Sacramento Children and Dental Care: Better Served than 5 Years Ago?

An Updated Study of Dental Geographic Managed Care (GMC) for Sacramento County Children

BARBARA AVED ASSOCIATES
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EXECUTIVE SUMMARY

"The dental plans have been religiously at the table and following up when we've had questions and are really trying to improve utilization in Sacramento."
—Medi-Cal Dental Advisory Committee Member

"It's understandable why the advocates would have been ticked off at us when you look back on some plans' performance." – GMC plan representative

"The Department is pleased to observe the continued success of the plans as evidenced by their continued efforts in beneficiary outreach and education and positive utilization trends."
— DHCS Medi-Cal Dental Program

Introduction

The most common and preventable disease of childhood is tooth decay, yet it remains the most prevalent unmet health care need for children.[1] In Sacramento County, among 8,041 low-income, predominantly preschool children screened in 2013-14, close to one-third showed some evidence of decay and needing treatment and 5% needing immediate treatment.[2] This is troubling because untreated tooth decay can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. Importantly, oral diseases are progressive and cumulative and become more complex over time—prevention is the key.

Half of all children in California are enrolled in the Medi-Cal program with coverage for dental services. Yet, children with Medi-Cal make fewer preventive dental visits than their peers not covered by Medi-Cal.[3] While close to two-thirds (64%) of California children with private dental benefits made a dental visit in 2013, only 52.4% of children with Medi-Cal saw a dentist that same year.[4] Although much effort has been made in Sacramento County in the last few years to boost children's access to dental services, there is still a need for "enabling conditions that help bring Medi-Cal-enrolled children and dental providers together."[5] A dilemma exists, however. Greater success in increasing utilization will in turn increase costs; hence, the Medi-Cal program must manage the trade-off between a desire to increase access and utilization while containing costs as the numbers of Medi-Cal eligible children rises. To do this, the State must aim for an optimal—or desirable—utilization rate that makes offering a children's program both meaningful and sustainable. Information in this report clearly demonstrates that higher reimbursement rates are the number one component of what will get more dentists to participate in the program, and that in turn will increase utilization.

[1] Benjamin RM. Oral Health: the Silent Epidemic. *Public Health Rep.* 2010 Mar-Apr; 125(2):158–159.
[2] Data from Smile Keepers, a mobile dental program of the County of Sacramento.
[3] Yarbrough C, Nasseh K, Vujicic M. Key Differences in Dental Care Seeking Behavior between Medicaid and Non- .Medicaid Adults and Children. Health Policy Brief, American Dental Association, September 2014.
[4] Vujicic, M, Kamyar Nasseh K. Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrows, Remains Large for Adults. Health Policy Institute, American Dental Association Research Brief. November 2015. Data source for Medi-Cal is Department of Health Care Services, Medi-Cal Dental Program. Data run February 2015.
[5] Ibid. p. 11.

The California Department of Health Care Services (DHCS) administers the Medi-Cal Dental Program. It is primarily a fee-for-service (FFS) structure where dentists are paid directly for the services they provide. In Sacramento County only, enrollment in managed care for dental services (as well as medical services) is mandatory for most Medi-Cal children; this model has been provided in the county since 1994 under the Geographic Managed Care (GMC) program. DHCS currently contracts with 3 dental managed care plans—Access Premier, Health Net and LIBERTY Dental Plan—that provide comprehensive dental care to about 140,000 Sacramento County children through networks of private providers and community clinics. The services that the plans provide are equivalent to those outlined in the FFS Manual of Criteria.

This report was prepared by BARBARA AVED ASSOCIATES, and updates our 2010 evaluation of the GMC dental program.[6] The study was initiated at the suggestion of the Medi-Cal Dental Advisory Committee and dental plans. The purpose was to learn what improvements have been implemented in the last 5 years, and to offer suggestions for improvement from other state Medicaid dental experiences in serving children with various dental service delivery models. Unlike our earlier study, we were not asked to recommend options for changing the GMC dental services model. For consistency (and lack of a full year of data for adult Medi-Cal dental services), the focus was again only on services for children. In addition to presenting current information regarding access, utilization, and quality of care, we address the importance of the respective roles of the DHCS, dental managed care plans, and stakeholders.

Study Methods

Data were analyzed from a variety of private and publicly available sources. Fresno County, a fee for service (FFS) county with comparable demographic and service characteristics to Sacramento County, was an appropriate comparison for some of our analyses. Various documents including GMC contract sections were reviewed, surveys of local dentists and GMC plan families were carried out, and interviews were conducted with State staff, local, state and national dental experts, dental managed care representatives, other state Medicaid program representatives, and local dental professionals, community leaders and other stakeholders. A subcommittee of the Medi-Cal Dental Advisory Committee provided guidance to the project.

Key Findings and Conclusions

There is Evidence of Improvement in the GMC Program Since 2010

- Although GMC continues to lag behind FFS in utilization, since our earlier study improvements have been implemented in the structure and management of the program, expansion of community services and in plan performance in some areas, better serving Sacramento County children.
- DHCS eliminated lower-performing contracted dental plans and added more reporting requirements to the remaining plans, with some of the data now visible on the DHCS dental website.
- DHCS added 11 Performance Measures and Benchmarks to the dental managed care contracts beginning in 2013. It uses these measures to monitor plan utilization and institute a structure of withholds and bonuses.

[6] *Sacramento Children Deserve Better: A Study of Geographic Managed Care Dental Services*, June 2010. http://www.barbaraavedassociates.com/samples/sacramento-GMC-report.pdf.

- Five children's dental clinics have been built in Sacramento County since 2009 with support from First 5 Sacramento without which utilization may not have increased to the extent it has; a 6th site is being built in Galt to open in early 2016. GMC plan contracts are now in place with all of these dental clinics plus several other community clinics operating in Sacramento County.

- Utilization of dental services for children in GMC has increased for all child age populations since 2008 by nearly 100%—from 20.2% to 39.6%. For age 0-3, the rate jumped 249%.

- According to the Medi-Cal Deputy Director, DHCS indicates it is satisfied thus far with the outreach efforts of the dental plans to boost utilization.

- In 2014, a higher proportion of Medi-Cal enrollees in aid codes (special classifications) that could remain in FFS or elect to enroll in GMC were enrolled in GMC than in 2009, which could be partly due to the BDE process discussed below.

- Efforts to raise awareness and practice regarding seeing a child by first tooth or first birthday have paid off. A higher percentage of surveyed dentists (74%) in GMC reports seeing a child by age 1; 72% of surveyed parents agree or strongly agree this is the time for a first dental visit; and 92% of surveyed parents agree or strongly agree baby teeth are important.

- GMC dentists have a much more positive view of the GMC program than do dentists who do not participate in the program though both groups believe reimbursement rates paid to dentists need to increase to retain current dentists and to recruit prospective providers.

- The accuracy of provider directories has improved since 2009 and the number of available providers has increased by nearly three-fold.

- GMC dental plans had varying degrees of success in meeting DHCS performance measure benchmarks. While no benchmark was fully met for all 0-20 age groups, all 3 plans exceeded the benchmarks for children age 0-3 for Annual Dental Visit, Use of Preventive Services and Exams/Oral Health Evaluations in 2014.

More Improvements are Still Needed

- A substantial proportion (67%) of GMC-eligible children in Sacramento did not receive a preventive service during 2014, though dental plans are being paid capitated rates for these children.

- The proportion of emergency department visits by all children 0-18 in Sacramento County for conditions that could have been treated in an ambulatory setting increased substantially between 2009 and 2014 with approximately 95% of these ED visits considered preventable in 2014. The public (Medi-Cal) bears two-thirds of the costs of this care.

- Challenges continue for children requiring sedation for dental care. Coordination between the medical plan that covers hospital and sedation service costs and the dental plans that cover the dental provider fee has not improved access and timeliness of care. Stakeholders and providers say DHCS policy letters in 2015 have not helped, and clarifications regarding the policies have been insufficient.

- Sacramento GMC utilization rates still lag those experienced by other California counties and the national Medicaid average. At 39.6%, Sacramento County trails both the statewide FFS average (52.5%) and the national Medicaid average (48%).

- There is no agreed-upon, articulated California oral health goal for a satisfactory level of utilization at the state, community or dental plan level. The majority of interviewed stakeholders believe 70% is a "reasonable, realistic goal" for children's utilization in California whether in Medi-Cal dental managed care or FFS.

- Stakeholders believe children's dental utilization has plateaued. They worry it "may have reached close to its maximum potential *unless certain steps are taken," such* as those implemented by the Washington state children's dental program. The diversion of serving adults when adult Medi-Cal benefits were restored in May 2014 may have contributed to this stagnation—which could be temporary. The trends must be monitored.

- California has not increased its reimbursement rates for Medi-Cal dental services since FY 2000-2001 and even implemented rate cuts during those 14 years. Rates paid to dental providers in California are some of the lowest in the country–approximately 31% of dentists' usual rates.

- The supply of licensed dentists is ample in the county but nearly 90% of dentists do not see children with Medi-Cal. Low reimbursement rates and challenges in navigating the program's administrative requirements were cited as key reasons by dentists who formerly took Medi-Cal patients but no longer do so. Half the dentist survey respondents cited higher reimbursement rates, payment made on a FFS basis and reduced administrative burdens as incentives that could entice them to see Medi-Cal patients in the future—potentially increasing the plans' provider networks. The other half said no incentive would change their decision regarding not taking Medi-Cal patients.

- Close to half (47.2%) of surveyed dentists who don't participate in GMC or FFS dental indicated provider rates would need to be increased by 50% or more, and one-third indicated a 70%-80% increase would be necessary, for them to start accepting children with Medi-Cal.

- Our earlier study recommendation, to restructure GMC as voluntary at enrollment (retain it but allow beneficiaries the choice of managed care or FFS), similar to how Medi-Cal dental services are structured in Los Angeles County, was not implemented. However, DHCS did implement a Beneficiary Dental Exception (BDE) Process in 2012 for Sacramento County for children whose families or caregivers experienced trouble in accessing care. The process is not working as originally intended by the legislation; of 573 opt-out requests received through July 2015, none were granted. However, DHCS assisted families in making appointments.

- Only half of respondents to the plans' 2015 Child Patient Satisfaction Surveys expressed satisfaction with the care they received. Even fewer were satisfied with "Finding a Dentist" and "Access to Dental Care." The access complaints were often related to families' requests for appointments on specific dates and at specific times, which dental offices cannot always fulfill.

- Long waits and negative interactions with office staff during dental visits, fear of dentists, and parents' lack of understanding about the importance of early oral health care continue to influence utilization levels among Sacramento GMC families. Awareness of *having* benefits is high, reported by 86% of surveyed members.

- Requests for public data from DHCS have become more complex and require much more time for fulfillment. The opportunities to engage with state staff informally and frequently about program features and data clarifications were more limited in 2015. Some data consistency issues still exist between plans' and DHCS data that were not able to be addressed with us.

Other States Have Experienced Successes DHCS and Sacramento County Could Pursue

- States are continually experimenting with ways to improve utilization of children's dental services. Some are continuing to examine or implement some form of dental managed care, some have implemented medical-dental integration models, and many are achieving efficiencies by contracting with third-parties to administer and/or serve as fiscal intermediaries for their Medicaid dental programs.
- Use of third-party administrators for benefit and financial management have led to improved provider outreach and participation, and in turn, increased children's utilization.
- In spite of the economy recovery since the 2008 recession, rate increases *have* been achieved in other states, particularly when targeted to specific preventive services and with support from the state dental associations.
- Training medical providers to provide preventive dental services and changes in scope of practice for mid-level practitioners has helped to increase access.

Recommendations for Improvement

The following recommendations—listed in order of what we think are most important to achieve program improvement and impact—are driven by the study's findings. A full description of the recommendations can be found at the end of this report.

The recommendations are presented by those that could be achieved in the short-term (within 1 year) and those that may require 1-2 years. Some speak to continuing progress on a specific achievement and increasing support for it, or for making further improvements. We indicate below who we think should take the lead for implementing the recommendation. In many cases, all 3 main parties—DHCS, the dental plans, and stakeholders (MCDAC, various organizations and advocates)—must play contributing roles for the potential of the GMC model to be realized. It will also be important for DHCS and MCDAC to work with legislators on items that would require legislative approval such as rate increases or certain policy changes.

Recommendation		***Lead****
Short-Term Implementation		
1.	Continue to refine incentives and withholds to encourage targeted improvement. Annually review and adjust benchmarks requiring increasingly higher levels of overall and preventive services utilization until plans' performance matches the statewide FFS averages for these 2 measures for children ages 0-3 and 0-20.	**D**
2.	Make the BDE process the genuine opt-out it was intended to be, while continuing to help families navigate appointments for their children whether in GMC or FFS.	**D, P**
3.	DHCS should increase support of the Sacramento County Medi-Cal Dental Advisory Committee, regularly engaging in policy planning, and making DHCS attendance at all meetings a workload priority. Staff from Department of Managed Health Care (DMHC) should be asked to attend MCDAC meetings on at least a quarterly basis.	**D, S, P**

Lead/Key Players: D = DHCS P = Dental Plans S = Stakeholders

4.	Reduce administrative burden for providers by streamlining the Denti-Cal application (e.g., online) and credentialing process for prospective FFS providers to maximize provider participation. The form or process for FFS providers hasn't been amended and is a real barrier. Although the dental plans can now enroll dentists, not all of Sacramento's children are in GMC and fixes to the FFS delivery system benefit GMC.	**D**
5.	Develop a method to track access to care for children who require general anesthesia dental treatment, report current data to MCDAC, and hold Medi-Cal dental plans and medical plans accountable for ensuring access to timely care for these children.	**D, P**
6.	Add language to GMC contracts or other policy mechanisms requiring plans to adopt formal network provider agreements to see children for their first dental visit "by first tooth or first birthday."	**D**
7.	Establish a mechanism to allow Sacramento County (and other entities) to recoup the cost of school-based prevention and dental screening services when provided to children with Medi-Cal dental benefits.	**D**
8.	Strengthen and closely monitor Medi-Cal managed *health care* plan responsibilities for making and following up on referrals for enrolled children for dental care, and for ensuring preventive oral health services are provided by primary care providers. Medical plans should and can play a stronger role in promoting members' oral health.	**D**
9.	Implement additional patient incentive strategies along with outreach and education to increase utilization, encourage the use of preventive services and reduce use of emergency departments for avoidable dental conditions.	**P**
Longer-Term Implementation		
1.	Look for and implement creative ways to increase provider reimbursement such as targeting specific services, procedures and/or age groups like other states that have successfully done if an across-the-board reimbursement rate cannot be achieved soon.	**D, S**
2.	Add "The Completion of Treatment Plans in 12 Months" to the DHCS Performance Measures and Benchmarks as a mandatory contract condition to reduce dental disease and reflect good practice. All DMHC/DHCS chart audits and data monitoring should include a review of the completed treatments performance measure.	**D**
3.	Continue to support and expand the capacity of community health center dental services.	**D, P, S**
4.	Increase strategies for greater local integration of oral health and primary care along a continuum and through a variety of models.	**D, S, P**
5.	Monitor progress in implementing the recommendations, and support a future follow-up evaluation study by an external party within the next 3 years.	**S, D**

Lead/Key Players: D = DHCS P = Dental Plans S = Stakeholders

INTRODUCTION

"The dental managed care plans are on board now, especially willing to go beyond the four walls." — Sacramento dentist referring to coordination with school-based oral health services

"Our family takes good care of their teeth. We brush and floss. So I don't see why we have to go to the dentist."— Sacramento parent responding to the GMC Member Survey

Early childhood caries (dental disease) is a preventable disease, yet it remains the most prevalent unmet health care need for children nationwide. Untreated decay affects 19.5% of 2-5 year olds, and 22.9% of 6-19 year olds;[7] and 40% of children age 2-11 in the United States have had dental caries in their primary (baby) teeth.[8] In California, the disparity in oral health between low-income and affluent children is the second worst in the nation, exceeded only in Nevada, according to a 2014 study by the Lucile Packard Foundation for Children's Health.[9] Disparity in oral health is particularly disturbing because dental disease can impact all aspects of children's lives, from their nutrition and sleep habits to their educational performance and self-esteem. Importantly, oral diseases are progressive and cumulative and become more complex over time. In 2013-14, more than one-quarter (29%) of low-income Sacramento children screened in preschools were found to have evidence of decay and needing treatment and 5% needing immediate treatment.[10]

Children with the highest prevalence of disease, including children with Medi-Cal, are the ones least likely to visit the dentist. While close to two-thirds (64%) of California children with private dental benefits made a dental visit in 2013, only about half (52.4%) of children with Medi-Cal saw a dentist that same year.[11] The problem is even greater among low-income and ethnically diverse children whose access to services is more limited:[12] Black and Hispanic children are less likely to use preventive or any dental care and, according to the Centers for Disease Control and Prevention, have the poorest oral health of any racial and ethnic groups in the United States.[13,14]

Having insurance is positively associated with utilization of dental services. Having *publicly-funded* dental insurance does not always equate to access, however. Half of all children in California are enrolled in Medi-Cal (California's Medicaid program). Children with dental benefits through Medi-Cal are less likely to visit the dentist than their peers with private insurance. The difference is most likely due to barriers to care within the Medi-Cal program,[15] as well as parents' lack of knowledge

[7] Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents. Centers for Medicare & Medicaid Services (CMS). September 2013 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html
[8] Bouchery E. Utilization of Dental Services Among Medicaid Enrolled Children. Medicaid Policy Brief 9, October 2012. Mathematica Policy Research, Inc.
[9] Schor E. Dental Care Access for Children in California: Institutionalized Inequality (Issue Brief). Palo Alto, CA: Lucile Packard Foundation for Children's Health; 2014. Cited in http://www.cdph.ca.gov/programs/Documents/CDPH_OHE_Disparity_Report_Final_Jun17_LowRes.pdf .
[10] Smile Keepers, a school-based program of the County of Sacramento.
[11] Vujicic, M, Kamyar Nasseh K. Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrows, Remains Large for Adults. Health Policy Institute, American Dental Association Research Brief. November 2015. Data source for Medi-Cal is Department of Health Care Services, Medi-Cal Dental Program, Data run February 2015.
[12] Vargas CM, Ronzio CR. Disparities in early childhood caries. *BMC Oral Health* 2006, 6(Suppl 1):S3 doi:10.1186/1472-6831-6-S1-S3
[13] Bouchery E. Utilization of Dental Services Among Medicaid Enrolled Children. Medicaid Policy Brief 9, October 2012. Mathematica Policy Research, Inc.
[14] http://www.cdc.gov/oralhealth/oral_health_disparities/index.htm
[15] U.S. Government Accountability Office. *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*. GAO/HEHS-00-149, September 2000.

about the importance of oral health[16] unawareness that their child's coverage includes dental benefits,[17] and challenges making appointments due to work schedules. While Medi-Cal dental benefits are available to all children enrolled in Medi-Cal throughout the state, about 4 in 10 Sacramento County children age 0-20 (and 2 in 10 children age 0-3) enrolled in GMC dental services received care in 2014.[18] While this represents a sizable increase from the proportion of children served 5 years earlier, utilization remains a challenge.

There is a direct relationship between provider willingness to participate in federally funded programs like Medi-Cal and the overall utilization of dental services. Numerous studies on access to dental care for children with Medicaid, including those of dentists, consistently cite 3 major reasons for lack of dentist participation in the following order of importance: low reimbursement rates; broken appointments and patient noncompliance; and burdensome administrative and enrollment processes associated with Medi-Cal. This study confirms that while utilization *has* increased in Sacramento County since 2008, all 3 reasons continue to be important issues for the Medi-Cal dental program as described later in this report.

A dilemma exists for the Medi-Cal dental program. Success in outreaching to eligible individuals, increasing provider networks, and reducing barriers to accessing care in order to increase utilization will in turn increase costs. California must manage the trade-off between its desire to increase access and utilization while containing costs as numbers of Medi-Cal eligibles increase. To do this, the State must determine an optimal—or desirable—utilization rate to aim for that makes offering a children's dental program meaningful and sustainable. Higher reimbursement rates are the number one component of what will allow more dentists to participate in the program according to surveyed Sacramento dentists.

Background

In FY 2014-15, Medi-Cal covered more than 12 million individuals statewide for dental as well as medical care—a 34% increase in Medi-Cal enrollment since the Affordable Care Act went into effect—which represents almost 1 in 3 Californians and more than half of the children in the state. The California Department of Health Care Services (DHCS) is responsible for administering this $92 billion program, of which the dental budget represents only a fraction—1.5%.

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. The majority of Medi-Cal beneficiaries are now enrolled in one of the State's contracted managed care organizations for *medical* services; *dental* services remains a predominantly fee-for-service (FFS) program referred to as Denti-Cal. However, only in Sacramento County do the vast majority of Medi-Cal beneficiaries receive their dental services through a mandatory dental managed care program called Sacramento Geographic Managed Care (GMC).[19] GMC was put into place only in Sacramento County in 1994 as a "pilot project" but is now an established, ongoing program.

Fueled by questions and concerns about access issues and low utilization rates, a deep examination of the Sacramento GMC dental program was undertaken in 2009-10 by Barbara Aved

[16] Hilton IV, Stephen S, Barker JC, Weintraub JA. Cultural factors and children's oral health: a qualitative study of carers of young children. *Community Dent Oral Epidemiol* 2007;35:429-438.
[17] Shulman S, Kell M, Rosenbach M. *SCHIP Takes a Bite Out of the Dental Access Gap for Low-Income Children. Final Report*. November 2004. Mathematica Policy Research, Inc.
[18] Data source: Department of Health Care Services, Medi-Cal Dental Services Division, May 2015.
[19] Children with Medi-Cal in Los Angeles County have the choice to enroll in a dental managed care plan or, like children in the rest of the state, receive services through the fee-for-services program; about 85% choose the latter.

Associates (BAA), [20] which revealed the model's failure to offer adequate access to care for most Sacramento' children resulting from decades of lack of oversight or accountability. Prompted by coverage in *The Sacramento Bee* in February 2012, and aided by a series of subsequent legislative hearings that found a lack of oversight of the dental managed care program including underutilization by beneficiaries, important changes followed. Some of these changes included:

- Passage of legislation (Assembly Bill 1467, June 2012) that implemented many of our recommendations by including mandates for monitoring, oversight and other program improvements.
- DHCS's decision not to re-contract with 2 of the 5 dental managed care plans.
- Implementation of a Beneficiary Dental Exception process (i.e., opt-out) for Medi-Cal beneficiaries in Sacramento County to access dental care through fee-for-service Denti-Cal when applicable.
- Authorization for the Medi-Cal Dental Advisory Committee (MCDAC)[21] in Sacramento County established by Sacramento County Charter on December 12, 2012 and authorized by AB 1467. The purpose of the committee is to provide guidance to improve dental managed care utilization rates, the delivery of oral health and dental care services, including prevention and education services.
- Additional requirements for reporting by contracted dental managed care plans with some data posted online on the DHCS Denti-Cal website.

In FY 2012-13, DHCS also identified the need for and organized 4 stakeholder Task Forces, assigning them specific duties:

1) Review RFP. Members reviewed the draft DHCS Request for Proposals (RFP) for the new GMC contracts, suggesting numerous changes; DHCS made the majority of the major changes according to the Task Force members.

2) Review Online Application. An online application for new Medi-Cal dental providers was proposed but has not been implemented and progress has stalled; part of the reason is because it was generic for both medical (MD) and dental (DDS) providers. (Note: although the dental plans can now enroll dentists, reducing barriers for prospective FFS providers can benefit GMC with expanded network capacity.).

3) Review Reimbursement Rates. Members made recommendations regarding increasing provider reimbursement rates. DHCS did review the rates but did not recommend an increase. This has not been implemented by DHCS.

4) Review Upcoming Issues of Specialists and Hospital Dentistry. The need to expand the GMC provider network to include more specialists (and to address the additional costs for these referrals) is a continuing issue. The need to create easier access for dental treatment of children who require general anesthesia (see page 42 of this report) continues.

DHCS indicated it has no plans to expand dental managed care to other counties in California at this time. This is a shift from 2010 when we conducted our original study. DHCS noted that due to the level

[20] The original GMC study, *Sacramento Children Deserve Better: A Study of Geographic Managed Care Dental Services*, 2010, can be accessed at http://www.barbaraavedassociates.com/samples/sacramento-GMC-report.pdf.

[21] The major accomplishments of the MCDAC are described in the annual report to the Sacramento County Board of Supervisors January 2015 which can be accessed at http://www.dhhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Monthly%20Meeting%20Documents/20150223/MA-MCMC-MCDAC-Presentation.pdf

of scrutiny surrounding the Medi-Cal dental program because of recent audits its primary focus/priority at this time was to address the issues highlighted in the audit reports.[22] Several key informants for this study suggested the change in priority may also be due to reactions to the relatively negative findings about the GMC dental program expressed in our original study by stakeholders.

The Current Study

The present study was initiated at the suggestion of the contracting dental managed care plans and the Medi-Cal Dental Advisory Committee to re-look at the GMC dental program. The study's main purposes were to examine access, utilization and quality of care factors and learn what improvements have been implemented in the last 5 years, and to make suggestions for improvement based on other states' Medicaid experience with various dental managed care models. For consistency between the 2 time periods, the study's focus remained on children age 0-20.

In carrying out the study, we addressed such questions as:

- What would it take to increase the likelihood of Sacramento County dentists participating in Medi-Cal?
- To what extent do children with Medi-Cal utilize the emergency department for dental conditions considered preventable?
- How do utilization rates in dental managed care compare to dental FFS?
- What kind of feedback has DHCS and the GMC dental plans received from member satisfaction surveys and grievances?

Although the focus of this study is Medi-Cal dental managed care, it references the Denti-Cal fee-for-service delivery system where necessary and appropriate as many facets of the FFS program drive the managed care program.

Unlike our earlier report, we were not charged with identifying options for changing the model or recommending whether the GMC dental program should be retained or dropped in favor of FFS.

The Promises of Dental Managed Care

In our original GMC dental study we discussed the potential benefits or promises that a dental managed care model holds for purchasers of services as well as beneficiaries. Because of its importance, we think it is worth repeating (see Table 1 on the next page).[23] Despite the incentive differences—potential under-treatment on the managed care side, potential over-treatment on the FFS side—managed care *can* effectively meet its access and utilization goals depending on how it is structured, managed and funded. Dental managed care can ensure linkage to a dental home, encourage use of benefits and promote preventive services—provided there are adequate controls in place and sufficient oversight to monitor key performance measures such as care standards and utilization rates. Because it has an enrolled population (members), Medi-Cal dental managed care has the possibility of improving access to care for thousands of low-income Sacramento County children as long as it lives up to its potential. Although some of these features are not unique to dental managed care and exist in FFS, the expectations for managed care membership should be higher because the delivery system represents a *system* of care.

[22] Personal communication, DHCS Medi-Cal Dental Division Chief, July 31, 2015.
[23] Marcus M, Coulter ID, Freed JR, Atchison KA, Gershen KA, Spolsky VW. Managed care and dentistry: promises and problems. *JADA*. 1995;126:439-446.

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 dental managed care plan provides the opportunity to link children with an established provider; families do not have to navigate on their own to find a provider as they do in the Medi-Cal fee-for-service system.
Increase utilization among eligible children	Enrollment in a dental managed care 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	Dental providers commonly cite "paperwork" as a barrier to participation. Simplified program administration, not present in FFS, is a common element in successful dental plan management.
Improve data/evaluation capacity	Performance measures have been established to ensure dental health plans meet quality criteria pursuant to Section 14459.6 of the Welfare and Institutions Code that provide relevant information about the quality of dental services provided by dental plans and 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.

Source: Marcus M, Coulter ID, Freed JR, Atchison KA, Gershen KA, Spolsky VW. Managed care and dentistry: promises and problems. 1995

Acknowledgements

A subcommittee of MCDAC acted in an advisory capacity for this study and we are grateful for their support, helpful suggestions and review of earlier drafts of this report (see Appendix 1 for a list of members).

Because the MCDAC had no funding source, the GMC dental plans agreed to support the study financially with a clear understanding concerning consultant and MCDAC independence. All 3 contracting GMC dental plans participated equally: Access/Premier Dental Plan, Health Net of California, and LIBERTY Dental Plan. We wish to acknowledge their cooperation in answering questions and providing information. In addition, two Sacramento dentists who believed there was a need to re-look at the GMC dental program, Dr. James Musser and Dr. Arash Aghakhani, also contributed financial support to the study. The consultants worked in total independence of all funders in designing the study, analyzing and interpreting data, reaching conclusions and making recommendations. None of the dental plans reviewed or provided comments on any draft of this report.

A number of national and local oral health experts and advocates, Sacramento County community leaders, public officials, and providers participated in interviews and offered their perspectives and ideas about ways to improve oral health care for Sacramento County children. Their questions helped to steer our data search, and their suggestions are reflected in our recommendations. We are also indebted to other states' Medicaid dental program staff for sharing their experience and insights.

The Department of Health Care Services, Medi-Cal Dental Services Division, was available to provide data and answer questions; workload and other priorities intervened to prevent the level of ongoing communication and support provided during the original GMC dental study. We provided a draft of this report to DHCS to comment on accuracy. Staff provided written comments so that corrections could be addressed, and we are appreciative of their help.

The consultant team for the study included Barbara M. Aved, RN, PhD, MBA; Dorothy Meehan, MBA, CPA; Jack C. Luomanen, DMD; and Michael Funakoshi. Robert Isman, DDS, formerly a dental consultant with DHCS, provided helpful advice about Medi-Cal dental data and other states' Medicaid dental programs.

The study authors hope this report contributes to continuing improvements in assuring access to quality dental care for low-income children—and their families, now that adult Medi-Cal dental benefits have been partially restored—in Sacramento County as well as throughout the state.

Disclaimer

This report has been produced independently by Barbara Aved Associates on the request of the Medi-Cal Dental Advisory Committee and the GMC dental plans, and does not necessarily represent the views of individual committee members or organizations represented on the Committee, or views of the individual GMC dental plans.

METHODS

"I think we are viewed as a thorn in the side of the Department [DHCS] because Sacramento is more disappointed and much more verbal about issues than the stakeholders in Los Angeles County. It's hard for DHCS to hear this." – Sacramento County Medi-Cal Dental Advisory Committee Member

Study Design

The consultants independently designed the study and prepared an overview that described the study purpose, main study questions to be answered, study approach, possible sources for the data, and a timeline. Because the dental plans were financially supporting the study, they along with DHCS and the Advisory Committee were given the opportunity to comment on the overview. While a couple of minor changes were made (e.g., key questions re-worded for clarity or added), ownership of the final study design rested with the consultant team.

Data Sources

The assessment findings in this report are organized by 3 main areas of dental services—access, utilization, and quality of care—although there is unquestionably an overlap among these categories (and raising the question, for example, When is a utilization issue really an access issue?). We used the following methods to carry out the study: a literature scan, data retrieval and analysis, expert interviews (written and verbal), and surveys. The availability and robustness of the public data sources data largely determined the extent of our ability to reach conclusions about each of these study areas.

The findings are based on the program at the time of the assessment. Changes or modifications may be planned for the future or under consideration (some are mentioned in this report where especially applicable), however only those activities and processes that existed in 2014 or at the time of this review were considered. Please note that we use footnotes on the bottom of each page for references/citations as well as explanations and other information that could be distracting if included within the text of the report.

Review of Literature

To give context to and meaning to our findings, interpretations, and recommendations we performed a review of journal articles, studies and relevant reports related to children's oral health.

Data Retrieval and Analysis

GMC plans are required by contract to submit quarterly utilization data to DHCS. DHCS posts the plans' data on its Medi-Cal dental managed care website[24] and generally utilizes it as the source for responding to requests for information about GMC. This publicly available data source was

[24] The most current GMC utilization data on the website as of December 2015 are Calendar Year 2014. http://www.denti-cal.ca.gov/provsrvcs/managed_care/perf_meas_GMC_rept_2014.pdf

accessed between May 2015 and September 2015 for information regarding Medi-Cal eligibility, enrollment, utilization, dental procedures and grievances. We also received data directly from DHCS over that 5-month period in requested data pulls, which we used in place of certain data on the website (e.g., GMC utilization) as well as certain information requested directly from the GMC plans. Please note that because DHCS sent initial and follow-up data to us at various times—with the need for back-and-forth emails with questions about figures—it was not always possible or practical to cite specific dates when identifying DHCS as the source of data under a chart or graph.

Where large data discrepancies existed between DHCS and the plans' data, the plans and the Department were invited to review and comment. Additionally, where 2014 plan data provided by DHCS differed greatly from what DHCS had provided to us in 2008-2009 for our earlier study, using the same parameters for the data pull, DHCS was asked to comment. DHCS stated it could not verify the accuracy of any data it provided during the earlier period, and reported to us that all data provided for the current study were correct.

While Sacramento County was the main area of interest, statewide and certain comparison-county data from the fee-for-service (FFS) system were used in analyzing trends and to compare with the managed care data. Using comparable rationale to our earlier GMC study and as used by others,[25] we chose Fresno County 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, we used CY 2014 as the study period. It was the most recent year for which data were available and was far out enough to look for improvements after legislatively required changes to the program.

Since 2012, DHCS made various efforts to improve dental managed care. This was done through collaboration with plans and stakeholders, including developing and implementing a new methodology for establishing and evaluating county specific performance measures and benchmarks in the GMC contracts for Sacramento County beginning January 1, 2013. To measure quality of services, we used DHCS 2014 *Performance Measures and Benchmarks*[26] (which were later updated) and examined data such as procedures and users for each CDT ("Current Dental Terminology," a manual of codes) category of procedures (e.g., diagnostic, preventive and restorative services). We also looked at plans' grievance data and problem reports received by DHCS as indicators of quality of care and quality of services.

The main elements of the DHCS contract with GMC plans were reviewed, specifically the expectations for scope of services, access, utilization and reporting requirements contained in Attachment A of the contract. All of the GMC plans sign the same contract; there are no differences.

We also used data from the 2014 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 sources, such as industry and national Medicaid data, were also reviewed where available. The 2014 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 for dental conditions that are considered avoidable with preventive care.

[25] *California Department of Health Services. Weaknesses in its Medi-Cal Dental Program Limit Children's Access to Dental Care*. Report 2013-125. Sacramento: California State Auditor, December 2014.
[26] http://www.denti-cal.ca.gov/provsrvcs/managed_care/perf_meas_GMC_rept_2014.pdf

Interviews

A number of key informants were identified as local and state opinion leaders, policy makers, dental experts, providers, and key advocates. Their historical recollections about GMC, including our original study, and perspectives and knowledge about the importance of children's oral health reflected a wide range of experience but fairly consistent opinions. (Not all interviewees have been identified in Attachment 2 as some information was provided on background.) The informants' comments and suggestions corroborated our recommendations.

GMC dental plan representatives were interviewed by telephone to answer detailed questions about plan features such as provider networks and outreach efforts. Plan staff supplied information from their own databases about enrolled Medi-Cal users and described quality assurance, referral, and grievance procedures. Any follow-up communication for clarifications occurred via e-mail.

A purposeful sample of other state Medicaid dental programs thought or known to have implemented some type of model of managed dental care or innovative FFS model was identified through the following sources: suggestions by key informant interviewees; review of studies; our previous work with other states, and the Medicaid/CHIP State Dental Association Director, Mary Foley, MPH. DHCS was not able to make recommendations for interviews with other states as staff stated they were unaware of any other state Medicaid dental managed care program models. We contacted the Medicaid and/or dental directors of the identified states by email between June and September 2015 and asked if they would participate in a telephone interview or at a minimum respond to questions by email. We completed these interviews in November.

Current DHCS process required staff to participate in the current study primarily by responding in writing to questions they requested be submitted in writing. Meetings were generally limited due to staff workload. While there was little opportunity for informal email communication and telephone conversations to address simple questions, and some responses were not timely, DHCS staff provided written responses to our questions.

Written and Telephone Surveys

We developed a survey for private dentists that the Sacramento District Dental Society (SDDS) sent online to its members.[27] Respondents, which included participating as well as non-participating Medi-Cal dental providers (in both GMC and FFS) were asked for their opinions and experience regarding the Medi-Cal dental program, and about certain practice characteristics.

We were able to use data from a DHCS-approved Member Survey the GMC dental plans conducted during the course of our study. We helped to develop the survey questions and analyzed the data. The purpose of the survey was to learn more specifically the reasons why GMC members do not always utilize their dental benefits. The surveys were printed in English and Spanish and mailed with a cover letter by each dental plan in September 2015 to 6,000 Sacramento GMC member families (2,000 to each plan's members) with children age 0-20 whose dental plan records showed no dental visit within the last year (FY 2014-15).[28] The plans were responsible for designing the sampling method for mailing the surveys. Members were informed if they returned their completed survey within 2 weeks, their name would be entered into a drawing.

[27] The survey had an adequate reach of Sacramento County dentists, as approximately 80% are members of the Sacramento District Dental Society, according to the SDDS.

[28] The dental plans also sent a similar survey to adult GMC dental members with no dental visit in the last year on record. The dental plans also sent the same child and adult survey to their Medi-Cal dental managed care members in Los Angeles County. The findings from the adult and LA surveys are not included in this report but are available from the dental managed care plans or the study author.

The incentive offered was a chance to win a Target Gift Card for $100.00, and there would be 2 winners drawn.

We conducted telephone interviews with a representative number of general and specialist dental offices in Sacramento County randomly chosen from each of the 3 dental plans' provider network lists. Calls to offices representing 243 unique dental providers in Sacramento (an 88% sample) were completed. The purpose was to check for accuracy of information, i.e., confirm if all of the dentists in the group/solo practice were current GMC providers for children, ask if there were any restrictions placed on acceptance of patients and inquire about dental office policy for age of first dental visit.

Finally, using the dental plans' GMC provider networks, we pulled a random sample of Sacramento dentists, community clinics and health centers and completed interviews to obtain additional views. Their perspectives complemented what we learned through the other data collection methods and informed our analysis.

Definitions

The following definitions used in this report may be helpful to readers unfamiliar with the Medi-Cal dental program:

Eligible Children	Children 0-20 enrolled in Medi-Cal whether or not they ever used a dental service; referred to as a "beneficiary" in Medi-Cal terms. For Sacramento GMC, this would be the children enrolled in a dental plan during the measurement period. For some analyses, "average monthly eligibles" was used. "Eligible" is equivalent to "member" in managed care terminology.
Beneficiary/Member	All children in the Medi-Cal FFS or Medi-Cal managed care systems are called beneficiaries. Beneficiaries enrolled in a GMC dental managed care plan are called members of that plan.
User	A Medi-Cal beneficiary who used at least one dental service during the measurement period. A user is a recipient of one or more dental procedures.
Utilization Rate	The percent of enrolled children who used at least one type of dental service in the measurement period.
Annual Dental Visit	The number of enrolled children in the same dental plan with 11 months of continuous eligibility (i.e., no more than a 1-month gap in eligibility), the percent of those children who received any dental procedure during the measurement period.
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 administered by the Department of Health Care Services (DHCS). "Denti-Cal" actually refers only to the *fee for service* (FFS) system and *not* to the dental managed care system. The dental managed care program is referred to as Dental Managed Care. In Sacramento County, this dental managed care program is referred to as Geographic Managed Care (GMC). 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.[29]

Study Limitations

For comparisons with our 2010 study, *Sacramento Children Deserve Better: A Study of Geographic Managed Dental Care Services*,[30] the focus of this study remained on children. Further, because Medi-Cal adult dental benefits were not restored in California until May 2014, a full year of adult data was not available for the current study.

It is possible that the queries and parameters DHCS used to derive the 2008 and 2009 data used in our earlier study were constructed differently than for the 2014 data, as there has been additional learning within DHCS that has occurred in the interim. Additionally, none of the dental staff who worked with us last time is currently employed in the Medi-Cal dental program. As a result, some of the data examined in the current study may not be directly comparable to the earlier study.

We did not make direct observations of the enrollment/disenrollment process or delivery of direct services at provider sites in this study. Auditing dental health records can provide additional, important documentation about the delivery of services; however, similar to the earlier study, the scope of this study did not include review of patient charts in provider offices.

Although the dental plans' Member Survey was mailed to members who had reportedly not visited a dentist in the last year, more than half of the respondents reported having taken their child to a dentist during that time. Thus, assuming the plans' records are accurate, the surveyed population could have been affected by response bias, since individuals who visited a dentist may have been more likely to complete the survey.

While we have tried to account in certain analyses for the number of children enrolled in each contracting GMC dental plan, meaningful differences in program features or performance could be masked by comparisons across the board when reporting on all GMC data in the aggregate.

[29] 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.
[30] The study can be accessed at http://www.barbaraavedassociates.com/samples/sacramento-GMC-report.pdf.

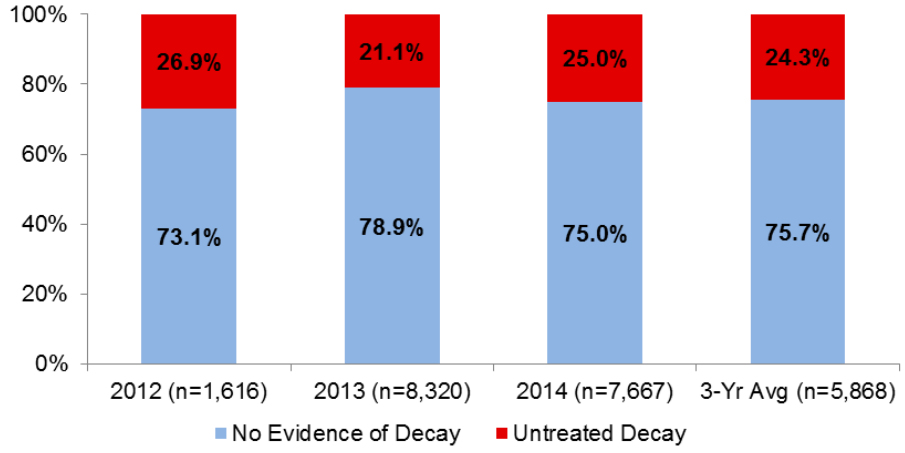
"No one ever told me you were supposed to take a little kid to the dentist. She still has her baby teeth."
– Parent respondent to the Member Survey

I. Extent of Dental Disease Among Sacramento County Children

What is the Prevalence of Oral Disease among Sacramento Children?

The consequences of poor oral health are particularly critical for children, and can have a huge impact on overall health as well as on a children's performance in school. Untreated decay affects 19.5% of 2-5 year olds, and 22.9% of 6-19 year olds;[31] and 40% of children age 2-11 in the United States have had dental caries in their primary (baby) teeth.[32] Prevalence of untreated decay in primary or permanent teeth among children from lower-income households is more than twice that among children from higher-income households.[33] While there are limited data available to measure the extent of dental disease among children in Sacramento County, pre-kindergarten assessments[34] provide a picture of disease prevalence. Based on the most recent 3-year average (2012-2014), screening results for the reporting school districts in Sacramento County (nearly all) show that one-quarter (24.3%) of the children had evidence of untreated dental decay (Figure 1).

Figure 1. Results of Pre-Kindergarten Dental Screenings, Reporting Schools in Sacramento County

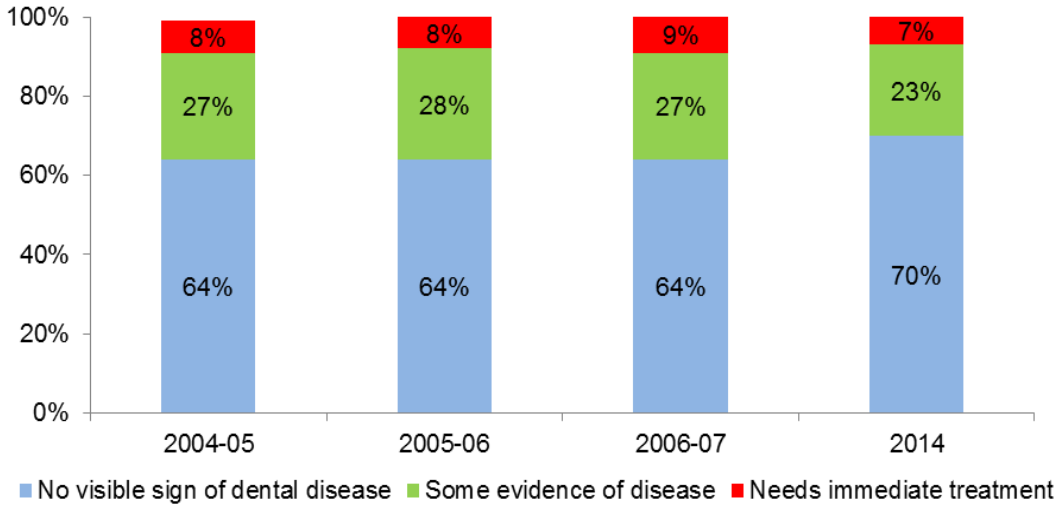


Source: California Dental Association AB 1433 Pre-K Reported Data

[31] Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents. Centers for Medicare & Medicaid Services (CMS). September 2013 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html
[32] Bouchery E. Utilization of Dental Services Among Medicaid Enrolled Children. Medicaid Policy Brief 9, October 2012. Mathematica Policy Research, Inc.
[33] http://www.cdc.gov/mmwr/preview/mmwrhtml/su6302a9.htm
[34] AB 1433 (enacted in 2006 through the efforts of the California Dental Association) required that children have a dental checkup by May 31 of their first year in public school, at kindergarten or first grade. The requirement for screening was later changed to a voluntary basis because of school funding issues and the removal of certain mandates. The CDA is working to restore the oral health screening requirement.

Data from Sacramento District Dental Society's Smile for Kids Day 2014 screenings of 25,500 children in grades K-6[35] are also helpful as prevalence of oral disease among Sacramento children. These screenings showed 70% needing no care, 23% needing some care (some evidence of disease), and 7% requiring urgent care (Figure 2).

Figure 2. Results of Preschool-Sixth Grade Dental Screenings, Sacramento County, Selected Years



Source: Data for the first 3 periods are from Sacramento County Smile Keepers Program and are preschool-6th grade. Data from the last period are kindergarten-6th grade, and are from the Sacramento District Dental Society.

The data from Smile Keepers, a school-based program of the County of Sacramento, indicated that among the 8,041 higher-risk and predominantly preschool children screened by that program in 2013-14, between one-quarter and one-third (29%) showed some evidence of decay and needing treatment and 5% needing immediate treatment (e.g., severe dental caries). The extent of decay from these screenings would be expected to be somewhat higher than the results of the other two screenings above as the Smile Keepers children were known to be a higher risk group, as children with Medi-Cal are generally considered to be.

At this time, DHCS and Sacramento County have not established a mechanism to allow Sacramento County to recoup the cost of the school-based dental screening services when provided to children on Medi-Cal.

[35] The screenings were performed by dentists in 102 lower-income area schools offering Title I free lunch programs.

II. Overview of the Medi-Cal Dental Program

"Dental plans don't over-impose the State's dental program requirements on our provider networks—just the policies and procedures Denti-Cal requires—not all of which we would want to impose, by the way."
— GMC Dental Plan representative

"*It usually comes down to a business decision a dentist has to make [to accept or not accept Denti-Cal/GMC]; don't blame the dentists for avoiding participation when they can*." – Sacramento policymaker

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

What are the Dental Benefit Requirements Under Medicaid (Medi-Cal)?

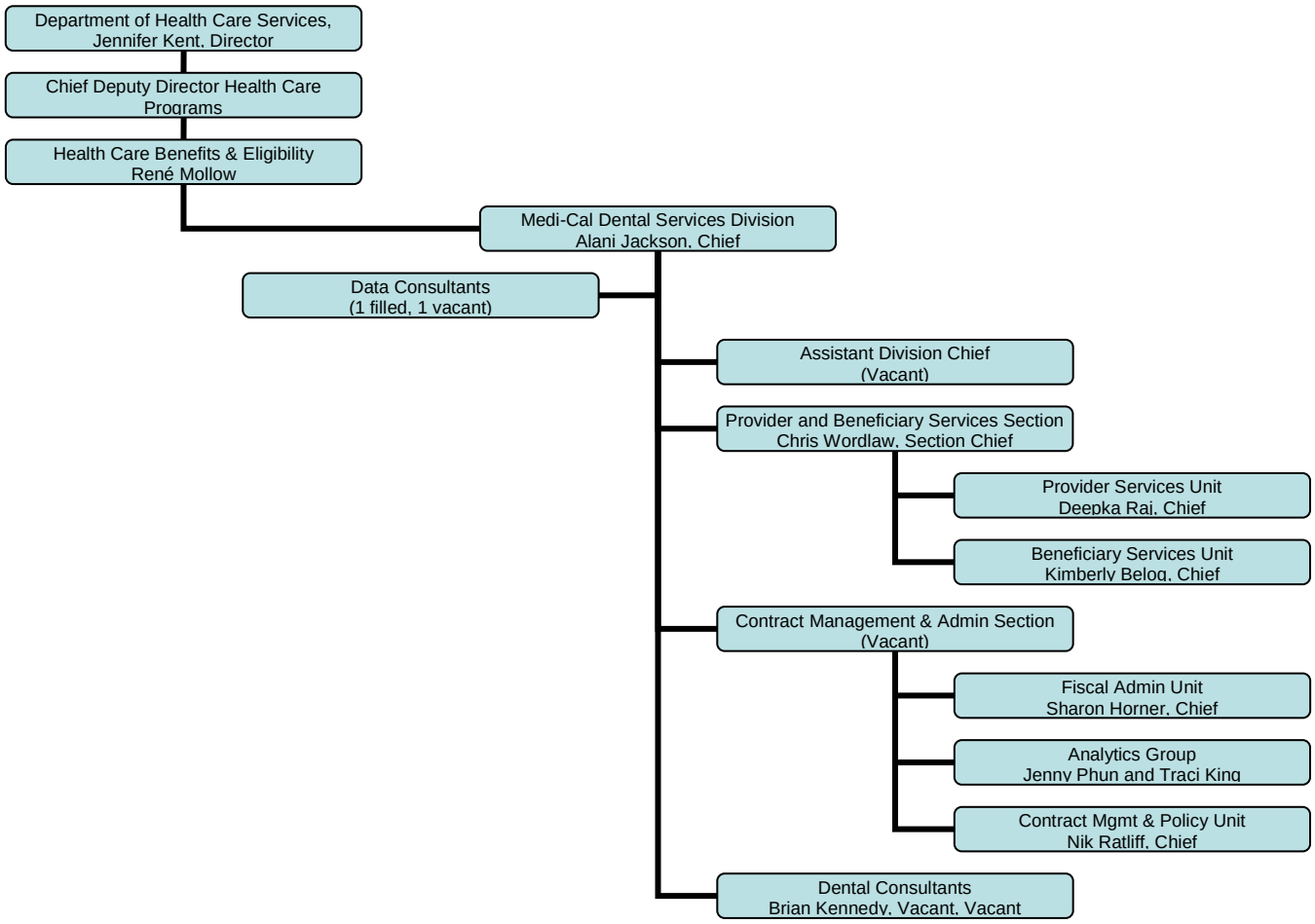
While most children age 20 and younger with full Medicaid benefits are entitled to dental services, states may choose whether to offer dental benefits to adults.[36] Children's services mandated through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit requires states to provide a comprehensive dental benefit to Medicaid-enrolled children.[37] Medicaid (which is called Medi-Cal in California) policy requires direct referrals of enrolled children to dental providers for comprehensive diagnostic, preventive and treatment services.[38]

How is the Medi-Cal Dental 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 on the next page. The chart is provided to help readers who are unfamiliar with how the Medi-Cal dental program fits into the Department. (The Medi-Cal *Managed Care* Division is responsible for *medical* managed care services.) As the purchaser of services, DHCS is responsible for oversight and monitoring of the dental program, which includes ensuring access to dental care services, availability of appropriate levels of care, quality of care delivered to beneficiaries, provider recruitment and outreach, policy and rate setting, and auditing.

[36] Most states now offer some amount of Medicaid adult dental benefits. California restored most adult Medi-Cal dental benefits in May 2014.
[37] Snyder A, Gehshan S. *State Health Reform: How Do Dental Benefits Fit In? Options for Policy Makers.* National Academy for State Health Policy. April 2008.
[38] Centers for Medicare and Medicaid Services. Dental Screening Services. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services. State Medicaid Manual. 2014, Part 5, Section 5123.2, pp. 10-93.

Figure 3. Organizational Responsibility for Medi-Cal Dental Program



Source: Medi-Cal Dental Services Division. August 2015.

The full Medi-Cal Dental Services Division (MDSD) organization chart shows 31 positions (inclusive of full-time, part-time, and Retired Annuitant positions); 3 of the positions were vacant and 1 was pending vacancy in August 2015. This is a slightly higher number of positions overall than at the time of our original GMC dental study.

There are 3 dentist positions (one of them is currently vacant) classified as Dental Program Consultants. Staff in the Analytics Unit work to prepare reports and respond to requests by the legislature, provider groups, advocates and others for data. Contract managers in the Contract Management and Administration Section are responsible for monitoring the contracts with dental managed care plans, e.g. reviewing plans' data submissions, quarterly grievance reports and compliance with standards of care.

An operational analysis of the Dental Division's capacity was not included in the scope of this study, so we are not able to comment on the adequacy or appropriateness of the numbers and types of staffing and organizational support available to the Division. However, we were regularly told throughout the study that workload and staffing levels made it a challenge to respond in a timely manner to our written requests for program information and data, as well as limit our

attempts to engage in discussions with staff to seek clarifications or follow up on information DHCS provided.

Medi-Cal Dental Managed Care

The majority of the statewide Medi-Cal dental program is administered as the Denti-Cal fee-for-services (FFS) Program, and its policies, including rates, are the foundation of the entire dental care program. In 2014, 90.4% of children with Medi-Cal were served in the DHCS FFS system. DHCS also administers a dental managed care program. The Department currently contracts with 3 dental managed care plans that serve both Sacramento County and Los Angeles Counties: Access Dental Plan, Health Net, and LIBERTY Dental Plan.[39] The dental plans in Sacramento contract under the Geographic Managed Care (GMC) 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* delivery system in Sacramento County. Except for certain non-mandatory aid codes, described later in the Utilization section of this report, Medi-Cal recipients in Sacramento County must select one of the available GMC dental plans for their dental care. In Los Angeles County, Dental PHP is a *voluntary* delivery system. Medi-Cal beneficiaries in LA can choose to enroll in one of the contracted dental managed care plans—which about 19% choose to do[40]—or receive services through the traditional fee-for-service system. 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.[41]

From the time eligibility is established, the Sacramento GMC beneficiary has a specified number of days in which to choose a dental plan. If the beneficiary has not made a choice during the eligibility and enrollment process (for example, at an enrollment services visit), they must do so within 30-45 days depending upon when they become eligible.[42] Otherwise, the beneficiary receives an "Intent to Assign" package notifying them that they have up to 10 days to choose one of the 3 GMC dental plans. If they do not respond, the Department's enrollment contractor, Healthcare Options (HCO), notifies them of the intent to make an automatic assignment via an "Intent-to-Default" letter. HCO makes up to 5 outbound telephone call attempts to those who don't respond before using a default algorithm where the system chooses the plan. Considerations in the algorithm include continuity of care, having a family member already in one of the GMC plans and keeping enrollments even among the plans.[43]

Medi-Cal dental managed care members enrolled in contracting plans receive dental benefits from dentists or community clinics 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 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 plan's provider network (they do not have to be enrolled in the FFS program, as of 2011). If the dentist refers a member for a covered service to a provider outside their network because the plan does not have a network specialist near the member's residence, the specialist does not need to be enrolled in the Denti-Cal program. In this situation there is no cost to the member. Any additional costs are the plan's expense.

[39] At the time of our original study in 2009-10, DHCS also contracted with 2 other dental managed care plans in Sacramento County: Western Dental and Community Dental Services, Inc.
[40] Data source: Department of Health Care Services, Medi-Cal Dental Division, July 22, 2015.
[41] http://www.denti-cal.ca.gov/WSI/ManagedCare.jsp?fname=ManagedCareOverview
[42] It can take up to 45 days to enroll a new member once a plan is chosen because it 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.
[43] Personal communication, Benjamin Cross, DHCS HCO, August 3, 2015.

Dental Managed Care Data

Robust data are necessary to monitor children's access and use of dental care. Incomplete, inaccurate, untimely data and under-reporting by dental plans were chronic data problems in the Medi-Cal dental managed care program at the time of our original GMC study. Due largely to legislative reform (AB 1467) and collaboration among DHCS, stakeholders and dental plans, more useful data are now available from DHCS and GMC plans and more of it is visible on the DHCS Denti-Cal website. However, challenges regarding timely access to this data remain. The reporting required for dental managed care plans, perhaps due to the need for greater accountability because payment is upfront, exceeds reporting requirements for FFS providers.

All plan data are external quality review organization (EQRO) validated as required by federal regulations for state Medicaid programs. An EQRO is the analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the health care services that a contracting managed care organization, or their contractors, furnished to Medicaid recipients.[44] The EQRO annually must verify data accuracy. Additionally, DHCS internal dental dashboard that has been implemented allows the Department to quickly and consistently monitor a plan's progress in regards to achieving their benchmarks, as well as monitoring the quality and accuracy of plan-reported data. (The dashboard is currently only internal; DHCS reports it is reviewing it to see which data can become outer-facing or shared. Since this remains an internal dashboard, data sharing and accountability can be an issue. It may therefore be impossible through this mechanism for other stakeholders to know about the progress a plan is making.) Given the importance MCDAC played in system improvement, this dashboard should be made available to this Committee.

Unlike our earlier study, we found little variance between the utilization rates shared by the plans and reported by DHCS. This is likely because in 2014 the utilization data DHCS provided to us came directly from what the plans reported to DHCS and DHCS posted. The data did not appear to be independently verified by DHCS. Unless otherwise noted, the GMC plan data we report in this study are what we received from DHCS.

In 2014-15 DHCS instituted a more complex process for responding to data requests and issued "Guidelines for Public Aggregate Reporting for DHCS Business."[45] Much of the data we requested fell under these guidelines and required 3 months for the initial response by the Department. Additional follow-up was necessary over another 2 months to receive all requested data and explanations. Staff workload, as well as the data release requirements of the new Guidelines, contributed to this stretch of time. This delay in timely access to data underscores the concerns raised by MCDAC and other stakeholders regarding the negative impact it has on effective oversight.

How are Medi-Cal Dental Services Reimbursed?

Fee-for-Service

DHCS contracts with Delta Dental of California, its fiscal intermediary for dental services,[46] which processes and adjudicates claims and reimburses providers based on the services they rendered.

[44] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html Final DHCS calculations of any payments from withholds are done after EQRO validation.
[45] http://www.dhcs.ca.gov/dataandstats/data/DocumentsOLD/IMD/PublicReportingGuidelines.pdf
[46] The DHCS contract with Delta Dental also requires Delta to remedy the dental access problems in underserved areas by outreaching to and recruiting new providers, including contracting with clinics, and maintaining existing providers; contacting beneficiaries to ensure they are aware of their dental benefits and assisting them in accessing dental providers that includes maintaining a referral system to link them to providers.

DHCS pays Delta Dental an upfront, capitated amount each month for the number of current Denti-Cal beneficiaries, paying per person, per month (PMPM). Enrolled Denti-Cal providers submit claims to Delta at the Medi-Cal rate for the service, as established by the program. The child FFS population accounted for approximately 70% of the 2014 total Denti-Cal claims.[47]

The Medi-Cal dental FFS capitated rate is used for determining the dental managed care capitation rate.

Payment Under 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. Beginning in the mid-1990s, the California Medical Assistance Commission (CMAC) had the responsibility for negotiating the rates for DHCS contracts with GMC medical and dental programs in Sacramento County. On July 1, 2012, CMAC was eliminated and the rate development and negotiation responsibility returned to DHCS.

California's Medi-Cal dental provider reimbursement rates, based on prior time's claims expenditures, are the basis for determining the PMPM capitation rate. DHCS actuaries calculate the PMPM fee based on FFS utilization experience and apply a percentage the State wants to save from what it projects it would have spent under FFS. The rates are not negotiated with the plans and all plans are paid the same amount. The chart below (Table 2) reflects the GMC capitation rates for child beneficiaries (age 0-20) from January 1, 2014 – June 30, 2015.[48] These PMPM rates include *both* the administrative and direct services portion of the rate. The rates for FY 2015-16 had not yet been determined at this writing.

Table 2. Dental Managed Care Per Member Per Month Rates

Time Period	Age 0-20
Jan 1, 2014 – Apr 30, 2014	$11.05
May 1, 2014 – June 30, 2014	$11.45
July 1, 2014 – June 30, 2015	$11.45

Source: Department of Health Care Services, Medi-Cal Dental Division, September 2015.

One of the dental plans passes on part of the managed care risk to their providers by paying them a capitated PMPM amount, while the other 2 reimburse their providers on a FFS basis for certain age members. As of June 2015, LIBERTY and Health Net began paying providers—who favor FFS—on a FFS basis for children age 0-7 (Health Net) and age 0-20 (LIBERTY) as an incentive to see more children and because the low cap rate was not working. All of the plans that contract with pediatric, oral surgeon, periodontal and other specialists report paying anywhere from 120%-140% above FFS rates to entice the specialists to see GMC dental plan patients.

[47] Medi-Cal Dental Services Rate Review July 1, 2015. California Department of Health Care Services. http://www.dhcs.ca.gov/Documents/2015_Dental-Services-Rate-Review.pdf

[48] By contrast, the current (July 1, 2014 – June 30, 2015) PMPM for adult beneficiaries is $8.42.

Conditions Precedent to Payment

DHCS added 11 Performance Measures and Benchmarks to the dental managed care contracts beginning in January 2013, developed from the measures previously used by Healthy Families Program and national dentistry measures. It uses these measures to monitor plan utilization and services of members–and in 2013 instituted a structure of withholds and bonuses for "exceptional performance on the selected utilization measures and age groups."[49]

Withholds. In response to our earlier recommendation and that of a subsequent MCDAC Task Force that reviewed the RFP for new dental plan contracts, a schedule of withholds was implemented. As applicable, the Department enforces a monthly 10% withhold of the capitated rates for each DMC plan which may be returned presuming the plan's ability to achieve their benchmarks. So, for example, if the most recent monthly PMPM rate is $11.05, the plan is paid 90% of it, or $9.95 per member. If the plan hits certain utilization measures it has a chance to get some of it back. The "incentive" is based on point values DHCS assigns to the annual utilization rates achieved on each measure and each age group within each measure. The point values are totaled and a portion of the withheld 10% of the monthly capitation payment can be earned back. According to DHCS, this incentive encourages the plans to continually improve their provision of services and beneficiary utilization, thus furthering the Department's goal of providing appropriate, quality services to enrolled beneficiaries.

Bonus Payment. DHCS awards the plans a bonus payment of up to 5% of the monthly capitation payment for exceptional performance on the selected utilization measures and age groups according to a schedule.

An example of the measure "Annual Dental Visit" is the bonus for children age 0-3: 10 points toward earning back some of the 10% withheld from the PMPM if the plan meets or exceed the established benchmark (described later in this report), and 20 points for the bonus if plans exceed the benchmark by greater than 5 percentage points. (The plans earn no points for children over age 6 for this measure.) It takes a minimum of 415 points to earn back 100% of the withhold, and a minimum of 400 points to earn 100% of the 5% bonus that could be paid to the plan.

How Much did DHCS Pay for Children's GMC Dental Services in 2014?

Table 3 on the next page shows the total DHCS reported it paid to the GMC dental plans in CY 2014, less a 10% withhold. The average payment to the plans per *eligible* (i.e., enrolled member) in 2014 was $165.29; payment ranged from $158.70 to LIBERTY to $170.55 to Health Net. For dental *users* (Annual Dental Visit) in 2014, DHCS paid an average of $417.49; the range per user was $467.12 paid to Access to $380.26 paid to LIBERTY.[50] By comparison, the DHCS payments per eligible and per user, respectively, in the FFS comparison county, Fresno, were lower at $156.26 and $319.84.

[49] Medi-Cal Dental Managed Care plan contract, Exhibit A, Attachment 6 Performance Measures and Benchmarks.
[50] These 2014 figures cannot be compared to our 2008 figures because 2 of the earlier dental plans are no longer GMC contractors, and Health Net was too new for its payment figures to be included in the earlier analysis.

Table 3. Amount DHCS Paid GMC Plans for Children's Dental Services, Cost Per Eligible and User, 2014

GMC Plan	Total Paid[1]	Number of Unduplicated Eligibles (Age 0-20)[2]	Payment per Eligible	Number of Unduplicated Users[3]	Utiliz Rate	Payment per Unduplicated User
Access	$7,927,070	46,882	$169.09	16,967	36.2%	$467.12
LIBERTY	$9,056,212	57,032	$158.79	23,816	41.8%	$380.26
Health Net	$6,262,720	36,720	$170.55	14,897	40.6%	$420.40
Total	$23,246,003	140,634	$165.29 (avg)	55,680	39.6% (avg)	$417.49 (avg)
Fresno County (FFS Comparison)	$29,127,998	186,402	$156.26	91,070	48.9%	$319.84

[1]Figures in this column are approximates.
[2]Eligibility is based on 11 months of enrollment with no more than one-month gap in eligibility.
[3]Figures are based on Annual Dental Visit. Includes unduplicated beneficiaries who used any dental service or had an FQHC (contracted with a GMC plan) encounter.
Source for all table columns except Payment per Eligible and Payment per Unduplicated User: Department of Health Care Services, Medi-Cal Dental Services Division. July 22, 2015 and December 4, 2015. Payment calculations per eligible and per user were performed by the authors.

Since the capitation *rate* did not vary among dental plans, some variance in the payments to plans is likely due to plans not always receiving their full capitation payments as the result of the payment withholds and bonuses described above. It should also be noted that all plans reimburse some services on a FFS basis and have other services that are wrapped up in the PMPM rate. These FFS services differ across plans and providers. The withholds and different payment structures may account for the differences in payment per eligible and payment per user between dental managed care and Fresno County FFS—and between the GMC payment data reported here and the 2008 data in our earlier study.

How do Medi-Cal Dental Rates Compare to Other States?

Economic studies have found a positive, albeit modest, relationship between Medicaid payment rates and dental care utilization.[51] The explanation of the positive relationship is because higher payments increase the supply of services to Medicaid patients by inducing more dentists to participate in the program.

The DHCS Medi-Cal Dental Program has expressed a desire to increase children's utilization of dental care services to at least the national Medicaid average utilization.[52] However, while most states' Medicaid payment rates are below market rates (which reflect general dentist fees), California's rates are substantially below national rates and among the lowest in the nation; they are significantly below the fees charged by most dentists—generally representing 30%-50% of dentists' fees.[53] In a comparison by the CA State Auditor of select FFS reimbursement rates in California with other states' Medicaid programs, the national average reimbursement for a periodic oral evaluation-established patient visit, for example, was $44.10 while California's maximum reimbursement for that visit type was $15.[54] While in the United States in 2013, Medicaid fee-for service reimbursement rate was, on average, 48.8% of commercial insurance charges for pediatric dental services, in California it was 29% (a -28.2% change from 10 years earlier).[55]

[51] Buchmueller TC, Orzol S, Shore-Sheppard LD. The effect of Medicaid payment rates on access to dental care among children. *Amer J Health Econ* Spring 2015(1);2:194-223.
[52] Personal communication with DHCS staff, April 22, 2015.
[53] *California Department of Health Services. Weaknesses in its Medi-Cal Dental Program Limit Children's Access to Dental Care*. Report 2013-125. Sacramento: California State Auditor, December 2014.
[54] Ibid.
[55] Nasseh K, Vujicic M, Yarbrough C. A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services. Research Brief. Health Policy Institute, American Dental Association. October 2014.

In July 2015, DHCS conducted a rate review that compared reimbursement rates of the top 25 most utilized Denti-Cal FFS procedures, with other comparable states' Medicaid Programs, in addition to the commercial rates from 5 different geographic regions around the nation.[56] The review found California's Schedule of Maximum Allowances for Denti-Cal FFS pays an average of 86.1% of Florida's Medicaid Program's dental fee schedule, 65.5% of Texas', 75.4% of New York's, and 129.2% of Illinois' Medicaid Program's dental fee index. State staff explained the intent of the rate review was not to draw conclusions about the link between low rates and less access or whether rate increases might be justified or not.

What is the Role of Department of Managed Health Care?

The California Department of Managed Health Care (DMHC) is responsible for licensing dental managed care plans. Its routine quality assurance surveys are focused on plans' commercial lines of business. However, DMHC has jurisdiction and authority to investigate any issue affecting the interests of enrollees, subscribers, and health plans. Pursuant to California Health and Safety Code §1380 and §1382, DMHC must regularly conduct administrative surveys and financial examinations of the dental plans participating in Medi-Cal dental managed care. In November 2013, DHCS finalized an Inter-Agency Agreement with DMHC to develop survey review tools specific to both Knox-Keene Act and DMC contract requirements. DMHC and DHCS now do joint dental program surveys, which minimize auditing interruptions for the dental plans, on a schedule DMHC sets.[57] DHCS staff stated they were not aware of how frequently the joint audits occurred but indicated they were informed by checking the schedule on the DMHC website. DHCS believes that collaboration between both departments has facilitated a strong working relationship to ensure plans are operating in accordance with the expectations of DHCS and DMHC.

What is the Role of the Medi-Cal Dental Advisory Committee?

W&I Code §14089.08 authorized the establishment of the Sacramento County Medi-Cal Dental Advisory Committee (MCDAC).[58] Its 19 members include dental providers, plans, advocates, and beneficiaries. The purpose of MCDAC is to provide input on the delivery of dental services, including oral health education, examine new approaches to beneficiary care and recommend improvements to DHCS. MCDAC holds monthly public meetings. Legislation requires DHCS to attend quarterly, and while DHCS staff used to attend monthly the frequency changed to quarterly in the summer of 2015 due to workload issues.

MCDAC has accomplished many specific improvements, partnering with local stakeholders, such as creating a car seat program for families in need of car seats for dental and medical appointments (over 200 distributed) and giving input to dental plans on outreach campaigns. Attachment 6 contains a list of MCDAC proposals, projects and collaborations with DHCS and the dental plans and the status of progress as of September 2015.

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

A brief description of the 3 Sacramento GMC dental managed care plans is summarized below in Table 4. Additional information about plans' dental networks and referral arrangements can be found on page 40.

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[56] Medi-Cal Dental Services Rate Review July 1, 2015. California Department of Health Care Services. http://www.dhcs.ca.gov/Documents/2015_Dental-Services-Rate-Review.pdf

[57] Reviewing the routine and non-routine DMHC/DHCS survey and audit reports was not included in the scope of work for this study. However, MCDAC informed us that in the last DMHC non-routine audit of the plans several deficiencies were detected. They noted that follow up reporting detailing whether dental plan corrective action has addressed these deficiencies has not occurred.

[58] A separate Los Angeles Stakeholders Group provides input on the delivery of oral health and dental care services in LA County, which offers both dental managed care and Denti-Cal FFS. Quarterly conference calls between LA and Sacramento shares "lessons learned."

Table 4. Summary of GMC Dental Plan Characteristics

Item	Access/Premier	Health Net of CA	LIBERTY Dental
History with GMC	Joined GMC in 1994.	Joined GMC in July 2008; contracts directly with GMC, but now subcontracts with LIBERTY for certain administrative services.	Joined GMC in May 2005.
Scope of plan	Dental only.	Medical and dental.	Dental only.
Medicaid dental managed care contracts in other states	Yes – Utah is one example. Medicaid program there is a type of managed care program and Access uses a mixed capitation/FFS model for reimbursing providers.	Yes – Arizona is one example.	Yes –as carved-in and imbedded in health plans. Florida is one example
Model of Delivery: Staff Model and/or Independent Provider Network	Contracts mostly with dental groups/solo dental practices but also with 3 Access staff model clinics (approx. 90%/10% mixed model now).	Contracts with approx. 72 dental groups/solo dental practices (mostly shared network with LIBERTY).	Contracts with a little more than 50 dental offices (mostly shared network with Health Net).
Provider compensation method* *New approaches are intended to provide information to see how various compensation models work to increase utilization.	Capitation + suppl. fee for age 0-20. Effective 2015, 2 bonus structures: a) an add'l PMPM for every child assigned in offices that reach the targeted annual dental visit;* b) for age 5-11, DDS gets add'l $75 if the full preventive pkg (exam, prophy, x-rays) was done; DDS gets $125 if treatment was also included within prevention visit (goal: provide as many services w/in 1 visit to reduce barriers and no-show rate). * e.g., if a DDS had the same 100 children in their office for 12 months and the bonus was $.40 that provider would earn $480 additional dollars (100x12 months x $.40 = $480)	Rates set by Health Net, not LIBERTY. Providers are paid on a FFS basis for children age 0-7; paid capitated rate for children age 8 – adult. Specialists are paid above Medi-Cal FFS rates. Providers are paid $100 for seeing age 0-3 (maximum of 1 time annually). Considering other strategies to increase utilization, e.g., a bonus system.	Effective 6/1/15, providers are paid on a FFS basis for children age 0-20, otherwise on a capitated basis. Paid at 100% of the Denti-Cal fee schedule (prior to 10% reimbursement cut). Specialists are paid close to commercial rates, i.e., approximately 140% of FFS rates. The plan is also negotiating moving all children in the Western* offices to that model as well. *LIBERTY took responsibility for Western's Medi-Cal enrolled children when DHCS stopped contracting with Western.

Table continues on next page

Item	Access/Premier	Health Net	LIBERTY
Frequency members are allowed to change dentist	Monthly.	Every month, before the 10th of the month (no mid-month transfers) unless urgent situation.	Allowed to change when requested.
Average wait for routine dental visit after requesting an appointment* *Can be influenced by patients requesting specific days and specific times and waiting for those specific requests to be met.	3 weeks, per contract requirement.	Within timely access standards per contract requirement. Avg wait for initial visit = 18.4 days; prevention visit = 21 days; routine visit = 17 days.	Within timely access standards per contract requirement.
Quality Assurance	Annual on site chart review; quarterly member survey; "secret shopper" program; 3 yr rotating audit; proactive in responding to grievances; every office gets "touched" once a month by a plan rep.	Subcontracted to LIBERTY Dental; audits are through CA Assn of Dental Plans which uses similar calibrations for all plans and is approved by DHCS; audits are shared through CADP warehouse.	Rigorous credentialing program (NCQA credentialing standards); 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.
Stated policy re: age at first visit[59]	Not a stated policy	Not a stated policy	Not a stated policy
Efforts in Sac. to increase utilization by children	Now doing "member engagement project," e.g. re-wording member services and consumer materials to be more reader friendly; more outreach; will start sending birthday reminders. Offers to use its Robo-dial to help GMC providers set up patient appts/reminders.	Leverage the health plan side to use physicians to promote oral health; 1/3 of dental members are in medical plan. Posters promoting oral health during pregnancy provided to primary care physician offices. Newsletters to providers.	Outbound calls to members; help parents to make appointments ("warm transfers"); mailings about oral health. Are considering other strategies such as school-based services and virtual dental home.

Source: Interviews and email communication with plan representatives.

[59] The DHCS contract with GMC plans does not contain a requirement concerning age of a child's first dental visit. DHCS only expects plans to send a generic reminder annually to all members regardless of age whether or not they made a dental visit. Although all of the dental plans support the policy of seeing a child by "the first birthday/the first tooth"—consistent with American Academy of Pediatric Dentistry and American Academy of Pediatrics recommendations—some contracted dentists do not want to see or can't manage children this young. If the plans become aware of this, and the parent wants a young child seen, the plan tries to find another dentist for the child.

III. Access Factors

"You lose money every time a Denti-Cal patient walks in the door."
— Sacramento dentist

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The plans' member services lines aren't as informed as they should be. If you happen to get someone more seasoned you're lucky." -- Patient advocate

What is the Medi-Cal Eligibility Period?

Once enrolled in Medi-Cal, the child is covered for dental benefits for a period of 1 year. Re-determination is required annually.[60]

What are Common Barriers to Getting Oral Health Services?

Barriers to accessing oral health services are complex, and are the result of a combination of both healthcare delivery system and patient personal factors. On the delivery side, lack of available resources and willing providers—which GMC was set up to help alleviate—low reimbursement, cumbersome administrative processes and lack of ability to manage very young children in the dental office account for the main barriers.

Common patient-related barriers that impact access include lack of perceived need and knowledge about the importance of oral health by parents, financial concerns (lack of dental insurance, high deductibles and/or share of costs), unawareness of having dental benefits, dental fear, and logistical challenges like transportation that can contribute to high rates of no-shows for appointments. GMC plans and providers consistently have cited these factors as adding to the challenge of providing dental services to GMC members.

Feedback from GMC Families

During the time of this study, the GMC plans conducted a DHCS-approved member survey, and they asked us to analyze the data. The plans were frustrated with the tepid responses to their outbound calls and other outreach campaigns to increase utilization, and wanted to learn more about parent attitudes, experiences and the factors that contributed to children not making a dental visit. Using their own sampling method, each dental plan mailed a survey to a random sample of 3,000 families with children enrolled in Sacramento GMC who reportedly had not utilized their dental benefits in the last year;[61] 184 completed surveys were returned. While a 6.1% response rate to a mailed survey is low even for somewhat unresponsive groups such as the Medicaid population,[62] and it would be easy to dismiss the findings based on the relatively small sample size, the results are important for revealing parents' opinions about their children's oral health and experiences with dental services. The findings are consistent with barriers identified by others,[63]

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[60] http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-05-w-attach.pdff

[61] The Member Survey, modified for adults, was also mailed to a random sample of *adult GMC* plan members. Both the Adult and the Child surveys were mailed to a random sample of members in the dental managed care program in Los Angeles as well. The results of the adult GMC and the Los Angeles surveys are available from the dental plans or the study author as are the full child results.

[62] Gibson PJ, Koepsell TD, Diehr P, Hale C. Increasing response rates for mailed surveys of Medicaid clients and other low-income populations. J Epidemiology 1999;149(11):1057-1062.

[63] Dental Care Survey, Medicaid Managed Care Members. New York State Department of Health Office of Managed Care. IPRO. February 2007. https://www.health.ny.gov/health_care/managed_care/reports/dental/docs/pdf/final_report_dental_care.pdf

and should be useful for DHCS, dental plans and stakeholders for implementing improvement strategies that reduce patient barriers.

Some of the encouraging survey findings included:

- 86% of families who responded were aware their child had dental benefits.
- 53.5% reported they *had taken* their youngest child age 1-6, and 56.5% *had taken* their oldest child age 7-20, to the dentist within the last year. (The survey inquired about the youngest and oldest children age 0-20).
- 70.7% reported taking their child for a regular dental check-up on their own initiative.
- 70% or more of parents strongly agreed or agreed that it was easy to make a dental appointment for their child, children should see a dentist by the first birthday (72%), and baby teeth are important (92%).

Some of the findings that require attention included:

- 5.1% of parents reported it had been 2 or more years since their youngest child had seen a dentist; regarding their oldest child, 7.6% had not seen a dentist in 2 or more years and 5.3% had never seen a dentist.
- Long waits and not liking the way they were treated at the dental office, fear of the dentist, and absence of tooth pain were the most common reasons for a child not having a dental visit. Some parents complained about waiting "for hours" because offices overbooked appointments, and not being able to take off "a whole morning or afternoon" for these appointments—access problems that discourage parents from keeping appointments and add to the dilemma of no-show rates.
- Other reasons for no dental visit, although ranking as less important to parents, included language barriers (7.4%), concerns about missing work (5.2%), and using brushing and flossing of their child's teeth as a substitute for a dental visit (4.3%). An additional 2.2% of parents acknowledged procrastinating or "just not getting around to it." These are important areas to address.
- 9.3% of parents reported "something was hurting" as the main reason for their youngest child's last dental visit.
- Parent education and understanding about the importance of maintaining children's oral health by regular dental visits and in the absence of any problems is still needed. This is evidenced by: 4.3% of parents who reported "I brush and floss my child's teeth myself so they don't need to go [to the dentist];" and 8.5% who declined the plan's offer to make a dental visit "because my child doesn't have any tooth problems to need to see a dentist."
- The low match between plans' records of no recent dental visit and the survey responses raises a question about the accuracy of the mailing lists for the survey. It also suggests surveyed parents may have over reported their children's dental utilization due to a variety of factors such as forgetfulness about the passing of time for a dental visit and possibly answering questions in a manner that would be viewed favorably by others.[64,65]

[64] Although the dental plans' Member Survey was mailed to members who had reportedly not visited a dentist in the last year, more than half of the respondents reported having taken their child to a dentist during that time. As we stated on page 16, the surveyed population could have been affected by response bias, since individuals who visited a dentist may have been more likely to complete the survey.
[65] Paulhus DL. Measurement and Control of Response Bias. In J.P. Robinson et al. (Eds.), Measures of Personality and Social Psychological Attitudes. San Diego: Academic Press, 1991. http://fermat.unh.edu/~mas2/Chapter2-Paulhus.pdf

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

While overall dentist supply affects the number of dentists available to treat Medi-Cal children, supply is not a limiting factor in Sacramento County. With approximately 1,103 licensed 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.[66] Approximately 80% or 792 of the county's active dentists are general or family dentists, and 4% of the remainder are pediatric specialists.[67]

Supply of dentists, however, does not address the question of whether dentists are willing to see children with Medi-Cal or even whether general dentists are trained to see the very youngest children. In 2014, DHCS reported there were 411 rendering providers (37% of Sacramento's licensed dentists) who rendered services to Denti-Cal FFS patients in Sacramento County. (A "rendering provider" is one who performs dental services for a patient.) These are not high volume providers. Of the 411 rendering dentists, 337 (82%) provided services for fewer than 50 Sacramento children ages 0-20 in the FFS system; only 74 saw more than 50 children. [68]

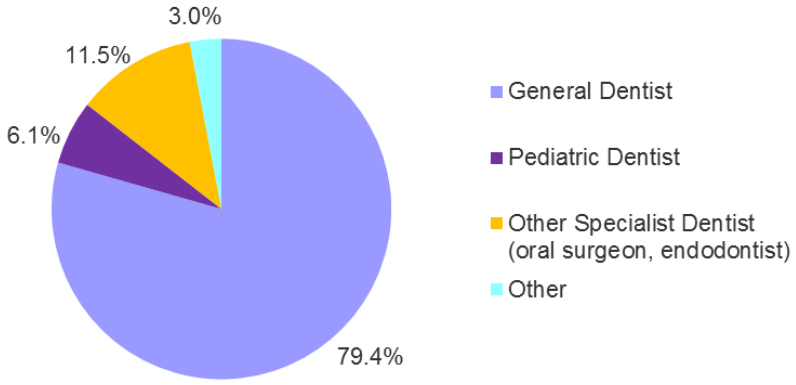
According to the 2014 state Auditor's Report,[69] the ratio of general dentist providers to beneficiaries willing to accept new Medi-Cal patients for Sacramento County as of December 2013 was 1:2,585. Of the California counties with existing dental providers who see Medi-Cal patients (11 were reported not to have any willing to see new Medi-Cal patients), there were 7 counties with worse provider-to-beneficiary ratios than Sacramento.

What are Sacramento Area Dentists' Experiences with Denti-Cal/GMC?[70] Feedback from the Dentist Survey

A total of 299 dentist members of the Sacramento District Dental Society (SDDS) responded to our survey that SDDS made available online,[71] generating a relatively high response rate of 37.4%. The survey addressed some of the same issues as the State Auditor's Report, but added questions about dentists' specific experience with GMC. Nearly 80% of the respondents were general dentists and 6.1% were pediatric dentists, generally reflecting the characteristics of the approximately 800 SDDS-member dental offices that could potentially have responded to the survey (Figure 4).

[66] Date source is California Dental Board as of June 8, 2015, accessed at http://report.oshpd.ca.gov/?DID=HWDD&RID=Provider_Count_By_License_Type. Note: the data online is updated to the most recent date.
[67] Personal communication with Executive Director, Sacramento District Dental Society, June 25, 2015. Note also that according to CDA, the 80% general dentist rule of thumb is a common reference, with the remaining 20% split among the specialties.
[68] Department of Health Care Services, Medi-Cal Dental Division. A rendering dental provider is a dentist who provides direct services.
[69] *California Department of Health Services. Weaknesses in its Medi-Cal Dental Program Limit Children's Access to Dental Care*. Report 2013-125. Sacramento: California State Auditor, December 2014.
[70] Because the term "Denti-Cal" may be more widely known in Sacramento County than "GMC," we use the term here, as we did in the survey, to refer to the entirety of the Medi-Cal dental program, i.e., inclusive of both FFS and managed care.
[71] Sacramento District Dental Society sent the survey for us with a cover letter co-signed by the Executive Director and the Chair of First 5 Sacramento. Because about 80% of Sacramento County dentists are members of the SDDS, most would have been reached with this survey.

Figure 4. Characteristics of the Sacramento Area Dentist Survey Respondents (n=299)



Source: Study author survey administered by Sacramento District Dental Society, May 2015.

Dentists' Current Participation in Medi-Cal Dental

A number of studies have confirmed that the limited provider network for federally funded programs such as Medi-Cal is one of the primary limiting factors for access to care for young children. Very few of the Sacramento dentist survey respondents participate in Medi-Cal's dental program—either as a GMC network provider or Denti-Cal FFS provider. About 10% of the mostly-general dentists reported accepting children with Denti-Cal—nearly the exact percentage who responded to the same survey question 5 years ago (Table 5).

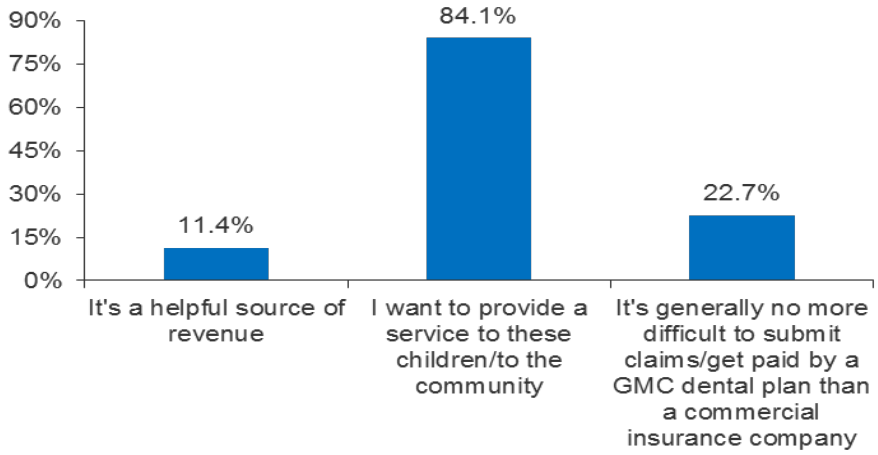
Table 5. Dentists' Participation in the Medi-Cal Dental Program (n=295)

Do you take children with Denti-Cal in this practice (either FFS or GMC)?		
Answer Options	**%**	**n**
Yes	10.2%	30
No	**89.8%**	**265**

Source: Study author survey administered by Sacramento District Dental Society, May 2015.

Wanting to provide a service to low-income children was the main reason that influenced participating dentists' decisions to participate, cited by 84.1% of the dentists enrolled with GMC (Figure 5). Close to one-quarter reported that the claims submission process was "no more difficult than with commercial insurance." About 7% of the respondents indicated that it was not *their* choice to participate but that of the dental office owner in which they practiced.

Figure 5. Main Factors that Influenced Dentists' Decision to Participate in Dental GMC (n=44)



Source: Study author survey administered by Sacramento District Dental Society, May 2015.
Note: respondents could select more than 1 response choice.

Dentists' Prior Participation in Medi-Cal Dental

Forty-two percent of the dentist respondents reported that while they no longer took Denti-Cal in their practice, they had done so in the past. Low reimbursement rates accounted for the main reason (78%) these dentists had dropped Denti-Cal. Close to 60% of these dentists had left the program due to some of the administrative issues that adds to the cost of seeing Denti-Cal patients such as "trying to get paid" and challenges with prior authorizations (Table 6).

Table 6. Dentists' Prior Participation in Medi-Cal Dental Program (n=127)

Did you ever take children with Denti-Cal in this practice? If Yes, why did you stop?		
Answer Options	**%**	**n**
Reimbursement Rates	78.0%	99
Administrative Concerns (provider enrollment, claims processing, prior authorization)	59.1%	75
Patient Behavior (no shows, patient management issues)	44.9%	57
Other	26.0%	33

Source: Study author survey administered by Sacramento District Dental Society, May 2015.
Respondents could check more than one response choice.

Although about one-quarter of the respondents said they stopped taking Denti-Cal for "other" reasons, their written-in comments largely reflected the response choices provided but with more specificity (Table 7). The comments mirror the findings of statewide studies we've conducted,[72,73] in which dentists consistently cite the same 3 primary reasons for non-participation in Denti-Cal:

[72] *Without Change it's the Same Old Drill: Improving Access to Denti-Cal Services for California Children through Dentist Participation.* Sacramento, CA: Barbara Aved Associates, October 2012. http://www.barbaraavedassociates.com/samples/denti-cal-final-report-nov-2-2012.pdf.
[73] *Provider Experience with Denti-Cal: Findings from a Market Study of California Dentists and Clinics*. Sacramento, CA: Barbara Aved Associates, January 2015 (unpublished).

- Reimbursements that are well below commercial rates;
- Difficulties in navigating the program's administrative requirements that can overwhelm small offices; and,
- Patients that can be harder to schedule and work with than private-pay patients.[74]

Table 7. Specific Reasons Sacramento Area Dentists Stopped Participating in Denti-Cal (n=19)

- Work in a practice that doesn't want to participate for all of the above reasons (n=4)
- High claims rejection by GMC plans for no good reason/low reimbursement (n=4)
- Missed appointments; patients put low value on services (n=3)
- Disagreed with changes in patient assignments made by GMC plans (n=3)
- Burdensome paperwork/continuous hassles (n=2)
- Restrictions on treatment (scope of services) (n=1)
- Difficulty in becoming a provider (n=1)
- It's easier to just take these kids for free and not participate (n=1)

Source: Study author survey administered by Sacramento District Dental Society, May 2015. Coded and analyzed by authors.

Incentives for Dentist Participation

While nothing would persuade more than half (54.6%) of the responding dentists to participate in Denti-Cal, 45.4% indicated certain factors that could make a difference (Table 8).

Table 8. What would Motivate Dentists to Take Denti-Cal? (n=249)

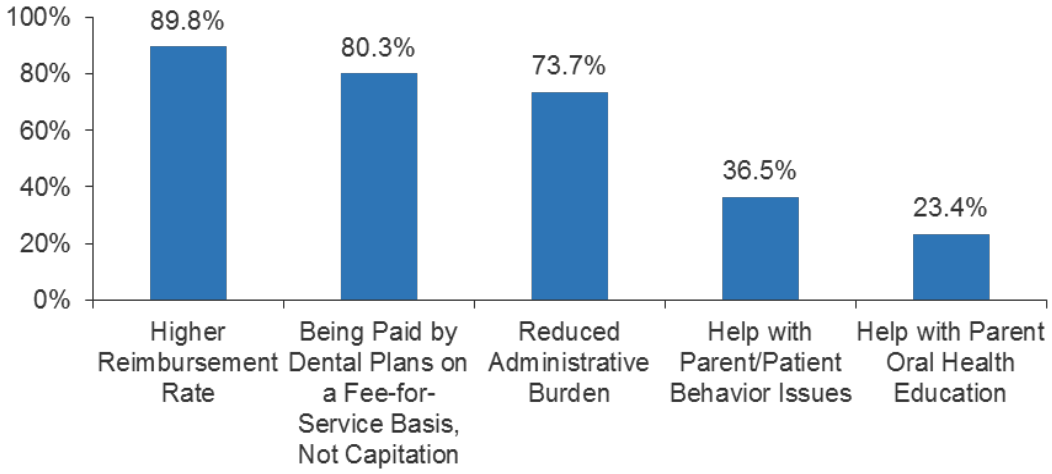
If you do not currently accept Denti-Cal, what would it take for you to see Denti-Cal children in your practice?		
Answer Options	%	**n**
Nothing; I don't wish to accept GMC/Denti-Cal	54.6%	136
I could be interested if certain changes occurred	45.4%	113

Source: Study author survey administered by Sacramento District Dental Society, May 2015.

The specific changes or improvements dentists said it would take to potentially interest them in participating again or ever in Denti-Cal or GMC essentially restated the factors that accounted for their never taking or having stopped taking Denti-Cal (Figure 6). The fact that 80% want to be paid by GMC plans on a FFS basis would seem to validate the recent switch by 2 of the plans to FFS reimbursement for members age 0-7.

[74] *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*. General Accountability Office, Washington: DC. 2000, pp. 10-11. http://www.gao.gov/new.items/he00149.pdf.

Figure 6. Changes that Could Affect Sacramento Dentists' Willingness to See Children with Denti-Cal (n=137)



Source: Study author survey administered by Sacramento District Dental Society, May 2015.
Respondents could select more than 1 response choice.

Dentists' Opinions about Rates

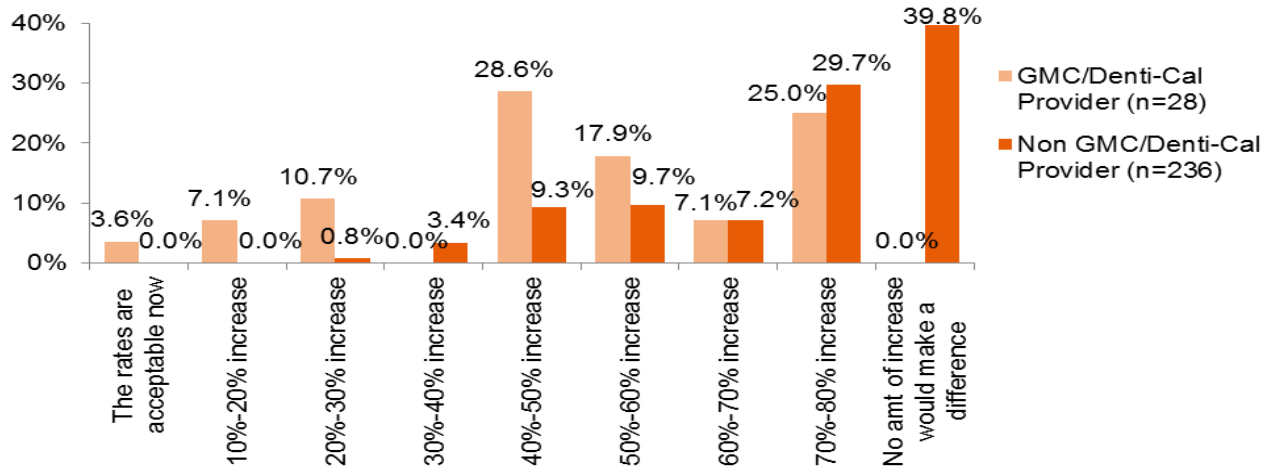
Because of the important, positive association between provider rates and utilization, we used the opportunity of this study to ask the dentists—regardless of whether they participated in Denti-Cal FFS or GMC—how much of an increase in Denti-Cal reimbursement would make a difference to their practice to accept children with Denti-Cal. Of 265 total responses, 47.2% indicated the rates needed to be increased by 50% or more. Close to one-third (29.1%) of non-participating providers and 24.9% of the participating providers said an increase of 70%-80% would be necessary for them to see children with Medi-Cal.

Notably, however, when asked specifically about rate improvement as a possible influence to see children with Medi-Cal, 39.8% of the providers who did not participate in either FFS or GMC said *no* amount of increase would make a difference in taking FFS or GMC in their practice (Figure 7).[75] There was no significant difference in the responses of the general dentists and the specialists.

A general dentist who contracted with one of the GMC plans expressed the representative comment "because typical office overhead is around 75%, raising fees to at least 70% of UCR (usual and customary rates) one might be able to see Medi-Cal patients without actually losing money; it's difficult to stay in business treating these patients."

[75] These findings are not as discouraging as they could be. Nothing could entice 47.6% of dental practices to participate again no matter what the rate change would be according to our recent statewide study of former Denti-Cal providers: *Provider Experience with Denti-Cal: Findings from a Market Study of California Dentists and Clinics*. Sacramento, CA: Barbara Aved Associates, January 2015 (unpublished).

Figure 7. Dentists' Opinions on Amount of Reimbursement Rate Change Needed to Participate in Medi-Cal Dental Program, by Participation Type

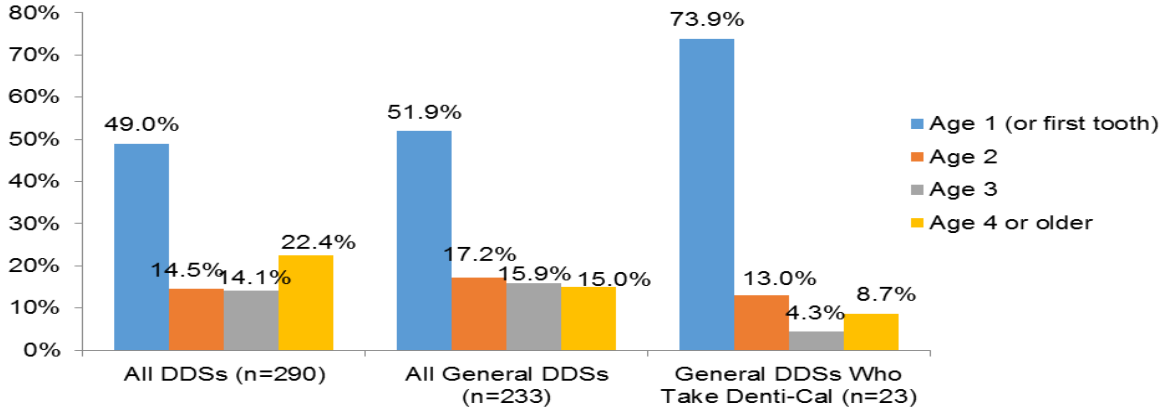


Source: Study author survey administered by Sacramento District Dental Society, May 2015.

Age the Surveyed Dentists Will See Child for First Dental Visit

To examine access issues for the youngest children in Sacramento County we asked dentists at what age they first start seeing children in their practice. Approximately one-half of all dentist respondents and all general dentist respondents (49% and 51.9%, respectively) reported they start seeing children by age 1 or the first tooth.[76] Notably, an even higher percentage, nearly three-quarters (73.9%), of the general dentists *who take either Denti-Cal or are in GMC* start seeing children at age 1 or the first tooth. This finding suggests that a concerted effort has been made in Sacramento County to follow the recommendation for "the first dental visit at the first tooth or first birthday."[77] Not unexpectedly, of the pediatric dentists 100% reported they saw children at the recommended age 1.

Figure 8. Age at Which Dentists First Start Seeing Children in the Practice



Source: Study author survey administered by Sacramento District Dental Society, May 2015.

[76] These percentages are impressive. In a representative sample of dentists statewide, 18% of general dentists started seeing children at age 1; 82.2% of pediatric dentists reported they saw children at the recommended age 1. http://www.barbaraavedassociates.com/samples/denti-cal-final-report-nov-2-2012.pdf. In a statewide sample of only Denti-Cal providers, 33% of dentists reported seeing children by age 1. *Dental Provider Network Capacity Survey Summary*. CA Department of Health Care Services, June 2015. http://www.denti-cal.ca.gov/provsrvcs/docs/dent_prov_netw_capac_srvy_sum_june_2015.pdf

[77] American Dental Association, American Academy of Pediatric Dentistry, American Academy of Pediatrics policy statements. 2014. http://www.aapd.org/media/policies_guidelines/p_eccclassifications.pdf

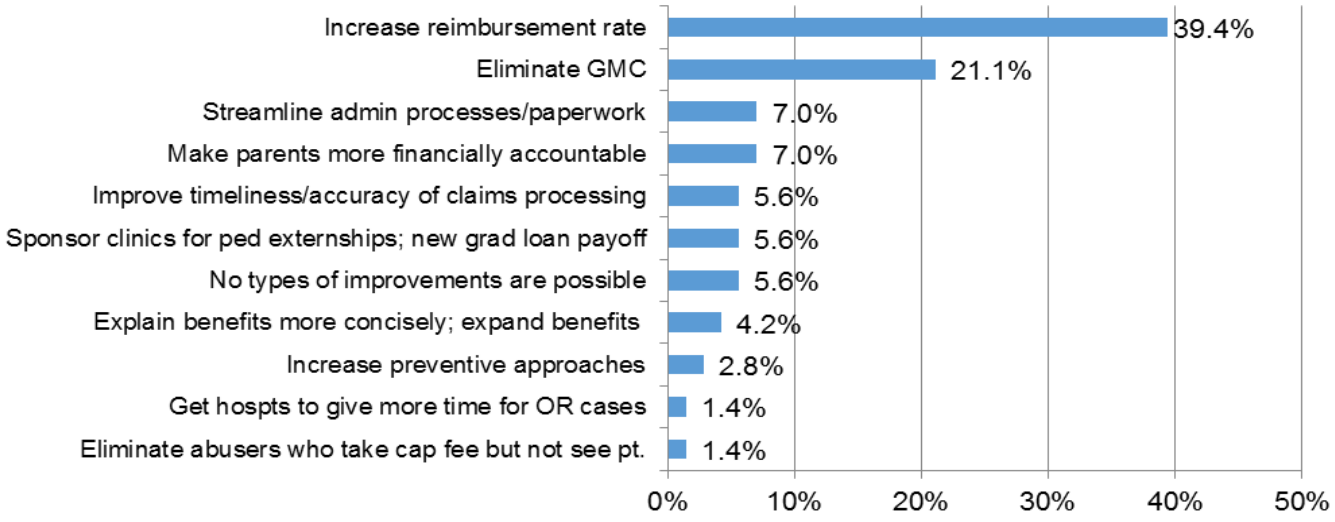
Dentists' Recommendations for Improvement

The dentists were asked to suggest how Denti-Cal and/or GMC could be improved; 52 of them supplied 71 responses. The results are displayed by total sample (Figure 9) and by GMC providers only (Figure 10). By a large margin, all respondents reiterated the problem low reimbursement rates have on provider agreement to participate and for participating dentists to agree to take more children. They said raising the rates was necessary to incentivize participation. This finding is consistent with the recent DHCS provider network capacity assessment in which over 90% of that statewide sample of Denti-Cal providers suggested that increasing reimbursement rates would encourage more provider participation.[78] The Sacramento dentist respondents said the State "needs to get serious" and provide equitable rates if it truly wanted to see an increase in children's utilization rates.

Of the total sample of dentists who responded (some of whom had never participated in FFS or GMC), 1 in 5 thought the GMC model should be eliminated, most saying they favored returning to the FFS option (Figure 9). Their reasons were that they thought the model "didn't work" for the benefit of patients (e.g., treatment delays, minimal work per patient for GMC plans to save money). Of the GMC provider respondents only, just 1 thought going back to FFS was better than the current GMC system. This is a more favorable finding about GMC as a model of care than in our earlier study. Of interest, close to 6% of all respondents thought no amount of improvement to GMC or Denti-Cal was possible "because the system is broken."

In addition to concerns about untimely claims processing and provider credentialing that needed to be more streamlined, dentists suggested that requiring radiographs for 4+ fillings and submission of x-rays of an intramural photo were examples of unnecessary "red tape." They noted that such requirements contributed to the administrative burden and unattractiveness of the program. A few dentists suggested the State should fund more community and school-based clinics to serve the Medi-Cal population and such sites could provide externship placements for pediatric residents as well as new dentists who needed to pay back student loans. Several dentists believed parents should participate in paying for a portion of dental care "so that they would put more value on it" and more attempts should be made to help them understand the importance of it.

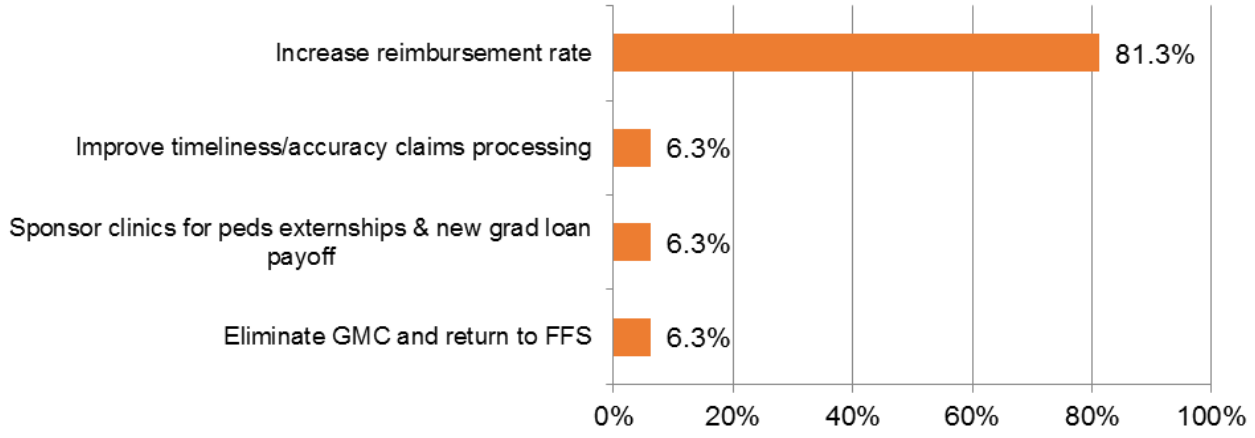
Figure 9. Dentists' Recommendations for Denti-Cal/GMC Improvement (Total Sample)



Source: Study author survey administered by Sacramento District Dental Society, May 2015. More than 1 answer could be provided.

[78] *Dental Provider Network Capacity Survey Summary*. CA Department of Health Care Services, June 2015. http://www.denti-cal.ca.gov/provsrvcs/docs/dent_prov_netw_capac_srvy_sum_june_2015.pdf

Figure 10. Dentists' Recommendations for Denti-Cal/GMC Improvement (GMC Providers Only)



Source: Study author survey, administered by Sacramento District Dental Society, May 2015.
Note: The sample is composed of 17 respondents who offered 21 suggestions.

How does GMC Plans' Provider Networks Affect Access?

Dental Offices and Clinics

A key issue in Medi-Cal dental services is having an adequate number of providers willing to see the number of children enrolled. GMC plans are required by contract to have a "complete provider network that is adequate to provide required covered services for Members in the service area." They are also obligated to have policies and procedures in place describing how they will monitor provider-to-patient ratios to ensure they are within specified standards, dentist supervision of non-dentist practitioners, and for providing emergency services. The Time and Distance Standard that plans must maintain for their network of primary care dentists are those that are located within 30 minutes or 10 miles of a member's residence unless DHCS has approved an alternative time and distance standard.

The plans are also required to maintain a complete list of specialists by type within the network as well as guarantee access to out-of-network providers and Federally Qualified Health Centers (FQHCs). DHCS approves the plans that the dental plans must submit to meet these various requirements, and is responsible for monitoring the extent to which they are accurate and implemented. Although DHCS has not conducted a formal network capacity assessment for the dental managed care program as it recently did for the dental FFS system,[79] the Department uses the Beneficiary Dental Exception (BDE) and grievance processes to help in monitoring managed care members' access to network providers (see page 53 for a description of BDE).

Compared to the 2009 plan provider network directories we reviewed during our earlier GMC study—which were somewhat out of date—the 2015 directories were mostly current and contained nearly triple the number of dental providers. The 3 plans' lists combined showed a total of 276 unique dentists (i.e., number of dental *providers*, not number of dental *offices*), 159 (58%) general dentists and 117 (42%) specialists. Of the offices we contacted (243, a 88% sample), the error rate for being shown as a GMC provider, when the office was not a provider, was 6.3% for general dentists and 16.2% for specialists (Table 9). The most common restriction general dentist offices

[79] *Dental Provider Network Capacity Survey Summary*. CA Department of Health Care Services, June 2015. http://www.denti-cal.ca.gov/provsrvcs/docs/dent_prov_netw_capac_srvy_sum_june_2015.pdf

reported was "not taking new GMC kids now because of capacity limitation," i.e., appointments were currently full and the child would have to be scheduled too far into the future. Only 2 offices reported the restriction of limiting sibling appointments to only 2 children in a family per visit.

Table 9. Errors and Problems Associated with Dental Plans' GMC Provider Network Lists

Type of Error or Problem	Error/Problem Percentage	
	General DDS contacts (n=138)	Specialist DDS contacts (n=105)
Not being a GMC provider	6.3%	16.2%
Not taking children at age 1/first tooth	9.0%	N/A
Placing some sort of restriction on taking patients	8.3%	0.0%

N/A = not asked.
Source: Study authors telephone interviews. September 2015.

Despite the mostly favorable findings from the provider list interviews, our results are somewhat inconsistent with a comparable review Sacramento District Dental Society conducted 3 months earlier. SDDS found an overall error rate of about 25% (i.e., providers on the GMC plans' lists who reported they were *not* GMC providers).[80] Because both SDDS and our telephone interviews asked essentially the same questions and talked to only office staff, the variance in results may be due to whomever one talks to on the telephone. This discrepancy may reflect the experience some patients face when calling a dental office on the provider list.

In relation to the size of its GMC enrollment, Health Net, followed closely by LIBERTY Dental (who share a large portion of providers in their networks), appears to have the most favorable access based on total network dentist size (Table 10). While LIBERTY Dental's network comprises nearly equal proportions of general dentists and specialists, the majority (75%) of Access Dental's providers are general dentists. Health Net provides GMC children the greatest access to specialist dentists.[81] All of the GMC plans contract with FQHCs and other types of community dental clinics that provide children with access to safety net providers. Of the 3 plans, Access Dental has the greatest percentage of clinic providers as part of its network based on total number of dentists and the proportion that are clinic-based.

Table 10. GMC Plans' Provider Network Characteristics.

	# of DDS Providers in Network	GMC Members/ Provider	GMC Members/ General DDS	GMC Members/ Specialist DDS	% of Network as Clinics	% of Western Clinics in Network	% Type of DDS in Network	
							Gen DDS	Specialist
Access	270	173.6	228.7	721.3	31.9	0	75.6	24.4
LIBERTY	799	71.4	139.4	146.2	16.9	39.2	51.0	49.0
Health Net	579	63.4	180.9	97.7	23.0	9.3	34.9	65.1

Source: GMC Plans' Provider Network Lists, July 2015. Calculations by study authors.

Western Dental, which had 46% of the GMC members during our earlier study, did not receive a GMC contract when contracts were renewed in 2012-13; LIBERTY Dental picked up the majority of

[80] Personal communication with Cathy Levering, Executive Director, SDDS, August 31, 2015.
[81] A small part of the difference between the plans' members-to-provider ratios could be due to the way the plans categorize dental providers. Note that pediatric dentists are considered specialists in the Sacramento GMC program.

its GMC enrollments. Western Dental had only ever seen Health Net members as a specialist in Orthodontics in Sacramento County, according to Health Net. Access Dental does not have any of the Western Dental clinics in its provider network.

In managed care, dentists who contract with a GMC plan see the number of patients they agree to have assigned to them as their dental home. (This is not the case in FFS where a Denti-Cal provider can see as many patients for which they have the capacity.) As a result of the 2012 legislation (AB 1467), and to address stakeholder concerns, the dental plans were required to send monthly Immediate Action Reports to DHCS that in addition to other things tracked provider office utilization. (The requirement to continue submitting this report was folded into the new contracts in 2013. The reports were previously available on the DHCS website but are no longer shown there after February 2013.) The plans report the number and percentage of provider offices whose GMC member utilization is at 4.0% or above, between 3.33% - 4.0% and below 3.33%. The plans take corrective action with the offices that fall below 4.0% (e.g., send a letter; follow up with a phone call) that could result in closing a provider's GMC member enrollments temporarily or permanently, and notifying DHCS of the number of these actions. Monitoring provider office utilization has particular significance in the managed care environment when providers are receiving monthly capitation payments for patients they may or may not see. Because 2 of the plans are now paying their providers on a FFS basis, with incentives for the youngest children, encounter data can be used to monitor whether the network providers are actually seeing GMC children assigned to them.

Hospital and Surgery Center-Based Dental Procedures

Not all treatment of early childhood caries can be accomplished without sedation. The American Academy of Pediatric Dentistry (AAPD) recognizes that non-pharmacological behavior guidance techniques are not viable for some pediatric dental patients.[82] According to the AAPD, some children with special health care needs have treatment conditions, acute situational anxiety, uncooperative age-appropriate behavior, immature cognitive functioning, disabilities, or medical conditions that require deep sedation/general anesthesia (GA) to undergo dental procedures in a safe and humane fashion.[83] For example, among 83,973 children younger than 6 years of age who had an ambulatory surgery in California in 2005, dental caries was the second most frequent diagnosis (12%). The surgery center utilization rate for early childhood caries in this group was highest among 3 year-olds, American Indians and Hispanics; Medi-Cal was the most frequent expected payer.[84] Parental acceptance of dental treatment with hospital- and surgery center-based GA has increased, and dentistry under GA has become a more commonplace occurrence.[85]

In the Medi-Cal dental program, pre-approval from the child's *medical* managed care plan is required for dental treatment under GA. This is because the medical portion pays for the facility fee and anesthesia fee and the dental portion pays for the dental procedure which includes the dentist's professional fee. The three plans authorize and pay dentists for hospital/facility-based encounters. Authorization for the hospital and associated charges is provided directly by the health plan. Despite existing law (AB 2003) that provides for GA for dental procedures rendered in

[82] Silverman J, Reggiardo P, Scott Litch CS. An Essential Health Benefit: General Anesthesia for Treatment of Early Childhood Caries. Technical Report 2-2012. Pediatric Oral Health Research and Policy Center. May 2012..

[83] American Academy of Pediatric Dentistry. Guideline on behavior guidance for the pediatric dental patient*. Pediatr Dent 2008;30(suppl):125-33.* American Academy of Pediatric Dentistry. Guideline on use of anesthesia personnel in the administration of office-based deep sedation/general anesthesia to the pediatric dental patient. Adopted 2001, Revised,2005, 2007, 2009.

[84] Yu Zhiwei etl al. Ambulatory Surgery for Early Childhood Caries in California, 2005. California Department of Public Health. Sacramento, CA. Presentation at 15th Annual Maternal and Child Health Epidemiology Conference, December 2008.

[85] Eaton JJ, McTigue DJ, Fields HW, Beck M. Attitudes of contemporary parents toward behavior management techniques used in pediatric dentistry. *Pediatr Dent,* 2005;27:107-113. See also Thikkurissy S, Smiley M, Cassamassimo PS. Concordance and contrast between community-based physicians' and dentist anesthesiologists' history and physicals in outpatient pediatric dental surgery. *Anesth Progress,* 2008 Summer;55(2):35-39.

a hospital or surgery center setting,[86] in Sacramento County, medical groups associated with some of the Medi-Cal managed care health plans have denied the validity of GA referrals for dental treatment. Compounding the problem, low Medi-Cal facility reimbursement rates have increasingly limited the number of hospitals and surgery centers willing to accommodate dental cases as operating room (OR) time competes for more financially equitable cases.[87] For at least the last 2 years—and continuing at the time of this writing—these two situations culminated in a significant access problem for Sacramento County children in GMC needing GA services.

Understanding the extent of the access problem is limited by the fact that there is no system in place in the Beneficiary Dental Exception (BDE) process specific to general anesthesia-related calls. The dental plans estimate they are aware of about 1-2 children a month who need to be referred for dental treatment requiring GA; this equates to at least 54 cases a year. Plans admit they do not always know of all cases, largely because it is the *referring dentist*—not the dental managed care plan—that has to make the necessary arrangements with the health plans and hospitals. The situation becomes complex if the facility where the dentist has privileges isn't where the health plan contracts or, unless the dentist obtains temporary privileges, the dentist goes to where he/she has privileges, which may not be a contracted facility and the health plan agrees and pays the hospital the Medi-Cal rate. (See Attachment 4, a flow chart of the hospital-based dentistry authorization process.)[88] Historically, the network dentists have had to try to handle this process on their own with essentially no intervention by the dental plans despite the plans' obligation to ensure members receive needed dental care. Where the patient has FFS, there is no dental plan to assist.

After multiple futile attempts to facilitate better access to GA dental procedures and smooth the health care plan authorization process, the Medi-Cal Dental Advisory Committee requested that DHCS establish guidelines and a streamlined approval process between medical and dental managed care plans. In response, DHCS issued an All Plan Letter (APL) describing the requirements for Medi-Cal managed care health plans to cover intravenous sedation and GA services provided for dental services in hospitals, ambulatory medical surgical settings, or dental offices.[89] Although DHCS interprets the APL as providing *guidelines* for what should be *considered*, medical plans have cited the new *policy* in denying care. Unfortunately, the APL has not helped to solve the problem.

Although they have no authority to mandate health plan authorizations, the dental plans have now agreed to take the lead on the approvals process for GA services. While DHCS and the dental plans facilitate the approvals on a case-by-case basis when circumstances have been brought to their attention, there is no formal policy at this time between medical and dental plans in Sacramento County to permanently solve the access problem. The issue is ongoing.

What is the Impact of Emergency Department Use for Avoidable Dental Care?

The use of the emergency department (ED) for dental problems serves as a marker for disparities in the quality of and access to adequate dental care as well as health literacy. Many Medi-Cal and other low-income families rely on EDs for their medical needs due to lack of access to primary care

[86] AB 2003, Chapter 790. Health and Safety Code Section 1367.71, and Insurance Code Section 10119.9 covers "GA and associated facility charges for dental procedures for managed health plan enrollees under 7 years of age, or who are developmentally disabled at any age, or for whom GA is medically necessary, if rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require GA to be rendered in a hospital or surgery center setting."

[87] Not only are dental cases in general low priority for hospital ORs and surgery centers but the problem worsened with increased demand when adult Medi-Cal dental cases began to compete for OR time after the restoration of adult benefits in May 2014.

[88] DHCS noted many inaccuracies with this flow chart and stated revisions from the Department were not used. Communication with DHCS staff December 2015.

[89] Department of Health Care Services, Medi-Cal Dental Division. All Plan Letter 15-012 (*Revised), August 21, 2015.*

resources, education and awareness.[90] Children enrolled in Medi-Cal have a consistently higher rate of visiting an ED one or more times in the past year than children covered by employer-sponsored insurance (ESI), according to a recent study. [91] Nearly one-quarter of Medi-Cal enrollees (24%) had been to an ED, compared to 13% of children with ESI in 2013. Visiting an ED for non-traumatic *dental* problems, which have risen over the past decade,[92,93] is likely a reflection of poor prevention and suggests lack of access to readily-available community dental services. Without adequate access to preventive ongoing 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.

As currently structured in GMC dental, there is an opportunity to cost shift[94] 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 (if the anesthesiologist is an MD), recovery room fee, and associated medical expenses. If the anesthesiologist is a dentist, the dental plans pay the dentist anesthesiologist. The dental plan pays for the procedure codes billed by the dentist[95] if a dentist sees the child (this would most likely be an oral surgeon as few general or pediatric dentists have hospital privileges). The billed procedure code includes 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 they get care in a hospital ED, the cost falls on the medical side. Although dental managed care dental services are not rewarded for minimizing ED use, all of the plans stressed that they are trying to promote more prevention as the best strategy for avoiding unnecessary ED dental visits. Health Net, because it provides both dental and medical care, has the greatest incentive to keep children out of the ED.

Are Hospital Emergency Departments Being Used Unnecessarily for Dental Care?

Using 2014 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.[96] We compared these data to the 2007-08 data for the same condition. The data were also 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. Some of the codes are considered to be *ambulatory care sensitive conditions* (ACS), i.e., those that reflect the conditions "that would likely or possibly benefit from better prevention or primary

[90] Of interest, Sacramento County has one of the highest overall uses of the ED by the Medi-Cal population for medical services. In 2013, Sacramento County ranked 52nd highest among the state's 58 counties, ahead of Fresno and Los Angeles counties. See Miller K, Yegian J, Yanagihara D. Healthcare Hot Spotting: Variation in Quality and Resource Use in California. Issue Brief 19, Integrated Healthcare Association. July 2015.
[91] Medi-Cal Versus Employer-Based Coverage: Comparing Access to Care. California Healthcare Foundation. July 2015. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalAccessComparedUrban.pdf
[92] Lee HH, Lewis CW, Saltzman B, Starks H. Visiting the emergency department for dental problems: trends in utilization, 2001 to 2008. *Amer J Pub Health.* Nov 2012;102(11):e77–83.
[93] Wall T. Recent trends in dental emergency department visits in the United States:1997/1998 to 2007/2008. *J Pub Health Dent.* Summer 2012;72(3):216–220.
[94] 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.
[95] 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.
[96] Oral conditions as a secondary diagnosis were not analyzed due to very small occurrences.

care,"[97] and are therefore potentially avoidable. (See Attachment 3 for a full description of ACS oral conditions.)

In 2014, 118,164 visits[98] to Sacramento County EDs were made by children age 0-18 for all reasons. Of these ED visits, 1,400 (1.18%) were due to a primary oral condition diagnosis; the majority (95.4%) were made for an *ACS* dental condition (Table 11 on the next page).[99] In our 2008 analysis, 67% of the ED visits for oral reasons had been made for an ACS condition. The higher proportion of ACS dental visits in 2014 raises questions and is inconsistent with the improvement in access to preventive dental care in Sacramento County between the 2 study periods.

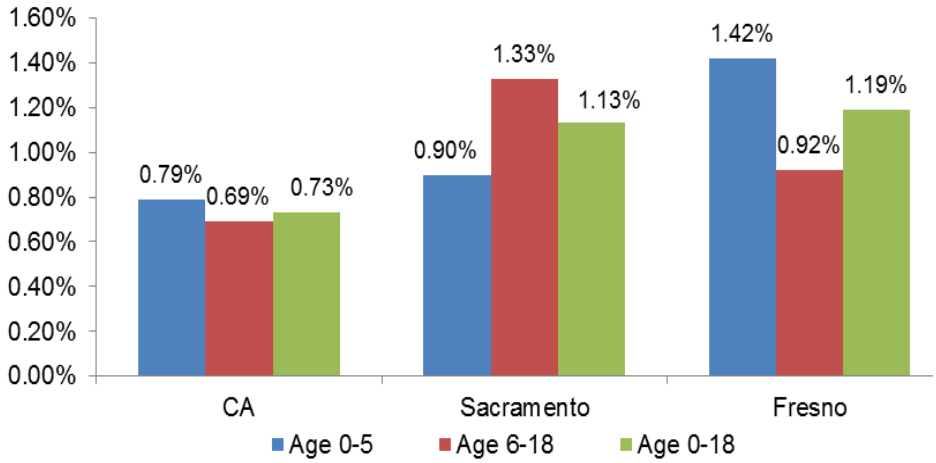
Table 11. ED Visits Made by Sacramento County Children, Age 0-18, 2014

	Age 0-5		Age 6-18		Age 0-18	
	n	%	n	%	n	%
All Reasons	55,412		62,752		118,164	
All Oral	522	0.94%	878	1.40%	1,400	1.18%
ACS Oral[1]	498	0.90%	837	1.33%	1,335	1.13%
ACS Oral as % of all Oral		95.4%		95.3%		95.4%

Source: Office of Statewide Health Planning and Development, Healthcare Information Resource Center.
[1]Ambulatory Care Sensitive Conditions. Primary ICD-9 Codes included in the analysis: 521-523, 528, and 529.

As Figure 11 below indicates, the proportions of ED ACS oral visits for children 0-18 in Sacramento County and with Fresno County (the comparison county) were somewhat similar, with both higher than the statewide average, with Fresno County slightly higher than Sacramento County. In Sacramento County, the percentage of visits was highest among 6-18 year-olds; the percentage of the youngest age group, 0-5, was similar to the statewide average.

Figure 11. ED Visits for ACS Oral Conditions[1] Made by Children Age 0-18 in California, Sacramento County and Fresno County, 2014



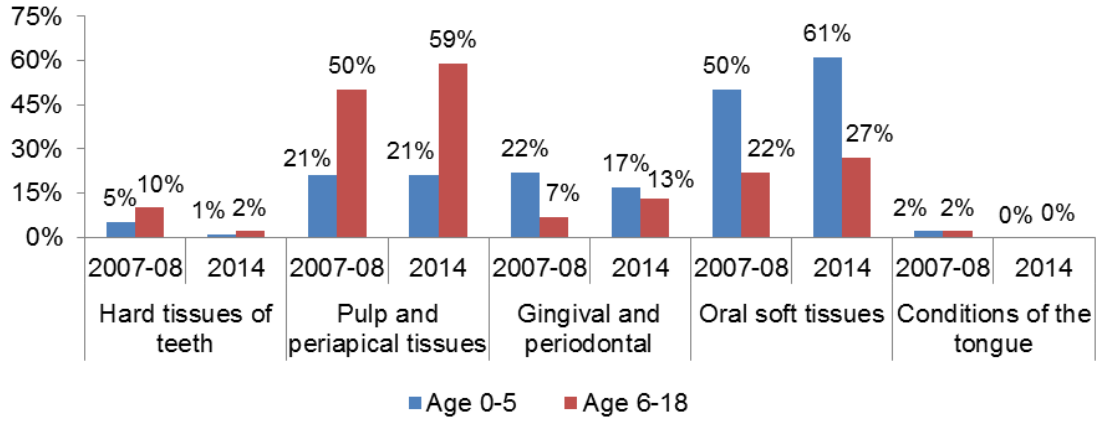
Source: Office of Statewide Health Planning and Development, Healthcare Information Resource Center.
[1]Ambulatory Care Sensitive Conditions. Primary ICD-9 Codes included in the analysis: 521-523, 528, and 529.

[97] Shortridge EF, Moore, JR. Use of Emergency Departments for Conditions Related to Poor Oral Health Care. Rural Health Research & Policy Centers, and NORC Walsh Center for Rural Health Analysis. Final Report, August 2010. Note also that there is concern dental conditions may be underrepresented because of hospital tracking data methodology.
[98] The number of unduplicated children making an ED visit for a preventable dental condition was not analyzed due to data insufficiency. According to the Office of Statewide Planning and Development, 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.
[99] This is a lower rate of ED use for ACS dental conditions than the national average. Nationally, more than 2% of all emergency department visits are now related to non-traumatic dental conditions, according to recent research. https://med.stanford.edu/news/all-news/2015/08/medicaid-dental-coverage-may-not-prevent-tooth-related-er-visits.html

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 in both 2007-08 and 2014 (Figure 12). Ongoing care at a dental home, and with preventive dental care could potentially have prevented the need for many of these ED visits.

Figure 12. ED Visits by Type of ACS Oral Conditions[1], Made by Sacramento County Children Age 0-18, 2007-08 and 2014



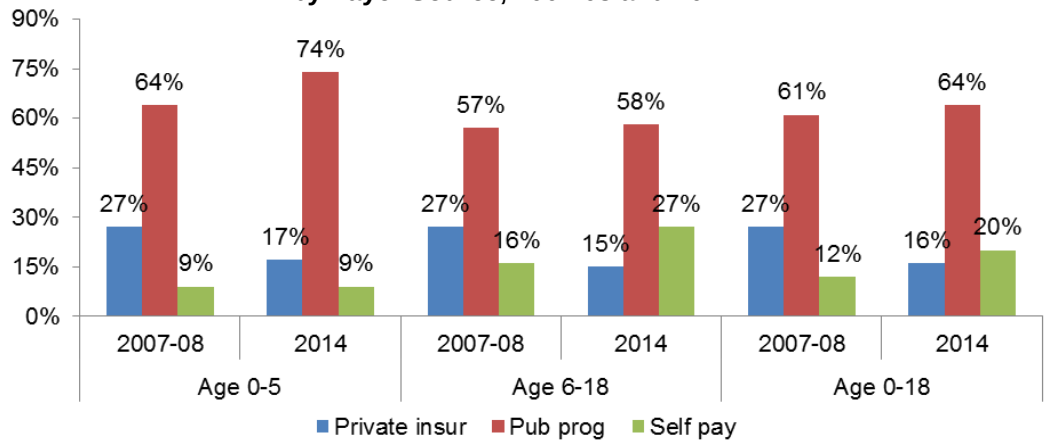
Source: Office of Statewide Health Planning and Development, Healthcare Information Resource Center.
[1]Ambulatory Care Sensitive Conditions. Primary ICD-9 Codes included in the analysis: 521-523, 528, and 529. Dental conditions may be underrepresented because of hospital tracking data methodology.

What Sources Paid for ED Visits?

Public programs picked up the tab for the clear majority (64%) of the ED dental visits considered preventable in 2014—a higher percentage than the 61% in 2007-08—made by Sacramento County children (Figure 13). This payer source is nearly entirely (99.7%) represented by Medi-Cal. An even higher proportion (74%) 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 education and prevention activities for families and caregivers and earlier intervention by Denti-Cal providers for children enrolled in GMC at the time of the ED visit.[100]

[100] 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, April 2015.

Figure 13. ED Visits for ACS Oral Conditions[1] Made by Sacramento County Children Age 0-18, by Payer Source, 2007-08 and 2014



Source: Office of Statewide Health Planning and Development, Healthcare Information Resource Center.
[1]Ambulatory Care Sensitive Conditions. Primary ICD-9 Codes included in the analysis: 521-523, 528, and 529.

The number and types of ACS oral conditions that took Sacramento County children to an ED in 2014 are broken out by payer source as displayed in Table 12 below. (See Attachment 3 for a reader-friendly description of these oral conditions.)

Table 12. Number of ED Visits Made by Sacramento County Children Age 0-18, by ACS Dental Conditions[1] and Payer Source, 2014

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	10	35	8	53	5	6	25	36	15	41	33	89
Diseases of pulp and periapical tissues	1	2	0	3	1	1	2	4	2	3	2	7
Gingival and periodontal diseases	8	41	7	56	30	111	10	151	38	152	17	207
Diseases of the oral soft tissues, excluding lesions specific for gingiva and tongue	5	40	0	45	7	23	3	33	12	63	3	78
Diseases and other conditions of the tongue	0	0	1	1	3	21	3	27	3	21	4	28
Total Number and Percent for age group	66 (17%)	286 (74%)	36 (9%)	388 (100%)	96 (15%)	371 (58%)	172 (27%)	639 (100%)	162 (16%)	657 (64%)	208 (20%)	1027 (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 county of residence. The 3 payer categories represent close to 80% of payers; the remainder comprises the "Other" category for this reporting item. Medi-Cal represents 99.7% of the "Public Program" payer category. Percentages are rounded.
Source: Office of Statewide Health Planning and Development, Healthcare Information Resource Center.

Table 13 shows the numbers of children in GMC and Sacramento FFS who visited a Sacramento ED for an ACS dental condition that Medi-Cal paid. Of the 3 dental plans, Health Net members age 0-18 as well as age 0-5 used the ED for a dental reason disproportionately less often than members of Access and LIBERTY. Medi-Cal paid for a higher proportion of the ACS dental ED visits by children in FFS compared to children in each of the 3 GMC plans, which suggests more access to preventive services in the dental managed care system than in FFS in Sacramento.

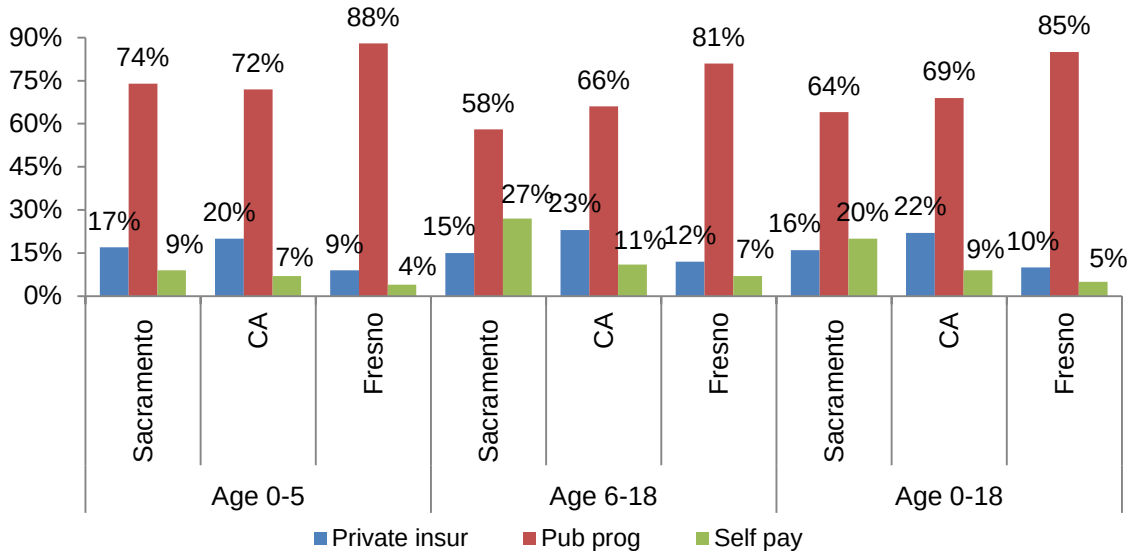
Table 13. Children's Rate of Use of a Sacramento ED [1] for an ACS Dental Condition Paid for by Medi-Cal in 2014

	Access Members		Health Net Members		LIBERTY Members		Sacramento FFS Beneficiaries	
	ED Users	ED Use Rate	ED Users	ED Use Rate	ED Users	ED Use Rate	ED Users	ED Use Rate
Age 0-5	83	.62	38	.36	105	.70	89	2.42
Age 0-18	161	.34	86	.23	247	.43	182	1.3

[1]Service location county. Children could have come from another county.
Source for ED Users: California Department of Health Care Services, Med-Cal Dental Division. Calculation of rates by study authors.

The number of ED *visits* per ED member user age 0-18 in GMC generally did not differ among plans: the ratios were 1.22 for Access and LIBERTY and 1.27 for Health Net. The ratio for Sacramento FFS was slightly higher at 1.57 visits per user. If visits to an ED for preventable dental conditions by children covered with Medi-Cal represent a failure of adequate access to preventive services, children Sacramento County GMC generally fare no worse than children in FFS across the state, and better than FFS in Fresno County (Figure 14). Sacramento County has a higher proportion of self-pay (which implies lack of insurance) than either Fresno County or statewide.

Figure 14. ED Visits for ACS Oral Conditions[1] Made by Children Age 0-18 in Sacramento County, Fresno County and California, by Payer



Source: Office of Statewide Health Planning and Development, Healthcare Information Resource Center.
[1]Ambulatory Care Sensitive Conditions. Primary ICD-9 Codes included in the analysis: 521-523, 528, and 529.

What was the Cost to Medi-Cal for ED Dental Visits?

Although it represents a relatively small proportion of overall hospital costs, DHCS reported that in 2014 Medi-Cal paid $1,394,693 for all costs (facility, pharmacy, lab, etc.) for Sacramento ED visits and in-patient hospital admissions for children age 0-18 for the ACS oral conditions (Table 14). The average payment for inpatient hospital costs was $17,580 per case. The average payment for ED visit costs was $36.56 per case.[101] Given that all but about 9.7% of Sacramento children with Medi-Cal are in GMC (discussed later in the Utilization section), it is probable that the majority of these costs were for GMC plan members.

Table 14. Amount DHCS Reported Medi-Cal Paid for Sacramento County ED and Hospital Users Age 0-18 with an ACS Dental Primary Diagnosis, 2014

	Age 0-5		Age 6-18		Age 0-18 Total	
Point of Service	n[1]	M-C Paid	n	M-C Paid	n	M-C Paid
ED Visit	298	$6,398	343	$17,039	641	$23,436
Inpatient Hospt	22	$72,548	56	$1,298,709	78	$1,371,257
Total	320	$78,946	399	$1,315,748	719	$1,394,693

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

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

Kaiser Child Health Plan

Kaiser Permanente (KP) provides medical, dental and vision coverage for children that are not eligible for other publicly-funded programs, such as Medi-Cal. This program primarily serves undocumented resident children in families whose income does not exceed 300% of the federal poverty level (FLP). The plan mirrors the same open enrollment period as Covered California and includes a monthly premium of $0, $10 or $20 per child depending on family income. As of April 2015, 6,093 children in Sacramento County ages 0-18 were enrolled in the KP Child Health Plan.[102]

Covered California

Pediatric dental care is one of the 10 essential health benefits included in the Patient Protection and Affordable Care Act (ACA). Covered California (California's implementation of the ACA) offers dental coverage to children from 0–19 years of age. In 2015, pediatric dental coverage became imbedded in the Covered California medical plan contracts. Health plans contract directly with dental plans to deliver pediatric dental care. In Sacramento County, the following medical plans provide imbedded pediatric dental coverage:

[101] When we questioned how Medi-Cal could pay only $36.56, on average, for an ED dental visit, DHCS confirmed the accuracy of their figures for *all* children with Medi-Cal in Sacramento County.
[102] Personal communication with Manager, Program Management Team, Charitable Health Coverage Operations, November 10, 2015.

Table 15. Covered California Plans

Health Plan	Embedded Dental Plan
Anthem Blue Cross	Anthem Blue Cross DHMO, DPPO[1]
Blue Shield of California	Blue Shield of California DPPO
Kaiser Permanente	Delta Dental of California DHMO
Western Health Advantage	Access Dental DHMO

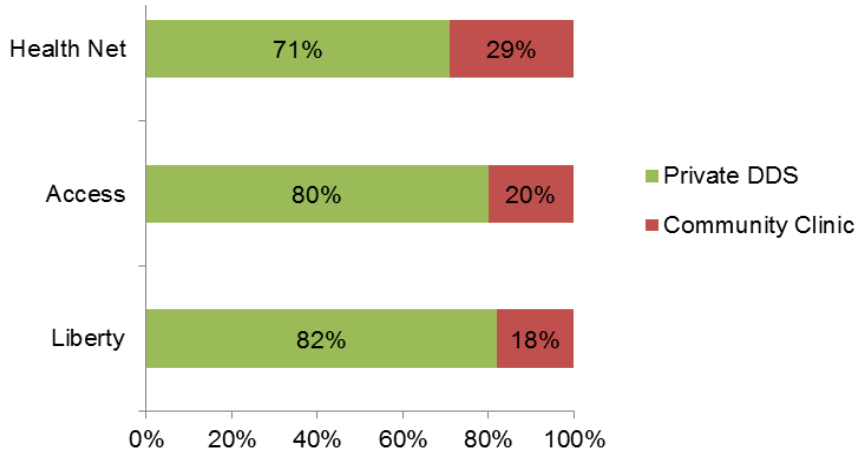
[1]Dental health maintenance organization and Dental Preferred provider organization.

Families with incomes greater than 266% and up to 400% of FPL are eligible for Covered California insurance plans, with varying premium subsidy depending on income. Due to the program's income levels, coverage under Covered California plans, while an option, does not represent a significant percentage of Sacramento's low-income children.

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

In addition to the private dentists who participate in GMC, a number of non-profit community dental clinics provide safety net services for Sacramento's low-income children. (Table 16, which begins on the next page, lists these resources.) The 3 Federally Qualified Health Center/FQHC Look-a-Like organizations are contracted by all 3 of the GMC dental plans. Approximately 29% of the GMC children enrolled in Health Net receive their care from a community clinic; an average of 19% of Access and LIBERTY members do as well (Figure 15).

Figure 15. Type of Plan Network Provider Where Sacramento Children in GMC Receive Dental Services



Source: GMC dental plans, June 2015.

Table 16. Children's Safety Net Dental Resources in Sacramento*

Organization/ Website	Address	Hours	Dental Services	Payment Options
Federally Qualified Health Centers (FQHC)[1]				
Sacramento Native American Health Center www.snahc.org	2020 J Street Sacramento	Mon-Fri 8 am - 6 pm Saturdays 8 am – 6 pm	Patient education, prevention and general dental including exams, x-rays, emergencies, fillings, extractions, cleanings, sealants, and fluoride.	Medi-Cal, GMC, some private PPO insurance, sliding scale
WellSpace www.wellspacehealth.org	Oak Park Community Health Center 3415 Martin Luther King Jr. Blvd. Sacramento North Highlands Multi-Service Center 6015 Watt Avenue, North Highlands Rancho Cordova Health center: 10423 Old Placerville Road Sacramento South Valley Community Health Center 8233 E. Stockton Blvd, Sacramento New in 2016: Galt	Mon-Sat. 9 am - 5 pm Hours/days vary by location. Some evening hours may also be available depending on location.	Patient education, prevention and general dental including exams, x-rays, emergencies, fillings, extractions, cleanings, sealants, and fluoride varnish; nitrous oxide sedation	Medi-Cal FFS and GMC; Uninsured; no CMISP (County Medically Indigent Services Program) or private insurance
FQHC Look-A-Like				
Health and Life Organization, Inc. dba Sacramento Community Clinics http://www.halocares.org	Southgate Dental Clinic (S. Sac) Assembly Court Dental Clinic (S. Sac) Del Paso Blvd. Dental Clinic Explorer Dental Clinic (Rancho Cordova)	Mon-Fri 8 am – 5 pm Saturdays 1 x month in some clinics	Patient education, exams, cleanings, fillings, fluoride varnish, extractions, crowns, root extractions (no IV sedation)	Contract with all 3 GMC dental plans, sliding fee schedule, private insurance (Delta PPO and Met Life only)

Table continues on next page

Organization/ Website	Address	Hours	Dental Services	Payment Options
Other Dental Clinics in Sacramento County				
University of California , Davis Medical Center Department of Otolaryngology	2315 Stockton Blvd, Sacramento	1 DDS only on staff Clinic days are Tues, Wed, Fri. OR/hospt consult day is Thurs	Must be referred by a UCD *physician*; full scope, including GA (~3-4 child GA cases/week); many but not all GA cases are for special needs or kids with certain health conditions (e.g., heart); some GA are parent-driven requests. Have to cap appts because can't accommodate demand; non-urgent appts are booked out 2 mos.	Private insurance and Medi-Cal* *Requires UCD to apply to DHCS for temporary opt-out of GMC; some-times denied with no reason given; parent required to f/u
Sacramento City College Dental Hygiene Clinic www.scc.losrios.edu/ dentclinic.html	3835 Freeport Ave Rodda Hall Sacramento	Hours vary by school semester. Call the clinic for current hours. Most children's services are offered in February.	Screenings, prophylaxis, x-rays, and sealants.	No private insurance or Medi-Cal; call clinic for current fee schedule.
Carrington College Dental Clinic www.carrington.edu/California	8909 Folsom Blvd Sacramento	Tues, Wed & Thursday: 8 am and 1 pm; Friday: 8 am Appointment required	Dental hygiene services including prophylaxis, fluoride treatment, x-rays, and sealants Preference is to start seeing children at age 4 and above	Free

* Does not address clinic capacity or wait times for required treatment. Information current as of October 31, 2015.

[1] Cares Community Health, an FQHC that offers dental services, was not included in this chart at the request of the agency due to concerns about its present inability to accommodate additional dental patients. The agency noted it hopes to be included in future GMC dental study updates.

THE BENEFICIARY DENTAL EXCEPTION (BDE) PROCESS

Legislation signed into law in 2012 created a process for Sacramento County children with GMC who have tried unsuccessfully to get dental treatment to be able to leave managed care and switch to the fee-for-service Medi-Cal dental program. The opt-out process is called the Beneficiary Dental Exception (BDE). AB 1467 provides that if a child is unable to access dental services within certain timeframes—which depend on the kind of appointment the child needs—his or her parents can contact DHCS by mail, phone or fax. Within 5 days of making contact with the family, DHCS attempts to set up an appointment for the child. If the Department cannot set up an appointment within a reasonable time—determined on a case-by-case basis—the child can move into the FFS system where they will remain unless they choose to opt back into a dental managed care arrangement. [103]

Although the BDE telephone number is disseminated to Sacramento GMC members via an annual mailer, it is a *general statewide call-in number,* not just for Sacramento County as intended. The BDE phone line is for *any* type of dental-related problem, and many of the calls are not specific to the BDE purpose. A random sample of monthly BDE reports shows the average proportion of BDE-related requests from phone calls, emails, faxes and regular mail to be 11.8% of the total contacts, although these data are for children *and* adults (the data are not available by age group).[104] As of the end of July 2015, there have been 573 BDE-related requests for children.[105] None of them has resulted in a transfer over to FFS (Table 17).

Table 17. Transfers to Fee for Service from Dental Managed Care, Sacramento County

GMC Dental Plans			Total
Access	Health Net	LIBERTY	
0	0	0	0

From September 2012 through July 2015.
Source: DHCS, Medi-Cal Dental Division, BDE data.

Advocates say despite the original intent of the legislation, which was to allow a genuine opt-out option from managed care, DHCS has interpreted the law as providing a means for making managed care work better, with DHCS having to serve as a back-up for the GMC plans' Member Services. It is only *after* a beneficiary has experienced an access problem or dissatisfaction that this process is essentially functioning. In only helping members access dental appointments—not trying to help them switch to FFS—some stakeholders feel the BDE intent is not being honored and how DHCS is interpreting the law is inaccurate.

In implementing the BDE process DHCS has appointed staff positions to help navigate dental appointments for members. Most of the types of BDE-related appointment visits for children have been categorized as routine (64.2%) or emergency (19.7%), and few (16.1%) as urgent or requiring a specialist (Table 18).

[103] Timeframes are based on Knox-Keene standards and are required per terms of plan contracts according to DHCS.
[104] http://www.denti-cal.ca.gov/WSI/ManagedCare.jsp?fname=bene_dental_exception
[105] *Ibid.*

Table 18. Total Children's BDE Requests, September 2012 – May 2015

BDE Category	Number and Percent of Requests
Emergency	108 (19.7%)
Urgent	48 (8.7%)
Routine	351 (64.2%)
Specialist	40 (7.3%)

Source: DHCS Medi-Cal Dental Managed Care, BDE Report.

According to DHCS data, a 31% no-show rate for appointments is typical even when the Department has helped to facilitate a referral for the child via the BDE process. Attempts are made to re-contact patients/parents to reschedule but a certain percentage (which varies month to month) do not answer or do not want to set up another appointment. Advocates believe the reasons for no-shows and disinterest in rescheduling appointments are the overbooking by dental offices—which some offices do to minimize the impact of empty chairs—long waiting times during appointments, and family dissatisfaction with interactions with dental office staff. This explanation seems to be supported by the feedback from the GMC Member Survey described on page 31.

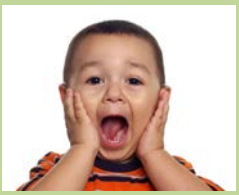
If the BDE legislation had been implemented as the advocates had expected, it would not necessarily mean these families would not have experienced access challenges, as access to care in Sacramento County is challenging in FFS as well. Regardless of the delivery system—GMC or FFS—it is clear DHCS has been needed to assist families in establishing dental homes for their children.

Flow Chart to Assist Families in Making Dental Appointments

In spring 2014, the Sacramento County Dental Health Program Coordinator, with assistance from members of the Medi-Cal Dental Advisory Committee, developed a flow chart to assist families in making an appointment with a GMC network dentist.[106] The 2-sided flow chart is written in both English and Spanish (see Attachment 5) and has been distributed to stakeholders and advocates in Sacramento County.

[106] Authored by Kate Varanelli, RDH, Dental Health Program Coordinator, County of Sacramento. How to Successfully Make a Dental Appointment with a Medi-Cal Dental Geographic Managed Care (GMC) Dentist. Spring 2014.

IV. Utilization of Services



"The increase in utilization [since the 2008 report] should be celebrated—but we've been stuck at that level for over a year and can't seem to improve." – Sacramento County dental care advocate

"We are far short of any ethical [utilization] number in Sacramento."
– Sacramento County healthcare executive

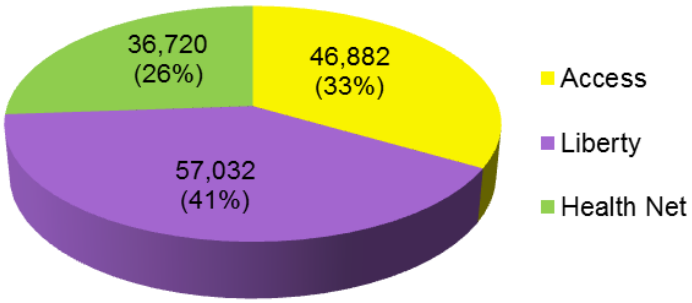
"How much do we truly want to increase utilization? Those dollars have to come from somewhere. So, in reality, how sustainable is increasing utilization?" – Key informant interview

The Centers for Medicare & Medicaid Services' (CMS) Oral Health Initiative established a goal for state Medicaid programs to achieve an increase of 10 percentage points, from FY 2011, relative to the percent of children age 1-20 who received a preventive dental service. [107] The national goal and target date is for at least 52% of enrolled children age 1-20 to receive a preventive dental service in federal fiscal year 2015.[108]

How Many and in Which GMC Plans Were Children Enrolled?

The distribution of the 140,634 Sacramento County children enrolled in GMC dental plans is shown in Figure 16. LIBERTY Dental, which picked up most of Western Dental's GMC members when Western was not awarded a contract in 2013, has the greatest proportion of GMC members at 41%, followed by Access Dental at 33% and Health Net at 26%.

Figure 16. Proportion of Enrollment by GMC Plan, Children Age 0-20, 2014



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

How Many Children Were Voluntarily Enrolled in GMC?

Most children covered by Medi-Cal in Sacramento are required to enroll in a GMC medical and dental plan. Some with certain aid codes (eligibility categories determined at the time of Medi-Cal application) cannot enroll in managed care at all, such as children with a Share of Cost. However, for children in some aid codes such as those listed below, it is voluntary. Families or caregivers of

[107] The goal pertains to children enrolled in Medicaid for at least 90 continuous days.
[108] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-10-2014.pdf

children without a mandatory aid code have the *choice* of enrolling children in a GMC plan if they prefer it over the traditional FFS system. Examples of categories of children who may be exempt from mandatory GMC enrollment in include:

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

In 2014, 13,642 (9%) of the Sacramento children were exempt from mandatory enrollment in GMC.[109] Nearly three-quarters (73%) of these children were enrolled in a GMC dental plan (Table 19) while the remainder were in the FFS system. A lower percentage (61%) of the youngest age group, 0-4, was enrolled in dental managed care, which was a reverse finding from our 2010 study. Possible explanations for a family or caregiver selecting enrollment in GMC over FFS when given a choice might be that families liked the convenience of being assigned a primary care dental provider, believing it might be easier for their child to see a pediatric dentist, or wanting all children in the family to be enrolled in the same system. Possible reasons for a parent or caregiver using the FFS system could be to choose the same Denti-Cal provider a relative or friend goes to, or in the case of foster care staying with the same provider while in temporary foster care or switching to the foster parent's provider for convenience.

Table 19. Dental System Enrollment of Children Age 0-19 with Non-Mandatory (Voluntary) Aid Codes that Allow Enrollment in GMC or FFS, 2014

Age Group	Non-Mandatory Eligible Children[1]	Number and Percent Who Were Enrolled in GMC[2]	Number and Percent in the FFS System
0-4	2,756	1,686 (61%)	1,070 (39%)
5-9	3,807	2,799 (74%)	1,008 (26%)
10-14	3,526	2,729 (77%)	797 (23%)
15-19	3,553	2,747 (77%)	806 (23%)
Total	13,642	9,961 (73%)	3,681 (27%)

[1]Number of eligibles in CY 2014 in only non-mandatory aid codes. No continuous eligibility requirement
[2]Beneficiaries enrolled in [2]GMC with non-mandatory aid codes in 2014, who remained in GMC as of December 2014.
Source: California Department of Health Care Services, Medi-Cal Dental Division.

How Does DHCS Measure and Monitor Utilization?

As described in Section III of this report (Overview of the Medi-Cal Program), DHCS added 11 Performance Measures and Benchmarks to the dental managed care contracts beginning in 2013. They were developed from the measures previously used by Healthy Families Program and national dentistry measures. The Department uses these measures to monitor plan utilization and services of members. Plans do not receive full payment when they fail to reach benchmarks and receive additional funding when they do.[110]

A benchmark is a documented previous performance level, which is different from a target. As an indicator of past performance, a benchmark is not static; it is dynamic. Benchmarks allow comparisons of previous averages to see if performance improves over time; if so, the benchmarks should be increased. A performance target, on the other hand, is the goal the program should be aiming for.

[109] DHCS Medi-Cal Dental Services Division, July 2015.
[110] Exhibit A, Attachment 6 in the GMC contracts shows which measures are contractual benchmarks; otherwise, they are not tied to withholds.

The dental managed care benchmarks are based on fee-for-service (FFS) utilization data from 2 years prior to the measurement period and are county specific. Sacramento County, due to its limited FFS enrollment, is comparable in Medi-Cal enrollment (and other characteristics) to Fresno County. Thus, FFS Fresno data are utilized for Sacramento County GMC benchmarks. (Note: we found some of the benchmarks posted on the DHCS website for 2014 to be different from benchmarks shown in a DHCS All-Plan Letter. DHCS said the posted figures were incorrect and to reference the All-Plan Letter for the correct figures.)[111] Several individuals who contributed to developing the benchmarks suggested that because they mimicked the former Healthy Families program's age groups may explain why there is no age 0-20 benchmark for most measures, only age 2-18. Healthy Families used performance measures (e.g., Annual Dental Visit, which is a national Healthcare Effectiveness Data and Information Set [HEDIS] measure)[112] but did not establish benchmarks.

Of the various utilization performance measures that dental plans must report to DHCS, the Annual Dental Visit (ADV) is the most appropriate measure for purposes of comparison with the data in our earlier GMC study. (The key difference is that ADV allows no more than a 1-month gap in eligibility whereas Overall Utilization of Dental Services Year 1, for example, requires no break.) Unless otherwise noted, we use the ADV when citing utilization rates in this report.

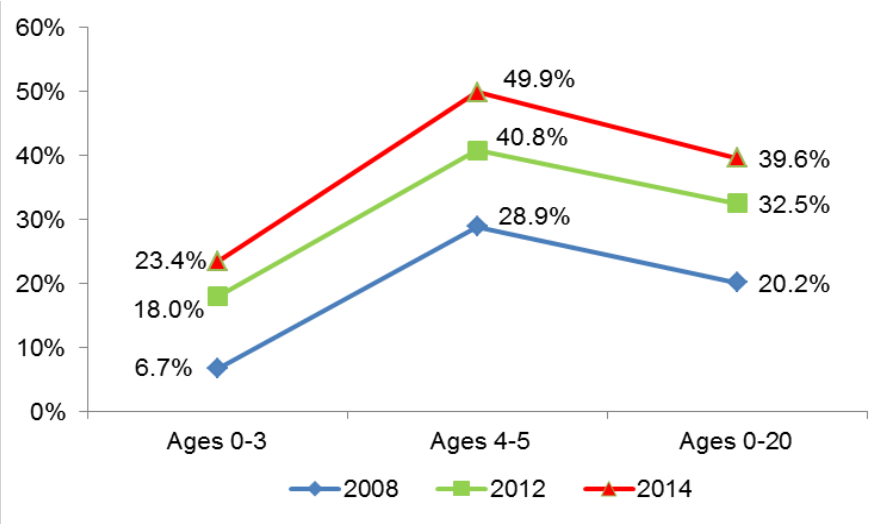
At the time of this writing, DHCS had modified the dental managed care performance measures and benchmarks, switching to a 90-day continuous enrollment as the basis and reducing the number of age categories to better align with the American Academy of Pediatric Dentistry's Periodicity Schedule and the CMS 416 report. The changes for GMC plans will become effective in CY 2016.

How Many Sacramento GMC Children are Utilizing Their Dental Benefits?

Sacramento County children's utilization of dental managed care benefits has shown a steady increase since the original GMC study. Whereas in 2008 about 20% of children age 0-20 enrolled in GMC dental plans had an annual dental visit, by 2014 the percentage had doubled to nearly 40% (Figure 17 on the next page). The 249% jump in utilization between 2008 and 2014 for the 0-3 age group is also significant despite the fact that it continues to be low as compared to other age groups.

[111] For additional information, refer to January 2015 All Plan Letter 14-010.
[112] Healthy Families Program 2012 Dental Quality Report. California Managed Risk Medical Insurance Board. December 2013. http://www.mrmib.ca.gov/mrmib/Agenda_Minutes_121813/Agenda_Item_10.c_2012_Dental_Quality_Report.pdf

Figure 17. Sacramento GMC Children's Utilization, Total GMC Plans, 2008, 2012 and 2014

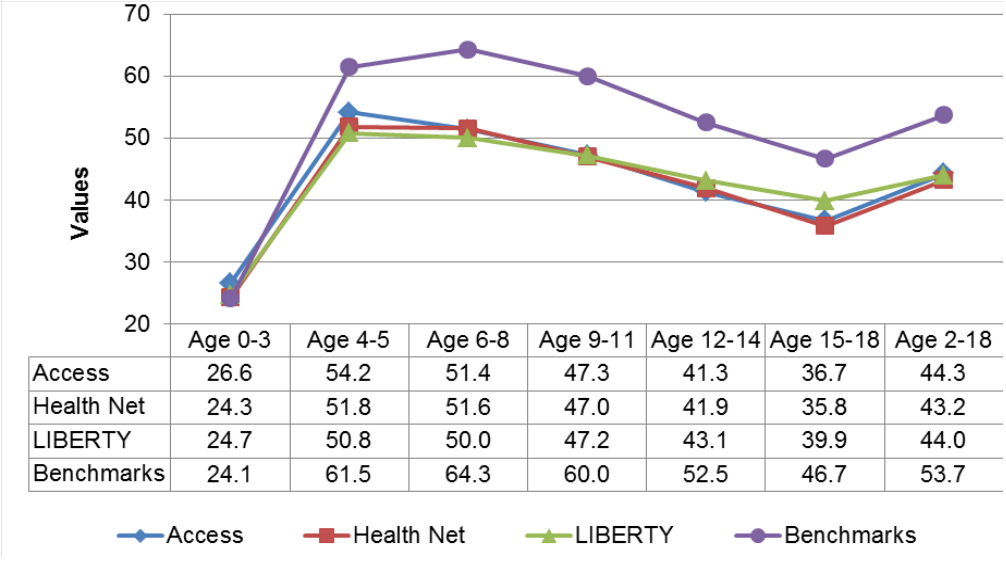


Source: California Department of Health Care Services, Med-Cal Dental Division

Sacramento GMC Utilization Relative to DHCS Performance Measures and Benchmarks

The data in this section illustrate the gaps between 2014 GMC plan performance for two utilization measures and DHCS expectations (benchmarks).[113] The first set of utilization data (Figure 18) displays the Annual Dental Visit measure. The benchmark values are provided in the last row of the data table under the graph. None of the benchmarks were met for the Annual Dental Visit (ADV) measure except for age group 0-3. For this age group, Health Net, LIBERTY Dental and, to an ever greater degree, Access Dental all *exceeded* the benchmark.

Figure 18. GMC Plan Performance (Annual Dental Visit) Compared to Benchmarks, 2014



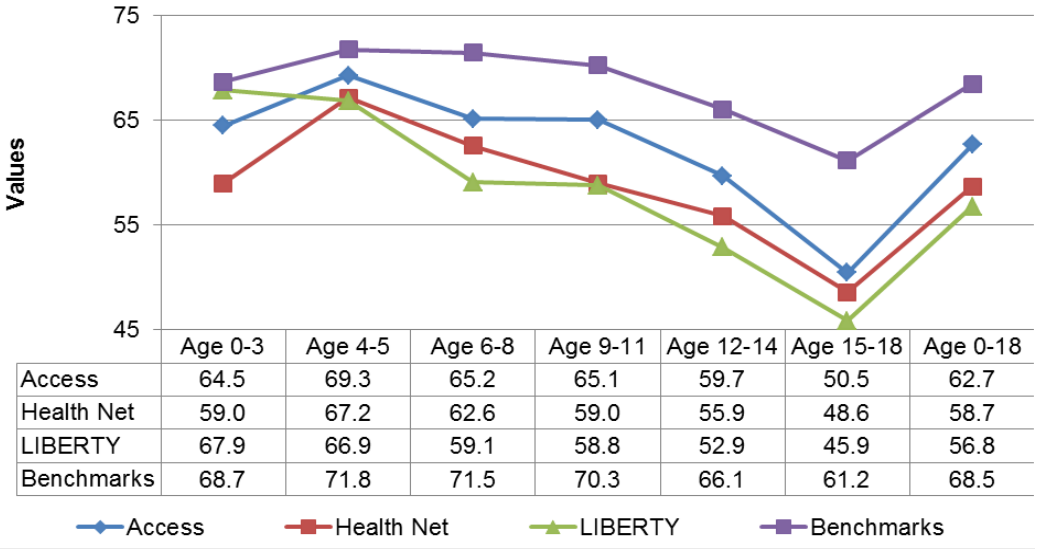
	Age 0-3	Age 4-5	Age 6-8	Age 9-11	Age 12-14	Age 15-18	Age 2-18
Access	26.6	54.2	51.4	47.3	41.3	36.7	44.3
Health Net	24.3	51.8	51.6	47.0	41.9	35.8	43.2
LIBERTY	24.7	50.8	50.0	47.2	43.1	39.9	44.0
Benchmarks	24.1	61.5	64.3	60.0	52.5	46.7	53.7

The age groups reflect those that were used in the Healthy Families program.
Source: California Department of Health Care Services, Medi-Cal Dental Division

[113] See http://www.denti-cal.ca.gov/provsrvcs/managed_care/perf_meas_GMC_rept_2014.pdf for full definitions of measures.

Figure 19 displays the utilization performance measure Continuity of Care.[114] None of the plans met the benchmarks for this measure. The measure is the percentage of children continuously enrolled for 2 years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in both the year prior to the measurement year and in the measurement year. It could be a particularly challenging benchmark to achieve for children age 0-3 who generally do not begin care until past age 1.

Figure 19. GMC Plan Performance (Continuity of Care) Compared to Benchmarks, 2014



	Age 0-3	Age 4-5	Age 6-8	Age 9-11	Age 12-14	Age 15-18	Age 0-18
Access	64.5	69.3	65.2	65.1	59.7	50.5	62.7
Health Net	59.0	67.2	62.6	59.0	55.9	48.6	58.7
LIBERTY	67.9	66.9	59.1	58.8	52.9	45.9	56.8
Benchmarks	68.7	71.8	71.5	70.3	66.1	61.2	68.5

The age groups reflect those that were used in the Healthy Families program.
Source: California Department of Health Care Services, Medi-Cal Dental Division

How does Sacramento GMC Compare in Utilization?

GMC Plans in Comparison to Each Other

Table 20 provides the number of eligibles, users, and utilization rate for the 3 GMC plans for 2014 based on Annual Dental Visit. The bar graphs that follow (Figures 20 and 21) display these data pictorially.

Table 20. Eligibles, Users and Utilization Rates, Children Enrolled in Sacramento GMC by GMC Plan, 2014

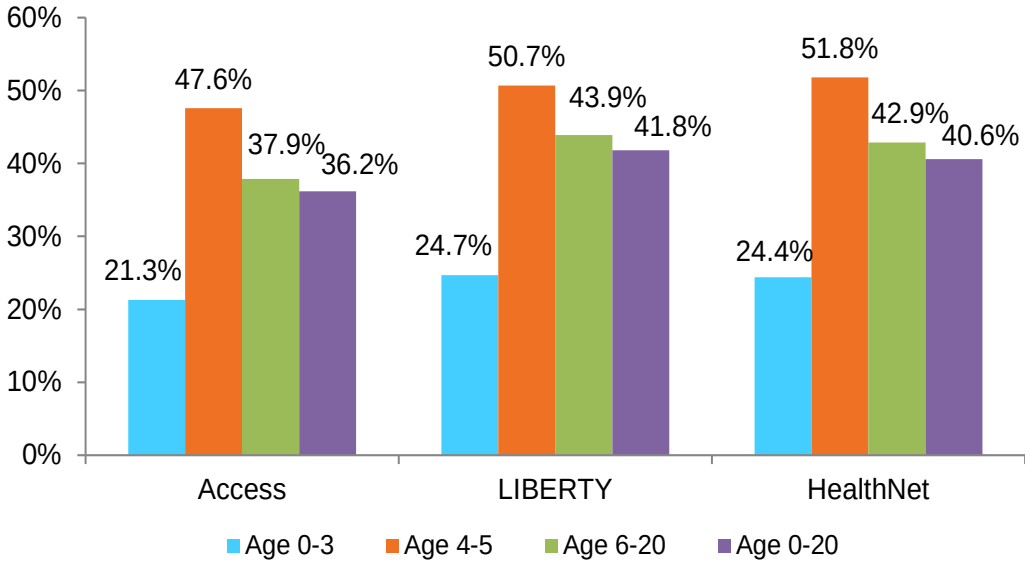
Plans	Age 0-3			Age 4-5			Age 6-20			Age 0-20		
	Users	Elig	%	Users	Elig	%	Users	Elig	%	Users	Elig	%
Access	1,724	8,079	21.3	2,687	5,647	47.6	12,556	33,156	37.9	16,967	46,882	**36.2**
LIBERTY	2,127	8,625	24.7	3,401	6,705	50.7	18,288	41,702	43.9	23,816	57,032	**41.8**
Health Net	**1,620**	**6,641**	**24.4**	**2,237**	**4,322**	**51.8**	**11,040**	**25,757**	**42.9**	**14,897**	**36,720**	**40.6**

Users = includes unduplicated beneficiaries who used any dental service or had an FQHC dental encounter.
Eligibles = the number of full-scope beneficiaries who had 11 of 12 months of eligibility in the same plan with no more than 1 month gap; data is based on a rolling 12-month period.
Source: Department of Health Care Services, Med-Cal Dental Division.

[114] An important difference between the ADV and Continuity of Care measures are the latter is number of members continuously enrolled in the same plan for the measurement period with no break in eligibility. See http://www.dental.ca.gov/provsrvcs/managed_care/perf_meas_GMC_rept_2014.pdf for full definitions of measures.

Compared to their 2008 performance, the differences in utilization rates among the dental plans is much smaller in 2014, though overall LIBERTY Dental Plan and Health Net, which have similar rates across each age group, have slightly higher rates than Access regarding children's utilization of dental services (Figure 20).

Figure 20. Utilization Rates by Sacramento GMC Plan, 2014



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

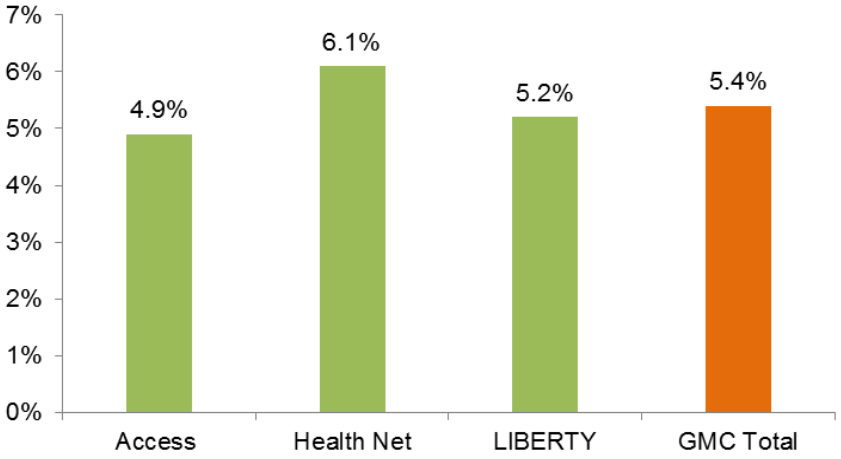
All of the GMC plans have their best utilization with the 4-5-year-old age group. In addition to the AB 1433 requirement, the relatively high utilization rate in this age group may also be attributed to the fact that many of these children are in Head Start preschools which also require a dental exam and reflect First 5 Sacramento's and other community efforts to promote oral health for young children from low-income families.

Utilization by First Tooth/First Birthday

Although 91% of the network dental offices we contacted report they will *see* children as young as age 1, only 5.4% overall of children in GMC younger than age 2 actually received a dental visit in 2014, despite dental plans' efforts in outreach and education to families of very young children (Figure 21). A somewhat comparable point of reference is the national Medicaid average for children 0-2 in which utilization was 7.5%.[115] However, it is important to note that this national age group is older because the range goes *through* age 2 (up to but not including a child's 3rd birthday), while the GMC group is *less than* age 2 (up to but not including the 2nd birthday). It is notable that Health Net has a higher utilization of the very young GMC children than the other plans. This may be because this plan includes both medical and dental services and children seen for well-child exams are more likely to be referred for dental visits in an integrated system.

[115] Use of Dental Care and Effective Preventive Services in Preventing Tooth Decay Among U.S. Children and Adolescents — Medical Expenditure Panel Survey, United States, 2003–2009 and National Health and Nutrition Examination Survey, United States, 2005–2010. *MMWR,* CDC, September 12, 2014 / 63(02);54-60. http://www.cdc.gov/mmwr/preview/mmwrhtml/su6302a9.htm#Tab1

Figure 21. Utilization (Annual Dental Visit) by Children Less than Two Years of Age, 2014

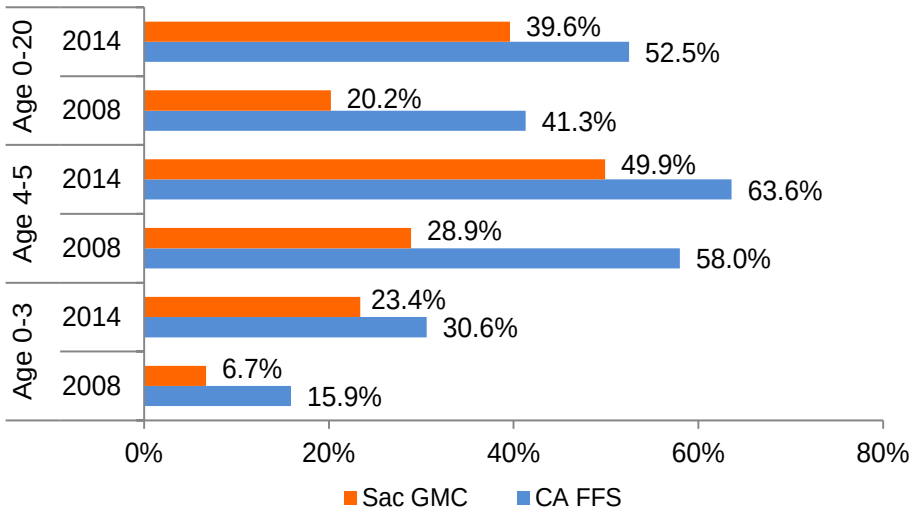


Includes unduplicated beneficiaries who used any dental service or had an FQHC encounter and any period of eligibility.
Source: California Department of Health Care Services, Med-Cal Dental Division

Sacramento GMC Utilization in Comparison to Statewide and Other Counties

Across the child age groups, utilization in Sacramento GMC in 2014 fell behind children with similar aid codes in the statewide FFS system, as depicted in Figure 22. However, the difference between the lower Sacramento and higher California utilization rates, which was very wide in 2008, was significantly narrower in 2014, reflecting the improvement that has been made in GMC utilization.

Figure 22. Dental Utilization by Children in Sacramento GMC and Comparable California FFS, by Age Group, 2008 and 2014



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

Table 21 on the next page displays children's FFS utilization on a county-by-county basis and the statewide average in 2014.

Table 21. FFS Utilization Rate by California County, in Order of Rate for Age Group, 2014

County	Age 0-3	County	Age 4-5	County	Age 6-20	County	Age 0-20
Marin	67.3	Monterey	78.3	Monterey	66.4	Marin	67.5
Monterey	48.9	Marin	78.1	Marin	65.8	Monterey	64.4
Napa	47.3	Glenn	72.2	Orange	60.9	Santa Cruz	58.6
Sonoma	46.6	Santa Cruz	70.6	Santa Barbara	60.8	Napa	58.3
San Luis Obispo	44.3	Santa Barbara	70.5	Santa Cruz	60.7	Glenn	57.8
San Francisco	44.1	Colusa	70.1	Colusa	59.9	Orange	57.5
Santa Cruz	43.5	Tehama	69.1	Los Angeles	59.8	Colusa	56.9
Glenn	42.8	Los Angeles	68.7	Napa	59.8	Santa Barbara	56.3
San Benito	39.0	Orange	68.4	Mono	59.7	Los Angeles	56.3
Lake	37.9	Mono	68.2	Santa Clara	59.4	Mono	55.7
San Diego	37.8	Kern	68.1	Madera	59.1	Sonoma	55.4
Sutter	36.9	Santa Clara	67.7	Glenn	59.0	Santa Clara	55.4
Tehama	36.8	Modoc	67.6	Ventura	57.9	San Francisco	55.1
Mono	36.5	San Diego	67.5	San Benito	57.7	Madera	55.0
Lassen	35.7	San Luis Obispo	67.2	Kern	57.3	Tehama	54.8
Orange	35.6	Sutter	66.6	Tehama	57.1	San Benito	54.8
Alameda	35.5	Ventura	66.6	Sutter	56.6	Sutter	54.4
Colusa	34.8	Madera	66.5	San Francisco	56.5	San Diego	54.3
Yuba	34.6	San Benito	66.5	San Diego	56.4	San Luis Obispo	54.2
Modoc	34.4	Napa	66.4	Tulare	56.4	Kern	53.8
Los Angeles	33.6	Lassen	65.8	Statewide	56.2	Ventura	53.6
Mendocino	33.3	Sonoma	65.7	Sonoma	55.8	Statewide	52.5
Santa Barbara	32.5	San Francisco	64.5	San Bernardino	54.9	Tulare	51.7
Madera	32.3	Statewide	63.6	San Luis Obispo	54.5	Alameda	50.6
Kern	31.8	Alameda	62.0	San Mateo	54.4	San Mateo	50.4
Santa Clara	30.8	Tulare	60.8	Fresno	53.9	Yuba	50.2
Statewide	30.6	Yolo	59.7	Riverside	53.8	San Bernardino	50.0
San Mateo	30.1	Yuba	59.7	Kings	52.9	Mendocino	49.4
Butte	29.3	Kings	59.5	Mendocino	52.5	Kings	49.1
Yolo	29.1	Del Norte	59.3	Alameda	52.4	Fresno	48.9
Ventura	28.6	Fresno	59.1	Yuba	52.0	Riverside	48.6
Del Norte	28.2	San Mateo	58.7	Inyo	50.8	Yolo	47.9
Kings	28.0	San Bernardino	58.0	Plumas	50.8	Del Norte	47.5
Tulare	27.8	Lake	57.4	Yolo	50.7	Lake	47.2
El Dorado	26.0	Riverside	57.4	Merced	50.6	Modoc	47.1
Plumas	24.7	Mendocino	57.1	Del Norte	50.4	Merced	46.0
San Bernardino	24.5	Butte	56.4	San Joaquin	49.9	Plumas	45.8
Inyo	24.1	Stanislaus	55.8	Contra Costa	48.7	Inyo	45.8
Solano	23.9	El Dorado	55.2	Lake	48.1	Butte	45.1
Fresno	23.5	Merced	54.8	Stanislaus	48.0	Lassen	45.0
Contra Costa	23.3	San Joaquin	54.7	Butte	47.2	San Joaquin	44.9
Merced	22.4	Inyo	53.5	El Dorado	47.0	Contra Costa	44.7
Riverside	21.9	Contra Costa	52.8	Modoc	46.8	El Dorado	44.4
Tuolumne	21.8	Humboldt	51.7	Mariposa	44.7	Stanislaus	44.0
Humboldt	21.6	Imperial	51.6	Lassen	44.2	Solano	41.0
Placer	21.6	Solano	51.5	Humboldt	43.9	Humboldt	40.5
Imperial	20.9	Plumas	50.9	Solano	43.6	Placer	39.1
Stanislaus	20.3	Shasta	46.8	Placer	42.6	Tuolumne	38.9
San Joaquin	18.4	Nevada	45.8	Shasta	42.5	Imperial	38.7
Shasta	18.1	Siskiyou	44.7	Tuolumne	41.7	Shasta	38.4
Amador	17.4	Calaveras	43.9	Nevada	41.0	Mariposa	38.3
Nevada	17.2	Placer	43.6	Imperial	40.7	Nevada	37.3
Calaveras	15.5	Tuolumne	41.5	Amador	39.9	Amador	36.3
Trinity	14.4	Amador	41.0	Calaveras	38.6	Calaveras	35.3
Siskiyou	13.8	Mariposa	34.9	Siskiyou	34.3	Siskiyou	31.5
Mariposa	13.5	Trinity	31.0	Trinity	31.8	Trinity	28.7
Sacramento	**11.4**	**Sacramento**	**27.5**	**Sacramento**	**30.2**	**Sacramento**	**26.4**

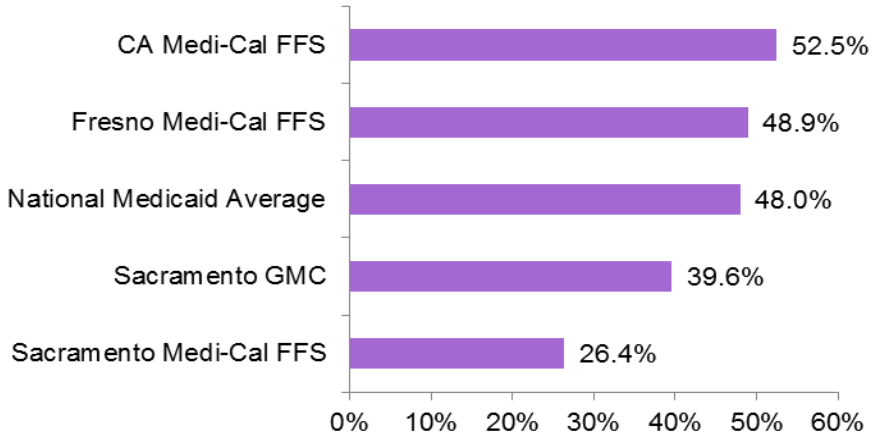
Children with Medi-Cal FFS dental coverage in the same aid codes as GMC enrollees. Alpine and Sierra Counties are missing due to suppressed data.
Source: Department of Health Care Services. Med-Cal Dental Division, data run August 8, 2015 and August 28, 2015.

It is not entirely clear why Sacramento County FFS ranks at the bottom of all counties in utilization. A probable reason is that the children in Sacramento FFS, which are a small population, are unique from children in FFS statewide. They largely include children with disabilities and children in foster care and other aid categories who may have greater access issues. Another factor that only partially satisfies the question is the influence community dental clinics have on the utilization rates in other counties. The contribution of these clinics to overall utilization rates far exceeds the contribution of private providers in many counties. While this might have been the case for Sacramento County in the past, when there were few community dental clinics, the increased number of sites in the county offering children's dental services should not be as much of an issue now for the low FFS utilization in Sacramento County.

Sacramento GMC Utilization in Comparison with State and National Averages

Utilization by children age 0-20 in Sacramento GMC in 2014 was still lower than the statewide FFS rate. GMC was also lower than both the national Medicaid average (which includes some dental managed care as well as FFS) [116] and the FFS comparison county, Fresno County, which was nearly the same as the Medicaid average (Figure 23).[117]

Figure 23. Children's Medicaid (Medi-Cal) Dental Utilization Rates, 2014



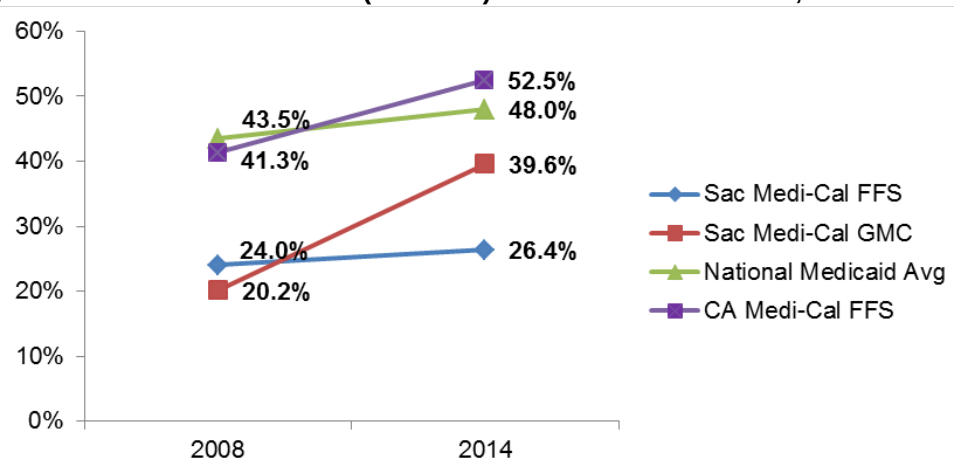
Source: California Department of Health Care Services, Medi-Cal Dental Division Medicaid/CHIP Report January 2015.

Figure 24 illustrates the extent of gain in children's increased utilization in FFS and dental managed care in Sacramento County between 2008 and 2014 compared to state and national figures. Sacramento GMC utilization grew at a slightly higher rate proportionately than the Medi-Cal dental FFS rate.

[116] Based on data reported by states on the Form CMS-41, children ages 1-20 enrolled in Medicaid and CHIP Medicaid Expansion programs (those eligible for Early and Periodic Screening, Diagnostic, and Treatment [EPSDT]), a median of 48.0% received a preventive dental service in 2013-14 and a median of 23.0% received a dental treatment service. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf Because of the method used by national Medicaid in calculating utilization, the national rate 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.

[117] It is of interest to note that dental care was 1 of 3 children's services in which Medi-Cal did not do as well as Medicaid in other states in a 2015 study that compared gaps in access and use of health services under the Medi-Cal program versus Medicaid. For children with similar health care needs and socioeconomic status, children on Medi-Cal were more likely than similar Medicaid enrollees in other states to not have had a dental visit in the prior year. Source: Medi-Cal Versus Medicaid in Other States: Comparing Access to Care. California Healthcare Foundation. July 2015. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalAccessComparedUrban.pdf

Figure 24. Children's Medicaid (Medi-Cal) Dental Utilization Rates, 2008 and 2014

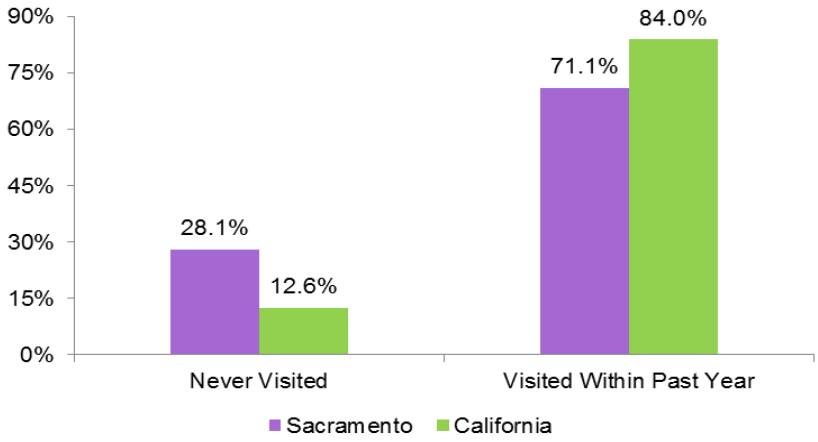


Source: California Department of Health Care Services, Medi-Cal Dental Division

Sacramento GMC Utilization in Comparison to the California Health Interview Survey

The California Health Interview Survey (CHIS) is a statewide population-based survey undertaken on a rolling basis 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 County parents of all income levels who responded to the 2013-14 CHIS survey,[118] 71.1% reported taking their child age 1-11[119] to a dentist within the past year, a lower proportion than the statewide average for this survey at 84.0% (Figure 25).[120]

Figure 25. Utilization of Dental Services by All Sacramento and California Children Age 1-11

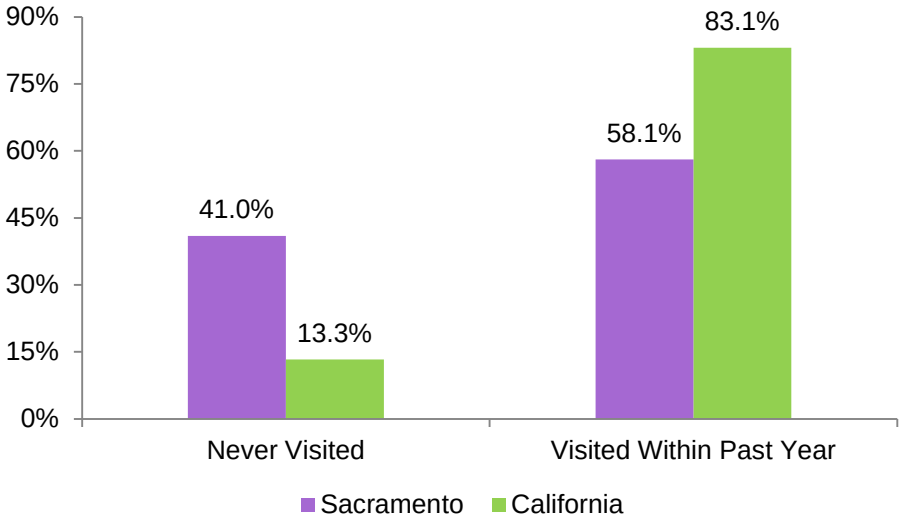


Source: California Health Interview Survey, 2014

[118] UCLA Center for Health Policy Research. http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography.
[119] For this measure, the CHIS question asks parents to include "any child up to age 11 with teeth so it is possible the age group contains some children <1."
[120] Some of the CHIS data for Sacramento children are considered "statistically unstable" due to small samples—which is true for other counties as well. It is 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.

When only children covered by Medi-Cal were examined for dental utilization in the CHIS survey, Sacramento children fared more poorly than the California average (Figure 26). Close to 60% of Sacramento children with Medi-Cal compared to about 83% children statewide at that same income level reported a dental visit with the past year. The gap between the county and the state figures was even wider for the proportion who had never made a dental visit.

Figure 26. Utilization of Dental Services by Sacramento and California Children Age 1-11, Covered by Medi-Cal



Source: California Health Interview Survey, 2014

What Do DHCS, Plans and Stakeholders Believe is a Realistic Utilization Goal?

In 2012, each state was required to develop an Oral Health Action Plan for children enrolled in Medicaid or a Children's Health Insurance Program (CHIP) with the following goals:[121]

- Increase the proportion of children who receive a preventive dental service by ten percentage points by 2015.
- Increase the proportion of children ages 6-9 who receive a dental sealant on a permanent molar tooth by 10 percentage points (target year not determined).

Beyond this federal requirement, California has not set long-term children's oral health goals for either FFS or dental managed care. We asked DHCS and the stakeholders interviewed for this study, *"What do you feel would be a reasonable goal that should be achieved for children's dental utilization in the State of California?"* Although most individuals were initially hesitant to put their finger on a specific number, when pressed they all identified a goal. Their responses ranged from "the same as the national Medicaid average" [DHCS] to "70%, or if we're talking about managed care, then 80%" [stakeholders]. The median response was close to 70%. Dental managed care plans think this goal is too unrealistic an expectation, and said collectively 50%-60% should be the target *("this would be as good as it's going to get in a 'country' like California"*).

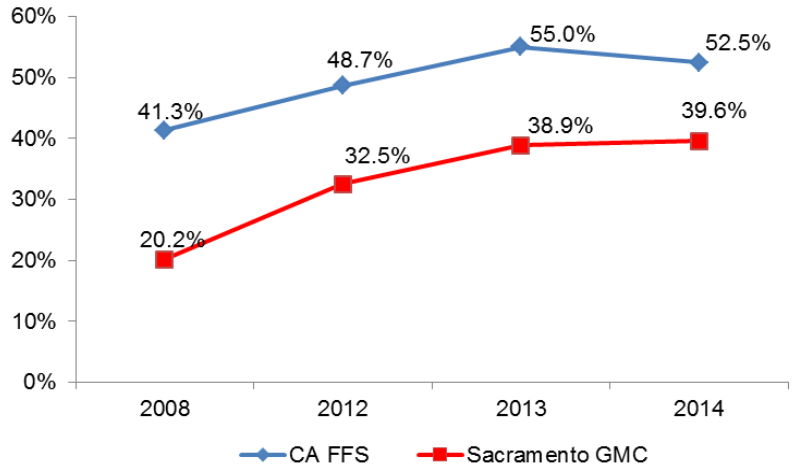
[121] http://www.medicaid.gov/chip/benefits/chip-dental-care-goals.html

Stakeholders are concerned that children's utilization in both FFS and dental managed care, which showed a steady rise since 2008 but decreased in FFS from 2013 to 2014, "has plateaued." A DHCS report to the legislature in 2015 concurred by stating "validation of claims data for contract year 2014 demonstrated the Sacramento County GMC average Annual Dental Visit (ADV) utilization percentage remained consistent in comparison to the previous contract year."[122]

The data in Figure 27 support the concerns of stakeholders. While it is too early to know if this is a temporary stall, there are possible reasons for why children's utilization has not continued to grow since 2013. The reasons include:

- Diversion of services from children to adults when adult Medi-Cal benefits were restored in May 2014 (plans report their membership used to be 75% children/25% adults but is now closer to 50% children/50% adults);
- Declining provider participation from frustration with low Medi-Cal reimbursement rates and rate cuts;
- The belief that without a mass consumer campaign and incentive strategy aimed at getting parents to recognize the value *and act on* good oral health, utilization has, according to some stakeholders, "reached close to its maximum potential."

Figure 27. Dental Utilization of Children Age 0-20 in CA Fee for Service (Denti-Cal) and GMC



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

[122] Department of Health Care Services Activities Relating to Medi-Cal Dental Managed Care Report to the Legislature April 2015. http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Dental%20Managed%20Care/Medi-Cal_Dental_Managed_Care.pdf

V. Quality of Care Issues

"Plans had to take a step back and see what it was going to take to add value to the program and not just push utilization, but do lots of outreach and improve provider satisfaction." -- GMC Plan representative

Some in GMC don't even know who their dentist is—that's why they use the ER. So, we're trying to do more outreach and education for prevention." -- GMC Plan representative

Covered dental services provided by Medi-Cal dental managed care plans to children 0-20 are the same dental services provided under the Denti-Cal fee-for-service (FFS) program and defined in Welfare and Institutions Code 14132(h), and in Title 22, California Code of Regulations, Sections 51059 and 51307.[123] California covers biannual dental screenings for children as well as covering medically necessary treatment services.[124] The biannual oral evaluation generally consists of an examination, x-rays, cleaning, a topical fluoride application, and oral hygiene instruction. Treatment services include fillings, crowns, and oral surgery.

The need to measure quality in the Medi-Cal dental program is "rooted in the basic responsibility to assure that the public receives optimal benefits from effective patient-centered dental care."[125] Measuring the quality of dental care whether provided through dental managed care plans or FFS is challenging because of limited diagnostic data collection to establish oral health benchmarks and limited availability of freely-accessible claims data that allow tracking oral health quality.

DHCS has made various efforts to improve dental managed care quality, collaborating with dental plans and stakeholders. While all of the Performance Measures and Benchmarks DHCS established for the dental managed care contracts beginning in 2013 can be considered quality of care related in the general sense, the 8 we report on below are direct quality measures, e.g., use of sealants, use of dental treatment services.

Additionally, per contract, all plans are required to conduct or participate in 2 Quality Improvement Projects (QIPs) per year approved by DHCS: a) an internal (IQIP) or a Small Group Collaborative (SGC) facilitated by a dental plan or DHCS, and b) a DHCS established and facilitated Statewide Collaborative. Examples of plan-proposed QIPs that DHCS approved effective August 2014 through July 2016 include one for Access and one shared by Health Net and LIBERTY:

Access Dental Plan	Objective: Identify variances within the enrolled population utilizing demographic information and statistics, such as ethnicity and cultural differences
Health Net **LIBERTY Dental Plan**	Objective: Increase the proportion of children age 6-9 enrolled for at least 90 days who receive a dental sealant on a permanent molar tooth by 4 percentage points over a 2-year period.

[123] http://www.denti-cal.ca.gov/WSI/ManagedCare.jsp?fname=ManagedCareOverview
[124] Coverage may continue until the last day of the month in which the child turns 21. California Code of Regulations 22 CCR § 50193.
[125] Quality Measurement in Dentistry: A Guidebook. Dental Quality Alliance (DQA). American Dental Association, 2012. p. 6.

How Did Plans Perform on Eight Quality Measures?

Below are the Performance Measure results the Sacramento GMC plans achieved compared to the benchmarks they were held to in 2014 for 8 quality-of-care measures. Table 22 shows a summary of their performance on these measures. We also examined dental plan performance data provided by DHCS for the 12 categories of procedure types used in CDT coding, with the same caveats as noted above (i.e., full scope, 11 months eligibility with no more than a 1-month gap), clarifying this request with DHCS in August 2015. The descriptions of the measures are those used by DHCS. Where it was available, we reviewed the same quality indicator data for the FFS comparative county, Fresno County. All data are from calendar year 2014.

Table 22. GMC Plans' Performance Measure and Benchmark Summary, 2014

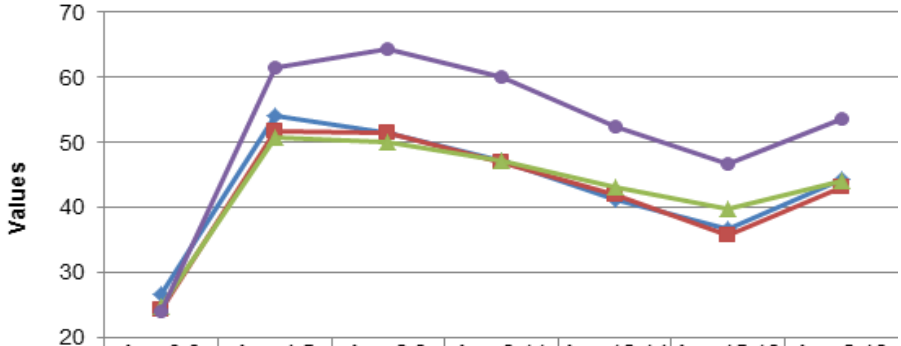
Performance Measure	Achieved by at least 1 Dental Plan	Notes
Annual Dental Visit	✓	For age 0-3 only, all 3 plans
Use of Preventive Services	✓	For age 0-3 only, all 3 plans
Use of Sealants		
Sealant to Restoration Ratio	✓	For age 10-14, Health Net only
Treatment/Prevention of Caries	✓	For age 0-3, Access only
Exams/Oral Health Evaluations	✓	For age 0-3 only, all 3 plans
Use of Dental Treatment Services		
Preventive Services to Fillings		

Based on Medi-Cal Dental Services Division performance measures for GMC plans, 2014.

Performance Measure: Annual Dental Visit

The Annual Dental Visit is the primary clinical quality measure for access. Regular visits to the dentist (beginning with the first tooth or first birthday) provide access to cleaning, early diagnosis and treatment, as well as education on how to prevent problems.[126] Although none of the GMC dental plans achieved the overall benchmark for this measure for children age 2-18, all of the plans exceeded it for the 0-3 age group (Figure 28) in 2014.

Figure 28. Percentage of Children Age 2-18 in Sacramento GMC With an Annual Dental Visit, 2014



	Age 0-3	Age 4-5	Age 6-8	Age 9-11	Age 12-14	Age 15-18	Age 2-18
Access	26.6	54.2	51.4	47.3	41.3	36.7	44.3
Health Net	24.3	51.8	51.6	47.0	41.9	35.8	43.2
LIBERTY	24.7	50.8	50.0	47.2	43.1	39.9	44.0
Benchmarks	24.1	61.5	64.3	60.0	52.5	46.7	53.7

Source: Medi-Cal Dental Services Division.

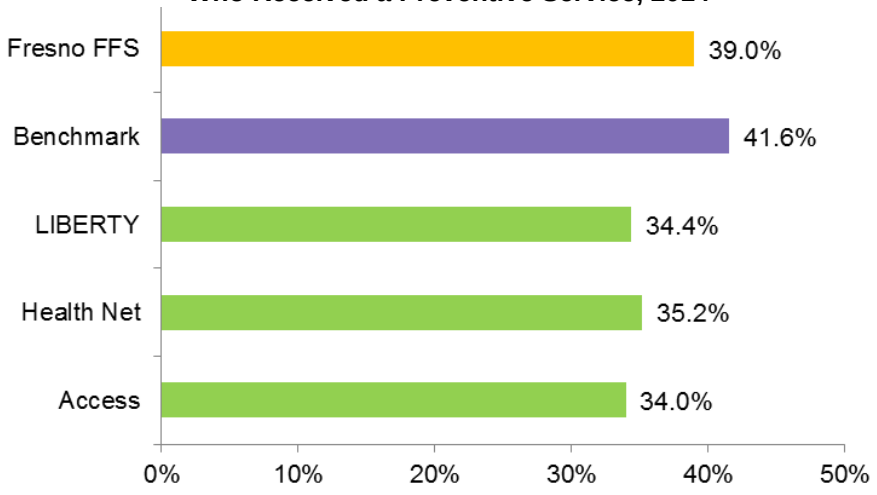
[126] National Quality Measures Clearinghouse. http://www.qualitymeasures.ahrq.gov/content.aspx?id=48682

Performance Measure: ***Use of Preventive Services***

This measure is defined as the percentage of GMC members continuously enrolled in the same plan for 11 out of 12 months with no more than a 1-month gap in eligibility who received any preventive dental service during the measurement period (2014). Prevention services play an important role in dental managed care both in terms of impact on the patient as well as cost containment. 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. Preventive dental services include teeth cleaning and topical fluoride application, and a new benefit since our earlier report—anticipatory guidance and oral health instruction. In terms of standard of care, the ideal is that within all populations, every enrolled child would receive a preventative procedure. But, as described above, the challenges in this population are continuity of care, people move, phones change, situations change, patients fall through the cracks and are lost to follow-up, coupled with little understanding by some parents of the importance of early oral health care.

All of the dental plans performed nearly the same as one another on the preventive services measure but fell short of the benchmark, which was 41.6% (Figure 29). Although also lower than the benchmark, the percentage of eligible children in Fresno FFS who received a preventive service was more favorable than Sacramento County dental managed care at 39%.

Figure 29. Percentage of Children Age 0-18 in Sacramento GMC and Fresno FFS Who Received a Preventive Service, 2014



Source: Medi-Cal Dental Services Division.

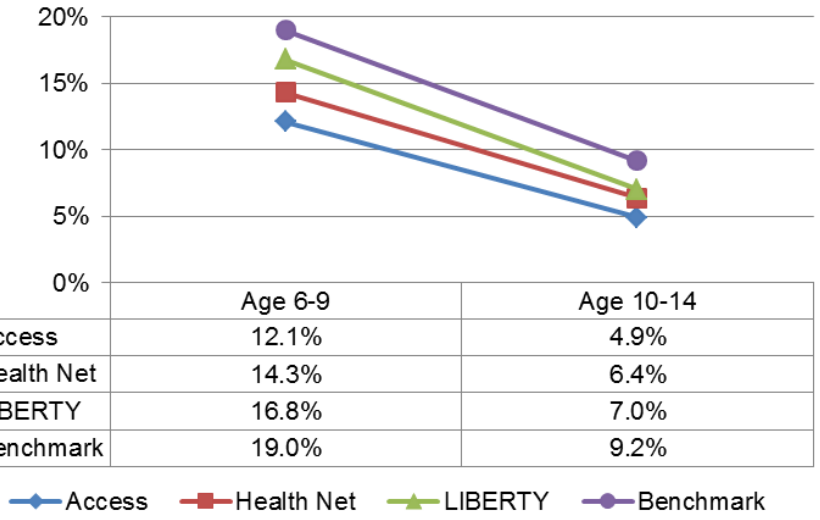
Performance Measure: ***Use of Sealants***

This is the percentage of members ages 6-9 and 10-14 continuously enrolled in the same plan during the measurement period with no more than a 1-month gap in eligibility who received a dental sealant on at least one permanent molar. Dental sealants have been proven to reduce decay rates. They are useful on both primary and permanent teeth, but are only a benefit (for both Denti-Cal and commercial insurance) on the occlusal, buccal or lingual surfaces of first and second permanent molars. These teeth erupt at ages 6-9 and 10-14 respectively. The clinical rule is that if there is no restoration or caries on any of these molars, a sealant should be placed as a preventative measure. The first permanent molar is significant in that it must remain intact and in the mixed dentition of the child to ensure proper spacing for the further erupting teeth to avoid

major malocclusion problems as the child grows. While not every child enrolled in Medi-Cal is at elevated risk for caries, many of these children are at higher risk for a high decay rate. So it is possible in some cases the number of sealants placed was hindered by decay that was already present and the child required a restoration rather than the sealant.

In the 6-9 age group, during which the first molar erupts, the GMC plans' sealant placement rate ranged from 12.1% for Access, to 14.3% for Health Net and 16.8% for LIBERTY, all falling short of the benchmark of 19.2% (Figure 30). (Note: there is no comparative data for Fresno County because sealants are not broken out of the FFS preventive services data, which include fluoride rinse, fluoride varnish, teeth cleaning, oral health instruction and sealants.)

Figure 30. Proportion of Children Age 6-9 and 10-14 in Sacramento GMC Who Received Dental Sealants, 2014



	Age 6-9	Age 10-14
Access	12.1%	4.9%
Health Net	14.3%	6.4%
LIBERTY	16.8%	7.0%
Benchmark	19.0%	9.2%

Source: Medi-Cal Dental Services Division.

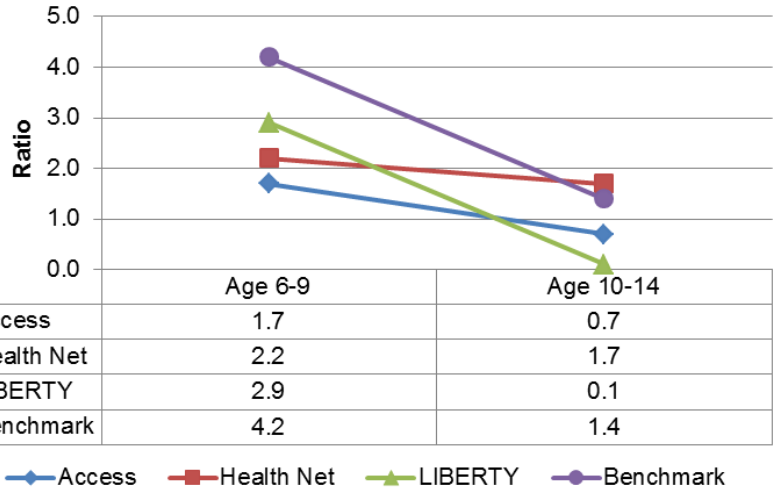
For the 10-14 age group, during which the second molar erupts, the plans' performance was 4.9% for Access, 6.4% for Health Net and 7.0% for LIBERTY, all falling short of the 9.2% benchmark. In this older cohort of children, factors such as decay, extracted molars and not being able to follow only those children who have been continuously eligible patients for 11 months limit the desired level of care. Optimally, a child would be followed from age 6-14 and the second molar would be sealed directly upon eruption.

Performance Measure: ***Sealants to Restoration Ratio (Surfaces)***

This measure is the ratio of occlusal surfaces of permanent first and second molars among members ages 6-9 and 10-14 enrolled in the same plan for 11 months receiving dental sealants to those receiving restoration. The higher the ratio, over time, indicates the greater use of sealants to reduce decay on these tooth surfaces.

In the 6-9 age group, for occlusal surfaces of first molars, Figure 31 shows LIBERTY had the best ratio of 2.9, followed by Health Net at 2.2 and Access at 1.7. With the benchmark at 4.2, the plans only scored between less than half and up to two thirds of the benchmark. While this ratio could have various interpretations, the lower scores could be indicative of "late to care" children who were only brought to treatment when they had symptom of pain or clinical signs of decay.

Figure 31. Sealant to Restoration Ratio of Children Age 6-9 and 10-14 in Sacramento GMC, 2014



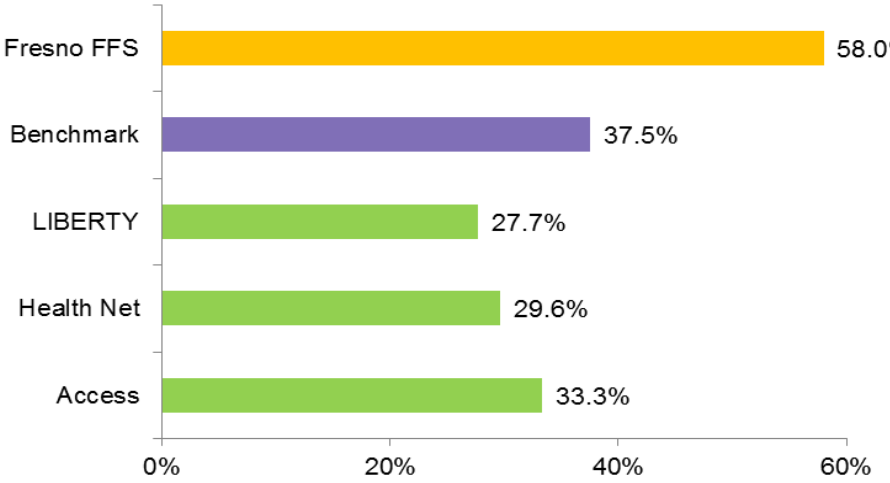
	Age 6-9	Age 10-14
Access	1.7	0.7
Health Net	2.2	1.7
LIBERTY	2.9	0.1
Benchmark	4.2	1.4

Source: Medi-Cal Dental Services Division.

Performance Measure: ***Treatment/Prevention of Caries***

This measure is the percentage of 0-18 year-olds who received *either* [author emphasis] treatment for caries *or* [author emphasis] a caries-preventive procedure. Combining caries prevention procedures and caries treatment procedures creates 3 groups to be counted in the analysis: those with a caries treatment, those with a preventative procedure and those with both. Among the plans, at 33.3% Access performed best relative to the benchmark of 37.5% (Figure 32 below). It appears Access is doing relatively better at maintaining preventative procedures as a compulsory part of its treatment planning. None of the plans reached the performance on this measure of the comparative FFS experience at 58%.

Figure 32. Proportion of Children Age 0-18 in Sacramento GMC and Fresno FFS Who Received Either Caries Treatment or a Caries Preventive Service, 2014



Source: Medi-Cal Dental Services Division.

Performance Measure: Exams/Oral Evaluations

This measure addresses the percentage of members who received a comprehensive or periodic oral health evaluation or, for members under 3 years of age, who received an oral evaluation and counseling with the primary caregiver. 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 its plan's dental services, she/he may not receive on oral examination and may only receive preventive services that may be delivered in a preschool or school-based program which are not tracked/credited to FFS or GMC performance measurements.

Children 0-3 are important in that an early oral examination is an ideal way to introduce a child to a non-traumatic dental experience. A "knee-to-knee" exam (parent and provider sitting face-to-face with knees touching, creating the surface for the child to lie on facing the parent) allows the parent to experience an educational moment, helping to reassure the child while they watch the visual exam and fluoride varnish application. As is well known in pediatrics, the best way to improve a child's health is through an informed and proactive parent. For utilization of children age 0-3, all the plans as well as Fresno FFS achieved at least double the benchmark (Table 23 on the next page), indicating the plans have become focused on seeing these youngest GMC members or the benchmark may be set too low.

In the 4-5 year-old age group, Access at 49.5% came closest to meeting the benchmark of 53.4% for oral exams and evaluations, but all of the dental plans underperformed relative to the comparable FFS level of services. For the total children 0-18, the plans did not reach the benchmark for this measure, and Fresno FFS exceeded it.

Table 23. Proportion of Children in Sacramento GMC and Fresno FFS Who Received an Oral Exam and/ or Oral Health Evaluation, 2014

	Age 0-3	Age 4-5	Age 0-18
Access Dental	24.5%	49.5%	37.9%
Health Net	22.5%	45.4%	36.4%
LIBERTY Dental	23.0%	45.8%	36.8%
Benchmark	**11.5%**	**53.4%**	**41.1%**
Fresno FFS	23.5%	59.1%	48.9%

Source: Medi-Cal Dental Services Division.

Performance Measure: Use of Dental Treatment Services

This measure is the percentage of members who received any dental treatment service during the measurement period, i.e., those who received treatment services excluding diagnostic or preventative procedures. Dental treatment services are a combination of all treatment modalities: restorative, endodontic, surgical and orthodontic. When combined, these services are suggestive of the current view of the dental disease rate of the population treated.

Although none of the dental plans met the benchmarks for any of the age groups shown in Table 24, LIBERTY came closest to meeting it for children age 0-3 as well as the total 0-18 age group, and Access was furthest from the benchmark. There was virtually no difference in performance among the plans in providing treatment services to children age 4-5. LIBERTY nearly tied the comparable FFS county for serving children age 0-3 and 0-18, and Health Net nearly tied it for children age 4-5.

Table 24. Proportion of Children in Sacramento GMC and Fresno FFS Who Received Dental Treatment Services, 2014

	Age 0-3	Age 4-5	Age 0-18
Access Dental	5.4%	25.9%	21.2%
Health Net	6.2%	26.9%	21.2%
LIBERTY Dental	6.9%	25.0%	23.0%
Benchmark	**8.1%**	**30.1%**	**25.4%**
Fresno FFS	7.0%	27.0%	23.0%

Source: Medi-Cal Dental Services Division.

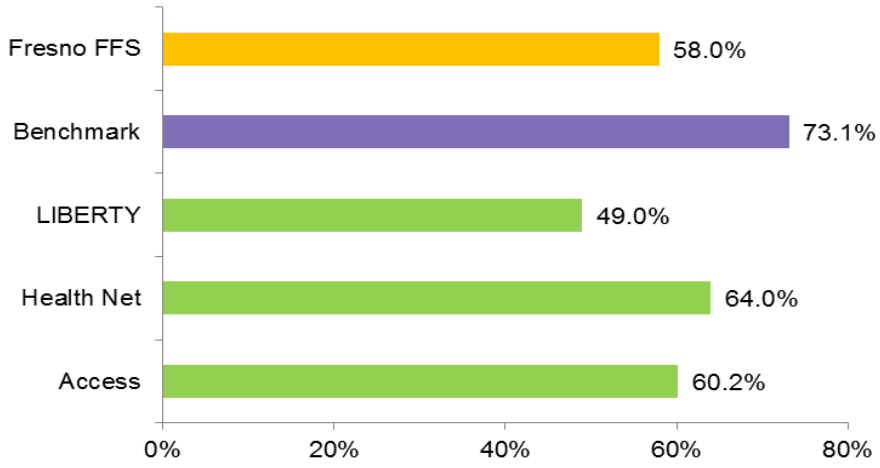
Performance Measure: Preventive Services to Fillings

This measure is defined as the percentage of members who received one or more fillings in the measurement period and who also received preventive services in the measurement period. The preventive services included a topical fluoride, a sealant application, preventative resin restoration or education to prevent caries. Treatment services include fillings, crowns, root canals, and oral surgery. Among this vulnerable population of Medi-Cal children 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 un-restorable teeth. 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 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.

Access and Health Net provided these services to children age 0-18 at 60.2% and 64.0%, respectively. Both plans performed at around 10 percentage points below the 73.1% benchmark, while LIBERTY performed at 24 percentage points below the benchmark (Figure 33).

Figure 33. Proportion of Children in Sacramento GMC and Fresno FFS Who Received Preventive Services and Fillings, 2014



Source: Medi-Cal Dental Services Division.

What Quality Assurance Methods do the GMC Plans Use?

Quality monitoring differs between the Denti-Cal FFS and GMC programs. In the FFS system, Delta Dental or DHCS responds to complaints and DHCS Audits and Investigations conducts quality audits of providers. In GMC, the dental plans 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;
- 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 dental 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 For 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 were handled, or services were denied or modified.[127]

Managed Care Problem Report Form

Medi-Cal Dental Services Division provides a Managed Care Problem Report Form (see Attachment 2) for reporting problems and other concerns, although awareness of this avenue of complaint may be limited for beneficiaries, the general public and advocates. According to DHCS, between January 2012 and December 2014, only 21 Problem Report Forms—of which 7 (33%) were for services provided to children—were submitted to DHCS related to Medi-Cal dental managed care problems. All 21 Problem Report Forms were submitted by the GMC plans through the State Hearing process.

DHCS also received 44 grievances directly from beneficiaries and/or organizations between January 2012 and December 2014. (DHCS reported it was not able to break out the number of children in these grievance data.) The nature of the complaints/grievances have principally been related to benefit coverage (for services not covered under the Medi-Cal Dental Program), appointment and referral timeframes, service quality, and inappropriate beneficiary billing.[128] When a beneficiary or organization contacts DHCS directly regarding a grievance, DHCS logs the contact in a manual tracking mechanism and works with the beneficiary to provide a warm transfer to the appropriate resource for grievance follow-up and resolution. DHCS reports it works closely with the Ombudsman's office as well as State agency partners to address beneficiary and organizational grievances.

GMC Plans' Quarterly Grievance Reports

Aside from the Problem Report Form, GMC plans are required by contract to keep a record of grievances. The Quarterly Report describes the number and type of complaints, and the average length of time and specific actions it took to resolve the grievance. DHCS reviews the quarterly deliverable to assure contract compliance. The plans' most recent (2013 and 2014) Quarterly Reports showed a total of 113 grievances recorded involving members age 0-20; 21.4% of these were for children age 0-5. The number of grievances represents an average of just 0.06% of the GMC plans' total GMC child membership—a similar proportion to our earlier study. The percentage of grievances submitted to Access Dental are slightly higher than ones to Health Net and LIBERTY, given the number of enrolled children in the Access plan.

Table 25 below shows the types of complaints filed on behalf of child members as categorized by the plans. The types of grievances tended to be characterized as "communication problems between patient and plan," "complaints about time in the dental chair" (quality of care), and "complaints about the front desk" (i.e., the customer service side of the office). Dispute about orthodontic coverage was a common reason for claim and coverage disputes. The variation of complaint types among plans is largely a reflection of how the plans categorized the complaints. For instance, an example of a "medical necessity" grievance at LIBERTY and Health Net would be that the plan denies a pre-treatment authorization for orthodontic treatment because the member does not have permanent dentition and that deciduous (baby) teeth are still present. Therefore, the member's oral condition does not qualify for the benefit based on an applicable plan limitation

[127] http://www.dhcs.ca.gov/services/Pages/Medi-CalDenti-Cal.aspx.
[128] Communication with DHCS Medi-Cal Dental Division, July 31, 2015.

and/or exclusion set forth by DHCS, which states that only cases with permanent dentition shall be considered medically necessary. An example of a grievance associated with "other" concerns would be that a member's mother wanted to bypass the plan's referral process and requested to have all of her children to be referred to a pediatric specialist without being seen by the general dentist.

Table 25. Number and Type of Grievances for Sacramento GMC Children Age 0-20, 2013-2014

GMC Plan/ Age of Member	No.	% of GMC Child Enrollment*	Grievance Category						
			Other	Medical Necessity	Quality of Service	Access/Availability	Claim	Coverage Dispute	Quality of Care
Access 0-5	17		0	0	6	4	0	0	7
Access 6-20	51		0	0	11	18	1	5	16
Total	68	0.11%	0	0	17	22	1	5	23
Health Net 0-5	3		0	1	0	0	1	1	0
Health Net 6-20	21		1	10	1	2	4	3	1
Total	24	0.05%	**1**	**11**	**1**	**2**	**5**	**4**	**1**
LIBERTY 0-5	4		2	1	1	0	0	0	0
LIBERTY 6-20	16		5	3	2	2	2	1	1
Total	20	0.03%	**7**	**4**	**3**	**2**	**2**	**1**	**1**
Total, all plans	**112**	**0.06%**	**8**	**15**	**21**	**26**	**8**	**10**	**25**

*Based on GMC plan average monthly enrollment.
Source: GMC Dental plans' self-reported Quarterly Reports to DHCS.

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. Scope of Work Exhibit A of the GMC contract contains many 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, Vietnamese and Armenian are the languages most available to members with limited-English proficiency or who are monolingual.

The Quarterly Grievance Reports are also required to identify grievances related to cultural sensitivity and linguistic access. None of the 2013 and 2014 Quarterly Report grievances involving children were described as being related to cultural and linguistic needs.

Results from the Plans' 2015 ASAG Member Satisfaction Surveys

In 2015, Access, Health Net and LIBERTY Dental plans contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of a Child Dental Satisfaction Survey as part of its process for evaluating the quality of dental services provided to child Medi-Cal plan members in Los Angeles and Sacramento Counties.[129] Table 26 shows results for 6 of the measures their study assessed. GMC families expressed similar satisfaction ratings with the overall care provided by the child's regular dentist and with how they were treated by the dental office or clinic, regardless of which plan their child was enrolled in (about half were satisfied). Access members gave a higher rating to their child's regular dentist than members did in Health Net or LIBERTY. However, Access members expressed greater *dis*satisfaction with measures related to access (finding a dentist, making an appointment) than either Health Net or LIBERTY members.

Table 26. Sacramento Parents' Satisfaction Rating of GMC Dental Plan Children's Services

Measure	LIBERTY n=235/15.4%*	Health Net n=313/19.9%*	Access n=246/16.1%*
	Percent saying "always satisfied" or "definitely yes" to satisfaction measures		
Finding a dentist	31.3	30.3	18.6
Access to dental care (problems with making appointments))	25.3	23.7	19.6
Care from dentist and staff (perception about how the family was treated)	52.0	49.9	52.0
Rating of regular dentist (based on a scale of 1-10 "from worst to best DDS")	43.8	40.3	47.0
Overall care provided by child's regular dentist	46.1	48.0	47.3
Rating of dental plan	48.9	45.0	48.4

Source: HSAG Child Dental Satisfaction Survey, May 2015, commissioned by the GMC dental plans.
*Sacramento County sample size and response rate.

When HSAG compared Medi-Cal dental managed care members in Los Angeles County and Sacramento County, Los Angeles County members of Access and Health Net expressed higher satisfaction ratings than Sacramento County members on some measures. The following were statistically significant differences according to the HSAG survey methods described in their report:

- Los Angeles County performed significantly higher than Sacramento County on 4 measures for Access Dental Plan: Rating of All Dental Care, Rating of Finding a Dentist, Access to Dental Care, and Would Recommend Dental Plan.
- Los Angeles County performed significantly higher than Sacramento County on the 2 measures for Health Net: Rating of Regular Dentist and Access to Dental Care.

There were no statistically significant differences between the Los Angeles County and the Sacramento County member satisfaction ratings for LIBERTY Dental.

[129] Health Services Advisory Group, Inc. (HSAG) Child Dental Satisfaction Survey, May 2015. The survey instrument was the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Dental Plan Survey HSAG modified to allow for administration to a child Medicaid population.

In its recommendations, HSAG remarked that enhancing effective dentist-patient communication can improve patient satisfaction and outcomes, and noted "indicators of good dentist-patient communication include providing clear explanations, listening carefully, and being understanding of patients' perspectives."[130] Their recommendations included the following:

- Increase effective dentist communication with parents/caretakers and child members to improve patient satisfaction and quality of care.
- Encourage providers to explore an open access scheduling model allowing for patients to schedule same-day appointments to increase continuity of care and reduce delays in patient care, patient wait times, and number of no-shows appointments.
- Engage and assist providers in examining and improving their systems' abilities to manage patient demand to achieve improved quality, timeliness, and access to care.
- Explore the implementation of quality of care metrics aimed at improving dental health outcomes at the provider-level to improve members' satisfaction with the delivery of care.
- Establish plan-level customer service performance measures to address potential areas of concern.
- Implement a customer service training program to teach the fundamentals of effective communication and a support structure to ensure learned skills are carried out by staff.

[130] Ibid.

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

"A state would generally choose to put its Medicaid dental program into a managed care model only if all 3 spokes were there—cost savings, quality, good outcomes." — National Medicaid dental expert

"Increased participation by dentists and integration [concerning Medicaid dental managed care] will not come until the dental schools teach integration and put the emphasis on prevention and the licensing boards require it." – Dental Director from another state

This section of the report provides information about the structure of children's Medicaid dental services in several other states. It highlights the influence of the federal government, specifically the Centers for Medicare and Medicaid Services (CMS), on what fine-tuning is going on within these and other states to improve the delivery and utilization of dental services for low-income children.

Influence from the Centers for Medicare and Medicaid Services

Oversight of the Medicaid program in the U.S. is the responsibility of the CMS. In its role of trying to improve health outcomes for the nation's population, it oftentimes approves exceptions to federal regulations and requirements by allowing program "waivers" to states to encourage experimentation with models of delivery and financing.[131] A look at recently awarded and pending Medicaid waivers provides insight into what the federal government (which covers 50% or more of a state's Medicaid costs) believes might be promising approaches to achieving program improvements.

From reviewing the recent or proposed waivers of states other than California, it quickly becomes apparent that the CMS supports[132]:

- Implementing managed care;
- Integrating medical managed care with other traditionally "non-medical" care, such as behavioral health long-term care and dental care, to improve coordination of services and treatment;
- Using intermediary and community organizations to achieve health outcomes such as Community Care Organizations and Regional Care Organizations;
- Experimenting with Accountable Care Organizations[133] as a potential alternative to managed care;

[131] Foundations and other funders often complement these waivers with grants and other contributions.
[132] At the time this report was undergoing final review, the CMS preliminarily approved California's Section 1115 waiver. Of the $6.2 billion waiver, $750 million is allocated for dental health improvement but this is proposed primarily for incentive programs for FFS dental not the managed dental programs in Sacramento and Los Angeles. Information about this waiver can be found at: http://www.californiahealthline.org/capitol-desk/2015/11/6-billion-waiver-gets-federal-approval and the waiver application can be found at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020KCFR_032715.pdf
[133] Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated care to their patients. Historically, ACOs have been used for commercial and Medicare patients. In recent years, the use of ACOs has become more common with dental care.

- Payment and incentive structures that reward performance;
- Quality of care measurement and reporting based on a review of waivers in recent years.

What Other States are Doing to Improve Children's Oral Health Services

Some thought leaders believe states' use of managed care by Medicaid dental plans is predicted to grow.[134] Some have noted that with large and more stable populations of covered patients, state Medicaid plans are in a position to experiment with cost-control measures that focus on oral health outcomes, rather than payment for individual procedures.[135] They point as examples to approaches being tried by Medicaid programs: adjusting the scope and frequency of covered services based on individual risk, e.g. CAMBRA (caries management by risk assessment, an evidence-based approach to preventing or treating dental caries at the earliest stages); reimbursement based on oral health outcomes; and additional compensation for early preventive services.

As this study was developing, several of these states were identified by key informants, other researchers, or noted in the literature as models to examine that could that could inform efforts in California for improving the state's Medi-Cal dental program for children. A number of states were contacted and of those that were willing to participate in this study, valuable information was collected. Some of these states provide children's dental services through variations of prepaid and managed care models, others through FFS. Conclusions from our interviews with state dental and public health representatives about their delivery models and review of supporting studies and documentation are summarized as follows:

- The decision to choose a FFS or a managed care approach to funding Medicaid dental services in some cases had been due to administrative leadership preference, response to public pressure, or lobbying efforts by dental-related professional associations as much as the evidence at the time supporting one model over another.
- Of those states utilizing a type of managed care model, fully integrated dental/medical services was unusual, although often mentioned as something desired in the future.
- As is occurring in California, most respondent states use third parties to assist with administering the program benefits or for processing claims (or both).[136]
- A number of states are experimenting with Accountable Care Organizations (ACOs) to improve access and utilization.
- The challenges expressed by states reviewed were not unlike what is experienced in California and Sacramento County: a small proportion of dental providers who are willing to participate in the Medicaid program and low payments to providers.

[134] Keckley P, Coughlin S. The U.S. health care market: a strategic view of consumer segmentation. Deloitte Center for Health Solutions, Deloitte Development LLC. 2012. In Diringer J, Phipps K, Carsel B. Critical Trends Affecting the future of Dentistry: Assessing the Shifting Landscape. Prepared for American Dental Association, May 2013.

[135] Diringer J, Phipps K, Carsel B. Critical Trends Affecting the future of Dentistry: Assessing the Shifting Landscape. Prepared for American Dental Association, May 2013.

[136] The State of California Department of Health Care Services currently has an open procurement (Request for Proposals) for both an Administrative Services Organization to manage the Medicaid dental program and a Fiscal Intermediary to handle dental claims. Deadline for both proposal submissions is December 4, 2015.

This section of the report provides information about the structure of children's Medicaid dental services in several other states. The states were identified by stakeholders and key informants based on their recent attempts and successes in improving outcomes for children. It highlights the influence of the federal government, specifically the Centers for Medicare and Medicaid Services (CMS), on what fine-tuning is going on within these (and other) states to improve the delivery and utilization of available dental services for children. These examples were explored to offer the Department of Health Care Services, dental plans and stakeholders ideas on strategies to consider in order to improve program performance.

From the review of data from these states and in-depth interviews with key state dental leaders, it seems clear there is “no one right way” or silver bullet to structuring and administering the Medicaid dental program for children. Table 27 (on the next page) provides a summary of key "take-aways" from our review followed by more detailed descriptions and comments in the narratives about each state that follow the chart.

Table 27. Examples of Selected States' Improvements in Children's Medicaid Dental Services

State	Dental Medicaid Model	Administrative Support Services Used	Reported Changes in Utilization	Contributors to Improvements	Future Plans
Colorado	Fee for Service (FFS)	Administrative Services Organization (ASO)	10 percentage point increase (from approx. 38% to 48%) in child dental utilization since 2011	ASO's success in expanding provider network (in one year had 75% increase of dentists taking at least 30 clients per year) Increase in provider rates (7% over 3 years) Dental society program (*Take 5*) to promote private dentists taking Medicaid children	No intention to shift to managed care
Florida	Integrated managed medical and dental care	State contracts with "comprehensive care plans" that commonly subcontract with dental benefit management organizations	8 percentage point increase (from approx. 18% to 26%) in child dental utilization since 2012 23% increase in participating dentists due to change in managed care contracts	Shift to integrated managed care Centralized state-managed complaint center Dental network standards included in integrated managed care contracts	Focus on prevention including well child visit by first year Quality measurement Use of mid-level medical providers for fluoride varnish and public health staff for application of dental sealants
Maryland	FFS (formerly managed care model but switched to FFS in 2009)	ASO	Up to 30 percentage point increase (from approx. 30% to 60%) in child utilization rate since 2009	ASO and dental advisory board recruitment of providers Streamlined provider application Targeted rate increases ASO follow up on "no shows" Application of fluoride varnish by medical practitioners	Increase in pay for performance and incentives with ASO

State	Dental Medicaid Model	Administrative Support Services Used	Reported Changes in Utilization	Contributors to Improvements	Future Plans
New Jersey	Dental managed care	Fiscal Agent organization	2 of 4 Managed Care Organizations achieved an increase in the rate of annual dental visits for children ages 1-2 years [137]	Member and provider interventions, such as member and provider education, member monetary incentives, physician fluoride varnish program	Testing the use of Accountable Care Organizations[138] as an alternative to managed care Managed care quality standards tied to performance incentives
Oregon	Integrated managed medical, behavioral and dental care	Use of "full risk" Coordinated Care Organizations[139]	Focuses primarily on quality measurement rather than utilization. Changes in utilization not available	Performance based incentive payments, including for dental sealants on permanent molars for children and early dental health assessments for children in state custody	Further development of CCOs More medical/dental integration (e.g., with diabetics) Teledentistry Changes in scope of practice
Rhode Island	Dental managed care	Utilizes a contracted claims administrator	11 percentage point increase (from approx.. 33% to 44%) in utilization for 0-10-year olds in Medicaid between 2005 and 2010	Increase in provider rates for preventive services More active participation of primary care physicians	Integration of medical and dental managed care
Texas	Dental managed care	Utilizes a contracted claims administrator	2% increase in utilization of preventive services 6% utilization increase of diagnostic services 6% reduction in utilization for orthodontic services	Coordinated care delivery system via regional partnerships Required performance improvement projects plans Incentives based on quality performance	Continued expansion of managed care Reducing administrative burden on providers Improved provider and member experiences

[137] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf

[138] Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated care to their patients. ACOs have been typically used for commercial and Medicare patients.

[139] Coordinated Care Organizations (CCOs) are networks of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid).

Colorado

In contrast to Oregon and Florida, Colorado provides dental care to its Medicaid participants using a FFS model.

Colorado has seen an increase in child Medicaid dental utilization of up to 10% since 2011; when asked for specific utilization data, state representatives declined to share it with us based on challenges with data comparison. They estimated current utilization is approximately 48%-50%. This increase was attributed primarily to the usage of an Administrative Services Organization (ASO), an active state dental association which has its "Take 5" program to encourage providers to serve Medicaid participants by “taking at least 5 patients,” and provider outreach efforts conducted by state personnel. While the ASO is responsible for ensuring provider capacity is sufficient and prepared, the State of Colorado still "owns the provider network." The separate areas of responsibility create some confusion regarding roles and accountability in maintaining the provider network. The first year of the contract with the ASO (2014) included incentive pay for growing the network.

Colorado too has challenges with provider rates, but unlike California has some recent history of obtaining increases. Within the last 3 years, it has increased rates by approximately 7% over 3 rate changes. Like California but on a smaller scale, Colorado shares a similar challenge related to the urban/rural geographic distribution of dentists across the state.

Current challenges and efforts focus on recruiting providers for rural areas, increasing access and developing virtual dental homes, like California, which is being funded by the Caring for Colorado Foundation. State interviewees also see the potential for use of Regional Coordinated Care Organizations (RCCOs) though not until the current program model has matured more.

Interviewees shared they do not expect to see a shift to managed care in the forecast. The state has a strong dental provider community and dental lobby. In 2013 when adult dental care was added, the bill language included a requirement for FFS reimbursement.

Florida

Until recently, Florida representatives reported the state ranked the lowest in dental Medicaid utilization in the U.S. (per the EPSDTCMS 416 report).[140] The state legislature responded to these disappointing statistics with approval of an expansion of an existing prepaid Medicaid dental program to create a mandated statewide dental managed care program. Currently, Florida has fully integrated medical/dental managed care for most of its Medicaid population. State dental representatives interviewed believe the change appears to be paying off.

The dental utilization for children has increased 8% since 2012, up from 18% to now close to 26%. The state has moved up two positions in state rankings on child Medicaid dental utilization. State dental interviewees reported the integrated medical/dental program outperforms the former stand-alone prepaid dental program based on HEDIS measures such as annual visit, preventive dental services, treatments and sealants. State of Florida interviewees reported the provider networks are growing due to the change as well—from approximately 1,885 in 2012 to over 2,300 as of June 2015.

[140] The annual EPSDT report (form CMS-416) provides information on participation in the Medicaid child health program. The information is used to assess the effectiveness of state EPSDT programs in terms of the number of individuals under the age of 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services.

The state contracts directly with Comprehensive Care Plans that often subcontract with Dental Benefit Management Organizations (BMOs). These subcontracting BMOs may be paid FFS rates, capitated rates or a combination of the two. The state does not monitor the sub-contract agreements. The state manages a statewide-centralized complaint program for providers and consumers that addresses all aspects of delivery including medical, dental, and provider payments. Complaints may be submitted online or via a toll-free number. The state tracks complaints, analyzes data, identifies trends and resulting needed changes.

The current emphasis of the state is on prevention and "turning the conversation around to measures of success" with stakeholders. A key focus is on school-based care and the creation of a sustainable sealant service model. Another is the application of fluoride varnish by mid-level medical practitioners.

Current challenges include the need for improved data, particularly regarding services that are delivered without billing/reporting to Medicaid (i.e., pro bono) and collection of dental data from health plans that are not paying their providers based on encounters. Another challenge the state is working on is better understanding of the true barriers to accessing care. Florida is participating in a CMS effort to identify the barriers the state can reduce.

Maryland

While a number of states have moved to managed dental care, Maryland is the exception. A state that once provided integrated dental care with medical care (with dental care included in contracts with the managed care organizations), in 2009 Maryland carved out dental care from managed care for children under 21 years of age and for rare and expensive cases. This change occurred in response to a tragic, highly publicized incident where a 12 year old child (Deamonte Driver) died from bacterial effects of an untreated abscessed tooth. While the incident was not attributed to managed care per se, state leadership demanded changes of the managed care system to prevent the recurrence of such incidents, and one of the major resultant changes was the switch back to FFS.

Initially after the change from dental managed care, recruitment and retention of dental providers was good. This was attributed to the use of an ASO and a dental advisory board that has assisted recruitment and retention efforts. This is in spite of the rates paid to the Medicaid dental providers, which are about 50% of the commercial rates (which is still much higher than California's 31%). Maryland pays the ASO a per member per month rate while the dental providers are paid FFS from a state-owned bank account from which the ASO pays claims.

Interviewees reported that the utilization prior to the carve-out was very modest—in the range of 30%. Increasing the provider base and outreach to participants and the community has brought it up to nearly 60% under the current FFS system. Once ranked in the U.S. as 44th -worst of 50 states in utilization, it now reports to be in the top 10 states in the country.

Improvement strategies that appear to be making a difference include: a streamlined provider application process; specific outreach by the ASO to those who fail to show up for appointments; focusing recent (January 2015) rate increases on specific, priority prevention-related procedure codes; and, implementation of a program that reimburses medical providers who apply fluoride varnish to children ages 9 months to 35 months old.

Besides contracting with the ASO, the state has a role in provider recruitment (credentialing), adjudicating claims, utilization review and pre-authorization of specific services.

There are no plans to move back to managed care from the current FFS Medicaid dental program model and in recent years behavioral health and substance use treatment services have also been carved out of managed care. Planned program improvements include the move to "pay for performance" for the ASO, increase in performance accountability and incentive payments. Like California, Maryland is currently in procurement of an ASO contractor.

New Jersey

New Jersey began implementing managed medical care in 1995 and in recent years has been moving toward integration of other health care services. Its most recent effort is the integration of long-term care and behavioral health services. Today nearly all Medicaid recipients are served through managed care organizations. Medicaid managed (capitated) children's dental services are provided via NJ Family Care that enrolls most of the Medicaid population in one of 4 managed care plans, 3 commercial and 1 non-profit organization.

New Jersey required all of its MCOs to implement Performance Improvement Projects (PIPs) to promote dental care for children. Two of its 4 MCOs achieved significant improvements: one related to increasing the rate of annual dental visits for children 1-2 years of age and another that increased the rate of annual visits for 2-3 year olds by almost 30% over a 3-year period. These MCOs used a combination of member and provider strategies such as member education on good oral hygiene via phone, letters, and websites; monetary incentives for completing a visit; distribution of dental provider information; and a fluoride varnish incentive program for primary care physicians who refer patients to dentists (with additional incentives if the patient completes the dental visit).

New Jersey complements its dental services program with a Children's Dental/Oral Health Program that the New Jersey Department of Health administers. The program is implemented by 3 Regional Oral Health Coordinators that are located throughout the state. This program provides oral health education information and age-appropriate activities conducted by dental hygienists, a school-based fluoride mouth rinse program, oral health education for public health and social service professionals as well as for participants in the Women, Infant and Children Supplemental Food Program (WIC).

In August 2011, New Jersey Governor Christie signed a bill to establish a 3-year Medicaid Accountable Care Organization (ACO) demonstration project to improve outcomes, access to care and quality of care while reducing costs. The ACO is being tested as an alternative to managed care, with particular emphasis on high-risk, high-cost users of services by integrating social services, and includes experimentation with pay-for-performance and incentives. In July 2015, the 3 groups that will be implementing this pilot effort were selected. The goal is to provide the "right care, at the right time at the right place," i.e., to reduce unnecessary hospital emergency room visits and hospital stays due to better consistent, coordinated care outside of hospitals. Oral health is included in the pilot with a specific goal of the demonstration to increase access to dental care. Some challenges associated with this pilot include the coordination of services between the ACOs and the MCOs and financial sustainability of the ACOs. A number of other states and health care providers and policy makers are anxious to see the results of this pilot once the 3-year period is complete.

Oregon

Oregon has a long history of managed health care, driven in large part by state leaders. Dental managed care was implemented in Oregon approximately 12 years ago. In 2012 Oregon moved from funding Dental Care Organizations (DCOs) directly to use of Coordinated Care Organizations

(CCOs) that integrate medical, behavioral and dental health. Dental care was fully integrated with medical care in 2014. These CCOs assume full risk for care of their enrollees. Rates paid by the state are statewide with some regional variation. Of the 16 CCOs in the state, some are staffed models, some pay FFS and others pay capitated rates to their providers.

There are no specific utilization requirements of the CCOs, and while several quality measures are used, the state is only beginning to add a dental measure which will likely relate to application of sealants.

Oregon sets aside 3% of its capitated budget for incentive payments. Currently, incentive payments are tied to medical performance measurement. The use of incentives, Oregon believes, is resulting in more of the CCOs showing interest in the state's outreach and population health efforts due to their potential positive impact on performance outcome measures included in the CCO contracts.

Oregon's approach is not without its challenges. Under both models—managed care and FFS—recruiting dentists is difficult due to the capitated or FFS rates offered. Changing from a DCO model to CCO was challenging due to the change in relationships: no longer did DCOs deal directly with the state but through the CCOs.

Oregon is one of 6 states that received a CMS State Innovation Model (SIM) grant to improve health and lower costs. Funds are being used to support the further development of CCOs, evaluate and improve on its managed care model of delivery, and test new payment models that focus on value rather than services. Oregon is also experimenting with dental projects and pilots. It is accepting proposals now and expects to fund a teledentistry project modeled after one in California, a dental therapy program modeled after Alaska's, and a pilot that allows providers to work outside of their traditional scope of practice. The state is also working to increase its medical/dental integration in areas that recognize the relationship of dental to medical issues such as diabetes and oral health.

Changing from a managed care model does not appear likely anytime soon. One Oregon interviewee shared the following: "Managed care results in better care, but is not cheaper. FFS is cheaper in the short term; Oregon is trying to take the longer view on care and health." Managed care is also seen as more compatible with population health, another interest of state representatives.

Rhode Island

With incentive funding by the Robert Wood Johnson Foundation, Rhode Island has been moving its Medicaid dental population into managed care through a program called RIte Smiles. United HealthCare Dental operates the program on behalf of the state. Improvements in dental utilization for children 0-10 years of age have occurred with the greatest jump occurring after the implementation of the RIte Smiles program in 2005 (33.2% in 2002 to 34.5% in 2005 and 44.2% in 2010).

The RIte Smiles program is one of the few or only Medicaid programs in the state that has seen provider rate increases since 1993. State interviewees considered the rates paid providers as still low, but an increase in provider reimbursement for preventive services is definitely attributed with increasing access. About one-half of the Rhode Island dentists participate in the RIte Smiles program.

Rhode Island is also receiving HRSA funding to help program participants learn about services available to them and current state efforts to increase utilization focus on first dental visit by age 1. While both medical and dental utilize a managed care model, Medicaid medical and dental services are not integrated. The programs, along with the state long-term care coverage, are separate programs.

Texas

Texas, like a number of other states, has a potpourri of health care models, reflecting its migration to managed care from FFS over recent years and the unique challenges of its rural counties. Texas contracts with 16 medical managed care plans several well-known national for-profit plans as well as over 10 non-profit plans. Texas is moving all of its SSI children into mandatory managed care plans. Effective March 1, 2012, Texas changed the service delivery model for Medicaid dental services from a fee-for-service (FFS) model to a capitated managed care model. The state authorized mandatory enrollment of children into a limited benefit plan for dental services.

Most children's dental services are provided via the State of Texas Access Reform (STAR) program. STAR is a managed care program established in 1993 by means of a 1115 (a) federal waiver. It is the program that serves CHIP and Medicaid children, newborns, pregnant women and some families and children[141]. Dental services offered are included in this managed care program. Texas contracts with two dental managed care organizations (DentaQuest and MCNA Dental) to cover dental services for its CHIP and Medicaid populations. These two dental managed care organizations (DCOs) must provide the same medically necessary covered dental services as FFS dental coverage.

The Texas Health and Human Services Commission (HHSC) is required to evaluate:

- Utilization trends
- Penetration rates
- Provider to client ratios
- Retention of dental providers
- Services provided
- Premium insurance revenue and managed care premium cost growth

While it is too early to fully assess this change to managed dental care, an initial year evaluation of this Texas program indicated an increase in utilization of preventive services (from 34% to 36%), a 6% increase in utilization for diagnostic services (from 31% to 37%) and a 6% decrease in utilization of orthodontic services, for which there had been concerns about over-utilization. The number of providers per enrolled DCO member who utilized services (12.3/1000), however, was lower than the prior year's ratio under FFS (15.1/1000).[142]

Statewide, Texas has shown notable improvements in children's oral health in recent years. Per the state's Oral Health and Basic Screening Survey (conducted every 5 years), between fiscal years 2008/09 and 2012/13 the following changes were found in children's oral health the percent of third graders in state public schools with:

[141] Exceptions are children or adults with Medicaid that live in nursing homes or other care facilities, and children in the state's foster care system.
[142] State of Texas HHSC, "Capitated Managed Care Model of Dental Services Final Report", Public Consulting Group, Inc., February 15, 2013

- Untreated dental decay decreased from 42.7 to 25.9
- Dental sealants on molars increased from 34.4 to 51.0
- Urgency for need for dental care decreased from 8.7 to 4.5

As reflected in its recent 1115 federal waiver extension application,[143] Texas HHSC plans to continue expansion of managed care and is working on initiatives to reduce administrative burdens for providers, streamline requirements, and standardize policies in managed care. It is also focusing on improving managed care provider and member experience in response to recent legislation.

Other States' Notable Efforts

Several states besides those described above are demonstrating success or experimenting with promising approaches to provide dental services to low-income state populations. Following are highlights.

Washington. The state's ABCD (Access to Baby and Child Dentistry) program for children, which we fully described in our earlier GMC dental report, continues to demonstrate success in reaching children early with dental services and is a nationally recognized model of success. The program includes training dentists in pediatric dental techniques (including behavior management of young children); training dental staff in communication and follow up; offering a comprehensive range of services; engaging community based organizations in outreach to families; addressing barriers related to families making and keeping appointments; engaging primary care medical providers to provide preventive oral health services during well-child checks; help with referrals and billing for dentists and medical providers; and enhanced payments for certain preventive and restorative services.

Minnesota. Since 2009, licensed dental therapists are allowed by law to provide preventive and restorative care under the supervision of a dentist. Advanced dental therapists are allowed to provide additional services. Supervising dentists have found use of these mid-level practitioners is profitable and access to oral health services for children has been increased, particularly in rural areas.

Kentucky. To encourage good oral health habits early, this state is educating child caregivers on child oral health so that all adults supporting a child are sending consistent, recurring messages on the importance of good preventive oral health care.

New York. The Center for Medicare and Medicaid Innovation has awarded a grant to the State of New York to implement a home visiting program for children with early childhood caries (ECCs). The program utilizes pediatric dental residents and mobile phone applications for education and tracking of nutrition and oral health practices. The New York University College of Nursing has added a curriculum related to oral examination to assist medical providers in assessing and discussing oral health issues with patients and referring them to appropriate dental care.

Massachusetts. The addition of a new mid-level category of dental practitioner is a part of legislation being considered in Massachusetts. The purpose of the legislation is to increase the number of practitioners in certain parts of the state and to address the fact that fewer than half of the children covered by the state's Medicaid program accessed dental services in 2014. If

[143] The Texas waiver renewal application can be found at: http://www.hhsc.state.tx.us/1115-docs/101415/TX%201115_ExtApp2015_AttachD_corrected.pdf

approved, dental hygiene practitioners will operate under the supervision of a dentist, similar to what exists in Minnesota.

From the above summary of state efforts, it seems evident that the following components of states' successfully increasing access to dental services for children, which has contributed to higher utilization include:

- Emphasis on prevention
- Provider payment incentives
- Provider enrollment improvements
- Contracts with third-party administrative organizations
- Close collaboration with the private dental community
- Integrated dental services
- Education campaigns for families

CONCLUSIONS

"When you have dentists who say they'd rather do it for free [see kids with Medi-Cal], That is a huge indictment on the program." – California legislator

"*Providers try to be accommodating but parents call the dental plan with complaints when they can't always get an appointment for a specific day and a specific time they want."* – GMC dental plan representative

The Geographic Managed Care dental program has been in place in Sacramento County since 1994, and after 21 years it is firmly established. During our study, DHCS did not indicate an interest in abandoning it or expanding the model to other counties,[144] and we did not discover anything that would result in a material change to the model in the near future.

The GMC model is structured in a way that allows for a comprehensive approach to dental care for children. It has the *potential* of improving access to services for thousands of low-income Sacramento County children. While it has come far, it still hasn't produced levels of utilization that matter when plans are prepaid for delivering services. Continued oversight and close monitoring and an equitable reimbursement structure for plans and providers are needed. A number of the recommendations in our earlier study have been implemented, which is positive. These are: establishment of the Medi-Cal Dental Advisory Committee; greater collaboration among stakeholders, DHCS and the dental plans; increased provider network capacity; support for children's community dental clinics; and establishment of performance incentives/penalties by DHCS.

While there has been progress in Sacramento GMC dental, a number of challenges remain that need immediate attention. The variability among dental plans in several performance areas (e.g., the percent of children receiving sealants; the proportion of children who received preventive services and fillings) while smaller than in our earlier study, presents opportunities for improvement in each plan. The gap between GMC plans' performance and Fresno County FFS on quality of care measures, for the indicators where the same service data were available, implies the need for ensuring better access to services—particularly preventive services—for children in the GMC dental managed care model.

While still not close enough to the Medi-Cal statewide average utilization rate for children, the nearly 100% increase in overall utilization in the last 5 years under GMC—from 20.2% in 2008 to 39.6% in 2014—is a positive trend that should be recognized. The outreach and education campaigns conducted by the dental plans helped account for the higher upswing in utilization among 0-3 year-olds. When adult dental benefits were restored in May 2014, there was a lot of pent-up demand and immediate dental needs that may have diverted dental plan attention to the needs of serving the adult population. This likely contributed to the slowdown in children's

[144] The State's federal 1115 waiver that was preliminarily approved in October 2015 by CMS does not reflect any expansion of dental managed care in the state Medicaid program.

utilization improvements. These trends need to be closely monitored to ensure children's use of dental services can be improved and make significant gains.

Stakeholders and dental plans, along with DHCS, have worked successfully toward more collaboration in development of policy and service delivery improvements though several important issues still need to be ironed out such as trying to clarify confusion around hospital dental procedures. To reach a more optimal rate of utilization under dental managed care, state-level policy changes related to the overall Medi-Cal dental program—which drives the dental managed care program—are required. Examples include improvement in reimbursement rates and additional streamlining of the Medi-Cal dental provider enrollment process. Sacramento could take advantage of additional strategies and approaches that other states have successfully implemented that were highlighted in this report. We suggest DHCS consider what these and other state Medicaid programs are doing successfully that have applicability to California. This includes implementing policies that make the program more attractive to prospective and current providers to expand access to care.

States are continually experimenting with ways to improve utilization of children's dental services among the Medicaid population. As we pointed out, some states are continuing to examine dental managed care as an approach. Some have found success through medical-dental integration models, or at least are considering how it can be implemented in their systems, and many are achieving efficiencies by contracting with third-parties to administer and/or serve as fiscal intermediaries for their Medicaid dental programs. Strategies that have been demonstrated to improve outcomes, including reduced administrative burdens to attract new providers and increase participation, as well as education and training of providers about early childhood oral health, could benefit Sacramento County and California if adopted. Most importantly, research indicates that whether dental 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 and providers. [145]

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

RECOMMENDATIONS

"Obtaining legislative approval for increased rates to providers was achieved when we partnered with the state dental association and targeted the increases to specific preventive service codes rather than across the board." – Non-California State Dental Representative

"Incentive payments were a key contributor to our improvements, including those paid to our Medicaid dental program's contracted Administrative Services Organization to increase the provider network." – Non-California State Dental Representative

The following recommendations, driven by the study findings, are listed in order of most importance to achieve program impact. They are organized by what could be achieved in the short-term (within 1 year) and those that may require 1-2 years. Some of the recommendations speak to continuing progress on an achievement but increasing support for it or making further improvements. While we have indicated who we think should take the lead for implementing the recommendation, in many cases, all 3 main parties—DHCS, the dental plans, and stakeholders (MCDAC and various organizations and advocates)—need to play contributing roles if the potential of the dental managed care model to provide appropriate and timely care for children is to be realized. Additionally, it will be important for DHCS and MCDAC to work with legislators on items that would require legislative approval such as rate increases or certain policy changes.

Recommendations for the Short-Term

1. Continue and increase performance penalties and incentives.

DHCS should continue to incorporate and refine the incentives and withholds in dental plan contracts to encourage targeted improvement. DHCS should annually review and adjust benchmarks requiring increasingly higher levels of overall and preventive services utilization until performance matches the statewide FFS average for children 0-3 and 0-20. Particular attention should be paid to utilization rates in the dental plans that pay network providers on a FFS basis to see what effect this new compensation arrangement has on utilization.

2. Use the Beneficiary Dental Exemption process as legislatively intended.

There is disagreement between stakeholders/advocates and DHCS about the intent and actual use of the BDE process. The statute allows DHCS staff to work with the dental managed care plan to schedule an appropriate appointment within specified timeframes, based on the identified needs of the beneficiary. Advocates believe DHCS has interpreted the law as providing a means for making managed care work better but not allowing a genuine opt-out and move into FFS Denti-Cal. While DHCS does help families navigate appointments for their children—essentially serving as a back-up for the plans' Member Services—its call center script should be altered and staff trained to also help families who request it to identify and establish a Denti-Cal provider in the FFS system as their child's choice for a dental home if this is what the family desires.

3. Continue MCDAC with Participation by DHCS

The Sacramento County Medi-Cal Dental Advisory Committee, working with DHCS, the dental plans and local organizations, has been a significant contributor to the many improvements made in the Sacramento GMC program over the last 5 years. The local oversight it provides and the attention it brings to matters that were neglected in 2010 prior to the Committee's formation suggests that further progress is possible. MCDAC impacts, such as the development of a streamlined approval process for hospital dental procedures between medical and dental plans, need to continue. MCDAC should further engage with DHCS in providing recommendations about plan performance and policy planning. Given the importance of MCDAC, more administrative support should be provided to enhance its effectiveness. Although DHCS is only required to attend MCDAC meetings on a quarterly basis (and in-person attendance is not required) participation at all meetings is valuable and essential. Staff from the Department of Managed Health Care—who are not required to attend—should be invited to attend MCDAC meetings on at least a quarterly basis as their past participation has been considered helpful for answering questions, clarifying processes, discussing program improvements. Additional studies will be needed to implement program improvements and/or monitor achievements. The current challenges in obtaining state data to do this will require full cooperation from DHCS. The level of effort we encountered in obtaining State data for this report was extraordinary and unanticipated.

4. Reduce the administrative burden for providers

To attract and retain dentists and maximize provider participation in the Medi-Cal dental program—which drives the managed care delivery system—DHCS needs to reduce the administrative burden as a barrier to participation. Administrative changes such as streamlining the provider application and credentialing process have been implemented successfully by other states. One of the recommendations 3 years ago was for an online Denti-Cal provider application. Progress on this strategy stalled. Although DHCS streamlined the application process in GMC by not requiring dental managed care providers to go through the FFS application process—and the dental plans have created a process that has significantly decreased the application process timeline for all prospective managed care providers—the challenge remains in the FFS system.

5. Create better access for hospital dentistry

To ensure children who need access to dental care under general anesthesia (GA) can access it, DHCS should identify a method to track access to care for children who require GA dental treatment, and hold Medi-Cal dental plans and medical plans accountable for ensuring access to timely care for these children. DHCS noted it created a process for access to GA services by releasing a Frequently Asked Questions (FAQ)document[146] that stakeholders say does not help clarify or ensure access, and aligned Dental and Medical requirements for consistency. DHCS intends to also issue an All-Plan Letter for dental managed care plans to use for guidance. In noting that GA is a prior authorization service and has explicit instructions for approval, DHCS believes if providers and plans follow the guidelines GA will be approved. DHCS should establish a clear system or path for children with Medi-Cal to access GA care and a single point of contact at DHCS for this. Data on access problems and resolutions should be included in monthly reports made available to MCDAC. These improvements need to move forward.

6. Require GMC dental plans to adopt formal policies for age at first dental visit.

Amend GMC contracts by adding language or some other sort of formal policy requiring plan network providers who serve children to see children for their first dental visit "by first tooth or first

[146] http://www.denti-cal.ca.gov/provsrvcs/FAQs/GA_IV_FAQs.pdf

birthday." The GMC contract does not contain any requirement concerning age at a child's first dental visit. Although the percentage of network providers—and Sacramento dentist survey respondents—seeing children earlier has increased since 2010, a formal policy could add further support and help improve compliance with professional recommendations. Since the dental plans (and perhaps network providers) are paid a per member per month fee beginning at a child's birth and enrollment, the plans should ensure that parent education includes the oral health needs of newborns.

7. Provide a means of reimbursement for school-based prevention and screening

Providing oral health services through school-based programs, including preschool, is an important strategy for meeting oral health goals. When Sacramento County (generally through grant funds) provides screening and fluoride varnish to children in low-income schools, the County is serving a large proportion of children enrolled in GMC dental plans.[147] However, there is no reimbursement mechanism to recoup the cost of these services as there is in some FFS counties which bill Delta Dental. The County cannot currently bill the GMC plans, although the State has already paid the plans for these services as part of the monthly capitation fee. We recommended in our earlier study that DHCS should establish a mechanism to allow Sacramento County to recoup the cost of school-based prevention and dental screening services when provided to children with GMC dental benefits, and identified a couple of potential strategies. This recommendation was not implemented and we feel it is important to make it again. Being able to recoup costs is a potential source of additional funding that could help build community capacity for identifying and referring children with early dental disease, and encourage families to utilize their children's dental benefits for preventive services and track the care.

8. Strengthen managed *health care* plan responsibilities for children's oral health

Although dental services are carved out of Medi-Cal managed *health care* plans, the medical plans should and can play a stronger role in promoting good oral health. DHCS should strengthen the plan responsibilities and performance in making and following up on referrals for dental care for enrolled children and providing preventive oral health services by medical providers. While reimbursement exists for primary care providers to provide fluoride varnish, oral health is too infrequently on the medical plans' radar as part of their patient education campaigns and this service may not be being maximized. DHCS can help with stronger contract language. The dental plans should look for opportunities to engage local medical managed care plans to help enrolled children access their dental benefits. These linkages may also reduce the relatively high volume of avoidable emergency room admissions for dental problems.

9. Offer patient incentive strategies along with outreach and education

DHCS and the dental plans, through Quality Improvement Projects (QIPs) and other strategies, should increase ways to promote the benefit of dental services directly to families. They should educate families and children about the importance of oral health and what part they play in maintaining it. Using additional channels of communication for outreach and education and implementing patient incentive strategies to increase utilization, encouraging the use of preventive services and reducing use of emergency departments for avoidable dental conditions should be part of the strategy. Consumer members of MCDAC have suggested that to improve outreach to parents different strategies such as radio and television should be used. DHCS encourages the plans to find ways to incentivize beneficiaries (per contract exhibit Attachment 17, Marketing),

[147] Sacramento County has not been providing dental sealants since 2009 when state and county funding was cut. Sealants are evidence based preventive procedure in reducing dental caries. Being reimbursed for preventive procedures will provide sustainability of the program.

requirement the plans to submit any marketing strategies to DHCS for approval. Dental plans could encourage the use of regular, preventive oral health services and boost utilization by offering creative patient incentives that families would value (a few focus groups can help identify such items). There is some evidence that suggests even relatively modest rewards can influence individuals' health-related behaviors including increasing preventive care among low-income and high-risk populations.[148] Gift cards for kept appointments and completed treatments and taxi vouchers to appointments are other examples of patient incentive strategies others have tried. One managed medical care plan that offers Medicaid members both medical and dental benefits implemented a patient incentive program to increase dental utilization using a monthly drawing for a free electronic toothbrush of $100 value.[149] The compliance rate of patients keeping appointments for their first (and subsequent) dental appointment could be greater.

Recommendations for the Longer-Term

1. Increase Denti-Cal reimbursement rates to increase provider participation in GMC

Rates paid to GMC dental plans are based on rates provided under FFS Denti-Cal. Therefore, increasing FFS rates would in turn increase GMC rates. Denti-Cal rates need to be brought more into line with market-based rates. (Market-based rates to dentists are those rates that will encourage 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 and more providers participate. If an across-the-board reimbursement rate cannot be achieved (provider feedback suggests greater participation requires a 60%-70% reimbursement rate increase), DHCS and advocacy organizations should look for and implement creative ways to increase provider reimbursement such as targeting specific services and procedures and age groups like other states that have successfully done.

2. Add "The Completion of Treatment Plans in 12 Months" to the DHCS Performance Measures and Benchmarks.

The performance measures for the plans are quite broad and up-to-date with current practice; the only thing missing is one that Health Resources and Services Administration (HRSA) uses in the review of Federally Qualified Health Centers. The significance of adding this performance measure to the GMC plan contracts, which should be mandatory, is overall reduction of the oral bacterial load by completing the course of treatment, i.e. removing or eliminating the disease causing bacteria, then restoring damaged tissue. There is a good chance of lower reinfection rates, given adequate hygiene, when treatment is completed in a timely manner. Historically, one of the challenges with this vulnerable population is follow-up: people move or lose phone service, resulting in incomplete treatment if it is extended for a long period of time, which in turn, causes poorer oral health (as all oral diseases are progressive) as well as overall health. Stakeholders described many situations were a child went to the dentist and received an exam and preventive services but the restorative treatment had not been completed. All DMHC/DHCS chart audits and data monitoring should include a review of the completed treatments performance measure.

[148] Sutherland K, Christianson JB, Leatherman S. Impact of targeted financial incentives on personal health behavior: a review of the literature. *Med Care Res Rev* 2008 65(6Supple):36S-78S.
[149] Personal communication with Benjamin Naté, Health Educator, Health Net.

3. 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. These safety net providers offer a "lifeline" for uninsured families and children with Medi-Cal and can offer the advantages of both primary medical and dental care. Dental service capacity has grown but it is still limited in some of the Sacramento clinics. Opportunities for supporting expansion at existing and new sites should be encouraged.

4. Increase strategies for medical dental integration.

Increasing strategies for greater integration of oral health and primary care makes good sense to address significant oral health care access issues. It expands entry points into the dental care system, especially for at-risk and underserved populations. Integration can occur along a continuum and through a variety of models. There are many ways DHCS and Sacramento County organizations can help advance the agenda of increasing utilization as well as eliminating oral health disparities through medical-dental collaborations, inter-professional training, and co-location of services. The outreach campaign Sacramento District Dental Society conducted to pediatricians and hospitals is an example of a local strategy to support more primary care engagement in children's oral health. Supporting school-based health centers is another example of an integrative model that would be relatively easy and potentially effective. Integration can increase the effectiveness of both dental and primary care professionals in preventing disease, and reduce the large number of preventable dental conditions, which as we found are too often treated in the emergency department.[150]

5. Monitor progress in implementing the recommendations.

MCDAC should continue to track progress in achieving the short- and long-term recommendations in this report, including planning for and supporting a future follow-up evaluation study of the GMC dental program by an external party within the next 3 years. It will be important to keep in mind the State data retrieval process can be lengthy and complex and this needs to be taken into account when estimating the time and costs of the study.

Next Steps to Implementation

Fourteen recommendations (9 in the short term, 5 for the longer term) are made in this study. Each requires an investment of time and money and all require collaboration or cooperation among one or more key players. We suggest the following immediate next steps for implementation:

- At the January MCDAC meeting, review the recommendations and determine which ones MCDAC wishes to undertake, prioritize them and develop a simple action plan for implementing them.

[150] Returning the Body to the Mouth: Integrating Oral Health and Primary Care. http://www.gih.org/files/FileDownloads/Returning_the_Mouth_to_the_Body_no40_September_2012.pdf

- Schedule and deliver a briefing to the Sacramento County Board of Supervisors (the authorizing body for MCDAC) to share the key findings from this report.
- Meet with DHCS to determine DHCS's interest in the MCDAC prioritized areas and level of ability to participate; make adjustments to priorities if needed based on DHCS feedback.
- Engage partners and other stakeholders to plan and support any policy or program changes.
- Identify and meet with key legislators and their staff to share the findings from this report, and work with them on items that would require legislative approval such as rate increases or certain policy changes.
- By July 2016, initiate a request to DHCS for child *and* adult dental utilization data for CY 2015. Examine the status/trend of children's utilization relative to the findings in this report. Determine the proportion of adult/child members in each GMC plan and for all plans combined to look for any meaning relative to trends in children's utilization.

ATTACHMENTS

ATTACHMENT 1

Medi-Cal Dental Advisory Committee

GMC Update Study Committee Members

(In Alphabetical Order by First Name)

Cathy Bowman Levering
Executive Director
Sacramento District Dental Society

Debra Payne, MSW
Oral Health & Effective Parenting Program Planner (Retired)
First 5 Sacramento Commission

Julie Beyers
Program Planner – Oral Health and
Medi-Cal Dental Advisory Committee Staff
First 5 Sacramento Commission

Kate Varanelli, RDH
Dental Health Program Coordinator
County of Sacramento

Nicette Short, MPA
Director of Public Policy
California Dental Association

Terrence W. Jones, DDS
Commissioner, First 5 Sacramento
Chair, Medi-Cal Dental Advisory Committee

ATTACHMENT 2

Interviews and Program Contacts[1]

(In Alphabetical Order by First Name)

Name	Affiliation
Alan Kislowitz	Health Plan Manager, State of Colorado
Beth Kidder	Assistant Deputy Secretary for Medicaid Policy & Quality Agency for Health Care, State of Florida
Bob Russell, DDS, MPH	Public Health Dental Director and Bureau Chief, State of Iowa
Bruce W. Austin, DMD, LMT	Statewide Dental Director, Oregon Health Authority
Catherine (Kay) Kabarsky	DentaQuest
Cathy Levering	Executive Director, Sacramento District Dental Society
Charlie Atkins	Policy Representative, State of Maryland
Claire Sibert	Division Chief, Acute Care, State of Maryland
Deborah Weston	Assistant Manager, Policy and Programs, Oregon Health Authority
Erica Floyd-Thomas	Agency for Health Care, State of Florida
Gail Reeder MPH	Dental Outreach Coordinator, State of Colorado
Griselda Zamora	Director, Sacramento Covered
James Musser, DDS	Sacramento Pediatric Dentist
Jonathan Porteus	CEO, WellSpace
Laura Smith	CEO, Washington Dental Service Foundation
Laurie A. Leonard, MS	Oral Health Program, Rhode Island Department of Health
Mary Foley, RFH, MPH	Director, Medicaid/CHIP State Dental Association
Michelle (Shelly) Lehner, DHMH	Deputy Director Acute Care, State of Maryland
Nancy D. Waring	Manager, Charitable Health Coverage Operations, Kaiser Permanente
Nicette Short, MPA	Director of Public Policy, California Dental Association
Pamela Caviness, DDS	Dental Director, Cares Community Health
Robert Isman, DDS, MPH	Dental Consultant, Retired, California DHCS Dental Consultant
Rodney Bughao, DDS	Sacramento Oral Surgeon
Sarah Tilleman	Health Programs Office, State of Colorado

[1]Interviews and contacts, including follow-up for additional information, were conducted via telephone or email, or both. Two additional interviewees spoke on background and requested anonymity.

PLEASE PRINT

MEDI-CAL DENTAL SERVICES BRANCH (MDSB)
MANAGED CARE PROBLEM REPORT FORM

Member's Name: _____ **CIN#, BIC#:** _____
First MI Last (Circle one)

Member's Address: _____

_____, CA _____
City Zip Code

Member's Phone #s _____ _____ _____
Home Work Cellular

Name of Dental Plan: _____ **Plan ID #** _____
Member's ID Number Assigned by Plan

Plan Dentist that is subject of Report: _____
Name Address Phone No.

PROBLEM DESCRIPTION

Date Event Occurred: _____ **Date Problem Identified:** _____

Has Member Filed a Grievance with the Plan? ☐ **Yes** ☐ **No** **Date Grievance Filed:** _____

Explanation of Problem, including Actions Taken: _____

(use additional pages if necessary)

Proposed Solution: _____

(use additional pages if necessary)

Able to resolve problem: ☐ **Yes** ☐ **No** ☐ **No action taken** **Date problem resolved:** _____

Person Completing Form: _____ **Area Code & Phone No.:** _____ **Date of Completion:** _____
Name *(PLEASE PRINT)*

G:/MDSB Public/Forms/DMC Problem Report form.doc 06/14/2007

ATTACHMENT 4

ACS Oral Conditions and Associated ICD-9 Codes[151]

The following descriptions help explain the various ICD-9 codes hospitals used in coding the Ambulatory Care Sensitive (ACS) oral conditions of the emergency department (ED) visits reported in this study.

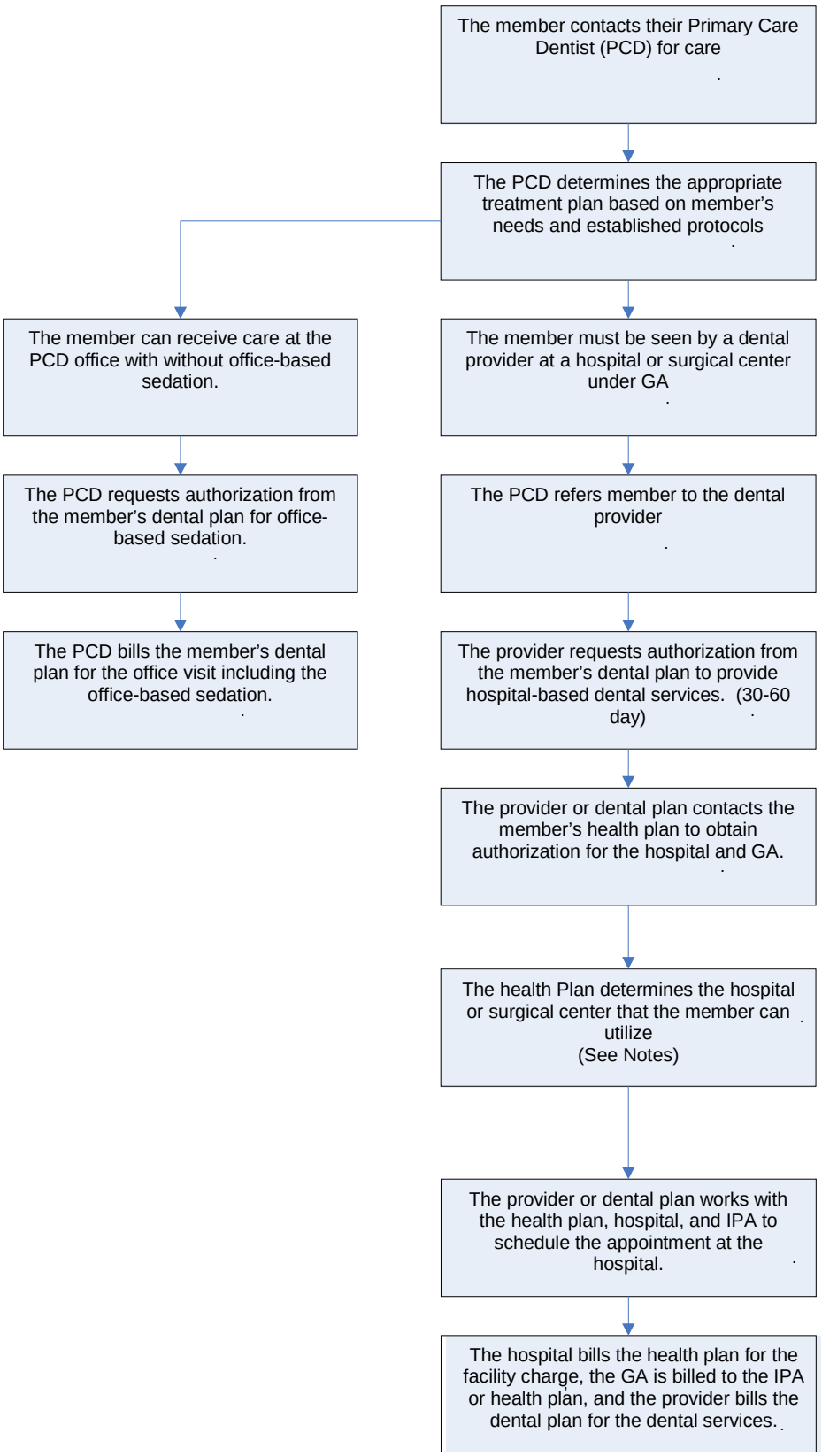
- "Pulp and periapical tissues" are "toothaches" that elicit pain through the "pulp" organ of the tooth which contains a nerve, blood vessels and fibrous connective tissue.
- "Periapical Tissues" are the jaw bone, the root nerve and blood vessels connected to the tooth and the periodontal ligament (connective tissue) that holds the tooth in the bone, at the top of the tooth. These are the tissues involved in a true abscess, when the infection of the caries eats through the tooth, then the pulp and out the tip (apex) of the tooth to eat/destroy the bone and surrounding tissues. This is the condition that causes swelling; there is no swelling when the infection is just in the tooth as it cannot expand.
- "Oral Soft Tissues" are the gingiva (gums) both attached and free, oral mucosa (inner cheeks, floor of the mouth, vestibule (inner lip area that attaches gums), lips, roof of the mouth, soft palate, hypo pharynx, tonsilar pillars. The things one can get here are cuts, bruising and trauma, cold sores, ulcers from food or drug allergy, burns (e.g., from pizza), Thrush (a fungus), cysts, Lichen Planus, infection (bacterial and virus)

All the above can also affect the tongue.

520.6 = "Disturbances in tooth eruption" – misplaced teeth, broken or retained baby teeth, infected eruption sac, premature permanent teeth.
520.7 = "teething syndrome" - painful teething, infection….
521.0 = "Unspecified Dental Caries"
522.1 = "Pulpitis" – infected or inflamed pulp
522.4 = "Acute apical periodontitis of pulpal origin"—a true abscess
522.5 = "Periapical abscess without sinus"
522.6 = "Chronic apical periodontitis"
522.7 = "Periapical abscess with sinus"
522.8 = "Radicular Cyst" - odontogenic cystic lesion of inflammatory origin.
523.0 = "Acute Gingivitis, Plaque induced" – gingival inflammation
523.1 = "Acute gingivitis, non-plaque induced"
523.2 = "Gingival recession – unspecified "
523.3 = "Aggressive periodontitis, unspecified"–inflammation and destruction of the periodontal ligament
523.4 = " Chronic periodontitis, unspecified"
523.5 = "Periodontosis" - a degenerative, non-inflammatory destruction of the periodontium, originating in one or more of the periodontal structures and characterized by migrating and loosening of the teeth in the presence or absence of secondary epithelial proliferation and pocket formation or secondary gingival disease.
523.6 = "Accretions of the teeth" - Hard or soft material deposited on a tooth surface, such as dental calculus or plaque and materia alba
523.8 = "Other specified periodontal disease"
523.9 = "Unspecified gingival or periodontal disease"
528.2 = "Oral Apthae " – Canker or Cold sore
528.6 = "Leukoplakia of the Oral mucosa or tongue" - a "whitish", flat lesion

[151] Prepared by Jack C. Luomanen, DMD, October 2015. Note: the ICD 9 Codes were in use at the time of this report and relevant to billing.

Hospital Based Dentistry Authorization Process*



Notes

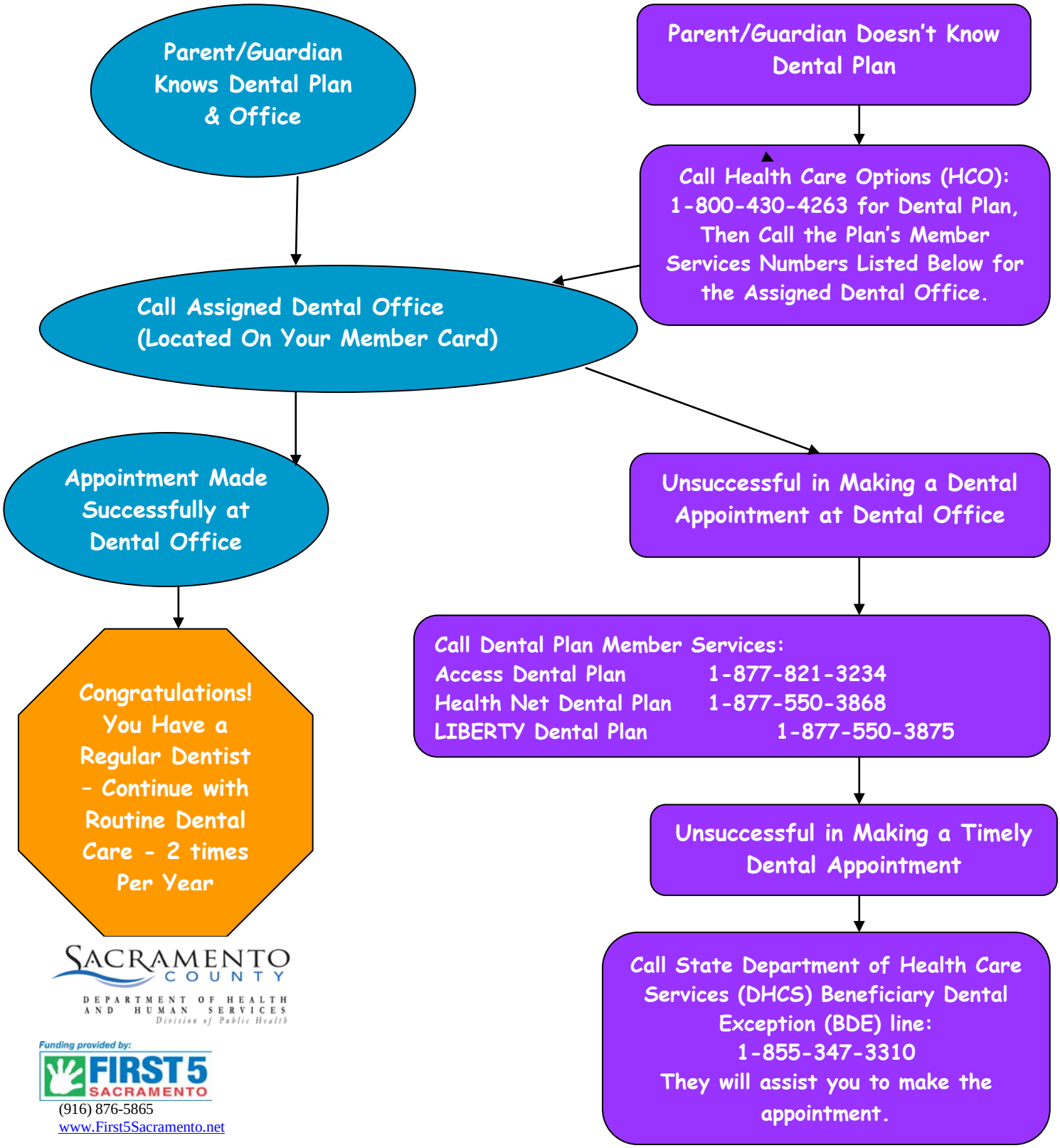
The provider must have privileges at the hospital. If not, the dental plan should work with health plan to identify a provider who does.

If the member is assigned to an IPA authorization for the GA must be obtained from the IPA. The provider or dental plan can contact the IPA directly or work with the health plan to obtain authorization from the IPA.

Authorization for the hospital is provided directly by the health plan.

*Prepared by Sean O'Brien, Health Net, 2015.

How to Successfully Make a Dental Appointment with a Medi-Cal Dental Geographic Managed Care (GMC) Dentist

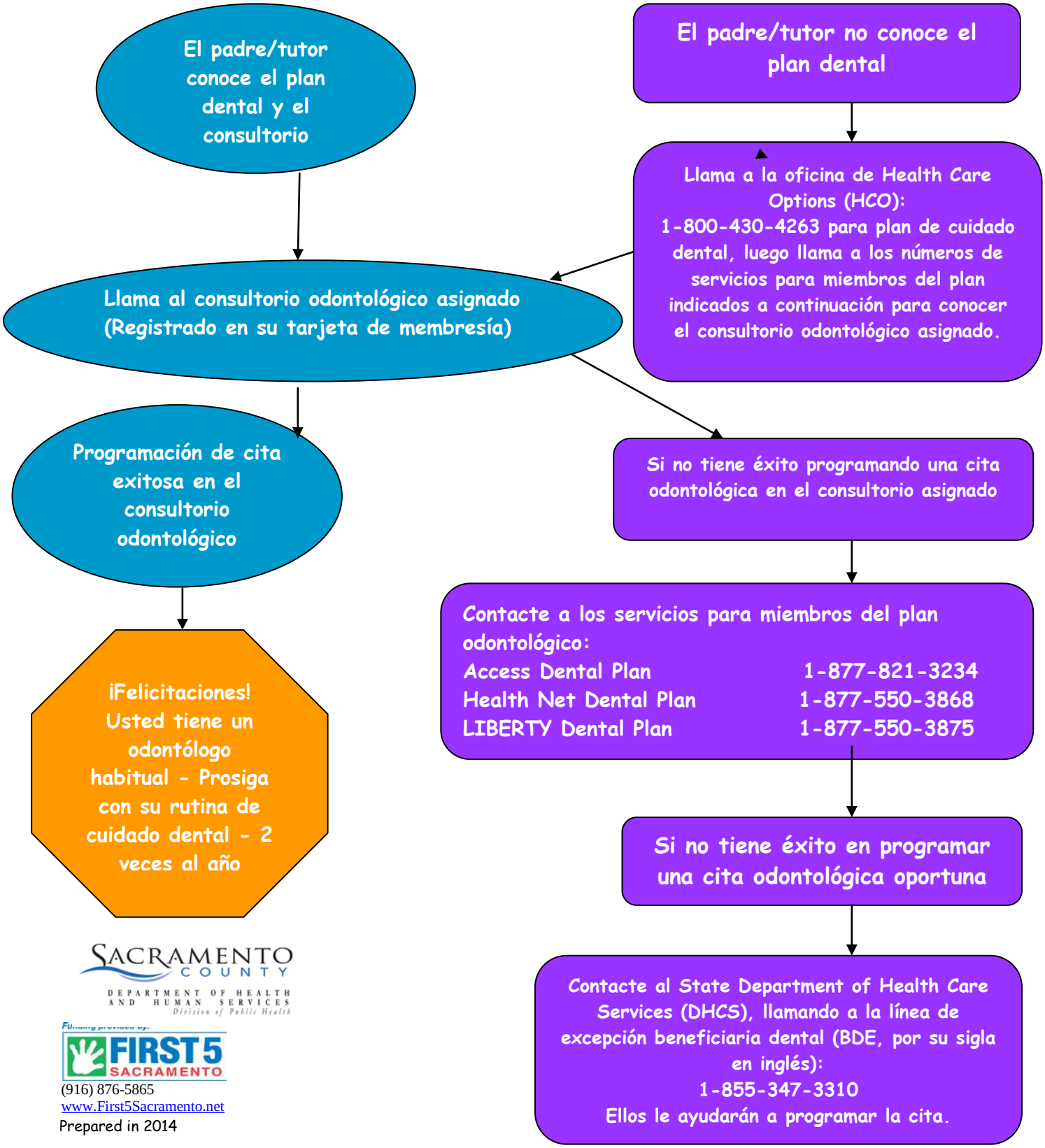


SACRAMENTO COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

Funding provided by:
FIRST 5 SACRAMENTO

(916) 876-5865
www.First5Sacramento.net

Cómo hacer una cita con un dentista del programa Medi-Cal Dental Geographic Managed Care (GMC)



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Prepared in 2014

ATTACHMENT 7

MCDAC Proposals, Projects and Collaboration with DHCS and the Dental Plans

Status as of September 2015

Proposal/Project	Responsible Parties	Current Status
Benefits Identification Card (BIC) Mailer	DHCS/Dental Plans/MCDAC/CA Stakeholders	DHCS Mailed/Phone Calls Received by DHCS & Referrals Made
Public Records Act (PRA) Data Request for Utilization Rates by Zip Code in Sacramento County	DHCS/First 5 Sacramento	DHCS denied three times then released with suppressed data in 2014 with new policy on data requests
Implement Pilot(s) to Improve Utilization Rates in Sacramento County • Mobile/off-site program for preschool & school-aged kids • Work with pediatricians on dental education & fluoride treatments • Increase reimbursements on targeted populations	DHCS/Dental Plans/MCDAC	On hold by DHCS until results from LA County on pilots implemented there
DHCS recommended to MCDAC to start conference calls with LA County Stakeholders	MCDAC/LA County Stakeholders	Bi-monthly Conference Calls
Statewide Outreach to Families that have not seen the Dentist in the Past Year	DHCS/Dental Plans	In progress
Updated Sacramento County GMC Report from 2010 "Sacramento Children Deserve Better"	DHCS/Dental Plans/Barbara Aved/MCDAC Advisory Committee	In progress for Dec 2015
More Accurate Referral List of Participating Dentists	DHCS/Dental Plans/SDDS	On-going
Meet with DHCS in-between MCDAC meetings to work on Program Improvements	DHCS/MCDAC	Met once by invitation from DHCS in May 2015; will meet when invited again
Input on Contract Language and Performance Measures for 2013 RFP	DHCS/MCDAC	New performance measures and benchmarks were included in the RFP
Change CHDP Guidelines from 3 years of age to age 1 for 1st Dental Visit	CHDP/DHCS/Legislature	Approved in Governor's Budget July 1, 2015
Input on Proposed Benchmarks to become effective in CY 2016	DHCS/MCDAC/CA Stakeholders	DHCS finalized Aug 19, 2015 for CY 2016 implementation
Input on Modified Policy for General Anesthesia and Intravenous Sedation	DHCS/MCDAC/All Stakeholders	In progress

Proposal/Project	Responsible Parties	Current Status
Reverse 10% Rate Reduction implemented by AB 97	DHCS/MCDAC/CA Stakeholders/ Legislature/ Budget Committee	Reduction reversed effective July 1, 2015
Raise Provider Reimbursement Rates	DHCS/MCDAC/CA Stakeholders/Legislature	In progress
Sacramento District Dental Society (SDDS) Outreach Campaign to Pediatricians and Hospitals	SDDS/MCDAC	Conducted more than once; dental education materials ordered by local dentists
Increase Fluoridated Water Districts in Sacramento County	DHCS/First 5 Sacramento/SDDS	When Golden State Water Company completes construction, 65% of Sacramento County will have fluoridated water
Build and Operate Children's Dental Clinics in Sacramento County	First 5 Sacramento contracted with FQHCs; input from MCDAC on needed services	Five Children's Dental Clinics are operating in Sacramento County with a sixth being built in Galt – operational early 2016
Requested Streamlined Approval Process for Hospital Dental Procedures between Medical and Dental Plans To ensure patients who need access to dental care under GA can access it, DHCS should identify a methodology to track the access to care for those patients, report that data to MCDAC, and hold contracted dental plans and medical plans accountable for ensuring access to timely care for these beneficiaries.	Dental and Medical Plans, DHCS	Health Net provided an Approvals Flowchart and worked to streamline the approvals process Dental Plans have agreed to take the lead on the approvals process but no formal policy between medical and dental plans yet DHCS and Dental Plans have facilitated process when cases have been brought to their attention In progress
Added Dental Infant Toothbrush & Educational Materials to the First 5 Sacramento "Kit for New Parents"	First 5 Sacramento/MCDAC	On-going; distributed to approximately 12,000 new parents each year
Created and Distributed Oral Health 8-Page Publication	First 5 Sacramento/MCDAC	100,000+ have been distributed since 2010
Created Car Seat Program for Families in Need of Car Seats for Dental & Medical Appointments	First 5 Sacramento/MCDAC	Over 200 car seats have been distributed through the Family Resource Centers (FRCs) after completion of a one hour class
Funding for the Smile Keeper's Program	First 5 Sacramento/Sacramento County	Fluoride Varnish & Dental Exams for over

Proposal/Project	Responsible Parties	Current Status
	DHHS	8,000 children annually
Funding for Expanded Dental Outreach to WIC and other agencies serving young children	First 5 Sacramento with Input from MCDAC	Funding awarded – Program start up in progress (Add-on to the Smile Keepers Program)
Funding for Dental Education Campaign	First 5 Sacramento with Input from MCDAC	Funding application under development by First 5 Sacramento