Fixing Denti-Cal

REPORT #230, April 2016

LITTLE HOOVER COMMISSION

DEDICATED TO PROMOTING ECONOMY AND EFFICIENCY IN CALIFORNIA STATE GOVERNMENT

To Promote Economy and Efficiency

The Little Hoover Commission, formally known as the Milton Marks "Little Hoover" Commission on California State Government Organization and Economy, is an independent state oversight agency.

By statute, the Commission is a bipartisan board composed of five public members appointed by the governor, four public members appointed by the Legislature, two senators and two assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

Contacting the Commission

All correspondence should be addressed to the Commission Office:

Little Hoover Commission
925 L Street, Suite 805,
Sacramento, CA 95814
(916) 445-2125
littlehoover@lhc.ca.gov

This report is available from the Commission's website at www.lhc.ca.gov.

Letter from the Chair

April 1, 2016

The Honorable Kevin de León
President pro Tempore of the Senate
and members of the Senate

The Honorable Jean Fuller
Senate Minority Leader

The Honorable Anthony Rendon
Speaker of the Assembly
and members of the Assembly

The Honorable Chad Mayes
Assembly Minority Leader

Dear Governor and Members of the Legislature:

A silent, hidden epidemic of tooth decay and disease is ravaging California, endangering the overall health of millions of residents and overpowering the state administrative machinery assigned to contain it. Enduring the worst of this epidemic and its larger associations with pregnancy risks, diabetes and respiratory and heart disease is a large, growing population with limited means – a third of the state's population and half of its children – that desperately needs government-provided healthcare that works. Yet Denti-Cal, California's Medicaid dental program, is widely viewed, historically, and currently, as broken, bureaucratically rigid and unable to deliver the quality of dental care most other Californians enjoy.

With dreadful reimbursement rates for dentists and slow, outdated paper-based administrative and billing processes that compare poorly with those of commercial insurers, Denti-Cal has thoroughly alienated its partners in the dental profession. Most California dentists want nothing to do with Denti-Cal and consequently, more than 13 million people eligible for coverage have few places to use their benefits. Eleven of California's 58 counties have no Denti-Cal providers at all or no providers willing to accept new patients covered by Denti-Cal, states a 2014 report by the California State Auditor. Only about half of Denti-Cal-eligible children see a dentist annually, in comparison to two-thirds of commercially-insured children.

This breakdown of professional relationships between state government and the dental community has sentenced millions of Californians to difficult, sometimes impossible, searches for nearby dental care. Many who do find dentists face complicated cross-town bus trips with children or lengthy rural drives in undependable cars. Hit especially hard are parents of special-needs children who find few dentists or dental surgeons willing to see their children. The system is so troubled that the director of a Long Beach children's clinic asked the Commission to consider a "nuclear option" that abolishes the Denti-Cal bureaucracy entirely – and gives families smart cards loaded annually with $500 to take to any dentist in California. Denti-Cal is so unsatisfying that civil rights groups have filed a civil rights complaint with the federal government alleging that the Medi-Cal health care delivery system, which includes Denti-Cal, effectively discriminates against 7.3 million California Latinos by providing them a separate, unequal level of care in comparison with others.

It would be easy to simply blame administrative staff within the Department of Health Care Services and its Denti-Cal division, but blame goes so much deeper. Successive legislatures and administrations have underfunded the Denti-Cal program and slashed reimbursement rates for dental providers to national lows. The state has historically lacked any strategy to prevent dental disease among its neediest populations. Major funders have apparently given up in the face of a problem that appears intractable. Californians, collectively, have turned a blind eye to containing a health emergency that is entirely preventable, yet sends too many people to expensive emergency rooms and costs school districts and employers millions of dollars in absences.

Fortunately, a few haven't given up. The Commission found reason for hope in an emerging consensus for fixing Denti-Cal's shortcomings among children's advocates, dental colleges, professional associations and the state itself. The Commission learned about novel, promising approaches in Alameda and Amador counties, and in Washington State, which could be rolled out statewide in California. It heard about successful pilot programs that take digital cameras, laptop computers and hand-held X-ray machines into community settings such as schools, clinics and neighborhood centers instead of waiting for people to come to a dentist's office.

None of these involve big, costly, across-the-board hikes in reimbursement rates to attract a few more Denti-Cal providers. Instead, they offer smaller targeted incentives to boost preventative care, and more importantly, reorient Denti-Cal toward prevention. Presently, Denti-Cal spends just 14 percent of its $1.3 billion budget on the preventative checkups that people with commercial insurance take for granted. The other 86 percent pays dentists to drill, fill, cap and extract – a formula that dooms Denti-Cal to a state of constant emergency and perennially being hauled before the Legislature to explain its inability to keep up with demand.

After concluding its study process in November 2015, the Commission learned the federal and state governments have jointly negotiated a five-year $740 million targeted incentive program to spur more dentists to offer preventative care to children. The Commission also learned of the scheduled June 2016 release of a 10-year prevention-focused state oral health plan by the Department of Public Health's new state dental director. The Commission believes both initiatives represent a significant opportunity for California to do better by the population it is supposed to help.

Digging out of this hole will take more than fixing Denti-Cal, although the state bears much responsibility to fix its antiquated processes and function more like commercial dental insurers. It will require a significant effort among funders, private and non-profit organizations, universities, the state and local governments, as well as the Governor and Legislature, to build a more coordinated, comprehensive system of preventative care. The recent expansion of Medicaid under the Affordable Care Act is steering millions more beneficiaries to a Denti-Cal program that is already dysfunctional. Denti-Cal's problems have festered for years without significant improvement. That must end. The Commission respectfully submits these findings and recommendations and stands prepared to help you take on this challenge.

Sincerely,

Pedro Nava
Chair, Little Hoover Commission

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Executive Summary

Among government programs labeled by participants and beneficiaries as broken, dysfunctional or an outright mess, few have achieved the notoriety of Denti-Cal, California's Medicaid dental program. A quiet bureaucratic backwater that has long resisted outside efforts at reform, Denti-Cal consistently falls short in caring for one-third of the state's 39 million residents and half of its children.

For these 13 million or more Californians of modest or little means, Denti-Cal is the only ticket to dental care outside of an emergency room. Yet by many accounts provided to the Commission during a seven-month review, its thicket of rules and outdated processes is baffling, frustrating and ultimately, often harmful to beneficiaries. The statistics portray a vicious circle of dysfunction. Most California dentists don't participate in Denti-Cal due to its low reimbursement rates and administrative obstructions. And fewer than half of people eligible for benefits use them in any given year because there are so few dentists who will see them. Millions of Californians, consequently, are going through life with rotting or missing teeth, debilitating pain, poor oral health habits and no preventative care.

The situation has grown so serious that a coalition of civil rights groups in December 2015 filed an administrative civil rights complaint with the U.S. Department of Health and Human Services, alleging that Medi-Cal and Denti-Cal are a separate and unequal system of California healthcare that "effectively deny" full benefits to more than seven million Latino enrollees.

The impacts of this poorly performing program ripple outward with expensive emergency room visits, missed school days and lost job opportunities, all representing lifetime or even multi-generational social costs for the state. Denti-Cal at best is getting by in the midst of its overwhelming mission. At worst, it fails to curb, and more importantly, prevent a worsening epidemic of oral distress in a sizeable amount of the state's population. California, through the Department of Health Care Services, essentially runs a program that is unable to attract enough dentists, unable to provide most beneficiaries access to care and seemingly, unable to change its ways.

The Commission during a study of this $1.3 billion state and federal program often heard that Denti-Cal is "broken," that it is beyond fixing and needs to be abolished and rebuilt from scratch. Many program participants seem stuck in cultures of mutual antagonism: dental providers against the state bureaucracy, the bureaucracy against providers it suspects of fraud, and beneficiaries against both for their inability to deliver care. This dysfunction has prevailed for years, finally exploding into the open with a searing December 2014 audit report on the Denti-Cal program and the subsequent April 2015 request for the Little Hoover Commission to conduct its own review.

The Commission, which held two hearings in September and November, 2015, learned about difficulties that millions of people encounter searching for dentists who accept new Denti-Cal patients or office hours that accommodate their work schedules. At least five counties have no Denti-Cal providers at all and many other counties have no providers who accept new Denti-Cal patients. The special needs and developmentally-disabled population is especially hard hit and unable to find providers. The Commission learned that this widespread inability to get care has translated to excessive demand for emergency care and dental surgery, which DHCS and health insurers are now limiting and stirring up even more antagonism among providers and beneficiaries.

Overall, it appears that the current Denti-Cal system

"There's a lack of access to care for children like mine. There's a very limited number of dental providers as well as a lack of facilities that are willing to provide the level of care that he needs. He has to have an anesthesiologist there. We've been very fortunate to have Sutter in our community, but the funding makes it very difficult for their bottom line to have it open enough to provide for our children and so they have to limit the access. As the rules are now he is only provided a cleaning, a scaling and root planing, deep cleaning every two years according to the authorization process. But when he is in pain – and he always cannot tell me – he tells me with his behavior by holding toys up close to his face that vibrate and make noise, and by rocking constantly to say this is hurting. And you look in his mouth and his gums are red and he has lots of scaling that needs to be done, but the rules say differently. And so it makes it very difficult."

Donnell Kenworthy of West Sacramento, mother of a special needs son, addressing the Commission in November 2015.

(From left: Donnell and D.J. Kenworthy, Sam and Chris Hickey)

creates high levels of havoc in the lives of people it is supposed to help. The entire system needs a thorough reorientation to preventative care and earlier intervention. Most of all, a state that has so long dawdled and promised reforms while people suffer must get the ball rolling in a new direction. Commission Chair Pedro Nava captured the Commission's sentiment in concluding the November 19, 2015, hearing. He said, "The testimony has been dramatic. There's no question that there is a disconnect between the issue of the State of California and what's in the best interest of the patient. I don't know how you can make an argument that is any different."

California is not Alone

There is no question that running a statewide dental program involving 13 million or more people is difficult – and California is hardly alone. It is difficult across the entire nation where Medicaid rates paid to dentists run well behind commercial rates and more people than ever are competing for a limited number of dentists. Nationally, too, many people with Medicaid dental coverage are not using it.

To outsiders peering in, the Denti-Cal program can appear almost impervious to reform due to being jointly run and funded by two large and sometimes seemingly incomprehensible bureaucracies, the state's Department of Health Care Services (DHCS) and the federal Centers for Medicare & Medicaid Services. Fortunately the Commission learned of strong consensus among key interest groups for new directions. Most of these involve expanding preventative care in a system that allocates 86 percent of its funding to drill, fill, cap, extract and perform root canals. The Commission takes great encouragement from this consensus. It also takes encouragement from major initiatives to spur more preventative care and higher percentages of beneficiaries making annual visits to a dentist. The Department of Health Care Services and the Centers for Medicare & Medicaid jointly announced in December 2015 a five-year $740 million initiative to provide targeted financial incentives to California dentists to treat more Denti-Cal patients and develop preventative approaches to care.

"Studies of Medicaid-insured populations have found that negative experiences with the dental care system discouraged many caregivers from obtaining dental services for their Medicaid-insured children. Searching for providers, arranging an appointment where choices were severely limited, and finding transportation left caregivers describing themselves as discouraged and exhausted. Caregivers who successfully negotiated these barriers felt that they encountered additional barriers in the dental care setting, including long waiting times and judgmental, disrespectful, and discriminatory behavior from staff and providers because of their race and public assistance status. Little of this fact is ever highlighted in Denti-Cal-related studies."

Conrado E. Bárzaga, M.D. Executive Director, Center for Oral Health. January 2016.

Simultaneously, California's new state dental director is crafting a 10-year statewide Oral Health Plan focused on a great expansion of preventative care, especially for children.

Yet in the meantime, countless thousands of Californians can't find a nearby dentist who will see them or their children.

The Little Hoover Commission recognizes that Department of Health Care Services Director Jennifer Kent and Denti-Cal Director Alani Jackson have been in their new posts for a year and express their intentions to make the program more effective. They have their work cut out, reforming within the massive Medi-Cal bureaucracy a small Denti-Cal division that appears by all accounts to have ossified over years and become stuck in its ways. During a heated March 27, 2015, joint legislative hearing on Denti-Cal's shortcomings, Director Kent, on the job only a few weeks, assured lawmakers who had expressed blistering criticisms of the program, "We will get it done."

It is more than a year later. Californians need to get it done. The time for excuses ran out a decade ago. Following a seven-month review, the Little Hoover Commission offers these 11 recommendations and their key implementation partners as a way forward.

A Path to Action: Begin With a Forceful Utilization Target

Recommendation 1: The Legislature should set a target of 66 percent of children with Denti-Cal coverage making annual dental visits. Additionally, the Legislature should:

- ***Conduct oversight hearings to assess progress or lack of movement on all initiatives designed to reach this target, and particularly on implementation of the five-year $740 million Denti-Cal targeted incentive plan to increase children's preventative dental visits.***
- ***Ensure the state dental director has adequate authority to see that the Denti-cal targeted incentive program aligns with the 2016 oral health plan.***

The Legislature should declare its intent that annual Denti-Cal utilization rates among children in California climb well into the 60 percent range, as is the case in approximately 20 percent of U.S. states. A specific target of two-thirds of children using their benefits annually, comparable to children with commercial insurance, will gradually stimulate and accelerate the necessary range of small and larger solutions by DHCS and its partners to get there. The Department of Health Care Services and the Centers for Medicare & Medicaid Services recently announced an experimental five-year incentive plan to focus on prevention and increase children's annual dental visits by 10 percentage points. However, it is uncertain that the plan will produce results to meet that goal.

Fortunately, the state's new Oral Health Plan being produced by State Dental Director Jayanth Kumar, DDS, within the California Department of Public Health and

scheduled for release in June 2016, also aims toward a 10-year increase in the numbers of children making an annual dental visit. While the Commission has strong hopes for these two plans, the Legislature, in addition to continuing strict performance oversight of the DHCS Denti-Cal program in general, should oversee both plans as they work in tandem and closely monitor their progress or lack thereof. The Legislature and Administration also should ensure that the state dental director has adequate authority to align the plans and publicly recommend and make necessary course changes to reach an improved utilization rate. California's entire dental health care bureaucracy should work with its partners in the private, public and non-profit sector toward a target of 66% utilization rates among children.

Key Short-Term Goals to Meet Utilization Target

Recommendation 2: the Department of Health Care Services should simplify the Denti-Cal provider enrollment forms and put them online in 2017.

Department of Health Care Services officials say they are in final review of plans to refine and shorten the Denti-Cal enrollment form from 34 pages to 10. The Commission commends this action and urges the Legislature to oversee its progress and keep it moving forward through the process of feedback from dental providers and department partners. The Commission also recommends that the state go further and facilitate Denti-Cal enrollment via an online application far sooner than the department's current estimated timetable of two to three years. Waiting up to three years to bring the department's enrollment process up to the online standards of commercial insurers will further bewilder a dental provider community that publicly called on the department to do online enrollment in 2008. The Commission recommends that the Legislature and Governor see that it is done in 2017.

Recommendation 3: the Department of Health Care Services should overhaul the process of treatment authorization requests.

- ***The department should reassess its policies using metrics that consider foremost the highest impacts on beneficiaries and their needs rather than the lowest behavior of a few providers.***
- ***The department should consult with an evidence-based advisory board during this reassessment.***

The Department of Health Care Services has made small, tentative moves toward easing concerns of dental providers over the need to routinely mail in X-rays with their claims for reimbursement. But questions remain about what procedures should require preauthorization from Denti-Cal before being conducted. Hearing witnesses told the Commission that commercial insurers do not routinely require X-rays or authorization in advance for routine dental work such as crowns, root canals and periodontal (gum) treatment. The Commission heard anecdotally that fraud rates are no different for Denti-Cal than commercial insurance, and accordingly, recommends a high-level department review of its preauthorization policies. The department's review, guided by an evidence-based advisory body, should focus foremost on the needs of beneficiaries rather than the current near-singular focus on fraud.

Recommendation 4: the Department of Health Care Services should implement a customer-focused program to improve relationships with its providers.

The Department of Health Care Services admittedly has a very difficult job to implement Denti-Cal for a growing population while paying low reimbursement rates dictated by the Legislature. But for the good of the Californians it serves, it simply must develop better day-to-day relationships with dental providers. The department should initiate customer-service-focused processes in 2016 to develop a stronger "partner mentality" and tone down the antagonism that seems to have become quite routine between it and providers and others.

Recommendation 5: the Department of Health Care Services should purge outdated regulations.

- ***The department should appoint a small number of staffers to spend eight to 10 weeks during 2016 to review rules and clear out needless regulatory clutter.***
- ***The Legislature should assess department progress through an oversight hearing or through budget hearings.***

Department of Health Care Services partners, including the California Dental Association, say many Denti-Cal rules were designed to combat particular episodes of fraud and have outlived themselves. While originally well-intended, some now have a larger negative impact of discouraging dental provider participation due to their impediments. Denti-Cal beneficiaries suffer the most harm when dentists balk at providing them care due to outdated and frustrating department rules.

Recommendation 6: the Legislature and Governor should enact and sign legislation in 2016 to create an evidence-based advisory group for the Denti-Cal program.

- ***The Governor and Legislature should appoint dental experts in early 2017 to guide development of Denti-Cal priorities and oversee policy decisions.***
- ***The Department of Health Care Services should begin to consult with the Denti-Cal advisory board in early 2017.***

The Department of Health Care Services has much work to do retool its Denti-Cal program to win over more providers and provide greater access to dental care statewide. Denti-Cal should be guided by an evidence-based advisory group, which consists of the state dental director and expert specialists who can weigh in on proposed decisions and make sure they are based on the best evidence and science and not merely on cost. This would be especially helpful to minimize the continual strife, confusion and even alleged harm to beneficiaries, including special needs populations, that the Commission heard about repeatedly in public comment during its two hearings.

Recommendation 7: the Legislature and Governor should fund a statewide expansion of teledentistry and the virtual dental home.

- ***The Legislature should pass and the Governor should sign AB 648 (Low).***

Californians have pioneered a simple technological solution – teledentistry – to better connect dentists and people in the neighborhoods where they live. The concept of a dental assistant with a laptop, digital camera and hand-held X-ray machine doing dental care under the supervision of a distant dentist who can review medical histories and X-rays from another computer and prescribe treatment should play a significant new role within the Denti-Cal system. In 2015, the Legislature considered AB 648 (Low) to allocate $3 million to scale up the Virtual Dental Home concept statewide in the wake of a successful pilot demonstration project. The bill, currently stalled short of a full Senate vote, should be passed and forwarded to the Governor for signing.

Key Long-Term Goals to Meet Utilization Target

Recommendation 8: 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.

- ***A coalition of public, private and non-profit organizations and funders, such as the California Healthcare Foundation, California Endowment, California Dental Association, California First 5 Commission and its county commissions, among others, should powerfully***

address the need for a more coordinated, comprehensive statewide system of preventative care.

- ***Others beyond state government, including universities, medical societies and foundations should convene a symposium to discuss and plan a way forward, then make it their continuing responsibility to help fund and sustain a permanent emphasis on preventative care.***
- ***Funders, celebrities, communicators, advocates and media firms should participate in a major statewide messaging campaign to educate families and children about habits for healthy teeth.***

The rapid increase of Denti-Cal beneficiaries in recent years combined with some of the nation's lowest reimbursement rates for participating dentists has left the Denti-Cal program increasingly unable to contend with an overload of dental disease. With only 14 percent of its annual budget allocated to prevention, Denti-Cal is likewise unable to stem the rising damage of poor dental health among its eligible population. The growing oral health crisis among Californians who lack commercial dental insurance coverage is a larger responsibility than the state's alone. A large, powerful coalition will be necessary to steer Denti-Cal funding toward preventative care, and especially recognize the power of case management in connecting a large vulnerable population to dentists and making sure people show up for appointments. Two powerful initiatives within the Department of Health Care Services and Department of Public Health are launching momentum in a preventative direction. Others beyond state government must build upon it and sustain this forward direction.

Recommendation 9: the Legislature and Department of Health Care Services should expand the concepts of Washington State's Access to Baby and Child Dentistry program and Alameda County's Healthy Kids, Healthy Teeth program to more regions of California.

- ***The Department of Health Care Services and the Legislature should actively encourage and help establish pilot projects based on these concepts with the potential of expanding them statewide.***
- ***The Legislature should assess department and pilot project progress.***

A new federal and state initiative to fund targeted incentives for dentists who care for Denti-Cal-eligible children provides great opportunity to expand preventative care to children five and under through programs with demonstrated successes in Alameda County and Washington State. With $185 million available in a federal-state fund for preventative dental care pilot projects during the next five years, the Access to Baby and Child Dentistry and Healthy Kids Healthy Teeth concept is ripe for expansion and testing beyond Alameda County. A pilot project, if successful, could demonstrate anew the ability of incentives to motivate dentists' participation, especially when backed with training and assistance for dentists, and an extensive case management system that conducts outreach at the community level to get eligible patients appointments with dentists and keep them. A pilot program will ideally feature networks of private, non-profit and public partners such as dental associations, medical schools, foundations and health agencies to fund and maintain these comprehensive outreach and case management efforts.

Recommendation 10: the Department of Health Care Services and California counties should steer more Denti-Cal-eligible patients into Federally Qualified Health Centers with capacity to see them.

- ***The Department of Health Care Services should include contact information for Federally Qualified Health Centers on its referral lists of dentists.***

- ***Counties should train eligibility workers to advise use of Federally Qualified Health Centers for dental care where appropriate.***
- ***Federally Qualified Health Centers with high demand for dental services and limited capacity should expand use of teledentistry options to provide preventative care in community locations and free up capacity for more intensive dental care in their offices and clinics.***
- ***Foundations and medical societies should consider funding targeted messaging or advertising campaigns to raise awaRenéss that Denti-Cal benefits can be used at nearby Federally Qualified Health Centers.***

California's more than 1,000 Federally Qualified Health Centers (FQHC) have integrated preventative care into their daily appointments in ways that largely do not occur in private dentist offices. Their reimbursement stream incentivizes FQHCs to prioritize low-cost preventative visits to minimize the high expenses and potential financial losses of restorative care. The incentive for private dentists is just the opposite, often prioritizing high-cost restorative care to make worthwhile the low reimbursement rates paid by Denti-Cal. Given that the federal government provides much higher reimbursement to dentists at FQHCs and pays nearly the entire cost of these reimbursements, the state and its partners alike would be wise to encourage the most people possible to receive care at a FQHC. Most FQHCs are located in neighborhoods that private dentists tend to avoid, but many people who live near one don't know that they provide dental care. The California Primary Care Association has invested in a CaliforniaHealthPlus branding campaign to promote FQHC services, including dental, but lacks funds for the necessary scale of statewide advertising. Funders and medical societies should consider ways to help. These federal facilities should become an even stronger part of the dental care safety net in California.

Recommendation 11: medical societies and non-profit organizations should recruit more pediatricians to provide preventative dental checkups during well-child visits.

- ***The California chapters of the American Academy of Pediatrics should lead in encouraging its members to perform preventative dental exams and apply fluoride varnish to Denti-Cal-eligible children.***
- ***County First 5 Commissions statewide should work to reinforce the message locally with pediatricians and primary care doctors.***
- ***Senator and pediatrician Richard Pan should write to pediatricians statewide stressing the importance and benefits of this practice.***

Representatives of Amador County have provided California a model that offers basic preventative dental care to children in rural counties that have few or no Denti-Cal providers. With a small start-up grant from Sutter Medical Group, the county established a program to recruit and train pediatricians to do dental exams, apply fluoride treatment as part of well-child visits and bill Medi-Cal for reimbursement. This program is a critical piece of the safety net in Amador County, where a visit to a dental office that accepts Denti-Cal might be as much as 60 miles away. Pediatricians did more than 1,000 flouride treatments in the first eight months of the program in 2015, and serve as an example to other counties in similar straits. A major statewide initiative on preventative care for children requires small programs and pediatricians everywhere to do what can be done. In 2015 the American Academy of Pediatrics (AAP) advised pediatricians to add fluoride varnish to their list of tasks during well-child visits from the age of six months to age five. Just as the state needs more initiatives like those in Amador County, more pediatricians statewide need to add this small preventative task to their well-child visits for Medi-Cal beneficiaries.

A Restart for Denti-Cal

For millions of Californians going to the dentist is an easy, familiar routine. They have insurance through their employers, manageable co-pays and seldom a problem finding a good neighborhood dentist. Every six months the dentist's office calls, emails or texts with a reminder of scheduled preventative checkups and cleanings, and most patients depart their appointments with a commercially-sponsored toothpaste, brush and floss.

Two-thirds of Californians take all this for granted.

For 13 million or more other Californians of modest or little means, going to the dentist is an entirely different experience, and often a difficult one. They have no-cost coverage through Denti-Cal, the state's Medicaid dental program, but frequently have problems finding a neighborhood dentist who will take them. An office that does accept Denti-Cal may be miles away and offer appointment hours inconvenient for their inflexible, daytime work schedules, require a challenging family trip by bus and no ability to routinely get X-rays and restorative procedures the same day. Millions of Californians take this experience, too, for granted.

"You have a third of all Californians who have small children who are stuck in this plan. And the fact that you're squeezing on one end of the balloon, as they say, it starts popping out the other. If people can't get in with prevention, they eventually show up for more serious treatments. Now you have cavities that aren't treated and you're putting in a crown. Then they set up in the emergency room with an abscess and now you're treating that. Then they have to have teeth extracted and then you're talking about dentures and on and on. You start to cause this ball to roll."

Senator Richard Pan. Testifying at September 24, 2015 Commission hearing.

"Dental care consistently ranks to the public as the most important type of health care after medical. Part of the reason is we are a society that judges people on their appearance. Think about how many comments you hear about people, how their teeth look, especially if they have missing teeth. We equate appearance with intelligence and respect. Do not underestimate the impact this has on self-esteem and their quality of life."

Assemblymember Jim Wood, DDS.[1]

This two-dimensional state of oral health care in California – and the shortcomings of the state's Medicaid dental program and other institutional systems in addressing it – is an unfair and needless condition in the lives of one-third of Californians and one-half of its children. Hard-to-access dental care endangers their overall health, their performance in school and their ability to get ahead. It costs California taxpayers hundreds of millions of avoidable dollars for emergency room visits, dental surgery and social consequences of unemployment and multi-generational poverty. All this became evident to the Commission during a seven-month review of Denti-Cal in 2015 and 2016 – conducted at the request of California lawmakers exasperated by the program's long-standing inability to deliver consistently convenient and dependable care.

First among issues is lack of access to care. Denti-Cal, a $1.3 billion state and federal program, designed with the best of civic intentions to give a hand to people in unenviable circumstances, appears by most accounts to be unavailable or difficult to use for children and adults who most need their teeth fixed, pulled or cleaned. The scale of this problem varies greatly depending upon

the source consulted, the time period covered and the methodology used to produce the numbers:

- In December 2014, the California State Auditor cited Centers for Medicare & Medicaid data to report that only 44 percent of California's 5.1 million Denti-Cal-eligible children aged 20 and under saw a dentist from October 2012 through September 2013.
- In December 2015, the Centers for Medicare & Medicaid, in approving the California Medi-Cal 2020 Demonstration, cited a figure of 37.8 percent of children 20 and under making a dental visit during the calendar year 2014.[2]
- In February 2016, the Department of Health Care Services (DHCS) stated that 51.8 percent of children 20 and under with Denti-Cal fee-for-service coverage had a dental visit from October 2014 through September 2015.[3]

"I think it's fair to say in short that Denti-Cal historically has been what the kids say is a 'hot mess.' Fair statement?"

Senator Holly Mitchell, addressing Department of Health Care Services Director Jennifer Kent at her January 20, 2016, confirmation hearing before the Senate Rules Committee.

"I would say that the kids are not far off."

Director Kent, in response.

Watch video of the exchange here

These variances add somewhat to the confusion about the true nature and magnitude of the problem in California. Perhaps the easiest thing to understand is how far all these numbers lag behind the 67 percent of California children with commercial coverage who visited the dentist in 2013, according to the American Dental Association.[4] Overall, children in rural areas are least likely to visit a dentist's office. Children three and under are also less likely to see a dentist, with fewer than 25 percent making visits in 2013, according to September 2015 Commission testimony provided by the Children's Partnership. Perhaps the silver lining to all these numbers is that they have improved since 2000 when only 32 percent of Denti-Cal-eligible children in California saw a dentist during the year, according to the American Dental Association.[5]

"In my counties this isn't working. There aren't enough dentists. When they say they'd rather do it for free it's a serious indictment of the program."

Senator and Commissioner Anthony Canella

Meanwhile, only 26 percent of eligible California adults with fee-for-service Denti-Cal coverage saw a dentist in 2014, according to February 2016 DHCS data.[6] It is obvious that millions of working, underemployed and disabled Californians and members of their families are moving through their lives without receiving the regular dental care for which they are eligible.

The reason for this lack of access to care is both obvious and simple, the root of the entire problem the Commission was asked to review:

- The great majority of California's 31,640 professionally-affiliated dentists – and a large share of those training to become dentists – want nothing to do with Denti-Cal.[7] Dentists widely shun the program, saying it is easier to provide free charity care to low-income people than to work for Denti-Cal reimbursement rates that rank among the lowest nationally and don't begin to cover their costs. Dentists also told the Commission the state's administrative requirements are far more complex and time-consuming than those of commercial insurance plans. They complained that, unlike commercial plans, state dentists consistently second guess their professional judgments. Dental billing specialists, too, chafe over outdated paper-

based billing programs long ago abandoned by commercial insurers.[8]

- In 2013, the American Dental Association (ADA) reported that 29 percent of California dentists participate in the state's Medicaid dental program compared to a national average of 42 percent. That puts California among the lowest nine states nationally, with participation rates between 20 percent and 30 percent.[9]

"Pediatric dentists have traditionally participated in Medicaid dental programs nationally at a higher rate than dentists as a whole and that is no longer the case in California. We have serious concerns that the current generation of pediatric dentists coming off our training programs look at the Denti-Cal program, because of the enrollment barriers, the administrative barriers, because of the low reimbursement rates, because of their high amounts of debt coming out – and these are people who are dedicated, they're taking two to three years of additional education to become pediatric dentists, they're taking two to three years of additional debt – and they look at Denti-Cal as irrelevant to their practice. We are losing a generation of pediatric dental clinicians and practitioners unless we make serious changes to the program now."

Dr. Paul Reggiardo, public policy analyst, California Society of Pediatric Dentistry.

A Silent Epidemic Throughout California

During its study the Commission heard story after story of conditions little known in the larger and more prosperous society of California: little children by the thousands with mouths full of rotting, ruined teeth, parents who don't understand basic preventative care, whole counties with no dentists who accept Denti-Cal. Witnesses, experts and dental practitioners collectively described a silent epidemic of dental decay enveloping California, a public health problem on the scale of diabetes and obesity – and worsening.

"We get 50 referrals a day for severe tooth decay," said Viveka Rydell, chief executive officer of the nonprofit PDI Surgery Center in Sonoma County. Denti-Cal-eligible children from 33 counties gravitate toward the center with its three-month waitlist. She said a typical case is a child, three and a half years old, with 10 to 18 cavities. "We have 10 kids in two operating rooms every day," said Ms. Rydell.

Plainly, a massive swath of California's oral health landscape is experiencing profound disorder and the state's signature dental plan for those of lesser incomes – as well as the larger health care infrastructure of California - is inadequately addressing the challenge. The Commission's study process produced abundant testimony about serious deficiencies within the state's Medicaid dental program. Yet it also showed a refreshing consensus among experts beyond the Department of Health Care Services (DHCS) on ways to make improvements in the short and longer term. The Commission took great encouragement from this consensus. The Commission also is hopeful, despite a few reservations about the potential effectiveness of particular strategies, that a new five-year $740 million federal and state initiative will help increase preventative dental care to children under 21. Likewise, it is encouraged by a comprehensive 10-year statewide oral health plan to be released in June 2016 by the State of California's new dental director and its anticipated emphasis on preventing dental disease. Both the problem and this developing consensus for solutions will be considered extensively inside this report and form the basis for the Commission's recommendations to the Governor and Legislature.

Broadly, the Commission concludes that California's Denti-Cal program also must begin a thorough years-long reorientation away from funding simple damage control – what the dental industry calls "drill and fill" – toward preventative care and intervention at the youngest possible age. (Currently, 14 percent of Denti-Cal funding goes to preventative care).[10] California also needs strong comprehensive case management at all levels of the

public health system to make more people aware of their Denti-Cal benefits, use them and show up for regular appointments. The Commission, in the wake of its two hearings on September 24, 2015, and November 19, 2015, senses that the state's Denti-Cal bureaucracy, in particular, may be overwhelmed and operating in a purely reactive mode to a condition of growing oral health chaos and rising antagonism from many of its beneficiaries, providers and interest groups trying to improve conditions for Californians who receive public assistance. Denti-Cal could greatly benefit from better partnerships, regular advice from a board of health evidence-focused experts to guide its decision-making and most important, new prevention-oriented goals and systematic ways to measure progress toward them.

This introductory chapter, in keeping with the Commission's mission to seek efficiency and economy within the state's executive branch, describes the Commission's Denti-Cal review process, the Denti-Cal program itself, the conditions it is trying to address and why it is hard for beneficiaries to access dental

"I'm the parent of an adult with special needs. He's been diagnosed with a [mental disability] and he also has autism. My son has been seen through a pediatrician since he was a small boy and he's been sedated to have a procedure done because he had behaviors. He bites. He would fall on the floor and hit himself. He hits himself on the walls. So the pediatrician has told me that it's traumatizing for him and also for the other patients that are being seen so he needs to be sedated.

And for that last two years, the last two or three years, I was told that he needs to be put on a wait list because sedation was not covered by Medi-Cal and that is very nerve-racking as a parent because we know he needs a procedure. He has cavities in some of his teeth and yet there's nothing that can be done. I can't even get a cleaning from him because they can't get in there. At home I brush his teeth for him and to floss. My husband and I have literally to put him on the floor and kind of sit on him and do as much as we can as fast as we can.

In some ways I was lucky. Through networking with other parents, I found Dr. (Rodney) Bughao who was willing to see my son, which is another headache, trying to find a pediatrician who is willing to see your son. Now that he is 18, he (Dr. Bughao) put him in the books and he was scheduled to have a procedure done in December (2015). However, I got a call three weeks ago saying my son was not going to be placed on the books because Blue Anthem (Anthem Blue Cross) was not coming back with authorization and a majority of the patients are being denied. With that being said, it just raised the level of concern. It's not a coincidence. My husband just two weeks ago started having toothaches. He had headaches. He couldn't go to work. He got an infection where he actually had a root canal, but with that procedure happening two weeks ago, he's normal. He can be put in a chair and get the procedure.

That caused me concern. My husband and I thought that if my son's in pain there's nothing I can do about it right now. He'll be back in pain and I'll have to deal with him hitting his head. So it's nerve wracking not knowing what or where. Because I haven't been told when. I was just told most likely you'll be denied. And I don't think it's fair. Not family-wise or to my son, where if he was in pain at any time. And I know it's about to happen because we know he has cavities already. So I just want to share my story with you guys."

Jesana Tran, Sacramento-area mother of an 18-year-old special needs son, addressing the Commission in November 2015.

care. It concludes with a recommendation designed to increase the number of eligible beneficiaries getting care, particularly preventative care to address an epidemic of tooth disease.

Origins of the Commission's Denti-Cal Study

The Little Hoover Commission initiated its examination of the state's Denti-Cal program after receiving a formal request for a review from Senator Richard Pan and Assemblymember Jim Wood on April 6, 2015. "Millions of low-income Californians on Denti-Cal are suffering because the promise of dental coverage by the state is not being fulfilled by Denti-Cal," the lawmakers stated in their joint letter. They asked the Commission "to undertake a review of the Denti-Cal program and identify the necessary steps to assure this vital program meets its purpose to provide access to dental care for many of the most vulnerable Californians including children." The letter stated: "Your report will help guide the Legislature as we work to hold DHCS accountable to both Denti-Cal beneficiaries and the public."

At a Glance: The Uncomplimentary 2014 Denti-Cal Audit

The California State Auditor reviewed the Department of Health Care Services (DHCS) Denti-Cal program in 2014, in response to an August 8, 2013, request to the Joint Legislative Audit Committee by then-Senators Bill Emmerson and Mark DeSaulnier. The two senators expressed concern "that California is not fulfilling its obligation to ensure children enrolled in Medi-Cal receive timely access to dental care." Stating that tooth decay is "the most common chronic disease children face and one of the top reasons they miss school," the two asked that an audit outline DHCS actions to increase children's use of Denti-Cal coverage and identify what more could be done.

The California State Auditor released its findings on Dec. 11, 2014. The audit reported that:

- "Information shortcomings and ineffective actions" by DHCS are putting child beneficiaries at higher risk of dental disease.
- Only 43.9 percent of children enrolled in Denti-Cal had seen a dentist the previous year – the 12th worst among states that submitted data.
- Reimbursement rates for the 10 most common dental procedures were 35 percent of the national average – and haven't risen since the 2000-2001 budget year.
- Eleven California counties had no Denti-Cal providers or no providers willing to accept new child patients covered by Denti-Cal: Del Norte, Tehama, Yuba, Sierra, Nevada, Amador, Calaveras, Alpine, Mariposa, Mono and Inyo counties.
- California might not have enough Denti-Cal-participating dentists to handle millions of new Denti-Cal beneficiaries as a result of the Affordable Care Act.
- DHCS had not adequately overseen its Denti-Cal administrative contractor, which had not "performed contract-required outreach for improving dental access in underserved areas."[11]

Since the audit findings DHCS is working with the California State Auditor to resolve concerns and performance shortcomings noted in the audit. As of March 2016 the department has implemented 15 recommendations and continues to work toward implementing additional recommendations. Among changes the department released its first published comparison in years of California's reimbursement rates to those nationally.[12]

The request from Senator Pan, a pediatrician and Assemblymember Wood, a dentist, followed in the wake of a biting December 2014 report from the California State Auditor regarding Denti-Cal shortcomings under supervision of DHCS. The audit cited reimbursement rates that are among the nation's lowest for dentists – and also one of the nation's lowest user rates of dental services for eligible low-income children. During a March 17, 2015, joint legislative committee hearing on the California State Auditor's findings, Senator Pan told his legislative colleagues, "I've seen too much suffering. I'm not sure I can stand it anymore. This department needs to change."

In a June 2015 conversation following the Commission's decision to pursue the review, Senator Pan reiterated to the Commission chair his belief that the entire Denti-Cal "culture" – in his view, largely unaccountable state administrators, reluctant, disgruntled dental providers and millions of Californians who use their benefits haphazardly – needs to change. He told the Commission chair that for the state bureaucracy in particular there appears to be "no consequences to doing a bad job. It doesn't seem as folks act as if they're being watched," he said. During the June 2015 conversation Senator Pan asked that the Commission consider four questions:

- Are children (and adults) getting the care they need?
- Is the state using its resources effectively?
- Is DHCS paying sufficient attention to overseeing the Denti-Cal program?
- Is the level and quality of administration good or not?

The Commission began its review almost exactly 50 years after President Lyndon Johnson signed legislation on July 30, 1965, creating the federal Medicaid program to provide affordable health care to low-income Americans in alliance with states. Medicaid's founding led, in turn, to California's March 1966 launch of Medi-Cal to implement the joint federal-state health insurance program. Both programs have undergone massive transformations in the decades since. The Commission's review of Denti-Cal also took place during one of the most sweeping transformations yet, as the Affordable Care Act (ACA) has added an estimated three million adult Californians to a state program still largely shunned by practicing dentists. This expansion comes, too, on the heels of moving an estimated 900,000 children from the Healthy Families program to Medi-Cal and Denti-Cal.[13] Within this expansionary context, it is easy to view the state's dental care program as bursting at the seams, and sense that without statewide momentum toward improvements for Denti-Cal and beyond, opportunity exists for greater difficulties.

An Introduction to Denti-Cal

To understand the workings of Denti-Cal it is best to briefly explain first the giant public health care systems under which it is housed – those of Medicaid and Medi-Cal. These two federal-state programs essentially operate as one combined program to deliver more than $90 billion worth of medical and dental care annually to 13 million or more eligible beneficiaries in California.

- **Medicaid** is the nation's largest health insurer with combined federal-state spending of $475 billion in the federal 2014 fiscal year that ended September 30, 2014. Medicaid represents the largest domestic federal program after Social Security and Medicare, and is often the second largest item in state budgets after elementary and secondary education. The program insures 70 million disadvantaged Americans, making it the largest source of federal funds for states. Typically, the federal government pays nearly 60 percent of its costs with states picking up the rest. Though two-thirds of Medicaid spending is for the elderly and disabled, the program has long been a lightning rod for debates about balanced state budgets and federal deficits.[14] Medicaid requires states to provide dental care to children up to 18 years of age and many states have extended it through age 20.[15]

- **Medi-Cal**, established as California's Medicaid program through November 1965 legislation signed by Governor Edmund Brown, Sr., pays health care bills for approximately 13 million or more enrolled Californians. Medi-Cal's combined

federal and state spending during the 2015-16 fiscal year that ends June 30, 2016, is expected to total $91 billion. The state's General Fund share is $18 billion. That is matched by a similar amount from local government contributions and health care-related taxes, and fees on hospitals, skilled nursing facilities and managed care plan providers. More than 75 percent of Medi-Cal enrollees are in managed care plans.[16]

- **Denti-Cal** is the Medi-Cal dental health care component, a public insurance program established soon after the 1966 creation of Medi-Cal. Denti-Cal budgeted $1.3 billion for enrollees during the 2015-16 fiscal year with the federal government contributing about 60 percent of the payment – $808 million – and the state allocating $526 million of its own funds. Denti-Cal estimates that 8,361 California dentists – about 25 percent of the state's total – provide services to Denti-Cal patients. Dentist participation rates vary by source, however. California is one of a few U.S. states that provide Medicaid dental benefits to adults.[17]

Denti-Cal's Tiny Niche in the Health Care System

One of the keys to understanding Denti-Cal's apparent low-priority status is its almost hidden existence within the massive state bureaucracy of the California Department of Health Care Services (DHCS). Denti-Cal's $1.3 billion budget allocation accounts for approximately 1.4 percent of the state's $91 billion in Medi-Cal spending overseen by DHCS during the 2015-16 budget year that ends June 30, 2016.

Denti-Cal's bureaucratic footprint, in short, is insignificant compared to other immense Medi-Cal responsibilities at DHCS. Advocates say this is a defining part of the problem with Denti-Cal – a small program easily out of sight and out of mind within the larger health care bureaucracy in Sacramento. Denti-Cal's administrative offices are not even housed within DHCS headquarters near the state Capitol, but located 15 miles east in the Sacramento suburbs.

Representatives of DHCS told the Commission that 38 department employees operate Denti-Cal through an administrative contract with Delta Dental, the nation's largest dental benefits company. A special Delta Dental of California division – with approximately 350 employees in 2015 – has for approximately 40 years operated as Denti-Cal's so-called Fiscal Intermediary and Administrative Services Only contractor.[18] This long tenure has led some to suggest the relationship between the state and Delta Dental may have grown too cozy. Presently, DHCS is working to reconfigure its administrative structure for Denti-Cal by splitting responsibilities for its Administrative Services Only and Fiscal Intermediary functions. The department is seeking proposals from firms to operate the two functions – processing and paying provider claims and conducting outreach to beneficiaries – separately. Interested bidders include Delta Dental and DentaQuest, another major benefits provider and contractor for state Medicaid dental programs. A DHCS official told the Commissionj in March 2016 that Denti-Cal anticipates having contracts fo the two functions in place on July 1, 2016. The awardees will begin fulfilling their new duties on July 1, 2017.

In essence, Delta Dental, operating in the same building as DHCS' Denti-Cal division, enrolls dentists into Denti-Cal, processes claims submitted by California dentists, pays dentists and authorizes treatments. The company also handles customer service operations, answering calls from clients and helping them find dentists near their homes. Delta Dental is assigned the responsibility of reaching out to eligible beneficiaries to make them aware of their Denti-Cal benefits and use them to get oral exams and dental treatment.[19]

The DHCS Denti-Cal division has oversight responsibility for Delta Dental's implementation of the program. The California State Auditor in 2014 and other critics have contended the department has not done well in fulfilling its oversight role. The state auditor, in an ongoing update of departmental progress toward its audit recommendations, notes that DHCS has implemented six recommendations for improved Delta Dental oversight. Among them, it reports that DHCS has provided Delta Dental contact information for its beneficiaries in underserved areas and required the firm to make them aware of their Denti-Cal benefits. The auditor also

reports that DHCS has implemented recommendations to review Delta Dental's outreach activities and implement measureable objectives. Likewise, DHSC implemented "tangible measurements to evaluate Delta Dental's performance of all functions under the contract." Finally, the auditor reports that DHCS has directed Delta Dental to:

- Submit an annual plan describing how it will remedy lack of access to dentists in underserved areas.
- Contract with other providers to add dental services in fixed facilities or mobile clinics in underserved areas.
- Develop a dental outreach and education program and submit an annual plan describing it at the end of each year. [20]

How Denti-Cal Pays Participating Dentists

Denti-Cal is vastly different from regular medical health care in that the majority of beneficiaries are covered through fee-for-service arrangements instead of the managed care model that has come to dominate most other medical care. The state pays dentists directly for services to its millions of beneficiaries. Unlike medical doctors who increasingly work for health plans, dentistry largely still remains a landscape of small independent businesses. (A primary exception is Orange County-based Western Dental, which operates 160 offices throughout California and employs approximately one-third of the state's dentists who accept Denti-Cal and see more than 100 Denti-Cal patients annually.[21] Western Dental saw approximately one million Denti-Cal patients in 2015, the firm reported in January 2016).[22]

More than 879,000 Denti-Cal beneficiaries do receive dental care through managed care plans started as experimental alternatives in the 1990s – all in Los Angeles County, where managed care plans are optional for beneficiaries and in Sacramento County where they are mandatory.[23] Both had relatively rough starts and poor track records in getting children into dentist offices for checkups, which has discouraged talk of their possible expansion to other counties or statewide.[24] But managed care plans in both counties, though continuing to lag behind fee-for-service models in getting children to visit dental offices, have improved their utilization rates in recent years – and helped more children who need care under general anesthesia. Sacramento County dentists also typically receive 10 percent higher reimbursement under managed care than other dentists in other counties.[25] Dentists, however, have traditionally opposed alternatives to the straight fee-for-service model that has long been the backbone of dentistry.[26] Indeed, the California Dental Association on January 25, 2016, urged the state to eliminate Sacramento County's managed care system for dental care.[27]

A Patchwork of Supplements to Denti-Cal

Given Denti-Cal's "bare-bones" coverage and the widespread absence of participating dentists in the program, California remains woefully short of adequate care for adults and children. A patchwork of supplemental programs has grown up to fill in some of the gaps.

First among these are Federally Qualified Health Centers (FQHC). The FQHC designation refers to hundreds of California health clinics and systems that operate in underserved, low-income and uninsured communities that private-practice dentists tend to avoid. Importantly, these nonprofit clinics also receive far higher dental care reimbursement rates from Medi-Cal than those that Denti-Cal provides to private dentists. This special designation and higher reimbursement rates has created a separate – and by many accounts, more comprehensive and superior – dental provider model for low-income Californians. DHCS records indicate that FQHCs provide approximately one-third of Medi-Cal dental care to adults and children in California – $374 million worth in 2014. The federal government picks up nearly all the cost of this FQHC-provided dental care – driving federal dollars to account for more than 60 percent of Denti-Cal's annual $1.3 billion budget.

Second are the state's First 5 county commissions, which are funded by tobacco sales taxes and which allocated $23 million to safety-net care for children in 2014.[28] First 5 commissions stem from 1998's Proposition 10, which established a 50-cent tax per pack of cigarettes to establish early childhood development and smoking prevention programs. Among standout First 5 programs

is Orange County's Healthy Smiles for Kids program, which partners with a collective of community clinics to fund and provide screenings, treatment and education. Orange County ranks first among California's 58 counties for utilization rates by young children with nearly half of the county's young Denti-Cal eligible children receiving at least a preventative visit in the past year.[29] Sacramento County's First 5 Commission, likewise, has helped finance six children's dental clinics in the county since 2009, a key factor in increasing the percentage of Denti-Cal-eligible children receiving dental services.[30]

Also supplementing Denti-Cal is the free care given to lower-income people by dentists who don't want the bother and expense of dealing with Denti-Cal billing procedures – and two annual "CDA Cares" events when California Dental Association professionals provide free treatments, including fillings, tooth extractions and even dentures to approximately 4,000 or more people. Lastly, is a sprinkling of county-funded dental care.

Dental Disease in California: Prevalance and Consequences

Dental disease is surprisingly prevalent in the U.S. and California, and is considered the most common childhood illness in the nation, according to September 24, 2015, testimony provided by the California Dental Association (CDA). The CDA's then-director of public policy, Nicette Short, told the Commission: "While [dental disease] 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."

California State Dental Director Jayanth Kumar, DDS, similarly testified that oral diseases are the "largest unmet health care need" for children. Dr. Kumar told the Commission, "The burden of oral diseases constitutes a major challenge because of the economic and social costs it imposes on society. In children, untreated disease can lead to impaired growth, altered speech, missed school days, difficulty in learning and lowered self-esteem."

Dr. Kumar noted specifically that California children with dental pain due to problem teeth miss 874,000 school days annually, costing school districts $29 million in attendance fees. He also said that children who report having recent tooth pain are four times more likely to have a low grade-point average, which can negatively impact their lifetime earning potential.

"When we initiated a dental program at the Alameda County-operated Women, Infants and Children (WIC) Nutrition Supplementation Program sites, which serves virtually the same population as that eligible for Medi-Cal, we found that as early as nine and 15 months of age, 20 percent of the infants and toddlers had already developed clinical evidence of the dental infection (white spot lesions)or frank decay on their "baby" teeth, and by age five, that proportion had risen to 70 percent having experienced tooth decay. This is particularly disconcerting since we know that dental decay, while, epidemic, is with appropriate early preventive and health promoting practices, nearly 100% preventable.

Dr. Jared Fine, retired 39-year Alameda County Dental Health Administrator[31]

Adults can have equally serious issues. "Infections in the mouth in adults have been linked to adverse pregnancy outcomes, coronary heart disease, stroke and respiratory disease," Dr. Kumar testified. "Often adults with poor dental health and missing teeth not only find it difficult to eat well and socialize, but also obtain employment."

These troubling conditions affect many Californians who qualify for Denti-Cal benefits. Dr. David J. Stone,

"I think it's sugar. Sippy cups with soda. Hawaiian Punch. Toddlers with cans of soda."

Dr. Katharine Foster, a Sonoma County pediatrician, answering a question from Commission Vice Chair Loren Kaye about why three-year-olds average a dozen or more diseased teeth at a Northern California dental surgery center.

a practicing pediatrician in Amador County, told the Commission at its November 2015 hearing, "There's a risk of caries (rotting teeth) anyplace where the water supply is deficient. Where there's frequent sugar exposure. Where there are developmental defects, family history of dental caries, minority status, low socioeconomic status or failure to use fluoridated toothpaste."

Too Few Dentists: The #1 Contributor to Dental Disease

But these reasons begin and end with not going to the dentist. And people with Denti-Cal coverage appear to have legitimate reasons for that in California.

- Witnesses from rural Amador County, where there are no Denti-Cal providers, told the Commission their residents must drive 60 miles to see a dentist who accepts Denti-Cal. Eleven counties have no Denti-Cal providers or no providers who accept new Denti-Cal patients, the California State Auditor reported in December 2014. Many more counties have far too few Denti-Cal dentists or specialists willing to treat the onslaught of dental decay.
- A representative of the Santa Monica-based Children's Partnership told the Commission its 2013 secret shopper survey of dentists who accept Denti-Cal found that a majority wouldn't see children under three – or had restrictive caveats on who they would take.
- California adults lost their Denti-Cal benefits altogether for five years beginning with 2009 budget cuts that placed them among adults in 35 states without dental benefits. The state restored benefits in May 2014 for exams, X-rays, fillings, root canals on front teeth and full dentures. Adults still have no coverage for root canals on

Relationship of Oral Health to Overall Health, Well-Being, and Quality of Life

Poor oral health has greater impacts on personal lives and society than policymakers might expect, according to the U.S. Surgeon General's Report on Oral Health in 2000. Among findings:

- The mouth is a portal of entry, as well as the site of disease for microbial infections, that affect overall health.
- Studies demonstrate association between periodontal diseases and diabetes, cardiovascular disease, stroke and adverse pregnancy outcomes. Diet, nutrition, sleep, psychological status, social interaction, school and work are affected by impaired oral health.
- Oral diseases and their treatment place a burden on society in the form of lost days and years of productive work. Acute dental conditions contribute to a range of problems for employed adults, including restricted activity, bed days and work loss, and school loss for children.
- Oral diseases and tooth loss contribute to compromised ability to bite, chew and swallow foods, limitations in food selection and poor nutrition.
- Oral-facial pain, as a symptom of untreated dental and oral problems, is a major source of diminished quality of life. It is associated with sleep deprivation, depression and multiple adverse psychosocial outcomes.
- Individuals with facial disfigurements due to oral diseases may experience loss of self-image and self-esteem, anxiety, depression and social stigma. These, in turn, may limit educational, career and marriage opportunities and affect other social relations.[32]

back teeth, partial dentures or treatment for gum disease. Adults also have an annual cap of $1,800, though that is flexible in the event of documented and approved medical necessity.[33] California children, deemed a higher policy priority, do not have these limitations.

Witnesses and experts made it clear to the Commission that California has great demand for dental services and a limited supply of professionals to provide it. Yet dentists, too, appear to have defensible and legitimate reasons to not participate in a state and federal program to meet the quiet emergency playing out in California homes.

California Reimbursement Rates are Among the Nation's Lowest

Of every concern about Denti-Cal, none have generated more political attention and resonated louder in the media than the program's low reimbursement rates for participating dentists and dental groups. A July 1, 2015, DHCS survey of rates paid to Medicaid dentists nationally showed that California dentists receive about one-third of what their colleagues nationally are paid for treating Medicaid-eligible patients. Reimbursement rates, indeed, haven't risen since the 2000-2001 budget year in California, and only in 2014 was a 2009 recession-driven 10 percent cut to reimbursement rates rescinded.

Dentists frequently expressed to the Commission their widely-held belief that taking too many Denti-Cal patients is a formula for bankruptcy. Two years ago in San Diego County, Dr. Lillia Larin, DDS, shut down a satellite office where 90 percent of patients had Denti-Cal coverage. "You had to work twice as hard to get the reimbursement to make the practice successful," she said. "The patient needs one or two fillings. Do I schedule a whole hour to make $30 when I need $200 to $300 to pay the bills? With a lot of patients I just do the job to prevent bigger problems for them down the line."

"If you don't have people willing to accept your product, such as Denti-Cal, what does that say about that?

Dr. and Senator Richard Pan, addressing the Commission in September 2015.

Like Dr. Larin, Dr. John Blake, DDS, executive director of the Children's Dental Health Clinic in Long Beach, shuttered a children's dental clinic in Bellflower during the summer of 2015. He testified to the Commission, "I carried that for a couple of years. I didn't think I could get any more efficient and make it work. It was losing $7,000 to $8,000 a month, a three-chair facility open four days a week."

In May 2015, the state's leading Denti-Cal provider,

Denti-Cal Reimbursement Payments Compared to Elsewhere in the U.S.

Procedure	California	New York	Illinois	Florida	Texas	National Average
Oral Exam	$15.00	$25.00	$28.00	$29.12	$28.85	$45.61
Set of X-Rays	$40.00	$50.00	$25.06	$58.24	$70.64	$123.70
Cleaning - Adult	$40.00	$45.00	$21.15	$36.40	$54.88	$85.38
Cleaning - Children	$30.00	$43.00	$41.00	$26.00	$36.75	$63.08
Fillings	$39.00	$50.00	$25.68	N/A	$116.38	$64.41
Crown	$75.00	$110.00	$91.11	$74.36	$227.05	$152.91

Source: Department of Health Care Services. July 1, 2015. "Medi-Cal Dental Services Rate Review." Pages 12, 13, 15. http://www.dhcs.ca.gov/Documents/2015_Dental-Services-Rate-Review.pdf

Orange County-based Western Dental announced it would stop taking new Denti-Cal patients at 13 California offices due to low reimbursement rates.[34] Simultaneously, Moody's Investor's Services downgraded the company's debt rating, saying its business model included a high proportion of Denti-Cal patients with low reimbursement rates.[35] In late 2015, the company announced that had reinstated Denti-Cal coverage at offices that had stopped accepting new Denti-Cal patients due to low reimbursement rates. [36]

The California Dental Association (CDA), as the state's trade association for dentists, says many of its members believe they are unfairly maligned as heartless in not accepting low-income patients covered by Denti-Cal. The CDA blames the state for running a public assistance dental program that doesn't begin to cover its members' costs. To add further aggravation to the financial losses of accepting Denti-Cal patients, they say, are difficult time-consuming administrative processes that compare poorly to commercial insurers and a patient population with higher "no-show" rates than the general population.

"It's pervasive. I hear it all the time, constant complaints. How many times will a provider put up with that and stay in the system? I think they won't," Dr. Terrence Jones, DDS, of Sacramento, told Commission staff.

Twenty-Five Years of Variable Denti-Cal Reimbursement Rates

California dentists have seen endless variability in reimbursement rates for treating Denti-Cal clients. Payment levels to dentists have fluctuated up and down for years due to court rulings, legislative actions, turbulence in the California economy and its subsequent impacts on the state budget. A timeline of Denti-Cal's historic rate instability during the last quarter century in California:

- In 1991, Denti-Cal reimbursement rates rose to cover 40 percent to 55 percent of customary billing charges in response to a federal court order in Clark v. Kizer/Coye. In 1992, a second federal court order raised Denti-Cal reimbursement rates to 80 percent of average billing charges.
- In 2000, state budget action raised Denti-Cal reimbursement rates another 6.8 percent, and added two annual regular cleanings and two dental exams to benefits for all beneficiaries.
- In 2003, the Legislature imposed a 5 percent cut in Denti-Cal reimbursement rates, effective January 1, 2004.
- In 2008, the Legislature imposed a 10 percent cut in reimbursement rates effective July 1, 2008. A federal court injunction halted the rate cut on August 18. On September 9, the Department of Health Care Services (DHCS) suspended the 10 percent reduction.
- In 2009, the Legislature eliminated Denti-Cal coverage for low-income adults.
- In 2013, the Legislature ordered a new 10 percent reduction in reimbursement rates beginning October 1, 2013.
- On December 1, 2013, DHCS exempted dental pediatric surgery centers from 10 percent cuts in reimbursement rates.
- In 2013, the Legislature restored partial eligibility of low-income adults for Denti-Cal effective May 1, 2014.
- In 2015, the Legislature raised Denti-Cal reimbursement rates by 10 percent effective July 1, 2015, a $60 million expense with the state responsible for $30 million.[37]

Drs. Blake, Jones and Larin all told the Commission they doubt the state will again increase reimbursement rates any time soon due to the costs. Yet all said it will take a sizeable hike to even dent the problem of dentists sitting out the Denti-Cal program. At a March 2015 Joint Legislative Audit Committee hearing about Denti-Cal, Senator Pan told his legislative colleagues "Even if we doubled rates, we would only be 70 percent of the national average."

Low Rates Incentivize Questionable Behavior, Raise Health Care Costs

At the September 2015 hearing, Senator Pan told the Little Hoover Commission it should consider the question: "How are Denti-Cal policies incentivizing provider behavior, some perhaps that are not necessarily ones that are desirable? When you have payment rates that do not adequately cover practice expenses there's pressure on providers then to make that up if they're going to be viable to perform high-volume, particularly more highly-paid services and procedures. Then the department responds when they see this higher volume by creating even more barriers to payment, which drives out even more providers and basically who are you left with? People who have figured out how to work the system to do high volume just to keep the practice viable. I think we have to recognize that."

Prospects for continued inaction on reimbursement rates also mean the impacts and costs ripple up the line at ever-greater expense to dental specialists, emergency rooms and hospital surgery suites. At the Commission's September 2015, hearing, Senator Pan also said, "You have a third of all Californians who have small children who are stuck in this plan. And the fact that you're squeezing on one end of the balloon, as they say, it starts popping out the other. If people can't get in with prevention, they eventually show up for more serious treatments. Now you have cavities that aren't treated and you're putting in a crown. Then they set up in the emergency room with an abscess and now you're treating that. Then they have to have teeth extracted and then you're talking about dentures and on and on. You start to cause this ball to roll."

Dr. Larin told Commission staff that one of her biggest challenges is finding specialists to take cases she can't handle. She told the Commission she has to pick up a phone and beg specialists to accept her emergency cases, often unsuccessfully. Consequently, she said, these patients end up in the emergency room at high cost to the local and state health system.

Dr. Rosa Arzu, dental director at Los Angeles-based Alta Med, the nation's largest FQHC, told Commissioners at

Civil Rights Complaint: Reimbursement Rates = Intentional Discrimination

California's low reimbursement rates for Medi-Cal and Denti-Cal prompted civil rights groups in December 2015 to file an administrative complaint with the U.S. Department of Health and Human Services, alleging that "Medi-Cal's inadequate, extremely low reimbursement rates – in both the fee for service and managed care settings – and its failure to adequately monitor access to medical care, effectively deny the full benefits of the Medi-Cal program to more than seven million Latino enrollees who rely on Medi-Cal for their health care."

Low reimbursement rates, the complaint alleges, have shriveled the supply of doctors and dentists available to Latinos, caused them long waits to see specialists and created a "separate and unequal system of healthcare in California." The well-to-do have commercial insurance or well-reimbursed Medicare coverage, states the complaint, while lower-income Latinos have a plan shunned by doctors and dentists. It states further that since 2000, Medi-Cal reimbursement rates paid to doctors and dentists in California have fallen behind Medicare rates of reimbursement in almost direct proportion to the numerical rise and statewide share of Latinos covered by Medi-Cal. The complaint seeks a federal investigation and a hike in Medi-Cal/Denti-Cal reimbursement rates to ensure that Medi-Cal enrollees enjoy the same quality of health care as other groups in the general population.[38]

the November 2015 hearing that people ask to have their teeth pulled out rather than endure the pain while waiting for reluctant specialists to see them. "When I have to refer patients, there are limited resources outside, of providers who want to see our patients," she testified, "especially when it comes to specialty services."

"I strongly advocate to preserve the teeth, not to extract them," Dr. Arzu told the Commission. "But patients get really frustrated that they cannot get treatment and they have pain. And you know, it's very painful so they want to go with the option of extracting the teeth. These are some of the areas where we continue and it's just getting worse. I really try to engage these providers, but the cost to treat these patients is very high and not sustainable for them."

History shows that the Legislature and Governor are reluctant to undertake the vast multibillion-dollar expenses it will require to significantly raise rates across the board in the future. As this is a political issue, the Commission did not directly engage in the subject nor make recommendations regarding wholesale reimbursement rate hikes during this study. The Commission did review, however, the workable alternative of highly-targeted rate hikes to address specific goals, such as more dental care in areas with great need and few providers, and also for preventative care, particularly for children. This will be discussed in greater detail in Chapter III.

Beyond Rates: Dentists Say Denti-Cal is "Broken" and "Dysfunctional"

California dentists told the Commission that the Denti-Cal care delivery system is not only difficult and frustrating for dental professionals, but worse, that it largely fails to serve its customers. "I'm now a veteran in this well-intended highly-flawed system called Denti-Cal," testified Dr. John Blake, DDS, executive director of the Long Beach-based Children's Dental Health Clinic, in September 2015. "We have created a system where now 53 percent of our state's children are eligible for a card that gives them access to free dental care. Please do not misinterpret my discontent; there are many children that would have no other access to dental care if this system was not in place. But that access to timely, appropriate care is no longer available. The problem is that the system has been allowed to morph into its current form of dysfunction, serving neither the patient nor the provider," he testified on behalf of himself and the California Dental Association, a trade association for approximately 26,000 California dental professionals.

Dr. Blake, among others, told the Commission it's hardly enough to tinker around the edges of the program. "What if you started from scratch and abolished the system?" he asked. "It truly is dysfunctional and broken." Dr. James Musser, DDS, a Sacramento-area

"One solution is what I have termed the "nuclear" option. Blow the whole system up and start from scratch. What might that system look like? Give each eligible child's family a traceable card (or smartphone app) with $500 loaded annually to be used for (non-esthetic/elective) dental care. They can go to any registered office of their choice and establish a dental home for their child. There would be an obvious incentive to arrest current dental disease, change destructive habits, keep and maintain a healthy mouth. Yes, parents may have to pay for annual dental services above the $500 limit. Most would not want to do this every year and would have a strong incentive to maintain optimal oral health. The one exception to this program would be those patients with documented special needs/ disabilities. There should still be a system of reimbursement for dentists that treat these complex patients, often under sedation or anesthesia. It has been difficult to ascertain the true current cost of the Denti-Cal system, but from the publicly available numbers I found, this proposed system would be cheaper than the current one. It would also put some responsibility back with patients/families and encourage a better dentist/patient relationship."

Dr. John Blake, DDS, Executive Director and Dental Director, Children's Dental Health Clinic, Long Beach.

dentist, responding to a Denti-Cal staff presentation during an August 2015 Sacramento County Medi-Cal Dental Advisory Committee meeting, used a decade-old Governor Arnold Schwarzenegger analogy, saying, "It's not enough to rearrange the boxes. We need to blow up the boxes." Dr. Paul Glassman, dental professor at the San Francisco-based Arthur A. Dugoni School of Dentistry at University of the Pacific, expressed similar sentiment in an August 19, 2015, letter to the Commission. In the letter, Dr. Glassman contended the state's entire approach to dental care for a vulnerable, needy population contributes to the problem:

- "The Denti-Cal system is organized with an emphasis on providing complex treatment which is needed after disease has progressed rather than an emphasis on reaching people early and preventing the development of disease.
- "The Denti-Cal system is organized to emphasize treatment services provided in dental offices and clinics. Unfortunately, the majority of Denti-Cal eligible people do not access services in these offices and clinics.

Other States Have Reformed Their Medicaid Dental Programs

Several U.S. states with problems similar to those in California have upgraded their Medicaid Dental programs in recent years to attract more dentists and raise utilization rates by those eligible for dental services. Some examples:

- **Minnesota:** Minnesota's dental administrator used a mobile dental clinic to visit underserved communities. The mobile clinic provided X-rays, exams, cleanings, fillings, extractions and fluoride treatments onsite. The program partnered with the University of Minnesota for faculty-supervised dental residents to provide care at the mobile clinic.[40]
- **Iowa:** Iowa established 24 regional dental coordinators as points-of-contact for families, providers and dentists in its program. Licensed dental hygienists act as these coordinators, developing local referral systems, coordinating care and training dental health care providers.[41]
- **Texas:** To increase dentist participation, Texas created the Dental Education Loan Repayment Program. Dentists who practice at least 12 months in underserved areas receive up to $10,000 to pay back their dental school student loans. Texas also created a toll-free hotline for program participants to receive one-on-one assistance over the phone.[42]
- **Virginia:** Virginia converted its dental care delivery system for Medicaid recipients from managed care to a single state administrator, which handles only handle dental care. A separate administrator covers medical care under Medicaid. [43]
- **Maryland:** Maryland also carved its Medicaid dental program out of managed care into a fee-for-service system. The state also developed a training and certification program for medical providers to conduct oral health exams and fluoride varnish. Maryland also permits dental hygienists to provide care at schools and Head Start centers.[44]
- **Connecticut:** Connecticut established a care coordination and case management team of eight dental health care specialists, with seven covering specific regions, and one working with special-needs clients. The state also established a bilingual client-focused call center to act as an intermediary between dentists and patients. The call center refers patients, schedules appointments and arranges transportation for clients.[45]

- "There is limited ability under the Denti-Cal system to receive payment for activities that bring dental services to community locations and provide services that emphasize prevention and early intervention." [39]

The State Should Set a Bold Target and Get Started

The Commission recognizes the enormity of the challenge facing DHCS staffers in providing quality dental care on the massive scale now necessary in California. By all accounts, the reimbursement rates set by the Governor and Legislature are simply too low to attract enough providers. "How many of you are still working for the same salary as you had in 1991?" one hearing attendee asked the Commission in September 2015. The DHCS Denti-Cal division must deal with a 25-year legacy of Legislature-driven reimbursement rates that have risen and fallen with the state of the economy – and which make the state an unstable and unreliable funding partner for the state's dental profession. The Commission equally recognizes from the experiences in other states that no matter what level reimbursement rates are, a limited number of dentists will participate.

More, the population eligible for Denti-Cal is not an easy one to bring into dental offices. Its members have limited transportation, limited time in their working lives and limited education about the importance of regular checkups and preventative care. Denti-Cal officials, meanwhile, must be vigilant for the inevitable fraud conducted by some providers while trying not to paint the entire profession with a broad brush. As the Commission has discovered during its study, DHCS' Medi-Cal and Denti-Cal staffers, too, must work with demanding partners who see or experience the dreadful, painful outcomes of poor dental care up close and want something done about it immediately. It cannot be easy for department staffers to keep their focus in the midst of so much raw, human need.

However, a worsening epidemic of rotting teeth, of toddlers needing surgery because their mouths are already ruined, of desperate parents being unable to get treatment for their special needs children and adults demands stronger action. The Commission senses that the Denti-Cal program is bureaucratically frozen in ways that will become more evident in the next chapter. The ability to progress beyond the current silent emergency requires a vision, and the ability to build a vision requires a target. California is familiar with setting targets, particularly to meet long-range environmental goals. The presence of targets will motivate employees, show progress and continually point efforts toward success. The Commission begins this report with the call to simply get more people to see a dentist or dental professional. The ways to do so are small and they are large. But they need to begin.

A Path to Action: Begin With a Forceful Utilization Target

Recommendation 1: The Legislature should set a target of 66 percent of children with Denti-Cal coverage making annual dental visits. Additionally, the Legislature should:

- ***Conduct oversight hearings to assess progress or lack of movement on all initiatives designed to reach this target, and particularly on implementation of the five-year $740 million Denti-Cal targeted incentive plan to increase children's preventative dental visits.***
- ***Ensure the state dental director has adequate authority to see that the Denti-cal targeted incentive program aligns with the 2016 oral health plan.***

The Legislature should declare its intent that annual Denti-Cal utilization rates among children in California climb well into the 60 percent range, as is the case in approximately 20 percent of U.S. states.[46] A specific target of two-thirds of children using their benefits annually, comparable to children with commercial insurance, will gradually stimulate and accelerate the necessary range of small and larger solutions by DHCS and its partners to get there. The Department of Health Care Services and the Centers for Medicare & Medicaid

Services recently announced an experimental five-year incentive plan to focus on prevention and increase children's annual dental visits by 10 percentage points. However, it remains uncertain if the plan will produce results to meet that goal. Separately, the state's new Oral Health Plan being produced by State Dental Director Jayanth Kumar, DDS, within the California Department of Public Health and scheduled for release in June 2016, also aims toward a 10-year increase in the numbers of children making an annual dental visit. While the Commission has strong hopes for these two plans, the Legislature, in addition to continuing strict performance oversight of the DHCS Denti-Cal program in general, should oversee both plans as they work in tandem and closely monitor their progress or lack thereof. The Legislature and Administration also should ensure that the state dental director has adequate authority to align the plans and publicly recommend and make necessary course changes to reach an improved utilization rate. California's entire dental health care bureaucracy should work with its partners in the private, public and non-profit sector toward a target of 66 percent utilization rates among children.

A Customer-Centered Upgrade

Many Little Hoover Commission studies deal with perceptions that state agencies adhere blindly to bureaucratic process and disregard legitimate issues of those they serve. But Denti-Cal may be unique in the widespread dislike that dental providers and other partners have for the state program and the outdated processes it uses. The Commission heard repeatedly during its study process that the state's administrative and billing processes are terrible in comparison to commercial insurance – and, along with low reimbursement rates, are a big reason why dental providers won't participate. Dentists told the Commission they feel nitpicked, second guessed and presumed dishonest by state government dental staffers whom they do not consider peers.

The Commission also heard that the Department of Health Care Services (DHCS), which administers Medi-Cal and Denti-Cal, is not good at inclusion. Witnesses and others interviewed by the Commission said officials responsible for Denti-Cal go through the motions of listening to outside advice, but seldom seem to act on it, and create arbitrary rules that make no sense to dentists accustomed to smooth-functioning commercial insurance plans. They told the Commission the department acts unilaterally in ways that harm its beneficiaries, particularly in the special needs community. Others said the department is awash in red tape that burdens the majority of providers to prevent fraud among a few, and is unaccountable and inexplicable in its decision-making to outsiders who advocate for improved care. This chapter addresses many of the issues that have alienated California's dental professionals. It also recommends a series of cultural and administrative changes to attract more dentists to the Denti-Cal program and, as a consequence, strengthen the oral health of all Californians. The department and its Denti-Cal division could benefit by focusing less on policies tailored for the lowest common denominator of provider and more on customer service and meeting the needs of its beneficiaries.

"I think sometimes the culture of the department, i.e., its rather rigid bureaucracy, is perceived, as instead of meeting the needs of that very needy, at-risk vulnerable community, that they have not been flexible enough or focused enough to meet that core need. I have for many years had some concerns about the way the department communicates with your beneficiaries, in writing, cultural competency, all those kinds of things."

Senator Holly Mitchell, addressing DHCS Director Jennifer Kent at her January 20, 2015 confirmation hearing before the Senate Rules Committee.

Billing and Administrative Issues

Dental professionals told the Commission that alongside low reimbursement rates Denti-Cal's everyday administrative issues make them think the system is broken and cause them to balk at enrolling and accepting patients. Dentists described complications experienced by their billing specialists that cost them more in administrative time than bills are worth. They complained – in a world of easy, commonplace online transactions – of their offices repeatedly faxing paper claim forms back and forth with the state and being rejected for seemingly trivial reasons. "The billing system is so different," Senator Richard Pan told the Commission. "You have to hire a biller who can deal with the system, a biller who understands Denti-Cal," he said.

The California Dental Association (CDA), in written testimony for the September 2015 hearing, summarized this frustration with billing and administrative issues expressed by many of its members: "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."

The CDA continued, "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."

Dr. David J. Stone, an Amador County pediatrician who provides oral exams for children in a county with no Denti-Cal providers, testified at the Commission's November 2015 hearing that in his practice he has

Inefficiencies of Denti-Cal are "Absolutely Staggering"

At the September 2015 hearing, Commission Vice Chair Loren Kaye asked Assemblymember Jim Wood what it would take to "get the ball rolling" on some Denti-Cal changes to improve dental provider participation. The Assemblymember, a former practicing dentist, answered:

"I have direct knowledge of all those challenges and quite frankly where *do* you start is a real challenge. Obviously, the reimbursement rates are a critical component, but the actual inefficiencies of the program are absolutely staggering. It took a long time to get my provider license. It shouldn't take that long to do that. It was much faster with private dental care like Delta Dental, to get it. Even though Delta is the administrator for Denti-Cal it was still a much more onerous procedure. I think the current process, which I will grant there is work being done on that, that application is like 40 pages long and a lot of that doesn't apply to dentists. And that's ridiculous in this day and age.

And you can't do it online. You can't access a lot of this stuff online. It's ludicrous. The billing challenges around how you bill for specific procedures. The requirement for preauthorization treatment for specific procedures like fillings, for crying out loud, make it really difficult. This is a challenging population of patients to work with. Having them come back multiple times to get treatment is really, really difficult.

"The billing part for the provider is the worst billing system of anything I have ever worked with in the 27 years I practiced dentistry. And more often than not, even with experienced staff, the return rate on claims was 25 percent because maybe you left a box out, or didn't process a fee somewhere, or didn't have the exact word for the description for why you were treating that specific tooth. Which I will say, you never have to do with a commercial carrier.

"It got to a point in my practice where I just simply said, 'You know what, you have a dollar threshold and if we get to that point, I'm not going to have my staff, at $25 an hour, which I was paying my person to do this, to chase a $30 dollar claim multiple times.' So there are multiple bites of the apple. But the inefficiencies of the program for providers being part of it, the treatment authorization challenges and the billing are things that could make a big difference and take a lot of that pressure off practitioners."

seen two pediatricians handily reimbursed for doing a particular oral procedure and two other pediatricians denied throughout 2015 for doing the same procedure – "and nobody can tell us why."

During that hearing, Commission Vice Chair Loren Kaye asked Mindy Epperson, a supervising pediatric nurse in Dr. Stone's practice, to provide specific examples of billing difficulties. Ms. Epperson had just testified that billing the state for oral health exams performed by pediatricians – in a county where lower-income people have no other dental care options – is not "as easy as I think they could or should be."

"Providing a clean bill is not as intuitive as you think it would be," Ms. Epperson told the Commission. "There are specific forms that need to be filled in. I'm trying to be polite. A PM 160 is required for every physical that we perform and that form in itself is very cumbersome. There are boxes, that if not checked, or there isn't information in them, we won't get reimbursed. We'll be denied right out of the gate. It's not filled in electronically. It's done by hand and then the coding and the cost is entered into that, and if any of those numbers are not visible, not completely visible on the faxed form, they will be denied."

The Commission learned in testimony and conversations with dental providers that improving two state processes alone – enrollment and pre-authorization for treatment – could go far to lessening provider frustrations with the Denti-Cal system. Fixes to the two issues that follow represent so-called "low-hanging fruit" that could show quick results in encouraging more dentists to accept Denti-Cal patients.

To its credit, the department and its Denti-Cal division, both under new leadership in 2015, has begun to streamline the two processes. In February 2016 DHCS officials told the Commission that it is in the review stage of simplifying and shortening the enrollment form. During the Commission's 2015 review, DHCS also eliminated a blanket policy that required dentists to send X-rays to the department to prove the need for nearly all work they perform. Both will be explained in greater detail later in this chapter. But for dental providers accustomed to largely being trusted by commercial insurers and easily signing up with them online, even these hints of promise may largely seem too little too late.

Enrolling as a Denti-Cal Provider is Time-Consuming, Difficult and Can't Be Done Online

California dentists get their first exposure to Denti-Cal's inefficiencies when they try to enroll to become providers. Numerous representatives of the dental business told the Commission it takes months to enroll with the state program in comparison to the easy process of enrolling in a commercial program.

"My son is a new dentist. It took almost three to four months to get enrolled as a Denti-Cal provider, San Diego County dentist Dr. Lillia Larin told the Commission during an August 2015 conversation. "If I want to add anyone into a commercial insurance plan it takes two weeks. It's so difficult. They ask for more and more."

"The time that it takes to do that, the hassle, the burden, it's tremendous," then-CDA Director of Public Policy Nicette Short testified at the September 2015 hearing. "The frustration that we have from our members who are trying to do the right thing and join the system. It takes in some cases six months to a year. We have stories of that. Mounds of paperwork that have to be faxed back and forth. It's simply just a hassle and barrier to providers that want to join the network and just give up."

Brianna Pittman, CDA legislative director, said new dentists typically don't accept Denti-Cal patients as they begin their practices because it takes up to six months to get enrolled in the program. By the time they receive approval to participate, she said, they often have built up a clientele with commercial insurance and do not need to accept Denti-Cal patients.

Ms. Short told the Commission that dentists must fill out 22 pages or more of paper forms tailored to doctors who are applying to become Medi-Cal providers. The state has no Denti-Cal enrollment form specifically for dentists. This often causes confusion among dentists unfamiliar with some terms used by medical doctors. "The form is 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," the CDA stated in written testimony. Small oversights, for example, such as failing to answer "NA" or "not applicable" to a question can cause paperwork to be kicked back to the applicant to start over, CDA representatives testified in September 2015. The CDA's message to the state Denti-Cal bureaucracy is as consistent as it has gone long unheeded. A California Healthline report once quoted then-CDA Manager of Policy Development Gayle Mathe as saying, "Enrollment for dentists should be simple and streamlined, an easy click-through process online." The date of the report: August 4, 2008.

Long-time Denti-Cal dentists also are required now to re-enroll with the program due to provisions in the federal Affordable Care Act which added several million new beneficiaries. "One of our members said it took a year. Another said it took seven months to re-enroll," said Ms. Short. Testifying to the Commission in September 2015, she described the case of a veteran Denti-Cal dentist who had leased the same dental office for 40 years, but had to make copies of the lease and all amendments to that lease over 40 years and fax them to Denti-Cal as part of his recertification application.

"Last year (2014), participating dentists were asked to re-enroll or signify that they no longer wished to provide care in the Denti-Cal system. Those that chose to stay in were met with a very lengthy application with odd, seemingly non-relevant questions. It took one of our staff members almost 40 hours gathering information to help our 17 dentists re-apply. This is not an efficient system and certainly does not encourage dentists to participate."

Written Testimony. Dr. John Blake, DDS., executive director, Children's Dental Health Clinic, Long Beach.

"We raised that with the department earlier this year (2015) and said there has to be a better way," Ms. Short told the Commission. "My understanding is that there was one provider 20 years ago, who used a P.O., who did the wrong thing, and now they have this process in place for *all* dentists." Ms. Short also told the Commission that CDA's internal Medi-Cal Working Group and other dentists have made repeated offers in recent years to meet with Denti-Cal staffers to discuss ways to simplify and improve the enrollment forms and eliminate them as a barrier to dental provider participation. She said no meetings have resulted from those offers.

Delta Dental to the State: Use Our Enrollment Form Instead

A Delta Dental of California representative testified to the Commission with an easier, more direct answer to the enrollment criticisms. Joe Ruiz, the firm's vice president for government affairs, said Delta Dental has offered the state a version of its online commercial application form.

"Our application for commercial is about 13 pages long, of which about 10 pages are actual contractual agreements and the other two or three are the application," he told the Commission. "That's about half as long as the length of the application for Denti-Cal's program. We've had a number of discussions with the department; let's just take our app and we can lift and shift the Delta application to the Denti-Cal program. Again, it's very well received, but as I understand there are administrative processes, there are things that are codified into regulation that have to be addressed before we just rebrand the Delta app with Denti-Cal and we're off and running.

Said Mr. Ruiz, "To me that's an example of what I would consider low hanging fruit. That makes it a lot easier

"It Wouldn't Be Good"

During the September 2015 hearing, Senator and Commissioner Anthony Canella asked Joe Ruiz, vice president for state government programs at Delta Dental of California, "As a commercial provider, what would happen to your firm if you provided the same level of service that the state provides through Denti-Cal?"

"It wouldn't be good," Ruiz answered.

"It wouldn't be good," Senator and Commissioner Canella repeated.

to get in the program and a lot easier to stay in the program. We know that is a significant barrier to provider participation."

During the September 2015, hearing, Commission Chairman Pedro Nava, told a representative of DHCS that it should ask the Legislature's assistance to deal with any regulatory obstacles to simply using Delta Dental's online enrollment form. He also suggested that the department take lessons from the commercial sector. "When Delta Dental is saying that perhaps under the right circumstances you can take their processes and their contract and put the State of California logo on it, then we need figure out how to help you get to that point so you aren't confronted with regulatory obstacles particularly if you get to the same objective, which is program integrity."

DHCS: A New Enrollment Package is in Final Review

In early 2016 DHCS told the Legislature and the Commission that it is working on a new version of the enrollment forms to ease some of the concerns expressed by participating dental providers. At her January 20 confirmation hearing before the Senate Rules Committee Director Jennifer Kent explained, "There's certain things about our application that we have to ask, back to federal law, so we can't get around those. But we have been in discussions with Delta (Dental) about using their network, using their providers to proxy, so if they want to be a Denti-Cal provider, can we just ask those questions that we have to on a federal level and let the credential of Delta stand in for the rest?"

On February 4, 2016, the department responded to a Commission question about the status of Delta Dental's offer to let the department use its online enrollment form:

> *"The Department's proposed group and individual provider enrollment package for Denti-Cal is currently undergoing final internal review. The Department intends to refine the standard Denti-Cal enrollment package by transforming the current 34-page provider enrollment application to 10 pages. The revised application will only contain required information necessary for completing the enrollment process thus aiding in streamlining the enrollment process with a goal towards increasing provider enrollment and participation. DHCS will share the final draft application with stakeholders, including legislative staff for review and comment; once it is finalized, it will be posted in the Denti-Cal provider manual."*

The Commission can't know the response from providers and department partners once the new form is introduced. Nor does it have a timetable for when new dentists might begin using it. A similar improvement described by DHCS to Commission staff in July 2015 – a proposed new online enrollment form available to Medi-Cal-only providers by year's end – had not yet been introduced as of February 2016.

The department also informed the Commission that there is no timeline to integrate dental providers into an online enrollment process such as that used by commercial insurers. Estimates from the department indicate that it hopes to begin enrolling dentists online in two to three years.[47] Such an extended timeline is disappointing. The Commission's October 2015 report, *A Customer-Centric Upgrade for California Government*, showed how new digital service teams inside the federal government are upgrading technology to remove performance bottlenecks like those described regarding the Denti-Cal enrollment form. The report also suggested it would be easier if "the Denti-Cal provider form is streamlined and modeled after commercial insurance provider applications, eliminating all fields that relate solely to Medi-Cal. Dentists complete and submit this simpler form online." If the State of California adopts similar digital service teams, the Denti-Cal enrollment form would make a worthy target.

Dentists Need Permission to Perform Routine Restorative Treatments

Dentists who have successfully enrolled to be Denti-Cal providers quickly run into a second obstacle unlike anything they encounter with commercial insurance

plans. Before they do the most complicated restorative dental procedures for their Denti-Cal patients they must first submit X-rays to the state and receive permission to perform the work or find themselves in the position of overcoming denials. While these procedures do not represent the majority of dental work done in California, they are frequently necessary given the long-untreated tooth decay experienced by many child and adult Denti-Cal patients. Pre-authorization requirements, too, are part of an administrative system that causes dentists to balk at becoming providers and further shrinks the amount of available dental care for lower-income Californians and their children.

"Compared to commercial insurance carriers, the Denti-Cal system is perversely challenging to navigate," Dr. Blake testified at the Commission at its September 2015 hearing. "Procedures that are not questioned and routinely paid by commercial carriers require pre-authorization, often delaying timely and necessary treatment. Examples are crowns, root canals and periodontal (gum) treatments. I have one full-time employee that dedicates her workweek to pre-authorizations and resubmissions."

Denti-Cal requires pre-authorization – a so-called Treatment Authorization Request (TAR) – for these more complicated restorative procedures as a way of preventing fraud among dental providers. Denti-Cal providers say, however, that the current blanket requirements amount to an extra burden on every provider to stem abuse by the few. They also require low-income patients who may rely on transit and have inflexible work hours to make not one, but two visits to the dentist.

Senator Pan, in a June 2015 conversation with Commission Chair Pedro Nava, said, "On Denti-Cal you take X-rays and tell the patient, 'Go home. I'll call you when I get it approved.' That's two visits. They (DHCS and Delta Dental) think they are reducing fraud, but it complicates in both worlds. You have two visits. You may have brought your child on the bus and you may have taken off work."

Dentists also have traditionally had to send pre-treatment X-rays to Denti-Cal for inspection as part of their reimbursement claims for routine fillings already done. Most of those X-rays were never reviewed, despite the time and expense that dental offices incurred in making duplicates and sending them to Denti-Cal. However, during the Commission's study process the department eliminated that blanket requirement. Dentists must still document the need for routine restorations such as fillings and prefabricated crowns by taking X-rays, but they are no longer required to send the X-rays to Denti-Cal with their requests for payment. The department told the Commission that X-rays are now only required if a random review suggests the need for Denti-Cal to see them. More complicated two- and three-surface restorations still require X-rays, however, when dentists submit their claims for reimbursement.[48]

Little Difference in Fraud Between Commercial Insurance and Denti-Cal

During the September 2015 hearing, Joe Ruiz, vice president, state government programs for Denti-Cal's administrator, was asked by the Commission if fraud is higher in state programs than in commercial insurers. Mr. Ruiz said he didn't have data to answer the questions, but speculated to the Commission that there is little difference between the two sectors.

While this change made by DHCS is commendable and easing the burden on dental offices to copy and mail their X-rays to the state, witnesses told the Commission it is possible for Denti-Cal to eliminate its requirements for preauthorization altogether. At the September 2015 hearing, Delta Dental's Mr. Ruiz told the Commission, "In the commercial world we don't require any prior authorizations." In written testimony, he stated, "Rather, we perform an analysis on dentists' utilization and based on the outcome, the provider may be placed in what we refer to as 'Focused Review.' When a provider is placed on Focused Review, we require additional documentation beyond what is normally required, usually additional radiographs and/or documentation to substantiate the needs for the treatment requested, or to demonstrate that the service meets our policy and the guidelines outlined in our Provider Handbook. Focused review lasts

DHCS Hasn't Asked Legislature to Help Erase Regulatory Obstacles

The Commission learned during a frank discussion with the department at the September 2015 hearing that many fixes of this scale require changes to state law – but that for years, as discontent with Denti-Cal has grown among providers, recipients and interested parties – the department hasn't asked the Legislature to make them. An exchange during the hearing between Commission Chairman Pedro Nava and DHCS Deputy Director René Mollow offered insight into lack of progress on concerns that cause dentists not to participate in Denti-Cal:

Chair Nava: "As it relates to the regulatory process where you say you can't just change the rules. You made a reference to that in your testimony. So can you explain to me what it is, how you are in the position where you can't make the changes that you need?"

Deputy Director Mollow: "We can make changes, but we have to go through regulation. So it would be a state law change."

Chair Nava: "That's my question. So if I have Senator Canella here who wants to know what it is you need to be able to do in order to expedite some of the elements of your program. What does he need to know about what you need to fix so that if I talk to you next year you don't tell me that we can't make those changes, because we're prohibited. What do you need to have different, that is in the purview of the Legislature, that can address some of the testimony that we've heard here today. Because I imagine that some of it is federal, but some of it is going to be state."

Deputy Director Mollow: "Yes, there's some things required by the state law. Part of it would be a consideration regarding administrative flexibility. And so again, our authority today to make programmatic changes, we have to go through a regulatory process. In other program areas we can go through and have administrative processes. So again, we'll issue, say a provider bulletin, usually it's a provider bulletin in this arena, followed up by, say, a regulation. That would give us the flexibility to make changes a little bit more quickly. But everything takes time. There are systems and all of that. But that would be one way for us, which for us as we're making those changes, where we can make those changes, make those policy interpretations through that vehicle, and then follow it up with regulation."

Chair Nava: "I'm going to assume – Senator Canella said he's been here five years – I'm going to assume that that request has not been made by your department. Have you made requests for legislative changes?"

Deputy Director Mollow: "That has not been something we have done."

Chair Nava: "You see, as a former legislator, this where I would say to the department, 'Where the hell have you been?' – in a nice way. Because if those are things the Legislature can weigh in – and that's a political issue, it's a political leadership issue – the push to make the change, seems to me, ought to come from the department. Because the last thing you want is an uneducated legislator saying they want to fix it. Because then there's unintended consequences that the Little Hoover Commission has to come back in and look at five years later. So, I'm just suggesting that one of the first things that ought to happen when you leave here is a meeting with whoever you need to meet with in your agency to talk about your legislative package. And then meet with Senator Pan and meet with Assemblymember Wood and meet with Senator Canella and come up with a bipartisan legislative proposal to get into the stuff that can be done. You're not going to be able to do all of it … But without some movement on the legislative front, you know, you don't want us coming back and asking you, 'How come you haven't done it yet.'''[49]

for at least six months, at which time we will re-evaluate the provider's utilization of the procedures."

Mr. Ruiz told the Commission that Delta Dental has recommended to DHCS that it adopt a similar approach for its Denti-Cal program. That has not come to pass. In the wake of its study process, the Commission concludes that recommending a blanket end to treatment authorization requests is a question beyond its expertise. Yet clearly, a high-level overhaul of the department's processes with X-ray submissions and preauthorization should remain prominent on the department's agenda – and also weigh expert input from a recommended new Denti-Cal advisory panel to be discussed later in this chapter. The California Dental Association told the Commission that many dental providers still believe the recent changes are just the beginning of what needs to be done and not the end. And just as clearly, if dental providers use the state's administrative rules and processes on X-rays and preauthorization as one more reason not to participate in Denti-Cal, the greater end result is lack of access to dental care for the ultimate audience of this program, the beneficiaries who need it.

Overhaul an Adversarial Culture and Sweep Away Outdated Rules

The Commission's September 2015 hearing, which spotlighted widespread frustrations experienced by professionals and beneficiaries who deal with DHCS, featured extensive DHCS testimony about eventual solutions and new initiatives, but caused some Commissioners to note a lack of actual concrete accomplishments being brought to their attention. Despite expressions by the department representative that DHCS can and will do better, the DHCS testimony and discussion with Commissioners seemed to reinforce sentiments of witnesses and those making public comment: that DHCS appears captured by bureaucracy and processes and is unable to advance a convincing agenda of change to fix Denti-Cal's obvious shortcomings and their harmful impacts on California's social fabric.

Understandably, given Denti-Cal's rapidly growing number of beneficiaries, its circumstances of operating a program with some of the lowest reimbursement rates in the nation, the necessity of clearing potential changes with a federal partner and its need for vigilance against fraud, its staffers might justifiably feel maligned, put upon and under constant siege from outsiders. Daily, they must contend with agitated partners greatly alarmed by a growing epidemic of dental decay, needy beneficiaries in pain and made desperate by their inability to obtain dental care and a professional provider class which has signaled its discontent by largely abandoning the

DHCS Concerns About Denti-Cal Fraud are Legitimate

Some California dentists do generate income with questionable procedures on Denti-Cal beneficiaries. A May 2015 report by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services identified questionable billing by 329 California dentists and six orthodontists in 2012. The report stated that Medicaid paid the identified providers $117.5 million for pediatric dental services that year. "Half of the dental providers with questionable billing worked for dental chains," stated the report. "The majority of those providers worked for five chains, two of which have been the subject of State and Federal investigations. A concentration of providers with questionable billing in chains raises concerns that these chains may be encouraging their providers to perform unnecessary procedures to increase profits." The report pointed out that questionable billings were not proved to be fraudulent, but raised suspicion by often falling well outside the norm of the number of daily visits and procedures and the amount of payments per child seen. "Our findings raise concerns that certain providers may be billing for services that are not medically necessary or were never provided," stated the report, which noted that follow-up investigations were continuing and would lead to appropriate action. The Office of Inspector General recommended that DHCS increase its monitoring efforts of dental providers to identify patterns of questionable billing, and particularly, those within dental chains. The department, in a letter to the OIG from Director Jennifer Kent, agreed with the recommendations and outlined several steps to implement increased monitoring.[50]

program. One can imagine how the Denti-Cal division, a small bit player in the infinitely larger Medi-Cal system, could circle its wagons and simply try to get through another day within California's massive state bureaucracy.

But an adversarial culture has become part of the problem with Denti-Cal.

Many dentists who participate in a program that pays little for their services told the Commission they feel nitpicked by bureaucratic rules and treated by the state as if they can't be trusted. "Our members feel they are assumed to be doing bad things and have to prove otherwise," Ms. Short, then-CDA's director of public policy, testified to the Commission in September 2015.

The dental profession complained repeatedly to the Commission of a regulatory thicket within DHCS that seems to originate with old cases of fraud – and now constantly perplexes honest operations to protect the state from fraudulent dental providers. From the depth of these complaints, it seems clear that DHCS could benefit from designating two or three staffers to review Denti-Cal rules and regulations, and in short order recommend sweeping away those that exist simply because they exist and ultimately do more harm to beneficiaries than good by driving away providers.

"We encourage the department to walk through all of those rules and figure out how did they come into being? Are they meeting a need for the department? Are they simply overly burdensome and causing too much grief to the providers to participate?" Ms. Short testified during the September 2015 hearing. She said dental providers understand that some rules exist as a barrier to fraud, but she suggested that a detailed analysis would help separate those rules that are necessary from those that needlessly complicate business operations and alienate dental professionals from Denti-Cal.

The dental profession and advocates for children and lower-income adults say the department is not good at seeking or considering outside views and makes poor decisions without input from external groups. Some of these decisions lead to further confusion as dental providers and interest groups try to interpret them, and also the reasons behind the changes. The department could go a long way to improve relationships with a customer-centric culture change that begins to envision dental providers and non-profit groups more as partners and less as outside adversaries. Two issues, unexpected when the Commission began its review, surfaced repeatedly during two public hearings and exemplified strains between the department and its dental providers.

A New Requirement for Advance X-rays

One issue involved a new rule, proposed to take effect in January 2016, to make Registered Dental Hygienist in Alternative Practice (RDHAP) providers obtain X-rays in advance for Scaling and Root Planing procedures performed on institutionalized patients. Advocates told the Commission the new rules would endanger the health of a largely immobile population that lives in skilled nursing facilities and can't travel to a dentist's office for X-rays. Members also said the rule change threatened the existence of a special dental provider classification, largely occupied by women with their own mobile businesses, created and designed nearly 20 years ago to expand dental services to more Denti-Cal-eligible patients statewide.

Department representatives told the Commission it seemed unusual to its analysts that among 100,000 Denti-Cal-eligible patients in skilled nursing facilities statewide nearly 88,000 received a Scaling and Root Planing during the 2013-2014 fiscal year that ended June 30, 2014. More, the representatives said, 135 RDHAPs performed two thirds of the procedures statewide, raising questions about their necessity – and hence the new policy requiring X-ray documentation.

Meetings between the department and advocates for RDHAPs – in the wake of repeated public expressions of concern by RDHAPs during the Commission's two hearings – led the department to suspend the new rule while discussions continue on both sides in 2016. The Commission again considers itself lacking in expertise to take a position on an issue that unexpectedly dominated its public comment sessions. Nonetheless, the Commission views the controversy as an example of decision-making conducted inside a relatively closed process – and one that would have ultimately resulted in limiting access to care. It, too, could have greatly benefited from the guidance of an independent advisory

committee and likely avoided the public dustup that resulted from a unilateral decision.

New Limits on Dental Surgery

A second issue that unexpectedly triggered extensive public comment at Commission hearings involved the availability of dental surgery and anesthesia in California. Surgery centers and the dental surgeons who operate within them essentially represent the end of the line in a Denti-Cal system that failed to provide earlier treatment. Surgeons told the Commission they are increasingly restricted in their ability to conduct oral surgery (under anesthesia) on children and special needs populations due to department rules that went into effect on August 21, 2015.

Advocates for dental surgery said the DHCS rules at best, are confusing, and require dentists to try an escalating range of alternative procedures before surgery – procedures that dentists, advocates and patients alike say are impossible and even life-threatening for children and special needs patients. The rules have caused some medical insurers – who are paid by Medi-Cal to provide anesthesia for surgeries that are paid by Denti-Cal – to suspend authorizations for anesthesia, despite the fact that anesthesia is clearly allowed. The Commission heard abundant confusion and pleas for help from parents of special needs children during its public comment sessions, and also received many emails from parents expressing desperation at being unable to find appropriate dental care for their children. All told the Commission that surgery is the only option for many special needs, autistic and developmentally-disabled children and adults who are unable to remain calm in a dentist's chair or tolerate procedures while awake. The California Dental Association told the Commission it had warned the department that its policy would be interpreted in a way that caused confusion. The department proceeded with its new policy. The Commission concedes that the department needs rules to prevent excessive reliance on surgery and anesthesia when other options exist, and also concedes that some dentists referring their patients to surgery centers may not fully document the need. But adding more gray area to the issue, advocates say that busy referring dentists balk at the state's excessive requirements for paperwork.

The Commission did not set out when beginning its review to investigate the intricacies of dental surgery rules and again declares its lack of expertise to recommend policy in this arena. However, the Commission saw clearly the vagaries of interpretation and the distress caused by a bureaucracy that writes or attempts to clarify rules without guidance or consult of an expert independent advisory board.

A Denti-Cal Advisory Board

During the November 2015 hearing, Dr. Paul Glassman, DDS, professor of dental practice at the University of the Pacific Arthur A. Dugoni School of Dentistry, suggested the idea of an evidence-based dental-only advisory board to weigh in on such issues just described and provide outside advice that might prevent the needless controversies of unilateral decision-making.

Dr. Glassman was asked by Chairman Nava, "Is there currently something like that in place at the department?"

"Not that I'm aware of," he answered. "They have a lot of stakeholder processes, but I don't think they function the way that I'm talking about." He told the Commission, "The department does a lot of work with stakeholders, so they have a lot of stakeholder hearings, but those are generally people lining up at the microphones and talking about their issue they think is important. They're not really scientific panels looking at the best evidence for particular procedures."

"And it's not necessarily an integrated part of the decision-making," Chairman Nava added.

"Right" Dr. Glassman answered.

The State of Oregon offers one example with its Health Evidence Review Commission, consisting of 13 members appointed by the Governor and Senate. The Commission, created by the Legislature in 2011, implements a nearly 30-year-old process in Oregon by which outside experts guide development of health care priorities, including those for Medicaid. The Commission reviews clinical evidence to produce a prioritized list used by

the state Legislature to allocate Medicaid funding in Oregon. It also produces evidence-based topics of interest to Oregon health plans, medical providers and the public. Members include five physicians, a dentist, public health nurse, behavioral health representative, provider of alternative medicine, retail pharmacist, insurance industry representative and two consumer representatives.[51]

"It seems to me that would be a critically important thing to institute in California," Dr. Glassman testified. "So you have evidence, you have rules that are being instituted, not only based on cost considerations, but also based on what's the best way to be able to improve the health of the population and do it at lower cost."

While the Oregon Commission covers the entire spectrum of medical care, the idea could be scaled down in California to consider only oral health and advise the Denti-Cal bureaucracy. Another example, also being considered in Oregon, is the Nevada Advisory Committee on the State Program for Oral Health. That panel, too, was created by the Nevada Legislature in 2011 and includes 13 members appointed by the administrator of the state Division of Public and Behavioral Health. Its members, who advise the state oral health program, include public healthcare professionals and educators, oral healthcare providers and national dental and other oral health organizations and their local or state chapter.[52]

Commission Chair Nava discussed the idea with DHCS Director Jennifer Kent and department executives in January 2016, but found little enthusiasm. Director Kent said informally that the department does not like having forced stakeholder advisory bodies, and added, "We have all kinds of advisory bodies." That might be the appropriate response for a successful program with good relations with its partners. Denti-Cal does not fall into that category.

Customer-Centered Targets for Denti-Cal

Denti-Cal's chief customers – its 13 million or more beneficiaries statewide – need DHCS and dental care providers to improve their relationships. In any sector, private or public, good relationships are built on a foundation of good customer service. Testimony received during the Commission's two hearings indicates that the state, through Denti-Cal, is falling short in serving dental providers and beneficiaries. By most accounts, California dentists who compare their Denti-Cal experiences with those of commercial insurers find the state the more difficult partner, still stuck in paper-based processes, a complexity of rules and forms and use of the U.S. Mail. Not only that, the state is less trusting of them than commercial insurers, asking more questions while paying only a fraction of the commercial rate.

These aren't the only reasons that dentists, as well as college professors training the next generation of dentists, talk down Denti-Cal. But they are part of the reason and they are easily fixable. As in Recommendation 1 in the previous chapter, fixing Denti-Cal's administrative barriers to dental provider participation requires a vison, with targets and 2016 and 2017 timetables. It is time to get started.

Key Short-Term Goals to Meet Utilization Target

Recommendation 2: the Department of Health Care Services should simplify the Denti-Cal provider enrollment forms and put them online in 2017.

Department of Health Care Services officials say they are in final review of plans to refine and shorten the Denti-Cal enrollment form from 34 pages to 10. The Commission commends this action and urges the Legislature to oversee its progress and keep it moving forward through the process of feedback from dental providers and department partners. The Commission also recommends that the state go further and facilitate Denti-Cal enrollment via an online application far sooner than the department's current estimated timetable of two to three years. Waiting up to three years to bring the department's enrollment process up to the online standards of commercial insurers will further bewilder a dental provider community that publicly called on the department to do online enrollment in 2008. The Commission recommends that the Legislature and

Governor see that it is done in 2017.

Recommendation 3: the Department of Health Care Services should overhaul the process of treatment authorization requests.

- ***The department should reassess its policies using metrics that consider foremost the highest impacts on beneficiaries and their needs rather than the lowest behavior of a few providers.***
- ***The department should consult with an evidence-based advisory board during this reassessment.***

The Department of Health Care Services has made small, tentative moves toward easing concerns of dental providers over the need to routinely mail in X-rays with their claims for reimbursement. But questions remain about what procedures should require preauthorization from Denti-Cal before being conducted. Hearing witnesses told the Commission that commercial insurers do not routinely require X-rays or authorization in advance for routine dental work such as crowns, root canals and periodontal (gum) treatment. The Commission heard anecdotally that fraud rates are likely no different for Denti-Cal than commercial insurance, and accordingly, recommends a high-level department review of its preauthorization policies. The department's review, guided by an evidence-based advisory body, should focus foremost on the needs of beneficiaries rather than the current near-singular focus on fraud.

Recommendation 4: the Department of Health Care Services should implement a customer-focused program to improve relationships with its providers.

The Department of Health Care Services admittedly has a very difficult job to implement Denti-Cal for a growing population while paying low reimbursement rates dictated by the Legislature. But for the good of the Californians it serves, it simply must develop better day-to-day relationships with dental providers. The department should initiate customer-service-focused processes in 2016 to develop a stronger "partner mentality" and tone down the antagonism that seems to have become quite routine between it and providers and others.

Recommendation 5: the Department of Health Care Services should purge outdated regulations.

- ***The department should appoint a small number of staffers to spend eight to 10 weeks during 2016 to review rules and clear out needless regulatory clutter.***
- ***The Legislature should assess department progress through an oversight hearing or through budget hearings.***

Department of Health Care Services partners, including the California Dental Association, say many Denti-Cal rules were designed to combat particular episodes of fraud and have outlived themselves. While originally well-intended, some now have a larger negative impact of discouraging dental provider participation due to their impediments. Denti-Cal beneficiaries suffer the most harm when dentists balk at providing them care due to outdated and frustrating department rules.

Recommendation 6: the Legislature and Governor should enact and sign legislation in 2016 to create an evidence-based advisory group for the Denti-Cal program.

- ***The Governor and Legislature should appoint dental experts in early 2017 to guide development of Denti-Cal priorities and oversee policy decisions.***
- ***The Department of Health Care Services should begin to consult with the Denti-Cal advisory board in early 2017.***

The Department of Health Care Services has much work to do retool its Denti-Cal program to win over more providers and provide greater access to dental care

statewide. Denti-Cal should be guided by an evidence-based advisory group, which consists of the state dental director and expert specialists who can weigh in on proposed decisions and make sure they are based on the best evidence and science and not merely on cost. This would be especially helpful to minimize the continual strife, confusion and even alleged harm to beneficiaries, including special needs populations, that the Commission heard about repeatedly in public comment during its two hearings.

Recommendation 7: the Legislature and Governor should fund a statewide expansion of teledentistry and the virtual dental home.

- ***The Legislature should pass and the Governor should sign AB 648 (Low).***

Californians have pioneered a simple technological solution – teledentistry – to better connect dentists and people in the neighborhoods where they live. The concept of a dental assistant with a laptop, digital camera and hand-held X-ray machine doing dental care under the supervision of a distant dentist who can review medical histories and X-rays from another computer and prescribe treatment should play a significant new role within the Denti-Cal system. In 2015, the Legislature considered AB 648 (Low) to allocate $3 million to scale up the Virtual Dental Home concept statewide in the wake of a successful pilot demonstration project. The bill, currently stalled short of a full Senate vote, should be passed and forwarded to the Governor for signing.

A New Direction Toward Prevention

"To a large extent, improving oral health requires individuals and families to engage in healthy habits such as appropriate feeding and eating habits, daily tooth brushing with a toothpaste containing fluoride and regular dental visits."

Dr. Jayanth Kumar, DDS, State Dental Director. Commission testimony, September 2015.

Californians who live quietly with aching, rotting or missing teeth, the millions who do not yet understand how their diets and habits may speed the ruin of their mouths and those of their children, need a game changer from forces more powerful than themselves. Troubling oral health conditions experienced by the state's large and growing Medi-Cal population run deeper than low reimbursement rates and old-fashioned paper-based administrative systems described during the Commission's first hearing – and in Chapter Two – that drive away and alienate thousands of potential Denti-Cal providers. Fixing those simple shortcomings should be relatively easy, and with continuing advocacy inside the department and beyond, could happen in the short run.

Beyond these fixes the Commission suggests that the entire state Medicaid dental system, as well as the efforts of funders and advocates for health and people of modest means, also needs to be reconsidered and steered in a new direction. The current system provides extensive care statewide, but still falls short for millions of people desperate for care and fails to adequately fulfill its role as a safety net. It is clear to the Commission that a deeper systemic issue makes Denti-Cal such a low-quality experience and unending oral health disaster: the program is so besieged with the state's dental health crisis that it can't recalculate priorities to improve long-term outcomes. Denti-Cal focuses nearly all its inadequate resources on the expensive and growing need for restorative care and pays little attention to the reasons the need exists. Denti-Cal, the Commission agreed, needs a massive, visionary reorientation toward *prevention* of tooth decay, particularly among the state's youngest children and pregnant women. Currently, the state invests 14 percent of its $1.3 billion budget on low-cost preventative visits, while spending 84 percent for high-cost visits to drill, fill, pull teeth and do root canals and crowns.[53] Without increased emphasis on preventative care, Denti-Cal is doomed to a permanent emergency of fixing millions of bad teeth with insufficient funding – and continually being hauled before the Legislature to explain its lack of progress. This massive shift will not be easy. It will take time and powerful partners and a keen eye on what, in government and politics, is called "the art of the possible." But doing so will pay significant dividends for California's quality of life and eventually in controlling healthcare spending.

"Dentistry is about prevention in order to avoid costly intervention at a later day. Why don't we have payment options that reflect this philosophy?"

Assemblymember Jim Wood, DDS. Testimony at the Commission's September 2015 hearing.

The Commission heard numerous ideas during its November 19, 2015, hearing to reorient both the Denti-Cal funding stream and the efforts of many oral health care partners in a preventative-oriented direction. Commissioners found encouragement in an emerging consensus on ways to begin and sustain such a shift – and learned that much is already being done inside and beyond California. It heard about promising results in

Washington and Texas that turned consistently poor outcomes – similar to those in California – into enviable national successes. Witnesses described the success of a long-standing pilot project that attracted dentists to deliver preventative care to children in Alameda County. Others from regions with no Denti-Cal providers told the Commission about recruiting pediatricians to provide preventative care during well-child visits. The Commission also learned about cost-effective managed care-style approaches to preventative oral care used by Federally Qualified Health Centers throughout California. Similarly, the Commission heard how Texas shifted from a perpetually struggling and unsuccessful fee-for-service model to a managed care approach that emphasizes prevention and cost savings – and easily attracts dental providers.

The Denti-Cal system is based on traditional "dental insurance" systems with an emphasis on volume-based reimbursement with the best reimbursement provided for the most complex treatment, needed after disease has progressed, rather than an emphasis on reaching people early and preventing the development of disease or for other interventions most likely to create a healthy population at the lowest cost."

Dr. Paul Glassman, DDS. Professor of Dental Care, Director of the Pacific Center for Special Care, University of the Pacific. Testimony at the November 2015 hearing.

The Commission learned, as well, that California is becoming a leader in teledentistry, also known as the Virtual Dental Home, which employs mobile camera phones, mobile X-ray units and the Internet to connect patients via onsite dental assistants and dentists at remote office locations. This easily enables a dental professional with a car and mobile digital equipment to visit Denti-Cal beneficiaries in community settings such as school sites and neighborhood centers to conduct routine exams, cleanings and simple procedures that free up dental offices for more complicated work. Experts repeatedly emphasized the importance of taking dental care into underserved areas rather than expecting beneficiaries to call, make appointments and show up at a dentist's office that may be miles from their homes. The high no-show rates among Denti-Cal patients that so greatly frustrate dental providers back up this contention.

Finally, in the wake of its hearings, the Commission learned more about two additional and highly promising developments: a $740 million state and federal initiative to focus on preventative dental care for children and young adults in California, and a 10-year, prevention-focused state oral health plan being crafted by California's new state dental director and scheduled to be unveiled in June 2016.

This collective consensus expressed by providers and other experts during the Commission's study process, and particularly, during its November 2015, hearing falls broadly into five categories:

- If you can't raise reimbursement rates across the board, try smaller, targeted hikes.
- Steer greater resources to preventative care, especially for children.
- Take dental care to where people are. Go mobile. Go to the schools.
- Use new video technology to connect people to care.
- Build a more coordinated dental care-delivery system that emphasizes regular visits and improved oral health habits. Add case management services to make sure people make and keep appointments. It works.

Promising: The Department's New Five-Year Experiment in Preventative Care

As the Commission conducted its 2015 review, DHCS engaged in a parallel track toward its own combined federal-state initiative to incentivize preventative care. The department announced its new program at year's end in 2015, six weeks after the Commission concluded its study process. During its review, the Commission

received only the barest details regarding the $740 million five-year initiative approved and partially funded by the federal government to expand preventative care with a variety of new test incentives and programs. This initiative, backed by a large influx of state and federal funding, represents a groundbreaking opportunity to begin addressing a long-neglected need in California. Though the particulars crafted by the department and Centers for Medicare & Medicaid Services in a largely internal negotiation reflect little of the specific consensus for preventative care solutions expressed by Commission witnesses the Commission understands that the federal government largely controls negotiations for such a large initiative. The state, however, should use the initiative's powerful momentum and potential flexibility to partner with providers and advocacy groups for fresh approaches and maximum benefit.

The new DHCS financial incentives aim to spur an increase of 10 percentage points in the number of children and young adults up to age 21 visiting the dentist annually – and will test whether California dentists will increase their participation in Denti-Cal. No one knows how these targeted incentives will work with a profession that expressed such deep wariness of the department during the Commission study process. Nonetheless, many, including the California Dental Association, cited the incentives as refreshing evidence of the state and federal government combining efforts to prioritize dental care and put a new focus on prevention.

The initiative has four components:

- **Targeted incentives for dentists to see more children**. The department plans to make two annual incentive payments to dentists who begin offering preventative care visits to Denti-Cal-eligible children aged one through 20 or expand the number of children receiving such visits in their offices. This is different from the financial incentives used in Washington State and Alameda County, where dentists simply receive higher or "enhanced" individual payments each time they see children up to age six for preventative or restorative care visits. California's new incentives "are not considered direct reimbursement for dental services under the State Plan," a description of the initiative states. Dentists will receive the two annual payments only after they see the number of new or extra patients determined by the state to be their share of a countywide number needed to increase child preventative dental visits by 10 percentage points over five years. The two annual payments will represent the equivalent of a 75 percent increase in reimbursement for the new or extra patients seen.

- **Paying dentists to create individualized treatment plans for high-risk children.** The state will establish pilot programs in a few selected counties and recruit dentists to create long-term treatment plans for children under six who are considered likely to develop serious dental problems due to their economic and home life circumstances. Dentists will receive payments for four annual office visits from high-risk children, three visits for moderate-risk children and two for low-risk children. These preventative visits will include exams, fluoride varnish and sealants and nutritional counseling. The department will monitor the outcomes to see if they reduce the number of emergency room visits and need for surgery under general anesthesia.

- **Incentives to keep seeing the same children over five years.** The state will make annual incentive payments to dentists who continue to see the same child year in and out. The annual incentive payment will rise with each additional year the dentist sees a child patient. The department plans to begin the program as a pilot in several counties and will implement it statewide if results are promising.

- **Funding for local pilot programs.** The state will approve up to 15 local pilot programs, largely in rural areas, that implement in their own ways some or all of the other ideas just described. The department aims to implement successful pilot programs statewide. This funding can represent no more than 25 percent of the entire $740 million.

The Commission, like many who participate in or monitor California's oral health landscape, views the increased funding and targeted incentives positively. But it is concerned that the infrequency of the incentive payments and the fact that they will greatly lag the occurrence of the appointments may deter dental providers, who mostly operate as small businesses, from participating. It remains possible that in five years results of the experiment will remain mixed and represent five more years of missed opportunity to make more than minimal improvements. While the state's direction for preventative dental care for children is now finalized and could represent the state's likely direction for the next five years, department representatives told Commission staff there are opportunities for some of the ideas suggested during the November 2015 hearing to become department-funded pilot projects and potentially be expanded statewide.

The Commission contends that two programs in particular, each with demonstrated success, represent good candidates for pilot project funding and further experimentation in California. The State of Washington through its Access to Baby and Child Dentistry Program (ABCD) and Alameda County through its Healthy Kids, Healthy Teeth initiative have shown that dental providers will treat children and provide early preventative care if they are financially incentivized to do so, receive training in treating young children and are part of a system of outreach efforts and comprehensive case management that guides people through the system and ensures they show up for appointments. Both programs will be described shortly in this chapter.

Also Promising: A New Prevention-Focused State Oral Health Plan

A state oral health plan scheduled for release in June 2016 promises to add more weight to the case for preventing tooth decay to lower demand for expensive publicly-financed dental care. State Dental Director Dr. Jayanth Kumar, DDS, appointed by Governor Brown to the new post in August 2015, has spent months consulting with a 53-member Oral Health Advisory Committee convened by the California Department of Public Health to write a 10-year prevention strategy for Californians. Members include California representatives of Medi-Cal and Denti-Cal, dental schools, dental professional associations, children's health advocates, First 5 commissions and county health officials, many of whom also provided insight and testimony to the Little Hoover Commission in its 2015-2016 Denti-Cal review.

Dr. Kumar told Commission staff in February 2016 that the oral health plan will focus on five areas and contain a two-year implementation plan to get it moving quickly in conjunction with the new Denti-Cal targeted initiatives. The goals:

- Improving oral health by addressing factors and conditions that drive tooth decay locally and concentrating on community-level intervention.
- Better aligning dental health programs at all levels of government and beyond to get more people into early treatment and preventative care.
- Building infrastructure and expanding capacity to do both of the above.
- Building systems to gather data that can focus efforts and set targets. (Dr. Kumar, as well as others, cited a troubling lack of data to quantify the state's oral health crisis).
- Building a communications strategy to get out the word about proper oral health care.

Dr. Kumar said a particular audience is parents of children five and under, who will hear about healthier habits for their children, including avoidance of bottles at bedtime. The Commission, too, views this oral health plan as a significant opportunity to build a coordinated statewide prevention movement, one that links government resources and leadership with the considerable finances and talent available and willing within California's private- and non-profit sectors.

Especially promising within the plan is a communications strategy. Those who see conditions on the ground told the Commission that tooth decay has become a problem

requiring the urgency of yesteryear's anti-tobacco campaigns. Many said that funders statewide should consider promoting a powerful multilingual and multicultural media campaign to relentlessly drive home a message that helps parents take steps to prevent dental problems for their children. Suggestions for funding sources included the California First 5 Commission, which has a multimillion-dollar communications budget from Proposition 10 tobacco taxes to finance early childhood development messaging campaigns. First 5 staff told Little Hoover Commission staff in early 2016 that it is not interested in veering from its current $67 million three-year media campaign to talk, read and sing to babies in the interest of early brain development. That leaves a variety of local, regional and statewide foundations, including county First 5 commissions, as potential funding sources. The Ad Council has already created a shelf-ready bilingual campaign of TV, radio and print media ads, as well as cartoons and Web apps. The media should prioritize use of this no-cost ad material. Additional financing also is needed to put the word out in a major new way on social and traditional media, billboards, buses and other public spaces.

Targeted Reimbursement Hikes I: Washington's Access to Baby and Child Dentistry Program

Targeted reimbursement rate hikes that incentivize specific goals generate positive outcomes, as the Commission learned from experiences in Washington State and Alameda County. Washington stands out as a national model that California can imitate in recruiting dentists to see young Medicaid-eligible children and getting those children in for annual checkups. In the mid-1990s only 21 percent of Medicaid-eligible children in Washington aged five and under visited the dentist yearly. The state has since increased that percentage to 51 percent, quadrupling the number of dental visits and outperforming the commercial insurance sector for the same age group.[54] Washington State now leads the U.S. in utilization of its Medicaid Dental program by young children.[55]

The importance of reaching this young population is underscored by the experiences of the Sonoma County dental surgery center noted earlier in this report: There, a typical case is a child, three and a half years old, with 10 to 18 cavities.

"We've been fairly successful in getting kids into care. It has not been easy and it has taken awhile," Laura Smith, president and chief executive officer of the Washington Dental Service Foundation, which manages the Washington State Access to Baby and Child Dentistry (ABCD) program, testified to the Commission in November 2015. "Still, 50 percent of kids aren't getting

The Two Key Tools of Preventative Care

Fluoride Varnish

Fluoride varnish, a topical dental applicant to prevent tooth decay, is applied to the surface of teeth. After using gauze to clean and dry the teeth, a specialist paints the varnish onto the teeth with a small brush. The varnish is sticky, and becomes hardened to teeth when it comes in contact with saliva. Varnish prevents new cavities and decay by entering the tooth enamel to make the tooth hard. The varnish application process takes less than two minutes. Studies show that children who receive varnish applications every three months have fewer cavities than those who receive it less often or not at all.

Dental Sealant

Dental sealant is a plastic material usually applied to the chewing surfaces of the back teeth, and acts as a barrier to prevent cavities where decay occurs most often. Sealants shield these vulnerable teeth by "sealing out" food and plaque. Sealant can be applied easily by dentists, who paint it directly onto tooth enamel. The plastic resin hardens, bonding into the grooves and depressions of the back teeth chewing surfaces. Sealants may last for several years before a reapplication is needed. Dentists can check the status of sealants during regular dental visits, and reapply when necessary.[56]

care. We still keep working on it," she added.

Ms. Smith called the Washington experience a hard climb out of conditions much like those that still exist in California. "Everyone knew the barriers," she told the Commission. "We had lower reimbursement rates and administrative hurdles. The dentists didn't understand who the population is and didn't want them in their offices." She said Spokane County in eastern Washington sparked the turnaround in the mid-1990s with a pilot project that identified barriers to care and systematically addressed each of them. In written testimony, Ms. Smith stated:

> *"There was recognition that early treatment, by the children's first birthday, was necessary for prevention. The traditional timeline of a first dental visit by age 3 or 4 was too late – the cavity process was well underway by then. Establishing good oral habits early in life could mean better oral health for a lifetime. Their goals were to engage more dental offices in serving young low-income children and connect with families and motivate them to bring their young children for care."*

Spokane County's ability to demonstrate results led the Washington Dental Service Foundation to offer $3.14 million in three-year startup grants to counties to replicate the program statewide. The grants and the collective efforts of governments and interest groups moved the ABCD program for children into all of Washington's 39 counties during a 15-year period spanning from 1999 to 2014. The ABCD program also has established cores of financial supporters at the local level who supplement efforts of the state Medicaid dental program. Among them are county health departments, local foundations, dental societies, the United Way, private donors and fund-raising efforts, Ms. Smith testified. She told the Commission at its November hearing the ABCD program also is partially funded with federal money.

Why Dentists Participate in ABCD

Key to the program is the enhanced reimbursement rates paid by Washington's Medicaid dental program to dentists who treat Medicaid-enrolled children up to age five. Dentists who participate in ABCD receive fees up to 60 percent higher than the state's standard reimbursement. "In 2014, ABCD-certified providers received $6 million in enhanced reimbursement through a state/federal 50:50 match," Ms. Smith testified to the Commission.

Such targeted incentives to reach a specific population represent an alternative to across-the-board reimbursement rate hikes to dentists that the Governor and Legislature have been reluctant to grant in California.

"To ensure sustainability after the start-up period, careful attention was paid to engaging all of the required resources (the health department, the local dental society, an initial cadre of participating dentists, a coalition that would guide and promote the program, and the backing of community leaders). Gaining support from local dentists and dental societies was key to beginning the local process. Recruiting general dentists to the ABCD Program began with the support and assistance of the local dental society, which sponsored an initial ABCD informational meeting between local dentists and ABCD state dental leadership and subsequently promoted the program to the membership.

"Public and private health and human services leaders in the county or region would then team up with these dentists and WDS Foundation's state-level ABCD staff to plan for and troubleshoot the program rollout. Each county was encouraged to tailor the program to fit its needs, culture, and circumstances. As a result, not all local programs look exactly alike and may differ in the organizations designated to execute the program and the community-based organizations that participate."

Laura Smith. November 2015 Commission hearing. Written Testimony.

"A small raise in overall rates won't necessarily help. It's about incentivizing what you want to see," Ms. Smith said.

Beyond the increased fees are additional benefits to dentists: An active public-private partnership that includes state government, dental societies, dentists, the University of Washington School of Dentistry and local health departments provides dentists training in treating young children, offers billing assistance to their office staffs, helps reduce no-shows and places a "dental champion" in each county to assist providers. The state also fixed some of the administrative problems that discourage dentists in California from participating. Washington dentists enroll in the ABCD program online in contrast to California's slower paper-based process to enroll in Denti-Cal. "On the payment side they redid the claims processing system in 2008-09," Ms. Smith told the Commission. "The payment process is easy and about as good as commercial." She said payment also is quick. "Paying claims takes about a week, same as commercial insurance."

Ms. Smith said the relative ease of the ABCD program for dentists has the added benefit of bringing more dentists into the larger Medicaid dental system. "Dentists first participate in ABCD and that's an entry into the Medicaid population," she said. "ABCD becomes the door they walk through to participate in the program."

Why Families Participate

The ABCD program also addresses two of the chronic problems of Medicaid dental programs nationally – families not being aware their children need care and the high no-show rate for appointments among participants. Ms. Smith told the Commission that ABCD embeds itself into local communities by establishing ABCD coordinators in county health departments who work with community organizations that work with the Medicaid population. Those organizations "carry the message of early dental visits and refer them to the ABCD coordinator for connection to a participating dentist," she said. "The ABCD program has been embedded in many local Head Start, Early Head Start, and Women, Infant and Children (WIC) Nutrition programs, which enroll and orient their clients, and at the same time, help achieve the agency's client oral health objectives. The coordinator also talks through the flow of a visit and establishes norms for the visit," Ms. Smith testified.

Ms. Smith told the Commission that families also receive coaching about dental office etiquette, including the need to keep appointments. "The local programs work with ABCD families who have difficulty keeping dental appointments, assuring that obstacles to care, such as lack of transportation and language barriers, are addressed," she testified.

The Preventatitive Edge

The ABCD program is unique, finally, for steering

Other ABCD Outcomes

- ABCD patients are more likely to seek care before oral health problems arise.
- Providers who have received ABCD training and participate in the program are more comfortable seeing young children and have a highly favorable view of the program.
- Peer-reviewed national publications have demonstrated that early prevention can substantially reduce future dental care costs and that ABCD is cost-effective method of improving oral health status of Medicaid-insured young children. Early intervention saves money for families, taxpayers and employers.
- The Smile Survey, the every five year assessment of children's oral health from Washington State, found that untreated decay was cut in half between 2005 and 2010, from 26% of low-income young children with untreated decay to 13 percent. Young children who are free of dental pain miss less school and are more ready to learn.[57]

enhanced funding to dentists to do preventative education for families in their offices and to pediatricians to do oral checkups of their young patients during regular well-child visits. In 2014, dentists who participate in ABCD received a new benefit worth $2.8 million statewide to educate their child patients and families about taking good care of their teeth. California dentists do not have the option of billing Denti-Cal for preventative education. Ms. Smith told the Commission that the Washington Dental Service Foundation in 2008 won legislative approval to reimburse primary care physicians at the enhanced ABCD rate for delivering oral health preventative services during children's regular checkups. Those services include screening, risk assessment, family education, fluoride varnish and referral to a dentist if necessary, she testified. She stated that more than 45 percent of Washington's practicing pediatricians and family practice physicians have been trained and certified to do the oral health preventative services.

Washington's ABCD program has earned repeated national honors for its innovation and positive outcomes, according to written testimony provided by Ms. Smith in November 2015. Backers of the program in California include the California Dental Association, the trade association for 26,000 dentists, and a pair of influential children's advocacy organizations, Children Now and the Children's Partnership. It is easy to presume widespread comprehensive support among these and other interests for trying such an approach in California and replicating it statewide. Ms. Smith's testimony at the November 2015 hearing provided ample evidence that Medicaid dental programs can move off traditional reactive approaches and successfully intervene earlier in the lives of its young beneficiaries. Washington State also proves that dentists will participate in a comprehensive system that rewards them financially and assists them in caring for a challenging population. The outcomes of Washington's ABCD program persuaded Alameda County 13 years ago to try something similar. It, too, succeeded.

Targeted Reimbursement Hikes II: Alameda County's Healthy Kids, Healthy Teeth

Alameda County launched *Healthy Kids, Healthy Teeth* (HKHT) in 2003 as a demonstration project, modeled on Washington's ABDC program, to improve care for the county's youngest Denti-Cal-eligible children. Begun with leadership from the then California Department of Health Services and a grant from the federal Health Care Financing Administration (later renamed the Centers for Medicare & Medicaid Services), it, too, is a systematic approach that has produced dramatic improvements in the numbers of Medicaid-eligible children receiving dental care.

Approximately 70 percent of eligible children below age five participate and make regular dental visits, program founder Dr. Jared Fine testified at the November 2015 hearing. That compares with 20 percent more than a decade ago, he said. The program features a small targeted incentive - $20 paid by the county – to supplement the standard Denti-Cal reimbursement rate for two annual oral exams, fluoride varnish and dietary and educational counseling to parents. The county stepped in with the financial incentive after the state proved unable to do so, Dr. Fine told the Commission.

"The original intent was that, just as was done in Washington, reimbursement rates would be raised for several common children's dental procedures," said Dr. Robert Isman, DDS, a former DHCS staffer who worked with Dr. Fine to establish the HKHT program. The state planned to fund the enhanced targeted reimbursements to dentists, he said. "At the time the grant proposal was written, California had a $12 billion budget surplus, but by the time the grant was awarded, the surplus had turned into a $12 billion deficit. Thus it became impossible to provide the rate increases the original proposal had envisioned," he told the Commission.[58]

Dr. Fine told the Commission that continued county general fund support, as well as direct federal Medicaid funding to the program, has helped Alameda County continue the targeted incentive program for preventative care beyond the initial startup phase funded by the federal grant more than a decade ago.

"The idea was to increase access to care for children and infants. We need to go toward that in California," said Dr. Fine, who retired in 2014 as dental health administrator

for the Alameda County Public Health Department. He said the $20 targeted rate reimbursement authorized by the state for Alameda County, "is designed to incentivize dentists to go to kids and treat kids. This is important because we do have benefits from preventative successes. We *can* prevent disease over time."

The alternative, he testified, is documented in the findings of Alameda County's 2005 Oral Needs Assessment conducted among public school students. The survey found that "by kindergarten 30 percent of all students had untreated decay. It also documented that students from low-income families had nearly twice the level of untreated dental decay and only half the benefit of preventive dental sealants as compared to their counterparts from more affluent families."

"As the Dental Health Administrator of the Alameda County Public Health Department for nearly 40 years, I was confronted by the day in and day out experience of attempting to address the epidemic level of dental disease in our young children and their families - from the toddlers who waited months for treatment under general anesthesia in the operating room because they were too young to be able tolerate treatment for extensive dental decay in an office setting, to tooth-decay-ravaged kindergarteners too embarrassed to smile, to elementary school students who were mysteriously disruptive only to be relieved when their dental conditions were discovered and the source of unrelenting dental pain treated."

Dr. Jared Fine. Former Dental Health Administrator. Alameda County Health Care Services Agency

Plenty of Participating Dentists Backed by Aggressive Outreach

In great contrast to the lack of dentists to treat Denti-Cal patients statewide, the HKHT program has expanded its pool of local providers who provide preventative care to children, Dr. Fine told the Commission. "The county pays those fees and we have as many dentists as we want," he said. Much like Washington's ABDC program, the program recruits dentists and provides training in treating young children. Participating dentists learn about child management, caries risk assessment, family education, use of preventative agents such as fluoride varnish, and also billings and claims processing.

Alameda County workers, meanwhile, conduct aggressive outreach programs to enroll children and make sure they get to their office visits. Dr. Fine testified that the county makes numerous presentations to community organizations that work with the Medi-Cal-eligible population to get children into HKHT and ultimately, into dental offices. Those locations include Head Start and early Head Start, preschools, Women, Infant and Children offices, community clinics, Medi-Cal enrollment offices, childcare centers and programs targeted to high-risk families.

Once enrolled, he testified, community health outreach workers who mirror the language and culture of enrollees visit them in person or call to stress the importance of dental visits and expectations to get regular care. These workers also help families deal with language barriers, link them with participating dental providers and help them get to their appointments if they have transportation issues. Dr. Fine's testimony reemphasized to the Commission the value of comprehensive coordination, systematic case management and education to make sure beneficiaries understand the benefits for which they are eligible, get enrolled and make their appointments.

Dr. Isman told the Commission that in 2007 a State Action Plan Committee within DHCS proposed replicating the success of *Healthy Kids, Healthy Teeth* with a new pilot project that would expand the concept to five additional California counties. The department didn't act on the proposal, however. Given the continued inability of the Denti-Cal program to adequately meet children's needs – and the availability of fresh funding for pilot projects in the new DHCS and CMS preventative care initiative – the time may be ripe to reconsider an expansion of HKHT well beyond Alameda County.

The Emergence of Teledentistry

California, more than most states, is moving toward a new model of care that incorporates video technology to examine more people outside the usual confines of a dentist's office. This technology may enable an approach in California that begins to resemble the better qualities of managed care – that is, spending for prevention rather than for the endless high cost of fixing teeth.

Dr. Paul Glassman, a professor of dental practice and Director of Community Oral Health at the San Francisco-based Arthur A. Dugoni School of Dentistry at the University of the Pacific, told the Commission that teledentistry can help reorient Denti-Cal, which he said is "organized with an emphasis on providing complex treatment which is needed after disease has progressed, rather than an emphasis on reaching people early and preventing the development of disease." As noted previously, that kind of cost management philosophy is the bedrock of managed care, and highlights an alternative way of bringing managed care-style benefits to Denti-Cal while not converting the current fee-for-service system into a managed care system statewide.

"The Denti-Cal system is organized to emphasize treatment services provided in dental offices and clinics. Unfortunately the majority of Denti-Cal eligible people face significant barriers that keep them from accessing services in offices and clinics and therefore do not receive services. Barriers include the limited number of providers willing to see people covered by Denti-Cal, location of dental offices and clinics in relation to where people live, hours that offices and clinics are open, cultural and language barriers, and challenges that people in low-wage jobs have getting time off work to take themselves or their children to dental appointments."

Dr. Paul Glassman, DDS. Professor of Dental Care, Director of the Pacific Center for Special Care, University of the Pacific. Testimony at the November 2015 hearing.

"We don't have a problem with no shows. We are delivering care in places where people are."

Dr. Paul Glassman, DDS. Professor of Dental Care, Director of the Pacific Center for Special Care, University of the Pacific. Testimony at the November 2015 hearing.

Dr. Glassman told the Commission in November 2015 about a teledentistry initiative, Virtual Dental Home, being pioneered by his university's dental school. The University of the Pacific's initiative takes dental hygienists and dental assistants out of the office and into the field to examine people where they are – in schools, Head Start centers, community centers and long-term care centers. Dental assistants under the supervision of a distant dentist arrive with a portable dental chair, laptop computer, digital camera and hand-held X-ray machine to do exams, take X-rays and pictures, create dental charts and collect dental and medical histories. They upload it all onto a secure website, where a dentist, perhaps hundreds of miles away, can review it and prescribe a treatment plan. Dental assistants and hygienists then do much of the work, such as simple fillings, cleaning and scaling, applying fluoride varnish or sealants and providing education about prevention. For more complicated work they refer patients to dentists, who get patients who are already examined and diagnosed with a treatment plan. As Dr. Glassman explained to the Commission, "Around two-thirds of people can be kept healthy in community sites by the services provided there by dental hygienists, and most of the remaining one-third who have advanced problems can be helped to get treatment in dental offices and clinics."[59]

This sounds relatively simple. But it required the 2014 passage of AB 1174 (Bocanegra and Logue) to enable dental assistants and dentists to bill Denti-Cal for their work while using teledentistry. Previous state law allowed Denti-Cal to pay only for face-to-face diagnosis and treatment. The new law enabled a July 1, 2015, DHCS directive allowing many dental providers to bill Denti-Cal for teledentistry care.[60] So far, the concept is largely considered a pilot project, supported by grants

A Denti-Cal Alternative: Federally Qualified Health Centers

Many people in California – especially those with "bare bones" Denti-Cal coverage with private dentists – don't realize they may have a better alternative at a Federally Qualified Health Center (FQHC). The FQHC designation refers to more than 1,000 California health clinics and systems that operate in underserved, low-income and uninsured communities that private-practice dentists tend to avoid. These nonprofit clinics also receive far higher dental care reimbursement rates from Medi-Cal than those that Denti-Cal provides to private dentists. This special designation and higher reimbursement rates has created a separate – and by many accounts, more comprehensive and superior – dental provider model for low-income Californians. DHCS records indicate that FQHCs provide approximately one-third of Medi-Cal dental care to adults and children in California – $374 million worth in 2014. The FQHCs of California provide more than two million dental visits each year.[62] The federal government picks up nearly all the cost of this FQHC-provided dental care – driving federal dollars to account for more than 60 percent of Denti-Cal's annual $1.3 billion budget.

The origins of these FQHCs are in President Lyndon Johnson's 1960s-era War on Poverty. The federal government, mindful of states that would provide the least amount of health care possible, established a "federal funding model that bypassed state interference." This fully-funded medical care model (that includes dental) supplements the shortcomings of state-run programs in poor communities. All clinics are nonprofit and run by local boards "to ensure responsiveness to community needs."[63]

Largest among California FQHCs is AltaMed, which operates 43 sites that provide medical and dental care to thousands of low-income adults and children in Los Angeles and Orange counties. (AltaMed's medical staff includes 27 dentists and 93 dental staffers. The dental staff examines and treats approximately 96,000 people yearly). Dr. Rosa Arzu, DDS, dental director at AltaMed, testified to the Commission in November 2015 that Medi-Cal, and not Denti-Cal, provides AltaMed a fixed amount of reimbursement per dental visit – typically about $200 – which enables AltaMed to bypass Denti-Cal's much-criticized enrollment forms, billing issues and advance permissions to provide many dental treatments. The Commission learned from Dr. Arzu's testimony that AltaMed (which reported revenues of $376 million in its fiscal year ending April 2014) dental care can be provided efficiently, holistically – and at lower long-term cost – within the FQHC model. Essentially, AltaMed receives the same approximate $200 reimbursement per visit, whether the visit is for a low-cost preventative exam and fluoride varnish or for an expensive four-hour restorative procedure. Much like managed care, the system incentivizes AltaMed to prevent dental problems that can cause it long-term financial losses. This is in contrast to Denti-Cal's standard fee-for-service system, which incentivizes participating dentists to do high-reimbursement procedures and minimize low-value preventative visits.

One partial solution to the Denti-Cal problem may include promoting FQHCs as a preferred center for dental care for millions of eligible beneficiaries. The centers are more likely to concentrate on preventative care and also more likely than traditional dental providers to go into community and neighborhood centers to provide care. This option also has cost advantages for the state as the federal government pays nearly all the cost of preventative and restorative care for Denti-Cal-eligible residents. Given the comprehensive system of dental care provided by FQHCs, Commission staff asked AltaMed representatives why struggling Denti-Cal beneficiaries would go through the well-documented trouble of trying to find a fee-for-service dentist who accepts Denti-Cal and may want only to do high-cost restorative procedures instead of preventative care. The answer was surprisingly simple and indicative of a larger need to help beneficiaries understand their options: "They don't know about it."

and foundations to provide dental services to about 3,000 people at 50 sites in 13 communities.


Assemblymember Evan Low

In 2015, lawmakers also considered AB 648 (Low) to allocate $3 million in state funds to scale up the Virtual Dental Home concept statewide. That bill passed the Assembly and cleared its Senate committees only to be placed on the Senate inactive file near the end of the 2015 legislative session.[61] The Commission recommends passage of the bill or similar legislative vehicle in 2016 and a signature from Governor Brown.

All encouragement should go to this method of delivering care in community settings such as schools, Head Start and Women, Infant and Children centers, which to date reports few incidences of "no shows." Teledentistry and a host of other developing technologies promises to play a major role in proposals to reorient Denti-Cal care for a new generation. It will help shift a system that simply fixes expensive problems to one that slowly gets ahead of problems and ramps up a more cost-effective and smarter focus on preventative care for the long term.

Scrapping What Doesn't Work and Starting Fresh: The Texas Experiment

Texas, population 27 million, is another large state that has struggled to mount an effective Medicaid dental program in its major urban areas and vast expanses of rural countryside. As in California, low provider reimbursement rates and cumbersome administrative hurdles combined to discourage dental providers from participating. The Commission learned at its November 2015 hearing how Texas in 2012 scrapped its fee-for-service Medicaid dental care system – under orders from the Texas Legislature the previous year – and turned the program over to three commercial health plans and a managed care approach. "Two things happened," Billy Millwee, a managing principal for the consulting firm Sellers Dorsey, who spent 20 years with the Texas Health and Human Services Commission and served as Texas Medicaid Director from 2009 through 2012, told the Commission. "There was more preventative care. And less invasive services." He told the Commission that dental managed care cut Texas Medicaid expenses by 30 percent – approximately $1.5 billion in its first three years.

The November 2015 hearing provided the Commission a first opportunity to consider the managed care model or approach as a possible fix or alternative to the current Denti-Cal system, which was widely acknowledged as "broken" during the first hearing. Though the Commission is not making recommendations to encourage the expansion of managed care within the state's Denti-Cal program, the emphasis on prevention now to save money later is impressive. It also stands in contrast to the state's current Denti-Cal fee-for-service system, which is stuck in a cycle of treating high-cost problems that it doesn't prevent.

California has two regional pilot managed care programs for Denti-Cal, one in Sacramento County that is mandatory for Denti-Cal patients, and one in Los Angeles County, which is optional. Both started in the mid-1990s and had relatively rough starts and poor track records in getting children into dentist offices for checkups, which has discouraged talk of their possible expansion to other counties or statewide.[64] But managed care plans in both counties have made advances in raising child utilization rates in recent years – and helped more children who need care under general anesthesia. Sacramento County dentists also typically receive 10 percent higher reimbursement under managed care than other dentists in California.

Dentists, however, who typically own their own businesses, have traditionally opposed alternatives to the straight fee-for-service model that has long been the backbone of dentistry.[65] As noted in Chapter One the California Dental Association has called on the state to end dental managed care in Sacramento County. In its preference for a fee-for-service model of care, the dental profession is a throwback to the medical profession which operated similarly until adapting to a managed care system. Less than a decade ago in May 2007, the Little Hoover Commission, in *A Smarter Way to Care: Transforming Medi-Cal for the Future*, urged the state to transition to a managed care approach for its large

Medi-Cal population, which was then tied to a costly, overburdened fee-for-service system. The Commission's report noted at the time that the Medi-Cal program "lacks a system or a structure to measure whether its outlays improve the health outcomes of enrollees." The same could easily be said today of the state's Denti-Cal program – especially in light of the managed care approach now institutionalized within Medi-Cal and also for new enrollees under Covered California and the Affordable Care Act.

Mr. Millwee told the Commission that he came to believe in 2010 there was a better way than fee-for-service, publicly-financed dental care in Texas. The state at the time contracted with a private sector claims administrator to run the program with no state dental staff to oversee it or steer policies. During that time the Texas Commission also endured a funding scandal in which providers billed and the claims administrator routinely approved a great expansion in expensive orthodontic care, which cost taxpayers millions of dollars and fueled a backlash against

When There Are No Denti-Cal Providers: Recruiting Pediatricians in Amador County

Amador County, in the Sierra Nevada foothills east of Sacramento, is a quiet landscape of cattle ranches, family wineries and small Gold Rush tourist towns. Among its 36,500 residents, settled mostly around the county seat of Jackson, there is not a single dentist who accepts Denti-Cal. (Trinity, Sierra, Alpine and Inyo counties similarly have none).[67] Dentists cite the same reasons as many of their counterparts in urban areas: low reimbursement rates and difficult state administrative processes, said Commission witness Nina Machado, a long-time public health specialist in the county. She is executive director of First 5 Amador, one of many local California commissions funded by tobacco tax revenue from 1998's Proposition 10. "What they tell me is that they would prefer to do it for free," Ms. Machado said.

Given the lack of options for the county's Denti-Cal-eligible residents, First 5 Amador and a county oral health task force of school nurses, dental hygienists and county health officials stepped into the vacuum with a unique pilot program launched in January 2015. It is recruiting county medical doctors to do dental exams and apply fluoride treatment to area children – and showing doctors how to bill California's Medi-Cal program for $18 to $30 as part of routine well-child exams. Ms. Machado has teamed with Sutter Amador Pediatrics' Dr. David J. Stone and supervising nurse Mindy Epperson, who collectively told the Commission in November 2015 that pediatricians did more than 1,000 flouride varnish treatments in the first eight months of the program.

It is considered a first-of-its-kind pilot project in California, a state where pediatricians have sometimes considered oral exams and fluoride varnish application too time-consuming and not their responsibility, even though they can be reimbursed by the state for providing it. Fortunately, California pediatricians are increasingly likely to begin doing so. Recommendations published by the American Academy of Pediatrics in September 2015 advised pediatricians to add fluoride varnish to their list of tasks during 10 well-child visits from the age of six months to age five.[68]

"We did not step on the toes of dentists in Amador County," Ms. Epperson told the Commission. "We never tell people we are their dental home. We are not. We are part of prevention."

Advocates for children's dental care told Commission staff they hope more pediatricians and primary care doctors begin to perform oral health screenings and fluoride varnish applications – because parents with Medi-Cal coverage are far more likely to take their children to the doctor than to the dentist. Medical doctors also are generally seen as strong authority figures during well-child visits, Ms. Machado told the Commission. "When doctors say something people really pay attention."

the state dental program.[66]

"There are all kinds of things you can do that you can't do in a state program. The state in a fee-for-service kind of model is constrained with a one-size-fits-all model. I have to do the same thing in Dallas as in I do in Muleshoe. They've got to be the same, but the community is very, very different. When you're operating a Medicaid dental program under a federal waiver you have a lot of opportunities to do things differently that are more appropriately designed for a community. You can target recruitment efforts, have differential reimbursement rates, cater services to a specific community or region, develop innovative programs."

Billy Millwee, managing principal for Sellers Dorsey. Testimony at the Commission's November 2015 hearing.

Mr. Millwee told the Commission how he slowly overcame the Texas Dental Association's traditional resistance to managed care by listening to its members' concerns and collaboratively designing a program that addressed those concerns. He also was able to persuade them of the potential benefits. "They like the idea of a dental product with metrics and quality control," he said. "People liked that and how it competes on metrics of preventative services and getting kids to do checkups. We did none of that with fee-for-service." Mr. Millwee said the collaboration continued while designing the new program's initial Request for Proposals and ultimately, its contracts with Delta Dental, DentaQuest and MCNA Dental. (Delta Dental eventually dropped out of the program). The entire process of consulting with dentists, writing an RFP and contracts and signing up health plans took about a year, he said.

The directive today to the participating health plans in Texas is relatively simple: "You have to cover dental benefits, but how you cover it is up to you," said Mr. Millwee. That has led to greater creativity, more cost controls and better data about outcomes, he said. While not attracting a groundswell of new dentists it made participating dentists happier, he said. Some receive more than the standard Medicaid rate for some services. Claims processing has improved, with bills paid in seven to 10 days. Enrollment forms to become a Medicaid dental provider are online and up to commercial standards.

Nationally, managed care remains the exception rather than the rule for states with Medicaid dental programs. But experts, including November 2015 witness Dr. Paul Glassman told Commissioners they believe the long-range direction and trend for Medicaid dental programs, including California, points toward managed care. In Texas, the model continues to hold its ground. "There's been no march on the Capitol to change it," Mr. Millwee said.

Conclusion and Recommendations: Ideas for the Long Run

Throughout its Denti-Cal review the Commission heard that rotting teeth and gum disease is almost entirely preventable, indeed, one of the most preventable of diseases. Healthier habits and diets, fewer sugary drinks and regular checkups can lead to a lifetime without pain or headaches, without missing school and work or ever rushing to the emergency room on a weekend. And yet dental disease is not being prevented for many among the 13 million or more Californians eligible for Denti-Cal. The Golden State, said so many Commission witnesses and sources who see it day in and out, is a landscape of growing, not receding dental illness. People are not getting the message. They don't know the impact of their habits on themselves and their children. They learn too late, when their toddlers need dental surgery, that this could easily have been prevented. And so it goes with Denti-Cal, overwhelmed by demand, and unable until perhaps now to steer its financial resources toward greater preventative care and slow the trajectory of rising demand for restorative care.

The Commission contends, in the wake of its review, that with one-third of the state's population and one-half of its children eligible for Denti-Cal, and their well-documented lack of access to care, other

significant players including foundations, universities, advocacy groups and private and non-profit health care organizations also need to step in and assume stronger leadership roles. California needs a massive new emphasis on curbing and preventing an epidemic of dental disease that a majority of people with commercial dental insurance seldom see. Without it, Denti-Cal's woes will continue to be simply the symptom of a far larger problem playing out in hundreds of thousands, if not millions of households, in California.

Two major new state government initiatives, a five-year $740 million preventative care agenda, and a prevention-focused 10-year state oral health plan to debut in June 2016, will likely set the tone for a new direction. It is critical that the state exercise the best possible leadership in implementing both. It also is critical that others beyond government step in to fill the vacuums that will remain, to seed the new ideas, encourage the experiments and fund those with promise.

The Commission offers the following additional recommendations, recognizing that not one big solution, but many, at all levels of government, in every county and region, will help improve the oral health of this eligible population, and consequently, that of California as a whole. The Commission learned during its review that there is no shortage of people who want to help. There is no shortage of ideas. Even within the Department of Health Care Services there is movement, as evidenced by small improvements to address administrative roadblocks and the larger vision of a well-funded initiative to incentivize preventative care. At her January 20, 2016, confirmation hearing before the Senate Rules Committee, Director Jennifer Kent, appointed by Governor Brown on January 26, 2015, said, "I feel better about the program today than the day I started. But I wouldn't say that it's settled by any stretch of the imagination, but I think we're in progress and I feel good about that."

As the Commission's second and final hearing neared its end in November 2015, Dr. Paul Glassman, University of the Pacific dental professor, addressed the Commission with a parting thought about what is possible in California. "We have an opportunity to really rethink how we deliver oral health to the population," he said. "The idea in the past, really for everyone from the dental profession to the lay population, has been dental health happens when you pick up a phone, you call, make an appointment and you go to a dental office. Unfortunately, that doesn't happen for way too many people. Now we have more structures, ideas and a long demonstration that can actually do things in a different way, that's more effective in getting to people, getting to them early and creating health, actually at a lower cost." The Commission expresses its optimism regarding prospects for success.

Key Long-Term Goals to Meet Utilization Target

Recommendation 8: State government, funders and non-profits should lead a sustained statewide "game changer" to reorient the oral health care system for identical beneficiaries toward preventative care.

- ***A coalition of public, private and non-profit organizations and funders, such as the California Healthcare Foundation, California Endowment, California Dental Association, California First 5 Commission and its county commissions, among others, should powerfully address the need for a more coordinated, comprehensive statewide system of preventative care.***
- ***Others beyond state government, including universities, medical societies and foundations should convene a symposium to discuss and plan a way forward, then make it their continuing responsibility to help fund and sustain a permanent emphasis on preventative care.***
- ***Funders, celebrities, communicators, advocates and media firms should participate in a major statewide messaging campaign to educate families and children about healthy teeth habits.***

The rapid increase of Denti-Cal beneficiaries in recent years combined with some of the nation's lowest reimbursement rates for participating dentists has left the Denti-Cal program increasingly unable to contend with an overload of dental disease. With only 14 percent of its annual budget allocated to prevention, Denti-Cal is likewise unable to stem the rising damage of poor dental health among its eligible population. The growing oral health crisis among Californians who lack commercial dental insurance coverage is a larger responsibility than the state's alone. A large, powerful coalition will be necessary to steer Denti-Cal funding toward preventative care, and especially recognize the power of case management in connecting a large vulnerable population to dentists and making sure people show up for appointments. Two powerful initiatives within the Department of Health Care Services and Department of Public Health are launching momentum in a preventative direction. Others beyond state government must build upon it and sustain this forward direction.

Recommendation 9: the Legislature and Department of Health Care Services should expand the concepts of Washington State's Access to Baby and Child Dentistry program and Alameda County's Healthy Kids, Healthy Teeth program to more regions of California.

- ***The Department of Health Care Services and the Legislature should actively encourage and help establish pilot projects based on these concepts with the potential of expanding them statewide.***
- ***The Legislature should assess department and pilot project progress.***

A new state and federal initiative to fund targeted incentives for dentists who care for Denti-Cal-eligible children provides great opportunity to expand preventative care to children five and under through programs with demonstrated successes in Alameda County and Washington State. With $185 million available in a federal-state fund for preventative dental care pilot projects during the next five years, the Access to Baby and Child Dentistry and Healthy Kids Healthy Teeth concept is ripe for expansion and testing beyond Alameda County. A pilot project, if successful, could demonstrate anew the ability of incentives to motivate dentists' participation, especially when backed with training and assistance for dentists, and an extensive case management system that conducts outreach at the community level to get eligible patients appointments with dentists and keep them. A pilot program will ideally feature networks of private, non-profit and public partners such as dental associations, medical schools, foundations and health agencies to fund and maintain these comprehensive outreach and case management efforts.

Recommendation 10: the Department of Health Care Services and California counties should steer more Denti-Cal-eligible patients into Federally Qualified Health Centers with capacity to see them.

- ***The Department of Health Care Services should include contact information for Federally Qualified Health Centers on its referral lists of dentists.***
- ***Counties should train eligibility workers to advise use of Federally Qualified Health Centers for dental care where appropriate.***
- ***Federally Qualified Health Centers with high demand for dental services and limited capacity should expand use of teledentistry options to provide preventative care in community locations and free up capacity for more intensive dental care in their offices and clinics.***
- ***Foundations and medical societies should consider funding targeted messaging or advertising campaigns to raise awaRenéss that Denti-Cal benefits can be used at nearby Federally Qualified Health Centers.***

California's more than 1,000 Federally Qualified Health Centers (FQHC) have integrated preventative care into their daily appointments in ways that largely do not occur in private dentist offices. Their reimbursement stream

incentivizes FQHCs to prioritize low-cost preventative visits to minimize the high expenses and potential financial losses of restorative care. The incentive for private dentists is just the opposite, often prioritizing high-cost restorative care to make worthwhile the low reimbursement rates paid by Denti-Cal. Given that the federal government provides much higher reimbursement to dentists at FQHCs and pays nearly the entire cost of these reimbursements, the state and its partners alike would be wise to encourage the most people possible to receive care at a FQHC. Most FQHCs are located in neighborhoods that private dentists tend to avoid, but many people who live near one don't know that they provide dental care. The California Primary Care Association has invested in a CaliforniaHealthPlus branding campaign to promote FQHC services, including dental, but lacks funds for the necessary scale of statewide advertising. Funders and medical societies should consider ways to help. These federal facilities should become an even stronger part of the dental care safety net in California.

Recommendation 11: medical societies and non-profit organizations should recruit more pediatricians to provide preventative dental checkups during well-child visits.

- ***The California chapters of the American Academy of Pediatrics should lead in encouraging its members to perform preventative dental exams and apply fluoride varnish to Denti-Cal-eligible children.***
- ***County First 5 Commissions statewide should work to reinforce the message locally with pediatricians and primary care doctors.***
- ***Senator and pediatrician Richard Pan should write to pediatricians statewide stressing the importance and benefits of this practice.***

Representatives of Amador County have provided California a model that offers basic preventative dental care to children in rural counties that have few or no Denti-Cal providers. With a small start-up grant from Sutter Medical Group, the county established a program to recruit and train pediatricians to do dental exams, apply fluoride treatment as part of well-child visits and bill Medi-Cal for reimbursement. This program is a critical piece of the safety net in Amador County, where a visit to a dental office that accepts Denti-Cal might be as much as 60 miles away. Pediatricians did more than 1,000 flouride treatments in the first eight months of the program in 2015, and serve as an example to other counties in similar straits. A major statewide initiative on preventative care for children requires small programs and pediatricians everywhere to do what can be done. In 2015 the American Academy of Pediatrics (AAP) advised pediatricians to add fluoride varnish to their list of tasks during well-child visits from the age of six months to age five. Just as the state needs more initiatives like those in Amador County, more pediatricians statewide need to add this small preventative task to their well-child visits for Medi-Cal beneficiaries.

The Commission's Study Process

This study represents the newest and third review of California's Medi-Cal system since 2007. The review played out against a backdrop of frustration expressed by many beneficiaries, providers and oral health care advocates with Denti-Cal rules, processes and fresh limits on care, especially in the realm of dental surgery. The study also took place while the state's Medicaid dental program solicited proposals from major dental insurers to restructure its financial and outreach processes and negotiated with the federal government for new experimental incentives to increase preventative care. While the insurers continue discussions with Denti-Cal regarding its request for proposals, the agreement reached with the federal government for a $740 million, five-year incentive program occurred after the Commission concluded its public process. The Commission had no opportunity to review direction of the incentive program in a public process.

In framing its study the Commission deliberately avoided proposals made by the dental community for an across-the-board hike in reimbursement rates. As stated earlier in this report, that is a political, rather than a governing issue. The Commission instead reviewed

and identified potential solutions for immediate state administrative issues and processes that frustrate dentists, and also focused on larger directional change to a preventative system for millions of Denti-Cal-eligible Californians.

The Commission initiated its Denti-Cal study in September 2015. The findings and recommendations presented in this report are based on oral and written testimony presented during two public hearings, extensive Commission staff research and interviews with more than 50 experts and representatives of groups interested in California's Medicaid dental program.

The Commission's first hearing on September 24, 2015, provided an overview of a taxpayer-supported safety net program for dental care that is encountering serious difficulties in getting dentists to provide care and beneficiaries to use their benefits. State lawmakers and partners from the dental community and children's health advocacy groups described administrative and financial deficiencies in the Denti-Cal program that discourage dentists from participating and result in widespread lack of access to care in a large eligible population. Denti-Cal administrators also described efforts to improve the program's relations with dentists and raise the number of beneficiaries making regular dental visists.

A second hearing on November 19, 2015, addressed the limited preventative care provided by the Denti-Cal program and reviewed best practices that get children into care before their teeth become an emergency situation. Experts testified about numerous potential approaches to reorient Denti-Cal's singular emphasis on funding expensive restorative procedures toward more cost-effective preventative care for the long haul in California.

Public hearing witnesses are listed in the appendices.

Throughout this study the Commission staff received much valuable input from experts throughout California on the daily realities dentists face in their offices, the difficulties faced by people of limited means to make and keep appointments, the widespread dislike that dental providers have for state bureaucratic processes and the legal, moral and financial implications of inadequate dental care. Others provided valuable insight into the public health system and emerging trends in dental care. Many more parents and caregivers wrote to the Commission or took time off work and traveled to Sacramento to provide public comment about the impacts of Denti-Cal deficiencies on real lives. For that the Commission is most grateful. All gave generously of their time, providing great benefit to the Commission. The findings and recommendations in in the report, however, are the Commission's own.

Appendices

Public Hearing Witnesses

September 24, 2015

Dr. John Blake, Executive Director, Children's Dental Health Clinic

Jenny Kattlove, Senior Director, Programs, The Children's Partnership

Dr. Jayanth V. Kumar, California State Dental Director, Department of Public Health

René Mollow, Deputy Director of Health Care Benefits and Eligibility, Department of Health Care Services

Dr. Richard Pan, California State Senator

Brianna Pittman, Legislative Director, California Dental Association

Joe Ruiz, Vice President of State Government Programs, Delta Dental of California

Nicette Short, Director of Public Policy, California Dental Association

Jim Wood, California State Assemblymember

November 19, 2015

Dr. Rosa Arzu, Dental Director, AltaMed Health Services

Mindy Epperson, RN Site Supervisor, Sutter Amador Pediatrics Center

Dr. Jared Fine, Former Dental Health Administrator, Alameda County Public Health Department

Dr. Paul Glassman, Professor of Dental Practice and Director of Community Oral Health, University of the Pacific School of Dentistry

Nina Machado, Executive Director, First 5 Amador

Billy Millwee, Former Texas Medicaid Director, 2009-2012, and Senior Strategic Advisor, Sellers Dorsey

Sean South, Associate Director of Policy & Legislation, California Primary Care Association

Dr. David J. Stone, Pediatrician, Sutter Amador Pediatrics Center

NOTES

1 Assemblymember Jim Wood, DDS. California State Assembly. Sacramento, CA. September 24, 2015. Little Hoover Commission. Hearing.

2 Department of Health and Human Services. Centers for Medicare & Medicaid Services. December 30, 2015. "California Medi-Cal 20-20 Demonstration." Page 69. Washington, D.C. On file.

3 Carolyn Brookins. Legislative Coordinator. Department of Health Care Services. Sacramento, CA. February 12, 2016. Written Communication. On file.

4 Health Policy Institute. American Dental Association. 2013. "The Oral Health Care System. A State-by-State Analysis." Page 26. Washington, D.C. http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthCare-StateFacts/Oral-Health-Care-System-Full-Report.pdf. Accessed February 3, 2016.

5 Health Policy Institute. See Endnote 4.

6 Carolyn Brookins. See Endnote 3.

7 The Henry J. Kaiser Family Foundation. "State Health Facts. Professionally Active Dentists." Washington, D.C. http://kff.org/other/state-indicator/total-dentists. Accessed July 29, 2015.

8 Senator Richard Pan. California State Senate. Sacramento, CA. June 23, 2015. Personal communication.

9 Health Policy Institute. See Endnote 4. (The nine states and districts with dentist participation rates between 20 percent and 30 percent include California, District of Columbia, Georgia, Kansas, Maryland, Missouri, New Jersey, North Carolina, Ohio and Washington).

10 Conrado E. Bárzaga, M.D. Executive Director. The Center for Oral Health. Pomona, CA. September 24, 2015. Little Hoover Commission. Public comment. Sacramento, CA. Also, Viveka Rydell. Chief Executive Officer. PDI Surgery Center. Sonoma, CA. Personal Communication.

11 August 8, 2013, letter from Senators Bill Emmerson and Mark DeSaulnier to Asemblymember Adam Gray, Chair, Joint Legislative Audit Committee. Also, California State Auditor. December 2014. "California Department of Health Care Services. Weaknesses in its Medi-Cal Dental Program Limit Children's Access to Dental Care." Report 2013-125. Pages 1-4. https://www.auditor.ca.gov/pdfs/reports/2013-125.pdf. Accessed September 4, 2015.

12 California State Auditor. "Report 2013-125 Recommendations." Pages 2-3. Sacramento, CA. https://www.auditor.ca.gov/reports/recommendations/2013-125. Accessed March 15, 2016.

13 Scott Graves. Director of Research. The California Budget & Policy Center. January 23, 2015. "California Budget Bites. Medi-Cal and the Governor's Proposed 2015-16 Budget: Health Care Reform Boosts Enrollment and Federal Funding." Sacramento, CA. http://calbudgetcenter.org/blog/medi-cal-and-the-governors-proposed-2015-16-budget-health-care-reform-boosts-enrollment-and-federal-funding. Accessed August 31, 2015.

14 The Kaiser Commission on Medicaid and the Uninsured. May 2015. "Medicaid at 50." Pages 1, 7, 8, 19, 20. Washington, D.C. http://files.kff.org/attachment/report-medicaid-at-50. Also "State Health Facts. Total Medicaid Spending." http://kff.org/medicaid/state-indicator/total-medicaid-spending. Accessed February 5, 2016.

15 U.S. Department of Health and Human Services. Office of Inspector General. January 2016. "Most Children with Medicaid in Four States are not Receiving Required Dental Services." Page 2. Washington, D.C. http://oig.hhs.gov/oei/reports/oei-02-14-00490.pdf. Accessed February 3. 2016.

16 Sandra R. Hernández, President & Chief Executive Officer. California Health Care Foundation. July 15, 2015. "Medi-Cal Comes to Main Street." Sacramento, CA. http://www.chcf.org/articles/2015/07/medical-comes-main-street#ixzz3ijkaPIkY. Also, Legislative Analyst Office. July 9, 2015. "Medi-Cal: Overview and Payment Issues." Sacramento, CA. Pages 2, 4, 5. http://www.lao.ca.gov/handouts/health/2015/Medi-Cal-Overview-and-Payment-Issues-070915.pdf. Accessed August 26, 2015.

17 California Department of Health Care Services. Sacramento, CA. September 24, 2015. "Department of Health Care Services Data." Written testimony.

18 Joe Ruiz. Vice President. State Government Programs. Delta Dental of California. Sacramento, CA. September 24, 2015. Written testimony.

19 Joe Ruiz. See Endnote 18.

20 California State Auditor. See Endnote 12.

21 Western Dental. News Release. November 16, 2015. "Western Dental Opening New Facility in Oakland, Accepting Denti-Cal Patients." Orange, CA. http://www.businesswire.com/news/home/20151116006363/en/Western-Dental-Opening-Facility-Oakland-Accepting-Denti-Cal. Accessed December 21, 2015.

22 Western Dental. News Release. January 29, 2016. "Western Dental Continues as State Leader; Accepting Denti-Cal Patients at All Locations." Orange, CA. http://

www.prnewswire.com/news-releases/western-dental-continues-as-state-leader-accepting-denti-cal-patients-at-all-locations-300212188.html. Accessed February 2, 2016.

23 California Department of Health Care Services. See Endnote 17.

24 Jocelyn Wiener. April 14, 2013. California Healthcare Foundation Center for Health Reporting. The Sacramento Bee. "Dental program for poor children improving." Sacramento, CA. http://www.sacbee.com/entertainment/living/family/article2577198.html. Accessed November 2, 2015.

25 John J. Carvelli. Executive Vice President. Liberty Dental Plan. Irvine, CA. June 18, 2016. Personal communication.

26 David Gorn. June 25, 2015. California Healthline. "Dental Managed Care Takes a New Tack." Sacramento, CA. http://www.californiahealthline.org/capitol-desk/2015/6/dental-managed-care-takes-a-new-tack. Accessed November 2, 2015.

27 The California Dental Association. January 25, 2016. News Release. "CDA Urges State to Eliminate Sacramento's Failed Dental Pilot Program." Sacramento, CA. http://www.cda.org/Portals/0/press/pr_0116_dental_pilot_program.pdf. Accessed February 2, 2016.

28 Moira Kenney. Executive Director. First 5 Association of California. March 17, 2015. Testimony to Joint Legislative Audit Committee, Assembly Committee on Health, Senate Committee on Health. Sacramento, CA.

29 Children & Families Commission of Orange County. February 2015. Policy Brief. "Children's Oral Health in Orange County." Santa Ana, CA. On file.

30 Barbara Aved Associates. December 2015. "Sacramento children and dental care. Better served than 5 years ago?" Sacramento, CA. Page 4. On file.

31 Dr. Jared Fine. Former Dental Health Administrator. Alameda County Health Care Services Agency. Oakland, CA. November 19, 2015. Written testimony to the Commission.

32 David Satcher, MD, Ph.D. United States Surgeon General. National Institute of Dental and Cranofacial Research. "First Surgeon General's Report on Oral Health." 2000. Executive Summary. Pages 1-5. Washington, D.C. http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf Accessed February 29, 2016.

33 Andrew Snyder and Keerti Kanchinadam. National Academy for State Health Policy. July 2015. "Adult Dental Benefits in Medicaid: Recent Experiences from Seven States." Page 13. Portland, Maine. http://www.nashp.org/wp-content/uploads/2015/07/Adult-Dental-Benefits-in-Medicaid-Recent-Experiences-from-Seven-States.pdf. Accessed November 2, 2015.

34 Jondi Gumz. The Santa Cruz Sentinel. June 1, 2015. "Fewer dentists in private practice accept Denti-Cal patients." Santa Cruz, CA. http://www.santacruzsentinel.com/health/20150601/fewer-dentists-in-private-practice-accept-new-denti-cal-patients. Accessed August 31, 2015.

35 Moody's Investor Services. May 8, 2015. "Rating Action: Moody's downgrades Premier Dental's (parent of Western Dental) CFR to Caa1 from B3; outlook negative." New York, N.Y. https://www.moodys.com/research/Moodys-downgrades-Premier-Dentals-parent-of-Western-Dental-CFR-to--PR_324586?WT.mc_id=AM~WWFob29fRmluYW5jZV9TQl-9SYXRpbmcgTmV3c19BbGxfRW5n~20150508_PR_324586. Accessed August 31, 2015.

36 Western Dental. See Endnote 21.

37 Department of Health Care Services. July 1, 2015. "Medi-Cal Dental Services Rate Review." Page 5. Sacramento, CA. http://www.dhcs.ca.gov/Documents/2015_Dental-Services-Rate-Review.pdf. Also: AB 82. June 13, 2013. Office of Senate Floor Analysis. "Budget Act of 2013: Health." Page 5. http://lisprdweblb.calegis.net:7010/LISWeb/faces/bills/billdetail.xhtml. California Department of Finance. June 2015. "California State Budget - 2015-16. Health and Human Services." Sacramento, CA. Page 26. http://www.ebudget.ca.gov/2015-16/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.

38 Mexican American Legal Defense and Education Fund. National Health Law Program. Civil Rights Education and Enforcement Center. December 15, 2015. Administrative Complaint. "Inadequate Access to Health Care Violates Latino Civil Rights in California's Medi-Cal Program." Los Angeles, CA. http://www.seiu-uhw.org/wp-content/blogs.dir/166/files/2015/12/CivilRightsComplaint_Text_12.15.15.pdf. Accessed December 29, 2015.

39 Dr. Paul Glassman, DDS. Professor of Dental Practice. Director, Pacific Center for Special Care. University of the Pacific. Arthur A. Dugoni School of Dentistry. San Francisco, CA. August 19, 2015. Letter to the Commission. http://www.lhc.ca.gov/studies/activestudies/denti-cal/Sept2015Hearing/Public%20Comments/UOPSchoolofDentistry.pdf. Accessed December 28, 2015.

40 UCare. February 2015. "Summary of UCare Dental Benefits." On file.

41 Iowa Department of Public Health. December 2008. "Inside I-Smile: A Look at Iowa's Dental Home Initiative for Children." http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=DAC3576F-0B60-43FB-AE21-BBF0F7BFAA25. Accessed October 16, 2015. Also, Tracy Rodgers. May 13, 2015.

"I-Smile partnership is making a difference." Children's Dental Health Project. Susan Tucker. https://www.cdhp.org/blog/360-i-smile-partnership-is-making-a-difference. Accessed October 16, 2015.

42 Texas Higher Education Coordinating Board. November 2010. "Overview: Loan Repayment Programs." On file. Texas Medical Association. "Agreement in Principle: Frew v. Hawkins." http://www.texmed.org/template.aspx?id=5748. Accessed October 16, 2015. Also: Kamyar Nassah, Ph.D., Marko Vujicic, Ph.D. and Cassandra Yarbrough, M.P.P. October 2014. "A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services." American Dental Association. http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx. Accessed October 16, 2015.

43 The Centers for Medicare & Medicaid Services. January 2011. "Innovative State Practices for Improving The Provision of Medicaid Dental Services." http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/8statedentalreview.pdf. Accessed October 19, 2015.

44 State of Maryland. "Dental Action Plan Template For Medicaid and CHIP Programs." http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/sohap-maryland.pdf. Accessed October 15, 2015.

45 Connecticut Dental Health Partnership. January 2014. "Connecticut Dental Health Partnership Fact Sheet." https://www.ctdhp.com/documents/69-%20CTDHP%20Fact%20Sheet%20-%20General%202014.pdf. Accessed October 16, 2015.

46 Kamyar Nassah, Ph.D., Marko Vujicic, Ph.D. and Cassandra Yarbrough, M.P.P. October 2014. "A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services." American Dental Association. http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx. Accessed October 16, 2015.

47 Carolyn Brookins. Legislative Coordinator. Department of Health Care Services. Sacramento, CA. February 8, 2016. Written Communication. On file.

48 Carolyn Brookins. Legislative Coordinator. Department of Health Care Services. Sacramento, CA. February 4, 2016. Written Communication. On file

49 September 24, 2015, hearing. California Channel. Recent Archives. (Minutes 115-118). http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=3232. Accessed December 30, 2015.

50 Suzanne Murrin. Deputy Inspector General for Evaluation and Inspections. The Department of Health and Human Services. Office of Inspector General. May 2015. OEI-02-14-00480. "Questionable Billing for Medicaid Pediatric Dental Services in California." Pages 8-13, 16-17. Washington, D.C. http://oig.hhs.gov/oei/reports/oei-02-14-00480.pdf. Accessed January 8, 2016.

51 Health Evidence Review Commission. "About Us." Salem, OR. http://www.oregon.gov/oha/herc/pages/index.aspx. Accessed February 8, 2016.

52 2011 Nevada Revised Statues. Chapter 439 – Administration of Public Health. NRS 439.2792. Carson City, NV. http://law.justia.com/codes/nevada/2010/title40/chapter439/nrs439-2792.html. Accessed February 8, 2016.

53 Conrado E. Bárzaga, M.D. Executive Director. The Center for Oral Health. September 2015. "Denti-Cal and the Wisdom Tooth(less): A Deeper Drill at a Complex Problem." Pomona, CA. Page 2. http://www.centerfororalhealth.org/images/issuebriefs/DentiCalBrief_09232015.pdf. Accessed February 17, 2016.

54 Laura Smith. President and CEO. Washington Dental Service Foundation. "Washington State's Access to Baby and Child Dentistry Program." On file.

55 Laura Smith. President and CEO. Washington Dental Service Foundation. Seattle, WA. November 19, 2015. Written testimony.

56 New York Department of Health. November 2009. "Fluoride Varnish – Frequently Asked Questions." https://www.health.ny.gov/prevention/dental/fluoride_varnish_faq.htm. Accessed October 20, 2015. Also: American Dental Association. 2014. "Sealants." http://www.mouthhealthy.org/en/az-topics/s/sealants. Accessed October 20, 2015.

57 Laura Smith. See Endnote 55.

58 Dr. Robert Isman, DDS. Former California State Dental Director. Former Dental Program Consultant, Department of Health Care Services. Sacramento, CA. December 8, 2015. Written communication. On file.

59 Dr. Paul Glassman. See Endnote 39. August letter to Commission.

60 California Department of Health Care Services. Denti-Cal Bulletin. Volume 31, Number 15. October 2015. "Teledentistry." http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_31_Number_15.pdf. Accessed October 26, 2015.

61 Legislative Information System. 2015. "Health Care Access Demonstration Project Grants: Virtual Dental Home Program." AB 648 (Low). Sacramento, CA. http://lisprdweblb.calegis.net:7010/LISWeb/faces/bills/billhistory.xhtml. Accessed

October 26, 2015.

62 Sean South. Associate Director of Policy and Legislation. California Primary Care Association. Sacramento, CA. November 19, 2015. Written testimony.

63 Julia Goebel. February 8, 2013. "A Brief History of Federally Qualified Health Centers." Notifymd.com. Northbrook, Illinois. http://www.notifymd.com/a-brief-history-of-federally-qualified-health-centers-fqhc. Accessed October 29, 2015.

64 Jocelyn Wiener. See Endnote 24.

65 David Gorn. June 25, 2015. California Healthline. "Dental Managed Care Takes a New Tack." Sacramento, CA. http://www.californiahealthline.org/capitol-desk/2015/6/dental-managed-care-takes-a-new-tack. Accessed November 2, 2015.

66 WFAA News 8. August 25, 2011. "Feds Investigate Texas dental Medicaid Program." Dallas-Fort Worth, Texas. http://www.wfaa.com/story/news/local/investigates/2014/08/14/13774502. Accessed October 26, 2015.

67 California Department of Health Care Services. Weaknesses in its Medi-Cal Dental Program Limit Children's Access to Dental Care." Report 2013-125. Page 25. https://www.auditor.ca.gov/pdfs/reports/2013-125.pdf. Accessed September 4, 2015.

68 Laird Harrison. Medscape Medical News. August 31, 2015. "AAP Adds Flouride Varnish to Anticipatory Guidance Schedule." New York, N.Y. http://www.medscape.com/viewarticle/850267. Also, American Academy of Pediatrics. August 31, 2015. "AAP Updates Well Child Visit Schedule." https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Updates-Well-Child-Visit-Schedule.aspx. Elk Grove Village, IL. Accessed February 12, 2016.

Little Hoover Commission Members

Chairman Pedro Nava *(D-Santa Barbara)* Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013. Advisor to telecommunications industry on environmental and regulatory issues and to nonprofit organizations. Former state Assemblymember. Former civil litigator, deputy district attorney and member of the state Coastal Commission. Elected chair of the Commission in March 2014.

Vice Chairman David A. Schwarz *(R-Beverly Hills)* Appointed to the Commission in October 2007 and reappointed in December 2010 by Governor Arnold Schwarzenegger. Partner in the Los Angeles office of Irell & Manella LLP and a member of the firm's litigation workgroup. Former U.S. delegate to the United Nations Human Rights Commission.

Scott Barnett *(R-San Diego)* Appointed to the Commission by former Speaker of the Assembly Toni Atkins in February 2016. Founder of Scott Barnett LLC, a public advocacy company, whose clients include local non-profits, public charter schools, organized labor and local businesses. Former member of Del Mar City Council and San Diego Unified School District Board of Trustees.

David Beier *(D-San Francisco)* Appointed to the Commission by Governor Edmund G. Brown Jr. in June 2014. Managing director of Bay City Capital. Former senior officer of Genetech and Amgen. Former counsel to the U.S. House of Representatives Committee on the Judiciary. Serves on the board of directors for the Constitution Project.

Senator Anthony Cannella *(R-Ceres)* Appointed to the Commission by the Senate Rules Committee in January 2014. Elected in November 2010 an re-elected in 2014 to the 12th Senate District. Represents Merced and San Benito counties and a portion of Fresno, Madera, Monterey and Stanislaus counties.

Jack Flanigan *(R-Granite Bay)* Appointed to the Commission by Governor Edmund G. Brown Jr. in April 2012. A member of the Flanigan Law Firm. Co-founded California Strategies, a public affairs consulting firm, in 1997.

Loren Kaye *(R-Sacramento)* Appointed to the Commission in March 2006 and reappointed in December 2010 by Governor Arnold Schwarzenegger. President of the California Foundation for Commerce and Education. Former partner at KP Public Affairs. Served in senior policy positions for Governors Pete Wilson and George Deukmejian, including cabinet secretary to the Governor and undersecretary for the California Trade and Commerce Agency.

Assemblymember Chad Mayes (*R-Yucca Valley)* Appointed to the Commission by former Speaker of the Assembly Toni Atkins in September 2015. Elected in November 2014 to the 42nd Assembly District. Represents Beaumont, Hemet, La Quinta, Palm Desert, Palm Springs, San Jacinto, Twentynine Palms, Yucaipa, Yucca Valley and surrounding areas.

Don Perata *(D-Orinda)* Appointed to the Commission in February 2014 and reappointed in January 2015 by the Senate Rules Committee. Political consultant. Former president pro tempore of the state Senate, from 2004 to 2008. Former Assemblymember, Alameda County supervisor and high school teacher.

Assemblymember Sebastian Ridley-Thomas *(D-Los Angeles)* Appointed to the Commission by former Speaker of the Assembly Toni Atkins in January 2015. Elected in December 2013 to represent the 54th Assembly District. Represents Century City, Culver City, Westwood, Mar Vista, Palms, Baldwin Hills, Windsor Hills, Ladera Heights, View Park, Crenshaw, Leimert Park, Mid City, and West Los Angeles.

Senator Richard Roth *(D-Riverside)* Appointed to the Commission by the Senate Rules Committee in February 2013. Elected in November 2012 to the 31st Senate District. Represents Corona, Coronita, Eastvale, El Cerrito, Highgrove, Home Gardens, Jurupa Valley, March Air Reserve Base, Mead Valley, Moreno Valley, Norco, Perris and Riverside.

Jonathan Shapiro *(D-Beverly Hills)* Appointed to the Commission in April 2010 and reappointed in January 2014 by the Senate Rules Committee. Writer and producer for FX, HBO and Warner Brothers. Of counsel to Kirkland & Ellis. Former chief of staff to Lt. Governor Cruz Bustamante, counsel for the law firm of O'Melveny & Myers, federal prosecutor for the U.S. Department of Justice Criminal Division in Washington, D.C., and the Central District of California.

Full biographies available on the Commission's website at www.lhc.ca.gov.

"Democracy itself is a process of change, and satisfaction and complacency are enemies of good government."

Governor Edmund G. "Pat" Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24, 1962, Sacramento, California