PAINFUL REALITIES: GENERAL ANESTHESIA ACCESS IN SACRAMENTO GMC DENTAL MANAGED CARE

June 2020

SACRAMENTO COUNTY ORAL HEALTH PROGRAM

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Sacramento County
Oral Health Program

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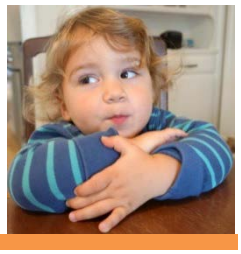


EXECUTIVE SUMMARY

"I have to say, getting clients access to dental care is the biggest challenge I have as a Service Coordinator." – Survey Respondent, Alta CA Regional Center

INTRODUCTION

Sedation, including general anesthesia (GA) can be of great help to patients during dental treatments to relieve anxiety, prevent pain and ensure the safety of the procedure. While regular dental visits, combined with good preventive home care, and feasible alternative approaches, can avoid some of the need for dental care provided with GA, dental treatment for some children and adults with special needs is only possible through GA because of their disproportionate oral health burden and limited ability to tolerate the requirements of receiving care.

It is important to understand at the outset that the system of care and coverage for GA services is fragmented and governed by multiple separate entities. Individuals with special health care needs in need of anesthesia for dental care are frequently covered by the Medi-Cal program due to a medical or developmental condition. Young children, however, requiring dental treatment under anesthesia due to extensive decay at an early age, are often covered by their parents' commercial dental plan or have no dental coverage. Health plans became legally responsible to cover the cost of GA for dental treatment when rendered in a hospital or surgery center for certain populations/age groups in 2000 with the enactment of (state law) AB 2003 (Strom-Martin). GA is a covered benefit in the Medi-Cal Dental Program regardless of the location of care or age of the patient if it is deemed medically necessary (federal law). Despite the laws governing these coverages, the health and dental plans that pay for these services have their own treatment approval policies. This patchwork of regulation, as we will see from the analysis below, frequently results in confusion and delayed or denied access to GA associated with dental treatment.

In Sacramento, Medi-Cal Geographic Managed Care medical and dental plans are responsible for authorizing GA dental services for Medi-Cal members. Denials of treatment authorization requests (TAR) for this service—higher by some plans and higher for some patient age groups—could have been largely avoided had the unclear, inconsistent Medi-Cal policies and guidance been addressed when the issue was first documented. TAR reviewers and the specialist dentists, or dentists who refer for GA, have disagreed on what constitutes "medical necessity;" reviewers have not always been satisfied with the type and level of detail provided to substantiate the patient's medical or other need for GA. Even when treatment has been approved, inadequate operating room time afforded to dentists in Sacramento hospitals and surgery centers has limited access to GA dentistry, adding to patient pain and suffering.

This study evolved from the continuing frustration of dental providers, in Sacramento and elsewhere, who provide care to patients who need GA, particularly children and adults with

special needs, and from parents in the community because their children and adult children comprise a big part of the GA service need. A subcommittee of the Medi-Cal Dental Advisory Committee—the Special Needs/General Anesthesia Committee—was formed to address the long-standing problem and engaged Barbara Aved Associates to conduct this study.

STUDY METHODS

We gathered and analyzed data from existing publicly available sources such as Department of Health Care Services (DHCS) and collected primary data. Primary data sources included surveys of local dentists, Alta California Regional Center staff and special needs families; and interviews with hospitals, surgical centers, including those outside of Sacramento, community health centers, and local medical and dental staff. We also conducted a purposeful review of the professional literature, studies, and relevant reports related to the study objectives. The Special Needs/General Anesthesia Committee approved the study design and provided overall guidance to the project.

KEY FINDINGS

- Confusing, unclear guidance and sometimes inconsistently applied criteria for approving dental GA requests has led to avoidable denials by GMC managed care plans (both dental and medical). Although improved, the problem has not been permanently resolved despite multiple policy letters and other communication from DHCS.
- While incomplete paperwork and eligibility issues have sometimes contributed, the main reason for denials is typically that reviewers want to see more evidence of medical necessity in the referring dentists' documentation—undervaluing dentist judgement of the need for GA.
- DHCS data confirmed complaints from the provider community about significant issues with one particular Medi-Cal managed health care plan: Anthem Blue Cross stood out as an outlier in denying GA requests based on "no medical necessity."
- GMC dental plans, in particular Health Net and LIBERTY for adult members, also showed a high rate of GA denials based on "no medical necessity." While complaints about this had not been raised by parents and providers as a significant problem at MCDAC meetings, these data reveal that GA denials are not exclusive to the medical plans.
- In a comparison of GMC dental with fee-for-service (FFS) dental using Fresno County as the proxy FFS, the average lag time (days) between the GA request and dental procedure (delivery of treatment) was 50 days for children 0-20 in GMC vs 32 days in FFS; for adults 21+, the lag time was 52 days vs 34 days, respectively, for the two age groups. Some dentist survey respondents reported lags of 6-9 months. Whether due to administrative delays, dentist backlogs or other reasons, services provided more than 30 days leaves patients with unnecessary suffering.
- Medi-Cal patients who can are having to pay out of pocket for GA dentistry. Medi-Cal managed care *health* plans, which are not required to pay for dental procedures performed in a dentist's

office, were not represented among the reported payers for these cases according to the surveyed dentists.

- The estimated number of dental GA cases last year across the 8 Sacramento hospitals equates to an average of about 2.9 cases per week, relatively few compared to the need for more operating room (OR) time. Dentist survey respondents cited this reason as the "major problem" contributing to delays in scheduling treatment.

- Incomplete/inaccurate data reporting make it difficult to know how many dental cases are treated under GA in hospital or surgery center settings. Sacramento hospitals are not consistent in reporting GA dentistry to the Office of Statewide Health Planning and Development (OSHPD) with codes that make that service clear.

- Given the downward pressure on hospital revenue due to the coronavirus pandemic, it will be more challenging than before to engage hospitals in offering more OR time; however, access will never increase without this happening.

- Given the disproportionate burden of dental disease among children and adults with special needs, and the fact that many cannot undergo regular and preventive dental care without anesthesia because of behavioral or other issues, linking clients to needed dental care is one the biggest challenges of the Service Coordinators at Alta CA Regional Center. Dental coordination there is by committee, not a dedicated position.

- When general dentist survey respondents reported providing GA in their office, none reported managing it themselves; all of them engaged a separate provider for that purpose.

- One of the important limiting factors for access to GA services is that most MD and DDS anesthesiologists do not participate in Medi-Cal. To wit, DHCS reports only one dentist anesthesiologist is enrolled as a Medi-Cal Dental Program provider.

- The most common barrier for surveyed dentists to see more patients with special needs was inadequate reimbursement for uncompensated time in patient management; nearly all said they had enough capacity for these patients.

- Pediatric dentists expressed the most comfort serving patients with special needs; the comfort level of the general dentists and oral surgeons increased as the patient ages increased.

- The majority of the surveyed dentists, except for pediatric dentists, reported not being familiar with and infrequently using alternative approaches to GA.

- We were able to receive responsive attention to our requests for data and answers to questions from Medi-Cal staff, though greater communication between the medical and dental staff—"both sides of the house"—could benefit internal processes, understanding of each other's data and interpretations, policy setting, monitoring and collaborative learning.

RECOMMENDATIONS

The 14 recommendations offered below are driven by the study's findings. A full description of them can be found at the end of this report.

1. Support and Raise Awareness of Alternatives to GA
2. Expand Operating Room Capacity for Dental Cases
3. Expand Dental and Medical Plan Coverage to Address Out-of-Pocket Cost for Families
4. Create Legislation that Requires Hospitals to Specifically Report on Dental Needs as a Separate Category in the Needs Assessment and Activity Reports
5. Enhance Hospital Reporting of GA Dental Cases
6. Create and Promote Training Opportunities for Providers in Alternative Approaches and Familiarity with Treating Patients with Special Needs
7. Increase Capacity of the Regional Center to Link Clients to Dental Services by Creating a Dental Coordinator Position
8. Communicate Clear, Consistent DHCS GA Policies and Continue to Monitor for Access
9. Promote Improved DHCS Dental-Medical Internal Communication
10. Maintain Medi-Cal Dental Funding, Eligibility and Scope of Benefits
11. Expand Parent Education on Oral Health
12. Continue Support for the Medi-Cal Dental Advisory Committee
13. Support a Dental Seat on the New Medical Managed Care Advisory Committee if Enacted with Proposed Legislation (SB 1029, Pan)
14. Create an Action Plan, Monitor Progress and Further Explore Related Questions

INTRODUCTION

"Dental surgeries are always the first to go. For budgetary reasons, I was asked to leave."— Dentist explaining why a hospital rescinded OR access

Going to the dentist can be especially difficult for patients with an underlying fear and anxiety about dentistry. For individuals with physical and intellectual disabilities, those fears and anxieties are compounded by sensory issues, negative behaviors, and the lack of dentists who are willing to see them.[1] Access to dental care for patients with special needs may also be limited by the ability of their caregiver to effectively evaluate their oral condition and/or by the person's own inability to express their pain or discomfort.[2] In addition to experiencing unique barriers, individuals with developmental disabilities experience higher rates of dental disease.[3]

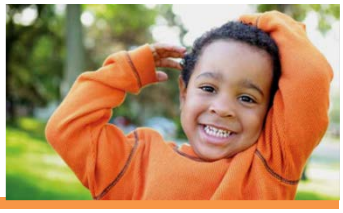
Additionally, many young children end up needing dental work done under general anesthesia (GA) due to extensive dental decay at a young age. They are developmentally too young to sit still for treatment, therefore dental work under GA is medically necessary. However, need for these cases must be reduced by increasing focus on, and access to, preventive care and also parent education on the importance of oral health.

In Sacramento County in 2018, there were an estimated 181,448 people, or 12.1% of the population, with disabilities[4] and about 1,040 practicing dentists. Studies indicate that fewer than 10% of dentists feel comfortable treating patients with disabilities because of their lack of training and experience, as well as the patients' negative reactions to common dental procedures.[5] Because patients with special needs often require dental treatment to be adapted to meet their oral health needs, for a proportion, dental treatment is only possible through sedation or GA.[6] Due to these reasons, along with other factors, there is a lack of access to care for patients with special needs.

According to some studies, approximately 5%-12% of dental patients will, at some time, need sedation services;[7] however, those estimates do not include people with anxiety who do not attend the dentist regularly. While other forms of sedation options—including alternative approaches—can make a difference for some people to successfully overcome fear, anxiety and discomfort, IV sedation (a sedative administered intravenously) and GA can be useful or indicated for facilitating dental treatment. The primary indication for general anesthesia among individuals with special needs, for example, is lack of patient cooperation due to anxiety, intellectual disability, or some other impairment.[8] In pediatric dentistry, rampant or extensive caries with an inability to cooperate in the dental clinic is the most common indication for treatment under GA.[9]

Approval for IV sedation/GA requires authorization by a patient's health insurance, both dental and medical. Lack of clear-cut, uniform, consistently applied policies has resulted in unnecessary denials for Sacramento dental providers who submit Treatment Authorization Requests (TARSs) for anesthesia services for patients with Medi-Cal, creating a barrier to receiving timely access to care. The problem has been reoccurring—sometimes seemingly "fixed," sometimes not—for at least the last decade as this report will show.

This report examines the extent to which GA dental services are sufficiently available in Sacramento County, including for children and adults with special needs, and offers a number of suggestions for improvement. Because patients with Medi-Cal experience far more problems accessing care the findings focus on the Medi-Cal population. Higher income/privately insured patients are more likely to pay out of pocket or be able to seek reimbursement from their private plan at rates that are acceptable to dental providers. Many people contributed to the information in this study making the assessment possible, enriching our understanding of the issues and adding insight to the recommendations (they are gratefully acknowledged in Attachments 1 and 2).



STUDY PROCESS AND DATA SOURCES

"We spend a lot of time talking about the authorization process because not getting paid at all is worse than getting paid a little, but to have a real discussion about all of this means we also need to talk about costs that aren't being covered." — Surgery center representative

STUDY DESIGN

We produced a study design that laid out the primary questions to be answered; identified the data needed to address the questions, the plan for collecting it, and potential data sources; and provided a timeline that was essentially determined by the short amount of time and availability of funding from March 1, 2020 to June 30, 2020.

A subcommittee of the Medi-Cal Dental Advisory Committee (MCDAC)—the Special Needs/GA Workgroup—reviewed and provided helpful suggestions to the study design, and acted in an advisory capacity for this study.

DATA SOURCES

Surveys

Dentists. To understand more about the local dental delivery system, we undertook a survey of Sacramento County dentists to identify those who provided sedation dentistry, to learn where and to which populations, including special needs, and to identify delivery system barriers. The survey was initially reviewed by the project workgroup, revised and then sent to local dentists who agreed to review it. Based on their feedback, the survey was finalized and formatted for online use (Attachment 7).

The dentists eligible to participate were all 1,040 practicing dentists who saw Sacramento County patients. The Sacramento District Dental Society (SDDS) emailed the survey to its members (who represent about 80% of practicing dentists in Sacramento County). To reach the remainder of Sacramento dentists, Sacramento County Oral Health Program emailed it to non-member Sacramento dentists. The providers were asked to fill out the survey whether or not they provided IV sedation/general anesthesia (GA) themselves, or saw Medi-Cal patients or served patients with special needs. Dentists completed the survey between March 20, 2020 and April 1, 2020. SDDS and SCOPH sent 2 emails during that time to encourage dentists to participate.

Special Needs Groups. We created a survey of Service Coordinators at Alta California Regional Center to learn more about their experience in linking clients to dental services. To get patient/family perspectives, we developed questions that the State Council on Developmental Disabilities and We EMBRACE, a support organization for families with children and adults with

special needs, posted on their social media platforms. The survey responses from these efforts were sent to us directly for coding and analysis.

Interviews

Sacramento Facilities. We called nine Sacramento hospitals and three ambulatory surgery centers (ASC) to inquire about operating room (OR) use, dentist schedules and number of cases, and anesthesiologist services. The information was generally obtained from phone calls and follow-up emails with surgery scheduling staff but in some cases included the chief medical officer or outpatient department manager or all three. We also spoke with four Sacramento community health centers to learn what access barriers they have encountered when serving and referring dental patients for treatment requiring sedation.

Other Dental Surgery Centers. We were invited to participate in one of the conference calls a coalition of 15 California dental surgery centers regularly schedules to problem solve concerns to learn whether their experience could be helpful to Sacramento. Some of the members sent follow-up information to what was provided during the call.

Key Informants. A number of experts provided helpful background and other information through telephone calls and emails such as walk-throughs of specific patient scenarios, explanations of dental service and GA benefits, service delivery set-ups, and financial issues. We also interviewed two specialist dental offices in Sacramento County with historical problems in obtaining GA approval for Medi-Cal patients, including those with special needs.

Data Retrieval

Publicly available Medi-Cal dental utilization data were retrieved from the Department of Health Care Services (DHCS) dental managed care and fee-for-service websites[10,11] and medical and dental claims data were provided by DHCS through a Public Records Act (PRA) request. DHCS also shared an internal analysis (May 2020) of dental anesthesia denials via a second PRA request.

Facility utilization data for Sacramento hospitals and ambulatory surgery centers was provided by the Office of Statewide Health Planning and Development (OSHPD).

Prevalence estimates for people in Sacramento County with special needs were retrieved from The Rehabilitation Research and Training Center on Disability Statistics and Demographics annual disability statistics compendium.[12]

Literature Review

To give context to and meaning to our findings, interpretations, and recommendations we performed a review of journal articles, studies and relevant reports related to the study purpose. We were particularly benefitted by the Legislative Analyst Office (LAO) report on dental access for individuals with developmental disabilities.[13]

STUDY CRITERIA AND DEFINITIONS

Children: Age 0-7; and 8-20; or, 0-20 when child age breakout was not available.

Adults: Age 21+

Special Needs: Defined in this study as any medical/cognitive/developmental condition that may render a person unable to safely cooperate with receiving dental treatment. The term "developmental disabilities," sometimes used independently or alternatively in this report, applies to a group of conditions that may cause physical, learning, language, or behavioral impairment (e.g., epilepsy, cerebral palsy, autism, intellectual disability). These conditions begin before the age of 18 and generally last throughout a person's life.[14]

Payment System: Focused on patients with Medi-Cal coverage.

Beneficiary: Children and adults covered by Medi-Cal fee-for-service (FFS) or managed care. Beneficiaries enrolled in a GMC medical or dental managed care plan are called members of that plan.

PA/TAR: The terms Prior Authorization and Treatment Authorization Request in Medi-Cal mean the same thing although the former is generally used by the medical side and the latter by the dental side; they are sometimes shown in this report as PA/TAR.

Types of Sedation: Defined in this study by route of administration. Oral (pharmacological method); inhalation (nitrous oxide); IV sedation; general anesthesia. In the first 3 situations, the patient maintains their own airway; in the latter, the patient needs their airway managed by an endotracheal tube. The level of sedation is entirely independent of the route of administration. Sedation and general anesthesia are a continuum.[15]

Geographic area: Patients: Sacramento County residents.
Medical Facilities: Sacramento Hospitals, surgery centers and dental clinics.
Dental Providers: any dental provider practicing in Sacramento County

STUDY SCOPE

This report assumes the reality that IV sedation and general anesthesia "is an integral part of dental practice,"[16] and some patients will, at some time, need to undergo treatment under some type of sedation. It does not address the question of whether IV sedation/general anesthesia is overused on patients, including those with special needs or developmental disabilities. Time and resources also precluded looking at the cost of anesthesia services or exploring related questions such as the underlying factors for out-of-pocket expenditures, and the potential relationship between cost containment/utilization control and GA "demand" and approval. It was also beyond the scope of the study to fully examine workforce issues such as scope of practice concerns and issues like single operator-anesthetist model of practice, whereby the operating dentist/oral surgeon can supervise and provide anesthesia at the same time.

BACKGROUND

"We end up spending more time on what the health plans need than what the patients need." – Dental Surgery Center representative

PURPOSE AND HISTORY

This study evolved from the continuing frustration of Sacramento dental providers to provide care to patients who need general anesthesia, particularly children and adults with special needs (SN), and from parents in the community who made us aware of the barriers because their children and adult children are a big part of the GA service need compared to their percent representation in the population.

The Sacramento Children's Dental Task Force initially took on this problem and continued to address it after the group was absorbed into the newly-created (AB 1467, July 2012) Medi-Cal Dental Advisory Committee (MCDAC). After numerous attempts over the next six years to document and resolve the barriers—efforts that included at a minimum countless state- and county-level meetings, phone calls and emails; legislative hearings; back and forth circulation of patient records documenting GA denials—MCDAC formed a SN/GA Workgroup and charged it with further investigating the problem and making recommendations. Barbara Aved Associates was engaged as the consultant firm to carry out this study.

A detailed Timeline (Attachment 3) underscores the attention this issue has received over the last decade, making it clear the problem is cyclical and statewide. Sacramento County has again served as the pioneer for addressing a dental access barrier and presenting recommendations that can benefit all patients in California.

OVERVIEW OF MEDI-CAL DENTAL SERVICES

In 2019, 528,678 Sacramento County residents (about 37% of the population) were eligible for coverage under Medi-Cal.[17] Alta California Regional Center, which serves the SN population, estimates more than 95% of its adult clients and about 65% of its child clients have Medi-Cal coverage.[18] In Sacramento County, the majority of Medi-Cal beneficiaries, 424,238 or 80%, receive care through the Geographic Managed Care (GMC) system.[19] Medical services are provided through enrollment in a GMC m*edical* managed health care plan, dental services through enrollment in a GMC *dental* managed care plan. Table 1 shows the current GMC medical and dental plans serving Sacramento.

Table 1. GMC Plans that Cover Sacramento Medi-Cal Beneficiaries

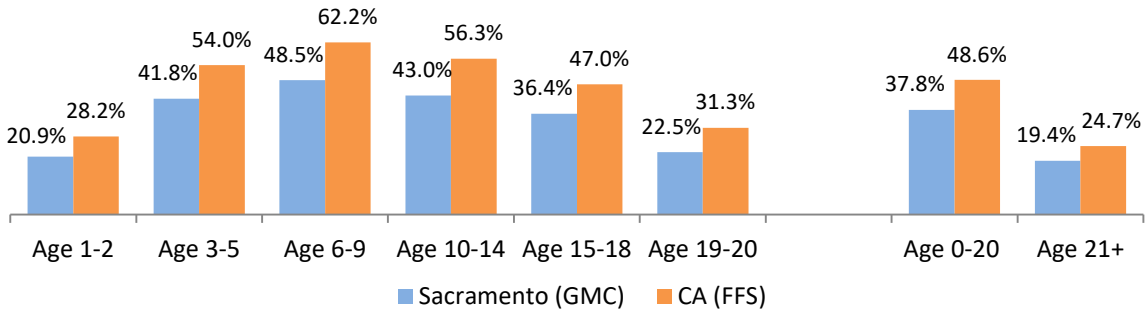
Managed Health Care Plans (medical)	Managed Dental Care Plans (dental)
Aetna Better Health of California Anthem Blue Cross Partnership Plan Health Net Community Solutions, Inc. Kaiser Permanente Molina Healthcare of California Partner Plan, Inc. Sutter Senior Care PACE (specialty care)	Access Dental Health Net of California LIBERTY Dental

Source: Department of Health Care Services. Medi-Cal Managed Care Health Plan Directory. June 2020.

REGULAR DENTAL CARE AS PREVENTIVE CARE

Because early, regular dental visits, combined with good preventive oral hygiene habits, can avoid some of the need for dental care provided with GA, the Sacramento County Medi-Cal utilization rates are noteworthy. Although dental visits statewide are not at an optimal level, for various reasons utilization in Sacramento lags behind the state for all age groups (Figure 1), a problem that has been described for at least the last decade[20] and persisted. Only about 38% of children and 19% of adults enrolled in GMC dental plans had an annual dental visit in FY 2018-19, despite increased efforts by the plans to address the problem.

Figure 1. Percent of Sacramento County GMC and California Medi-Cal Beneficiaries with an Annual Dental Visit, FY 2018-19



Source: Department of Health Care Services. Medi-Cal Dental Services Program.

The suspension in spring 2020 of all dentist office visits except emergency services based on state and professional (ADA/CDA) guidance during the COVID-19 pandemic is expected to reduce dental utilization rates in 2020 and possibly beyond, as the ongoing viability of dental practices will be severely tested by months of closure and new infection control/PPE costs. The hope of improved utilization in the near future will also inevitably be impacted with the expected reduced funding as the Governor's May 2020 budget revise below states,[21] worsening the damage already done to Medi-Cal dental access:

> *"As a result of the COVID-19 pandemic…. the Department estimates* ***a decrease in medical and dental fee-for-service (FFS) utilization*** [emphasis added]…."

FINDINGS

"We should have been given the option of anesthesia. When our son was younger, I would lie across his body and hold his arms down, another assistant would control his legs and another would hold his head as still as possible in a vice grip position. He would scream and cry through the whole ordeal so hard that he would burst the capillaries all over his cheeks. It was more like a torture scene from the TV show "24" than a dental visit."— Father of a child with special needs

SPECIAL NEEDS POPULATIONS

Distinctive Needs for Dental Care

A summary of national surveillance of children with special health care needs found that dental care remains the most frequently cited unmet health need for these children. Much evidence shows that their unmet needs for restorative care is because of advanced problems that ultimately stem from inadequate preventive care.[22] Research also shows that individuals with special health care needs are at higher risk for dental diseases compared with their healthier counterparts, due mainly to the following:[23,24]

- Poor oral hygiene due to cognitive, behavioral, physical and/or communication challenges
- Reduced clearance of foods from oral cavity
- Impaired salivary function
- Frequent use of medications that are high in sugar and/or impact gingival development

For some patients with SN, dental treatments require extra appointments or longer appointment times because the patient needs extra time to alleviate anxiety or because the dentist cannot work as quickly as he or she would with another patient. Patients with developmental disabilities may need additional supports at appointments, such as special accommodations or behavior desensitization.[25]

A particularly difficult challenge for patients with developmental disabilities is the transition from pediatric to general dentists as they age. That is because pediatric specialists generally receive some training in working with that population, whereas general dentists tend to have little or no such experience.[26]

Medi-Cal has recognized the need for additional appointment time and recently added a new "behavior management benefit" to cover the extra time needed to treat patients with SN.[27] DHCS policy is that the code can only be used when GA is *not* the way the behavior is managed, i.e., it is to be used when behavior is modified through other means instead of anesthesia.

Estimating the Need for GA Dental Services

The Department of Developmental Services does not have a tracking system to know many individuals in the state have special dental needs. There is more information available about children with SN than adults. Using recent U.S. estimates for children, approximately one in six, or about 17%, of those aged 3 through 17 have one or more developmental disabilities.[28] (A similar proportion, 17.6%, has been estimated for that age group in Sacramento County[29].) Extrapolating the U.S. proportion in Sacramento means an estimated 51,938 children age 3-17 could have developmental disabilities.[30] If we include younger children, the estimated SN child population age 0-17 becomes 61,877. A rough estimate of the number of Sacramento adults age 18+ with SN suggests 119,571 could be expected (calculated by subtracting the estimated number of children from the estimated 181,448 Sacramento residents with disabilities). [31] It should be recognized that these are likely undercounts if one expands the projection to include emotional and other disabilities. While a significant number of them may need anesthesia because of behavioral or other issues, and where alternative approaches are not feasible, estimating who or how many children and adults with SN needs anesthesia for dental treatment is not reasonable.

Regional Center Services

The Department of Developmental Services contracts with 21 Regional Centers (RC) to provide services and supports to persons with developmental disabilities, including dental services. Sacramento County is served by Alta California Regional Center (ACRC). One can enter a RC multiple ways; for example, at birth by working with hospitals and pediatricians that identify children with early intervention needs. People can be entered into a RC at any age, and after age 3 a person may have an open case forever.

ACRC is one of the very few regional centers that does not have a Dental Coordinator position.[32*] Instead, there is a multidisciplinary dental committee that is overseen by the Community Services Department; its director acts as the de facto dental coordinator. The committee is expected to assist the 182 Service Coordinators in helping to link families with services—an onerous charge.

ACRC reported serving 15,185 Sacramento clients in 2018, approximately 48% (7,289) of whom were children ages 0-17.[33] Many of these children also received services from the California Children's Service (CCS) program. (There are close to 6,100 children currently enrolled in CCS in Sacramento County[34].) While not all clients with SN are or need to be enrolled in RC services, all of them, likely anybody else, needs to be connected with a regular source of dental care, and hopefully one that is adapted to their unique needs.

Collaboration with HALO

To expand access to dental services for SN patients, ACRC provided funding for a new dental clinic site that Health and Life Organization (HALO), a federally qualified health center, is hoping

[*] AB 2634, introduced in February 2020 would have, by December 31, 2021, require a contract between the Department and a regional center to require the regional center to have, or contract for, a full-time dental coordinator, or equivalent thereof, to serve consumers.

to complete by the end of 2020. The funds include support for the purchase of adaptive equipment needed to better serve SN patients. In anticipation of the clinic opening, Dr. Paul Glassman of California Northstate University provided a limited amount training on SN issues to HALO staff, but the current coronavirus pandemic has slowed down some of these collaborative efforts.

Service Coordinator Input

Seventy-one (39%) of the 182 ACRC Service Coordinators responded to our survey about experience linking clients to dental services. The staff assigned to adults, who carry a monthly caseload of about 74 individuals, reported being asked "in a typical month" to help with a referral for an average of 2.0 clients for regular dental care and by the same number for care with GA (Table 2). For children, SCs reported monthly average referrals for 1.9 and 1.2 children for regular office-based and hospital-based care, respectively.

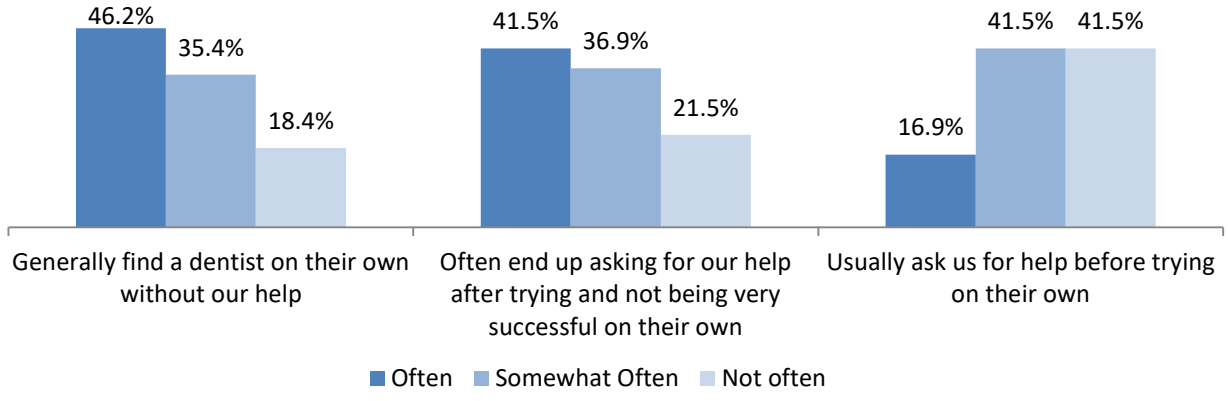
Table 2. Average Number of ACRC Clients Needing a Dental Referral from a Service Coordinator in a Typical Month (n=65)

Adult Clients				Child Clients*			
# of SCs	Average Caseload	Avg # referred to DDS for regular dental care	Avg # referred to DDS for IV sedation/GA	# of SCs	Average Caseload	Avg # referred to DDS for regular dental care	Avg # referred to DDS for IV sedation/GA
45	73.7	2.0	2.0	23	78.2	1.9	1.2

Note: Three Service Coordinators had both adult and child clients.
*ACRC defines children as age 0-17; adults as age 18+.
Source: Alta CA Regional Service Coordinator Dental Survey, study author.

Sometimes, SCs are not aware of all of the needs in their caseloads if the person or parent finds resources on their own. The extent to which SCs said they were aware families were able to find a dentist or the frequency with which they asked the SC for help are shown in Figure 2. Their responses indicate close to half (46.2%) are "often" able to find a dental provider on their own for regular and ongoing care, while 16.9% of families "often" do not even try but rely on the SC before seeking services.

Figure 2. ACRC Families' Ability to Find a Dentist (n=67)



Source: ACRC Service Coordinator Survey

The *main* barriers the SCs reported encountering in trying to help families find dental care can be summed up in the chart below (Table 3). However, to do full justice to their feedback, see the extensive comments they provided to this question in Attachment 6.

Table 3. Main Barriers to Finding/Using Dental Services Identified by Service Coordinators

- Client/family lack of understanding about insurance coverage, where to go.
- Scope of services, e.g., no wisdom teeth extraction available.
- Inconsistent instructions/information/inadequate documentation from the dental office.
- Incomplete documentation by pediatrician in order to move forward with specialist dental appointment; primary care MD incorrectly/not completing required paperwork.
- Only one ACRC-vendored dentist that does sedation dentistry (Dr. Bughao).
- Client (or family's) dental fear/anxiety or sensory issues, e.g., with autism having fear of someone close to your face.
- Patient/family lack of follow-through, e.g., appointment cancelations, not completing requirements on time (health checks ups, etc.).
- Ability for patient accommodations, e.g., dentists who do not: take clients in wheelchairs due to not having equipment to transfer a client out of their chairs and into the dental chair; treat someone with spastic CP or Autism; give first appointment in the day so client does not have to wait for their appointment.

Source: ACRC Service Coordinator Survey

Parent Perspectives

Eleven parents responded to our survey questions posted on various social media platforms. Close to half of them (45.5%) reported *usually* being able to find a dentist on their own (with another 18.2% agreeing, but with a qualifying explanation), generally corroborating the Service Coordinators' observations. About two-thirds (63.6%) said the family member with SN was usually able to receive regular (preventive) dental care without the need for sedation/GA (Table 4), which runs a bit counter to the written-in experiences they shared below.

Table 4. Families' Ability to Find/Access Dental Services (N=11)

	Yes	Yes (with a qualifier)	No
Have you *usually* been able to find a dentist in Sacramento for your child/adult child without help?	5 (45.5%)	2 (18.2%)	4 (36.4%)
Has your child/adult child *usually* been able to receive regular preventive dental care (e.g., cleanings) in Sacramento without the use of sedation/general anesthesia?	7 (63.6%)	0 (0.0%)	4 (36.4%)

Sometimes there is no alternative to anesthesia as these examples of access problems and experiences—most related to GA, some not—shared by 10 of the parents highlight:

- *"It's been impossible. He won't sit for anyone. We don't know where to look or what to do. I feel lost."*
- *"Scheduling regular visits has been difficult. The current dentist that we are assigned to has cancelled the last two scheduled routine visits (pre Covid-19 so that is not an available excuse). We've been trying to find a more special needs friendly dentist as a result."*
- *"My child/teen has had regular dental care since he was very young. I think because we started him young and created social stories about the dentist, it just became something familiar to him. We've never done sedation or anesthesia."*
- *"No services without sedation. A few years ago, my daughter attempted a teeth cleaning from an RDHAP, but this procedure failed as the RDHAP could only clean the front of her front teeth. Because of her movements, there was a near miss of her eye with a sharp cleaning instrument also. Since then my daughter has always used sedation dentistry."*
- *"My son has never been able to receive preventative care without physical restraints or sedation of some type. We have used general anesthesia twice at a dental office when they brought someone in to do the anesthesia and we did it once at a hospital as an outpatient. Currently we are using oral sedation and have had decent success."*
- *"My son has had IV sedation 3 times so far for dental care. The ones that were done in a dental office were not covered by insurance so we had to pay out of pocket. The one that was done at a hospital was covered by insurance but the dentist had limited equipment so could not do x-rays and some other things."*
- *"No, it's impossible. We had to give up and now I think his dental health is suffering."*
- *"My child has had anesthesia for the last several years which was the only way to get dental cleanings every few years."*
- *"General anesthesia was denied by the patient's insurance plan because they said 'no medical necessity' and 'lack of documented need.'"*
- *"I think with the proper education and desensitization program and training—if we could find such a dentist—she would be able to get cleanings without sedation and that would be fabulous."*

MEDI-CAL AUTHORIZATION PROCESS

IV sedation/GA is a benefit of the Medi-Cal program, though prior authorization is required. In the GMC dental program, the *dental plans* prior authorize and pay dentists for the services they provide in hospitals and surgery centers; pre-approval for GA is also required from the patient's *medical* GMC managed care plan.[35] (An exception is made when IV sedation/GA is medically necessary to treat an emergency medical condition.[36]) This division of authorizations and approvals is because the medical side of Medi-Cal pays for the facility and anesthesia fees and the dental side pays for the dental procedures which includes the dentist's professional fee. In

GMC, dental approval requests are referred to as Treatment Authorization Requests (TARS) and medical approval requests as Prior Authorizations (PA), though the two terms mean the same thing and are interchangeable according to DHCS.

Dental Review Process. Dentists in the GMC provider network who provide or refer for IV sedation/GA submit PA requests to the GMC dental plan. (In LIBERTY's network, for example, these are typically general dentists who do the procedures.) The GMC Dental Directors review and are responsible for approving the requests from the network dentists. When there are questions, the Director talks directly with the dental provider to get more information/ clarification, sometimes requesting additional documentation. Once the questions have been satisfactorily answered and any additional documentation is provided, the approvals can be given. For pediatric and adult patients with SN, the process is the same but the patient must have a referral letter from their physician.[37] The GMC plans have up to 30 days to approve or deny a PA. (Medical managed care plans have up to 14 calendar days from receipt of a request to render a decision.)

Sufficient awareness of insurance system complexities is required to successfully submit TARs/PAs. Dental offices without expertise may experience extensive lag time resulting from the need to provide additional information or appeal a denied request. For example, knowing:

- How much detail is required to justify a patient's condition described as "cognitively impaired and uncooperative?" (The answer: making sure to add "as evidenced by significant…." and giving multiple descriptors, despite feeling one is going overboard in justification.)
- What should a provider do in circumstances where they are unable to perform an evaluation or take radiographs of a patient unless the patient is under sedation? (The answer, according to DHCS policy: when an examination and radiographs cannot be rendered without sedation, only the general anesthesia or intravenous sedation should be requested on the TAR).

Existing law (AB 2003) makes explicit provision for "GA and associated facility charges for dental procedures for managed health plan enrollees under 7 years of age, or who are developmentally disabled at any age, or for whom GA is medically necessary, if rendered in a hospital or surgery center setting."[38] However, the law also permits each health plan to enact policies for prior authorization. Those, overlaid with DHCS' GA policies (below), results in confusing inconsistencies:

- "Children under 7 years of age do not automatically qualify for general anesthesia or intravenous sedation. Beneficiaries of all ages must meet the criteria delineated in the policy to qualify for anesthesia or sedation services."
- Regional Center consumers (individuals with developmental and other disabilities) are not exempt from the Treatment Authorization Request (TAR) requirement."

These seemingly contradictory rules have accounted for some of the confusion that has occurred with GA approvals and payments. The Flow Chart in the Appendices (Attachment 5),

Treatment Authorization Request (TAR) Process for Intravenous Sedation or General Anesthesia in the Sacramento County GMC Dental Program, created as part of this study, is based on a DHCS Provider Bulletin (April 2020 Volume 36, Number 11), and intended to reduce confusion, helping providers with the burden placed upon offices to navigate this complicated system. The Flow Chart focuses on the GMC dental program as the majority of the Sacramento Medi-Cal population is enrolled in that system. Note that the TAR process is different for patients that receive IV sedation in dental offices using DDS anesthesiologists.

Dental Prior Authorization Experience

In October 2016, the American Dental Association adopted and published a set of *Guidelines for the Use of Sedation and General Anesthesia by Dentists* to assist providers in the delivery of safe and effective sedation and anesthesia.[39] The Guidelines provide detailed sedation information, outline educational requirements and lay out comprehensive clinical guidelines dentists should use including the appropriate pre-operative assessment process for patients prior to undergoing general anesthesia. They do not address *patient selection*, that is, *who* should receive IV sedation/GA because, like any licensed health professional, dentists are expected to use their professional judgement in applying appropriate criteria and be the final arbiter on patient selection. Yet, health plan reviewers, including those in Sacramento, rely on the judgement of nurse and/or physician utilization reviewers who may not always understand what it takes for a dentist to have to perform procedures in the small space of an open mouth using sharp instruments.

Using the GMC dental plans' Annual Dental Visits (ADV) of "any dental service during the period," in order to get a sense of GA demand, we calculated the percentage of GMC members who requested/needed GA in FY 2018/19. Using the number of members who received any dental service as a denominator, a dental prior authorization was requested *on average* for about 4.4% of children 0-20 and 3.2% of adults in FY 2018-19 (a lower proportion of patients than the estimated demand in population-based studies).[40,41] The variation by dental plans seen in Table 5 is striking, with the lowest proportion of requests in Access, and the highest in Health Net, for both children and adults, respectively.

Table 5. Percent of GMC Dental Plan Members with Annual Dental Visit who had GA Request, FY 2018-19

	Access		Health Net		LIBERTY	
	# w/ ADV	% w/ GA request	# w/ ADV	% w/ GA request	# w/ ADV	% w/ GA request
Children 0-20	26146	1.1%	25455	6.5%	39829	5.0%
Adults 21+	14680	1.1%	17193	4.4%	23712	3.6%

Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020. Unweighted percent GA: author calculation.

Table 6 on the next page displays the GMC dental plans' FY 2018-19 PA/TAR histories to show the number of initial approvals/denials/appeals/final approvals. Very few of these denials were appealed; of the seven that were, two were approved.

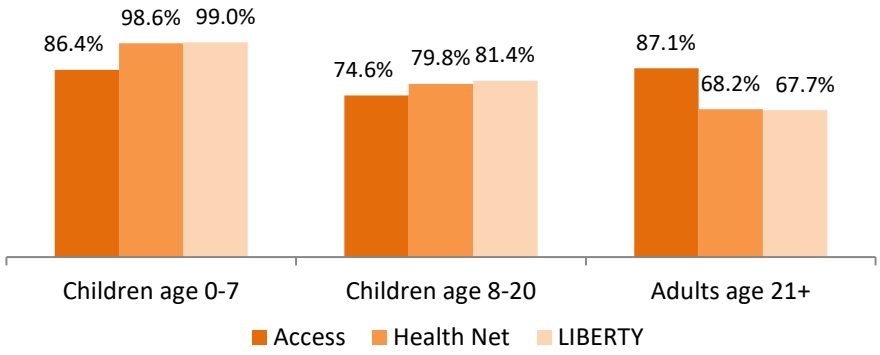
Table 6. Sacramento GMC Dental Plans Dental TAR/PA Approval Rates, 2018-19

	Access			Health Net			LIBERTY		
	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+
# of GA requests	147	130	163	1333	416	759	1482	495	848
# of TARs/PAs approved upon 1st request	127	97	142	1314	332	518	1467	403	574
# of TARs/PAs denied upon 1st request	30	28	21	19	84	241	15	92	274
Initial approval rate	***86.4%***	***74.6%***	***87.1%***	***98.6%***	***79.8%***	***68.2%***	***99.0%***	***81.4%***	***67.7%***
Number of TARs/PAs denied upon 1st request that were appealed	0	0	0	0	1	0	0	0	6
Number of TARs/PAs denied upon 1st request appealed and approved	0	0	0	0	0	0	0	0	2
Approval rate after denial	***NA***	***NA***	***NA***	***NA***	***0%***	***NA***	***NA***	***NA***	***33.3%***
Avg lag time (days) between original TAR/PA submission and dental procedure (delivery of treatment services)	42	30	25	60	54	56	61	54	75

Note: Data pulled using CDT Code 9220.
Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020.

Looking at only the GMC dental plans' *initial* approval rates from Table 6 above to highlight the variation by age group and plan (Figure 3), we can see in the case of Health Net and LIBERTY denials increased as the age of the patients increased; this was also true for the children enrolled in Access but approvals for the adults—which were significantly higher than the rates for adults in the other two plans—actually increased.

Figure 3. GMC Dental Plans' Initial Approval Rate of GA Requests by Age Group, 2018-19



Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020.

As Table 7 indicates, the main reason for denials by Health Net and LIBERTY dental plans was "GA not indicated based on medical necessity"—similar to the main reason given by the managed medical care plans—while Access's were largely inadequate documentation and questions about eligibility.

Table 7. Sacramento GMC Dental Plans' Most Common Reasons for Dental TAR/PA Denials, 2018-19

	Access			Health Net			LIBERTY		
	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+
Inadequate documentation	9	1	1					1	4
No medical necessity			4	14	82	241	8	91	273
Required referral/NOA[1]	14	14	7						
Rendering provider terminated/no longer valid		3	6						
Duplicate process	3	4							
Out of network				5	2		7		

Note: Data pulled using CDT Code 9220.
[1]A Medi-Cal Notice of Action (NOA) is a written notice that gives Medi-Cal applicants and beneficiaries an explanation of their eligibility for coverage or benefits.
Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020.

To assess whether this pattern of approval/denial ratio was unique to GMC plans or consistent throughout Medi-Cal dental, we compared GMC with comparable data from Fresno County which in several studies, has served as the FFS proxy because its demographics, service delivery system and population share similar characteristics with Sacramento.[42,43] In the match of Fresno County FFS dental with GMC dental, Fresno PA denial rates, determined by Delta Dental, were lower (Table 8). This difference was the case for all age groups, but significantly so for the older children and adults.

Table 8. Sacramento Total GMC and Fresno County FFS Dental TAR/PA Approval Rate Comparison, 2018-19

	Sac GMC Total			Fresno FFS		
	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+
# of GA requests	2962	1041	1770	241	1267	863
# of TARs/PAs approved upon 1st request	2908	832	1234	237	1196	768
# of TARs/PAs denied upon 1st request	64	204	536	4	71	95
Initial approval rate	***98.2%***	***79.9%***	***69.7%***	***98.3%***	***94.4%***	***89.0%***
Number of TARs/PAs denied upon 1st request that were appealed	0	1	6	1	12	16
Number of TARs/PAs denied upon 1st request appealed and approved	0	0	2	1	4	10
Approval rate after denial	***NA***	***0%***	***33.3%***	***100%***	***33.3%***	***62.5%***
Avg lag time (days) between original TAR/PA submission and dental procedure (delivery of treatment services)	54	46	52	27	37	34

Note: Data pulled using CDT Code 9220.
For Sacramento County, the information is processed through the GMC plans (Access, Health Net and LIBERTY). For Fresno County it is processed through the dental ASO in the FFS delivery system.
Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020.

While "GA not indicated based on medical necessity," was the most common reason for TAR/PA denials in GMC, denials in FFS were most commonly due to "procedure not a benefit when additional services are denied or when no additional services were submitted for the same date of service" (Table 9).

Table 9. Sacramento GMC and Fresno County FFS, Most Common Reasons for Dental TAR/PA Denials, 2018-19

	Sac GMC Total			Fresno FFS		
	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+
Inadequate documentation	9	2	7	2		4
No medical necessity	22	173	514		7	43
Required referral/NOA[1]	14	14	7			
Rendering provider terminated/no longer valid		**3**	6			
Duplicate process	3	4	2			
Out of network	12	2				
Procedure not a benefit when additional services are denied or when no additional services submitted for the same date of service.					32	18
Authorization no longer valid				1	17	16

Note: Data pulled using CDT Code 9220.
[1]A Medi-Cal Notice of Action (NOA) is a written notice that gives Medi-Cal applicants and beneficiaries an explanation of their eligibility for coverage or benefits.
Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020.

Medical Plan Authorization Request Experience

Because there were a lot of anecdotal complaints about variation in denials for dental GA by Medi-Cal managed health care plans, with specific plans being reported as problematic, this study requested data to examine the issue and which plans were different. In medical plan data provided to us by DHCS for 706 children age 0-20 with and without developmental disabilities (DD),[44] *one plan stood out as an outlier in its denial rates: Anthem Blue Cross; these were the children with DD, which is a puzzling finding (Table 10).

Aetna Better Health of California, the newest GMC medical managed care plan covering Sacramento County, with 5,446 enrollees as of February 2020,[45] did not report any requests for GA during FY 2018-19. (United Community Health Plan of CA, which covered Sacramento members until 2019, also reported zero dental GA requests during that same reporting period.)

Table 10. GMC Medical Plans Dental TAR Approval Rates for CHILDREN with and without Developmental Disabilities, 2018-19

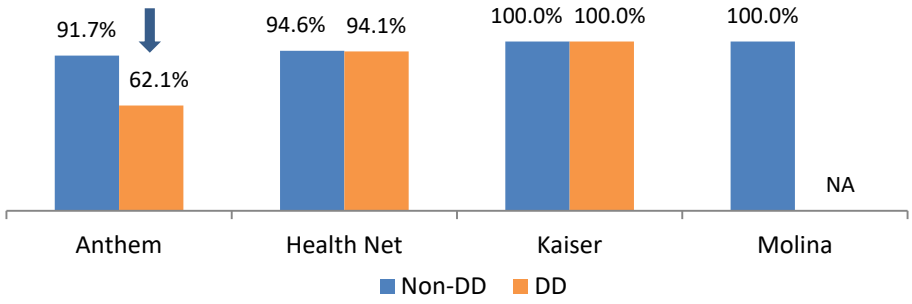
	Anthem		Health Net		Kaiser		Molina	
	Non-DD	DD	Non-DD	DD	Non-DD	DD	Non-DD	DD
Total requests	411	29	111	34	61	54	6	0
Total approved	377	18	107	32	61	54	6	0
Total denied	34	11	4	2	0	0	0	0
Approval rate	***91.7%***	***62.1%***	***96.4%***	***94.1%***	***100%***	***100%***	***100%***	***NA***
Denials due to no documentation	0	0	0	0	0	0	0	0
Denials for not meeting medical necessity	11	4	0	0	0	0	0	0
Denials due to other	23	7	4	2	0	0	0	0

Note: GMC plan-submitted data in accordance with APL 15-012 (general anesthesia administered by an MD for dental procedures), not by CPT codes.
Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020.

* See Endnote 44 for an explanation of why the GMC dental data were not broken out by the DD/non-DD population.

Looking only at the medical plans' *initial* approval rates of children with and without DD (Figure 4), the variance illustrates the extent to which Anthem Blue Cross cases of patients with SN were significantly lower than in the other plans—consistent with complaints that had been raised to DHCS.

Figure 4. GMC Medical Plans' *Initial* Approval Rate of Dentists' GA Requests for Children with and without Developmental Disabilities, 2018-19



NA = No requests for GA.
Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020.

The variance in the GMC medical plan data for 275 adults with and without developmental disabilities for GA requests in 2018-19 was not as wide as for the children. However, here again Anthem, with 84.6% approval, was farthest away from the statewide Medi-Cal managed care health plan approval rate specific to dental cases of 95% [46] (Table 11).

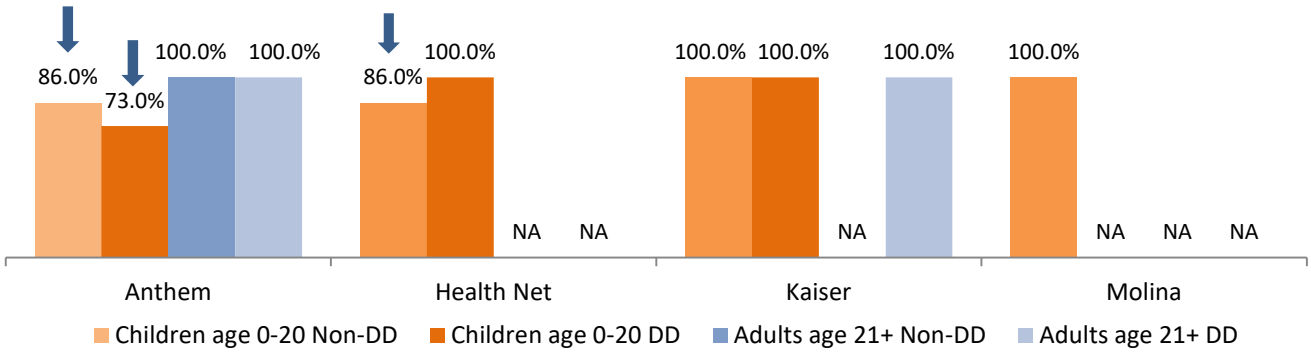
Table 11. Sacramento GMC Medical Plans Dental TAR Approval Rates for ADULTS with and without Developmental Disabilities, 2018-19

	Anthem		Health Net		Kaiser		Molina	
	Non-DD	DD	Non-DD	DD	Non-DD	DD	Non-DD	DD
Total requests	149	8	6	60	6	45	1	0
Total approved	126	8	6	55	6	45	1	0
Total denied	23	0	0	5	0	0	0	0
Approval rate	***84.6%***	***100%***	***100%***	***91.7%***	***100%***	***100%***	***100%***	***NA***
Denials due to no documentation	0	0	0	0	0	0	0	0
Denials for not meeting medical necessity	12	0	0	0	0	0	0	0
Denials due to other	11	0	0	5	0	0	0	0

Note: GMC plan-submitted data in accordance with APL 15-012 (general anesthesia administered by an MD for dental procedures), not by CPT codes.
Source: Department of Health Care Services, Medi-Cal Dental Division, May 22, 2020.

Based on ongoing concerns about dental GA denials expressed in recent years by various groups, DHCS took steps to independently audit a random sample of GA requests in addition to its annual routine audits of managed health care plans (Figure 5). The purpose was to look for variances from the statewide approval rate. Two plans stood out as outliers in the analysis of 150 cases in Sacramento pulled for CY 2020 Quarter 1: Anthem Blue Cross for children with and without DD (4 of the 7 denials due to "no medical necessity"), and Health Net for non-DD children (denials due to "other reasons").

Figure 5. DHCS Internal Audit Results of Approval Rates for Dental GA for Children and Adult with and without Developmental Disabilities, 2020 Quarter 1 (n=150)



NA = No requests for GA.
Statewide approval rate is 95%. No data were reported for the other Sacramento GMC plan, Aetna Better Health of California.
Source: Department of Health Care Services, Medi-Cal Medical Managed Care Division, June 3, 2020.

Specific Sacramento Dental Office Experience

Ongoing Medi-Cal medical managed care plan denials of TARS from two of the busiest Sacramento dental practices that offer GA dentistry in a hospital or surgical center setting—Dr. James Musser and Dr. Rodney Bughao—have because of denials served for years as the catalyst for addressing the GA access problem in Sacramento (and, in some ways, the state). Sixty- plus documented cases of GA denials for SN and non-SN populations from one of these practices were presented to DHCS by the Sacramento District Dental Society in 2016 as examples of the problem (the patient records were subsequently lost and had to be copied again by SDDS and re-submitted to the state). As of this writing, the following is the situation concerning TARs:[47]

Dr. Mussser's practice

2019	Anthem (direct)	Anthem (med grp)	Hills Physician	River City	Partnership	CA Hlth & Wellness	Kaiser
% approved	98.9%	100%	100%	100%	99.9%	100%	42%

Prior to 2019, the office told Anthem Blue Cross patients to disenroll from ABC if they wanted dental care because ABC direct was denying some of the cases. In early 2020, with improved communication between dental office staff and ABC and thorough documentation of the patients served (mainly under age 8 with medical complications), approvals began to occur.

Dr. Bughao's practice

2017-2019	Anthem		Health Net		Molina		CA Hlth & Wellness	Kaiser	Medi-Cal FFS
	Direct	Med Grp	Direct	Med Grp	Direct	Med Grp			
% approved	6.2%*	100%	100%	100%	100%	100%	100%	100%	100%

*42.8% of Anthem appeals reviewed by Anthem internal review process were subsequently approved. 100% of Anthem appeals reviewed by the *external* review body were approved.

The patients in this practice are typically older child and adults with special needs.
With facilitation in the first week of May by members of the MCDAC SN-GA Workgroup and the study author, Anthem agreed to re-review the denied TARS. As of this writing (June 19) the re-review is still ongoing.

Note: Anthem Direct = patients are covered directly by the insurance company (not served by one of the ABC contracted medical groups) and ABC is responsible to pay the hospital and anesthesia fee.
Anthem Med Group = patients are assigned to a medical group. If the arrangement is shared risk, the medical group is to approve GA and ABC to approve the facility rate; for full risk, the medical group must approve both the facility fee and GA.

These examples—along with the PA/TAR findings described above—are included as an illustration of what has occurred and what it has taken to bring some degree of resolution—though not necessarily permanent closure—to a chronic problem that has discouraged additional provider participation in Medi-Cal and could have been settled a decade ago by clear, consistent policies developed through medical/dental collaboration. The findings also highlight the longstanding disagreements between providers and health insurance utilization views of provider diagnoses.

HOSPITAL/SURGERY CENTER-BASED DENTAL TREATMENT

Hospital services account for one of the highest shares of health care costs,[48] and operating rooms (ORs) are a very expensive part of that "property." Accordingly, hospitals have to prioritize the services they provide. While the Sacramento hospitals, especially the non-profits that have community benefits requirements (and historically operate on thin margins), do want to help with the dental/GA access issue, they were clear during interviews about the need to look for opportunities to capitalize on revenue and bring in the highest-viability service lines (i.e., cases): their priorities, they explained, are business- and surgeon-driven. Ambulatory surgery centers (ASCs) also have to consider resource use differences when determining cost by provider by service.

Sacramento Facility Reported Dental Cases

Table 12 on the next page displays information the Sacramento County hospitals and surgical centers were willing to share about the dental services provided there. The information is a point-in-time effort to describe current OR capacity to the extent facility staff had the information to provide. While all descriptions are what was typical pre-COVID, only a few facilities said they temporarily reduced or made other changes due to COVID when these conversations took place (May 2020). The facility information lines up with where dentists reported taking their GA cases (see dental survey results later in this report).

Table 12. Capacity for Dental Services with GA by Type of Facility[1]

FACILITY	CAPACITY[2]
	Hospitals
Sutter Medical Center (Sutter General)	▪ 1 primary DDS and ~ 10 other DDSs regularly use the facility ▪ 2 full block days/week (Thursdays and Fridays) ▪ Currently booked out 4 months ▪ Accepts Medi-Cal ▪ Includes SN patients
Sutter Roseville – Outpatient Dept.	▪ 1 DDS; only on a flex-time/fill-in basis (when surgeons are on vacation); ~ 250 cases/year ▪ Accepts Medi-Cal ▪ No SN patients
Dignity (Mercy) San Juan Hospital	▪ ~ 4 DDSs regularly use the facility ▪ Not on block but "hit or miss" basis; do 2-3 cases per session ▪ ~ 14 cases/month (170 cases/year) ▪ Some cases done in their outpatient surgery center ▪ Includes SN (children primarily), all done in hospital
Dignity (Mercy) Folsom	▪ Only cases that can't be done in an outpt. surgery center; ▪ ~1 case every 3 mos. ▪ No pediatric cases
Dignity (Mercy) General	▪ 4 DDSs regularly use the facility ▪ Block schedule (1 day/week) ▪ ~ 6-8 cases/week ▪ Accepts Medi-Cal ▪ Includes SN patients
Kaiser Roseville	▪ 6 DDSs with block time; 3 DDSs with flex time. ▪ Every Monday; 2nd and 4th Tuesdays; all Fridays except the 4th ▪ ~ 35-45 cases/month ▪ Scheduled out 3 months; but some DDSs have their own backlog ▪ Accepts Medi-Cal ▪ Includes SN patients ▪ They do the pediatric cases for the other Kaiser hospitals ▪ Anesthesia also provided by CRNAs (Certified RN Anesthetists)
Kaiser South Sacramento	▪ 1 DDS with block time; 5 DDSs with open block at other times ▪ Every Friday (2 operating rooms available) ▪ Accepts Medi-Cal ▪ Includes SN patients ▪ Anesthesia also provided by CRNAs
Kaiser Sacramento (Morse Ave.)	▪ No dental cases performed; children referred to Kaiser Roseville
UC Davis Medical Center Dental Clinic	▪ 1 DDS (a UCD dentist); ~ 8-15 cases/month ▪ GA only available for current patients with sign-off by their own UCD medical provider ▪ No Medi-Cal; only accept patients with Delta PPO ▪ Includes SN cases

FACILITY	CAPACITY[2]
	Surgery Centers[3]
Greater Sacramento Surgical Center	▪ 3 DDSs with block time (1 DDS/day/month) ▪ Includes SN patients ▪ Booked out 3 weeks (though pts. are booked out longer ▪ *As of 6/4/20 no longer accepts Medi-Cal FFS or Anthem GMC insurance; they are suggesting these patients change insurance if they want to be seen.*
Folsom Surgery Center	▪ 2 DDSs; both block and flex-time ▪ No Medi-Cal ▪ No SN patients
Fort Sutter Surgery Center	▪ 4 DDSs with block days/week (1 operating room) ▪ Usually booked out 2-3 weeks ahead (thought DDSs may have their own backlog) ▪ Accepts Medi-Cal ▪ Exclusively SN cases (children and adults)

[1]Does not include oral and maxillofacial surgery cases (e.g., reconstructive surgery of the face, mouth, jaw; trauma surgery).
[2]All anesthesia services are provided by MD anesthesiologists unless otherwise noted.
[3]Surgery centers not included were either closed at the time of this study (e.g., Dignity Health Plaza Surgery Center, Elk Grove) or do not provide any dental services (e.g., Capitol City Surgery Center, vision only).

Access to GA, already rail thin, can change without forewarning. In an email to providers, Greater Sacramento Surgery Center (GSSC) announced effective June 4, 2020, it would no longer accept Medi-Cal FFS or GMC patients with Anthem insurance. This decision is expected to be devastating to Anthem-enrolled patients, because GSSC was one of the few facilities in the area to take this insurance. (The facility cited not receiving payment from Anthem for dental cases in over a year as the reason.) Anthem patients will now be limited to a single facility, and will have to wait much longer for OR time. GSSC is suggesting that these patients change insurance if they want to be seen at their facility.

Sacramento Facility Data Reported to OSHPD

Table 13 shows data reported to the Office of Statewide Planning and Development for the number of dental GA cases performed in Sacramento hospitals and ambulatory surgery centers (ASC), requested to supplement the information we received from facility staff interviews.

Based on the reporting codes we instructed OSHPD to use (see next section), there were a total of 1,129 dental surgical cases reported by eight Sacramento hospitals. (We were told that only hospital data were available from OSHDP as the agency stopped accepting data from all free-standing ASCs in December 2011.) These hospital dental cases equate to an average of 94 cases per month; across the 8 hospitals it equates to an average of 2.9 cases per week, relatively few compared to the need for OR time, and inconsistent with the interview-reported data shown in Table 12.

Table 13. Non-Trauma Dental GA Cases Reported by Sacramento Hospitals Based on Selected Codes,* CY 2018

Facility Name	Children 0-20	Adults 21+
Dignity Folsom	< 11[1]	< 11
Dignity San Juan	36	< 11
Dignity Mercy General	< 11	< 11
Kaiser Roseville	**	< 11
Kaiser Sacramento	0	< 11
Kaiser South Sacramento	259	43
Sutter Medical Center (Sutter General)	102	337
Sutter Roseville	326	< 11
Total	736 (65.2%)	393 (34.8%)

*Based on using Primary Diagnosis K02.9 or CPT 41899 anywhere in the dataset.
[1]There were 1-10 cases in the cells masked with "<11."
**>10 cases but masked per OSHPD.
Source: Office of Statewide Planning and Development, June 4, 2020.

Patient discharge data for the Sacramento-area hospitals in 2018 also showed 182 records where the principal diagnosis was "dental" but based on other ICD-10 dental codes. However, because these were *discharges*, i.e., patients having been admitted as inpatients, the cases were likely due to conditions outside of the focus of this study, e.g., oral and maxillofacial conditions such as traumatic injuries of the face, mouth and jaws.

An Explanation of Reporting Codes

Medical coding is extremely complex, and determining which codes for OSHPD to use was challenging. All hospitals and hospital-based surgery centers report their diagnoses to OSHPD in ICD-10 codes and their procedures in CPT codes.[49] Although there is a Current Procedural Terminology (CPT) code for dental anesthesia (00170), which DHCS was able to use to retrieve dental PA/TAR data for this report, it turned out that no Sacramento area facilities reported the use of this code to OSHPD in 2018 (in fact, only 24 facilities in California did so). Although we may have missed some dental GA cases performed in Sacramento facilities (or picked up additional ones), we instructed OSHPD to use Primary Diagnosis K02-2.9 or CPT 41899 anywhere in the dataset for the following reasons:

- Current Procedural Terminology (CPT) code 41899 is defined as "Other Procedures on the Dentoalveolar Structures" but is frequently used as a "catch all" for things that don't fit strictly under other codes. For example, all codes that end in xxx99 are typically "other procedures," sometimes used for pulling a tooth or for the facility fee that a surgical center or hospital charges the plan to cover anesthesia and other facility costs. It was considered in this study to be a proxy for GA.

- Based on a small sample of dental records one of the hospital Surgical Services Informaticists pulled for us, that reported dental GA data using ICD-10 K02.9 ("dental caries, unspecified"), we asked OSHPD to use the whole ICD-10 K02 – K02.9 series used to code

dental caries and tooth decay, to capture surgical data that would likely serve as a proxy for most of the dental GA cases related to PAs/TARs.

Inconsistent data reporting, combined with the multiple insurance and payer systems involved, has made it difficult to capture and describe the full universe of GA cases in Sacramento.

Anesthesiologist Services

Hospitals contract with anesthesiologists who may or may not typically work with dentists or Medi-Cal. Inadequate OR time as a facility barrier is inextricably connected to the limitations on professional anesthesia time, particularly for patients with Medi-Cal. Kaiser and UC Davis have their own anesthesia providers, Dignity Health contracts with a medical staffing service called Vituity, and the Sutter system and other Sacramento dental GA cases are served by Central Anesthesia Service Exchange Medical Group, Inc. (CASE), a doctor-owned group of over 90 anesthesiologists. Using CASE as an example, the anesthesia providers are paid by unit of service* which, depending on the payer, can vary as much as ten-fold, with Medi-Cal reimbursing the least amount for the same service. CASE accepts Medi-Cal but the group reports their ability to do so has always been tenuous. To make it work, the group depends on offsets from volume business on higher-end payers (making internal adjustments to average out compensation among the physicians); offering extra GA capacity (which they said they rarely have) to hospitals for low-value cases like dental so hospitals at least meet their staffing costs; and the goodwill of those in their group who realize "these patients have nowhere else to go."[50] CASE further explained that when hospitals have full capacity, "low paying cases get kicked out—and dental is the first to go."

Summary of Hospital Dental GA

From our conversations with facility representatives, it seems that:

- Hospitals and surgery centers choose to limit capacity to provide dental procedures relative to other surgical procedures due to fiscal reimbursement. Limited capacity means long waiting lists—in many cases, months—particularly affecting patients with special needs.
- Although it is possible some hospitals and ASCs may be open to having more *dentists* use their ORs, no one wants more dental *cases* in the OR.
- Dentists value and are likely protective of the OR block time they have secured at these hospitals. Many have longstanding relationships with the hospital groups and MDs that made these decisions.
- None of the facilities includes "dental" among the surgical services they list on their websites suggesting, perhaps, they do not want to highlight this service.

* Each anesthesia code is assigned a base unit value; one unit of time is recorded for each 15-minute increment of anesthesia time.

- The hospitals reported they are basically able to offer these GA dental services because they are provided as part of their Community Benefits[**] program where the financial losses can be written-off.
- While a deep analysis of population-to-dental-GA-ratio is beyond the scope of this study, it does appear that current OR capacity does not meet enough of the need with surgery scheduling backlogs as only one indication.
- The success of dentists to be able to provide services in these hospitals and ASCs appears to be related to the following factors:
  - dentists who can work on a flex-based schedule;
  - dentists establishing personal, historical relationships;
  - anesthesia providers who are able to accept cases regardless of the payer since they are paid based on the number of units of service they provide no matter the payer; and,
  - facilities with a strong sense of mission to accommodate these cases.

It is important to recognize that incredible hospital financial losses—including physician and ambulatory operations out of the hospital—due to the coronavirus pandemic[51] are likely going to make the already-tight surgery schedules available for dental GA cases even tighter in the future. However, the recent announcement of federal Provider Relief Funds that will be available to safety net hospitals that serve a disproportionate number of Medi-Cal patients or provide large amounts of uncompensated care is expected to help.[52]

FQHCs AND OTHER COMMUNITY HEALTH CENTERS

Federally qualified health clinics and other community health centers provide a range of dental services to Sacramento residents. Interviews with four organizations describe the results of their experience with GA referrals and services to patients with special needs (Table 14 on the next page). All of the organizations refer out for GA; 3 of the 4 serve SN patients (adults and children) to the extent the dentists feel capable of doing so. GMC dental patients needing GA are referred to their dental plan; generally the referring dentist's preauthorization request is approved according to these health centers, though on average 20%-25% of the time requests are denied and have to be resubmitted, adding to the wait time from referral to treatment. Patients in the Medi-Cal dental FFS system (Denti-Cal) needing GA seem to have a more challenging time in finding a provider and receiving timely treatment.

[**] The IRS requires 501(c)(3) private not-for-profit hospitals to provide charitable community benefits in exchange for their tax exemption. Hospitals meet certain needs of their communities through the provision of essential health care and other services. California's private not-for-profit hospitals provide a wide range of benefits to their communities in addition to those reflected in the financial data reported to the state. Under the "community benefit" standard, spending that promotes community health, in addition to charity care, counts toward meeting the requirements.

Table 14. Community Health Clinic Dental Experience with GA and Special Needs Patients

Organization	Description
Health and Life Organization (HALO) dba Sacramento Community Clinics	▪ No GA, but much time is spent trying desensitization to reduce the need for GA. ▪ GMC patients are referred to GMC dental plans. The patient's medical provider (MD) provides the letter documenting the need for GA. ▪ SN children and adults are seen but referred when treatment needs exceed clinic provider capacity. ▪ Denti-Cal FFS patients needing GA are referred to "any available Denti-Cal provider" list (not verified as up-to-date).
One Community Clinic	▪ No GA; referred to GMC dental plan (LIBERTY and Health Net only) to find a provider. Approval process generally smooth. ▪ Self-pay/sliding fee scale children needing GA are referred to a list of 4 local pediatric dentists. ▪ Denti-Cal FFS adult patients have to be referred out of county (Fairfield) because no available Sacramento DDS. ▪ Wait time from referral to treatment is ~ 2 months (even for urgent cases). ▪ SN children and adults are seen but referred when treatment needs exceed clinic provider capacity.
Sacramento Native American Health Center	▪ No GA; referred to GMC dental plan to find provider. 70% of the time approval is smooth; 20% denied with most later approved (but with lots of back and forth); 10% the clinic gives up and refers to UCSF (which is a 2 month wait). ▪ SN children and adults are seen but referred when treatment needs exceed clinic provider capacity. ▪ Denti-Cal FFS patients and self-pay/sliding fee scale patients needing GA are referred to "any available Denti-Cal provider" list (patient feedback indicates ~50% satisfaction).
WellSpace Health	▪ GMC GA referrals are to 1 local dentist; private patients (usually Delta PMI) to Salida Surgery Center (Stanislaus County). ▪ Refers all SN patients to other dental providers. ▪ The referral specialist (DDS) is responsible for submitting the preauthorization request to the GMC dental plan or if Denti-Cal FFS patient then to Denti-Cal, and appealing/ reprocessing denials. Often much back and forth with process. ▪ Wait time for GA is 2-6 months; some patients returning for their 6-month recall visit still have treatment pending; at 6 months, the clinic has to re-start the referral process.

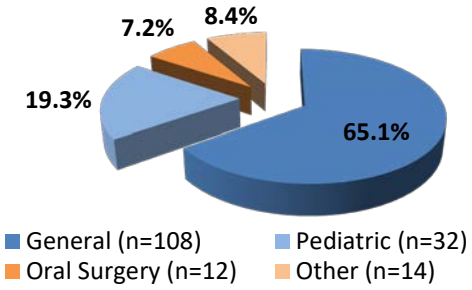
Source: Information provided by organization representatives, May 21-28, 2020.

DENTAL DELIVERY SYSTEM: PRIVATE OFFICES

The Study Sample

The survey of Sacramento dentists—which supplements earlier information—helped us to understand more about the local dental delivery system to provide sedation services and to serve individuals with special needs. We received a total of 166 usable surveys from practicing Sacramento dentists, yielding a 16% response rate*(Figure 6).

Figure 6. Survey Respondents' Type of Dental Practice

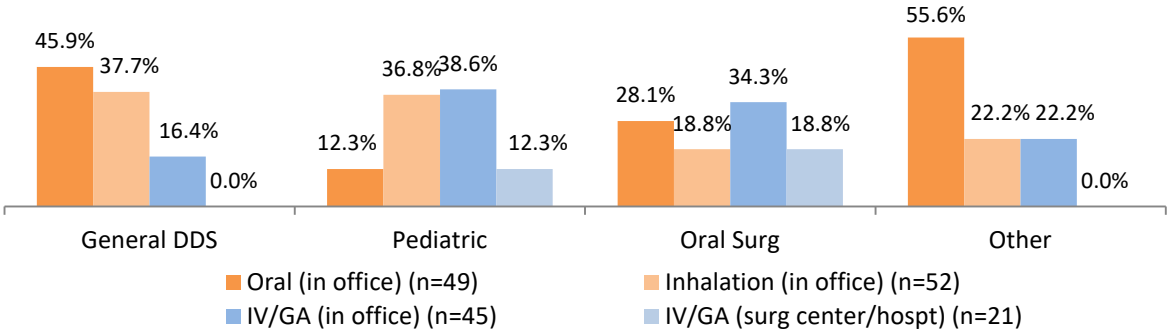


The respondents generally reflected the type of dentists who practice in Sacramento with the exception of pediatric providers who were somewhat over-represented (Figure 1). Close to two-thirds (65.1%) of the respondents were general dentists. As a group, the response rate of other specialists was relatively close to the specialist dentist profile of Sacramento dentists. The "other" group self-identified fairly equally as endodontists, periodontists, orthodontists and dental anesthesiologists.

Sedation Services

Slightly over half (52.4%) of the dentists reported providing some form of sedation dentistry (Figure 7). Although all of these dentists reported using IV conscious sedation or GA,*only pediatric dentists and oral surgeons provided it in a surgery center or hospital.

Figure 7.Type of Sedation Dental Practices (n= 166)



Note: the numbers represent types of sedation, i.e., a dentist could report using more than one type.

* The survey was sent to all 1,040 practicing dentists in Sacramento; the survey reached 910 of them from the SDDS member mailing list and 130 from the SCOHP non-member mailing list.

* The necessary skip pattern in the electronic survey required the question to be written as, "Do you provide IV/conscious (patient maintains own airway) or General anesthesia (GA) (patient needs airway managed by endotracheal tube) in…..? so that it was not always possible to tease out whether the respondent provided just one or both of these methods.

Location and Management of Sedation Services

Due to reported lack of access, and to better understand the locations and providers who are providing this type of care, we asked questions about these matters. Tables 15 and 16, respectively, describe the sedation management arrangements in office and facility settings. As Table 15 shows, pediatric dentists were the most likely among the dentists to use IV sedation/ GA in the office setting. In the office, oral surgeons tended to manage IV/conscious sedation themselves while performing the dental procedure while pediatric dentists appeared more likely to use a contracting arrangement with an anesthesia provider. Although a number of the general dentists also managed IV/conscious sedation themselves while performing the dental procedure, all of them reported contracting with an anesthesiologist when providing GA in their office.

For the most part, dentists contract with *non* Medi-Cal/Denti-Cal anesthesiologists, either MDs or DDSs. (Dental Anesthesiology is one of the 10 recognized dental specialties requiring additional training and licensure.[53]) The dentists' accompanying comments in the Appendices (Attachment 7) make it clear this is because an insufficient number of MD and DDS anesthesiologists are enrolled in the Medi-Cal program due to low reimbursement rates. *To wit, DHCS reports only one dentist anesthesiologist is enrolled as a Medi-Cal Dental Program provider.* Though Certified Registered Nurse Anesthetists (CRNAs) do practice in some Sacramento facilities, as noted above in the interviews with hospital representatives, none of the respondent dentists reported contracting with a CRNA provider to manage sedation services in either an office or facility setting.

Table 15. Types of Sedation Management Arrangements used by Dentists in Office

Who manages the IV/Conscious Sedation anesthesia during the dental procedure in your office?

	Gen DDS (n=7)	Ped DDS (n=15)	Oral Surg (n=11)	Other (n=2)
I do, as well as perform the dental procedure	6 (85.7%)	4 (23.5%)	11 (91.7%)	2 (66.7%)
I contract with a non-Medi-Cal MD anesthesiologist	2 (28.6%)	2 (11.8%)	0 (0%)	0 (0%)
I contract with a Medi-Cal MD anesthesiologist	0 (0%)	1 (5.9%)	0 (0%)	0 (0%)
I contract with a non-Medi-Cal DDS anesthesiologist	4 (57.1%)	8 (47.1%)	1 (8.3%)	1 (33.3%)
I contract with a Medi-Cal DDS anesthesiologist	1 (14.3%)	2 (11.8%)	0 (0%)	0 (0%)
I contract with a non-Medi-Cal CRNA	0 (0%)	0 (0%)	0 (0%)	0 (0%)
I contract with a Medi-Cal CRNA	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Who manages the General Anesthesia during the dental procedure in your office?

	Gen DDS (n=5)	Ped DDS (n=19)	Oral Surg (n=11)	Other n=2)
I do, as well as perform the dental procedure	0 (0%)	4 (23.5%)	11 (91.7%)	2 (66.7%)
I contract with a non-Medi-Cal/Denti-Cal MD anesthesiologist	3 (60.0%)	2 (11.8%)	0 (0%)	0 (0%)
I contract with a non-Medi-Cal MD anesthesiologist	0 (0%)	1 (5.9%)	0 (0%)	0 (0%)
I contract with a Medi-Cal MD anesthesiologist	4 (80.0%)	8 (47.1%)	1 (8.3%)	1 (33.3%)
I contract with a non-Medi-Cal DDS anesthesiologist	0 (0%)	2 (11.8%)	0 (0%)	0 (0%)
I contract with a Medi-Cal DDS anesthesiologist	0 (0%)	0 (0%)	0 (0%)	0 (0%)
I contract with a non-Medi-Cal CRNA	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Note: the numbers represent number of arrangements and not dentists, i.e., a dentist could use more than one type of sedation management arrangement in the office.

Table 16. Types of Sedation Management Arrangements used by Dentists in Surgery Center or Hospital

	Gen DDS (n=2)	Ped DDS (n=13)	Oral Surg (n=6)
I do, as well as perform the dental procedure			
I contract with a non-Medi-Cal MD anesthesiologist	2 (100.0%)	6 (46.2%)	5 (83.3%)
I contract with a Medi-Cal MD anesthesiologist		10 (76.9%)	4 (66.7%)
I contract with a non-Medi-Cal DDS anesthesiologist			1 (16.7%)
I contract with a Medi-Cal DDS anesthesiologist			
I contract with a non-Medi-Cal CRNA			
I contract with a Medi-Cal CRNA			

Note: the numbers represent number of arrangements and not dentists, i.e., a dentist could use more than one type of sedation management arrangement.

Nine of the dentist respondents named a surgery center and 15 named a hospital where they provided either IV sedation or GA or both (Table 17). (The dentists were not asked what percentage of cases they provided at each facility or to describe their service arrangements there.) The facilities they named lined up with the hospital and ASC resources identified earlier in this report.

Table 17. Surgery Centers and Hospitals Where Dentists Provide IV Sedation/GA Dental Services

	Surgery Center	Hospital
General DDS (n=2)	Fort Sutter - 1	Kaiser* - 2
Pediatric (n=8)	Fort Sutter – 3 Sutter Roseville Surgery Center – 1 Greater Sacramento Surgery Center – 1 Roseville Surgery Center – 1 Woodland – 1	Kaiser Roseville – 5 Sutter Roseville – 2 Sutter General – 1 Mercy San Juan – 3 Mercy General – 3 Dignity Woodland – 1 Kaiser Vacaville – 1 Sutter Davis – 1
Oral Surgeon (n=5)	Fort Sutter – 1 Mercy General – 1 Folsom Surgery Center – 1	Mercy General – 4 Sutter General – 2 Kaiser* – 1

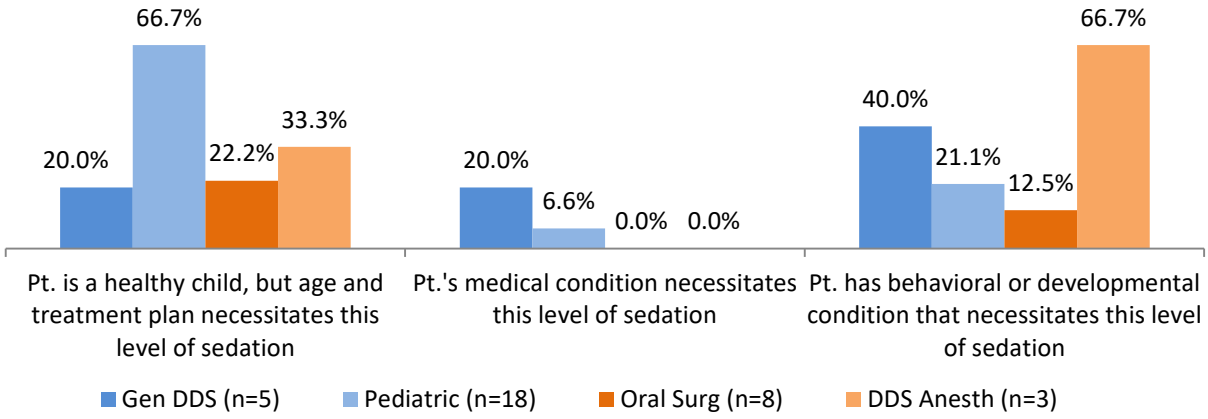
*Unspecified Kaiser Hospital.

Patient Selection Criteria for Sedation

The respondents were asked to answer the question, “For the patients you choose to sedate with IV sedation/GA, what percentage is chosen for the following reasons (3 criteria were listed)?” Figure 8 shows the percentage who dentists who said they used these criteria for more than half of their patients. The first criterion, healthy children, age and treatment plan, was a more important consideration for pediatric dentists than other dentists; two thirds (66.7%) of them accepted more than half of their patients for IV sedation/GA for this reason, while only 20% of the general dentists, 22.2% of the oral surgeons and 33.3% of the dental anesthesiologists said they did. Choosing patients due to a medical condition was relatively more important for the general dentists than for the other dentists. Behavioral concerns or

developmental conditions were particularly important for dental anesthesiologists and general dentists as 66.7% and 50.0%, respectively, reported choosing over half of their IV sedation/GA patients for this reason.

Figure 8. Percent of Dentists who use Selected Criteria for more than half of their IV Sedation/GA Patients



Payer Source

Looking at the payer sources for patients who received IV sedation/GA, it appeared that the coverage came from the commercial plans (both medical and dental) and, to a somewhat greater extent, at least for the pediatric respondents, from patient out-of-pocket (Table 18). It also appeared that for these dentists, Medi-Cal managed care *medical* plans were not represented among the payers.

Table 18. Estimated Payer Source for Patients who Receive IV Sedation/GA* (n=28)

	General DDS (n=6)				Pediatric (n=14)				Oral Surg (n=8)			
	0-25%	26-50%	51-75%	76-100%	0-25%	26-50%	51-75%	76-100%	0-25%	26-50%	51-75%	76-100%
Medi-Cal Dental FFS						2.9%		2.9%				
Medi-Cal Dental GMC					2.9%	2.9%		20.0%	15.3%			
Medi-Cal Medical GMC												
Commercial health plan	10.0%			10.0%		2.9%		2.9%	15.8%			5.3%
Commercial dental plan		20.0%			20.0%		2.9%	8.6%		21.1%	10.5%	5.3%
Patient out-of-pocket	10.0%	10.0%	10.0%	30.0%	28.6%	2.9%			21.1	15.8%		

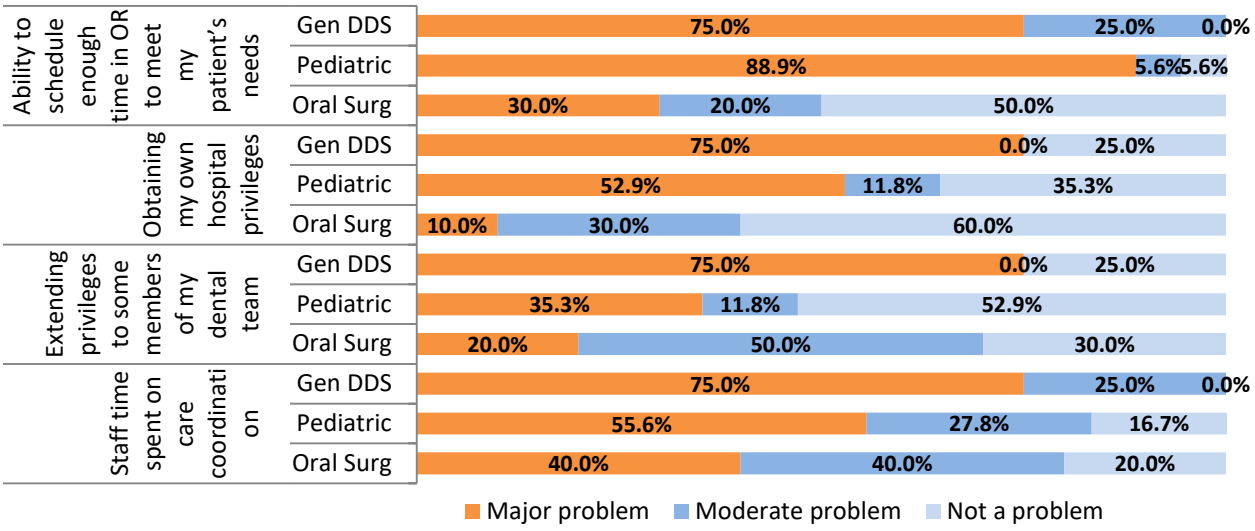
*Percent of respondents, not percent of cases.

Main Barriers

The general and pediatric dentists reported the main barrier they encountered when trying to schedule hospital dental services, regardless of the patient's payer source, was being allowed enough OR time to meet their patients' needs—cited as a "major problem" for at least three-quarters of them (Figure 9). The general dentists also ran up against the problems of hospital

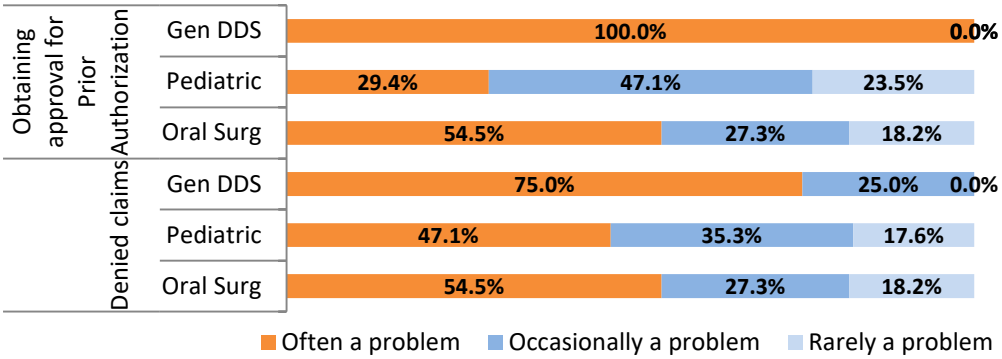
privileges (for themselves and their dental team members) and the time it took for care coordination such as transportation, communication and informed consent. The oral surgeons experienced these barriers much less often than the other types of dentists.

Figure 9. Main Barriers Dentists Identified in Scheduling Hospital Dental Services, all Payer Sources (n=32)



A few dentists identified problems obtaining GA for patients with commercial health insurance as well. All of the general dentists said obtaining prior authorization approval was "often a problem," as was denied claims for most of them. While all of the pediatric dentists experienced these barriers, they did so with the least frequency (Figure 10).

Figure 10. Main Barriers in Scheduling Hospital Dental Services, Commercial Payers (n=33)



We asked the dentists to identify *which* commercial insurance plans posed the barriers "occasionally" or "often" and 18 of them provided comments. The most frequent responses were: "private insurance does not cover IV sedation; it's not a covered benefit; anesthesiologist does not take insurance; parents have to pay out-of-pocket." When a commercial plan was identified, it was Anthem Blue Cross, Delta, Kaiser, United HealthCare and LIBERTY somewhat equally—answers that indicate providers were referring to both dental and medical plans. About half of the respondents wrote in "all of them" or "most of them" as presenting a problem.

Sedation Referrals

The dentists were asked where they referred patients who needed sedation they did not provide. Another Sacramento dental practice was the most common (53.1%) referral resource (Figure 11). Table 19 lists the various places where patients were referred, however we did not verify whether these practices had adequate capacity to see the referred patients—or even if they provided GA. A couple of the dentists who sent their patients to UCSF added, "UCSF does not want Medi-Cal patients."

Figure 11. Referral Sources for IV Sedation/GA (n=98)

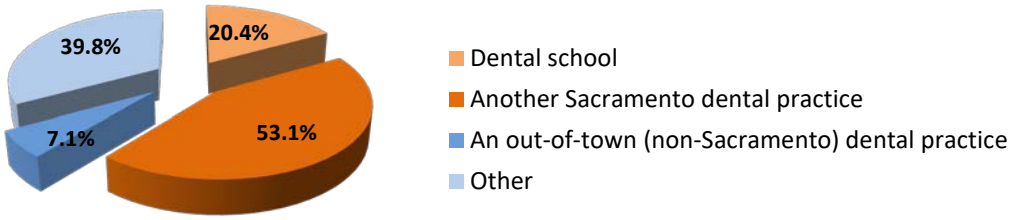


Table 19. Referral Sources for Patients who Need Sedation the Surveyed Dentists did not Provide[1] (n=81)

	Type of Dentist Respondent			
Places	General DDS	Pediatric	Oral Surg	Other Specialist
Dental Schools	UCSF (n=8) UOP (n=3)	UCSF (n=1)	UCSF (n=3) UOP (n=1)	UCSF (n=2)
Another Sacramento DDS Practice	Oral surgeons[2] (n=7) American River Dental (n=3) Pediatric DDS[2] (n=3) Rancho Cordova[2] (n=2) Valley Oral Surgery[2] (n=2) Sacramento Oral Surgery Capitol Oral Surgery Sacramento Surgical Arts Surfside Dental Group Dr. Bughao + 10 other DDSs each named once	Children's Choice Dr. Bughao Weideman Dental	Dr. Bughao (n=2) Greenhaven Dental	Dr. Acheson Midtown[2]
Another out-of-town DDS practice	Travis Air Force Base		Fresno[2] Vallejo[2]	
Other	Back to insur co. (n=6) Nowhere/don't refer (n=5) Pediatric DDS[2] (n=2) Specialist DDS[2] (n=2) SDDS (n=2)	Hospital[2] (n=3) Back to the insur co.	Back to the insur co. (n=2)	SDDS "Whoever can help"[2]

The names of these dental practices and facilities—identified as a referral source by the dentists who did not themselves provide IV sedation/GA—is not meant to suggest there is capacity in any one of them to see more patients.

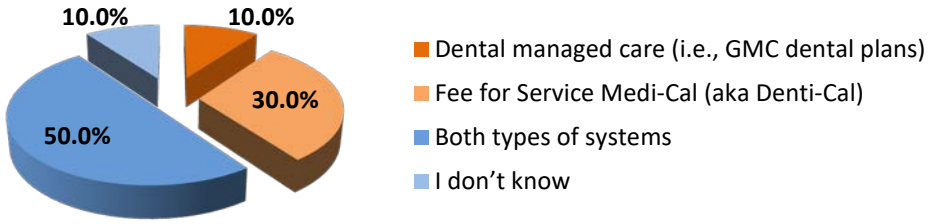
[1] In order of frequency mentioned.

[2] No additional identifying information was given.

Dentists' Medi-Cal Dental Program Experience

Very few (40, or 23.4%) of the dentists responded to the question asking whether they were a Medi-Cal provider, limiting our understanding of Medi-Cal-specific issues. Of the 10 who responded affirmatively, 1 was a general dentist and 9 were pediatric dentists. Half of them participated in both fee-for-service and dental managed care (Figure 12).

Figure 12. Type of Medi-Cal Provider (n=10)



Seven of the 10 Medi-Cal providers answered questions about this experience. The typical time lag between submission of Treatment Authorization Requests (TARS) and approval was reported to be less than 3 months by about half of the respondents; the others reported it was between 6-9 months. The similar proportion experienced the same time lag between submission of TARs and scheduling the authorized treatment.

The most common reason for receiving a denial was "documentation fails to show treatment was medically necessary." One of the pediatric dentists commented their office had received denials "if there are less than 4 teeth that need treatment, even if child refuses to cooperate." Although most (about 90%) of the initial denials were appealed and later approved, when there was a non-completion of treatment it was generally due to the following reasons, in order of mention: the patient not following through on making/keeping the treatment appointment and the patient not receiving medical clearance from the primary care physician.

If the respondents had observed a pattern of inefficient handling of appeals/requests for review and exceptions/denials from either a Medi-Cal Managed Care medical or dental plan, they did not identify them when invited to do so.

Additional Medi-Cal Dental Experience

Three of the dentists remembered seeing one of the Department of Health Care Services All-Plan Letters (APL) or the Provider Bulletin (vol. 35, no. 8, August 2019)* regarding prior authorization for IV sedation and GA services. Two of them said it was "mostly understandable" and one thought it was "clear enough," *though these 3 respondents had all experienced denials trying to follow those requirements.*

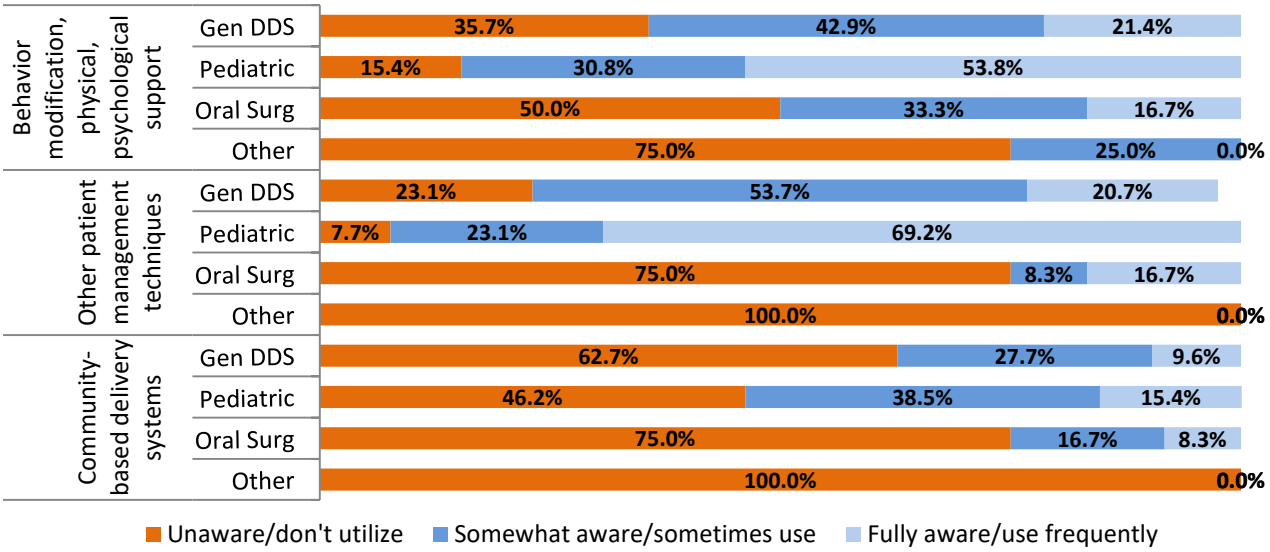
The surveyed dentists reported seeing very few IV sedation/GA patients with Medi-Cal who lived outside of Sacramento County; those they did see were generally children age 6 and under.

* For links to these and other DHCS policy documents, please see the Timeline in Attachment 3.

Dentists' Use of Alternative Approaches to IV Sedation/GA

Because of the challenges of providing dental services under sedation or GA, and to reduce its use when possible, we asked about alternative approaches dentists were aware of or used; for example, behavior modification, and physical and psychological support (e.g., patient immobilization/restraint, desensitization), and non-restorative techniques to stabilize a tooth without drilling. As a group, the other dental specialists, followed by oral surgeons, were the least likely to be aware of or make frequent use of any of these approaches, while the pediatric dentists were the most likely to (Figure 13). Community-based care delivery systems (seeing patients in settings where they are more comfortable to desensitize) was the approach all of the dentist groups were least aware of/used less frequently.

Figure 13. Dentists' Awareness/Frequency of Use of Alternative Approaches

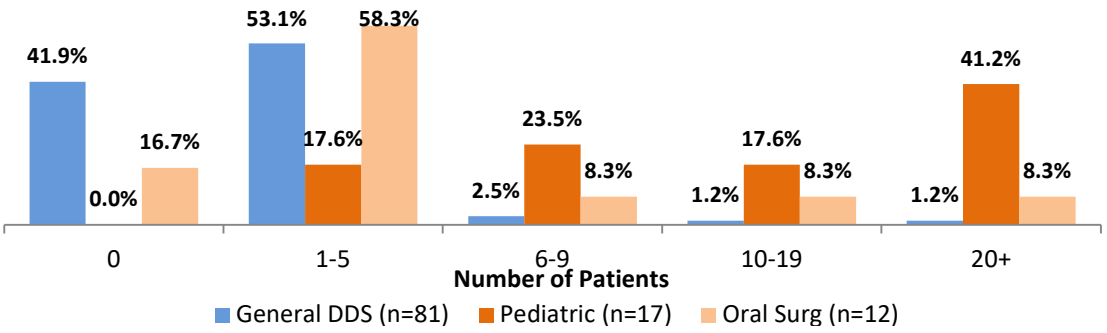


Patients with Special Needs

Dentists in each practice type, except for the "other dental specialists", reported seeing at least *some* patients with special needs.* Pediatric dentists, predictably, saw the most children ages 0-20 with special needs, with none of them reporting zero and 41.2% of them reporting 20+ "in a typical month" (Figure 14). About the same proportion of general dentists reported seeing zero children with special needs as seeing 1-5. While 1-5 was the typical number of special needs children seen by the oral surgeons, one-quarter or more said they saw 6-20+ in a typical month.

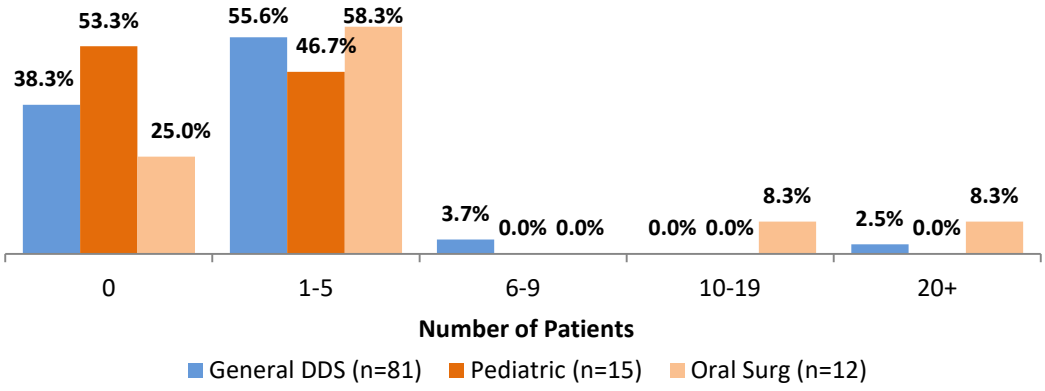
* Defined in the survey as any condition--medical, cognitive, developmental, injuries—that makes standard dental procedures more difficult without some form of sedation/anesthesia, e.g., autism, seizure disorder, cerebral palsy.

Figure 14. Number of Children (age 0-20) with Special Needs Seen in a Typical Month



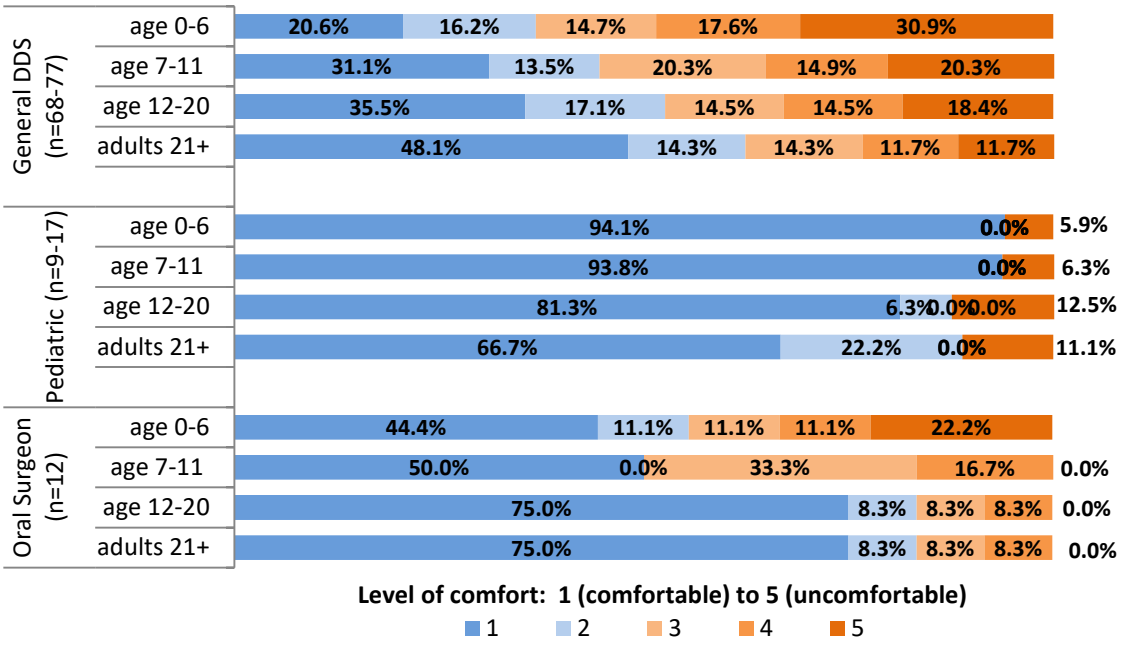
Very few of the practices reported seeing adult patients (age 21+) with special needs as 38.3% of the general dentists answered that they saw zero and 55.6% of them said 1-5 "in a typical month"(Figure 15). Close to half (46.7%) of the pediatric dentists, who likely retained some of their child patients with special needs as adults, reported typically seeing 1-5 adults a month.

Figure 15. Number of Adults (age 21+) with Special Needs Seen in a Typical Month (n=108)



Dentists were asked to indicate how comfortable they were - or would be - in seeing patients with special needs in their practice (using a scale of 1-5 with "1" being "comfortable" and "5" being "uncomfortable"). Pediatric dentists, as would be expected, were more likely to express a great deal of comfort when seeing children with special needs (Figure 16 on the next page). In fact, of the 17 pediatric dentists who answered the question about the youngest age group, 16 (94.1%) marked "1" on the survey (the other respondent marked "5"). Six (75%) of the 8 (75%) dentists who answered the question regarding adult patients with special needs also answered with a "1." The comfort level of the general dentists and oral surgeons increased as the patient ages increased.

Figure 16. Dentists' Comfort Level Seeing Patients with Special Needs (n=108)

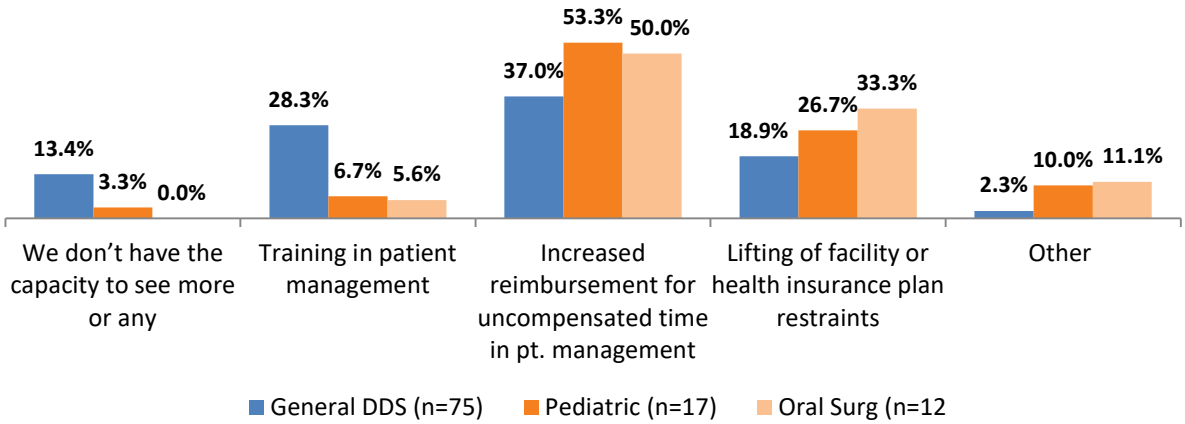


Note: Some dentists only answered the question for some of the age groups; hence, the range of n's.

Ability to See More Patients

Due to lack of access reported by parents and advocates, the study asked what would be required for dental practices to take more patients with special needs. Increased reimbursement for uncompensated time spent in patient management was the main thing dentists said it would take for them to see more of these patients in their practice, according to 53.3% and 50.0% of pediatric dentists and oral surgeons, respectively (Figure 17). Better reimbursement was an important factor for general dentists as well, with 37% citing that reason. Removing the restraints posed by health insurance plans or facilities accounted for 18.9% (general dentists) to 33.3% (oral surgeons) of the barriers. Relatively few of the respondents said they did not have the capacity to see more or any patients with special needs, giving the impression that if these financial and structural barriers were addressed access could be expanded for this population.

Figure 17. What it would Take for Dentists to see More Patients with Special Needs (n=104)



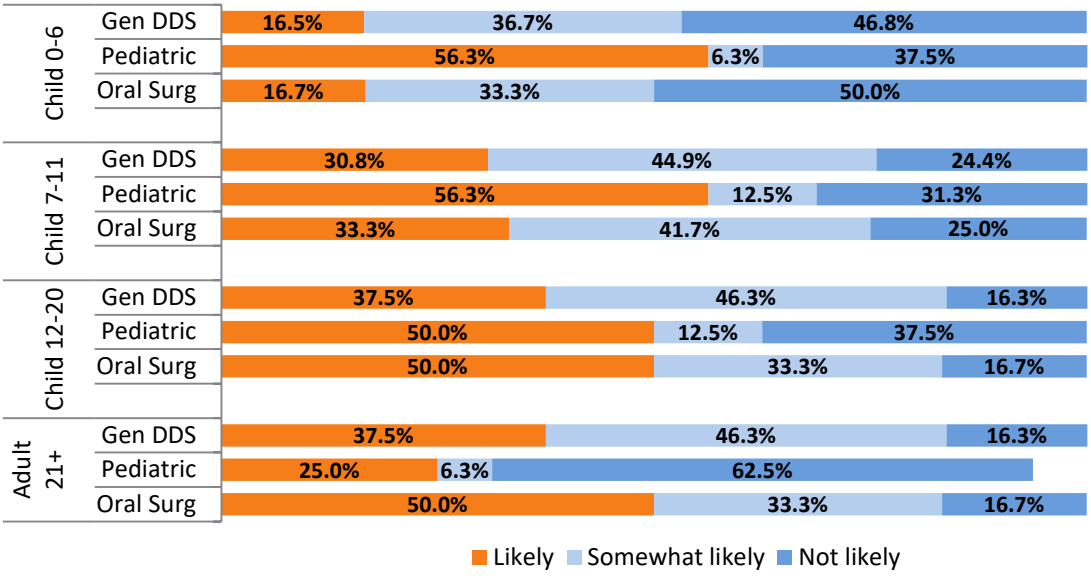
Except for one dentist who said, "We need doors on the operatory to create a sound barrier to other patients," and another who said "It really depends on the type of disability," all of the 11 "other" written-in comments on what it would take to see more patients with special needs, including 2 of the 4 dental anesthesiologists who responded to this question, commented on needing better reimbursement for the GA service and hospital OR space. It is worth noting the extensive comments offered by one respondent, in this case relative to Medi-Cal:

> *"The refusal of hospitals to give space to dentists to use the OR for sedation of these special needs patients is the issue. This combines with the abysmally low reimbursement Denti-Cal rate for sedation, including Oral Conscious Sedation. We suspended OCS for pediatrics as we could not afford to do it for $25. We have DEA license fees just for storing the meds on site, reams of paperwork to review orally with the parents, consultation appts, treatment plan approval, and finally, treatment of these patients. Then, the parents may have fed the kid that morning, or the kid may not feel well and has to be sent home, then they might not show up (a big problem with Denti-Cal patients). Then we have an unfilled 3-hr slot and I have to pay 3 employees and the MD anesthesiologist. You can train all the people you want to, but the reality is that,* ***if given a reasonable reimbursement on a dentist's UCR fee schedule, there would be a zillion pediatric dentists in California willing to treat these kids*** [emphasis added]. *For these and a few other reasons, I did not renew my Pediatric OCS certification this year.*

The Difference Training May Make

Reportedly, less than 10% of dentists feel comfortable treating patients with disabilities because of their lack of training and experience.[54] Although the pediatric dentists in this survey expressed the greatest amount of comfort seeing children with special needs, they seemed the likeliest to say additional training could result in an increase, even by a small number, of patients with special needs in their practice (Figure 18). Patient age was more of a factor for general dentists and oral surgeons. The older the age group, the more likely additional training would make to their seeing an increase in patients with special needs in their practice.

Figure 18. Dentists' Likelihood of Seeing More Patients with Special Needs with Training (n=107)



Interest in More Information/Training

The lack of preparedness of dentists to treat patients with special needs can influence their degree of willingness to treat those patients. Similarly, unawareness of alternative approaches to sedation/GA makes use of them less likely. Overall, close to two-thirds (63.2%) of the 116 dentists who responded to the question (47 skipped it) declined the opportunity to receive more information/training related to the dental needs of patients with special needs or to alternative approaches to IV sedation/GA (the survey question combined these two topics). Table 20 details the differences in acceptance by type of dentist.

Table 20. All Dentists' Responsiveness to being Contacted for More Information/Training (n=116)

Type of Dentist	Contact Information Provided	Declined ("No Thanks")
General (n=82)	39%	61%
Pediatric (n=16)	31%	69%
Oral Surgeon (n=11)	9%	91%
Other Specialist (n=3)	33%	77%
Dental Anesthesiologist (n= 2)	50%	50%
Orthodontist (n=2)	50%	50%

The names of the 42 dentists who provided contact information for receiving information/ training have been shared with the Sacramento Oral Health Program for follow-up.

Dentists' Additional Comments

The survey respondents were invited to write in additional comments that added insights about capacity and barriers. Attachment 7 contains verbatim input (except where it was necessary to remove identifying information) from 21 of the dentists who provided additional input. (Note that some did not participate in Medi-Cal so comments relative to that program may not reflect current situations.) The types of dentists who offered comments were generally proportionate to their representation in the survey.

Summary of Dentist Capacity

The dentist survey, although a reasonable reflection of current IV sedation/GA practices in Sacramento, yielded a relatively low response rate. It could be that dentists who use IV sedation/GA were most likely to respond, and perhaps those that do not provide it thought their input was not needed. While a larger sample size would have given us a better understanding of the access children and adults have to dental care using sedation/GA, the findings contribute interesting information about some facets of the local dental delivery system capacity.

While the limited number of respondents to questions about Medi-Cal failed to yield more information about approvals and denials for sedation/GA, data in other sections of this report shed light on specific problems. We learned that half of the dentists who answered this question experienced a 6-9 month delay in TAR approvals—an unacceptable wait according to DHCS policy. Unless respondents did not understand the payer question to be asking about *medical* vs. dental, Medi-Cal managed care *medical* plans not being represented among the

payers represents what we have been hearing all along – patients who can, are paying out of pocket, some being asked "bring $600 cash." Medi-Cal managed *medical* care was really not paying for this. (See endnote 55 for information about Medi-Cal fund recovery assistance for members who have paid out of pocket.[55])

Additionally, some dental offices have asked (wrongly) their Medi-Cal patients to pay out of pocket for the anesthesia service. This finding reinforces the negative impact of low Medical re-imbursement rates for these providers. Poor payment to anesthesiologists to provide IV sedation/GA results in less access to the population needing dental care with this service.

Inadequate hospital OR time was as limiting a factor to access as was inadequate reimbursement for hospitals and surgery centers—the two are of course related. Except for the oral surgeons, insufficient OR time was considered a "major problem" by over three-quarters of the surveyed dentists.

OTHER COUNTIES' SURGERY CENTER EXPERIENCE

GA authorization rates by health insurers shared by two non-Sacramento surgery centers, PDI in Windsor and Children's in Stockton, are shown in Table 21 as a comparison to the experience in Sacramento County. It is worth noting that the Medi-Cal contracting health plan covering Sonoma County—where the majority of PDI patients come from—approved 100% of the TAR requests. Most of the denials from these plans were said to be due to eligibility and benefits-related issues such as "not a covered service" or "no out of network services."

None of the six non-Sacramento area surgery centers we spoke with located between Tulare and Sonoma counties, including those in the table below, reported serving any patients from Sacramento in the last year. (PDI said they have seen 9 Sacramento patients since opening in 2009.)

Table 21. Insurance Approvals/Denials of non-Sacramento Dental Surgery Centers, CY 2019

	PDI[1]			Children's[2]			
	Health Plan/Insurance						
	Anthem (Private)	Health Net (private)	Partnership Health Plan of CA (PHP)	Kaiser	Anthem (Medi-Cal)	CA Health Wellness	Partnership of CA (PC)
Total requests	20	2	1638	5	119	143	251
Total approvals	5	2	1638	0	113	139	242
Approval rate	25%	100%	100%	0%	95.0%	97.2%	96.4%

[1]Information provided by Pediatric Dental Initiative (PDI), Windsor, May 28, 2020.
[2]Information provided by Children's Dental Surgery Center, Stockton, June 8, 2020.

ALTERNATIVE APPROACHES TO GA

Managing pain and anxiety in patients has always been an essential part of dentistry.[56] Poorly managed pain control can instigate fear and negative response in patients, which becomes an obstacle for clinicians to create a positive overall patient experience.[57] While some children (and adults) are relatively cooperative during a dental visit, some demonstrate behaviors that

disrupt the procedure and make the safe delivery of acceptable treatment very difficult. Ideally, behavior management techniques can be used which enable treatment to be completed, reducing or avoiding the need for general anesthesia.

The most common alternate approaches to GA in dentistry include:

- Behavior modification, physical and psychological support, i.e., patient immobilization/ restraint, desensitization.
- Desensitization procedures, for example, by both dental and non-dental providers can be performed beginning at any age and can be started very early, though it should be noted can take significant amounts of time and multiple appointments, and that is often the barrier. Some dentists, especially those who are less experienced in working with patients with developmental disabilities, may resort to using GA, rather than providing behavioral supports.
- Other management techniques, i.e., non-restorative techniques to stabilize a tooth without drilling or possibly without the need for GA, e.g., interim therapeutic restorations and Silver Diamine Fluoride.
- Community-based care delivery systems, i.e., bringing care to where people are, with the goal of minimizing barriers to access and addressing problems early; seeing patients in settings where they are more comfortable, that function to desensitize/increase ability to receive dental treatment at some point, e.g. virtual dental home, teledentistry, registered dental hygienists in alternative practice.

People with special needs are considered a disproportionate part of the GA service need possibly because a higher percent of them are referred for sedation or anesthesia compared to their percent representation in the population. The two groups most likely to be referred for dental care under sedation or anesthesia are young children and people with development disabilities. Some health professionals believe that the "need" for sedation or anesthesia—with the availability of the alternatives described above—may be lower than the number of people referred for services using these modalities.[58]

Recommendations for alternative approaches that could reduce the number of patients that progress to the point of needing GA for dental care were developed by the Medi-Cal Dental Advisory Committee Special Needs/ General Anesthesia Workgroup and are included in the Recommendations section of this report.

RECOMMENDATIONS

"We know that as a whole, the state and dentists are not able to provide the best care we can of the special needs patient population due to lack of funding and difficulty finding a surgery center and/or hospital willing and able to schedule and pay for this type of service." – Dentist survey respondent

While it is clear that reducing some of the need in the future for GA is dependent on more oral health education and better utilization of preventive services, IV sedation/GA will remain an important part of dentistry for facilitating treatment. The following recommendations, in no order of importance or priority, and driven by the study findings, are intended to identify actions that DHCS, MCDAC, California Hospital Association and partnerships with other organizations and advocates need to take to increase access to GA dentistry if timely care for people with special needs and others with rampant dental disease is to be realized.

1. Support and Raise Awareness of Alternatives to GA*

Behavior, Physical, and Psychological Support

- Develop funding to support desensitization at multiple levels
- Develop training programs for oral health and non-oral health care providers to perform desensitization procedures. Tie completion of the training program to eligibility to receive payment under the payment systems described above.
- Identify and address barriers that keep Regional Centers and other organizations from deploying structured identification and desensitization programs.

Medical Management

- Develop easily available and accessible education programs for dental providers to enhance knowledge and understanding of medical and behavior intervention strategies.
- Tie completion of certified education programs to enhanced payment rates for prevention and early intervention procedures and for behavior support (i.e. support that leads to adoption of "mouth healthy habits").

Community-Based Care Delivery Systems

- Clarify the rules and regulations that apply to community-based delivery systems so there is clear support for the multiple components that comprise these systems.
- Expand support for care management (patient navigation, case management) in FFS and other reimbursement systems.
- Develop and support new entities and systems that can support care navigation and other aspects of community-based care delivery. Consider using the new in lieu of service systems being developed in the Cal AIM program.

* Developed by the SN/GA Workgroup.

- Explore integration of medical and dental health care payer sources. (Consider the Health Plan San Mateo pilot as an example.)

Integrated Community Clinical Linkage Programs

- Develop support systems for dentists who provide targeted referrals with pre-screened patients who have progressed through prevention and desensitization procedures and are matched to a dentist with the skills and office environment where a successful procedure can be predicted, and referral support to ensure the dentist has all required information needed to provide dental care.
- Develop funding mechanisms for entities that could provide the services described above.

2. Expand Operating Room Capacity for Dental Cases

Local Hospitals

We understand using hospital operating rooms for dental cases displaces the opportunity for more profitable procedures. We also fully recognize that ongoing pressure to reduce health system spending will require hospitals to find new operational efficiencies to survive in a post-COVID-19 environment.[59] Nonetheless, GA dentistry is a legitimate and necessary part of surgical services— just as the mouth is a legitimate and important part of the human body. A *small* increase in OR time—on perhaps less traditional days and times of the week—should be explored at area hospitals, with facilitation by the California Hospital Association, starting with the facilities that have made this service part of their mission. The further write-offs to hospitals' Community Benefits Plans—required as a condition of non-profit status—should be emphasized. The CARES Act and the Paycheck Protection Program and Health Care Enhancement Act that allocated relief funds to hospitals and other health care providers that serve Medi-Cal patients may also help.[60]

Dental Surgery Center

The timing of this recommendation for expanding surgical GA capacity is also unfortunate but a necessary conclusion of this report. We suggest the idea of establishing a dental surgery center in Sacramento be put back on the table—even if at the far end. A comprehensive feasibility study should explore the opportunities for start-up funding such as a private donor "oral health champion." First 5 Sonoma, for instance, was largely responsible for creating PDI, Inc., that in the last dozen years has served over 22,000 Northern CA children and educated 20,000 families. The Sacramento hospitals could be asked to support a new center as part of their Community Benefits obligation—and perhaps as a way of avoiding expanding their own OR capacity for dental GA cases. Reimbursement from private health insurance and Medi-Cal would support but not be sufficient to meet ongoing operating costs.

The new dental school being created at California Northstate University is an excellent place to consider establishing such a surgical center.

3. Create Legislation that Requires Hospitals to Specifically Report on Dental Needs as a Separate Category in the Needs Assessment and Activity Reports

As a condition of their tax exempt status, private not-for-profit hospitals are required, every 3 years, to perform a community needs assessment (CNA) and report in their Community Benefits reports on their activities that support their needs assessment. Although oral health comes up as a need in nearly all CNAs, it seems persistently ignored in reports of community benefits/charity care. Including oral health in the community benefit assessment and activity reports would encourage greater attention to the dental needs of California communities and encourage hospitals to work with their local community partners to address those needs.

4. Enhance Hospital Reporting of GA Dental Cases

An interesting outcome of our data request and subsequent questions to the Office of Statewide Health Planning and Development was alerting OSHPD to hospitals' non-reporting and/or inconsistent type of reporting of dental anesthesia codes during the data validation process. According to one review done for us by a Patient Data Section analyst, hospitals were indicating the type of drug administered on the patient record, but those codes were not reported nor were hospitals reporting dental anesthesia codes. We were informed OSHPD "intends to begin doing outreach" with the facilities to require reporting after becoming aware of this issue; we suggest a follow-up inquiry to OSHPD next year to see if this has been achieved.

5. Expand Dental and Medical Plan Coverage to Address Out-of-Pocket Cost for Families

Medi-Cal health insurance coverage should be provided for medically necessary GA and facility charges for pediatric dental procedures done in a hospital, surgery center or dentist's office. Currently, Medi-Cal managed health care plans are not required to pay for procedures performed in a dental office, only in hospitals and surgery centers. Because of this, unless a dentist takes their cases to a hospital—which because of limited OR time restricts access—patients provided GA dentistry who can are asked to pay for the service out of pocket (OOP). The extent of the OOP issue was not able to be fully examined in this study due to time but should be further explored and addressed.

6. Create and Promote Training Opportunities for Providers in Alternative Approaches and Familiarity with Treating Patients with Special Needs

The use of sedation is an important component of dental treatment and more practitioners may need to develop their care in this area. It seems feasible from the dentist survey responses to suggest that more training to increase providers' (and dental staff) skills and comfort level with patients with special needs could result in more access for this population, at least for older children and adults. Increased availability of dental sedation could remove a barrier to dental care for many highly anxious pediatric and adult patients who may not otherwise receive treatment.

Education about the importance of GA dentistry should also be provided for physicians and other primary care staff—many of whom have limited knowledge about oral health—particularly concerning patients with special needs in an effort to minimize oral health disparities within this population. Medical providers would likely be able to understand the further benefit of having GA for individuals with special needs is the ability to do multiple non-dental tests or examinations for those patients whose behavior prohibits such exams.

7. Increase Capacity of Regional Center to Link Clients to Dental Services

Whether or not AB 2634 passes, Alta California Regional Center should have a dedicated Dental Coordinator. With responsibility for over 15,000 clients each year, a Dental

Committee cannot hope to fully assist the Service Coordinators in responding to families' requests for dental service referrals when there are problems—much less in ensuring their clients are making regular dental visits for ongoing care.

8. Communicate Clear, Consistent DHCS GA Policies and Continue to Monitor for Access

Despite attempts to clarify policies around GA dental services with multiple and various Provider Letters and Provider Bulletins to help providers avoid denials by GMC managed care plans, the problem has been cyclical – every couple of years it is "fixed" and then there are documented cases of denials again. This needs to be resolved permanently with observance of AB 2003 and consistent application of current policies by Medi-Cal medical-dental collaboration. The *Treatment Authorization Request (TAR) Process* Flow Chart in the appendices—validated by both GMC medical and dental plan reviewers for this study—should be offered to providers to help with what is clearly a complex and challenging process.

Additionally, DHCS should continue to routinely monitor and audit a sample of Sacramento dental GA approvals to look for and, importantly, address the outlier denials by the health and dental plans.

9. Promote More DHCS Internal Dental-Medical Communication

We were appreciative during this study to gain access to Medi-Cal's medical-side staff—through requests to the dental staff—when there were questions about data, but believe both staff teams could benefit from greater internal communication. The historical silo that has existed between the "dental side" and "medical side" of Medi-Cal makes it more challenging for staff to understand each other's processes and datasets, share learning, decide on mutually beneficial policies and guidance, and monitor practices that could better take into account the medical-dental issues that affecting beneficiaries and providers.

10. Maintain Medi-Cal Dental Funding, Eligibility and Scope of Benefits

It seems clear that raising reimbursement rates for hospitals, surgery centers and anesthesia providers would increase the incentive for this group to open up their facilities and services in order to increase access to dental care for those that require treatment with IV sedation/GA. (While rate increases may not be sufficient on their own—patient case management responsibilities and administrative burdens must also be addressed—provider participation increases generally follow rate increases.) While increasing reimbursement is not in the cards for FY 20/21, we strongly encourage the Administration, DHCS and the California Department of Public Health to maintain *current* levels of oral health-related funding and scope of benefits. Dental services are an easy target—witness the giving and taking back, giving and once again proposing to take back, adult benefits—because the relationship of oral health to good general health and the favorable cost-benefit of these services are not well understood. The Medi-Cal program, which in 2015-16 was a $92 billion program, spent only a tiny fraction of the amount—1.5%—on the dental budget.[61]

Dental disease, which is largely preventable, causes pain and disability for children and adults who do not have access to proper oral health services. It also contributes to the high costs of care, including the cost to hospitals of seeing patients with dental pain in the emergency department. As more Californians are expected to shift from employer-based to public health insurance coverage from unemployment due to the coronavirus pandemic, continued Medi-Cal funding is even more essential for dental care.

11. Expand Parent Education on Oral Health

Although we did not collect primary data on the issue during this study, it would be remiss to not include among the recommendations the importance of increasing efforts to educate parents and other caregivers about the importance of oral health, especially in view of some of the recent Sacramento OH studies. The 2018 OH Needs Assessment, for example, found an average of 34% of preschool children screened in the last three years by various programs with evidence of untreated dental decay.[62] Low parent priority (including thinking their child was too young to see a dentist) and fear of the dentist were the most common barriers to taking their children to the dentist for 123 interviewed Sacramento parents.[63] Oral health education messages, integrated with other related efforts, are needed to address the serious lack of knowledge about early childhood oral health.

12. Continue Support for MCDAC

The Medi-Cal Dental Advisory Committee (MCDAC) brings the dental and other stakeholder communities together in Sacramento County. It has served as a channel for improving communication, successfully identifying issues and influencing policies and practices, and increasing access to services for Medi-Cal beneficiaries statewide. Regardless of whether GMC will continue in Sacramento County, MCDAC should be retained.

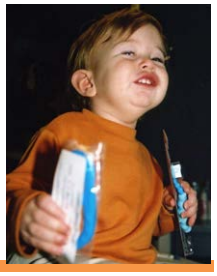
13. Support a Dental Seat on the New Medical Managed Care Advisory Committee

SB 1029 includes proposing the creation of a new medical managed care advisory committee. To be fully representative of Californians' health needs, the committee should have dental representation. This is particularly important if the GMC dental system is retained in Sacramento County. To better coordinate, MCDAC would pass information to the Committee through this seat.

14. Create an Action Plan, Monitor Progress and Further Explore Related Questions

To "operationalize" the recommendations, MCDAC should by December 2020 create an Action Plan that identifies the parties that should take the lead and others to play contributing roles and engage their commitment in implementation. The Action Plan should also describe the major activities that need to be carried out (for example, MCDAC and DHCS will need to work with legislators on items that would require legislative support such as rate increases or certain policy changes); identify the timeline; and describe the plan for monitoring and reporting progress.

This study was limited by the amount of available time and resources. There could be further benefit to addressing whether there has been a push to reduce the amount of GA in dental care to patients with Medi-Cal, including those with SN, and exploring related questions such as the potential relationship between cost containment/utilization control and GA "demand" and approval.



APPENDICES

ATTACHMENT 1

Acknowledgements

(In alphabetical order by first name)

Study Workgroup

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- Dharia McGrew, California Dental Association
- Gayle Mathe, California Dental Association
- Jan Resler, Sacramento Oral Health Program
- Stacey Kennedy, Sacramento Oral Health Program

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- Dr. Terrence Jones
- Dr. Kart Raghuramen
- Dr. Cherag Sarkari

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- Barbara, Kaiser Roseville
- Belinda Wells, Children's Dental Surgery Center, Long Beach
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- Chris Adams, Sutter Medical Center (Sutter General)
- David King, Kaiser South
- Dennis McIntyre, MD, Anthem Blue Cross
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- Jeremy Pierson, Happy Bear Dental Surgery Center, Tulare
- Judy, Fort Sutter Surgery Center
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Paul Glassman	CA Northstate University
Robin Blanks-Guster	Parent Advocate
Robyn Alongi	Sacramento County Public Health – Dental Transformation Initiative
Rodney Bughao	Specialty care dentist
Rolande Tellier	CA Northstate University
Rosanna Jackson	CA Department of Public Health – Office of Oral Health
Sonya Bingaman	State Council on Developmental Disabilities
Stacey Kennedy	Sacramento County Public Health
Susan Mahonga	California Health & Wellness
Terrence Jones	Medi-Cal Dental Advisory Committee, private dentist

As of May 22, 2020

2010-2020 Timeline Summary: A Decade of Effort to Increase Access to IV Sedation/General Anesthesia Dental Services, Including for Individuals with Special Needs

Date (or approx.)	Milestone/Meeting/Document	Participant/Author
6/2010	Presentation of GMC Dental Study to Sacramento County Board of Supervisors highlighting the problem[1]	Barbara Aved Associates First 5 Sacramento
2/12/2012	Sacramento Bee article on access following GMC Dental Study	Center for Health Care Reporting, Jocelyn Weiner
2/13/2012	Letter to DHCS in response to Sacramento Bee article; outlines expectations	Senator Steinberg
2/21/2012	Letter from DHCS to Senator Steinberg regarding DHCS actions DHCS will take.	DHCS, Toby Douglas, Director
3/5/2012	March 5, 2012 Dental Geographic Managed Care (DMC) expectations including GA meeting.*	DHCS, Letter from Toby Douglas to Managed Care Dental Plans
3/7/2012	GMC Plan expectations to correct poor performance *	DHCS, Toby Douglas, Director Senator Steinberg
6/2012	Medi-Cal Dental All Plan/ Stakeholder Meeting	Diane Van Maren, Senator Steinberg's office, DHCS, GMC Dental Plans, Children's Dental Taskforce
6/20/2012	Children's Dental Task Force Hospital Dental Subcommittee meeting	Children's Dental Task Force
6/23/2012	Senator Steinberg meeting on closing Sutter operating rooms for GA Dental	Senator Steinberg's office, State Capitol MCDAC Hospital Dental Subcommittee DHCS, Rene Mollow
7/01/2012	AB1467 established Medi-Cal Dental Advisory Committee (MCDAC); DHCS required to attend 4 times per year and Sacramento Health Advisory Committee 2 times per year. Reports to the BOS and legislature annually.	Senator Steinberg and staff; Debra Payne, First 5 Sacramento, representative membership, including GMC dental plans, DHCS
1/01/2013	New GMC contracts begin; 3 plans reduced from 5 with new performance measures	LIBERTY, Health Net & Access Dental Plans
1/29/13	SDSS forms a Denti-Cal GA Task Force to identify/gather information about GA access issues; multiple monthly meetings (and follow-up phone calls and emails) fail to resolve denials, hospital limitation and reimbursement problems.	Sacramento District Dental Society, First 5 Sacramento DHCS representatives

Continued on next page

[1] Posting to Sacramento County Oral Health page.

Date (or approx.)	Milestone/Meeting/Document	Participant/Author
11/14/2013	DHCS Policy Letter 13-002[2] to clarify Medi-Cal managed care *health plans* requirements for IV sedation/GA for dental services.	DHCS, GMC Medical Plans
6/9/2014	Letter to all Sacramento County hospitals regarding OR closures to dental cases	Senator Steinberg, Sutter, Dignity, UC Davis and Kaiser Hospitals
6/23/2014	Hospital Dentistry Task Force Formed including 3 workgroups: ▪ Protocol Development ▪ Administration Changes ▪ Expanding Provider Pool	Senator Steinberg, Sutter, Dignity, UC Davis and Kaiser Hospitals, MCDAC, statewide advocates
7/22/2014	Letter to Senator Steinberg from Ambulatory Surgery Centers (ASC) regarding GA issues	CA Surgery Centers
7/30/2014	Guidelines for decisions about hospital dentistry, anesthesia, and sedation presented to Senator Steinberg and legislative committee members	Dr. Paul Glassman
8/26/2014	Senator Pan Letter to DHCS: Report to Assembly Health Committee	Senator Pan, DHCS, Toby Douglas, Director
9/01/2014	Guidelines for Decisions Regarding Hospital Dentistry, Anesthesia, and Sedation[3]	General Anesthesia Protocols Workgroup
9/23/14	MCDAC Chair Remarks to Health Assembly Committee	Dr. Terry Jones, MCDAC Chair
10/13/2014	DHCS Progress Report Letter to Senator Steinberg	DHCS, Toby Douglas, Director
2014	The Effects of Managed Care on Hospital Based Surgeries and Dental Ambulatory Surgical Centers submitted to Senator Steinberg and Hospital Committee	David Thompson, Managing Member, Future Health Services
Early 2015	MCDAC requests DHCS establish guidelines and a streamlined approval process between medical and dental managed care plans.	MCDAC
8/21/2015	DHCS All Plan Letter (APL) 15-012:[4] requirements for Medi-Cal managed care *health plans* to cover IV sedation/GA for dental services in hospitals, ambulatory medical surgical settings, and dental offices.	DHCS, GMC Health Plans

Continued on next page

[2] https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13-002.pdf
* Need to find on DHCS site (not an APL format, I have a copy)
March 5, 2012 Dental Geographic Managed Care (DMC) expectations meeting.
[3] Paul Glassman, DDS, White Paper, posting to Sac County Oral Health page
[4] https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-012.pdf

Date (or approx.)	Milestone/Meeting/Document	Participant/Author
12/2015	Update to the GMC Dental Study[5] presented that highlights the continuing access problem	Barbara Aved Associates MCDAC, GMC Dental Plans
1/26/2016	SDDS re-constitutes the Denti-Cal GA Task Force saying no significant improvement since 2013 in TARS and reimbursement.	Sacramento District Dental Society, DHCS representatives
2016	60+ documented cases of GA denials for SN and non-SN populations presented to DHCS by Sacramento District Dental Society	SDDS, MCDAC, DHCS
4/01/ 2016	Revised APL 15-005:[6] instructions to Dental Managed Care Plans regarding prior authorization for IV sedation/GA	DHCS, GMC Dental Plans
9/27/2016 – 7/17/2017	SDDS Denti-Cal GA Task Force requests clarification from DHCS on APL and its interpretation; documents a large increase in denials by ABC with no resolution during multiple meetings (and follow-up phone calls/emails).	Sacramento District Dental Society, DHCS representatives
6/28/2017	Dental All Plan Letter (APL 17-004 (Supplement to Revised Dental APL 15-005):[7] adjudication instructions for Treatment Authorization Requests (TARS)	DHCS, GMC Dental Plans
9/2018	Improving Access to Dental Services for Individuals with Developmental Disabilities[8]	Legislative Analyst Office
6/2019	MCDAC authorizes the formation of a Special Needs/General Anesthesia Committee charged with identifying problems and making recommendations; monthly meetings held through 6/24/2020	MCDAC, SNGA Committee
2/2020	MCDAC/SNGA engage a consultant study on GA-SN access	MCDAC, SNGA Committee, Barbara Aved Associates

Note: This timeline represents only the major milestones and meetings and not the numerous phone calls, emails and in-person meetings that occurred over the past decade.

[5] Posting to Sac Co. Oral Health web site

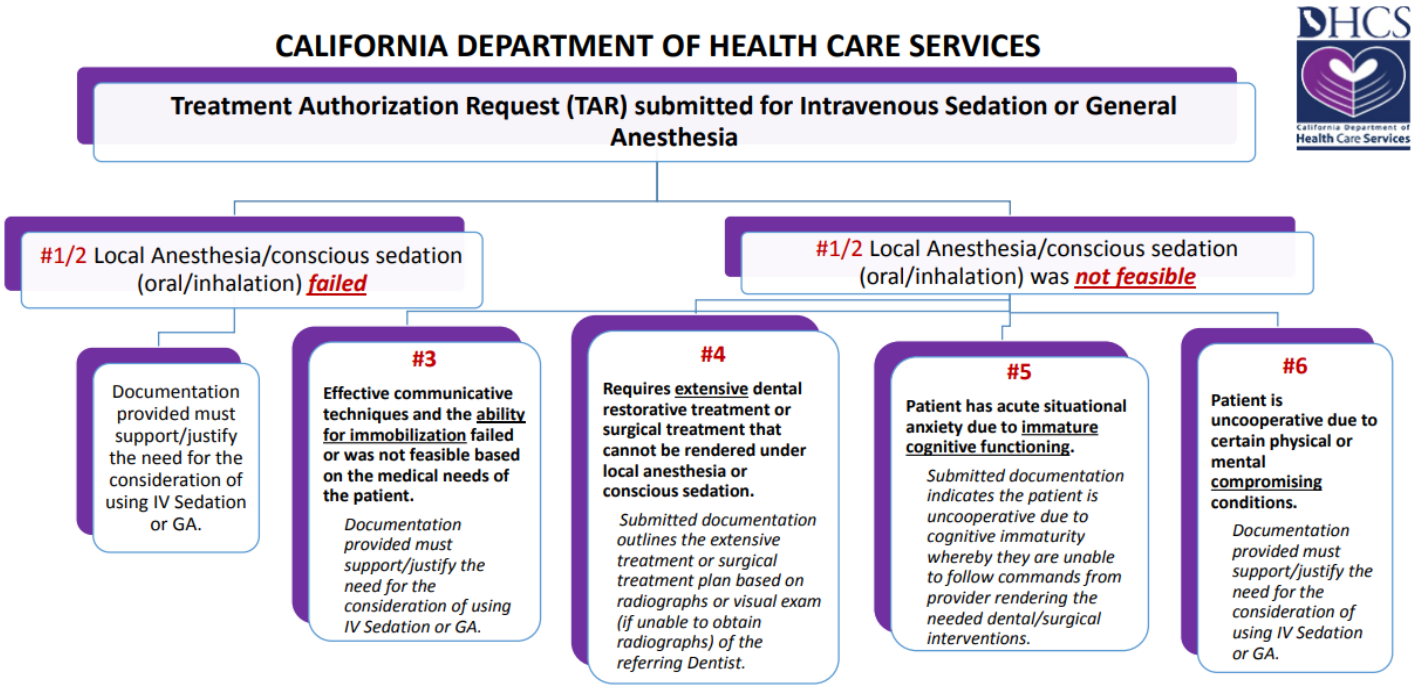
[6] https://www.dhcs.ca.gov/services/Documents/MDSD/2015%20DAPLs/APL%2015-005.pdf

[7] https://www.dhcs.ca.gov/services/Documents/MDSD/2017%20DAPLs/APL17_004.pdf

[8] www.lao.ca.gov

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES Treatment Authorization Request (TAR) submitted for Intravenous Sedation or General Anesthesia

(Provider Bulletin, APRIL 2020 Volume 36, Number 11)



When a provider determines that a beneficiary meets one of the criteria of 3-6, it is not automatically considered to be documentation that conscious sedation or IV sedation was not feasible; rather the submitted documentation of the criteria that was met must be clearly stated in the patient's records and the submitted documentation requesting GA must clearly demonstrate the need for this covered benefit. ***April 2017***

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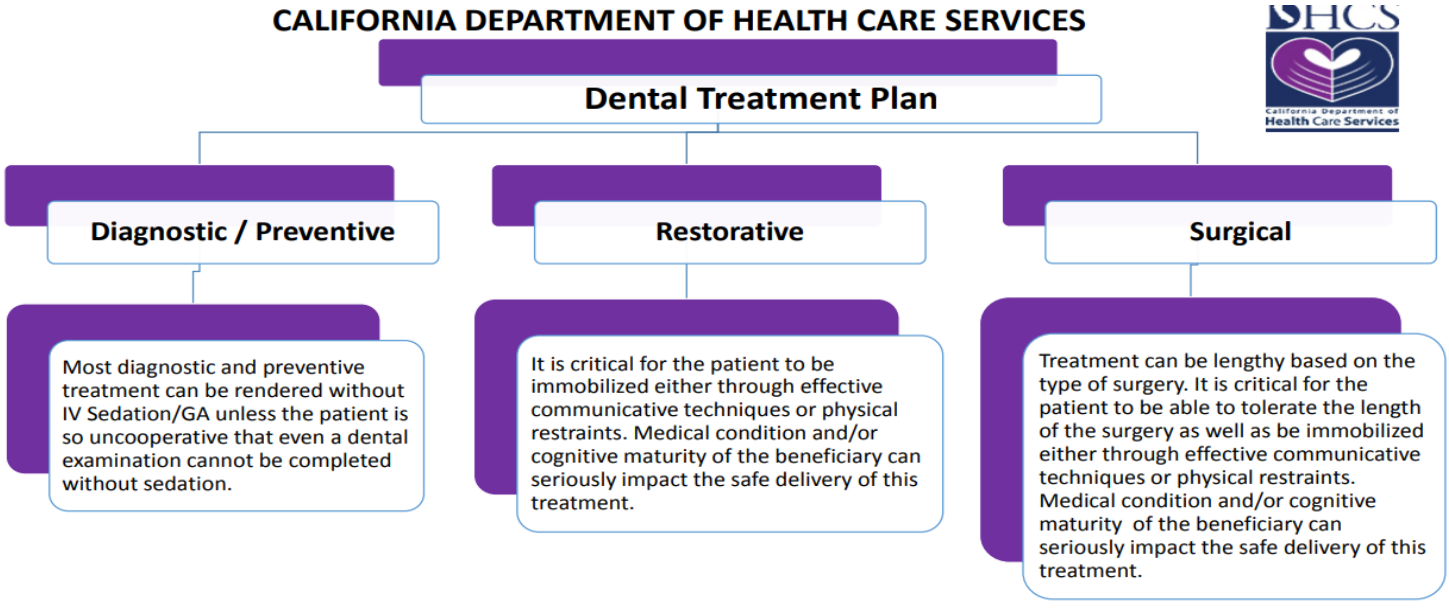

Extensive dental treatment is not defined by the number of procedures rendered but the treatment that can be reasonably tolerated and rendered in a safe and humane fashion based on cognitive maturity and medical condition of the beneficiary. ***April 2017***

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ATTACHMENT 5

Medi-Cal Dental Treatment Authorization Request (TAR)/Pre-Authorization Process for Intravenous (IV) Sedation or General Anesthesia Services in Hospitals & Surgery Centers

When Local Anesthesia/Conscious Failed or was not Feasible

STEP 1
DDS sees pt. and starts PA process:
Denti-Cal FFS | GMC Dental Plan

No Pre-Authorization Required

Ok to proceed to Medical Insurance

Authorization Required

GMC network dentist submits referral to GMC dental plan

Dental Plan denies: submit appeal to Dental Plan

Dental Plan approves referral to specialty hospital dentistry provider[1]

DDS submits TAR to patient's GMC Medical Plan

CONFIRM!
- If hospital and MD anesthesiologist are in pt.'s GMC medical network
- If TAR goes to Plan or pt.'s medical group

STEP 2
Submit Medical Insurance Authorization (Treatment Authorization Request, TAR)

GATHER AND PREPARE REQUIRED DOCUMENTATION using DHCS criteria below

- Effective communication techniques and the ability for immobility failed or was not feasible based on the medical needs of the patient (describe with examples)
- Requires extensive dental restorative treatment that cannot be rendered under local anesthesia or conscious sedation, e.g., "needs 3 crowns, 2 extractions, expect 90 minutes anesthesia time, etc."
- Patient has acute situational anxiety due to immature cognitive functioning as evidenced by e.g., significant developmental delay; aggressive behavior in dental office; refusal to open mouth or cooperate with a dental exam; or pre-cooperative age (0-3 years)."
- Patient is uncooperative due to certain physical or mental compromising conditions, as evidenced by…

Step 3
If TAR approved, schedule treatment

Treatment Complete

Step 3
If TAR denied, submit appeal

Appeal Approved, schedule treatment

Treatment Complete

Step 4
Appeal Denied

Step 5
Pursue Independent Medical Review [2] (IMR) via DMHC or State Fair Hearing

[1] If a patient receives *in-office* IV sedation, there is a different protocol for DDS anesthesiologists. Dental plans can approve *in-office DDS* anesthesia; they cannot approve MD anesthesia in a hospital/surgery center.

[2] Patients can appeal with an IMR first and do not need to wait until an internal insurance plan appeal denies their request. Once they receive the initial denial, patients can select an IMR or internal appeal; it is up to the patient.

MAIN BARRIERS TO DENTAL CARE IDENTIFIED BY ALTA CA REGIONAL CENTER SERVICE COORDINATORS*

CHILD-SPECIFIC COMMENTS

- A dental specialist who saw a child referred by a general dentist was surprised to learn the child had special and medical needs; he refused to do the service as he felt the child should have been referred to a hospital setting.
- Not enough dentists that take Medi-Cal and understand disabilities and/or a specific diagnosis.
- Some families have experienced dentists that have made rude comments and appear to not know how to work with children with developmental disabilities. Because of this, the parents do not have trust and confidence in the dentists to care for their child. With experiences with bad dentists over the years, it's hard for these families to open up and give another dentist a chance. Some families are also not open to sedation dentistry simply because they don't understand funding for the service and pros and cons of the service.
- CPS (child placement services) is slow and providers are frustrated with the long and generally unsuccessful process. The Resource Specialist Program generally ends up doing it on their own.
- Insurance confusion. Many don't know that through Medi-Cal they have to see the doctor *assigned* to them to process any kind of insurance claim or denial. Many may see a dentist that takes their insurance but can't figure out the medical denial in order to pass on funding to ACRC.
- Appointments are not typically long enough to give the patient time to get comfortable with staff and the physical demands of an exam (unfamiliar touching, holding mouth open, etc.).
- Assigned dental office does not provide assistance with referral paperwork to a specialized dentist or does the assigned dental office does not communicate back to the insurance that they cannot serve client. Family is unsure how to get referral to a dentist that can serve their child.
- Even though their children have special needs, insurance requires them to make 2 visits to a regular dentist prior to any specialized referrals. The majority of the time the children are unable to tolerate a 1st visit, let alone a 2nd visit. Many with Autism literally can't tolerate someone handling them. Once they make the 2 visits and are referred out, parents report the referrals often don't actually occur, or are made to the wrong specialist, and they are asked to start all over again; including returning to the original dentist who was unable to treat the child in the first place.
- Not all the parents are taking their children regularly for a checkup. Perhaps they just think the dentist is only needed when you have dental pain. I don't think everyone understands how important it is to have a checkup every six months.
- Appointment cancelations, not following through, now completing requirements on time (health checks ups, completed documentation by pediatrician in order to move forward with specialist dental appointment, primary care incorrectly/not completing required paperwork etc.
- The majority of the families that I serve have attempted to take their child to the dentist at most 1 to 2x but was unsuccessful, usually because the child is uncooperative or scared of being at

Table continues on next page

the dentist. These families don't return as they feel embarrassed and judged and usually just wait until their child is complaining of pain in their teeth or some type of issues with the child's teeth is visible. Even after giving the families encouragement and discussing with parents about the importance of dental health, these families choose to wait until it's absolutely necessary to seek out dental care services.

ADULT-SPECIFIC COMMENTS

- Clients want to feel safe going to a dentist who will understand them. Experiences really vary between great and terrible.
- Highest need is for dental sedation practices that do not pull teeth leaving the client toothless. Some of my clients have difficulty with follow through in general.
- Client does not know which dental managed care plan they have, once they have a dental provider they think no services are covered so they are hesitant to return.
- Families often want sedation dentistry for clients when it may not really be needed—the family seems to presume sedation dentistry is less distressing to the client.
- Many dentist do not take clients in wheelchairs due to not having equipment to transfer a client out of their chairs and into the dental chair.
- Finding a dentist who will treat someone with spastic CP or Autism. Asking for the first appointment in the day so the client does not have to wait for their appointment.

GENERAL COMMENTS (NO AGE GROUP SPECIFIED)

- Many adults or client families don't realize that they have access to Denti-Cal through their Medi-Cal. Often times the family just needs to be told that they do have coverage and to call to see who the provider is.
- Sometimes dental providers do not enter the correct information for GA referral. I've encountered inconsistent directions/information from the dental office and their workers, as staff are reporting conflicting information on the procedure process and what is needed to be done by the clients.
- Some families are uneasy about having the client under sedation.
- The process to get a dentist letter stating need for sedation/referral is an ordeal as well. We'll get verbal notifications from the home dentist that referrals were submitted and when we contact the insurance later on, they report that no referral was received.
- Dental plans seem to complicate the pursuit of Denti-Cal-funded services—families and even the dental plans do not seem to understand how a client may get needed services within or outside of one's assigned plan. Some families/clients are not aware that Denti-Cal is again in place after the cuts of a decade ago.
- Last year I had a client that had to wait at least 6 months to be seen by the dentist; she was in a high degree of pain the whole time. Her transportation vendor eventually refused to transport her to her day program due to the fact that she was screaming so much (from being in pain). She went to the ER for this, but because her teeth weren't infected, she was told to see a dentist.

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- Clients do not use the resource of looking for a Denti-Cal dentist (the Denti-Cal website) and may go to a non-Denti-Cal provider or with the provider who wants to get more money than what Denti-Cal provides and presents the client with a large dollar estimate that they cannot afford; leading to them asking ACRC to fund their dentistry which then results in SC trying to get them back to a Denti-Cal dentist that has scruples. This SC has found that calling Denti-Cal directly and asking for a referral is helpful.
- Sedation dentistry referrals take about 6 months for a new person.
- No wisdom teeth extraction available.
- Regular and specialized dentists don't accept Medi-Cal. Clients are afraid to go to the dentist. Clients don't value preventative dental care. Clients can't afford dental care. Clients complain about quality of care received from Medi-Cal dentists.
- Assigned dental provider is a far distance from the client's home and transportation may be an issue.
- Even when client has immediate or urgent needs the process is complicated.

*Comments are mostly verbatim; some were edited for length.

Additional Comments Provided by Surveyed Dentists*

GENERAL DENTISTS

It takes more time to serve special need patients, we should be reimbursed accordingly.

Sacramento County has unique insurance that allows only big corporate to survive with this type of insurance small businesses would not make it due to financials

We see patients with disabilities when they are manageable without sedation. Appropriate treatment is sometimes a compromise if ideal treatment is not possible.

We see several patients with special needs in our office who no longer need any sedation at all. However, there are some that cannot tolerate ANY procedure (even one as basic and non-invasive as an exam) without sedation. Training will help providers sort out which cases can be seen in the office, but will not be able to address the access to care issue without other measures in place. Providing sedation in the office is costly in terms of education, permitting, additional training for doctors and staff, additional supplies and emergency equipment, higher costs for malpractice insurance. These are beyond the uncompensated extra time that the majority of patients with special needs and their families require to get through scheduling, consent, and completing procedures. This issue is certainly not one that any dentist should take lightly.

The biggest problem with state funded insurance is poor compensation for procedures to begin with and keeping mind the increased chair time that is need for behavior management business runs in loss which is not doable for small business owner to sustain. If compensation is increased and training is provided by state to providers then possible it can be doable.

Medi-Cal reimbursement is already below our cost of doing business. To see Special Needs patients at those rates is suicide for any private dental practice, such as mine.

There are not enough anesthesiologists who do sedation on adults.

More a matter of funding than anything. If provider was properly remunerated there would be ample supply. No one is willing or able to pay, consequently there are few providers available.

PEDIATRIC DENTISTS

In Sacramento, I noticed the strengths of dental managed cared. It has become an invaluable tool that creates access to dental care for patients who normally would not know that it exists.

With FFS Denti-Cal it is often times impossible for patients to get appropriate care as there are no specialists that accept Denti-Cal or their General Dentist does not know where to refer them. When it comes to working with FFS Denti-Cal, we have had a lot of trouble collecting for the services that we provide. This is very frustrating and discourages us from participating.

I believe the managed care is doing an amazing job providing time, resources and proper financial compensation for taking care of patients. I have not encountered one problem with LIBERTY and Health Net in terms of access and providing services to children in need of dental work. Denti-Cal FFS has so many restriction, poor customer service and very low, unrealistic compensation. I dropped my

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enrollment in Denti-Cal a few years ago and refuse to work with Denti-Cal due to so many bureaucracy and denied claim and lack of respect to providers.

We need more block time at the hospitals!

I use an anesthesia provider in my office who does not participate in Denti-Cal, therefore anesthesia cannot be billed and I cannot help these kids. Plus, reimbursement is hit or miss so it's not worth the trouble.

Having a dedicated Dental Surgery Center for our community would be wonderful!

Access to sedation and general anesthesia services for vulnerable populations is a topic that has been on my mind since the day I began practicing dentistry back in June of 1989. A significant percent of both of my practice is special care individuals. We have been using general anesthesia for only the healthy younger children who need a lot of treatment. Otherwise, we have developed fun and inventive ways to ease the fears of these incredible patients and their care-givers. Our desire was to start a new surgery center that would address the needs of special care adults. With all of the cost, compliance regulations and other current issues we've abandoned the idea for now. We need a champion for these people to step up to get the patients help. The surgery center and hospitals need to get properly reimbursed for their efforts for this to motivate them to schedule dental procedures. Financial burden is also placed on the dental provider who cares for these individuals without general anesthesia. It is the time that is spent on coaxing and familiarizing the patient with dental sounds and feelings. We have so many special care children and adults who need extra time at their appointment and we generally do not charge an extra fee for that time. These families need extra everything including paying extra for all sorts of therapy or home care needs. Another extra fee can be very difficult for these families.

ORAL SURGEONS

These patients may require General Anesthesia to perform safe and correct treatment without compromise- a simple fact

Major constraint - third party payment.

The continued decrease in reimbursement fees is making it hard to provide extra time and care needed to see many of these folks. In some cases I would not cover my overhead with the reimbursements from the insurance company. Patients on medical have no financial responsibility for their care and many then take no personal responsibility for their clinical care or post op care. Their expectations are high and are quick to lay blame for routing post op problems. Most dentists do not want to deal with this population of people.

OTHER DENTAL SPECIALISTS

As a specialist, I frequently see patients with unique need that cannot be addressed by the General Dentist. The insurance providers are very good at ensuring their patients receive timely and high quality specialty care. I have specifically seen this in the specialties of Pediatrics, Endodontics, and Oral Surgery.

This population has many challenges that exacerbate their access care issues. The most significant challenge Is funding at levels that enables more facilities to function and provide care to more patients. [Programs must be funded] at a level that ensures financial stability and sustainability. Other specialty programs generally are much more predictable in this regard.

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DENTAL ANESTHESIOLOGISTS

Denti-Cal fee for service has historically denied too many claims despite the provider going through all the necessary pre-operative steps.

Denti-Cal has huge issues and I used to work to provide anesthesia for their patients. They have huge delays with reimbursing me as an anesthesia provider. Working with Denti-Cal in the past has been akin to being a driver trying to do anything at the DMV - except imaging going to the DMV on a daily basis!! This is a nightmare and I would move to another state. No referral network as well as an antiquated paper processing system is a major problem. Never mind the vast majority of dental surgery centers have closed in the past several years due to the neglect from Denti-Cal. Having worked at many of these dental surgery centers I can tell you that the Sacramento GMC has been attentive, reimburses in a timely manner, and is very interested in proving good service to both dentists as well as patients.

*Some of the dentists' comments about the GMC dental program may reflect historical experience and a lack of knowledge about current policies or processes.

SACRAMENTO COUNTY DDS SURVEY QUESTIONS
DENTAL DELIVERY SYSTEM CAPACITY FOR IV SEDATION/GA SERVICES*

Dear Dentist: Sacramento County has long had an access problem to IV sedation/general anesthesia (GA) dentistry, especially for people on Medi-Cal (Denti-Cal), young children with extensive decay and individuals with special needs (SN). Sacramento Public Health is funding a study to learn the extent of the problem and produce recommendations. This survey is one of the most important parts of the study, providing critical findings about the dental delivery system capacity. This survey is for all dentists who see Sacramento County patients – whether or not you provide IV sedation/GA yourself, or see Medi-Cal patients, or see patients with SNs. SDDS is fully on board with this survey and we urge you to participate. Please respond by April 2, 2020. Thank you.

1. What type of dentistry do you practice?
2. Do you provide any type of sedation dentistry?*
3. Do you provide Oral sedation or Inhalation sedation (patient maintains own airway)? Check all that apply.
4. Do you provide IV/conscious (patient maintains own airway) or General anesthesia (GA) (patient needs airway managed by endotracheal tube) in your office?
5. Who manages the IV/Conscious Sedation anesthesia during a dental procedure in your office? (check all that apply)
6. Who manages the General anesthesia during a dental procedure in your office? (check all that apply)
7. Do you provide IV/conscious (patient maintains own airway) or General anesthesia (GA) (patient needs airway managed by endotracheal tube) in a hospital or surgery center?
8. Do you provide IV/conscious (patient maintains own airway) or General anesthesia (GA) (patient needs airway managed by endotracheal tube) in a hospital or surgery center?
9. Who manages the IV/Conscious Sedation anesthesia during a dental procedure in a hospital or surgery center?
10. Who manages the General anesthesia during a dental procedure in a hospital or surgery center? Which ones?
11. For the patients you choose to sedate with IV sedation/GA, what percentage are chosen for the following reasons?
12. Please estimate the payer source percentages for your patients who receive IV sedation/GA services:
13. What main barriers have you encountered when scheduling hospital (in OR) dental services (regardless of the patient's payer source)? Indicate extent of problem.
14. How often have you encountered the following problems with obtaining IV sedation/GA for your patients covered by commercial health plans (private insurance)? (Indicate frequency of problem)
15. If any of the above are occasionally or often a problem: from which insurance plan(s)?
16. Are you a Medi-Cal Dental provider?*
17. As a Medi-Cal Dental provider, which "system" do you participate in?

For TARS (or Prior Authorization Requests) submitted to FFS <u>dental</u> or GMC <u>Dental</u> Managed Care:

18. What percentage (%) of your TARs are approved the first time around (i.e., without appeal)?
19. What is the typical time lag between submission of TARs and approval?
20. What is the typical time lag between submission of TARs and scheduling the authorized treatment?

* These questions were formatted for SurveyMonkey and do not show the skip patterns that were used. Due to length, the response choices are not included here.

21. What are the main reasons given for denials? (

22. What percentage (%) of your denied TARs are approved after appeal?

23. What percentage (%) of approved TARs go uncompleted?

24. What are the main reasons for non-completion?

25. If you've observed a pattern of inefficient handling of appeals/requests for review and exceptions/denials, from which Medi-Cal Dental Managed Care (GMC) plans are they issued? (Name of plans)

NOTE: Medi-Cal questions 18-25 repeat but now ask about experience on the medical side; for example, for TARS (or Prior Authorization Requests) submitted to Medi-Cal Medical Managed Care plans.

26. Please estimate the number of your IV sedation/GA patients with Medi-Cal who live outside of Sacramento

27. Have you seen a copy of the Department of Health Care Services (DHCS) All-Plan Letter (APL)/Provider Bulletin that addresses prior authorization for IV sedation and GA services?

28. How well did you understand the All-Plan Letter (APL)/Provider Bulletin to be able to apply the policies?

29. Where do you refer patients who need sedation that you do not provide?

30. The following are some of the alternative approaches to IV sedation/GA that dentists use. To what extent are you aware of and use these alternative approaches?

31. In a typical month how many children (age 0-20) with special needs do you see?

32. In a typical month how many adults (age 21+) with special needs do you see?

33. On a scale of 1-5, how comfortable are you - or would you be - in seeing patients with special needs in your practice in the following age groups?

34. What would it take to see more or any patients with special needs in your practice? (Check all that apply)

35. If you received additional training about how to meet the dental needs of patients with special needs, how likely would you be to increase, even by a small number, the number of these patients in your practice?

36. If you would be interested in having more information/training related to the dental needs of patients with special needs or alternative approaches to sedation/GA please provide your contact information.

37. Please provide any additional information/comments you think would shed additional light on access problems:

ENDNOTES

[1] Dent J. Special Needs Dentistry: Making a Difference for Patients and Caregivers. *Dentistry Today*, March 2019.
[2] Hennequin M, Faulks D, Roux D. "Accuracy of Estimation of Dental Treatment Need in Special Care Patients" *J Dent* 2000 Feb;28(2):131-6. doi: 10.1016/s0300-5712(99)00052-4.
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[13] Improving Access to Dental Services for Individuals with Developmental Disabilities. Legislative Analyst Office, September 2018.
[14] Alta California Regional Center, https://www.altaregional.org/developmental-disabilities
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