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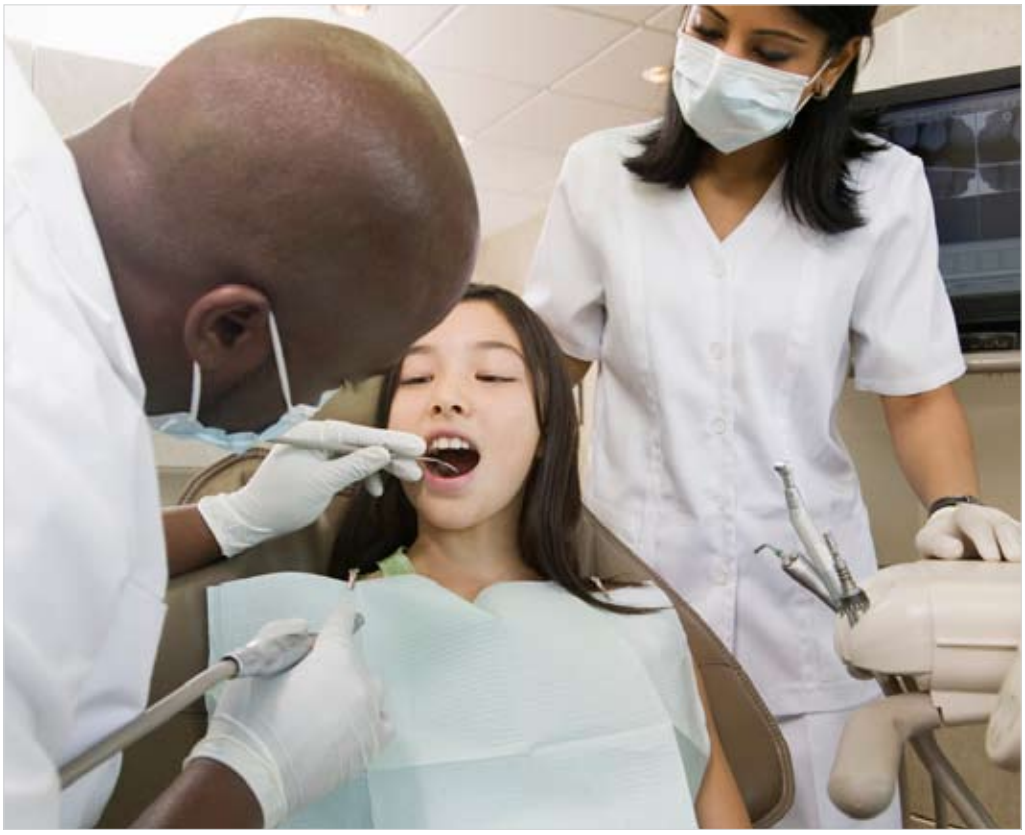

Managing California's Medicaid Dental Program:
Lessons from Other States

July 2009

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Prepared for
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by
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About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

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I. Introduction

There is growing evidence that better integrating physical and oral health services improves health outcomes and reduces costs.

Access to oral health services is an important underpinning of good health overall. It has been shown to reduce the incidence and severity of a range of serious diseases and conditions, and to enhance functionality. Because there are significant disparities in oral health care between low-income and other Americans, federal and state policymakers have long been concerned about ensuring access to dental services for Medicaid beneficiaries.

In recent years, a number of states have examined their Medicaid dental programs and implemented reforms to improve oral health care for beneficiaries. In some states, these reforms have included changes in the administration of the Medicaid dental program, with the goal of improving both access to and use of services.

To learn from these states' experiences, Health Management Associates (HMA) was asked by the California HealthCare Foundation to examine how several states administer their dental programs and to share insights. The purpose of this project was to identify key considerations that could help California improve access to oral health care services for the Medi-Cal population.

II. Background: A Nationwide View

The disparities in oral health care between low-income and other Americans are well documented. The U.S. Government Accountability Office reported that three in five children enrolled in Medicaid had experienced dental decay, one in three had untreated tooth decay, and roughly one child out of nine had untreated tooth decay in three or more teeth.[1] Further, lower-income populations use fewer dental services than their higher-income counterparts: Nearly a third of people from poor and low-income families had an annual dental visit compared with 58 percent of individuals in high-income families.[2] A 2000 report by the U.S. surgeon general characterized such disparities as a "silent epidemic" of dental and oral disease among low-income populations.[3]

Under Medicaid, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program (known as the Child Health and Disability Prevention program in California) requires that all states provide dental services to beneficiaries under the age of 21. Even so, states report relatively low levels of access and utilization for Medicaid-eligible children, especially preventive services. For most adults, dental care is an optional benefit, and about one-third of states provide a comprehensive dental benefit for adult beneficiaries.[4] Most states opt to provide only limited, emergency-related dental services for Medicaid-eligible adults. A 2005 survey found that, even among states that offer a comprehensive Medicaid dental benefit, only about half of beneficiaries reported having a check-up during the 12 months prior to the interview.[5]

Dental care has long-term cost implications. Research suggests that access to dental services reduces the incidence and treatment costs of a variety of diseases and conditions. A 2004 study of preschool-age children eligible for North Carolina's Medicaid program found that delaying the first preventive dental care visit increased the chance that a child would require more restorative and emergency dental services in the future, compared with a child who received a preventive visit before age 1.[6]

Moreover, there is growing evidence that better integrating physical and oral health services improves health outcomes and reduces costs. Such findings spurred Aetna to implement a Dental/Medical Integration Program for its commercial plan beneficiaries. This program offers enhanced educational services and dental benefits to commercial beneficiaries with diabetes, coronary artery disease, and/or cerebrovascular disease.[7]

For Medicaid beneficiaries, however, dental coverage does not equal access to services. Nationally, less than half of all dentists enroll as Medicaid providers.[8] Burdensome administrative requirements, the challenges of working with Medicaid beneficiaries, and low payment rates, particularly when compared with commercial rates, are commonly cited as issues that limit Medicaid participation by dentists.[9]

III. Medicaid Dental Access in California

Until recently, California's Medi-Cal program offered comprehensive dental services to all full-scope Medi-Cal beneficiaries. During 2004, more than 8.5 million people were eligible at some point for Medi-Cal-covered dental services, and Medi-Cal payments were in excess of $600 million.[10] Since 2006, budget constraints have limited adult dental benefits to $1,800 per beneficiary per year (although a number of procedures and eligibility categories are exempted from the cap), and most adult dental benefits were eliminated effective July 1, 2009.

The majority of Medi-Cal beneficiaries receive services through Denti-Cal, the state's fee-for-service dental program. California's Department of Health Care Services (DHCS) also operates dental managed care programs in Sacramento and Los Angeles counties. Enrollment in these programs is mandatory for Medi-Cal beneficiaries in Sacramento County and voluntary for beneficiaries in Los Angeles County.

As in other states, California's Medicaid (Medi-Cal) dental access and utilization rates are low. In 2004, only 26 percent of beneficiaries used dental services, with children, pregnant women, and seniors using the least. Thirteen percent of Medi-Cal beneficiaries had never been to a dentist, compared with 5 percent of people with commercial health insurance.[11] A 2007 survey found that 44 percent of adult beneficiaries reported not having Medi-Cal dental benefits even though Medi-Cal provides them.[12] Among California's children, those in higher-income households (with family incomes above 300 percent of the federal poverty level) were more likely to have seen a dentist within the past 12 months than lower-income children: About 85 percent of higher-income children reported having a dental visit in the last year compared with just over 75 percent of lower-income children.[13]

Only 40 percent of the state's dentists in private practice accept Medi-Cal patients, and the majority are general practitioners; specialty access is even more limited.[14] Group dental practices, as well as community health centers, provide a significant amount of the services available to Medi-Cal beneficiaries.[15] Low provider participation rates are driven, in part, by Medi-Cal's low reimbursement rates, which are one-third to one-half of dentists' usual fees.[16] Efforts to increase reimbursement to dental providers have been stalled by ongoing budget constraints.[17]

Program Administration

Within DHCS, the Medi-Cal Dental Services Branch (MDSB), a part of the Fiscal Intermediary and Contracts Oversight Division, is responsible for managing the Medi-Cal dental program. MDSB manages Medi-Cal's two dental programs differently because of their different structures.

Denti-Cal Program

DHCS administers Denti-Cal through a contract with Delta Dental of California (Delta California). The Denti-Cal contract is structured in a manner typical of Medicaid fiscal intermediary (FI) contracts. Delta California operates the program using the California Dental Medicaid Management Information System.[18] This system supports functions such as eligibility verification, beneficiary services, provider services, utilization review, claims processing, and reporting. Delta California also

operates a call center with an integrated voice response system, conducts quality management activities, notifies beneficiaries of coverage decisions, and participates in fair hearings.

DHCS establishes the criteria for services provided, and Delta California conducts the treatment authorization request process and pays claims using these criteria on the state's behalf.[19] It should be noted that a number of these criteria and processes have been enacted in state statute to counter fraud and abuse in the program, and leave DHCS, and thus Delta California, with limited discretion in the way they are implemented.

DHCS pays Delta California for administrative services on a per-member-per-month basis tied to program enrollment. Under the terms of the contract, Delta cannot lose or gain more than $4 million per year. Delta California pays providers on a fee-for-service basis using the Medi-Cal fee schedule.

Dental Managed Care Program

In Los Angeles and Sacramento counties, DHCS contracts with nine Knox-Keene-licensed dental managed care plans to provide dental services to Medi-Cal beneficiaries.[20] The dental plans assume full financial risk for providing the Medi-Cal dental benefit in return for a negotiated monthly capitation payment. While the plans are required to offer the same services as Denti-Cal, they are provided within a managed care model that allows plans to manage utilization.

Lack of Dental Coverage in Medi-Cal Managed Care Contracts

It is important to note that about half of all Medi-Cal beneficiaries are enrolled in Medi-Cal managed care plans, but dental services are not included in the plans' contracts with the state and the plans' responsibility for dental services is limited.[21] As a result, there is limited coordination of Medi-Cal managed care beneficiaries' physical health and dental care services. Over the years, some Medi-Cal health plans have indicated an interest in including dental coverage in their contracts. Discussions with DHCS have generally faltered around the issue of rates. Most recently, CenCal Health (CenCal), the County Organized Health System serving Santa Barbara and San Luis Obispo counties, identified dental care as a critical unmet need for its members. The plan has approached DHCS on an exploratory basis to discuss issues related to the possible assumption of this benefit by CenCal, but no decision has been made.[22]

IV. Medicaid Dental Administration in Selected States

HMA identified five states — Arizona, Michigan, New Jersey, Rhode Island, and Virginia — that use administrative models that differ from California's. Through interviews with state officials, dental benefits managers, and health plans, HMA explored how these models operate to identify potential lessons for California. Michigan, Rhode Island, and Virginia have implemented major changes in their programs' administrative structures and contract with dental benefits managers (DBMs) to manage their fee-for-service dental programs. Arizona and New Jersey include dental services in their managed care health plan contracts and have worked with the plans to improve access and utilization.

State Contracts with Dental Benefits Manager for a Fee-For-Service Dental Program

Michigan, Rhode Island, and Virginia contract with dental benefits managers to help the state administer fee-for-service dental programs, including organizing dental provider networks and actively managing beneficiary utilization. Each of these states enrolls many Medicaid beneficiaries in managed care health plans for physical health care services, but dental benefits are administered separately. The states moved to a DBM arrangement as a part of larger reforms of their Medicaid dental programs. The focus of reform has been on services for children; none of these states provides comprehensive dental benefits to adults. A number of common elements emerged across these states' efforts, including:

Key Findings

The states studied in-depth—Arizona, Michigan, New Jersey, Rhode Island, and Virginia—as well as the Healthy Families Program (HFP), use different models to administer their dental programs. Arrangements include: contracting with dental benefits managers (DBMs) for administrative services only; contracting with dental managed care organizations; and contracting with full-risk managed health care plans for both physical and oral health services. Some of the study states rely on a single administrative model, while others use more than one model across their programs. Some states significantly restructured the Medicaid dental program, while others made incremental changes. Other findings:

- Stakeholder involvement and buy-in is critical to the success of any reform effort. Senior-level executive and legislative branch leadership is also important.
- Reforming the Medicaid dental program does not lead to cost savings in the short term due to beneficiaries' unmet needs and resulting pent-up demand for oral health care services. However, cost-effectiveness improves as utilization moves away from restorative services and toward preventive care.
- Administrative and payment issues are critical for providers and contribute to low rates of provider participation. The study states reduced or streamlined administrative requirements and, in many cases, increased reimbursement rates to improve participation.
- Integration of physical and oral health services has not been a priority, although some states and health plans are beginning to focus on this.

- Changes were guided by a high-level oral health task force that included legislative and executive branch officials, dental associations, and consumer groups;
- The states are committed to streamlining administrative requirements for providers;
- The states look to their dental benefits managers to provide administrative services only, and retain financial risk for their dental programs;
- The DBMs pay their dental providers on a fee-for-service basis; and
- The states work with their DBMs to monitor beneficiary access and utilization of services.

As described below, each of the three states has some unique aspects to it program.

Michigan's Healthy Kids Dental Program

Implemented in 2000, Michigan's Healthy Kids Dental program now operates in 61 of the state's 83 counties. These counties are primarily rural and serve about one-third of eligible children under age 21. Children in the remaining 22 counties, including the Detroit metropolitan area, receive care through the state's fee-for-service dental program.

Provider participation was a key problem for Michigan. Prior to 2000, less than 20 percent of the state's dentists participated in the Medicaid program, which spurred the state to convene the Medicaid Dental Task Force to evaluate it. The task force recommended building on the success of Michigan's Children's Health Insurance Program (CHIP) dental program, which is modeled on a commercial program.

Healthy Kids Dental is administered through a contract with Delta Dental of Michigan, Ohio, and Indiana (Delta Michigan), which also serves as the DBM for the state's CHIP program. In contracting with a DBM, the state was particularly interested in obtaining access for Medicaid beneficiaries to a larger, commercial network of dental providers. Accordingly, dentists participating in Delta Michigan's commercial network must see Medicaid beneficiaries unless they are not accepting new patients. This has increased access significantly for Michigan's Medicaid beneficiaries because Delta Michigan's network includes about 95 percent of the state's dentists. In addition, Delta Michigan uses the same policies and procedures across both its commercial and Medicaid lines of business, which providers find easy to navigate.

The state pays Delta Michigan a fixed payment per beneficiary per month for both administrative services and payment of provider claims. The state reconciles claims paid annually with Delta Michigan. To pay providers, Delta Michigan uses a statewide fee schedule that is higher than the traditional Medicaid dental fees.

Michigan tracks selected process measures to monitor the impact of the Healthy Kids Dental Program. Since the program started:

- Dental visits for enrolled children are 50 percent higher than for children in the traditional Medicaid dental program;
- Geographic access to dentists has improved for enrolled patients; and
- Parents reported high rates of satisfaction with the program, and 92 percent reported improvements in their children's health as a result of Healthy Kids Dental.[23]

Rhode Island's RIte Smiles Program

Rhode Island's RIte Smiles program was implemented statewide in 2006 in response to the

recommendations of a senate commission on oral health. In addition to focusing on access, the state has sought to increase the use of preventive dental services and reduce the use of emergency departments for dental care. To maintain budget neutrality, only children born on or after May 1, 2000, are enrolled in the program. Children born prior to this date up to age 21, continue to receive dental services through the state's fee-for-service system.

Rhode Island contracts with UnitedHealthcare Dental (United) as its dental benefits manager. The company provides dental administration and care management services, is responsible for developing and maintaining a provider network, and pays claims. To facilitate participation, providers may elect to participate only in RIte Smiles rather than the entire Medicaid dental program.

Rhode Island pays United a fixed payment per enrolled child per month. The contract includes a risk-sharing and gain-sharing arrangement designed to ensure the monthly payment adequately covers the cost of services provided, while limiting United's profit margin.

Access to and utilization of dental services has improved after the program's inception. Since 2006, provider participation has increased from 27 to 217 providers, including every pediatric dentist in the state.[24] Within the first year of implementation, 34 percent of RIte Smiles patients had visited a dentist, compared with 21 percent of fee-for-service participants. Rhode Island also monitors the use of preventive care and has found that 27 percent of children enrolled in RIte Smiles receive a preventive visit, compared with 17 percent of fee-for-service participants.[25]

Virginia's Smiles for Children Program

Started in 2005, Virginia's Smiles for Children program serves all Medicaid- and CHIP-eligible children under age 21.

Provider participation was a key consideration for Virginia. Prior to 2005, Virginia offered dental services to Medicaid beneficiaries through the health plan contracts in managed care regions of the state or through the fee-for-service program in the remainder of the state. Dental providers objected to following administrative procedures that varied by health plan and found it difficult to keep track of beneficiaries who transitioned between different types of coverage (managed care and fee-for-service) and between health plans.

In 2004, on the recommendation of an oral health task force led by the Medicaid director, the general assembly approved consolidating Medicaid dental services for children into a single, statewide program managed by a DBM, and approved an unprecedented 30-percent increase in program funding.

Virginia selected Doral Dental USA (Doral) as the Smiles for Children dental benefits manager. The state pays Doral a fixed payment per enrolled child per month to cover administrative services. Doral pays providers on a fee-for-service basis using a single, statewide fee schedule, and the state reimburses Doral for claims paid.

The state tracks performance measures that align with Smiles for Children goals and has seen improvements in both utilization and provider participation:

- In 2005, less than one-quarter of children under age 21, and less than a third of children ages 3 to 20, received dental services. By 2007, utilization rates had increased to 35 percent for children under age 21 and to 43 percent for children ages 3 to 20.

- In 2005, only 13 percent of Virginia's licensed dentists participated in Medicaid, and only 50 percent of providers who participated submitted claims. By 2007, 23 percent of Virginia's dental providers participated in the program and 83 percent submitted claims. [26]

While Virginia cannot attribute these improvements solely to the transition to a dental benefits manager, the state believes Doral has played a key role in improving access and provider satisfaction.

State Contracts with Managed Care Plans to Provide Dental Benefits

Two of the studied states, Arizona and New Jersey, contract with managed care plans to provide both physical health care and dental services to Medicaid beneficiaries. In each state, the health plans are paid a capitated monthly fee and are at financial risk for services provided. Some of the plans choose to provide the dental benefit themselves by contracting directly with providers, while others subcontract with dental benefits managers. Both states work closely with the health plans to address access and utilization issues and monitor performance.

Unlike the three DBM states discussed above, Arizona and New Jersey have not elected to make wholesale changes in the way they administer their Medicaid dental programs. Instead, they are tackling issues related to access and utilization through their existing administrative structures.

Arizona

Arizona's Medicaid program — the Arizona Health Care Cost Containment System, or AHCCCS — contracts with 18 health plans to provide all Medicaid-covered benefits to beneficiaries, including dental services (either comprehensive or emergency services).

Like other states, Arizona has made changes to increase participation by dental providers. These efforts started in 1997 when the legislature created the Interim Study Committee on Dental Care to assess dental care services provided to children enrolled in Medicaid. The study committee directed AHCCCS to convene a task force to improve the availability and delivery of dental services to children.

As a result of the task force's recommendations, AHCCCS made a significant change in how the Medicaid health plans pay their dental providers. After many years of allowing plans to determine how to do this, AHCCCS explicitly prohibited capitating dental providers and now requires that the plans pay providers on a fee-for-service basis. Additionally, AHCCCS has strengthened contractual requirements to ensure they are consistent with the standard of care in the dental community, and has established dental network requirements. For example, AHCCCS updated the health plan contracts to clarify that beneficiaries can see a dental provider at least twice a year for preventive care. With these changes as a foundation, the state and the plans have conducted outreach to providers to increase participation in the program.

To monitor dental access and utilization, health plans are required to report results of the HEDIS annual dental visit measure, and AHCCCS works with plans on dental-related quality improvement projects. For example, in the early 2000s, health plans implemented a number of interventions designed to encourage annual dental exams for children age 3 to 8. Interventions implemented by one or more of the health plans as part of this quality improvement project included: (1) pay-for-performance strategies to reward primary care physicians or dentists who meet specified oral health performance targets; (2) education of Head Start and Special Supplemental Nutrition Program for

Woman, Infants, and Children (WIC) staff about the importance of oral health; (3) follow-up activities conducted with beneficiaries who miss appointments; and (4) development of utilization profiles to provide feedback to providers about visit rates or to identify specific members requiring services. In one year, utilization for this group of children increased from 52.2 to 57.7 percent.[27]

New Jersey

Similarly, New Jersey's Medicaid program (known as NJ FamilyCare) contracts with five health plans to provide physical and oral health services on a capitated basis to the majority of beneficiaries. The health plans generally reimburse dental services providers on a fee-for-service basis.

As in Arizona, the health plans are responsible for recruiting dental providers (including specialists), negotiating provider payment rates, conducting member outreach, and establishing and managing prior authorization requirements.

Significantly, New Jersey is exploring how to integrate physical and oral health care services for Medicaid beneficiaries. NJ FamilyCare uses an integrated medical/dental model that provides coordinated, interdisciplinary care for beneficiaries with complex health issues. For example, in organ transplant cases, medical providers work closely with dental providers to ensure that all dental issues are addressed so transplant opportunities are not delayed or missed.

The Medicaid health plans are required to track EPSDT-related utilization rates and to report on utilization using the HEDIS dental measure. While New Jersey credits its model with improving provider networks, access and utilization remain a concern (2006 HEDIS results indicate that about 21 percent of children between the ages of 2 and 3 received at least one dental visit in a 12-month period, compared with 43 percent of children between the ages of 4 and 6),[28] and the state continues to work with the plans to improve the program. For example, in 2007, the Center for Health Care Strategies partnered with the state to create New Jersey Smiles. Under this quality collaborative, stakeholders, including the health plans, work with pediatric primary care providers and dentists in urban areas to improve integration of medical and oral health services by enhancing access to pediatric dental care among children age 5 and younger.[29]

V. Additional Model: Healthy Families Dental Program

In addition to examining various states' initiatives for improving access to oral health services for underserved populations, the researchers also looked at California's Healthy Families Program (HFP), which provides dental services to low-income children. The Managed Risk Medical Insurance Board (MRMIB) administers the program.

To provide services to HFP subscribers across the state, MRMIB contracts with six dental plans, including two dental exclusive provider organization (EPO) plans and four dental maintenance organizations (DMOs). Delta Dental and Premier Access serve as the EPOs, and the DMO plans include Access Dental Plan Inc., SafeGuard Dental Plan, Health Net Dental Plan, and Western Dental Plan.

MRMIB negotiates plan-specific capitation rates with the participating plans, which are responsible for delivering services to their subscribers. Three of the plans pay their contracted dental providers on a capitated basis, two pay providers on a fee-for-service basis, and one plan's providers are salaried employees.

To expand the choice of plans available to subscribers, MRMIB has allowed additional DMOs into the program over time. Overall, MRMIB has found contracting with dental maintenance organizations to be more cost-effective than the exclusive provider organization model, and this has become increasingly important as California's growing fiscal crisis puts increased pressure on the program's budget. However, MRMIB has also found that member satisfaction is significantly lower in the DMOs than in the dental EPO plans. Delta Dental has been closed to new enrollment in a number of counties because its rates did not fall within the ranges set for those counties by MRMIB. However, Delta has retained its existing beneficiaries and accepted their siblings when the plan is closed to new enrollment.

To monitor dental access and utilization, MRMIB collects data reported by dental plans and conducts satisfaction surveys. MRMIB found that between 1999 and 2004, the percentage of HFP subscribers receiving an annual dentist visit or a prophylaxis treatment remained relatively constant (ranging from 53 to 58 percent, and from 42 to 53 percent, respectively).[30]

In 2007, MRMIB approved the use of eight new dental quality indicators, several of which focus on access and use of services. These measures include: the HEDIS annual dental visit measure; overall utilization of dental services; utilization of preventive dental services; use of dental treatment services (to compare preventive and restorative services); examinations/oral health evaluations conducted; treatment/prevention of caries; ratio of fillings to preventive services; and continuity of preventive care provided from year to year.[31] Plans will report these measures to MRMIB for the first time based on the 2008 calendar year.

VI. Common Themes

Several common themes emerged from the research on the administration of the studied state programs and Healthy Families Program.

Active Stakeholder Involvement Is Important for Program Reform

Nearly all of the case study states emphasized the importance of stakeholder involvement in developing and implementing changes to their programs. Medicaid directors or interested legislators formed or called for task forces to conduct studies, review options, and make recommendations about improving the Medicaid dental programs in their states.

Senior-level executive branch or legislative leaders played prominent roles in several states. Virginia's efforts were led by the state Medicaid director, who played an active role. In Arizona, senior-level members of the executive branch, including the governor's office and the Medicaid director, led the project. Rhode Island's reform was led by the chair of the Special Senate Commission on Oral Health, who has since become the state's lieutenant governor.

To ensure the programmatic reforms were well-received and reflected a state's individual characteristics, all of the study states emphasized the need to actively engage a range of dental stakeholders, including state dental associations, dental schools, dental plans, dental professionals, physicians, Head Start representatives, schools, and consumer advocates.

Payment Issues Are Critical for Dental Providers

Most case study states indicated that dental providers understand Medicaid programs are not able to reimburse providers at rates equal to those of commercial plans, but the case study states also acknowledge that providers also must be able to cover their costs. Michigan, Rhode Island, and Virginia each increased provider reimbursement as part of their reform efforts.

Among the study states, providers are typically paid on a fee-for-service basis. Arizona, Michigan, Rhode Island, and Virginia all commented that this is necessary to promote provider participation. In contrast, several of the HFP dental maintenance organizations pay providers on a capitated basis, which MRMIB noted could reflect the prevalence of dental managed care in some of California's larger counties, such as Los Angeles.

Additionally, several case study states indicated that dental providers are willing to be paid a lower amount if claims are paid accurately and in a timely manner. To this end, New Jersey is planning to move to one-day turnarounds for clean claims submitted electronically by a specific time.

None of the case study states reported using pay-for-performance incentives to encourage improved access and utilization, although some Medicaid health plans in Arizona have used this strategy.

Administrative Issues Are Also Important for Providers

All of the study states agreed that provider participation is the backbone of ensuring access. In addition to increasing reimbursement rates, streamlining or reducing administrative requirements is important in increasing participation.

The study states noted that most dentists work as sole practitioners or in small groups, and some

commented that dentists find it challenging to have in-office expertise to manage contracts. Virginia and Michigan both indicated that dentists prefer to work with a single entity (e.g., a dental benefits manager) rather than with multiple health plans with differing administrative requirements. To address these concerns within a managed care structure, Arizona has changed health plan contracts to promote procedural consistency across plans.

To ease one of dentists' most commonly cited concerns about working with Medicaid beneficiaries, several study states highlighted the importance of addressing "no-show" rates. Virginia works with providers to identify, track, and trend no-show rates for enrollees, and patients are contacted about the importance of keeping appointments.[32] Rhode Island's DBM assists providers with no-shows and credits this with significant improvement in provider satisfaction. Arizona requires plans to work with dental providers to address and monitor no-shows. For example, Health Choice Arizona's member services department sends follow-up letters to members who have missed appointments.

Pent-Up Demand Delays Cost Savings

Most of the case study states cautioned that pent-up demand for dental services delays cost savings associated with program changes. However, several states noted they are beginning to see increased cost-effectiveness due to reform efforts. While Michigan has yet to realize any cost savings, state officials cited evidence of increased cost-effectiveness as member utilization moves away from costly restorative care to preventive and primary care services. Rhode Island also anticipates that spending on dental services will decline over time with the shift to a preventive care model. Similarly, MRMIB has found the initial years following expansion of access to dental services can be expensive, but costs decrease over time as utilization patterns change.

Integration of Services Is in Infancy

Among the study states, the focus to date has been on increasing access and utilization of dental services rather than integrating physical and oral health care. Several states noted that the link between dental health and physical health is not strong, citing the dearth of research on the benefits of integration or documented savings. One of the health plans noted that integration of physical and oral health services is not part of traditional medical or dental training, and Doral Dental commented on the challenge of developing information systems capable of efficiently sharing information between medical and dental providers.

However, some of the study states are exploring limited integration strategies. For example, Michigan is considering training primary care physicians on the importance of having a first dental visit by age 1 and providing fluoride varnish applications. Rhode Island recently modified its Early and Periodic Screening, Diagnostic, and Treatment periodicity schedule to include a dental visit by age 1; the state's dental benefits manager is charged with informing dentists and primary care physicians about the requirement.

The health plans interviewed for this project also are focused on integration. In New Jersey, AmeriChoice trains medical care providers in the early recognition of dental problems in children and reimburses physicians for these services. The plan reimburses providers for dental referrals that result in a dental visit (providers receive 40 percent of their original reimbursement amount for successful referrals), and AmeriChoice data indicate that dental utilization doubles in medical practices that participate in the referral program. Finally, the plan reimburses dentists to screen for diabetes as part of the dental exam.

VII. Considerations for California

Like other states, California is struggling with how to improve access and utilization of services for Medicaid beneficiaries. While program funding is clearly important, how the program is administered also affects the provision of services. The experiences of the study states and the Healthy Families Program provide insights for California to consider in weighing alternative approaches to administering the Medi-Cal dental program.

Transition from Payer to Purchaser

The study states have transitioned, or are transitioning, from being *payers* of Medicaid dental claims to *purchasers* of services by actively partnering with vendors to improve access and utilization. This change is similar to the shift that many states (including California) have made over the past decade for their Medicaid managed care programs. In a similar way, Medi-Cal could become a "value-based purchaser" for the dental program.

Under such a framework, Medi-Cal would focus on the services purchased and the results achieved. Rhode Island provides an example. Its reform efforts were guided by the legislature's intent that the state become a "prudent purchaser" of dental care services. This led the state to contract with a dental benefits manager and developing process and outcomes measures to track the DBM's performance.

Medi-Cal could develop a standard set of metrics based on the findings from the California HealthCare Foundation's *Denti-Cal Facts and Figures* report in 2007 and HFP's dental quality indicators. The metrics could then be used to monitor the dental program, make programmatic decisions, and gauge the value of the oral health services purchased on behalf of beneficiaries. These metrics could include:

- Percentage of beneficiaries who have at least one visit per year;
- Distribution of services (i.e., preventive, diagnostic, and other dental treatment services) provided to Medi-Cal beneficiaries;
- Ratio of fillings to preventive services provided;
- Amount of dental-related services provided in the emergency department and inpatient hospital setting; and
- Number of California dentists participating in the program and number providing services to Medi-Cal beneficiaries.

Establish High-Level Task Force

Changes made by most of the study states were guided and supported by a high-level task force that was actively involved in framing goals and objectives, assessing options, and developing recommendations and implementation strategies.

California could establish a similar task force that would include a range of dental care stakeholders. Likely members might be: Department of Health Care Services staff (including representation from the Medi-Cal Dental Services Branch; Medi-Cal Managed Care Division; and Child Health and Disability Prevention program), MRMIB staff, dental associations including the California Dental Association, community clinics, consumer advocacy groups, Delta California, the dental managed care

plans, dental and health care professionals, and the Oral Health Access Council.

Ideally, the task force would be initiated and led by a senior-level representative from the executive branch (e.g., a member of the Governor's staff or the Medi-Cal director) or a member of the legislature interested in oral health issues. Senior-level leadership would be particularly important for California because any changes that lead to improved access and greater utilization would likely result in increased costs and could require changes in statute.

The task force could be charged with both short-term and long-term goals. A short-term goal might be to examine options associated with the upcoming reprocurement of Denti-Cal's fiscal intermediary (FI) contract. Longer-term goals may focus on developing and implementing a road map to improved oral health for all eligible Medi-Cal beneficiaries. Lessons from other states and the HFP could inform this process, but options and recommendations should reflect the Medi-Cal context.

Align Dental Access and Program Integrity Goals

Program integrity is a significant concern for the Medi-Cal dental program because of past fraud and abuse. This history has led to significant controls on utilization, many of which are statutory and/or more stringent than those found in the commercial market. Dental providers find these requirements burdensome, which may limit their participation in the Medi-Cal program.

It will be important for Medi-Cal to align its access goals with its program integrity goals to ensure they are complementary rather than working counter to one another. A first step could be an analysis of the statutorily required provisions to determine whether they are having their intended impact and whether they could be modified to be less burdensome for dental providers in good standing with the program.

Use Dental FI Reprocurement as Opportunity

After exercising available contract extensions, DHCS will need to have a new dental FI (fiscal intermediary) contract in place in 2012. To meet this timeline, the procurement process would begin in late 2009 or early 2010. Reprocurement of the dental FI contract presents DHCS with the opportunity to restructure the contract to focus on improving access, utilization, and outcomes. Suggestions from the study states:

- Incorporate access and utilization performance measures as well as administrative measures;
- Track beneficiary utilization of dental services over time and telephone or email beneficiaries who do not access dental care services within a specified time frame;
- Design and implement initiatives with participating dentists and beneficiaries to address appointment no-shows; and
- Secure access to a commercial dental network to supplement the Medi-Cal dental network.

In addition to reviewing other states' contract language, DHCS may want to solicit input and information from possible vendors, including Delta California, through a request for information regarding approaches that could be used to address key issues in California. Information gathered through this process could be used to structure the request for proposals that DHCS will issue to reprocure this contract.

Measure Dental Program Performance

In the interim, DHCS may want to incorporate performance measures into its existing FI and dental managed care contracts. The study states and the HFP include performance measures in their dental benefits manager or managed care plan contracts, and several states commented on the importance of doing so as part of managing their dental programs.

Currently, DHCS is exploring whether to include the HFP performance measures, or a similar set of measures, in the FI and dental managed care plan contracts.[33] Performance measures used by other states may provide additional metrics appropriate for the Medi-Cal dental program. Medi-Cal should continue to evaluate the best set of performance measures for the dental program and work with the FI and dental managed care plans to implement them.

Partner with Medi-Cal Managed Care

Over the past 10 years, the Medi-Cal Managed Care Division (MMCD) has implemented value-based purchasing strategies on behalf of more than 3 million Medi-Cal beneficiaries. MMCD requires plans to measure health plan performance and member satisfaction and provides incentives (both financial and non-financial) to improve the quality of services provided. For example, MMCD publishes the annual HEDIS results for the health plans; publicly recognizes high-performing health plans at the MMCD annual quality conference; and uses performance data to help determine health plan enrollment for members who do not voluntarily select a health plan.

Given California's sustained experience with Medi-Cal managed care, there may be partnership opportunities for the state to explore with the health plans. For example, MDSB could coordinate with the Medi-Cal Managed Care Division and the plans to reach out to Medi-Cal beneficiaries about the dental program and the importance of good oral health. In addition, MDSB and MMCD could work more closely to ensure compliance with existing health plan requirements regarding dental benefits. For example, although MMCD notified its health plans in 2007 that the topical application of fluoride is a covered benefit for members under the age of 6,[34] the Medi-Cal Dental Services Branch indicated that the benefit has not been monitored closely or enforced. MDSB and MMCD could work with the health plans to track implementation of this requirement. While these activities could require an enhancement in the managed care capitation rates, they also offer the opportunity to reach roughly half of all Medi-Cal beneficiaries.

Given the interest the Medi-Cal health plans have shown in carving dental services into their contracts over the years, MDSB and MMCD should continue to explore the potential to pilot a dental carve-in with CenCal. This would give the state and the plans the opportunity to assess how this model would work under the Medi-Cal managed care program and evaluate this approach in terms of access, utilization, outcomes, and cost.

Improve Outreach and Education of Beneficiaries and Providers

DHCS could work with the California Dental Association (CDA) and other provider groups, consumer advocacy organizations (e.g., Western Center on Law and Poverty), schools, clinics, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) sites, Delta California, and the dental managed care plans to develop strategies to proactively conduct Medi-Cal beneficiary and provider outreach and education about the importance of oral health care and how to obtain services. As in other states, MDSB could

analyze enrollment and utilization data to identify beneficiaries who are not using dental services and implement strategies to encourage them to do so. It should be noted that the current FI contract neither requires nor prohibits Delta California from undertaking such activities and would need to be revised.

In addition, Medi-Cal could work with health care providers, including via the Medi-Cal managed care plans, to provide training on the dental program and the importance of preventive dental care for overall health.

DHCS could look to other initiatives in California as models for outreach and education. For example, the First Smiles program was a four-year, statewide initiative funded by First 5 California designed to provide education and training to medical and dental professionals and education to community-based organizations (e.g., WIC and Head Start programs) aimed at increasing access to preventive oral health services for young children.[35] Similarly, Alameda County's Healthy Kids, Healthy Teeth demonstration project offered training to dental and medical providers to increase access to dental services and improve the oral health of children age 5 and younger eligible for Medi-Cal.[36]

VIII. Conclusion

States that have struggled with dental care access and utilization offer valuable insights and models for California to consider. These states have tackled reform from various angles that have included reducing or streamlining administrative requirements and, in some cases, increasing provider reimbursement. Some also have pursued new administrative approaches (such as contracting with a dental benefits manager) while others have implemented incremental approaches within the context of their state environment.

Despite California's current fiscal crisis, which limits the amount of new funding available, California should chart a course to improve the Medi-Cal dental program. In particular, the reprocurement of the Denti-Cal FI contract offers an opportunity to begin to change the way Medi-Cal provides dental benefits and to introduce managed care principles into the Denti-Cal program. Simultaneously, a Medi-Cal dental task force could develop a vision and approach for longer-term changes to improve access and utilization within the dental program.

IX. Methodology

The information included in this issue brief is based on HMA interviews with state Medicaid officials in five states: Arizona, Michigan, New Jersey, Rhode Island, and Virginia. The researchers interviewed representatives from two dental benefit managers (Delta Dental of Michigan, Ohio, and Indiana, and Doral Dental USA) and two managed care health plans (United/AmeriChoice and Health Choice Arizona) that contract with state Medicaid programs to provide health and dental services. Officials from the California Department of Health Care Services (DHCS), which administers the Medi-Cal dental program, and the Managed Risk Medical Insurance Board (MRMIB), which administers the Children's Health Insurance Program (CHIP), known as Healthy Families, were interviewed. In addition, representatives from Delta Dental of California, which serves as the fiscal intermediary for the Medi-Cal fee-for-service dental program, were also interviewed.

State Interviewees

Arizona

Robert L. Birdwell, D.D.S.
Dental Director
Arizona Health Care Cost Containment System

California

Robert Isman, D.D.S., M.P.H.
Dental Program Consultant
Medi-Cal Dental Services Branch
California Department of Health Care Services

Michelle Marks
Chief, Medi-Cal Dental Services Branch
California Department of Health Care Services

Janette Lopez
Chief Deputy Director
California Managed Risk Medical Insurance Board

Michigan

Christine M. Farrell, R.D.H., M.P.A.
Program Specialist, Medical Services Administration
Michigan Department of Community Health

New Jersey

Margaret M. Bennett, M.S.N., R.N., A.P.N.
Director, Office of Quality Assurance
Division of Medical Assistance and Health Services
New Jersey Department of Human Services

Carol Grant
Chief of Operations
Division of Medical Assistance and Health Services
New Jersey Department of Human Services

Clifford Green, D.M.D.
Assistant Director, Office of Quality Assurance
Division of Medical Assistance and Health Services
New Jersey Department of Human Services

New Jersey, cont.

Valerie J. Harr
Deputy Director
Division of Medical Assistance and Health Services
New Jersey Department of Human Services

Bonnie Stanley, D.D.S.
Chief, Bureau of Dental Services
Division of Medical Assistance and Health Services
New Jersey Department of Human Services

Rhode Island

Martha Dellapenna, R.D.H., M.Ed.
Oral Health Access Project Manager
Center for Child and Family Health
Rhode Island Department of Human Services

Virginia

Sandra Brown
Dental Program Manager
Virginia Department of Medical Assistance Services

Dental Benefits Manager/ Health Plan Interviewees

Allen Finkelstein, D.D.S
Chief Dental Officer
United/AmeriChoice

Robert Freeman
Deputy C.E.O.
CenCal Health

Michael Kaufmann
Senior Vice President of Government Programs
Delta Dental of California

Kevin Kline
Vice President, Client Services
Doral Dental USA, LLC

Richard Lantz
Manager of Government Relations
Delta Dental of Michigan, Ohio, and Indiana

Garrett Leaf
Vice President, Denti-Cal
Delta Dental of California

Nancy McEwen
Dental Program Manager
Health Choice Arizona

Endnotes

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17. For a summary of the *Clark v. Kizer* settlement, see *Clark v. Coye*, 967 F. 2d 585 (9th Cir. 1992) at caselaw.lp.findlaw.com/scripts/getcase.pl?court=9th&navby=case&no=9315930&exact=1.

18. The California Dental Medicaid Management Information System is a state-owned information system. The system consists of an integrated set of procedures and computer processing systems capable of claims processing as well as storing and retrieving information. States are required to have these CMS-approved systems unless this requirement is waived by the federal government, and states generally contract with a fiscal agent or intermediary to operate the system.

19. Medi-Cal-covered dental services are defined in the California Welfare and Institutions Code and in Title 22, California Code of Regulations.

20. Knox-Keene refers to the Knox-Keene Health Care Service Plan Act of 1975. Health care service plans or specialized health care service plans operating in California are required to obtain a Knox-Keene license granted by the California Department of Managed Health Care. This license ensures that such organizations meet certain minimum standards and gives them the right to conduct business in the state.

21. Dental requirements for health plans participating in the Medi-Cal Managed Care Program include referring members to the Medi-Cal dental program beginning at age 3 and providing an oral health assessment as part of the member's initial and periodic health assessments as required under the Child Health and Disability Prevention program.

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36. For information on Healthy Kids, Healthy Teeth, see the Alameda County Public Health Department Web site (www.acphd.org/user/services/AtoZ_PrgDtls.asp?PrgId=39).

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