

Sacramento Children Deserve Better



A Study of Geographic Managed Care Dental Services

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Sacramento, California

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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.

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 fair hearing requests 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.^a

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

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.

^a 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.

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.



INTRODUCTION

“Treating the poverty population the way you treat the employed population, by giving them a [dental plan] card makes their income status invisible to others and is a good thing.”—former County official

Tooth decay is the most common and preventable disease of childhood yet access to dental services for many children remains “an elusive healthcare benefit.”⁴ If Sacramento children mirror children in the rest of the state, by third grade almost two-thirds are affected by dental disease and more than one-quarter have untreated dental decay, making it the number one children’s health problem.⁵ The problem is even greater among low-income, uninsured and minority children whose access to services is limited.⁶

Having publicly-funded dental benefits does not equate to access, however. Children with dental benefits through Medi-Cal (California’s Medicaid program) are less likely to visit the dentist than their peers with private insurance, a difference most likely due to barriers to care within the Medi-Cal program,⁷ as well as parents’ lack of knowledge about the importance of oral health⁸ and of the fact that their child’s coverage includes dental benefits.⁹ While some scope of Medi-Cal dental benefits are available to all children enrolled in Medi-Cal throughout the state, *only about 2 in 10 Sacramento County children age 0-20 (and 1.3 in 10 children age 0-5), on average, received a dental service in 2008—*one-half the amount received by children statewide.

The Medi-Cal program is administered through the California Health and Human Services Agency by the California Department of Health Care Services (DHCS), and includes medical and dental benefits for eligible populations. The Medi-Cal *Dental Services Division* is responsible for the provision of comprehensive dental services to children enrolled in Medi-Cal. Under increasing pressure to control costs, in the late 1980s and early 1990s DHCS looked to managed care as a method to reduce expenditures, with the expectation that this system would also provide timely access to care, including preventive services.

As of December 2009, 20 managed health plans, contracted by the state, provide medical care services to approximately 3.8 million Medi-Cal enrollees in 25 of the most populous counties in California, including Sacramento.^b In only one county, Sacramento, the greatest majority of Medi-Cal beneficiaries receive *dental* services mandatorily through 5 managed care dental plans participating in Sacramento Geographic Managed Care (GMC). The GMC dental program provided dental care services to 23,747 Medi-Cal children in 2008, 20.2% of the average monthly eligible 117,000 children.

^b DHCS intends to expand Medi-Cal managed care into 5 additional counties during calendar year 2010.

The Promises of Dental Managed Care

Like medical managed care, dental managed care holds a number of promises for purchasers of services as well as beneficiaries and dental providers¹⁰ as illustrated in the table below. Despite the incentive differences—under-treatment on the managed care side, over-treatment on the FFS side—managed care *can* effectively meet its access and utilization goals. It can provide a dental home, encourage use of benefits, promote preventive services—provided there are adequate controls in place and sufficient oversight capacity to monitor key performance measures such as care standards and utilization rates. Even though Medi-Cal dental managed care has the potential to improve access to care for thousands of low-income children in Sacramento County, the GMC dental program has unfortunately not lived up to its potential.

Table 1. The Promises and Expected Benefits of Dental Managed Care

What are the Promises of Dental Managed Care?	What are the Expected Benefits?
Provide a “dental home” for beneficiaries	Obtaining care through a managed dental plan provides the opportunity to link children with an established base of care.
Increase utilization among eligible children	Enrollment in a dental plan occurs at the time of enrollment in a medical plan under GMC. This should encourage utilization of services, particularly screening and prevention services.
Improve use of preventive services	Prevention services play an important role in terms of early intervention; maintaining a recall schedule allows the child the benefit of continued observation and if treatment is deemed necessary, a less invasive procedure.
Increase access to specialty services	Plans can be held accountable for ensuring that enrolled children are receiving appropriate and timely referrals for pediatric specialty services.
Assure quality assurance activities	By centralizing administration associated with providing care, there is an opportunity to have better and more efficient collection of information on the quality of services provided.
Reduce the administrative burden on the dental providers	“Paperwork” is often cited as a barrier to participation in Denti-Cal by dental providers. Simplified program administration, not present in FFS, is a common element in successful dental plan management.
Improve data/ evaluation capacity	Although national standards for measuring dental quality are limited, measures <i>have</i> been developed by the Healthy Families program that provide relevant information about the quality of dental services provided by dental plans that also allow for comparisons of performance.
Control costs	Under managed dental care, the State of California can predict and limit its overall costs by contracting at a fixed, pre-determined payment per member per month. Financial risk is shifted from the State to the dental plans.
"Privatize" a government-sponsored health insurance program	While not generally an articulated goal of GMC, in a political environment where there is pressure to reduce government—as it is today—managed care provides an opportunity for the private sector to conduct work formerly carried out by state employees (e.g., quality assurance activities).

Background of Geographic Managed Dental Care in Sacramento

GMC was put into place in Sacramento County in 1994 as a “pilot project”—which some still consider it to be—but is now an established, mature program. Although offered as a model to many other counties by DHCS it was never of interest to those counties and there was no competition for it. Mandatory medical and dental GMC^c currently exists only in Sacramento County. The State believed that Sacramento County had the required patient demographics (e.g., a large county Medi-Cal enrollment to offer to dental managed care plans), sufficient provider base, and political environment to make the pilot successful and strongly encouraged local officials to participate in the medical and dental areas.¹¹

As local officials involved at the time recall, Sacramento County was not generally enthusiastic about GMC, but wanted to participate in some way if Medi-Cal was going in a managed care direction. Authority for local decision making, evaluation criteria and methods, and strategies for meaningful state-local collaboration were vague, however. Concerns about proposed County costs for enrolling clients at the time of eligibility determination led the State to instead hire an independent enrollment contractor. A Sacramento GMC Commission was established by the County with local grants and other monies with the expectation that it would oversee the program, but the Commission was disbanded several years later in frustration when it failed to gain necessary status with the State, limiting its impact. Its advisory role got little support, and responses to requests for the plans’ data were not sent, or were provided in an untimely manner or contained inaccurate data.¹²

Current and Past Studies

This study 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 was commissioned in response to recommendations from an earlier study,¹³ sponsored by Cover the Kids, with support by First 5 Sacramento and the California Dental Association Foundation, which identified local oral health resources and gaps, recommended improvements, and pointed to the need for greater accountability for Sacramento GMC.

Prior research suggests that at least three critical issues surrounding the use of managed care in dentistry be addressed: the financial question of equity for both the patient and the provider; the quality of care provided under capitated systems; and the need for regulation by government agencies.¹⁴ Three earlier independent studies examined Sacramento GMC relative to these issues, although most focused on medical, not dental services.

An evaluation of the impact of GMC on service use (primarily medical services) at community clinics was undertaken by Korenbrot and colleagues in 1998, and documented declines in clients, encounters and revenues at Sacramento clinics with the introduction of managed care.¹⁵ The study pointed to the need for more effective approaches to integrate safety net providers into Medi-Cal managed care plans and emphasized the role these

^c Except for some in limited scope aid codes.

essential providers play in offering geographically accessible and culturally sensitive quality services.

A comprehensive evaluation of the GMC dental program comparing it to the traditional fee-for-service (FFS) system was conducted by Mercer, Inc., in 2001, and highlighted both strengths and weaknesses in the FFS and GMC programs.¹⁶ While advocates with concerns about limited access believed the “report suggests that GMC offers an insignificant benefit for Denti-Cal beneficiaries,” they also believed it provided “too few conclusive findings to seek a repeal of the program.”¹⁷ A 2003 report produced by the Community Services Planning Council, which focused on medical services, shared Mercer’s conclusion that “the GMC dental program contained mixed findings about access and quality of care....and while the Department of Health Care Services seems to have better oversight over GMC dental plans than providers in fee-for-service Denti-Cal, there are still significant areas for improvement, particularly in preventive care for children.”¹⁸

Few or no actions have been taken by the State or professional and local groups to significantly re-structure the GMC program based on any of these analyses. Continuing questions and concerns—along with misperceptions and misinformation—from local stakeholders and the lack of program data and accountability led to the present study. We were asked to identify and compile all available data to substantiate largely-anecdotal concerns about access, utilization and quality of oral health services.

BARBARA AVED ASSOCIATES was asked to focus on children, especially those ages 0-5, enrolled in the Sacramento managed care dental plans and:

- Identify the strengths and challenges of the GMC model;
What is effectively working and what is not?
- Identify and examine alternative dental care models and compare them to GMC, including pros and cons of each alternative and barriers to implementation;
What have other counties/states learned that could be implemented to improve access and utilization in Sacramento?
- Develop recommendations on how to improve the current system of coverage and care, based on findings and successful strategies elsewhere, or recommend an alternative model with the necessary steps for implementation.
Should a strategy be implemented to return to FFS, adopt a different structure, or make specific improvements in GMC?

This study, conducted between September 2009 and April 2010, occurred somewhat parallel to the work of Sacramento Health Care Improvement Project (SHIP)—an effort by a coalition of provider organizations, advocates and funders to propose improvements to the current GMC program. Although SHIP is focusing primarily on *medical* managed care, and may ultimately consider a different structure than the current GMC model, the strategies it has proposed are compatible with our recommendations to improve GMC in Sacramento.

Study Team

The team for this study consisted of Barbara M. Aved, RN, PhD, MBA, Dorothy Meehan, MBA, CPA, and Jack C. Luomanen, DMD. Barbara is President of BARBARA AVED ASSOCIATES, a Sacramento-based consulting firm focusing on evaluation, strategic planning, and community health delivery systems for public and private sector organizations. Dorothy is Principal of MEEHAN CONSULTING ASSOCIATES which provides assessment, planning and organizational development support to health-related nonprofit and public sector clients. Jack is a dental public health consultant to non-profit, community, county, State and Federally Qualified Health Centers in the design, operation and evaluation of dental services, including Denti-Cal. Kelly Beaumont, MS, and Philip Avedschmidt, BA, provided data and research assistance.

Acknowledgements

This study was funded by First 5 Sacramento, which works to improve the lives of the county's youngest children and their families. We especially thank Debra Payne, MSW, First 5 Sacramento, who provided project guidance, and the members of the Children's Dental Task Force and GMC subcommittee who offered helpful suggestions and feedback throughout the project.

Department of Health Care Services, Medi-Cal Dental Services Division, gave extraordinary attention to our data collection requirements. We are indebted to staff, in particular Danny Lee, Chief, Dental Managed Care Unit, and Bob Isman, DDS, Dental Program Consultant, who made time for frequent communication, and agreeably tolerated our numerous questions and requests for data and reviewed sections of the report for accuracy. Without their cooperation we would still be winding our way through internal administrative and data mazes.

A number of oral health experts, community leaders, public officials, and advocates participated in interviews and offered their perspectives and ideas about ways to improve oral health care for young children in Sacramento County. Their questions helped steer our data search, and their suggestions are reflected in our recommendations.

We also wish to acknowledge the cooperation of the GMC managed care dental plans; they graciously responded to our frequent questions and requests for information, including performing several special data runs for this study. The plan representatives who were our main contacts for this study included:

- | | |
|---------------------------|---|
| Access Dental Plan | - Ms. Terri Abbaszadeh, VP Plan Administration |
| Community Dental Services | - Mr. Joseph Sivori, President |
| Health Net | - Ms. Eileen McGee-Davidson, Manager/State Programs |
| Liberty Dental Plan | - Ms. Francine Ramirez, Members Services Manager |
| Western Dental Services | - Lou Amendola, DDS, Chief Dental Director |

The study authors hope this report creates the opportunity to make a positive change to improve the system of dental care for low-income children in Sacramento County.



DATA AND METHODS

“With fee-for-service you have better data because it’s linked to an invoice, but this doesn’t exist with managed care.”—Retired local program manager

“It’s too difficult to capture data from providers.”—GMC managed care dental plan representative

The findings in this report are organized by three main areas—access, utilization, and quality of care—although there is unquestionably an overlap among these categories, raising the question, for example, When is a utilization issue really an access issue? To carry out the study, the following primary methods were used: analysis of data, interviews, and surveys. The availability and robustness of the State data largely determined the extent of our ability to reach conclusions about each of these study areas.

Data Analysis

GMC plans are required by contract to submit quarterly data to DHCS, and this publicly available data source was accessed for the main body of information regarding Medi-Cal eligibility, enrollment, utilization, encounters, procedures, and grievances. Information about how utilization rates were calculated is contained in Appendix 2. While Sacramento County was the main area of interest, statewide and certain comparison-county data from the fee-for-service (FFS) system, such as claims data, were used in analyzing trends and to compare with the managed care data. Using comparable rationale to what was used in the Mercer study, we chose Fresno as the proxy or FFS comparison county for some of the analyses because its demographics, service delivery system and population share similar characteristics with Sacramento County. For most of the analyses, 2008 was used as the study period because it was the most recent year for which data were available. Because Health Net did not re-contract with DHCS until July 2008, however, it was excluded in some of the analyses, and these places are noted.

While much of the data were sent to us directly by the State, some were requested of and sent by the GMC plans. In cases where plans provided unduplicated patient counts, DHCS verified that the method plans used for this were accurate. Some of the data requests required special reports by DCHS—and in a couple of cases appeals by us to the Department to prioritize our requests in the seemingly-long queue of DHCS data workload. In some cases staff helped to refine our questions to identify the most appropriate reports. Data requests were maintained in logs and continuously tracked to monitor progress during frequently-held discussions with Department staff; staff was unfailingly accommodating in providing data and answering our many questions. We provided a draft of this report to DHCS to comment on accuracy. Staff provided written comments and revisions were made.

We also used data from the 2007 California Health Interview Survey (CHIS) to examine dental service utilization among Sacramento children at various income levels. CHIS data are a key source of population-based data about social and health behaviors, and the largest state health survey in the U.S., which provides a valuable supplement to existing data from public programs. Other “benchmark” data sources, such as industry and national Medicaid data, were also reviewed where available.

2007 and 2008 discharge data from the Office of Statewide Health Planning and Development for Sacramento County facilities was used to examine emergency department (ED) use by children when an oral condition was the primary diagnosis. Our primary purpose was to use ED visits as a proxy measure for access and to see how well publicly-funded programs were keeping children out of the ED.

Health Rights Hotline (HRH) provided empirical data concerning calls/requests for assistance related to access and quality concerns about children's dental services, including the type of problem by plan and resolution of the problem. Again, hotline data for Fresno County was used to compare a FFS county with GMC. Additionally, we reviewed findings of the 2007 Healthy Families member survey to learn how families rated the dental care provided by their child's dental plans and providers.

To measure quality of services, we selected 5 of the 7 indicators developed and used by the Healthy Families Program (HFP). Representatives from the 3 Sacramento GMC dental plans that also contract with HFP participated in developing these indicators. HF is one of the few programs in the nation that measures dental quality, and in April 2010 published a *HFP 2008 Dental Quality Report*.

The main elements of the DHCS contract with GMC plans were reviewed, specifically the expectations for scope of services, access, utilization and reporting requirements. The contract is *162 pages*. All of the GMC plans sign the same contract; there are no differences. The current contract term is May 1, 2008 through December 31, 2012.

Interviews and Surveys

GMC dental plan representatives were interviewed by telephone and in person to answer detailed questions, and numerous follow-up communications occurred via e-mail throughout the project. Plan staff supplied information from their own databases about enrolled Medi-Cal users—which because they differed from the DHCS data are also shown in this report—and described quality assurance, referral, and grievance procedures. At our request, they also offered suggestions for improvements to the current GMC system.

As related state agencies, staff from the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board Healthy Families Program was interviewed to learn about their role and relationship to the dental managed care program. HFP produced a special data run for this study from the statewide *HFP 2008 Dental Quality Report*, breaking out key findings for Sacramento County.

Key informants were identified as local and state opinion leaders, policy makers, dental experts, providers, and key advocates. Their historical recollections and perspectives and knowledge about the importance of children’s oral health reflected a wide range of experience and opinions about GMC. Interview notes were validated by the informants when possible but the authors accept full responsibility for the displays, interpretation and information presented in this report. (The interviewees have not been identified in the report because some information was provided in confidence.) The informants’ comments and suggestions corroborate our recommendations.

Using local directories of Sacramento private practice dentists from GMC plans’ provider networks (primarily Liberty and Health Net’s), we pulled a random sample of 50% (N=17) of general dentists to interview. A letter explaining the study and requesting a brief telephone conversation about the GMC program was faxed and/or e-mailed to each provider’s office after calling to confirm the contact information and alert the office. A copy of the questions we intended to ask was also sent. Only one dentist responded and participated in an interview. Second attempts were not made to follow up with non respondents. In addition, several local dentists and dental leaders not participating in GMC—some of whom formerly took Denti-Cal children—were identified and interviewed for their perceptions about the program, although this was not a systematically drawn sample.

During the course of this study the Sacramento District Dental Society conducted a member survey regarding Denti-Cal. We were able to piggyback our interest in certain information and add questions to the survey so that some of the data would be pertinent to our purpose.

Finally, we proposed a plan to validate timeliness of appointments and compliance with the American Academy of Pediatric Dentistry and American Academy of Pediatrics age-at-first visit recommendation from information supplied by the plans. However, DHCS refused our request to conduct secret shopper telephone calls to a representative sample of provider offices and staff model clinics, and would not allow other authorized parties to implement this method as part of our study.

Definitions

Because use of the following terms can be confusing, these definitions are provided to assist the reader:

Eligibles	The number of individuals already covered by (enrolled in) Medi-Cal (not the number of individuals in a county whose family income would <i>make them eligible</i> to be covered) whether or not they ever used a dental service. For Sacramento GMC, this would be the number of individuals enrolled in a dental plan during the measurement period. For some of the analysis, “average monthly eligibles” was used. “Eligible” is equivalent to “enrollee” or to “member” in managed care terminology.
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User	A Medi-Cal beneficiary who used at least one dental service during the year. A user is a recipient of one or more procedures.
Utilization Rate ^d	The percent of eligible children who used at least one dental service in the year.
Encounters	The number of dental visits a child made. (Multiple procedures can be provided during a single encounter.)
Procedure	The type of dental service provided, e.g., a dental sealant.
Medi-Cal dental program	This terminology refers to the overall dental program of Medi-Cal dental services administered by the Department of Health Care Services (DHCS). Denti-Cal actually refers only to the <i>fee for service</i> (FFS) system and not to the dental managed care system. To be inclusive and avoid confusion between the two systems, the term “Medi-Cal dental” is used throughout this report; where it is FFS specific, “Denti-Cal” is used. ^e
Beneficiary/Member	All children covered by Medi-Cal FFS or managed care are called beneficiaries. Beneficiaries enrolled in a GMC dental managed care plan are called members of that plan.

Study Limitations

Time and budgetary restrictions determined the methods we used to conduct the study. No direct observations of the enrollment process or delivery of direct services at provider sites were made in this study. While parents of Medi-Cal children were not interviewed, a review of patient satisfaction surveys and various grievance reports served as a proxy measure.

Auditing health records can provide additional, important documentation about the delivery of services; however, funding for this study did not allow for review of patient charts in provider offices.

Data Concerns

Complete encounter data from GMC plans are necessary to monitor children’s access to dental care; however the lack of quality information collected and produced by the State continues to be a concern. As early as 2001, an examination of Medi-Cal medical managed care data by the Medi-Cal Policy Institute concluded that the data could not be used to evaluate quality of care, monitor access, and compare managed care to FFS; the

^d Because much of the interpretation of this report depends on a clear understanding of utilization rates and how they are calculated, please see Appendix 2 for a discussion of these calculations.

^e DHCS administers Denti-Cal through a contract with Delta Dental of California. It administers the dental managed care program by contracting with Knox-Keene-licensed dental managed care plans.

report identified problems at every level from plans to DHCS.¹⁹ The Mercer report noted that “data under-reporting is an industry-wide problem for dental managed care programs and industry estimates are that as many as 50% of all managed care services may go unreported.”²⁰ The problem is not limited to California. Although all states are required to submit Medicaid encounter data to the government, most states currently produce incomplete data according to the findings of a national study.²¹

Timeliness, completeness, accuracy, as well as under- and over-reporting by plans, are chronic data problems in Medi-Cal managed care, including dental managed care services. While some improvements have been implemented since the earlier reports, the same data-related problems were encountered in the present study.

Although DHCS was responsive to our data requests, there were few reports that could be generated or retrieved easily *and* be considered complete, accurate or credible the first go-round. Nearly all of the reports came with qualifications, some relatively minor but some major. For instance, when we first received the encounter data, the information was entirely missing for one GMC plan but this fact was not noticed until pointed out by us after reviewing the requested report.^f DHCS explained that something in the system inexplicably had “stripped out” or caused a miscoding of data for the “missing” plan—potentially affecting the integrity of most of the plans’ data. Resolving the problem took about 5 months.

It is very challenging to evaluate the GMC program when data are reported differently by the dental plans than what is produced in State reports, and differently by the State in its various reports. For example, utilization data from the GMC plans and DHCS could not be reconciled during this study. DHCS could not explain why there was such variances between the utilization rates it reported—which came from the plans themselves—and the rate data the GMC plans sent us, although a number of queries were attempted. Initially, DHCS provided eligibility and utilization information based on “unduplicated eligibles” because it preferred this denominator for calculating utilization rates. However, because the contracts with dental plans requires them to submit utilization data based on using “average monthly eligibles” as the denominator, DHCS agreed to allow some comparisons of plans using the latter method, although it still believes that this method tends to overstate utilization and can result in odd results, e.g., utilization rates of more than 100% (see Appendix 2 for more discussion about methodologies). While the gap between DHCS and plan data narrowed after this change in calculation method, there were still discrepancies in rates across the plans for most age groups of children. While we used the Department’s data in the analyses for this study, the utilization rates from DHCS and the GMC dental plans are compared in a detailed table in Appendix 3.

^f DHCS explained it was unaware of the missing data because it was discovered in a report generated by an information technology system that is not routinely used to monitor plan performance.

FINDINGS



“One of the big benefits of this [GMC] model to the state is that the oversight has shifted from the state to the plans as part of the contractual requirement. The state role has really diminished.” – Local official

I. Extent of Dental Disease Among Sacramento Children

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

How does the Prevalence of Oral Disease among Sacramento Children Compare to other California Children?

The consequences of poor oral health are particularly critical for children, and can have a huge impact on overall health as well as children’s readiness for school. While there are limited data available to measure the extent of oral disease among children in Sacramento County, the following studies provide a picture of oral disease prevalence. It does not appear from these data that Sacramento area children have an unusually high oral disease rate compared to the state as a whole.

Regional data, provided by the Dental Health Foundation, in which Sacramento schools are included, are available and show little variation between the region and the state except for the percentage of children with some amount of caries experience, which is lower in this region (Table 2). The percentage of children in this region with “any caries” and “rampant caries” experience is the lowest in the state, which could be reflective of dental preventive programs in place in these local counties.

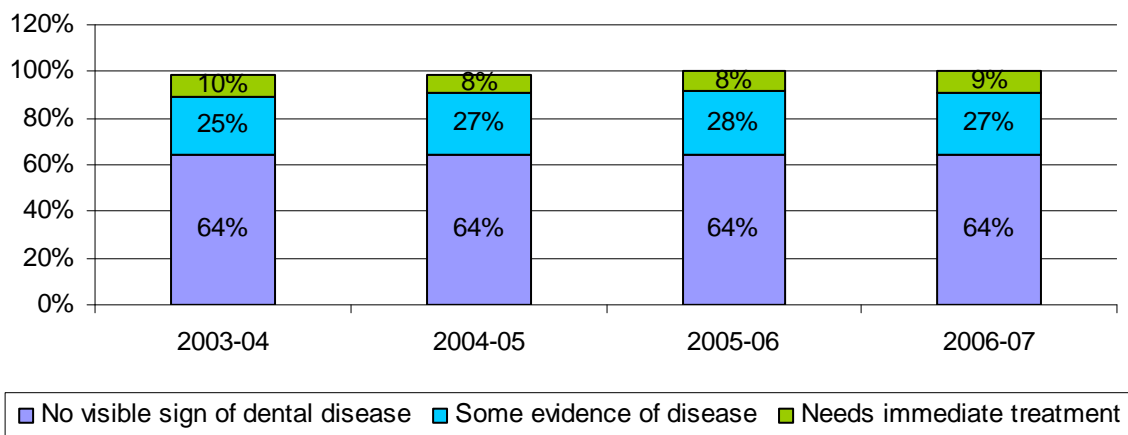
Table 2. Oral Health Status of Third-Grade Children, California and Region 6

Criteria	California (n=10,444)	Region 6* (n=640)
Percent with caries experience (1 or more cavities, filled or unfilled)	70.9%	42.1%
Percent with untreated decay	28.7%	22.1%
Percent with rampant caries (7 or more, filled or unfilled)	22.5%	10.7%
Percent needing early dental treatment	22.6%	21.1%
Percent needing urgent dental care (in addition to untreated decay, signs of infection or abscesses)	4.2%	3.5%

*Sacramento schools made up the largest proportion of Region 6. Other counties were Yolo, Placer, and El Dorado.
Source: Dental Health Foundation. Oral Health Assessment of California’s Kindergarten and 3rd Grade Children. 2006.

Data from Smile Keepers, a program of the County of Sacramento, shown in Figure 1, indicate that among the 24,000 children screened in 2007, more than one-quarter (27%) showed some evidence of decay and needed treatment, generally reflecting children in the rest of the state.²² The percentage, 9%, of those who needed immediate treatment (e.g., severe dental caries) is higher than the regional proportion found in the Dental Health Foundation assessment because of different samples of schools and children. (The Dental Health Foundation survey was of a representative sample of the population, while the Smile Keepers survey was of a high risk population: schools with at least 50% of the children on Free School Lunch.) The outcomes of the Smile Keepers screenings did not change appreciably between 2003 and 2007.

Figure 1. Results of Preschool-Sixth Grade Dental Screenings, Sacramento County, 2003-2007



Source: Sacramento County Department of Health and Human Services, Smile Keepers Program.

II. Overview of Medi-Cal Dental Managed Care



“Managed care is not attractive to organized dentistry; that’s why the State hasn’t expanded this model.”— GMC managed care dental plan representative

The information in this section provides a context for understanding the Medi-Cal Dental Services Program and its relationship to contractors, providers, and other related state agencies.

What are the Required Dental Benefits Under Medicaid (Medi-Cal)?

Under Medicaid, most children age 20 and younger with full Medicaid benefits are entitled to dental services, but states may choose whether to offer dental benefits to adults (most adult Medi-Cal dental services were eliminated in July 2009 due to state budget cuts). Children’s services are mandated through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, which requires that state programs pay for treatment found to be medically necessary, whether or not it is included in the state’s regular set of covered services. This means that states are required to provide a comprehensive dental benefit to Medicaid-enrolled children.²³ Medicaid policy requires direct referrals of enrolled children to dental providers for comprehensive diagnostic, preventive and treatment services.²⁴

Which Counties Have Dental Managed Care Programs?

In 1991, legislation (Assembly Bill 337) amended various sections of the Welfare and Institutions Code to establish the California Managed Care Initiative which expanded managed care in the Medi-Cal program. The Initiative resulted in the development of several competitive plan models for delivery of health care services to Medi-Cal beneficiaries in targeted counties throughout California. In 1994, the Geographic Managed Care (GMC) Pilot Project made enrollment mandatory primarily for most low-income children and families with no share of cost. This plan model allows beneficiaries the option of choosing from among multiple commercial plan alternatives. GMC exists for *medical* care in 3 counties (Sacramento, Los Angeles—which uses the Prepaid Health Plan model—and San Diego) and *dental* care in 2 counties (Sacramento and Los Angeles).

Dental services are not included in Medi-Cal managed care plans’ contracts with the state, and the plans’ responsibility for dental services is limited to referring members to the Medi-Cal dental program and providing an oral health assessment as part of the initial and periodic health assessments as required under the Child Health and Disability Prevention Program. As a result, “there is limited coordination of Medi-Cal managed care beneficiaries’ physical health and dental care services.”²⁵

The Department of Health Care Services contracts with 5 dental managed care plans in Sacramento County and 8 in Los Angeles County that provide dental services to Medi-Cal beneficiaries. The dental plans in Sacramento contract under the Geographic Managed Care program while in Los Angeles they contract under a managed care program referred to as Prepaid Health Plans (PHP). Uniquely, Dental GMC is a *mandatory* program in Sacramento County. Except for non-mandatory aid codes, described in the Utilization section of this report, Medi-Cal recipients in Sacramento County who are eligible to receive dental services must select one of the available GMC plans for their dental care. From the time eligibility is established, the beneficiary has 30 days to choose a dental plan. If the beneficiary has not enrolled in a plan by day 20, they are notified by DHCS via an “Intent-to-Default” letter that a plan will be chosen for them if they do not respond in writing and choose a plan within the next 10 days. If they do not respond by day 30, then DHCS defaults the person into a plan.⁹ In Los Angeles County, Dental PHP is a *voluntary* program. This program was established to allow Medi-Cal recipients the option to enroll in Dental Managed Care plans as an alternative to the Medi-Cal Dental FFS program. All Medi-Cal dental managed care plans are licensed by the State of California, Department of Managed Health Care, pursuant to the Knox-Keene Health Care Service Plan Act of 1975.²⁶

Medi-Cal Dental Managed Care recipients enrolled in contracting plans receive dental benefits from dentists within the plan’s provider network. Covered dental services provided by Medi-Cal Dental Managed Care plans are the same dental services provided under the Denti-Cal Fee-for-Service (FFS) Program as defined in Welfare and Institutions Code 14132(h), and in Title 22, California Code of Regulations, Sections 51059 and 51307. Dentists who wish to provide services to Dental Managed Care enrollees must participate in the Dental Managed Care plan’s provider network and be enrolled in the Denti-Cal FFS Program.²⁷ However, there are cases for specialty care where this would not apply. If the dentist refers a member to a provider outside their network because the plan does not have a network specialist near the member’s residence, and the referral is for a covered service, the specialist does not need to be enrolled in the Denti-Cal program. And, in this situation there is no cost to the member. Any additional costs are the plan’s expense.

What are the State’s Plans for Expanding Dental Managed Care?

DHCS indicates it has no specific plans to expand dental managed care to other counties in California at this time. However, it is considering an expansion proposal by some of the dental plans. In July 2009, a coalition of plans, including Access, Liberty and Health Net, proposed to the Governor’s Office and DHCS that counties with Medi-Cal *medical* managed care also include *dental* managed care as a voluntary option. They also proposed the State start by automatically defaulting existing and new beneficiaries in Los Angeles County into dental managed care rather than the FFS program, allowing them the option of moving later into FFS.

⁹ However, it can take up to 45 days to enroll a new member once a plan is chosen, and depends on when in the month DHCS receives the beneficiary’s choice form. This has to do with when the form is loaded into the Medi-Cal Eligibility Data System. It can also take up to 45 days for an existing member’s plan change to take effect.

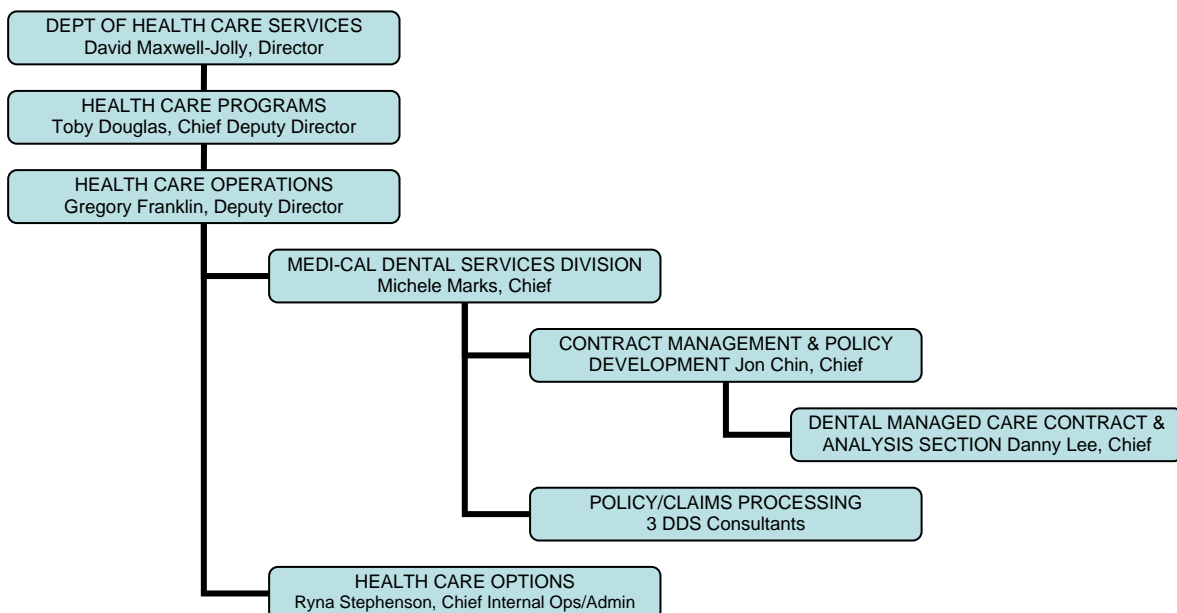
The plans' proposal is based on the premise that the State will achieve cost savings and beneficiaries will receive better care in managed care than FFS. (As substantiation for available cost savings, the proposal states "*dental managed care plans participating in LA are willing to accept premiums that would be at a 10% discount to the State's current cost in providing dental benefits under FFS.*") The plans maintain that in LA the aggregate capacity of the plans exceeds the total available beneficiaries, and that "thousands of providers currently in the plans' networks" have the capacity to serve the potential beneficiary pool. The managed care dental plans also expressed a willingness to work with DHCS to "develop a set of performance standards and guarantees that would ensure the appropriate levels of care are delivered to all beneficiaries."

DHCS and the Governor's Office staff have raised a number of questions since a November 2009 meeting with the coalition—including asking what safeguards the plans are going to put into place "to police themselves" (perhaps because DHCS understands it doesn't have the capacity to do adequate oversight)—and are continuing to dialogue with the plans. According to DHCS, there is no timeline for making any expansion decisions.

How is the State's Dental Managed Care Program Organized?

The Medi-Cal *Dental Services* Division of DHCS is responsible for administering a program of comprehensive dental services for children entitled to Medi-Cal benefits, as displayed in the organization chart below. (The Medi-Cal *Managed Care* Division is responsible for *medical* managed care services; its GMC Unit manages GMC *medical* services.) Within the Dental Services Division, the Dental Managed Care Contract and Analysis Section manages all of the dental managed care contracts. The Division contracts with 5 Sacramento GMC dental plans. The Health Care Options Branch contracts with Maximus, the firm that is responsible for the GMC enrollments.

Figure 2. Organizational Responsibility for Administering Sacramento GMC Dental Program



Source: Adapted from DHCS Organization Charts, January 2010.

What are State Agencies' Roles in Relation to Children's Dental Managed Care?

Department of Health Care Services, Medi-Cal Dental Services Division

As the purchaser of services, the Medi-Cal program is responsible for “oversight and monitoring of access to program services, quality of care delivered to enrollees, availability and timeliness of appropriate levels of care, and internal structural systems established by contracted health plans,” according to the Quality Strategies it publishes.²⁸ The Department’s document also states that “since the expansion of the Medi-Cal managed care program during the mid-1990s, DHCS has made continuous strides in monitoring quality of care and evaluation of service delivery provided to the enrolled populations, largely low-income children and families.” These “quality strategies” have not been applied to Medi-Cal’s *dental* program, nor have quality indicators been established and evaluation results produced. As a buyer of dental services, Medi-Cal is expected to maintain the capacity—whether through internal or contracted-out resources—to effectively manage and monitor compliance with contract terms and conditions that include access, utilization and quality of services provided to children.

The only *dental* professional positions in Medi-Cal Dental Services Division (MDSD) are 3 dentists, 2 classified as Dental Program Consultants (DPC) and 1 classified as a Dental Consultant (DC), housed in Policy/Claims Processing. (A Dental Hygienist position has been vacant for several months now since the last incumbent retired, but that position is assigned to the FFS program). Previously, there were 5 DPC/DC positions to handle Medi-Cal dental program issues; however, the Division eliminated 2 of these when making staffing reductions. State staff estimates that approximately 15% of the total DPC/DC positions’ time commitment is spent related to GMC compared to attention to FFS issues. The GMC-related activities generally involve responding to complaints and requests for data and advising about policies.

Contract managers in the Dental Managed Care Contract and Analysis Unit are responsible for monitoring GMC contracts, e.g. reviewing plans’ quarterly grievance reports and compliance with standards of care. None have clinical experience. There are 5 positions in that unit; however at the time of this report, 2 of those 5 positions are vacant.

While DHCS notes that because approximately 95% of Medi-Cal Dental beneficiaries are enrolled in FFS a greater time commitment is required for FFS issues, the Dental Services Division does not have adequate capacity in terms of the number and type of staff positions to fulfill all of its oversight responsibilities for GMC. The State’s ability to oversee and manage programs has been further reduced because of “Furlough Fridays.” Beginning July 10, 2009, DHCS is closed 3 Fridays of each month pursuant to Executive Order S-13-09; it is unknown how long this staff reduction will continue.

Initiatives Concerning Children

Working with advocates and other agencies, Medi-Cal Dental Services Division agreed there was a critical need for dental services for beneficiaries ages 0-3, and in 2007 proposed an Early Childhood (0-3) Dental Health Initiative. The initiative was implemented in the second quarter of 2008 as a voluntary activity for GMC plans. MDSD asked the

dental plans to assess their current level of care for the 0-3 population and develop an action plan to increase access to care and utilization of services. The plans submitted action plans, some of which were more detailed than others. MDSD asks the plans periodically if they have implemented any of the items in their action plans; State staff believed that although they are making some effort, the amount of effort has varied among plans. However, since this is a voluntary program MDSD explained it cannot require the plans to participate.

Department of Managed Health Care

Staff from the Department of Managed Health Care (DMHC) explained that the role they had in relation to Dental Managed Care plans was limited to licensing them. They stated that their routine quality assurance surveys^h (see note “e” below) were “limited to plans’ commercial lines of business,” i.e., not plan services funded by public dollars such as Medi-Cal. However, DMHC has jurisdiction and authority to investigate any issue affecting the interests of enrollees, subscribers, and health plans, and indicated that if they became aware of a problem involving a non-commercial enrollee (e.g., a Medi-Cal program patient), they “might investigate or refer the matter to DHCS because of DHCS’s familiarity with specific services required by the [Medi-Cal/Denti-Cal] contract.” On occasion, when there were more staff, Medi-Cal dental staff accompanied DMHC staff on their quality assurance surveys.

At one time DMHC and DHCS talked about developing a formal MOU (memorandum of understanding) about roles and relationships regarding managed care plans, but DMHC decided not to pursue it, and instead defer to DHCS because of its contractual relationship with providers. DMHC has a direct relationship with DHCS only with regard to the *medical services* component of Medi-Cal (not dental services). And, even this is not with all of the Medi-Cal managed care health plans, only about 18 of them. There are 3 areas that DMHC looks at exclusively: a) HIV access issues; b) grievances and plan websites to assure enrollees know how to file a grievance; and c) independent medical reviews. There is no formal monitoring relationship between DMHC and the Medi-Cal Dental Services Division relative to GMC services.

California Medical Assistance Commission

Since the mid-1990s, the California Medical Assistance Commission (CMAC) has negotiated the Department of Health Care Services’ contracts with the GMC programs in Sacramento and San Diego counties. CMAC drafts the GMC contracts and contract amendments based on the information provided by DHCS. CMAC is responsible for “negotiating” the contract rates with the plans, obtaining signatures/approvals from the plans, and approving the contracts/amendments. After CMAC’s final approval, the contract/amendment is forwarded to DHCS for approval and execution.

^h DMHC refers to their quality assurance monitoring visits as “surveys,” while DHCS refers to theirs (which are performed by the Audits & Investigations Division for medical services) as “audits.” DMHC contracts with outside clinician staff, including dentists, to conduct their surveys.

However, the dollar range DHCS gives CMAC for negotiating the rates has become so narrow there is virtually no room to negotiate, according to CMAC.²⁹ This significantly reduced CMAC's flexibility. In agreement with DHCS, the rate development and negotiation responsibility is going from CMAC back to DHCS effective July 1, 2010 if this provision in the Governor's FY 2010/11 budget is approved. DHCS re-assumed rate setting responsibility for County Organized Health Systems and the Two-Plan Model (described later in this report) about 3 years ago.

In fiscal year 2008-09, the Dental Managed Care plans were paid at the upper payment limit, i.e., the same level as the FFS rates. Therefore, according to DHCS, there were no State General Fund savings due to dental managed care rate negotiations in Sacramento GMC.³⁰

Healthy Families Program

The Healthy Families (HF) program, administered by the California Managed Risk Medical Insurance Board (MRMIB), is described here because it is another significant public source of children's health care coverage. HF offers similar medical and dental benefits as Denti-Cal but to children in families with slightly higher incomes. Children age 0-18 in families that meet income requirements are eligible for HF health, dental, and vision coverage if they are uninsured with no employer-sponsored health insurance in the last three months and not eligible for or enrolled in no-cost Medi-Cal.

All dental care for children in HF is provided by dental managed care plans. MRMIB contracts with 2 different types of dental plans, "open network" and "capitated" plans. Of 5 dental plans that contract with HF in Sacramento, 3 are also GMC contractors: Access, Western and Health Net. A HF *2008 Dental Quality Report*, published in April 2010, concluded that children in open network plans consistently received dental services at a higher rate than children enrolled in capitated plans.

A state law change starting November 1, 2009, limits dental plan choices for some families who do not have any child enrolled in HF for 2 consecutive years. New children will have limited dental plan choices during the first 2 consecutive years of enrollment. This means the children cannot choose Delta Dental or Premier Access if other dental plans are available in their county and zip code area.

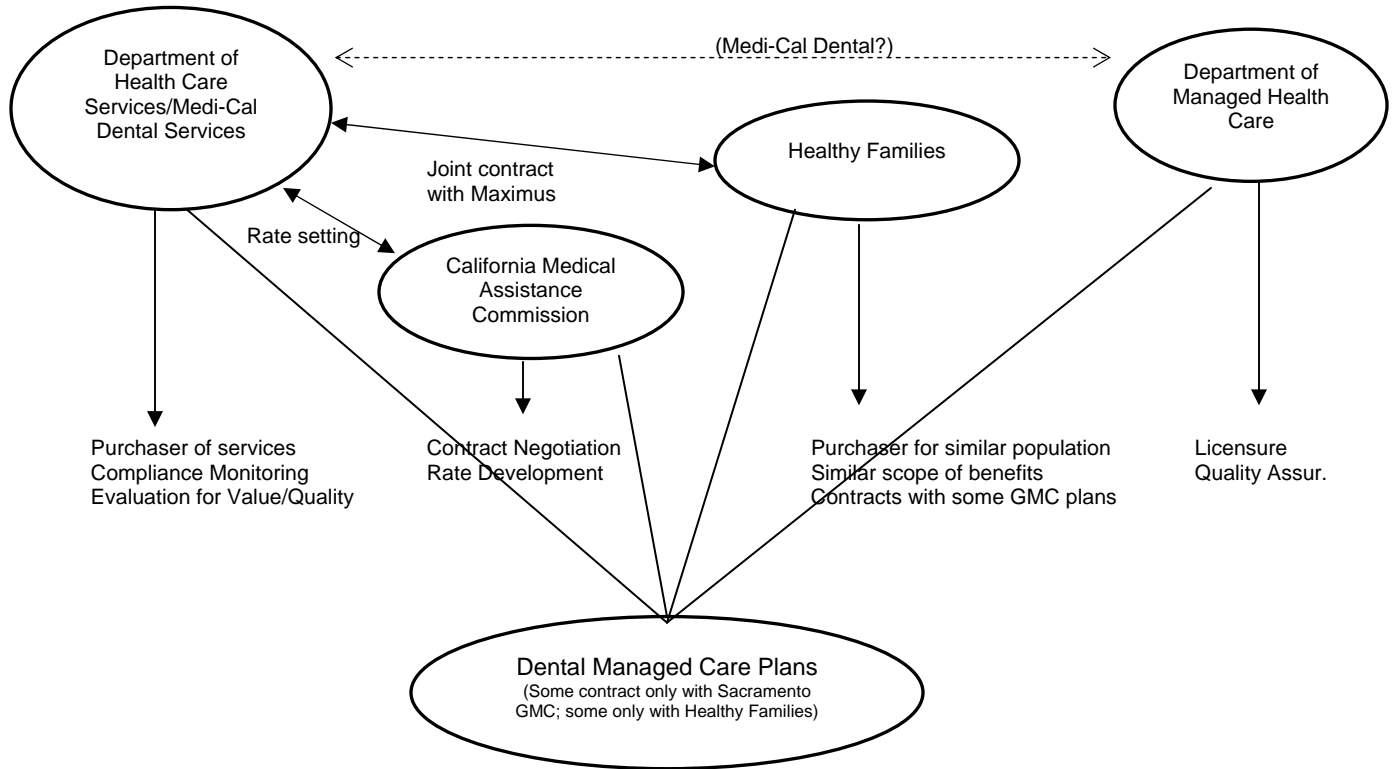
The HF program has begun to establish minimum performance standards and benchmarks and hold contracting plans accountable, but according to staff "dental has fallen behind medical." Collecting and analyzing data from plans is the way the program monitors quality. HF also evaluates members' satisfaction by conducting an annual survey among parents. MRMIB funding has not been available to produce such a report since 2007, however.

HF and Medi-Cal, while sharing a common application process, similar scopes of benefits for children, and comparable service delivery systems, have a limited relationship (HF and Health Care Options Branch in DHCS have a joint contract with Maximus); there is no regular forum for communication and sharing policies, data, and program results, according to State staff of both programs. Informally, staff has participated in specific

activities on an ad hoc basis, for example a Denti-Cal dental program consultant participated in development of the HF dental quality measures.

The relationship of these State agencies vis-à-vis GMC Dental Managed Care plans is displayed in the diagram on the next page (Figure 3).

Figure 3. Roles and Relationships of State Agencies in Relation to Sacramento GMC Dental



An Oral Health Workgroup convened by DHCS, that includes these and other state agencies as well as organizations with ties to oral health, such as the California Dental Association, was set up informally many years ago, and meets on a quasi-regular basis or as issues come up that the group wants to address.

How are Medi-Cal Dental Services Reimbursed?

Fee-for-Service

In a very simplified version of the FFS payment system, DHCS contracts with Delta Dental Plan and pays it an upfront, capitated amount each month for the number of current Denti-Cal beneficiaries, paying it the same per person, per month (ppm) rate as the managed dental plans, which is intended to cover administrative and direct service costs. This is not a managed care capitated rate, and Delta does not assume the responsibilities of a managed care plan.¹ Enrolled Denti-Cal providers submit claims to Delta and claims are paid by Delta at the Medi-Cal rate for the service, as established by the program.

¹ According to State staff, the capitation rate is purely for purposes of funding the Premium Fund. Currently, there is a maximum loss/gain of \$4 million +/- to the Fund. If claims cost \$50 million more than the rate, Delta cannot lose more than \$4 million; if claims cost \$50 million less, Delta still cannot gain more than \$4 million. Hence, the risk is minimized for both DHCS and Delta, and there is also the opportunity for cost savings on both sides.

California's Medi-Cal dental provider reimbursement rates are used for determining the dental managed care capitation rate. While most states' Medicaid payment rates are substantially below market rates, California's rates are among the lowest in the nation^j—significantly below the fees charged by most dentists, generally representing 30%-50% of dentists' fees.³¹ In an analysis of select 2008 data for dentist fees, only 5 states had lower Medicaid reimbursement than California for periodic oral evaluation visits, for example.³²

Dental Managed Care

GMC dental plan contractors accept full financial and operational risk for providing the required scope of services. Unlike providers in FFS Denti-Cal, GMC plans do not submit claims to Delta Dental or the State for services provided. The plans are paid upfront by DHCS on a capitation basis: a set amount based on the number of enrollees, paid on a per-member-per-month (pmpm) basis. Payment made in the current month is for the prior month's number of enrollees. Some of the plans report they pass on part of the managed care risk to their providers by also paying them a capitated pmpm amount, while others reimburse their providers on a FFS basis (but less than the full Denti-Cal FFS rate). All of the plans that contract out for pediatric dental service referrals pay those providers FFS and the GMC dental plans report having to pay anywhere from 120%-150% above FFS rates to entice the specialists to see GMC dental plan patients. Consequently, the plans attempt to provide pediatric specialty services in-house.

California's Medi-Cal dental provider reimbursement rates, based on prior time period's claims expenditures, are the basis for determining the pmpm capitation rate. DHCS actuaries calculate the pmpm fee, applying a percentage the State wants to save from what it projects it would have spent under FFS, and CMAC "negotiates" the rate (i.e., take-it-or-leave-it) with contracting dental plans.^k

CMAC negotiations with the dental plans are confidential under the Public Records Act, and the contract terms and conditions are exempt from public disclosure for 1 year and the contract rates for 4 years (Govt. Code §6254(q).) In responding to an inquiry from the Sacramento District Dental Society (SDDS), CMAC shared with SDDS that the rate effective on January 1, 2008 was \$10.11.³³ (Rates can increase/decrease at any point in the contract term at a minimum of every six months, but typically change on a yearly basis.) Although still not reasonable market rates, during this same period, by contrast the pmpm rates in Michigan and Central New York were \$14.61 and \$12.56, respectively.^{34,35} The pmpm capitated rate for TANF (Temporary Assistance for Needy Families) and CHIP (Children's Health Insurance Program) members in Arizona in 2008 was \$23.54.³⁶

^j Largely because of these low rates, 40% of California's private dentists accept Dent-Cal, and the vast majority of these are general practitioners rather than pediatric or orthodontic specialists, according to *Denti-Cal Facts and Figures: A Look at California's Medicaid Dental Program*. California Healthcare Foundation. March 2007.

^k DHCS contracts with Mercer, Inc. to work with its actuaries in setting rates for managed *medical* care; Mercer does not develop rates for dental managed care.

Conditions Precedent to Payment

It is common in State contracting to define performance requirements and typically provide incentives for strong performance and sanctions for failures. DHCS withholds monthly capitation payments to dental plans for certain conditions, and reserves the funds for future payment pursuant to specific requirements for performance. Currently, up to 4% can be withheld for failure to meet performance standards for the following measures:

- Preventive services — 2% may be withheld
- Quality Improvement Plan — 1% may be withheld
- General Operations — 1% may be withheld

The contract historically has also included a 3% withhold for a Utilization Management measure. Plans were expected to achieve a 38% utilization rate (the rate did not differentiate by age groups and combined children's and adults' utilization). *However, this provision was removed from contracts and is no longer enforced.* The withhold for utilization performance was rescinded in July 2009 by a previous DHCS official and dental plans are no longer required to comply with this measure. No written record of this decision could be located by State representatives. They recall, however, that the decision was initially a result of the 10% provider payment reduction; the plans made the case that the reduction, along with the withhold, made it almost impossible to do business. DHCS conceded to that and agreed to remove this provision. Although ultimately the payment reduction was overturned in court, the Department upheld its commitment to forgo this withhold.

DHCS reports that all plans in the past had some payment withheld for failing to reach this pre-established rate, although some experienced it more frequently than others. State representatives report, however, that current withhold percentages do not provide, for at least one plan, a sufficient incentive to provide adequate levels of care.

How Much Did DHCS Pay GMC Plans for Children's Dental in 2008?

As shown in Table 3 on the next page, the payment to GMC dental plans per *eligible* (i.e., enrolled member) in 2008 ranged from \$74.10 to Community Dental Services to \$86.57 to Western Dental. Since the capitation *rate* did not vary among plans, the variance in these payments is due to plans not always receiving their full capitation payments as the result of the precedent to payment withholds described above—mainly plans not meeting utilization thresholds, since they had generally been able to meet the other measures.¹ According to historic State records for GMC, Community Dental has been the least able to meet the utilization threshold, as evidenced in these data.

¹ Another, but less likely, reason for the difference in payment per eligible *could* be the result of different lengths of eligibility. If Community Dental, for instance, had a greater percentage of their members in the plan the whole year than others the amount paid to them would be higher; likewise, if a plan picked up a bunch of members near year end they may not have received a lot in payment for the new members but the members are included in the denominator.

Table 3. Total Amount Paid for Medi-Cal Dental Services for Children Ages 0-20, 2008

GMC Plan	Total Paid to GMC Plan	Number of Unduplicated Eligibles*	Payment per Eligible	Number of Unduplicated Users	Utiliz Rate	Payment per Unduplicated User
Access	\$4,050,308	46,941	\$86.29	10,612	22.6	\$381.67
Community	\$1,059,800	14,303	\$74.10	523	3.7	\$2,026.39
Liberty	\$2,030,080	25,058	\$81.02	6,120	24.4	\$331.71
Western	\$6,112,072	70,603	\$86.57	6,200	8.8	\$985.82
Total	\$13,394,750	156,905	\$85.37	23,455	14.9	\$571.08
Fresno County (FFS Comparison)	\$18,502,686	180,122	\$102.72	62,787	34.9	\$294.69

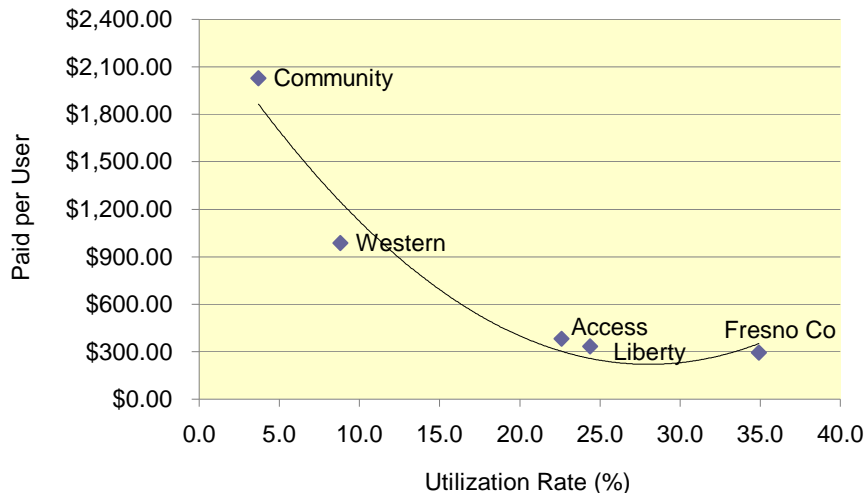
Notes: Full-year data is not available for Health Net. Sacramento GMC eligibles is the number enrolled in each plan; Fresno FFS eligibles is roughly equivalent to the number of enrollees per plan.

*Because plans are paid on the basis of unduplicated eligibles (i.e. payment made in the current month is for the prior month's number of enrollees), unduplicated eligibles are the appropriate figures to use for calculating payment information.

Source: Department of Health Care Services, Medi-Cal Dental Services Division. Payment calculations were performed by the authors.

One way of measuring value in the GMC dental program is to compare utilization with payments made for the provision of care. The lower the utilization, the higher the payment per user—and the lower value per dollar spent by the State. The variances in the payment per unduplicated *user*, attributable to the differences in dental utilization rate, are illustrated in the following graph (Figure 4). In 2008, the payment to Sacramento GMC dental plans per unduplicated user ranged from \$2,026.39 for Community Dental Services to \$331.71 for Liberty Dental Plan, more than a five-fold difference. Using this parameter, the GMC plans reflecting the best value to the State in 2008 were Liberty, which was similar to Fresno FFS, our comparative county, and Access (Health Net was too new to be included in these data).

Figure 4. Utilization by Payment per User, Sacramento GMC Plans and Fresno FFS, 2008



Note: Utilization rate is based on unduplicated eligibles because payment per user is based on unduplicated eligibles.

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

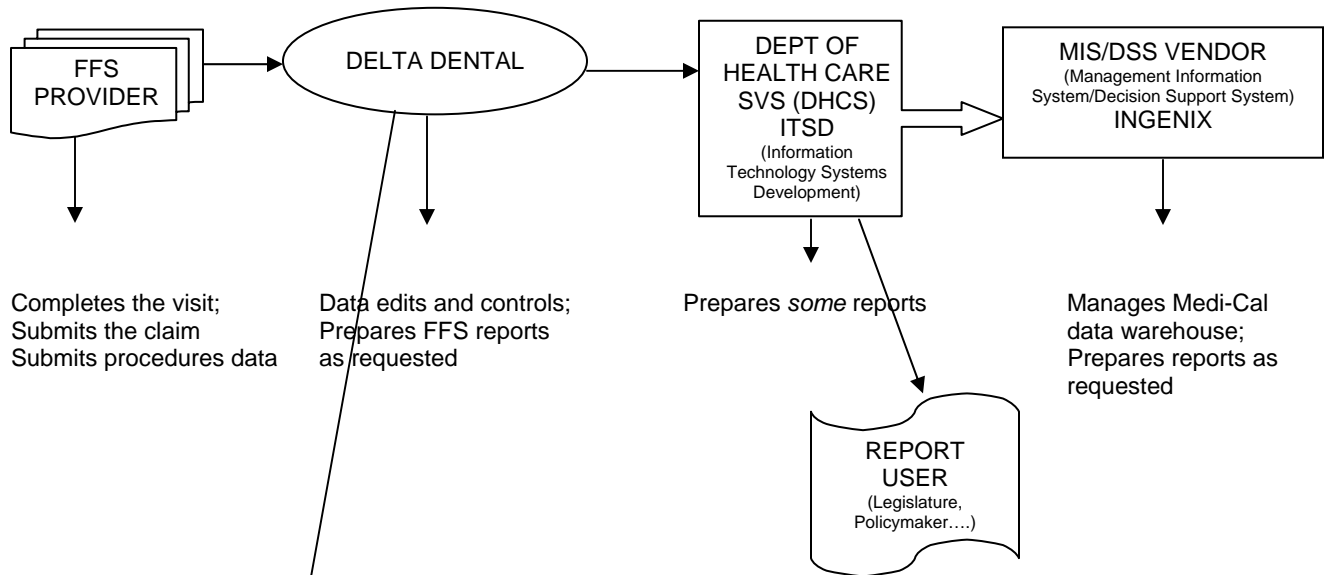
How are Data Reports Generated?

Data accuracy, completeness and timeliness are chronic problems in Medi-Cal, evidenced again in this study. The flow of data to the State from FFS providers and GMC dental plans for the generation of data reports is extremely complex and has been studied in detail elsewhere,³⁷ and its many challenges are well documented. As has been noted in these studies, the reimbursement method has significant influence on data process and accuracy within state information systems. In FFS models, there is an incentive to submit data for all procedures provided at all encounters, because procedures serve as the basis for payment. In managed care arrangements, that direct relationship between encounter and payment is missing. With capitation, the direct link “is removed between accurate data submission and reimbursement....data submission is a contract requirement rather than a means of payments and, as such, requires more innovative means of monitoring and incentivizing.”³⁸

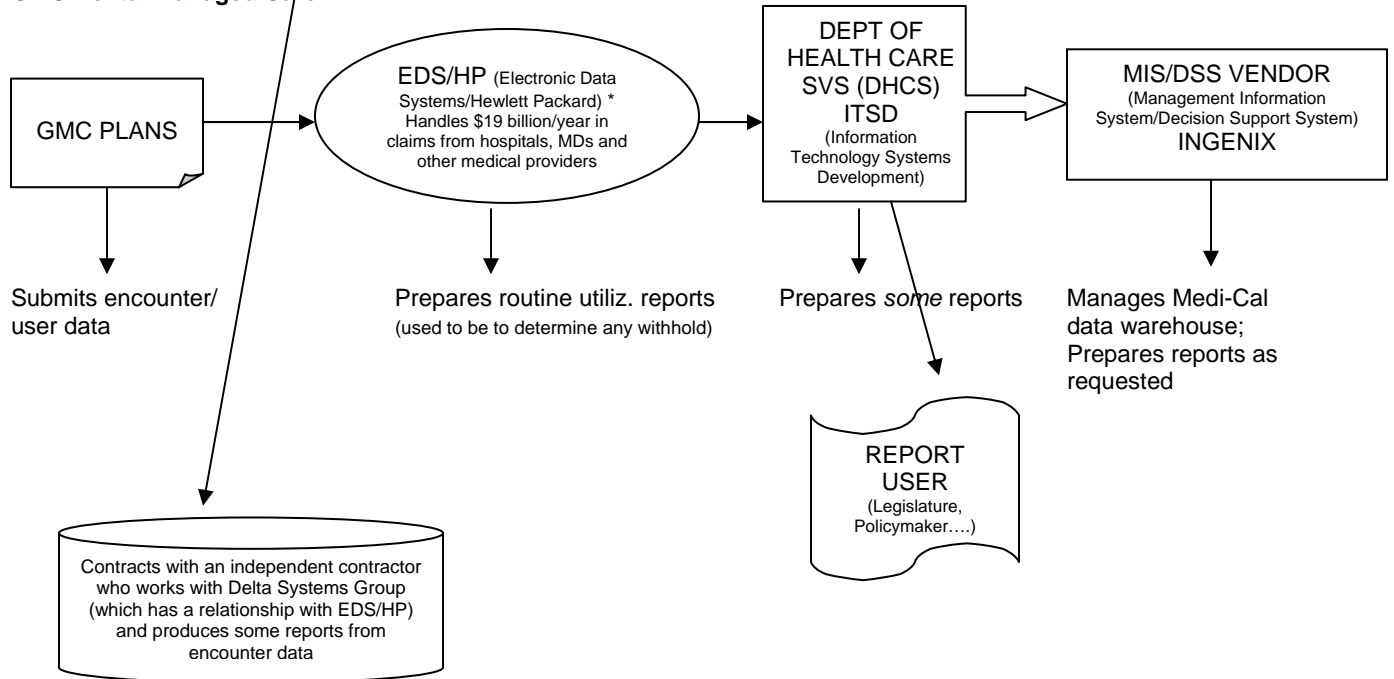
Submission of encounter information only impacts payment when withholds are under consideration, so there is little incentive at the provider level to submit complete data. The simplified diagram in Figure 5 on the following page can be helpful for understanding the main processes, roles and expectations for producing FFS and managed care data reports.

Figure 5. Data Flow and Report Generation in FFS and GMC Dental.

Fee for Services



GMC Dental Managed Care



(Note: ITSD stands for Information Technology Services Division.)

* HP acquired EDS 2 years ago, which held the contract for 18 years. The State just awarded the new 10-year contract to ACS (Affiliated Computer Services) but HP has challenged the State's decision in court.

What are the Characteristics of the Dental Plans that Participate in GMC?

A brief description of the 5 Sacramento GMC dental managed care plans is summarized in Table 4. Additional information about plans' dental networks and referral arrangements can be found on pages 35-36.

Table 4. Summary of GMC Dental Plan Characteristics*

Item	Access	Community	Health Net	Liberty	Western
History with GMC	Joined GMC in 1994	Joined GMC in 2005	Joined GMC in July 2008	Joined GMC in May 2005 replacing Delta and Safeguard	Joined GMC in 1994
Scope of plan	Dental only	Dental only	Both medical and dental	Dental only	Dental only
Medicaid dental managed care contracts in other states	No	No	Yes	Yes	Not currently but prior experience
Model of Delivery: Staff Model and/or Independent Practice Association (provider network)	Uses staff dentists plus has contracts with IPA dentists (approx. 50/50 mixed model)	Uses staff dentists in 4 Sacramento locations plus contracts with 12 IPA offices; general	Contract with approx. 35 IPA providers (mostly shared network with Liberty). Contracts with Liberty for administrative services.	Contract with approx. 35 IPA providers (mostly shared network with Health Net).	Staffed centers plus contracts with approx. 20 IPAs; operate 7 centers in Greater Sacramento with 3 handling GMC enrollees
Payment method to providers	Salary for employed DDS; IPA dentists paid a capitated rate. Effective 1/1/10 supplemental fee for each fluoride varnish provided to ages 0-3	Dentists are capitated; specialists paid FFS above Medi-Cal FFS rates; staff dentists are also providers for Liberty and Health Net	IPA providers are paid a capitated rate (approx 35% below usual and customary) plus \$ per procedure; specialists are paid 10% or higher above Medi-Cal FFS rates	IPA providers paid capitated rate (approx 35% below usual and customary) plus \$ per procedure.	Non-staff model dentists paid capitation (per month, per member), a per-encounter reporting fee, lab fees and supplemental payments

Table continues on next page

Item	Access	Community	Health Net	Liberty	Western
Frequency members are allowed to change dentist	Monthly	Any time	Any time	Any time	Monthly (at any time exceptions for cases with special situations)
Average wait for routine dental visit after requesting an appointment	3 weeks, per contract requirement	3 weeks, per contract requirement	3 weeks, per contract requirement	3 weeks, per contract requirement	3 weeks, per contract requirement
Quality Assurance	Annual on site chart review; quarterly member survey; "secret shopper" program; 3 yr rotating audit	Conducts sample (N=24) chart audits; compares these with other plans through shared audit warehouse; quarterly provider meeting	On site facility and sample (N=10) chart review audits with 3 yr rotation; recently surveyed Sac. IPA dentists to ask about waiting time for new appt.	Rigorous credentialing program; pre-contract on-site review; focused audits with 3 yr rotation; plan reps contact provider offices each quarter; blind calls to offices "regularly" with documentation	Large QA dept in LA that covers state; 7-8 dentists conduct reviews
Stated policy re: age at first visit ^m	AAPD and AAP guidelines (Age 1)	Age 2 "when child is more manageable and has more teeth"	AAPD and AAP guidelines (Age 1)	AAPD and AAP guidelines (Age 1)	AAPD and AAP guidelines (Age 1)
Efforts in Sac. to increase utilization by children	Sends reminder letter for ages 0-3 members every quarter including reminder to provider offices	No outreach to members; limited to annual newsletter to providers about children	Newsletters to providers	Outbound calls to members; help parents to make appointments ("warm transfers")	No outbound calls. Annual newsletter to members that contains something about children

*Source: Interviews and email communication with plan representatives. Not all information could be verified in this study.

^m The GMC contract does not contain a requirement concerning age of a child's first dental visit. Although all of the dental plans except Community stated their policy was to start seeing a child by "the first birthday/the first tooth"—consistent with American Academy of Pediatric Dentistry^m and American Academy of Pediatrics recommendations^m—not all staff at the dental offices are aware of or comply with this policy. In telephone calls we made to several offices posing as a mother of a 9-month old child on Medi-Cal who wanted to know when to first bring her child for a dental exam, the most common response was "age 2-3." When we notified the dental plans of the findings one responded and said they were beginning training that day at each of their offices to correct the situation.

III. Access Factors



“I see Denti-Cal, but only family of existing private patients.”
—Sacramento private practice dentist

“Kids in GMC seem to be having better access to specialty care than they did under FFS when they had to find it for themselves; at least in GMC plans are required to link them to pediatric specialty services.”—
County Health official

What is the Medi-Cal Eligibility Period?

Once enrolled in Medi-Cal, the child is covered for a period of 1 year. Re-certification is required annually. Eligibility was reduced to 6 months on July 1, 2009. However, the State had to revert back to the 1-year period as a condition of receiving federal stimulus funds; this condition remains under Health Reform laws.

What are Common Barriers to Getting Oral Health Services?

Barriers to accessing oral health services for children are multifaceted and complex. Lack of available resources and willing providers—which GMC was set up to alleviate—restrictive policies, provider attitudes and lack of cultural and linguistic competence among dental providers account for the main barriers on the health systems side. Common patient-related barriers include lack of perceived need and knowledge about the importance of oral health, financial concerns (lack of dental insurance, high deductibles and share of costs), dental fear, and logistical challenges such as transportation.

GMC plans want the State to be more active in helping them to reduce these common family-related challenges which include:

- *Lack of knowledge about the importance of dental care.* Some parents do not understand the connection between diet and tooth decay and failing to seek oral health services, particularly for young children. Many parents, including those who are well educated, believe baby teeth are not important because they will be replaced by permanent teeth.
- *Parents’ own fear or anxiety with dental care.* In surveys and focus groups this has been stated as a reason for not taking their child to a dentist.^{39,40} Personal experiences with dental care when encountering pain may influence caregivers’ attitudes about access and enthusiasm for dental care for young children.⁴¹
- *“No show” appointments.* Transportation and getting time off from work are practical barriers frequently cited by low-income parents that contribute to their inability to keep scheduled appointments. High no-show rates deter providers from accepting these families.

- *Acculturation and language barriers.* Difficulty speaking English to effectively communicate with providers has also been shown to have some impact on determining use of dental care.⁴² Similar to FFS providers, GMC plans are required by contract to address the cultural and linguistic needs of Medi-Cal members.

To What Extent is the Supply of Local Dentists a Barrier to Access?

While many factors contribute to low use of dental services among Medi-Cal children, including those related to responsibility of the family, a major deterrent is finding a dentist who accepts this form of coverage. Issues surrounding participation of dentists in the Medi-Cal program are complex. Many studies have documented low payment rates, burdensome administrative requirements, and patient compliance issues as the primary reasons why dentists do not want to accept Medicaid patients in their practice.⁴³ While overall dentist supply can affect the number of dentists available to treat Medi-Cal children, supply is not a limiting factor in Sacramento County.

With approximately 1,124 dentists, of which 990 (88%) are estimated to be in active practice, Sacramento County is considered to have a medium-to-high supply with an estimated dentist-to-population ratio of 3.5 dentists/5,000 population, mirroring the average statewide ratio.⁴⁴ * Approximately 80% or 792 of the county's active dentists are general or family dentists, and 2%-3% of the remainder are pediatric specialists.⁴⁵ Supply, however, does not address the question of whether general dentists are willing to see children with Denti-Cal or even whether general dentists are trained and agreeable to see the very youngest children.

How Many Dentists Participate in GMC, and How are Dental Services Organized?

Two of the Sacramento GMC dental plans use contracted providers only for general dental services; another 2 use primarily an employed staff model, and another uses a blend of staff and contracted providers.

Access and Western utilize a staff model of salaried dentists to serve GMC enrollees. Both plans report generally not encountering problems recruiting dentists (for example, because some dentists want part-time work there is more flexibility for managing staffing). At the Access dental centers, the staff model dentists give preference to GMC members, but also see some limited FFS Denti-Cal patients. (Some of their staff model offices do not accept any Denti-Cal patients.) The independent dentists contracted with Access have to see the GMC patients but it is up to them whether to see Denti-Cal patients or not.⁴⁶ Access reports a "generally stable" network of contracted dentists.

Liberty, Health Net and Community Dental Services utilize an Independent Practice Association (IPA) network of private practice dental offices for GMC children. Liberty and Health Net share nearly the same provider panel. Their November 2009 directories, which were somewhat out of date (several numbers were discontinued or dentists no longer

* The active-dentist-per-5,000 population ratio in California ranges from 0.0 in Alpine County to 6.1 in San Francisco County. One-third (18 of 58) of the counties have ratios higher than Sacramento's (and California's) 3.5 ratio.

worked there when we made telephone calls), show approximately 36 IPA general dentists as available to see GMC children.

Community Dental Services' IPA provider panel, which overlaps somewhat with the other plans' IPA panels, includes 30 dentists in 11 offices. Community also has staff model clinics called SmileCare Dental Group and Community, as well as Liberty and Health Net, utilize those general dentists as well for GMC children. SmileCare has 4 locations in Sacramento with GMC members assigned to a center. However, because SmileCare representatives told us it was closed to new membership for general dentistry and has been for many months, the adequacy of the provider network is not entirely clear.ⁿ SmileCare stated that it "has a very high turnover in employees and is frequently replacing staff that are no longer at these facilities."

Pediatric Specialty Care Providers and Referrals

Unlike the FFS system, dental plans can be held accountable for ensuring that enrolled children are receiving appropriate and timely referrals for pediatric specialty services. While all plans have specialist networks—including the staff model dental plans—the networks for all of the plans are limited by the unwillingness of local pediatric dental specialists to accept Medi-Cal dental rates.

Community's staff model clinics, SmileCare Dental Group, serve as a resource for specialty care but not for *pediatric* care as there are no pediatric dentists in SmileCare for Sacramento. Community's pediatric referral arrangements are with 3 private pediatric practices, and in 2008 they made approximately 420 GMC pediatric referrals. Liberty contracts with 9 private pediatric specialist offices in Sacramento; Health Net contracts with 8 of those 9. In 2008, Liberty GMC had 439 pediatric referrals and Health Net GMC had 53 pediatric referrals.

Access lists 3 offices, one with several providers, along with in-house pediatric specialists for its pediatric specialty referrals. The number of combined referrals to 2 of the outside resources (one provider did not receive any referrals in this period) in 2008-2009 was 58 GMC children. In 2008, Western reported 1,287 referrals to pediatric specialists, about 75% of which were referred within the staff model and 25% to contracted independent network offices (private pediatric practices, not owned by Western).

While there is a distance-to-provider requirement (within 10 miles or 30 minutes from a member's residence) in the GMC contract, it only applies to primary care dentists. The specialist can be any distance away the plan deems reasonable with the following proviso: the contract requirement states that the specialist be located within the plan's service area. None of the GMC plans' referral resource lists included pediatric specialists who were located outside of Sacramento County, and none indicated during interviews that out-of-county specialist resources were used.

ⁿ When we talked with one of the SmileCare offices in the plan's general dentistry directory we were also told they didn't see anyone younger than age 3 because "the 3 year old child is so small" and they tell the parent to "call a pediatric dentist for an appointment." We reported the result of this telephone call to Community Dental. All of the GMC plans indicated this was NOT their policy.

How Interested are Sacramento Dentists in Denti-Cal?

Of the approximately 900 Sacramento County dentists that were sent the Sacramento District Dental Society's (SDDS) 2009 Denti-Cal^o survey, 168 (19%) responded. Very few of the total Sacramento respondents participate in public programs (Table 5). Ten percent of these mostly-general dentists reported accepting Denti-Cal children, and 13.8% are on the Healthy Families provider panel. It appeared that anywhere from 20-30 of the survey respondents were affiliated with GMC plans, although inconsistencies in responses made it a little difficult to know for sure.

Table 5. Sacramento Dentists' Participation in Public Programs

Do you accept any Denti-Cal patients?		
Answer Options	Percent	No.
Yes, children only	10.1%	17
No (neither now nor formerly for adults)	88.7%	149
I am considering accepting Denti-Cal	1.2%	2
<i>answered question</i>		168
<i>skipped question</i>		0
Are you listed on a provider panel for the Healthy Families program?		
Yes	13.8%	22
No	86.2%	137
<i>answered question</i>		159
<i>skipped question</i>		9

Source: Sacramento District Dental Society Survey, November 2009.

While nothing would persuade more than half (52.8%) of the responding dentists to participate in Denti-Cal, as shown in Table 6 on the next page, higher reimbursement and reduced administrative burdens might make a difference for approximately 40% and 30%, respectively, in seeing Denti-Cal children in their practice.

^o The survey used the term "Denti-Cal" so for some questions respondents may have considered that to mean FFS and others to mean GMC, or for some respondents it might have meant either or both systems.

Table 6. What would Motivate Sacramento Dentists to take Denti-Cal?

If you do not currently accept Denti-Cal... What would it take for you to see Denti-Cal children in your practice? (Check all that apply)		
Answer Options	Percent	No.
Nothing; I don't wish to accept Denti-Cal	52.8%	85
Higher reimbursement [fee for service or capitation] rates	40.4%	65
Reduced paperwork burden	29.8%	48
Other (please describe)	12.4%	20
<i>answered question</i>		161
<i>skipped question</i>		7

Source: Sacramento District Dental Society Survey, November 2009.

These findings mirror numerous surveys and reflect the interviews we conducted for this study, in which dentists cited 3 main reasons for non-participation in Denti-Cal:

- reimbursements that are often well below their commercial fees;
- difficulties in navigating the program's administrative requirements that can overwhelm small offices; and,
- a clientele that is harder to schedule and work with than private-pay patients.⁴⁷

In echoing these sentiments, the SDDS survey respondents offered the comments summarized in Table 7, in rank order of mention, reflecting both health system and patient-responsibility factors related to Denti-Cal FFS or GMC.

Table 7. Factors that Affect Sacramento Dentists' Willingness to See Denti-Cal Children

<p>Health System-Related</p> <ul style="list-style-type: none"> ▪ Restrictive treatment requirements/policy restrictions (<i>"Less manipulation of treatment recommendations"</i>) ▪ Claims processing hassles (<i>"Excessive documentation and so many hoops to jump through to get paid"</i>) ▪ Low reimbursement rates (<i>"It's normally not worth my time to fight with Denti-Cal, so I basically give away my services for free as a community service"</i>) ▪ Not having the ability to limit participation and the number of children seen (<i>"Be able to completely stop being a provider if and when I so desire"</i>) ▪ Not being treated as a professional (<i>"Being treated as a scumbag"</i>) <p>Patient Responsibility-Related</p> <ul style="list-style-type: none"> ▪ No-show rate (<i>"Have them show up or be reimbursed for missing appointments"</i>) ▪ Patient behavior (<i>"Families who leave a mess in the office"</i>) ▪ Patient attitude (<i>"Reduction in the attitude of entitlement"</i>)

Source: Sacramento District Dental Society Survey, November 2009. Coded and analyzed by study authors.

Are There Practice Limitations in GMC?

In general, dentists who were associated with a GMC plan do not place restrictions on their participation (Table 8). For the approximately one-third who do, limits on benefits, locations, time of day, and the number of children were reported.

Table 8. Practice Limitations in GMC

(Sacramento Only) If you contract with a GMC plan for Denti-Cal, what limitations are there on your participation? (Check all that apply)		
Answer Options	Percent	No.
None	68.0%	17
The number of kids you'll see	8.0%	2
The location where you'll see them	12.0%	3
The days/time of day you'll see them	12.0%	3
The scope of services you provide to them	20.0%	5
Other (please specify)		6
<i>answered question</i>		25
<i>skipped question</i>		143

Source: Sacramento District Dental Society Survey, November 2009.

How Likely are Local Dentists to Participate in Denti-Cal Without GMC?

When Sacramento dentists were asked about their likelihood of participating in Denti-Cal "if there was no more GMC," about 7 in 10 (69.8%), indicated they were "unlikely" or "somewhat unlikely" to do so (Table 9). Eleven percent, however, stated they would be "likely" and another 19.2% indicated they would be "somewhat likely." This 30.2% of respondents' potential interest in participating in Denti-Cal without GMC is much greater than the current rate of participation in Denti-Cal among respondents.

Table 9. Sacramento Dentists' Likelihood of Participating in non-GMC Denti-Cal

If there was no more GMC in Sacramento County and FFS Denti-Cal was re-instated, what is the likelihood you would take Denti-Cal children in your practice?		
Answer Options	Percent	No.
Likely	11.0%	16
Somewhat likely	19.2%	28
Somewhat unlikely	12.3%	18
Unlikely	57.5%	84
<i>answered question</i>		146
<i>skipped question</i>		22

Source: Sacramento District Dental Society Survey, November 2009.

Are Hospital Emergency Departments Being Used Unnecessarily for Dental Care?

Visiting an emergency department (ED) for dental care suggests poor prevention and access to community dental services, according to a report supported by the California HealthCare Foundation.⁴⁸ The study, which focused primarily on adults, found that *most children who end up in the ED for preventable dental conditions are ages 5 and under.*

Without adequate access to oral health care, dental diseases and conditions may go untreated, resulting in unnecessary ED use and, in extreme situations, hospitalization. Hospital EDs are not equipped to provide definitive treatment for toothaches and dental abscesses. According to a Pew report, no reliable national data exist on what low-income families do when their children have dental problems but cannot access regular care, but anecdotal evidence suggests that a sizeable number turn to emergency rooms.⁴⁹ Children who are taken to hospital EDs for severe dental pain “can end up in a revolving door that costs Medicaid—and taxpayers—significantly more than preventive and primary care.”⁵⁰

Using 2007 and 2008 discharge data from the Office of Statewide Health Planning and Development (OSHPD) for Sacramento facilities, we examined ED use by children when an oral condition was the primary diagnosis.^p The data were broken out by payer type to see how well publicly-funded programs are keeping children out of the ED. The oral conditions were identified by primary ICD-9 diagnosis codes. The five codes considered to be ambulatory care sensitive conditions (ACS)^q are reported below as these reflect conditions that could have been handled in an outpatient non-emergency setting if addressed soon enough.⁵¹

Children ages 0-18 made 1,643 visits to Sacramento County emergency departments in 2007-2008 due to a primary oral condition diagnosis.^r Of these ED visits, 1,098 (67%) were made for an ACS condition (Table 10 on the next page).

ⁱ Oral conditions as a secondary diagnosis were not analyzed due to very small occurrences.

^j The primary ICD-9 codes identified for oral conditions are 520-529; the subset of ACS conditions are based on ICD-9 codes 521-523 and 528-529.

^r The number of unduplicated children making an ED visit for a preventable dental condition was not analyzed due to data insufficiency. More than 40% of children do not have a social security number at the time of the ED encounter and thus cannot be uniquely identified.

Table 10. Visits to Sacramento County EDs for Preventable Dental Conditions,¹ by Payer, Children Ages 0-18, 2007 – 2008

Primary ICD-9 Codes	Age 0-5				Age 6-18				Age 0-18			
	Private Insur ²	Pub Prog	Self Pay	Total	Private Insur	Pub Prog	Self Pay	Total	Private Insur	Pub Prog	Self Pay	Total
Diseases of hard tissues of teeth	4	20	3	27	17	76	14	107	21	96	17	134
Diseases of pulp and periapical tissues	30	68	13	111	81	155	42	278	111	223	55	389
Gingival and periodontal diseases	38	76	7	121	6	21	11	38	44	97	18	159
Diseases of the oral soft tissues, excluding lesions specific for gingiva and tongue	68	178	26	272	40	63	18	121	108	241	44	393
Diseases and other conditions of the tongue	3	5	2	10	6	5	2	13	9	10	4	23
Total Number and Percent for age group	143 (27)	347 (64)	51 (9)	541 (100)	150 (27)	320 (57)	87 (16)	557 (100)	293 (27)	667 (61)	138 (12)	1098 (100)

¹ Ambulatory care sensitive conditions; primary ICD-9 Codes Included in the analysis: 521-523, 528, and 529.

² Although not specified in the reporting form, this likely refers to *medical* insurance.

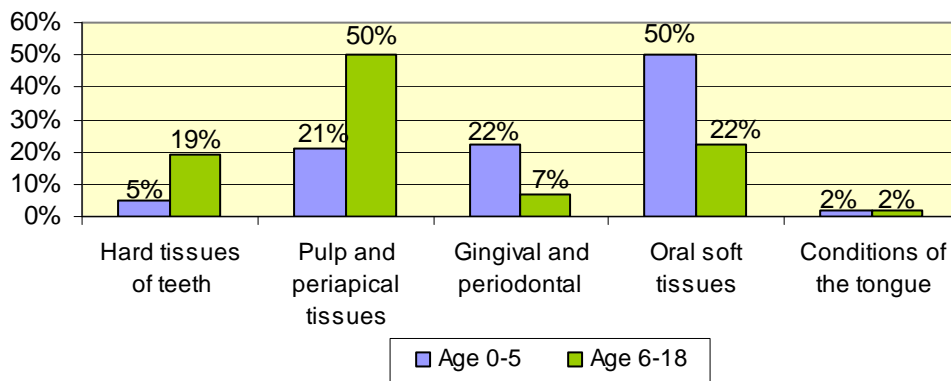
Notes: Data are by facility location, not county of residence. Medi-Cal represents 99.7% of the "Public Program" payer category. Percents are rounded.

Source: Office of Statewide Health Planning and Development, Healthcare Information Resource Center. Data Run November 2009.

What Type of Oral Conditions Took Children to an ED?

Inflammation due to infections for children 0-5 and inflammation and tooth pain for children 6-18, were the most common reasons children visited the ED, regardless of payer type (Figure 6). Good outpatient care could potentially have prevented the need for many of these ED visits.

Figure 6. Preventable ED Visits by Type of Oral Condition, Children 0-5 and 6-18, 2007-2008

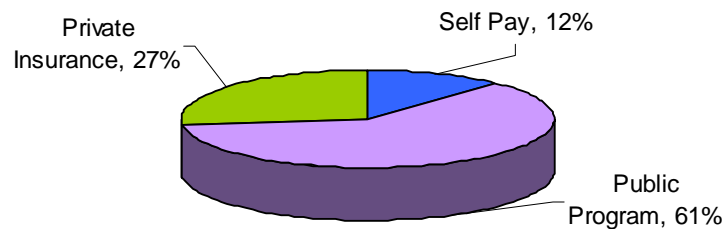


Source: Office of Statewide Health Planning and Development

What Sources Paid for ED Visits?

When considering all Sacramento County ED use for dental reasons by children, public programs picked up the tab for the clear majority (61%) of the ED visits considered preventable (Figure 7). This payer source is nearly entirely (99.7%) represented by Medi-Cal. An even higher proportion (64%) of the 0-5 year-olds' visits was paid for by the public programs category. The disproportionately high percentage of ED visits covered by a government program suggests the need for increased prevention activities of families and caregivers and earlier intervention by Denti-Cal providers for those children enrolled in GMC at the time of the visit.⁵

Figure 7. Percent of Preventable ED Visits by Type of Payment Source, Children Age 0-18, 2007-2008



Source: Office of Statewide Health Planning and Development

While a small proportion of overall ED costs, in 2008 Medi-Cal paid a total of \$106,635 for all costs (facility, pharmacy, lab, etc.) for Sacramento ED visits and in-patient hospital admissions for children age 0-18 for the mostly-avoidable oral conditions (Table 11). The costs paid for children 0-5 was \$51,523. Given that all but about 8% of Sacramento Medi-Cal children are in GMC (discussed later in the Utilization section), it is probable that the majority of these costs were for GMC members.

⁵ Hospitals have electronic capacity to determine Medi-Cal eligibility at the time of the ED visit; and, Medi-Cal can cover up to three months retroactive from the date of application. Thus it is possible that some of the visits Medi-Cal paid for could have been patients that were actually in the "self pay" (which includes uninsured) category at the time of the visit, hence potentially over-stating the implications of lack of access to preventive services. Instructions to hospitals for ED data reporting are not specific about coding payer source at time of visit. Some, like UC Davis Medical Center and Mercy General, record the expected payer at time of admission, and some the *actual* payer, such as Sutter General, according to personal communication with these hospitals.

Table 11. Amount Paid by Medi-Cal for Sacramento County ED and Hospital Users Age 0-18 with an ACS Dental Primary Diagnosis, 2008

Point of Service	Age 0-5		Age 6-18		Total	
	No. of Children	M-C Paid	No. of Children	M-C Paid	No. of Children	M-C Paid
Emergency Room	219	\$19,029	188	\$17,083	407	\$36,112
Inpatient Hospital	15	\$32,495	19	\$38,028	34	\$70,523
Total	234	\$51,523	207	\$55,111	441	\$106,635

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

How Does the Current System Encourage or Discourage Emergency Department Use for Dental Care?

As currently structured, there is an opportunity to cost shift¹ from the dental to the medical side. When a child enrolled in Sacramento GMC receives oral care in a hospital setting (outpatient or inpatient), the child’s medical plan pays for the admission exam, operating room fee, anesthesiologist fee,^u recovery room fee, and associated medical expenses. The dental plan pays for the procedure codes billed by the dentist^v if a dentist sees the child (this would most likely be an oral surgeon as very few general dentists have hospital privileges). These costs include the professional fee and any appliances/devices the dentist uses or provides to the child.

With medical managed care there is an incentive to keep enrollees out of the hospital as plans have to contract with hospitals and take the costs out of their capitation rate. On the dental side, however, if plans and their providers do not provide preventive services to children, and if they have to get care in a hospital ED, the cost falls on the medical side. The disproportionate use of the ED by children enrolled in Sacramento GMC compared to the 2 FFS counties displayed in Figure 7 above suggests a higher frequency of use of EDs as a way of getting care. Dental managed care dental services are not rewarded for minimizing ED use. Health Net, because it provides both dental and medical care, may be an exception because it has an incentive to keep children out of the ED.

What Strategies Exist for Managing ED Use?

In 2007, Medi-Cal Managed Care Division (MMCD) established a statewide collaborative to reduce ED visits. One of its Quality Indicator goals is to reduce avoidable ED visits by children 1-19 years of age by 10% by October 2011. MMCD was prompted to create the project after baseline survey results of the contracted managed care plans revealed that members enrolled in Medi-Cal managed care made frequent ED visits; often viewed the

¹ Cost shifting is when the cost of a service is moved from the person who incurred it to the person in a better position to pay, e.g. when hospitals shift the burden from the public sector to the private sector or, in this case, when the cost for providing dental services is borne by the medical services side, which can distort the true cost of services.

^u If the anesthesia provider is a DDS, then the dental plan pays for the anesthesiologist.

^v If the dentist is capitated, he/she won’t bill by procedure code. If the dentist is being paid FFS, the plans may differ in whether they pay the costs of appliances on top of the fee for the procedure.

ER as their usual source of care; and did not want to contact their primary care physician or wait for an appointment.⁵² MMCD, which does not have authority related to dental, only medical managed care contracts, has not addressed ED use by children for avoidable oral conditions. Medi-Cal Dental Services, which has authority over dental but does not have Quality Indicators,^w has not required managed dental plans to participate in the assessments of ED use when related to oral conditions as a primary diagnosis.^x

What Other Dental Insurance Programs are Available to Low-Income Children in Sacramento County?

These programs are not substitutes for Medi-Cal. Children eligible for free Medi-Cal are generally not eligible for these other programs. The other programs are discussed to show the contrast between the programs and Medi-Cal.

Healthy Families

As described on page 25, Healthy Families offers similar medical and dental benefits as Denti-Cal but to children age 0-18 in families with slightly higher incomes. As of September 2008, Sacramento County dental enrollment in Healthy Families was distributed across participating plans as shown in Table 12.

Table 12. Enrollment in Dental Plans That Do Business with Both Healthy Families (Children Age 0-18) and Sacramento GMC (Children Age 0-20), 2008

Program	Dental Plans			
	Access	Health Net	Western	Total
Sacramento HF (Average membership, 2008)	3,938	559	3,065 (limited to specific zip codes)	7,562
Sacramento GMC (During 2008)	48,925	4,927*	73,577	127,429

*July-December only; the GMC dental contract began July 1.

Source: Managed Risk Medical Insurance Board, Healthy Families Program.

Cover the Kids/Healthy Kids

Of the approximately 362,480 children ages 0-18 in Sacramento County, the Healthy Kids program estimated that 16,000 (5%) did not have any form of medical or dental coverage in 2007. (The figure is likely to be higher in the current economy.) About two-thirds (10,560) of these children were actually eligible for subsidized programs such as Medi-Cal and Healthy Families but are not enrolled for various reasons. Approximately 8,600 were not eligible due to citizenship status. In 2006, Cover the Kids (CTK), Sacramento's Children's Health Initiative—a broad-based collaborative of business, education,

^w Quality indicators in health care are norms, criteria, standards, and other direct quantitative or qualitative measures used in determining the quality of care.

^x GMC dental plans do not collect ED data. They have no EDs contracted and unless the plan is billed by a rendering DDS for a service provided in an ED—which none did in 2008—they make no payments to EDs.

community-based and health organizations—launched the Healthy Kids (HK) insurance product. HK is available for children not eligible for existing public programs whose family incomes are between 251% - 300% of the federal poverty level, and children up to 300% of the federal poverty level regardless of immigration status.

Currently, about 1,000 Sacramento children age 0-18 receive care through the HK product. Dental services are provided through Delta Dental's dental plan, with a scope of benefits similar to Denti-Cal and Healthy Families. Three foundations, Blue Shield, Sierra Health Foundation, and The California Endowment, along with Sacramento County and First 5 Sacramento, have picked up the tab for HK premiums funding. The fund is administered by Healthy Kids Healthy Future, a Regional Children's Health Initiative which in addition to Sacramento, includes Yuba, Colusa, El Dorado, and Placer counties. The David and Lucile Packard Foundation covers a portion of the administrative costs of the program.

CTK conducts outreach to families throughout Sacramento County to identify children eligible for the subsidized programs—including Kaiser's Child Health Plan—and assists them with the application process, as well as provides case management services to help maintain coverage. While CTK has no formal relationship with the GMC dental program at a higher level, at the service level it helps families enrolled in GMC who are experiencing access or utilization problems by connecting them to someone in the plan who can help. CTK routinely follows up with families it has assisted at least 3 times a year to encourage parents to make use of the dental benefits.

HK premium funding is not sustainable without continued private-source funding. Because premium funding for children age 6-18 will expire in October 2010, beginning in May 2010 the program will stop enrolling children in this age group and begin a phased-out disenrollment. However, county First 5 Commissions in this region have committed premium funding through 2011 to sustain the program for children 0-5.⁵³

Similar to public programs' experience, there is a "disconnect" between having coverage and utilizing the benefits. Of the 956 Sacramento children 0-18 covered by HK on average each month in 2008, 96 (10.04%) children used a dental service—a *utilization rate lower than Sacramento GMC*—which HK cannot explain.

What Safety Net Resources are Available for Children in Sacramento County?

The following dental clinics (Table 13) provide some safety net services for Sacramento's low-income families although not all of them provide a dental home where comprehensive, regular oral health services may be accessed.



Table 13. Children’s Safety Net Dental Resources in Sacramento

Organization/ Website	Address/ Phone Number	Hours	Services	Payment Options
Sacramento County Dental Clinics				
Sacramento County Primary Care Clinic	4600 Broadway Sacramento, CA 95820 (916) 874-8300	Mon-Fri 8:00 am-5:00 pm No appointments taken. First come, first served beginning at 8:00 am and again at 1:00 pm	Preventive and limited restorative services for CHDP children 0-18 with physician referral	Free for qualified individuals.
Other Clinics in Sacramento County				
Sacramento City College Dental Hygiene Clinic www.scc.losrios.edu/ dentclinic.html	3835 Freeport Ave Rodda Hall Sacramento, CA 95822 PH: (916) 558- 2303	Hours vary by school semester. Call the clinic for current hours. Most children services are offered in February.	Screenings, prophylaxis, x-rays, and sealants. Most children services are offered in February.	No private insurance or Medi-Cal; call clinic for current fee schedule.
Western Career College Dental Hygiene Clinic	8909 Folsom Blvd Sacramento, CA 95826 PH: (916) 361- 5168	Tues, Wed and Thursday: 8 am and 1 pm; Friday: 8 am	Hygiene services including prophylaxis, x- rays, and sealants.	Free hygiene, \$10 for x- rays, cash only
Organization/ Website	Address/ Phone Number	Hours	Services	Payment Options
Sacramento Native American Health Center www.snahc.org	2020 J Street* Sacramento, CA 95814 PH: (916) 341- 0575 *Children’s dental clinic scheduled to open July 2010 (funded by First 5 Sacramento)	Mon-Fri 8am-6pm	Patient education, prevention and general dental including exams, x-rays, emergencies, fillings, extractions, cleanings, sealants, and fluoride.	Medi-Cal, some private PPO insurance, sliding scale

Table continues on next page

Organization/ Website	Address/ Phone Number	Hours	Services	Payment Options
The Effort	<p>2 locations:</p> <p>Oak Park Community Health Center* 3415 Martin Luther King Jr. Blvd. Sacramento, CA 95817 916-233-4910</p> <p>North Highlands Multi-Service Center* 6015 Watt Avenue, Suite 2 North Highlands, CA 95660 916-679-3925</p> <p>*Scheduled to open July 2010 (funded by First 5 Sacramento)</p>	Mon-Fri 9am-5pm	Patient education, prevention and general dental including exams, x- rays, emergencies, fillings, extractions, cleanings, sealants, and fluoride.	Medi-Cal FFS and Managed Care; Healthy Families, Healthy Kids and uninsured; no CMISP (County Medically Indigent Services Program) or private insur.

Note: Current as of April 21, 2010.

IV. Utilization of Services

"It's normally not worth my time to fight with Denti-Cal, so I basically give away my services for free as a community service."—Sacramento pediatric dentist

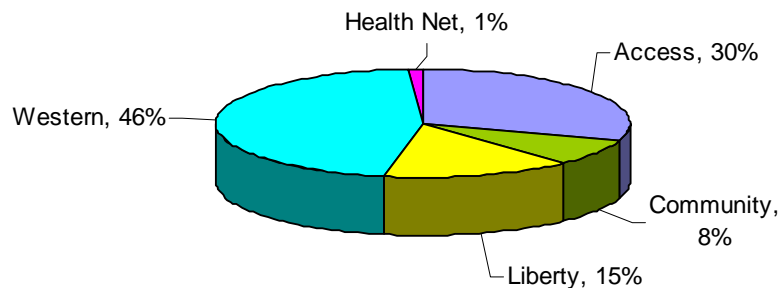


Annual dental utilization rates for Sacramento GMC children lag behind those of children with Denti-Cal in most other California counties. GMC plans have not provided an adequate level of outreach to try to get assigned children to utilize their dental benefits. While some have made “warm calls” (i.e., outreach) to members in other counties, Sacramento has received little attention except for periodic (usually annual) communications about children’s oral health, typically included in newsletters to parents and to providers. 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.

How Many Children Were Enrolled in GMC in 2008? In Which Dental Plans Were They Enrolled?

In 2008, there was an average monthly enrollment of 117,402 children age 0-20 in Sacramento GMC dental plans. The distribution of enrollment in GMC dental plans is shown in Figure 8. Close to half (46%) were members of Western Dental, and about one-third were enrolled in Access Dental. Health Net began contracting in mid 2008, so the proportion of its GMC membership was low.

Figure 8. Proportion of Enrollment by GMC Plan, Children Age 0-20, 2008



Note: Health Net contract began 7/1/08.
Source: California Department of Health Care Services

How Many Children Voluntarily Enrolled in GMC?

Most Medi-Cal children in Sacramento are required to enroll in a GMC medical and dental plan. Some aid codes cannot enroll in managed care at all, such as children with a Share of Cost. However, because some aid codes (eligibility categories determined at the time of Medi-Cal application) such as those listed below are voluntary, beneficiaries not assigned a mandatory aid code have the *choice* of going into a GMC plan if they prefer it over the traditional FFS system. Examples of categories of children that may be exempt from mandatory enrollment in GMC include:

- Refugees
- Children in the Adoption Assistance Program
- Children in the Kinship/Guardianship Assistance Program
- Children with disabilities
- Children in Foster Care

In November 2009, 22,283 Sacramento children age 0-19 were exempt from mandatory enrollment in GMC. Of these, roughly half (48.6%) *voluntarily* chose to enroll in a GMC dental plan (Table 14) while the remainder elected to be in the FFS system. A higher proportion of the children age 0-4, 57.3%, than older children voluntarily enrolled in GMC. It is not known why families with the youngest children would select GMC over FFS when given a choice. It is possible that families liked the convenience of being assigned a primary care dental provider, or maybe they thought it would be easier to get a child in to see a pediatric dentist if enrolled in a dental managed care plan.

Table 14. Newly Enrolled Children Age 0-19 with Non-Mandatory (Voluntary) Aid Codes, November 2009

Age Group	Chose FFS	Chose to Enroll in GMC	Total
0-4	1,754	2,352	4,106
5-9	2,453	2,782	5,253
10-14	3,194	2,750	5,944
15-19	4,047	2,951	6,998
Total	11,448	10,835	22,283

Note: Data were not available for age 20. The calculation was based on unduplicated counts of children who enrolled during 2008, not those who were already enrolled prior to 2008.

Source: California Department of Health Care Services, Health Care Options.

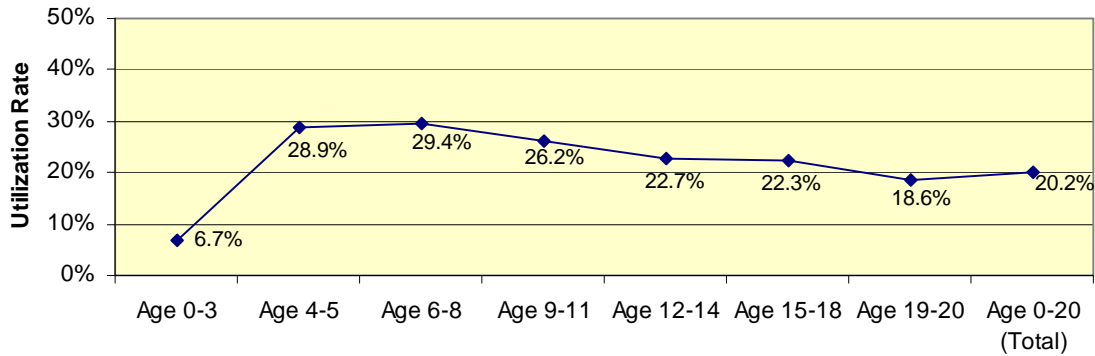
How Many Sacramento GMC Children are Utilizing Their Dental Benefits?

In 2008, on average, 1 of 5 children enrolled in GMC dental plans utilized their dental benefits, a rate that failed to meet the national average of 43.5% of enrolled Medicaid children receiving dental services.^y The age groups with the highest utilization were ages

^y Medicaid HEDIS 2008 audit mean, accessed at <http://ncqa.org/tabid/334/Default.aspx>. This is based on unduplicated eligibles, while the Sacramento GMC figure is based on average monthly eligibles. When GMC utilization is calculated using unduplicated eligibles as the denominator, the utilization rate is even lower.

4-5 and 6-8 (28.9% and 29.4%, respectively); the 0-3 age group had the lowest utilization, 6.7% (Figure 9).

Figure 9. Utilization by Age Group, All GMC Plans, 2008



Source: California Department of Health Care Services

How Do GMC Plans Compare in Utilization Rates?

Table 15 provides the number of average monthly eligibles, users, and utilization rate for the 5 GMC plans, for 2008 (the most recently available annual data) provided by DHCS. The 2 bar graphs that follow (Figures 10 and 11) display these data pictorially. Overall, Liberty Dental Plan does the best job regarding utilization of oral health services for children, particularly those ages 0-3, although for ages 4-5 Access Dental Plan's rate is similar to Liberty's. In general, Health Net and Access have comparable rates for children. Children enrolled in Community Dental, and to a lesser extent, Western Dental, have the lowest utilization rates among the plans.

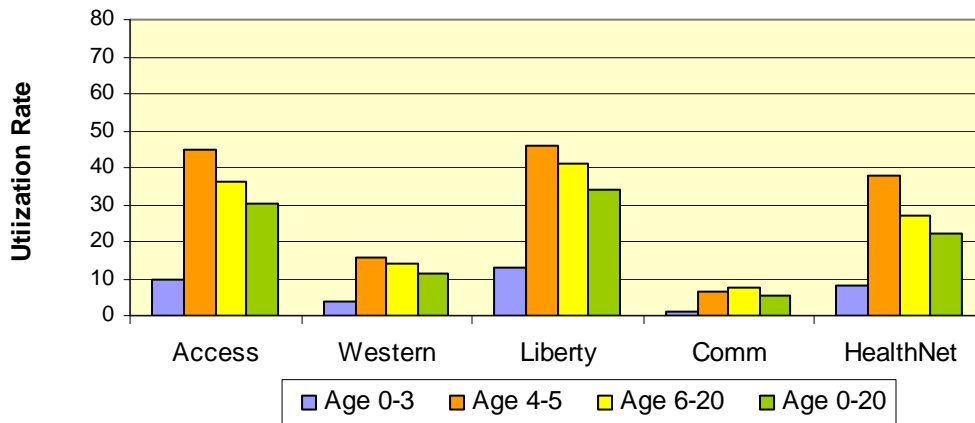
Table 15. Denti-Cal Users, Average Monthly Eligibles, and Utilization Rates, by Plan and Age Groups, 2008

Plans	Age 0-3			Age 4-5			Age 6-20			Age 0-20		
	Users	Elig	%	Users	Elig	%	Users	Elig	%	Users	Elig	%
Access	860	8955	9.6	1799	3997	45.0	8013	22087	36.3	10612	35039	30.3
Community	25	2698	0.9	69	1052	6.6	429	5683	7.5	523	9433	5.5
HealthNet ¹	36	432	8.3	58	153	38.0	198	738	26.8	298	1323	22.1
Liberty	621	4692	13.2	872	1886	46.2	4627	11287	41.0	6120	17865	34.3
Western	529	14283	3.7	879	5650	15.6	4792	33807	14.2	6200	53740	11.5

¹Health Net began GMC contract July 2008; data are for 6 months. Users = a member aged 0-20 who received at least one dental service during 2008. Eligibles = the number of average monthly eligibles enrolled in the health plan during 2008. Source: Department of Health Care Services.

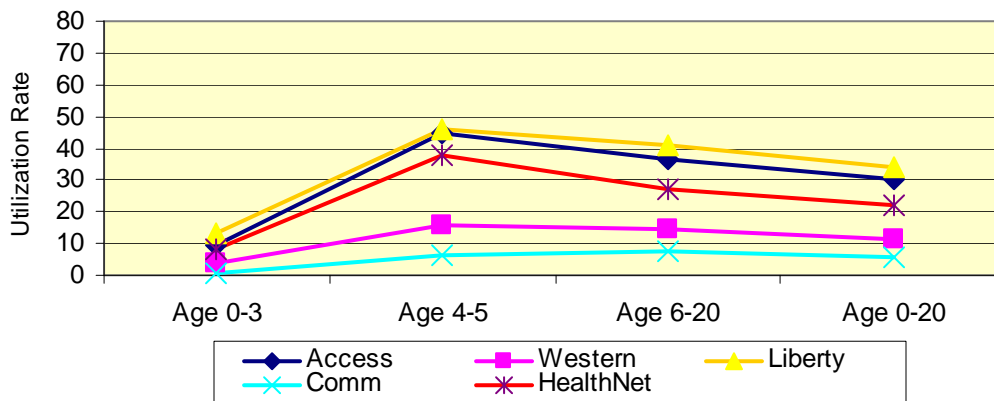
When ages are grouped 0-3 years, 4-5 years, and 6-20 years, all of the GMC plans do the best job with the 4-5-year-old age group. This age group may have a high utilization rate because of the 2006 law (AB 1433) requiring a dental check-up by May 31 of a child's first year in public school, at kindergarten or first grade, or may also be attributed to the fact that many of these children are in Head Start preschools which also require a dental exam. The utilization of 4-5 year-olds may also be reflective of First 5 Sacramento's and other community efforts to promote oral health for young children from low-income families.

Figure 10. Utilization Rate by Sacramento GMC Plan, by Age Group, 2008



Source: California Department of Health Care Services.

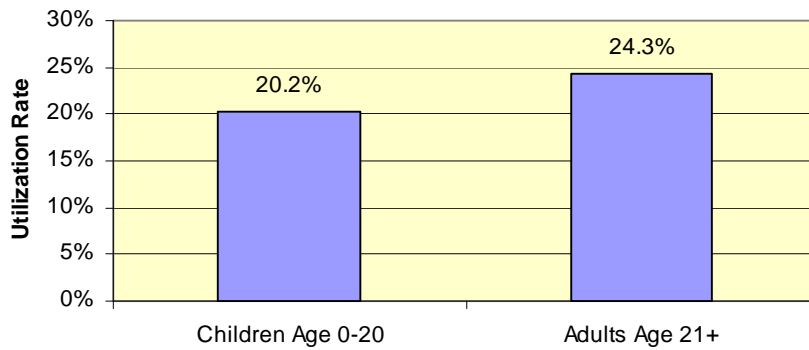
Figure 11. Utilization Rate by Age Group, by Sacramento GMC Plan, 2008



Source: California Department of Health Care Services.

While neither the child nor the adult utilization rates met the GMC contract threshold of 38% in 2008, GMC plans' utilization rates on average for adult (age 21+) GMC members were not considerably different from child members in 2008 (Figure 12).

Figure 12. Utilization by Children and Adults, GMC Plans, 2008

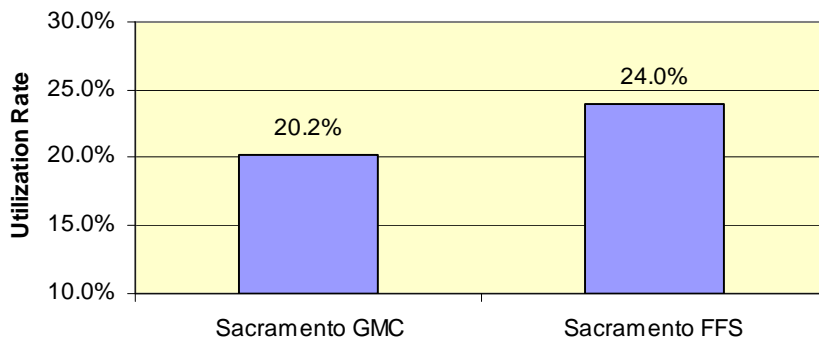


Source: California Department of Health Care Services

Sacramento GMC Utilization Compared to Sacramento FFS Utilization

When GMC dental plan eligibles and FFS eligibles in Sacramento County are compared on an "apples-to-apples" basis by including only those FFS eligibles who are in the same aid codes as those in the GMC plans, on average, utilization rates were lower for GMC (20.2%) than under FFS (24.0%) for children ages 0-20 (Figure 13). Though not depicted on the bar graph, two plans (Access and Liberty) had rates higher than FFS, three plans (Western, Community and Health Net) had lower rates.

Figure 13. Sacramento County Utilization Rate, GMC and FFS Children Age 0-20 in Similar Aid Codes, 2008

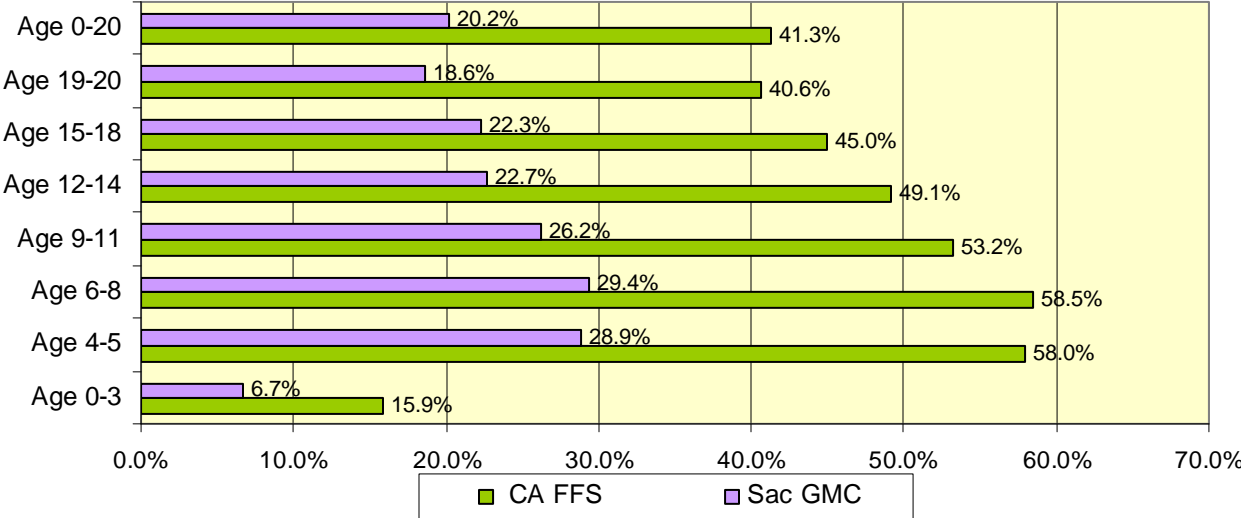


Source: California Department of Health Care Services

Sacramento County GMC Utilization Compared to the State by Age Group

Across the child age groups, Sacramento GMC dental utilization rates are approximately one-half of the utilization rates for children with similar aid codes statewide as depicted in Figure 14.

Figure 14. Dental Utilization of Sacramento GMC and Comparable California FFS Children, by Age Group, 2008



Source: California Department of Health Care Services

Sacramento County Utilization Compared to Other Counties

Regardless of age group, Sacramento dental utilization lags behind 33 other counties. In relatively comparable populations of FFS children (children in the same aid codes as GMC children), Sacramento’s rate of FFS dental care use, 24.0%, is one the lowest of any of the most populous counties in the state (Table 16 on the next page), ranking it in 34th place of 58 counties for children age 0-20. The utilization rate for Sacramento children age 0-3 is less than half the statewide rate (6.1% compared to 15.9%); and for children age 4-5, it is about half (28.9% compared to 58.0%). Matched against the study proxy county, Fresno, Sacramento children age 0-5 fare poorly, as Fresno’s utilization rate is similar to the state rate.

Table 16. Utilization Rate by County, Age 0-20, in Order of Rate for Age Group, 2008

County	Age 0-3	County	Age 4-5	County	Age 0-20
Marin	28.4	Orange	72.7	Orange	50.2
Monterey	28.0	Los Angeles	68.8	Los Angeles	49.9
Orange	21.4	Kern	66.8	Monterey	45.6
Los Angeles	21.2	Monterey	66.3	Kern	44.1
Kern	21.2	Marin	65.2	San Bernardino	42.3
Lassen	20.1	San Mateo	61.4	Santa Clara	41.6
Santa Cruz	17.3	Santa Barbara	60.7	Riverside	41.5
San Diego	17.1	Ventura	59.4	California Total	41.3
San Mateo	16.6	Santa Clara	59.2	Marin	41.0
San Luis Obispo	16.5	San Luis Obispo	58.9	Fresno	39.8
California Total	15.9	California Total	58.0	San Mateo	39.8
Imperial	15.3	Riverside	57.9	San Diego	38.7
Santa Clara	15.1	Fresno	57.5	Madera	38.3
San Bernardino	14.0	San Bernardino	56.3	San Francisco	36.9
Madera	13.5	Santa Cruz	56.0	Santa Cruz	36.8
Fresno	13.0	Madera	54.0	Ventura	36.7
Riverside	12.8	San Diego	52.2	Placer	35.7
San Francisco	12.7	San Joaquin	51.8	San Joaquin	34.6
Ventura	12.6	El Dorado	48.2	Santa Barbara	34.6
San Benito	12.2	San Francisco	47.3	Alameda	34.5
Placer	12.0	Tulare	47.1	San Luis Obispo	34.3
Kings	11.8	Imperial	46.7	El Dorado	34.2
El Dorado	10.9	Sutter	46.7	Sutter	33.2
Tulare	10.9	Kings	46.0	Tulare	32.8
Alameda	10.9	Alameda	45.0	Stanislaus	31.9
Santa Barbara	10.5	Lassen	44.7	Imperial	31.6
Calaveras	10.5	San Benito	44.7	Calaveras	31.2
Tuolumne	9.7	Placer	44.6	Solano	30.9
San Joaquin	9.6	Merced	43.2	Kings	30.6
Merced	9.6	Stanislaus	43.0	Merced	30.6
Sonoma	9.5	Sonoma	41.6	San Benito	30.2
Amador	9.1	Solano	40.6	Contra Costa	30.1
Napa	8.5	Calaveras	39.6	Yolo	28.5
Sutter	7.8	Contra Costa	39.6	Sonoma	26.3
Contra Costa	7.4	Yolo	37.8	Sacramento	24.0
Yuba	7.2	Tuolumne	33.1	Yuba	23.5
Stanislaus	7.1	Mariposa	33.1	Mariposa	23.0
Solano	6.4	Yuba	32.1	Shasta	22.3
Mariposa	6.2	Alpine	31.6	Butte	20.7
Sacramento	6.1	Siskiyou	30.8	Siskiyou	20.7
Yolo	5.8	Sacramento	28.9	Lassen	20.6
Siskiyou	5.7	Colusa	25.2	Trinity	19.7
Shasta	5.1	Napa	25.1	Tuolumne	19.0
Trinity	4.8	Butte	23.5	Amador	18.6
Butte	4.4	Amador	22.5	Napa	18.6
Mendocino	4.3	Shasta	22.2	Nevada	14.7
Nevada	4.0	Tehama	15.9	Colusa	14.5
Colusa	3.7	Trinity	15.8	Tehama	12.9
Inyo	3.7	Nevada	15.1	Glenn	12.5
Glenn	3.6	Mendocino	14.5	Plumas	11.7
Lake	3.3	Plumas	13.3	Lake	10.3
Tehama	3.2	Glenn	12.4	Inyo	8.4
Sierra	2.8	Lake	12.3	Mendocino	8.4
Plumas	2.7	Mono	11.1	Alpine	8.1
Humboldt	2.7	Inyo	10.4	Del Norte	6.2
Mono	2.1	Humboldt	7.9	Humboldt	5.4
Modoc	1.8	Modoc	7.8	Sierra	5.2
Del Norte	1.5	Sierra	6.8	Modoc	5.0
Alpine	-	Del Norte	5.5	Mono	4.7

Children with Medi-Cal FFS dental coverage in the same aid codes as GMC enrollees. Sacramento County users and eligibles consist primarily of those who were in voluntary aid codes and chose not to enroll in a GMC dental plan.
Source: Department of Health Care Services.

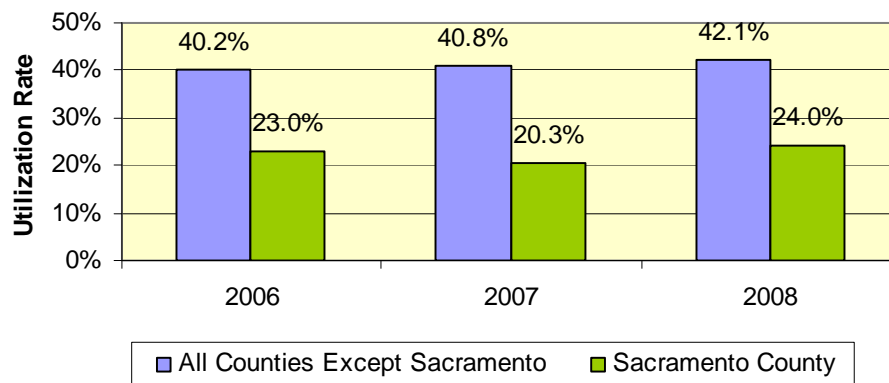
An important factor that may influence the utilization rates in other counties is the existence of community dental clinics. The contribution of community dental clinics to overall utilization rates far exceeds the contribution of private providers in many counties, according to State staff; this has not been the case in Sacramento County as few local community clinics offer dental services.

And, while Los Angeles County, the other dental managed care county, has relatively high dental utilization of children, it is important to note that in LA: a) dental managed care is voluntary (and fewer than 15% of children choose it); b) there are large numbers of dentists who take FFS Denti-Cal (and many who take disproportionately high numbers of Denti-Cal dental patients); and c) there is a wide network of community health clinics throughout the county.

Sacramento County FFS Utilization Compared Over Time

Sacramento County FFS also does not stack up well to the rest of the state when looking at the 2006 to 2008 data. As shown in Figure 15, Sacramento FFS utilization rates—which have been fairly consistent between 2006 and 2008—are less than half the rates for California children age 0-20 in FFS with GMC aid codes.

Figure 15. FFS Utilization in California and Sacramento, Children Age 0-20, 2006-2008

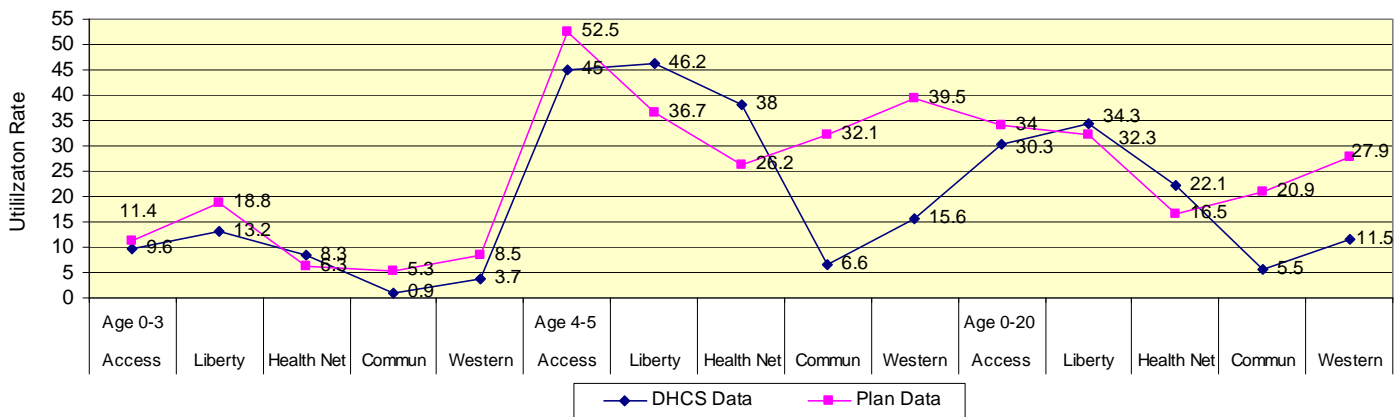


Source: California Department of Health Care Services

Sacramento GMC Utilization Data from GMC Plans Compared to DHCS Data

GMC dental plans' utilization data disagreed with the utilization reports DHCS generated based on the data plans submitted to them. Figure 16 illustrates the variance between what the dental plans sent us and what DHCS reported for 2008, displayed by age groups. (See Appendix 3 for a detailed table of utilization rates by age groups by individual plans.) Using average monthly eligibles as the parameter for calculating utilization rates, the pink line in the graph shows the DHCS data and the blue line shows the dental plans' data. Overall, the plans with the greatest variance are Community Dental followed by Western Dental. Among children 0-20, Community reports a utilization rate nearly 4 times the rate reported by DHCS; Western reports over twice the rate of DHCS. For children age 4-5, the differences between these plans' and the State data are even wider.

Figure 16. Comparison of DHCS and GMC Plans' Data for Children's Dental Utilization, by Age Group, 2008



Source: DHCS Data: California Department of Health Care Services. GMC Plans' Data: GMC Dental Plans.

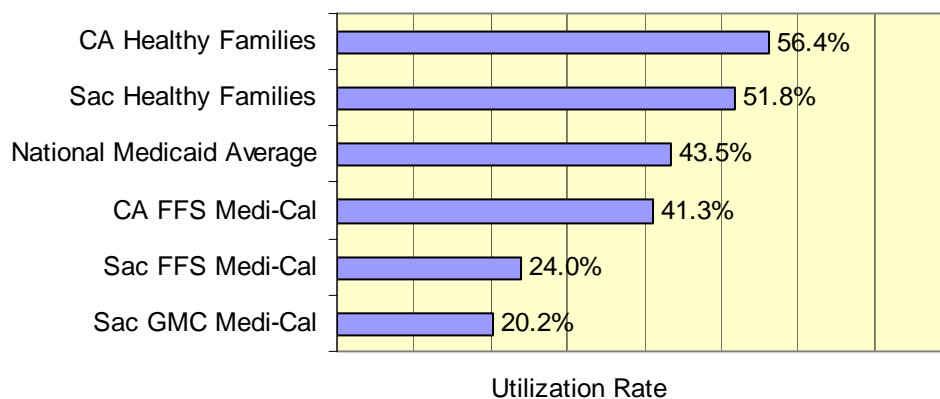
All of the dental plans were sent a detailed table (Table A-1 in Appendix) 3 showing the differences between the plans' utilization data and what DHCS reported and invited to comment; 2 plans responded. Western Dental explained they had been "reporting data with an 'old system' for searching through encounters, and as a result of this [GMC study] and the Healthy Families HEDIS (Healthcare Effectiveness Data and Information Set) reporting, we audited the results and found out that reported data was incomplete." Consequently, Western stated they have been "working on some new programming to locate and report all of the encounters," and that the data they sent to us for this study were more accurate data. Health Net stated "there was a difference in the formulas used to compute the average monthly eligible count that caused our utilization by age range to differ from those reported by the DHCS," and said they "re-ran the numbers and agree completely with the percentages presented by the State." Health Net emphasized that established plans with steady enrollment would experience a higher level of utilization than

one with new membership and state that “rapid growth between July 2008 and December 2008 (over 500% in 6 months) also played a large role.”

How Do Sacramento GMC Utilization Rates Compare to Similar Programs and State and National Averages?

As Figure 17 illustrates, children’s dental utilization in 2008 is lowest in Sacramento GMC when viewed against Medi-Cal FFS, the national Medicaid average (which includes both FFS and dental managed care), and the state and local Healthy Families program. However, in comparing dental utilization among programs the differences in data methodology approaches have to be taken into account. For instance, government programs often have different purposes and agendas in mind when they report data and, thus, use different ways of calculating utilization. (See Appendix 2 for a discussion of these differences.) Because of the methods used by Healthy Families and national Medicaid, the utilization rates in those programs will always be reported as higher than Sacramento GMC. Nonetheless, it unlikely the differences between dental utilization in Sacramento GMC and similar programs are *solely* attributed to the differences in calculation methods.

Figure 17. Children's Dental Utilization Rates by Type of Public Program Coverage, 2008



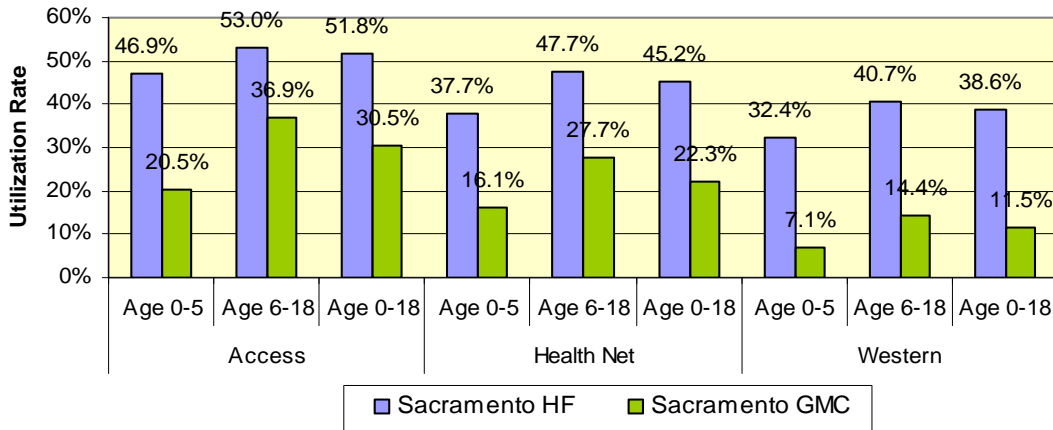
Note: HF data ages 0-18; Medi-Cal data ages 0-20.
 Source: California Department of Health Care Services; California Healthy Families; NCQA Medicaid HEDIS Audit.

GMC and Healthy Families

While not directly comparable as well because of a slightly different age and income range—and not all dental plans overlap—it is of interest to view the differences in utilization rates, by age group, of children enrolled in Sacramento GMC and Sacramento Healthy Families in the 3 dental plans common to both programs (Figure 18 on the next

page). As in GMC, Access Dental has higher utilization rates for HF children 0-5 (and all its HF members) than Health Net and Western Dental.^z

Figure 18. Utilization Rates in Sacramento GMC and Sacramento Healthy Families Program of Dental Plans in Common, in Healthy Families Age Eligibility Group, 2008



Source: California Department of Health Care Services; California Healthy Families

Sacramento GMC and the Healthy Kids/Healthy Future Program

Although also not directly comparable (due to a slightly different age and income range of children), the utilization rate of children enrolled in Children’s Health Initiatives (CHI) is provided here for reference. CHIs operate in 29 counties across California work to enroll eligible children into health insurance programs funded at the federal, state and local level. And, they provide health coverage for children not eligible for and at slightly higher incomes than Medi-Cal or Healthy Families, through their Healthy Kids insurance program.

In 2006, the California CHIs that contracted with Delta Dental as their dental plan for Healthy Kids (representing 13 counties) had an average dental utilization rate of 66.7% for ages 2-18 (for ages 2-6 the rate was 61.7%).⁵⁴ However, in 2008, the utilization rate for *Sacramento’s* CHI, Healthy Kids (HK), was well below those levels—just under 10% for children age 0-18, and just under 8% for children age 0-5—lower than both the statewide CHI average and the Sacramento GMC average (Table 17 on the next page).⁵⁵ Part of the difference between the Sacramento CHI and GMC may be attributable to the fact that Healthy Kids includes coverage for undocumented residents who may have more access barriers, such as language, and a culture that puts less emphasis on preventive dental

^z HF data for Sacramento dental managed care plans reflect the revised figures the plans were allowed to send to HF in January 2010.

care. However, this difference would not explain why utilization rates for *Sacramento* CHI were so much lower than the statewide CHI.^{aa}

Table 17. Dental Utilization in GMC and Sacramento and Statewide Healthy Kids Programs, by Age Group, 2008

	Age 0-5	Age 6-18	Age 0-18
Sacramento GMC ¹	13.1%	23.4%	19.1%
Sacramento CHI ²	7.9%	10.5%	9.9%
	Age 2-6	Age 7-18	Age 2-18
Statewide CHI ³	61.7%	67.9%	66.7%

The CHI programs used the HEDIS measure of utilization; GMC used average monthly eligibles.

Sources: ¹ California Department of Health Care Services. ² Healthy Kids, Sacramento, February 2010. ³ *Dental Utilization in California's Children's Health Initiatives' Healthy Kids Programs*. Center for Community Health Studies, University of Southern California. July 2008.

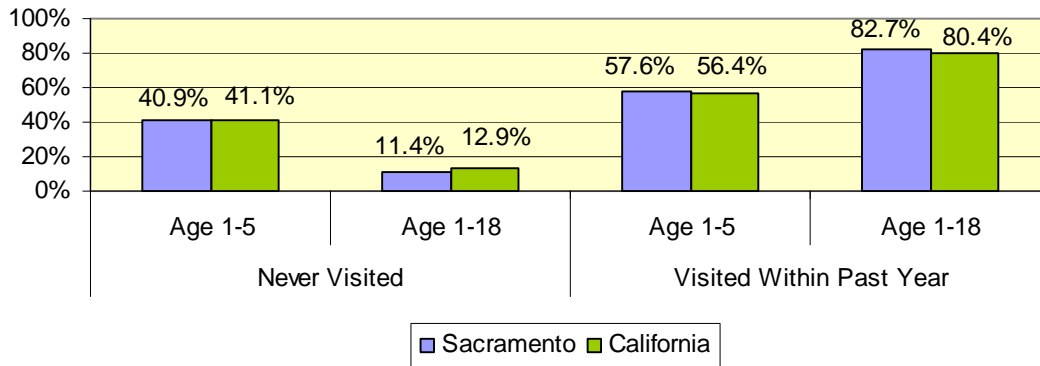
Sacramento GMC Utilization and the California Health Interview Survey

The California Health Interview Survey (CHIS) is a statewide population-based survey undertaken every 2 years. The survey is given to a representative group of households across the state who responds to verbal questions by an interviewer over the telephone. The survey results contain information about children's last dental visit and allow for another look at dental health access in California counties and statewide. Among Sacramento parents of all income levels who responded to the 2007 CHIS survey, 57.6% reported taking their child age 1-5^{bb} to a dentist within the past year. For children age 1-18, the percentage was even higher, 82.7%. A slightly higher percentage of Sacramento children than California children statewide, of both age groups, reported visiting a dentist within the past year (Figure 19 on the next page).

^{aa} The difference between HK and GMC utilization rates is not attributable to a higher proportion of HK members being age 0-5, as some have thought, because First 5 helps fund the HK premiums. About 25% of the HK Sacramento members are age 0-5, whereas in GMC 37% of the children are age 0-5.

^{bb} Some of the CHIS data for Sacramento children age 1-5 are considered "statistically unstable" due to small samples—which is true for other counties as well. While this limits their interpretation, the data are included in this report because of their interest to First 5. It is also important to note that self-reported utilization may be higher than that which can be verified by claims data. For example, parents either can't really remember when their child had a dental visit or may respond the way they think is expected by the interviewer.

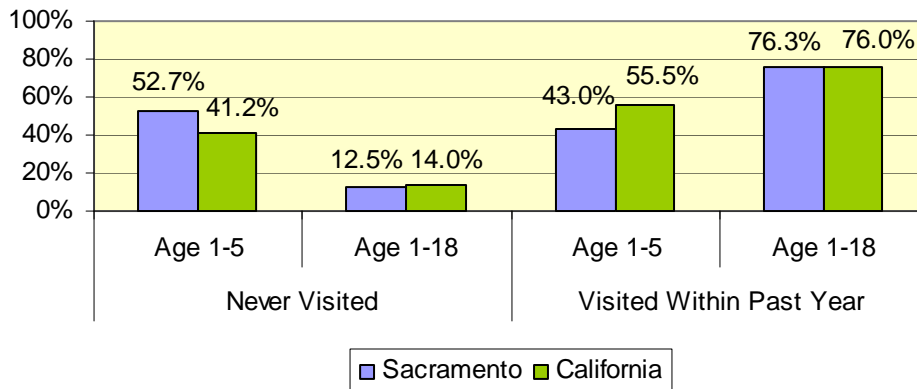
Figure 19. Utilization of Dental Services by Sacramento Children at All Income Levels, 2007



Source: California Health Interview Survey, 2007.

However, when dental services utilization was examined by family income, low-income Sacramento children did not fare quite as well as the California average (Figure 20). More than half (52.7%) of Sacramento children age 1-5 who qualify for Medi-Cal or Healthy Families (i.e., under 250% of the federal poverty level), compared to 41.2% of children statewide at that same income level reported never visiting a dentist within the past year. And, among those who did see a dentist, a higher proportion of low-income Sacramento children than California children age 1-5 had not made a visit within the past year.

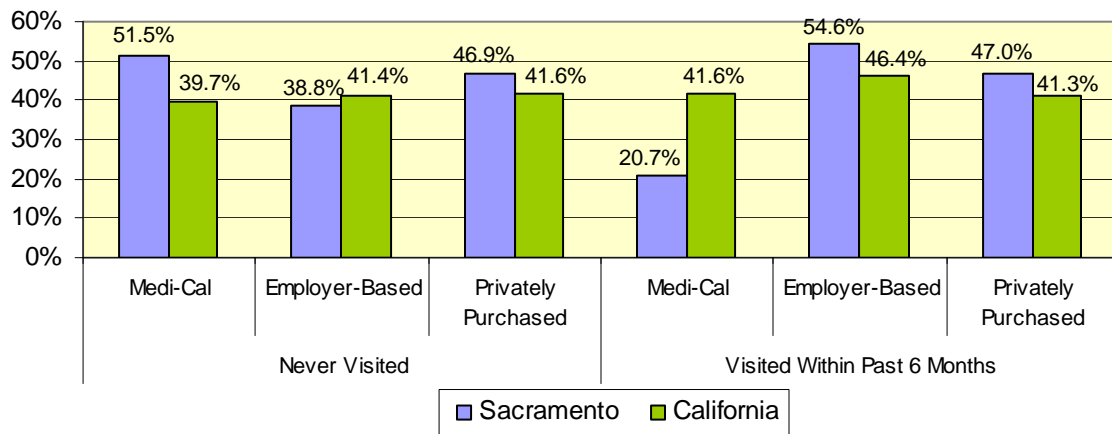
Figure 20. Utilization of Dental Services by Sacramento Children Below 250% of the Federal Poverty Level, 2007



Source: California Health Interview Survey, 2007.

The proportion of Sacramento children age 1-5 that had some form of coverage who did *not* visit a dentist within the past 6 months was highest among those covered by Medi-Cal compared to those covered with privately-purchased or employer-based coverage as shown in Figure 21. Similarly, of those children who *did* see a dentist, a lower proportion of Medi-Cal children of that age in Sacramento than in the rest of the state visited a dentist within the past 6 months.

Figure 21. Dental Visit Experience by Type of Health Insurance Coverage, Children Age 1-5, Sacramento and California, 2007

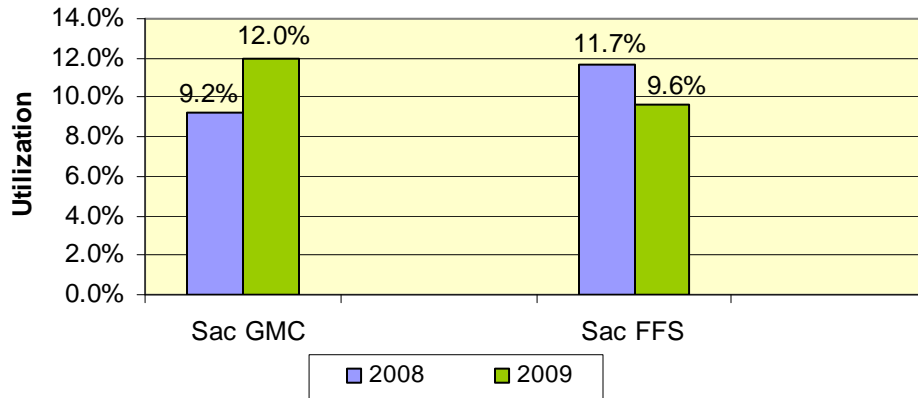


Source: California Health Interview Survey, 2007.

What are the Utilization Trends Since 2008?

Looking at the first 6 months of 2008 and 2009 (data for the last 6 months of 2009 are less reliable, since claims are still coming in for that period), on average, monthly utilization rates increased slightly for children in GMC plans. Over the same period, children's monthly utilization rates in Sacramento FFS declined. As shown in the graph below (Figure 22), there was an average increase in utilization between 2008 and 2009 from 9.2% to 12% for ages 0-20 in GMC plans and a decrease from 11.7% to 9.6% in FFS.

Figure 22. Average Monthly Dental Utilization, First 6 Months of 2008 and 2009, Sacramento GMC and FFS, Children Age 0-20



Note: Health Net data not included in 2008 because contract did not begin until July 2008. Western had missing user data in 2008. Source: California Department of Health Care Services, Medi-Cal Dental Services Division.

Although it's still too early to tell from these data, State staff believes it is likely children's FFS utilization rates will be higher (and adults rates lower) in 2009 than in 2008 because of the adult dental cuts in Medi-Cal and some providers attempting to compensate for the lost adult revenue by seeing more children.⁵⁶ To the extent that GMC dental providers are being paid by the plans on a FFS basis, they would expect to see the same thing happen with them, for the same reasons. In addition, even if utilization rates stay the same, the actual number of children receiving care will probably increase because the number of eligibles is increasing as a result of the economy.

The expansion of community clinic-based children's dental services through The Effort and Sacramento Native American Health Center, funded by First 5 Sacramento, is expected to boost utilization in Sacramento County beginning in late 2010.

V. Quality of Care Issues



“The State is doing its job but is mostly not engaged.”— GMC dental plan representative referring to State oversight of GMC.

“For what we do on it, the GMC rates are pretty decent.”— GMC plan representative

Measuring the quality of dental care provided through managed care dental plans is difficult. Beyond the issues of access and utilization, standards for measuring dental quality are limited, and data from providers are often insufficient. Identifying specific preventive and treatment areas for performance measurement is still considered in its early stages.⁵⁷

The National Committee for Quality Assurance has only one HEDIS^{CC} dental quality measure—annual dental visit (children ages 2-18 continuously enrolled for the past year with no more than a 45-day break in eligibility who had at least 1 dental visit during the measurement year)—used for nationwide dental plan comparison. One measure is not sufficient to evaluate quality, so for purposes of this study 5 quality indicators used by the California Healthy Families Program, which serves a similar population, were used.

How Did Plans Perform on Quality Measures?

The examination of procedures and encounters reported by the Sacramento GMC plans and provided by DHCS was used for measuring quality of care. The same service data for the FFS comparative county, Fresno, were also reviewed. All data were from 2008. What was analyzed in this chapter was the proportion of services provided to *eligible GMC children* (service type or volume whether or not children used a dental services), and the ratio of services to *users* (service type or volume provided to children that *did* receive a dental service).

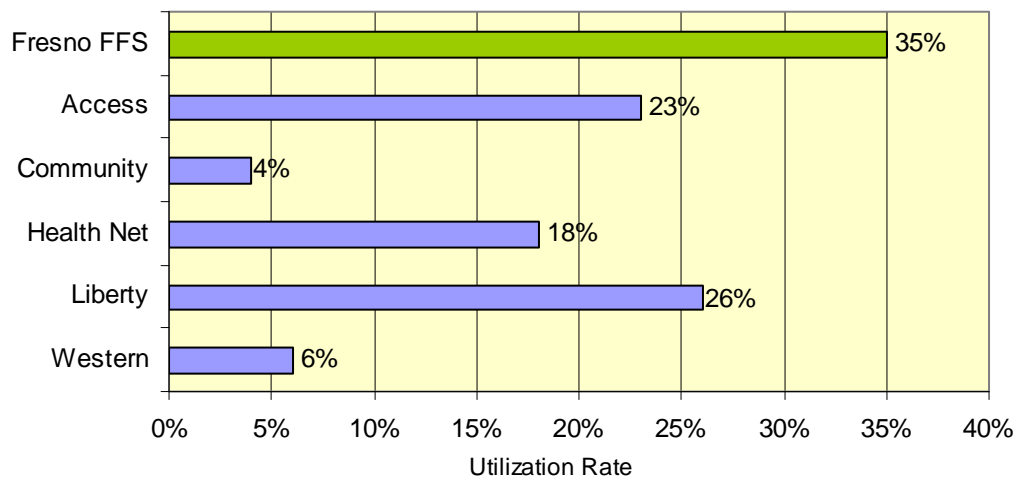
Examinations

Regular oral examinations allow for preventive services to be delivered, as well as early detection of caries and other dental conditions. If an enrolled child does not utilize their plan's dental services there is no opportunity to receive preventive services (except as may be delivered in a preschool or school-based program). Figure 23 on the next page shows the proportion of *enrolled* (i.e., eligible) children who received an examination in 2008. (Table 18 following the bar graph shows what proportion of eligible children who *utilized* any dental service actually got this service.) Approximately one-quarter of the GMC children enrolled in Liberty and Access dental plans in 2008 received an oral health examination; fewer than 7% of the children enrolled in Community and Western did. By

^{CC} Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on dimensions of care and service.

contrast, slightly more than one-third of Medi-Cal covered children in Fresno County received an oral health examination.

Figure 23. Proportion of Eligible Children Age 0-20 in Sacramento GMC and Fresno County FFS Who Received an Oral Examination, 2008



Source: California Department of Health Care Services.

GMC dental *users* in Health Net, Access, Liberty and Community received a range of .82 to .70 comprehensive or periodic exams per user, respectively, as shown in the last column of Table 18. Western provided these exams at about two-thirds of the rates of the other dental plans. Children in Fresno FFS, on the other hand, were provided more than 1 exam per unduplicated user, much higher than any of the Sacramento GMC dental plans.

Table 18. Oral Examination Ratios, Children Age 0-20 and Age 0-5, 2008

Measure 1: The ratio of 0-20 year-olds who received a comprehensive or periodic exam.

GMC Plan	Exam/Unduplicated User, Age 0-5 Only	Exam/Unduplicated User All Children
Access	.21	.78
Community	.02	.70
Health Net	.15	.82
Liberty	.22	.77
Western	.04	.48
Fresno FFS Comparison	.23	1.27

Medi-Cal Dental Codes: D0120, D0150.

Source: California Department of Health Care Services; data calculation by study authors.

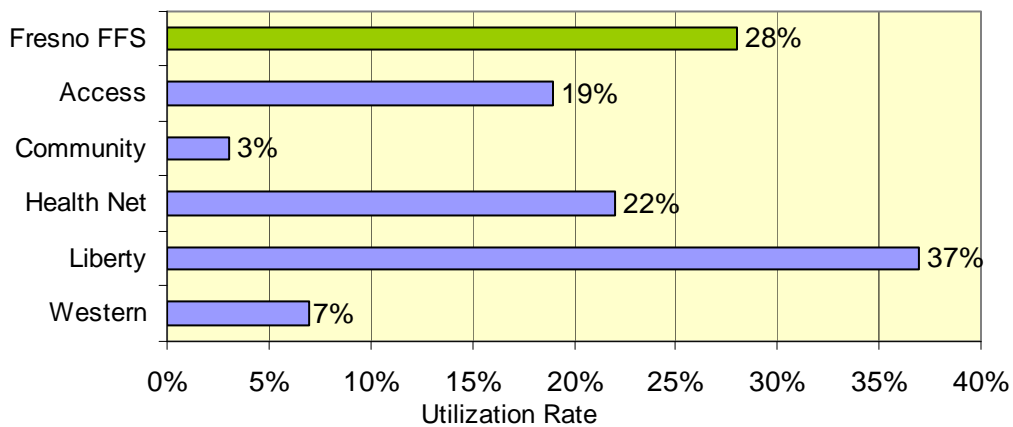
Table 18 also shows the exam data for users in the 0-5 age group since in these early years an oral examination is an ideal way to introduce a child to the dental office. While the ratios of exams per user for the youngest children were very low, Access and Liberty performed about the same, and both were similar to Fresno FFS. By comparison, Western and Community reported very few examination and evaluation services for this population. The low numbers of a comprehensive or periodic exam in the reported data suggests that the majority of the 0-5 year old users may have had an urgent care service or had the problem addressed and did not have a full exam.^{dd}

Prevention Services

Prevention services play an important role in managed care both in terms of impact on the patient as well as cost containment. Preventive dental services include teeth cleaning and topical fluoride application. (Note: anticipatory guidance, nutrition counseling, and oral health education are not covered GMC benefits; they may or may not have been provided, depending on the thoroughness of the provider.) Preventive services are less invasive and less costly than treatment services. Periodic visits for prevention services also provide an opportunity for observation and early intervention when necessary.

Despite the importance of early preventive services, fewer than 4 in 10 of the *eligible* GMC children received preventive dental care in 2008 (the range was 3% to 37%) as displayed in Figure 24. A greater proportion of Liberty's than the other plans' members and Fresno FFS eligibles received preventive services.

Figure 24. Proportion of Eligible Children Age 0-20 in Sacramento GMC and Fresno County FFS Who Received a Preventive Service, 2008



Source: California Department of Health Care Services.

^{dd} While there *is* a specific CDT code, D0145, titled "oral evaluation for a patient under 3 years of age and counseling with primary caregiver," which was adopted in 2007, it is not a covered benefit under the California Denti-Cal program and would not have been included in the DHCS data. Hence, it stands to reason that exams for children age 0-3 and age 4-5 would be reported under the codes for periodic examination, D0120 or comprehensive examination, D0150. For children age 0-3, these examinations may have been "knee to knee" exams because of the impossibility of an infant or toddler sitting in a dental chair and tolerating an oral examination.

Among the children that *utilized* a dental service in 2008, Liberty and Health Net were the only Sacramento GMC plans to achieve ratios of over 1.0 of preventative services to users (Table 19). (A ratio of greater than 1.0 means some users received more than 1 service in the measurement year, e.g., they returned for a second visit at a 6-month interval as recommended by the American Dental Association for cleaning and fluoride treatment.) Surpassing Liberty to a small extent was the FFS comparison county, Fresno, with a 1.17 preventative services to user ratio.

Table 19. Preventive Dental Services Ratios, Children Age 0-20, 2008

Measure 2: The ratio of 0-20-year-olds who received any preventive dental services in the measurement year.	
GMC Plan	Prevention Services/Unduplicated User
Access	.61
Community	.62
Health Net	1.02
Liberty	1.07
Western	.58
Fresno FFS Comparison	1.17

Medi-Cal Dental Codes: D1000-D1999.

Source: California Department of Health Care Services; data calculation by study authors.

Treatment Services

Treatment services include fillings, crowns, root canals, and oral surgery. Among this vulnerable population of Medi-Cal users it is common for an individual to have multiple treatment visits or multiple treatments per visit, e.g., more than 1 filling and probably more than 1 of the multiple surface fillings and/or extractions of unrestorable teeth. Liberty had the highest overall treatment-to-user ratio, at 1.75, besting the Fresno County FFS ratio (Table 20). Access and Western treatment/user ratios were somewhat similar to each other, at 1.43 and 1.37, respectively, while Community's fell below 1.0.

Table 20. Dental Treatment Services Ratios, Children Age 0-20, 2008

Measure 3: The ratio of 0-20 year-olds who received treatment services other than diagnostic or preventative.	
GMC Plan	Treatment Services/Unduplicated User
Access	1.43
Community	.89
Health Net	1.02
Liberty	1.75
Western	1.37
Fresno FFS Comparison	1.54

Medi-Cal Dental Codes: D2000-D9999.

Source: California Department of Health Care Services; data calculation by study authors.

The treatment and prevention of dental caries measure calculates the percentage of children seen by a dentist who received treatment for caries or a caries-preventive procedure. Caries preventive procedures (e.g., topical fluoride, sealants) along with early diagnosis and treatment can prevent many of the unnecessary complications from caries such as pain, infection, trouble chewing, disturbed sleep, missed days of school and more serious health conditions.

In treatment and preventive services per unduplicated user, Liberty showed almost 3 services per user, while Health Net, Access, and Western showed approximately 2 services per user, and Community showed about 1.5 procedures per user (Table 21). Liberty not only treated disease at the highest rate, but recognized the need to add preventive services for those children to help protect them from further decay. FFS users in Fresno County received about the same level of treatment and prevention services/user as Community, the GMC plan with the lowest ratio.

Table 21. Treatment and Prevention of Caries Ratios, Children Age 0-20, 2008

<i>Measure 4: The ratio of 0-20 year-olds who received treatment for caries, or a caries-preventive procedure.</i>	
GMC Plan	Caries Treatment or Caries Preventive Services/Unduplicated User
Access	2.04
Community	1.51
Health Net	2.04
Liberty	2.83
Western	1.95
Fresno FFS Comparison	1.62

Medi-Cal Dental Codes: D2000-D2999, and D1203, D1204, D1206, D1310, D1330, D1351.
 Source: California Department of Health Care Services; data calculation by study authors.

When dental caries is present, preventive services are most needed because the presence of disease indicates a high risk individual. In the filling-to-fluoride/sealant ratio we look at users who had one or more fillings (and therefore were at higher risk of cavities) who either received a preventive service, such as topical fluoride and dental sealants. While topical fluoride and dental sealants are particularly effective methods of reducing the prevalence of caries in children at high risk for caries, these services are underused. According to the CDC, children from lower income families are almost twice as likely to have decay as those from higher income families but only half as likely to have sealants.⁵⁸

As shown for Sacramento GMC and Fresno FFS in Table 22 on the next page, Fresno FFS showed the best fluoride-sealant-to-filling ratio as 92% of children who received a filling got a prevention procedure. Liberty was a close second with 89%. Approximately half of those in Access and Community (41.0% and 52.0%, respectively) who received 1 or more fillings also received some prevention procedure while in Western the proportion was less than one-third (28.%), which is an ineffective level of services for this high risk

population. Routine dental care is the combination of prevention and treatment services to reduce the recurrence of disease. When dental providers only repair and do not care for or improve/strengthen the tissues involved—since in these high risk children dental disease is usually progressive and may not be reversed or arrested—a child’s future oral health may be compromised.

Table 22. Filling to Preventive Service Ratios, Children Age 0-20, 2008

Measure 5: The ratio of 0-20 year-olds who received 1 or more fillings who received a topical fluoride or a sealant application.	
GMC Plan	Percent of users who received one or more fillings/users who received preventive (topical fluoride, sealant) services
Access	41%
Community	52%
Health Net	62%
Liberty	89%
Western	28%
Fresno FFS Comparison	92%

Medi-Cal Dental Codes: D2000-D2999, and D1203, D1204, or D1351, D1310, D1330.
 Source: California Department of Health Care Services; data calculation by study authors.

How Does DHCS Oversee the Provision of Medicaid Children’s Dental Services?

States recently reported actions they have taken to improve children’s access to Medicaid (Medi-Cal in California) dental services in a nationwide survey conducted by the Government Accountability Office (GAO).⁵⁹ As shown in Table 23 on the next page, California reported utilizing only one of the methods used to monitor the statewide provision of dental care to children in FFS and dental managed care. Only 10 other states reported as few methods. Although California did not report having any of the children’s dental care goals identified in the GAO survey, the category “other state goals” was marked as its survey response.

Table 23. Response of California Department of Health Care Services to Selected Items in the GAO Survey of State Medicaid Dental Programs, 2008

Methods Used to Monitor the Statewide Provision of Dental Care to Medicaid Children						
<i>CMS-416 data¹</i>	<i>Claims and/or encounters data from dental managed care plans</i>	<i>Phone calls to dental managed care plans re. concerns</i>	<i>Beneficiary satisfaction surveys</i>	<i>Survey for problems obtaining services</i>	<i>Survey to monitor oral health of children</i>	<i>Other methods</i>
Yes	Yes	No	No	No	No	No
Statewide Utilization Goals for Providing Dental Care to Medicaid Children						
<i>% of children who receive any dental care in a given period is to exceed a certain threshold</i>	<i>% of children who received dental preventive services it to exceed a certain threshold</i>	<i>Ratio of participating dental providers in Medicaid exceeds a certain threshold</i>	<i>% of children who received restorative procedures for oral health exceeds a certain threshold</i>	<i>% of children who report difficulty finding dental care is to fall below a certain threshold</i>	<i>Other state goals</i>	
No	No	No	No	No	Yes	

¹ The federally required reporting form in which states submit data on children’s dental services participation in the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

Source: California response to GAO Survey of state Medicaid directors conducted between December 2008 and January 2009.

What Methods Does DHCS Use to Monitor GMC Plans’ Performance?

As a buyer of dental services, Medi-Cal would be expected to maintain the capacity—whether through internal or contracted resources—to effectively manage and monitor compliance with contract terms and conditions that include access, utilization and quality of services provided to children. As illustrated in Table 24 below, DHCS described that it utilizes multiple methods to monitor the provision of dental care in GMC. The primary method is the collection and review of monthly utilization data and quarterly reports from managed care dental plans to ensure the plans are complying with their contract terms. DHCS verification of plans’ reports is limited. There is no oversight of plan performance by proactively and routinely conducting periodic site visits, dental chart reviews, and secret shopper telephone calls for these functions. The capacity in terms of level and types of staff classifications falls short of what is needed to fulfill the oversight role.

Table 24. DHCS Methods for Monitoring/Improving Children’s Dental Services in Sacramento GMC

Measure/Method	Used by DHCS?	If Yes, How? How Frequently?
Utilization data for % of children who received annual visit, systematically* tracked	Yes	Utilization reports. Semi-annually
Encounter data for # and type of preventive and treatment services to check for appropriateness, systematically* tracked	Yes	Monthly encounter data reports. Monthly.
Regular,* rotating site visits to a sample of provider offices with sample chart reviews	No; Limited activity by plans	Plans are not required to make site reviews to each provider office each year. They are required when a new plan is starting and when a new provider/facility is being added to the network.
Ratio of DDS providers to enrolled kids	No	No verification of adequacy of managed care provider networks
Maximum waiting times when families schedule dental appointments	Yes	Dependent on plan compliance with contract requirement. Limited; initial visits by new members are reported in plans’ quarterly reports showing the time from the members’ enrollment to their first appointment.
Maximum time interval when general DDS refers for pediatric specialty care and appointment is made with the referral specialist.	No	Dependent on plan compliance with contract requirement. State staff receives only information about the number of referrals; staff would only question the plan “if there are a very low number of referrals.”
<i>State</i> -funded or initiated specific efforts to encourage parents to get enrolled kids to use dental benefit	Yes	Plans are asked to voluntarily provide updates of their efforts to encourage enrollment of children (e.g., marketing materials, outreach, phone calls) to increase utilization of children ages 0-3. The State is also in the process of developing a brochure which received input from State and local Child Health and Disability Prevention dental program staff, and was vetted by a group of advocacy stakeholders. The brochure is awaiting senior management approval before being printed in limited quantity and translated so that it can be field-tested prior to printing in quantity.
<i>State</i> -funded or initiated specific effort to recruit more dentists to participate in Denti-Cal	No	At this time there are no efforts required of plans to recruit more dentists beyond what is required by contract. For FFS, Delta is contractually required to do recruiting and the dental plans are responsible on the managed care side.

*Defined here as routine, proactive as opposed to infrequent or in response to complaints.

Source: Response by Medi-Cal Dental Services Program to authors’ query.

What Quality Assurance Methods do the GMC Plans Use?

Quality monitoring differs between the Denti-Cal and GMC programs. Unlike the FFS system, in which Delta Dental or DHCS responds to complaints and DHCS Audits and Investigations intermittently conducts quality audits, dental managed care plans are contractually required to implement quality assurance (QA) plans and conduct regular QA activities. The activities undertaken by the plans include the following:

- Tracking and reporting grievances and describing how they were resolved in quarterly reports submitted to DHCS.
- Credentialing of new dental providers when a dentist is added to the plan network.
- Conducting sample chart audits on an annual basis.
- Conducting facility and provider audits in dental offices
- Making blind calls to provider offices regarding attempts to make an appointment, to inquire about various office policies affecting members, etc.
- Helping members make appointments with network dentists by staying on the telephone during the call
- Training providers
- Conducting member surveys to ask about quality
- Distributing periodic newsletters to providers with updated clinical and practice information.

What Were the Most Commonly-Documented Concerns From GMC Members?

Medi-Cal provides beneficiaries and advocates avenues for filing formal complaints, grievances, and requests for a Fair Hearing when there are complaints about how benefits/services are/were handled, or services have been denied or modified.⁶⁰

Managed Care Problem Report Form

Medi-Cal Dental Services Division provides a Managed Care Problem Report Form (see Attachment 4) for reporting problems and other concerns, although it may not be generally available to the public or widely distributed to advocates. According to DHCS staff, for 2008 and 2009, there were no grievances filed using this form. This is in conflict, however, with information shared by Sacramento County Health Department staff who stated they submitted 2 of these forms during that period. State staff said that by the time they are aware of complaints they've usually been forwarded by some other governmental office that the member has contacted with a complaint letter, or the member has filed a fair hearing request, or calls the Dental Services Program directly.

GMC Plans' Quarterly Grievance Reports

GMC plans are required by contract to keep a record of grievances and the Quarterly Reports describe the number and type of problem and the action taken to resolve it. A review of the plans' most recent (2009) Quarterly Reports by Medi-Cal Dental Services staff showed a total of 36 grievances recorded involving members age 0-20 (.03% of the total GMC child membership). We asked staff to use their own judgment, contacting the plans for clarification where necessary, in categorizing these complaints as Access-Related, Quality-Related, and Other; their conclusions are shown in Table 25.

The types of grievances were equally distributed across the 3 categories of complaints. Overall, in order of type of complaint plans reported for the Other category, the complaints were characterized as "personality issues between patient and provider," "communication problems between patient and plan," and in 1 case a dispute about orthodontic coverage.

Table 25. Number and Distribution of Grievances for Sacramento GMC Children Age 0-20, 2009

Dental Plan	Number and Type of Complaint				Percent of Total GMC Grievances	Percent of Enrolled Children	Over/Under-represented in Complaints*
	Access-Related	Quality-Related	Other	Total			
Access	2 (33%)	3 (17%)	7 (58%)	12 (100%)	33%	29%	Over
Community	4 (57%)	1 (14%)	2 (29%)	7 (100%)	19%	5%	Over
Health Net	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0%	3%	Under
Liberty	5 (71%)	0 (0%)	2 (29%)	7 (100%)	19%	16%	Over
Western	1 (10%)	8 (80%)	1 (10%)	10 (100%)	28%	47%	Under
Total	12 (33%)	12 (33%)	12 (33%)	36 (100%)	100%	100%	

*Based on GMC plan enrollment distribution in 2009.

Source: Department of Health Care Services, Medi-Cal Dental Services Division; plans' self-reported Quarterly Reports.

Given the number of enrolled children in its plan, Community Dental's complaints are disproportionately high (over two and one-half times expected given the number enrolled). Complaints for Access and Liberty are slightly higher than their proportion of enrollees. Health Net's and Western's reported complaints are low given their proportion of enrolled children.

State staff believes that the number of grievances for some of the plans is actually higher than reported.^{ee} However, they pointed out they have no way to prove that except by going out in the field and auditing the plans, and unfortunately they do not have the resources or budget to do site audits. One plan with a staff model expressed the belief that their model "allows more control over customer services" as the explanation for why the number of its grievances is relatively low.

^{ee} Although none of these involved members age 0-20, DHCS said there were a few instances in 2008-2009 where they were contacted directly with a complaint from a member who said they filed a grievance with their plan. Yet in the plan's Quarterly Report there was no indication of that grievance. When State staff contacted the plan and asked them to explain the discrepancy, the general answer was that it was an oversight or there had been a staff change.

Fair Hearings

Of the 29 “Request for a State Hearing” filings for Medi-Cal children age 0-20 in Sacramento County in 2008-2009, 11 (38%) were for GMC members (Table 26).^{ff} Although significantly more children were enrolled in GMC than FFS in Sacramento, the higher utilization of dental services in FFS—and the alternative avenue GMC member have to file a grievance with the plans—might have accounted for the greater proportion of fair hearing requests from FFS beneficiaries.

Table 26. Number of Fair Hearings in 2008-2009 for Sacramento Children Age 0-20

Type of Medi-Cal	Number
GMC	11
FFS	18

Source: Department of Health Care Services, Medi-Cal Dental Services Division

Calls to Health Care Hotlines

The Health Rights Hotline (HRH) provides free assistance and information about health care rights to residents in Sacramento as well as other surrounding counties. HRH staff regularly provides advocacy services to families experiencing barriers or authorization issues with their medical and dental care.

We examined HRH contacts to determine the magnitude of dental care-related calls to overall calls, and to determine if calls related to children’s dental care are changing any differently than calls in general.⁹⁹ Of all calls to Health Rights Hotline in Sacramento concerning a client with a Sacramento zip code, in 2009 12 calls, or approximately 1%-2% of all calls to HRH, concerned dental issues for GMC children age 0-20 (Table 27). Over the last 7 years, there has been a decline in all calls to HRH, with about the same amount of decline in GMC dental calls for ages 0-5 and ages 6-20 as all calls to HRH. The data suggest that dissatisfaction with dental access and coverage in GMC is not a substantial problem.

HRH believes the decline in calls of all types cannot be attributed solely to fewer complaints, however. HRH explains the decline as due to staff reductions.⁶¹ When HRH takes a call, it becomes a case, but it cannot handle all calls for advocacy. Because there are a maximum number of calls that can be taken each day, the receptionist tells callers they should call back the next morning when that point is reached. It is not known how

^{ff} It was possible that some GMC members filed both a grievance and a fair hearing request; we were not able to research this potential for duplication. Nevertheless, the number of both types of complaints is low in relation to the number of enrollees.

⁹⁹ Although HRH tries to keep coding of complaints uniform, the coding is done by the staff based on how they view the issues in each case. For example, lack of “access to specialists” could be either that HRH did not get those calls or that advocates decided to code those cases as something else such as “finding a provider” or “waiting for authorization” cases.

many of those turned away actually call back at another time, limiting our ability to evaluate the significance of this level of complaints.

Table 27. Calls to the Health Rights Hotline, Including Sacramento GMC Children’s Dental, 2003-2009

Calls	2003	2004	2005	2006	2007	2008	2009	% Change 2003-2009
Total Hotline Calls	2789	3185	2685	2355	2251	2024	1249	-55.2%
GMC Dental Calls for Children Age 0-5	9	15	23	4	7	7	3	-66.7%
GMC Dental Calls for Children Age 6-20	18	32	45	11	13	21	9	-50.0%
Total GMC Dental Calls for Children Age 0-20 (Percent of Total Calls)	27 (1.0%)	47 (1.5%)	68 (2.5%)	15 (.6%)	20 (.9%)	28 (1.4%)	12 (1.0%)	-55.6%

Note: a “call” is the same as a case accepted for advocacy by HRH.
Source: Health Rights Hotline, Sacramento, March 2010.

The most common dental problem HRH staff noted for very young children (age 0-5), was for complaints related to poor/inappropriate care, in 17.6% of the calls, followed by access to specialists/delay in authorization, 16.2% (Table 28). Calls related to eligibility or coverage, including how to change dental plans, were the third most common concern.

Table 28. Nature of Sacramento GMC Dental Calls to the Health Rights Hotline, Age 0-5, 2003-2009

Nature of Call/Issue	2003	2004	2005	2006	2007	2008	2009	7-Year Total
Poor/inappropriate care/treatment/facility	1	4	0	1	2	4	0	12 (17.6%)
Access to specialist/delay in authorization	0	7	3	1	0	0	0	11 (16.2%)
Eligibility/coverage	2	0	7	0	1	0	0	10 (14.7%)
Finding a provider	1	1	1	0	2	1	2	8 (11.8%)
Delay/denial of care	2	0	3	0	1	2	0	8 (11.8%)
Language/transportation barrier	1	1	3	0	1	0	0	6 (8.8%)
Other	1	0	3	1	0	0	0	5 (7.3%)
Billing problem	0	1	2	1	0	0	1	5 (7.4%)
Patient education	1	1	1	0	0	0	0	3 (4.4%)
Total	9	15	23	4	7	7	3	68 (100.0%)

Source: Health Rights Hotline, Sacramento, March 2010.

For children age 6 or older, calls related to delay/denial of care were the most common by a relatively wide margin from the next most common calls—poor/inappropriate care and eligibility/coverage issues, followed by language/transportation barriers (Table 29). Access to a specialist/authorization delay calls on behalf of older children accounted for about half the proportion of these calls for children age 0-5 (9.4% and 16.2%, respectively).

Table 29. Nature of Sacramento GMC Dental Calls to the Health Rights Hotline, Age 6-20, 2003-2009

Nature of Call/Issue	2003	2004	2005	2006	2007	2008	2009	7-Year Total
Delay/denial of care	1	11	12	4	5	3	1	37 (24.8%)
Poor/inappropriate care/treatment/facility	3	7	4	2	2	2	1	21 (14.1%)
Eligibility/coverage	2	1	12	1	0	4	1	21 (14.1%)
Language/transportation barrier	1	3	6	2	1	1	2	16 (10.7%)
Finding a provider	1	1	2	1	3	5	1	14 (9.4%)
Access to specialist/delay in authorization	4	4	4	0	0	1	1	14 (9.4%)
Patient education	4	2	0	0	1	4	0	11 (7.4%)
Other	1	1	2	0	1	1	2	8 (5.4%)
Billing problem	1	2	3	1	0	0	0	7 (4.7%)
Total	18	32	45	11	13	21	9	149 (100.0%)

Source: Health Rights Hotline, Sacramento, March 2010.

Comparison to Fresno County

As shown in Table 30, the Fresno Health Consumer Center, located in the FFS comparison county, had even fewer calls related to children's dental issues than the Health Rights Hotline in Sacramento. Staff in Fresno pointed out how reluctant many families in their county were to voicing a complaint but was not able to speculate why the proportion of *dental* calls to total calls was so low.⁶²

Table 30. Nature of Fresno FFS Dental Calls to Fresno Hotline, Age 0-20, 2003-2009

Nature of Call/Issue	2003	2004	2005	2006	2007	2008	2009	7-Year Total
Finding a provider	0	0	0	0	0	0	0	0
Access to specialist/delay in authorization	0	0	0	0	0	0	0	0
Poor/inappropriate care/treatment/facility	0	0	1	0	0	0	0	1
Delay/denial of care	0	0	1	0	0	0	0	1
Billing problem	0	0	1	0	0	0	0	1
Language/transportation barrier	0	0	0	0	0	0	0	0
Eligibility/coverage	0	5	0	0	0	0	0	5
Patient Education	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0
Total Children's Dental Calls	0	5	3	0	0	0	0	8
Total Hotline Calls	519	922	1270	1007	532	387	659	5296
Percentage of Dental Calls to Total Calls	0%	0.5%	0.2%	0%	0%	0%	0%	0.2%

Source: National Health Law Program, April 2, 2010.

What Concerns Have Been Noted Specific to Cultural and Linguistic Competence?

Culturally and linguistically appropriate services are critical for communicating with patients and addressing oral health concerns within the context of the patient and their family. Ethnic, racial and language groups have unique issues in receiving linguistic and culturally appropriate oral health services.

GMC plans are required by contract to address the cultural and linguistic needs of members. At least 7 of the 18 Attachments in the contract Scope of Work Exhibit A contain terms and conditions related to this area, including assurances for oral interpreters, signers, translated written information, health education intervention, and ethnic diversity of providers. According to plan materials, Spanish, Chinese, and Vietnamese are the languages most available to members with limited-English proficiency or monolingual.

The Quarterly Grievance Reports plans submitted by the dental plans to DHCS are required to include grievances related to cultural sensitivity and linguistic access. Except where plans have noted in their reports such grievances and how they were resolved—or a formal complaint is independently lodged by a member—it would be unlikely DHCS would be aware of noncompliance in this area given its limited ability to make site visits to plans and/or their provider offices. None of the 2009 Quarterly Report grievances involving children related to cultural and linguistic needs.

Another method of measuring dental plans' provision of linguistically competent care was to evaluate language-related complaints received by the Health Rights Hotline and Fresno Health Consumer Center. Hotline calls related to language barriers between 2003 and 2009 in Sacramento were minimal. (See Tables 28 and 29 above.)

VI. What Lessons Can We Learn From Other Dental Care Models?



"Dentists are with managed care where physicians were 25 years ago; dentists still see it as a threat to their business."— Local physician

Other Medi-Cal Dental Care Delivery Models: California

There are three general approaches to providing health care coverage to Medi-Cal enrollees in the State of California: County Organized Health Systems, the Two-Plan model and Geographic Managed Care. A brief description of these models, including the approach to dental coverage, is presented below, with an example of each.

County Organized Health System: Solano, Napa, Yolo and Sonoma Counties

Medicaid Reform legislation (Title XIX, Social Security Act, Section 1115), passed in 1982, allowed the Medi-Cal program to contract with County Organized Health Systems (COHS) which are organized and operated by the county. Medi-Cal beneficiaries in COHS counties have a wide choice of managed care providers, and do not have the option of getting services through the traditional Medi-Cal fee-for-service system unless authorized by the plan. Federal law limits the number of beneficiaries who can be in a COHS, and because the State was already at this limit when GMC was offered to it, Sacramento County was excluded. Sacramento formally proposed increasing the COHS limit to be a part of that model but the proposal did not get far. There are five COHSs in the state covering 11 counties and approximately 21% of the Medi-Cal population. Partnership HealthPlan of California is the COHS nearest to Sacramento.

Four counties—Solano, Napa, Yolo and Sonoma—are currently joined together under the Partnership HealthPlan of California (PHPC). PHPC has established a medical provider network for each of these counties, but hopes to combine these into one network ultimately. PHPC utilizes community clinics extensively, but not exclusively. By mid-2011 Lake and Mendocino counties will join PHPC. PHPC can add additional counties with approval by the State. Preference is given to counties contiguous to other counties currently in the PHPC.

With PHPC, the contracted Medi-Cal capitation rate does not include dental care. Under COHS, dental care is typically provided through a fee-for-service arrangement. Covered children obtain provider information from the State and make their own arrangements for care. That dental care, however, may be provided by a clinic contracted by the COHS, but the clinic is paid by the State, not through the managed health care plan.

Two-Plan Model: Los Angeles County

The principal model implemented during the Medi-Cal managed care expansion was the Two-Plan model. In the early 1990s, the Two-Plan model was selected by the State for the largest counties in California. Under this model there are two options for Medi-Cal enrollees. The first is a county-developed plan with its own managed care (Knox Keene) licensure. This option is commonly referred to as “the local initiative”. The other option is a commercial managed care plan. Because of its population size, Los Angeles has the largest Two-Plan Model in the state. LA Care is the “local initiative” and Health Net is the commercial plan option. As in Sacramento, an independent organization, Health Care Options, enrolls eligible individuals in coverage.

Like the other counties except Sacramento, Los Angeles children’s dental care enrollment is separate from medical enrollment. Eligible families are provided a list of medical and dental providers from which to choose. While care is provided through managed care plans on the medical side, in LA enrollees have the voluntary option of choosing coverage through a managed care dental plan. If members do not choose between FFS and managed dental care, they are automatically assigned to FFS. DHCS staff explained that when the State began shifting FFS beneficiaries into managed care, Los Angeles was unwilling to participate for dental so the Department agreed to make enrollment in a dental plan voluntary. For various reasons, including geographic concentrations of providers, proportionately more dentists in LA are willing to participate in Denti-Cal than dentists in Sacramento.

While 8 managed care companies contract for Denti-Cal business in LA., the greatest majority (approximately 86%) of beneficiaries choose Delta Dental, the traditional fee-for-service option. According to the DHCS, when the managed care option is chosen for dental care, it is generally because of geographical convenience or because other family members or friends have chosen it.

Geographic Managed Care: San Diego

Besides Sacramento, San Diego is the only other county in the state with a GMC model of delivering medical services to its Medi-Cal eligible population. In San Diego, the State contracts with 5 managed medical care plans to provide coverage to Medi-Cal eligible individuals. A program called Healthy San Diego informs persons about their health care choices. It reaches thousands of people each month who apply for or renew their benefits. Presentations, presented by Health Care Options, the enrollment entity, are provided at the Family Resource Centers throughout the county. A Healthy San Diego Professional Advisory Committee (the current Chair is a dentist) is in place to oversee and provide guidance to the program.

San Diego GMC is different than Sacramento because in San Diego, Medi-Cal dental services have always been “carved out” of managed care; Medi-Cal beneficiaries there receive dental care from available FFS providers. According to local sources, the County specifically got itself excluded from the proposed Medi-Cal dental managed care program because it “did not have faith” in the adequacy of the State rates for covering the cost of services.⁶³

Other States' Approaches to Improving Children's Dental Services

States are continually experimenting with ways to improve utilization of children's dental services among the Medicaid covered populations. More and more states are examining managed care as an approach to providing dental care services. The reasons for this can vary, but cutting costs and providing dental homes for children—in addition to increasing utilization—are among the most commonly hoped-for outcomes of dental managed care. Widely accepted strategies that have been demonstrated to improve utilization outcomes 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

Research by the Urban Institute showed that several states were using their children's health insurance program (CHIP) as an opportunity to test new delivery systems for dental services.⁶⁴ Under separate programs from Medicaid, more state CHIP programs are using managed care arrangements to deliver dental services than is typical under Medicaid. According to their survey, states' decision to use managed care was made with the primary goal of improving access—"by using managed care, states are purchasing a clearly established and identified network of providers." It was also noted that, importantly, "raising payment levels has been a priority for many Medicaid programs in recent years." The authors concluded 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.

Per the federal General Accountability Office, in 2009, 21 states provided some coverage of Medicaid children's dental services through managed care contracts. The chart that begins on the following page (Table 31) summarizes improvements achieved by key states in recent years and reasons for those improvements.

Table 31. State Strategies to Improve Medicaid Dental Child Utilization Rates

State	Increase/Change Achieved	Strategies Employed						Comments
		Reimbursement Rate Increases	Increased monitoring and accountability	Administrative Improvements	Collaborative Partnerships	Financial reward/penalties	Outreach, education & Case Mgmt. Services	
Alabama	76% increase utilization over 6 year period beginning 2000; also a 76% increase in enrolled providers	X		X	X		X	Rates were increased in 2000 to 100% of Blue Cross/Blue Shield fees; private funds were raised for outreach and helping families navigate the program.
Arizona	25.3% increase in utilization for children 3-8 years from 2002-2004 years. 2007: achieved 62.4% utilization rate for children 3-8 years		X		X	X	X	Dental coverage is included with/through medical coverage. Dental plans are capitated; dental providers are paid based on fee-for-service schedule.
Michigan	43% increase in utilization over 6 year period from year 2000; 150% increase in providers for same period	X		X	X			Rates increased to 100% of usual charges during pilot; later rates were reduced and there was a 14% decline in providers; uses "dental ambassador" to mentor dentists and uses a dental benefits administrator.
Rhode Island	Increased dental utilization rates for children under 3 by over 100% from 2007 to 2008; increased number of participating dentists in dental program for children under 6 from 27 to approximately 175 since 2006.	X					X	Families enrolled in HMO unless they opt for FFS. Exception: children born after May 1, 2000 enrolled in dental HMO. Uses third party to manage the benefits and help families participate. Offers enhanced reimbursement for services provided to children 0-6 years.

State	Increase/Change Achieved	Strategies Employed						Comments
		Reimbursement Rate Increases	Increased monitoring and accountability	Administrative Improvements	Collaborative Partnerships	Financial reward/penalties	Outreach, education & Case Mgmt. Services	
South Carolina	54% increase in utilization over 6-year period beginning 2000; 93% increase in enrolled providers over same period	X		X	X		X	Raised provider rates to 75 th percentile of commercial rates; private foundation funds used for outreach
Tennessee	38% increase in utilization over 4 years beginning in 1999. 120% increase in providers for the same period	X		X	X			Increased provider rates to 75 th percentile of regional fee survey; contracts with one central dental administrator; other activities include gathering input through a dental advisory committee, recruiting community-based dentists, and additional education and outreach.
Virginia	33% increase in utilization in one year; 62% increase in providers for the same period	X		X			X	Raised provider rates by 28% in 2005; additional 2% increase for oral surgery in 2006; implemented one central administrative contract; and reduced prior authorization requirements.
Washington	Nearly 100% increase in access for children under 6 over a 10-year period ; over 6-fold increase for children under 2	X		X			X	Enhanced reimbursement for selected Medicaid preventive services; dental staff and family education; raised provider rates to 75 th percentile of usual charges for specific procedures; limited preauthorization and increased electronic claims submissions.

Arizona

Arizona has achieved significantly higher child dental care utilization rates than Sacramento and other California counties. In 2007, Arizona achieved dental utilization rates for children 3-8 years of age *in excess of 60%*.^{hh} As a result, Arizona is considered a model for the country in its provision of Medicaid dental services.

The State of Arizona's approach to dental coverage has many similarities to the California managed care approaches, with some important differences. One of the most significant differences is that in Arizona, dental care is managed through the *medical* managed care plan, i.e., the state contracts with medical managed care plans that, in turn, contract with dental managed care plans and other providers. Managed care plans (both medical and dental) are paid a capitated rate but individual dental providers are paid on a fee-for-service basis. The provider fee schedule is publicly available. A referral is not needed for children 3-20 years of age but is required for children under 3 years. (In recent years, the target age for first dental visit was lowered from 3 years to 1.)

Arizona's utilization improvement has been achieved in large part due to a comprehensive Oral Health Program Improvement Project implemented in 2002, which includes close monitoring of performance by the State, sanctions of up to \$200,000 per year for not meeting minimum performance requirements and mandated corrective actions for the managed dental care plans.

Arizona has also enacted legislation which allows dental hygienists to extend oral health services into underserved communities while providing formal links between hygienists and dentists through affiliated practice arrangements

Rhode Island

Rhode Island is another state with another effective approach for increasing oral health access for Medicaid children, focusing on children age 0-10. The state Medicaid program contracts with a dental managed care plan, UnitedHealthcare Dental, to administer the program. The dental plan had to be willing to reach out to the Medicaid community and to its own providers to get them to participate in the program. They acknowledged that there was a lot of reluctance and mistrust on the part of providers about Medicaid patients, but worked very hard to encourage their participation in the program. Among other things, UnitedHealthcare Dental does one-on-one recruitment of dentists in their offices, provides continuing education about pediatric dentistry and ensures that dentists get reimbursed more quickly than they did under the fee-for-service system. Since its inception in 2006, the number of dentists participating in Medicaid statewide jumped from 27 to 129 according to published reports.⁶⁵

^{hh} Using the HEDIS measure.

In 2008, the National Academy for State Health Policy⁶⁶ highlighted state practices that show potential for improving administration and delivery of dental care in publicly-funded programs. Some include:

- Use of “contact capitation” which withholds payments to contractors until the patient is actually seen by the dentist (Minnesota);
- Use of medical providers to provide dental care by integrating oral health screenings into child medical exams and reimbursing physicians for applying fluoride varnish (North Carolina);
- Shifting savings achieved through prevention activities to increased reimbursement to providers who treat children (Rhode Island);
- Use of a single third party program administrator (Michigan and other states).

Other Promising Practices

Recommendations to states in a Dental Medicaid Reform proposal in 2003⁶⁷ that hold potential for success in dental contracting—and have applicability for Sacramento GMC—include the following ideas:

- Accessing ready-made provider networks;
- Encouraging participation of safety-net providers;
- Contracting for case management strategies (e.g. clinical protocols, risk assessment, and disease management guidelines);
- Contracting for care integration between primary and specialty dentists;
- Empowering vendors to implement their own access initiatives (e.g. case managers, school-linked services, and private dentist contracting to health centers); and
- Allowing dentists to negotiate terms of participation.

CONCLUSIONS AND RECOMMENDATIONS



“This report reinforced what we knew, but the big surprise was the differences among the plans.” – State representative

Similar to medical care delivery over the last couple of decades, dental care is moving, albeit more slowly, toward managed care, though not in California by any means. Other states have begun to shift more of their Medicaid children into dental managed care systems, having implemented the necessary rate increases and supplementary support activities to experience improvement in utilization rates. Without such measures, the model of delivery raises important questions about access and utilization. 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.

Geographic Managed Care dental program has been in place in Sacramento County since 1994. Yet, while other researchers and advocates have reviewed and raised questions about GMC, warranting action for improvement, limited attention has been paid by State policymakers to proactively monitor this program, evaluate it, or improve it. Of note, no other county government has expressed an interest in implementing this model in the more than 15 years GMC has been in place.

When examining utilization rates, access factors, and quality issues affecting children, we considered the following questions in recommending whether Sacramento should pursue changing to an alternative model of dental care for Medi-Cal eligible children:

- What are the pros and cons of opening up this system by making enrollment in managed care dental plans *voluntary*?
- What are the fiscal, political, system and other costs of dismantling it?
- Are the potential benefits (e.g., free market access to Denti-Cal dentists) worth a change? Will more Sacramento dental providers sign up to take more Denti-Cal children than already agree to contract with GMC plans?
- Will these dentists be able to easily find pediatric specialists who will willingly take their Denti-Cal referrals?

We concluded that if Medi-Cal dental managed care is to continue in Sacramento, Medi-Cal beneficiaries should have a choice to enroll in this system—and, optimally, would *want* to—or to access care through an open network. We also believe that State-level policy changes related to performance/accountability and supplementary efforts, such as making

Medi-Cal dental services more attractive, are required to improve children's dental services.

Unless the Denti-Cal payment rates improve—which without some sort of miracle they will not anytime soon—and the claims payments system is radically simplified (for instance, relaxation of treatment authorization requirements, although few children's procedures require TARS), dental provider participation in the Medi-Cal dental program in Sacramento is unlikely to change in any substantive way, regardless of the delivery model. Further, without implementation of a focused outreach and case management campaign to complement these improvements to facilitate utilization of benefits—as other states have learned—Sacramento children's rates of dental use will not substantially increase.

Options Considered

The following 3 options for Sacramento County were considered for recommendation, along with relative arguments for and against the alternative. All options assume the implementation of *some* level of needed improvement strategies listed in this report.

Option 1: Keep the current mandatory GMC system

Arguments for:

- The infrastructure is already in place.
- Some better-performing plans are already offering Medi-Cal dental services
- Potentially greater access to specialists
- Opportunity for a dental home
- Some sort of quality assurance exists at the plan level
- Cost control is more predictable
- There is opportunity for medical-dental integration when both are under the same system

Arguments against:

- Beneficiaries do not have a choice of participation in managed care
- Has not demonstrated that having a dental home leads to better (or even equal, in some cases) utilization of benefits
- Some of the resources and leadership needed to make required improvements appear not to be available, especially in the short-term
- Given the utilization rates of some of the GMC plans, there is less value for the State in relation to what is being spent in some of the dental plans

Option 2: Get rid of GMC and keep only the FFS system

Arguments for:

- Utilization data from other counties supports a FFS model
- More Sacramento dentists (according to the Dental Society's survey) indicated an interest in participating in Denti-Cal than participate now
- The State would not be paying for care that children aren't getting

Arguments against:

- No assurance of a dental home; parents are on their own to find a provider
- Access to specialists could be reduced
- At odds with what other states are doing with their children's Medicaid dental programs
- Costs to the State could increase if capitation rates are lower than FFS rates

Option 3: Keep the GMC system, but make it voluntary to allow the FFS alternative

Arguments for:

- Maximizes choice for beneficiaries
- Still allows for a dental home for beneficiaries enrolled in a dental plan
- Might increase the total number of Sacramento dentists willing to take some or more children with Denti-Cal
- Utilization rates could increase
- Provides an opportunity for dental-medical integration in plans that offer both medical and dental managed care
- Community clinics with dental services would be guaranteed direct access to Denti-Cal, i.e., they would not have to rely on a relationship with a dental plan

Arguments against:

- Could raise costs for GMC plans (or put some out of business) because plans rely on volume for economic viability
- There is some risk of over-utilization that could increase the cost to the State of the FFS program

Recommended Alternative: Option #3

The following should be implemented 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.ⁱⁱ

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

ⁱⁱ 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 Improvement Strategies

The following recommended actions are tied to implementing the recommended alternative. They are listed in order of potential for shorter-to-longer term implementation—not in order of their importance.

1. Establish local oversight

A local entity with authority for local oversight of children’s dental services—focusing first on the necessary legislative and other steps to make GMC a voluntary program—should be established by the Sacramento Board of Supervisors (BOS). Healthy San Diego is a model for local oversight, even though dental services are not part of its GMC program, because it has developed the requisite leadership and influence to improve access to services. Given its collaborative role in reforming the medical “safety net” and improving access to quality care for underserved populations in the region, the most feasible body for the BOS to consider is the Sacramento Health Care Improvement Project’s (SHIP) Children’s Dental Task Force as it may provide the necessary long-term stability. Additional funding support may be necessary to make this a reality.

Specific recommendations for the oversight body include: a) it should be given the authority to bring pressure to the State when necessary to increase dental access and utilization to at least the statewide average; b) it should not be composed of providers who have a stake in the outcomes (conflict of interest), and should include advocates and clients; and c) it should have the ability to evaluate GMC and FFS by getting robust data from the State, without undue effort, to shed light on access and utilization trends. The additional data should be included in updates to the *Sacramento County Children's Report Card* and that process used to regularly collect and monitor the data.

2. Terminate GMC contracts now with dental managed care plans that consistently under-perform

Our review indicated there is extreme variation among plans’ performance that warrants attention. The State’s interest in expanding Medi-Cal managed care should not override its ability to terminate contracts or decline to do business with plans that do not provide care at levels consistent with the FFS system. The low utilization rates in the poorest-performing plans suggest DHCS should not continue to contract with these plans as Medi-Cal children are not receiving the benefits for which they are eligible. Plans are being rewarded for not seeing children.

3. Add contract language that requires GMC dental plans to adopt professional standards for age at first dental visit.

The GMC contract does not contain any requirement concerning age at a child’s first dental visit. Although we were told by 4 of the 5 GMC dental plans that their policy was consistent with the American Academy of Pediatric Dentistry and American Academy of Pediatrics “by first birthday or first tooth” recommendation, our study showed several of the offices were unaware of or not in compliance with the stated policy. After adding the necessary contract language, DHCS should monitor plans’ compliance with this provision,

including requiring training of office staff and providers. If some plans' offices or clinics are not set up to handle very young children, DHCS should assess the extent to which this limitation poses an access barrier for GMC members.

4. Examine reasons why parents don't more fully utilize children's dental benefits

Talking to a sample of low-income parents in Sacramento whose children are covered by GMC, Healthy Families, and Healthy Kids/Healthy Future programs would be extremely valuable for learning the reasons they aren't taking greater advantage of their children's dental benefits. It would not be difficult or costly to design an approach for sampling a representative group of Sacramento parents to identify specific barriers—and to what extent each might be unique to each coverage plan—and develop recommendations for appropriate solutions. Supporting such a study as a complement to this study would be beneficial as a next step.

5. Increase performance penalties/incentives

DHCS monitoring of utilization tends to be on an overall basis but not at an individual plan level. When there was a penalty associated with it, there was monitoring to calculate whether there should be a withhold. Reinstigate the pay for performance in GMC contracts regarding the withhold for low utilization thresholds, increase the percentage of this withhold, and separate children's from adults' (to the extent adult services are covered) utilization.

Sacramento County and the State should not accept the level of utilization seen in Sacramento GMC. Since the former withhold percentage of 3% did not provide, for at least a couple of the plans, a sufficient incentive to provide adequate levels of care, the pay for performance condition should be reinstated and raised to a level where plans are not rewarded for failing to provide care to enrolled children. Children's and adults' utilization rates should be separated so that children's, especially those age 0-5, use of dental benefits can be regularly monitored.

DHCS should withhold first payments to dental managed care plans until a child receives a first visit that includes one of the examination codes. 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.

6. Improve State oversight of plan performance

As has been documented by various studies, active and effective program oversight by state agencies, like sufficient payment rates to adequate numbers of providers, is essential to ensuring accessible dental services in Medicaid. The current capacity in terms of number and types of staff in the Medi-Cal Dental Program falls short of what is needed to adequately oversee plan performance. The program should routinely and proactively conduct periodic site visits, dental chart reviews, and secret shopper telephone calls. Grievance data have too many holes in them to be depended upon as a measure of quality. Passive oversight by responding to contacts concerning complaints is insufficient.

More DHCS infrastructure for the dental program is required to adequately fulfill State administration responsibility.

State initiatives without oversight are of limited value. DHCS's Early Childhood (0-3) Dental Health Initiative is well meaning but is a voluntary program. The Department should *require* all plans to participate, and monitor plans' outreach and education efforts. The dental brochure the Department expects to make available is one way it can help plans improve parents' awareness of the value of children's dental services.

The Medi-Cal Dental Program should also establish more formal ties and regular communication at various levels with related state agencies/programs and make them aware of how they can help provide oversight that benefits the Medi-Cal population. The interaction with the Department of Managed Health Care, for instance, is mostly intermittent and should be strengthened to at least the level of DMHC's interaction with Medi-Cal Health Plans.

7. Improve State data capacity

Similar to previous studies, it was difficult in some cases to draw conclusions about GMC and dental plan performance—and compare it to FFS—from the encounter and other data reported by plans and produced by DHCS. Although DHCS staff was very responsive to requests for data, the level of effort required to obtain what was needed for this report was extraordinary, and would not be possible in the future without funding for this purpose. The Department should be held accountable for producing higher quality (accurate, more complete) and more timely user-friendly reports that can be used by Sacramento County to monitor access, quality and costs.

8. Continue to support and expand the capacity of community health center dental services.

Federally Qualified Health Centers (FQHCs) offer a sustainable model of community-based dental care and are recognized as providing culturally and linguistically competent services. The Sacramento clinics state they have been able to attract high quality staff and are interested in expanding their services but present capacity is limited. These safety net providers offer a “lifeline” for uninsured families and children with Denti-Cal who need primary medical and dental care.

9. Facilitate clinics' access to contracting for Medi-Cal dental patients either directly with DHCS or via subcontracts with GMC dental plans

Community clinic providers want to serve low-income patients; this is tied to their mission. Increasing the participation of clinics in Sacramento GMC can eliminate some barriers to access (e.g., culture, linguistic) and potentially increase utilization of services.

10. Establish dental managed care quality indicators

DHCS has made continuous strides in monitoring quality of care and evaluating service delivery provided to the low-income children and families enrolled in Medi-Cal *medical*

managed care plans. These quality strategies have not been applied in Medi-Cal's *dental* managed care program, however, nor have quality indicators been established and evaluation results produced.

If the State is going to retain—and expand—Medi-Cal dental managed care, DHCS should hold plans accountable to standards that demonstrate patients get care at levels at least as good as a FFS model. Quality measures, such as those used by Healthy Families in this study, should be established and evaluated. For further consideration, in addition to looking at rates of treatment and prevention, which really are basics of quality indicators, further studies and DHCS might also look for completed treatment plans during the year. From a year to year perspective, an important indicator would be if there was a reduction in both the overall rate of decay (e.g., fillings), and a reduction in teeth extracted. Also informative would be to assess changes in overall utilization rates that might be tied to patients' satisfaction and continued use of the facility/provider. These latter findings would be indicators of the effectiveness of the prevention techniques as well as overall health by retaining more of the natural dentition.

11. Put more emphasis on preventive services

Hospital emergency department visits by Sacramento Medi-Cal children associated with preventable oral conditions, and ratios of prevention-services-to-users in Sacramento GMC, are only two of the indications we found that more support should be directed toward activities that increase prevention services. Performance indicators and outreach efforts, as well as State and local quality monitoring should take prevention services into greater account. Two ways of achieving this are school-based efforts and training medical providers to expand oral health services and referrals.

12. Integrate dental with medical

The perception that oral health is separate from and less important than general health has been ingrained in the health care system. Private practice settings and isolation from other health services have helped create the impression that oral health is not part of one's overall health.⁶⁸ DHCS and Sacramento County organizations can help advance the agenda of increasing utilization as well as eliminating oral health disparities through collaborations among dentistry, medicine, and the other health professions.⁶⁹ Administering both a managed care medical and a managed care dental system in Sacramento County provides the opportunity for collaborative efforts, and both the local medical and dental societies have the potential to participate to a greater degree. Educating and involving pediatricians and family practice physicians in early childhood oral health has been demonstrated to be successful in California in increasing anticipatory guidance, referrals and preventive services.⁷⁰ Using pediatric providers makes perfect sense since they see infants, young children, and their caregivers many times in the first two years of life for well-child care and immunizations, whereas most families don't take young children to the dentist until they are three or older.⁷¹

13. Promote more education/awareness and outreach activities

Not all parents recognize the importance of very early childhood oral health. However, the consequences for disadvantaged populations are more serious as these children are at higher risk for oral disease and have more limited access to services even when they have dental benefits. While GMC plans have not provided a sufficient level of outreach to get GMC members to use their benefits, it is not realistic for DHCS to assume the administrative overhead in the dental plans' capitation rate is sufficient for doing a lot more than sending annual newsletters and distributing health education materials in provider offices. The State should consider funding a statewide strategy for an outreach and awareness campaign and helping families navigate the program similar to Alabama's.

Local programs can look for ways to link oral health education more closely to related programs and services such as WIC (Women, Infant, and Child) services. Integrating oral health education at WIC sites is making a difference, especially for 1-year olds, according to the Dental Health Foundation,⁷² because, unlike at Head Start centers, parents are *at* WIC when their child is receiving services.

14. Expand school-based prevention and screening programs, and allow the County to recoup the cost of these services

Providing oral health services through school-based programs, including preschool, is an important strategy for meeting oral health goals. When screening, fluoride varnish, and sealants are provided by the County (generally through grant funds) to children in low-income schools, the County is serving a large proportion of children enrolled in GMC dental plans. However, there is no reimbursement mechanism to recoup the cost of these services like there is in some FFS counties which bill Delta Dental. The County cannot bill the GMC plans (it may require legislation), although the State has already paid the plans for these services as part of the monthly capitation fee.

DHCS should include a provision in the next round of GMC dental contracts for school-based oral health providers (through a rendering Medi-Cal provider) to bill the child's plan for services provided. Or, DHCS should create a pool of grant funds that can support the County's school-based programs. It is not recommended that these services be "carved out" of plans' capitation rates because of the potential that some GMC children might *not* receive school-based oral health services.

15. Increase Denti-Cal rates to increase provider participation

Denti-Cal rates should be brought more into line with market-based rates. (Market-based rates to dentists are those rates that will induce a significant portion of available providers to participate.) *Success in improving the oral health status of low-income children depends on sufficiency of provider payment.* Dentist supply in Sacramento is sufficient to guarantee a meaningful increase in provider network capacity if Denti-Cal rates are raised, at least to the level to cover the providers' cost of delivering care. We are fully aware of the fiscal impact of this recommendation and the economic environment in which we're making it.

In a number of states, innovations that have included market-based payments for dental services and benefits administration processes that use or mimic commercial dental insurance have produced encouraging and substantial improvements in dentists' participation in Medicaid, and Medicaid enrollees' utilization of services.⁷³

16. Increase Recruitment of Denti-Cal Dentists

One of the success factors in increasing dentist participation in the Medi-Cal program hinges on successful outreach efforts targeting dentists.⁷⁴ One of the contractual responsibilities of Delta Dental on the FFS side is to recruit dentists into the Denti-Cal program; on the managed care side plans are expected to approach dentists to participate. DHCS should consider increasing support to Delta to expand targeted outreach and recruitment efforts in Sacramento GMC (and other managed dental care counties) that, in tandem with community clinics, could help to increase the network of available dental providers.

What Did the Dental Plans Recommend to Improve GMC?

When asked about their recommendations for improving GMC, plans nearly uniformly believed the Medi-Cal Dental Program should play a greater role in raising awareness of the importance of children's oral health and encouraging parents to take advantage of their children's dental benefits. Some plans also suggested the State should proactively help in some way to decrease the appointment no-show rate, which adds to the cost of care. (DHCS maintains that these are plan responsibilities, and allowance for it is included in the capitation rate.) Three of the plans called for increased financial incentives for plan performance, with one plan recommending increased capitation rates to improve GMC (Table 31).

Table 31. Plans' Recommendations to Improve GMC

	Access	Community	Health Net	Liberty	Western
Plan recommendations	1) higher capitation rates; 2) increased State support to address the no-show rate	Increased State support to 1) address the no-show rate; 2) encourage utilization (no specifics offered)	More State support for a) outbound calls to outreach to members to build awareness; 2) incentive pay for preventive services	"Pay for performance" and increased capitation rates; increase number of enrollees per plan to make GMC a more economically feasible model; increased State oversight	Encourage State to 1) do patient education to raise awareness; 2) facilitate MD/DDS collaboration (including by working with Medi-Cal <i>medical</i> managed care, e.g. pediatrician offices)

*Source: Interviews and email communication with plan representatives.



IMPLEMENTATION PLAN

“Sacramento County missed the boat on GMC in 1994 when the State invited us to the table—so we were frozen out of the [decision-making] process.” — Local official

“The State blew us off when we tried to get metrics and numbers about how GMC was going.”—Former GMC Commission member

Fifteen recommendations were made in this study, and each requires some level of cost and workload. While the Sacramento First 5 Commission may not necessarily agree with or act upon all of them, clearly other partners may have an interest in doing so collaboratively or on their own. The Sacramento First 5 Commission should determine and prioritize which recommendations it wishes to undertake, at least in the short-term, and develop an action plan for implementing them.

Parties and Roles

The Sacramento County Board of Supervisors may not be aware of the extent to which Sacramento lags behind many other counties of comparable size in use of dental services by low-income children *with dental coverage*. First 5 should schedule and deliver a briefing to the BOS about the key findings of this study as soon as possible. The Commission may want to do this in collaboration with representatives from the Children’s Dental Task Force.

Because the BOS is a legislatively authorized, permanent body with the necessary infrastructure (e.g., standing committees), it should be asked to assume leadership responsibility for local oversight of children’s dental services; the BOS can do this by appointing an entity for carrying out this function—essentially re-establishing a “GMC Commission” but with broader responsibility. The Sacramento Health Care Improvement Project’s (SHIP) function as a convener, and its role in improving access to quality care for underserved populations in the region, makes it the most feasible body for assuming this oversight responsibility, accountable to the BOS. SHIP would likely charge the Children’s Dental Task Force with carrying out the steps in this implementation plan.

Legislative authority will be needed to implement the policy change of making GMC dental voluntary. A Sacramento area assembly member or senator will need to be identified who is willing to support the necessary legislation.

Meetings with State staff, particularly from the Medi-Cal Dental Services Division, will be necessary to establish an ongoing working relationship and to gain their support—as far as

possible—for implementing some of the recommended improvement strategies. We found the representatives we worked with in this study to be genuinely concerned about the findings and interested in improvement.

Champions and partners that could assist with implementation include the following:

- California Dental Association (CDA) policy department staff
- Sacramento District Dental Society
- Public Health Advisory Board (PHAB), which is appointed by the BOS
- Health Rights Hotline, an advocacy organization with current knowledge of children’s dental issues
- Western Center on Law and Poverty, an advocacy organization which can similarly help
- Local hospital emergency department managers, who would have an interest in reducing avoidable ED visits due to preventable oral conditions

Timeline (Anticipated Completion Dates)

- Initial planning meeting with stakeholders – August 2010
- Appointment of oversight body – September 2010
- Introductory and initial planning meeting with DHCS – October 2010
- Partnership meetings with CDA and Sacramento District Dental Society policy staff – October 2010
- Development and passage of legislation for voluntary GMC dental – July 2011
- Recruitment campaign to increase dental provider participation – September 2011
- New round of DHCS contracting with dental managed care plans – July 2012

Barriers to Implementation

The following are the likeliest challenges in implementing the recommended alternative and improvement strategies:

- Time – human resources, e.g., a portion of a staff person’s time, will need to be assigned to this plan at least for the near future; additional State staff time is going to be needed to make changes and improve State functions.
- Funds – financial support (which will include pro bono time) will need to be generated to implement many of the strategies. The costs to the State and local organizations/funders will vary from relatively modest (e.g., study of parents to identify low utilization, inter-professional training) to relatively costly (e.g., recruitment of targeted dentists).
- Political will – it’s unknown whether there will be legislative (and Administration) support for the legislative action necessary to change GMC dental to voluntary.
- Dental plan resistance – dental plans may view the change of GMC to voluntary as “weakening” the system too greatly to ensure economic viability and some may choose not to do Denti-Cal business in Sacramento. On the other hand, defaulting children

who do not automatically choose a provider into a dental managed care plan may be favorable enough that plans do not resist the policy change.

- Policy issue – the impact of changing GMC dental to voluntary but leaving GMC medical as mandatory is unknown and may have systems complications for the State (and Sacramento County providers); the only currently contracting dental plan in Sacramento that is also a medical plan is Health Net.
- Dental provider willingness – changing GMC dental to voluntary and allowing dentists to begin seeing Denti-Cal children does not automatically guarantee dentists would sign up to accept any or more children with Denti-Cal; it is a false hope to think so. While there was a favorable response of some dentists to the Sacramento District Dental Society survey that they would be “likely” to accept Denti-Cal, the respondents did not indicate *how many* Denti-Cal children they would be willing to take. For a sufficient number of dental providers to participate at a sufficient enough level to impact access, the State must implement improvement strategies as other states have done.



Appendices

APPENDIX 1

First 5 Sacramento Children's Dental Task Force GMC Subcommittee Members

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Notes on the Calculation of Dental Utilization Rates

Comparing dental utilization among programs is a challenge because of the differences in data methodology approaches. Initially, DHCS provided this study with dental utilization rates based on “unduplicated number of children” as the denominator: the utilization rate for children age 0-20 was calculated by dividing the unduplicated number of children who received at least one dental service in a given year by the number of children enrolled in a GMC plan for any length of time during that year. That method resulted in numerous problems in trying to reconcile the data with the utilization rates the GMC plans sent us. As a consequence, DHCS determined it would use “average monthly eligibles during the study year” for calculating utilization rates because it was consistent with the way plans submit their data to DHCS. Utilization rates will always be reported as higher using average monthly eligibles than when using unduplicated eligibles as the denominator. While even this method did not resolve the differences between the DHCS and the plan data, the gap narrowed for 3 of the 5 dental plans.

Dental managed care plans that contract with Healthy Families follow the NCQA HEDIS* technical specifications for Annual Dental Visit. This defines the eligible population as all members who were continuously enrolled during the measurement year (2008) who had no more than one gap in enrollment of up to 45 days. The use of the HEDIS method for the denominator means that utilization rates will always be reported as higher than when using unduplicated eligibles as the denominator. (DHCS points out that whether HEDIS is higher than average monthly eligibles or vice versa depends on the vagaries of enrollment/disenrollment.)

Unlike Medi-Cal, the Managed Risk Medical Insurance Board requires its contracting dental managed care plans to submit Healthy Families data that is audited by an independent third party, and plans must submit an auditor certification to MRMIB. The auditor ensures the systems and process are in place to collect the data and that plans are following the specifications set by MRMIB or NCQA, but does not assure the accuracy of what is reported. Thus, even though their data were audited, HF plans were able to change and resubmit their data.

Other calculation approaches for determining dental utilization have been used or are under consideration elsewhere. There are pros and cons to each method. For example, one approach is to use the Full-Time Equivalent (FTE) method, which is similar to calculations of FTEs in the workplace and has certain advantages.⁷⁵ The Centers for Medicare and Medicaid Services (the federal agency which administers Medicare,

* The National Committee for Quality Assurance (NCQA) is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality, and its seal is a widely recognized symbol of quality. Health plans are NCQA accredited. Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and services. To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by NCQA. The national Medicaid average reported by NCQA also uses the HEDIS measure.

Medicaid, and the Children's Health Insurance Program), has for many years used unduplicated eligibles as the denominator in reports that states are required to submit annually on EPSDT program performance. However, according to State staff, CMS is planning on changing this calculation to use at least 90 days of continuous eligibility, which a number of states, including California, believe is too short a period of continuous eligibility and a more HEDIS-like indicator should be used.

Researchers have observed that without “a clear understanding of the implications of using different methodological approaches to calculating dental utilization rates, it is very difficult to appropriately evaluate access to dental care for enrollees in these [various] programs.”⁷⁶

Detailed Table of Medi-Cal GMC Utilization Rates

Table A-1. Medi-Cal GMC Dental Users, Eligibles, and Utilization Rates, by Plan and Age Groups, 2008

	Ages 0-3			Ages 4-5			Ages 6-8			Ages 9-11			Ages 12-14			Ages 15-18			Ages 19-20			Ages 0-20		
	Users	Elig	Utilz Rate	Users	Elig	Utilz Rate	Users	Elig	Utilz Rate	Users	Elig	Utilz Rate	Users	Elig	Utilz Rate	Users	Elig	Utilz Rate	Users	Elig	Utilz Rate	Users	Elig	Utilz Rate
DHCS DATA¹																								
Access	860	8955	9.6	1799	3997	45.0	2250	5152	43.7	1811	4645	39.0	1529	4671	32.7	1916	5900	32.5	447	1720	26.0	10612	35039	30.3
Commun	25	2698	0.9	69	1052	6.6	111	1362	8.2	102	1198	8.5	80	1178	6.8	103	1447	7.1	33	498	6.6	523	9433	5.5
HlthNet	36	432	8.3	58	153	38.0	57	169	33.8	46	167	27.6	39	154	25.3	43	178	24.2	13	71	18.4	292	1323	22.1
Liberty	621	4692	13.2	872	1886	46.2	1207	2645	45.6	1043	2388	43.7	931	2414	38.6	1135	2978	38.1	311	863	36.0	6120	17865	34.3
Western	529	14283	3.7	879	5650	15.6	1241	7239	17.1	937	6613	14.2	983	7309	13.5	1254	9462	13.3	377	3185	11.8	6200	53740	11.5
Total	2071	31060	6.7	3677	12738	28.9	4866	16566	29.4	3939	15011	26.2	3562	15726	22.7	4451	19965	22.3	1181	6337	18.6	23747	117402	20.2
PLANS' DATA²																								
Access	1006	8802	11.4	2065	3936	52.5	2469	5075	48.7	2008	4579	43.9	1632	4606	35.4	2066	5816	35.5	473	1686	28.1	11719	34500	34.0
Commun	121	2292	5.3	374	1164	32.1	405	1440	28.1	340	1239	27.4	274	1239	22.1	355	1528	23.2	107	571	18.7	1976	9473	20.9
HlthNet	56	892	6.3	91	347	26.2	96	364	26.4	71	362	19.6	69	341	20.2	70	394	17.8	18	159	11.3	471	2859	16.5
Liberty	487	2579	18.8	831	2263	36.7	1225	3154	38.8	1048	2784	37.6	919	2608	35.2	1147	3468	33.1	296	1563	18.9	5953	18419	32.3
Western	1054	12463	8.5	2109	5334	39.5	2623	6596	39.8	2152	5952	36.2	2142	6674	32.1	2732	8614	31.7	648	2683	24.2	13460	48316	27.9
Total	2724	27028	10.1	5470	13044	37.4	6818	16629	36.4	5619	14916	32.9	5036	15468	29.0	6370	19820	28.3	1542	6662	20.2	33579	113567	26.3

Note: Because Health Net began GMC contract July 2008, data are for 6 months. Users = a member aged 0-20 who received at least one dental service during 2008. Eligibles = the number of average monthly enrollment in the health plan during 2008.

Source: Department of Health Care Services, March 3, 2010,¹ and contracting dental plans, March-April 2010²

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