AGENDA

Assembly Budget Subcommittee #1
On Health and Human Services

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

"An Examination of Dental Care for Children Enrolled in Medi-Cal and Healthy Families in L.A. County"

Friday, November 9, 2012, 2-5 pm
Culver City City Hall, Council Chambers

1. **Overview, History, and General Landscape**
   This panel will provide basic information about children's access to dental care in L.A., how and where children receive dental care, historical information on managed dental care in L.A., and data on access to care. The panel also will review the significant events of the past year related to dental managed care in California, including new statute adopted through the Budget Act of 2012.

   ***Ross Brown**, Fiscal and Policy Analyst*
   Legislative Analyst's Office

   ***Jim Crall**, DDS, Chair, Public Health and Community Dentistry*
   UCLA

2. **Challenges to Providing Dental Care to Low-Income Children in L.A.**
   This panel will explore the historical problems and shortcomings associated with dental managed care in L.A., including the differences and similarities to Sacramento. The panel also will illuminate on-going barriers to dental care in both managed care and fee-for-service.

   ***Barbara Aved,** PhD, MBA, President*
   Barbara Aved Associates

   ***Lynn Kersey**, MA, MPH, Executive Director*
   Maternal and Child Health Access

   ***Tina Kim**, MSPH, CPH, Policy Specialist, Government & External Affairs*
   Community Clinic Association of Los Angeles County

   ***John L. Blake**, DDS, Executive Director, Dental Director*
   Children's Dental Health Clinic

   ***Barbara Facher**, MSW, Social Worker*
   The Alliance for Children's Rights

3. **Healthy Families Program Transition to Medi-Cal**
   This panel will highlight challenges specific to the transition of Healthy Families Program children to Medi-Cal, specific to dental care in L.A. The panel will also discuss the successful aspects of dental managed care successful in the Healthy Families Program.

   ***Janne Olson-Morgan**, Fiscal and Policy Analyst*
   Legislative Analyst's Office

   ***Kathleen Hamilton**, Director, Sacramento Governmental Affairs*
   The Children's Partnership

   ***Ellen Badley**, Deputy Director of Benefits and Quality Monitoring Division*
   Managed Risk Medical Insurance Board

4. **State and Health Plan Responses**
   This panel will provide an opportunity to both the Department of Health Care Services, which oversees the Medi-Cal program, and dental managed care plans to discuss both past and on-going challenges to providing dental care to children in Medi-Cal, their perspectives on the problems brought to light over the past year, and a review of the changes that have been, or will be, made to improve care.

   ***Rene Mollow**, MSN, RN, Deputy Director, Health Care Benefits & Eligibility*
   Department of Health Care Services

   ***Reza Abbaszedeh**, DDS, Chief Executive Officer*
   Premier Access Dental and Vision

   ***Sean O'Brien**, Director, Dental Operations, State Health Programs*
   Health Net

   ***Amir Neshat**, DDS, Chief Executive Officer*
   Liberty Dental

5. **Stakeholder Reactions**
   This panel will provide additional general information on children's dental care in L.A., as well as providing reactions and responses to previous speakers.

   ***Sonya Vasquez**, Policy Director*
   Community Health Councils

   ***Nicette Short**, Policy Analyst*
   California Dental Association

6. **Public Comment**

BACKGROUND

Holly J. Mitchell, Chair

2:00-5:00 p.m. – City Hall, Council Chambers
9770 Culver Blvd, Culver City, CA

"An Examination of Dental Care for Children Enrolled in Medi-Cal and Healthy Families in L.A. County"

The Denti-Cal Program

The Denti-Cal program, a component of the Medi-Cal program, provides comprehensive dental care only to children, as the 2009 Budget Act eliminated dental benefits for adults in the Medi-Cal program. For children in Medi-Cal, dental care is provided on a fee-for-service basis in all counties except one: Sacramento, which only has managed care for dental care. With a few exceptions, Medi-Cal recipients in Sacramento are mandatorily enrolled in one of the Dental Plans. It is the only county in the state that has mandatory managed care for dental services. Los Angeles County utilizes both fee-for-service and managed care for the provision of dental services; however, enrollment in managed care is done on a voluntary basis, and only about 15 percent of Medi-Cal recipients in Los Angeles enroll in a dental managed care plan.

Covered dental services under managed care are the same dental services provided under the Fee-For-Service Denti-Cal Program. These services include 24-hour emergency care for severe dental problems, urgent care (within 72-hours), non-urgent appointments (offered within 36-days), and preventive dental care appointments (offered within 40-days).

Los Angeles County

Across the state, approximately 3.6 million children are covered by the Medi-Cal program, including dental coverage. Of the total, approximately 356,000 receive their dental care through managed care, the vast majority of whom are in Los Angeles (L.A.). In L.A. County, approximately 1.2 million families choose between dental managed care and fee-for-service in Medi-Cal. Of those, approximately 220,000 are covered through managed care plans, at a state cost of $32.6 million (total funds), as compared to $162 million for fee-for-service. The Department of Health Care Services (DHCS) cites the cost per child at $159.32 in fee-for-service compared to $148.74 in managed care. By comparison, in Sacramento County, approximately 136,000 children are in Medi-Cal, all of whom receive their dental care through managed care.

State Oversight of Managed Care

The DHCS and Department of Managed Health Care (DMHC) share oversight of managed care plans in the state. Both departments have the statutory authority to conduct quality reviews. The DHCS conducts annual reviews on the quality of services provided to Medi-Cal beneficiaries by medical managed care plans. These studies include the collection and annual public reporting of data measuring their performance according to the nationally recognized Health Plan Employer Data and Information Set (HEDIS) indicators. For medical plans, the DHCS establishes minimum performance levels for HEDIS indicators. Both departments conduct periodic medical audits of health plans that evaluate the overall performance of the health plan in providing care to enrollees.

Historically, both departments have utilized these monitoring tools only on medical plans, by and large ignoring the operations of dental plans, despite dental plans also being licensed under Knox-Keene. Dental plans were not required to submit annual reports on timely access as required of medical plans. The DMHC indicates that their primary tool for becoming aware of problems with any managed care plan, of any type, is through their consumer complaint data.

First 5 Report on Sacramento's Geographic Managed Care

In 2010, First 5 of Sacramento commissioned the "Sacramento Deserves Better" report, produced by Barbara Aved Associates, which analyzes access, utilization, and quality of dental care under Sacramento's Geographic Managed Care (GMC) Dental Services model. Key findings from this report include the following:

- Only 20 percent of children in GMC Dental Services used a dental service in 2008 as compared to over 40 percent of children in Medi-Cal statewide who are predominately in Fee-For-Service;
- Only 30 percent of children in GMC Dental Services received a dental service in 2010;
- Sacramento GMC Dental Services is consistently one of the lowest-ranking counties for Medi-Cal dental access in the entire state;
- Dental plans have not complied with a "first tooth/first birthday" recommendation for the initial dental visit;
- Inadequate prevention services were provided; and,
- The state provided minimal oversight of GMC Dental Services contracts.

Early in 2012, through a series of articles and editorials, the *Sacramento Bee* brought attention to the dire conditions of Sacramento County's pediatric dental managed care program that is a component of the State's Medi-Cal program. The *Bee* coverage focused on the findings of the report commissioned by First 5 of Sacramento, which revealed shockingly low utilization rates and highlighted a series of examples of specific children who have been in desperate need of dental care, yet unable to access the care they needed without significant delays, worsening conditions, prolonged pain, and a significant amount of fear, frustration, and relentless advocacy on the part of their parents.

In response, Sacramento County formed a GMC Dental Subcommittee, consisting of numerous local stakeholders, to develop recommendations for the DHCS to improve the GMC Dental Services model. This Subcommittee developed key recommendations, including:

- Provide for "voluntary" enrollment in lieu of existing "mandatory" enrollment;
- Implement the Healthy Families Program utilization strategies and dental quality measures in Medi-Cal dental contracts;
- Allow families who choose a Federally Qualified Healthcare Center (FQHC) clinic as a dental home to maintain it;
- Develop comprehensive contracts with strong performance measures, including the ability to withhold payments if standards are not met, and the ability to provide incentives for outreach and performance;
- Improve state oversight, including data analysis, on-site visits and audit reviews of Dental Plan performance;
- Address the need for increased patient education and outreach strategies to support access to dental services and rights of Medi-Cal patients to services; and,
- Make improvements to the Medi-Cal Ombudsman process.

DHCS Response and Action

In response, the DHCS has undertaken a substantial corrective action plan for dental managed care, with a focus on Sacramento's GMC. The DHCS actions in 2012 have included the following:

- Met with the five Dental Plans serving Sacramento to discuss how to implement immediate actions to improve access to dental care for children;
- Provided a letter to Dental Plans articulating immediate expectations and necessary improvements;
- Convened a stakeholder work group to obtain recommendations for improvement, including suggestions for improving the DHCS draft Request for Application (RFA), which is used as the basis for contracting with Dental Plans;
- Communicated with beneficiaries by: 1) letter on the importance of dental care as well as on how to access care; and, 2) by phone with beneficiaries who have not accessed care in the past 12 months;
- Began collecting utilization data from plans which the department shares with the stakeholder group;
- Increased monitoring of plans and providers based on data that indicates low utilization rates;
- Implemented a beneficiary dental exception process, per 2012 budget trailer bill (summarized below); and,
- Implemented changes to all dental plan contracts, including adoption of all Healthy Families Program HEDIS measures.

2012 Budget Act Trailer Bill

In response to the First 5 report, subsequent press coverage, legislative hearings and stakeholder input, provisions to address the shortcomings of dental managed care were included in AB 1467 (Budget Committee), Chapter 23, statutes of 2012, the 2012 omnibus health budget trailer bill. This bill includes the following key provisions:

- ***Sacramento Stakeholder Advisory Committee.*** The bill allows Sacramento County to establish a stakeholder advisory committee to provide input on the delivery of oral health and dental care. It authorizes the advisory committee to provide input to the DHCS and to the Sacramento County Board of Supervisors. Requires DHCS and the Sacramento County Department of Health and Human Services advisory committee to meet with this advisory committee.

- ***Beneficiary Dental Exception***. The bill authorizes the Director of DHCS to establish a beneficiary dental exception (BDE) process in which Medi-Cal beneficiaries who are mandatorily enrolled in dental health plans in Sacramento County can move to fee-for-service Denti-Cal. The BDE is to be available to beneficiaries in Sacramento who are unable to secure access to services through their managed care plan, within time-frames established within state contracts and state law.

- ***Dental Plan Performance Measures***. The bill requires DHCS to establish a list of performance measures to ensure that dental health plans meet quality criteria. The bill requires DHCS to post on its website on a quarterly basis, beginning January 1, 2013, the list of performance measures and each plan's performance. The bill requires the performance measures to include: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers. The bill also requires DHCS to designate an external quality review organization to conduct external quality reviews for all dental health plan contracting.

- ***Dental Plan Marketing and Information***. The bill requires each dental plan to submit its marketing plan; member services procedures, beneficiary informational materials, and provider compensation agreements to DHCS for review and approval.

- ***Annual Reports***. The bill requires DHCS to submit annual reports to the Legislature, beginning March 15, 2013, on dental managed care in Sacramento and Los Angeles, including changes and improvements implemented to increase Medi-Cal beneficiary access to dental care. The bill also requires the DMHC to provide the Legislature, by January 1, 2013, its final report on surveys conducted and contractual requirements for the dental plans participating in Sacramento.

- ***Amendments to Contracts***. Requires DHCS to amend contracts, upon enactment of the statute, with dental health plans to reflect and meet the requirements of this new statute.

Managed Care: Medical vs. Dental

The delivery of medical care is substantially different than the delivery of dental care, and therefore managed care in the medical world is quite different from dental managed care. Specifically, physicians and other medical providers often work in groups, clinics, or other medical settings where the care and financial risk can be spread out among providers. Dentists, by and large, work as individual small businesses. Historically, some dental plans have paid dentists on a fee-for-service basis while others have chosen to pay dentists a capitated payment. This effectively shifts the financial risk from the plans to the dentists, many of whom state that the payments are much too low for them to be able to manage the risk of this fairly high need, expensive population. In this scenario, the dental plan is not actually managing the care or managing utilization.

New Study on Fee-for-Service. Dental health plans recently contracted with Barbara Aved Associates to conduct research on Medi-Cal's fee-for-service dental care. The study found, in part, that: 1) 97 percent of non-participating dentists cited low reimbursement rates as the reason for not participating; 2) 90 percent of general dentists said it was somewhat or very difficult to find a pediatric dentists accepting Medi-Cal referrals; and, 3) 38 percent of general dentists and 69 percent of pediatric dentists who take Medi-Cal have 15 percent or less of their patient population in Medi-Cal. The author concludes that children in Medi-Cal are getting adequate dental care, largely due to insufficient provider participation, reflecting low reimbursement rates. The author recommends: 1) streamlining the provider enrollment process; 2) increasing rates; 3) adopting more quality measures; 4) increasing monitoring of utilization data; and, 5) increasing public oral health education to families.

Oral Health Leadership in California

In general, California has treated dental care, within the state's safety net, and oral public health strategies as a low priority, as evidenced by the following:

- Adult dental benefits were eliminated from the Medi-Cal program in 2009;
- The state lacks a dental director or other identified state leader on oral health;
- Two state departments regulate and oversee managed care plans, but have had little focus on dental health plans;
- Low reimbursement rates have led to insufficient Medi-Cal participation by dentists;
- Excessive bureaucracy and application delays have discouraged many dentists from participating in Medi-Cal; and,
- An inadequate investment has been made in oral health education.

Policy Issues:
Some policy issues that the Legislature may want to consider include:

Rate Setting

- *Managed Care*: Currently, the Medi-Cal program pays dental plans a per member per month capitated payment, which is based on fee-for-service utilization data. The plans then set the rates for paying the dentists, outside of any statutory or regulatory requirements. It has been suggested that the state should explore utilizing the same rate setting methodology utilized in Medi-Cal's medical managed care whereby the state establishes actuarially sound rates. The DHCS has proposed a rate reduction as part of the new dental plan contracts from $11.83 per child per month to $11.46.

- *Fee-for-service*: The fee-for-service rates paid by the State were developed many years ago and have not been reduced for roughly a decade or more, according to the DHCS. Dentists were included in the most recent Medi-Cal provider 10 percent rate reduction adopted by the Legislature and Governor, but this rate reduction for dentists was enjoined by the court and never implemented.

Pediatric Dentists. Both general dentists and pediatric dentists provide primary dental care to children in Medi-Cal. The case can be made that pediatric dentists should be preferred, yet several barriers exist which discourage and limit access to their services. Pediatric dentists have completed 2-year residencies in pediatric care and have chosen to develop an expertise specifically in caring for children. As with any specialty, pediatric dentists devote significantly more time to caring for kids than do other dentists and arguably provide superior care. This level of expertise and comfort with treating children becomes especially important in the context of caring for children who have significant dental care needs, as is the case with the Medi-Cal population in general. Nevertheless, dental plans and others have viewed pediatric dentists as specialists only, rather than as primary care dentists, stating that many pediatric dentists refuse to accept general dentistry rates. In some plans, in order for a child to be referred to a pediatric dentist, the child must have experienced at least three failed treatment visits with a general dentist, a process that can be quite traumatizing for a child. The overall number of pediatric dentists in the state may be quite small, possibly insufficient to treat the entire Medi-Cal population; however, to the degree that they are available, they should be equally accessible to both publicly and privately insured patients. Children in Medi-Cal receive their primary medical care from pediatricians, and similarly, pediatric dentists have the potential to provide the best primary dental care to these children.

Medical Loss Ratio. Medical managed care plans are required to operate with a "Medical Loss Ratio," which dictates how much of their revenue can be spent on administrative overhead and how much must be spent on direct care. Dental plans have no such restrictions.

Excess Bureaucracy. Numerous dentists have stated in the press and various reports that the combination of low rates and excessive bureaucracy make the Medi-Cal program simply unaffordable for them. The state needs to simplify and decrease the time involved with applications in order to increase participation by dentists.

Health Education. A significant investment in oral health education and other public health strategies would go a long way in improving the health of all Californians and reducing health care costs for the state. For example, the *Alameda County WIC Oral Health Program* has been cited as a model program, from which critical lessons can be learned for reducing dental care needs and costs. With a federal grant, Alameda County implemented a pilot program that provided preventive dental services to low-income children ages 9 months through five years at WIC sites. The services included: 1) oral health education for parents; 2) prevention and screening; and, 3) case management. A UC Berkeley health economist conducted an evaluation of the program and found that:

- Program participants required approximately 42.4 percent less restorative and other corrective care than those not participating;

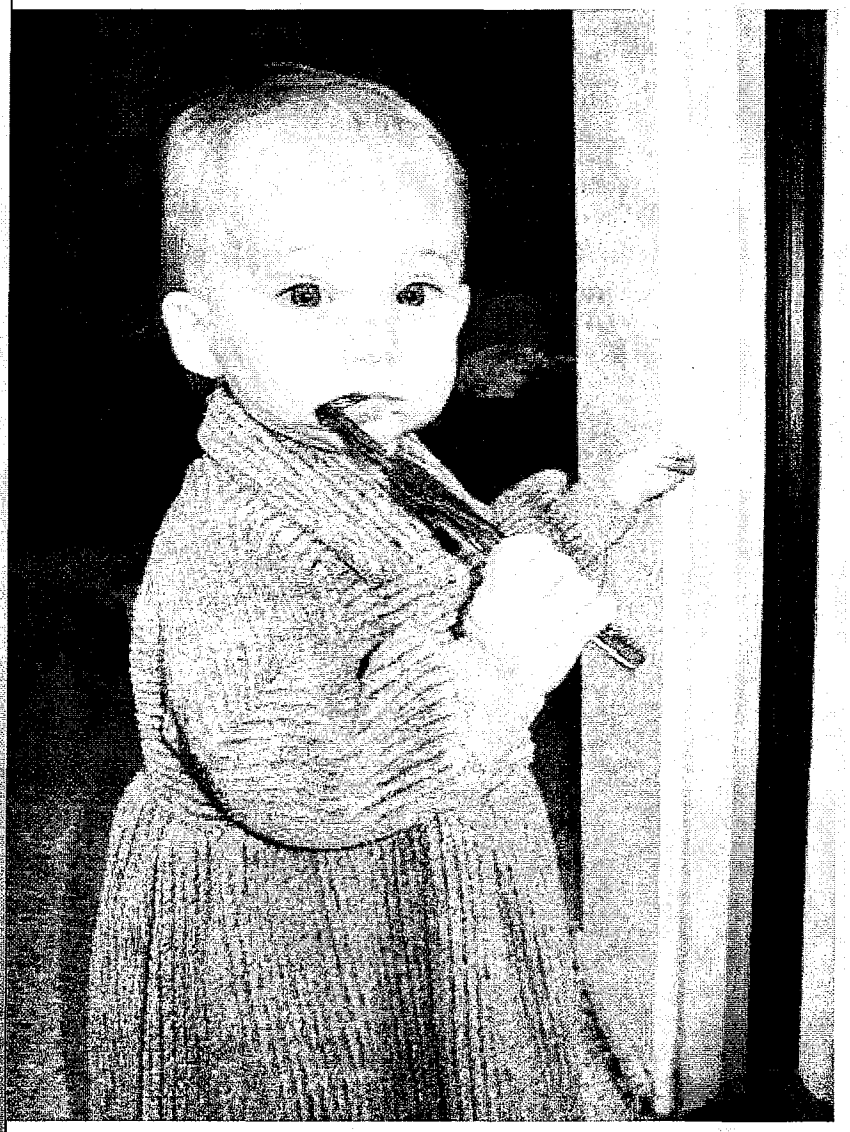
- The average cost savings per participant per year, relative to the average child on Denti-Cal in Alameda County, was 54 percent; and,

- The pilot project, which included 1,200 children, resulted in $107,280 in overall annual cost savings. If the project were extended to all children in the Denti-Cal program in Alameda County, the savings were estimated to be $913,757.

Expanded Workforce. In response to chronic shortages of dentists, models of care have been developed that rely on expanding the roles and responsibilities of additional "dental team members" in order to fill in the gap. As described in a December 2011 report published by The Children's Partnership, *Expanding California's Dental Team to Care for Underserved Children,* successful models have been implemented in Alaska's Native communities and in many other countries that involve training alternative providers (sometimes called dental therapists) with "carefully defined scopes of practice." California may benefit from exploring the potential to employ this type of model of care in order to vastly increase access for low-income children.

FIRST 5 SACRAMENTO

Sacramento Children Deserve Better



A Study of Geographic Managed Care Dental Services

EXECUTIVE SUMMARY

BARBARA AVED ASSOCIATES
Sacramento, California

June 2010

Our Vision

Sacramento will have strong and inclusive communities, safe and healthy families, and valued children who can realize their potential and enjoy productive and fulfilling lives.

Our Mission

The First 5 Sacramento Commission is committed to supporting the healthy development of children zero to age five, the empowerment of families and the strengthening of communites.

This study was funded by:

FIRST 5 SACRAMENTO
Valued Children Realizing their Potential

EXECUTIVE SUMMARY

"Your baseline of what's acceptable changes when you see this stuff over and over again." — School nurse referring to high-volume Denti-Cal plan providers' becoming immune to children's oral conditions they think aren't serious enough to address.

Introduction

The most common and preventable disease of childhood is tooth decay, but access to dental services for many children remains "an elusive healthcare benefit."[1] The problem is even greater among low-income, uninsured and minority children whose access to services is limited.[2] Having dental coverage, however, does not equate to access as children with Medi-Cal (California's Medicaid program) dental benefits are less likely to visit the dentist than their peers with private insurance.

Under increasing pressure to control costs, the California Department of Health Care Services (DHCS) began in the late 1980s to look to managed care for its Medi-Cal beneficiaries as a method to reduce expenditures, with the expectation that this system would also provide timely access to care, including preventive services. Although mandatory Medi-Cal for *medical* managed care has been implemented in nearly half of California's counties, only in Sacramento County is managed care for *dental* services mandatory for most Medi-Cal beneficiaries—provided since 1994 through 5 dental plans that participate in the Sacramento Geographic Managed Care (GMC) program.

Questions and concerns—along with anecdotal information, misperceptions and misinformation—continue to be raised about GMC by advocates and other stakeholders about whether this model is effectively meeting its goals. Even though Medi-Cal has the potential to markedly improve access to dental care for thousands of low-income children in Sacramento County, evidence suggests the GMC dental program has unfortunately not lived up to its potential.

This study, conducted by BARBARA AVED ASSOCIATES, is a deep look at Sacramento GMC, focusing exclusively on children's dental services. It was supported by First 5 Sacramento as a part of its continuing efforts to improve children's oral health. The study provides important new information about access, utilization and quality of dental care for low-income Sacramento County children, and gives a much clearer understanding of the respective roles of key players—particularly of the State of California and the contract managed care dental plans. The study illustrates the strengths and shortcomings of the GMC system in relation to Fresno, a similar Central Valley county, and other states utilizing managed dental care models, and moves the community toward implementing changes to improve the system of dental care for Sacramento's low-income children.

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[1] Pisani D. State programs face challenges in widening access. *J California Dent Assoc.* 2002;30(2):36-7.
[2] U.S. Department of Health and Human Services. Oral health in America: A report of the Surgeon General, Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000. NIH Publication no. 00-4713.

Study Methods

To carry out the study, 2008 data were analyzed from a variety of private and publicly-available sources, including reports obtained through special requests. Fresno, a fee for service (FFS) county with comparable characteristics to Sacramento, was used as a proxy for some of the analyses. Various documents, including GMC contracts, were reviewed, a survey of local dentists was carried out, and interviews were conducted with State staff, dental managed care representatives, local dental professionals, advocates, and community leaders.

While DHCS and other agencies agreeably accommodated our requests for data and offered staff time to support the study, we encountered frequent problems with obtaining timely and accurate data. Our request to anonymously examine the timeliness of appointments in contracted dental offices was not approved by DHCS, and so dental plan information about access could not be verified. The scope of this study did not allow for dental chart reviews or interviews with parents whose children were covered by Medi-Cal.

Key Findings

Access-Related

- While 4 of the 5 GMC dental plans' policy is to start seeing children by "the first birthday or the first tooth"—consistent with the recommendation from professional organizations—phone calls to selected offices revealed that not all staff knew or complied with that policy.

- Some Sacramento children are using the emergency department (ED) as a way of getting care for an oral condition considered preventable. Medi-Cal picked up the tab for 61% of these visits. These children were likely GMC members, suggesting the need for increased prevention and earlier intervention by GMC dental plans. Dental plans are not on the hook for covering these ED costs.

- For the number of children enrolled in GMC, the proportion of dental-related grievances and requests for fair hearings to DHCS and contacts to the Health Rights Hotline was small. However, these data may not be useful for understanding access and quality issues.

- 70% of dentists responding to the Sacramento District Dental Society survey said they were "unlikely" or "somewhat unlikely" to take Denti-Cal children "if there was no more GMC." The 30% with potential interest is much greater than the current rate of participation in Denti-Cal among respondents.

Utilization-Related

- One-fifth of the approximately 117,000 children age 0-20 enrolled in the 5 GMC dental plans received services in 2008. The range was 34.3% (Liberty Dental) to 5.5% (Community Dental). The statewide utilization for Medi-Cal children in the same year was 41.2%.

- The utilization rate for the youngest children in GMC was extremely low: utilization for children age 0-3 was less than half the statewide rate (6.1% compared to 15.9%); and for children age 4-5, it was about half the statewide rate (28.9% compared to 58.0%).

- Across the dental plans, the age groups with the highest utilization rate were the 4-5 and 6-8 age groups, which may be attributed to Assembly Bill 1433 requiring a dental check-up by May 31 of a child's first year in public school, at kindergarten, or first grade, or the fact that many of these children are in Head Start preschools which also require a dental exam. This is an example of where policy may have a significant effect on the behavior of families.

- Among the 58 counties in California, Sacramento children's dental utilization lags behind 33 other counties.

- Sacramento dental utilization rates are lower than the statewide averages across nearly all programs for low-income children. A unique characteristic of the dental programs here that may contribute to this situation is that in Sacramento dental care is predominantly delivered through managed care dental plans, and some of the same plans serve more than one of the programs.

- While dental plans clearly bear responsibility for any hurdles they may put up to limit access, the State, as the purchaser of services, and beneficiaries also play a part in low utilization rates in GMC.

Quality of Care-Related

- A substantial proportion of eligible Sacramento GMC children did not receive a preventive service (the range among plans was 3% - 37%), although the dental plans received per-member-per-month payments for all children.

- Among the children who actually *utilized* a dental service, Liberty and Health Net achieved ratios of over 1.0 of preventative services to users (i.e., some children returned for a second visit at a 6-month interval as recommended by the American Dental Association for cleaning and fluoride treatment.) Fresno FFS surpassed all GMC plans with a 1.17 preventive services to user ratio.

- GMC dental *users* in Health Net, Access, Liberty and Community received a range of .82 to .70 comprehensive or periodic examinations per user, respectively. Western provided these exams at about two-thirds of those rates. Children in Fresno FFS, on the other hand, were provided 1.27 exams per unduplicated user.

- Among vulnerable populations it is common for children to have multiple treatment visits or multiple treatments per visit. Liberty had the highest overall treatment-to-user ratio, at 1.75, besting the Fresno County FFS ratio. Access and Western treatment/user ratios were 1.43 and 1.37, respectively, while Community's fell below 1.0.

Medi-Cal Dental Services Program

- Sacramento GMC dental is not saving the State money. According to DHCS, the State did not experience any savings due to GMC dental managed care rate negotiations in 2008; costs for GMC were generally comparable to an equivalent FFS system.

- There are wide performance gaps among the dental plans. In terms of children's utilization of services, the highest value to the State was with Liberty Dental Plan, followed by Access Dental Plan. Health Net was too new in 2008 to draw many conclusions but appeared to offer similar value to Access. Western Dental and, by a wide margin, Community Dental Services, served fewer children relative to payment per dental user.

- While most states' Medicaid dental payment rates are substantially below market rates, California's rates are among the lowest in the nation; this results in local dentists' unwillingness to participate in Medi-Cal and limits beneficiaries' access to services.

- The Medi-Cal Dental Services Division does not have adequate capacity in number and type of staff positions to fulfill oversight responsibilities of GMC. Monitoring of plan performance is primarily reactive, not proactive.

- State data integrity continues to be a problem. The data DHCS generates from internal monitoring reports is not always timely, accurate, or complete. In one case, data was totally missing for one dental plan in a report sent to us and was not noticed by the Department until we pointed it out. Dental plans' data vary widely from the plan data distributed by DHCS. For example, Community reported a utilization rate nearly 4 times the rate reported by DHCS; Western reported over twice the rate of DHCS. The reasons for the differences were never fully reconciled.

Lessons Learned from Other States

States are continually experimenting with ways to improve utilization of children's dental services among the Medicaid (Medi-Cal in California) population. More states are examining managed care as an approach, most commonly for cutting costs and providing dental homes for children, in addition to increasing utilization.

Widely accepted strategies that have been demonstrated to improve outcomes, which could benefit California if adopted, include:

- Increase in provider rates
- Reduction of the administrative burden associated with Medicaid
- Outreach to beneficiaries regarding how to best access and utilize care
- Education of parents to better understand the importance of preventive services
- Education of providers about very early childhood oral health

Research concludes that whether managed care plans succeed in improving access to dental care depends, in large part, on the extent to which states hold the plans accountable for meeting their contractual obligations and the adequacy of the capitation rates paid to plans. [3]

Recommended Alternative

Of the options considered, we recommend the following for children's Medi-Cal dental services in Sacramento County:

> *GMC should be voluntary in Sacramento County, the same as it is in Los Angeles County, allowing Medi-Cal beneficiaries a choice to enroll in either a dental managed care plan or seek care from a FFS Denti-Cal dental provider. Except for those who fall under certain aid codes, beneficiaries who do not choose a provider should be defaulted into a GMC plan, applying the same assignment criteria (e.g., geographic proximity of patient to provider) as is currently used, with the ability to make a change. This default to GMC should only be allowed if changes can be made to dental plan contracts with the State, specifically the addition of stricter penalties for low utilization and withholding of payments to the plans until the patient is first seen by a dental provider.*[4]

At the time of this report, the DHCS was unsure if implementing this recommendation would require legislative or regulatory change.

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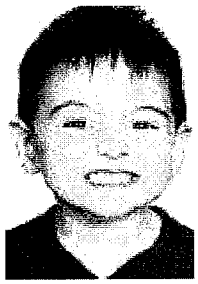
[3] Almeida RA, Hill I, Kenney GM. Does SCHIP Spell Better Dental Care Access for Children? An Early Look at New Initiatives. Urban Institute. July 2001.

[4] The capitation rate would probably have to be adjusted for members age 0-1 when few children would be likely to have a dental visit.



Recommended Strategies for Improvement

The following actions supplement the recommended alternative, and are listed in order of potential for shorter-to-longer term implementation—not in order of importance.

1. The Sacramento County Board of Supervisors should appoint a local body charged with real authority for oversight of children's dental services, focusing initially on the GMC program. The most feasible body to consider is the Sacramento Health Care Improvement Project (SHIP) and First 5 Sacramento Children's Dental Task Force ("Children's Dental Task Force") as it may provide the necessary long-term stability.

2. DHCS should terminate GMC contracts now with dental managed care plans that consistently under-perform.

3. DHCS should add to the GMC contract now language requirement that a child's first dental visit comply with the recommendation of the American Academy of Pediatric Dentistry and American Academy of Pediatrics "by first birthday or first tooth."

4. A study should be supported to explore and drill down on reasons why parents don't more fully utilize their children's dental benefits; specific strategies should be designed as a result of the findings.

5. DHCS should increase GMC contract performance penalties/incentives for children's utilization to a level that has higher economic consequences for plan performance.

6. DHCS should improve State oversight of dental plan performance.

7. DHCS should improve data capacity for dental FFS and managed care services.

8. DHCS and local policymakers and stakeholders should continue to support and expand the capacity of community health centers to provide children's dental services.

9. DHCS and local policymakers should facilitate clinics' access to contracting for GMC patients either directly with DHCS or via subcontracts with GMC dental plans.

10. DHCS should establish dental managed care quality indicators.

11. Performance indicators, outreach efforts, and quality monitoring by State and local entities should put more emphasis on preventive services.

12. More opportunities should be supported in Sacramento County to integrate dental with medical, such as inter-professional training. Organizations such as the California Dental Association Foundation and the Sacramento District Dental Society can help.

13. DHCS and local policymakers and stakeholders should promote more oral health education/awareness and outreach activities aimed at low-income families.

14. Policymakers and local stakeholders should support efforts to expand school-based prevention and screening programs, and DHCS should establish a mechanism to allow Sacramento County to recoup the cost of these services when provided to children with Medi-Cal dental benefits.

15. DHCS should increase Denti-Cal rates to a level that increases provider participation to improve access to services.

16. DHCS should increase efforts to recruit more Denti-Cal dentists, including pediatric specialists.

Implementation Plan

Parties, Roles, and Timeline

The First 5 Sacramento Commission, in collaboration with representatives from the Children's Dental Task Force, should:

- Determine and prioritize which recommendations it wishes to undertake, at least in the short-term, and develop an action plan for implementing them. (August 2010)
- Schedule and deliver a briefing to the Sacramento Board of Supervisors (BOS) about the key findings of this report. (September 2010)
- Request that the BOS assume leadership responsibility for local oversight of children's dental services (September 2010)
- Support a study to intensely examine family reasons that contribute to low utilization of children's dental benefits (September 2010)

The Sacramento County BOS should:

- Appoint the entity for local oversight—essentially re-establishing a "GMC Commission" but with broader responsibility. The Sacramento Health Care Improvement Project's (SHIP)—and Children's Dental Task Force—role in improving access to quality care for underserved populations in the region and the Public Health Advisory Board (PHAB) make these the most feasible bodies to consider. (September 2010)

- Help create legislative authority, if it is required, to implement the policy change of making GMC dental voluntary in Sacramento. (July 2011)

The new local oversight entity should:

- Establish a relationship and initiate meetings with State staff from the Medi-Cal Dental Services Division to gain their support for implementing the recommended improvement strategies for which it has direct and indirect responsibility. (October 2010)

- Engage partners and stakeholders, such as the Sacramento District Dental Society, to plan and support policy changes (September 2010)

Champions and partners that could assist with implementation include:

- California Dental Association to advocate for policy change;
- Sacramento District Dental Society to work with the provider community;
- The Health Rights Hotline, an advocacy organization with current knowledge of children's dental issues;
- Western Center on Law and Poverty, an advocacy organization;
- Public Health Advisory Board (PHAB), which is appointed by the BOS;
- Local hospital emergency department managers, who would have an interest in reducing avoidable ED visits due to preventable oral conditions.

Barriers to Implementation

The potential challenges to implementation, described in the report, include necessary human resources (staff time); the need for financial support; the question of political will; possible resistance from GMC dental plans and local dental providers; and policy considerations for changing the Medi-Cal dental delivery system in Sacramento.

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WITHOUT CHANGE IT'S THE SAME OLD DRILL

Improving Access to Denti-Cal Services for California Children Through Dentist Participation

EXECUTIVE SUMMARY

BARBARA AVED ASSOCIATES

OCTOBER 2012

INTRODUCTION

California faces a continuing challenge of achieving and maintaining an adequate level of dentist participation in its Medicaid (Medi-Cal) dental program. Increasing investments in Medicaid is difficult during tight fiscal times, but some states have shown that it is possible to make improvements with limited dollars.

The demand for Medi-Cal coverage will only grow—from the transition of Healthy Families enrollees, expanded eligibility in health reform, and a sluggish economic recovery that leaves some children without coverage.

This study by BARBARA AVED ASSOCIATES examined the extent of private practice dentist participation in the Medi-Cal dental fee-for-service program ("Denti-Cal"), the factors that account for their willingness to participate, and the challenges for increasing children's access to care. Denti-Cal claims data, a dentist survey, key informant interviews and existing research were used in the analysis.

KEY FINDINGS

Of the dentists surveyed in this study:

- 24.8% participate in the Denti-Cal program.
- 38% of general dentists and 69% of pediatric dentists who take Medi-Cal have 15% or fewer children with Medi-Cal in their practices.
- The number one reason for not accepting Medi-Cal is low reimbursement, reported by 97% of non-participants.
- 54% of general dentists do not accept children until they are at least 3 years old.
- 90% of general dentists said it was very or somewhat difficult to find a pediatric dentist to take Medi-Cal problem referrals.
- 53% of dentists in the Healthy Families Program are willing to accept Medi-Cal patients.
- 80% who discontinued their participation in the Healthy Families Program did so because of low reimbursement.
- If reimbursement and administrative processes improved about 80% of general dentists and 65% of pediatric dentists indicate it is at least somewhat likely they would take children with Medi-Cal, regardless of current participation.

Denti-Cal claims data show:

- 82% participating in Medi-Cal program served fewer than 100 new children with Medi-Cal.
- High frequency of restorative and endodontic services may indicate a lack of preventative services for children.
- The high submissions of claims for extractions suggest that the children's teeth were unsalvageable at the time of the visit.
- Medi-Cal beneficiaries use the hospital emergency department for dental services at higher rates than privately insured children.

Previous studies show:

- 47.8% of all children ages 0-20 with Medi-Cal did not make a dental visit in 2011; 66% of children age 3 and younger did not see a dentist in 2011.
- California lags behind 39 other states in utilization of *any* dental services and behind 37 states in the percentage of children receiving *preventive* dental services under the EPSDT benefit.
- California's Denti-Cal reimbursement rates are nearly the lowest in the nation.
- The number of dentists participating in the Denti-Cal program has declined over the last 5 years.
- Provider distribution and access for specialty care is less than general dental care.
- Community Health Centers throughout the state report a high level of need for dental services as well as long waits for appointments.

- A relatively low percentage of parents report problems in trying to find a Medi-Cal dentist for their child, but not all studies ask specific questions that can uncover access and quality issues.

CONCLUSIONS

Children who bear a disproportionate burden of dental disease are not getting adequate dental care—and not getting it early enough. Improved access to care is dependent on participation in Denti-Cal by the private practice community. But, too few Denti-Cal providers, due mainly to inequitable reimbursement, has created access problems resulting in utilization of services that lags behind other states.

There are too many extractions (inadequate preventive care leads to unsalvageable teeth), the ER is being used for dental care that could have been handled in a non-emergency setting if addressed sooner, there is inadequate use of sealants (less preventive care resulting in more decay), and there are no quality measures for Denti-Cal except utilization.

Implementing needed improvements in the Denti-Cal program is essential to creating more access to improve children's oral health.

RECOMMENDATIONS

1. Make Denti-Cal more attractive to encourage participation. Streamline and expedite the dental provider enrollment process.
2. Simplify claims submission to reduce provider burden and lower costs.
3. Raise Medi-Cal dental fee-for-service rates.
4. Recruit more dentists into the Medi-Cal dental program by targeting those most likely to enroll.
5. Adopt more quality measures for the Denti-Cal program.
6. Monitor Denti-Cal utilization rates, provider participation and providers-to-eligibles ratios.
7. Monitor Denti-Cal claims for patterns linked to over utilization and patient safety.
8. Sponsor more trainings for general dentists to increase their comfort and skill level in seeing younger children.
9. Expand outreach and education to families on the availability and importance of early, regular dental care for children.
10. Make Denti-Cal data more easily accessible and in more usable formats.
11. Collect EPSDT dental data from federally funded clinics that allow more accurate reporting of utilization rates.
12. Support the collection of more recent and consistent CHIS (California Health Information Survey) data on oral health.
13. Identify a "legislative champion(s)" willing to be visible in taking on an oral health leadership role.
14. Examine more closely the reasons why more parents do not fully utilize Medi-Cal dental benefits for their children.
15. Outreach to women whose pregnancies are covered by Medi-Cal to educate women about the importance of getting a dental visit for themselves and their children.

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000. - 14198.2.] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 2.91. Geographic Managed Care Pilot Project [14089. - 14089.8.] *(Heading of Article 2.91 amended by Stats. 1991, Ch. 95, Sec. 7.)*

14089.08. (a) Sacramento County may establish a stakeholder advisory committee to provide input on the delivery of oral health and dental care services, including prevention and education services, dental managed care, and fee-for-service Denti-Cal. The advisory committee shall include, but not be limited to, local nonprofit organizations, representatives from the First Five Sacramento Commission, representatives and members of the local dental society, local health and human services representatives, representatives of Medi-Cal dental managed care plans, Medi-Cal enrollees, and other interested individuals. The advisory committee may meet on a monthly basis.

(b) The advisory committee may submit written input to the State Department of Health Care Services or the Sacramento County Board of Supervisors, as applicable, regarding policies that improve the delivery of oral health and dental services in Sacramento under the Medi-Cal program or county-administered health care system.

(c) The State Department of Health Care Services shall meet periodically, but at least on a quarterly basis, with the advisory committee to facilitate communication, dissemination of information, and improvements in the provision of oral health and dental care services under the Medi-Cal program in the County of Sacramento. The dissemination of information shall include data reported from performance measures and benchmarks used by the department.

(d) The advisory committee may meet periodically, but at least twice annually, with the Sacramento County Department of Health and Human Services advisory committee established pursuant to Section 14089.07.

(e) No state General Fund moneys shall be used to fund advisory committee costs or to fund any related administrative costs incurred by the county.

(Added by Stats. 2012, Ch. 23, Sec. 79. Effective June 27, 2012.)

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000. - 14198.2.] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 2.91. Geographic Managed Care Pilot Project [14089. - 14089.8.] *(Heading of Article 2.91 amended by Stats. 1991, Ch. 95, Sec. 7.)*

14089.09. (a) It is the intent of the Legislature to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental health managed care plans in the Counties of Sacramento and Los Angeles through implementation of performance contracting to ensure dental health plans meet quality criteria and timely access to dental care, as contained in Section 14459.6, and implementation of a beneficiary dental exception process for Medi-Cal beneficiaries in the County of Sacramento to access dental care through fee-for-service Denti-Cal when applicable.

(b) (1) The Director of Health Care Services shall exercise his or her authority under Section 14131.15 to establish a beneficiary dental exception (BDE) process, as described in paragraph (2), for Medi-Cal beneficiaries mandatorily enrolled in dental health plans in the County of Sacramento. The BDE process shall be implemented no later than July 1, 2012, and shall be in effect for as long as mandatory enrollment for dental care is in effect in the County of Sacramento. The department shall consult with the advisory committee established pursuant to Section 14089.08 regarding potential modifications to the BDE process. For purposes of emergency access to dental care issues, the department shall establish specific processes under the BDE to accommodate for these issues.

(2) The BDE shall be available to Medi-Cal dental managed care beneficiaries in the County of Sacramento who are unable to secure access to services through their managed care plan, in accordance with applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). The BDE shall allow a beneficiary to opt-out of Medi-Cal dental managed care and move into fee-for-service Denti-Cal where the beneficiary may select his or her own dental provider on an ongoing basis. The beneficiary shall remain in fee-for-service Denti-Cal until the time he or she chooses to opt in to a dental managed care arrangement.

(3) Beneficiaries shall be notified of the BDE option, which shall include the process for access to emergency visits, through a letter from the department detailing the process, directions on how to fill out the BDE form, and where to access the BDE form. A hard copy of the BDE form shall accompany the letter from the department. The BDE form, directions on how to fill out the BDE form, and a description of the process shall also be posted on the department's Internet Web site for easy access by beneficiaries and the public. The department shall also notify and inform dental managed care plans of the BDE process and its operation.

(4) Upon receipt of the BDE form, the department shall have no more than three business days to contact the beneficiary. The department shall, within five business days from the date of contact with the beneficiary, work with the beneficiary and the dental plan to schedule an appointment within the applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(A) If an appointment is not available, the department shall approve and process the BDE and move the beneficiary into fee-for-service Denti-Cal.

(B) If an appointment is available, the beneficiary shall receive from the department a followup telephone call after the appointment to assess how the visit went and to determine if there is a need for any additional followup.

(5) Based on the followup as identified in subparagraph (B) of paragraph (4), to the extent no additional access issues to contractually required services are identified, the BDE shall be closed and the beneficiary shall remain in the selected dental plan.

(c) The department shall take all necessary steps to implement the BDE process as described in this section and shall, monthly, publicly report on the department's Internet Web site the number of individuals requesting the BDE and the specific outcome of each request, including, but not limited to, summary data on the types of visits subject to the BDE process, the services provided, description of timely access to care, the delivery system in which services were provided, beneficiary satisfaction, and the department's perspective of the outcome. The information provided on the department's Internet Web site shall be deidentified in accordance with the Health Insurance Portability and Availability Act of 1996 (HIPAA), including Section 164.514 of Title 45 of the Code of Federal Regulations, and shall not contain any personally indentifiable information according to the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).

(d) The department shall consult with stakeholders in the development of the BDE form and related materials.

(Added by Stats. 2012, Ch. 23, Sec. 80. Effective June 27, 2012.)

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 8. Prepaid Plans [14200. - 14499.77.] *(Chapter 8 added by Stats. 1972, Ch. 1366.)*

ARTICLE 5. Standards for Prepaid Health Plans [14450. - 14464.] *(Article 5 added by Stats. 1974, Ch. 983.)*

14459.6. (a) The department shall establish a list of performance measures to ensure dental health plans meet quality criteria required by the department. The list shall specify the benchmarks used by the department to determine whether and the extent to which a dental health plan meets each performance measure. Commencing January 1, 2013, and quarterly thereafter, the list of performance measures established by the department along with each plan's performance shall be posted on the department's Internet Web site. The Department of Managed Health Care and the advisory committee established pursuant to Section 14089.08 shall have access to all performance measures and benchmarks used by the department as described in this section.

(1) The performance measures established by the department shall include, but not be limited to, all of the following: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

(2) The survey of member satisfaction with plans and providers shall be the same dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as used by the Healthy Families Program.

(3) The department shall notify dental health plans at least 30 days prior to the implementation date of these performance measures.

(4) The department shall include the initial list of performance measures and benchmarks in any dental health contracts entered into between the department and a dental health plan pursuant to Section 14204.

(5) The department shall update performance measures and benchmarks and establish additional performance measures and benchmarks in accordance with all of the following:

(A) The department shall consider performance measures and benchmarks established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(B) The department shall notify dental health plans at least 30 days prior to the implementation date of updates or changes to performance measures and benchmarks. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to provide transparency to the public.

(C) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures and benchmarks for retention on, addition to, or deletion from the list, consider all of the following criteria:

(i) Monthly, quarterly, annual, and multiyear Medi-Cal dental managed care trended data.

(ii) County and statewide Medi-Cal dental fee-for-service performance and quality ratings.

(iii) Other state and national dental program performance and quality measures.

(iv) Other state and national performance ratings.

(b) In establishing and updating the performance measures and benchmarks, the department shall consult the advisory committee established pursuant to Section 14089.08, as well as dental health plan representatives and other stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(c) In evaluating a dental health plan's ability to meet the criteria established through the performance measures and benchmarks, the department shall select specific performance measures from those established by the department in subdivision (a) as the basis for establishing financial or other incentives or disincentives, including, but not limited to, bonuses, payment withholds, and adjustments to beneficiary assignment to plan algorithms. These incentives and disincentives shall be included in the dental health plan contracts.

(d) (1) The department shall designate an external quality review organization (EQRO) that shall conduct external quality reviews for any dental health plan contracting with the department pursuant to Section 14204.

(2) As determined by the department, but at least annually, dental health plans shall arrange for an external quality of care review with the EQRO designated by the department that evaluates the dental health plan's performance in meeting the performance measures established in this section. Dental health plans shall cooperate with and assist the EQRO in this review. The Department of Managed Health Care shall have direct access to all external quality of care review information upon request to the department.

(3) An external quality of care review shall include, but not be limited to, all of the following: performance on the selected performance measures and benchmarks established and updated by the department, the CAHPS member or consumer satisfaction survey referenced in paragraph (2) of subdivision (a), reporting systems, and methodologies for calculating performance measures. An external quality of care review that includes all of the above components shall be paid for by the dental health plan and posted online annually, or at any other frequency specified by the department, on the department's Internet Web site.

(e) All marketing methods and activities to be used by dental plans shall comply with subdivision (b) of Section 10850, Sections 14407.1, 14408, 14409, 14410, and 14411, and Title 22 of the California Code of Regulations, including Sections 53880 and 53881. Each dental plan shall submit its marketing plan to the department for review and approval.

(f) Each dental plan shall submit its member services procedures, beneficiary informational materials, and any updates to those procedures or materials to the department for review and approval. The department shall ensure that member services procedures and beneficiary informational materials are clear and provide timely and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits.

(g) Each dental plan shall submit its provider compensation agreements to the department for review and approval.

(h) The department shall post to its Internet Web site a copy of all final reports completed by the Department of Managed Health Care regarding dental managed care plans.

(Added by Stats. 2012, Ch. 23, Sec. 114. Effective June 27, 2012.)

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000. - 18996.] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000. - 15766.] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 8. Prepaid Plans [14200. - 14499.77.] *(Chapter 8 added by Stats. 1972, Ch. 1366.)*

ARTICLE 5. Standards for Prepaid Health Plans [14450. - 14464.] *(Article 5 added by Stats. 1974, Ch. 983.)*

14459.8. (a) By no later than March 15, 2013, with annual updates thereafter, the department shall provide the fiscal and appropriate policy committees of the Legislature with either a comprehensive report or separate reports on dental managed care in the Counties of Sacramento and Los Angeles. This report shall articulate specific changes and improvements implemented to increase Medi-Cal beneficiary access to preventive services and dental treatment, the utilization of services, and beneficiary satisfaction. Key measures, outcomes, and department findings pertaining to participating dental managed care plans and provider networks shall also be included.

(b) Any report provided pursuant to subdivision (a) on the County of Sacramento shall also provide data regarding the outcomes and findings from the beneficiary dental exception (BDE) process implemented by the department pursuant to Section 14089.09, including the consideration of voluntary enrollment in the County of Sacramento as compared to the existing mandatory enrollment.

(c) The department may seek foundation funding or federal grant funding to facilitate data analysis and reporting as applicable for this purpose.

(Added by Stats. 2012, Ch. 23, Sec. 115. Effective June 27, 2012.)

SEC. 112. Section 14204 of the Welfare and Institutions Code is amended to read:

14204. (a) Pursuant to the provisions of this chapter, the department may contract with one or more prepaid health plans in order to provide the benefits authorized under this chapter and Chapter 7 (commencing with Section 14000) of this part. The department may contract with one or more children's hospitals on an exclusive basis for a specified population in a specified geographic area. Contracts entered into pursuant to this chapter may be awarded on a bid or nonbid basis.

(b) In order to achieve maximum cost savings the Legislature hereby determines that expedited contract process for contracts under this chapter is necessary. Therefore, contracts under this chapter shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(c) The department shall amend contracts with dental health plans in effect on the date the act that added this subdivision and Section 14459.6 become effective to provide Medi-Cal dental services authorized under this chapter and Chapter 7 (commencing with Section 14000) to Medi-Cal beneficiaries who reside in a specified geographic area to meet the requirements of Sections 14089.09 and 14459.6.

SEC. 124. By no later than January 1, 2013, the Department of Managed Health Care shall provide the fiscal and appropriate policy committees of the Legislature with its final report on surveys conducted under the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and the department's contractual requirements, for the dental plans participating in the Sacramento Geographic Managed Care Program.

LAO
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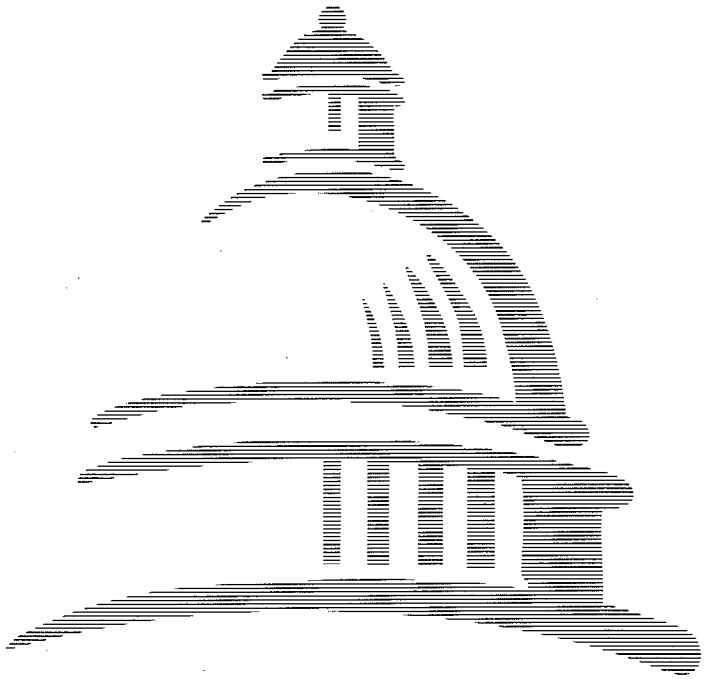
November 9, 2012

Overview of Children's Dental Services in Medi-Cal and the Healthy Families Program

LEGISLATIVE ANALYST'S OFFICE

Presented to:
Assembly Budget Subcommittee No. 1 on
Health and Human Services
Hon. Holly J. Mitchell, Chair



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Organization of Handout

☑ ***Organization of Handout.*** This handout provides:

- Background on dental services for children in Medi-Cal.
- Summary of enrollment and expenditures for Medi-Cal children's dental care.
- Recent administrative actions to improve Medi-Cal dental managed care (DMC).
- Recent legislative actions to improve DMC.
- Summary of new DMC contracts that incorporate legislative changes.
- Background information on dental services for children enrolled in the Healthy Families Program (HFP).
- A brief description of the dental quality measures used by HFP.
- The transition of HFP enrollees to Medi-Cal.

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Background on Dental Services for Children in Medi-Cal

☑ ***Medi-Cal Has Two Different Models for Delivering Dental Services.*** The Medi-Cal Program administered by the Department of Health Care Services (DHCS) covers dental services for approximately 4 million children under age 21. Medi-Cal uses two different models for delivering dental services to children: fee-for-service (FFS) and DMC.

- ***FFS.*** In the FFS dental model (also known as Denti-Cal), beneficiaries may receive dental services from any provider who accepts Medi-Cal payments and agrees to see them. Dental providers receive a payment for each service provided to the Medi-Cal beneficiary.
- ***DMC.*** In the DMC model, Medi-Cal pays dental plans a set amount per member per month (also known as a capitation rate) to provide dental care to children enrolled in the plan. Generally, enrollees may only receive services from providers that are within the plan's provider network.

☑ ***Only Two Counties Have DMC.*** Denti-Cal exists in all 58 counties in California, but only two counties, Sacramento and Los Angeles, have DMC.

- ***Mandatory DMC in Sacramento County.*** In Sacramento, almost all children are mandatorily enrolled in a DMC plan. If a child's parent(s) or guardian(s) do not choose a DMC plan, the child will be automatically assigned to one.
- ***Voluntary DMC in Los Angeles County.*** In Los Angeles, children may voluntarily enroll in a DMC plan. However, if they do not choose to enroll in a DMC plan, they are automatically enrolled in Denti-Cal.

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Summary of Enrollment and Expenditures for Medi-Cal Children's Dental Care

☑ ***In Calendar Year 2011, Medi-Cal Paid Approximately $544 Million for Dental Services for Children.*** The state pays roughly 50 percent of these costs from the General Fund and the federal government pays the rest.

☑ ***Statewide, Denti-Cal Is the Dominant Model for Delivering Dental Services to Children Enrolled in Medi-Cal.*** The distribution of enrollment and expenditures between Denti-Cal and DMC statewide are:

- ***Most Children Are Enrolled in Denti-Cal.*** About 3.6 million children (91 percent) are in Denti-Cal. Total annual expenditures for this population are approximately $491 million.
- ***Fewer Children Are Enrolled in DMC.*** About 357,000 children (9 percent) are in DMC. Total annual expenditures for this population are approximately $53 million.

☑ ***In Los Angeles County, DMC Is an Option, but Denti-Cal Is the Dominant Delivery System.*** The distribution of enrollment and expenditures between Denti-Cal and DMC in Los Angeles County are:

- ***Most Children Are Enrolled in Denti-Cal.*** Over 1 million children (78 percent) are in Denti-Cal in Los Angeles County. Total annual expenditures for this population are approximately $162 million.
- ***Fewer Children Are Enrolled in DMC.*** Approximately 219,000 children (22 percent) are enrolled in DMC in Los Angeles County. Total annual expenditures for this population are approximately $33 million.

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Recent Administrative Actions to Improve DMC

☑ ***The Administration Took Several Steps in 2012 to Address Concerns About Access to Care.*** The administration took several actions in calendar year 2012 that were intended to address concerns that have been raised about children's access to care in DMC. Some of these actions included:

- ***Issued "Immediate Action Expectations" for Dental Plans.*** In March and April of 2012, DHCS issued immediate action expectations for DMC plans. Some of the expected actions included (1) enhancing outreach and education to beneficiaries and providers, (2) implementing financial incentives for providers to provide services to Medi-Cal enrollees, and (3) requiring plans to submit an annual report on beneficiaries' timely access to care.

- ***Created Stakeholder Workgroups in Sacramento and Los Angeles Counties.*** The DHCS scheduled monthly meetings with interested stakeholders and all DMC plans to discuss issues and make recommendations intended to improve results for DMC.

- ***Conducted Additional Surveys of DMC Plans in Sacramento.*** The Department of Managed Health Care (DMHC) conducts routine surveys and financial examinations of dental plans every three years. In March 2012, in response to concerns about access to care, DMHC initiated non-routine surveys of DMC plans in Sacramento County. In addition, DMHC is planning an annual survey and examination process for the Medi-Cal contracts for all DMC plans that will begin in 2013.

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Recent Legislative Actions to Improve DMC

☑ ***Legislature Passed Measure Aimed at Improving Access in DMC.*** In June 2012, the Legislature enacted Chapter 23, Statutes of 2012 (AB 1467, Committee on Budget), which contained several provisions intended to enhance children's access to dental care—specifically children who are enrolled in DMC. Some of the major provisions included:

- ***Established Beneficiary Dental Exception Process in Sacramento County.*** Created a process for beneficiaries in Sacramento County who are unable to secure access to services through their DMC plan to opt-out of DMC and move into Denti-Cal.
- ***Authorized Sacramento Stakeholder Advisory Group.*** Required DHCS to meet periodically with a stakeholder advisory committee to facilitate improvements in the provision of dental care in Sacramento County.
- ***Required New Performance Measures and Benchmarks for Plans.*** Performance measures and benchmarks related to provider network adequacy, utilization of dental services, and member satisfaction with plans and providers are to be included in contracts with dental plans.
- ***Required Annual Report to the Legislature.*** Required DHCS to provide the Legislature with annual reports on DMC that include actions taken to improve access to care, utilization of services, and beneficiary satisfaction.

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New DMC Contracts Incorporate Legislative Changes

☑ ***New Contracts Awarded to DMC Plans Will Implement Changes.*** In October 2012, new Medi-Cal contracts were awarded in Sacramento and Los Angeles Counties. These contracts are scheduled to take effect in January 2013 in Sacramento and July 2013 in Los Angeles. Among other things, the new contracts have a variety of new reporting requirements and penalties for failure to meet benchmarks for utilization and access to care. For example, up to 13 percent of payments to DMC plans may be withheld for failure to meet specified performance standards or procedural requirements.

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Background on Dental Services for Children In Healthy Families Program (HFP)

☑ ***The HFP Provides Dental Care Through Two Different Models.*** The HFP, administered by the Managed Risk Medical Insurance Board (MRMIB), provides managed dental care through two different models—Open Network and Primary Care plans. In Primary Care plans, each enrollee has a primary care dentist who authorizes dental care provided by specialists. In Open Network plans, enrollees are not assigned a primary care dentist. In both models, MRMIB pays a per-member, per-month negotiated rate to the dental plan, and rates are confidential.

☑ ***Enrollment in HFP Dental Care.*** There are about 860,000 children enrolled in dental care through the HFP program statewide. Los Angeles County has about 217,000 of those children, or roughly a quarter of the enrollees. Most children in Los Angeles County are enrolled in Primary Care plans.

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Dental Services Quality Measurements for HFP Plans

☑ ***The HFP Uses Several Dental Services Quality Measures.*** The MRMIB monitors dental plan performance based on prevention, treatment, and utilization of services. Additionally, MRMIB measures the satisfaction of HFP families with dental plans and their dentists through the Dental Consumer Assessment of Health Plans and Systems (D-CAHPS) survey.

- ***Dental Performance Measures.*** The HFP dental measures include measurements relating to the use of preventive care, the use of dental treatments, and the utilization of dental services.
- ***D-CAHPS.*** The D-CAHPS survey consists of about 30 questions, some of which ask families to rate their satisfaction with their child's regular dentist and dental plan.

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Transition of HFP Enrollees to Medi-Cal

☑ ***Healthy Families Enrollees Will Be Transitioning to Medi-Cal.*** In January, the Governor proposed to shift all children enrolled in HFP to Medi-Cal over a nine-month period beginning October 2012. The Legislature ultimately enacted Chapter 28, Statutes of 2012 (AB 1494, Committee on Budget), a modified version of the proposed transition. The legislation authorized a slower timeframe for the transition and several requirements aimed at minimizing disruptions in care for children and ensuring an adequate network of providers. The children who are likely to be able to keep the same provider(s) as they transition from HFP to Medi-Cal will be transitioned first.

☑ ***The Transition in Los Angeles County.*** Approximately 68,000 children in Los Angeles County will be transitioned from HFP to Medi-Cal on March 1, 2013. These children are enrolled in HFP health plans that also contract with Medi-Cal. Their dental care will be transitioned concurrently with their health care. The remaining children will be transitioned in the second phase, on April 1, 2013, and in the third phase, on August 1, 2013.

- ***Some Children Will Remain in the Same Dental Plan.*** If an enrollee is in an HFP dental plan that is also a Medi-Cal DMC plan, the enrollee will stay in that plan.
- ***Some Children Will Be Enrolled in Denti-Cal.*** If an enrollee is in a HFP dental plan that is not a Medi-Cal DMC plan, the enrollee will be enrolled into Denti-Cal.

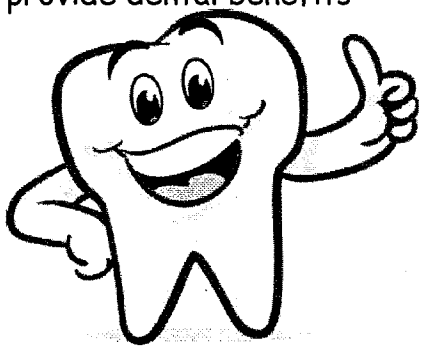
LOS ANGELES COUNTY

Do you know that your child still has dental coverage?

Your child is moving from the **Healthy Families Program** into Medi-Cal and now has dental coverage through the Medi-Cal Dental program!

What is the Medi-Cal Dental program?

The Medi-Cal Dental program is the part of the Medi-Cal program that will provide dental benefits for your children who have been covered by the Healthy Families Program.



Who is covered?

All Healthy Families Program children up to their 19th birthday who are moving to Medi-Cal are covered. After their 19th birthday they may be eligible for other Medi-Cal programs.

For families living in Los Angeles County:

If your child is enrolled in Access Dental, Health Net of CA, SafeGuard Dental or Western Dental through the Healthy Families Program they will stay in the same dental plan in the Medi-Cal Dental Program. If your child is not in one of these dental plans, they will automatically be enrolled into Denti-Cal (www.denti-cal.ca.gov). Either way you can choose to change your child's dental plan or enroll them into Denti-Cal by contacting Health Care Options at 1-800-430-4263. Please see below for the dental plans available in Los Angeles County.

What services are covered?

The dental benefits available to children in the Medi-Cal Dental program are very similar to those in the Healthy Families program and include:

- Exams and preventive services including cleanings, fluoride treatments and sealants
- Fillings
- Root canals
- Crowns
- Relief of pain and infection

Los Angeles County Dental Plan Choices:	
Access Dental	(888) 414-4110
Care 1st	(888) 273-3181
Denti-Cal	(800) 322-6384
Health Net of CA	(800) 977-7307
LIBERTY Dental	(888) 703-6999
SafeGuard Dental	(800) 880-3080
Western Dental	(800) 805-8000

Please check with your child's Dental Managed Care plan or Denti-Cal about what benefits are available.

How does my child get the dental services they need? (Checklist)

Dental Managed Care Plans

- ☐ Contact your child's Dental Managed Care plan to:
  - ☐ Find out what services your child can receive
  - ☐ Find a dentist
- ☐ Contact dentist to make appointment
- ☐ Go to dental appointment (Don't forget to take your child's dental plan identification card!)

Denti-Cal

- ☐ Contact Denti-Cal (1-800-322-6384) to:
  - ☐ Find out what services your child can receive
  - ☐ Find a dentist
- ☐ Contact dentist to make appointment
- ☐ Go to dental appointment (Don't forget to take your child's Beneficiary Identification Card!)