Sacramento Children Deserve Better

A Study of Geographic Managed Care Dental Services

EXECUTIVE SUMMARY

BARBARA AVED ASSOCIATES
Sacramento, California
June 2010
Our Vision

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

Our Mission

The First 5 Sacramento Commission is committed to supporting the healthy development of children zero to age five, the empowerment of families and the strengthening of communities.
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“Your baseline of what’s acceptable changes when you see this stuff over and over again.” — School nurse referring to high-volume Denti-Cal plan providers’ becoming immune to children’s oral conditions they think aren’t serious enough to address.

Introduction

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

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

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

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

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Study Methods

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

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

Key Findings

Access-Related

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

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

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

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

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

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

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

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

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

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

Quality of Care-Related

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

- Among the children who actually utilized a dental service, Liberty and Health Net achieved ratios of over 1.0 of preventative services to users (i.e., some children returned for a second visit at a 6-month interval as recommended by the American Dental Association for cleaning and fluoride treatment.) Fresno FFS surpassed all GMC plans with a 1.17 preventive services to user ratio.
GMC dental users in Health Net, Access, Liberty and Community received a range of .82 to .70 comprehensive or periodic examinations per user, respectively. Western provided these exams at about two-thirds of those rates. Children in Fresno FFS, on the other hand, were provided 1.27 exams per unduplicated user.

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

Medi-Cal Dental Services Program

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

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

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

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

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

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

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

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

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

Recommended Alternative

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. DHCS should establish dental managed care quality indicators.

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

12. More opportunities should be supported in Sacramento County to integrate dental with medical, such as inter-professional training. Organizations such as the California Dental Association Foundation and the Sacramento District Dental Society can help.
13. DHCS and local policymakers and stakeholders should promote more oral health education/awareness and outreach activities aimed at low-income families.

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

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

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

Implementation Plan

Parties, Roles, and Timeline

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

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

The Sacramento County BOS should:

- Appoint the entity for local oversight—essentially re-establishing a “GMC Commission” but with broader responsibility. The Sacramento Health Care Improvement Project’s (SHIP)—and Children’s Dental Task Force—role in improving access to quality care for underserved populations in the region and the Public Health Advisory Board (PHAB) make these the most feasible bodies to consider. (September 2010)
- Help create legislative authority, if it is required, to implement the policy change of making GMC dental voluntary in Sacramento. (July 2011)

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

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

Champions and partners that could assist with implementation include:

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

**Barriers to Implementation**

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