NOTE: This tool was developed by the Medicaid-CHIP State Dental Association to assist State Medicaid Dental Programs in the development of their State Oral Health Action Plans for CMS.

Oral Health Action Plan Template
For Medicaid and CHIP Programs

STATE: CALIFORNIA
AGENCY: CALIFORNIA DEPT. OF HEALTH CARE SERVICES
PROGRAM NAME: MEDI-CAL DENTAL PROGRAM
PROGRAM TYPE REFLECTED IN THIS TEMPLATE: ____MEDICAID ____CHIP __X__COMBINED MEDICAID /CHIP

STATE CONTACT: Andrew McCray
TITLE: CHIEF
AGENCY: CALIFORNIA DEPT. OF HEALTH CARE SERVICES
PROGRAM: MEDI-CAL DENTAL SERVICES DIVISION
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INSTRUCTIONS

It is best to complete separate templates for each of your State's Medicaid and CHIP dental programs. If your State has a combined Medicaid and CHIP dental program, or if you are implementing common improvements across both Medicaid and CHIP dental programs, you may complete a single template for both programs.

ORAL HEALTH INITIATIVE GOALS

1) To increase the proportion of children ages 1-20 enrolled in Medicaid or CHIP for at least 90 consecutive days who receive a preventive dental service by 10 percentage points over a five-year period. Target year is FY 2015.

2) To increase the proportion of children ages 6-9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period. Target year has not yet been determined.

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TYPE OF DENTAL DELIVERY SYSTEM

SERVICE DELIVERY FOR DENTAL	Calendar year implemented	Number of children currently enrolled	If a new dental delivery system was launched since 2005, please explain why the new dental delivery system model was chosen.
Fee For Service	1966	3,241,045 as of 01/2013	
Administered by the State agency, including CARVED OUT of medical managed care			
Administered by a contractor, including CARVED OUT of medical managed care			
Administered by a contractor or contractors, but CARVED IN to medical managed care			
Other FFS (describe) Administered by State agency AND, in part, by a partially at risk contractor (FIscal Intermediary)	1966	3,241,045 as of 01/2013	
Dental Managed Care	1994	326,529 as of 01/2013	
CARVED IN to medical managed care			

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CARVED OUT of medical managed care (see below)	1994, 1997	326,529 as of 01/2013	
Other dental managed care (describe) Two separate programs: Geographic Managed Care (GMC), where 3 dental plans cover beneficiaries in one county, most of whom are mandated to enroll; 2) Prepaid Health Plan (PHP), where 7 dental plans (3 effective 7/1/2013) cover beneficiaries who can voluntarily enroll in one of the plans or in FFS.	1994 - GMC 1997-PHP	138,473 188,056 as of 01/2013	

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"PARTICIPATING" DENTAL PROVIDERS

"Participating"= submitted at least one claim. "Actively participating"= submitted at least $10,000 in claims.	YEAR DATA IS FOR:	NUMBER LICENSED IN STATE	Primary Dental Delivery System Type: ___________________		Secondary Dental Delivery System Type: _____________________	
			# PARTICIPATING	# ACTIVE	# PARTICIPATING	# ACTIVE
DENTISTS (Total)	Nov 2011 Jan 2013	30,512 (total licensed) 31,603 (in state)	9,429 (SFY11-12)	5,113 (SFY11-12)		
DENTAL HYGIENISTS RDH - in state RDHAP - in state	Jan 2013 Jan 2013	16,413 427	0 119 (CY 2012)	0 79 (CY 2012)	0	0
OTHER DENTAL MID-LEVEL		0	0	0	0	0
DENTAL SPECIALISTS (enumerated by type)	Nov 2011					
General Dentists		25,307	NA	NA	NA	NA
Oral Surgeons		784	NA	NA	NA	NA
Orthodontists		1,388	NA	NA	NA	NA
Endodontists		761	NA	NA	NA	NA
Pediatric Dentists		798	NA	NA	NA	NA
Periodontists		810	NA	NA	NA	NA
Other Specialties		664	NA	NA	NA	NA

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Describe any specific access challenges in your State, such as rural areas, dental health professional shortage areas, etc.

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"PARTICIPATING" NON-DENTAL (MEDICAL) PRIMARY CARE PROFESSIONALS PROVIDING ORAL HEALTH CARE SERVICES

"Participating"= submitted at least one claim for oral health services. "Actively participating"= submitted at least $10,000 in claims.	YEAR DATA IS FOR:	NUMBER LICENSED IN STATE	# PARTICIPATING	# ACTIVE
MDs - Physicians and Surgeons DOs	As of 5/1/2012 As of 8/1/2012	130,440 5,057	2,237	0
NURSE PRACTITIONERS	2011	17,032	0	0
PHYSICIAN ASSISTANTS	As of Sept 2012	8,104	0	0
OTHER NON-DENTAL MID-LEVEL PROVIDERS	NA	NA	NA	NA

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NOTE: This tool was developed by the Medicaid-CHIP State Dental Association to assist State Medicaid Dental Programs in the development of their State Oral Health Action Plans for CMS.

In January 2013, the Department of Health Care Services (DHCS) began efforts to transition approximately 860,000 children from California's CHIP program (known as the Healthy Families Program (HFP)) into the Medicaid program (Medi-Cal). This transition involved one of the largest numbers of individuals that has ever transferred from a single program into the Medi-Cal Program. The transition was a phased process, beginning January 2013 and will be coming to a close shortly with the last phase of the transition scheduled for no earlier than November 1, 2013. These children have been enrolled in HFP dental managed care plans prior to the transition and have been transitioning into the Medi-Cal Dental FFS system ("Denti-Cal") in all but two counties (Sacramento County and Los Angeles County). Due to the size of this transitioning population, DHCS has been paying particularly close attention to the dental network adequacy. Overall the transition has been a success, and Denti-Cal has been able to successfully certify network adequacy for each of the phases thus far. Throughout the transition, DHCS has conducted extensive provider outreach efforts and has closely monitored provider enrollment including the tracking of HFP provider enrolment into the Denti-Cal system. Thus far, DHCS has seen that many HFP providers have continued care for their HFP children and have even been willing to take on new beneficiaries after enrolling in the Denti-Cal program. DHCS has institutionalized the metrics used by the HFP transition and plans to continue to utilize these measurements post-transition to ensure quality of care and network adequacy. DHCS will also continue reviewing the level of administrative simplification that the dental program can implement in order to improve provider experience through assessing our claims adjudication process and the provider enrollment process.

As of February 1, 2012, there were 321 Dental Health Professional Shortage Area (DHPSA) designations in the State, encompassing a population of 2,495,300, or 6.7% of the State population. The estimated underserved population is 1,338,955. It is estimated that 378 practitioners would be needed to remove the DHPSA designations and 398 to achieve the target population-to-practitioner ratio of 5,000:1 (4,000:1 in areas with unusually high need). Most of these are facility DHPSAs such as Federally Qualified Health Centers, Rural Health Clinics, Correctional Facilities, or other types of facilities, but those designations are only for those specific facilities and do not count as designations for the region. There are officially 68 DHPSAs that cover a geographic region as of February 8, 2013 of which 50 are low-income (population) designations and 18 are geographic designations.

California cut most optional Medicaid adult dental services effective July 2009. As a consequence, most adults have only been eligible to receive "Federally Required Adult Dental Services," largely limited to services for the relief of pain, infection and trauma. There are several reports in the literature suggesting that children whose parents have access to dental care are themselves more likely to use dental care. Thus, some anticipated that children's utilization would decline following the adult service reductions. However, other evidence from states that cut adult benefits suggests that providers might compensate for the loss of revenue from adults by seeing more children. This is indeed what has been observed in California: Between the first quarter of 2008 and the second quarter of 2012, the quarterly utilization rate for children ages 0-20 increased from 10.5% to 12.4%, an 18% increase. However, the increase was far more dramatic for the youngest children. For those ages 0-3, the increase was 288%, and for those ages 4-5, the increase was 918%.

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Although federally funded clinics were originally included among the providers targeted by the rate reduction, a recent decision by the Ninth U.S. Circuit Court of Appeals ruled that adult dental care must be restored in these facilities.

Another impact of the adult dental reductions, evidenced by several recent reports, appears to have been an increased use of emergency rooms for ambulatory care sensitive dental conditions, i.e., preventable conditions--those for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

Fortunately, the FY 2013-14 budget will restore many adult dental benefits beginning in May 2014. Services to be restored include several diagnostic, preventive and restorative procedures, full dentures and anterior root canals.

In addition to shortages of providers who provide care to children enrolled in Medi-Cal, many families face socio-economic barriers to accessing dental care. Low-income families often do not have affordable transportation options, lose pay when they miss work, e.g., to take a child to a dental appointment, and need to arrange and pay for child care for other children.

At the same time California severely reduced adult dental coverage, funding was suspended for the California Children's Dental Disease Prevention Program (CCDDPP), a comprehensive school-based preventive dental program that operated in approximately half the counties in the State, that provided oral health services including dental screenings, fluoride varnish and mouth rinses, dental sealants, and oral health education to the lowest income children in elementary schools, preschools and Head Start centers.

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Describe the activities you have underway and/or plan to implement in order to achieve the dental goal(s). Here are some examples of types of activities. Please describe how you are doing, or plan to do, any of these in your State. Please also add and describe any additional activities you have underway or plan to implement.	
Overall approach to outreach	Many of the activities described below are conducted by the Outreach Unit of Delta Dental of California, the fiscal intermediary for California's FFS dental program ("Denti-Cal"). These activities are largely requirements of California's contract with Delta. Some have observed that the impact of these activities has not been well documented—or at least not well-known or felt in the dental community. **The Department of Health Care Services, Medi-Cal Dental Services Division (MDSD) plans to review the contractual requirements pertaining to Delta's Outreach activities and, with stakeholder and Delta input, develop measureable objectives for the Outreach Unit that better reflect activities that are believed most likely to improve access.**
Education/outreach to dentists, dental hygienists, and state/national dental associations	Delta Dental of California, the fiscal intermediary for California's FFS dental program ("Denti-Cal"), has an Outreach Unit that currently travels to all counties meeting with dentists, California chapters of national dental associations (e.g., American Academy of Pediatric Dentistry) and dental schools; provides enrollment and billing training for Registered Dental Hygienists in Alternative Practice (RDHAPs); and attends California Dental Association (CDA) scientific sessions, local dental society meetings and conferences. Delta also offers both in-person and webinar Provider Enrollment Workshops and monthly Enrollment Assistance Days for providers seeking assistance in submitting an enrollment application. In recent months, the enrollment process has been made considerably more user-friendly. Providers are additionally supplied with educational information and tools on the Denti-Cal website to mitigate program challenges. Newly licensed providers are also contacted on a bi-annual basis to recruit new providers into Denti-Cal's network. **Since January 2013, providers have been mailed postcards each month to inform them of the resources available to them on the Denti-Cal website. Providers who practice in communities with low utilization or little participation on the referral list will also be**

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	targets of call campaigns, provider mailings, and field office visits. MDSD has determined that dental hygienists are permitted to bill for preventive dental services provided in public health programs to Medi-Cal beneficiaries. **MDSD is in the process of establishing policy and requesting system changes that will enable hygienists to bill for these services. MDSD will make this information available to the California Dental Hygienists' Association and other interested parties.** **MDSD will review the feasibility of listing RDHAPs on the Denti-Cal website to help link more homebound special needs and institutionalized children with preventive care.** **MDSD will direct its Dental Managed Care staff and Delta Dental's Outreach Unit to inform Denti-Cal and dental managed care providers about the goals of this action plan through provider bulletins, the Denti-Cal website, webinars, the California Dental Association (CDA) and other stakeholder groups.** **MDSD will meet with the California Dental Association and local dental societies, California Society of Pediatric Dentistry, California Dental Hygienists' Assn. and local dental hygiene societies, State and local MCAH and CHDP programs, Oral Health Access Council and local oral health coalitions to develop preventive services promotion strategies/outreach activities relevant to each provider group.** **MDSD will meet with Medi-Cal dental managed care plans to discuss ideas for Quality Improvement Projects aimed at increasing the number of children who receive preventive dental services.** **MDSD will meet with the California Head Start Association and local Head Start programs, California Department of Education, California WIC Association and local WIC programs, State and local First 5 Commissions, California Association of School-Based Health Centers, State and local MCAH and CHDP programs, Oral Health Access Council and local oral health coalitions to develop strategies/outreach activities relevant to each non-dental office setting aimed at increasing the delivery of preventive services in non-dental office settings.**

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Education/outreach to pediatricians, family practitioners and state/national medical associations	Delta's Outreach Unit meets with county medical societies and members of the California Division of the American Academy of Pediatrics in an attempt to encourage family practitioners/pediatricians to provide early dental health information to parents. **The Outreach Unit plans to continue reaching out to medical societies to encourage their patients to routinely utilize dental services.** See section on Other Oral Health Improvement Initiatives for a description of the First Smiles Program, which specifically targeted training and education to both medical and dental providers. DHCS is also represented on a Dental Committee of the American Academy of Pediatrics, District IX (California), Chapter 1. This chapter, which includes 47 Northern California counties, has been quite active in training pediatricians to do oral health assessments and fluoride varnish applications. California is one of the states that provides Medi-Cal reimbursement to medical providers (physicians and nurse practitioners) who provide fluoride varnish applications to children under 6. **MDSD will request the Medi-Cal Managed Care Division to communicate the goals of this action plan through its all plan meetings.**
Education/outreach to beneficiaries	Delta's Outreach Unit conducts 12 county Health Fairs each year, provides oral hygiene education to various groups/agencies (Teen Mom programs, Sacramento Food Bank-parenting classes). The Outreach Unit meets with county Departments of Social Services (DSS) and public health offices to distribute Denti-Cal program information and beneficiary educational material. They meet with many social services and public health offices, focusing on counties that historically have fewer dentists. They mainly meet with DSS employees to provide their contact information and talk about Denti-Cal. They distribute the "Have a Healthy Smile" brochure which describes the Denti-Cal program, gives the beneficiary a toll-free number and informs them what to bring to their dental appointment. At Health Fairs, they give out the same brochure and provide information on xylitol, oral hygiene and brushing techniques. They also distribute oral health education videos. **The Outreach Unit is planning on improving the quality of educational material that is**

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	being released to the beneficiary population and participating in surveys to evaluate the effectiveness of current outreach methods to beneficiaries. A beneficiary satisfaction telephone survey was recently conducted of an initial group of 10,000 beneficiaries who transitioned from the Healthy Families Program to Medi-Cal. Beneficiaries were asked 1) if their child had been scheduled for a dental visit since they moved to Medi-Cal (28% of 349 respondents answered yes), and 2) of those who answered yes to the first question, if their experience in making or keeping an appointment with a dentist was better, the same or worse following their move to Medi-Cal (39% of the 92 respondents said better, 3% said worse and 58% said it was the same). Denti-Cal maintains a website that includes a list, by county, of dentists and federally funded clinics accepting Medi-Cal beneficiaries. This website also includes a link to the Insure Kids Now (IKN) website, which allows more specific search features (e.g., distance to a provider's office, whether they are accepting new patients) than the Denti-Cal website. DHCS was recently commended by Mission Analytics Group, which is working with CMS and HRSA to improve the data available for families of children enrolled in Medicaid and CHIP who are looking for dentists for their children. California was ranked as one of the best states in the nation in terms of the quality and accuracy of the data submitted to the IKN Dental Locator. Sacramento and Los Angeles County beneficiaries enrolled in dental managed care plans who have not had a dental visit in the past 12 months have been called by their dental plans and encouraged to make a dental visit. MDSD meets regularly with stakeholders in Sacramento and Los Angeles County to address barriers to care. These groups have collaborated with MDSD to create educational brochures for Medi-Cal enrollees and their families.
Coordination with Federally Qualified Health Centers	The Outreach Unit provides training and assistance to FQHCs, Rural Health Clinics and Indian Health Clinics. They train clinic staff on Denti-Cal billing and criteria as these clinics are required to follow Denti-Cal Program criteria. The Unit also attends FQHC

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	roundtables and IHS conferences. **If possible, particularly in rural counties, Outreach Unit staff meet with clinic directors to discuss the possibility of expanding their facilities to increase access into the area.** Relatively recently, DHCS established a mechanism whereby dental hygienists working in FQHCs could be considered billable providers in those settings. More recently, DHCS established new policy that allows FQHCs to contract for dental services provided outside the "four walls" of the clinic. **MDSD will work with DHCS staff that oversee FQHC billing to clarify the settings and conditions under which RDHAPs and RDHs are permitted to bill for services provided to Medi-Cal beneficiaries in FQHC settings.** It was recently discovered that the dentist referral list on the Denti-Cal website did not include federally funded clinics (FQHCs, Rural Health Clinics, Tribal Health Clinics) among the referral sites. **This has been remedied and these clinics are now listed, by county.** **MDSD will partner with the California Primary Care Association (CPCA) and the Community Clinic Association of Los Angeles County (CCALAC) to inform FQHCs and other federally funded clinics about this action plan and its goals.** To date, federally funded clinics have not been required to report procedure codes for dental services provided to their Medi-Cal enrolled patients. Consequently, DHCS has been unable to report on the CMS-416 form anything other than whether clinic patients have received any dental procedure, i.e., no data has been able to be provided on the extent to which diagnostic, preventive, sealant, or treatment services were provided. **DHCS has begun a project to address this, and once complete, clinics will be required to report procedure codes.**
Undertaking administrative simplifications	The Denti-Cal program is undertaking administrative simplifications in the enrollment process by supporting the Department of Health Care Services, Provider Enrollment Division (PED) in the CalPES system, which would increase the level of automation and streamline parts of the enrollment process. Denti-Cal is expecting to adopt the CalPES enrollment system by the end of 2016. The Denti-Cal program additionally addresses administrative simplification with regard to claims processing by modifying provisions in the Manual of Criteria (MOC) every two years. The current MOC revision cycle included

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	changes to the MOC such as allowing providers to submit a root canal treatment request and a crown request at the same time rather than wait for the root canal TAR first, removing the periodontal evaluation chart submission requirement for TARs on deep cleanings, and removing the prior authorization requirement for immediate complete dentures. In general, Denti-Cal examines procedures every two years where there are written documentation requirements to see if the specified requirements are necessary to determine medical necessity for procedures. Denti-Cal has also engaged with the stakeholder community and the California Dental Association (CDA) specifically to develop useful resources and tools to supplement the Provider Handbook with regard to information on how to successfully submit claims to Denti-Cal.
Using electronic health records and/or supporting dental providers in their efforts to qualify for meaningful use incentive payments	See section on electronic health records.
Coordination with Maternal and Child Health (MCH) Title V programs (Title V is the Federal/State program focused on assuring the health of all mothers and children, and Children with Special Health Care Needs (CSHCN).	While there are no specific requirements for coordinating with Maternal and Child Health programs in the Medi-Cal Dental Program, Denti-Cal addresses dental related issues for special needs children through referrals, coordinating with contacts at surgery centers, clinics, dental schools, the California Children's Services program and other agencies as needed to ensure they receive the care they need. California's Title V program, located in the Department of Public Health, is in the process of updating a 5-year work plan for local health jurisdictions (LHJs), the purpose of which is to provide a sample of objectives that LHJs might select for their annual Scopes of Work, and give them a longer time period in which to achieve these objectives. The intent is to "nudge" them toward common State MCAH goals, one of which (still in draft) is to "Increase access and link children to a dental home where possible to ensure they get preventive care on an annual basis." The draft action plan contains a number of short- and medium-term objectives aimed at increasing children's access to preventive dental services, and proposes involvement of local medical and dental organizations and providers, advocacy organizations and the Medi-Cal dental program. **MDSD plans to meet with the State MCH program Oral Health Consultant to try to**

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	devise a way in which the California Home Visitation Program can encourage public health nurses in the program to provide fluoride varnish applications during home visits.
Collaboration with dental schools and dental hygiene programs	The Outreach Unit and Dental Policy staff work closely with the six California dental schools. Medi-Cal Dental Program training is provided to dental school clinic directors and students twice yearly at each school. The Outreach Unit collaborates with the schools to remedy access to care issues and/or assists those patients who need specialty dental care. Delta Provider Relations staff also provide billing/criteria training at the hygiene schools. **Once a mechanism is in place to allow dental hygienists to enroll as billing providers in the Denti-Cal program (see Enrollment of Registered Dental Hygienists as Denti-Cal billing providers below), DHCS plans to publicize this information to dental hygiene schools in the hope that some of the students may be interested in pursuing such activities once they are licensed.**
If your State is a CHIPRA quality demonstration grantee, describe how you are coordinating activities with those being undertaken under the CHIPRA demonstration.	NA
Changing or increasing reimbursement rates or approaches	No current plans to increase rates. A legal challenge to a Legislative proposal to reduce payments by 10%, retroactive to June 1, 2011, was recently decided in DHCS's favor by the Ninth Circuit Court of Appeals and it is anticipated that this reduction will be implemented shortly. **DHCS is considering a proposal for a risk-stratified caries management demonstration project that would pay a fixed fee for bundled diagnostic and preventive services, market rates for basic services and discounted market rates to contracted specialists for the most expensive, catastrophic services.**

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	As described below (see medical-dental collaboration), DHCS is involved in a project that will be exploring interest in alternative reimbursement models that emphasize preventive services for younger children and/or those who have not had a dental visit in the past 12 months, which could include a model encompassing a global capitation rate for medical and dental services. DHCS has also had several exploratory meetings with Dr. Paul Glassman at the University of the Pacific School of Dentistry to discuss a new model of dental care delivery ("Virtual Dental Home") that involves providing preventive and temporizing care in community settings (e.g., schools, Head Start centers, nursing facilities) without the need for a dentist on site, using teledentistry. Recent legislation enacted in California encourages the use of telehealth technology, including teledentistry, to provide services to Medi-Cal beneficiaries. Additionally, two bills have been introduced that would require Medi-Cal to pay for "store and forward" costs associated with teledentistry. **MDSD is currently considering what new Denti-Cal policies and procedures need to be developed to accommodate this technology.** For example, current law requires Medi-Cal to provide a facility and transmission fee to the originating telehealth site. However, Denti-Cal does not have a mechanism to allow dental providers to claim these fees. **DHCS plans to address this parity issue between medical and dental services in Medi-Cal.**
Other: Enrollment of Registered Dental Hygienists as Denti-Cal billing providers.	Currently, the only dental hygienists who can be enrolled as Denti-Cal billing providers are Registered Dental Hygienists in Alternative Practice (RDHAPs). However, California law allows Registered Dental Hygienists (RDHs) to provide preventive dental services unsupervised in public health programs. Consequently, **DHCS is in the process of establishing a mechanism to enroll RDHs and allow them to be billing providers for preventive services provided in public health programs such as WIC and Head Start centers, schools and child care settings.** This is expected to increase the number of children receiving preventive services.
Other: Development of Dental Dashboard	**Work is underway, with completion scheduled for November 2013, on development of an interactive performance measurement dashboard that will allow staff to access**

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	dental data on eligibility, utilization and expenditures through an interactive business intelligence tool. This tool will allow these data to be analyzed from multiple perspectives, e.g., by age group, race/ethnicity, aid code category, county, scope of coverage, length of eligibility, FFS vs. managed care, and procedure category. This will allow the Department to much more effectively address questions about the program, identify issues and specific populations that need to be improved and then use this information to continuously work toward program improvements.
Other: Deployment of GIS mapping software	**DHCS has purchased GIS software and will be arranging for staff training that will enable mapping by county or ZIP code any of the data derived from the Dental Dashboard described above. In addition, this software will be used to analyze distance and travel time to provider offices, which will add to the Department's ability to quickly identify access problems and devise solutions.**
Other: Fluoride varnish programs in Head Start centers	Approximately 80-90% of Head Start and Early Head Start children in California are either Medi-Cal eligible or are in the process of transitioning from Healthy Families (California's CHIP program) to Medi-Cal. Dental hygienists in several counties provide fluoride varnish applications to children in Head Start programs, but rarely are claims for these services submitted to the Denti-Cal program (see section above on enrollment of RDHs as Denti-Cal billing providers for one remedy being planned). California law also allows any individual, including unlicensed personnel, to provide fluoride varnish applications under the written "prescription" (i.e., protocol) of a physician or dentist. **DHCS is currently exploring the legal issues involved in arranging a Memorandum of Understanding between a Head Start agency and the Department that would allow Medi-Cal eligibility information to be provided to the Department in order for reports on dental services received by Head Start children to be reported to the Head Start agency. Once these arrangements have been worked out, DHCS would like to arrange for training of Head Start staff to provide fluoride varnish applications and be able to bill for them.** It is expected that this would capture many preventive procedures that are being provided to Head Start children but not being reported because they are not being billed.
Other: Medical-dental collaboration	**DHCS is an active participant in a demonstration project funded by the DentaQuest Foundation to Children Now aimed at testing strategies in Los Angeles County to**

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	engage with health and dental plans, and oral health care providers and primary care physicians (PCPs), to strengthen medical-dental collaboration. The project includes 1) Tracking progress made by dental plans to identify and contact Medi-Cal-enrolled children under the age of 6 in Los Angeles County who have not had a dental visit in the past 12 months (DHCS is currently exploring a mechanism to identify children in both FFS and dental managed care plans who have not had a dental visit in the past 12 months); 2) Creating a system to identify the health plan of each non-utilizing child, and relay this information to the child's health plan; 3) Working with participating health plans to identify the PCP for each non-utilizing child. and high-opportunity PCPs (those with large numbers/ percentages of non-utilizing children); 4) Coordinating with health plans to work with PCPs to provide tools and support for oral health education and referrals; and 5) Exploring interest among dental plans to design alternative reimbursement models that emphasize preventive services for younger children and/or those who have not had a dental visit in the past 12 months.
Other: Identification and follow-up of CHDP children with no dental visit in past year	The Child Health & Disability Prevention (CHDP) program is the 'EPS' component of the EPSDT program in California. Every county has a local CHDP program that is responsible for providing dental assessments as part of a comprehensive health assessment and referring children with suspected or detected dental problems to a dentist at any age. The CHDP program recommends that a child be referred to a dentist by age 1, and requires such a referral by age 3. Through the DHCS data warehouse, it should be possible to identify those children who have received a health assessment but have not had a dental visit subsequent to that assessment for any user-defined period of time. **DHCS will explore whether a template can be developed that could provide lists of those children for use by local CHDP programs to follow up with the families of those children and encourage them to see a dentist.**
Other: Enhance data capabilities	DHCS maintains a data warehouse that contains eligibility, claims and encounter data on a rolling 10-year timeframe. In the past it has been difficult to get accurate data on billing and rendering dental providers because of how claims data from Delta Dental are transmitted to and entered by the data warehouse. This has made accurate analysis of

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	provider participation problematic. **Steps have been taken in the past year to correct this problem, and resolution is expected within the next few months.** There has also been a longstanding problem with respect to the quality of managed care data in the data warehouse. **Recently DHCS launched an Encounter Data Improvement Project that is reviewing the quality of both medical and dental managed care data.** It is expected that when this project is completed the reliability of the dental managed care data should be much improved.
Other: Quality Improvement Activities	**MDSD has developed 11 performance/quality measures on which the current three dental managed care contractors in Sacramento and Los Angeles Counties are required to report.** The measures are age group-specific and baseline benchmarks have been established for each measure. Using a point system, plans can receive bonus payments for outstanding performance, and face financial sanctions for less-than-satisfactory performance. The FFS Denti-Cal program will be reporting using the same measures, but will not be subject to the same sanctions or bonuses being used with the dental managed care plans. **DHCS will also be considering using some or all of the new performance measures recently developed by the Dental Quality Alliance (DQA).** These are the only dental performance measures that have been tested for feasibility, validity and reliability. **The dental managed care plan contracts also require them to undertake two Quality Improvement Projects (QIP) each year--one to be dictated by DHCS and applicable to all plans, and the other to be plan-specific as determined by each plan (and approved by DHCS). In addition, plan contracts require the use of an External Quality Review Organization (EQRO) to monitor and validate the QIPs, as well as validate all performance measure data submitted by the plans. Finally, the contracts require plans to conduct patient satisfaction surveys based on a dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) that has been used for several years by the Healthy Families Program. The CAHPS survey results will also have to be validated by the EQRO.**
Other: Participation in Medicaid Oral Health Learning Collaborative	California is one of seven states selected to participate in a Center for Health Care Strategies (CHCS) sponsored Medicaid Oral Health Learning Collaborative that includes

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	peer-to-peer learning as well as individual and group technical assistance from national experts in oral health quality-improvement. Each state is required to develop at least one objective for each of the two CMS goals and then, using a CHCS Quality Improvement Framework and Project Planning and Measurement Tool, develop very specific plans for meeting its objectives. The first meeting of the Collaborative was held on May 20-21, 2013, and an intensive series of calls with CHCS experts and other states is planned over the next year. **The California team has selected several objectives related to the CMS goals to work on over the next four years.**

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Other Oral Health Improvement Initiatives
Has your State undertaken any initiatives within the last 5 years to increase the number of children who receive oral health or dental services? If so, please describe those activities. While there have been no DHCS-sponsored initiatives within the last 5 years specifically targeted at increasing the number of children receiving oral health/dental services, the Department has undertaken a number of activities, noted above, to try to increase provider participation and increase beneficiary demand. The Department has also been an active participant in projects led by other entities aimed at increasing children's access. These include being on the advisory committee for a project funded by the DentaQuest Foundation to California's CHIP program (known as Healthy Families) aimed at fostering medical-dental collaboration and improving access for children ages 0-6 in several Southern California counties. That project was recently taken over by Children Now, and DHCS remains an active member of that project's advisory committee, and is assisting the project in identifying children with no dental visit in the past year and making that information available to health plans so that they can encourage families they serve to take their children to the dentist. First 5 California, funded from a voter-approved tax on the sale of tobacco products, supports selected statewide initiatives and 58 county

commissions throughout the state to improve the lives of children from the prenatal period to the time they enter kindergarten. First 5 funded an Early Childhood Oral Health Initiative, launched in 2004, in recognition of the link between a child's oral health and their overall health, and the critical gap in access faced by many low-income families to preventive and treatment services based in part on provider and parent knowledge, attitudes and involvement. First Smiles, one of the Initiative's two components, was a 4-year, $7 million statewide education and training program conducted in 2004-2008 and co-administered by the California Dental Association Foundation (CDAF) and the Dental Health Foundation (DHF--now the Center for Oral Health). First Smiles' goal was to deliver provider education and training targeted to medical and dental professionals, and consumer education targeted to community-based organizations such as WIC and Head Start that have significant early interaction with parents and other caregivers of children 0-5.
What impact did those initiatives have? Do you consider those activities to have been successful? If so, please describe. First Smiles trained 15,230 California dental and medical providers (90% of the overall goal) and an additional 883 staff from community service organizations received training in children's oral health. The program drew a more diverse population of dentists and physicians in race/ethnicity, gender and years in practice compared to those professionals in active practice in California. All training participants exhibited a great deal of knowledge in most areas of the curriculum content (80% average correct posttest scores). Both dental and medical providers did least well in understanding that there is no general difference in the behavioral issues of children aged 0-5 with special needs versus all children 0-5. More than 90% of providers who took a First Smiles course reported being satisfied with the training, learning new information and skills and believing they could apply the information in their practices; 57% of dental providers and 45% of medical providers had recommended the course to a colleague 6 months later. Parents demonstrated a fair amount of knowledge (73% average correct score on posttest) after receiving education about children's oral health, and retained it 6 months later (matched sample follow-up posttest). The highest self-perceived increase in skill level for dental and medical providers was the ability to communicate with parents and provide education and anticipatory guidance. Dental providers next reported increased clinical skills in learning how to perform a knee-to-knee exam, and medical providers in assessing dental caries risk and protective factors. Medical providers maintained the same perceived level of skill increase due to the training six months later as they did right after taking the course; dental providers reported a slightly lower level at the time of follow up. Six months after the training, 16% (25 of 156) of general dentists reached at follow up said they were seeing more children aged 0-5 in their practices; close to 80% reported having the capacity to accommodate requests for appointments for this age group. Six months after the training, dental providers significantly increased the frequency of performing the following procedures: for children 0-5, application of fluoride varnish and discussion of an infant's bottle or breast feeding practices. For pregnant patients, discussion of breast feeding practices and recommendations to chew xylitol gum more often. As a result of what they learned at the course, six months later dentists increased by 8.3% and 8.7%, respectively, delegation of two procedures to other dental professionals: placing sealants and applying

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topical fluoride. 60.8% of parents had taken their child to a dentist in the last year when initially asked the question; 6 months after receiving oral health education from the program 64.1% reported doing so, an important though not statistically significant increase in utilization of dental services. See *www.cdafoundation.org/Portals/0/pdfs/**first5**_finalevalrpt.pdf* for more information.
If the activities did not achieve the results that you had expected, please describe the lessons learned. The type of training was significant for the dental providers' knowledge gain: participants did less well overall in the 2-hour than the 4-hour course. The main barriers dentists cited to taking more 0-5-year-old children were managing this age group in a dental office is difficult (e.g., crying/behavior issues) and having too-full or limited-hours practices. More staff and training for providing parent education and managing young children's behavior are what medical and dental providers said it would take to see more children aged 0-5. It was generally felt that, for both dental and medical providers, hands-on experience examining and providing fluoride varnish to crying children was a particularly important factor in their willingness and comfort in assuming these new functions. For community agency staff, an inability to integrate a new program component into the agency's programming, and inadequate time for staff to deliver oral health education to parents, were the main barriers they identified.

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Dental Data Measurement
Does your State compute or report the National Committee for Quality Assurance's (NCQA) HEDIS dental measure or a modification of it? (Dental care: percentage of members 2 through 21 years of age who had at least one dental visit during the measurement year." Web site: http://qualitymeasures.ahrq.gov/content.aspx?id=14998) If yes, describe how that data compares with the data submitted on line 12.a of the CMS-416 and/or Section III, G.1.a. of the CHIP Annual Report (Total Enrollees Receiving Any Dental Services). We have computed and reported on variations of the HEDIS Annual Dental Visit (ADV) measure, using different age groups (typically the CMS-416 age groups) and slightly different methodology (see below). When computing the ADV measure using CMS age groups and children who have been continuously eligible in the same plan for 11 or more months during the measurement year, we have consistently found higher utilization rates than those reported to CMS on the CMS-416 form. For example, for State Fiscal Year 2011-12, the utilization rate for children ages 0-20 continuously enrolled in any dental plan for 11 or more months was 50.6%, while for children enrolled for 3 or more months it was 42.9%. The likely reasons are described below. We strongly believe that the CMS method of only using 90 or more days of continuous eligibility treats children enrolled for as little as 3 months and those enrolled for as long as 12 months the same, when those children will have had an unequal opportunity to have made a dental visit. This methodology is also inconsistent with many other HEDIS measures, which are the most widely used performance measures in health care.
If the HEDIS measure result differs from the result reported on CMS-416, line 12.a, or the CHIP Annual Report, Section III, G.1.a., please explain why you think there is a difference. The CMS-416, line 12a measure is based on EPSDT children continuously eligible for at least 90 days during the Federal Fiscal Year. Age is calculated as of September 30. Children are counted once if they received any CDT-coded procedure. Children are counted regardless of whether they remained in the same dental plan during their period of eligibility. The HEDIS ADV is based on children continuously eligible for 12 months during the Calendar Year, with no more than a one-month break in eligibility. Age is calculated as of December 31. The ADV excludes several CDT codes: D5900-5999 (all Maxillofacial Prosthetics codes), D6000-D6199 (all Implant Services codes) and all Fixed Prosthodontics codes (D6200-D6999) except D6205. The ADV also includes several CPT and ICD-9 procedure codes used by medical providers. The only age group used with the ADV that is the same as an age group on the CMS-416 is the 15-18 group. Although there is no ADV requirement that children remain in the same dental plan during their period of continuous eligibility, the fact that the ADV is only used with commercial health/dental plans with a Medicaid book of business suggests that most of the children reported would have been in the same plan for the reporting period.

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If you use a modification of the HEDIS measure, please describe the modification. For the past couple of years, we typically have been reporting to the public using a HEDIS-like methodology, based on children continuously enrolled in the same plan for 11 or more months during the reporting year, with no break in eligibility. We have reported using both Calendar Year and State Fiscal Year (July-June), depending on the request and the audience. We have typically reported based on children receiving any CDT code, i.e., we have not excluded the CDT codes excluded by the ADV definition. We also have excluded the CPT and ICD-9 procedure codes included in the ADV specifications. We have typically reported using the CMS-416 age groups rather than the ADV age groups, and age has been reported as the child's oldest age during the reporting period. We recently gained the ability to report based on a more HEDIS-like measure of length of eligibility, i.e., any 11 months of eligibility during a 12-month reporting period, rather than 11 continuous months.

Reimbursement Strategies: What are your current reimbursement rates for the following 10 procedures for services provided to children eligible for Medicaid and CHIP? Please describe any increases or decreases in these reimbursement rates that have occurred in the last five years.
For more than a decade, there have been numerous proposals on the part of the Administration to reduce reimbursement rates to dental providers. Often these proposals have resulted in lawsuits which typically have resulted in rejection of rate reductions. In February 2008, legislation was enacted that would have cut $1.3 billion from the Medi-Cal program, including a 10% cut in Denti-Cal payments, effective July 1, 2008, for the Fiscal Year 2008-09. In May 2008, a coalition of health care providers filed a lawsuit against the State to prevent the planned cuts from taking effect. The rate cut was only in effect for about 6 weeks—until August 18—at which time the US District Court issued a preliminary injunction to stop it, a ruling appealed by the State but subsequently upheld by the US Ninth Circuit Court of Appeals. AB 1183, Statutes of 2008, enacted a 1% rate cut effective March 1, 2009, which remains in effect. All of the fees shown in the table below reflect this 1% cut. In March 2011, AB 97 was enacted, which included a 10% reduction in reimbursement for dentists, pharmacists and other Medi-Cal providers. CMS approved the rate cuts on October 27, 2011, based on documentation provided by DHCS purporting that access to care for Medi-Cal patients would not be impacted by the reduction. DHCS said the reductions would be retroactive to June 1, 2011. While the rate cut exempted hospitals and children's medical providers (on the basis that the state could not make the case that access to these entities would not be affected), it did not exempt children's dental providers. The State indicated it would take several months before the reductions could be implemented and that it would develop a plan to recoup the 10% retroactively to June 1. On November 3, 2011, the California Hospital Association filed a lawsuit against the State and the Department of Health and Human Services

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(HHS) to block the reductions, citing violation of the provisions of Medicaid law which require reimbursement rates sufficient to ensure beneficiaries have equal access to providers and services as the general public. A group of individual pharmacists filed a second suit shortly thereafter. Both sought a preliminary injunction to block implementation of the cuts until the cases could be fully considered by the courts.

On November 21, 2011, the California Dental Association (CDA) joined with the California Medical Association, the California Pharmacists Association, and the National Association of Chain Drug Stores in a lawsuit challenging the adequacy of the information provided by the State to support the rate cut approval. The suit claimed the CMS action in approving the rate cuts was arbitrary and capricious and that the providers' cost to deliver care was insufficiently considered. In addition, the suit alleged that CMS did not follow procedural requirements in reviewing the State Plan Amendment and applied a wrong legal standard. It also cited violation the equal access provisions of Medicaid law.

On January 30, 2012, the US District Court issued a tentative ruling to block State officials from moving forward with the rate cut. The State appealed the ruling and the case was heard on October 10, 2012 by the U.S. Ninth Circuit Court of Appeals. On December 13, 2012, the Appeals Court upheld the 10 percent rate cut. The Court said it was required to defer to the U.S. Department of Health and Human Services, which had decided previously that lowering the Medi-Cal rates was unlikely to reduce access to health care. Finally, on January 28, 2013, the California Medical Association (CMA) filed a request for an *en banc* review by the Ninth Circuit Court of Appeals to stop the State from implementing the rate cut. On May 30, 2013, the court denied that request. Accordingly, DHCS is proceeding with plans to implement the rate cut, retroactive to June 1, 2011.

In a separate lawsuit, the California Association of Rural Health Clinics and a community health center in Kings County sued DHCS and state officials over the rate cuts, alleging that the Medi-Cal changes conflict with federal law. A court order reinstated the coverage in October 2010. The State resumed payments for such services until May 2011, when it received CMS approval to eliminate coverage of benefits considered optional under Medi-Cal. DHCS then determined it had the authority to recoup payments that were made during the court-mandated period. On July 5, 2013, U.S. Ninth Circuit Court of Appeals ruled that the cuts made to Medi-Cal services for individuals in rural and other underserved areas were illegal. The ruling applies only to those beneficiaries receiving services at federally funded health centers. DHCS is currently reviewing potential next steps.

With enactment of AB 97 (see above), effective July 1, 2009, California eliminated coverage for a number of optional Medicaid services, including most adult dental services. The only adult dental services that continue to be covered are those for residents of nursing facilities, "Federally Required Adult Dental Services" (FRADS), which are primarily emergency dental services for the relief of pain, trauma and infection, and pregnancy-related dental services, which are limited to a few diagnostic, preventive and periodontal procedures, but include no restorative services. There was speculation at the time these cuts were made that children's access to dental care might suffer because of evidence in the literature suggesting that children whose parents lack Medicaid coverage are less likely to receive dental services than their counterparts whose parents have such coverage. For the most part, this does not seem to have occurred. In fact, it appears that children's

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utilization of dental services has *increased*, particularly for those ages 0-5, since the cuts were enacted. This is believed due to both private providers and dentists compensating for their loss of revenue from adults by seeing more children.

With enactment of the State's FY 2013-14 Budget, some of the adult dental benefits that had been cut will be restored, effective in May 2014. These include several diagnostic, preventive and restorative procedures; full dentures, including repairs and relines; and anterior root canals.

Current Reimbursement Rates		Current Fees (reflect 1% rate cut currently in effect)	Plans to Adjust
D0120	Periodic Oral Exam	$14.85	See above
D0140	Limited Oral Evaluation, problem focused	$34.65	See above
D0150	Comprehensive Oral Exam	$24.75	See above
D0210	Complete X-rays with Bitewings	$39.60	See above
D0272	Bitewing X-rays – 2 films	$9.90	See above
D0330	Panoramic X-ray film	$24.75	See above
D1120	Prophylaxis (cleaning)	$29.70	See above
D1203	Topical Fluoride (excluding cleaning) [Ages 0-5/6-20]	$17.82/$7.92	See above
D1206	Topical Fluoride Varnish [Ages 0-5/6-20]	$17.82/$7.92	See above
D1351	Dental Sealant	$21.78	See above

Efforts Related to Dental Sealants

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Assessment of Current School-based, School-linked, Head Start or Early Childhood Dental Programs	Comment:
Do you encourage or plan to encourage dental providers in your State to provide dental sealants?	Yes _x__ No ____
If yes, how do you communicate that information to providers?	Comment: **DHCS plans to issue a Provider Bulletin to promote increased use of sealants, citing the evidence-based literature supporting their use. This will be coordinated with promotional efforts by the State's Child Health and Disability Prevention (CHDP) program (considered the 'EPS' component of the EPSDT program) and Maternal, Child and Adolescent Health (MCAH) program.** Also, sealants are one of the preventive procedures that dental hygienists can provide in public health programs without supervision. See description elsewhere in this Plan regarding plans to enroll hygienists as Denti-Cal billing providers and to promote this to dental hygiene schools. **MDSD will establish policy allowing RDHs to become Denti-Cal billing providers for preventive services provided in public health programs and will work with California Dental Hygienists' Association and local dental hygiene societies to promote.** **MDSD will encourage school-based health centers to provide and bill for sealants, and will work with California Association of School-Based Health Centers to promote.** **MDSD will meet with the California Dental Association and local dental societies, California Society of Pediatric Dentistry, California Dental Hygienists' Association and local dental hygiene societies to develop sealant promotion strategies/outreach activities relevant to each provider group aimed at increasing dental provider participation.**

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	MDSD will meet with the California Department of Education, California Association of School-Based Health Centers, State and local MCAH and CHDP programs, Oral Health Access Council and local oral health coalitions to develop sealant promotion strategies/outreach activities relevant to each non-dental office setting aimed at increasing the delivery of sealants in non-dental office settings. **MDSD will meet with Medi-Cal dental managed care plans to discuss ideas for Quality Improvement Projects aimed at increasing the number of children who receive sealants in non-dental office settings.**
Have you seen an increase in the number of children receiving sealants over the last year or years? If yes, please explain.	Yes _x__ No ____ Comment: The number of children ages 0-20 enrolled in any plan for 11 or more months of the year who received at least one sealant increased from 215,126 in FY08-09 to 281,562 in FY11-12, a 30.9% increase. As a percentage of the eligible population, the utilization rate increased from 7.95% to 8.94%, a 12.5% increase. The specific reason(s) for the increase in utilization rate are unknown, but might be due to better understanding of sealants by dental providers, promotion and an evidence-based review by the American Dental Association, and promotion by children's advocacy organizations.
Does your state support school-based or school-linked dental sealant programs?	Yes ____ No _x__ There used to be a school-based sealant component in the California Children's Dental Disease Prevention Program administered by the California Department of Public Health (CDPH), but funding for this program was suspended effective July 1, 2009 as a result of the State's fiscal situation. Although there is currently no financial support from either DHCS or CDPH for school-based sealant programs, there are a number of School-Based

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	Health Centers (SBHCs) in California that provide dental services, including sealants.
If yes, how many Medicaid or CHIP enrolled children were served by these programs in the past year? Are you continuing to see increases in the number of children served by these programs?	# NA Comment:
How many sealants were placed in these programs in the past year?	# NA
Has funding from the Centers for Disease Control and Prevention (for oral health infrastructure development) contributed to these efforts? Please describe.	Yes ____ No _x___ Comment: NA

Collaboration with Dental Schools or Dental Hygiene Schools
Do you have a dental school or dental hygiene program in your State? If yes, do you have any arrangement with the dental school or dental hygiene program to treat Medicaid beneficiaries, serve in rural areas, provide educational opportunities, etc.? Please describe. There are six ADA accredited dental schools in California. All six are enrolled providers for Denti-Cal beneficiaries, and have programs that provide onsite prior authorization, which is monitored by the Medi-Cal Dental Services Division (MDSD). Together, the six dental schools provided 29,523 services to 4,867 Medicaid children under 21 between February 1, 2012 and January 31, 2013. In addition, the University of California and the University of the Pacific Schools of Dentistry have pilot programs in CAMBRA (Caries Management by Risk Assessment) for Medi-Cal beneficiaries, also monitored by MDSD. There are 29 entry-level dental hygiene programs in the State. Numerous dental, dental hygiene, and dental assistant programs independently provide outreach activities throughout the State.

Plans to Expand Dental School or Dental Hygiene Program Collaboration

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Describe any plans to initiate or expand collaboration with dental school or dental hygiene program?
See Collaboration with dental schools and dental hygiene programs above.

Electronic Dental Records
Describe the use of electronic dental records by providers in your State for the Medicaid and CHIP populations. Estimate the percentage of dental providers using electronic dental records. Is the dental record integrated with the medical record? How is the State supporting dental provider efforts to qualify for meaningful use incentive payments? There is no current source of information on the use of electronic dental records by dental providers. However, a survey conducted in 2010 by Edge Research entitled "Health Information Technology in California Dental Practices" stated that "Only 23% of California dentists say they have fully implemented an EDHR system in their practice" (http://www.chcf.org/publications/2010/08/health-information-technology-in-california-dental-practices-survey-findings). No information is available on the extent to which medical and dental records are integrated, but the likelihood is that this is a rare occurrence. The Department of Health Care Services has a website to provide assistance to providers interested in participating in the Medi-Cal EHR Incentive Program (http://medi-cal.ehr.ca.gov/). As of January 12, 2013, 6,412 providers, including 482 dental providers, had successfully demonstrated their ability to adopt, implement or upgrade (/A/I/U) their EHR systems and received a payment.

Technical Assistance
Indicate areas of interest or topics about which you would be interested in receiving technical assistance. Designing an algorithm for auto-assigning more members to dental managed care plans that demonstrate an increase in utilization or in the number of children who receive specific services, e.g., preventive services or sealants. Establishing evidence-based baselines for existing/new/redefined performance measures and how best to link performance to financial and other incentives/sanctions.

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Designing a value-based financing system for Medicaid dental benefits.
Other Materials or Links to Relevant Websites
If you would like to submit copies of materials or provide links to relevant websites for additional information, please do so as attachments to this template.

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