

DEPARTMENT OF HEALTH CARE SERVICES
HEALTHY FAMILIES PROGRAM TRANSITION TO MEDI-CAL
DENTAL CONTINUITY OF CARE PROVISIONS

The Department of Health Care Services (DHCS) Medi-Cal Dental program has initiated new or modified existing policies to ensure continuity of care for children transitioning from the Healthy Families Program (HFP) to Medi-Cal. Departmental Dental Operating Instruction Letters (DOIL) were sent to the dental fee-for-service fiscal intermediary, Delta Dental of California (Delta) to implement the new or changes in policy. In addition to new/changed program policies, the DHCS will conduct further transition activities to assess the transition and identify if further actions are needed. Below is information on each new or change in policy that the program is executing.

NEW/CHANGED POLICIES – DENTAL OPERATING INSTRUCTION LETTERS

DOIL 12-176 – HFP Continuity of Care

Similar to the Medi-Cal Dental program, the HFP dental plans also require providers to obtain prior authorization on certain procedures before performing and billing the program for services. In order to provide continuity of care for children transitioning from the HFP to the Denti-Cal program (the Medi-Cal fee-for-service dental program), this DOIL will instruct Delta on how to handle claims for services that have previously approved HFP prior authorizations.

Current Process:

The Denti-Cal Program requires approved prior authorization for certain services prior to treatment being performed by providers. When a provider submits a claim for payment of services performed, a system edit occurs to ensure all required prior authorizations were received and that the services are authorized by the Denti-Cal Program prior to payment. Services that did not receive the required prior authorization or are not a benefit of the Denti-Cal Program are denied for payment.

Change in Policy:

DHCS has instructed Delta to honor approved prior authorizations issued by the HFP dental plans where the services are covered by Denti-Cal and the provider bills for a Denti-Cal approved procedure. Delta has been instructed to pay claims where:

- The child has eligibility under aid code 5C, 5D, H1, H2, H3, H4, H5
- The approved prior authorization procedure with HFP; that is not a covered Denti-Cal service, has a comparable Denti-Cal procedure (regardless of material).
- The services are provided within the HFP dental plan approved authorization period.
- The services are performed by an enrolled Denti-Cal provider.
- The provider submits proof of the prior authorization by the HFP dental plan.

A provider bulletin (Volume 28, No. 17), titled *Healthy Families Program Transition: Continuing Dental Treatment of Your Healthy Families Program Beneficiaries*, was posted in the month of December on the Denti-Cal website (www.denti-cal.ca.gov) informing providers of change in policy.

DOIL 12-177 – Provider Referral Procedure Change and Improvement – Implement A “Warm” Transfer Process for Beneficiaries Requesting Provider Referral Information

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DHCS has received ongoing feedback from advocates and stakeholders that the current provider referral process for beneficiaries is ineffective.

Current Process:

When beneficiaries currently call the Denti-Cal Beneficiary Telephone Service Center (TSC) for a provider referral, they are given a list of up to three providers to contact in their area. However, it is possible that one or all of the providers referred to the beneficiary may not be valid or accepting new patients. Additionally, in many instances when the beneficiary calls the providers given to them from TSC, he/she is unable to find a provider who will provide the needed services. As a result, the beneficiary may call the TSC multiple times before he/she finds a provider that will treat him/her.

Change in Policy:

To ensure that a Denti-Cal provider is located and will treat the beneficiary, Delta was directed to implement a "warm" (conference) calling process for all beneficiaries who call the Denti-Cal Beneficiary TSC to locate a provider in their area.

When a beneficiary calls the Denti-Cal Beneficiary TSC for a provider referral, TSC will contact a provider to confirm with the provider that he/she is accepting Denti-Cal patients and can provide the services required by the beneficiary. Once this confirmation is received, TSC will conference in the provider to the beneficiary to schedule an appointment on that phone call. Delta is to research most cost effective feature to transfer (conference) these calls.

Delta is to track the number of provider referral calls on a daily basis and provide a report that shows the number of calls per day by month. The report should also list outcomes, including *Received*, *Unresolved*, and *Resolved*, on locating provider to provide the necessary services to the beneficiary. Delta is to also use manual tracking process to identify provider referral calls from beneficiaries transitioning from the HFP to Medi-Cal and to identify beneficiaries who are referred to provider office outside the 10 miles or 30 minutes time and distance standard from the address requested or is referred to a provider outside the county they requested.

In addition, Delta is to develop internal processes to identify providers listed on the referral list who are not actively accepting new patients and to document those geographical areas that are lacking providers willing to accept new patients. Delta is to incorporate this new process into the Provider Outreach Strategy submitted for approval annually.

A provider bulletin will be posted in the month of January on the Denti-Cal website (www.denti-cal.ca.gov) informing providers of change in policy.

DOIL 12-178 – Denti-Cal Provider Referral Form and Call Campaign

The Medi-Cal Dental program providers currently have access to a free referral service for accepting Denti-Cal patients. This referral service is a resource for enrolled Denti-Cal providers to build, maintain, or increase their patient base while making available the highest level of dental service to the State's medically needy. DOIL 12-181 dated November 14, 2012 instructed Delta that signatures are no longer required on the Medi-Cal Dental Patient Referral Service (Provider Referral) forms.

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Current Process:

The Provider Referral form is included in provider enrollment packets, mailed out annually, and accessed online on the Denti-Cal website. Providers mail the form to Denti-Cal to request to be added to the Provider Referral list, to be removed from the referral list, or to update their information.

Change in Policy:

DHCS instructed Delta to replace the Provider Referral form currently located on the Denti-Cal website and included as part of the provider enrollment packet with the attached revised Provider Referral form. Additionally, a signature is no longer required for the provider to be placed onto or removed from the Provider Referral list, or to update their existing information. Delta shall begin adding providers to the Provider Referral List via phone calls into the Provider Customer Service line, mail, email, and fax. Providers emailing the form will be directed to send the form to a specified departmental email address.

Delta was instructed to call the providers to capture any additional information needed to complete the revised Provider Referral form and notify the provider once he/she has been added to the Provider Referral List.

A provider bulletin will be posted in the month of January on the Denti-Cal website (www.denti-cal.ca.gov) informing providers of change in policy.

DOIL 12-181 – Denti-Cal Provider Referral List

The Medi-Cal Dental Program providers currently have access to a free referral service for accepting Denti-Cal patients. This referral service is a resource for enrolled Denti-Cal providers to build, maintain, or increase their patient base while making available the highest level of dental service to the State's medically needy.

Current Process:

Providers cannot be added to or deleted from the Provider Referral list, or update their existing information without a signed Referral form.

Change in Policy:

DHCS instructed Delta that signatures are no longer required on the Medi-Cal Dental Patient Referral Service (Provider Referral) forms. Effective immediately, DHCS instructs Delta Provider Outreach staff to identify and add all active Denti-Cal billing providers to the Provider Referral List who stated in the Provider Survey that they want to be added to the list.

DHCS instructed Delta to input the below information, gathered from the survey, and update the Provider Master File (PMF) in CD-MMIS:

1. Provider Referral
2. Wheelchair Accessible
3. Special Needs
4. Specialist

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If the survey results do not have data to complete all fields in the PMF when adding the provider to the referral list, Delta is instructed to leave those field(s) blank in the PMF.

DOIL 12-183 – Medi-Cal Dental Provider Enrollment Transformations – Preferred Provisional Provider Status and Changing Effective Dates to Date an Application Is Received

The Welfare and Institutions (W&I) Code Section 14043.26(d) allows providers who meet the criteria identified in that section to be considered within 60 days for enrollment in the Medi-Cal program as preferred provisional providers. Based upon the authority granted to the director of the DHCS in W&I Code Section 14043.75(b), the director has established the procedures described in the Instructions section of this DOIL. The described procedures below must be followed for a provider to request enrollment in the Medi-Cal Dental program as a preferred provisional provider.

In order to align Delta's enrollment process with that of DHCS, Provider Enrollment Division (PED), this DOIL is to reform the current effective date of enrollment for providers to the date in which Delta initially received the enrollment application package.

Current Process:

Delta currently validates the enrollment of providers through an initial, manual credentialing process for new Denti-Cal enrollment applications. Delta does not currently perform any credentialing for the preferred provisional provider status as specified in the Instructions section of this DOIL.

Also, the effective date of enrollment for an applicant being credentialed through Denti-Cal is the date the credentialing analyst determines that the application has been thoroughly reviewed and qualifies under the requirements articulated by law. Delta does not currently input an effective date which reflects the date the application was received.

Change in Policy:

All providers applying under preferred provisional provider status shall be processed and notified of Denti-Cal's decision within 30 days of the receipt of the application. The effective date of enrollment will be granted to qualified providers, as defined by the specifications below, with the date the provider's application is received. Providers currently in Denti-Cal's enrollment inventory who wish to invoke the preferred provisional provider status must submit the cover letter certifying the four criteria.

Delta shall report the status of providers applying under the preferred provisional provider status to DHCS upon request. A provider bulletin, titled *Medi-Cal Dental Provider Enrollment: Preferred Provisional Provider Status*, will be posted in the month of December on the Denti-Cal website (www.denti-cal.ca.gov) informing providers of change in policy.

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OTHER DENTI-CAL TRANSITION ACTIVITIES

BENEFICIARY SATISFACTION SURVEYS

Once a child transitions, it is important that Denti-Cal assess why they have or have not accessed services and were they satisfied with their services. To accomplish this, a survey will be sent to all transitioned children to determine reasons for utilization of dental services, how to educate families on accessing dental services, and what common issues or barriers families/children may face when accessing dental services. This survey will be developed in collaboration with stakeholders. A workgroup has been established to begin developing the survey, messaging, and timing of the survey.

DENTAL MANAGED CARE

Included in the contracts between DHCS and the dental managed care plans are requirements for the dental plans to ensure continuity of care for beneficiaries transitioning from the HFP to Medi-Cal. The requirements include:

- Dental managed care plans will provide children who are transitioning from the HFP to Medi-Cal continued access to their current Primary Care Dentist if the Primary Care Dentist is a contracted provider in the dental plan's Medi-Cal provider network. The dental plans will also provide continued access if the Primary Care Dentist is not within the dental plans' Medi-Cal provider network, if the nonparticipating provider agrees in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services and who are practicing in the same or a similar geographical area as the nonparticipating provider, including, but not limited to, payment for services, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.
- Dental managed care plans will provide for the completion of covered services for the treatment of certain specified conditions if: (a) the services were being provided by a provider that is within the dental plan's Medi-Cal provider network at the time of the transition, or (b) the covered services were being provided by a nonparticipating provider who agrees to comply with the plan's contractual terms and conditions. Beneficiaries are entitled to continuation of services from such providers for the following circumstances and timeframes:
 - a. An acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration).
 - b. A serious chronic condition. Completion of covered services under this paragraph shall not exceed 12 months from the transition date or 12 months from the effective date of coverage for a newly covered beneficiary.
 - c. Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the transition date or within 180 days of the effective date of coverage for a newly covered beneficiary.

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- Dental managed care plans will develop care plans on how beneficiaries will continue to receive services which they had been receiving at the time of transition, if the beneficiaries that transition into Medi-Cal are not able to remain with their Primary Care Dentists. The dental plans will report this care plan to the Department to show continuity of care is being provided and the outcome of the dental plan's care plan.