



Joint Oversight Hearing

Senate and Assembly Health Committees

California Department of Health Care Services

Weaknesses in Its Medi-Cal Dental Program
Limit Children's Access to Dental Care

(Report 2013-125, December 2014)

Wednesday, March 4, 2015
Room 4202, State Capitol
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Medi-Cal Dental Testimony

Do Medi-Cal Reimbursement Rates Ensure Access to Care

Good morning Senator Hernandez, Assemblymember Bonta, and committee members.

I'm Dale Carlson with the CA State Auditor's Office. In December 2014, my office issued an audit report concerning weaknesses in California's Medi-Cal dental program limiting access to dental care. For that audit, my office was tasked with understanding how the Medi-Cal dental program operated by Health Care Services was fulfilling its mandate to ensure that children enrolled in Medi-Cal received the dental care for which they are eligible. I was the team leader for that audit.

To address our charge, we examined three components that collectively affect access to dental care:

- Beneficiary utilization
- Provider participation
- Reimbursement rates paid to providers of Medi-Cal dental services

I'll summarize the results we found for each of these three components and explain the connections between them. I'll then describe two other report sections related to access.

Regarding beneficiary utilization, we concluded that children's use of Medi-Cal dental services was low (pp. 18 – 22 of audit report).

Utilization is the annual rate at which Medi-Cal beneficiaries aged 0 through 20 received at least one dental service.

Absent utilization standards from Health Care Services against which to measure CA's rates, we used federal data to compare CA's utilization rates with national averages and the utilization rates for other states using federal data for FFY 2012–13

CA's rate was 44 percent

National average rate: 48 percent

CA's rate was the 12th worst for the states included in the data

Other states: ranged from a low of 24 percent in Ohio to a high of 63 percent in Texas

Relying on DHCS's data, we calculated CA's utilization rate for dental services by child beneficiaries in 2013 to be about 41 percent.

We also calculated the utilization rates for each of CA's 58 counties. For 2013, the rates ranged from a low of 6.4 percent in Alpine County to a high of 53 percent in Monterey County. (See Figure 2, p. 20; and Table A.1, pp. 61–62)

To understand the factors that contributed to low utilization rates generally, we reviewed numerous published studies. The studies cited several reasons for low utilization rates, including the relatively small number of dentists participating in Medicaid and the uneven distribution of dentists geographically.

Regarding provider participation, we concluded that many California counties may lack a sufficient number of dental providers (pp. 22–30)

We defined provider participation in two ways:

- the number of providers who actually rendered Medi-Cal dental services in the past year, which we called “active providers”
- the number of providers who were willing to provide dental services to new Medi-Cal patients, which we called “willing providers”

Because Health Care Services had not formally established criteria to measure provider participation, we used a ratio of one dental service provider for every 2,000 child beneficiaries as a benchmark for provider participation. We used this ratio because:

Health Care Services used this ratio to monitor provider participation during the transition of the Healthy Families Program into Medi-Cal during 2013.

State regulations require this ratio for health care service plans.

Using this ratio, we estimated that California as a whole had a sufficient number of active Medi-Cal dental providers for the five years we examined (2009 through 2013): the ratio never exceeded 1:807, well below the 1:2,000 ratio. (See Table 4, p. 24)

Because beneficiaries and providers are not uniformly distributed throughout the state, we calculated ratios for CA's 58 counties.

Regarding counties, Health Care Services' data showed that five counties may not have any “active” Medi-Cal dental providers for child beneficiaries in 2013: Alpine, Amador, Inyo, Sierra, and Trinity. These five counties had about 2,000 Medi-Cal child beneficiaries who received dental services in 2013. (See Figure 3, p. 25 and Table A.5, pp. 65–66 for the details)

We say “may” because we found some weaknesses in the department's provider data that may cause an undercount of providers.

Concerning “willing” providers, the department's data showed that 27 of the State's 58 counties either did not have any dental providers or may not have had enough dental providers willing to accept new Medi-Cal patients. The department's data showed that these 27 counties had about 468,000 Medi-Cal child beneficiaries who did not receive dental services in 2013. (See Figure 4, p. 27; and Table A.6, p. 67 for the details)

No willing providers (11 counties): Alpine, Amador, Calaveras, Del Norte, Inyo, Mariposa, Mono, Nevada, Sierra, Tehama, and Yuba.

Not enough willing providers (16 counties) (ratio exceeded 1:2,000): Butte, Colusa, El Dorado, Glenn, Humboldt, Kings, Lake, Mendocino, Merced, Sacramento, San Luis Obispo, Shasta, Sonoma, Stanislaus, Tuolumne, and Yolo.

Looking again to published studies, they identified several reasons for providers not participating in Medicaid. One reason we examined was low reimbursement rates.

Regarding reimbursement rates, we concluded that CA's rates for Medi-Cal dental are low (pp. 30–34)

We compared CA's reimbursement rates for its fee-for-service dental to national and regional averages, and to the rates for other states. When looking at the top 10 dental procedures most frequently authorized for payment, the averages we calculated were: (See Table 5; p. 52)

California:	\$22
National (from the American Dental Association):	\$62
Regional (Pacific Region: AK, CA, HI, OR, and WA):	\$70
Connecticut:	\$53
Texas:	\$35
Washington (children through age 5):	\$45
Washington (overall):	\$28

We chose CT, TX, and WA because their utilization rates were among the top five mentioned in a June 2013 study we examined.

Officials from these three states believed their reimbursement rates were one of the factors leading to their states' higher utilization rates.

California's reimbursement rates for dental services were last increased in fiscal year 2000–01. Further, California reduced reimbursement payments for dental services by 10 percent for most providers effective September 2013, essentially the same thing as a 10 percent cut in reimbursement rates.

We also examined Health Care Services' compliance with a state law to annually assess reimbursement rate adequacy and found it was not doing so (pp. 40 – 42)

State law requires Health Care Services to conduct annual reimbursement rate reviews for dental services under Medi-Cal and to periodically revise the rates. The purpose of the review is to ensure that Medi-Cal beneficiaries have reasonable access to dental services.

Health Care Services performed this annual review only twice since fiscal year 2000–01. In its December 2011 review, it pointed out that CA paid an average of 31.5 percent of the statewide average commercial usual, customary, and reasonable rates; that beneficiary utilization was increasing slightly; and that provider participation was decreasing slightly. However, it did not comment on the adequacy of the reimbursement levels nor connect the facts it mentioned to its reimbursement rates.

In its February 2013 review, it pointed out that CA paid an average of 31.3 percent of the statewide average commercial usual, customary, and reasonable rates; and that the reimbursement rates were adequate based on increased utilization rates, and increases in the number of children receiving services.

The acting division chief stated that:

- The department did not perform the reviews before 2011 because of the State's fiscal climate and its own workload.
- Until 2011, he was unaware of this provision of law.
- Health Care Services performed the 2011 and 2013 reviews only at the request of the department's legal counsel.
- Health Care Services has not finalized a plan to perform these reviews in the future.

DHCS has not complied with its plan for monitoring Medi-Cal child beneficiaries' access to dental services (pp. 42 – 44)

As part of its state plan amendment—which it submitted to CMS for approval—to reduce payments by 10 percent, Health Care Services also submitted a monitoring plan in which it told CMS it would monitor predetermined metrics on a quarterly or annual basis to ensure that beneficiary access is comparable to services available to the general population in the same geographic area.

The monitoring plan included three measures related to dental services:

1. The difference in the number of child beneficiaries from one quarter to the next.
2. The number of child beneficiaries divided by the number of active dental providers.
3. The number of child beneficiaries who had at least one dental visit in the past 12 months divided by the total number of child beneficiaries.

As of October 2014, DHCS still had not issued its first monitoring report.

DHCS did not have a specific release date for its report.

Status of Recommendations

We made several recommendations to Health Care Services regarding these issues, which the department agreed to implement.

- (1 and 2) Establish criteria for assessing beneficiary utilization and provider participation.
- (3 and 4) Develop procedures to periodically identify counties or other geographic areas where utilization rates or provider participation ratios fail to meet criteria and take action to resolve declining trends.
- (8) Immediately resume performing its annual reimbursement rate reviews, as state law requires.
- (9 and 10) Immediately adhere to its monitoring plan and compare CA's utilization results to the utilization results of the three surveys mentioned in the state plan.

In its 60-day response to our report, Health Care Services stated that it was still implementing the recommendations for these issues. It indicated that it planned to implement about half the recommendations for these issues by July 2015 and that the implementation date for the remaining recommendations was “ongoing” or “pending”.

Health Care Services' next response is due in June 2015.

I'm happy to answer any questions you have regarding our report.