Department of Health Care Services
Little Hoover Commission Hearing: Medi-Cal Dental Services
March 22, 2018
State Capitol, Room 437

Utilization Rate

1. What is the current utilization rate for all Denti-Cal beneficiaries, ages 1-20? Please provide one number, or an explanation if multiple numbers are provided.

As of December 2017, based on the most recent published (Calendar Year (CY) 2016) Medi-Cal Dental Services Performance Measures for Fee-for-Service (FFS)[1] and Dental Managed Care (DMC)[2], the utilization rate for annual dental visits (ADV) for beneficiaries ages 0-20 is 44.5 percent and for ages 1-20 is 46.3 percent.

Dental utilization is measured by ADV, which is based on the ratio of eligible beneficiaries who had at least one dental visit[3] or at least one dental encounter at a Federally Qualified Health Center (FQHC)[4] within a one-year period. A beneficiary has to be continuously enrolled in the same dental plan for at least 90 days to be considered eligible.

Sixty Percent Goal

2. You have testified that you have chosen not to pursue a 60 percent utilization rate and instead are focusing on a far more modest increase to achieve a 47 percent utilization rate. However, representatives from the California Health and Human Services Agency have said that a 60 percent utilization rate is the program's goal. Please explain this discrepancy. Please provide DHCS documents stating this utilization goal and provide information to the Commission on specific steps the department is taking to reach it as well as any challenges DHCS sees in achieving that rate.

When DHCS met with the Little Hoover Commission in October, DHCS indicated a more modest immediate goal of 47.84 percent, which is identified in the Medi-Cal 2020 Waiver, Dental Transformation Initiative (DTI) Special Terms and Conditions (STCs). DHCS intends to build upon the utilization momentum of the DTI, but our focus of 47 percent for purposes of the DTI does not negate DHCS' desire to surpass this DTI utilization goal and achieve greater utilization. DHCS shares the goal of reaching 60

[1] Dental Fee-for-Service Performance Measures for Calendar Year 2016 as of December 2017
http://www.dhcs.ca.gov/services/Documents/MDSD/Fee%20For%20Service%20Performance%20Measures/FY_16-17_Q2_FFS_PM_report_SNC_update_with_data_source_and_query_date.xls
[2] Geographic Managed Care Plans Performance Measures for Calendar Year 2016 as of December 2017
http://www.dhcs.ca.gov/services/Documents/MDSD/Dental%20Managed%20Care%20Performance%20Measures/GMC_PM_Q2_12.27.17_v1_with_data_source_and_query_date.xls
Prepaid Health Plans Performance Measures for Calendar Year 2016 as of December 2017
http://www.dhcs.ca.gov/services/Documents/MDSD/Dental%20Managed%20Care%20Performance%20Measures/PHP_PM_Q2_12.27.17_v1_with_data_source_and_query_date.xls
[3] Current Dental Terminology (CDT) D0100 to D9999
[4] Current Procedural Terminology (CPT) 00003

percent annual utilization among Medi-Cal enrolled children, and is committed to using efforts authorized under state law and approved by the federal government to make progress toward that goal and beyond, as stated in the Medi-Cal Children's Dental Utilization Report to the Legislature released February 2018.

Current steps DHCS has taken include:

- Dental Transformation Initiative
  DHCS is committed to using efforts such as the Dental Transformation Initiative (DTI) to improve children's dental utilization in order to reach a 60 percent utilization rate and beyond. During CY 2016, DHCS performed a variety of outreach efforts to increase children's dental utilization and overall provider participation. A large part of this effort was focused on DTI targeting Medi-Cal children ages one through 20, with the goal of increasing preventive service utilization for this population by 10 percentage points across five years. The STCs require DHCS to prepare an awareness plan that describes (a) how DHCS has generated awareness of the availability of incentives for providing preventive dental services to children, including steps taken to increase awareness of the DTI among dental as well as primary care providers, and (b) how DHCS has generated awareness among enrollees of the availability of, the importance of, and how to access preventive dental services for children. The awareness plan was published in the DTI Annual Report released December 29, 2017. This report also provides additional details and updates on each of the projects, or domains, that are implemented as part of the DTI, including descriptions of how each domain is structured and how DHCS intends to evaluate each of these interventions.

- Beneficiary and Provider Outreach Plans (Fee for Service)
  With the recent separation of the 2004 dental Fiscal Intermediary (FI) contract into two contractors – a dental Administrative Services Organization (ASO) contract and a dental FI contract – the dental ASO has begun to increase focus on areas such as provider and beneficiary outreach to increase utilization. The ASO is tasked with raising awareness of the Medi-Cal Dental Program for covered beneficiaries to encourage them to fully utilize their Medi-Cal dental benefits. The ASO will analyze claim data and focus beneficiary outreach in identified underutilizing counties, and focus provider outreach efforts in counties with low provider participation, with the goal towards increasing access and reducing utilization barriers.

- Dental Managed Care
  One current effort in Sacramento is Early Smiles Sacramento (ESS), a collaboration between the DMC plans in Sacramento County and Center for Oral Health to increase children's utilization of preventive services. ESS performs screenings for children in area schools and at community events, and then connects the family with a local dental provider. ESS also provides training to primary care providers to integrate preventive dental care into well-child visits. Preliminary results from the ESS effort are as follows:

- 57 percent of the children were successfully navigated to a dental home and had a dental visit.
- 22 percent of eligible ESS children received dental sealants during their dental visit on at least one permanent molar.
- 35 percent of the children navigated by ESS received treatment for dental disease during their dental visit.
- ESS, conservatively calculated, can potentially increase the rate of ADV by 5.1 percent over 5 years.

➢ AB 97 (Committee on Budget, Chapter 3, Statutes of 2011) 10 percent Provider Payment Reduction Exemption (Dental Providers)
Effective June 24, 2015, the Budget Act of 2015 (AB 93, Weber, Chapter 10, Statutes of 2015) restored the 10 percent provider rate reduction for Medi-Cal dental providers.

➢ Proposition 56 – 40 Percent Supplemental Provider Payments
Last year's budget act, AB 120 (Ting, Chapter 22, Statutes of 2017, §3, Item 4260-101-3305), allocated funds for specific DHCS health care expenditures during state fiscal year 2017-18 and included up to $140M for supplemental payments on select dental services for providers who bill the Dental FI or DMC plans. The categories of dental services are restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, visits and diagnostics. Providers can receive a supplemental payment at a rate equal to 40 percent of the Dental Schedule of Maximum Allowances (SMA) for specified codes for dates of service during July 1, 2017- June 30, 2018. Payments to providers began in December 2017 retroactive to July 1, 2017. Payments through February 17, 2018, total approximately $55.6M. For more information on Proposition 56, please visit our dedicated webpage.

➢ Adult Dental Benefit Restoration
With the recent adult dental benefit restoration, effective January 1, 2018, DHCS is hopeful that access to these benefits, and outreach and education efforts associated with this benefit restoration, will have a residual impact on children's dental utilization as their parents are now able to seek additional dental benefits.

➢ Stakeholder Engagement
Additional DHCS efforts to increase utilization for children include ongoing work with stakeholders, such as the California Dental Association, California Primary Care Association, Dental Hygiene Committee of California, Sacramento District Dental Society, Medi-Cal Dental Advisory Committee, and Medi-Cal Dental Los Angeles Stakeholder groups, inclusive of children's advocacy groups – Children Now, First 5 California, The Children's Partnership and more.

DHCS believes our current program efforts, along with the DTI, Proposition 56 supplemental payments, adult dental restoration and utilization, and targeted outreach for beneficiary education and provider participation, will help DHCS achieve the desired impact of generating higher overall dental utilization among Medi-Cal children. These efforts remain a high priority for DHCS as it constantly seeks to improve services and promote patient-centered, coordinated care for Medi-Cal beneficiaries. DHCS acknowledges that improving child dental utilization has been challenging historically, but is committed to working with stakeholders, the Legislature, and the federal government to support policy that will assist DHCS in achieving the goal of 60 percent annual child dental utilization and beyond.

Legislative Report

3. **Please provide a copy of the Legislative Report due on October 1, 2017. If the report is not yet available, please provide an estimate of when it will be submitted and an explanation for the delay.**

We have included a copy of the report with this written testimony. It was provided to the Legislature on February 8, 2018 and has also been posted to the DHCS website here.

Enrollment Data

4. **How many dentists currently are enrolled in the Denti-Cal program and in which counties are they located? Please provide rates of provider enrollment over the last five years, including overall enrollment and enrollment by county. What is the specific goal for number or percentage increase for overall enrollment by the department? Does the department have specific numerical goals on increasing providers in particular geographic areas?**

Figure 1: Statewide Fee-For-Service Provider Enrollment – Last 5 Calendar Years

Fee-For-Service Providers CY 2013 through CY 2017 (approximate as of December 2017)						
	Category	**2013**	**2014**	**2015**	**2016**	**2017**
1	Billers	4,976	4,969	4,557	4,502	4,570
2	Service Offices	5,927	5,926	5,474	5,413	5,544
3	Total Unduplicated Renderers	15,420	15,709	15,832	10,771	9,865

**data from dental ASO, December 2017.*

Observations regarding Figure 1:

- Billing providers from 2013 to 2017 has decreased by approximately 8 percent, but has recently seen an uptick from 2016 to 2017 of 1.5 percent.

- Service office locations have declined by 6.5 percent in this five-year period, but have also seen an increase in the last year of 2.4 percent.
- Rendering providers have decreased significantly over the five year period; however, it is largely due to a focused revalidation record clean-up that occurred in 2016 and occurs annually thereafter, which removed rendering providers who had not revalidated and had no claim activity for the past 24 months.

Billers are enrolled dental providers that may have more than one service office location, and some billers may also have multiple rendering providers within a location. *Renderers* are dental providers enrolled under a billing provider and may render dental services at more than one service office location. Renderers may include dentists and allied dental professionals such as Registered Dental Hygienists or Registered Dental Hygienists in Alternative Practice.

Please see *Appendix 1: FFS Dental Provider enrollment by county for the last five years* for FFS provider enrollment by county for the same five year period – 2013-2017.

DHCS' specific goal for FFS statewide enrollment is to increase the number of actively participating Medi-Cal dentists who have provided at least one service in the calendar year by at least ten (10) percentage points over four years. DHCS also implemented a streamlined provider application, which has reduced new provider enrollment processing times and is intended to assist in increasing overall provider enrollment by reducing the administrative burden of participating in the program. Dental provider enrollment is performed by the ASO (Delta Dental) and as part of their contract, Delta Dental is required to increase the number of providers by 2.5 percentage points in the first contract year and by 2.5 percentage points in each of the first three contract extension years from Fiscal Year (FY) 2018-FY 2021.

In an effort to attain the above goals, DHCS and Delta Dental have implemented various FFS outreach and enrollment efforts to increase provider participation. These efforts include enrollment workshops, provider training seminars throughout the state, and presentations on Medi-Cal dental services in local communities. DHCS and the ASO also target providers in underserved areas within California and the border communities due to the absence or low number of Medi-Cal providers in those areas. While the ASO conducts outreach and enrollment activities statewide, it focuses on areas where the number of enrolled dental providers and/or facilities providing dental services to Medi-Cal beneficiaries is low in relation to the Medi-Cal population or sub-population in the area.

Provider Enrollment Process

5. **How have processing times changed since the department implemented the new provider application? Additionally, please describe the**

department's plans to develop a fully-online enrollment process for providers.

In January 2017, DHCS implemented a dental specific provider application, Form 5300, which reduced the Medi-Cal enrollment forms from four separate documents to one consolidated application form for both individual and group dental offices enrolling as new providers or for enrollment revalidation. With the implementation of the streamlined provider application, the application processing time has been reduced because the new applications are arriving with fewer errors and requiring less remediation from the providers. Assembly Bill 2207 (Wood, Chapter 613, Statutes of 2016) allowed DHCS to discontinue requiring providers to resubmit an enrollment application that has been deemed incomplete if the missing information is available elsewhere within the application packet.

In a comparison of a one-year period (October 2016-October 2017), the maximum provider enrollment processing timelines for both new and revalidation applications decreased from 99 days to 34 days and 324 days to 147 days, respectively – both well within the 180 day contractual processing requirement. New enrollment also more than doubled from 34 to 78 new applications.

Provider Application Approval Timeframes - New & Revalidation: From Date Received* to Enrollment

Month-Year	Total # New Apps	Shortest # Days to Enroll	Longest # Days to Enroll	Average # Days to Enroll	Total # Revalidation Apps	Shortest # Days to Re- Enroll	Longest # Days to Re-Enroll	Average # Days to Re-Enroll
October-16	34	3	99	19	37	3	324	64
October-17	78	4	34	14	10	5	147	41

*Note: date received = the date a complete application is received.

In the future, DHCS plans to expand the use of its recently implemented web-based provider enrollment application, the Provider Application and Validation for Enrollment (PAVE) system, to dental providers. PAVE is designed to simplify and accelerate the enrollment processes for Medi-Cal providers. PAVE is being rolled out in phases for various provider types to allow for outreach and training of the provider community and to ensure the system and application meet DHCS's business needs and each provider type that is integrated into the system. The streamlined provider application was designed with PAVE in mind to ensure fields were applicable in our paper process but also easily transferred into PAVE.

Treatment Authorization Requests Process

6. **Some dentists have described an overly burdensome approval process where X-rays are rejected and payment is denied causing delays in service authorization and delivery. What has the department done to investigate these processes to determine the impact on providers, and ultimately, patients?**

DHCS acknowledges that Treatment Authorization Requests (TARs) can at times create some delays to care or reimbursement; however, a TAR process is federally and statutorily required to demonstrate medical necessity and for utilization control for certain procedures. To minimize the burden on providers, DHCS only asks for the minimal number of radiographs in order to determine medical necessity. TARs are typically denied when the radiographs are lacking in diagnostic quality. Radiographs are vitally necessary and a requirement to determine the medical need for major procedures such as root canal treatment, laboratory processed crowns and scale and root planing. TARs and the accompanying supporting documentation are the vehicle for DHCS to make a determination of medical necessity for the proposed treatment plan and are designed to protect patients from having to undergo unnecessary or clinically inappropriate treatment.

Since 2015, DHCS has removed the TAR requirement for root canal treatment (RCT) for beneficiaries under the age of 21 or pregnant beneficiaries, as well as removed the arch film requirement (6 or more x-rays) for crowns if an RCT has been rendered within the previous 6 months.

In 2016, the dental fiscal intermediary was instructed to reduce the average TAR turnaround time from fifteen (15) to five (5) business days. DHCS informed providers about the turnaround time for TARs via a provider bulletin issued in September 2017, Volume 33, Number 10, page 18. Our records reflect a significant decrease in the turnaround time for TARs since we implemented these administrative changes. Please see the data displayed in Figures 2 and 3 below.

Figure 2 Dental Managed Care

	Access Dental Plan		Health Net Dental Plan		LIBERTY Dental Plan	
Month of 2017	Incoming TARs	Average Days Processed	Incoming TARs	Average Days Processed	Incoming TARs	Average Days Processed
January	571	2.09	3,079	1.4	2,016	1.48
February	614	1.41	3,291	2.14	2,189	2.22
March	642	1.44	3,914	1.64	2,654	1.62
April	564	1.21	3,378	1.69	2,325	1.71
May	608	1.40	3,810	2.21	2,604	2.27
June	526	1.37	3,608	1.77	2,540	1.86
July	540	1.43	3,432	1.79	2,319	1.74
August	611	1.39	3,927	1.68	2,736	1.66
September	515	1.30	3,493	1.41	2,390	1.35
October	590	1.52	3,949	2.15	2,671	2.12
November	470	1.62	3,787	2.52	2,538	2.75
December	385	1.15	3,241	1.4	2,282	1.52

Figure 3 Fee-For-Service (Delta Dental)

	Fee-for-Service	
Month of 2017	Incoming TARs	Average Days Processed
January	34,943	9.70
February	43,758	9.10
March	67,246	7.60
April	44,844	4.50
May	43,873	4.50
June	50,703	4.40
July	38,705	4.00
August	57,525	4.00
September	42,313	3.70
October	44,116	3.30
November	49,520	3.30
December	37,020	3.50

Advisory Input

7. **DHCS has opposed recommendations and legislative proposals to create an evidence-based advisory group for the Denti-Cal program, suggesting it is unnecessary because of existing stakeholder engagement efforts where DHCS seeks input, feedback, advice and recommendations from participants regarding barriers to access to care. Please provide specific examples of how the department integrates feedback from dental experts to ensure program policy and process decisions are based on the best evidence and science available.**

DHCS' Medi-Cal Dental Services Division employs two Dental Program Consultants who regularly participate in oral health events, national conferences, stakeholder convenings, completed continuing education to maintain their licenses, and also engage with ASO Dental Consultants to evaluate the best evidence and science when considering policy and process decisions.

Efforts to achieve the stated goals of the proposed Denti-Cal Advisory Group (oversee dental policy, increase utilization rates among children, and improve relationships with providers) are well underway in existing forums. DHCS provides and participates in ongoing opportunities for stakeholder engagement and advisory committees, including policy discussions on dental issues across the state which include, but are not limited to the:

- Medi-Cal Dental Advisory Committee held monthly in Sacramento County;
- Los Angeles Dental Stakeholder Meeting held every other month in Los Angeles County;
- DHCS Stakeholder Advisory Committee;
- Medi-Cal Children's Health Advisory Panel;
- California Department of Public Health's Oral Health Advisory Committee; and
- Stakeholder engagement webinar series and DTI workgroups.

In all of these forums, DHCS seeks input, feedback, advice, and recommendations from participants, particularly as it relates to barriers to access to care and increasing utilization of dental services. It is important to note that DHCS added a dental representative to the DHCS Stakeholder Advisory Committee as of the February 25, 2016 meeting based on stakeholder feedback and DHCS also engaged in extensive conversations with representatives of the Medi-Cal Children's Health Advisory Panel, discussing, over the course of several meetings, recommendations regarding the Medi-Cal dental program specific to the needs of children.

The participants in these groups include clinicians, advocacy groups, legislative and congressional staff members, beneficiaries, and other state agency staff with knowledge and expertise in evidence-based dental practice and scientific literature, who participate

without any form of compensation from the department. DHCS is deeply engaged in these efforts and is committed to remediating identified shortfalls.

DHCS also partners with the Department of Public Health Oral Health Program and various stakeholders, such as the California Dental Association, California Primary Care Association, and the Dental Hygiene Committee of California, to enhance beneficiary and provider awareness regarding eligibility, participation, and billing practices for the Medi-Cal dental program and associated initiatives.

Over the last few years, stakeholder feedback has helped guide DHCS in making improvements to the Medi-Cal Dental program by issuing policy guidance and clarity on coverage for pregnant women and the use of general anesthesia, streamlining dental provider enrollment, and reducing TAR timelines. DHCS also expanded the availability of dental data by including it in the California Health and Human Services Open Data Portal (https://data.chhs.ca.gov/) and developed a dedicated Medi-Cal Dental webpage (http://www.dhcs.ca.gov/services/Pages/MediCalDental.aspx), which provides useful information to the public. Also, as part of these various stakeholder meetings, DHCS provides ad hoc data and analysis for topics that have been requested to be discussed in these forums.

DTI Pilot Projects

8. **Are all pilots currently fully operational, including all agreements executed? If not, why not? Please provide information on performance metric established for each domain and how performance is being measured and reported. How will DHCS measure success for each domain?**

Under Domain 4 of the DTI, 13 of the 14 Local Dental Pilot Projects (LDPPs) have executed agreements, and the last agreement (Kern County) is expected to execute by March 2018, as Kern County has cited difficulties approving the final draft of its agreement. There were 15 LDPP applications selected to participate in this domain. However, Northern Valley Sierra Consortium notified DHCS on November 6, 2017, that it will not proceed with the grant opportunity due to unforeseen circumstances and natural disasters that forced it to reallocate county resources to address immediate needs.

The Medi-Cal 2020 Waiver's STCs outline the performance metrics established for each domain. DHCS will be responsible for reporting on data and quality measures to the Centers for Medicare and Medicaid Services on an annual basis in the demonstration annual report, as well as quarterly updates.

Domain 1 seeks to increase the use of preventive dental service utilization for children ages one (1) to twenty (20) by ten (10) percentage points over the five (5) year

demonstration period from the baseline year utilization rate of 37.84%. The performance metrics established for this domain to track and report information include: analyzing the percentage of beneficiaries who receive any preventive dental service during the measurement period, using claims data to determine the number of service office locations providing preventive services, and tracking the change in participation from dental providers. DHCS will measure performance in Domain 1 by evaluating the increase in utilization of children's preventive services throughout the State, while also analyzing the change in access to care, which will be measured by the number of active providers serving Denti-Cal patients in each county. DHCS will use the project results to aid in determining the effectiveness of provider incentive payments increasing provider participation in the Medi-Cal program, analyze changes in cost per capita, and ultimately to determine the effectiveness of the program overall.

Domain 2 seeks to assess caries risk and to manage the disease of caries using preventive services and non-invasive treatment approaches instead of more invasive and costly restorative procedures. DHCS will measure performance in Domain 2 by measuring the provision of Caries Risk Assessment (CRA) procedures, the impact to dental exams and the use of preventive services associated with this domain. DHCS will also monitor the effectiveness of treatments by tracking assessment movement from high risk to the lower risk categories or from the lower risk to standard treatment methods. DHCS will report on the number of incentive payments and the total amount expended by this domain, by county and age range. Additionally, DHCS will use the domain reporting metric results to determine if this provider incentive program is effective in encouraging providers to perform a CRA for the targeted population and to ensure completion of the appropriate treatment plan for the management of childhood caries, if the utilization of emergency room visits for dental issues among the targeted children declines, if expenditures of emergency room visits for non-traumatic dental issues among targeted children declines, and if the utilization of and expenditures (including anesthesia and facility fees) for the targeted children receiving dental related general anesthesia declines.

Domain 3 seeks to increase dental continuity of care for children enrolled in the Medi-Cal program, who receive annual dental exams from a dentist at the same service office location year after year. DHCS will measure performance in Domain 3 by tracking and measuring the number of children who receive preventive services performed by the same provider on a continuous annual basis for the duration of the DTI. The increase in continuity of care will be used to measure success in Domain 3.

Domain 4 seeks to increase dental prevention; caries risk assessment and disease management, and continuity of care among Medi-Cal children by LDPPs. The performance metrics for the Domain 4 LDPPs are based on one or more of the domains described above, as well as metrics delineated in their individual proposals. DHCS will evaluate each LDPP based on its individual project design, incorporating metrics from Domains 1-3 where applicable.

DHCS also published the DTI Annual Report for Program Year 1, which includes an evaluation and comparative analysis of preventive dental service utilization for children age 1-20 in CY 2014 and CY 2016.

Highlights include:

- Domain 1: Preventive service utilization for children ages 1-20 increased by 4.67 percentage points, bringing it from 37.80 percent in CY 2014 to 42.47 percent in CY 2016.

- Domain 3: From CY 2015 to CY 2016, across the 17 pilot counties, the percentage of children receiving continuity of care from the same service office location increased by 2.6 percentage points, bringing it from 12.2 percent to 14.8 percent.

- DHCS observed two positive results beyond the performance measures identified above. First, from CY 2014 to CY 2016 utilization of preventive services increased 7.46 percent in Domain 3 counties; and second, utilization of preventive services increased 3.74 percent in non-Domain 3 counties.

Stakeholder Input

9. **Given the goals of the Dental Transformation Initiative include increasing use of preventive services and increasing continuity of care for children, beyond allowing consumers to sign up for emails from the department, please describe how the DTI pilot projects are incorporating patient experiences and feedback from patients or parents of patients.**

The STCs require DHCS to obtain an independent contractor to conduct an evaluation of the DTI program. DHCS will contract with the evaluator to provide a multivariate analysis that employs appropriate comparisons and integrates administrative, survey, and qualitative data to assess the impact of DTI interventions on provider participation, service use, expenditures, continuity of care, and related outcomes. DHCS is in the process of securing an evaluation contractor to perform all evaluation activities. Medi-Cal beneficiary and dental provider surveys will be used to measure perceptions of quality of care. Surveys and interviews the evaluator will conduct include:

- A web-based survey of a statewide sample of Medi-Cal dental providers that can support descriptive and impact analyses. The intent is to sample 1,403 practices stratified by domain, with oversampling of Domain 2 and 3 practices. All providers would get questions relevant to Domain 1, with additional sections for questions relevant to Domains 2 and 3.
- A computer-assisted telephone interview survey with a sample of Medi-Cal beneficiaries in Domain 2 and 3 counties to learn about their experiences with

different aspects of the demonstration and their views on dental care. The intent is to sample 1,754 beneficiaries stratified by domain. We will compare beneficiaries served by Domain 2 opt-in providers versus others served by providers who do not opt in.

The intent of these surveys is to address multiple needs. For example, Medi-Cal beneficiary and dental provider surveys may include questions on access to care, quality of care, and/or whether provider incentive payments are an effective method to encourage service office locations to provide preventive dental services and continuity of care to more Medi-Cal children or enroll as a Medi-Cal dental provider.

In addition, for Domain 4, the majority of the LDPP pilots have a care coordination component, in which the pilot coordinator will provide outreach efforts to establish dental homes for their members. Coordinators will use various forms of data and member feedback to target their efforts to provide the greatest impact on their pilots.

Department of Health Care Services
Little Hoover Commission Hearing: Medi-Cal Dental Services
March 22, 2018
State Capitol, Room 437

Appendix 1: FFS Dental Provider enrollment by county for the last five years

County Name	Calendar Years				
	2013	2014	2015	2016	2017
Out of State	8	9	4	6	7
Alameda	733	665	322	272	268
Alpine	0	0	0	0	0
Amador	2	0	1	1	1
Butte	186	120	25	28	29
Calaveras	1	1	0	0	0
Colusa	1	1	2	2	2
Contra Costa	430	330	151	141	153
Del Norte	5	5	5	4	4
El Dorado	25	27	24	32	23
Fresno	548	248	248	212	217
Glenn	1	1	1	1	1
Humboldt	20	20	15	11	11
Imperial	70	72	38	29	30
Inyo	0	0	0	0	0
Kern	453	245	213	181	208
Kings	82	14	22	22	24
Lake	5	5	5	4	4
Lassen	3	3	2	2	1
Los Angeles	5,080	5,021	4,156	3,344	3,446
Madera	70	29	30	28	31
Marin	47	52	51	21	24
Mariposa	0	0	0	0	0
Mendocino	6	5	4	6	6
Merced	287	153	51	41	50
Modoc	2	2	2	2	2
Mono	3	1	0	0	0
Monterey	208	212	70	72	72
Napa	19	27	17	21	29
Nevada	17	16	6	5	4
Orange	1,866	1,900	1,612	1,167	1,238
Placer	81	55	58	54	59
Plumas	3	2	1	1	1
Riverside	1,383	1,336	1,047	629	678

Department of Health Care Services
Little Hoover Commission Hearing: Medi-Cal Dental Services
March 22, 2018
State Capitol, Room 437

County Name	Calendar Years				
	2013	2014	2015	2016	2017
Sacramento	739	420	310	220	223
San Benito	12	12	10	8	8
San Bernardino	1,358	1,256	910	738	782
San Diego	1,057	991	684	558	595
San Francisco	398	373	192	163	170
San Joaquin	580	341	176	147	172
San Luis Obispo	47	55	37	32	32
San Mateo	242	251	78	81	84
Santa Barbara	187	208	72	72	82
Santa Clara	722	682	465	417	433
Santa Cruz	97	109	64	36	35
Shasta	199	108	27	26	28
Sierra	0	0	0	0	0
Siskiyou	5	4	3	1	1
Solano	426	337	96	86	89
Sonoma	298	241	94	68	68
Stanislaus	462	371	139	122	135
Sutter	136	46	42	52	55
Tehama	3	2	1	1	1
Trinity	1	1	1	1	1
Tulare	284	137	136	116	129
Tuolumne	9	9	5	5	5
Ventura	481	419	345	244	261
Yolo	48	47	28	27	28
Yuba	0	0	0	0	0