



2009 DENTAL QUALITY REPORT HEALTHY FAMILIES PROGRAM

California Managed Risk Medical Insurance Board
Benefits and Quality Monitoring Division





CALIFORNIA MANAGED RISK MEDICAL INSURANCE BOARD

HEALTHY FAMILIES PROGRAM (HFP)

MRMIB provides and promotes access to affordable coverage for comprehensive, high quality, cost effective health care services to improve the health of Californians.

Acknowledgements

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EXECUTIVE SUMMARY

Introduction

The 2009 Dental Quality Report for the Healthy Families Program (HFP) presents information on the oral health services provided during 2009 to children in the program by the six participating dental plans. The report includes findings for eight performance measures, including one Healthcare Effectiveness Data and Information Set (HEDIS) measure and second year results for seven measures developed specifically for HFP by an advisory group of dental experts.

The performance measures by category are as follows:

Utilization of Dental Services

- Annual Dental Visit (HEDIS measure)
- Overall Utilization of Dental Services

Examinations

- Examinations and Oral Health Evaluations
- Continuity of Care

Prevention and Treatment

- Preventive Dental Services
- Treatment and Prevention of Caries
- Filling to Preventive Services Ratio
- Utilization of Dental Treatment Services

Dental care for children in HFP is provided by dental managed care plans. MRMIB contracts with two different types of dental plans, Dental Exclusive Provider Organizations (EPOs) and Dental Health Maintenance Organizations (HMOs). In 2009, the den-

tal EPOs, Delta Dental and Premier Access, served approximately forty-five percent (45%) of HFP members. The dental HMOs, Access Dental, Health Net Dental, SafeGuard Dental and Western Dental, served approximately fifty-five percent (55%) of HFP members. In the past 2 years there have been budget cuts and program changes that have limited the choice of plans available in each county. New members are required to enroll in a dental HMO for the first two years and many members do not have the option of selecting a dental EPO in their county. In addition, Delta Dental EPO has been closed to new enrollment in several counties, including Los Angeles, for the past few years. As a result of these changes, enrollment in the EPOs is declining. At the end of 2010, only about thirty-eight percent (38%) of HFP members were enrolled in a dental EPO. As such, unless the dental HMOs make significant improvement in their performance, it is expected that the HFP average and the percentage of HFP children receiving services will decline in subsequent years.

Summary of Overall Results

There are significant differences in performance based on plan type. Children in EPOs consistently receive dental services at higher rates than children enrolled in dental HMOs. Overall, the program average for all measures increased in 2009. Several measures show an improvement of nearly three percentage points from 2008. In addition, the lowest performing plans in 2008, Health Net Dental and Western Dental, improved significantly in most measures. Individual plan and program performance for 2008 and 2009 is presented in Appendix B.

Summary of Overall Results (continued)

Other findings from the report include:

- Overall, six out of ten HFP children had a dental visit in 2009.
- Continuous enrollment in the same dental plan significantly increases the likelihood of a child receiving dental care.
- Overall, about half of HFP children received an examination or oral health evaluation. More than six out of ten children enrolled in a dental EPO had an examination compared to only about four out of ten children in a dental HMO.
- Half of HFP children received a treatment or preventive service for caries.
- Seventy-seven percent (77%) of children who had a filling in the past year also received a topical fluoride or sealant application in 2009.
- One-third of HFP children had a dental treatment service.
- Oral health disparities continue among ethnic groups, language groups, regions and income level. African American children and children in the northern region received dental services at significantly lower rates compared to other ethnic groups and geographic regions.

Conclusion

The second year results for the oral health performance measures indicate that the program is making incremental improvement in access to and utilization of oral health services. However, significant improvement is needed from the dental HMOs, in particular, as more children are enrolled in these plans.

Through support from the California Health Care Foundation (CHCF), in 2010 MRMIB launched an oral health quality improvement project, “Healthy Smiles—Healthy Families.” The goals of the project are to increase access and utilization of oral health services by HFP children ages 1-6. MRMIB is working with national experts, as well as the HFP dental plans, to improve the oral health of young children enrolled in HFP.

Importance of Oral Health

Tooth decay, or cavities, is one of the most common and most treatable health problem affecting children. Untreated tooth decay can lead to pain, trouble eating and sleeping, missed days of school, poor self esteem and costly dental treatment later on. Facts and figures from state and national reports highlight the need for considerable improvement in the dental care provided to children, particularly those from lower-income families.

- The Centers for Disease Control and Prevention (CDC) reports that “tooth decay affects one-fourth of U.S. children aged 2-5 and half of those aged 12-15. About half of all children and two-thirds of children aged 12-19 from low income families have had decay. Children and adolescents of some racial and ethnic groups and those from lower-income families have more untreated decay.”¹
- In 2008, the United States Government Accountability Office (GAO) reported that one in three, or 6.5 million, children ages 2 to 18 enrolled in Medicaid had untreated tooth decay.²
- In California, approximately 6.3 million children— or two-thirds of all children in the state— suffer needlessly from poor oral health by the time they reach third grade.³
- American children miss about 1.6 million school days each year due to dental disease.⁴ Approximately 7 percent of California children missed school due to a dental problem in 2007.³
- In 2010, Americans will spend \$106 billion on dental care in-

cluding many expensive treatments that could have been mitigated or avoided if children received adequate dental care. Between 2009 and 2018, annual spending for dental services is expected to increase 58 percent from \$101.9 billion to \$161.4 billion. Approximately one-third of the money will go to dental services for children.⁵

Oral Health Provisions of Health Care Reform

The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires states to take several actions to address the high rate of dental disease in low-income children and the barriers to accessing care. The law requires states to provide dental coverage to children enrolled in CHIP and education of parents of newborns enrolled in Medicaid and CHIP about their babies’ dental health. To address the most common barrier of finding a dental provider to treat a child enrolled in Medicaid or CHIP, the Department of Health and Human Services (HHS) posts a list of current dentists participating in Medicaid and CHIP on its [Insure Kids Now](#) website. CHIPRA also requires the GAO and HHS to study children’s access to oral health care and expand access to services, education and research related to oral health.²

While CHIPRA requires states to provide dental coverage to children enrolled in CHIPs beginning in 2010, California has been providing dental coverage to children in HFP since the program began in 1997. Mandatory dental coverage in all CHIPs along with the other provisions of CHIPRA should finally provide national information and state-by-state comparison data on the number of children enrolled in CHIPs receiving dental services.

BACKGROUND

Monitoring Dental Quality in HFP

At the end of 2009 there were 882,434 children in California with dental coverage through HFP. The 2009 Dental Quality Report for the Healthy Families Program (HFP) presents information on the quality of dental care provided to children enrolled in HFP during 2009. The report includes findings for eight dental performance measures, including one HEDIS measure and first year results for 7 new measures developed specifically for HFP by an advisory group of dental experts.

The Managed Risk Medical Insurance Board (MRMIB) monitors the quality of services provided to children in the program by annually collecting and reporting data on dental performance measures from the dental plans. The HFP is one of the few programs in the country that measures dental quality and MRMIB has been at the forefront of developing dental quality measures. However, CHIPRA requires CHIPs to report on dental services for federal fiscal year 2010.

National standards for measuring dental quality are limited. Over the years there have been numerous changes in the standards of care and recommended preventive treatment options. To address these changes, in 2007 MRMIB established a Dental Quality Advisory Committee to develop new measures that would provide relevant information about the quality of dental services provided by dental plans and allow for comparisons of dental plan performance. In 2008, the dental plans submitted first year data related to services provided in 3 broad categories: Utilization of Dental Services, Examinations, and Prevention and Treatment. The results can be found in the [2008 Dental Quality Report](#).

The measures by category are as follows:

- **Utilization of Dental Services**
 - ◇ Annual Dental Visit (HEDIS measure)
 - ◇ Overall Utilization of Dental Services
- **Examinations**
 - ◇ Examinations and Oral Health Evaluations
 - ◇ Continuity of Care
- **Prevention and Treatment**
 - ◇ Preventive Dental Services
 - ◇ Treatment and Prevention of Caries
 - ◇ Filling to Preventive Services Ratio
 - ◇ Utilization of Dental Treatment Services

A detailed description of each measure is in Appendix A.

MRMIB requires all dental plans to have their data collection and reporting processes audited by an independent third party to ensure that the data is reliable and accurate.

In addition to collecting data on the quality of dental services received by children in the program, MRMIB has administered the Dental Consumer Assessment of Healthcare Providers and Systems (D-CAHPS) survey to assess members' satisfaction with the dental services they receive. The HFP is the only program in the country using the D-CAHPS survey to measure satisfaction. However, due to lack of funding, the D-CAHPS has not been administered since 2007. MRMIB is planning to administer the D-CAHPS survey in 2011.

BACKGROUND

Dental Plan Models

All dental care for children in HFP is provided by dental managed care plans. MRMIB contracts with two different types of dental plans, dental EPOs and dental HMOs. In 2009, the dental EPOs, Delta Dental and Premier Access, served approximately 45% of HFP members. The dental HMOs, Access Dental, Health Net Dental, SafeGuard Dental, and Western Dental, served approximately 55% of HFP members. Total enrollment by plan as of December 2009 is presented in Appendix C.

The dental EPOs allow members to select any dentist from the dental plan's network. Members do not have to select a primary care dentist and can choose to see a different dentist each time they need care. Members do not need a referral to see a dental specialist. Dental providers are paid on a fee-for-service basis when services are provided. MRMIB pays higher rates to the dental EPOs than to the dental HMOs.

The dental HMOs require members to select a primary care dentist who coordinates the member's dental care. Members are required to get prior authorization from their primary care dentist to see a specialist for non-emergency dental services. The primary care dentist receives a monthly capitation payment from the plan for each assigned member.

While reading this report, it is important to keep in mind that in some counties, members have a choice of only one dental plan type. For example, in Los Angeles, the dental EPOs are closed to new enrollment and in some of the Northern region counties, there are no dental HMOs.

SUMMARY OF KEY FINDINGS

- The 2009 program average for all measures increased from 2008. The lowest performing plans in 2008 improved significantly in most measures.
- The percentage of HFP children going to a dentist increased from 2008 to 2009. Nearly 6 in 10 (59%) of HFP children went to the dentist for any reason in 2009 compared to 56% in 2008. However, the 2009 rate is below the rate in 2006 when 62% of HFP children had a dental visit. (Figure 1).
- There are significant differences in the performance of the different plan models. Members enrolled in a dental EPO consistently received dental services at higher rates than members enrolled in a dental HMO. In particular, members enrolled in Health Net Dental consistently received dental services at the lowest rate among the HMOs and, in some cases, at half the rate of children enrolled in the EPOs.
- Continuous enrollment in the same dental plan significantly increases the likelihood of a child receiving dental care. Children who were continuously enrolled in the same dental plan for 3 years received a dental service at a significantly higher rate (68%) compared to those enrolled in the same plan for 2 years (57%) or 1 year (48%) (Figure 8). More than three-quarters (77%) of children who were continuously enrolled in the same plan and had a cleaning or oral evaluation in 2008 also received a cleaning or oral evaluation in 2009 (Figure 22).
- Overall, a little over half (54%) of HFP children received an examination or oral health evaluation. Six out of ten children enrolled in an EPO had exams. Only four in ten (40.5%) children enrolled in a HMO had exams (Figure 15).
- Children enrolled in a dental EPO consistently received dental preventive and treatment services at much higher rates compared to children enrolled in a dental HMO.
- Overall, half of HFP children received a preventive dental service such as a teeth cleaning, topical fluoride application or counseling on nutrition and oral hygiene. Less than four out of ten (39%) children enrolled in a HMO received a preventive service compared to nearly seven out of ten (68%) children enrolled in an EPO (Figure 29).
- Half of HFP children received treatment for caries or a caries-preventive procedure. Only about one-third of children in the HMOs received these services compared to more than 60% in EPOs (Figure 36).
- Overall, seventy-seven percent (77%) of children who received a filling in the past year received a topical fluoride or sealant application in 2009. Eight out of ten (83.6%) children enrolled in an EPO who received a filling also received a preventive service compared to six out of ten (65.9%) children enrolled in a HMO (Figure 43).
- Less than one-third of HFP children received a dental treatment service in 2009. (Figure 50).

SUMMARY OF KEY FINDINGS

Demographic analysis revealed several distinct and consistent differences across ethnicity, spoken language, region and age:

- Asian/Pacific Islanders, particularly Vietnamese and Chinese speakers, consistently received services at the highest rates.
- African Americans received services at the lowest rates regardless of plan type.
- English and “Other” language speakers received dental services at a lower rate than those who spoke Spanish, Chinese, Vietnamese and Korean.
- Children in the Northern region received dental services at significantly lower rates regardless of plan type.
- Despite the American Academy of Pediatric Dentistry (AAPD) recommendation that children begin seeing a dentist once the first tooth erupts and no later than 12 months of age, HFP children under age 6 were the least likely to have received any type of dental service.
- Children in families with the highest income level, 200% to 250% Federal Poverty Level (FPL), received dental services at a slightly lower rate than those in families with lower incomes.

Figure 1. Individual Plan Rates for Annual Dental Visit

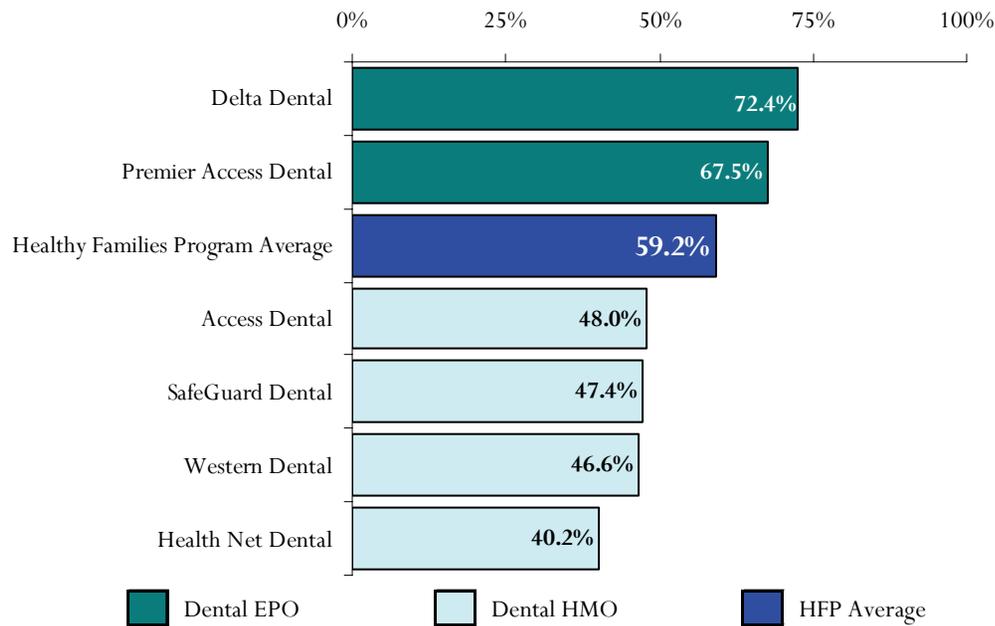
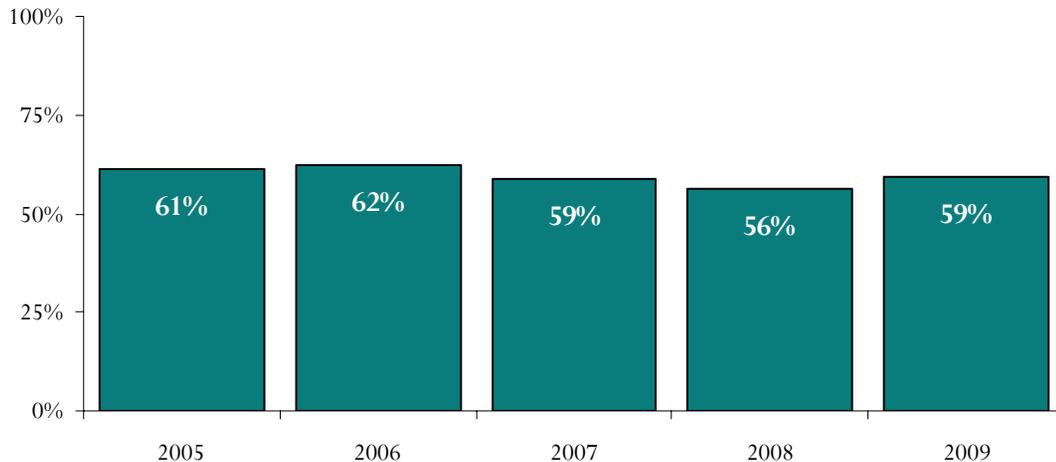


Figure 2. 5 Year Trend for Annual Dental Visit



Measure Definition

The *Annual Dental Visit* measure estimates the percentage of children ages 2 to 18 years of age who were continuously enrolled for the past year with no more than a 45 day break in enrollment and who had at least one dental visit during the measurement year.

Why Is This Important?

The American Academy of Pediatric Dentistry (AAPD) recommends that children receive their first dental examination when their first tooth comes in, usually between 6 and 12 months of age. The AAPD recommends a dental check-up at least twice a year for most children or more often depending on a child's risk status.

The early dental visits are critical to establishing a dental home and providing education and guidance on good oral health. Regular dental visits lead to early detection of dental disease, preventing more extensive care in the future.

Overall Results

Fifty-nine percent (59%) of HFP children between the ages of 2 and 18 had at least one dental visit in 2009, an increase of 3 percentage points from 2008. The percentage of children enrolled in an EPO who had a dental visit increased by 2 percentage points in 2009 (from 70% in 2008 to 72% in 2009.) The percentage of children enrolled in a dental HMO who had a dental visit increased by 8 percentage points (from 38% in 2008 to 46% in 2009.)

UTILIZATION OF DENTAL SERVICES — ANNUAL DENTAL VISIT

Figure 3. Annual Dental Visit by Spoken Language

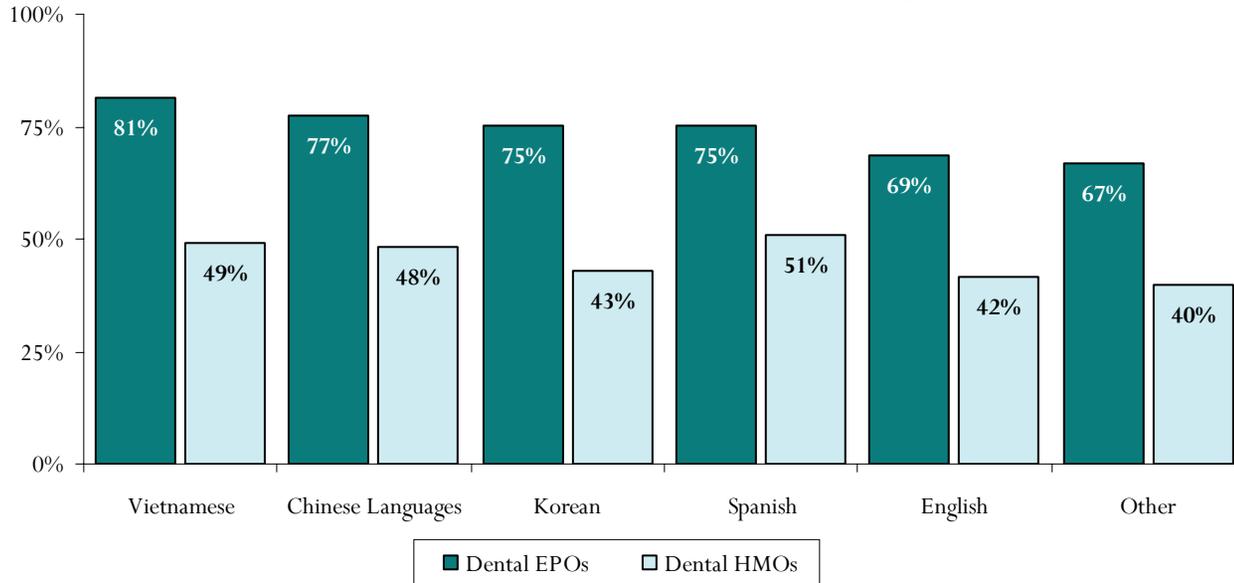
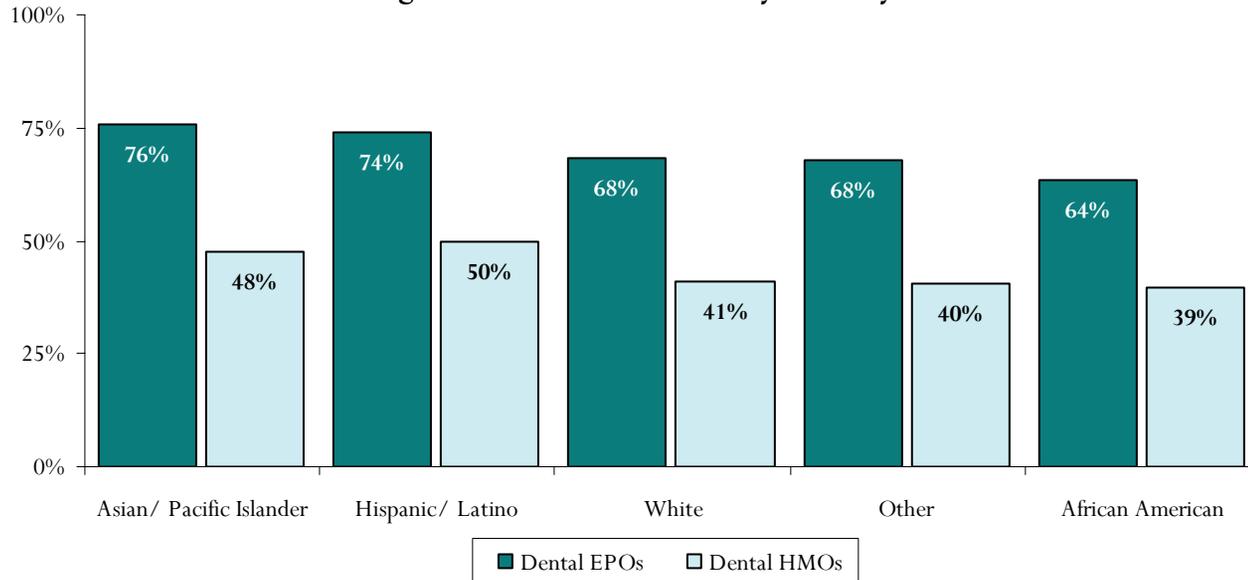


Figure 4. Annual Dental Visit by Ethnicity

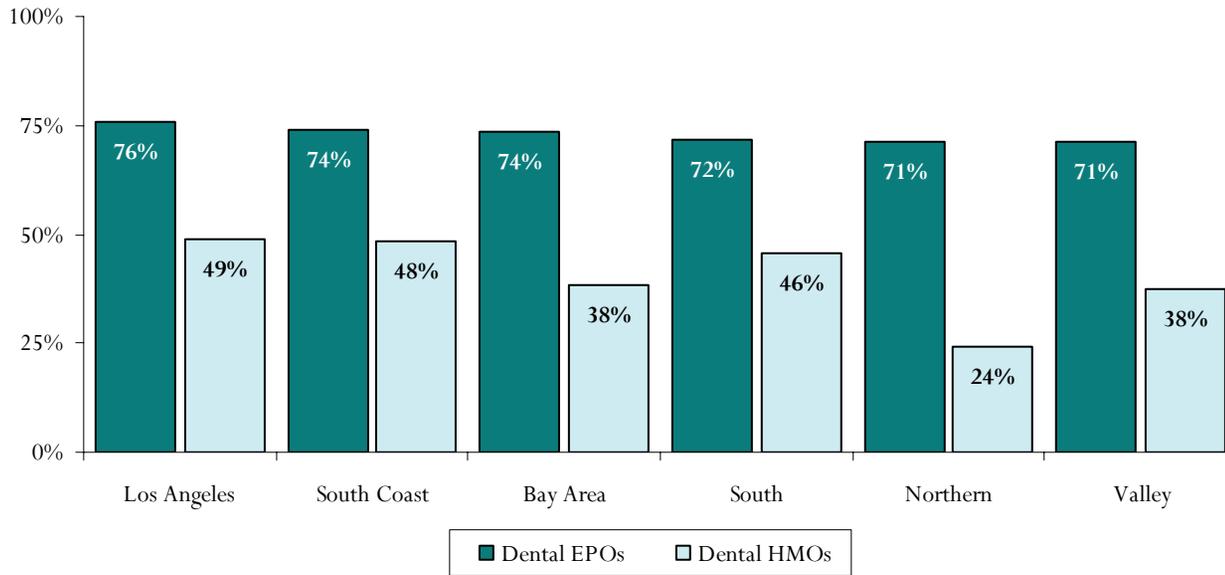


Key Findings About Demographics

- Asian language speakers had a dental visit at significantly higher rates than the other language groups, except for Korean speakers in the dental HMOs.
- English and “Other” language speakers received a dental visit at the lowest rates regardless of dental plan type.
- African American children received a dental visit at the lowest rate in both the EPOs and HMOs.

UTILIZATION OF DENTAL SERVICES — ANNUAL DENTAL VISIT

Figure 5. Annual Dental Visit by Region



Key Findings About Demographics

- Regional variation in annual dental visit rates was less in the EPOs than in the HMOs.
- Children enrolled in a dental HMO in the Northern region received a dental visit at about half the rate of those in the southern regions.
- Children ages 7 to 12 years old received a dental visit at the highest rates in the EPOs and HMOs.
- Less than four out of ten children, ages 2 to 6, enrolled in a dental HMO went to the dentist in 2009, despite the AAPD's recommendation that children begin seeing a dentist by their first birthday.
- Children in families with the highest income (201% to 250% FPL) had a dental visit at a slightly lower rate than children in families with lower incomes.

Figure 6. Annual Dental Visit by Age Group

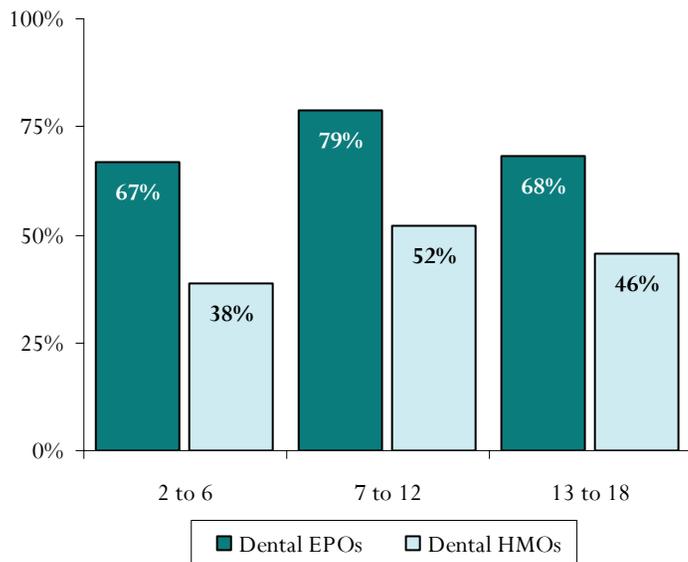
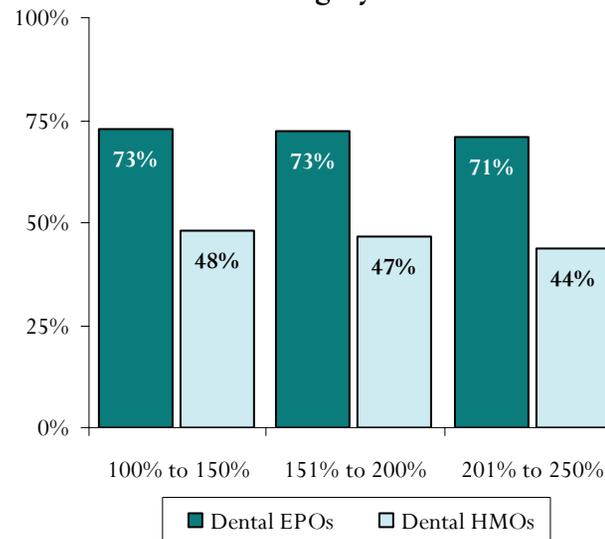


Figure 7. Annual Dental Visit by FPL Category



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UTILIZATION OF DENTAL SERVICES — OVERALL UTILIZATION OF DENTAL SERVICES

Figure 8. Individual Plan Rates for Overall Utilization of Dental

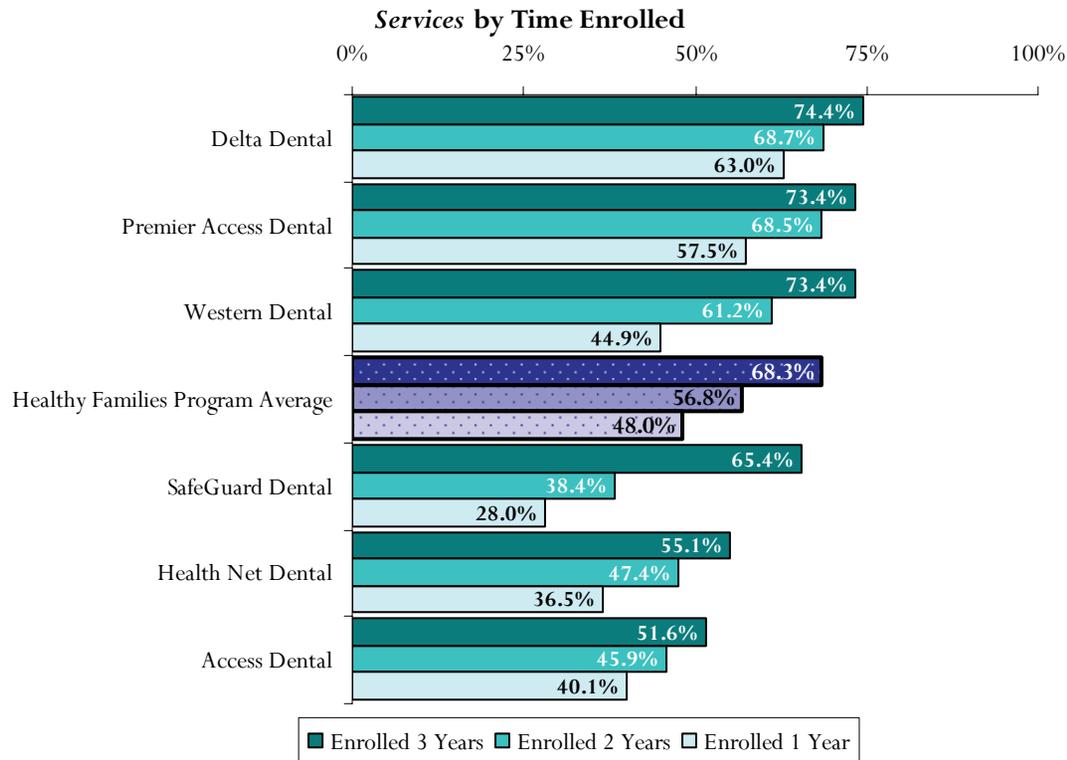
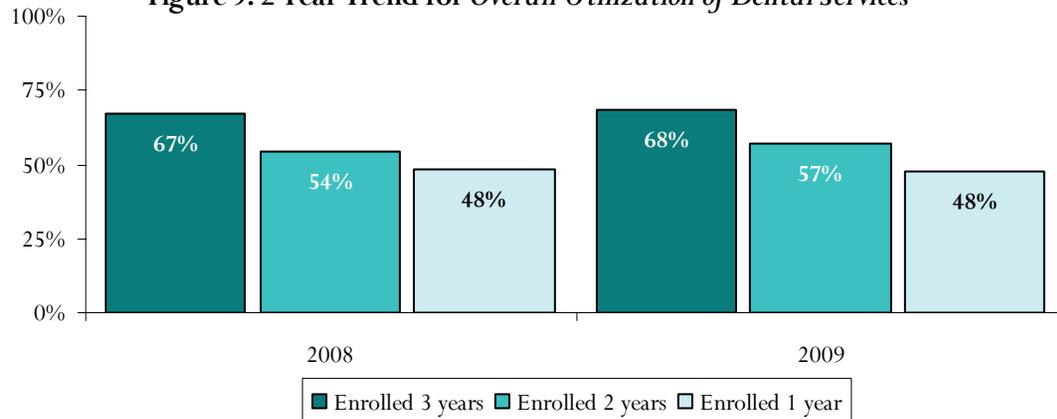


Figure 9. 2 Year Trend for Overall Utilization of Dental Services



Measure Definition

The *Overall Utilization of Dental Services* measure estimates the percentage of children who were continuously enrolled in the plan for one, two and three years who received any dental service, including preventive services, over those periods.

Why Is This Important?

This measure looks at the quality of care that members receive over time and the importance of establishing a dental home. According to the AAPD, “children who have a dental home are more likely to receive appropriate preventive and routine oral health care.”⁶

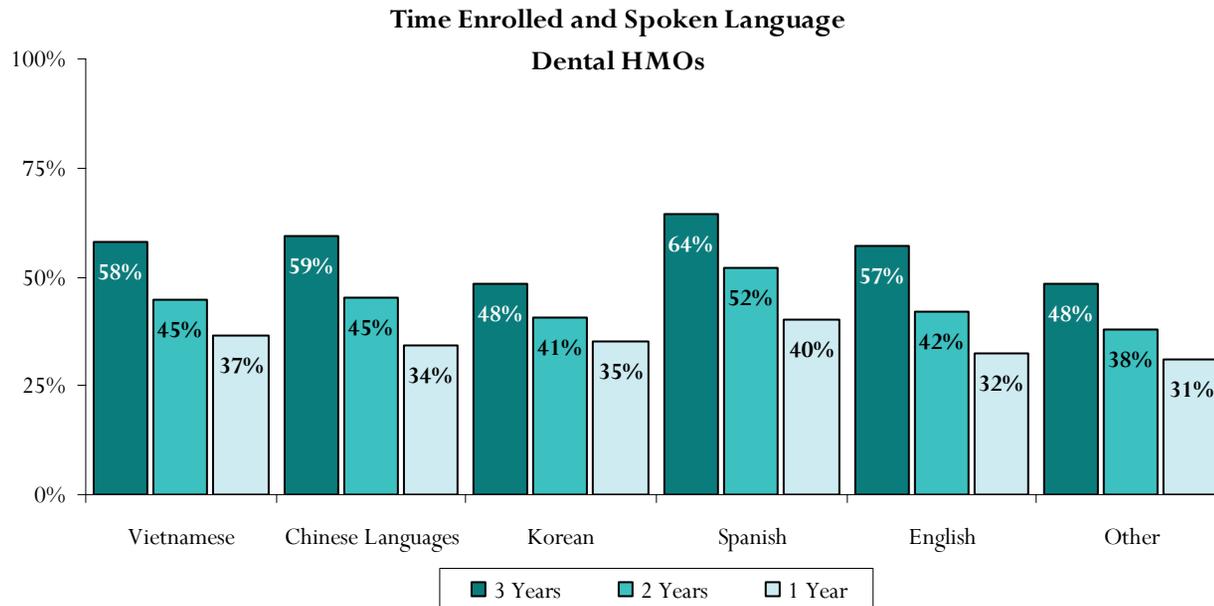
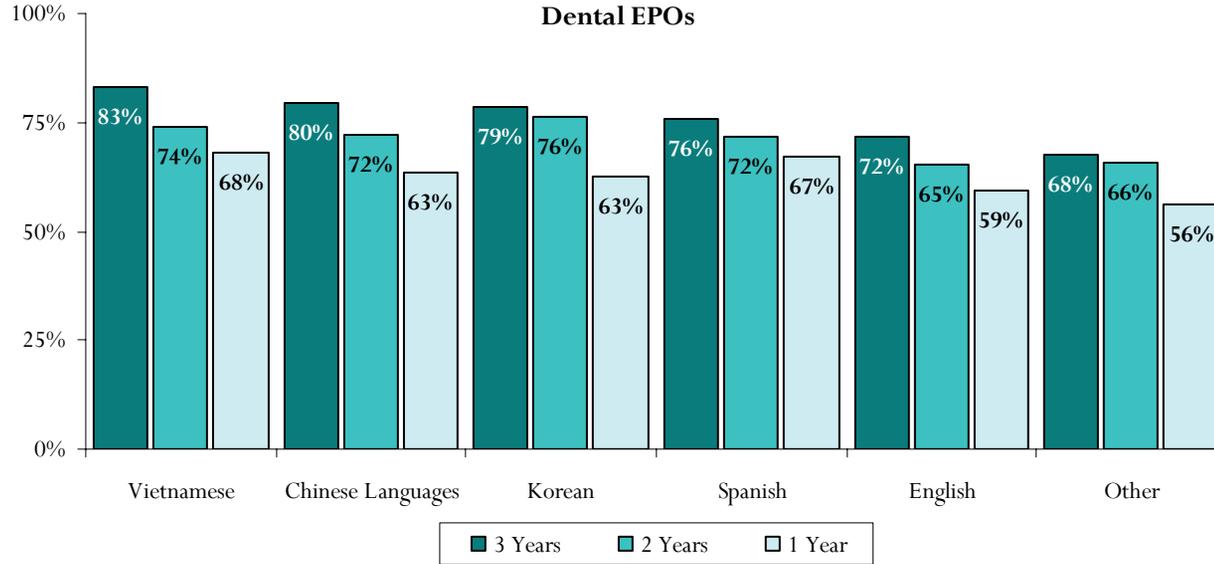
Overall Results

The results indicate that the longer a child is continuously enrolled, the more likely they are to have had a dental visit at some point. Some of these children, particularly those enrolled in the same plan for 3 years, likely have established a dental home where they receive regular and continuous care.

Nearly 7 out of 10 HFP children who were continuously enrolled in the same plan for 3 years received a dental service compared to less than 5 out of 10 children enrolled in the same plan for 1 year. There is very little difference in rates between 2008 and 2009.

While children enrolled in a dental EPO received a dental service at a higher rate than those in HMOs, the differences are not as pronounced as for other measures. In particular, children enrolled for 3 years in Western Dental received a dental service at the same rate as those enrolled in an EPO. It continues to be concerning that even over a 3 year period, 25 % of children enrolled in HFP did not receive any dental services. In the case of Health Net Dental and Access Dental, nearly half of the children enrolled did not receive any dental services over a 3 year period.

Figure 10a. Overall Utilization of Dental Services by Time Enrolled and Spoken Language



Key Findings About Demographics

- Children who were enrolled for only one year in a dental HMO had a dental visit at about half the rate of children who spoke the same language and were enrolled for one year in a dental EPO.
- Asian language speakers enrolled in an EPO had a dental visit at the highest rate while Spanish speakers received dental services at the highest rate in a dental HMO.
- Less than one-third of English and “Other” language speakers enrolled in a dental HMO for one year received a dental service.

UTILIZATION OF DENTAL SERVICES — OVERALL UTILIZATION OF DENTAL SERVICES

Figure 11a. Overall Utilization of Dental Services by Time Enrolled and Ethnicity
Dental EPOs

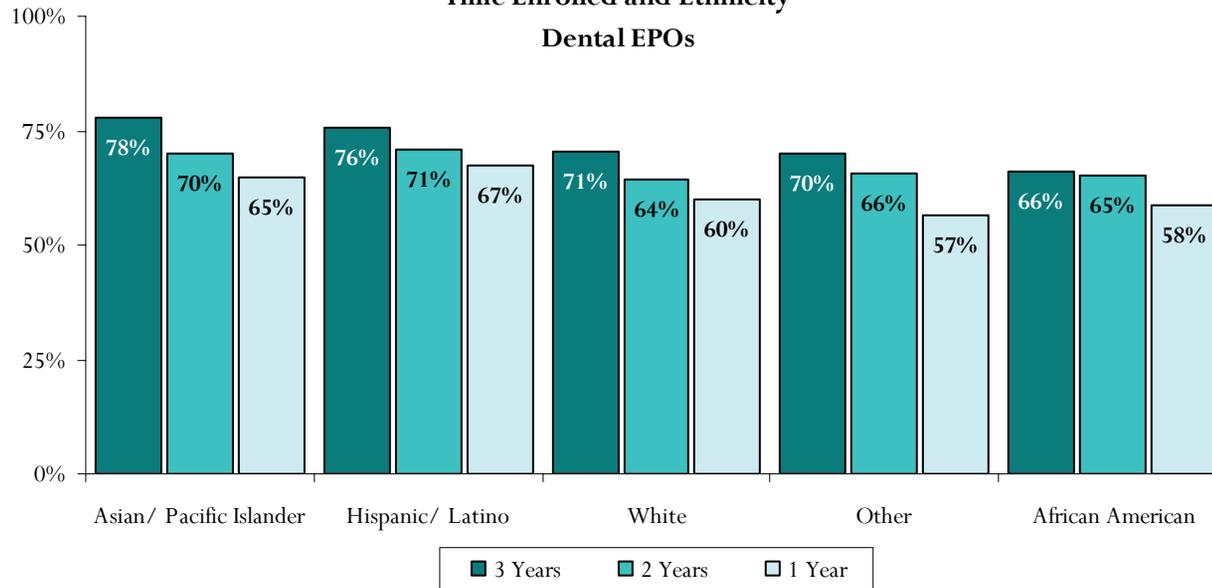
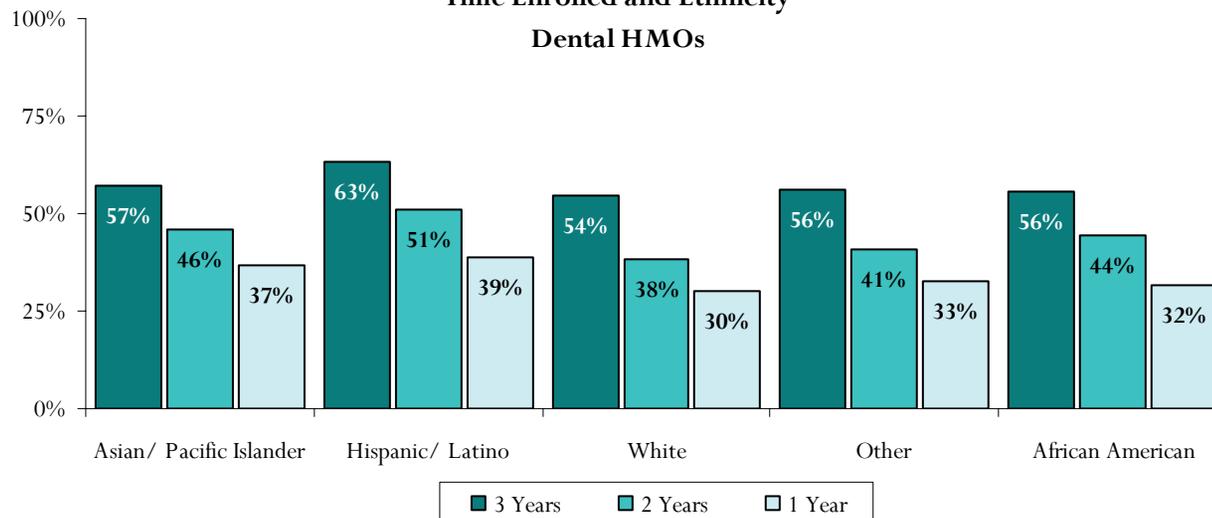


Figure 11b. Overall Utilization of Dental Services by Time Enrolled and Ethnicity
Dental HMOs



Key Findings About Demographics

- Asian/Pacific Islander children enrolled in an EPO for 3 years received a dental service at the highest rate (78%) while only 57% of Asian/Pacific Islander children in a dental HMO had a visit during that time period.
- There was less variation in the percentage of children who received a dental visit regardless of ethnicity and the amount of time a child was enrolled in an EPO compared to the differences by time enrolled for those in dental HMOs. Continuous enrollment appears to be a more important factor in whether a child receives dental services in the dental HMOs.
- White, African American and children of “Other” ethnicities received a dental service at the lowest rates regardless of plan type or time enrolled.

UTILIZATION OF DENTAL SERVICES — OVERALL UTILIZATION OF DENTAL SERVICES

Figure 12a. Overall Utilization of Dental Services by Time Enrolled and Region
Dental EPOs

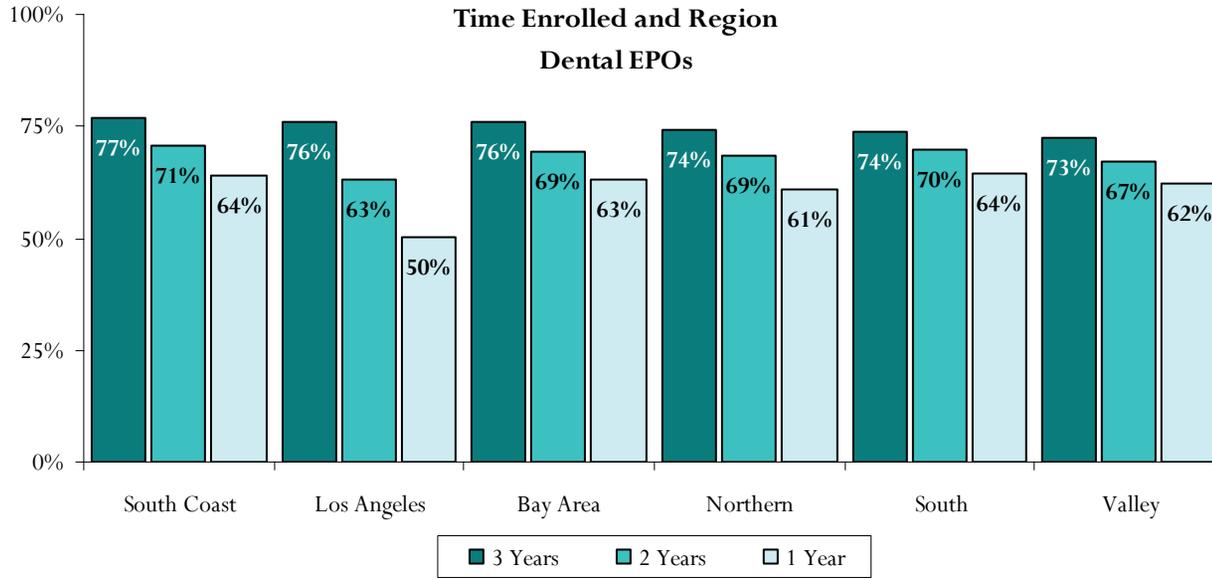
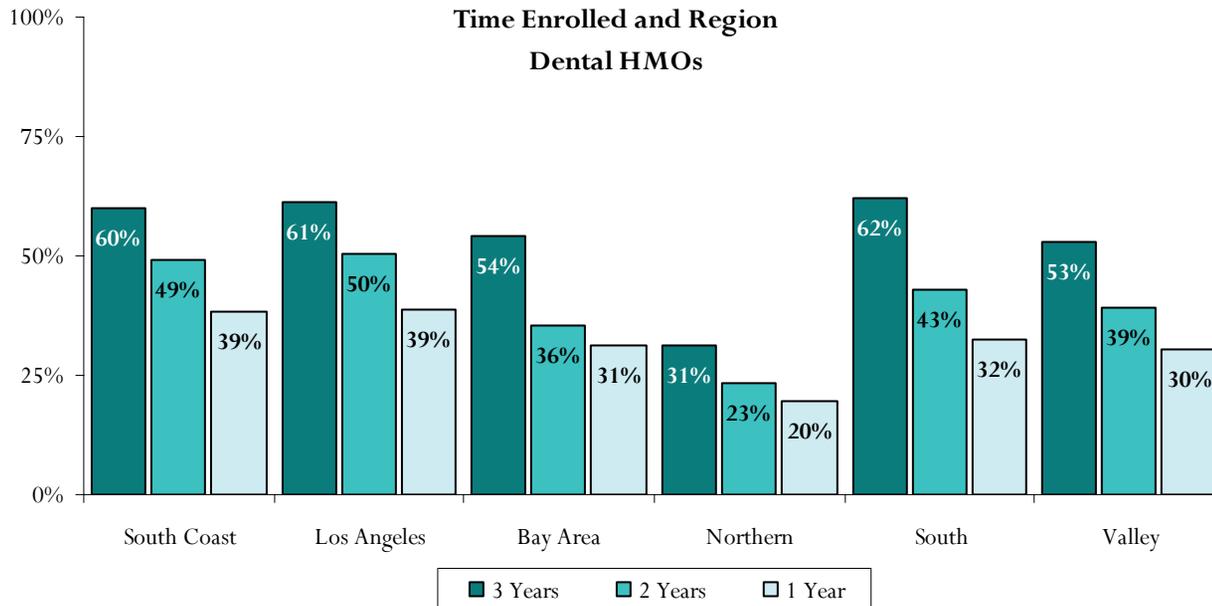


Figure 12b. Overall Utilization of Dental Services by Time Enrolled and Region
Dental HMOs

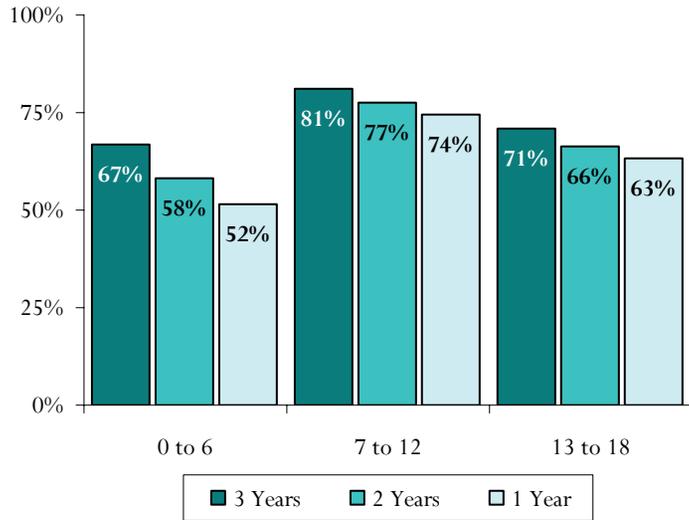


Key Findings About Demographics

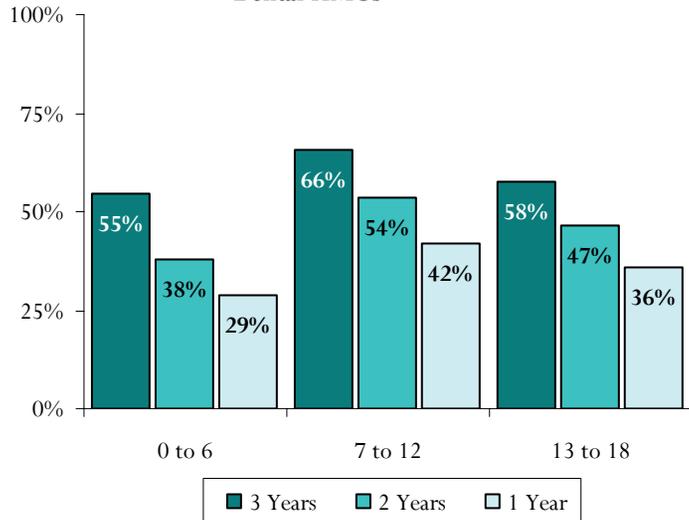
- For children continuously enrolled in an EPO for 1, 2 or 3 years, there were minimal differences in the rate that they received dental services by region. The one exception is in Los Angeles where children enrolled in an EPO for 1 year received a dental service at a much lower rate (50%) compared to children in other regions.
- Children enrolled in a dental HMO in southern California received a dental service at higher rates than those in northern California regardless of time enrolled in the plan.
- Even after being enrolled in the same plan for 3 years, less than one-third of children in the Northern region enrolled in a dental HMO received a dental service. Less than one-quarter of kids enrolled for 1 or 2 years received a dental service.

UTILIZATION OF DENTAL SERVICES — OVERALL UTILIZATION OF DENTAL SERVICES

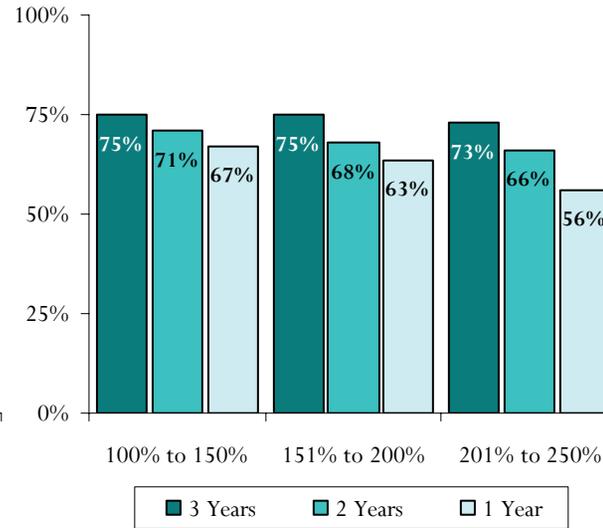
**Figure 13a. Overall Utilization of Dental Services by Age Group
Dental EPOs**



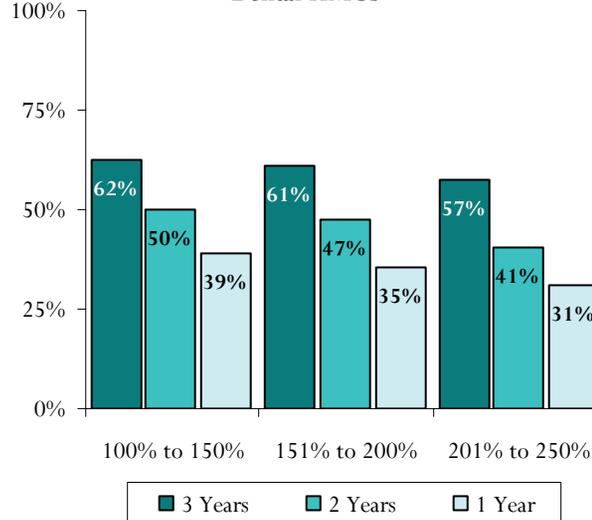
**Figure 13b. Overall Utilization of Dental Services by Age Group
Dental HMOs**



**Figure 14a. Overall Utilization of Dental Services by Time Enrolled and FPL
Dental EPOs**



**Figure 14b. Overall Utilization of Dental Services by Time Enrolled and FPL
Dental HMOs**



Key Findings About Demographics

- The trends for EPO and HMO were similar with children ages 7 to 12 receiving dental services at the highest rates regardless of time enrolled.
- Less than one-third of children under the age of 6 who were enrolled in a dental HMO for one year had a dental visit.
- More than 30% of children, ages 0 to 6, enrolled in an EPO for three years did not go to the dentist at all during that time period. Forty-five percent (45%) of same age children enrolled in a dental HMO did not go to the dentist at all in 3 years.
- Children in families with the highest income (201% to 250% FPL) received a dental visit at lower rates than children in families with lower incomes regardless of time enrolled or plan type.

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Figure 15. Individual Plan Rates for Examinations and Oral Health Evaluations

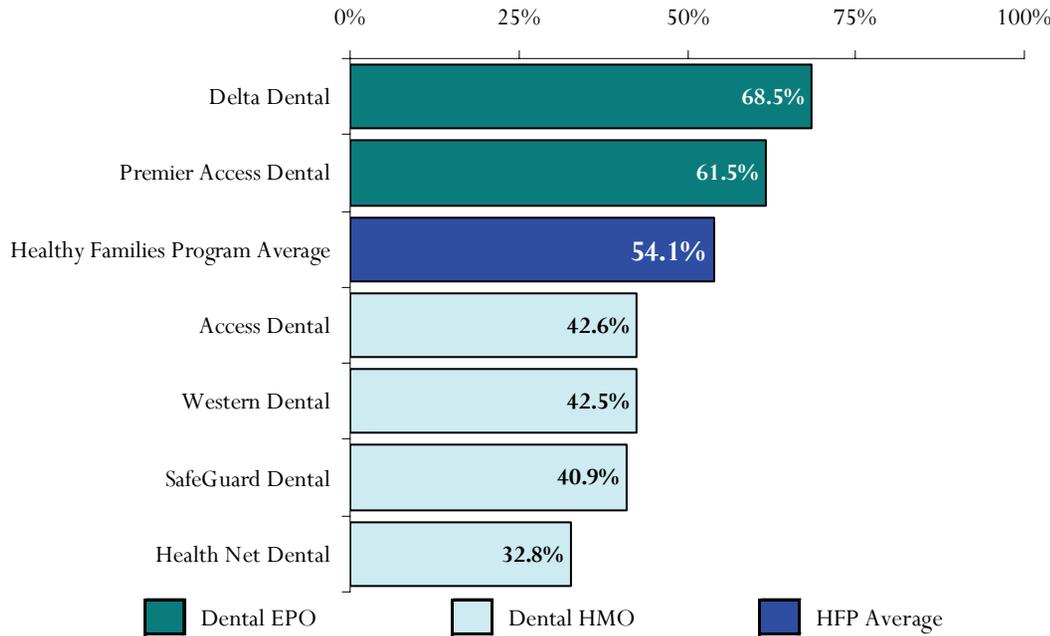
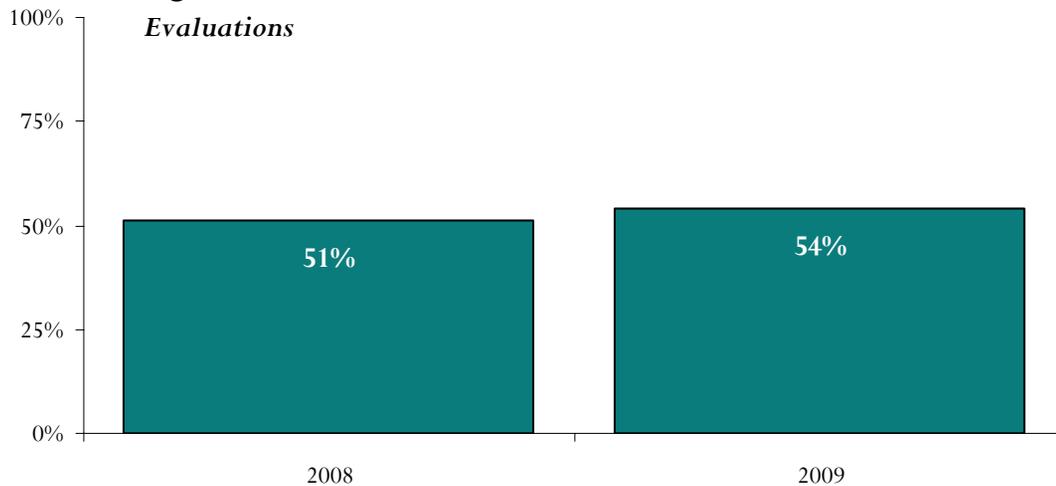


Figure 16. 2 Year Trend for Examinations and Oral Health Evaluations



Measure Definition

The *Examinations and Oral Health Evaluations* measure estimates the percentage of HFP children who:

- received a comprehensive or periodic oral health evaluation or,
- for members under 3 years of age, those who received an oral evaluation and counseling with the primary care giver in the measurement year.

Why Is This Important?

In the early years, an oral evaluation is a good time to introduce a child to the dental office and to establish a dental home. At these visits, the dentist will provide counseling to the caregiver on good oral hygiene and diet. The dentist will also evaluate the development of the new teeth and the risk for caries. Regular examinations allow for preventive services to be delivered, as well as the early detection of caries and other dental conditions. This is also the age at which children begin to lose their baby teeth and the dentist will evaluate the development of permanent teeth and recommend treatment to correct any problems.

Overall Results

Slightly more than half (54%) of HFP children received an oral health evaluation in 2009, an increase of three percentage points from 2008. Over six out of ten children enrolled in an EPO received an examination compared to approximately four out of ten children in Access Dental, Western Dental and SafeGuard Dental and three out of ten children enrolled in Health Net Dental.

Figure 17. Examinations and Oral Health Evaluations by Spoken Language

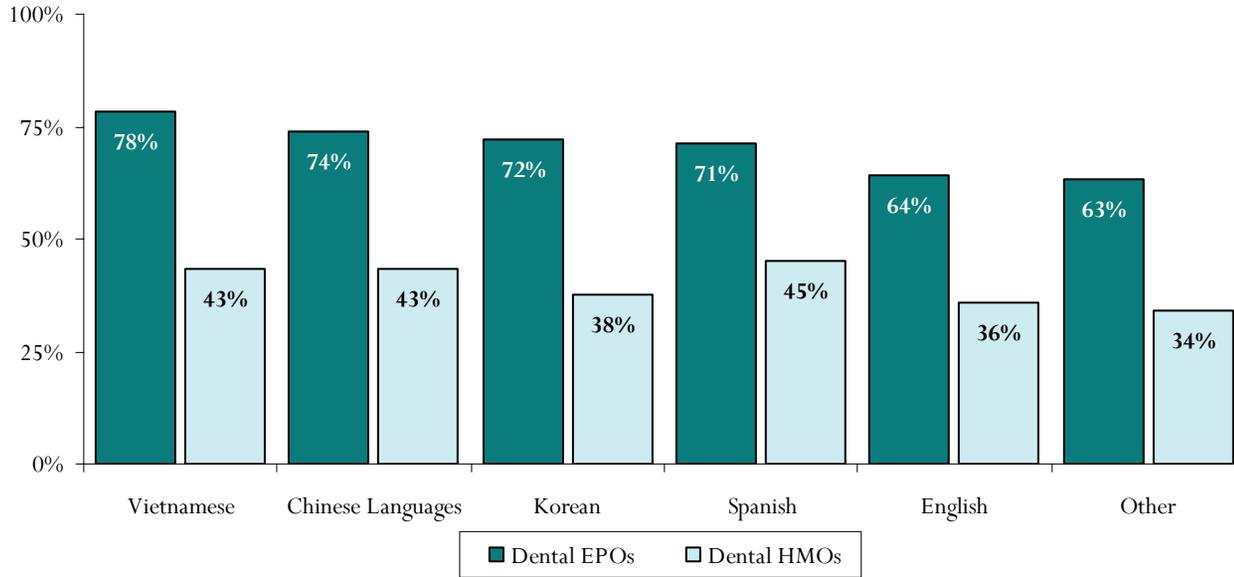
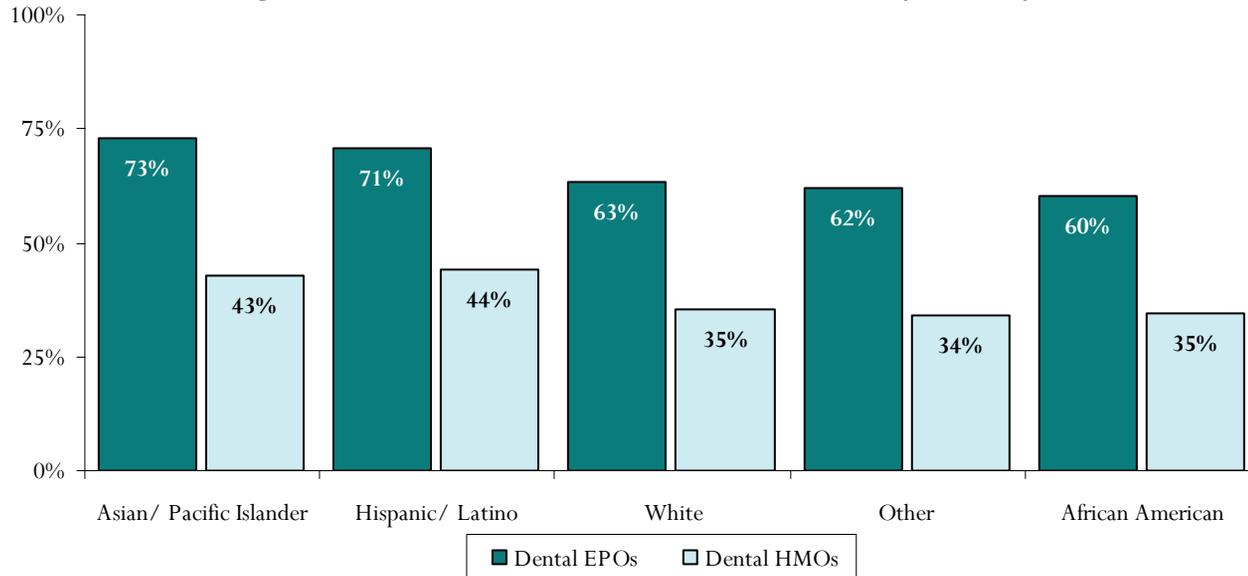


Figure 18. Examinations and Oral Health Evaluations by Ethnicity



Key Findings About Demographics

- Spanish speakers in dental HMOs received an examination or oral health evaluation at the highest rate.
- English and “Other” language speakers received an examination or oral health evaluation at significantly lower rates in both the EPOs and HMOs.
- Regardless of plan type, Asian/Pacific Islander and Hispanic children received an examination or oral health evaluation at significantly higher rates compared to other ethnic groups.
- White, African American and children of “Other” ethnicities received an examination or oral health evaluation at the lowest rate regardless of dental plan type.

EXAMINATIONS — EXAMINATIONS AND ORAL HEALTH EVALUATIONS

Figure 19. Examinations and Oral Health Evaluations by Region

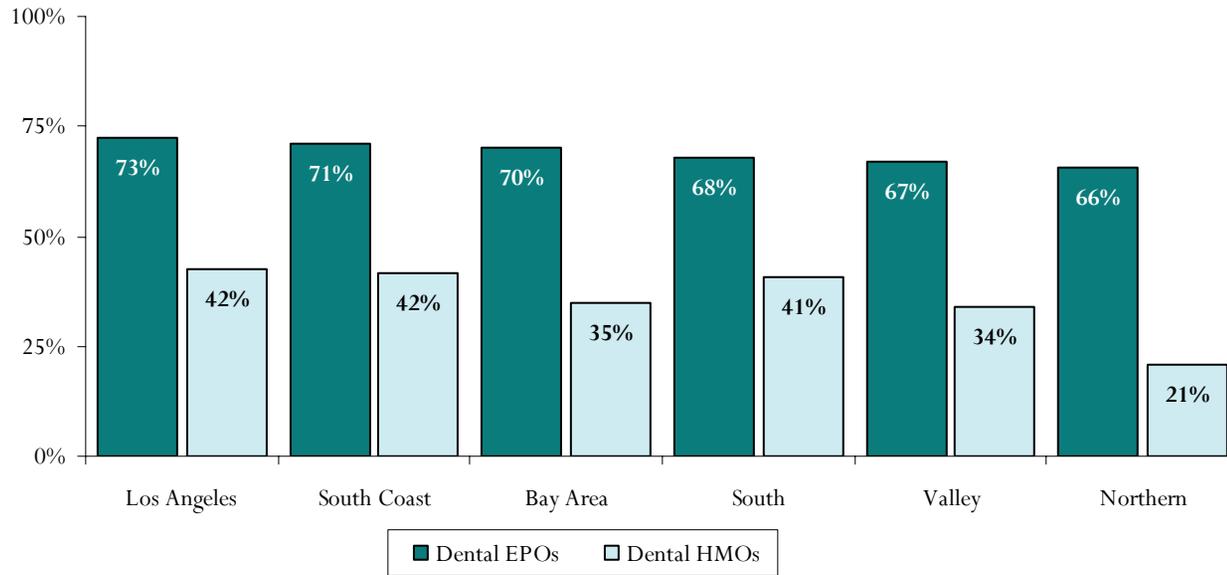


Figure 20. Examinations and Oral Health Evaluations by Age Group

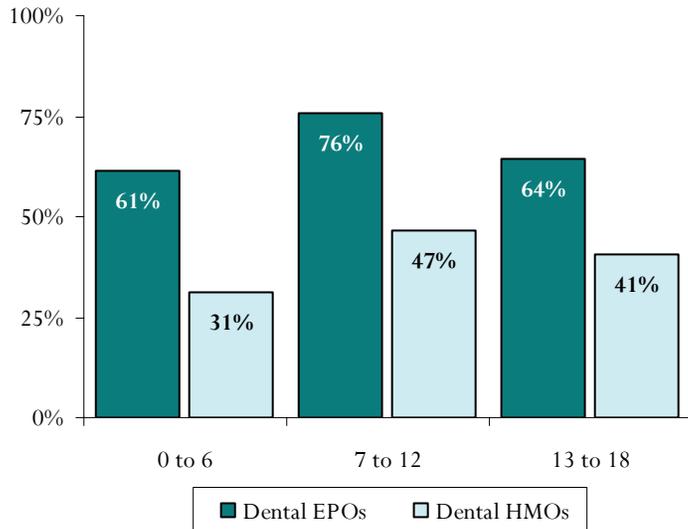
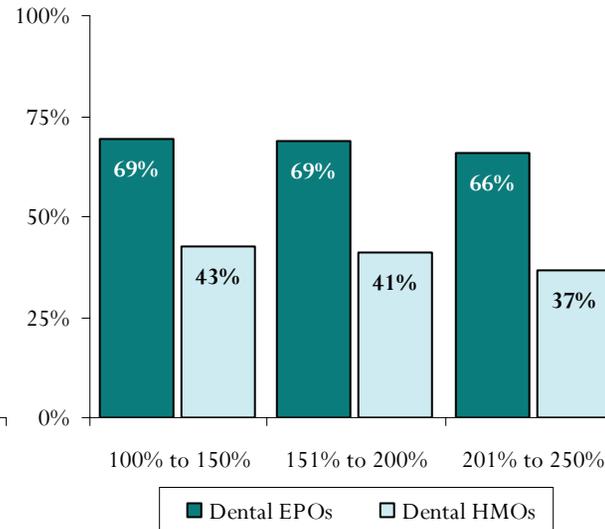


Figure 21. Examinations and Oral Health Evaluations by FPL Category



Key Findings About Demographics

- While children in the Northern region were the least likely to have had an examination or oral health evaluation, children in this region enrolled in an EPO received an examination at three times the rate of those enrolled in a HMO.
- Only 20% of children in the northern region enrolled in a dental HMO received an exam or oral health evaluation.
- Children ages 0 to 6 who were enrolled in a dental EPO received an examination or oral health evaluation at twice the rate of similar aged children enrolled in a dental HMO.
- Despite the importance of early dental visits, only 39% of children under the age of 3 enrolled in a EPO and 14% of children enrolled in a dental HMO had an oral health evaluation or examination.
- Children in families with the highest income level (201% to 250% FPL) received an examination or oral health evaluation at slightly lower rates than children in lower income categories.

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Figure 22. Individual Plan Rates for Continuity of Care

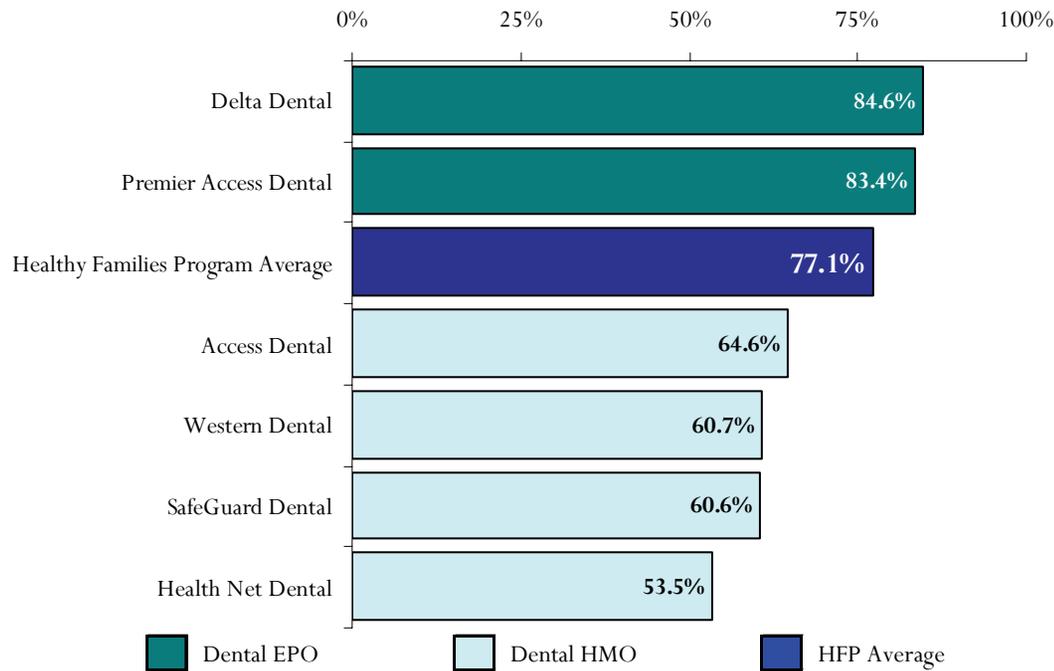
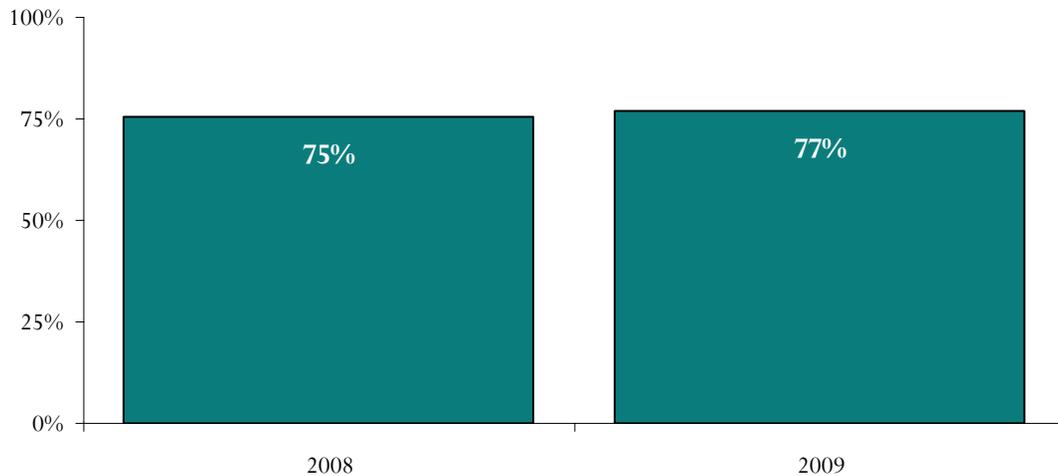


Figure 23. 2 Year Trend for Continuity of Care



Measure Definition

The *Continuity of Care* measure estimates the percentage of HFP children who were enrolled in the same plan for two years with no gap in coverage and received a comprehensive oral evaluation or a prophylaxis in the year prior to the measurement year and in the measurement year.

Why Is This Important?

This measure looks at whether continuous enrollment in a dental plan leads to regular dental visits. It also looks specifically at the children who receive an exam or teeth cleaning to see if they are more likely to go back to the dentist on an annual basis.

Overall Results

Seventy-seven percent (77%) of HFP children who were continuously enrolled in the same plan for two years had either an oral evaluation or teeth cleaning in 2009, an increase of two percentage points from 2008. This is considerably higher than the 54% of children who received an examination in 2009 as reported in the *Examinations and Oral Health Evaluations* measure. Individual dental plan rates ranged from 54% to 85% compared to dental plan rates that ranged from 33% to 69% for the *Examinations and Oral Health Evaluations* measure.

The results support the idea that children who are continuously enrolled, even those enrolled in a dental HMO, are more likely to go to the dentist on a regular basis for examinations and teeth cleanings. Stability of coverage and an ongoing relationship with a dentist would seem to be a key component of ongoing oral health care.

Figure 24. Continuity of Care by Spoken Language

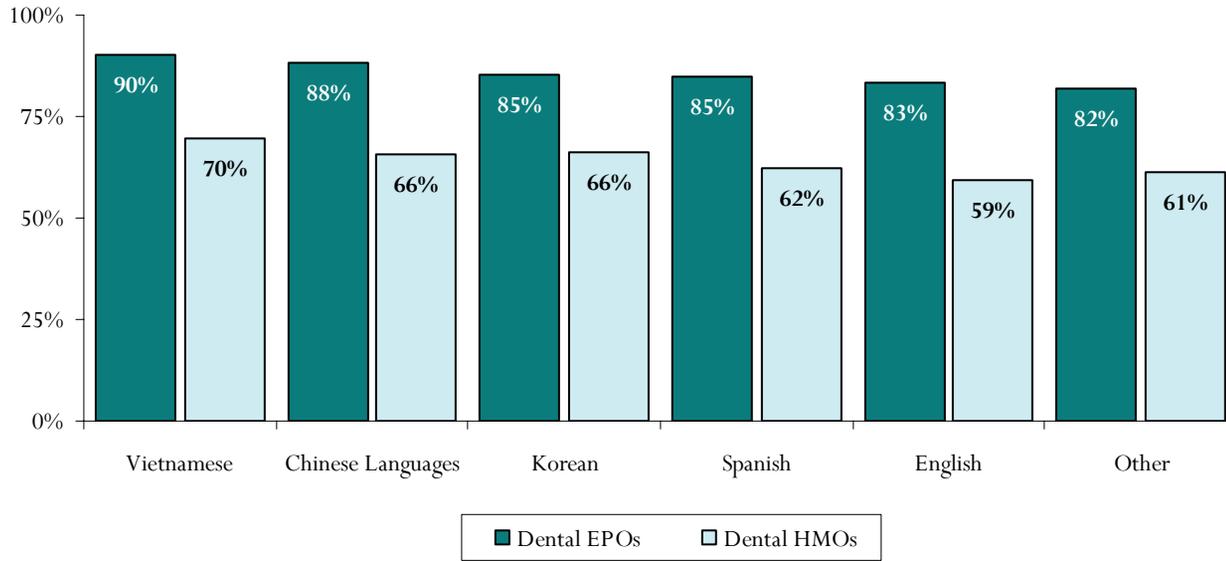
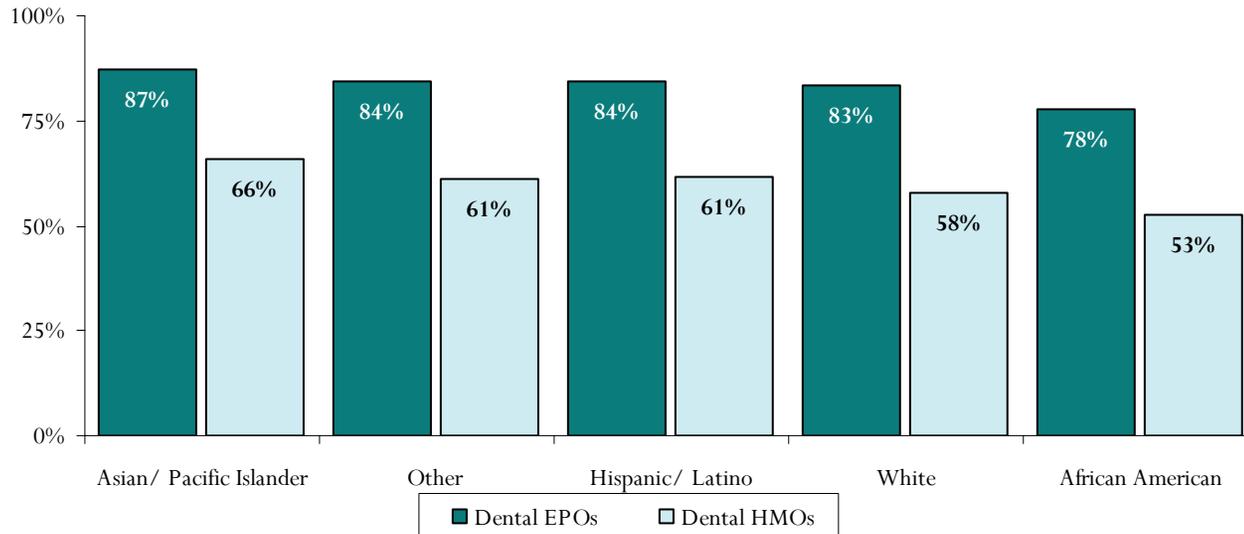


Figure 25. Continuity of Care by Ethnicity



Key Findings About Demographics

- Nearly nine out of ten Vietnamese and Chinese speakers enrolled in the same dental EPO for 2 years received an annual oral evaluation or prophylaxis in both years compared to seven out of ten children who speak the same language but are enrolled in a dental HMO plan.
- English and “Other” language speakers enrolled in the same plan for 2 years received an annual oral evaluation or prophylaxis at the lowest rates regardless of dental plan type.
- African American children enrolled in the same plan for 2 years received an annual examination or teeth cleaning at significantly lower rates than children of other ethnicities regardless of type of dental plan.

Figure 26. Continuity of Care by Region

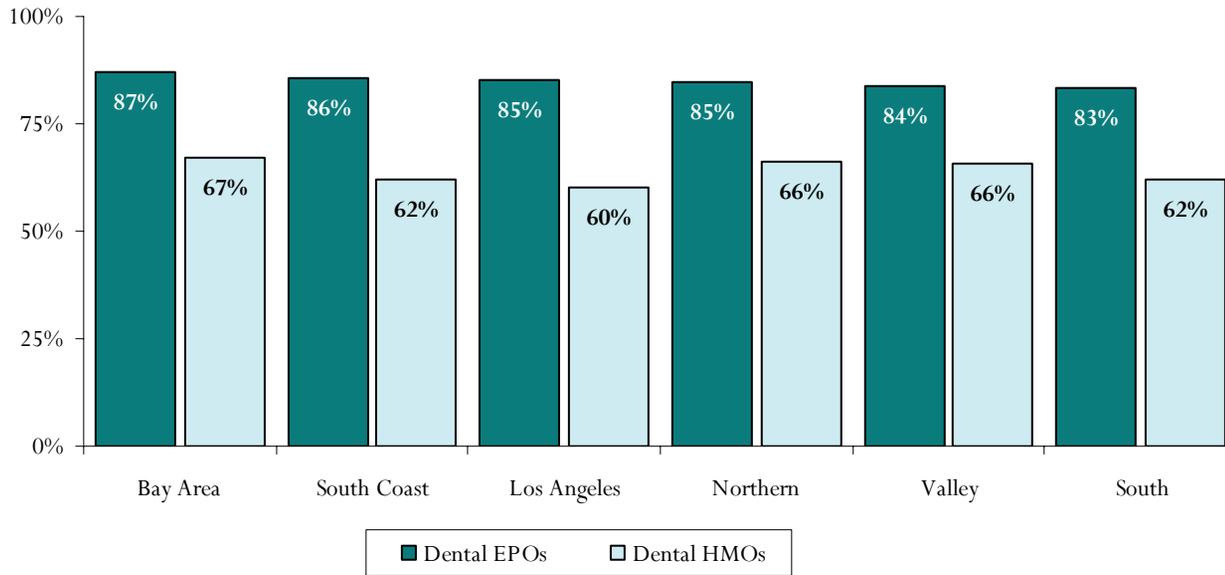


Figure 27. Continuity of Care by Age Group

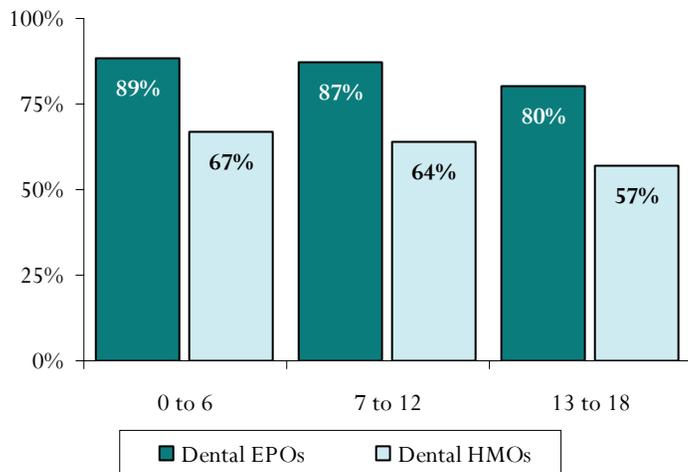
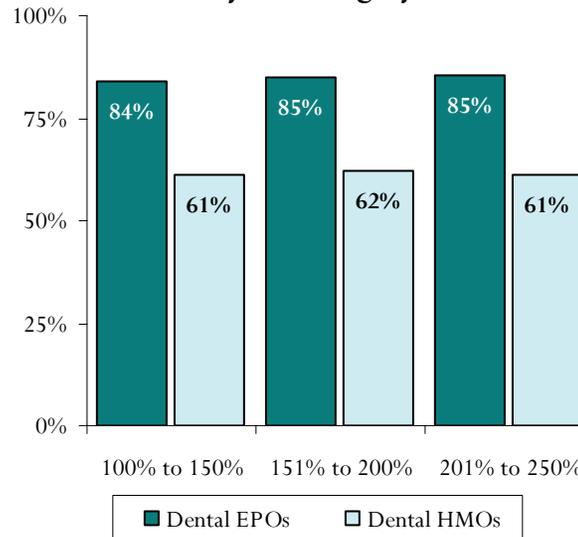


Figure 28. Continuity of Care by FPL Category



Key Findings About Demographics

- There were minimal differences among the regions in the number of children continuously enrolled in a dental EPO for 2 years and who received an oral examination or teeth cleaning.
- Children in the southern California regions who were enrolled in a dental HMO received an oral examination and teeth cleaning at the lowest rates.
- Unlike the other dental measures, the youngest children, ages 0 to 6, received an oral examination or prophylaxis at the highest rate in both plan types.
- There were no significant differences by family income.

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Figure 29. Individual Plan Rates for Preventive Dental Services

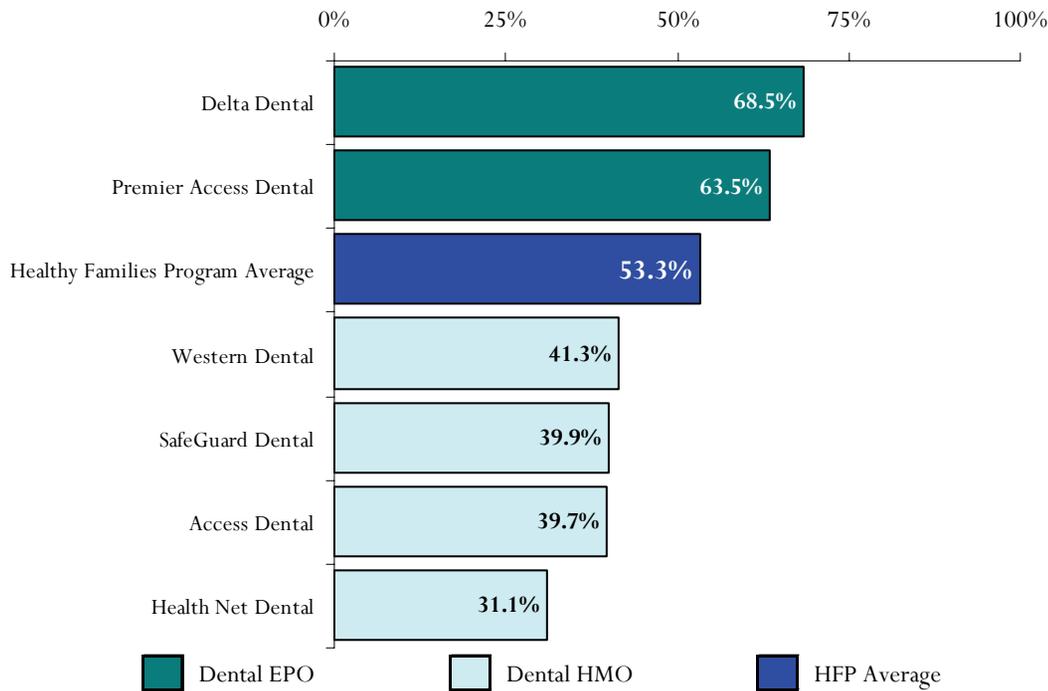
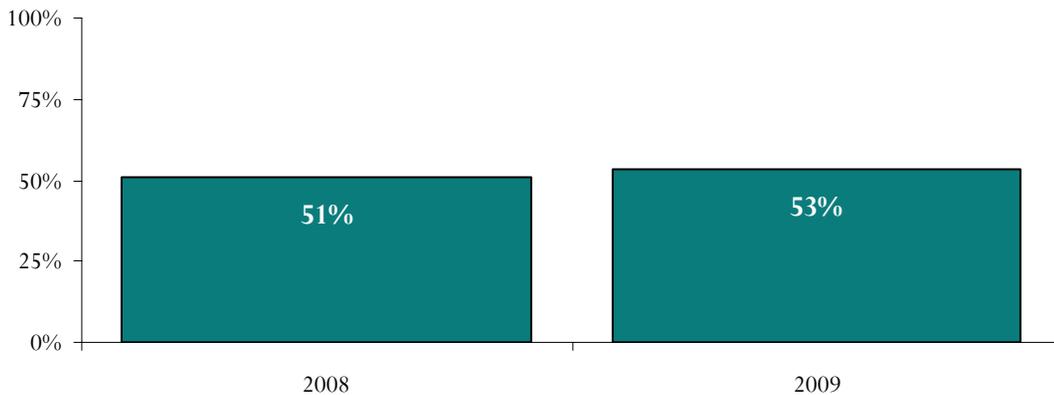


Figure 30. 2 Year Trend for Preventive Dental Services



Measure Definition

The *Preventive Dental Services* measure estimates the percentage of HFP children that received any preventive dental service in the measurement year.

Why Is This Important?

Preventive dental services include teeth cleaning, topical fluoride application, nutritional counseling and oral hygiene instruction. Early prevention is key to long term oral health and in reducing the need for extensive and costly dental services in the future.

Overall Results

Slightly more than half (53%) of HFP children received a preventive dental service in 2009, an increase of two percentage points from 2008. Individual dental plan rates ranged from 31% to 69%.

Despite the recommendation that every child go to the dentist for a preventive dental service at least once a year, less than half of children enrolled in the HMO plans received preventive services.

Health Net Dental nearly doubled the percentage of children receiving preventive dental services from 17.5% in 2008 to 31.1% in 2009.

Figure 31. Preventive Dental Services by Spoken Language

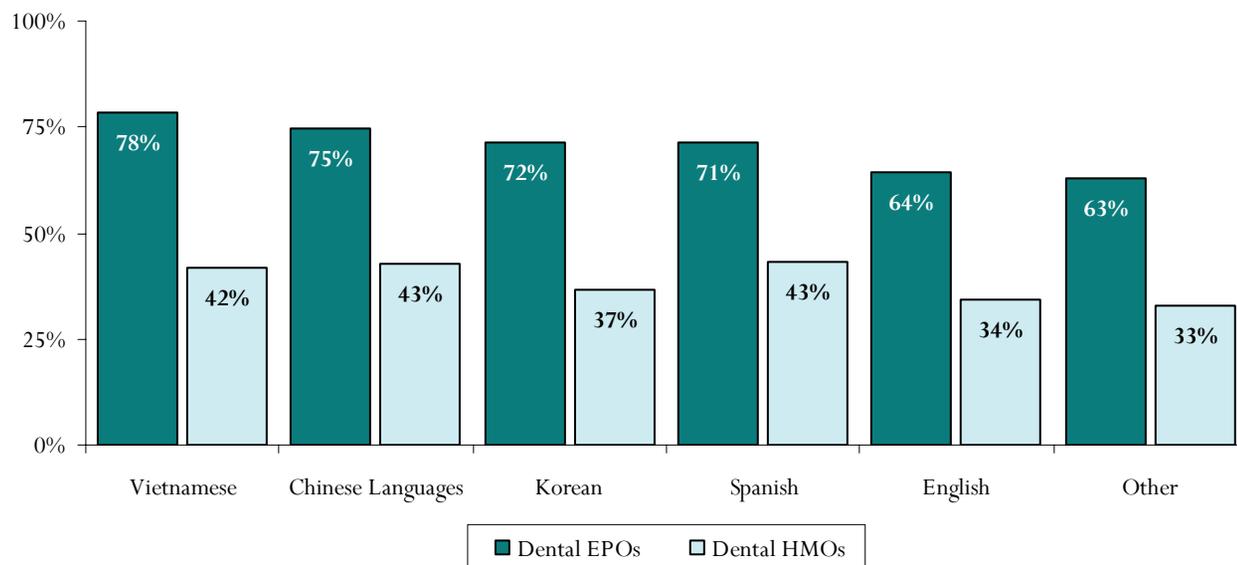
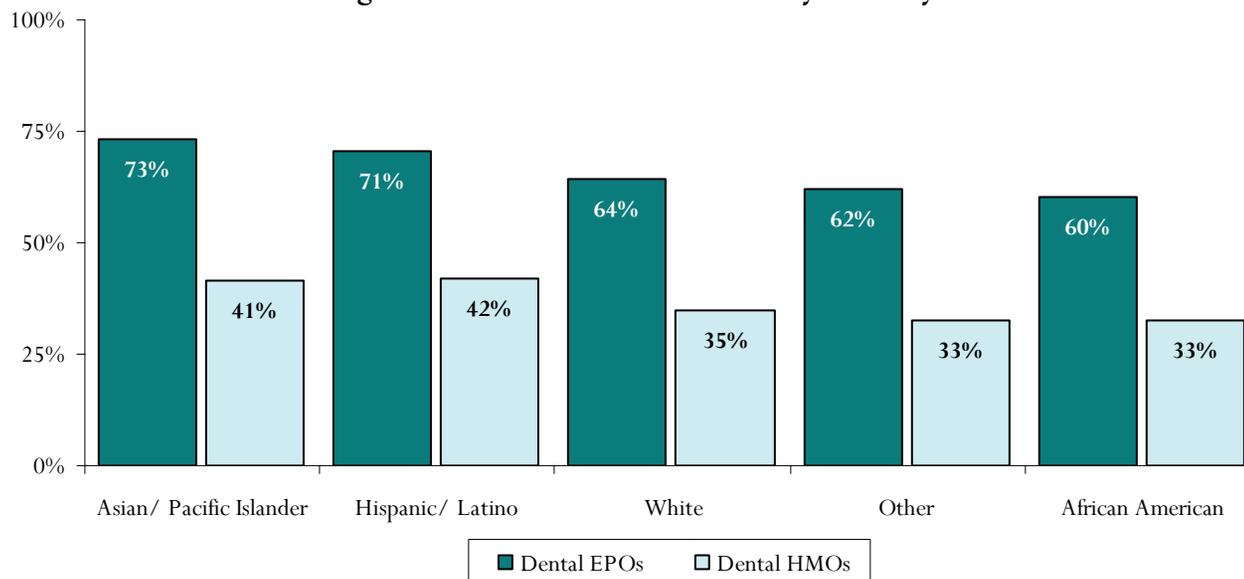


Figure 32. Preventive Dental Services by Ethnicity



Key Findings About Demographics

- English and “Other” language speakers received a preventive dental service at the lowest rates in both types of dental plans. Korean speakers in the dental HMOs also had a low rate.
- Children in the dental EPOs received a preventive dental service at nearly twice the rate of children of the same ethnicity in the HMOs.
- White, African American and children of “Other” ethnicities received a preventive dental service at significantly lower rates compared to other ethnic groups in both types of dental plans.

PREVENTION AND TREATMENT — PREVENTIVE DENTAL SERVICES

Figure 33. Preventive Dental Services by Region

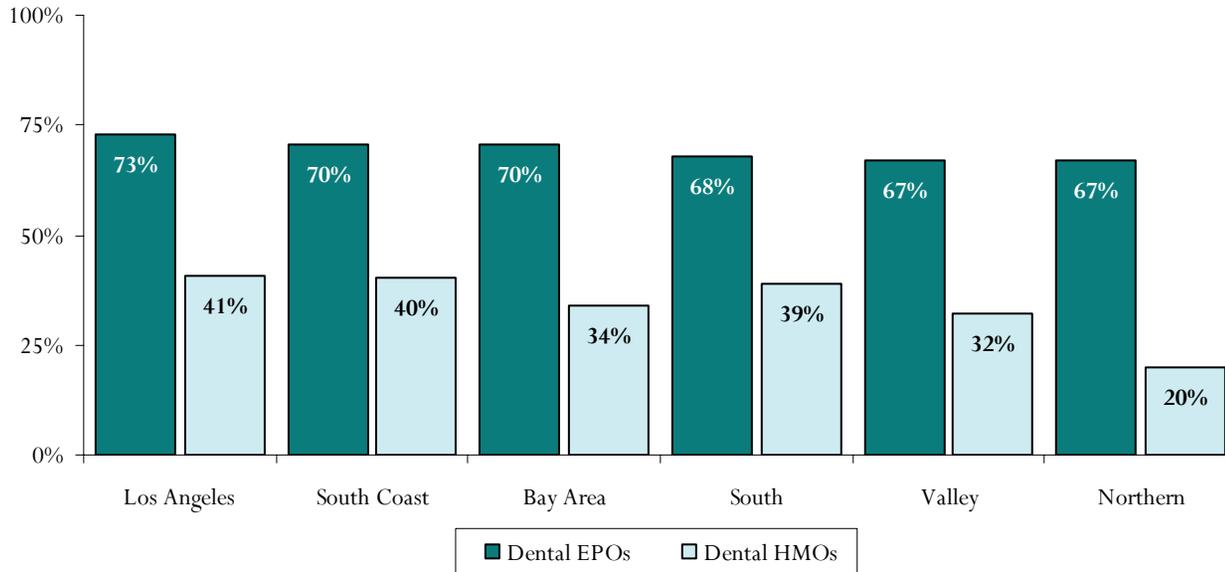


Figure 34. Preventive Dental Services by Age Group

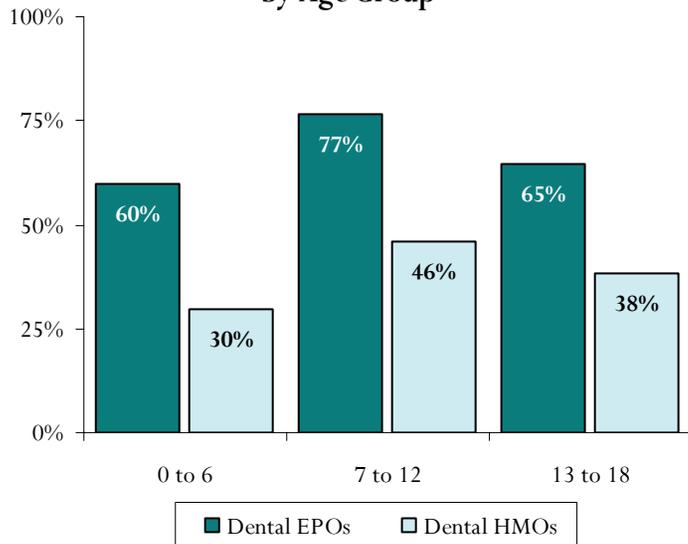
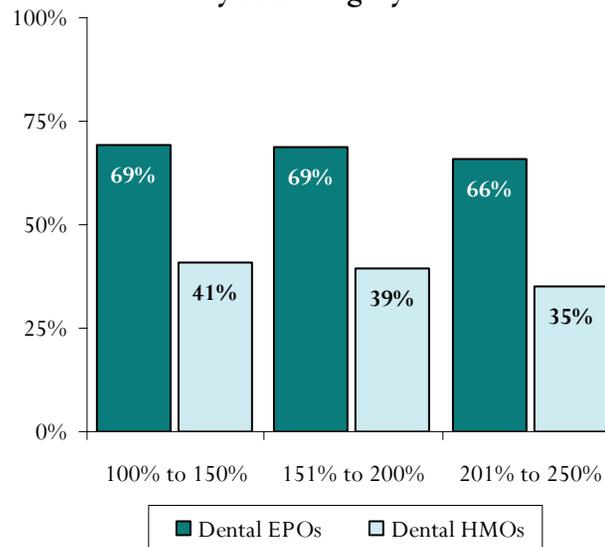


Figure 35. Preventive Dental Services by FPL Category



Key Findings About Demographics

- Only one in five children in a dental HMO in the Northern region received a preventive dental visit.
- Despite the importance of early preventive dental care, less than one-third of children ages 0 to 6 enrolled in a dental HMO received a preventive dental service. This is half the rate of similar aged children enrolled in a dental EPO.
- Children in families with the highest income level (201% to 250% FPL) received a preventive dental service at slightly lower rates than children in lower income categories.

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Figure 36. Individual Plan Rates for Treatment and Prevention of Caries

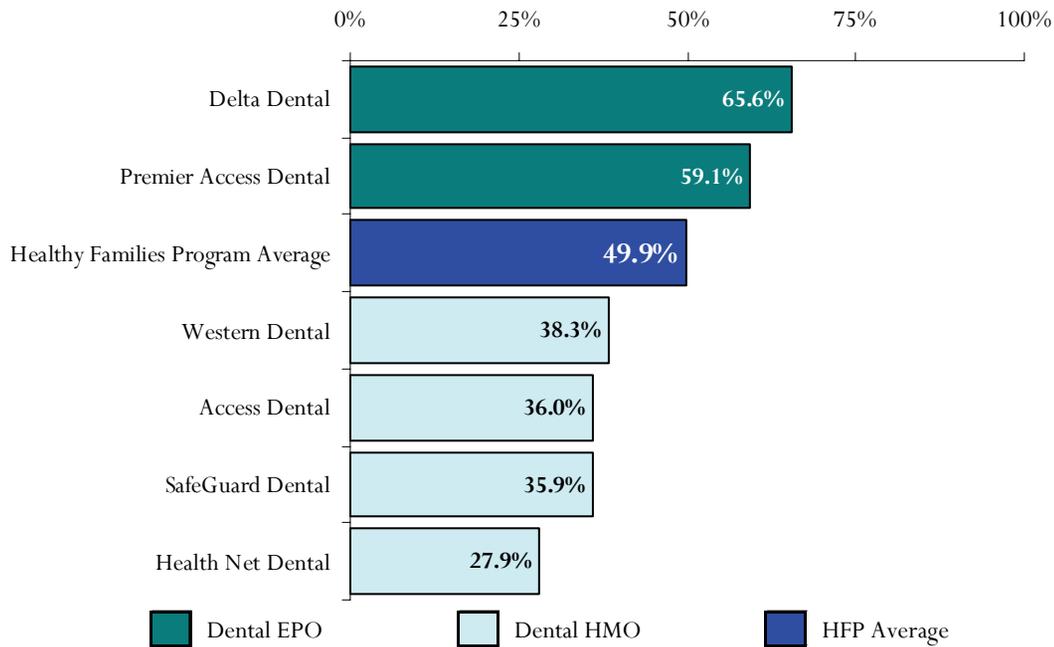
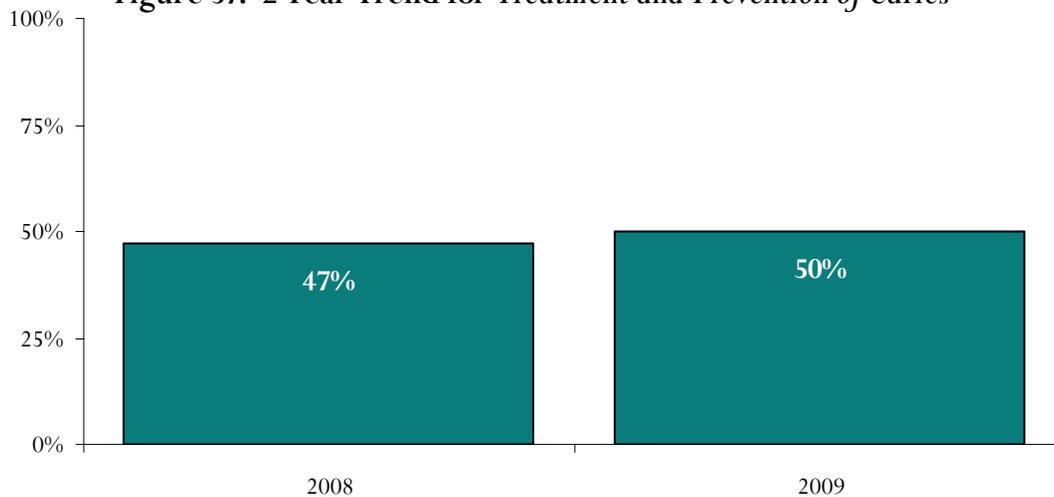


Figure 37. 2 Year Trend for Treatment and Prevention of Caries



Measure Definition

The *Treatment and Prevention of Caries* measure estimates the percentage of HFP children who received either treatment for caries or a caries-preventive procedure during the measurement year.

Why Is This Important?

The presence of dental caries is the single most common, yet preventable, disease of childhood. According to CDC, “Tooth decay affects more than one-fourth of U.S. children aged 2-5 and half of those ages 12-15. About half of all children and two-thirds of children aged 12-19 from low income families have had decay.”¹

Caries-preventive procedures include topical fluoride, nutrition counseling, oral hygiene instruction and sealants. These preventive procedures along with early diagnosis and treatment can prevent many of the unnecessary complications from caries such as pain, infection, trouble chewing, disturbed sleep, missed days of school and more serious health conditions.

Overall Results

Half of HFP children received treatment for caries or a caries-preventive procedure in 2009, an increase of three percentage points from 2008. Individual dental plan rates ranged from 28% to 66%.

About six out of ten children enrolled in a dental EPO received treatment for caries or a caries-preventive procedure compared to less than four out of ten children enrolled in a dental HMO.

Figure 38. Treatment and Prevention of Caries by Spoken Language

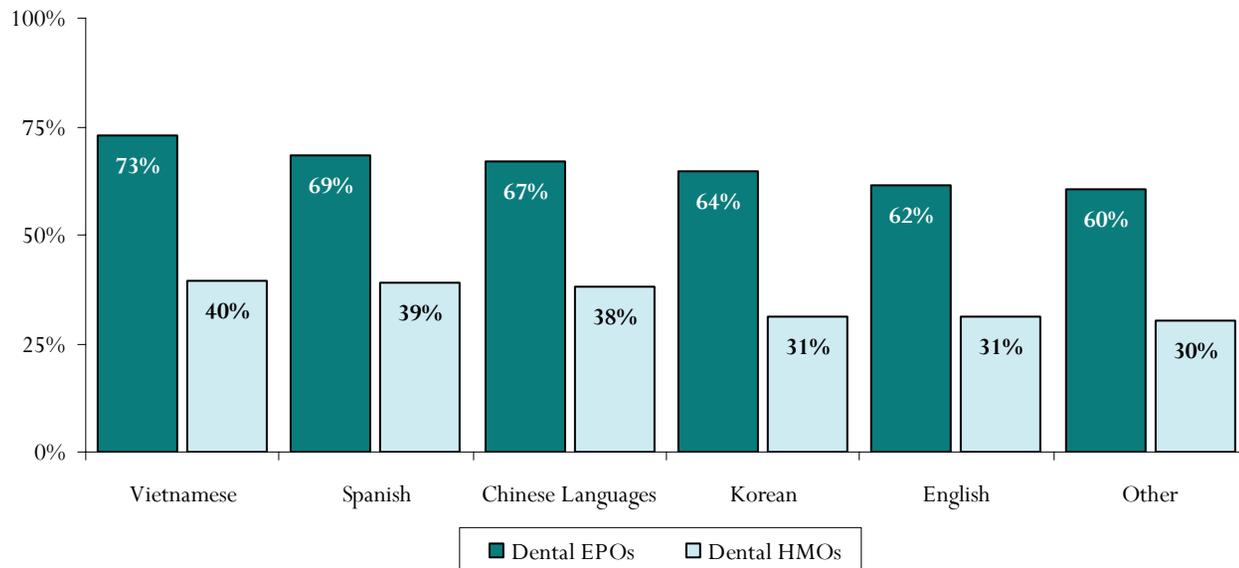
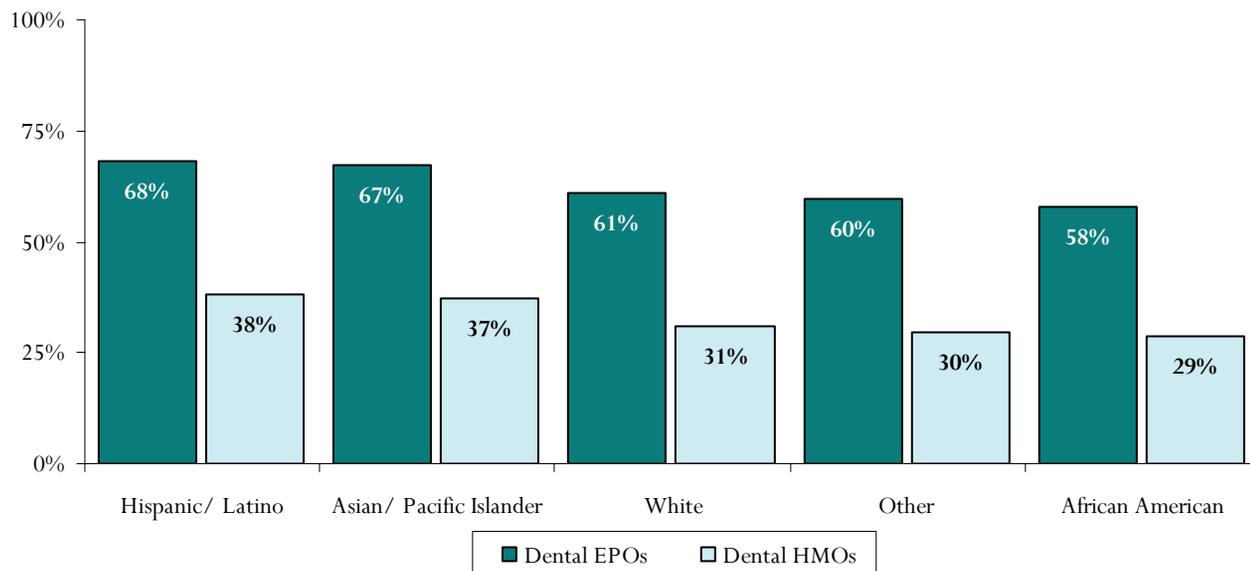


Figure 39. Treatment and Prevention of Caries by Ethnicity



Key Findings About Demographics

- Vietnamese speakers enrolled in a dental EPO received treatment for caries or a caries-preventive procedure at the highest rate.
- Korean, English and “Other” language speakers received treatment for caries at the lowest rates regardless of dental plan type.
- White, African American and children of “Other” ethnicities received treatment for caries at significantly lower rates than other ethnic groups in both the EPOs and HMOs.

Figure 40. Treatment and Prevention of Caries by Region

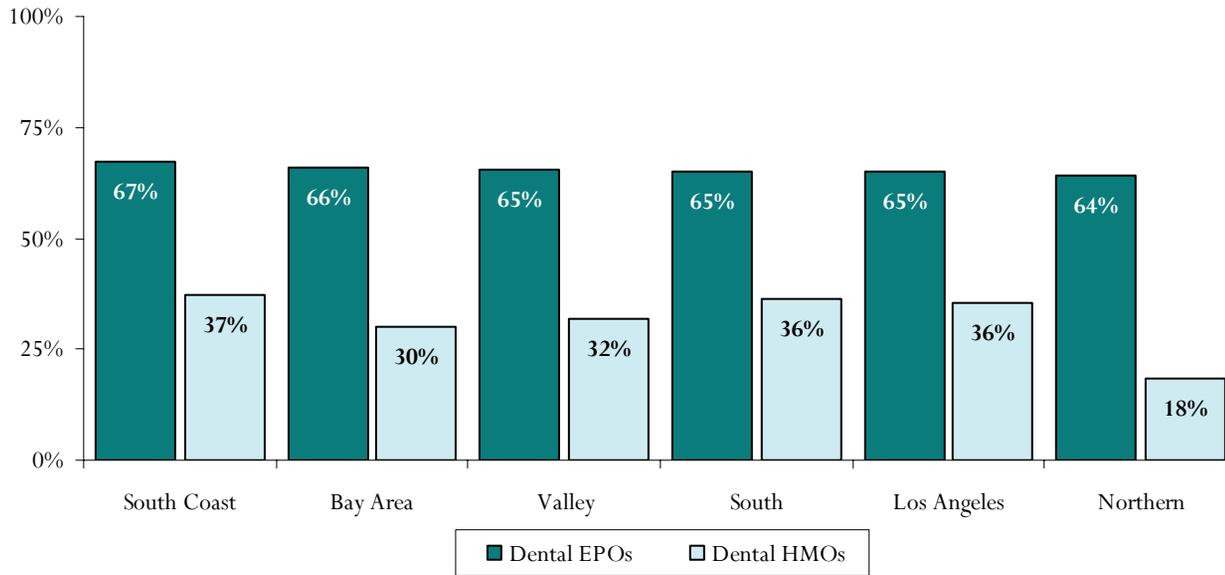


Figure 41. Treatment and Prevention of Caries by Age Group

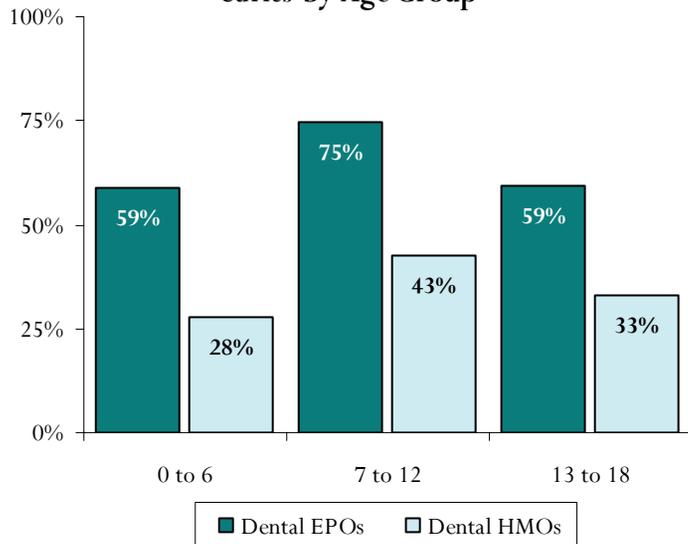
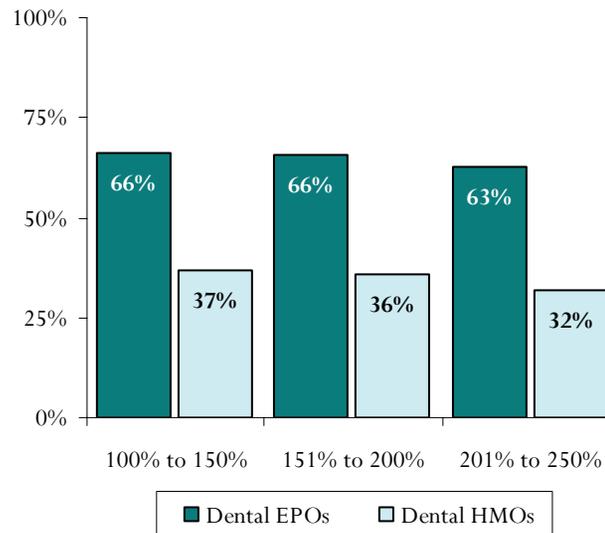


Figure 42. Treatment and Prevention of Caries by FPL Category



Key Findings About Demographics

- There were only minor differences among regions in the number of children in the dental EPOs who received treatment or a preventive service for caries.
- Children in the HMO plans in the southern California regions received a treatment or preventive service at significantly higher rates than children in the northern California regions. In particular, less than 20% of children enrolled in dental HMOs in the Northern region received these services; half the rate of children in the southern California regions enrolled in a dental HMO.
- Children ages 0 to 6 enrolled in a dental EPO received a treatment or preventive service at twice the rate of children in the same age group who were enrolled in a dental HMO.
- Children enrolled in a dental EPO in families with the highest income level (201% to 250% FPL) received a caries related service at a slightly lower rate.

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PREVENTION AND TREATMENT— FILLING TO PREVENTIVE SERVICES RATIO

Figure 43. Individual Plan Rates for *Filling to Preventive Services Ratio*

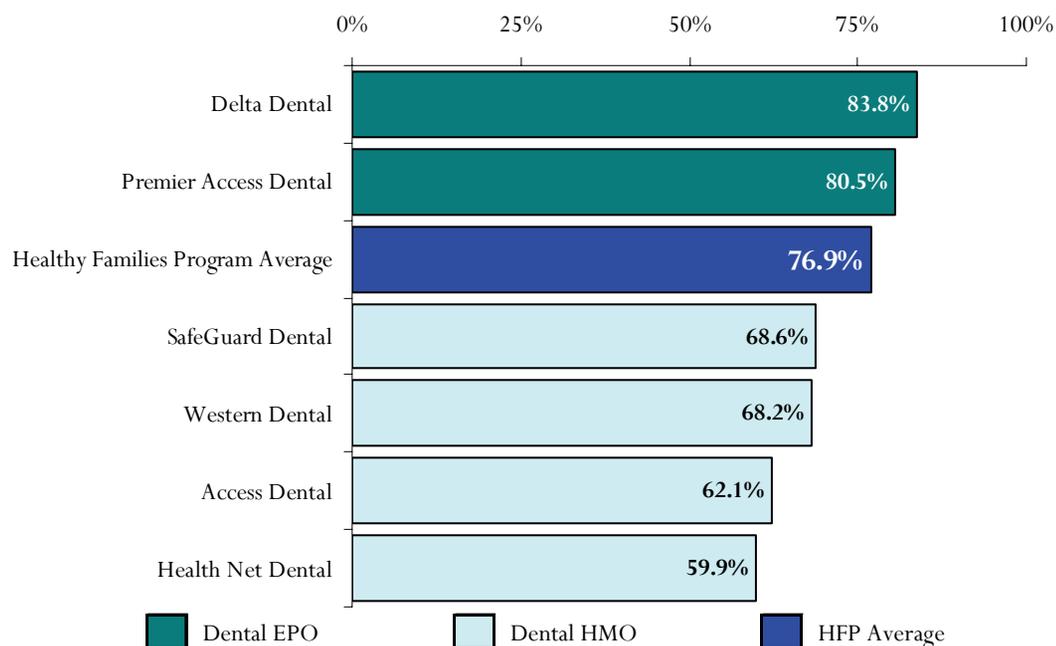
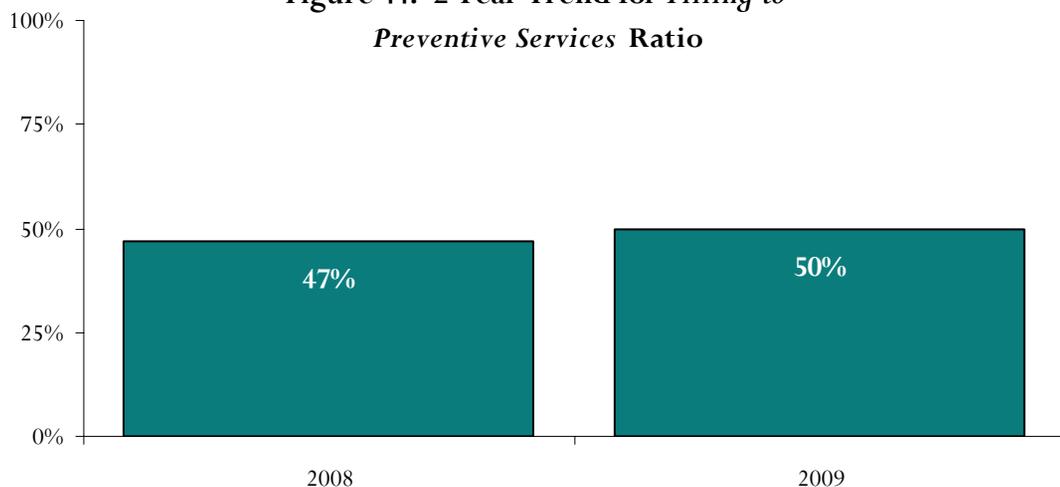


Figure 44. 2 Year Trend for *Filling to Preventive Services Ratio*



Measure Definition

The *Filling to Preventive Services Ratio* measure estimates the percentage of HFP children who had one or more fillings in the past year and who received a topical fluoride or sealant application in the measurement year.

Why Is This Important?

Topical fluoride and dental sealants are safe and effective methods of reducing the risk of caries, particularly in those children at a high risk for caries. Yet, according to the CDC, “only about one-third of children aged 6-19 years have sealants. Although children from lower income families are almost twice as likely to have decay as those from higher income families, they are only half as likely to have sealants.”⁷

Overall Results

Based on the dental plan’s data, 153,450 children in HFP received a filling (or 25% of HFP enrollees who were continuously enrolled for 11 out of 12 months.) Of these, 117,998 (or 77%) received a topical fluoride or sealant application in 2009. This is an increase of three percentage points from 2008. Individual dental plan rates ranged from 60% to 84%.

PREVENTION AND TREATMENT— FILLING TO PREVENTIVE SERVICES RATIO

Figure 45. *Filling to Preventive Services Ratio by Spoken Language*

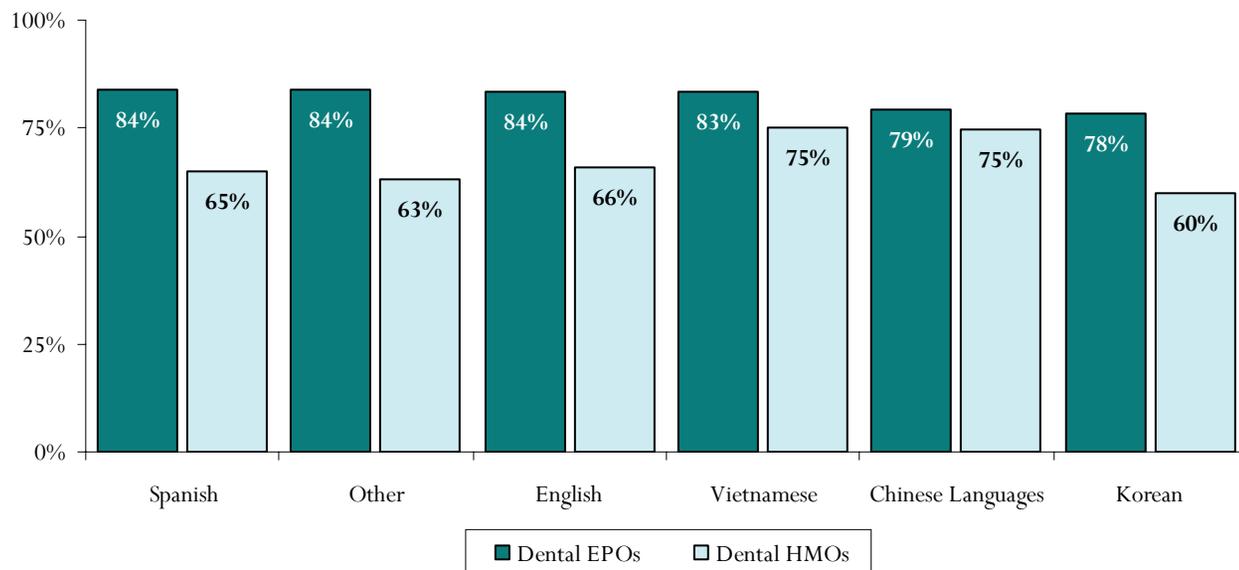
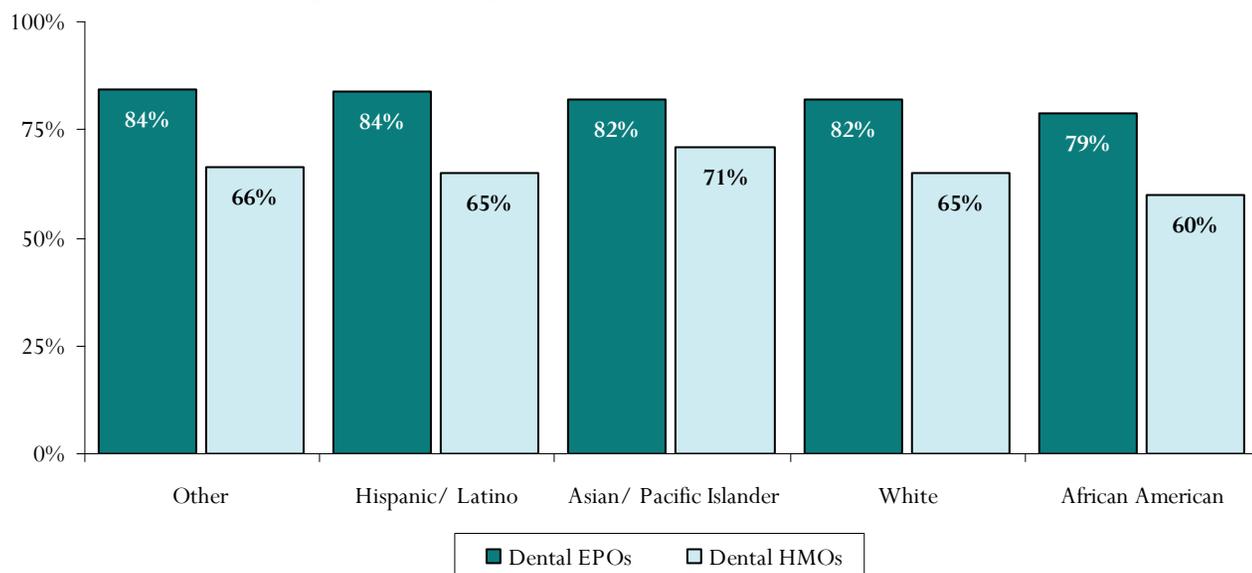


Figure 46. *Filling to Preventive Services Ratio by Ethnicity*



Key Findings About Demographics

- Korean language speakers who received a filling also received a topical fluoride or sealant application at lower rates than other language speakers regardless of dental plan type.
- African-American children received a filling and a preventive service at lower rates than other ethnicities in both EPOs and dental HMOs.

PREVENTION AND TREATMENT— FILLING TO PREVENTIVE SERVICES RATIO

Figure 47. Filling to Preventive Services Ratio by Region

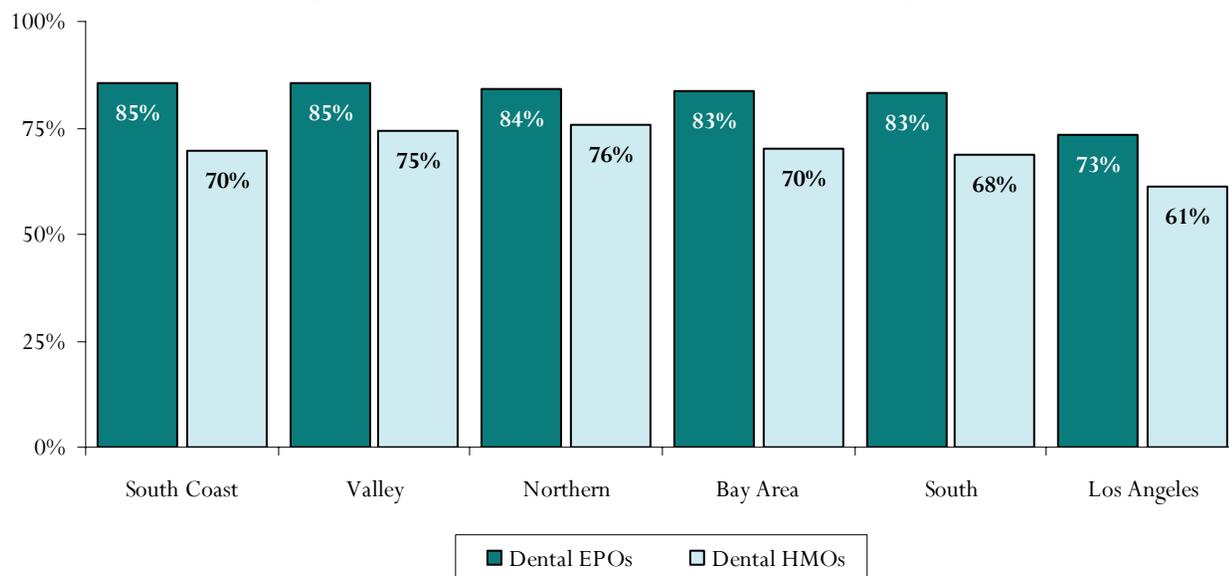


Figure 48. Filling to Preventive Services Ratio by Age Group

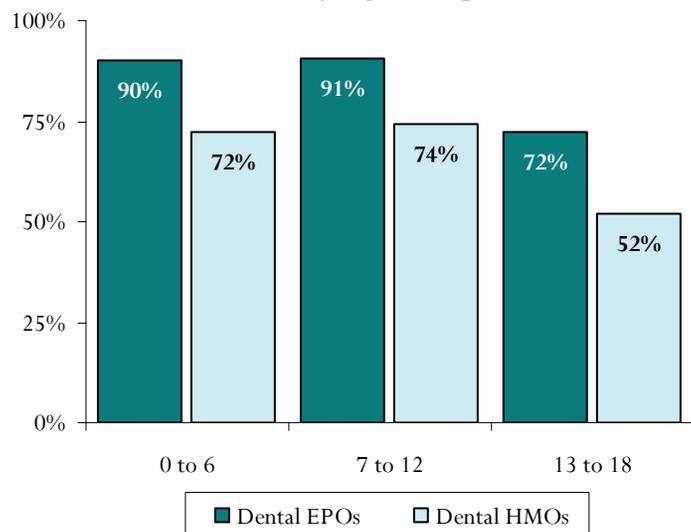
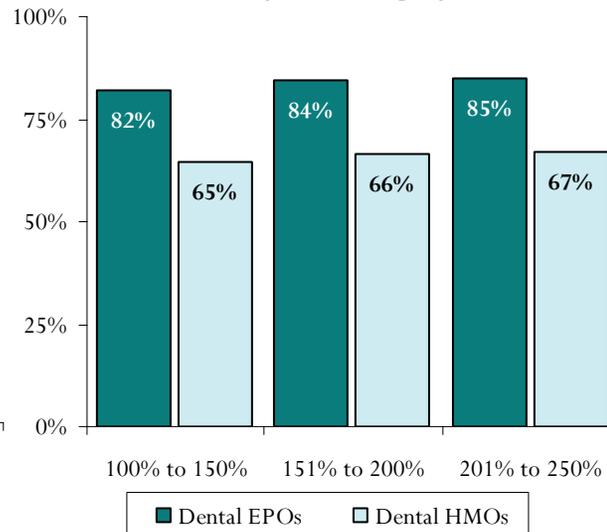


Figure 49. Filling to Preventive Services Ratio by FPL Category



Key Findings About Demographics

- Children in the Los Angeles region who had a filling received a preventive service at significantly lower rates compared to children in the other regions regardless of dental plan type.
- Children under the age of 8 were the most likely to have received a topical fluoride or sealant application after a filling.
- The higher a family's income, the more likely a child was to have received a preventive procedure after a filling.

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Figure 50. Individual Plan Rates for Use of Dental Treatment Services

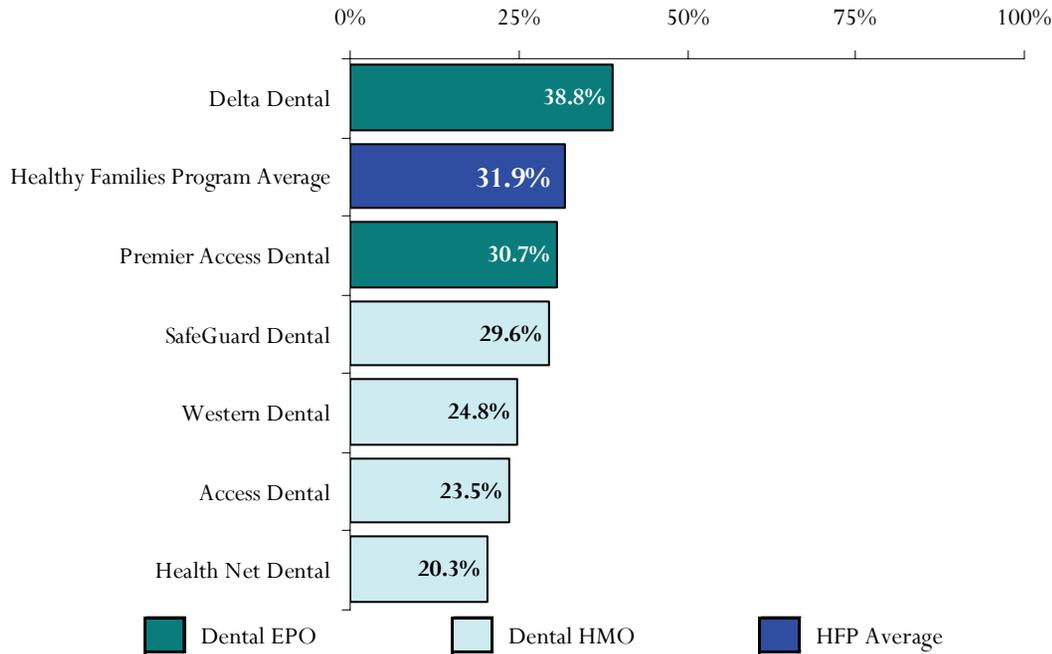
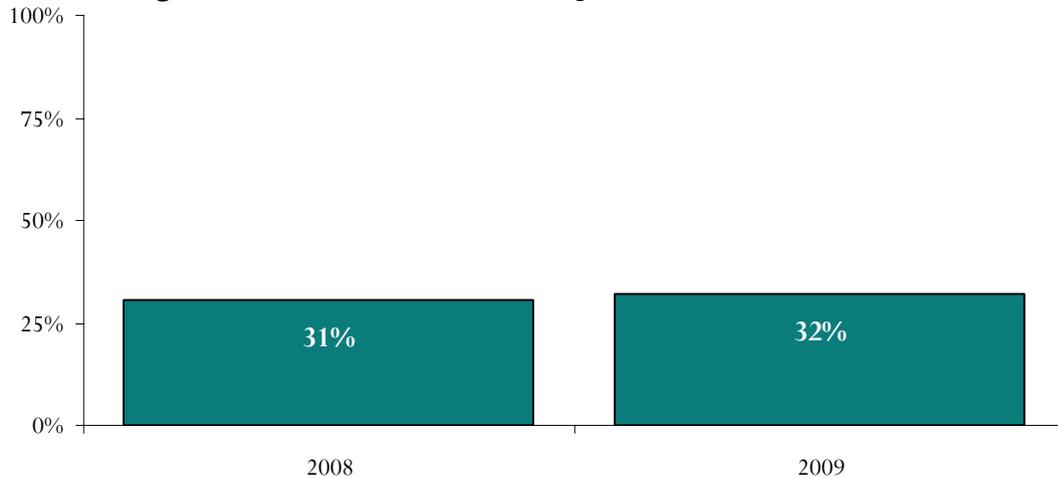


Figure 51. 2 Year Trend for Use of Dental Treatment Services



Measure Definition

The *Use of Dental Treatment Services* measure estimates the percentage of HFP children who received any dental treatment service, other than diagnostic or preventive services, in the measurement year.

Why Is This Important?

Dental treatment services include fillings, crowns, root canals, and oral surgery. The 2006 California Smile Survey found that more than half of kindergartners and 70% of third graders had a history of tooth decay and 28% had untreated tooth decay. The problem was worse for low-income and minority children. Untreated tooth decay can lead to pain, infection, difficulty eating and sleeping, difficulties concentrating in school and serious health conditions. Early intervention and treatment is critical to preventing further tooth decay and more serious health problems.⁸

Overall Results

About one-third (31%) of HFP children received a dental treatment service in 2009. Individual dental plan rates ranged from 39% to 20%. Less than one-third of Kindergarten age children and received a dental treatment service. It is difficult to draw any conclusions from the results because the plan data does not show how many children needed a dental treatment service. Still, nearly 200,000 out of about 600,000 children continuously enrolled in HFP in 2009 received a dental treatment service.

PREVENTION AND TREATMENT — USE OF DENTAL TREATMENT SERVICES

Figure 52. Use of Dental Treatment Services by Spoken Language

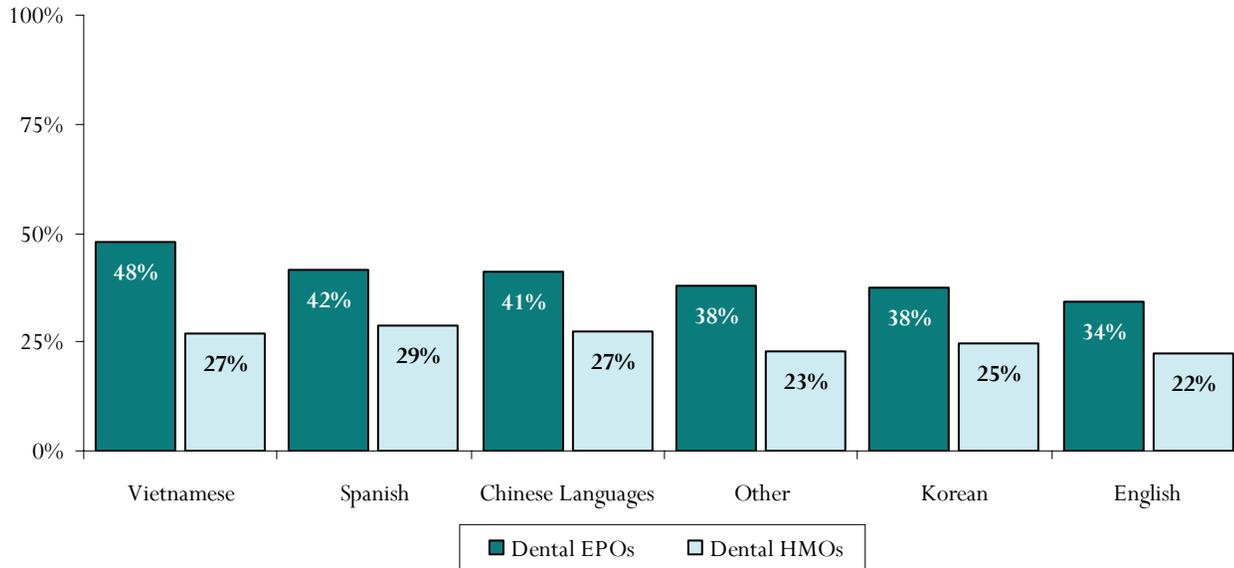
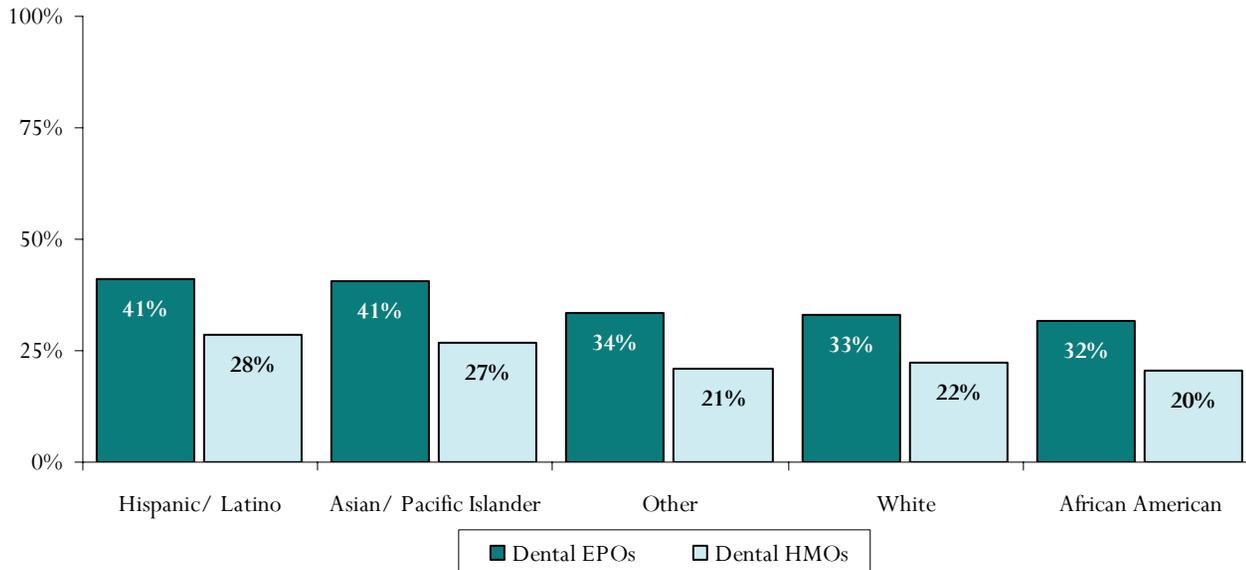


Figure 53. Use of Dental Treatment Services by Ethnicity



Key Findings About Demographics

- Vietnamese speakers in the EPO plans received a dental treatment service at a significantly higher rate than children who speak other languages, particularly English.
- Less than one-quarter of English, Korean and “Other” language speakers who were enrolled in an HMO plan received dental treatment services.
- White, African American and children of “Other” ethnicities received a dental treatment service at significantly lower rates than other ethnic groups in both types of dental plans.

PREVENTION AND TREATMENT — USE OF DENTAL TREATMENT SERVICES

Figure 54. Use of Dental Treatment Services by Region

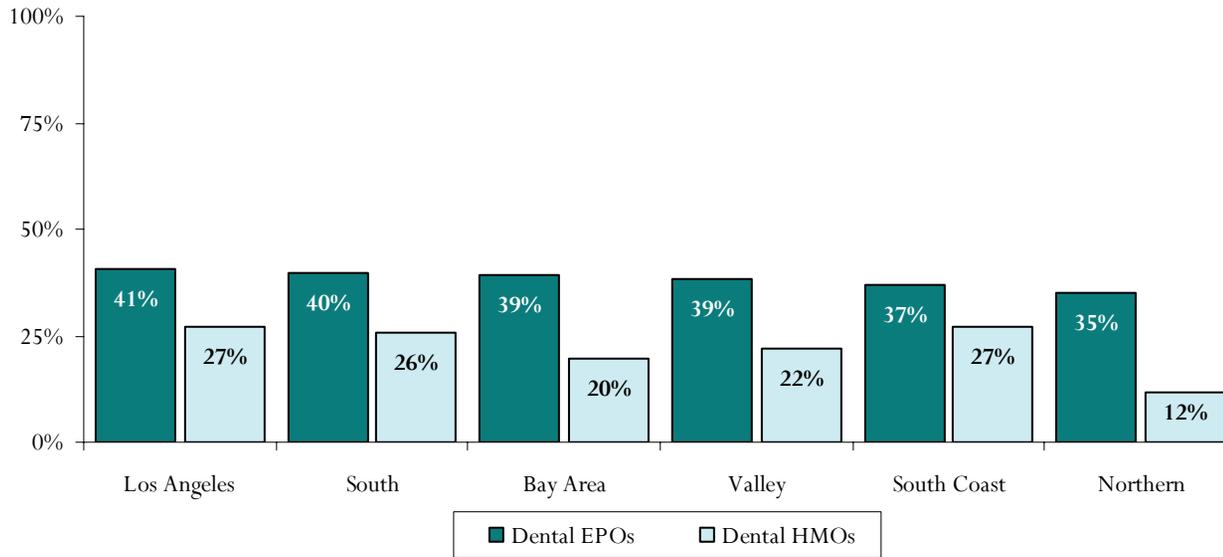


Figure 55. Use of Dental Treatment Services by Age Group

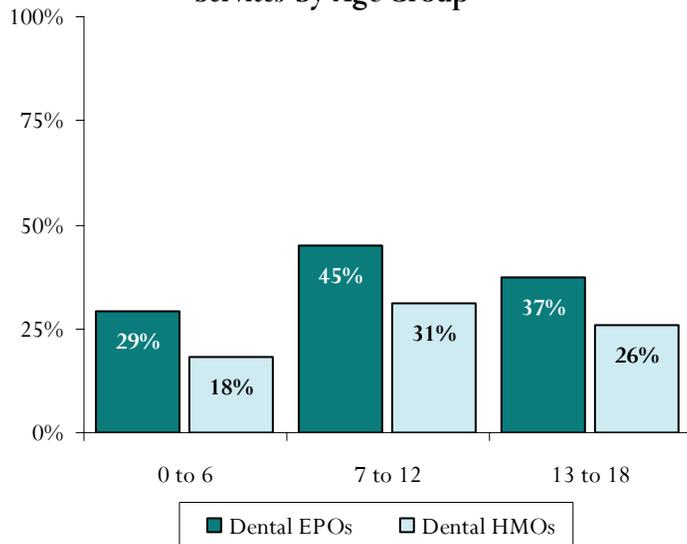
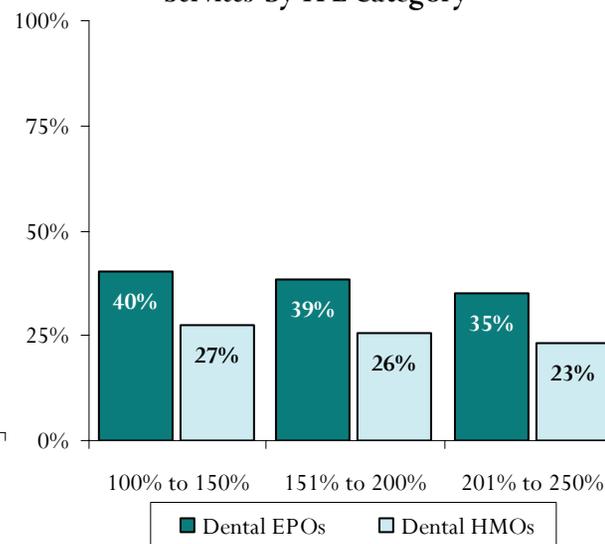


Figure 56. Use of Dental Treatment Services by FPL Category



Key Findings About Demographics

- Children in the Northern region were the least likely to have received a dental treatment service with only about 10% of children enrolled in a dental HMO receiving dental treatment services.
- Children ages 0 to 6 were the least likely to have received a dental treatment service.
- Children in families with the highest income level (201% to 250% FPL) received a dental treatment service at lower rates than children in families with lower incomes.

CONCLUSION

The second year results for the oral health performance measures indicate that the program is making incremental improvement in access to and utilization of oral health services. However, significant improvement is needed from the dental HMOs, in particular, as more children are enrolled in these plans.

In 2010, MRMIB, through support from the California Health Care Foundation (CHCF), began working with the Center for Health Care Strategies (CHCS) on a project entitled “Healthy Smiles - Healthy Families: Improving Oral Health for Children in California’s Healthy Families Program.”

The goals of the project are to:

- Improve access to diagnostic, preventive and dental treatment services for children ages 1 to 6;
- Increase the number of young children with a source of regular and continuous dental care;
- Increase the integration and interface of medical and dental services in HFP;
- Identify high-risk and at-risk children and provide case management to avoid unnecessary acute care services; and
- Increase the number of young children who receive fluoride varnish.

National experts recommend MRMIB focus on the following four measures for performance improvement in young children:

- *Overall Utilization of Dental Services*
- *Examinations and Oral Health Evaluations*
- *Preventive Dental Services*
- *Use of Dental Treatment Services*

CHCS will work with MRMIB staff, national experts and representatives from the dental plans through 2011 to implement strategies to improve access to dental services for children in HFP.

APPENDIX A. MEASURE SPECIFICATIONS

ANNUAL DENTAL VISIT

The percentage of enrolled members, 2-18 years of age, who had at least one dental visit during the measurement year. Members who have had no more than one gap in enrollment of up to 45 days during the measurement year should be included in this measure.

Numerator: One or more dental visits with a dental practitioner during the measurement year.

Denominator: The eligible population for each age group and the combined total.

OVERALL UTILIZATION OF DENTAL SERVICES

The percentage of members, 0 to 18 years of age, continuously enrolled in the same plan for 1, 2, and 3 years who received any dental service, including preventive services, over those periods.

Numerator (1): Number of members continuously enrolled in the same plan for 1, 2 or 3 years who received any dental service (D0100-D9999), including preventive services, over those periods.

Denominator (1): Number of members continuously enrolled in the same plan for 1, 2 or 3 years.

EXAMINATIONS AND ORAL HEALTH EVALUATIONS

The percentage of members, 0 to 18 years of age, enrolled for at least 11 of the past 12 months who received a comprehensive or periodic oral evaluation or, for members under three years of age, those who received an oral evaluation and counseling with the primary caregiver in the past year.

Numerator: Number of members enrolled for at least 11 of the past 12 months who received a comprehensive or periodic exam (D0120 or D0150) or, for members under three years of age, who received an oral evaluation and counseling with the primary caregiver (D0145) in the past year.

Denominator: Number of members enrolled for at least 11 of the past 12 months.

CONTINUITY OF CARE

The percentage of members, 0 to 18 years of age, continuously enrolled in the same plan for 2 years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in the year prior to the measurement year who also received a comprehensive or periodic oral evaluation or a prophylaxis in the measurement year.

Numerator: Number of members in the denominator who also received a comprehensive or periodic oral evaluation (D0120, D0150) or a prophylaxis (D1110, D1120) in the measurement year.

Denominator: Number of members continuously enrolled in the same plan for 2 years with no gap in coverage who received a comprehensive oral evaluation (D0150) or a prophylaxis (D1110, D1120) in the year prior to the measurement year.

PREVENTIVE DENTAL SERVICES

The percentage of members, 0 to 18 years of age, enrolled for at least 11 of the past 12 months who received any preventive dental service in the past year.

Numerator: Number of members enrolled for at least 11 of the past 12 months who received any preventive dental service (D1000-D1999) in the past year.

Denominator: Number of members enrolled for at least 11 of the past 12 months.

TREATMENT AND PREVENTION OF CARIES

The percentage of members, 0 to 18 years of age, enrolled for at least 11 of the past 12 months, who received a treatment for caries or a caries-preventive procedure.

Numerator: Number of members enrolled for at least 11 of the past 12 months who received a treatment for caries (D2000-D2999) or a caries-preventive procedure (D1203, D1204, D1206, D1310, D1330, D1351).

Denominator: Number of members enrolled for at least 11 of the past 12 months.

APPENDIX A. MEASURE SPECIFICATIONS

FILLING TO PREVENTIVE SERVICES RATIO

The percentage of members, 0 to 18 years of age, enrolled for at least 11 of the past 12 months with 1 or more fillings in the past year who received a topical fluoride or sealant application.

Numerator: Number of members enrolled for at least 11 of the past 12 months with 1 or more fillings (D2000-D2999) who received a topical fluoride (D1203, D1204 or D1206) or sealant application (D1351), or education to prevent caries (D1310 and D1330).

Denominator: Number of members enrolled for at least 11 of the past 12 months with one or more fillings.

USE OF DENTAL TREATMENT SERVICES

The percentage of members, 0 to 18 years of age, enrolled for at least 11 of the past 12 months who received any dental treatment, other than diagnostic or preventive services, in the past year.

Numerator: Number of members enrolled for at least 11 of the past 12 months who received any dental treatment (D2000-D9999) in the past year.

Denominator: Number of members enrolled for at least 11 of the past 12 months.

APPENDIX B. INDIVIDUAL PLAN AND PROGRAM PERFORMANCE, 2008 - 2009

Table 1. Individual Plan and Program Performance for Annual Dental Visit, 2008 - 2009

Plan Name	2008	2009	Percentage Change
HFP Program Average	56.4%	59.2%	2.8%
Access Dental	46.7%	48.0%	1.3%
Delta Dental	70.0%	72.4%	2.4%
Health Net Dental	23.9%	40.2%	16.3%
Premier Access Dental	67.6%	67.5%	-0.1%
SafeGuard Dental	45.8%	47.4%	1.6%
Western Dental	40.5%	46.6%	6.1%

Table 2. Individual Plan and Program Performance for Examinations and Oral Health Evaluations, 2008 - 2009

Plan Name	2008	2009	Percentage Change
HFP Program Average	51.3%	54.1%	2.8%
Access Dental	40.4%	42.6%	2.2%
Delta Dental	65.8%	68.5%	2.7%
Health Net Dental	17.7%	32.8%	15.1%
Premier Access Dental	60.5%	61.5%	1.0%
SafeGuard Dental	39.8%	40.9%	1.1%
Western Dental	36.5%	42.5%	6.0%

Table 3. Individual Plan and Program Performance for Continuity of Care, 2008 - 2009

Plan Name	2008	2009	Percentage Change
HFP Program Average	75.4%	77.1%	1.7%
Delta Dental	82.5%	84.6%	2.1%
Premier Access Dental	82.5%	83.4%	0.9%
Access Dental	61.7%	64.6%	2.9%
Health Net Dental	36.1%	53.5%	17.4%
SafeGuard Dental	57.2%	60.6%	3.4%
Western Dental	54.7%	60.7%	6.0%

Table 4. Individual Plan and Program Performance for Preventive Dental Services, 2008 - 2009

Plan Name	2008	2009	Percentage Change
HFP Program Average	50.8%	53.3%	2.5%
Access Dental	38.5%	39.7%	1.2%
Delta Dental	65.7%	68.5%	2.8%
Health Net Dental	17.5%	31.1%	13.6%
Premier Access Dental	63.2%	63.5%	0.3%
SafeGuard Dental	38.9%	39.9%	1.0%
Western Dental	35.7%	41.3%	5.6%

APPENDIX B. INDIVIDUAL PLAN AND PROGRAM PERFORMANCE, 2008 - 2009

Table 5. Individual Plan and Program Performance for Treatment and Prevention of Caries, 2008 - 2009

Plan Name	2008	2009	Percentage Change
HFP Program Average	47.1%	49.9%	2.9%
Access Dental	33.5%	36.0%	2.5%
Delta Dental	62.4%	65.6%	3.2%
Health Net Dental	17.7%	27.9%	10.2%
Premier Access Dental	58.4%	59.1%	0.7%
SafeGuard Dental	33.6%	35.9%	2.3%
Western Dental	32.3%	38.3%	6.0%

Table 6. Individual Plan and Program Performance for Filling to Preventive Services Ratio, 2008 - 2009

Plan Name	2008	2009	Percentage Change
HFP Program Average	74.8%	76.9%	2.1%
Access Dental	60.2%	62.1%	1.9%
Delta Dental	82.0%	83.8%	1.8%
Health Net Dental	54.8%	59.9%	5.1%
Premier Access Dental	79.1%	80.5%	1.4%
SafeGuard Dental	59.5%	68.6%	9.1%
Western Dental	67.8%	68.2%	0.4%

Table 7. Individual Plan and Program Performance for Use of Dental Treatment Services, 2008 - 2009

Plan Name	2008	2009	Percentage Change
HFP Program Average	30.5%	31.9%	1.4%
Access Dental	22.9%	23.5%	0.6%
Delta Dental	37.8%	38.8%	1.0%
Health Net Dental	14.2%	20.3%	6.1%
Premier Access Dental	32.2%	30.7%	-1.5%
SafeGuard Dental	27.5%	29.6%	2.1%
Western Dental	21.4%	24.8%	3.4%

APPENDIX B. INDIVIDUAL PLAN AND PROGRAM PERFORMANCE, 2008 - 2009

Table 8. Individual Plan and Program Performance for Overall Utilization of Dental Services, 2008 - 2009

Plan Name	2008 Enrolled 3 Years	2009 Enrolled 3 Years	Percentage Change	2008 Enrolled 2 Years	2009 Enrolled 2 Years	Percentage Change	2008 Enrolled 1 Year	2009 Enrolled 1 Year	Percentage Change
HFP Program Average	66.8%	68.3%	1.5%	54.4%	56.8%	2.4%	48.3%	48.3%	0.0%
Delta Dental	74.1%	74.4%	0.3%	67.2%	68.7%	1.5%	65.6%	63.0%	-2.6%
Premier Access Dental	72.2%	73.4%	1.2%	67.1%	68.5%	1.4%	64.4%	57.5%	-6.9%
Access Dental	50.1%	51.6%	1.5%	44.9%	45.9%	1.0%	43.5%	40.1%	-3.4%
Health Net Dental	40.6%	55.1%	14.5%	39.1%	47.4%	8.3%	18.3%	36.5%	18.2%
SafeGuard Dental	60.3%	65.4%	5.1%	44.9%	38.4%	-6.5%	29.6%	28.0%	-1.6%
Western Dental	56.1%	73.4%	17.3%	57.1%	61.2%	4.1%	40.9%	44.9%	4.0%

APPENDIX C. DENTAL PLAN ENROLLMENT

Table 9. HFP Enrollment by Dental Plan for December 2009

Dental Plan	HFP Enrollment for December 2008	Percentage of Total Enrollment
Access Dental	142,488	16.1%
Delta Dental	365,633	41.4%
Health Net Dental	92,589	10.5%
SafeGuard Dental	141,704	16.1%
Premier Access Dental	34,955	4.0%
Western Dental	105,063	11.9%

APPENDIX D. DENTAL PLAN ENROLLMENT BY COUNTY

Table 10. Dental Plan Enrollment by County as of December 2009

County	Access Dental	Delta Dental	Health Net Dental	Premier Access	SafeGuard Dental	Western Dental
Alameda	2,339	13,719	337		1,726	2,276
Alpine				2		
Amador		265		120		
Butte	405	2,156		868		243
Calaveras		424		238		
Colusa		1,249		262		
Contra Costa	1,505	7,939			1,217	1,932
Del Norte		153		386		
El Dorado		1,406	136	1,392		
Fresno	1,470	16,055	1,628		595	1,596
Glenn		1,002		337		
Humboldt		750		2,738		
Imperial		3,819	196	386		606
Inyo		169		132		
Kern	1,257	19,465	1,238		1,461	1,338
Kings		2,414	82	1,078		425
Lake		968		634		
Lassen		130		120		
Los Angeles	59,324	15,877	44,284		68,874	36,947
Madera		3,479	72	368		389
Marin		1,524	94	1,270		103
Mariposa		144		52		
Mendocino		1,179		1,152		
Merced	854	7,401	121			539
Modoc		90		65		
Mono		456				
Monterey	1,205	14,189	129	2,601		849
Napa		3,067	141	616		
Nevada		660		1,689		

County	Access Dental	Delta Dental	Health Net Dental	Premier Access	SafeGuard Dental	Western Dental
Orange	18,905	6,744	14,004		29,976	13,751
Placer		3,045		1,307		388
Plumas		186		87		
Riverside	13,788	30,803	8,305		11,580	10,606
Sacramento	3,237	17,894	1,348		956	2,852
San Benito	2	1,425	25	268		165
San Bernardino	11,942	25,452	7,067		11,000	9,420
San Diego	11,500	40,117	8,305		7,437	7,223
San Francisco	854	9,203	133		508	571
San Joaquin	2,125	15,210	690			1,926
San Luis Obispo		4,889				309
San Mateo	1,324	6,917			823	1,181
Santa Barbara		2,735		5,789	1,022	1,155
Santa Clara	4,099	21,684	648		2,845	2,349
Santa Cruz		5,303	149	548		379
Shasta	529	2,444		717		313
Sierra		22		21		
Siskiyou		217		477		
Solano	888	3,904				509
Sonoma		7,017	242	4,226		530
Stanislaus	1,943	9,270	724	1		1,296
Sutter	398	2,493		396		176
Tehama		763		691		
Trinity		148		104		
Tulare		8,958	1,142	2,296		1,365
Tuolumne		1,025				
Ventura	2,316	13,642	1,349		1,684	1,356
Yolo		2,661		1,198		
Yuba	278	1,313		321		
Total:	142,487	365,633	92,589	34,953	141,704	105,063

APPENDIX E. MAP OF CALIFORNIA REGIONS

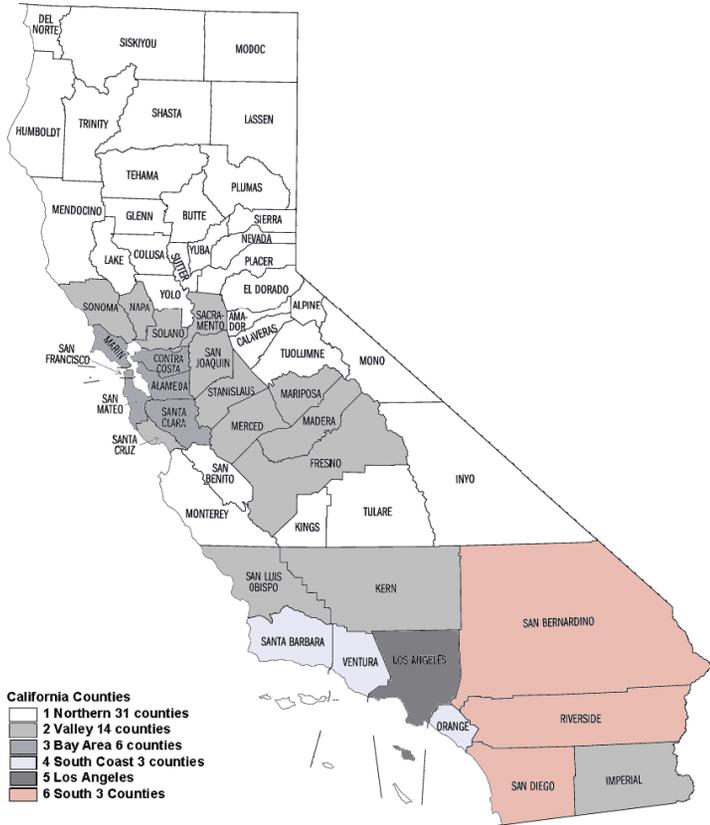


Table 11. Counties within each region and HFP enrollment as of December 2009

Region	Counties	Total Enrollment in Dental EPO Plans	Percentage of Region Enrollment	Total Enrollment in Dental HMO Plans	Percentage of Region Enrollment
Northern	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare,	74,057	90%	8,255	10%
Valley	Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus	123,114	79%	33,604	21%
Bay Area	Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara	62,256	70%	26,864	30%
South Coast	Orange, Santa Barbara,	28,910	25%	85,518	75%
Los Angeles	Los Angeles	15,877	7%	209,429	93%
South	Riverside, San	96,372	45%	118,173	55%
TOTAL HFP ENROLLMENT		400,586	45%	481,843	55%

APPENDIX F. DEMOGRAPHIC PROFILE

Table 12. Demographic Profile of Children Continuously Enrolled in the Plan for 11 out of 12 Months

Age (years)	HFP Overall	Access Dental	Delta Dental	Health Net Dental	Premier Access Dental	SafeGuard Dental	Western Dental
0	172	0	6	0	0	166	0
1	8,361	0	4,373	1,165	0	2,823	0
2	21,778	3,329	8,265	1,842	877	4,758	2,707
3	27,878	4,053	11,344	2,224	1,082	5,914	3,261
4	29,438	3,886	12,590	2,255	1,175	6,162	3,370
5	30,118	4,236	13,086	2,199	1,125	6,355	3,117
6	32,587	4,653	14,692	2,299	1,240	6,633	3,070
7	36,587	5,262	16,714	2,736	1,219	7,322	3,334
8	39,490	5,713	18,080	2,658	1,410	7,899	3,730
9	40,560	5,858	18,642	2,895	1,415	8,024	3,726
10	40,545	5,722	18,783	2,871	1,398	8,072	3,699
11	40,140	5,702	18,946	2,754	1,340	7,875	3,523
12	39,970	5,601	18,743	2,785	1,324	7,935	3,582
13	40,165	5,835	18,864	2,715	1,279	7,842	3,630
14	40,077	5,794	18,784	2,899	1,152	7,749	3,699
15	39,563	5,725	18,623	2,686	1,274	7,621	3,634
16	38,256	5,399	18,068	2,598	1,224	7,369	3,598
17	36,937	5,381	17,259	2,478	1,138	7,067	3,614
18	35,219	4,742	17,167	2,397	954	6,907	3,052
TOTAL	617,841	86,891	283,029	44,456	20,626	124,493	58,346

FPL Category	HFP Overall	Access Dental	Delta Dental	Health Net Dental	Premier Access Dental	SafeGuard Dental	Western Dental
100% to 150%	220,235	32,133	97,227	16,112	6,667	45,110	22,986
151% to 200%	246,610	34,600	114,256	17,524	8,338	48,723	23,169
201% to 250%	150,996	20,158	71,546	10,820	5,621	30,660	12,191
TOTAL	617,841	86,891	283,029	44,456	20,626	124,493	58,346

APPENDIX F. DEMOGRAPHIC PROFILE

Table 12. Demographic Profile of Children Continuously Enrolled in the Plan for 11 out of 12 Months

Ethnicity	HFP Overall	Access Dental	Delta Dental	Health Net Dental	Premier Access Dental	SafeGuard Dental	Western Dental
African American	10,572	1,321	4,237	1,103	89	2,336	1,486
Asian/Pacific Islander	69,277	10,257	35,075	4,410	513	15,826	3,196
Hispanic/Latino	335,225	50,223	154,094	23,322	9,768	63,995	33,823
Other	140,658	19,072	57,300	12,413	4,563	30,876	16,434
White	61,356	6,018	32,323	3,082	5,666	11,029	3,238
TOTAL	617,088	86,891	283,029	44,330	20,599	124,062	58,177

Spoken Language	HFP Total	Access Dental	Delta Dental	Health Net Dental	Premier Access Dental	SafeGuard Dental	Western Dental
Chinese Languages	21,622	3,160	11,538	1,438	52	4,994	440
English	267,611	32,526	122,099	20,828	11,597	57,411	23,150
Korean	8,056	2,106	2,386	461	15	2,747	341
Other Languages	15,226	2,328	7,586	945	182	3,106	1,079
Spanish	290,842	44,573	132,116	19,740	8,722	53,125	32,566
Vietnamese	13,731	2,198	7,304	918	31	2,679	601
TOTAL	617,088	86,891	283,029	44,330	20,599	124,062	58,177

Demographic Region	HFP Overall	Access Dental	Delta Dental	Health Net Dental	Premier Access Dental	SafeGuard Dental	Western Dental
Northern	59,057	1,016	42,766	178	11,242	2,460	1,395
Valley	107,624	7,137	79,025	1,869	4,643	8,188	6,762
Bay Area	61,079	2,937	49,596	13	611	4,953	2,969
South Coast	79,993	14,498	19,487	7,819	4,086	24,231	9,872
Los Angeles	162,689	41,015	15,168	26,404	3	56,314	23,785
South	146,065	20,256	76,512	8,044	9	27,861	13,383
TOTAL	616,507	86,859	282,554	44,327	20,594	124,007	58,166

ENDNOTES

¹ Centers for Disease Control and Prevention (CDC). *Oral Health: Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers, At A Glance 2010*. Available On-line at: <http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm>

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³ California Health Care Foundation. *Denti-Cal Facts and Figures*, May 2010. Available On-line at: <http://www.chcf.org/publications/2010/05/dental-facts-and-figures>

⁴ Nadereh Pourat and Len Finocchio. *Racial and Ethnic Disparities In Dental Care For Publicly Insured Children*. *Health Affairs*, 29 no.7 (2010): 1356-1363. Available On-line at: <http://content.healthaffairs.org/content/29/7/1356.full?ijkey=OR9Zf6tmdgyb2&keytype=ref&siteid=healthaff>

⁵ Pew Center on the States. *The Cost of Delay: State Dental Policies Fail One in Five Children*. Available On-line at: http://www.pewcenteronthestates.org/uploadedFiles/Cost_of_Delay_web.pdf

⁶ American Academy of Pediatric Dentistry. *Policy on the Dental Home*. Available On-line at: http://www.aapd.org/media/PoliciesGuidelines/P_DentalHome.pdf

⁷ CDC. *Oral Health: Preventing Cavities, Gum Disease, and Tooth Loss*, March 2009, Available On-line at: <http://www.cdc.gov/nccdphp/publications/aag/doh.htm>

⁸ “Mommy, It Hurts to Chew.” *The California Smile Survey: An Oral Health Assessment of California’s Kindergarten and 3rd Grade Children*, February 2006. Available On-line at: <http://www.healthysmilesoc.org/Documents%20for%20Site/California%20Smile%20Survey.pdf>