Assembly Bill No. 2207

CHAPTER 613

An act to amend Sections 14132.915 and 14459.6 of, to add Sections 14184.72, 14184.73, 14184.74, and 14184.75 to, and to add Article 4.10 (commencing with Section 14149.8) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 25, 2016. Filed with Secretary of State September 25, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2207, Wood. Medi-Cal: dental program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that certain optional benefits, including, among others, certain adult dental services, are excluded from coverage under the Medi-Cal program. Existing law, beginning May 1, 2014, or the effective date of any necessary federal approvals, whichever is later, provides that only specified adult dental services are a covered Medi-Cal benefit for persons 21 years of age or older.

This bill would require the department to undertake specified activities for the purpose of improving the Medi-Cal Dental Program, such as expediting provider enrollment and monitoring dental service access and utilization. The bill would require a Medi-Cal managed care health plan to provide dental health screenings for eligible beneficiaries and refer them to appropriate Medi-Cal dental providers. This bill would provide that those provisions shall only be implemented to the extent that the department obtains any necessary federal approvals and federal matching funds.

Existing law requires the department to establish a list of performance measures to ensure the dental fee-for-service program meets quality and access criteria required by the department. Existing law requires the department to annually post on October 1 the list of performance measures and data of the dental fee-for-service program for the previous calendar year on its Internet Web site. Existing law also requires the department to establish a list of performance measures to ensure dental health plans meet quality criteria required by the department. Existing law requires the department to post, on a quarterly basis, the list of performance measures and each plan's performance on the department's Internet Web site.

This bill would add performance measures to the lists for both the dental fee-for-service program and dental health plans described above, as specified. The bill would, as of October 31, 2016, eliminate the requirement that the

department annually post the performance measures and program data relating to the dental fee-for-service program for the previous calendar year on October 1 and instead would require the department, commencing January 31, 2017, to post that information for the previous fiscal year on its Internet Web site on or before January 31 of each year. The bill, commencing April 30, 2017, and on specified dates thereafter, would require the department to post dental fee-for-service program performance data, the dental health plan performance measures, and each dental health plan's performance on a quarterly basis for the preceding fiscal quarter on its Internet Web site. The bill would require the department to ensure, to the greatest degree possible, that the categories of data and performance measures selected for the dental fee-for-service program and for dental health plans are consistent with one another. The bill would require the department, no sooner than July 1, 2019, to annually publish specified utilization data for both the dental fee-for-service and dental managed care programs from the preceding calendar year and to make this information available on its Internet Web site.

Existing law establishes the Medi-Cal 2020 Demonstration Project Act, under which the department is required to implement specified components of a Medicaid 1115(a) demonstration project, referred to as California's Medi-Cal 2020 demonstration project, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services (CMS). Existing law requires the department to implement the Dental Transformation Initiative (DTI), a component of the Medi-Cal 2020 demonstration project, under which DTI incentive payments, as defined, within specified domain categories would be made available to qualified providers who meet achievements within one or more of the project domains, and would require the department to evaluate the DTI as required under the Special Terms and Conditions.

This bill would require, consistent with the Special Terms and Conditions and the evaluation requirement described above, the department's reports of data and quality measures submitted to CMS and made publicly available for each of the domain areas under the DTI to include specified information.

The people of the State of California do enact as follows:

SECTION 1. Section 14132.915 of the Welfare and Institutions Code is amended to read:

14132.915. (a) (1) The department shall establish a list of performance measures to ensure the dental fee-for-service program meets quality and access criteria required by the department. The performance measures shall be designed to evaluate utilization, access, availability, and effectiveness of preventive care and treatment.

(2) Prior to establishing the quality and access criteria described in paragraph (1), the department shall consult with stakeholders, including

representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(3) The performance measures established by the department to monitor the dental fee-for-service program for children shall include, but not be limited to, all of the following:

(A) Overall utilization of dental services.

(B) For each provider, all of the following:

(i) Number of annual dental visits.

(ii) Number of annual preventive dental services.

(iii) Number of annual dental treatment services.

(iv) Number of annual examinations and oral health evaluations.

(C) Number of applications of dental sealants and fluoride varnishes.

(D) Continuity of care and overall utilization over an extended period of time.

(E) All of the following ratios:

(i) Sealant to restoration.

(ii) Filling to preventive services.

(iii) Treatment to caries prevention.

(F) No sooner than January 1, 2018, number of beneficiaries requiring general anesthesia to perform procedures.

(4) The performance measures established by the department to monitor the dental fee-for-service program for adults shall include, but not be limited to, all of the following:

(A) Overall utilization of dental services.

(B) For each provider, all of the following:

(i) Number of annual dental visits.

(ii) Number of annual preventive dental services.

(iii) Number of annual dental treatment services.

(iv) Number of annual examinations and oral health evaluations.

(C) Treatment to caries prevention ratio.

(5) The performance measures shall be reported as aggregate numbers and as percentages, if appropriate, using standards that are as equivalent to those used by managed care entities as feasible. Performance measures for the dental fee-for-service program for children shall be reported by age groupings if appropriate.

(b) The department shall include the initial list of performance measures in any dental contract entered into between the department and a fee-for-service contractor on or after enactment of this section.

(c) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures for retention on, addition to, or deletion from, the list of performance measures, consider all of the following criteria:

(1) Annual and multiyear Medi-Cal dental fee-for-service trended data.

(2) Other state and national dental program performance and quality measures.

(3) Other state and national performance ratings.

(d) On October 1, 2014, for the 2013 calendar year, and on or before October 1, 2016, for the 2015 calendar year, the list of performance measures established by the department along with the data of the dental fee-for-service program performance shall be posted on the department's Internet Web site.

(e) Commencing January 31, 2017, for the 2015–16 fiscal year, and annually on or before January 31 for each preceding fiscal year thereafter, the list of performance measures established by the department along with the data of the dental fee-for-service program shall be posted on the department's Internet Web site.

(f) Commencing April 30, 2017, for the July 2016 to September 2016, inclusive, fiscal quarter, and quarterly thereafter on or before April 30, July 31, October 31, and January 31 for the fiscal quarter ending seven months prior, the data of the dental fee-for-service program performance shall be posted on the department's Internet Web site.

(g) The department may amend or remove performance measures and establish additional performance measures in accordance with all of the following:

(1) The department shall consider performance measures established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(2) The department shall notify a fee-for-service contractor, at least 30 days prior to the implementation date, of any updates or changes to performance measures. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to maintain transparency to the public.

(3) In establishing the performance measures, the department shall consult with stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(h) The department shall annually prepare a summary report of the nature and types of complaints and grievances regarding access to, and quality of, dental services, including the outcome. Commencing January 31, 2017, for the prior fiscal year, and annually thereafter, for each preceding fiscal year, this report shall be posted on the department's Internet Web site.

(i) The department shall ensure, to the greatest degree possible, that the categories of data and performance measures selected under this section are consistent with the categories of data and performance measures selected under Section 14459.6.

(j) No sooner than July 1, 2019, the department shall annually publish utilization data from the preceding calendar year and post this material on its Internet Web site. The utilization data shall be made publicly available for both the dental fee-for-service and dental managed care programs. The utilization data shall include all of the following information:

(1) Number of patients seen on a per-provider basis.

(2) Number of annual preventative dental services, dental treatment services, examinations, and oral health evaluations rendered by each provider during each calendar year.

(3) Number of beneficiaries who received general anesthesia services.

SEC. 2. Article 4.10 (commencing with Section 14149.8) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 4.10. Medi-Cal Dental Program

14149.8. (a) The department shall expedite the enrollment of Medi-Cal dental providers by streamlining the Medi-Cal provider enrollment process. The department shall pursue and implement all of the following activities, to the extent permitted by federal law:

(1) Create a dental-specific enrollment form.

(2) Pursue an alternative automatic enrollment process for a provider already commercially credentialed by either a dental fee-for-service contractor or an administrative services contractor for the purpose of providing services as a commercial provider.

(3) Discontinue requiring providers to resubmit an enrollment application that has been deemed incomplete if the missing information is available elsewhere within the application packet.

(4) To the extent that the department expedites the enrollment of Medi-Cal dental providers by streamlining the Medi-Cal provider enrollment process, the department shall publish the criteria for those processes in applicable provider bulletins and manuals.

(b) (1) The department shall maintain the provider network on a monthly basis by deactivating a billing provider who has not, over a continuous 12-month period, submitted a claim for reimbursement for services rendered.

(2) Prior to deactivating a provider described in paragraph (1), the department shall send a notice to the provider informing the provider that the provider shall be deactivated from the dental program unless the provider requests reactivation within six months after the date of the notice. The department shall not disenroll a provider until six months after the date of that notice. This paragraph shall not be implemented until the date the department implements and programs the necessary system changes to the California Dental Medicaid Management Information Systems to implement this paragraph, or no sooner than July 1, 2017, whichever is later.

(3) In order to improve the quality of the dental provider network, the department also shall exercise additional measures as appropriate and permitted by law, including, but not limited to, temporary suspensions. The parameters and criteria developed by the department for additional measures for deactivations and disenrollments shall be published in applicable provider bulletins and manuals.

(c) (1) The department shall monitor access and utilization of Medi-Cal dental services in the fee-for-service and managed care delivery systems to assess opportunities to improve access and utilization, including an annual review of the treatment authorization review process.

(2) The department shall assess opportunities to develop and implement innovative payment reform proposals within the Medi-Cal dental programs.

(d) The department shall explore additional opportunities to improve the Medi-Cal Dental Program, in consultation with stakeholders and as deemed appropriate by the department and to the extent permitted by federal law, including, but not limited to, the following:

(1) Aligning the provision of dental anesthesia services with that of medical anesthesia services, including the ability to bill for applicable facility fees and ancillary services.

(2) Adjusting other utilization controls for specialty services, as appropriate, to promote access to care while still protecting program integrity.

(3) Expanding the scope of beneficiary outreach activities required by an entity that is contracted with the department to more broadly address underutilization throughout the state.

(e) Prior to implementing an action pursuant to subdivision (d), the department shall post the proposed action on its Internet Web site at least 30 days before implementation.

(f) The department shall work with dental managed care plans that contract with the department for the purposes of implementing the Medi-Cal Dental Program, which includes, but is not limited to, contracts authorized pursuant to Sections 14087.46, 14089, and 14104.3, to provide beneficiaries with access to dental plan liaisons to assist in the coordination of care for enrolled members.

(g) A Medi-Cal managed care health plan shall do all of the following:

(1) Provide dental screenings for every eligible beneficiary as a part of the beneficiary's initial health assessment.

(2) Ensure that an eligible beneficiary is referred to an appropriate Medi-Cal dental provider.

(3) Identify plan liaisons available to dental managed care contractors and dental fee-for-service contractors to assist with referrals to health plan covered services.

(h) (1) To increase the efficiency and timeliness of changes, any contract amendment, modification, or change order to any contract entered into by the department for the purposes of implementing the state Medi-Cal Dental Program shall be exempt, except as provided in paragraph (2), from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, as well as Sections 11545 and 11546 of the Government Code, in addition to any policies, procedures, or regulations authorized by those provisions.

(2) Paragraph (1) shall not exempt the department from establishing a competitive bid process for awarding new contracts pursuant to Section 14104.3, as well as for awarding new dental contracts pursuant to Sections 14087.46 and 14089.

(i) Prior to implementing any change pursuant to this section, the department shall consult with, and provide notification to, stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(j) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific policies and procedures pertaining to the dental fee-for-service program and dental managed care plans, as well as applicable federal waivers and state plan amendments, including the provisions set forth in this section, by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until regulations are adopted.

(2) No later than December 31, 2018, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(k) This section shall be implemented only to the extent that all of the following occur:

(1) The department obtains any federal approvals necessary to implement this section.

(2) The department obtains federal matching funds to the extent permitted by federal law.

SEC. 3. Section 14184.72 is added to the Welfare and Institutions Code, immediately following Section 14184.71, to read:

14184.72. In connection with the evaluation of the DTI required by Section 14184.71, the department's report of data and quality measures submitted to the federal Centers for Medicare and Medicaid Services (CMS) and made publicly available pursuant to the Special Terms and Conditions for the Increase Preventive Services Utilization for Children domain shall include, but not be limited to, all of the following:

(a) A detailed description of how the department has operationalized the domain, including information identifying which entities have responsibility for the components of the domain.

(b) The number of individual incentives paid and the total amount expended under the domain for the current program year.

(c) An awareness plan that describes all of the following:

(1) How the department has generated awareness of the availability of incentives for providing preventive dental services to children, including steps taken to increase awareness of the DTI among dental and primary care providers.

(2) How the department has generated awareness among beneficiaries of the availability of, the importance of, and how to access preventive dental services for children.

(3) The different approaches to raising awareness undertaken among specific groups, including age groups, rural and urban residents, and primary language groups. These approaches shall be developed in conjunction with interested dental and children's health stakeholders.

(d) An annual analysis of whether the awareness plan described in subdivision (c) has succeeded in generating the utilization necessary, by subgrouping, to meet the goals of the domain, and a description of changes to the awareness plan needed to address any identified deficiencies.

(e) Data describing both of the following:

(1) The use of, and expenditures on, preventive dental services.

(2) The use of, and expenditures on, other nonpreventive dental services.

(f) A discussion of the extent to which the metrics described for the domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain.

(g) An analysis of changes in cost per capita.

(h) A descriptive analysis of program integrity challenges generated by the domain and how those challenges have been, or will be, addressed.

(i) A descriptive analysis of the overall effectiveness of the activities in the domain in meeting the intended goals of the domain, any lessons learned, and any recommended adjustments.

SEC. 4. Section 14184.73 is added to the Welfare and Institutions Code, to read:

14184.73. In connection with the evaluation of the DTI required by Section 14184.71, the department's report of data and quality measures submitted to the federal Centers for Medicare and Medicaid Services and made publicly available pursuant to the Special Terms and Conditions for the Caries Risk Assessment (CRA) and Disease Management Pilot domain shall include, but not be limited to, all of the following:

(a) A detailed description of how the department has operationalized the domain, including information identifying which entities have responsibility for the components of the domain.

(b) The number of individual incentives paid and the total amount expended, by county, under the domain in the current demonstration year.

(c) A descriptive assessment of the impact of the domain on targeted children in the age ranges of under one year of age, one through two years of age, three through four years of age, and five through six years of age, for all of the following:

(1) Provision of CRAs.

(2) Provision of dental exams.

(3) Use of, and expenditures on, preventive dental services.

(4) Use of, and expenditures on, dental treatment services.

(5) Use of, and expenditures on, dental-related general anesthesia, including facility costs.

SEC. 5. Section 14184.74 is added to the Welfare and Institutions Code, to read:

14184.74. In connection with the evaluation of the DTI required by Section 14184.71, the department's report of data and quality measures submitted to the federal Centers for Medicare and Medicaid Services and made publicly available pursuant to the Special Terms and Conditions for the Increase Continuity of Care domain shall include, but not be limited to, all of the following:

(a) A detailed description of how the department has operationalized the domain, including information identifying which entities have responsibility for the components of the domain.

(b) The number of individual incentives paid and the total amount expended, by county, under the domain in the current demonstration year.

(c) A descriptive assessment of the impact of the domain, with respect to targeted children, of all of the following:

(1) Provision of dental exams.

(2) Use of, and expenditures on, preventive dental services.

(3) Use of, and expenditures on, other nonpreventive dental services.

(d) A discussion of the extent to which the metrics prescribed for the domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain.

(e) An analysis of change in cost per capita.

(f) A descriptive analysis of program integrity challenges generated by the domain and how those challenges have been, or will be, addressed.

(g) A descriptive analysis of the overall effectiveness of the activities in the domain in meeting the intended goals of the domain, any lessons learned, and any recommended adjustments.

SEC. 6. Section 14184.75 is added to the Welfare and Institutions Code, to read:

14184.75. In connection with the evaluation of the DTI required by Section 14184.71, the department's report of data and quality measures submitted to the federal Centers for Medicare and Medicaid Services and made publicly available pursuant to the Special Terms and Conditions for the Local Dental Pilot Program domain shall include, but not be limited to, all of the following:

(a) A detailed description of how the department has operationalized this aspect of the demonstration project, including the solicitation and selection process.

(b) The number of pilot projects funded and the total amount expended, by project, under the domain in the current demonstration year.

(c) A description of the pilot projects selected for award that for each project shall include, but not be limited to, all of the following:

(1) Specific strategies for the project.

(2) Target populations.

(3) Payment methodologies.

(4) Annual budget for the project.

(5) Expected duration of the project.

(6) Performance metrics by which the project shall be measured.

(7) The intended goal of the project.

(d) An assessment of the pilot projects selected for award that includes for each project all of the following:

(1) Project performance and outcomes.

(2) Project replicability.

(3) Challenges encountered and actions undertaken to address those challenges.

(4) Information on payments made by the department to the project.

(e) A descriptive assessment of the impact of the Local Dental Pilot Program domain on achieving the goals of the Increase Preventive Services Utilization for Children, Caries Risk Assessment and Disease Management Pilot, and Increase Continuity of Care domains.

(f) A descriptive analysis of program integrity challenges generated by the domain and how those challenges have been, or will be, addressed.

SEC. 7. Section 14459.6 of the Welfare and Institutions Code is amended to read:

14459.6. (a) The department shall establish a list of performance measures to ensure dental health plans meet quality criteria required by the department. The list shall specify the benchmarks used by the department to determine whether and the extent to which a dental health plan meets each performance measure. Commencing January 1, 2013, and quarterly thereafter, the list of performance measures established by the department along with each plan's performance shall be posted on the department's Internet Web site. The Department of Managed Health Care and the advisory committee established pursuant to Section 14089.08 shall have access to all performance measures and benchmarks used by the department as described in this section.

(1) Commencing April 30, 2017, the quarterly reporting required by this subdivision shall be posted in the following manner:

(A) On or before April 30, 2017, the reporting shall be posted for the July 2016 to September 2016, inclusive, fiscal quarter.

(B) After April 30, 2017, the reporting shall be posted on a quarterly basis on or before April 30, July 31, October 31, and January 31 for the fiscal quarter ending seven months prior.

(2) The performance measures established by the department shall include, but not be limited to, all of the following: provider network adequacy, overall utilization of dental services, annual dental visits, the total number of patients seen on a per-provider basis and the total number of dental services rendered by each provider during each calendar year, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

(3) The survey of member satisfaction with plans and providers shall be the same dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as used by the Healthy Families Program.

(4) The department shall notify dental health plans at least 30 days prior to the implementation date of these performance measures.

(5) The department shall include the initial list of performance measures and benchmarks in any dental health contracts entered into between the department and a dental health plan pursuant to Section 14204.

(6) The department shall update performance measures and benchmarks and establish additional performance measures and benchmarks in accordance with all of the following:

(A) The department shall consider performance measures and benchmarks established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(B) The department shall notify dental health plans at least 30 days prior to the implementation date of updates or changes to performance measures and benchmarks. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to provide transparency to the public.

(C) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures and benchmarks for retention on, addition to, or deletion from the list, consider all of the following criteria:

(i) Monthly, quarterly, annual, and multiyear Medi-Cal dental managed care trended data.

(ii) County and statewide Medi-Cal dental fee-for-service performance and quality ratings.

(iii) Other state and national dental program performance and quality measures.

(iv) Other state and national performance ratings.

(b) In establishing and updating the performance measures and benchmarks, the department shall consult the advisory committee established pursuant to Section 14089.08, as well as dental health plan representatives and other stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(c) In evaluating a dental health plan's ability to meet the criteria established through the performance measures and benchmarks, the department shall select specific performance measures from those established by the department in subdivision (a) as the basis for establishing financial or other incentives or disincentives, including, but not limited to, bonuses, payment withholds, and adjustments to beneficiary assignment to plan algorithms. These incentives and disincentives shall be included in the dental health plan contracts.

(d) (1) The department shall designate an external quality review organization (EQRO) that shall conduct external quality reviews for any dental health plan contracting with the department pursuant to Section 14204.

(2) As determined by the department, but at least annually, dental health plans shall arrange for an external quality of care review with the EQRO designated by the department that evaluates the dental health plan's performance in meeting the performance measures established in this section. Dental health plans shall cooperate with and assist the EQRO in this review. The Department of Managed Health Care shall have direct access to all external quality of care review information upon request to the department.

(3) An external quality of care review shall include, but not be limited to, all of the following: performance on the selected performance measures

and benchmarks established and updated by the department, the CAHPS member or consumer satisfaction survey referenced in paragraph (2) of subdivision (a), reporting systems, and methodologies for calculating performance measures. An external quality of care review that includes all of the above components shall be paid for by the dental health plan and posted online annually, or at any other frequency specified by the department, on the department's Internet Web site.

(e) All marketing methods and activities to be used by dental plans shall comply with subdivision (b) of Section 10850, Sections 14407.1, 14408, 14409, 14410, and 14411, and Title 22 of the California Code of Regulations, including Sections 53880 and 53881 of Title 22 of the California Code of Regulations. Each dental plan shall submit its marketing plan to the department for review and approval.

(f) Each dental plan shall submit its member services procedures, beneficiary informational materials, and any updates to those procedures or materials to the department for review and approval. The department shall ensure that member services procedures and beneficiary informational materials are clear and provide timely and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits.

(g) Each dental plan shall submit its provider compensation agreements to the department for review and approval.

(h) The department shall post to its Internet Web site a copy of all final reports completed by the Department of Managed Health Care regarding dental managed care plans.

(i) The department shall ensure, to the greatest degree possible, that the categories of data and performance measures selected under this section are consistent with the categories of data and performance measures selected under Section 14132.915.

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