

An act to amend and repeal Sections 14087.46, 14089.09, and 14459.6 of, and to add Section 14149.81 to, the Welfare and Institutions Code, relating to Medi-Cal.

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14087.46 of the Welfare and Institutions Code is amended to read:

14087.46. (a) The department shall implement a dental managed care program for Medi-Cal beneficiaries to achieve major cost savings, while ensuring access and quality of care, pursuant to this section.

(b) The department shall issue a request for proposals and award contracts on a competitive basis to one or more dental health care service contractors licensed pursuant to the Knox-Keene Health Care Service Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) in each county or region that the department determines to be feasible. The department may contract with county organized health systems.

(c) To ensure access and continuity of care, the department shall award contracts ~~only~~ to plans that agree to negotiate in good faith and subcontract with any provider who agrees to provide dental services to Medi-Cal beneficiaries at a reimbursement rate comparable to that paid by the plan to other participating providers. ~~Plans A plan~~ shall contract whenever feasible with traditional and safety net providers of dental services to Medi-Cal beneficiaries. In evaluating the plans, the department shall assign favorable weighting to contractors that include traditional and safety net providers.

(d) The department shall implement a process to inform ~~all Medi-Cal beneficiaries of their choices~~ each Medi-Cal beneficiary of their choice of participating dentists and to allow a beneficiary to chose or change ~~his or her~~ their participating dentist.

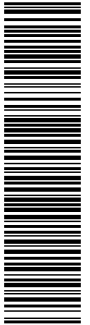
(e) The department shall make every effort to achieve operational contracts to place ~~all~~ Medi-Cal beneficiaries in dental managed care by October 1, 1995. The department may determine which counties or categories of Medi-Cal beneficiaries are to be included in the dental managed care program. If the department has achieved one or more operational managed care contracts in a county or region, fee-for-service dental services shall not be an option for selection by a beneficiary, except that the department may provide for fee-for-service dental care if needed to ensure adequate access in rural or underserved areas, or for unique populations.

(f) The department shall require ~~all participating plans~~ a participating plan to provide, at a minimum, the full scope of dental benefits pursuant to state and federal law.

(g) In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this section shall be exempt from the Public Contract Code.

(h) ~~Medi-Cal beneficiaries~~ A Medi-Cal beneficiary shall be able to receive their dental care from federally qualified health centers and rural health clinics certified pursuant to Public Law 95-210 that provide dental care in their service area. At the time of informing the Medi-Cal beneficiary of ~~his or her choices~~ their choice of participating dentists, the beneficiary shall be informed of this option. Federally qualified health centers and rural health clinics shall continue to be reimbursed for dental services through the medical payment system in accordance with federal regulations.

(i) The department shall monitor the implementation of dental managed care, and for each of the first three years of implementation, shall annually evaluate the program on a county-by-county basis in terms of access, quality of care, and cost



savings. The evaluation shall be provided to the Legislature within 120 days of the close of each of the three fiscal years.

(j) The department shall seek ~~all~~ federal waivers necessary to allow for federal financial participation in the program implemented pursuant to this section. This article shall not be implemented unless and until the director has executed a declaration, to be retained by the director, that approval of all necessary federal waivers have been obtained by the department.

(k) (1) Commencing no sooner than January 1, 2021, and subject to Section 14149.81, the department shall ensure that dental services provided as part of dental managed care in the Counties of Los Angeles and Sacramento are exclusively rendered under a fee-for-service delivery system.

(2) This section shall become inoperative on the effective date specified by the director in their certification, as described in subdivision (h) of Section 14149.81, and shall be repealed six months after the date the certification is complete.

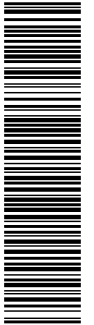
SEC. 2. Section 14089.09 of the Welfare and Institutions Code is amended to read:

14089.09. (a) It is the intent of the Legislature to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental health managed care plans in the Counties of Sacramento and Los Angeles through implementation of performance contracting to ensure dental health plans meet quality criteria and timely access to dental care, as contained in Section 14459.6, and implementation of a beneficiary dental exception process for Medi-Cal beneficiaries in the County of Sacramento to access dental care through fee-for-service Denti-Cal when applicable.

(b) (1) ~~The Director of Health Care Services shall exercise his or her~~ The director shall exercise their authority under Section 14131.15 to establish a beneficiary dental exception (BDE) process, as described in paragraph (2), for Medi-Cal beneficiaries mandatorily enrolled in dental health plans in the County of Sacramento. The BDE process shall be implemented no later than July 1, 2012, and shall be in effect for as long as mandatory enrollment for dental care is in effect in the County of Sacramento. The department shall consult with the advisory committee established pursuant to Section 14089.08 ~~regarding on~~ potential modifications to the BDE process. For purposes of emergency access to dental care issues, the department shall establish specific processes under the BDE to accommodate for these issues.

(2) The BDE shall be available to any Medi-Cal dental managed care ~~beneficiaries~~ enrollee in the County of Sacramento ~~who are~~ unable to secure access to services through their managed care plan, in accordance with applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). The BDE shall ~~allow~~ authorize a beneficiary to ~~opt-out~~ opt out of Medi-Cal dental managed care and move into fee-for-service Denti-Cal where the beneficiary may select ~~his or her~~ their own dental provider on an ongoing basis. The beneficiary shall remain in fee-for-service Denti-Cal until the time ~~he or she chooses~~ they choose to opt in to a dental managed care arrangement.

(3) ~~Beneficiaries~~ Each beneficiary shall be notified of the BDE option, which shall include the process for access to emergency visits, through a letter from the department detailing the process, directions on how to fill out the BDE form, and where



to access the BDE form. A hard copy of the BDE form shall accompany the letter from the department. The BDE form, directions on how to fill out the BDE form, and a description of the process shall also be posted on the department's ~~Internet Web site~~ internet website for easy access by beneficiaries and the public. The department shall also notify and inform dental managed care plans of the BDE process and its operation.

(4) Upon receipt of the BDE form, the department shall have no more than three business days to contact the beneficiary. The department shall, within five business days from the date of contact with the beneficiary, work with the beneficiary and the dental plan to schedule an appointment within the applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(A) If an appointment is ~~not available~~, unavailable, the department shall approve and process the BDE and move the beneficiary into fee-for-service Denti-Cal.

(B) If an appointment is available, the beneficiary shall receive from the department a followup telephone call after the appointment to assess how the visit went and to determine if there is a need for any additional followup.

(5) Based on the followup as identified in subparagraph (B) of paragraph (4), to the extent no additional access issues to contractually required services are identified, the BDE shall be closed and the beneficiary shall remain in the selected dental plan.

(c) The department shall take ~~all~~ necessary steps to implement the BDE process as described in this section and shall, ~~monthly, publicly report~~ section, and shall publicly report, on a monthly basis, on the department's ~~Internet Web site~~ internet website the number of individuals requesting the BDE and the specific outcome of each request, including, but not limited to, summary data on the types of visits subject to the BDE process, the services provided, description of timely access to care, the delivery system in which services were provided, beneficiary satisfaction, and the department's perspective of the outcome. The information provided on the department's ~~Internet Web site~~ internet website shall be deidentified in accordance with the Health Insurance Portability and Availability Act of 1996 (HIPAA), including Section 164.514 of Title 45 of the Code of Federal Regulations, and shall not contain any personally ~~identifiable~~ identifiable information according to the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).

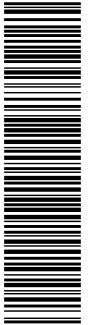
(d) The department shall consult with stakeholders in the development of the BDE form and related materials.

(e) (1) Commencing no sooner than January 1, 2021, and subject to Section 14149.81, the department shall ensure that dental services provided as part of dental managed care in the Counties of Los Angeles and Sacramento are exclusively rendered under a fee-for-service delivery system. Upon the completion of the delivery system transition, the BDE shall terminate.

(2) This section shall become inoperative on the effective date specified by the director in their certification, as described in subdivision (h) of Section 14149.81, and shall be repealed six months after the date the certification is complete.

SEC. 3. Section 14149.81 is added to the Welfare and Institutions Code, immediately following Section 14149.8, to read:

14149.81. (a) Notwithstanding any law, and commencing no sooner than January 1, 2021, the department shall transition enrollees of Medi-Cal dental managed care



plans in the Counties of Los Angeles and Sacramento who receive dental services through a Medi-Cal dental managed care contract, as authorized pursuant to Sections 14087.46, 14089, and 14104.3, to the Medi-Cal dental fee-for-service delivery system, in accordance with this section.

(b) The department shall undertake activities it deems necessary to transition the delivery of Medi-Cal dental services in the Counties of Los Angeles and Sacramento to a fee-for-service delivery system, including terminating dental managed care contracts and any other related contracts.

(c) (1) The department shall develop a transition plan for transferring Medi-Cal beneficiaries from a dental managed care system to the dental fee-for-service delivery system.

(2) The department shall provide the transition plan to the applicable fiscal and policy committees of the Legislature no later than 90 days before the starting date for the transition identified by the department.

(d) The department shall consult with interested stakeholders, including beneficiaries, providers, Medi-Cal dental fee-for-service contractors, and Medi-Cal dental managed care plans, on the development of the transition plan as described in subdivision (c) for individuals who transition to the fee-for-service delivery system.

(e) The department shall commence the transition of enrollees pursuant to this section at least 90 days after the date the department submits the transition plan to the specified committees pursuant to subdivision (c).

(f) (1) Effective July 1, 2020, and until the director certifies that the transition of enrollees pursuant to this section is complete pursuant to subdivision (h), any Medi-Cal dental fee-for-service contractor, including the dental fiscal intermediary contractor, the administrative services contractor, and any other entity identified by the department that provides contracted services related to the dental fee-for-service delivery system, and each Medi-Cal dental managed care plan shall report to the department, within 30 days of any request made by the department, information identified as applicable to the implementation of this section.

(2) The department shall specify the required form, manner, and frequency of information reporting required pursuant to this subdivision.

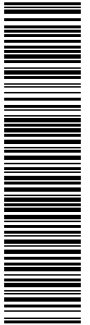
(g) The department shall implement this section consistent with Section 14149.8, to the extent those provisions apply.

(h) The director shall certify in writing when the transition of enrollees pursuant to this section is complete. The certification shall be posted on the department's internet website and a copy of the certification shall be provided to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel of California.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of information notices, plan letters, or other similar instructions, without taking regulatory action.

(j) (1) The department shall seek any federal approvals it deems necessary to implement this section.

(2) This section shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and is not otherwise jeopardized.



SEC. 4. 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~~ a dental health plan meets 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.~~ internet website. The Department of Managed Health Care and the advisory committee established pursuant to Section 14089.08 shall have access to ~~all the~~ 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 former Healthy Families Program.

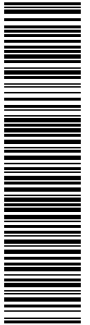
(4) The department shall notify dental health plans at least 30 days prior to the implementation date of these performance measures.

(5) The department shall include the initial list of performance measures and benchmarks in any dental health ~~contracts~~ contract 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 a dental health plans plan 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~~ internet website 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~~ 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 a qualified external quality review organization (EQRO) that shall conduct external quality reviews for any dental health plan contracting with the department pursuant to Section 14204.

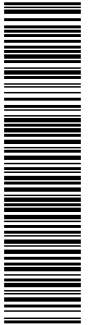
(2) As determined by the department, but at least annually, dental health plans shall arrange for an external quality of care review with the EQRO designated by the department that evaluates the dental health plan's performance in meeting the performance measures established in this section. ~~Dental health plans~~ A dental health plan 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) (A) No later than July 1, 2018, the department shall require that the dental EQRO shall have sufficient information to use in performing the review, and the department shall require the external quality review (EQR) to comply with the following requirements:

(i) The information used to carry out the review shall be obtained from the EQR-related activities in accordance with federal Medicaid regulations, including Section 438.358 of Title 42 of the Code of Federal Regulations, or, if applicable, from a Medicare or private accreditation review as authorized under Section 438.360 of Title 42 of the Code of Federal Regulations.

(ii) For each EQR-related activity, the information gathered for use in the EQR shall include the elements described in federal Medicaid regulations, including the elements described in Section 438.364(a)(2)(i) to (iv), inclusive, of Title 42 of the Code of Federal Regulations.

(iii) The information provided to the EQRO in accordance with this paragraph is obtained through methods consistent with the protocols established by the federal



Secretary of Health and Human Services in accordance with federal Medicaid regulations, including Section 438.352 of Title 42 of the Code of Federal Regulations.

(iv) The results of the reviews are made available as specified in federal Medicaid regulations, including Section 438.364 of Title 42 of the Code of Federal Regulations.

(B) The qualified EQRO shall produce and submit to the department an annual EQR technical report in accordance with Section 438.364(a) of Title 42 of the Code of Federal Regulations. The department shall finalize the annual technical report by April 30 of each year.

(C) Once the annual technical report is finalized, the department shall post by April 30 of each year the most recent copy of the annual EQR technical report on the ~~Internet Web site~~ internet website required under Section 438.10(c)(3) of Title 42 of the Code of Federal Regulations.

(D) 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~~ internet website. The department shall provide printed or electronic copies of the information specified under Section 438.364(a) of Title 42 of the Code of Federal Regulations, upon request, to interested parties, such as participating health care providers, enrollees and potential enrollees of the managed care plan entity, beneficiary advocacy groups, and members of the general public.

(E) The department shall make the information specified in Section 438.364(a) of Title 42 of the Code of Federal Regulations available in alternative formats for persons with disabilities, when requested.

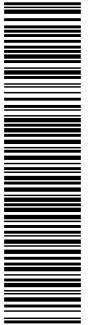
(e) All marketing methods and activities to be used by dental plans shall comply with subdivision (b) of Section 10850, Sections 14407.1, 14408, 14409, 14410, and 14411, and Title 22 of the California Code of Regulations, including Sections 53880 and 53881 of Title 22 of the California Code of Regulations. 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 on its ~~Internet Web site~~ internet website 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.



(j) This section shall become inoperative on the effective date specified by the director in their certification, as described in subdivision (h) of Section 14149.81, and shall be repealed six months after the date the certification is complete.

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LEGISLATIVE COUNSEL'S DIGEST

Bill No.  
as introduced, \_\_\_\_\_.  
General Subject: Medi-Cal dental services: delivery systems.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services, including dental services, are provided to qualified low-income persons under various delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law authorizes the department to provide health care services to beneficiaries through models of managed care, including geographic managed care and prepaid health plans, and requires the department to implement a dental managed care program. Dental services are provided under geographic managed care in the County of Sacramento and prepaid health plans in the County of Los Angeles.

This bill would, subject to federal approval and federal financial participation, require the department to transition enrollees of Medi-Cal dental managed care plans in the Counties of Los Angeles and Sacramento to the Medi-Cal dental fee-for-service delivery system, to undertake activities, including the termination of the dental managed care contracts, necessary to transition the new delivery system, to develop a transition plan on this matter, to consult with stakeholders on the development of that plan, and to provide that plan to fiscal and policy committees of the Legislature. The bill would require the department to commence the transition of enrollees at least 90 days after the date the department submits the transition plan to those committees. The bill would require the director to certify in writing when the transition of enrollees is complete, and would provide that the certification be posted on the department's internet website and a copy of the certification be submitted to specified individuals, including the Secretary of State. The bill would require any Medi-Cal dental fee-for-service contractor, including the dental fiscal intermediary contractor, and each Medi-Cal dental managed care plan, to report to the department, within 30 days of any request made by the department, information on the implementation of the transition, and would require the department to specify those reporting requirements. The bill would authorize the department to implement these provisions by various means, including plan letters, and would make conforming changes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

