



**CALIFORNIA
ASSOCIATION
OF DENTAL
PLANS**

News

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DECEMBER 1999

President's Report

by Troy Becker

▶ On behalf of Executive Director Jackie Miller, The Board of Directors and the entire CADP organization, we hope all of you are enjoying a happy, safe and healthy Holiday Season.

This past year proved to be a challenging one for everyone involved in the association, but a year worth the effort. Despite our facing quite certainly the most difficult legislative year in our organization's history, CADP brought sensibility where it belonged. More importantly, we established ourselves as a credible negotiator. Like many of you, I was sad to see the misinformation spread by the CDA this year regarding CADP's position on external review. However, in my view, this incident did more to strengthen our message with those legislators who count than it harmed us. This year proved that even the most extreme tactics don't always pay when common sense is at issue.

This year also brought some surprises (other than the normal, Commissioner leaves, new Democratic Governor, new Department of Managed Care, etc.). For years CADP has prodded the Department of Corporations to stop the spread of unlicensed dental plans, even providing the DOC with reams of material on these plans, with little action taken. Finally, quite unexpectedly, Acting Commissioner William Kenefick put illegal plans on notice that the State would not tolerate their activity and began the process of "slamming the door" on plans that blatantly violate laws we pay to abide by. In addition, after years of meeting with the DOC to address issues having an impact on day-to-day plan activity, we were finally responded to in a fashion most unfamiliar to us - quickly and, more important, objectively. Everyone at CADP hopes our dialogue with the Department continues in this fashion, as it has proven to be the most effective process for clearing up issues that can have a tremendous impact on our organizations.

I would be remiss if I didn't thank everyone for their support and grassroots efforts in 1999. Without that support, our activities would be very much diminished.

Remember - register to attend CADP's 2000 Legislative Conference, January 25-26, at the Hyatt Regency, Sacramento. An updated conference program is included in the newsletter.

Wishing all of you a new millennium filled with happiness and prosperity—

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**CALIFORNIA
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OF DENTAL PLANS**

News

The CADP News is published quarterly. Your suggestions and/or comments are encouraged. Please write or call:

**CALIFORNIA ASSOCIATION OF
DENTAL PLANS**

One Capitol Mall, Suite 320,
Sacramento, CA 95814-3229

916/446-3122 • FAX: 916/441-6484

Jackie Miller, Executive Director

email: westword@cal.net

Dental Director Dots and Dashes

by D.E. FitzGerald, DDS, Chair, Quality Assurance Committee

At its November meeting in Anaheim, hosted by PacifiCare Dental and Vision, the Dental Directors and other members of the CADP Quality Assurance Committee tackled a busy agenda. It was another productive meeting, with the sponsors of three on-going projects ready to make substantive reports.

Dr. Charles Stewart reported that the curriculum for the Auditor Training Course had now been copyrighted. This last impediment to expanding the marketing of calibrated training was applauded by all. Interest in the Course has continued to grow; even the interim courses are filling rapidly. Of particular note is the growing interest from non-dentists and interest from people out-of-state. Dr. Stewart sought and received permission to stagger expiration dates to control the demand for specific dates of training.

Not wholly unrelated, Jackie Miller reported that the Department of Health Services had requested permission to use the CADP standard audit tool as a reporting re-

quirement for elements of some of their California operations. This is a definite acknowledgment of CADP's leadership role in the industry.

Dr. FitzGerald and others who participated in the beta test to assess feasibility of sharing digital site audit information reported a general success for the project. The next stage is to gather interested parties to review results of the beta test and listen to proposals from the chosen vendor for the clearinghouse. This is scheduled for early January.

Probably the most interesting project was covered in a report from Dr. FitzGerald on a meeting that CADP representatives had with William Kenefick, Acting Commissioner of the Department of Corporations, and Shereef Aref, who heads the medical survey function. It came about following CADP's request for a meeting with the Department because of concerns about the current audit activity of the Department's new contractor. Facts and opinions from an informal poll of Dental Direc-

tors, as well as a plan survey conducted earlier by CADP regarding survey teams' requests for original charts, supplied the substance of the letter. Mr. Kenefick was most cordial and provided an opportunity for representatives to meet Mr. Aref. While we did not receive total support for every point of concern, the general feeling following the meeting was that Mr. Kenefick was responsive and appreciative of having the facts brought to his attention. A subsequent letter to the Association substantiated this.


The impact of legislation on dental director activities in particular and plans in general occupied the remainder of the meeting. There was also renewed interest in developing Standard Performance Measures.

The strength of the committee lies in the energy and commitment of all its members. Attendance now numbers close to forty and more seem interested in working on sub-committees. The year 2000 promises to be full of significant change.

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For more information, please contact:
Dale S. Miller, Esq., Henry A. Holguin, Esq.
or Michael A. Dowell, Esq.

CADP/DOC Meeting Productive

As a result of CADP's October 19 letter to William Kenefick, Acting Commissioner, Department of Corporations, and a follow-up meeting between CADP and DOC on November 12, the Department has responded to concerns raised in the November CADP dental directors' meeting as a result of the newest round of audits, the first since the Department outsourced the on-site review and data gathering process. CADP concerns had focused on the following: (1) requirement that original dental charts be provided; (2) CDT-2 Code 1110 procedures; (3) requirement that plans validate RDA and RDH credentials; and (4) unannounced visits of dental providers. During that meeting, Mr. Kenefick indicated that bringing these concerns to the Department's attention was appropriate and that, where possible, workable solutions and/or compromises could be achieved. Both CADP and Department representatives agreed that the meeting had been helpful, recommending that such meetings take place semi-annually. He promised that after reviewing these matters further, he would follow up with a formal response.

Subsequently, CADP executive director Jackie Miller and Mr. Kenefick had several discussions clarifying the Association's concerns and the Department's regulatory authority. He responded formally on December 9, in correspondence to the Association. The following is a synopsis of his comments:

Dental charts - the Department will notify the dental survey contractor to provide at least three weeks' notice to the plans of the provider sites to be surveyed and which records will be reviewed at the provider offices. He reiterated that it is the plan's responsibility to provide the contractor with "clear, legible and complete copies of the provider's dental records and other documentation," including radiographs.

CDT-2 Code 1110 procedures - the Department is studying the literature submitted by CADP and is discussing the matter with the dental survey contractor. (This is a matter for follow-up - Ed.)

Validation of RDA and RDH credentials - Mr. Kenefick reiterated that validation of credentials under Knox-Keene is the plan's responsibility, but may be delegated to providers. When this requirement is delegated, the plan must have a mechanism in place to assure that all providers and allied health care professionals are properly credentialed.

For contracted providers, as opposed to a staff model, the Department will instruct the contractor to look at the evidence that the plan reviewed in concluding that the supervising dentist complied with its contract requirements as well as those of the Knox-Keene Act regarding credentialing of allied health professionals. Contracting dentists should make the information available to surveyors at the site visit.

Unannounced visits - Mr. Kenefick reiterated that the De-

partment has authority to conduct unannounced visits, with respect to both routine or non-routine surveys. However, "subject to the absence of facts and circumstances indicating otherwise," the Department will instruct the contractor to give three weeks' notice to the plan of provider offices that will be visited during the routine dental survey.

Forum to discuss concerns and problems - the Department agreed that a more regular forum is necessary to facilitate the discussion of issues or concerns of the Association, including standards of care, quality assurance oversight, dental survey issues, etc., and recommends that meetings take place semi-annually.

Legislative Update

▶ **Villaraigosa to Step Down as Assembly Speaker**— Assembly Speaker Antonio Villaraigosa (D-Los Angeles), recently announced that he will step down from his post in April. Villaraigosa, who is term out in 2000 and is running for mayor of Los Angeles, will ask the Assembly to vote on his replacement on January 24. He has endorsed one of his top allies, Assemblyman Robert Hertzberg (D-Sherman Oaks), currently chair of the powerful Rules Committee.

▶ **CDA to Move Ahead with SB 292**— The CDA, thwarted in its attempt to include dental in external review legislation during the 1999 session, plans to pursue its dental external review measure, SB 292 (Figueroa), in 2000. In the October 14 issue of *CDA Update*, William Emerson, DDS, chair of CDA's Council on Legislation, stated that ". . . this will be a separate and distinct issue for next year." Dr. Emerson also indicated that the CDA is likely to pattern its provisions after the external review program in Texas.

▶ **Legislative Implementation Guidelines Available**— CADP has forwarded its annual legislative report to member plans. Compiled by Richard Spohn of Nossaman, Guthner, Knox & Elliott, CADP's legislative advocate, the report provides guidelines for implementing mandates for dental managed care plans. It addresses the more significant managed care measures enacted into law in 1999, including SB 21 (Figueroa) - health plan liability; AB 55 (Migden) - independent external review; SB 189 (Schiff) - grievance procedures; SB 59 (Perata) - utilization review; AB 12 (Davis) - second opinions; AB 285 (Corbett) - telephone advice services; AB 78 (Gallegos) - Department of Managed Care; and SB 59 (Brulte) - "silent PPO's."

To request a copy of the report, please contact the CADP administrative office; 916/446-3122; e-mail: westword@cal.net.

CADP Questions DOC's Assessment Policies

CADP has written to the Office of Administrative Law (OAL) in support of Healthdent of California's request that it determine whether the Department of Corporations' policy of imposing an assessment on a Knox-Keene plan for subscribers or enrollees of a different plan who are treated in the assessed facility but who are not subscribers or enrollees of the assessed plan is a "regulation," as defined by the Government Code. Healthdent had challenged the Department's authority to impose such assessments, asserting that it resulted in duplicate assessments, and requested that OAL determine whether this policy was a regulation subject to the requirements of the Administrative Procedure Act.

In its letter of December 8, 1999, CADP supported Healthdent, asserting that the Department did not have the authority to impose such assessments, that it results in plan overassessments, and that the Department receives a duplicate assessment for the same enrollee. We also pointed out that the policy could significantly and unnecessarily increase the assessments paid by Knox-Keene plans which own dental offices.

The Department has until December 27 to respond; the deadline for the OAL decision is January 26, 2000.

Governor Appoints Interim Managed Care Dept. Director

Governor Gray Davis has appointed Daniel Zingale as Interim Director of the Department of Managed Care. Zingale, 39, of Washington, DC, had served as executive director of the AIDS Action Council and AIDS Action Foundation since 1997. From 1993-1997, he was director of public policy for the Human Rights Campaign, and from 1991-1993, he was managing director of the American Psychological Association. Mr. Zingale also served as deputy controller and chief of staff in the State Controller's Office. He received his bachelor of arts degree from the University of California, Berkeley, and a master's degree in public administration from Harvard University. Many in Sacramento had expected the Governor to appoint someone already familiar with California's health industry; however, Michael Bustamante, the Governor's spokesperson, said Zingale was selected because of his understanding of both healthcare advocacy and the needs of business.

The Department of Managed Care is scheduled to take over the managed health care functions currently under the Department of Corporations by July 1, 2000.

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Attorneys at Law

- Corporate/Securities
- Litigation
- Labor/Employment Law
- Health Care

Questions about our firm may be addressed to

Robert J. Kane (Labor) at (949) 725-4127

Michael Zablocki (Managed Care) at (949) 725-4146

660 Newport Center Drive, Suite 1600

Newport Beach, CA 92660

(949) 725-4000



*Season's
Greetings*



State Auditor Report Critical of Dept. of Corporations

In its 1999 audit report, the California State Auditor was critical of the Department of Corporations. According to then-state auditor Kurt Sjoberg, despite budget increases of \$6.5 million, improvements in consumer protection were limited; in addition, the report determined that health plans had paid more for the cost of their regulation than the department actually spent.

The following is a portion of the audit report's "Results in Brief":

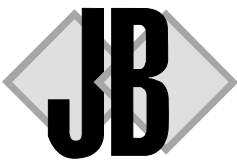
Despite receiving a \$6.5 million budget increase in August 1997 to enhance its regulation of health care service plans (health plans), the Department of Corporations (department) has shown only limited improvements in its efforts to protect health plan enrollees from inadequate medical care. Our audit revealed that, during fiscal year 1997-98 and the first half of fiscal year 1998-99, the department failed to produce appropriate reports and to resolve promptly enrollee complaints against

their health plans. Furthermore, evidence from our review suggests that the lack of competent leadership during these periods contributed significantly to the poor performance in the department's Health Plan Division (division), which is largely responsible for ensuring that health plans comply with the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). This Act includes laws designed to ensure the provision of adequate health care by financially sound health plans. Further, our audit disclosed that the department's Health Plan Program (program) did not spend millions of dollars in its budgets for fiscal years 1996-97 and 1997-98 partly because the program did not meet intended staffing and performance levels. Because health plan fees comprise a substantial part of the revenues the department collects to cover the costs of regulating health plans, these budget surpluses indicate that health plans paid more fees than necessary for their regula-

The report also concluded: "For the 116 health plans licensed in California as of June 30, 1997, the excessive fund balance resulted in each plan paying an average of \$50,800 more than necessary for its regulation during fiscal year 1997-98. Further, because the program bases its assessments for health plans in part on each plan's number of enrollees, the overpayments equaled about 5.3 cents per enrollee for fiscal year 1996-97 and 10.6 cents per enrollee for fiscal year 1997-98. For fiscal year 1998-99, the overpayment could be as much as 9.8 cents per enrollee."

For a free copy of the report, contact:
California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814
(916) 445-0255

The report is also available at the Bureau's website, at: www.bsa.ca.gov/bsa/

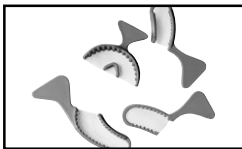


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Federal Update

Information courtesy of Jay Grant & Associates

▶ **HHS Opens New Data Bank**— The Department of Health and Human Services has opened its new data bank. The Healthcare Integrity and Protection Data Bank will store information on civil judgments (except malpractice judgments) against health care providers, criminal convictions, federal and state licensing and credentialing actions, and incidents of exclusion of providers from federal and state programs. The data bank supplements the 10-year-old National Practitioner Data Bank, which contains reports on malpractice payments and adverse actions related to privileges, licensing and professional society membership. Government agencies and private health plans (including dental plans) must begin making reports to the new data bank on adverse actions taken since August 21, 1996, the date the Health Insurance Portability and Accountability Act (HIPAA) was enacted. It mandated the data bank's creation to help combat health care fraud and abuse.

Government agencies and private health plans may request reports from the new data bank beginning early in 2000. The general public will not have access to information in the data bank, but subjects of reports may have copies of reports concerning themselves.

▶ **HHS Extends Privacy Comment Period**— The Department of Health and Human Services (HHS) is extending the comment period on proposed regulations providing for the privacy of medical records. The period will be extended for an additional 45 days, to February 17, 2000. The initial 60-day comment period began when the regulations were published on November 3, and was scheduled to end January 3. In announcing the extension, HHS stressed the complexity of the issue and the need to give the public

adequate time to thoroughly review the proposed regulations. A number of major health organizations had also called for an extension.

▶ **Steps Proposed to Deal with Medical Errors**— Responding to the Institute of Medicine's recent report that medical errors cause the deaths of between 44,000 and 98,000 people annually, the Clinton Administration has announced several steps designed to help address the issues. Actions to be undertaken include calling on the Quality Interagency Coordination Task Force to develop strategies for reducing medical errors and working with the private sector to improve quality, requiring health plans participating in the Federal Employee Health Benefits Program to use error reduction and patient safety techniques, requiring federal health programs to use the latest error reduction techniques, and providing more funds in the upcoming budget for health quality and patient safety initiatives.

At the same time, the American Hospital Association announced that it will be working with the Institute for Safe Medication Practices to develop methods for reporting medical errors, establish lists of the best error-preventing procedures hospitals have developed, and suggest steps they can take to track their progress in preventing errors.

Senator Edward Kennedy (D-MA) also announced that he will introduce legislation to help implement the Institute's recommendations, including creation of a new Center for Patient Safety in the Agency for Healthcare Research and Quality. Health care organizations would be required and encouraged to report deaths and near misses resulting from medical errors. Republican Senators Jim Jeffords (VT) and Bill Frist (TN) indi-

cated that the legislation creating the new Agency for Healthcare Research and Quality would address the medical error issue and should receive the primary focus before moving ahead with additional legislation.

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In the News...

▶ **Class Action Suits Filed Against HMOs**—A coalition of attorneys involved in the \$200 billion tobacco industry lawsuit has filed class action suits against five major managed care insurance companies. The suits are similar to one recently filed against Aetna. The defendants this time are CIGNA, Foundation Health Systems, Humana, PacifiCare, and Prudential (now part of Aetna). The lawyers seek to get around the ERISA limitation by utilizing anti-racketeering laws, charging that the companies are defrauding their patients through arrangements with providers to deny or delay care. A coalition spokesperson has indicated that a goal of the suits is a settlement ratified by Congress.

▶ **PMI to Offer Coverage and Enrollment Online**—PMI will begin offering a web-based enrollment system, effective January 1. Available only in California, program and enrollment information will be available online for two new individual dental HMO programs, one for individuals and families, and one tailored for seniors. The site also links to PMI's dentist directory.

▶ **DHS' Office of Medi-Cal Dental Services Moves**—The California Department of Health Services' Office of Medi-Cal Dental Services (OMDS) has moved to a new location:

Office of Medi-Cal Dental Services
11155 International Drive
Rancho Cordova, CA 95670-6096
OMDS main number: (916) 464-3888
Fax: (916) 464-3783

Dr. Bryan Quattlebaum's direct number: (916) 464-0374

▶ **PacifiCare Health Systems to Provide Independent Review**—PacifiCare Health Systems, Inc., will offer access to independent external review (IER) of medical coverage decisions to enrollees in nine states. The process is already offered in Arizona and Texas, with Colorado, Nevada, Oregon

and Washington to offer the program by January 1. It will take effect in Oklahoma on February 1, California on April 1 and Ohio by May 1. The program will be offered to enrollees in its HMO, preferred provider organization and point-of-service plans. It will contract with multiple independent review organizations in each state to oversee the IER program.

▶ **State Court Upholds HMO Arbitration Clauses**—In a 6-1 ruling, the California Supreme Court has refused to create an avenue to sidestep arbitration clauses in HMO contracts. The Court rejected a claim that patients can get their cases decided by juries rather than arbitrators if they sue under the state's Consumer Legal Remedies Act. That law gives consumers a right to sue businesses that commit deceptive practices, such as false advertising, and it declares that any waiver of the right to sue is invalid. If a suit asks for an injunction and seeks damages, the damage portion—that part asking the HMO to give money to the patient it allegedly has harmed—still must be decided by an arbitrator, the Court ruled. The justices allowed only a narrow exception, ruling that some requests for injunctions to halt deceptive practices may be filed in court.

▶ **DOC Halts Health Plan in Southern California**—In early November, the Department of Corporations ordered the National Consumers Benefits Association (NCBA and/or NCBA Healthplus), based in Riverside, to cease operations, barring the organization from soliciting or enrolling new members. Determining that it was operating unlawfully, the Department directed the plan to terminate all health care service plan operations by November 30. Following a December 1 court denial to allow the plan to continue operating pending an administrative hearing, the Department issued a warning to enrollees to make immediate, alternative arrangements for health coverage.

▶ **CAHP Recommends Two-Tier Benefit System**—The California Association of Health Plans has recommended to the Legislature that managed care companies be given more freedom to create lower-cost, basic health benefit plans, which would provide fewer benefits and services than offered in typical benefit plans. Walter Zelman, President & CEO, indicated that CAHP's proposal could be one of the solutions in resolving the issue of California's uninsured population, which now numbers seven million. Zelman indicated that a two-tiered plan might require policyholders to accept only generic drugs, forgo coverage of mental health services or have smaller physician panels from which to select a primary care physician.

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