JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

ADVOCATE'S GUIDE

Oral Health for Older Adults in California

UPDATED APRIL 2025

Tiffany Huyenh-Cho, Director, California Medicare and Medicaid Advocacy

Samantha Morales, Senior Policy Advocate

ABOUT THIS GUIDE

This guide is designed for advocates and individuals who provide assistance to low-income older adults and people with disabilities to better connect their clients to quality oral health care. The first portion of this guide focuses on why oral health matters and provides a summary of the current state of oral health for older adults in California. The second portion of this guide provides an overview of health insurance coverage options for oral health including a detailed summary of the Medi-Cal Dental program. The third portion of this guide reviews unique barriers encountered by certain sub-populations of older adults, including individuals dually enrolled in Medicare and Medi-Cal and individuals residing in institutional settings like nursing facilities. The guide ends with an overview of treatment alternatives for people who do not have health insurance. We also have included resources and supplemental materials in the Appendices to assist with advocacy.

Justice in Aging strives to make the information in this guide as accurate as possible as of the publication date (April 2025). However, programs serving this population are always evolving. To get the most up-to-date information on oral health for older adults, to sign up for alerts, and to learn about Justice in Aging webinars and other trainings, please visit our website at justiceinaging.org or send us an email at info@justiceinaging.org.

Justice in Aging

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the

courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income enrollees and populations who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency. Justice in Aging provides technical assistance and advice to advocates, but cannot represent individuals in their claims for benefits.

Acknowledgments

The guide is funded in part by grants from Cal Wellness and the Delta Dental Foundation. We would also like to thank our colleagues at the Center for Medicare Advocacy and Neighborhood Legal Services for their significant contributions to the original guide published in 2018.

TABLE OF CONTENTS

About This Guide 1

Justice in Aging 1

Acknowledgments 2

Introduction: Why Oral Health Matters 5

California and National Perspectives: The State of Oral Health for Older Adults 5

The Impact of Poor Dental Care on the Health of Older Adults 6

Dental Insurance Coverage for Older Adults 6

Original Medicare 6

Medicare Statute Excludes Routine Dental Care 7

Exception: Medicare Covers Dental Care "Inextricably Linked" to Other Covered Services 7

Federal Advocacy to Expand Oral Health Coverage in Medicare 8

Medicare Advantage 8

Medi-Cal Dental 9

Medi-Cal Basics 9

Medi-Cal Dental Overview 9

Medi-Cal Dental Delivery System 9

Medi-Cal Dental Covered Benefits 11

Medi-Cal Dental Coverage Limitations 12

Accessing Medi-Cal Dental 13

Billing Prohibitions 16

Medi-Cal Dental Appeals and Grievances 17

Integration and Medi-Cal Dental 18

Program of All-Inclusive Care for the Elderly (PACE) 18

Commercial Plans & Dental Savings Plans 19

Commercial Plans 19

Dental Savings/Discount Plans 19

Special Populations 19
Dual Eligible Medicare and Medicaid Enrollees 19
Medicare Advantage or other Dental Coverage + Medi-Cal Dental 20
Medicare-Medicaid Plans 21
Nursing Facility Residents 22
Access to Services 22
Oral Hygiene 23
Lost Dentures 23
Residential Care Facilities for the Elderly 24
Residents of Intermediate Care Facilities for the Developmentally Disabled 24
Other Oral Health Treatment Options 24
Federally Qualified Health Clinics – Community Clinics 24
Veterans Affairs 25
Dental Schools 25
Pop-Up Clinics 25
Conclusion 25
Appendix A – Resources 26
Consumer Assistance Resources 26
Written Resources 26
State Agencies 27
Coalitions and Federal Resources 27
Dental Schools 27
Appendix B – Medi-Cal Dental Reason for Action Codes 28
Endnotes 31

INTRODUCTION: WHY ORAL HEALTH MATTERS

Oral health is an essential aspect of overall health for people of all ages, but especially for older adults whose oral health conditions compound over the lifetime and place them at increased risk for many oral diseases, including tooth decay, dental root decay, gum disease, and oral cancer.[1] Similar to older adults across the country, older adults in California experience significant challenges when attempting to access oral healthcare.

California and National Perspectives: The State of Oral Health for Older Adults

The state of oral health for older adults in California is notably poor. Nearly one third of adults 65 and over have lost six or more permanent teeth, and nearly nine percent of older adults aged 65-74 have complete tooth loss.[2] Tooth loss in nursing facilities is regrettably much higher. Over one third of nursing facility residents in California report complete tooth loss and one-third of that group do not have any dentures.[3] In fact, the oral health of individuals residing in California's skilled nursing facilities is significantly poorer than those living in the community on all measures including untreated decay, ability to chew, and gum health.[4] Similarly, individuals with disabilities, particularly individuals with developmental disabilities, experience poorer oral health and barriers to treatment than people without disabilities.[5]

DATA NOTE

Unfortunately, most of the California-specific data available on the status of oral health across populations is more than ten years old and many measures are not available for older adults age 65 and over. This is an area in need of ongoing advocacy. Most California counties have received funding from the Department of Public Health to improve oral health at the local level.[6] Accordingly, counties have drafted strategic plans that will include the collection of oral health data. In 2019, the California Department of Public Health Office of Oral Health published the California Oral Health Surveillance Plan 2019-2023 (CA OH Surveillance Plan) to provide a strategic approach for the development and implementation of California's first oral health surveillance system.[7]

It is important that advocates for older adults continue to work at both the state and county levels to ensure that the needs of older adults are represented, including the need for data collection specific to older adults. To get engaged, contact the Department of Public Health's Oral Health Program.

While intersectional data on oral health outcomes based on age and race is not available in California, national data reveals stark disparities. For example, nationwide, 17% of older adults have no remaining natural teeth. While that rate has been steadily decreasing in recent years, the proportion of Black older adults with complete tooth loss is about 30%—almost double the national average—with minimal change over the past decade.[8] National data also shows that Black, American Indian, Alaska Natives (AI/AN), and Mexican-American older adults all have higher rates of untreated tooth decay and tooth loss, as well as poorer access to preventive services than white older adults.[9]

National data for nursing facilities also shows oral healthcare disparities are wider for lower income, rural and residents of color as compared to white residents. For example, AI/AN residents were 34% more likely and Black residents 16% more likely to have no natural teeth compared to white residents. Residents in rural nursing facilities are 70% more likely to experience dental problems than residents of urban nursing facilities.[10]

The Impact of Poor Dental Care on the Health of Older Adults

There is agreement among dental experts that poor oral health has a substantial impact on the general health of older adults. Tooth decay and associated mouth pain lead to weight loss and poor nutrition, and exacerbate chronic conditions like diabetes and heart disease–conditions that individuals are more likely to acquire later in life.[11] Poor oral health also leads to increased infections, which research associates with higher risk for heart and lung disease, experiencing a stroke, having diabetic complications, and can result in aspiration pneumonia, followed by hospitalization and death – particularly among nursing facility residents.[12] [13] [14] Further, for older adults with weakened immune systems, oral infections can become chronic.[15]

Most recently, oral health has been linked to Alzheimer's and dementia.[16] Research shows that poor oral health increases the risk of developing dementia and, conversely, individuals with dementia are more likely to have poor oral health.[17]

Poor oral health care also has a significant impact on overall quality of life. For example, mouth pain disrupts sleep, increasing the likelihood for depression and insomnia.[18] Ongoing pain associated with untreated oral health disease increases the likelihood that opioids will be prescribed and the chance of abuse.[19]

Communities of color and those living in poverty are also about twice as likely as the general older adult population to report that poor oral health negatively impacts their satisfaction with life.[20] They report to a greater extent oral pain, food avoidance, and self-consciousness or embarrassment because of their mouth, teeth, or dentures.[21]

> Oral health and overall health are linked. **When the body is healthy, the mouth is more likely to be healthy, too.** And, vice versa.

As more older adults get back into the workforce,[22] poor oral health can significantly interfere with both the ability to secure employment and maintain it. A quarter of Californians report that the appearance of their mouth and teeth affect their ability to interview for a job.[23] Nationally, employed adults lose more than 164 million hours of work annually due to dental disease or dental visits.[24]

With such significant health, social, and economic impact, the need to address barriers to oral health care is essential. This guide provides tools for advocates to connect older adults to oral health coverage and care, and presents opportunities for advocates to engage in systemic advocacy.

DENTAL INSURANCE COVERAGE FOR OLDER ADULTS

Original Medicare

This section describes oral health coverage for individuals who have Original Medicare without Medi-Cal coverage. To review how oral health coverage works for individuals enrolled in Medicare and Medi-Cal, known as Dually Eligible individuals, see page 19.

Medicare Statute Excludes Routine Dental Care

Medicare is a federal health insurance program that is the primary source of coverage for adults age 65 and over and for certain individuals with disabilities under age 65.[25] Original Medicare, unfortunately, does not cover most dental treatment. Under the law, dental services "in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth" are specifically excluded from Medicare coverage.[26] Accordingly, routine dental care like preventive or restorative dental services will not be covered by Medicare, except in very limited circumstances as described below.

Exception: Medicare Covers Dental Care "Inextricably Linked" to Other Covered Services

Under the Medicare statute, dental coverage is allowable under a narrow exception when dental services are needed to treat an underlying medical condition.[27] Starting in 2022 and every year thereafter, the Centers for Medicare & Medicaid Services (CMS) has released guidance clarifying this exception and when it applies.[28] For example, the new guidance makes clear that Medicare will pay for dental examinations and needed dental services to treat Medicare-covered organ transplant, head and neck cancer, cancer prior to or during chemotherapy, cardiac valve replacement, or valvuloplasty procedure, and allows these services to be rendered in an inpatient setting covered under Medicare Part A and an outpatient setting paid under Medicare Part B.[29]

Most recently, under the Physician Fee Schedule final rule for 2025, CMS clarified that Medicare payment can be made for dental services that are inextricably linked to Medicare covered dialysis services for the treatment of end-stage renal disease. Covered services include dental or oral examinations received on an in-patient or out-patient basis, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection.[30]

While the exception remains narrow, the clarifying guidance will help Medicare enrollees with complex health care needs obtain medically necessary dental services that are "[...] inextricably linked and substantially related and integral to the clinical success of other covered medical services."[31]

Since the guidance of Medicare's limited coverage of medically necessary dental services is new, CMS and providers in the medical and oral health space continue to work on implementation. Justice in Aging will provide ongoing education on this coverage as we learn more. See also the discussion below on oral health coverage for people dually eligible for Medicare and Medi-Cal.

EXAMPLE: MEDICARE AND "INEXTRICABLY LINKED" DENTAL COVERAGE

Ms. Smith has been diagnosed with cancer and is set to begin chemotherapy. However, because of an infected tooth, her oncologist has informed her that they cannot begin chemotherapy because it compromises her immunity, putting her at risk of even greater infection. Under the new guidance, Medicare will pay for treatment of the infected tooth through a root canal or extraction in order for Ms. Smith to start chemotherapy. However, any additional dental services, such as a dental implant or crown to replace the removed tooth, would not be considered "immediately necessary" to eliminate the infection prior to starting chemotherapy. As such, an implant or crown would not be inextricably linked and integral to the clinical success of treating Ms. Smith's cancer, and therefore would not be covered by Medicare.[32]

Federal Advocacy to Expand Oral Health Coverage in Medicare

CMS Administrative Advocacy

Justice in Aging is part of a broad coalition of oral health advocates and providers known as the Consortium for Medically Necessary Oral Health Care continuing the work to further clarify when Medicare will cover dental treatment that is "inextricably linked and substantially related and integral to the clinical success of other covered medical services."[33] The Consortium is advocating for CMS to consider the incorporation of additional chronic conditions including diabetes and various autoimmune diseases as eligible for Medicare coverage of medically necessary oral and dental treatment services. For more information, visit the Consortium for Medically Necessary Oral Health Coverage.

Legislative Advocacy

There is a national campaign underway to add dental services to those benefits covered under Medicare Part B. Justice in Aging as well as a number of other national consumer organizations such as Families USA, Center for Medicare Advocacy, and AARP and oral health organizations such as CareQuest, have been engaged in this effort. For more information, visit the Oral Health section of Justice in Aging's website. You can also join the Oral Health Progress and Equity Network ("OPEN") to get engaged.

Medicare Advantage

This section describes oral health coverage for individuals who have chosen a Medicare Advantage plan, and who do not also have Medi-Cal coverage. To find out how coverage works for dually eligible individuals enrolled in Medicare and Medi-Cal, see page 19.

Medicare Advantage (MA) plans, also known as Medicare Part C, are managed care plans that contract with CMS to provide hospital, outpatient, and other health care services to Medicare enrollees who have decided to receive their Medicare benefits via these health plans rather than through Original Medicare.[34] Many Medicare enrollees join MA plans in order to reduce their out-of-pocket medical expenses and to obtain benefits not covered by Original Medicare, such as dental care.[35]

MA plan members must use the plan for all their medical needs and follow the plan's rules, including network provider rules, except in certain circumstances such as emergency and urgent care situations.[36] In most cases, if members use a provider outside the plan's network, including dental providers, without plan authorization, they will have to pay a higher co-payment or the full cost of the service.[37]

Most MA plans offer dental benefits – as of 2021, 94% of individuals enrolled in an MA plan had some form of dental coverage.[38] However, the scope of dental care covered by these plans varies widely from plan to plan. Most plans (86%) offer extensive coverage, while some (14%) cover only routine examinations and cleanings. MA plans, like other forms of dental coverage, also often impose limits on the frequency of a covered dental care (e.g. one cleaning per year; or one set of dentures once every five years).[39]

Costs for dental coverage also vary. While few plans overall (10%) charge a premium for dental coverage, most plans have significant cost sharing, particularly for more costly dental services. For example, for restorative services, most plans pay just 50% of the covered service, leaving the member responsible for the remaining 50%. It is also common for plans to limit the total amount they will pay for dental care in a given year – called the "maximum benefit amount."[40]

ADVOCACY TIP

If the primary reason an individual wants to join an MA plan is to obtain dental coverage, it is important to carefully compare different plans on coverage and cost. For individuals who take prescription medications or have multiple providers that they would like to continue seeing, it is also important to consider MA plan provider networks and the plan's list of covered drugs, also known as the formulary.[41] The Health Insurance Counseling Assistance Program (HICAP) in California provides free and objective Medicare counseling. A HICAP counselor can help individuals compare different MA plans and their dental offerings. To reach your local HICAP, call 1-800-434-0222, or California Department of Aging Medicare Counseling.

Medi-Cal Dental

Medi-Cal Basics

The primary source of dental coverage for low-income older adults in California is through Medi-Cal. The Medi-Cal program is primarily administered by the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC) also has oversight of Medi-Cal managed care health plans. Most older adults (age 65 and over) and people with disabilities (including blindness) are eligible for Medi-Cal under the Aged, Blind, or Disabled Program if they have countable income at or less than 138% of the Federal Poverty Level ($1801/mo. for an individual in 2025; $2,433 for a couple).[42]

Older adults may also qualify for Medi-Cal through programs that have higher income limits, including the 250% working disabled program and medically needy "share of cost" Medi-Cal.[43]

There are two primary ways Medi-Cal delivers medical benefits: 1) Medi-Cal managed care plans and 2) fee-for-service.[44] Individuals enrolled in a Medi-Cal managed care plan must see providers contracted with the plan. The plan makes the decision as to what treatment it will authorize for an enrolled member. Today, nearly all Medi-Cal recipients are enrolled in a managed care plan for their medical benefits. One exception are individuals who qualify for Medi-Cal through the medically needy pathway and have a share of cost.[45]

Medi-Cal Dental Overview

Any individual who is eligible for Medi-Cal is also eligible for dental benefits through Medi-Cal Dental (formerly referred to as Denti-Cal).[46] The history of the Medicaid dental benefit in California has been uneven. Except for Federally Required Adult Services (FRADS), adult dental benefits are an optional benefit under federal law.[47] Accordingly, states do not have to provide dental benefits. When states do elect to cover dental benefits, we often see them eliminated when states face a financial downturn. California experienced this in 2009, at which time adult dental benefits were eliminated for adults residing in the community (benefits remained intact for individuals residing in skilled nursing facilities or intermediate care facilities for the developmentally disabled).[48] Thankfully, with much advocacy, benefits were partially restored in May 2014 and fully restored in January 2018.[49]

Below is a summary of the Medi-Cal Dental program including how benefits are delivered, what benefits are covered, limitations in coverage, how benefits are accessed, and Medi-Cal Dental appeals and grievances.

Medi-Cal Dental Delivery System

The delivery system for dental benefits under Medi-Cal is "carved out." This means that dental benefits are provided through a system that is separate from the one that provides medical benefits. Dental benefits are delivered either

through Fee-for-Service (FFS) or through a separate dental plan in Los Angeles and Sacramento counties. If an individual is enrolled in a Medi-Cal managed care plan, that plan is not responsible for providing the dental benefit.[50]

WHAT'S THE DIFFERENCE BETWEEN DENTAL MANAGED CARE AND FEE-FOR-SERVICE?

In fee-for-service, Medi-Cal enrollees can see any provider enrolled in Medi-Cal Dental. Conversely, enrollees in a DMC plan must see dental providers contracted with the plan. DMCs are required to have an adequate network of providers and meet both time and distance standards,[51] which is not required in fee-for-service to the same degree.

DMC plans are required to provide the same benefits that individuals receive in fee-for-service. There is no difference in benefit packages, and evaluations comparing managed care to fee-for-service show no meaningful differences in utilization rates.[52] It is important to note that in the fall of 2023, DHCS issued provider and member bulletins to inform the public that DMC plans failed to meet parity with statewide FFS utilization averages in all required measures. As a result, DHCS granted Medi-Cal enrollees in Sacramento County the option to disenroll from their DMC plans and go back on the Medi-Cal dental FFS effective December 1, 2023.[53]

Under managed care, both DHCS and the Department of Managed Health Care (DMHC) provide oversight of the dental plans, providing enrollees in managed care additional avenues for advocacy.[54] For example, appeals and complaints can be submitted to both DMHC and DHCS for enrollees in DMC plans. An individual may also contact the Medi-Cal Managed Care Ombudsman at 1-888-452-8609 for guidance about how to address a problem or complaint.[55]

Most individuals statewide receive their dental benefits through Medi-Cal Dental fee-for-service. This means that an individual can go to any dental provider who is contracted with Medi-Cal Dental. As with Medi-Cal generally, the Department of Health Care Services (DHCS) oversees the Medi-Cal Dental program. Since October 2023, DHCS has contracted with Gainwell Technologies to carry out dental business operations like processing claims, treatment authorizations, and provider applications (previously Delta Dental was responsible for this role).[56]

Medi-Cal enrollees in Los Angeles and Sacramento counties have the option to join a separate Dental Managed Care (DMC) plan rather than receive their dental services through fee-for-service.[57] Currently, the three DMCs available in both counties are: Access Dental Plan; Health Net Dental; and Liberty Dental.[58]

HEALTH PLAN OF SAN MATEO INTEGRATION PILOT

As noted above, Medi-Cal managed care plans are not responsible for the delivery of dental benefits. However, a pilot is underway to fully integrate dental care with medical and behavioral health by the Health Plan of San Mateo. This pilot became effective January 1, 2022, and aims to test the impact to oral health care access and quality when integrated under one plan.[59]

Medi-Cal Dental Covered Benefits

The Medi-Cal Dental program benefit package is now fairly comprehensive since benefits were fully restored as of January 1, 2018.[60]

Medi-Cal Dental now covers most preventive and restorative services including exams, cleanings, fluoride treatment, diagnostic testing (e.g. x-rays), fillings, crowns, root canals on both anterior and posterior teeth, gum treatment, and partial and full dentures.[61] Medi-Cal Dental also covers all Federally Required Adult Services (FRADs). FRADs are dental services that could be performed by a medical doctor (e.g., extractions).[62] As a general rule, Medi-Cal Dental will only pay for the lowest cost procedure that will correct the dental problem.[63] There are also additional limitations on dental benefits as described below.

The following is a quick reference guide for covered benefits. The details of all covered services, including all covered dental codes and their limitations, are spelled out in their entirety in the DHCS Medi-Cal Dental Provider Handbook.

Quick Reference Guide for Covered Benefits

PROCEDURE	FULL SCOPE	RESIDING IN A FACILITY (SNF/ICF)
Initial Exam	Yes (1x/36 mos.)	Yes (1x/36 mos.)
Periodic Exam	Yes (1x/12 mos.)	Yes (1x/12 mos.)
Prophylaxis (Cleaning)	Yes	Yes
Fluoride	Yes	Yes
X-rays	Yes (1x/14 mos.)	Yes (1x14 mos.)
Crowns	Yes (1x/36 mos.)	Yes (1x/36 mos.)
Laboratory Processed Crowns	Yes (limited	Yes (limited
Scaling and Root	Yes (1x/24 mos.)	Yes (1x/24 mos.)
Full Mouth Debridement	No	Yes (1x/12 mos.)
Periodontal Maintenance	Yes (1x/24 mos.)	Yes (1x/24 mos.)
Anterior Root Canals	Yes (1x/per tooth)	Yes (1x/per tooth)
Posterior Root Canals	Yes (1x/per tooth)	Yes (1x/per tooth)
Partial Dentures	Yes (1x/5 years)	Yes
Full Dentures	Yes (1x/5 years)	Yes
Extractions	Yes (when medically necessary)	Yes (when medically necessary)
Emergency Services	Yes (1x/per DOS, per provider)	Yes (1x/per DOS, per provider)
Fillings/Restorations	Yes (1x/per tooth, per DOS when medically necessary)	Yes (1x/per tooth, per DOS when medically necessary)

**Starting July 1, 2022, Medi-Cal Dental now covers laboratory-processed crowns on posterior teeth (i.e., molars) when medically necessary to restore a tooth to normal function.*[64]

Not covered for adults: Molar sealants and orthodontics (braces) are only covered for children and teenagers under the age of 21.[65]

Teledentistry: DHCS enables providers the flexibility to use teledentistry as a modality to render certain services.[66]

New Benefits (2023 and 2024): The Caries (tooth decay) Risk Assessment (CRA) bundle and Silver Diamine Fluoride (SDF) are two new benefits added to the Medi-Cal Dental Program in alignment with national dental care standards.

Silver Diamine Fluoride is a relatively new form of fluoride treatment that has been found effective in slowing and stopping dental caries (tooth decay) in children and adults, and in particular has shown efficacy in management of root decay in older adults.[67] Medi-Cal Dental will cover these treatments in certain cases.[68] For example, Medi-Cal Dental will cover SDF for adults once every 6 months when a dental provider submits required documentation demonstrating medical necessity and showing, "[...] the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal."[69]

As of December 1, 2024, Medi-Cal dental providers are allowed to bill and receive reimbursement via Medi-Cal Dental for covered oral health education and oral health navigation services provided to members by eligible Community Health Workers (CHWs).[70]

Medi-Cal Dental Coverage Limitations

Medically Necessary

All dental services must be deemed medically necessary in order to be reimbursed by Medi-Cal Dental. Medical necessity refers to the criteria used to decide if covered services are necessary and appropriate for the treatment of the teeth, gums, and supporting structures according to professionally recognized standards of practice.[71]

Scope and Type

Almost all dental services covered under Medi-Cal Dental are limited in scope. For example, you can only receive one cleaning (prophylaxis) per year and coverage for crowns or dentures every five years. There are narrow exceptions to these limitations. For example, a dentist can request prior authorization for more frequent cleanings for a patient with a physical limitation and/or an oral condition that prevents daily oral hygiene.[72]

Further, while dentures are only a benefit once in a five-year period, an individual can obtain a new denture sooner if they can adequately document and meet five exceptions:

1. Catastrophic loss of the prosthetic beyond the control of the individual with required documentation including and not limited to a demonstration of continued medical necessity;
2. Need for a new prosthesis due to surgical or traumatic loss of the oral-facial structure;
3. If the denture is no longer serviceable as certified by a dentist;
4. Dentures no longer fit due to significant medical condition requiring medical documentation from the dental provider; or
5. For a non-catastrophic loss or misplacement, "Documentation must include an explanation of preventive measures instituted to alleviate the need for further replacement."[73]

Dental services are also limited in type. For example, Medi-Cal Dental will not pay for a gold crown, but will reimburse for prefabricated metal and resin crowns, and certain forms of porcelain crowns. Similarly, Medi-Cal Dental will only pay for lab processed crowns when a tooth has suffered specific forms of damage.[74]

Annual Soft Cap

Medi-Cal Dental for adults 21 years of age or older has an annual soft cap for benefits of $1800.[75] The soft cap does not apply to medically necessary services and procedures such as those rendered to residents of long-term care facilities, emergency services with the required documentation, dentures, services that are federally mandated

including FRADS in addition to other services.[76] Except for procedures deemed medically necessary, dental providers have the responsibility to verify the soft cap to ensure it has not been reached prior to rendering services.

Accessing Medi-Cal Dental

Finding a Provider

To find providers, enrollees in dental managed care plans in Sacramento and Los Angeles counties can contact their plans directly or access their plan's provider directory online. Enrollees in Medi-Cal Dental Fee-For-Service can go to the "Medi-Cal Provider Directory" online for a list of providers organized by county and city. [77] Though Medi-Cal does not guarantee that providers listed will be accepting new patients, the directory provides an option to include providers that are accepting new patients. Enrollees who need assistance finding a dental provider in their area can ask for care coordination assistance. Medi-Cal Dental is responsible for providing care coordination services and assisting people with locating providers, accessing appointments, obtaining translation services, and getting transportation.[78] Medi-Cal Dental can also assist members by providing referrals to Medi-Cal dentists that would not otherwise accept new patients outside of the DHCS referral process.[79] Individuals or their representatives can call Medi-Cal Dental at 1-800-322-6384 or complete the online care coordination form to request coordination assistance.

LACK OF MEDI-CAL DENTAL PROVIDERS

There are a number of factors that contribute to California's dearth of Medi-Cal Dental providers. First, the elimination of adult dental benefits in 2009 through 2014 led some providers to leave the Medi-Cal Dental system altogether. The top two factors identified by Medi-Cal Dental that affect dental providers participation are reimbursement rates and the administrative burden of processing treatment authorization and claims.[80]

There has been some progress in addressing these issues. For example, California increased reimbursement rates for supplemental payments for targeted dental services for providers who bill under the Dental Fiscal Intermediary or DMC plans starting in 2017 - 2018, and with payment suspensions removed, these payments are slated to continue indefinitely.[81] In addition, Medi-Cal Dental simplified the provider enrollment process with the Provider Application and Validation for Enrollment (PAVE) online provider portal and eliminated paper applications starting October 31, 2022. Providers must now complete all enrollment related activities and revalidation via the provider portal.[82] With the full restoration of dental benefits in January 2018, administrative streamlining, and the supplemental payments, which vary between 20 -60 percent of the Schedule of Maximum Allowances (SMA) across most covered dental services,[83] these efforts combined with the State's provider outreach plans may have led to positive increases in the provider participation rates. [84] Medi-Cal Dental continues to engage in provider outreach to increase enrollment.[85]

Despite these advances, however, administrative obstacles in the program persist. Providers report that treatment authorization requirements and claims processing rules are so burdensome that some do not want to participate in the program at all.[86]

There are certain rural areas of the state that have no Medi-Cal Dental providers accepting patients, including for example, Alpine and Mariposa counties. In these counties and others, call the Medi-Cal Dental Beneficiary line at 1-800-322-6384. Also, listed on page 24, see additional oral health treatment options.

Prior Authorization

Except for emergency services, most Medi-Cal Dental services require a dental provider to obtain prior approval before rendering services, called a treatment authorization request (TAR). It is important to note that a Clinical Screening by a Clinical Screenings Dentist (CSD) is required for all TARs for members in state licensed facilities including Intermediate Care Facilities (ICFs), and Skilled Nursing Facilities (SNFs), except for cases involving less than four extractions, or less than three restorations.[87]In certain cases, x-rays must also be submitted with the TAR. In situations when x-rays cannot be obtained because of the patient's medical condition, physical ability, or cognitive function, photographs may be taken instead. However, documentation explaining why x-rays were not taken must be included in the TAR or claim.[88] The Provider Handbook sets forth which procedures require prior authorization and what additional documentation is required for services to be rendered.[89]

Notice of Authorization

If a provider submits a treatment authorization, the provider will receive a notice of authorization either approving or denying the authorization. If the authorization is denied, the provider will be informed of the reason why and has the option to submit a request to reevaluate the authorization.[90] A list of adjudication codes can be found in Section Seven of the Provider Handbook.[91]

Notice of Action

The beneficiary should also receive a notice of action (NOA) from Medi-Cal Dental (or from the managed care plan in those counties) when an authorization for treatment is denied or modified. This notice should include a reason for the denial and provide the beneficiary the opportunity to appeal the notice.[92] Included in this guide in Appendix B are the Reason for Action Codes summarizing the reasons why a claim has been denied. Appeals and grievances are discussed in more detail on page 17.

ADVOCACY TIP

Individuals should always receive a notice explaining why a service was denied. If an individual has only received notice verbally from their provider, they should contact Medi-Cal Dental or their Medi-Cal Dental plan to report that they did not receive a formal notice of action and to request one.

Advocates working with enrollees have reported instances where providers either have not submitted a TAR at all or have submitted one incorrectly, then informed the patient that the service has been denied and the individual will have to pay out-of-pocket. To ensure enrollees receive the benefits they are eligible for, it is important to report any instance in which a notice has not been received.

Co-Payments

Providers can no longer collect copayments from Medi-Cal Dental enrollees as Medi-Cal's authority to collect payment ended on January 1, 2023.[93]

Share of Cost

Some Medi-Cal recipients who are over the income limit for Medi-Cal become eligible with a share of cost (SOC) also known as a spend-down amount. SOC eligibility functions much like a deductible: Medi-Cal (or in this case Medi-Cal Dental) will not pay for services until the individual has incurred enough medical (including dental)

expenses to meet their monthly SOC. The provider is allowed to require the Medi-Cal Dental enrollee to pay their SOC on the day the services are rendered.[94]

Transportation

Medi-Cal recipients are entitled to transportation to medical appointments, which include dental appointments, but securing transportation to dental treatment is different based on the type of transportation needed.[95]

Non-Emergency Medical Transportation

If an individual needs transportation via medical mode of transportation – known as Non- Emergency Medical Transportation (NEMT) – the individual should first try to contact their Medi-Cal plan to arrange transportation. Medical transportation via NEMT includes wheelchair or litter vans. While Medi-Cal plans are not required to arrange NEMT to carved out services like dental, some Medi-Cal plans opt to do so. If the Medi-Cal plan will not arrange the NEMT transportation or if the individual is not enrolled in a Medi-Cal plan, the Medi-Cal Dental provider is required to set up NEMT transportation to the appointment. Regardless of Medi-Cal coverage type, in order to receive NEMT transportation services, all individuals will need a prescription from their provider. The provider will then need to submit documentation demonstrating medical necessity through prior authorization.[96]

Medi-Cal dental providers are authorized to contact NEMT transportation companies and submit all requests directly to them. The transportation company will then submit a TAR to the Clinical Assurance and Administrative Support Division (CAASD) within DHCS, who will review and approve the TAR if medical necessity is demonstrated.[97]

Non-Medical Transportation

If the individual can travel by standard conveyance (e.g. car, bus, etc.) – known as non-medical transportation (NMT) – but has no means of obtaining this type of transportation, the individual's Medi-Cal plan is required to provide NMT to dental services. [98] To set up a ride, enrollees should contact their plan directly and ask about transportation providers approved by the plan in their area. Individuals not enrolled in a Medi-Cal plan should send an email request to coordinate transportation services without confidential information to DHCSNMT@dhcs.ca.gov. They can also contact transportation providers directly to schedule services if they have their contact information. Unlike NEMT, the dental provider has no responsibility to arrange NMT. To avoid coverage issues, individuals should utilize only Medi-Cal approved transportation.[99]

Day of Appointment

On the day of an appointment, individuals should bring their Medi-Cal card (a.k.a. beneficiary identification card) with them. If the individual is in a separate dental plan, they should also bring their dental plan card. If an individual needs interpreter services, the dental provider must provide one free of charge. The dental provider also must comply with the Americans with Disabilities Act and is prohibited from discriminating on the basis of race, color, national origin, sex (including sexual orientation or gender identity), age or disability.[100]

If an individual cannot find a dentist that speaks their language, they have the right to an interpreter at no charge. Individuals should contact the Medi-Cal Dental telephone service center at 1-800-322-6384 to request an interpreter.

Billing Prohibitions

Medi-Cal Dental providers are prohibited from billing Medi-Cal recipients for any Medi-Cal Dental covered service other than for share of cost (as described above).[101] There are limited circumstances when providers are allowed to enter into a private contract and charge enrollees. For example, providers can only charge for non-covered services if the individual understands that it is not a covered benefit and that they will be responsible for payment.[102] Medi-Cal Dental providers who violate these rules are subject to sanctions up to three times the Medi-Cal reimbursement rate.[103] Medi-Cal Dental providers can also be reported to California Dental Board or sued under the state's Consumer Legal Remedies Act and the Unfair Competition Law for improper billing.[104]

Upselling, and Dental Credit Cards

Although most basic benefits are now covered under Medi-Cal Dental, providers may attempt to upsell uncovered services that may be better quality, or new treatments not yet covered by Medi-Cal Dental (e.g. Arestin, bone grafts). First, providers are prohibited from making a Medi-Cal Dental covered service contingent on receiving an uncovered service.[105] And as stated previously, providers can only charge Medi-Cal Dental recipients for uncovered services if the individual is informed that the services are not covered by Medi-Cal Dental and that the individual will be responsible for payment for those non-covered services. Medi-Cal Dental providers are encouraged to provide this information in writing.[106]

Generally speaking, because Medi-Cal recipients do not have the income or resources to pay for uncovered services, it is advisable that they limit the treatment they obtain to those services covered by Medi-Cal Dental.

However, if an individual, having been informed of the above, decides to proceed with the treatment, they will be responsible for the cost. Many providers will offer patients the opportunity to finance the cost of these uncovered services through a dental or care credit card. Medi-Cal recipients should be very cautious about entering into these credit arrangements.[107] Advocates should encourage clients not to feel rushed to enter into the agreement, to read the terms and conditions carefully, and to first explore all other low- or no-cost options discussed below. Often, these credit cards and similar payment arrangements expose the individual to very high interest rates that can lead to a cycle of debt. Individuals who do not speak English should request that the information be provided to them in a language they understand before signing any documents.

There are additional special protections for dental credit cards. As of July 1, 2020, providers and their staff are prohibited from arranging for or establishing an open-end credit or loan that contains a deferred interest provision and from completing any portion of an application for credit or a loan for the patient or establishing an application that is not completely filled out and signed by the patient.[108] Providers and their staff are required to provide patients with a written notice of credit, written treatment plan, an estimate of costs, and signed acknowledgment that the patient's rights and responsibilities were provided in the appropriate threshold language. [109] If the provider fails to comply with these requirements, the individual is entitled to relief pursuant to the Consumer Legal Remedies Act and Unfair Competition Law.[110]

If your client has entered into a dental or care credit arrangement, it is advisable that they obtain legal representation. The Health Consumer Alliance has trained legal services attorneys on this topic who are equipped to assist with these types of cases. See Appendix A for contact information.

Medi-Cal Dental Appeals and Grievances

What's the difference between an appeal and grievance?

An appeal is a formal way of asking Medi-Cal Dental or a Medi-Cal Dental plan to change a decision regarding coverage. A grievance is any complaint other than one for a coverage decision (e.g., a provider was rude to the enrollee or provided poor quality of care).

Appeals

Medi-Cal Dental Fee-for-Service

Many major dental services require the provider to submit a treatment authorization request (TAR) prior to rendering services. In instances where the TAR is denied, both the individual and the provider should receive a notice informing them of the denial and the reason for the denial (see Appendix B for denial codes and reasons). Since most Medi-Cal Dental recipients are in fee-for-service, they have a right to request a state fair hearing as soon as they receive a notice of action denying a service. The hearing must be requested within 90 days of the date of the notice.[111]

Medi-Cal Dental Managed Care

Individuals enrolled in a Medi-Cal dental managed care plan have a different appeals process than fee-for-service. After receiving a denial notice, the individual must first file an appeal with the dental plan. If the dental plan denies the appeal, the individual can request a state fair hearing or continue with the plan appeals process by requesting an internal medical review (IMR) or do both. For example, if an individual asks for an IMR first, but does not agree with the decision, they can still ask for a state hearing later. However, if the individual asks for a state hearing first, and the hearing has already taken place, the individual cannot ask for an IMR. In this case, the state hearing has the final say.[112]

Grievances

It is important to file a complaint or grievance with Medi-Cal Dental or the Medi-Cal Dental plan any time an individual experiences a problem with the Medi-Cal Dental program. This ensures that the Medi-Cal Dental program is made aware of issues individuals face in the program and the program remains accountable to address these issues. Grievances should be filed in instances where an appeal has been filed if the issue goes beyond just a standard denial of coverage, and also in instances where an individual has to wait long periods for an appointment, received poor care, was treated rudely, was not provided language assistance, or was improperly billed.

Medi-Cal Dental Fee-For-Service

An individual can file a grievance by contacting the Medi-Cal Dental Telephone Service Center at 1-800-322-6384. The complaint can be taken over the phone. The individual can also file a complaint by filling out a complaint form and mailing it to Medi-Cal Dental. Medi-Cal Dental must acknowledge receipt of the grievance within five (5) days of receiving the complaint and must make a conclusion within 30 days. If the individual is not satisfied with the conclusion, they can request a state fair hearing.[113]

Medi-Cal Dental Managed Care

If the individual is in a dental managed care plan, the grievance should be filed with the plan. It is important to ask the plan to formally take a grievance. While some issues can be resolved quickly, it is problematic when plans do not formally accept and respond to a grievance since there is no record of the incident. We therefore recommend that advocates insist that plans record the grievance.[114]

Integration and Medi-Cal Dental

As mentioned previously, Medi-Cal Dental is a carved-out benefit and is not integrated with the delivery of medical care. Medical doctors are unlikely to examine an individual's mouth, and likewise, dental providers do not always consider the individual's medical condition in treating their oral health issues. For example, older adults often take multiple medications, many of which cause dry mouth and exacerbate oral health issues. Similarly, diabetes increases the risk of infections forming in the mouth, so the need for regular gum treatment is very important. In an ideal integrated world, we would see medical providers connecting their patients with diabetes to oral health providers. In recent years, there have been updates to the Medi-Cal dental program to help with integration of dental care with medical care.

Medi-Cal Dental Case Management

Dental Case Management is a specific program offered by Medi-Cal Dental to support Medi-Cal enrollees who have complex health care needs and face challenges scheduling and coordinating treatment plans involving multiple medical and dental providers. This program aims to assist individuals with significant medical, physical, or behavioral conditions that require specialized care, including people with physical, developmental, mental, sensory, behavioral, cognitive, or other impairments that require medical management, hospital dentistry, health care intervention, and/or use of specialized services or programs.[115]

To obtain Dental Case Management, an individual's medical provider, dental provider, caseworker, or healthcare professional must make a referral by completing the Case Management Referral Form. Referrals are evaluated by the Medi-Cal Dental Customer Service Center.

Medi-Cal Plan Responsibilities

Assembly Bill 2207 requires Medi-Cal plans to include a dental screening in the health risk assessment they must conduct for each enrollee.[116] If Medi-Cal plans are not assisting with connecting their members to dental services, it is important for advocates to report this to the Department of Health Care Services.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to older adults who meet the following eligibility criteria: individuals must live in the PACE service area; be 55 or over; meet a nursing facility level of care; and be able to safely live in the community.[117] PACE plans provide all Medicare and Medi-Cal covered services, including covered dental services, at a PACE site. If the PACE site is unable to perform a covered dental service at the site, the individual will be referred to a community provider.

Commercial Plans & Dental Savings Plans

Commercial Plans

Older adults who are not eligible for Medi-Cal, and who have the financial means, may want to consider purchasing a commercial dental plan. There are common features with these plans that individuals should compare when shopping for coverage.[118] These plans will include costs for monthly premiums and an annual deductible that must be met before the plan will pay for services. Plans almost always will also have a low annual benefit maximum (e.g. ranging from $1,000 - $2,000).[119] Another common feature is a waiting period: individuals have to be enrolled in the plan for six months, for example, before being eligible to receive most covered services. Most services will not be covered at 100%. Instead, the individual will be responsible for coinsurance or the plan will offer a discount on major services (e.g. 25% discount on services by in-network providers).

Advocacy from the California Dental Association (CDA) and others in 2023 resulted in passage of several bills that offer promising opportunities to improve commercial dental plans for consumers and providers in California. For example, Assembly Bill 1048 and Assembly Bill 952 are important to uplift as both took effect January 2025. Assembly Bill 1048 prohibits denials based on pre-existing conditions, prohibits plans in the large group market from imposing waiting periods, and requires state regulatory review of the premiums charged by dental plans to help protect consumers from unreasonable or unjustified rates.[120] Assembly Bill 952 works to provide more transparency and eliminates confusion for consumers by requiring dental plans to disclose through their online patient portal or upon a dental office's request whether the patient's plan is state regulated.[121]

Dental Savings/Discount Plans

Dental Savings/Discount Plans are not really plans at all in the traditional sense. Rather, an individual pays an annual fee and then receives discounts from providers who have agreed to accept the plan. The discounts vary depending on the service sought. For example, an individual could receive a 60% discount on an annual exam and a 40% discount on a crown. Unlike a commercial plan, these savings plans typically do not have annual benefit maximums or waiting periods. Again, it is important for individuals to compare plans for cost, benefits, and access to providers.[122]

ADVOCACY TIP

There have been reports that some dental savings plans are not all they claim to be. Advocates report that after enrollment, individuals learn of hidden fees or that many of the providers who are listed do not in fact participate in the discount program. Individuals should carefully review the fine print of these plans and look into whether the providers listed are participating in the program. Advocates should report any instances of fraudulent discount cards to the Department of Managed Health Care, the Better Business Bureau, and the Consumer Financial Protection Bureau.

SPECIAL POPULATIONS

Dual Eligible Medicare and Medicaid Enrollees

Dually eligible people – individuals who have both Medicare and Medi-Cal coverage – often experience unique barriers to accessing care because of their dual status. The primary barriers duals face in accessing oral health care

occur when they opt to enroll in a Medicare Advantage (MA) plan that offers dental coverage as a supplemental benefit. They may encounter difficulties because of how the MA plan interacts with their Medi-Cal Dental coverage. Dual eligible individuals should review their MA plan dental coverage carefully and understand the dental coverage provided by the plan. MA dental supplemental benefits are often not comprehensive. Below is a summary of how coverage should work.

Medicare Advantage or other Dental Coverage + Medi-Cal Dental

For dually eligible people, Medicare coverage pays primary on Medicare covered services, and Medicaid coverage pays as a secondary health insurance payor.[123] Hence, Medi-Cal is typically always the payor of last resort. This means that for a dually eligible individual enrolled in an MA plan that includes dental coverage, the MA plan should be primary with few exceptions. Accordingly, dually eligible individuals should see dental providers that are contracted with their MA plan for MA covered dental services.

Since Medi-Cal Dental is secondary or payor of last resort, dual eligible enrollees in MA plans at times are improperly billed for services that are covered by Medi-Cal Dental. In these situations, dually eligible individuals are still protected from billing as long as they are treated by a Medi-Cal Dental provider – even if the provider is not contracted with the MA plan. [124] This often occurs when a person is mistakenly treated by a dental provider they thought was in their MA plan's network (but is not in the MA network) or when they did not know their MA plan offered dental benefits that are also covered by Medi-Cal and they went to their Medi-Cal Dental provider for services.

ADVOCACY TIP

If a dual eligible is billed for a Medi-Cal covered service, it should raise a red flag. Most likely, with few exceptions, the billing is improper. Justice in Aging has a toolkit on improper billing of dual eligibles that includes fact sheets, sample letters to send to providers, and other resources.

EXAMPLE 1: IMPROPER BILLING CASE

Ms. White is dually enrolled in Medicare and Medi-Cal. She is enrolled in an MA plan that includes dental coverage for root canals. The MA plan will pay 30% of the root canal. Medi-Cal will fully cover the root canal. Ms. White seeks treatment for her root canal with the MA contracted dental provider, who then bills her for 70% of the cost of the root canal. Ms. White has been illegally billed.

The MA plan dentist is prohibited from billing a dually eligible individual for a Medi-Cal covered service pursuant to state law (and in certain circumstances federal law).[125] Instead, the provider must submit a crossover claim to Medi-Cal. Medi-Cal will pay the provider up to the Medi-Cal approved amount. This might be less than what the provider would receive under the MA plan. The provider, however, must accept the Medi-Cal payment as payment in full. The provider is prohibited from billing the dual eligible for the remaining balance.[126]

Medi-Cal will only reimburse dental providers that are enrolled in the Medi-Cal program. To enroll, dental providers will need to complete an online application via the Provider Application and Validation for Enrollment (PAVE) provider portal.[127]

EXAMPLE 2: IMPROPER BILLING CASE

Mr. Carter is dually enrolled in Medicare and Medi-Cal. His MA plan offers full coverage of root canals. However, he did not know this. Instead, he went to his dental provider who accepts Medi-Cal, but is not in-network for his MA plan. Medi-Cal would pay for these services in full and Mr. Carter is protected from being billed. This is because the dental services are considered to be non-MA covered services. In these instances, his MA plan is not primary payor, so Medi-Cal can be billed. (See, CMS third-party liability guidance).

To minimize issues with billing, it is advisable that dually eligible individuals who have MA plan dental coverage seek treatment with a dental provider who is contracted with their plan when possible. They can explain to the MA plan contracted provider that they also have Medi-Cal Dental coverage and should not be charged for services covered by Medi-Cal Dental. MA enrollees who encounter issues related to billing with in-network providers or are refused services due to their Medi-Cal enrollment should contact their MA plans to receive assistance as plans are responsible for ensuring enrollees are not discriminated against due to their source of payment. [128]

ADVOCACY TIP

Since Medi-Cal Dental now offers fairly comprehensive dental coverage for free, it is important for dually eligible enrollees to evaluate whether it makes sense to be enrolled in a Medicare Advantage (MA) plan that offers dental – especially if their primary reason for enrolling in the MA plan is to obtain dental coverage. The individual should evaluate whether enrollment in the plan outweighs the likelihood of being improperly billed for services. The individual should also investigate whether their existing health care providers are in the MA plan network—the plan may be of no benefit to the individual if it costs them their relationship with a valued health care provider (because the provider is out of network), yet gains them nothing they don't already have under Medi-Cal Dental. We recommend that duals consult with a HICAP counselor in making this decision (see Appendix A).

When an individual buys a standalone dental plan to reduce their countable income to become eligible for Medi-Cal, also known as meeting a share of cost,[129] the individual should make sure to buy a plan that provides the most value above that already offered by Medi-Cal Dental. Advocates should explain to their dually eligible clients how standalone dental plan coverage should work with their Medi-Cal Dental coverage to minimize issues.

Medicare-Medicaid Plans

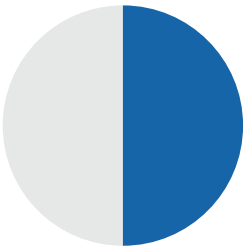
On January 1, 2023, Cal MediConnect plans transitioned to Medicare Medi-Cal plans (MMPs or Medi-Medi plans) provided by the same companies that provided Cal MediConnect plans.[130] The transition occurred in all Coordinated Care Initiative (CCI) counties including: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. Medi-Medi plans are a special type of MA plan known as a Dual Eligible Special Need Plan (D-SNP) and are responsible for delivering all Medicare and Medi-Cal benefits under one plan (with exceptions, such as carved-out dental benefits). In 2023, Medi-Medi plans were offered only in the seven counties listed above. In 2024, Medi-Medi plans were extended to five additional counties including Fresno, Kings, Madera, Sacramento, and Tulare. By 2026, these plans will be available to dual eligible Californians in additional counties.[131]

Dental benefits continue to be carved-out from Medi-Medi plans, which means that plan enrollees still receive their dental care coverage from Medi-Cal Dental.[132] Some Medi-Medi Plans also offer supplemental dental benefits—these supplemental benefits wrap around what is delivered by Medi-Cal Dental. DHCS requires that plans include information about Medi-Cal Dental benefits in any materials that provide member information about the dental supplemental benefits.[133] As exclusively aligned enrollment (EAE) plans,[134] Medi-Medi plans are required to have aligned networks of providers, such that their contracted dental providers must also be enrolled in Medi-Cal Dental to help retain continuity and minimize improper billing.[135]

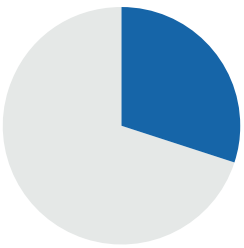
Nursing Facility Residents

Nursing facility residents have poorer oral health than the general population. This is true despite the fact that nursing facility residents retained full dental benefits under Medi-Cal when they were eliminated for adults living in the community in 2009.[136] While coverage is comprehensive, nursing facility residents face different barriers to access. For example, residents receive their oral health treatment primarily within the walls of the nursing facility since residents have a more difficult time seeking treatment in the community. The result is that most residents only receive treatment when they have an acute need and receive fewer preventive services. With a growing number of Black and Hispanic/Latino residents in nursing facility care, and with documented disparities in the quality of care provided by nursing home facilities serving communities of color,[137] oral health care remains an equity issue that requires sustained advocacy. We hope with strong advocacy we can improve oral health care access across all California nursing homes including those that serve communities of color. Here are specific ways to advocate for residents in nursing facilities.

Nursing Facility Residents Have Poorer Oral Health[138]



50% of older adults in nursing facilities have **untreated tooth decay**



27% of older adults in nursing facilities **need gum treatment immediately**

One third of older adults in nursing facilities **have lost all their teeth**

Access to Services

Nursing facilities are required to assess a resident's dental and nutritional status upon admission, and thereafter quarterly, and when there is a significant change in the resident's condition.[139] Nursing facilities are required to complete the Minimum Data Set (MDS) – a federally required clinical assessment of all residents in Medicare and Medicaid certified nursing homes. Two sections of the MDS identify oral health needs. Section K includes questions around the resident's ability to swallow and their nutritional status, and Section L specifically covers oral health problems, including broken or loosely fitting dentures, no natural teeth, mouth ulcers or lesions, obvious cavities, broken teeth or loose teeth, mouth pain, and inflamed or bleeding gums.[140]

If oral health needs are identified during the assessment or anytime thereafter, the facility is required to assist residents in obtaining both routine and 24-hour emergency dental care. Dental needs and how they are to be addressed must be included in the care planning process.[141] In practice, this often means that nursing facilities will arrange for a dentist to visit a facility on a regular basis, and residents who are experiencing acute dental issues will be signed up to be seen. But facilities are required to do more. Specifically, pursuant to federal law, facilities are directly responsible for the oral health needs of their residents.[142]

> Pursuant to **federal law,** facilities are directly **responsible for the oral health needs of their residents.**

The facility is required to make sure a dentist is available to residents through having a contract arrangement with a dentist or employing a staff dentist. If a resident is unable to pay for dental services, the facility is supposed to attempt to find alternative care or funding to ensure the resident has the highest practicable level of well-being. The facility is also supposed to ensure access to routine care (e.g., gum treatment, cleanings) and must, if necessary or requested, assist the resident in making dental appointments and arranging transportation to and from those dental services.[143]

Nursing facilities are not permitted to charge for personal hygiene items, including dental floss, denture cleaner, denture adhesive, denture cups, toothpaste, or toothbrushes for residents who are paying for their stay through Medicare or Medi-Cal.[144]

Oral Hygiene

Many residents in nursing facilities are unable to carry out the activities required to maintain their oral health. For these residents, nursing facilities are required to provide services such as brushing of the teeth, cleaning dentures, and cleaning the mouth and tongue to maintain oral mucosa.[145]

Lost Dentures

Nursing facility residents' dentures often go missing. This is problematic when dentures are a covered benefit only every five years under Medi-Cal Dental. California facilities are required to establish and maintain a written inventory of a resident's property, including dentures.[146] Facilities are also required to engrave a resident's dentures to mark ownership.[147] Federal rules require facilities to have a policy in place that identifies instances when the loss or damage of dentures is the facility's responsibility and prohibits the facility from charging the resident for the loss or damage when the facility is at fault. Facilities also must make a referral to a dental provider within three (3) business days when dentures are lost or damaged.[148]

ADVOCACY TIP

Nursing facility residents with dentures should ensure their dentures are engraved and also recorded on their personal property inventory list. Residents should also take pictures of their dentures. If dentures go missing, the resident should report the loss immediately to the facility administrator, the long-term care ombudsman, and file a police report. Residents then should write a demand letter to the nursing facility requesting reimbursement for the lost dentures. With a police report, Medi-Cal beneficiaries may also be successful in obtaining new dentures through Medi-Cal Dental.[149]

Residential Care Facilities for the Elderly

Residential Care Facilities for the Elderly (RCFE), also referred to as "Assisted Living" or "Board and Care" are non-medical facilities for older adults who require assistance with activities of daily living. RCFEs are required to assist in arranging for dental care for residents and provide assistance with meeting dental needs, including assisting with providing or arranging transportation to dental services.[150]

Residents of Intermediate Care Facilities for the Developmentally Disabled

Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) provide care and support services to individuals with a developmental disability whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services. California state law sets forth additional and specific requirements around the provision of dental care in ICF-DDs.[151] For example, ICF-DD staff must be trained on nutrition and how to properly conduct oral hygiene. The facility must also maintain a permanent dental record for each resident and record dental progress and have in place a formal arrangement for providing residents with dental services.

OTHER ORAL HEALTH TREATMENT OPTIONS

Some older adults do not have access to any dental coverage or only have limited coverage through Medicare or commercial plans. There are a number of options available that, while not comprehensive or always available, are worth exploring.

Federally Qualified Health Clinics – Community Clinics

There are 2,641 Federally Qualified Health Clinics including community health centers (CHCs) in California that provide care to 5,797,252 million Californians.[152] CHCs are nonprofit, tax-exempt clinics that are licensed as community or free clinics, as defined under Section 1204 of the California Health and Safety Code, and provide comprehensive services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. The term "CHCs" includes federally designated community health centers, migrant health centers, rural health centers, and frontier health centers. CHCs provide a variety of community services including primary medical care, pediatrics and prenatal care, behavioral health care, and oral health care. Many community health centers have full dental clinics that can provide more comprehensive dental services. A searchable list of community health centers is available at the California Department of Health Care Access and Information (HCAI) website.

Community health centers accept both Medi-Cal and Medicare as well as most commercial insurance options. CHCs serve all patients regardless of their ability to pay, which makes them an attractive option for older adults seeking dental care who do not have coverage through Medicare. One barrier older adults may face when attempting to get care is long wait lists due to high demand. Many CHCs have urgent care hours and walk-in appointment slots, so it is advisable for an individual to contact the community health center in their area to determine how and when the CHC can best serve them, and confirm what dental services are provided.

ADVOCACY TIP

If an older adult wants to seek dental treatment at a community health center it could be advantageous to establish the CHC as the health home. This ensures the integration of all care an older adult may need. This may mean changing Medicare providers to a CHC provider or utilizing the CHC for other health care needs like behavioral health treatment if that is a need.

Community health centers are Medi-Cal providers and bill Medi-Cal for dental services rendered. If an individual has Medi-Cal Dental coverage, but is unable to find a Medi-Cal Dental provider in the community, seeking care at a community health center may be an option.

Veterans Affairs

The VA offers comprehensive dental care benefits to certain qualifying Veterans.[153] If the individual does not qualify for VA dental benefits, individuals enrolled in the VA health plan can enroll in a VA dental health plan for a reduced price through the VA Dental Insurance Program.[154]

To find out if they qualify for any dental care, Veterans can do any of the following:

- Consult their local Veterans Affairs Medical Center,
- Contact the VA at 1-877-222-VETS (8387),
- Visit VA Health Care
- Visit VA Disability Compensation
- Seek assistance from a Patient Advocate

Dental Schools

There are seven dental schools in California.[155] These schools often provide treatment to populations in need. Services are usually provided on a sliding scale and many dental schools will accept Medi-Cal Dental insurance. Not all dental schools provide treatment to all populations, so it is important to contact the school to determine whom the school serves and whether the treatment sought is a service the school offers. See Appendix A for a list of schools and contact information.

Pop-Up Clinics

There are efforts to bridge gaps in access to dental care by providing care at large pop-up clinics. These clinics are generally staffed by volunteers and provide a range of different services for free. The pop-up clinics are usually set up in a public space. Since these events are usually crowded with long waits, it is also important to do some research before traveling to a pop-up clinic to ensure the services the individual needs are being offered. Pop-up clinics can be located through the clinic schedule of the America's Dentists Care Foundation.

CONCLUSION

Oral health is essential to overall health. While California has taken a critical step in ensuring low-income older adults have fairly comprehensive coverage through Medi-Cal Dental, barriers to accessing those benefits and quality treatment are significant. It is our intention that this guide will help advocates navigate the system and empower them to identify and address systemic barriers to oral healthcare.

APPENDIX A – RESOURCES

Consumer Assistance Resources

Below is a list of consumer assistance programs that can assist with individual client issues. This is not intended to be a comprehensive list.

- Health Consumer Alliance - The HCA helps individuals and families get the health care services they need, while working to identify and address systemic health care issues impacting all Californians. Call 888-804-3536.
- Asian Americans Advancing Justice, Southern California - Advancing Justice-LA provides legal services and education to individuals, especially those who do not speak English as a first language. Call 888-349-9695.
- Health Insurance Counseling & Advocacy - HICAPs provide free, objective information and counseling on Medicare. Call 800-434-0222.

The following is a list of organizations engaged in systemic oral health advocacy in California for adults.

- California Dental Association
- California Black Health Network
- California Pan Ethnic Health Network
- California Primary Care Association
- Center for Oral Health
- Health Access
- Justice in Aging
- Latino Coalition for a Healthy California
- Maternal & Child Health Access
- National Health Law Program
- SCOPE LA
- Visión y Compromiso
- West Health
- Western Center on Law & Poverty

Written Resources

- Medi-Cal Dental Member Handbook
- Medi-Cal Dental Provider Handbook
- Medi-Cal Dental Provider Bulletins
- Dental Services through Medi-Cal (Disability Rights California)
- California State Oral Health Plan
- State of Oral Health in California Report
- Center for Oral Health, A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults
- Little Hoover Commission Report, Fixing Medi-Cal Dental (April 2016)
- Little Hoover Commission Follow up Letter, Medi-Cal Dental Program Still Broken (October 2017)
- Justice in Aging Letter to Little Hoover Commission (February 2018)
- Little Hoover Coalition Implementation Review of Medi-Cal Dental Program (September 2024)

- Latino Coalition for a Healthy California, "*Sonrisas Saludables*: 2024 State of Latine and Indigenous Oral Health in California," June 2024

State Agencies

- Department of Public Health, Oral Health Program
- Department of Health Care Services – Medi-Cal Dental
- Smile California
- Department of Managed Care
- Little Hoover Commission

Coalitions and Federal Resources

- California Oral Health Progress and Equity Network (OPEN)
- Pacific Center for Equity in Oral Health
- Latino Coalition for a Healthy California
- California Dental Association
- Office of Disease Prevention and Health Promotion, "Healthy People 2030: Oral Conditions"
- National Institute of Dental and Craniofacial Research, "Oral Health in America: Advances and Challenges," December 2021
- Center for Medicare Advocacy
- Families USA
- Administration on Community Living
- American Dental Association

Dental Schools

- Loma Linda University School of Dentistry, Loma Linda
- University of California, Los Angeles School of Dentistry, Los Angeles
- University of California, San Francisco School of Dentistry, San Francisco
- University of the Pacific Arthur A. Dugoni School of Dentistry, San Francisco
- The Herman Ostrow School of Dentistry of USC, Los Angeles
- Western University of Health Sciences College of Dental Medicine, Pomona
- California Northstate University, College of Dental Medicine

APPENDIX B – MEDI-CAL DENTAL REASON FOR ACTION CODES

REASON FOR ACTION CODES

01 Your aid code covers emergency services only.

02 Information submitted by your dentist about your current dental condition does not meet our minimum requirements for approval of this service.

03 The request for dental treatment marked with an "R" was changed to the procedure marked with an "S." This change was based on the information submitted by your dentist concerning your current dental condition or on program guidelines.

04 Our records show this service(s) or a similar service(s) was previously authorized, paid for, or completed. (For example: In some cases, procedures are limited to once in 12 months or once in five (5) years and cannot be authorized again except under special circumstances, which must be documented by your dentist.)

05 We are unable to verify your dentist's enrollment to participate in the program on the date the request was submitted.

06 The service as requested by your dentist, IS NOT A BENEFIT OF THE PROGRAM. Please contact your dentist for a different treatment plan.

07 You did not appear for a scheduled screening examination or failed to bring existing denture(s) (full or partial). Please contact your dentist to resubmit a request for this procedure.

08 Your dentist did not submit enough information to allow us to process this request. Please contact your dentist to resubmit a request with new information.

09 X-rays show that the tooth does not meet the requirements for a crown. At least 51% of the tooth must be missing and/or decayed. The tooth may be restored with a filling.

10 X-rays show that the tooth/teeth may have an infection; please contact your dentist as another service may be needed first.

11 Based on x-rays, your dentist's charting and/or confirmed by information we received from our screening examination, you do not have sufficient gum disease to need a deep scaling.

12 This service cannot be authorized because it is related to a denied procedure in the same treatment plan submitted by your dentist.

13 Based on the information submitted by your dentist and/or received from a screening examination, your current dental condition is stable and the requested service is not needed at this time.

14 Based on x-rays and/or confirmed by information we received from a screening examination, it has

been determined that the tooth/teeth has/have worn down naturally or you have bruxism (teeth grinding). The requested service is not a benefit of the program to restore teeth worn down naturally or by bruxism or that do not have decay or have not fractured.

15 X-rays show the tooth is too broken down and cannot be repaired. Your dentist may be able to provide a different treatment.

16 Our records show that the tooth has been restored with an acceptable filling or stainless steel crown.

17 X-rays show the service requested cannot be approved because gum disease has destroyed the bone around the tooth. Your dentist may be able to recommend a different treatment.

18 The minimum requirements for orthodontic treatment could not be verified by the Handicapping Labial-Lingual Deviation Index or submitted study models.

19 A partial denture can be a benefit only when there is a full denture on the opposite arch.

20 Root canal treatment must be satisfactorily completed before a crown can be considered.

21 Tooth is not fully developed. Your dentist may be able to recommend a different treatment.

22 Treatment is not necessary because neither x-rays nor documentation supports that there is nerve damage.

23 A stayplate can be a benefit only to replace a missing permanent front tooth.

24 X-rays show that additional extractions are necessary before the treatment plan can be approved; please contact your dentist.

25 Based on information submitted by your dentist, your teeth are in such a poor condition that the requested partial denture is not a benefit under this program.

26 Based on the information submitted by your dentist, your teeth are stable at this time and should not be replaced by a full denture.

27 Based on the information submitted by your dentist, you have no opposing full denture; therefore, you do not qualify for a partial denture. However, if you are missing front teeth, you qualify for a stayplate.

28 Based on x-rays, your dentist's charting, and/or confirmed by information we received from our screening examination, your teeth and/or gums are in such poor condition that the requested treatment is not a benefit under this program. Your dentist may be able to recommend a different treatment.

29 Deep scaling and gum treatments are not a benefit for children, except for cases where medications have caused the overgrowth of gum tissue.

30 Fixed bridges are allowable when severe epilepsy, paraplegia or uncontrollable spasticity prevents the use of a removable denture.

31 Tooth is not in its normal position and cannot be repaired under this program.

32 Based on information received from a screening examination, your existing denture is satisfactory at this time.

33 Based on information received from a screening examination, it has been determined that you cannot adapt to a denture because of physical limitations or health conditions.

34 The requested service is not necessary because there are enough teeth remaining in this arch to support the opposing denture.

35 During your screening examination, you indicated you do not want extractions or any other dental services at this time.

36 The number of authorized visits has been adjusted because you will turn 21 years of age before treatment is completed. Please make arrangements with your dentist.

37 The tooth is not visible on the submitted x-rays.

38 Based on x-rays and/or confirmed by information we received from our screening examination, you need additional treatment from your dentist before the procedure can be considered.

39 X-rays show there is not enough space present for the requested false tooth.

40 This program does not cover orthodontics when there are still baby teeth present.

41 Based on x-rays and/or confirmed by information we received from our screening examination, we have determined that you have bruxism (teeth grinding). The treatment of bruxism is not a benefit of this program.

42 The procedure is not a benefit for a baby tooth or for a baby tooth ready to fall out. Your dentist may be able to recommend a different treatment for your condition.

43 The procedure requested will not correct your dental problem. Your dentist may be able to recommend a different treatment for your condition.

44 Based on information received from your dentist, it is determined that the requested service is for cosmetic reasons only. Services for cosmetic purposes only are not a benefit of the program.

45 Your current denture can be made satisfactory by a laboratory reline.

46 We are unable to verify your eligibility in this program.

47 Your dentist must contact California Children's Services prior to submitting this procedure for payment or authorization.

48 EPSDT-Supplemental Services are not a benefit for patients 21 years and older.

49 The EPSDT-Supplemental Service(s) requested is not medically necessary.

ENDNOTES

1 U.S. Department of Health and Human Services, National Institutes of Health, "Oral Health in America: Advances and Challenges," § 3B at 1, (2021), (Accessed February 6, 2025).

2 California Department of Public Health, "Status of Oral Health in California: Oral Disease Burden and Prevention 2017," (April 2017).

3 Center for Oral Health, "A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults," (March 2018), at 8.

4 *Id*.

5 National Council on Disability, "Neglected for Too Long: Dental Care for People with Intellectual and Developmental Disabilities," (Fall 2017).

6 See California Department of Public Health, "California Oral Health Plan 2018-2028," (January 2018).

7 CA Department of Public Health, Office of Oral Health. "California Oral Health Surveillance Plan 2019-2023," 4 (Sept. 2019).

8 National Institutes of Health, *supra* note 1 at 3B-32; National Institute of Dental and Craniofacial Research, "Tooth Loss in Seniors," (Accessed August 3, 2024).

9 National Institutes of Health, *supra* note 1 at 3B-2; See also National Institute of Dental and Craniofacial Research, "Dental Caries (Tooth Decay) in Seniors (Aged 65 and older)," (last visited August 3, 2024).

10 Chamut, Steffany, et al. "Oral Health Among Medicare Beneficiaries in Nursing Homes." JAMA Network Open, 6(9), Sept. 2023 (last visited August 3, 2024).

11 Journal of Nutrition, "Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants," (February 2010).

12 Health and Human Services, "Oral Health in America: A Report of the Surgeon General," (2000).

13 NIH, *supra* note 1, at 3B-3.

14 Jennifer M. Pusins et al., "Oral Health and Aspiration Pneumonia," Today's Geriatric Medicine, Vol. 11, No.6, (2018), p. 16.; See also F. Müller, "Oral Hygiene Reduces the Mortality from Aspiration Pneumonia in Frail Elders," 94(3 Suppl.) Journal of Dental Research. 14S (Mar. 2015); Mikaela Brock et al., "The Relationships Among Periodontitis, Pneumonia and COVID-19," Fig. 1, Frontiers in Oral Health (Jan. 21, 2022).

15 HHS, *supra* note 12 at 283.

16 See National Institutes of Health, "Large Study Links Gum Disease with Dementia," (July 9, 2020); M. Beydoun et al., "Clinical and Bacterial Markers of Periodontitis and Their Association with Incident All-Cause and Alzheimer's Disease Dementia in a Large National Survey," 75(1) J. Alzheimer's Disease 157 (2020); Keshava Abbayya et al., "Association between Periodontitis and Alzheimer's Disease," 7(6) N. Am. J. Med. Sci. 241 (Jun 2015).

17 NIH, *supra* note 1, at 3B-14.

18 NIH, *supra* note 1 at 2A-20; 3B-19; 5-2.

19 Bryan Nack et al., "Opioid Use Disorder in Dental Patients: The Latest on How to Identify, Treat, Refer and Apply Laws and Regulations in Your Practice," 64(3) Anesthesia Progress 178 (2017).

20 HHS, *supra* note 12.

21 American Journal Public Health, "Burden of Oral Disease Among Older Adults and Implications for Public Health Priorities," (March 2012).

22 Linda Childers, "Why More Retirees Are Going Back to Work," AARP (September 29, 2023).

23 American Dental Association, Health Policy Institute, "Oral Health and Well-Being in California," (2015).

24 HHS, *supra* note 12 at 3.

25 See Centers for Medicare and Medicaid Services, "Original Medicare (Part A and B) Eligibility and Enrollment," (Accessed February 7, 2025).

26 42 U.S.C. § 1395y(a)(12).

27 *Id*.

28 42 C.F.R. § 411.15(i)(3).

29 CMS, "HHS Finalizes Physician Payment Rule Strengthening Access to Behavioral Health Services and Whole-Person Care," (Nov. 1, 2022) (Accessed February 7, 2025).

30 CMS, "Fact Sheets: Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule," (Nov. 1, 2024) (Accessed January 18, 2025).

31 42 C.F.R. § 411.15(i)(3)(i).

32 *Id*.

33 42 C.F.R. § 411.15(i)(3)(i).

34 CMS, "Health Plans-General Information," (Accessed February 7, 2025).

35 Meredith Freed et al., Kaiser Family Foundation, "Medicare and Dental Coverage: A Closer Look," (July 28, 2021) [hereinafter "A Closer Look"].

36 See CMS, "Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections," Section 20, Rev. 121, Issued: 04-22-16, p.29. (Accessed February 7, 2025).

37 *Id*. at 6.

38 Freed, *supra* note 35.

39 *Id*.

40 *Id*.

41 Medicare Rights Center, "Questions to Ask Before Joining Medicare Advantage," (2025) (Accessed February 7, 2025).

42 See DHCS, "2025 Federal Poverty Levels," Letter No.:25-01, (January 21, 2025), (Accessed February 7, 2025).

43 For more on Medi-Cal eligibility pathways, see Western Center on Law & Poverty, "Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates," (March 2016).

44 See DHCS, "Medi-Cal Dental Managed Care," (Accessed August 04, 2024).

45 Cal. Welf. and Inst. Code § 14184.200; Tiffany Huyenh-Cho, "Advocates Guide: CalAIM for Older Adults and People with Disabilities," Justice in Aging (March 2023) p. 8.

46 See DHCS, "Medi-Cal Dental Provider Handbook," § 4 at 5 (2024), (Accessed February 7, 2025).

47 Medicaid, "Mandatory & Optional Medicaid Benefits," (Accessed August 4, 2024).

48 Federally Qualified Health Centers (FQHCs) sued to force California to continue to fund their dental services under Medicaid. The Ninth Circuit held that, under the federal Medicare and Medicaid statutes, the state was obligated to continue to fund FQHC dental services through its Medicaid program, despite that it had terminated Medicaid state plan dental benefits. *See California Association of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1016-17 (9th Cir. 2013).

49 WIC § 14131.10(b)(2)(C); DHCS Medi-Cal Dental, "Provider Bulletin," Vol 33, No 14 (Nov. 2017), (Accessed February 7, 2025).

50 DHCS, *supra* note 44; Welf. & Inst. Code 14087.46(a), Welf. & Inst. Code 14089.09(a)

51 DHCS, "Medi-Cal Dental Managed Care (DMC) Methodology Overview," p.3 (May 31,2024) (Accessed July 10, 2024).

52 See DHCS, "Dental Data Reports," (Accessed February 8, 2025).

53 See DHCS, "Provider Bulletin," Vol. 39, No. 25 (Nov. 2023); DHCS, "Member Bulletin," Vol. 6, No. 12 (Oct. 2023).

54 See DHCS, "Managed Care Monitoring," (Accessed February 8, 2025); CA Department of Managed Health Care, "About Us,"(Accessed February 8, 2025).

55 See DHCS, "Medi-Cal Managed Care and Mental Health Office of the Ombudsman," (Accessed February 8, 2025).

56 DHCS, "DHCS Stakeholder Updates: July 1, 2022," (Last mod. Oct. 10, 2022).

57 DHCS, "Medi-Cal Dental Member Handbook," p. 2 (2023)

58 DHCS, "Managed Care Plan Directory," (Accessed July 09, 2024).

59 DHCS, Medi-Cal Dental, "Provider Bulletin," Vol. 37, No. 21, (October 2021) (Accessed February 7, 2025).

60 See DHCS, "What are the Medi-Cal Benefits?" (Accessed February 8, 2025)

61 See DHCS, "Medi-Cal Dental," (Accessed February 8, 2025); DHCS, *supra* note 46, § 5 at 1.

62 DHCS, *supra* note 46, § 10 at 10-1.

63 *Id*., § 2 at 21.

64 DHCS, "Provider Bulletin," Vol. 38, No. 35, November 2022.

65 DHCS, *supra* note 53, at 9.

66 DHCS, *supra* note 46, § 4 at 4-22.

67 American Dental Association, "Silver Diamine Fluoride," (Accessed February 8, 2025).

68 DHCS, *supra* note 46, § 4 at 16-17.

69 *Id*. at 17.

70 DHCS, "Provider Bulletin," Vol. 40, Number 37 (October 2024) (Accessed November 11, 2024).

71 DHCS, *supra* note 53, at 14.

72 DHCS, *supra* note 46, § 5 at 26.

73 DHCS, "Provider Bulletin," Vol. 40, No. 13, (March 2024); See also *supra* note 46, § 5 at 83; *supra* note 46, § 6 at 49-50.

74 *Id*., DHCS, *supra* note 46, § 5 at 40-43.

75 DHCS, *supra* note 46, § 4 at 19.

76 Cal. Welf. & Inst. Code § 14080(a); DHCS, *supra* note 46, § 10 at 13.

77 DHCS, "Medi-Cal Dental: Medi-Cal Provider Directory," (Accessed July 17, 2024).

78 DHCS, "Member Bulletin," Vol. 7, No. 5, (March 2024).

79 See the DHCS Medi-Cal Dental provider referral policy at DHCS, "Provider Bulletin," Vol. 40, Num. 39, November 2024, (Accessed February 4, 2025).

80 DHCS, Medi-Cal Dental Services Division, "2021 Statewide Provider and Member Surveys," (Accessed July 18,2024).

81 DHCS, "Medi-Cal Dental Services Rate Review," p. 5 (October 2019), (Accessed July 18, 2024); DHCS, "Provider Bulletin" Vol. 37, Num. 28, (December 2021) (Accessed July 19, 2024).

82 DHCS, "Provider Bulletin" Vol. 40, Num. 28, (July 2024) (Accessed July 18, 2024).

83 DHCS "Proposition 56 Supplemental Dental Payments," (Accessed July 20, 2024); DHCS, "Current Dental Terminology (CDT) Codes and Schedule of Maximum Allowances (SMAs) for Proposition 56 Supplemental Payments," (Accessed July 20, 2024).

84 California Dental Association, "CDA Major Issues & Priorities," (April 2023).

85 DHCS, and Dental Administrative Service Organization, "2023 Medi-Cal Dental Member and Provider Outreach Plan2023 Medi-Cal Dental Member and Provider Outreach Plan," pp. 2 and 17 (2023) (Accessed July, 19,2024).

86 DHCS, *supra* note 80.

87 DHCS, "Clinical Screening Dentist Manual," v. 1.1, pp. 8 and 25, (August 22, 2024). Note the manual was made available to advocates via a Public Records Act request.

88 DHCS, "Professional/Paraprofessional Adjudication Manual," v. 1.1, p. 64 (August 22, 2024). Note the manual was made available to advocates via a Public Records Act request.

89 DHCS, *supra* note 46 § 2 at 15, and § 5.

90 DHCS, *supra* note 46, § 6 at 19-20.

91 DHCS, *supra* note 46, § 7.

92 DHCS, *supra* note 53, at 23.

93 DHCS Medi-Cal "Provider Bulletin," Vol. 40, Num. 19, (May 2024), (Accessed July 24,2024).

94 DHCS, *supra* note 46, § 4 at 4-7.

95 DHCS, "Transportation Services," (Accessed Aug. 3, 2022).

96 DHCS, *supra* note 46, § 9 at 24.

97 *Id*.

98 DHCS, "All Plan Letter 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses," (May 18, 2022), (Accessed February 8, 2025).

99 DHCS, *supra* note 95.

100 See Americans with Disabilities Act of 1990, 42 U.S.C. § 12182(a); Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116(a).

101 DHCS, *supra* note 46, § 2 at 17.

102 DHCS, *supra* note 102.

103 WIC § 14019.4(c).

104 California Civil Code § 1780(c); California Business and Professions Code §§ 17200 et seq.

105 DHCS, *supra* note 102.

106 DHCS, *supra* note 46, § 2 at 19.

107 Consumer Financial Protection Bureau, "Medical Credit Cards and Financing Plans," (May 2023) (Accessed February 8, 2025); For additional information, see National Consumer Law Center, "Dealing with Medical Debt: Consumer Advice from NCLC," (2018), (Accessed February 8, 2025).

108 California, State Legislature, S.B. 639 § 654.3(b)(e), Oct. 12, 2019.

109 Business & Professions Code § 654.3 (i)(j)(1); See also CA Assembly Bill 171; DHCS Medi-Cal "Provider Bulletin" Vol. 39, Num. 16, (July 2023), (Accessed July 26, 2024).

110 Business & Professions Code § 654.3(k); California Civil Code § 1780.

111 DHCS, *supra* note 53, at 32.

112 DHCS, "Grievance and Appeal Requirements, Notice and "Your Rights" Templates," (Aug. 31,2022), (Accessed July 26, 2024); 42 CFR 438.402(c)(2)(ii).

113 DHCS, *supra* note 53, at 28-32.

114 DHCS, *supra* note 112, at 2.

115 See DHCS, "Dental Case Management Program," (Accessed February 8, 2025).

116 California, State Legislature, Assembly Bill No. 2207, p.2., Feb. 18, 2016; see also WIC §14149.8(g).

117 DHCS, "Program for All Inclusive Care for the Elderly," (Accessed Feb. 8, 2025).

118 See Kimberly Lankford, "5 Things You Should Know About Dental Coverage and Medicare," AARP, (Apr. 19, 2023).

119 Freed, *supra* note 35.

120 California, State Legislature, Assembly Bill No. 1048, (Oct. 8, 2025); See California Dental Association (CDA), "Governor signs second CDA-sponsored dental plan reform bill in 2023," Oct. 9, 2023, (Accessed July 27, 2024).

121 California, State Legislature, Assembly Bill No. 952, (July 27, 2023); California Dental Association (CDA), "CDA-sponsored bill signed into law, improves dental plan disclosures for dentists, patients," Aug. 3, 2023, (Accessed July 27, 2024).

122 See GoodRx Health, "What Is a Dental Savings Plan?" April 3, 2023, (Accessed 07/29/2024).

123 CMS, "A Quick Guide to Medicare and Medicaid," March 2024, (Accessed July 29, 2024).

124 CMS, "Provider Enrollment and Third Party Liability for Items an Services Rendered to Dually Eligible Individuals," January 14, 2025, at 2, (Accessed February 6, 2025).

125 WIC § 14019.4; 42 U.S.C. § 1396a(n)(3)(B).

126 DHCS, "Dental Benefits for Patients Dually Eligible for Medicare and Medi-Cal: Information for Dental Providers," p. 2-3, January 2024, (Accessed July 29, 2024).

127 *Id*. at 2–4.

128 42 C.F.R. § 422.504(g)(1)(iii); CMS, *supra* note 36, at § 10.5.2.

129 DHCS, *supra* note 46, § 4 at 7.

130 DHCS, "Information for Beneficiaries: Medi-Medi Plans," (Accessed April 13, 2023).

131 See DHCS, "California Advancing and Innovating Medi-Cal (CalAIM) Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans)," (Accessed June 15, 2023); DHCS, "Medicare Medi-Cal Plans (Medi-Medi Plans)," (Accessed July 30, 2024); DHCS, "Medicare Medi-Cal Plan List," (Accessed July 30, 2024).

132 DHCS, "Medicare Medi-Cal Plans (Medi-Medi Plans)," at 2 (Accessed July 30, 2024).

133 DHCS, "Exhibit A: Scope of Work Exclusively Aligned Enrollment D-SNP" 2025 SMAC, p.25, (Accessed July 31, 2024).

134 DHCS, "CalAim Dual Eligible Special Needs Plans Policy Guide Contract Year 2025," p. 3, June 2024, (Accessed July 31, 2024).

135 DHCS, *supra* note 135, at 7.

136 Center for Oral Health, *supra* note 3.

137 Ttyana P. Shippee, et al. "Addressing Racial and Ethnic Disparities in Nursing Homes," AARP Public Policy Institute, p. 4., February 1, 2024, (Accessed August 2, 2024).

138 *Id*.

139 42 CFR § 483.20(b)(1)(xi).

140 CMS, "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual," v. 1.15, p. 14, October 2017, (Accessed July 31, 2024).

141 42 CFR § 483.55(a)(1) (for skilled nursing facilities); 42 CFR § 483.55(b)(1) (for nursing facilities).

142 Surveyor's Guideline to 42 CFR section 483.25, Appendix PP to CMS State Operations Manual.

143 42 CFR § 483.55(a)(4).

144 42 CFR § 483.10(f)(11)(i)(E).

145 42 CFR § 483.24(a)(2); and Surveyor's Guideline to 483.24(a)(2), F677, Appendix PP to CMS State Operations Manual.

146 HSC § 1289.4(d).

147 HSC § 1289.4(h).

148 42 CFR § 483.55(a)(3)(5).

149 DHCS, "Provider Bulletin," Vol. 40, No. 13, (March 2024), (Accessed July 31, 2024).

150 22 CCR § 87465.

151 22 CCR § 76359.

152 See the National Association of Community Health Centers, "California Health Center Fact Sheet," (February 2025) (Accessed February 26, 2025).

153 See the U.S. Department of Veterans Affairs, "VA Dental Care," (Accessed August 01, 2024).

154 U.S. Department of Veterans Affairs, "VA Dental Insurance Program (VADIP): Fact Sheet," (Sept. 2017); See also the U.S. Department of Veterans Affairs, "VA Dental Insurance Program (VADIP)," (Accessed August 1, 2024).

155 For more information about the Dental Schools of California, see Dental Board of California "List of California approved dental schools," (Accessed August 1, 2024).