Medi-Cal Dental Managed Care (DMC) Methodology Overview

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1. Executive Summary

The Department of Health Care Services (DHCS) is responsible for certifying Dental Managed Care (DMC) provider networks on an annual basis. The network certifications are required to be submitted to the Center for Medicare and Medicaid Services (CMS) one time per year.

DHCS established and adheres to a network certification process and submission requirements. DMC plans are required to submit documentation that demonstrates the capacity to serve the expected enrollment in each service area in accordance with DHCS' standards for access to care established under the authority of CMS Medicaid and CHIP Final Rule, CMS-2390-F (Final Rule) Sections 438.68, 438.206, and 438.207.

2. Annual Network Methodology

A. Time or Distance Standards – Geographic Access Maps

The Final Rule required DHCS to establish network adequacy standards effective July 1, 2018. The California Welfare and Institutions Code (WIC) section 14197 outlines California's state-specific network adequacy standards, as set forth in Attachment A. They include time or distance standards and are applicable to all dental managed cate plans. See table 1 below for reference to the Network Adequacy standards.

Table 1. Network Adequacy Time and Distance Standards

Provider Type	DMC Time and Distance Standards
Primary Care Dentists	10 miles or 30 minutes from the member's residence
Total Dentists (Primary Care and Specialty)	10 miles or 30 minutes from the member's residence

DHCS completed a time or distance geospatial analysis for Medi-Cal Dental Managed Care (DMC) Plans using County provided Medi-Cal beneficiary address information and provider location data submitted by DMC Plans. DHCS staff used ArcGIS software and data to geolocate the addresses for both beneficiaries and providers, then a time or distance analysis was completed on the geolocated points using the ArcGIS Origin Destination Cost Matrix Tool. Time or Distance values were calculated and captured for all network providers. The resulting data set shows the time or distance relationship from providers to adult beneficiaries and providers to youth beneficiaries.

DHCS notifies DMC plans of deficient zip codes for both adults and children/youth.

1. Secret Shopper Surveys

DHCS conducts periodic surveys, at least on an annual basis of all dental managed care plans to determine network access and availability through Secret Shopper Surveys. DHCS via randomization accomplished by macro functions selects plan offices and contact office to inquire about provider availability, timing to obtain an appointment via all appointment timing types, and language services available. In completing this audit, the Plan and Providers were evaluated for their compliance with contract. The DMC Plans are notified of the findings and ensure contract compliance by educating and monitoring providers for contract compliance.

2. Alternative Access Standard (AAS) Requests

WIC §14197 allows DMC plans to submit alternative access standards (AAS) requests for time or distance standards for dental offices. AAS requests may only be submitted when the DMC plan has exhausted all other reasonable options for contracting with providers in order to meet the applicable standards, or if DHCS determines that the requesting DMC plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

DMC plans that are unable to meet time or distance standards for assigned members are notified and must submit an AAS request to DHCS, using a DHCS reporting template. DMC plans' AAS requests are organized by zip code and county and include the driving time and/or the distance, in miles, between the nearest in-network provider(s) and the most remote members. The request must detail the DMC plan's contracting efforts, including an explanation of the circumstances which inhibited the ability to obtain a contract.

DHCS reviews the request for AAS and approves or denies each request on a zip code and provider type basis. DHCS-approved AAS requests are valid for three contract years and must be resubmitted to DHCS for approval every three years unless there is a change in network circumstance which requires a resubmittal pursuant WIC § 14197(f)(3)(C).

Historically, DHCS monitored beneficiary network access on an on-going basis and included the findings to CMS in the Network Adequacy Certification Report required under Title 42 Code of Federal Regulations part 438.66(e). Prospectively this process has been replaced with the Network Adequacy Assurance Tool. DHCS will post all approved alternative access standards on its website.

A. Service Fulfillment – Capacity and Composition Methodology

DHCS developed a methodology to confirm that the maximum number of providers did not exceed the ratio standard of provider to beneficiary. The methodology considers the DMC plan's network composition to determine that the number of providers needed,

and maximum number of members to meet expected requirements. See Table 2 for reference to the Network Adequacy standards.

Provider to Member Ratio

Table 2. Network Adequacy Provider to Member Ratio Standards

Provider Type	Provider to Member Ratio Standards
Primary Care Dentists	1:1,200
Total Dentists (Primary Care and Specialty)	1:2,000

Each DMC plan was required to provide a list of contracted providers and dental offices as part of their monthly and annual submissions. To verify the network composition for the DMC plan, DHCS analyzed the list of submitted providers and facilities, and enrollment numbers per managed care plan.

For further validation of expected utilization, DMC plans were also required to provide projections of members who will seek treatment.

To determine DMC plans' network capacity and sufficiency to serve the Medi-Cal population, DHCS compared the expected utilization (as calculated by DMC plans) and the expected utilization estimate (as calculated by DHCS). DHCS developed benchmarks for utilization in annual dental visit and preventive services among measures for Calendar Year 2022 to monitor expected utilization and actual outcomes.

The provider network evaluation consisted of reviewing the DMC plan's compliance with contractual, state and federal requirements including network composition and additional certification requirements, as applicable.

In accordance with Title 42 of the Code of Federal Regulations (CFR) Section 438.207(b)(1), DMC plans are required to have a provider network composed of the appropriate range of preventative, primary care, and specialty services for the expected number of members within the DMC plan. DMC plans are required to contract with the required provider types outlined in their DMC contract agreement.

DHCS applied the methodology described in the appendix evaluate the DMC plan's provider network to ensure it can meet the needs of the anticipated number of members.

In addition to the application of the methodology described, where a DMC plan is determined deficient for any mandatory access standard requirement, the plan is allowed to submit an AAS request (subject to approval by DHCS) for capacity and

composition. The AAS request must outline the immediate plan (e.g., out of network providers) for provision of services and a long-term plan to obtain providers for all service areas.

DMC plans must contract with the following provider types or facilities based on contractual, State, or federal requirements:

- Primary Care Dentists;
- Endodontics;
- Oral and Maxillofacial Surgery
- Orthodontics;
- Pedodontics;
- Periodontics; and
- Prosthodontics.

DMC plans submitted contractual deliverables which included the following information: the name of the provider and facility, the location of the provider and facility, and the DMC plan's contract status with the provider and facility.

DHCS reviewed the DMC plan's submissions and validated the information with DHCS data sources to ensure compliance.

B. Language Capabilities

DMC are required to maintain and monitor a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services for all members, including those with Limited English Proficiency (LEP). DMC Plans are also required to make oral interpretation in person and over the phone and auxiliary aids, such as Teletypewriter (TTY), Telecommunications Device for the Deaf (TDD), and American Sign Language (ASL) services available and free of charge for any language. To demonstrate compliance with these requirements, the plans must submit subcontracts for interpretation and language line services. In addition, plans are required to report, in the Plan's provider directory and in the NACT, the cultural and linguistic capabilities of network providers, including languages (ASL inclusive) offered by the provider or the provider's office staff and whether the provider has completed cultural competence training, which is also a contractual requirement.