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

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

EXECUTIVE SUMMARY

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"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

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, these children make fewer preventive dental visits than their peers not covered by Medi-Cal;[3] close to two-thirds (64%) of California children with private dental benefits made a dental visit in 2013.[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 improvement. A dilemma exists, however—greater success in increasing utilization will in turn increase costs. Thus, the State must manage the trade-off between a desire to increase access while containing costs as the numbers of Medi-Cal eligible children rises. An optimal utilization rate that makes offering a children's program both meaningful and sustainable needs to be established. This report 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.

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

This report summary, prepared by BARBARA AVED ASSOCIATES, presents highlights of the full study that updated our 2010 evaluation[5] of the GMC dental program. The purpose was to learn what

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

improvements have been implemented in the last 5 years, and to offer suggestions from other state Medicaid dental experiences that can benefit children statewide.

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 analyses. 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 programs, and local dental professionals, community leaders and other stakeholders. A subcommittee of the Sacramento County Medi-Cal Dental Advisory Committee (MCDAC) provided guidance to the project.

Key Findings and Conclusions

There is Evidence of Improvement in GMC Dental Since 2010

- Although GMC continues to lag behind FFS utilization, improvements have been implemented in the structure and management of the program, expansion of community services and in some plan performance 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. It uses these measures to monitor plan utilization and institute a structure of withholds and bonuses.
- 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 2016. GMC plan contracts are now in place with all of these dental clinics plus several others 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%.
- 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.
- Efforts in Sacramento 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 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 recruit prospective providers; capacity is still limited.
- The accuracy of provider directories has improved since 2009 and the number of available providers has increased nearly three-fold.

- While no performance benchmark was fully met for all 0-20 age groups, the 3 dental 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. 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" whether in Medi-Cal dental managed care or FFS.
- Stakeholders believe children's dental utilization has plateaued. The diversion of serving adults with high dental needs when Medi-Cal benefits for adults 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. Sacramento dentists who formerly took Medi-Cal patients cited low reimbursement rates and challenges navigating the program's administrative requirements as key reasons. Half the dentists said higher reimbursement rates, payment made on a FFS basis and reduced administrative burdens were 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 the dentists indicated provider rates would need to be increased by 50% or more; one-third indicated a 70%-80% increase would be necessary for them to start accepting Medi-Cal patients.
- DHCS implemented a Beneficiary Dental Exemption process in 2012 for Sacramento County children to opt out of GMC when experiencing 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. DHCS assisted these families in making appointments.

- Half of the respondents to the dental 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 dental appointment attendance 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, but less than in 2010.

Other States Have Experienced Successes DHCS and Sacramento Could Pursue

- Some states' Medicaid programs 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 economic recovery since the 2008 recession, provider 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 and other primary care providers to provide preventive dental services and changes in scope of practice for mid-level practitioners has helped to increase access.

Recommendations for Improvement

Key recommendations in the study are separated into Short-Term (within 1 year) and Longer-Term (requiring 1-2 years) categories. They include who should take the lead for implementing the recommendation. The three main parties–DHCS, the dental plans, and stakeholders (MCDAC, various organizations and advocates)–must play contributing roles in implementing recommendations. Working with legislators may be needed on items that would require legislative approval such as rate increases or certain policy changes.

	Recommendation	***Lead****
Short-Term Implementation		
1.	Adjust benchmarks, requiring increased performance for overall and preventive services utilization until it reaches statewide FFS averages 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.	Increase support/involvement with MDAC, regularly engaging in policy planning	**D, S, P**
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.	**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.	Require GMC plans through contract language 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 to recoup the cost of school-based prevention and dental screening services when provided to children with Medi-Cal.	**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.	**D**
9.	Implement patient incentive strategies to increase utilization, encourage the use of preventive services and reduce use of emergency departments for avoidable dental conditions.	**P**
Longer-Term Implementation		
1.	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 "Completion of Treatment Plans in 12 Months" to the Performance Measures and Benchmarks as a mandatory contract condition to reduce dental disease and reflect good practice.	**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

Next Steps to Implementation

- Review the recommendations at the January MCDAC meeting and determine which ones MCDAC wishes to undertake, prioritize them and develop a simple action plan for implementing them.
- 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.
- 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, request 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 all plans combined to look for meaningful trends.