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State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

DATE: June 15, 2018
TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS
SUBJECT: APL 18-007: REQUIREMENTS FOR ORAL HEALTH ASSESSMENTS

PURPOSE:

The purpose of this Dental All Plan Letter (APL) is for the Department of Health Care Services (DHCS) to provide Medi-Cal Dental Managed Care (DMC) plans with instructions regarding requirements to conduct an initial screening of each new member using an Oral Health Information Form (OHIF).

This APL also provides DMC plans with instructions regarding the requirement to submit an initial screening policy, including the plan-specific OHIF to DHCS for review and approval no later than July 13, 2018, and implement the policy by August 13, 2018.

Lastly, this APL establishes a definition for members with Special Health Care Needs (SHCN) to assist DMC plans in identifying members with SHCN for the purpose of conducting assessments and developing treatment plans.

BACKGROUND:

Currently, DHCS Contract, Exhibit A, Attachment 13, requires DMC plans to provide dental case management to each member. Effective July 1, 2017, Title 42 CFR §438.208(b) incorporated additional requirements for the delivery of care and coordination of services for all members. To demonstrate alignment with these federal requirements, DHCS will be amending the DMC contracts to ensure DMC plans:

1. Conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful¹; and
2. Share with DHCS or other managed care plans serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities.²

¹ Title 42 CFR §438.208(b)(3)

² Title 42 CFR §438.208(b)(4)

In addition, Title 42 CFR §438.208(c) addresses specific services for members with SHCN. The following federal requirements remain unchanged as DMC plans are currently required to:

1. Implement mechanisms to comprehensively assess members identified as having SHCN to identify any ongoing special conditions that require a course of treatment or regular care monitoring³; and
2. Produce a member-specific treatment or service plan for those members that are determined through assessment to need a course of treatment or regular monitoring.⁴

POLICY:

Initial Written Screening for All New Members

DMC plans must develop and implement an OHIF to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members.

DHCS requires DMC plans to send an OHIF to all newly enrolled members using a DHCS-approved form. Please refer to the attached enclosure for the sample OHIF that should be used as a baseline template. DMC plans should customize the form based on the individualized needs of its member population and ensure that the updated information on the OHIF is provided at or below a sixth (6th) grade reading level, as required by DHCS Contract, Exhibit A, Attachment 14.D.3.

In addition, each DMC plan must submit to the Department an initial screening policy that includes the following:

1. The plan's process for sending an OHIF to each new member, including a pre-paid envelope for mailing back the completed form;
2. The plan's process for ensuring that within 90 days of each new member's date of enrollment, at least two telephone call attempts are made and documented to remind new members to return the OHIF, if it has not been returned;
3. The plan's process for utilizing information obtained from the completed OHIF to complete an initial screening of each new member's needs; and
4. The process for sharing with DHCS, and any other Medi-Cal Managed Care or DMC plans serving the member, the results of any identification and assessment of that member's needs to prevent duplication of activities.

³ Title 42 CFR §438.208(c)(2)

⁴ Title 42 CFR §438.208(c)(3)

Members with SHCN

DMC plans are currently required to identify and assess members with SHCN and produce a treatment or service plan for those members that are determined through assessment to need a course of treatment or regular monitoring. However, the term SHCN was not previously defined. Therefore, for additional clarification, DHCS establishes the following definition of members with SHCN:

Members who have, or are at, an increased risk for a chronic physical, behavioral, developmental, or emotional condition and who also require health or related services of a type or amount beyond that required by members generally.

DMC plans are advised to revisit existing policies and procedures to ensure conformity and compliance with the above definition and Title 42 CFR §438.208(c) requirements.

REQUIREMENTS:

By July 13, 2018, each DMC plan must submit an initial screening policy, including the plan-specific OHIF, to DHCS for review and approval. The initial screening policy and plan-specific OHIF must be consistent with the DHCS policy described above. Each DMC plan must implement the policy by August 13, 2018. DMC plans must submit to DHCS any changes to their initial screening policy within ten (10) calendar days of any changes, and annually no later than thirty (30) calendar days after the beginning of every calendar year.

If you have any questions, please contact dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by:

Alani C. Jackson, MPA
Chief, Medi-Cal Dental Services Division
Department of Health Care Services

Enclosure

Medi-Cal Oral Health Information Form

You are receiving this form because you are eligible to enroll in a new Medi-Cal Dental Managed Care plan. Your new plan will use this form to make sure you get the appropriate level of care.

Please use a black or blue pen to answer the following questions. Complete one form for each person in your family who is enrolling in a new Dental Managed Care plan.

If you have questions, please call [plan name], toll free at 1-800-xxx-xxxx

Monday through Friday, between 8:00 a.m. and 5:00 p.m. TDD/TTY users should dial 1-800-xxx-xxxx.

Please return completed form to:
[DMC plan name and address.]

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Name of Person Completing Form: _____

Name of Person Enrolling in [plan name]: _____

Date of birth: __ __ / __ __ / __ __ __ __

- | | | |
|--|-----|----|
| 1. Has it been more than 12 months since your last dental visit? | Yes | No |
| 2. Do you have pain when eating cold, hot, or sugary foods? | Yes | No |
| 3. Do you have a broken tooth or teeth? | Yes | No |
| 4. Is your mouth dry? | Yes | No |
| 5. Do your gums bleed when you brush or floss? | Yes | No |
| 6. Have you had any gum (periodontal) treatments? | Yes | No |
| <i>If applicable:</i> | | |
| 7. Do you wear dentures or partials? | Yes | No |
| 8. Are you currently receiving radiation or chemotherapy? | Yes | No |
| 9. Are you pregnant? | Yes | No |
| 10. Do you see a doctor regularly for a chronic medical condition? | Yes | No |

If Yes, circle/fill in all that apply:

Cancer Diabetes Kidney Disease Other _____

Return this form to your Dental Managed Care plan.

I understand that this information will be disclosed to my new dental plan.

Signature: _____ Date Signed: __ __ / __ __ / __ __ __ __

If not signed by beneficiary, specify relationship: Parent of minor Guardian Other representative

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