



November 8, 2017

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

Terri Hardy, Associate Executive Director
Little Hoover Commission
925 L Street, Suite 805
Sacramento, CA 95814

Dear Ms. Hardy and Chairman Nava,

During the public comment period of the Little Hoover Commission's October 26, 2017 business meeting you and your fellow commissioners expressed interest in learning more about the California Dental Association's (CDA) current thoughts on the status of the Denti-Cal program. Prior to the commission's release of the *Fixing Denti-Cal* report (April 2016), CDA provided comments at various hearings (2015) expressing concerns regarding Medicaid beneficiary access to dental care and the three elements which needed to be addressed in order to increase provider participation in the Denti-Cal program. These elements included enhancing the reimbursement rates, reducing the administrative burdens for obtaining authorization and payment of services, and streamlining the provider enrollment/re-certification process.

Since the Commission's 2015 hearings and the subsequent report released in 2016, there have been several changes and new initiatives in the Denti-Cal program, outlined below. It is too early to say whether these efforts have or will drastically improve the program, but each of these changes demonstrates a heightened awareness of Denti-Cal beneficiaries' challenges accessing dental care, while also recognizing the importance of oral health to beneficiaries' overall health. CDA is hopeful that these programmatic improvements may ultimately result in a program that better serves the oral health of California's 13.5 million Denti-Cal beneficiaries.

The Dental Transformation Initiative (DTI)

Approved in late 2015, as part of California's 1115 Waiver from CMS, 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, there is a fourth domain that provides funding for 15 local pilot projects that 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 the Department of Health Care Services (DHCS) over the past 18 months and participates in regular DTI stakeholder meetings, provides feedback to the department on development of documents, 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 Caries Risk Assessment Pilot which helps train dentists in best practices for treating young children (Domain 2). Providers who take this free online course learn behavior management techniques that potentially alleviate the need to treat many children using forms of sedation and anesthesia that are often provided in more expensive health care settings such as surgery centers and hospitals.

CDA has clearly stated that the department must ensure that the DTI dollars are spent on improvements that are both measurable and sustainable. Currently there are no publicly available data to determine 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 is anticipated for release by DHCS at the end of 2017 (per the Medi-Cal 2020 1115 Waiver Special Terms and Conditions approved by CMS). This 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.

The addition of \$750 million over five years represents a tremendous investment in the Denti-Cal program, but a great amount of work and continued implementation is still required. CDA is eager to see what the data from the first year will show, but acknowledges that this is a 5-year study and will be looking forward to the development of the data over time as well.

Proposition 56: Tobacco Tax

One of the key issues that CDA has expressed concerns about is the critically low reimbursement rates of Denti-Cal. Research in several states during the past decade has illustrated that Medicaid reforms, coupled with improved reimbursement rates, are directly tied to dentists' ability to participate in the Medicaid program and substantial increases in access to dental care for enrollees. Further, in your report, the commission recommended "state government, funders and non-profits should lead a sustained statewide 'game changer' to reorient the oral health care system for Denti-Cal beneficiaries toward preventative care". To that end, CDA co-sponsored the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), which raised the state's tobacco tax by \$2 per pack and was approved by an overwhelming majority of voters in the state. This revenue was intended to decrease healthcare costs to the state through prevention of smoking related chronic diseases and improve access to Medi-Cal patients through provider rate increases.

The initiative also included a \$30 million ongoing allocation to the state dental director's office; funding that will serve as a "game changer" for oral public health. 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 expanding the state oral health program, 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 will be allocated to local health departments or jurisdictions.

After extensive negotiation between the Legislature and the Governor in early 2017, the state budget for 2017-2018 included an initial state allocation of \$140 million of the tobacco tax income for increased Denti-Cal provider reimbursement, with the potential for more in future budget years. With federal matching funds, this could represent a groundbreaking total of nearly \$400 million investment in Denti-Cal provider reimbursements in the 2017-2018 budget year.

In September, DHCS submitted a proposed State Plan Amendment (SPA) to CMS that proposes to augment the Denti-Cal rates with a 40% supplemental payment on hundreds of procedure codes. If approved by CMS, this investment in Denti-Cal will represent the first significant increase in provider reimbursement in decades. The Prop 56 funds have not yet been distributed; however, DHCS has estimated that CMS approval will be granted late 2017 and providers will start receiving supplemental payments in January 2018. CDA has expressed concerns to the Legislature and the Department about the timing of the program implementation and an increased need for transparency and stakeholder engagement in future Prop 56 program years (please see our attached comment letter on Prop 56).

Restoration of Adult Dental Benefits

In addition to the allocation of Proposition 56 funds to improve reimbursement for Medi-Cal providers, the state budget for 2017-18 included the full restoration of adult dental benefits for beneficiaries beginning in January of 2018. Previously eliminated in 2009 due to the state budget crisis, partial adult dental benefits were restored in May 2014. The restoration of the full adult dental benefit package presents an opportunity to further improve the oral health of the 7 million Denti-Cal enrolled adults throughout the state. The 40 percent rate supplements from Proposition 56 revenue will also apply to some of the newly restored adult benefits, such as endodontics, prosthodontics and oral surgery.

This benefit restoration is also dependent on CMS approval, which can take 90 days or longer to be processed. Although the budget was passed and signed in June 2017, at the time of this writing the Department has not yet formally submitted the SPA to request federal approval of the adult benefit restoration. CDA believes that the restoration of the additional benefits will

provide another opportunity to improve the Denti-Cal program, but has concerns that the delayed implementation prolongs the will of the Legislature and Governor.

Administrative Improvements and Data Transparency

In addition to the reimbursement and benefit issues noted, 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 reducing the length of time it takes for the department to process those applications. Last year, we provided feedback to the Department 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.

The department implemented the new streamlined Denti-Cal provider application in early 2017. CDA appreciates this incremental step toward reducing the administrative burden to enroll dentists as Denti-Cal providers. According to DHCS these two changes have reduced the average new provider enrollment application processing time to approximately 30 days. To date, the department has not released any data to validate whether this change has resulted in an increased number of new enrolled providers.

Over the course of this past year, DHCS has also 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.

CDA conveys information about changes in the Denti-Cal program regularly to our 27,000 member dentists utilizing multiple channels: print (*CDA Update*), email (regional and statewide e-newsletters), live presentations (*CDA Presents*, component dental society meetings), etc.

CDA remains concerned with many aspects of the administration of the Denti-Cal program. In addition to near-term concerns about implementation of Prop 56 and adult dental benefit restoration, CDA will continue to suggest improvements to the program regarding improved reimbursement rates, the scope of the oral health benefit package, and reducing burdensome authorization and payment policies. Additionally, as of the writing of this letter, the Department had not yet released the annual Medi-Cal Dental Services Rate Review for 2016, which provides a comparison California's Medi-Cal dental reimbursements rates against other Medicaid programs in the country, in addition to the commercial rates from five different geographic regions around the nation. The rate review also provides an updated number of providers participating in the Denti-Cal program. Without this data, it is difficult to say whether the recent efforts and initiatives are encouraging more providers to participate. In the long-term, CDA would like to see program reforms that utilize healthcare quality metrics and a

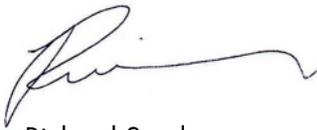
data-driven system that prioritizes prevention of disease and improvement of overall health of the population.

Despite these concerns and desire for additional data, 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 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. 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 shares the commission's interest in monitoring developments made by DHCS to improve access to dental care. Please consider CDA a partner and resource as the commission continues to evaluate Denti-Cal program improvements.

Please feel free to contact me with any further questions. I may be reached at 916.554.4905 or via email at Richard.Stapler@cda.org.

Thank you,



Richard Stapler
Vice President, Public Affairs
California Dental Association

Attachments

c: Carole D'Elia, Executive Director
Little Hoover Commission



Testimony of the California Dental Association for the
Little Hoover Commission Hearing on Denti-Cal on September 24, 2015

The California Dental Association (CDA) is pleased that the Little Hoover Commission is evaluating the operations and outcomes of the state's Denti-Cal program. As an engaged stakeholder in the Denti-Cal program on behalf of our members and their patients, CDA is very interested in seeing program improvements which will enhance access to oral health care for the millions of children and adults who are Denti-Cal beneficiaries.

Dental disease is one of the most common childhood illnesses in the United States. While it is easily treatable when children have access to dental care, it is more prevalent than asthma and obesity combined, can lead to other medical conditions such as ear and sinus infections and affects school attendance and performance. Children with poor oral health are nearly three times more likely than their counterparts to miss school as a result of dental pain and California students miss an estimated 874,000 school days annually due to dental problems. Additionally, it greatly affects the overall health and employability of adults and can have detrimental impacts on effectively treating older adults with chronic illnesses.

Denti-Cal is a small fraction (about 1 percent) of the overall budget for the Medi-Cal program, but oral health has a tremendous impact on Medi-Cal beneficiaries' overall health, and we appreciate the focus on it today.

There are now over 12 million Medi-Cal beneficiaries with dental benefits in California. As pointed out in the State Auditor's report of December 2014, less than half of the children enrolled in the Denti-Cal program in 2013 were able to access basic dental care. Recent estimates from the Department of Health Care Services (DHCS) indicate that only one in four adults enrolled in the Denti-Cal program

accessed any dental treatment during 2014 once adult benefits were partially restored.

Addressing the deficiencies of this complicated program will take a multi-faceted approach. We talk about it as a three-legged stool: Reimbursement rates, provider network improvements, and administrative barriers in the program.

These three elements include targeted provider reimbursement increases coupled with programmatic improvements in treatment delivery, streamlining the time-consuming and overly burdensome provider enrollment process and finally, simplifying the complicated administrative hurdles needed for reimbursement of covered services. Addressing all three of these issues would result in more dentists able to participate in the network, therefore improving access to care for beneficiaries.

Reimbursement Rates

The Medi-Cal Dental Services Rate Review Report released by the department in July found that California's 2014 reimbursement rates for the 25 most common Medicaid dental services were well below those in the comparable states of New York, Texas and Florida. Additionally, the review states that California's Denti-Cal

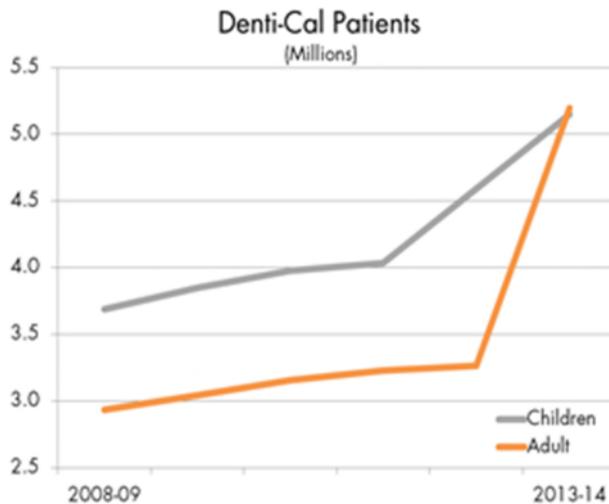


How CA rates compare to other states & commercial average

reimbursement rates are only 31 percent of the national average for commercial insurance.

These exceptionally low reimbursement rates come at a time when the number of people who are covered by the Medi-Cal program is growing exponentially. Since

2008, there has been a 77 percent increase in the number of adults enrolled and a 40 percent increase in children enrolled as a result of the Medi-Cal eligibility expansion, the Healthy Families transition and the partial restoration of adult benefits. Meanwhile, the number of dentists participating in the Denti-Cal program has dropped by nearly 15 percent during that time.



Documented experiences in several states during the past decade have illustrated that Medicaid reforms, coupled with improved reimbursement rates, are directly tied to dentists' ability to participate in the Medicaid program and substantially increased access to dental care for enrollees.

Increasing reimbursement rates to providers has led to increases in utilization and provider network size in a number of other states. Maryland provided targeted rate increases and saw a rise in the number of children receiving access to dental care from 44 percent to 64 percent. The state also saw a 62 percent increase in provider participation. Similarly, Virginia increased its provider rates by 28 percent and the percentage of children accessing dental services increased from 24 percent to 56 percent. Virginia also saw a 145 percent rise in dentists participating in the network.

Recent analysis by the state and other entities indicate that this is true of California dentists as well. Dentists indicated they would be more inclined to either begin participating as a Denti-Cal provider or increase the number of Denti-Cal patients treated in their practices if reimbursement rates were increased.

While the reversal of the AB 97 10 percent rate reduction as approved in the 2015-16 state budget is an important first step in rebuilding Denti-Cal, as noted in recent

reports from the department, a great amount of work remains to ensure access to care for California's beneficiaries.

Targeted Program Improvements with Provider Incentives

CDA believes it is necessary to make substantive program improvements to ensure access to high quality dental care for California's beneficiaries. Targeted program improvements and rate increases that would incentivize providers to join the Denti-Cal network and the provision of cost-effective preventive services to young children and older adults can lead to great success.

Focused changes should improve access to prevention and basic dental care treatment services for at-risk children by implementing a proven program that targets care to that population and provides enhanced reimbursement rates for key services.

In the Access to Baby and Child Dentistry (ABCD) program in Washington State and the Healthy Kids Healthy Teeth program in Alameda County, Medicaid works with community agencies, like Head Start and WIC, to refer children age 0 to 5 to dentists who are certified participants in the program and, therefore, receive an enhanced reimbursement rate for certain prevention and basic treatment services.

Implemented statewide, local community health workers would be used to identify vulnerable children enrolled in the Medicaid program less than five years old, and link to a network of dental providers who are uniquely trained to treat these younger and more difficult-to-treat beneficiaries.

By augmenting current reimbursement rates for certain key services, which include cleanings, fluoride application and basic restorations, when provided by a select group of providers uniquely trained to care for very young children, the state can begin to transform its program to one that improves access to important treatment, sets children up for a lifetime of better oral health and improves access to care by encouraging provider participation in the program. This program design has a

proven record of increased access to care, improved oral health outcomes, recruitment of dentists to the program and reduced per capita costs to the state.

To incentivize providers to enroll and serve this population, the state should provide an enhanced reimbursement to dentists who either: (1) enroll and participate in a California version of the ABCD training program; (2) complete training in a streamlined Pediatric Oral Health Access Program (POHAP®) or (3) are board- certified pediatric dentists.

Additionally, the state will have to take action to authorize and reimburse for one of the services instrumental in the success of this program: Family Oral Health Counseling. Family oral health education allows the dental practitioner to provide a comprehensive counseling session to parents and children on the need and best methods for ensuring good oral health. This consultation includes education as well as demonstrations to parents of proper hygiene techniques, dietary consultation, and fluoride supplement prescriptions, if appropriate. It is essential to provide education about the value and methods for establishing a proper oral hygiene routine for children early in life to help ensure the development of strong and healthy teeth. Parents, as consistent role models, are key to setting a daily routine and making children understand the importance of good oral hygiene. This is a foundational element of this program's success.

To accomplish the goal of implementing this innovative care model, some programmatic changes and additional support are needed within the Department of Public Health.

Training to Increase Pediatric Dental Workforce

As referenced previously, the POHAP® helps expand the network of general dentists trained to treat young children. This can improve access to care for the youngest beneficiaries, creating a lifetime of improved oral health while increasing long-term savings for the state. Funding through the Oral Health Program in the

Department of Public Health could provide this training to 1,000 general dentists a year to increase dentist capacity and encourage participation in the proposed California ABCD program. In addition to the long-term cost savings of providing preventive care for children, it should be considered as part of the fiscal analysis that general dentists who participate in the POHAP® training will be trained in child behavior management techniques that could alleviate the need to treat as many children using different forms of sedation and anesthesia, including general anesthesia in more expensive health care settings such as surgery centers and hospitals.

Invest in care coordinators/community outreach workers dedicated to dental beneficiary and provider engagement

Proven successful in similar programs, having public health staff at the local level dedicated to identifying and supporting beneficiaries' access to dental care and informing and recruiting dentists to join the program's network of providers is a critical and much needed addition to California's oral health system of care. A dedicated staff person in each county's Children's Health and Disability Prevention (CHDP) Program could be charged with:

- Conducting an aggressive outreach campaign to recruit families of children ages 0-5 in Medicaid into the ABCD-like program;
- Orienting enrollees on dental treatment expectations and responsibilities, helping to resolve barriers to access (addressing missed patient appointments, informing beneficiaries of transportation policies), and providing case management services, including linking families with participating providers; and
- Recruiting dental providers into the program and linking them to educational components on child management, caries risk assessment, family education, and use of preventive treatments.

Building upon the readily available infrastructure in local CDHP programs is an efficient way to effectively provide the support both families and providers need to ensure the program's success.

Expanding Access through Virtual Dental Homes

Leveraging teledentistry programs will help address the state's need to provide more comprehensive care in rural and underserved areas effectively and efficiently, particularly the older adult population and school-aged youth.

The Virtual Dental Home (VDH) model allows dental hygienists in community settings (e.g., community clinics, nursing homes, preschools) to provide basic care for patients under the direction of a dentist using tele-health technology. A VDH grant program using public and private funds would expand the model into the state's greatest areas of need. One-time funding of several million dollars phased in over three years would provide start-up elements such as training, equipment and technical support to help advance the VDH model in underserved areas.

Dental School Clinic Support

There are six dental schools in California. Dental school clinics represent a win-win endeavor for Denti-Cal, as the Denti-Cal patient population looks to the universities as reliable sources for quality care and provides future dentists with a broad scope of experience in a high volume setting to refine their skills and develop a social awareness of the needs the Medicaid population. Operating a dental school clinic carries the burden of additional costs that come with educating students and necessary faculty oversight of treatment, but the clinics also bring significant value to the community and patients they serve. The lack of adequate Denti-Cal reimbursement is creating a financial hardship for dental school clinics which can affect tuition costs result in students shouldering the burden with increased student loan debt to offset the costs of providing care to Denti-Cal beneficiaries in the

community. Dental schools should be carved out of the Denti-Cal fee schedule and reimbursed at rates established for the pre-doctoral clinics.

Provider Incentives

In addition to the work noted above that can be done through the state budget and administrative processes, the administration is in the midst of negotiating a Medicaid waiver with the federal government and there are opportunities to make some critical changes to the program.

One example of program enhancements the state should explore includes provider incentive programs similar to one recently approved for Colorado's Medicaid dental program. To increase provider participation in the state's dental program, Colorado Medicaid includes supplemental incentive payments to providers who either increase the number of Denti-Cal patients in their practice or begin participating as Denti-Cal providers. Colorado's Medicaid recently received Centers for Medicare and Medicaid Services (CMS) approval for a state plan amendment that will pay qualifying dentists supplemental Medicaid payments upon providing two services to a new Medicaid patient receiving dental services for the first time. New and existing dental providers will be eligible for the supplemental payment, which could earn any single dentist a maximum performance payment of \$3,000.

Provider Network Engagement

To ensure patients have accurate information about the dentists who are part of the provider network and there is a sufficient network of providers able to see patients, the state needs to ensure it has accurate information regarding the number of providers and capacity of those providers, as well as simplify its enrollment process. This is the second leg of the stool.

Accurate Provider Network Information

It has been well documented in several legislative hearings that the department's referral list of Denti-Cal providers is woefully out of date. This creates time-

consuming and frustrating barriers to care for patients with coverage who are trying to see a dentist. The department needs to determine which providers in their network are active, taking new patients, and how many Denti-Cal patients the dentists on the state's list can see. This will tell them how many patient appointments are actually available each month on a county-by-county basis. Without this, we do not have a true handle on what access to care actually looks like for dental patients.

Provider Enrollment

The provider enrollment and recertification process should not be so complex that it acts as a barrier by dissuading provider participation. The current process takes many hours, requires the submission of a lengthy paper application, and in most cases over 40 pages of attachments. The form is also designed for all health care providers and some of the questions may not apply to the dentist and when not answered completely can be rejected. One requirement of the form includes a copy of the original building lease agreement for the provider's dental practice, including all modifications. In one example CDA brought to the department's attention last year, a provider who had been serving Denti-Cal patients for more than 40 years in the same location had to renew his enrollment. His lease document and all modifications over the 40 years amounted to 26 pages that this long-standing Denti-Cal provider had to copy and fax to the department. There must be a better, more efficient way for the state to affirm a providers' operating location. We are aware of re-enrollments that have taken several months or even up to a year. The state needs to more efficiently and effectively work with its network and potential network of providers on enrolling in the program if we want a robust network and real access to care for patients.

Administrative Efficiencies

While reimbursement rates and network support plays a critical role in enhancing provider participation, reducing burdensome administrative processes is the third leg of the three-legged stool.

The system and extensive paperwork that providers must go through to obtain reimbursement for the care they provide is exceptionally time-consuming and cumbersome. There are rules and processes in the state's program that do not exist within the commercial coverage system, which make it more difficult for dentists to incorporate Denti-Cal services into the rest of their practice. We hear from members that ambiguous criteria, delayed payments, inconsistent treatment authorizations and extensive documentation requirements provide additional barriers to provider participation in the program. Dentists have expressed dissatisfaction with the Medi-Cal program's increasingly more complicated processes and feel they are left without an engaged partner in the department to address these issues. Additionally, dentists have expressed the notion that the Denti-Cal administrators do not respect their professional judgment regarding patient care, creating a lack of positive provider sentiment in the program.

CDA and our members welcome the opportunity to work with new leadership within the department to address these kinds of concerns held by their dental providers. Addressing administrative barriers is an essential element to ensure increased access to care for beneficiaries.

Conclusion

When you have a system of care that provides needed dental treatment to less than half of the children who are eligible for services and when studies show that the number of dental-related emergency room visits for adults continues to increase, it is clearly a serious problem that needs multiple strategies to address it.

This will take program improvements like streamlining the enrollment process and reducing the administrative burdens facing providers, and there is significant evidence available that the low provider rates are part of the access crisis.

We strongly encourage the state to provide additional resources for investments in the program and focus attention on developing program improvements. With smart investments of both time and money, the state can ensure an adequate network of providers are available to treat Denti-Cal beneficiaries.

We look forward to working with the Little Hoover Commission, the administration, and the legislature to continue the process of addressing these serious issues.



February 1, 2016

Pedro Nava, Chairman
The Little Hoover Commission
925 L Street, Suite 805
Sacramento, CA 95814

SUBJECT: Denti-Cal

Dear Mr. Nava,

The 1115 Waiver that California signed with the Center for Medicaid and Medicare Solutions (CMS) at the end of last year provides an important investment and opportunity to improve Denti-Cal, but does not address all the issues that CDA and other advocates have raised about the problems facing the program.

The \$6.2 billion Waiver provides the state with \$740 million over five years for a Dental Transformation Initiative within Denti-Cal, with another possible \$10 million if the state hits certain utilization goals. It focuses on providing incentives for services to children in three categories: early prevention, caries risk assessment and disease management, and continuity of care. There is also a fourth category for local pilot projects, with money going to entities that address one of the three domains through alternative programs.

CDA is excited for the opportunities to improve Denti-Cal made available through the Waiver and is focused on what must be accomplished to ensure the additional funding supports sustainable program improvements. To that end, we suggest several areas where improvements are still needed and the Little Hoover Commission recommendations could focus:

1) Accountability in increased utilization and improved health outcomes:

- The waiver provides significant dollars for a 5-year period and it is uncertain whether the state will continue to get federal money for these services after the waiver expires. Evaluation is needed in order to determine effective programmatic strategies; to redirect spending during the Waiver period to maximize benefit and determine what programs should be continued after the 5-years. This provides the opportunity for ongoing information gathering and evaluation in order to change direction as needed.
- To do this, the state needs data collection and reporting capability beyond Denti-Cal's current system, which collects only utilization and dollars spent. To effectively measure oral health outcomes and program impact, a continuous, comprehensive state oral health surveillance system must be developed.

2) Denti-Cal problems that the Waiver does not address:

- Administrative burdens and complex, inefficient enrollment procedures: both remain significant barriers to dentist participation and retention in the Denti-Cal program. CDA has stressed the critical "three

legged stool” of rates, administrative burdens, and provider enrollment; and reforms in other states have shown success with streamlining these functions without reducing program oversight or experiencing increased fraud. Additionally, the Waiver does not address provider relations, including lack of communication and engagement with dental providers and out of date provider network information.

- Incentives for new dentists: the Waiver does not provide a stimulus for dentists to enroll and start serving the Denti-Cal population, as new and current Denti-Cal providers will receive Waiver incentive payments in the same way. Without targeted outreach and incentive, CDA is concerned that the program will have limited success attracting new dentists and whatever gains are realized will be primarily within the existing provider network.
- Dental School Clinics: dental school clinics represent a win-win endeavor for Denti-Cal, as the Denti-Cal patient population looks to the universities as reliable sources for quality care and provides future dentists with a broad scope of experience. These clinics carry the additional burden of educating students, and the lack of adequate reimbursement creates hardship both for schools seeing Denti-Cal patients and for dental students whose tuition offsets the cost of providing care at a loss. The state should explore new funding models that provide increased funding for dental school clinic care.

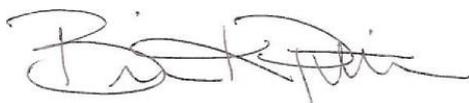
3) Proven programs that warrant additional attention:

- ABCD (Access to Baby and Child Dentistry) program: the ABCD program has successfully increased dental visits for very young children in Washington State and has been effective as well in Alameda County (Healthy Kids, Healthy Teeth). The program provides increased reimbursement as part of a package that includes additional pediatric/behavior management training for dentists, oral health counseling for families and care coordinators/ community outreach workers for beneficiary and provider engagement. While the Waiver dollars include some increased prevention reimbursement, there is no structure or funding for the other essential parts of the program.
- Virtual Dental Home: telehealth options for linking patients in community settings with comprehensive care should continue to be explored.

The 1115 Waiver presents California with an important opportunity to explore new incentives and payment structures in order to expand access to care for children in Denti-Cal. The state must ensure that the Waiver dollars are spent on improvements that are both measurable and sustainable. Further, despite the significant investment in the Waiver, barriers to care will still exist for Denti-Cal enrollees and the state must explore additional strategies to address them.

Thank you for your consideration of these issues, and we look forward to working with the Little Hoover Commission, the governor, and the legislature to address the serious issues facing the Denti-Cal program.

Sincerely,



Brianna Pittman
Legislative Director



August 3, 2017

Department of Health Care Services
Attn: Director's Office
P.O. 997413, MS 0000
Sacramento, CA 95899-7413

Dear Director Kent,

On behalf of our 27,000 member dentists, the California Dental Association (CDA) appreciates the opportunity to provide comment on the "Proposed One-Year Supplemental Payment for Certain Dental Services Using Proposition 56 Tobacco Tax Funds Allocated for the 2017-2018 State Fiscal Year". CDA is pleased with the momentous investment in the Denti-Cal program resulting from the Proposition 56 tobacco tax revenue (Prop 56). The investment of \$140 million (Healthcare Treatment Fund) along with applicable federal funds, represents the largest shift in reimbursement rates for Denti-Cal since 1992.

CDA applauds DHCS for its due diligence in swiftly proceeding with development of the State Plan Amendment to ensure the timely goals of providing increased patient access and provider supplemental payment for 2017-18. Prior to January, CDA seeks DHCS engagement in a stakeholder process to collaborate on data points related to the supplemental payments, including its potential impact on Medi-Cal beneficiaries and the sustainability of provider participation. This would also provide increased transparency and assist in any evaluations. Further, CDA believes discussion would facilitate our mutual overall goal to improve the Denti-Cal Program.

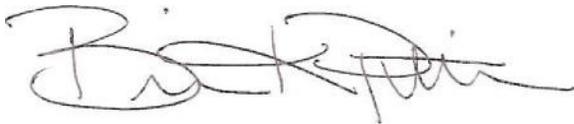
Prevention, especially for children, is at the core of effectively managing dental disease and reducing the cost burden of severe conditions. While incentivizing prevention should always be a high priority, we recognize that additional investment in those services at this time would potentially cloud the analysis of data being collected in the innovative Dental Transformation Initiative (DTI). However, since the DTI is a limited-term program, we encourage the department to consider adding preventive dental services across the lifespan to the Prop 56 supplemental payment program in the future.

CDA also appreciates the full restoration of the adult dental benefit package. In particular, 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. We understand that the department lacks current data on the unmet need and potential utilization of periodontal benefits at this time, and has chosen not to apply supplemental payments under Prop 56. However, given the importance of periodontal care and the potential long-term cost savings to the state, we encourage the DHCS to consider supplemental payments for periodontal services in future program years.

CDA looks forward to continuing to work with the Department to ensure the Prop 56 supplemental payments are implemented as smoothly as possible. As always, we want to support your efforts to optimize the Denti-Cal program through ongoing evaluation of benefit utilization and reimbursement policies. Please do not hesitate to contact either Ann Milar (Ann.Milar@cda.org) or me (Brianna.Pittman@cda.org) with any questions or concerns regarding our comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Brianna Pittman". The signature is fluid and cursive, with a large initial "B" and a long, sweeping underline.

Brianna Pittman
Legislative Director
California Dental Association