18 and 2018-19 budget years.

Establishing oral health leadership in California and developing a robust, high-functioning public oral health program are two of CDA's top policy priorities. We were active in the efforts that brought Dr. Jay Kumar to California as our state dental director, and in the success of providing the oral health program sustainable funding within Proposition 56's funding formula. CDA is excited

by these advancements and looks forward to continued engagement with the oral health program and oral health stakeholders to support the success of these endeavors.

The Dental Transformation Initiative (DTI)

Approved in late 2015, the Dental Transformation Initiative (DTI) committed an additional $750 million investment in the Denti-Cal program over a five-year period (2016-2021). The initiative focuses on providing incentives for increasing utilization of dental services provided to children (ages 0-20) utilizing three domains: early prevention, caries risk assessment and disease management, and continuity of care. Additionally, a fourth domain provides funding for 14 local pilot projects to address one or more of the domains through innovative, alternative programs. The individual domains of the DTI officially launched in mid-2016 and January 2017.

CDA has been an active DTI partner of DHCS and participates in regular DTI stakeholder meetings, provides feedback to the department, and engages in significant outreach and education to encourage our members to participate in the program. CDA developed a groundbreaking new online education course that is a key element of the Domain 2 Pilot, which helps train dentists in best practices for working with young children and their families to set goals and prevent the onset of dental disease (TYKE: Treating Young Kids Every Day).

CDA has clearly stated that the department must ensure that the DTI dollars are spent on improvements that are both measurable and sustainable. There is little data on whether the DTI is in fact moving the needle on increased utilization or improved oral health of Denti-Cal beneficiaries. The first quantitative report of program year 2016 metrics and utilization was released by DHCS at the end of 2017, and while preliminary, the data look promising. Analysis of these data will be essential for understanding the effectiveness of the DTI domains, in order to replicate what works or transition dollars away from initiatives that are not producing the desired improvements.

**Conclusion:**

Since the 2016 release of the Little Hoover Commission's Denti-Cal report, CDA has witnessed renewed attention to solving the ongoing challenges within the Denti-Cal program. However, despite this progress, we remain concerned with aspects of the administration of the Denti-Cal program and will continue to suggest improvements regarding reimbursement rates, the scope of the oral health benefit package, and reducing burdensome authorization and payment policies. In the long-term, CDA would like to see program reforms that utilize healthcare quality metrics and a data-driven system that prioritizes prevention of disease and improvement of overall health of the population.

Despite the concerns we have expressed here, we would be remiss by failing to recognize that the multi-pronged endeavors undertaken by the department, stakeholders, and providers represents a significant effort to improve access to dental care for Denti-Cal beneficiaries. While the efforts and improvements will take several years to yield results, between the supplemental rate enhancements gained through Proposition 56, the restoration of full adult dental benefits, and continued

reductions in the administrative burden, CDA remains cautiously optimistic about the Denti-Cal program. We strongly believe that it will take continued commitment and meaningful engagement from the state to create real and lasting change. The problems are not solved, but we are pleased to be a partner on these initiatives and improvements, stemming from a recognition by policy makers of the historical dysfunction within the program.

CDA looks forward to its continued partnership with the commission in its evaluation of the Denti-Cal program. Please feel free to reach out with any questions.

Thank you,

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California Dental Association

c: Terri Hardy, Acting Executive Director
Little Hoover Commission