Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee Meeting Agenda

Agenda

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

DENTAL HYGIENE COMMITTEE OF CALIFORNIA
2005 Evergreen Street, Suite 2050 Sacramento, CA 95815
P (916) 263-1978 | **F** (916) 263-2688 | **www.dhcc.ca.gov**

Notice is hereby given that a public meeting of the Dental Hygiene Committee of California (DHCC) will be held as follows:

FULL COMMITTEE MEETING AGENDA

The DHCC welcomes and encourages public participation in its meetings. The public may take appropriate opportunities to comment on any issue before the DHCC at the time the item is heard.

Sunday, May 3, 2015
9:00 a.m. – Adjournment
Embassy Suites Anaheim-Orange
400 N. State College Blvd.
Orange, CA 92868
(714) 938-1111

9:00 a.m. Dental Hygiene Committee of California – Full Committee – Open Session

Reconvene of Full Committee

Roll Call/Establishment of Quorum

1. Public Comment for Items Not on the Agenda
2. Update from the Dental Board of California
3. Update on the BreEZe Computer System
4. Budget Report
5. Discussion and Possible Action to Increase the DHCC Application and Original Licensure Fees
6. Update on Approval of RDH Educational Programs (Feasibility Study), *CCR, Title 16, Division 11, §§ 1104, 1104.1 and 1104.2*
7. Discussion and Possible Action to Amend Proposed Regulatory Language as a Result of Comments Received During the 90-day Public Comment Period for DHCC's Rulemaking to Add CCR, Title 16, Division 11, §1100 Relevant to Definitions
8. Discussion and Possible Action to Amend Proposed Regulatory Language as a Result of Comments Received During the 45-day Public Comment Period for DHCC's Rulemaking to Add CCR, Title 16, Division 11, §§1101, 1121, 1122, 1124, 1126, 1127, and 1133 relevant to Administration and Examinations

9. Discussion and Possible Action to Amend Proposed Regulatory Language as a Result of the Office of Administrative Law's Disapproval of DHCC's Rulemaking Relevant to Educational Program Requirements - *CCR, Title 16, Division 11, §§1103, 1105, 1105.1, 1105.2, 1105.3, 1105.4 and 1106*

10. Discussion and Possible Action to Amend Proposed Regulatory Language as a Result of the Office of Administrative Law's Disapproval of DHCC's Rulemaking Relevant to Remedial Education - *CCR, Title 16, Division 11, §1108*

11. California State Auditor Report regarding Children's Access to Dental Care – Informational Only

12. Legislative and Regulatory Subcommittee Report:

The DHCC may take action on any items listed on the Legislative and Regulatory Subcommittee Agenda and the recommendations provided by the subcommittee.

13. Licensing and Examination Subcommittee Report:

The DHCC may take action on any items listed on the Licensing and Examination Subcommittee Agenda and the recommendations provided by the subcommittee.

14. Enforcement Subcommittee Report:

The DHCC may take action on any items listed on the Enforcement Subcommittee Agenda and the recommendations provided by the subcommittee.

15. Education Subcommittee Report:

The DHCC may take action on any items listed on the Education Subcommittee Agenda and the recommendations provided by the subcommittee.

16. ***Closed Session***

The DHCC may meet in closed session to deliberate on disciplinary matters pursuant to Government Code §11126 (c)(3)

Return to Open Session

17. Future Agenda Items

18. Adjournment

Public comments will be taken on agenda items at the time the specific item is raised. The Committee may take action on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. For verification of the meeting, call (916) 263-1978 or access DHCC's Web Site at **www.dhcc.ca.gov**.

The meeting facilities are accessible to individuals with physical disabilities. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Anthony Lum at (916) 576-5004, via e-mail at: anthony.lum@dca.ca.gov or send a written request to DHCC at 2005 Evergreen Street, Ste. 2050, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help to ensure availability of the requested accommodation.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Roll Call

Establishment of a Quorum

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 1

Public Comment for Items Not on the Agenda

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 2

Update from the Dental Board of California:

A verbal report will be provided.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 3

Update on the BreEZe Computer System

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

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MEMORANDUM

DATE	May 3, 2015
TO	DHCC Committee Members
FROM	Lori Hubble, Executive Officer
SUBJECT	**Agenda Item 3 –** Update on BreEZe Computer System

The BreEZe configuration for DHCC was approved by DHCC on November 18, 2014. This proposed configuration provides a streamlined solution for DHCC staff, applicants, and licensees to apply for, renew, and service their DHCC-issued license(s). At the forefront of the entire BreEZe configuration process, the DHCC license base and general public's needs have been heavily considered. Significant work and intense efforts have been applied to this process by DHCC staff to ensure a smooth transition from our current software to BreEZe for both internal and external constituents. We are building this system to benefit YOU.

Of note: An implementation of this magnitude demands explicit attention to detail. Traci Napper has contributed on many levels to the configuration including all aspects of the DHCC's internal and external workflows, cash handling, license lookup, and numerous tiny and critical details. Defining the testing process is equally as demanding as configuring the system, itself, as DHCC must test every aspect of the BreEZe System before you have an opportunity to test it, yourselves! Nancy Gaytan has reviewed the enforcement portion of the configuration to ensure the data is configured correctly benefitting DHCC probationers and the general public with all aspects of the enforcement module. Eleonor Steiner has been scrutinizing the configuration regarding examinations and licensing with the same attention to detail.

Most recently, Traci Napper, Nancy Gaytan, and Eleonor Steiner have been meticulously reviewing all data from the old system that has been "migrated" into the new BreEZe System incrementally. The information they are validating includes all data in the system such as First and Last Name, SSN, birthdate, enforcement cases linked to licensees, license numbers, issue dates, and every bit of data that BreEZe requires to serve the DHCC population well.

DHCC's goal is to build a replacement data system that enables our population base to apply, renew, maintain, and service their licenses electronically, quickly, and easily. We are on track to meet that goal as a result of DHCC staff's knowledge, commitment, and contributions to BreEZe. Our latest proposed date to begin using BreEZe is February of 2016.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 4

Budget Report

DEPARTMENT OF CONSUMER AFFAIR

DENTAL HYGIENE COMMITTEE OF CALIFORNIA

4/15/2015

AGENDA ITEM 4

BUDGET REPORT
FY 2014/15 Expenditure Projection
For the Period Ending March 31, 2015

OBJECT DESCRIPTION	FY 2014-15 BUDGET ALLOTMENT	CY EXPENDITURES (MONTH 9)	PERCENT SPENT	Budget office PROJECTIONS TO YEAR END	UNENCUMBERED BALANCE
PERSONNEL SERVICES					
Salary & Wages	458,475	296,854	65%	**430,000**	28,475
Temp Help 907	57,000	33,075	58%	**45,000**	12,000
Proctors 915	1,881	0	0%	**0**	1,881
Allocated Proctor	0	173	0%	**300**	(300)
Committee/Bd members (901)	24,400	2,800	11%	**6,000**	18,400
Overtime	0	9,049	0%	**14,000**	(14,000)
Benefits	198,555	139,238	70%	**180,000**	18,555
Salary Savings	0	0	0%	**0**	0
TOTAL PERS SVS	**740,311**	**481,189**	**65%**	**675,300**	**65,011**
OPERATING EXPENSES & EQUIPMENT					
General Expense	8,653	5,369	62%	**8,653**	0
Minor Equipment 226	21,928	497	0%	**3,500**	18,428
Fingerprint Reports	3,220	0	0%	**0**	3,220
Printing	4,358	9,263	213%	**11,000**	(6,642)
Communication	4,812	1,761	37%	**2,500**	2,312
Postage	14,063	9,620	68%	**13,500**	563
Insurance	0	0	0%	**0**	0
Travel In state	16,743	18,567	111%	**25,000**	(8,257)
Travel Out of state	0	0	0%	**0**	0
Training	1,800	0	0%	**0**	1,800
Facilities Ops	30,120	57,090	190%	**62,000**	(31,880)
Utilities	0	0	0%	**0**	0
C&P Serv. Internal	24,323	6	0%	**0**	24,323
**C&P Serv. External	15,984	9,391	59%	**15,984**	0
Departmental Services:					
OIS Pro Rata	153,701	113,193	74%	**153,701**	0
Indirect Distrb Cost	93,669	67,761	72%	**93,669**	0
Interagency Services	29,635	0	0%	**0**	29,635
IA with OPES (formerly OER)	0	5,304	0%	**6,000**	(6,000)
DOI - Pro Rata	2,922	2,115	72%	**2,922**	0
Public Affairs Pro Rata	2,858	2,067	72%	**2,858**	0
PCSD Pro Rata	3,109	2,262	73%	**3,109**	0
Consolidated Data Centers	1,594	106	7%	**1,594**	0
Data Processing	2,558	2,339	91%	**2,558**	0
Central Adm. Services (Pro Rata)	74,669	56,002	75%	**74,669**	0
EXAMS					
Exam supplies & freight	1,612	0	0%	**0**	1,612
Exam Site rental	18,567	20,780	112%	**22,000**	(3,433)
Exam Contracts	251,348	35,671	14%	**75,000**	176,348
Expert Examiners (SME)	19,392	18,358	95%	**19,392**	0
ENFORCEMENT					
Attorney General	75,137	45,043	60%	**75,137**	0
Off of Admin Hearings	3,120	5,717	183%	**6,500**	(3,380)
Evidence/Witness	36	9310	25861%	**12,000**	(11,964)
Court Reporter Services	0	450	0%	**2,000**	(2,000)
Div. of Investigations (DOI Pro Rata)	0	0	#DIV/0!	**0**	0
Major Equipment	0	0	#DIV/0!	**0**	0
Other Items of Expense	117	0	0%	**0**	117
Vehichle op	0	0	#DIV/0!	**0**	0
Special Adj - OE&E	0	0	0%	**0**	0
Total OE & E	**880,048**	**498,042**	**57%**	**695,246**	**184,802**
TOTAL EXPENDITURES	**1,620,359**	**979,231**	**60%**	**1,370,546**	**249,813**
Legislative Exam Appropriation	0	0		**0**	0
NET APPROPRIATION	**1,620,359**	**979,231**	**60%**	**1,370,546**	**249,813**
Scheduled, Other Reimbursement	**(1,000)**			**(1,000)**	0
Distributed Costs	**(5,000)**			**(5,000)**	0
Unscheduled Reimbursement					0
NET, TOTAL EXPENDITURES	**1,614,359**	**979,231**	**61%**	**1,364,546**	**249,813**
NOTES/ASSUMPTIONS					
			Surplus/Deficit		**15.5%**

DHCC REVENUE TRACKING

	COMDA				DHCC							
Fiscal Year (FY)	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2015-16
DHCC Revenue per FY	$493,986	$596,112	$753,321	$1,100,851	$1,353,365	$1,307,531	$1,121,228	$972,322	$1,536,487	$1,450,952	$0	$0

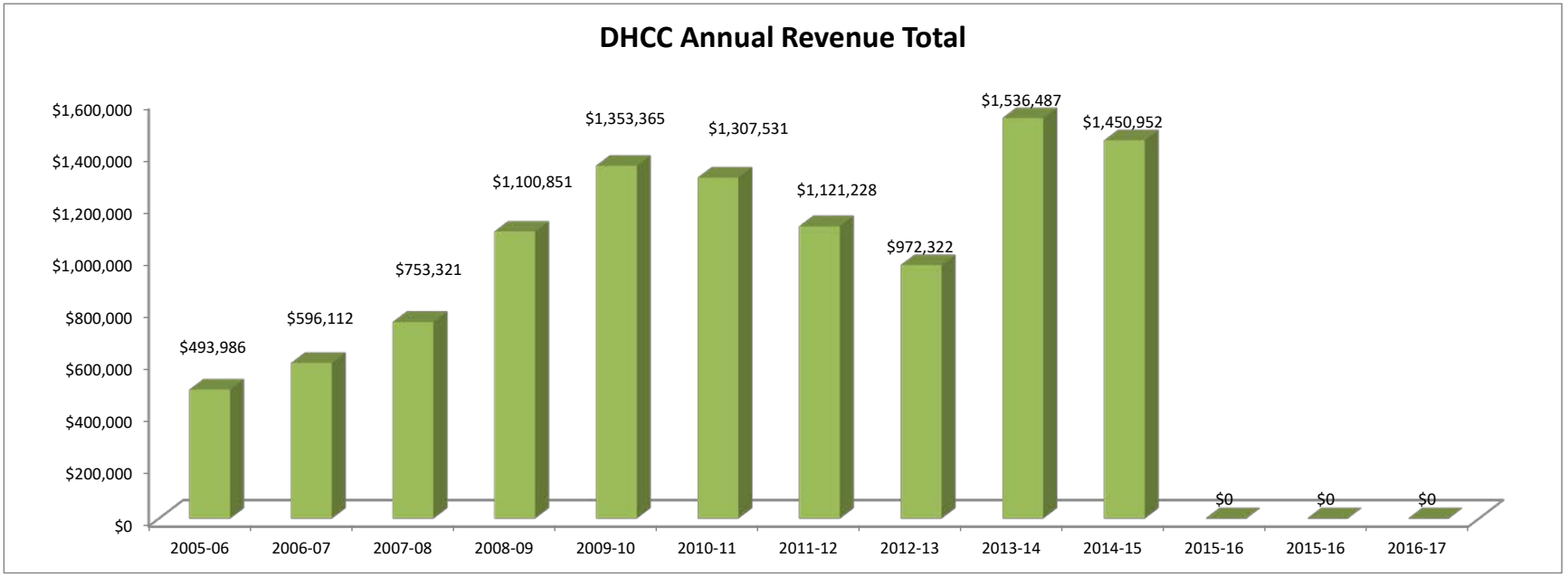
Notes:

a) Revenue for FY 2014-15 is thru March 2015

b) $80 License Renewal Fee increase to $160 effective 1/1/2014

c) Exam Fees - $220 for FY 2005/06 - 2008/09; increased to $525 in FY 2009/10

d) DHCC established in FY 2009/10



3140 - State Dental Hygiene Fund
Analysis of Fund Condition

Prepared 4/21/15

(Dollars in Thousands)

2015-16 Governor's Budget w/ BreEZe SPR 3.1

		Actual 2013-14	CY 2014-15	BY 2015-16	BY+1 2016-17	BY+2 2017-18
BEGINNING BALANCE		$ 588	$ 826	$ 717	$ 489	$ 209
Prior Year Adjustment		$ -1	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 587	$ 826	$ 717	$ 489	$ 209
REVENUES AND TRANSFERS						
Revenues:						
114300	Other Motor Vehicle Fees	$ -	$ -	$ -	$ -	$ -
125600	Other regulatory fees	$ 13	$ 12	$ 14	$ 14	$ 14
125700	Other regulatory licenses and permits	$ 423	$ 341	$ 323	$ 323	$ 323
125800	Renewal fees	$ 1,060	$ 1,159	$ 1,241	$ 1,241	$ 1,241
125900	Delinquent fees	$ 14	$ 15	$ 15	$ 15	$ 15
141200	Sales of documents	$ -	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ -	$ -	$ -	$ -	$ -
150300	Income from surplus money investments	$ 2	$ 2	$ 2	$ 1	$ -
160400	Sale of fixed assets	$ -	$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ -	$ -	$ -	$ -	$ -
161400	Miscellaneous revenues	$ 1	$ -	$ -	$ -	$ -
164300	Penalty Assessments	$ -	$ -	$ -	$ -	$ -
Totals, Revenues		$ 1,513	$ 1,529	$ 1,595	$ 1,594	$ 1,593
Totals, Revenues and Transfers		$ 1,513	$ 1,529	$ 1,595	$ 1,594	$ 1,593
Totals, Resources		$ 2,100	$ 2,355	$ 2,312	$ 2,084	$ 1,802
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ -	$ -	$ -	$ -	$ -
8880 Financial Information System for CA (State Operations)		$ 7	$ 1	$ 3	$ -	$ -
Budget Act						
1110 Program Expenditures (State Operations)		$ 1,267	$ 1,614	$ 1,632	$ 1,665	$ 1,698
	2015-16 BreEZe SFL	$ -	**$ 23**	**$ 188**	**$ 210**	$ -
Total Disbursements		$ 1,274	$ 1,638	$ 1,823	$ 1,875	$ 1,698
FUND BALANCE						
Reserve for economic uncertainties		$ 826	$ 717	$ 489	$ 209	$ 104
Months in Reserve		6.1	4.7	3.1	1.5	0.7

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ON-GOING.

B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR BEGINNING IN BY+1.

C. ASSUMES INTEREST RATE AT 0.3%.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 5

Discussion and Possible Action to Increase the DHCC Application and Original Licensure Fees

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

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2005 Evergreen Street, Suite 2050, Sacramento, CA 95815
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MEMORANDUM

DATE	April 23, 2015
TO	DHCC Committee Members
FROM	Anthony Lum, Assistant Executive Officer
SUBJECT	**Agenda Item 5 - Discussion and Possible Action to Increase the DHCC Application and Original License Fee**

Background

The Dental Hygiene's Application Fee has been at its current level of $50 for at least 10 years and prior to the Committee's inception in FY 2009/10. Since that time, administrative cost and the cost of doing business have increased significantly for staff to conduct a thorough review of the applications. Much of the staff's work consists of follow-up communications, creating and maintaining an electronic record of the applicants in the department's databases, cashiering of the fees rendered, and many times, a re-review of an application when it is resubmitted after being deemed deficient without further cost to the applicant. In addition, the increase in fees will help to offset some of the Committee's expense of implementing a new computer system that will make the application process much easier for the applicant. An applicant will be able to apply for licensure online in real time and pay the fee using a credit card.

Committee Action Requested

❑ Staff recommends to the full committee to approve a $50 increase to the Application Fee to $100 by resolution to cover the increasing administrative costs to process applications.

Original License Fee – Staff recommends tabling this action until a future date in order to allow for further analysis of any fiscal impact to the Committee's revenue by current legislation that would mandate the Committee to prorate the fee.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 6

Update on Approval of RDH Educational Programs (Feasibility Study), CCR, Title 16, Division 11, §§1104, 1104.1, and 1104.2

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	April 23, 2015
TO	Dental Hygiene Committee of California Committee Members
FROM	Guadalupe Castillo, Legislative and Regulatory Analyst
SUBJECT	**Agenda Item 6 – Update on Approval of RDH Educational Programs (Feasibility Study), *CCR, Title 16, Division 11, §§ 1104, 1104.1 and 1104.2***

Approval of RDH Educational Programs, *CCR, Title 16, Division 11, §§ 1104, 1104.1 and 1104.2*

This regulatory package was submitted to the Department of Consumer Affairs (DCA) for review on January 23, 2015. Once reviewed and approved by DCA and its umbrella agency, Business, Consumer Services and Housing Agency, the file will proceed to the Department of Finance for review and approval before it is submitted to the Office of Administrative Law for its review. The rulemaking file expires on July 25, 2015.

Committee Action Requested

❑ Informational only. No action requested.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 7

Discussion and Possible Action to Amend Proposed Regulatory Language as a Result of Comments Received During the 90-day Public Comment Period for DHCC's Rulemaking to Add CCR, Title 16, Division 11, §1100 Relevant to Definitions

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	April 23, 2015
TO	Dental Hygiene Committee of California
FROM	Donna Kantner, DHCC Staff
SUBJECT	**Agenda Item 7 –** Discussion and Possible Action to Amend Proposed Regulatory Language as a result of Comments Received During the 90-day Public Comment Period for the DHCC's Rulemaking to Add *CCR, Title 16, Division 11, §1100* Relevant to Definitions

Background

At its December meeting, the Committee approved proposed regulatory language relating to definitions. The proposed text was transmitted to the Dental Board on December 11, 2014 according to the requirements of Business and Professions Code Section 1905.2, and a 90-day public comment period placed the public hearing on April 30, 2015. The Dental Board provided its response on March 5, 2015.

Several dental hygiene educational program directors have sent the same consistent comments regarding this rulemaking, and thus have been grouped together in the staff recommendations. Comments received to date and staff recommendations regarding those comments are included in this item.

Please note that additional comments may be made from this date forward, as well as at the hearing on April 30, 2015, therefore this item is only partially complete. The fully completed item with all comments received will be hand-carried to the meeting for discussion and action by the Committee.

COMMENTS RECEIVED IN WRITING

The Dental Board of California (Board) provided the following response in accordance with the provisions of Business and Professions Code Section 1905.2, which requires the Board to approve, modify, or reject recommendations regarding scope of practice to the Committee within 90 days of submission of the recommendation to the Board. In a letter dated December 11, 2014, the Committee requested the Board's comments on the proposed regulations. Following is a summary of comments and staff's recommendations:

1. Regarding proposed section 1100(c), the Board recommends that the definition of assessment be amended to include "utilized within the scope of dental hygiene practice and pursuant to Business and Professions Code Section 1910.5", noting that there are limitations on the use of diagnostic tools and instruments by a registered dental hygienist and this amendment would provide clarification and address concerns that the definition could be interpreted to be outside the registered dental hygienist's scope of practice.

   Staff Recommendation: Staff recommends acceptance of this comment and amendment of the text as recommended by the Board to read:

   (c) "Assessment" means the systematic collection, analysis, and documentation of the oral and general health status and patient needs through a variety of methods, including choice of radiographs, diagnostic tools, and instruments utilized within the scope of dental hygiene practice and pursuant to Business and Professions Code Section 1910.5.

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2. Regarding proposed section 1100(h), the Board's response stated that it "did not find any issues related to scope of practice but recommends the Committee consider adding a definition for 'dental hygiene diagnosis' since it is not currently defined in the Code or in regulation and would provide clarification and consistency."

   Staff Recommendation: Staff recommends acceptance of this comment and suggests amending the text to add a definition for dental hygiene diagnosis to clarify the term for users and the public. Staff suggests the following text be added to the proposed regulatory language:

   (i) The dental hygiene diagnosis is a component of the overall dental diagnosis. It is the identification of an existing or potential oral health problem that a dental hygienist is educationally qualified and licensed to treat. The dental hygiene diagnosis utilizes critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data.

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3. Regarding proposed section 1100(j) defining dental hygiene therapeutic interventions, the Board recommends the addition of "provided within the scope of dental hygiene practice" for clarity and consistency.

   Staff Recommendation: Staff recommends acceptance of this comment and suggests amending the text as suggested by the Board, to read as follows:

   "Dental hygiene therapeutic interventions" means specific procedure or set of procedures, provided within the scope of dental hygiene practice, designed to intervene in the disease process to produce a therapeutic benefit.

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4. Regarding section 1100(r) which defines “refer”, the Board recommends amending the text as follows , to provide clarification and address concerns that the definition could be interpreted to be outside the scope of a registered dental hygienist:

   “Refer” means through dental hygiene assessment, diagnosis, or treatment, it is determined that services are needed beyond the practitioner’s competence or area of expertise.

   Staff Recommendation: Staff recommends acceptance of this comment and amendment of the text as suggested by the Board.

   Dr. Vickie Kimbrough, RDH, MBA, PhD, Dental Hygiene Program Director for Southwestern College, submitted comments regarding section 1100 as well as sections 1101, 1126 and 1127. Marva White, educator at the dental hygiene program at Fresno City College, M. Diane Melrose, Director of the Dental Hygiene Program at USC School of Dentistry, Roberta Lawrence, Co-director of Cypress College Dental Hygiene Program, Brenda Kunz, Dental Hygiene Program Director at Carrington College in Sacramento, educator Joanne Noto, Donna Smith, Associate Professor of Clinical Dentistry in the Division of Periodontology, Diagnostic Sciences, and Dental Hygiene at the Ostrow School of Dentistry of USC, and Phyllis Spragge, Director of the Dental Hygiene Program at Foothill college all wrote in support of Dr. Kimbrough’s comments. Only those comments pertaining to section 1100 are contained in this item.

5. Regarding section 1100(b) defining the administration of nitrous oxide and oxygen used as an analgesic, Dr. Kimbrough recommended that the Committee consider replacing the term ‘dental’ with ‘dental hygiene’ in keeping with the scope of dental hygiene practice and to provide clarity and consistency.

   Staff Recommendation: Staff recommends rejection of this comment because the administration of nitrous oxide and oxygen may only be performed by a dental hygienist under the direct supervision of a licensed dentist. Therefore, the procedure or procedures being performed may be dental procedures performed by the dentist while instructing the dental hygienist in the administration of the analgesic nitrous oxide and oxygen. We would not choose to prohibit the dental hygienist from assisting the dentist in the area of analgesia by limiting the allowed area of treatment to dental hygiene.

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6. Regarding section 1100(i), which defines “dental hygiene preventive services,” Dr. Kimbrough recommends removal of the phrase “and improve the patient’s quality of life” in keeping with a true definition of dental hygiene preventive services which ends with “and promote oral health.”

   Staff Recommendation: Staff recommends rejection of this comment. As part of the discussion in the ad hoc subcommittee that developed this proposed text, the subcommittee explained to staff that much of dental hygiene preventive services, which include screening for oral cancer, nutrition counseling and promoting

smoking cessation has beneficial effects on the patient's entire well-being, not only the health of the oral cavity. Smoking cessation can improve not only the patient's health, but also relationships and finances, by eliminating "smoker's breath" and the high cost of purchasing cigarettes. Recent research shows that inflammation of the mouth which occurs from periodontal disease can contribute to a myriad of health conditions including heart disease, diabetes and cancer, so if dental hygiene preventive services can prevent or delay the onset of such diseases, it definitely would improve the patient's quality of life.

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7. Regarding section 1100(j), which defines "dental hygiene therapeutic interventions," Dr. Kimbrough recommends adding "oral" to "the disease process" to prevent misinterpretation by the public.

   Staff Recommendation: Staff recommends rejection of this comment for the same reasons described above.

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8. Regarding section 1100(s) defining root planning, Dr. Kimbrough recommended removing the word "all" and removing or changing the word "tooth," noting that using the word "all" in this context indicates that root surfaces will never have residual calculus and toxic materials after the root planning procedure, when in actuality they can only be removed at a competent level by a dental hygienist based on the oral conditions of the patient. She indicated that the word "tooth" should be eliminated due to the fact that the root surface is referenced in this definition, or "root" should replace the word "tooth" for consistency.

   Staff Recommendation: Staff recommends acceptance of this comment and modification of the text as follows:

   "Root planing" means the process of instrumentation which removes ~~all~~ residual calculus and toxic materials from the root to produce a clean, smooth ~~tooth~~ surface.

Carrie Gordon, VP Government Affairs for the California Dental Association (CDA) provided written comments in a letter dated April 22, 2015. CDA commented on four subsections of the proposed regulations and stated that its primary objective is to ensure that the Committee and the Dental Board meet their statutory responsibilities as described in code and there is clarity regarding the process for addressing scope of practice issues moving forward. Following are CDA's comments and staff's recommendations:

9. Regarding section 1100(c) defining the term "assessment", CDA noted that this term does not appear in the code, however "dental hygiene assessment" does, adding that the two are not synonymous. CDA stated that the proposed definition "broadly describes the record collection activities conducted on behalf of the dentist to be used by that dentist for diagnosis and treatment planning" and that those activities may also be performed by dental assistants.

Staff Recommendation: Staff recommends acceptance of this comment, noting that the Dental Board had similar concerns regarding clarity and therefore the text was modified as recommended by the Dental Board in comment 1 above.

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10. Regarding section 1100(h) defining the term "Dental hygiene care plan", CDA was concerned with the use of the term "dental hygiene diagnosis" that conflicts with Business and Professions Code section 1908(b)(1) prohibiting dental hygienists from "Diagnosis and comprehensive treatment planning."

    Staff Recommendation: This statute broadly prohibits anyone but a dentist from performing a dental diagnosis and comprehensive dental treatment planning. All dental hygiene educational programs that are accredited by the American Dental Association's Commission on Dental Accreditation (CODA) are required to teach dental hygiene diagnosis as a component of the dental hygiene process of care, which is the standard of care within the dental hygiene industry. This is a part of the complete dental diagnosis that is performed by the dentist. The Dental Board noted this in their comments dated March 5, 2015, and recommended that the Committee add a definition for "dental hygiene diagnosis" to add clarification and consistency to these proposed regulations. Therefore, according to the provisions of Business and Professions Code Section 1905.2, we have added a definition for "dental hygiene diagnosis" into the proposed text as described in comment 2 above.

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11. Regarding section 1100(i) defining the term "dental hygiene preventive services", CDA felt that this definition "too broad and vague to be suitable regulatory language," and proposed the following alternative language:

    "Dental hygiene preventive services" are the specific procedures provided within the scope of dental hygiene practice, as specified in Business and Professions Code Sections 1910(a) & (b), whose primary benefit is to prevent oral disease.

    Staff Recommendation: Staff recommends rejection of this comment. CDA's proposed definition would be unnecessarily restrictive and not reflective of actual dental hygiene practice. Dental hygienists not only clean teeth, but routinely provide nutrition counseling and promote cessation of smoking and other forms of tobacco use that are harmful to patients oral and overall health.

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12. Regarding section 1100(r) defining the term "Refer", CDA questioned the appropriateness of the definition, and felt it was limited to listing some of the circumstances of referral rather than defining the action itself, suggesting the following modified text:

    "Refer" means the action a dental hygienist must take after determining that services are needed beyond the hygienist's competence and/or scope of practice to provide, to ensure that the patient is directed to a healthcare provided who can provide that care.

Staff Recommendation: Staff recommends rejection of this comment. The Dental Board recommended in its May 5, 2014 comments that this definition be clarified by adding "dental hygiene" before "assessment." Therefore, according to the provisions of Business and Professions Code 1905.2, we have amended the text accordingly.

COMMENTS RECEIVED AT THE REGULATORY HEARING ON APRIL 30, 2015

Any additional written comments received and all comments received at the regulatory hearing will be hand-carried to the meeting including staff recommendation provided if necessary.

Committee Action Requested

❑ 1) Discuss each comment and either accept or reject staff's recommendation and amend the text as necessary, providing a rationale to be included in the rulemaking file.
❑ 2) If any amendments to the text are accepted, direct staff to notice the proposed changes for a 15-day comment period and delegate to the Executive Officer the authority to adopt the final text and make any nonsubstantive changes necessary to complete the rulemaking file if no adverse comments are received.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY · GOVERNOR EDMUND G. BROWN JR
DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, California 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

March 5, 2015

Lori Hubble, Executive Officer
Dental Hygiene Committee of California
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

Subject: Proposed Addition of California Code of Regulations, Title 16, Section 1100, Relating to Dental Hygiene Definitions

Dear Ms. ~~Hubble~~ Lori:

The Dental Board of California (Board) is in receipt of your letter dated December 11, 2014 requesting the Board's comments on the Dental Hygiene Committee of California's (Committee) proposed addition of California Code of Regulations, Title 16, Section 1100 relative to definitions.

Pursuant to Business and Professions Code (Code) Section 1905.2, the Board is required to approve, modify, or reject recommendations regarding scope of practice to the Committee within 90 days of submission of the recommendation to the Board. This letter serves as the Board's response to your letter. The Board respectfully requests this letter also be included as part of the rulemaking file and considered as written comments received during the public comment period.

The Board met on February 27, 2015 to discuss the Committee's proposal. Of the twenty-two proposed definitions, the Board offers the following comments on four:

1. Subdivision (c) of the Committee's proposed language defines "assessment" as the systematic collection, analysis, and documentation of the oral and general health status and patient needs through a variety of methods, including choice of radiographs, diagnostic tools, and instruments.

   The Board recommends the definition be amended to include: "...utilized within the scope of dental hygiene practice and pursuant to Business and Professions Code Section 1910.5." There are limitations on the use of diagnostic tools and instruments by a registered dental hygienist; therefore the Board's proposed amendment would address concerns that the definition could be interpreted to be outside the scope of a registered dental hygienist and provide clarification to the reader.

2. Subdivision (h) of the Committee's proposed language defines "dental hygiene care plan" as an organized presentation or list of interventions to promote health or prevent disease of the patient's oral condition; plan is designed by the dental hygienist based on assessment data, dental hygiene diagnosis, and consists of services within the scope of dental hygiene practice.

   The Board did not find any issues related to scope of practice but recommends the Committee consider adding a definition for "dental hygiene diagnosis" since it is not currently defined in the Code or in regulation and would provide clarification and consistency.

3. Subdivision (j) of the Committee's proposed language defines "dental hygiene therapeutic interventions" as the specific procedure or set of procedures designed to intervene in the disease process to produce a therapeutic benefit.

   The Board recommends amending the definition as follows: ""Dental hygiene therapeutic interventions" means specific procedure or set of procedures, provided within the scope of dental hygiene practice, designed to intervene in the disease process to produce a therapeutic benefit." The Board found that other definitions included qualifying statements to indicate that procedures are limited to the dental hygiene scope of practice and determined that this recommended amendment would provide clarity and consistency.

4. Subdivision (r) of the Committee's proposed language defines "Refer" to mean through assessment, diagnosis, or treatment, it is determined that services are needed beyond the practitioner's competence or area of expertise.

   The Board recommends amending the definition as follows: ""Refer" means through dental hygiene assessment, diagnosis, or treatment, it is determined that services are needed beyond the practitioner's competence or area of expertise." The Board determined this recommendation would address concerns that the definition could be interpreted to be outside the scope of a registered dental hygienist and provide clarification to the reader.

If you have any questions, please do not hesitate to contact me at (916) 263-2188 or Karen.Fischer@dca.ca.gov.

Sincerely,

Karen

Karen M. Fischer, MPA,
Executive Officer

cc: Fran Burton, MSW, President, Dental Board of California

Kantner, Donna@DCA

From: Vickie Kimbrough-Walls <vkimbrough@swccd.edu>
Sent: Monday, March 02, 2015 9:52 AM
To: Castillo, Guadalupe@DCA
Cc: Kantner, Donna@DCA; Gay Teel (gayteel@gmail.com)
Subject: Comments on SS: 1100 Definitions
Attachments: Comments for DHCC.pdf

Good morning,
Please see attached comments being submitted on two documents: Definitions SS. 1100 and SS 1101, 1121, etc.

Thank you

Vickie

Dr. Vickie Kimbrough RDH, MBA, PhD
Director, Dental Hygiene
Southwestern College
Higher Education Center at National City
880 National City Blvd., National City, CA 91950
619-216-6670 | 619-216-6678 fa
vkimbrough@swccd.edu

CDHEA

California Dental Hygiene Educators' Association

Kesa Hopkins, President
Chuck Cort, Vice President
Judy Yamamoto, Secretary
Jeanice Howard, Treasurer
Pamela Powers, Past President
Gay Teel, Executive Director

Dental Hygiene Committee of California
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

February 12, 2015

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of the dental hygiene program Directors of the California Dental Hygiene Educators' Association, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

§1100. Definitions

5. **(b)** 'Administration of nitrous oxide and oxygen, means the administration of nitrous oxide and oxygen when used as an analgesic during **dental** treatment.

Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
Justification: In keeping with the scope of dental hygiene practice, and attempting to define/describe the duties of the dental hygienist, the term dental implies dental treatment/procedures versus dental hygiene treatment/procedures. Using the terms dental hygienist/dental hygiene provide clarity and consistency.

6. **(i)** 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health **and improve the patient's quality of life**.

Comment: It is recommend that the Committee consider removing '**and improve the patient's quality of life**'.
Justification: In keeping with a true definition of dental hygiene preventive services, services end after 'promote oral health'. Improving quality of life is an implied action or result of preventive services and may or may not occur for any given patient. ***The revised definition would read:***

*(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology **and** promote oral health.*

7. **(j)** 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in the disease process to produce a therapeutic benefit.

Comment: It is recommend that the Committee consider inserting the word 'oral' prior to the terms disease process.
Justification: In keeping within the scope of dental hygiene practice, inserting the word 'oral' defines the specific disease process under the purview of the dental hygienist. Without it, the disease process can be interpreted multiple ways by the general public. ***The revised definition would read:***

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in the oral disease process to produce a therapeutic benefit.

8. **(s)** 'Root planing' means the process of instrumentation which removes all residual calculus and toxic materials from the root to produce a clean, smooth tooth surface.

Comment: It is recommend that the Committee consider removing the word 'all' and removing or changing the word 'tooth'.
Justification: Using the word 'all' in this context and definition indicates that root surfaces will never have residual calculus and toxic materials after the root planing procedure. Without the option, education, license, and skill to flap gingival tissue and expose all root surfaces, residual deposits and toxins cannot be removed at the level of 'all'. They can be removed at a competent level based on the oral conditions of the patient and skill of the licensed dental hygienist.

The word 'tooth' should be eliminated due to the fact the root surface is referenced in this definition, or 'root' should replace the word 'tooth' for consistency purposes.

B. Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

§1126. Conduct of Dental Hygiene Committee of California Clinical Examinations.

(b) Grading examiners shall not view applicants during the performance of the 3 examination assignments. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for a minimum of five years.

Comment: It is recommend that the Committee consider revision of the second sentence, to address the true intent of the five-year requirement.
Justification: The current verbiage of the sentence is unclear. Is it to be interpreted as the RDH, RDHAP, and RDHEF will be an examiner for five years or that the dental hygienist must have had an active license for five years?

CDHEA

California Dental Hygiene Educators' Association

Kesa Hopkins, President
Chuck Cort, Vice President
Judy Yamamoto, Secretary
Jeanice Howard, Treasurer
Pamela Powers, Past President
Gay Teel, Executive Director

§1127. Dental Hygiene Committee of California Clinical Examination Review Procedures; Appeals.

(a) An applicant who has failed an examination shall be provided **with notice, upon written request**, of those areas in which he or she is deficient.

Comment: It is recommend that the Committee consider **automatic notice** of deficient areas to those who fail the examination.
Justification: During presentation of the CRDTS and WREB examination to the California dental hygiene educators at the annual conference in February 2015, both testing agencies automatically provide written information to the candidate on deficiencies. A mandate to request documentation from the DHCC on deficiencies for the California examination is the creation of an unnecessary obstacle hindering forward movement toward re-examination, licensing, and employment. Other testing agencies are more candidate friendly than California in this respect.

(b) An appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The Executive Officer shall **respond** to the appeal in writing and may request a personal appearance by the applicant. The Committee shall thereafter take such action as it deems appropriate.

Comment: It is recommend that the Committee consider including a timeline for the expected response from the Executive Director.
Justification: Timelines for reporting, licensing, change of address, and submissions by licentiates or those applying for a dental hygiene license, and disciplinary cases to name only a few is required and mandated by the DHCC. For those waiting for a response from the DHCC, the same parameters to respond to inquisitions by those the DHCC serves and the general public should be included.

From: Marva White [mailto:marvawhite@yahoo.com]
Sent: Monday, February 23, 2015 2:53 PM
To: DCA, dhccinfo@DCA
Cc: Joanne Pacheco
Subject: Wording for the Code of Regulations for Dental Hygiene Pratice

Re: Section 1100 of Article 1 and Article 2 of Division 11 of Title 6 of the Code of Regulations

To Whom it May Concern:

I have been a Dental Hygienist for 50 years both as a clinical hygienist and a dental hygiene educator at Fresno City College. I am concerned about some of the wording used in the Code of Regulations being written for dental hygiene practice. I would like to confirm support of the wording submitted by Dr. Vickie Kimbrough, RDH, PhD, Director of the Southwestern College Department of Dental Hygiene. The suggestions made in her letter of February 12, 2015, are needed to clarify the intent of the regulations as they relate to the practice of the dental hygienist.

Respectfully,
Marva White BS, RHD, MS

Kantner, Donna@DCA

From: Hubble, Lori@DCA
Sent: Wednesday, February 25, 2015 9:13 AM
To: Castillo, Guadalupe@DCA
Cc: Kantner, Donna@DCA
Subject: Definitions Comments
Attachments: Comments for DHCC-Kimbrough (3).pdf

From: M. Diane Melrose [mailto:mmelrose@usc.edu]
Sent: Monday, February 23, 2015 9:37 PM
To: DCA, dhccinfo@DCA; Hubble, Lori@DCA
Subject: Support of Comments

To Whom It May Concern,

I am in agreement with the comments made by Vicki Kimbrough.

Sincerely,
Diane

M. Diane Melrose, RDH, BS, MA
Director, Dental Hygiene
Herman Ostrow School of Dentistry of USC
925 W. 34th Street, DEN 4330
Los Angeles, CA 90089-0641

YES I CAN!

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Southwestern College Dental Hygiene Program, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

§1100. Definitions

(b) 'Administration of nitrous oxide and oxygen, means the administration of nitrous oxide and oxygen when used as an analgesic during **dental** treatment.

Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
Justification: In keeping with the scope of dental hygiene practice, and attempting to define/describe the duties of the dental hygienist, the term dental implies dental treatment/procedures versus dental hygiene treatment/procedures. Using the terms dental hygienist/dental hygiene provide clarity and consistency.

(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health **and improve the patient's quality of life**.

Comment: It is recommend that the Committee consider removing '**and improve the patient's quality of life**'.
Justification: In keeping with a true definition of dental hygiene preventive services, services end after 'promote oral health'. Improving quality of life is an implied action or result of preventive services and may or may not occur for any given patient. ***The revised definition would read:***

*(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology **and** promote oral health.*

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in **the disease process** to produce a therapeutic benefit.

Comment: It is recommend that the Committee consider inserting the word 'oral' prior to the terms disease process.
Justification: In keeping within the scope of dental hygiene practice, inserting the word 'oral' defines the specific disease process under the purview of the dental hygienist. Without it, the disease process can be interpreted multiple ways by the general public. ***The revised definition would read:***

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in the oral disease process to produce a therapeutic benefit.

(s) 'Root planing' means the process of instrumentation which removes **all** residual calculus and toxic materials from the root to produce a clean, smooth **tooth** surface.

Comment: It is recommend that the Committee consider removing the word 'all' and removing or changing the word 'tooth'.
Justification: Using the word 'all' in this context and definition indicates that root surfaces will never have residual calculus and toxic materials after the root planing procedure. Without the option, education, license, and skill to flap gingival tissue and expose all root surfaces, residual deposits and toxins cannot be removed at the level of 'all'. They can be removed at a competent level based on the oral conditions of the patient and skill of the licensed dental hygienist.

The word 'tooth' should be eliminated due to the fact the root surface is referenced in this definition, or 'root' should replace the word 'tooth' for consistency purposes.

B. Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

§1126. Conduct of Dental Hygiene Committee of California Clinical Examinations.

(b) Grading examiners shall not view applicants during the performance of the 3 examination assignments. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for **a minimum of five years**.

Comment: It is recommend that the Committee consider revision of the second sentence, to address the true intent of the five-year requirement.
Justification: The current verbiage of the sentence is unclear. Is it to be interpreted as the RDH, RDHAP, and RDHEF will be an examiner for five years or that the dental hygienist must have had an active license for five years?

§1127. Dental Hygiene Committee of California Clinical Examination Review Procedures; Appeals.

(a) An applicant who has failed an examination shall be provided **with notice, upon written request**, of those areas in which he or she is deficient.

Comment: It is recommend that the Committee consider **automatic notice** of deficient areas to those who fail the examination.
Justification: During presentation of the CRDTS and WREB examination to the California dental hygiene educators at the annual conference in February 2015, both testing agencies automatically provide written information to the candidate on deficiencies. A mandate to request documentation from the DHCC on deficiencies for the California examination is the creation of an unnecessary obstacle hindering forward movement toward re-examination, licensing, and employment. Other testing agencies are more candidate friendly than California in this respect.

(b) An appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The Executive Officer shall **respond** to the appeal in writing and may request a personal appearance by the applicant. The Committee shall thereafter take such action as it deems appropriate.

Comment: It is recommend that the Committee consider including a timeline for the expected response from the Executive Director.
Justification: Timelines for reporting, licensing, change of address, and submissions by licentiates or those applying for a dental hygiene license, and disciplinary cases to name only a few is required and mandated by the DHCC. For those waiting for a response from the DHCC, the same parameters to respond to inquisitions by those the DHCC serves and the general public should be included.

Respectfully submitted

Dr. Vickie Kimbrough, RDH, PhD
Director
Southwestern College Dental Hygiene

Kantner, Donna@DCA

From: Roberta Lawrence <rlawrence@cypresscollege.edu>
Sent: Thursday, March 05, 2015 3:57 PM
To: Castillo, Guadalupe@DCA; donna.kanter@dca.ca.gov
Subject: Written comments for 3/18 & 4/30 meetings
Attachments: MARCH 2015.docx

Follow Up Flag: Follow up
Due By: Wednesday, April 08, 2015 8:00 AM
Flag Status: Flagged

Ms. Castillo and Ms. Kanter,
Please accept the attached written comments to be presented to the March 18 and April 30, 2015 regulatory hearings.
Sincerely,

ROBERTA LAWRENCE, RDH, MS
Co-Director Cypress College Dental Hygiene Program
714-484-7291
rlawrence@cypresscollege.edu
9200 Valley View Street
Cypress, CA 90630

Dental Hygiene Committee of California
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

March 5, 2015

RE: Proposed Language for:

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations § 1100. Definitons
And
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Cypress College Dental Hygiene Program, please consider these comments submitted for specific areas of the proposed language found in the above mention documents for March 18, 2015 and April 30, 2015.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations § 1100. Definitions

(b) "Administration of nitrous oxide and oxygen" means the administration of nitrous oxide and oxygen when used as an analgesic during dental treatment.

Comment: It is suggested the Committee add the word "hygiene" to dental treatment.
Rational: This indicates the use of nitrous oxide/oxygen would be for dental hygiene treatment only and would not be confused with treatment provided by a dentist.

(i) "Dental hygiene preventive services" means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health and improve the patient's quality of life.

Comment: It is suggested the Committee remove the wording improve the patient's quality of life.
Rational: Dental hygiene services may not improve every patient's quality of life depending upon other factors, such as medical conditions and life situations.
Suggestion: "Dental hygiene preventive services" means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health."

(j) Dental hygiene therapeutic interventions" means specific procedure or set of procedures designed to intervene in the disease process to produce a therapeutic benefit.

Comment: It is suggested the Committee add the word "oral" before the term disease
Rational: Adding the term oral prevents any confusion on the type of disease prevention and keeps within the scope of practice for dental hygiene

Suggestion: Dental hygiene therapeutic interventions" means specific procedure or set of procedures designed to intervene in the oral disease process to produce a therapeutic benefit.

(s) Root planing" means the process of instrumentation which removes all residual calculus and toxic materials from the root to produce a clean, smooth tooth surface.

Comment: It is suggested the Committee remove the word "all" and change the wording of tooth surface to root surface.
Rational: Removal of "all" residual toxins indicates definitive treatment with the knowledge the root surface is completely rid of all toxins and calculus. To determine this; a dentist need to flap the area for direct vision of the areas root planed. The term tooth indicates both crown and root surfaces. To keep consistent terminology only the roots are planed.

B. Section 1101 of Article21 of Division 11 of Title 16 of the California Code of Regulations

§ 1124. General Procedures for the Dental Hygiene Committee of California Clinical Examination

(d) No person shall be admitted to an examination clinic unless he or she is wearing an identification badge.

Comment: It is suggested the Committee remove add wording to include the interpreter for the non-English speaking patient.
Rational: It adds clarification to the applicant that the interpreter will also need an identification badge. This will allow the interpreter to go into the grading area if requested by an examiner (c) and will follow the regulation (d) stating no person shall be admitted to an examination clinic unless he or she is wearing an identification badge.
Suggestion: No person shall be admitted to an examination clinic unless he or she is wearing an identification badge. This included patients and interpreters of non-English speaking persons.

§ 1126. General Procedures for the Dental Hygiene Committee of California Clinical Examination

(b) Grading examiners shall not view applicants during the performance of the examination assignment. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for a minimum of five years.

Comment: It is suggested the Committee to change the wording to allow for the fact an RDH, RDHAP or RDHEF with an inactive license or on probation would not be used as an examiner.
Rational: The grading examiner should have an "active" license for a minimum of five years.

§ 1127. General Procedures for the Dental Hygiene Committee of Clinical Examination Review Procedures; Appeals.

(a) An applicant who has failed an examination shall be provided with notice, upon written request, of those areas in which he or she is deficient.

Comment: It is suggested that the Committee consider automatic notice of deficient areas to those who fail the examination.
Rational: During the presentation of the CRDTS and WREB examination to the California Dental Hygiene Educators at the annual conference in February 2015, both testing agencies automatically provided written information to the candidate on deficiencies. Having the same consistent protocol as the other agencies for the applicants removes any confusion or obstacle that may hinder re-examination. Requiring applicants to provide written request loose time in applying for the next exam while waiting for mail to be exchanged.

(b) An appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The Executive Officer shall respond to the appeal in writing and may request a personal appearance by the applicant. The Committee shall thereafter take such action as it deems appropriate.

Comment: It is suggested that the Committee consider incorporating a timeline for the expected response from the Executive Director.
Rational: Timelines for reporting, licensing, change of address, etc. is required and mandated by the DHCC. For those waiting for a response from the DHCC, same constraints to respond to inquisitions by those the DHCC serves and the general public should be included.

Sincerely,

Roberta Lawrence, RDH, MS
Co-Director
Cypress College Dental Hygiene Program

From: Kunz, Brenda [mailto:BKunz@carrington.edu]
Sent: Tuesday, February 24, 2015 9:42 AM
To: Castillo, Guadalupe@DCA
Subject: Comments for DHCC Section 1100

Guadalupe,
I would like my comments added to the "Call for Comment". As Program Director of Carrington College, Sacramento Campus, let it be known that I, Brenda Kunz, agree with Vickie Kimbrough's document attached in this email. I agree with all comments made in each section of the attached document.

CARRINGTON COLLEGE
The Starting Point for Health Care Careers.

Brenda Kunz, RDH, MSET
Program Director, Dental Hygiene
Ext. 41165

8909 Folsom Blvd.
Sacramento, CA 95826
p: (916) 361-5165
e: bkunz@carrington.edu

www.carrington.edu

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Southwestern College Dental Hygiene Program, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

§1100. Definitions

(b) 'Administration of nitrous oxide and oxygen, means the administration of nitrous oxide and oxygen when used as an analgesic during **dental** treatment.

Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
Justification: In keeping with the scope of dental hygiene practice, and attempting to define/describe the duties of the dental hygienist, the term dental implies dental treatment/procedures versus dental hygiene treatment/procedures. Using the terms dental hygienist/dental hygiene provide clarity and consistency.

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Comment: It is recommend that the Committee consider removing '**and improve the patient's quality of life**'.
Justification: In keeping with a true definition of dental hygiene preventive services, services end after 'promote oral health'. Improving quality of life is an implied action or result of preventive services and may or may not occur for any given patient. ***The revised definition would read:***

*(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology **and** promote oral health.*

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Comment: It is recommend that the Committee consider inserting the word 'oral' prior to the terms disease process.
Justification: In keeping within the scope of dental hygiene practice, inserting the word 'oral' defines the specific disease process under the purview of the dental hygienist. Without it, the disease process can be interpreted multiple ways by the general public. ***The revised definition would read:***

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in the oral disease process to produce a therapeutic benefit.

(s) 'Root planing' means the process of instrumentation which removes **all** residual calculus and toxic materials from the root to produce a clean, smooth **tooth** surface.

Comment: It is recommend that the Committee consider removing the word 'all' and removing or changing the word 'tooth'.
Justification: Using the word 'all' in this context and definition indicates that root surfaces will never have residual calculus and toxic materials after the root planing procedure. Without the option, education, license, and skill to flap gingival tissue and expose all root surfaces, residual deposits and toxins cannot be removed at the level of 'all'. They can be removed at a competent level based on the oral conditions of the patient and skill of the licensed dental hygienist.

The word 'tooth' should be eliminated due to the fact the root surface is referenced in this definition, or 'root' should replace the word 'tooth' for consistency purposes.

B. Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

§1126. Conduct of Dental Hygiene Committee of California Clinical Examinations.

(b) Grading examiners shall not view applicants during the performance of the 3 examination assignments. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for **a minimum of five years**.

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Justification: During presentation of the CRDTS and WREB examination to the California dental hygiene educators at the annual conference in February 2015, both testing agencies automatically provide written information to the candidate on deficiencies. A mandate to request documentation from the DHCC on deficiencies for the California examination is the creation of an unnecessary obstacle hindering forward movement toward re-examination, licensing, and employment. Other testing agencies are more candidate friendly than California in this respect.

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Comment: It is recommend that the Committee consider including a timeline for the expected response from the Executive Director.
Justification: Timelines for reporting, licensing, change of address, and submissions by licentiates or those applying for a dental hygiene license, and disciplinary cases to name only a few is required and mandated by the DHCC. For those waiting for a response from the DHCC, the same parameters to respond to inquisitions by those the DHCC serves and the general public should be included.

Respectfully submitted

Dr. Vickie Kimbrough, RDH, PhD
Director
Southwestern College Dental Hygiene

From: Joanne Noto [mailto:jomnoto12@gmail.com]
Sent: Monday, February 23, 2015 9:05 PM
To: DCA, dhccinfo@DCA
Subject: Input on Sect 1100 Article 1 Div 11 and Sect 1101 Article 2 Div 11

Hi Lori and Staff
I have carefully reviewed the attached comments of Vicki Kimbrough on the proposed language changes in title 16 of the CCR [Sect 1100 Article 1 Div 11 and Sect 1101 Article 2 Div 11]. As an educator of 36 years and a dental hygiene clinician, I strongly support her input to you .
Please give these suggestions your serious consideration.
Thank you for listening.
Joanne Noto

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Southwestern College Dental Hygiene Program, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

§1100. Definitions

(b) 'Administration of nitrous oxide and oxygen, means the administration of nitrous oxide and oxygen when used as an analgesic during **dental** treatment.

Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
Justification: In keeping with the scope of dental hygiene practice, and attempting to define/describe the duties of the dental hygienist, the term dental implies dental treatment/procedures versus dental hygiene treatment/procedures. Using the terms dental hygienist/dental hygiene provide clarity and consistency.

(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health **and improve the patient's quality of life**.

Comment: It is recommend that the Committee consider removing '**and improve the patient's quality of life**'.
Justification: In keeping with a true definition of dental hygiene preventive services, services end after 'promote oral health'. Improving quality of life is an implied action or result of preventive services and may or may not occur for any given patient. ***The revised definition would read:***

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(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in **the disease process** to produce a therapeutic benefit.

Comment: It is recommend that the Committee consider inserting the word 'oral' prior to the terms disease process.
Justification: In keeping within the scope of dental hygiene practice, inserting the word 'oral' defines the specific disease process under the purview of the dental hygienist. Without it, the disease process can be interpreted multiple ways by the general public. ***The revised definition would read:***

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in the oral disease process to produce a therapeutic benefit.

(s) 'Root planing' means the process of instrumentation which removes **all** residual calculus and toxic materials from the root to produce a clean, smooth **tooth** surface.

Comment: It is recommend that the Committee consider removing the word 'all' and removing or changing the word 'tooth'.
Justification: Using the word 'all' in this context and definition indicates that root surfaces will never have residual calculus and toxic materials after the root planing procedure. Without the option, education, license, and skill to flap gingival tissue and expose all root surfaces, residual deposits and toxins cannot be removed at the level of 'all'. They can be removed at a competent level based on the oral conditions of the patient and skill of the licensed dental hygienist.

The word 'tooth' should be eliminated due to the fact the root surface is referenced in this definition, or 'root' should replace the word 'tooth' for consistency purposes.

B. Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

§1126. Conduct of Dental Hygiene Committee of California Clinical Examinations.

(b) Grading examiners shall not view applicants during the performance of the 3 examination assignments. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for **a minimum of five years**.

Comment: It is recommend that the Committee consider revision of the second sentence, to address the true intent of the five-year requirement.
Justification: The current verbiage of the sentence is unclear. Is it to be interpreted as the RDH, RDHAP, and RDHEF will be an examiner for five years or that the dental hygienist must have had an active license for five years?

§1127. Dental Hygiene Committee of California Clinical Examination Review Procedures; Appeals.

(a) An applicant who has failed an examination shall be provided **with notice, upon written request**, of those areas in which he or she is deficient.

Comment: It is recommend that the Committee consider **automatic notice** of deficient areas to those who fail the examination.
Justification: During presentation of the CRDTS and WREB examination to the California dental hygiene educators at the annual conference in February 2015, both testing agencies automatically provide written information to the candidate on deficiencies. A mandate to request documentation from the DHCC on deficiencies for the California examination is the creation of an unnecessary obstacle hindering forward movement toward re-examination, licensing, and employment. Other testing agencies are more candidate friendly than California in this respect.

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Respectfully submitted

Dr. Vickie Kimbrough, RDH, PhD
Director
Southwestern College Dental Hygiene

From: Donna Marie Smith [mailto:donnasmi@usc.edu]
Sent: Thursday, February 26, 2015 11:32 AM
To: DCA, dhccinfo@DCA
Cc: M. Diane Melrose
Subject: comments for DHCC

To Whom It May Concern:

I would like to state that I strongly support the comments and changes that were suggested by Dr. Vickie Kimbrough, RDH, Phd in the attached document.

If you need any further comment from me please email me at the address at the bottom of this page.

Sincerely,
Prof. Donna Smith

Donna Smith, RDHAP, BSDH, MSEd
Associate Professor of Clinical Dentistry
Division of Periodontology, Diagnostic Sciences, and Dental Hygiene
Ostrow School of Dentistry of USC
Norris Dental Science Center
925 West 34th Street DEN 4343
Los Angeles, California 90089-0641
Tel: 213-740-1072 or 213-740-1086
cell: 310-804-5417
FAX: 213-740-1094
E-mail donnasmi@usc.edu

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Southwestern College Dental Hygiene Program, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

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Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
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Respectfully submitted

Dr. Vickie Kimbrough, RDH, PhD
Director
Southwestern College Dental Hygiene

Castillo, Guadalupe@DCA

From: Phyllis Spragge <spraggephyllis@fhda.edu>
Sent: Tuesday, April 21, 2015 11:19 AM
To: Kantner, Donna@DCA
Cc: Hubble, Lori@DCA; Castillo, Guadalupe@DCA
Subject: RE: comment letter re: proposed regulations
Attachments: DHCC letter February 2015.pdf

Categories: Regulations

Attached, thanks!

Phyllis Spragge, RDH, MA
Director, Dental Hygiene
Foothill College
12345 El Monte Road
Los Altos Hills, CA 94022
(650) 949-7467
http://www.foothill.edu/bio/programs/dentalh/

From: Kantner, Donna@DCA [Donna.Kantner@dca.ca.gov]
Sent: Tuesday, April 21, 2015 9:48 AM
To: Phyllis Spragge
Cc: Hubble, Lori@DCA; Castillo, Guadalupe@DCA
Subject: RE: comment letter re: proposed regulations

Hi Phyllis,

I just realized that no comments were attached. Can you please send the attachment to me?
Thanks!

Donna Kantner, Staff Analyst
Dental Hygiene Committee of California
(916) 263-1978
Fax (916) 263- 2688

From: DCA, dhccinfo@DCA
Sent: Monday, February 23, 2015 4:30 PM
To: Phyllis Spragge
Subject: RE: comment letter re: proposed regulations

Thank you, Phyllis, for your comments on the proposed regulations. I have forwarded your comments to our Legislative and Regulatory Analyst, Guadalupe Castillo.

If you have any further questions, please email us back or look on our website at: www.dhcc.ca.gov

Thank you.

The Dental Hygiene Committee of California
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

From: Phyllis Spragge [mailto:spraggephyllis@fhda.edu]
Sent: Monday, February 23, 2015 11:51 AM
To: DCA, dhccinfo@DCA
Subject: comment letter re: proposed regulations

Please find attached my comments regarding Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions and Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations.
Regards, Phyllis Spragge

Phyllis Spragge, RDH, MA
Director, Dental Hygiene
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12345 El Monte Road
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Foothill College Dental Hygiene Program
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(650) 949-7335 • Fax (650) 947-9788

February 23, 2015

Dental Hygiene Committee of California
2005 Evergreen Street, Suite 2050 Sacramento, CA 95815

RE: Proposed Language for
Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions and Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

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Respectfully submitted
Phyllis Spragge, RDH, MA
Director
Foothill College Dental Hygiene

Castillo, Guadalupe@DCA

From: Schaubach, Diane <Diane.Schaubach@cda.org>
Sent: Wednesday, April 22, 2015 3:49 PM
To: Castillo, Guadalupe@DCA
Cc: Kantner, Donna@DCA
Subject: Dental Hygiene Committee of CA - Comments
Attachments: CDAComments_DHCCpracticeDefintions_4-2015.doc.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Attached are CDA's comments regarding DHCC's draft practice definitions

Diane Schaubach
Public Policy
CDA | CDA Foundation | TDIC | TDIC Insurance Solutions
1201 K Street, 15th Floor
Sacramento, CA 95814
916.554.4996
916.498.6145 (fax)
Diane.Schaubach@cda.org
cda.org

MOVING FORWARD. TOGETHER.

April 22, 2015

Ms. Guadalupe Castillo
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed language for Title 16, Division 11, California Code of Regulation, Section, 1100

Dear Ms. Castillo:

The California Dental Association (CDA) appreciates the opportunity to provide comments and express concerns related to the dental hygiene practice definitions proposed for California Code of Regulations, Section 1100. CDA has expressed significant concerns in the past that definitions in this package are intended to clarify dental hygiene practice, and as they relate to scope of practice per Business & Professions Code Sections 1905 (a) (8) and 1905.2 are required to be submitted by the Dental Hygiene Committee of California (Committee) as recommendations to the Dental Board (Board). We appreciate the Committee's decision to do so at its December 2014 meeting. CDA has continued to voice concern with this process; however, advising that the Committee does not have statutory authority to promulgate regulations related to scope, but rather, that action must be taken by the Board should it agree with the Committee's recommendation that regulations to define dental hygiene practice are needed. CDA's primary objective related to these process concerns is to ensure that the Committee and the Board meet their statutory responsibilities as described in code and there is clarity regarding the process for addressing scope of practice issues moving forward.

Having expressed CDA's position on the proper statutory process at several hearings and in letters to the Board, Committee, and Department of Consumer Affairs, we would like to take the opportunity during this public comment period to communicate our concerns with the definitions themselves.

CDA's overarching concern with the proposed definitions described below is their potential to introduce ambiguity into regulations. Both statute and regulation require rigorous precision and specificity, both of which are missing in these proposed definitions. In some instances, the definitions stretch current law, in others, they use broad descriptive phrases that add confusion, not clarity, and still in others, they do not accomplish the stated need or purpose. Further, as described below, they do not meet Office of Administrative Law requirements in the areas of authority, clarity, non-duplication, and/or necessity.

It is our experience that regulations that are not precise, specific and consistent with statute allow for multiple interpretations and become problematic in the future. Based on these regulatory requirements, we detail our concerns below:

9.

Subsection 1100 (c) "Assessment:" The Committee has proposed a definition for "assessment," however, this term does not appear in the B & P code. The term that <u>does</u> appear is "dental hygiene assessment," and the two are not synonymous. The proposed definition broadly describes the record collection activities conducted on behalf of the dentist to be used by that dentist for diagnosis and treatment planning. While these record collection ("assessment") activities are performed by dental hygienists, they are *also* performed by dental assistants.

California Dental Association
1201 K Street, 14th Floor
Sacramento, CA 95814

916.443.0505
800.232.7645
916.443.2943 fax
cda.org

The term "dental hygiene assessment" however, as it appears in B & P Code Section 1908 (a), describes a dental hygienist-specific function performed to assist in determining appropriate dental hygiene care. This is clearly demonstrated in the phrasing and punctuation of 1908 (a), which states, "The practice of dental hygiene includes dental hygiene assessment and development, planning and implementation of the dental hygiene care plan."

B & P Code Section 1915 reinforces the intent that this term describe a dental hygiene specific function by restricting this duty to hygienists, stating, "no person other than a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions or a licensed dentist may . . . perform dental hygiene procedures on patients including . . . *dental hygiene assessment* (italics added) . . ."

Should the definition for "assessment" be approved as submitted, it creates confusion and potential for misinterpretation in the future with regard to these same duties when performed by a dental assistant.

Further, the initial statement of reasons' (ISOR) explanation for the necessity of the proposed definition - that it is necessary to differentiate between "assessment" and "diagnosis," as diagnosis can only be performed by a dentist - does not hold up to scrutiny. The words "assessment" and "diagnosis" are common and well-understood terms. No further explanation of the meaning of these words is necessary.

For these reasons, the proposed definition fails to meet the threshold for regulatory clarity and necessity as defined by the Office of Administrative Law and should be rejected. Should the Board conclude that a definition is necessary, that definition should be for a "dental hygiene assessment," which is the term used in B & P code sections 1908 and 1915.

10. **Subsection 1100 (h) "Dental Hygiene care plan:**" CDA's concern with the proposed definition is that it uses a term, "dental hygiene diagnosis," that conflicts with statute - a concern that was first raised during the Board's deliberation on a 2014 Committee education regulatory proposal (Title 16, Division 11, Article 3, Sections 1103 – 1106). At that time, the Board's legal counsel expressed concern with the Committee's use of the term "dental hygiene diagnosis," stating that the term does not appear in statute, and further, that B & P Code Section 1908 (b) (1) specifies that "diagnosis" is not in the dental hygiene scope of practice. Testimony in that hearing noted that educational programs use the term and since the proposed regulations were limited to educational programs, the definition offered by American Dental Educators Association (ADEA) could be provided specifically for use by, and limited to, educational programs.

However, the current proposal uses the term for dental hygiene practice and is no longer limited to education. Per Board counsel's 2014 caution, as statute defining dental hygiene practice does not contain the term "dental hygiene diagnosis," and explicitly excludes "diagnosis" from a hygienist's scope, its use in this definition creates conflict between statute and regulations. To address this concern, CDA suggests the following:

> "Dental hygiene care plan" means an organized presentation or list of interventions to promote health or prevent disease of the patient's oral condition; plan is designed by the dental hygienist based on evaluation of dental hygiene assessment data, ~~dental hygiene diagnosis,~~ and consists of services within the scope of dental hygiene practice.

11. **Subsection 1100 (i) "Dental Hygiene preventive services:"** The definition proposed contains the phrase, "promote oral health and improve the patient's quality of life," which encompasses many

procedures in both the dentist's and hygienist's scope of practice and is too broad and vague to be suitable regulatory language.

In particular, the ISOR references the need to clarify B & P Code Section 1911 (c), which specifies the services a dental hygienist may provide without supervision in a government created or run public health program, as follows: "dental hygiene preventive services in addition to oral screenings, including, but not limited to the application of fluorides and pit and fissure sealants." As statute already states the preventive services a hygienist may provide unsupervised in Section 1911 (c), and moreover lists specific preventive procedures in Section 1910 (a) & (b), any accepted "dental hygiene preventive services" definition must explicitly comport with statute. The definition as proposed fails OAL's threshold for authority (enlarges statute), non-duplication (rephrases statute), and clarity (can reasonably be interpreted to have more than one meaning).

To address these concerns, CDA proposes the following:

> "Dental Hygiene preventive services" are the specific procedures provided within the scope of dental hygiene practice, as specified in Business and Professions Code Sections 1910 (a) & (b), whose primary benefit is to prevent oral disease.

12. **Subsection 1100 (r) "Refer:"** CDA questions the appropriateness of this definition, noting it lacks a key element the law requires of all healthcare providers with regard to referral – that it must occur when there is care required that is outside of a healthcare provider's scope of practice to provide. Further, the definition is limited to listing some of the circumstances for referral, rather than defining the "referral" action itself.

With these concerns, and those expressed above regarding introducing the term "dental hygiene diagnosis" into practice definitions, CDA offers the following alternative definition for the term "refer:"

> "Refer" means the action a dental hygienist must take after determining that services are needed beyond the hygienist's competence and/or scope of practice to provide, to ensure that the patient is directed to a healthcare provider who can provide that care.

CDA respects the Committee's responsibilities to promulgate regulations to meet its obligations and appreciates the Committee's commitment to licensees and the public. Notwithstanding this responsibility, as CDA has previously stated, the Business and Professions Code grants authority to the Dental Board of California on issues related to dental hygiene scope of practice and CDA recognizes the Board's jurisdiction in this matter. Further, we believe that the Committee's and Board's obligation to serve and protect the public is best met when the Board and the Committee approach the regulation of the dental professions in a manner that supports dental team members working together to provide integrated and comprehensive patient care. We appreciate the thoughtful consideration of the issues raised and our recommendations to address them. Further, in keeping with B & P Code Section 1905.2 acknowledge that the Board must approve them.

Please do not hesitate to contact us with questions or concerns.

Sincerely,

Carrie Gordon

Carrie Gordon
VP, Government Affairs

Dental Hygiene Committee of California
Department of Consumer Affairs

Proposed Regulations

Changes to the originally proposed language are indicated by single ~~strikeout~~ for deleted text and by single underline for added text and are highlighted for ease of location.

§1100. Definitions.
For purposes of this division:
(a) "Administration of local anesthesia" means the administration of local anesthetic agents by infiltration injection or conductive injection.
(b) "Administration of nitrous oxide and oxygen" means the administration of nitrous oxide and oxygen when used as an analgesic during dental treatment.
(c) "Assessment" means the systematic collection, analysis, and documentation of the oral and general health status and patient needs through a variety of methods, including choice of radiographs, diagnostic tools, and instruments utilized within the scope of dental hygiene practice and pursuant to Business and Professions Code Section 1910.5.
(d) "Basic supportive dental procedures" means fundamental duties or functions as referenced in California Code of Regulations Section 1067(l).
(e) "Committee office" means the Committee office located in Sacramento, California.
(f) "Executive Officer" means the Executive Officer appointed by the Committee.
(g) "Dental assistant" means an unlicensed person as referenced in California Code of Regulations (CCR) Section 1067(b).
(h) "Dental hygiene care plan" means an organized presentation or list of interventions to promote health or prevent disease of the patient's oral condition; plan is designed by the dental hygienist based on assessment data, dental hygiene diagnosis, and consists of services within the scope of dental hygiene practice.
(i) A "dental hygiene diagnosis" is a component of the overall dental diagnosis. It is the identification of an existing or potential oral health problem that a dental hygienist is educationally qualified and licensed to treat. The dental hygiene diagnosis utilizes critical decision making skills to reach conclusions about the patient's dental hygiene needs based on all available assessment data.
(~~i~~j) "Dental hygiene preventive services" means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health and improve the patient's quality of life.
(~~j~~k)"Dental hygiene therapeutic interventions" means specific procedure or set of procedures, provided within the scope of dental hygiene practice, designed to intervene in the disease process to produce a therapeutic benefit.
(~~k~~l) "Dental hygiene treatment plan" means an organized presentation or list of interventions to promote health or prevent disease of the patient's oral condition designed by the registered dental hygienist in alternative practice based on assessment

data and consists of services within the scope of practice of the registered dental hygienist in alternative practice.
(~~l~~m) “Ethics” for the purposes of the examination required by Section 1917(d) of the Code, means an act or acts in accordance with the California Dental Hygienists’ Association (CDHA) or the American Dental Hygienists Association (ADHA) Code of Ethics.
(~~m~~n)“Gross trauma” means a burn, deep laceration, long laceration and/or puncture to soft tissue, hard tissue, and/or bone.
(~~n~~o) "Licentiate" or “Licensee” means any individual licensed or registered by the Committee.
(~~o~~p) “Periodontal debridement” means the process by which hard and soft deposits are removed from the supragingival and subgingival surfaces of the teeth, including the disruption of bacterial cell walls of nonadherent plaque.
(~~p~~q) “Periodontal evaluation record” means that part of the dental hygiene assessment document pertaining to the clinical observations of the gingiva, periodontal pocket probe depths, measurement of the location of the free gingival margin/recession, calculation of attachment loss, measurement of keratinized/attached gingiva, detection of marginal and deep bleeding on probing, detection of suppuration, detection of furcation involvement, detection of fremitus and mobility, and assessment of plaque and calculus accumulations.
(~~q~~r) “Polishing the coronal surfaces of teeth", or “coronal polishing” means a procedure limited to the removal of plaque on and stain from exposed tooth surfaces, utilizing an appropriate rotary instrument with rubber cup or brush and a polishing agent.
(~~r~~s) “Refer” means through dental hygiene assessment, diagnosis, or treatment, it is determined that services are needed beyond the practitioner’s competence or area of expertise.
(~~s~~t)"Root planing" means the process of instrumentation which removes ~~all~~ residual calculus and toxic materials from the root to produce a clean, smooth ~~tooth~~ surface.
(~~t~~u)“Scaling” means the removal of calculus and dental biofilm from the supragingival and subgingival exposed tooth surfaces.
(~~u~~v) "Soft tissue curettage" means the removal of the inflamed soft tissue lateral to the pocket wall, which is not subgingival curettage referring to the procedure that is performed apical to the epithelial attachment, severing the connective tissue attachment down to the osseous crest.
(~~v~~w) “Treatment facility” for purposes of section 1902 of the Code means any place where oral health services are provided.

Note: Authority cited: Section 1905, Business and Professions Code. Reference: Sections 1902, 1905, 1908, 1909, 1910, 1911 and 1917, Business and Professions Code.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 8

Discussion and Possible Action to Amend Proposed Regulatory Language as a Result of Comments Received During the 45-day Public Comment Period for DHCC's Rulemaking to Add CCR, Title 16, Division 11, §§1101, 1121, 1122, 1124, 1126, 1127, and 1133 Relevant to Administration and Examinations

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

DENTAL HYGIENE COMMITTEE OF CALIFORNIA
2005 Evergreen Street, Suite 1050, Sacramento, CA 95815
P (916) 263-1978 | **F** (916) 263.2688 | **www.dhcc.ca.gov**

MEMORANDUM

DATE	May 3, 2015
TO	DHCC Committee Members
FROM	Donna Kantner, DHCC Staff
SUBJECT	**Agenda Item 8 –** Discussion and Possible Action to Amend Proposed Regulatory Language as a result of Comments Received During the 45-Day Public Comment Period for the DHCC's Rulemaking to Add *California Code of Regulations (CCR), Title 16, Division 11, §1101, 1121, 1122, 1124, 1126, 1127 and 1133* Relevant to Administration and Examinations

Background

At its December 2014 meeting, the Committee approved proposed regulatory language relating to administration and examinations. The hearing was noticed as required by law and held on March 18, 2015.

Following are comments received in writing and at the regulatory hearing, along with staff's recommendations and proposed amendments to the text.

COMMENTS RECEIVED IN WRITING

Vickie Kimbrough-Walls, Director of the dental hygienist educational program at Southwestern College, provided three written comments relative to the proposal. Comments have been numbered for easier location:

1. In proposed **Section 1126(b)** Ms. Kimbrough-Walls felt the "current verbiage of the sentence is unclear. Is it to be interpreted as the RDH, RDHAP, and RDHEF will be an examiner for five years or that the dental hygienist must have had an active license for five years?" and recommended that "the Committee consider revision of the second sentence to address the true intent of the five-year requirement."

   Staff Recommendation: Staff recommends acceptance of this comment, and proposes the following to clarify that the requirement is that a licensee must hold an active license for at least five years before he or she can be considered for appointment as a grading examiner.

(b) Grading examiners shall not view applicants during the performance of the examination assignments. ~~A~~ To be considered for appointment as a grading examiner, a licensee shall be a California licensed RDH, RDHAP, or RDHEF for a minimum of five years.

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2. In proposed **Section 1127(a),** Ms. Kimbrough-Walls recommended that the Committee consider automatic notice of deficient areas to those who fail the examination.

   Staff Recommendation: Staff recommends rejection of this comment. All applicants who fail the clinical examination currently receive notification of the deficient areas. If the applicant wishes to receive a copy of the actual grade sheet, he or she must request it in writing. Neither the DHCC's current computer system nor the new BreEZe computer system has the capability to provide such specific information automatically.

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3. In proposed **Section 1127(b),** Ms. Kimbrough-Walls commented that timelines for reporting changes of address, submitting applications, and disciplinary cases are mandated, and recommended that the Committee consider including a timeline for the expected response from the Executive Director.

   Staff Recommendation: Staff recommends rejection of this comment. Appeals must go to the Committee, who meets only twice yearly. Any specified timeline would exceed 180 days to allow the Executive Officer to agendize the appeal at a meeting of the Committee.

Ms. Marva White, BS, RHD, MS, educator; Ms. M. Diane Melrose, RDH BS, MA, Dental Hygiene Program Director at USC; Ms. Brenda Kunz, RDH, MSET, Dental Hygiene Program Director at Carrington College in Sacramento; Joanne Noto, dental hygiene clinician; Donna Smith, RDHAP, DSDH, MSEd, Associate Professor of Clinical Dentistry in the Division of Periodontology, Diagnostic Sciences, and Dental Hygiene of the Ostrow School of Dentistry of USC; and Phyllis Spragge, RDH, MA, Director of the Dental Hygiene Program at Foothill College each provided a letter of support for the comments made by Ms. Kimbrough-Walls. Those comments are addressed above.

Roberta H. Lawrence, RDH, MS provided four written comments relative to the proposal: Comments have been numbered for easier location.

1. Regarding proposed **Section 1124(d),** Ms. Lawrence "suggested the Committee remove add wording to include the interpreter for the non-English speaking patient."

   Staff Recommendation: Staff recommends rejection of this comment as duplicative. The regulation as written is all-inclusive. Anyone entering the examination clinic must have an identification badge.

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2. Regarding proposed **Section 1126(b),** Ms. Lawrence comments, "It is suggested the Committee to change the wording to allow for the fact an RDH, RDHAP or RDHEF with an inactive license or on probation would not be used as an examiner."

Staff Recommendation: Staff recommends acceptance of this comment and the modified language to read:

~~A~~ To be considered for appointment as a grading examiner, a licensee shall be a California licensed RDH, RDHAP, or RDHEF with an active license for a minimum of five years.

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3. Regarding proposed **Section 1127(a),** Ms. Lawrence echoed Ms. Kimbrough-Walls request for "automatic notice of deficient areas to those who fail the examination."

   Staff Recommendation: Staff recommends rejection of this comment for the same reasons cited above.

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4. Regarding proposed **Section 1127(b),** Ms. Lawrence had the same comment as Ms. Kimbrough-Walls that a timeline for the Executive Officer's response be established.

   Staff Recommendation: Staff recommends rejection of this comment for the reasons identified above.

COMMENTS RECEIVED AT THE REGULATORY HEARING ON March 18, 2015

No comments were received at the public hearing conducted on March 18, 2015.

Committee Action Requested

❑ 1) Discuss each comment and either accept or reject staff's recommendation, providing a rationale that will be included in the rulemaking file.
2) Discuss and accept or reject the additional amendments drafted by staff.
3) Take action to accept the text as modified.
4) If amendments are accepted, direct staff to notice the proposed changes for a 15-day comment period and delegate to the Executive Officer the authority to adopt the regulatory text and make any nonsubstantive changes necessary to complete the rulemaking file if no adverse comments are received.

Kantner, Donna@DCA

From: Vickie Kimbrough-Walls <vkimbrough@swccd.edu>
Sent: Monday, March 02, 2015 9:52 AM
To: Castillo, Guadalupe@DCA
Cc: Kantner, Donna@DCA; Gay Teel (gayteel@gmail.com)
Subject: Comments on SS: 1100 Definitions
Attachments: Comments for DHCC.pdf

Good morning,
Please see attached comments being submitted on two documents: Definitions SS. 1100 and SS 1101, 1121, etc.

Thank you

Vickie

Dr. Vickie Kimbrough RDH, MBA, PhD
Director, Dental Hygiene
Southwestern College
Higher Education Center at National City
880 National City Blvd., National City, CA 91950
619-216-6670 | 619-216-6678 fa
vkimbrough@swccd.edu

CDHEA

California Dental Hygiene Educators' Association

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of the dental hygiene program Directors of the California Dental Hygiene Educators' Association, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

§1100. Definitions

(b) 'Administration of nitrous oxide and oxygen, means the administration of nitrous oxide and oxygen when used as an analgesic during **dental** treatment.

Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
Justification: In keeping with the scope of dental hygiene practice, and attempting to define/describe the duties of the dental hygienist, the term dental implies dental treatment/procedures versus dental hygiene treatment/procedures. Using the terms dental hygienist/dental hygiene provide clarity and consistency.

(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health **and improve the patient's quality of life**.

Comment: It is recommend that the Committee consider removing '**and improve the patient's quality of life**'.
Justification: In keeping with a true definition of dental hygiene preventive services, services end after 'promote oral health'. Improving quality of life is an implied action or result of preventive services and may or may not occur for any given patient. ***The revised definition would read:***

*(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology **and** promote oral health.*

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in **the disease process** to produce a therapeutic benefit.

Comment: It is recommend that the Committee consider inserting the word 'oral' prior to the terms disease process.
Justification: In keeping within the scope of dental hygiene practice, inserting the word 'oral' defines the specific disease process under the purview of the dental hygienist. Without it, the disease process can be interpreted multiple ways by the general public. ***The revised definition would read:***

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in the oral disease process to produce a therapeutic benefit.

(s) 'Root planing' means the process of instrumentation which removes **all** residual calculus and toxic materials from the root to produce a clean, smooth **tooth** surface.

Comment: It is recommend that the Committee consider removing the word 'all' and removing or changing the word 'tooth'.
Justification: Using the word 'all' in this context and definition indicates that root surfaces will never have residual calculus and toxic materials after the root planing procedure. Without the option, education, license, and skill to flap gingival tissue and expose all root surfaces, residual deposits and toxins cannot be removed at the level of 'all'. They can be removed at a competent level based on the oral conditions of the patient and skill of the licensed dental hygienist.

The word 'tooth' should be eliminated due to the fact the root surface is referenced in this definition, or 'root' should replace the word 'tooth' for consistency purposes.

B. Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

§1126. Conduct of Dental Hygiene Committee of California Clinical Examinations.

(b) Grading examiners shall not view applicants during the performance of the 3 examination assignments. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for **a minimum of five years**.

Comment: It is recommend that the Committee consider revision of the second sentence, to address the true intent of the five-year requirement.
Justification: The current verbiage of the sentence is unclear. Is it to be interpreted as the RDH, RDHAP, and RDHEF will be an examiner for five years or that the dental hygienist must have had an active license for five years?

CDHEA

California Dental Hygiene Educators' Association

Kesa Hopkins, President
Chuck Cort, Vice President
Judy Yamamoto, Secretary
Jeanice Howard, Treasurer
Pamela Powers, Past President
Gay Teel, Executive Director

§1127. Dental Hygiene Committee of California Clinical Examination Review Procedures; Appeals.

(a) An applicant who has failed an examination shall be provided **with notice, upon written request**, of those areas in which he or she is deficient.

Comment: It is recommend that the Committee consider **automatic notice** of deficient areas to those who fail the examination.
Justification: During presentation of the CRDTS and WREB examination to the California dental hygiene educators at the annual conference in February 2015, both testing agencies automatically provide written information to the candidate on deficiencies. A mandate to request documentation from the DHCC on deficiencies for the California examination is the creation of an unnecessary obstacle hindering forward movement toward re-examination, licensing, and employment. Other testing agencies are more candidate friendly than California in this respect.

(b) An appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The Executive Officer shall **respond** to the appeal in writing and may request a personal appearance by the applicant. The Committee shall thereafter take such action as it deems appropriate.

Comment: It is recommend that the Committee consider including a timeline for the expected response from the Executive Director.
Justification: Timelines for reporting, licensing, change of address, and submissions by licentiates or those applying for a dental hygiene license, and disciplinary cases to name only a few is required and mandated by the DHCC. For those waiting for a response from the DHCC, the same parameters to respond to inquisitions by those the DHCC serves and the general public should be included.

From: Marva White [mailto:marvawhite@yahoo.com]
Sent: Monday, February 23, 2015 2:53 PM
To: DCA, dhccinfo@DCA
Cc: Joanne Pacheco
Subject: Wording for the Code of Regulations for Dental Hygiene Pratice

Re: Section 1100 of Article 1 and Article 2 of Division 11 of Title 6 of the Code of Regulations

To Whom it May Concern:

I have been a Dental Hygienist for 50 years both as a clinical hygienist and a dental hygiene educator at Fresno City College. I am concerned about some of the wording used in the Code of Regulations being written for dental hygiene practice. I would like to confirm support of the wording submitted by Dr. Vickie Kimbrough, RDH, PhD, Director of the Southwestern College Department of Dental Hygiene. The suggestions made in her letter of February 12, 2015, are needed to clarify the intent of the regulations as they relate to the practice of the dental hygienist.

Respectfully,
Marva White BS, RHD, MS

Kantner, Donna@DCA

From: Hubble, Lori@DCA
Sent: Wednesday, February 25, 2015 9:13 AM
To: Castillo, Guadalupe@DCA
Cc: Kantner, Donna@DCA
Subject: Definitions Comments
Attachments: Comments for DHCC-Kimbrough (3).pdf

From: M. Diane Melrose [mailto:mmelrose@usc.edu]
Sent: Monday, February 23, 2015 9:37 PM
To: DCA, dhccinfo@DCA; Hubble, Lori@DCA
Subject: Support of Comments

To Whom It May Concern,

I am in agreement with the comments made by Vicki Kimbrough.

Sincerely,
Diane

M. Diane Melrose, RDH, BS, MA
Director, Dental Hygiene
Herman Ostrow School of Dentistry of USC
925 W. 34th Street, DEN 4330
Los Angeles, CA 90089-0641

YES I CAN!

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Southwestern College Dental Hygiene Program, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

§1100. Definitions

(b) 'Administration of nitrous oxide and oxygen, means the administration of nitrous oxide and oxygen when used as an analgesic during **dental** treatment.

Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
Justification: In keeping with the scope of dental hygiene practice, and attempting to define/describe the duties of the dental hygienist, the term dental implies dental treatment/procedures versus dental hygiene treatment/procedures. Using the terms dental hygienist/dental hygiene provide clarity and consistency.

(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health **and improve the patient's quality of life**.

Comment: It is recommend that the Committee consider removing '**and improve the patient's quality of life**'.
Justification: In keeping with a true definition of dental hygiene preventive services, services end after 'promote oral health'. Improving quality of life is an implied action or result of preventive services and may or may not occur for any given patient. ***The revised definition would read:***

*(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology **and** promote oral health.*

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in the disease process to produce a therapeutic benefit.

Comment: It is recommend that the Committee consider inserting the word 'oral' prior to the terms disease process.
Justification: In keeping within the scope of dental hygiene practice, inserting the word 'oral' defines the specific disease process under the purview of the dental hygienist. Without it, the disease process can be interpreted multiple ways by the general public. ***The revised definition would read:***

(j) 'Dental hygiene therapeutic interventions' means specific procedure or set of procedures designed to intervene in the oral disease process to produce a therapeutic benefit.

(s) 'Root planing' means the process of instrumentation which removes all residual calculus and toxic materials from the root to produce a clean, smooth tooth surface.

Comment: It is recommend that the Committee consider removing the word 'all' and removing or changing the word 'tooth'.
Justification: Using the word 'all' in this context and definition indicates that root surfaces will never have residual calculus and toxic materials after the root planing procedure. Without the option, education, license, and skill to flap gingival tissue and expose all root surfaces, residual deposits and toxins cannot be removed at the level of 'all'. They can be removed at a competent level based on the oral conditions of the patient and skill of the licensed dental hygienist.

The word 'tooth' should be eliminated due to the fact the root surface is referenced in this definition, or 'root' should replace the word 'tooth' for consistency purposes.

B. Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

§1126. Conduct of Dental Hygiene Committee of California Clinical Examinations.

(b) Grading examiners shall not view applicants during the performance of the 3 examination assignments. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for a minimum of five years.

Comment: It is recommend that the Committee consider revision of the second sentence, to address the true intent of the five-year requirement.
Justification: The current verbiage of the sentence is unclear. Is it to be interpreted as the RDH, RDHAP, and RDHEF will be an examiner for five years or that the dental hygienist must have had an active license for five years?

§1127. Dental Hygiene Committee of California Clinical Examination Review Procedures; Appeals.

(a) An applicant who has failed an examination shall be provided **with notice, upon written request**, of those areas in which he or she is deficient.

Comment: It is recommend that the Committee consider **automatic notice** of deficient areas to those who fail the examination.
Justification: During presentation of the CRDTS and WREB examination to the California dental hygiene educators at the annual conference in February 2015, both testing agencies automatically provide written information to the candidate on deficiencies. A mandate to request documentation from the DHCC on deficiencies for the California examination is the creation of an unnecessary obstacle hindering forward movement toward re-examination, licensing, and employment. Other testing agencies are more candidate friendly than California in this respect.

(b) An appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The Executive Officer shall **respond** to the appeal in writing and may request a personal appearance by the applicant. The Committee shall thereafter take such action as it deems appropriate.

Comment: It is recommend that the Committee consider including a timeline for the expected response from the Executive Director.
Justification: Timelines for reporting, licensing, change of address, and submissions by licentiates or those applying for a dental hygiene license, and disciplinary cases to name only a few is required and mandated by the DHCC. For those waiting for a response from the DHCC, the same parameters to respond to inquisitions by those the DHCC serves and the general public should be included.

Respectfully submitted

Dr. Vickie Kimbrough, RDH, PhD
Director
Southwestern College Dental Hygiene

Kantner, Donna@DCA

From: Roberta Lawrence <rlawrence@cypresscollege.edu>
Sent: Thursday, March 05, 2015 3:57 PM
To: Castillo, Guadalupe@DCA; donna.kanter@dca.ca.gov
Subject: Written comments for 3/18 & 4/30 meetings
Attachments: MARCH 2015.docx

Follow Up Flag: Follow up
Due By: Wednesday, April 08, 2015 8:00 AM
Flag Status: Flagged

Ms. Castillo and Ms. Kanter,
Please accept the attached written comments to be presented to the March 18 and April 30, 2015 regulatory hearings.
Sincerely,

ROBERTA LAWRENCE, RDH, MS
Co-Director Cypress College Dental Hygiene Program
714-484-7291
rlawrence@cypresscollege.edu
9200 Valley View Street
Cypress, CA 90630

Dental Hygiene Committee of California
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

March 5, 2015

RE: Proposed Language for:

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations § 1100. Definitons
And
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Cypress College Dental Hygiene Program, please consider these comments submitted for specific areas of the proposed language found in the above mention documents for March 18, 2015 and April 30, 2015.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations § 1100. Definitions

(b) "Administration of nitrous oxide and oxygen" means the administration of nitrous oxide and oxygen when used as an analgesic during dental treatment.

Comment: It is suggested the Committee add the word "hygiene" to dental treatment.
Rational: This indicates the use of nitrous oxide/oxygen would be for dental hygiene treatment only and would not be confused with treatment provided by a dentist.

(i) "Dental hygiene preventive services" means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health and improve the patient's quality of life.

Comment: It is suggested the Committee remove the wording improve the patient's quality of life.
Rational: Dental hygiene services may not improve every patient's quality of life depending upon other factors, such as medical conditions and life situations.
Suggestion: "Dental hygiene preventive services" means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health."

(j) Dental hygiene therapeutic interventions" means specific procedure or set of procedures designed to intervene in the disease process to produce a therapeutic benefit.

Comment: It is suggested the Committee add the word "oral" before the term disease
Rational: Adding the term oral prevents any confusion on the type of disease prevention and keeps within the scope of practice for dental hygiene

Suggestion: Dental hygiene therapeutic interventions" means specific procedure or set of procedures designed to intervene in the oral disease process to produce a therapeutic benefit.

(s) Root planing" means the process of instrumentation which removes all residual calculus and toxic materials from the root to produce a clean, smooth tooth surface.

Comment: It is suggested the Committee remove the word "all" and change the wording of tooth surface to root surface.
Rational: Removal of "all" residual toxins indicates definitive treatment with the knowledge the root surface is completely rid of all toxins and calculus. To determine this; a dentist need to flap the area for direct vision of the areas root planed. The term tooth indicates both crown and root surfaces. To keep consistent terminology only the roots are planed.

B. Section 1101 of Article21 of Division 11 of Title 16 of the California Code of Regulations

§ 1124. General Procedures for the Dental Hygiene Committee of California Clinical Examination

(d) No person shall be admitted to an examination clinic unless he or she is wearing an identification badge.

Comment: It is suggested the Committee remove add wording to include the interpreter for the non-English speaking patient.
Rational: It adds clarification to the applicant that the interpreter will also need an identification badge. This will allow the interpreter to go into the grading area if requested by an examiner (c) and will follow the regulation (d) stating no person shall be admitted to an examination clinic unless he or she is wearing an identification badge.
Suggestion: No person shall be admitted to an examination clinic unless he or she is wearing an identification badge. This included patients and interpreters of non-English speaking persons.

§ 1126. General Procedures for the Dental Hygiene Committee of California Clinical Examination

(b) Grading examiners shall not view applicants during the performance of the examination assignment. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for a minimum of five years.

Comment: It is suggested the Committee to change the wording to allow for the fact an RDH, RDHAP or RDHEF with an inactive license or on probation would not be used as an examiner.
Rational: The grading examiner should have an "active" license for a minimum of five years.

§ 1127. General Procedures for the Dental Hygiene Committee of Clinical Examination Review Procedures; Appeals.

(a) An applicant who has failed an examination shall be provided with notice, upon written request, of those areas in which he or she is deficient.

Comment: It is suggested that the Committee consider automatic notice of deficient areas to those who fail the examination.
Rational: During the presentation of the CRDTS and WREB examination to the California Dental Hygiene Educators at the annual conference in February 2015, both testing agencies automatically provided written information to the candidate on deficiencies. Having the same consistent protocol as the other agencies for the applicants removes any confusion or obstacle that may hinder re-examination. Requiring applicants to provide written request loose time in applying for the next exam while waiting for mail to be exchanged.

(b) An appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The Executive Officer shall respond to the appeal in writing and may request a personal appearance by the applicant. The Committee shall thereafter take such action as it deems appropriate.

Comment: It is suggested that the Committee consider incorporating a timeline for the expected response from the Executive Director.
Rational: Timelines for reporting, licensing, change of address, etc. is required and mandated by the DHCC. For those waiting for a response from the DHCC, same constraints to respond to inquisitions by those the DHCC serves and the general public should be included.

Sincerely,

Roberta Lawrence, RDH, MS
Co-Director
Cypress College Dental Hygiene Program

From: Kunz, Brenda [mailto:BKunz@carrington.edu]
Sent: Tuesday, February 24, 2015 9:42 AM
To: Castillo, Guadalupe@DCA
Subject: Comments for DHCC Section 1100

Guadalupe,
I would like my comments added to the "Call for Comment". As Program Director of Carrington College, Sacramento Campus, let it be known that I, Brenda Kunz, agree with Vickie Kimbrough's document attached in this email. I agree with all comments made in each section of the attached document.

CARRINGTON COLLEGE
The Starting Point for Health Care Careers.

Brenda Kunz, RDH, MSET
Program Director, Dental Hygiene
Ext. 41165

8909 Folsom Blvd.
Sacramento, CA 95826
p: (916) 361-5165
e: bkunz@carrington.edu

www.carrington.edu

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Southwestern College Dental Hygiene Program, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

§1100. Definitions

(b) 'Administration of nitrous oxide and oxygen, means the administration of nitrous oxide and oxygen when used as an analgesic during **dental** treatment.

Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
Justification: In keeping with the scope of dental hygiene practice, and attempting to define/describe the duties of the dental hygienist, the term dental implies dental treatment/procedures versus dental hygiene treatment/procedures. Using the terms dental hygienist/dental hygiene provide clarity and consistency.

(i) 'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology, promote oral health **and improve the patient's quality of life**.

Comment: It is recommend that the Committee consider removing '**and improve the patient's quality of life**'.
Justification: In keeping with a true definition of dental hygiene preventive services, services end after 'promote oral health'. Improving quality of life is an implied action or result of preventive services and may or may not occur for any given patient. ***The revised definition would read:***

(i) *'Dental hygiene preventive services' means those services provided by the dental hygienist that prevent oral disease or pathology **and** promote oral health.*

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Comment: It is recommend that the Committee consider inserting the word 'oral' prior to the terms disease process.
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(s) 'Root planing' means the process of instrumentation which removes all residual calculus and toxic materials from the root to produce a clean, smooth tooth surface.

Comment: It is recommend that the Committee consider removing the word 'all' and removing or changing the word 'tooth'.
Justification: Using the word 'all' in this context and definition indicates that root surfaces will never have residual calculus and toxic materials after the root planing procedure. Without the option, education, license, and skill to flap gingival tissue and expose all root surfaces, residual deposits and toxins cannot be removed at the level of 'all'. They can be removed at a competent level based on the oral conditions of the patient and skill of the licensed dental hygienist.

The word 'tooth' should be eliminated due to the fact the root surface is referenced in this definition, or 'root' should replace the word 'tooth' for consistency purposes.

B. Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

§1126. Conduct of Dental Hygiene Committee of California Clinical Examinations.

(b) Grading examiners shall not view applicants during the performance of the 3 examination assignments. A grading examiner shall be a California licensed RDH, RDHAP, or RDHEF for a minimum of five years.

Comment: It is recommend that the Committee consider revision of the second sentence, to address the true intent of the five-year requirement.
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§1127. Dental Hygiene Committee of California Clinical Examination Review Procedures; Appeals.

(a) An applicant who has failed an examination shall be provided **with notice, upon written request**, of those areas in which he or she is deficient.

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Comment: It is recommend that the Committee consider including a timeline for the expected response from the Executive Director.
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Respectfully submitted

Dr. Vickie Kimbrough, RDH, PhD
Director
Southwestern College Dental Hygiene

From: Joanne Noto [mailto:jomnoto12@gmail.com]
Sent: Monday, February 23, 2015 9:05 PM
To: DCA, dhccinfo@DCA
Subject: Input on Sect 1100 Article 1 Div 11 and Sect 1101 Article 2 Div 11

Hi Lori and Staff
I have carefully reviewed the attached comments of Vicki Kimbrough on the proposed language changes in title 16 of the CCR [Sect 1100 Article 1 Div 11 and Sect 1101 Article 2 Div 11]. As an educator of 36 years and a dental hygiene clinician, I strongly support her input to you .
Please give these suggestions your serious consideration.
Thank you for listening.
Joanne Noto

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,

On behalf of Southwestern College Dental Hygiene Program, please see comments being submitted for specific areas of the proposed language found in the above named documents.

A. Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations

§1100. Definitions

(b) 'Administration of nitrous oxide and oxygen, means the administration of nitrous oxide and oxygen when used as an analgesic during **dental** treatment.

Comment: It is recommend that the Committee consider replacing the term 'dental' with 'dental hygiene'.
Justification: In keeping with the scope of dental hygiene practice, and attempting to define/describe the duties of the dental hygienist, the term dental implies dental treatment/procedures versus dental hygiene treatment/procedures. Using the terms dental hygienist/dental hygiene provide clarity and consistency.

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Respectfully submitted

Dr. Vickie Kimbrough, RDH, PhD
Director
Southwestern College Dental Hygiene

From: Donna Marie Smith [mailto:donnasmi@usc.edu]
Sent: Thursday, February 26, 2015 11:32 AM
To: DCA, dhccinfo@DCA
Cc: M. Diane Melrose
Subject: comments for DHCC

To Whom It May Concern:

I would like to state that I strongly support the comments and changes that were suggested by Dr. Vickie Kimbrough, RDH, Phd in the attached document.

If you need any further comment from me please email me at the address at the bottom of this page.

Sincerely,
Prof. Donna Smith

Donna Smith, RDHAP, BSDH, MSEd
Associate Professor of Clinical Dentistry
Division of Periodontology, Diagnostic Sciences, and Dental Hygiene
Ostrow School of Dentistry of USC
Norris Dental Science Center
925 West 34th Street DEN 4343
Los Angeles, California 90089-0641
Tel: 213-740-1072 or 213-740-1086
cell: 310-804-5417
FAX: 213-740-1094
E-mail donnasmi@usc.edu

Dental Hygiene Committee of California **February 12, 2015**
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

RE: Proposed Language for

Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions
and
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Dear Committee Members,

On behalf of Southwestern College Dental Hygiene Program, please see comments being submitted for specific areas of the proposed language found in the above named documents.

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Respectfully submitted

Dr. Vickie Kimbrough, RDH, PhD
Director
Southwestern College Dental Hygiene

Castillo, Guadalupe@DCA

From: Phyllis Spragge <spraggephyllis@fhda.edu>
Sent: Tuesday, April 21, 2015 11:19 AM
To: Kantner, Donna@DCA
Cc: Hubble, Lori@DCA; Castillo, Guadalupe@DCA
Subject: RE: comment letter re: proposed regulations
Attachments: DHCC letter February 2015.pdf

Categories: Regulations

Attached, thanks!

Phyllis Spragge, RDH, MA
Director, Dental Hygiene
Foothill College
12345 El Monte Road
Los Altos Hills, CA 94022
(650) 949-7467
http://www.foothill.edu/bio/programs/dentalh/

From: Kantner, Donna@DCA [Donna.Kantner@dca.ca.gov]
Sent: Tuesday, April 21, 2015 9:48 AM
To: Phyllis Spragge
Cc: Hubble, Lori@DCA; Castillo, Guadalupe@DCA
Subject: RE: comment letter re: proposed regulations

Hi Phyllis,

I just realized that no comments were attached. Can you please send the attachment to me?
Thanks!

Donna Kantner, Staff Analyst
Dental Hygiene Committee of California
(916) 263-1978
Fax (916) 263- 2688

From: DCA, dhccinfo@DCA
Sent: Monday, February 23, 2015 4:30 PM
To: Phyllis Spragge
Subject: RE: comment letter re: proposed regulations

Thank you, Phyllis, for your comments on the proposed regulations. I have forwarded your comments to our Legislative and Regulatory Analyst, Guadalupe Castillo.

If you have any further questions, please email us back or look on our website at: www.dhcc.ca.gov

Thank you.

The Dental Hygiene Committee of California
2005 Evergreen Street, Suite 2050
Sacramento, CA 95815

From: Phyllis Spragge [mailto:spraggephyllis@fhda.edu]
Sent: Monday, February 23, 2015 11:51 AM
To: DCA, dhccinfo@DCA
Subject: comment letter re: proposed regulations

Please find attached my comments regarding Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions and Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations.
Regards, Phyllis Spragge

Phyllis Spragge, RDH, MA
Director, Dental Hygiene
Foothill College
12345 El Monte Road
Los Altos Hills, CA 94022
(650) 949-7467
http://www.foothill.edu/bio/programs/dentalh/

Foothill College Dental Hygiene Program
12345 El Monte Road, Los Altos Hills, CA 94022
(650) 949-7335 • Fax (650) 947-9788

February 23, 2015

Dental Hygiene Committee of California
2005 Evergreen Street, Suite 2050 Sacramento, CA 95815

RE: Proposed Language for
Section 1100 of Article 1 of Division 11 of Title 16 of the California Code of Regulations §1100. Definitions and Section 1101 of Article 2 of Division 11 of Title 16 of the California Code of Regulations

Dear Committee Members,
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Phyllis Spragge, RDH, MA
Director
Foothill College Dental Hygiene

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 9

Discussion and Possible Action to Amend Proposed Regulatory Language as a Result of the Office of Administrative Law's Disapproval of DHCC's Rulemaking Relevant to Educational Program Requirements - CCR, Title 16, Division 11, §§1103, 1105, 1105.1, 1105.2, 1105.3, 1105.4, and 1106

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

DENTAL HYGIENE COMMITTEE OF CALIFORNIA
2005 Evergreen Street, Suite 1050, Sacramento, CA 95815
P (916) 263-1978 | **F** (916) 263.2688 | **www.dhcc.ca.gov**

MEMORANDUM

DATE	May 3, 2014
TO	DHCC Committee Members
FROM	Donna Kantner, DHCC Staff
SUBJECT	**Agenda Item 9 –** Discussion and possible action to amend proposed regulatory language as a result of the Office of Administrative Law's disapproval of DHCC's rulemaking relevant to Educational Programs - *California Code of Regulations (CCR), Title 16, Division 11, §§1103, 1105, 1105.1, 1105.2, 1105.3, 1105.4 and 1106*

Background

At its December 2013 meeting, the Committee approved proposed regulatory language relating to requirements for California registered dental hygienist educational programs. The hearing was noticed as required by law and held on April 28, 2014. Comments were received and brought to the Committee's May 2014 meeting for discussion. The Committee amended the text and directed staff to notice for public comment. The 15-day public comment period began May 22, 2014 and no further comments were received. The completed rulemaking file was submitted to Department of Consumer Affairs in July 2014 for review and approval, to the Department of Finance in January 2015, and to the Office of Administrative Law (OAL) in February 2015. On April 16, 2015 OAL notified us that the file would be disapproved due to clarity and consistency issues. We have 120 days to make the following corrections to the language that will allow it to achieve OAL approval.

OAL Comments

OAL objected to the use of the term "diagnosis" in section 1103(j), which defines the term 'dental hygiene process of care,' noting that, "As pointed out by the [Dental] Board, Business and Professions Code section 1908, subdivision (b)(1), states that "the practice of dental hygiene does not include . . . [d]iagnosis and comprehensive treatment planning." OAL stated that although the Committee modified the text, "This proposed language is still inconsistent with Business and Professions Code section 1908 because it does not limit the definition of dental hygiene process of care in the context of education, but rather continues to imply that dental hygiene diagnosis can be included in the dental hygiene scope of practice. Thus, proposed regulation section 1103, subdivision (j), as written, is not consistent with Business and Professions Code section 1908, subdivision (b)(1). OAL suggested modifying the term to be consistent

with section 1908 and making the changes available for public comment for 15 days, adding that any comments made must be summarized and responded to in the final statement of reasons.

OAL noted that four phrases used in the regulatory text lacked clarity. The first was numerous references to, "approved accreditation standards," stating that since those accreditation standards are undefined, the regulation is unclear. The Commission on Dental Accreditation's "Accreditation Standards for Dental Hygiene Programs, January 2013" has been incorporated by reference to clarify which approved accreditation standards are used by the Committee.

OAL felt the term "reasonable period of time" as used in Section 1103(z) to be unclear. This phrase has been revised to remove this text and clarify that additional time outside of instructional hours may be required of students to ensure that they are prepared to perform laboratory or clinical coursework during class time.

OAL stated that the written plan "required by the Commission on Dental Accreditation (CODA) is unclear to users." The text has been revised to make clear that if the program has a written plan prepared to submit for CODA accreditation which contains all of the required elements, it may submit that plan to the Committee to meet the requirement.

OAL stated that the regulation does not explain what constitutes a "substantive or major change" as used in section 1105.3(a)(2)(B). The text has been revised to eliminate the terms "substantive or major."

Finally, Legal Counsel suggested that section 1105.2(d)(3)(E)(i), (ii) and (iii) be struck from the text and replaced with a reference to the requirements contained in existing section 1107. Identical text was placed in both proposed regulations because it was impossible to know which regulation would be effective first. Now that section 1107 is effective, this proposed text is duplicative and needs to be removed.

Committee Action Requested

❑ 1) Discuss and take action to accept the text as modified to OAL's comments.
❑ 2) If amendments are accepted, direct staff to make any necessary changes to the final statement of reasons, notice the document and the proposed changes for a 15-day comment period and delegate the authority to the Executive Officer to adopt the changes and to make any nonsubstantive changes necessary to complete the rulemaking file.

TITLE 16
California Code of Regulations
Professional and Vocational Regulations
Division 11
Dental Hygiene Committee of California

ARTICLE 3. EDUCATIONAL PROGRAMS

Changes to the originally proposed language are indicated by single ~~strikeout~~ for deleted text and by single underline for added text. The most recent changes are indicated by double ~~strikeout~~ for deleted text and double underline for added text and are highlighted for ease of location.

§ 1103. Definitions.
For purposes of this division, the term:

(a) "Academic year" means a period of education consisting of a minimum of forty-five (45) quarter units, thirty (30) semester units, or a duration deemed equivalent thereto by the Committee.

(b) "Analgesia" means a state of decreased sensibility to pain, such as that produced by using nitrous oxide and oxygen with or without local anesthesia.

(c) "Clinical instruction" means instruction in which students receive supervised patient care experiences in performing procedures in a clinical setting to achieve safe and effective clinical outcomes. The instructor to student ratio shall meet approved accreditation standards~~.~~ as contained in the Commission on Dental Accreditation's "Accreditation Standards for Dental Hygiene Programs (Effective January 1, 2013)" hereby incorporated by reference and referenced throughout as "approved accreditation standards."

(d) "Clinical practice" means the planned learning experiences designed for students to apply dental hygiene knowledge and skills to meet course objectives in a variety of Committee-approved clinical settings. Clinical practice may include learning experiences provided in various settings, including, but not limited to, dental hygiene skills labs, simulation labs, and computer labs, as well as health care agencies.

(e) "Clinical setting" means a setting that accommodates patient care.

(f) "Clinical outcome" is the result derived from a specific intervention or treatment.

(g) "Competencies" means statements describing the abilities needed to practice dental hygiene, including skills, understanding, and professional values, that are performed independently in realistic settings.

(h) "Competent" means possessing the knowledge, skills and values required in the dental hygiene process of care to practice dental hygiene or provide instruction within a dental hygiene educational program.

(i) "Curriculum" means an organized set of courses of learning which are prerequisite to the award of a degree or diploma.

(j) "Dental hygiene process of care" means the application of scientific, evidence-based knowledge in the identification and treatment of actual or potential patient health problems as related to oral health .

The dental hygiene process of care includes assessment, dental hygiene evaluation~~diagnosis~~, planning and outcome identification, implementation, evaluation and documentation, and will serve as the accepted professional standard for decision making. ~~The dental hygiene diagnosis is a component of the overall dental diagnosis. It is the identification of an existing or potential oral health problem that a dental hygienist is educationally qualified and licensed to treat. The dental hygiene diagnosis utilizes critical decision-making skills to reach conclusions about the patient's dental needs based on all available assessment data.~~

(k) "Didactic instruction" means instruction through lectures, seminars or demonstrations, as distinguished from clinical or laboratory instruction.

(l) "Distance education" means education to deliver instruction to students who are separated from the instructor and to support regular and substantive interaction between the students and instructor, either synchronously or asynchronously using one or more of the following technologies:

(1) the internet;
(2) one-way and two-way transmissions through open broadcast, closed circuit, cable, microwave, broadband lines, fiber optics, satellite or wireless communication devices;
(3) audio conferencing;
(4) video cassettes, DVDs, and CD-ROMS, if the cassettes, DVDs or CD-ROMS are used in a course in conjunction with any of the technologies listed in (l)(1-3).

(m) "Educational program" means a progressive or planned system of training, instruction or study.

(n) "Goal" means an intention or expectation that requires several tasks to produce the desired result.

(o) "Graduate" means a dental hygiene student who has completed all required studies within a dental hygiene educational program and has obtained a degree.

(p) "Homebound" means a person who is unable to receive care in a dental office or clinic due to a disabling physical or mental condition.

(q) "Laboratory instruction" means instruction designed to perform procedures using instructional materials in which students receive supervised experience performing procedures. The instructor to student ratio shall meet approved accreditation standards.

(r) "Learning experience" means those activities planned for students by the faculty that are designed to meet the objectives of the required course of instruction, including the basic standards of competent performance.

(s)"Learning outcomes" are statements that clearly state the expected knowledge, skills, values and competencies that students are expected to acquire in both didactic and clinical coursework.

(t) "Local anesthesia" is the temporary loss of sensation, such as pain, in the oral cavity, produced by an injected anesthetic agent without inducing loss of consciousness.

(u) "Mission" means an institution's stated educational reasons to exist. The mission shall have all of the following characteristics:

(1) It shall include the institution's goals concerning the education which students will receive, including the acquisition of the body of knowledge presented in the educational program, the development of intellectual, analytical, and critical abilities, and the fostering of values such as a commitment to pursue lifelong learning;

(2) It shall relate to the educational expectations of the institution's students and faculty and the community which the institution serves.

(v)"Nitrous Oxide-Oxygen" is an inhalation agent used to achieve analgesia.

(w) "Outcomes assessment" means an ongoing process aimed at improving student learning that includes a profile of measures evaluating the effectiveness of the program in meeting its goals and learning outcomes.

(x) "Preclinical instruction" means instruction in which students receive supervised experience using instructional materials to prepare them for clinical experiences to achieve safe and effective clinical outcomes. The instructor to student ratio shall meet approved accreditation standards.

(y) "Quarter" means at least ten (10) weeks of instruction.

(z) "Quarter unit" means at least ten (10) hours of college or university level instruction during a quarter. ~~plus a reasonable period of~~ Additional time outside of instruction ~~which an institution requires~~ may be required for a student to devote to preparation for planned learning experiences, such as preparation for instruction, study of course material, or completion of educational projects.

(aa) "Remedial education" means education designed to achieve competency required for initial, continuation, or reinstatement of licensure, and may be required for purposes of discipline. Remedial Education is the act or process of correcting a deficiency and its intent is to restore skills to competency.

(ab) "Semester" means at least fifteen (15) weeks of instruction.

(ac) "Semester unit" means at least fifteen (15) hours of college or university level instruction during a semester plus a reasonable period of time outside of instruction which an institution requires a student to devote to preparation for planned learning experiences, such as preparation for instruction, study of course material, or completion of educational projects.

(ad) "Service learning" is a teaching and learning experience that combines community service with academic preparation. Students engaged in service learning learn about their roles as dental professionals through provision of patient care and related services in response to community-based problems.

(ae) "Sponsoring institution" means an institution of higher education approved or who has applied for approval for a dental hygiene educational program. If the sponsoring institution has more than one campus, the campus where the physical location of the educational program exists shall be deemed the sponsoring institution.

(af) "Staff" means professional, technical, and clerical employees of the institution to support its educational program.

(ag) "Technology" means equipment, tools, and devices that are used to facilitate and support teaching and learning.

(ah) “Wet laboratory” is a term used to distinguish classical benchtop experiments handling biological material from computer analysis or other theoretical work.

Note: Authority cited: Section 1905, Business and Professions Code. Reference: Sections 1905 and 1917, Business and Professions Code.

§1105. Requirements for RDH Educational Programs.

As of January 1, 2016, educational programs for registered dental hygienists shall comply with the requirements set forth below in order to secure and maintain approval by the Committee.

(a) Administration and Organization. There shall be a written program mission statement that serves as a basis for curriculum structure. Such statement shall take into consideration the individual difference of students, including their cultural and ethnic background, learning styles, and support systems. It shall also take into consideration the concepts of dental hygiene, which must include the dental hygiene process of care, environment, health-illness continuum, and relevant knowledge from related disciplines.

(b) Instruction.

(1) Instruction upon all levels shall be conducted upon the premise that dental hygiene education must meet the test of a true university discipline and shall include lectures, laboratory experiments and exercises and clinical practice under supervision by the faculty.

(2) For purposes of this section the term "university discipline" is a level of instruction at least equivalent to that level of instruction represented by college courses in the basic sciences commonly offered or accepted in approved California dental schools.

(3) The length of instruction in the educational program shall include two academic years of fulltime instruction at the postsecondary college level or its equivalent, and a minimum of 1,600 clock hours.

(4) The instructor to student ratio shall meet approved Commission on Dental A~~a~~ccreditation standards.

(5) Instruction involving procedures that require direct supervision ~~by a dentist~~ shall be supervised by a faculty dentist who possesses an active California license or special permit with no disciplinary actions.

(c) Standards of Competency. Each educational program shall establish and maintain standards of competency. Such standards shall be available to each student, and shall be used to measure periodic progress or achievement in the curriculum.

(d) The policies and procedures by which the educational program is administered shall be in writing, shall reflect the mission and goals of the program, and shall be available to all students.

(e) The educational program shall have a written plan ~~as required by the Commission on Dental Accreditation~~ for evaluation of all aspects of the program, including admission and selection policy and procedures, attrition and retention of students, curriculum management, patient care competencies, ethics and professionalism, critical thinking, and outcomes assessment, including means of student achievement. If the program has a written plan as required by the Commission on Dental Accreditation which includes each of the elements listed above, a copy of such plan may be submitted to meet this requirement.

(f) Admission.

(1) The minimum basis for admission into an educational program shall be the successful completion of all of the following:

(A) A high school diploma or the recognized equivalent, which will permit entrance to a college or university accredited by an agency recognized by the U.S. Department of Education or Council for Higher Education Accreditation; and,

(B) College-level general education courses in the topic areas of:

(i). Oral and Written Communication
(ii) Psychology
(iii) Sociology
(iv) Mathematics
(v) Cultural Diversity*
(vi) Nutrition*

*This course is required prior to graduation, and may be waived as an admission requirement if included within the dental hygiene program curriculum.

(C) College-level biomedical science courses, each of which must include a wet laboratory component, in:

(i) Anatomy
(ii) Physiology
(iii) Chemistry
(iv) Biochemistry
(v) Microbiology

(2) Admission of students shall be based on specific written criteria, procedures and policies. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability shall be utilized as criteria in selecting students who have the potential for successfully completing the educational program. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability and the scope of practice of and employment opportunities for dental hygienists.

(g) The program shall have published student grievance policies.

(h) There shall be an organizational chart that identifies the relationships, lines of authority and channels of communication within the educational program, between the program and other administrative segments of the sponsoring institution, and between the program, the institution and extramural facilities and service learning sites.

(i) The educational program shall have learning resources, including faculty, library, staff and support services, technology and physical space and equipment, including laboratory and clinical facilities, to support the program's stated mission and goals and in accordance with approved accreditation standards.

(j) The educational program director shall have the primary responsibility for developing policies and procedures, planning, organizing, implementing and evaluating all aspects of the program.

(k) The number and distribution of faculty and staff shall be sufficient to meet the educational program's stated mission and goals.

(l) When an individual not employed in the educational program participates in the instruction and supervision of students obtaining educational experience, his or her responsibilities shall be described in writing and kept on file by the dental hygiene program.

(m) As of January 1, 2017, ~~I~~in a two-year college setting, graduates of the educational program ~~must~~ shall be awarded an associate degree, and in a four-year college or university, graduates ~~must~~ shall be awarded an associate or baccalaureate degree.

Note: Authority cited: Section 1905, Business and Professions Code. Reference: Sections 1905 and 1941, Business and Professions Code.

§ 1105.1. Faculty.

(a) "Program Director" or "Interim Program Director" means a registered dental hygienist or dentist who has the authority and responsibility to administer the educational program in accordance with approved accreditation standards. The educational program may have an Interim Program Director for a maximum of twelve (12) months. The director shall have a full-time appointment as defined by the institution, whose primary responsibility is for the operation, supervision, evaluation and revision of the program. The program director shall meet the following minimum qualifications:

(1) Possess an active, current dental or dental hygiene license issued by the Committee or the Dental Board of California (DBC), with no disciplinary actions;

(2) Possess a master's or higher degree from a college or university accredited by an agency recognized by the U.S. Department of Education or Council for Higher Education Accreditation ~~that includes course work in dental hygiene, education, public health or administration~~;

(3) Documentation of two (2) years' experience teaching in pre- or post-licensure registered dental hygiene or dental programs. This requirement may be waived for an Interim Program Director; and

(4) Documentation of a minimum of 2,000 hours in direct patient care as a registered dental hygienist, or working with a registered dental hygienist.

(b) "Program faculty" means an individual having a full-time or part-time agreement with the institution to instruct one or more of the courses in the educational program's curriculum. ~~As required by the program, the individual shall be responsible for advising students, facilitating and evaluating student progress in learning and clinical outcomes and providing didactic or clinical instruction.~~ The individual shall hold a ~~bachelor's~~ baccalaureate degree or higher from a college or university accredited by an agency recognized by the U.S. Department of Education or Council for Higher Education Accreditation, and possess the following:

(1) An active California dental or dental hygiene license or special permit with no disciplinary actions; or

(2) A postsecondary credential generally recognized in the field of instruction; or

(3) A degree in the subject~~, professional license, or credential at least equivalent to the level of instruction~~ being taught or evaluated.

(4) All program faculty shall have documented background in educational methodology every two years, consistent with teaching assignments.

(c) Clinical teaching faculty shall have direct patient care experience within the previous five (5) years in the dental hygiene area to which he or she is assigned, which can be met by either:

(1) Two (2) years experience providing direct patient care as a registered dental hygienist or dentist; or

(2) One (1) academic year of dental or ~~registered~~ dental hygienist level clinical teaching experience~~ or its equivalent~~.

(d) Didactic teaching faculty shall possess the following minimum qualifications:

~~(1) A bachelor's degree or higher from a college or university accredited by an agency recognized by the U.S. Department of Education or Council for Higher Education Accreditation, in the designated dental hygiene area; or~~

~~(2)~~ Current knowledge of the specific subjects taught, which can be met by either:

~~(A) Possessing a degree, professional license or credential at least equivalent to the level of education being taught or evaluated; or~~

(~~B~~1) Having completed twelve (12) hours of continuing education in the designated subject area; or

(~~C~~2) Two (2) semester units or three (3) quarter units of dental hygiene education related to the designated dental hygiene area; or have national certification in the designated dental hygiene area.

(e) Faculty Responsibilities**.**

(1) Each faculty member shall assume responsibility and accountability for instruction, evaluation of students, and planning and implementing curriculum content as required by the educational program.

(2) Each faculty member shall participate in an orientation prior to teaching, including, but not limited to, the educational program's curriculum, policies and procedures, strategies for teaching, and student supervision and evaluation.

(~~2~~3)Each faculty member shall be competent in the area in which he or she teaches.

Note: Authority cited: Section 1905, Business and Professions Code. Reference: Sections 1905 and 1941, Business and Professions Code.

§ 1105.2. Required Curriculum.

(a) The curriculum of an educational program shall meet the requirements of this section.

(b) The curriculum shall include education in the dental hygiene process of care and shall define the competencies graduates are to possess at graduation, describing (1) the desired combination of foundational knowledge, psychomotor skills, communication skills, and professional behaviors and values required, (2) the standards used to measure the students' independent performance in each area, and (3) the evaluation mechanisms by which competence is determined.

(c) The organization of the curriculum shall create opportunities for adjustments to and research of, advances in the practice of dental hygiene to ensure that graduates will have the knowledge, skills, and abilities to function within the dental hygiene scope of practice.

(d) The content of the curriculum shall include biomedical and dental sciences and dental hygiene sciences and practice. This content shall be of sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the educational program's standard of competency.

(1) Biomedical and Dental Sciences Content

(A) Cariology
(B) Dental Materials
(C) General Pathology and/or Pathophysiology
(D) Head, Neck and Oral Anatomy
(E) Immunology
(F) Oral Embryology and Histology
(G) Oral Pathology
(H) Pain management
(I) Periodontology
(J) Pharmacology
(K) Radiography
(L) Dental Anatomy and Morphology

(2) Dental Hygiene Sciences and Practice Content

(A) Community Dental Health
(B) Dental Hygiene Leadership
(C) Evidence-based Decision Making and Evidence-based Practice
(D) Health Informatics
(E) Health Promotion
(F) Infection and Hazard Control Management
(G) Legal and Ethical Aspects of Dental Hygiene Practice
(H) Medical and Dental Emergencies
(I) Oral Health Education and Preventive Counseling
(J) Patient Management
(K) Preclinical and Clinical Dental Hygiene
(L) Provision of Services for and Management of Patients with Special Needs
(M) Research

(3) Approved educational programs shall, at a minimum, specifically include instruction in local anesthesia, nitrous oxide-oxygen analgesia and periodontal soft tissue curettage in accordance with the provisions of this subdivision.

(A) An educational program shall provide infection control equipment according to the requirements of CCR Title 16, Division 10, Chapter 1, Article 1, Section 1005.

(B) An educational program shall provide at least one complete nitrous oxide-oxygen unit for each six (6) students enrolled in the course and shall include a fail-safe flowmeter, functional scavenger system and disposable or sterilizable nasal hoods for each laboratory partner or patient. All tubing, hoses and reservoir bags shall be maintained and replaced at regular intervals to prevent leakage of gases. When not attached to a nitrous oxide-oxygen unit, all gas cylinders shall be maintained in an upright position, secured with a chain or in a cart designed for storage of gas cylinders.

(C) An educational program shall comply with local, state, and federal health and safety laws and regulations.

(i) All students shall have access to the program's hazardous waste management plan for the disposal of needles, cartridges, medical waste and storage of oxygen and nitrous oxide tanks.

(ii) All students shall have access to the program's clinic and radiation hazardous communication plan.

(iii) All students shall receive a copy of the program's bloodborne and infectious diseases exposure control plan, which shall include emergency needlestick information.

(D) General Curriculum Content. Areas of didactic, preclinical and clinical instruction shall include:

(i) Indications and contraindications for all patients of:
1. periodontal soft tissue curettage;
2. administration and reversal of local anesthetic agents;
3. nitrous oxide-oxygen analgesia agents

(ii) Head and neck anatomy;

(iii) Physical and psychological evaluation procedures;

(iv) Review of body systems related to course topics;

(v) Theory and psychological aspects of pain and anxiety control;

(vi) Selection of pain control modalities;

(vii) Pharmacological considerations such as action of anesthetics and vasoconstrictors, local anesthetic reversal agents and nitrous oxide-oxygen analgesia;

(viii) Recovery from and post-procedure evaluation of periodontal soft tissue curettage, local anesthesia and nitrous oxide/oxygen analgesia;

(ix) Complications and management of periodontal soft tissue curettage, local anesthesia and nitrous oxide-oxygen analgesia emergencies;

(x) Armamentarium required and current technology available for local anesthesia, nitrous oxide-oxygen analgesia and periodontal soft tissue curettage;

(xi) Techniques of administration of maxillary and mandibular local infiltrations, field blocks and nerve blocks, nitrous oxide-oxygen analgesia and performance of periodontal soft tissue curettage;

(xii) Proper infection control procedures according to the provisions of Title 16, Division 10, Chapter 1, Article 4, Section 1005 of the California Code of Regulations;

(xiii) Patient documentation that meets the standard of care, including, but not limited to, computation of maximum recommended dosages for local anesthetics and the tidal volume, percentage and amount of the gases and duration of administration of nitrous oxide-oxygen analgesia;

(xiv) Medical and legal considerations including patient consent, standard of care, and patient privacy.

(E) Specific Curriculum Content.

Curriculum relating to the administration of local anesthetic agents, administration of nitrous oxide-oxygen analgesia, and performance of periodontal soft tissue curettage shall meet the requirements contained in California Code of Regulations Title 16, Division 11, section 1107.

~~(i) Local anesthetic agents curriculum must include at least thirty (30) hours of instruction, including at least fifteen (15) hours of didactic and preclinical instruction and at least fifteen (15) hours of clinical instruction. Preclinical instruction shall include a minimum of two (2) experiences per injection, which may be on another student. Clinical instruction shall include at least four (4) clinical experiences per injection on four different patients, of which only one may be on another student. Curriculum must include maxillary and mandibular anesthesia techniques for local infiltration, field block and nerve block to include anterior superior alveolar (ASA) nerve block (infraorbital), middle superior alveolar nerve block (MSA), anterior middle superior alveolar nerve block (AMSA), posterior superior alveolar nerve block (PSA), greater palatine nerve block, nasopalatine (P-ASA) nerve block, supraperiosteal, inferior alveolar nerve block (to include Gow-Gates technique), lingual nerve block, buccal nerve block, mental nerve block, incisive nerve block and intraseptal injections. One clinical experience per injection shall be used to determine clinical competency. The competency evaluation for each injection and technique must be achieved at a minimum of 75%.~~

~~(ii) Nitrous oxide-oxygen analgesia curriculum must include at least eight (8) hours of instruction, including at least four (4) hours of didactic and preclinical instruction and at least four (4) hours of clinical instruction. This includes at least two (2) preclinical experiences on patients, both of which may be on another student, and at least three (3) clinical experiences on patients, of which only one may be on another student and one of which will be used to~~

~~determine clinical competency. Each clinical experience shall include the performance of a dental hygiene procedure while administering at least twenty (20) minutes of nitrous oxide-oxygen analgesia. The competency evaluation must be achieved at a minimum of 75%.~~

~~(iii) Periodontal soft tissue curettage curriculum must include at least six (6) hours of instruction, including at least three (3) hours of didactic and preclinical instruction and at least three (3) hours of clinical instruction. Education may include use of a laser approved for soft tissue curettage. This includes at least three (3) clinical experiences on patients, of which only one may be on another student and one of which will be used to determine clinical competency. The competency evaluation for this procedure must be achieved at a minimum of 75%.~~

Out-of-state dental hygiene programs that are accredited by the Commission on Dental Accreditation or an approved accrediting body and who provide instruction according to this subdivision may be approved by the Committee to meet the requirements set forth in Business and Professions Code section 1909.

Note: Authority cited: Section 1905 & 1909, Business and Professions Code. Reference: Sections 1905 and 1941, Business and Professions Code.

§ 1105.3. Changes to an Approved Program.

(a) Each dental hygiene program holding a certificate of approval shall:

(1) File its legal name and current mailing address with the Committee at its principal office and shall notify the Committee at said office of any change of name or mailing address within thirty (30) days prior to such change. It shall give both the old and the new name or address.

(2) Notify the Committee within ten (10) days of any:

(A) Change in fiscal condition that will or may potentially adversely affect applicants or students enrolled in the dental hygiene program.

(B) ~~Substantive or major c~~Change in the organizational structure, administrative responsibility, or accountability in the dental hygiene program, the institution of higher education in which the dental hygiene program is located or with which it is affiliated that will affect the dental hygiene program.

(C) Programmatic i~~I~~ncrease or decrease in program enrollment of more than 10%.

(D) Programmatic r~~R~~eduction in program faculty or support staff of more than 10%.

(b) An approved dental hygiene program shall not make a substantive change without prior Committee approval. These changes include:

(1) Change in location, ownership or educational program expansion through an additional campus or distance education.

(2) Expansion, reduction or elimination of the program's physical facilities.

(3) Any changes that require a report to the Commission on Dental Accreditation or equivalent accrediting body shall require approval from the Committee.

Note: Authority cited: Section 1905, Business and Professions Code. Reference: Section 1905, Business and Professions Code.

§ 1105.4. Appeals Process.

(a) The Committee may deny or withdraw its approval of an educational program. If the Committee denies or withdraws approval of a program, the reasons for withdrawal or denial will be provided in writing within ninety (90) days.

(b) Any educational program whose approval is denied or withdrawn shall be granted an informal conference before the Executive Officer or his or her designee prior to the effective date of such action. The educational program shall be given at least ten days' notice of the time and place of such informal conference and the specific grounds for the proposed action.

(c) The educational program may contest the denial or withdrawal of approval by either:

(1) Appearing at the informal conference. The Executive Officer shall notify the educational program of the final decision of the Executive Officer within ten days of the informal conference. Based on the outcome of the informal conference, the program may then request a hearing to contest the Executive Officer's final decision. An educational program or program applicant shall request a hearing by written notice to the Committee within 30 calendar days of the postmark date of the letter of the Executive Officer's final decision after the informal conference. Hearings shall be held pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Or;

(~~3~~2)Notifying the Committee in writing the program's election to forego the informal conference and to proceed with a hearing pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Such notification shall be made to the Committee before the date of the informal conference.

Note: Authority cited: Section 1905, Business and Professions Code. Reference: Sections 1905 and 1941, Business and Professions Code.

§ 1106. Radiation Safety Certificate.

(a) Certificates. A certificate may be issued by an approved California dental hygiene program to their dental hygiene student ~~or graduate~~ who successfully completes the radiation safety course as part of the student's curriculum. A dental hygiene student ~~or graduate~~ shall be deemed to have successfully completed the course if the student has met all the course requirements and has obtained passing scores on both written and clinical examinations that includes theory and clinical application in radiographic techniques.

(b) A dental hygiene student ~~or graduate~~ who has received certification from an educational program approved the Committee shall be allowed to operate dental radiographic equipment~~, including the determination of radiographs,~~ for the purpose of oral radiography.

Note: Authority cited: Sections 1905 , 1905.5(m), Business and Professions Code. Reference: Section 1905, Business and Professions Code; and Section 106975, Health and Safety Code.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 10

Discussion and Possible Action to Amend Proposed Regulatory Language as a Result of the Office of Administrative Law's Disapproval of DHCC's Rulemaking Relevant to Remedial Education - CCR, Title 16, Division 11, §1108

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

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MEMORANDUM

DATE	May 3, 2014
TO	DHCC Committee Members
FROM	Donna Kantner, DHCC Staff
SUBJECT	**Agenda Item 10 –** Discussion and possible action to amend proposed regulatory language as a result of the Office of Administrative Law's disapproval of DHCC's rulemaking relevant to Remedial Education - *California Code of Regulations (CCR), Title 16, Division 11, §1108*

Background

At its December 2013 meeting, the Committee approved proposed regulatory language relating to requirements for remedial education programs. The hearing was noticed as required by law and held on March 25, 2014. No comments were received and the completed rulemaking file was submitted to the Department of Consumer Affairs in April 2014 for review and approval, to the Department of Finance in December 2014, and finally to the Office of Administrative Law (OAL) in February 2015. On March 30, 2015 OAL notified us that the file would be disapproved due to clarity, necessity, and procedural issues. We have 120 days to make the following nonsubstantive changes to the language that will allow it to achieve OAL approval.

OAL Decision

OAL stated:

> "First, the Committee adopted regulatory text requiring all remedial courses be at the post-secondary educational level 'in an approved dental hygiene educational program'. (See Minutes, at p.10.) However, the Committee prepared, submitted to OAL, and made available to the public for comment regulatory text omitting the requirement that courses be in an approved dental hygiene educational program. (See proposed Section 1108, subd. (a)(3).)
>
> Second, with respect to the Application for Approval of Course in Remedial Education form (Application Form), incorporated by reference into the regulations, the Committee agreed to (1) add a column to the section on Course Faculty Information for the status of out-of-state licenses to provide a certification. (See Minutes, at p.10.) However, the Committee prepared, submitted to OAL, and made available to the public regulatory text omitting both of these approved requirements

from the Application Form. (See proposed Section 1108, subd. (a)(2); Application Form DHCC RE-01 (12/2013), incorporated by reference therein.)

Third, the Committee adopted regulatory text requiring remedial education faculty to possess California licenses to practice dentistry or dental hygiene, but only those licensees 'with no disciplinary actions.' (See Minutes, at p.10.) However, as discussed further in the Clarity section below, it is unclear whether the regulatory text the Committee prepared, submitted to OAL, and made available to the public, omitted the qualification that licensees have no disciplinary actions."

Regarding the clarity issues, OAL noted that the language in Section 1108(b)(2)(A) relative to faculty requirements could either be interpreted as faculty can never have had a disciplinary action or faculty cannot have any disciplinary action within those two years of licensure before providing instruction. OAL felt that since it could be subject to interpretation, this subsection lacks clarity.

A second instance of lack of clarity was noted in Section 1108(b)(2)(A), in that it may be interpreted either that faculty must have a California license with no disciplinary actions to practice dentistry or dental hygiene against that California license, or that they may have no disciplinary actions to practice dentistry or dental hygiene in any jurisdiction. Again, OAL felt that this could be subject to interpretation and therefore is unclear. The intent as expressed at the Committee's December 2013 meeting, is that a licensee who has had any disciplinary action against his or her license should be prohibited from providing instruction to students.

The third instance involved the recordkeeping provisions in Section 1108(b)(6). OAL noted that this section enumerates a list of five classes of records; however, the Application Form asks the applicant to answer whether ten classes of records will be retained, including the five listed in the regulatory text. Additionally, they noted that "the Application Form asks whether the applicant will keep all of these records 'pursuant to Title 16, Division 11, of the California Code of Regulations.' (Ibid.) Notably, Division 11 of Title 16 of the California Code of Regulations covers a wide array of topics spread over multiple regulatory sections." OAL felt this regulatory section "is not easily understood by those persons directly affected by them and is unclear."

Nonsubstantive changes were made to the attached text of Section 1108 to address these issues and if the nonsubstantive changes accurately reflect the desire of the Committee, then the Committee may adopt them. The public will be noticed for 15 days and the package resubmitted to OAL under Government Code §113494 by July 30, 2015. Additional information regarding the express terms of the proposal will need to be drafted by staff and included in an addendum to the Initial Statement of Reasons.

Committee Action Requested

❑ 1) Discuss and take action to accept the text as modified to OAL's comments.
❑ 2) If amendments are accepted, direct staff to draft an addendum to the initial statement of reasons and to notice the document and proposed changes for a 15-day comment period and delegate the authority to the Executive Officer to adopt the changes and to make any nonsubstantive changes necessary to complete the rulemaking file.

[All New Text]

TITLE 16
California Code of Regulations
Professional and Vocational Regulations
Division 11
Dental Hygiene Committee of California
ARTICLE 3. EDUCATIONAL PROGRAMS

Changes to the originally proposed language are indicated by single ~~strikeout~~ for deleted text and by single underline for added text and are highlighted for ease of location.

§1108. Remedial Education.

(a) Approval of Remedial Education Course.

The Committee shall approve only those educational courses for remedial education pursuant to section 1917.3 of the Code that continuously meet all course requirements. Each approved course shall be subject to review by the Committee at any time. Continuation of approval will be contingent upon compliance with these requirements.

(1) A remedial course shall offer instruction in the following skills:

(A) Dental hygiene assessment and development, planning and implementation of a dental hygiene care plan;

(B) Exploration and detection of calculus, and periodontal probing;

(C) Hand and sonic or ultrasonic instrumentation to remove plaque biofilm and calculus;

(D) Administration of local anesthesia, nitrous oxide oxygen analgesia and performance of soft tissue curettage;

(E) Appropriate use of materials and devices used in dental hygiene practice; and

(F) Process of developing, reviewing and documenting outcomes of treatment and interventions provided to patients.

(G) All laws and regulations pertaining to the practice of dental hygiene.

(2) An applicant course provider shall submit an "Application for Approval of a Course in Remedial Education," DHCC RE-01(~~12/2013~~05/2015) hereby incorporated by reference, accompanied by the appropriate fee, for approval of a new course and shall receive approval prior to operation.

(3) All courses shall be at the postsecondary educational level in an approved dental hygiene educational program.

(4) Each approved course shall consist of a combination of didactic, laboratory, and clinical instruction and provide a minimum of 50 hours of remedial education.

(5) Each approved course shall submit a biennial report "Report of a Course in Remedial Education" DHCC RE-03 (12/2013) hereby incorporated by reference.

(b) Requirements for Approval of Course in Remedial Education.

(1) Administration. In order to be approved, each course shall provide the resources necessary to accomplish education as specified in this section. Course providers shall be responsible for informing the Committee of any changes to the course content, physical facilities, and faculty, within 10 days of such changes.

In order to be eligible for admission to the course, the course provider shall require course applicants to:

(A) Provide evidence of failure to pass a clinical examination as set forth in section 1917.3 of the Code or provide a probationary order ordering the student to attend a remedial education course offered under this section;

(B) Provide evidence of current certification in Basic Life Support for health care providers as required by Section 1016(b)(1)(C) of Article 4 of Chapter 1 of Division

10 of Title 16 of the California Code of Regulations (CCR); and

(C) Provide evidence of graduation from an educational program for dental hygienists approved by the Commission on Dental Accreditation or an equivalent accrediting body approved by the Committee.

(2) Faculty. Pre-clinical and clinical faculty, including course director and supervising dentist(s) shall:

(A) Possess a valid, active California license with no disciplinary actions at any time in any jurisdiction to practice dentistry or dental hygiene for at least two (2) years immediately preceding any provision of course instruction;

(B) Provide pre-clinical and clinical instruction only in procedures within the scope of practice of their respective licenses; and,

(C) Complete an educational methodology course within the last two (2) years; and

(D) Be calibrated in instruction and grading by the course provider.

(3) Facilities and Equipment. Pre-clinical and clinical instruction shall be held at a physical facility. Physical facilities and equipment shall be maintained and replaced in a manner designed to provide students with a course designed to meet the educational objectives set forth in this section. A physical facility shall have all of the following for use by the students:

(A) A lecture classroom, a patient clinic area, laboratory, and a radiology area.

(B) Access to equipment necessary to develop dental hygiene skills.

(C) Infection control equipment shall be provided as described in CCR Title 16, Division 11, Chapter 1, Article 1, Section 1005.

(4) Health and Safety. A course provider shall comply with local, state, and federal health and safety laws and regulations.

(A) All students shall have access to the course's hazardous waste management plan for the disposal of needles, cartridges, medical waste and storage of oxygen and nitrous oxide tanks.

(B) All students shall have access to the course's clinic and radiation hazardous communication plan.

(C) All students shall receive a copy of the course's bloodborne and infectious diseases exposure control plan, which shall include emergency needlestick information.

Faculty shall review with each student the information listed in (A) – (C).

(5) Remedial Education. Remedial education shall be given in a dental hygiene program approved by the Committee. Each course shall provide students the clinical facilities, equipment, and resources necessary to accomplish remedial education as provided in this section.

(6) Recordkeeping. A course provider shall possess and maintain the following for a period of not less than 5 years:

(A) Individual student records, including those necessary to establish satisfactory completion of the course.

(B) Copies of individual student remedial education plans.

(C) Copies of lab and clinical competency documents.

(D) A copy of faculty calibration plan, faculty credentials, licenses, and certifications including documented background in educational methodology within previous two years.

(E) Copies of student course evaluations and a summation thereof.

(F) Copies of curriculum, including course syllabi, exams, sample test questions and clinic rubrics.

(7) Curriculum and Learning Resources.

(A) The organization of the curriculum for remedial education shall be flexible, creating opportunities for adjustments in instruction in the skills listed in subdivision (a)(1) of this section.

(B) Curriculum shall include methods to assess and evaluate students' skills in order to create an individualized plan for remedial education.

(C) A remedial education plan shall include learning outcomes, results of assessments of student skills to be remediated, methods of remediation, measures to evaluate didactic and clinical competency and criteria for completion.

(D) Curriculum shall prepare the student to assess, plan, implement and evaluate procedures as provided in subdivision (a)(1) of this section to perform with competence and judgment.

(E) Curriculum shall require adherence to infection control standards as provided Section 1005 of Title 16 of the California Code of Regulations.

(F) Students shall be provided a course syllabus that contains:

(i) Course learning outcomes;

(ii) Titles of references used for course materials;

(iii) Content objectives; and

(iv) Grading criteria which includes competency evaluations and lab and clinic rubrics to include problem solving and critical thinking skills that reflect course learning outcomes.

(G) Successful completion shall require students to achieve competency at a minimum of 75% in each of the skills to be remediated.

(c) Certificate of Completion. A course provider shall issue and provide the Committee with an original "Certification of Completion of Remedial Education Course," DHCC RE-02 (12/2013), hereby incorporated by reference, only after a student has successfully completed the requirements of his or her remedial education plan.

(d) Appeals.

(1)The Committee may deny or withdraw its approval of a course. If the Committee denies or withdraws approval of a course, the reasons for withdrawal or denial will be provided in writing within ninety (90) days.

(2) Any course provider or applicant whose approval is denied or withdrawn shall be granted an informal conference before the Executive Officer or his or her designee prior to the effective date of such action. The applicant or course provider shall be given at least ten days' notice of the time and place of such informal conference and the specific grounds for the proposed action.

(3) The applicant or course provider may contest the denial or withdrawal of approval by either:

(A) Appearing at the informal conference. The Executive Officer shall notify the course provider of the final decision of the Executive Officer within ten days of the informal conference. Based on the outcome of the informal conference, the course provider may then request a hearing to contest the Executive Officer's final decision. A course provider shall request a hearing by written notice to the Committee within 30 calendar days of the postmark date of the letter of the Executive Officer's final decision after informal conference. Hearings shall be held pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Or;

(B) Notifying the Committee in writing the course provider's election to forego the informal conference and to proceed with a hearing pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Such notification shall be made to the Committee before the date of the informal conference.

Note Authority cited: Sections 1905 and 1906, Business and Professions Code. Reference: Sections 1917.3 and 1944, Business and Professions Code.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL HYGIENE COMMITTEE OF CALIFORNIA
2005 Evergreen Street, Suite 2050 Sacramento, CA 95815
P (916) 263-1978 | F (916) 263-2688 | www.dhcc.ca.gov

Application for Approval of Course in Remedial Education

Business & Professions Code §1917.3 and §1944, 16 CCR §1104~~, and §1108~~.

Non-Refundable Fee: $300 (Must accompany application)

Receipt	_____	RC	_____
Date filed	_____	$	_____
Approved	_____	Denied	_____
RP#	_____		

Course Provider _____ Phone Number _____

Email Address _____

Name and Title of Course Director

_____

Affiliated Dental Hygiene or Dental Program

_____

Mailing Address of Course Provider* City State Zip

_____

*Course provider mailing address is public. If you wish to provide a P.O. Box, you must also provide a physical address and be sure to specify that the physical address is not to be used as your address of record.

Requirements for Course

A course must be approved prior to operation. Each approved course must submit a biennial report. Course records shall be subject to inspection by the Committee at any time. The Committee may withdraw approval at any time that it determines that a course does not meet the requirements of the law. Course providers must inform the Committee of any changes to course content, faculty and physical facilities within 10 days.

1. Will the course offer remedial instruction in assessment and probing, exploration and detection of calculus, hand and sonic or ultrasonic instrumentation to remove plaque biofilm and calculus, administration of local anesthesia and nitrous oxide-oxygen analgesia and performance of periodontal soft tissue curettage, appropriate use of materials and devices used within dental hygiene practice, process of developing, reviewing and documenting outcomes of treatment and interventions provided to patients?

Yes ☐ NO ☐

2. Course Faculty Information

Name	License Type	License No.	License Expiration	Out-of-State License Status	Date of Educational Methodology

(Attach additional sheets if needed)

Course director and clinical and preclinical faculty must possess a valid, active California license for at least two years. Attach copies of each license and proof of education in educational methodology for all faculty and faculty calibration plan. Certification for all out-of-state licenses ever held by course faculty must be provided.

3. Will there be a lecture classroom, patient clinic area and radiology area for use by students? Attach a facility site map indicating each of these areas.

Yes ☐ NO ☐

4. Will all students have access to equipment necessary to develop dental hygiene skills in the duties being taught pursuant to Section 1108(b)(3)?

Yes ☐ NO ☐

5. Will faculty review with each student the hazardous waste management plan for disposal of needles, cartridges, medical waste, storage of nitrous oxide and oxygen tanks and the course's clinic and radiation hazardous communication plan? Attach a copy of both the hazardous waste management and hazardous communication plan.

Yes ☐ NO ☐

6. Will all students receive a copy of the bloodborne and infectious diseases exposure control plan, including the emergency needlestick information? Attach a copy as provided to students.

Yes ☐ NO ☐

7. Will the course clearly state curriculum subject matter, specific instruction hours in the individual areas of didactic, pre-clinical and clinical instruction, and include written course and specific instructional learning outcomes that will be accomplished within the framework of the course, including theoretical aspects of each subject as well as practical application? Attach a copy of sample curriculum, including student evaluation mechanism.

Yes ☐ NO ☐

8. Will the course's duration allow a student to develop competence in all necessary areas of instruction? Attach a sample course schedule.

Yes ☐ NO ☐

Recordkeeping

9. Will you retain for at least 5 years copies of curriculum, syllabi, exams, sample test questions and clinic rubrics, copies of faculty credentials, faculty calibration plan and individual student records including evaluations and summations thereof pursuant to Title 16, Division 11 of the California Code of Regulations?

Yes ☐ NO ☐

10. Will each student be issued a certificate of successful completion only after achievement of a minimum of 75% in each competency and has successfully completed the requirements of his or her remedial education plan?

Yes ☐ NO ☐

Acknowledgement

11. Have you reviewed Business & Professions Code §1909 and Title 16, Division 11 of the California Code of Regulations?

12. Do you agree to abide by the requirements set forth in Business & Professions Code §1909, and Title 16, Division 11 of the California Code of Regulations? Do you acknowledge that failure to do so may result in loss of course approval?

The Committee may approve or deny approval of any course. If the Committee denies approval of a course, the reasons for denial will be provided in writing within 90 days.

Certification

I certify under the penalty of perjury under the laws of the State of California that the statements made in the application are true and correct.

_____ _____

Signature of Course Director or designee Date

_____

Printed Name of Course Director or designee Date

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by the Dental Hygiene Committee of California, 2005 Evergreen Street, Suite 2050, Sacramento, CA 95815, Executive Officer, 916-263-1978, in accordance with Business & Professions Code, §1900 et seq. The information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Each individual has the right to review his or her own personal information maintained by the agency as set forth in the Information Practices Act unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted may, under limited circumstances, be made public.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 11

California State Auditor Report Regarding Children's Access to Dental Care – Informational Only

California State Auditor

December 2014

California Department of Health Care Services

Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care

Report 2013-125

The first five copies of each California State Auditor report are free. Additional copies are $3 each, payable by check or money order. You can obtain reports by contacting the California State Auditor's Office at the following address:

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California State Auditor

Elaine M. Howle State Auditor
Doug Cordiner Chief Deputy

December 11, 2014 2013-125

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor (state auditor) presents this audit report concerning how the Medi-Cal Dental Program (program), administered by the California Department of Health Care Services (Health Care Services), is fulfilling its mandate to ensure that children enrolled in Medi-Cal (child beneficiaries) receive the dental care for which they are eligible. This report concludes that Health Care Services' information shortcomings and ineffective actions are putting child beneficiaries at higher risk of dental disease.

Federal data showed that nearly 56 percent of the 5.1 million children enrolled in Medi-Cal in federal fiscal year 2013 did not receive dental care through the program. Our review of Health Care Services' data for 2011 through 2013 found similar results. Studies we reviewed concerning utilization cite low provider participation among the factors contributing to low utilization rates. A primary reason for low dental provider participation rates is low reimbursement rates. California's dental reimbursement rates are relatively low compared to national and regional averages and to the reimbursement rates of other states we examined. For example, California's rates for the 10 dental procedures most frequently authorized for payment within the Medi-Cal program's fee-for-service delivery system in 2012 averaged $21.60, which is only 35 percent of the national average of $61.96 for the same 10 procedures in 2011.

Although California as a whole appeared to have an adequate number of active providers to meet child beneficiaries' dental needs as of January 2014, five counties may lack active providers. In addition, 11 counties had no providers willing to accept new Medi-Cal patients while 16 other counties appear to have an insufficient number of providers. Furthermore, recent changes in federal and state laws that increase the number of children and adults who can receive additional covered dental services make us question whether there will be enough dental providers to meet the needs of Medi-Cal beneficiaries. We estimate that these changes could increase the number of individuals using Medi-Cal dental services from 2.7 million to as many as 6.4 million people.

Health Care Services has also failed to adequately monitor the program. For instance, it has not complied with state law requiring it to annually review reimbursement rates to ensure reasonable access of Medi-Cal beneficiaries to dental services. In addition, Health Care Services has not enforced certain terms of its contract with Delta Dental of California (Delta Dental) related to improving beneficiary utilization rates and provider participation. For instance, under this contract, in effect since 2004, Health Care Services has not required Delta Dental to contract with fixed facilities or mobile clinics to provide dental services in underserved areas. Health Care Services also fails to track each county's ratio of providers to beneficiaries, and thus cannot effectively measure children's access to and availability of dental services in each county, nor can it accurately predict whether sufficient numbers of providers are available to meet the increasing needs of the program.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Contents

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Summary

Results in Brief

Through the California Medical Assistance Program (Medi-Cal), the State of California participates in the federal Medicaid program, which provides health care services to the aged, disabled, and indigent. The California Department of Health Care Services (Health Care Services) is the single state agency responsible for administering Medi-Cal. Unfortunately, Health Care Services' information shortcomings and ineffective actions are putting children enrolled in Medi-Cal—child beneficiaries—at higher risk of dental disease.[1] Health Care Services is responsible for meeting the health care needs, including the dental needs, of enrolled individuals and families who rely on public assistance under Medi-Cal. According to the U.S. Department of Health and Human Services (HHS), tooth decay is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services. Tooth decay in children can cause significant pain and loss of school days, and it can lead to infections and even death.

Child beneficiaries in the Medi-Cal Dental Program (program) can receive services under two delivery models: fee-for-service and managed care. Although California's utilization rate for child beneficiaries—the proportion of children who had at least one dental procedure performed during the year—increased by as much as 1.2 percentage points each year from 2011 to 2013, its annual utilization rates are still lower than those of many other states. Despite this fact, Health Care Services has not established criteria for assessing utilization rates under the fee-for-service model. Data from HHS's Centers for Medicare and Medicaid Services (CMS) indicate that nearly 56 percent of the 5.1 million children enrolled in Medi-Cal in federal fiscal year 2013—October 1, 2012, through September 30, 2013—did not receive dental care through the program. The CMS data indicate that the national average utilization rate was 47.6 percent and ranged from a low of 23.7 percent in Ohio to a high of 63.4 percent in Texas for that same federal fiscal year. CMS's data also indicate that California's utilization rate of 43.9 percent was the 12th worst among the states that submitted data. Our review of Health Care Services' data for 2011 through 2013 found similar results. Studies we reviewed concerning utilization rates for Medicaid child beneficiaries suggested several reasons for low utilization rates, including an uneven distribution of dentists nationwide and a relatively small number of dentists who participate in Medicaid.

Audit Highlights . . .

Our audit of the California Medical Assistance Program (Medi-Cal) Dental Program, administered by the California Department of Health Care Services (Health Care Services), highlighted the following:

- *Although the proportion of children who had at least one dental procedure performed during the year —utilization rate—increased each year from 2011 to 2013, Health Care Services has not established criteria for assessing utilization rates under the fee-for-service model.*
- *While overall California appears to have an adequate number of active providers to meet the dental needs of child beneficiaries, some counties lacked active providers for children in the program.*
- *California's reimbursement rates for the 10 dental procedures most frequently authorized for payment within the program in 2012 averaged $21.60—only 35 percent of the national average for these same procedures in 2011.*
- *We estimate that recent changes in federal and state laws could increase the number of individuals using dental services through Medi-Cal from 2.7 million to as many as 6.4 million.*
- *Health Care Services has not reviewed reimbursement rates annually as required and thus, may remain unaware of their impact on access to dental services.*
- *Health Care Services has not enforced certain contract provisions related to increasing utilization.*
- *Health Care Services' current data collection efforts lack the specificity required to fully meet federal and state reporting requirements.*

[1] We refer to people enrolled in Medi-Cal as *beneficiaries*. Individuals under age 21 enrolled in Medi-Cal are *child beneficiaries*.

Health Care Services also has not formally established criteria for assessing provider participation under the fee-for-service model. Therefore, we used a ratio of one provider to every 2,000 child beneficiaries—or 1:2,000—for this audit as an indicator of geographic areas in which an insufficient number of dental service providers may exist. We chose this ratio primarily because state regulations require that all managed care enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider and that providers exist in such numbers and distribution so that all enrollees experience a ratio of at least one primary care provider (on a full-time equivalent basis) to every 2,000 enrollees. As of January 2014, California as a whole appeared to have an adequate number of active providers to meet the dental needs of child beneficiaries because its provider-to-beneficiary ratio for child beneficiaries did not exceed 1:2,000.[2] However, some counties lacked active providers for children in the program. For example, Health Care Services data showed that five counties with roughly 2,000 child beneficiaries who received at least one dental procedure in 2013 may not have any active Medi-Cal dental providers. Because of data limitations, we were unable to identify the providers rendering dental services to these 2,000 child beneficiaries. Furthermore, Health Care Services' data show that in 2013 11 counties had no dental providers willing to accept new Medi-Cal patients and that 16 counties had provider-to-beneficiary ratios above 1:2,000, indicating there may be an insufficient number of dental providers willing to accept new Medi-Cal patients. Health Care Services has taken some actions to increase the fee-for-service delivery system's provider participation, such as simplifying the administrative process by implementing an automated provider enrollment system, but much remains to be done.

Studies indicate that one of the primary reasons for low dental provider participation is low reimbursement rates. California's dental reimbursement rates are relatively low compared to national and regional averages and to the reimbursement rates of other states. For example, California's reimbursement rates for the 10 dental procedures most frequently authorized for payment within the program in 2012 averaged $21.60, which was only 35 percent of the national average of $61.96 for those same 10 procedures in 2011. California has not raised its dental reimbursement rates since fiscal year 2000–01, and it implemented in September 2013 a 10 percent state-mandated payment reduction for most dental service providers.

[2] To be counted as an active provider for the purposes of this audit, a provider must have rendered at least one program dental procedure to at least one child beneficiary in the past year.

Although the statewide active provider-to-beneficiary ratio of 1:807 in 2013 appears sufficient to provide reasonable access to dental services for child beneficiaries, recent changes in federal and state laws that increase the number of children and adults who can receive additional covered dental services make us question whether California will have enough available dental providers to meet the needs of Medi-Cal beneficiaries. For example, federal and state law expanded Medi-Cal's eligibility income limits and restored limited dental services for adult beneficiaries. We estimate that these changes in federal and state laws could increase the number of individuals using dental services through Medi-Cal from 2.7 million to as many as 6.4 million.

Health Care Services also has not complied with state law requiring it to review reimbursement rates annually. The purpose of this review is to ensure the reasonable access to dental services by Medi-Cal beneficiaries. Health Care Services stated that it did not perform these reviews because of its workload and the State's fiscal climate. However, Health Care Services did not notify the Legislature that it would not be conducting these reviews. Although Health Care Services is working toward a plan to incorporate annual rate reviews into its workload, it did not provide us with an estimated date of completion. If Health Care Services does not perform annual reimbursement rate reviews, it remains unaware of the impact of its reimbursement rates, and it cannot reasonably justify requesting from the Legislature changes to the reimbursement rates to ensure reasonable access to dental services by Medi-Cal beneficiaries.

In addition, Health Care Services has not complied with its plan for monitoring access to services. In its monitoring plan, Health Care Services stated that it would report yearly on its comparison of the results from a specific dental utilization metric with results from three national and statewide surveys. However, we evaluated a draft copy of the dental portion of Health Care Services' access monitoring report, and the draft does not compare the results from Health Care Services' utilization metric with the three surveys in its plan. According to the chief of the provider and beneficiary services section, Health Care Services' Medi-Cal Dental Services Division (division) did not include the comparisons because it thought another division was responsible for completing the dental metrics in the monitoring plan. He further stated that the division would be revising the dental section of the report to include the comparisons proposed in the monitoring plan. Because Health Care Services has not compared its child beneficiaries' utilization data for Medi-Cal dental services to the results of the three surveys, it lacks information necessary to determine whether California's utilization rates are low.

Health Care Services' actions related to improving beneficiary utilization and provider participation have been ineffective. Our analysis of beneficiary utilization rates and provider-to-beneficiary ratios indicates that these activities have not resulted in meaningful improvements. For example, beneficiary utilization rates statewide increased by only 1.2 percentage points from 2011 to 2012 and by 1 percentage point from 2012 to 2013. Health Care Services is also not enforcing its key contract provisions related to improving beneficiary utilization rates and provider participation. Health Care Services has contracted with Delta Dental of California (Delta Dental) since 2004, at a maximum amount payable of up to $8.6 billion, to help administer the program. According to that contract, Delta Dental is responsible for performing several beneficiary and provider outreach activities. Even though Health Care Services believes that Delta Dental has fully complied with these provisions, we remain convinced that Delta Dental has not performed contract-required outreach for improving dental access in underserved areas. For instance, Delta Dental has not contracted with entities to provide additional dental services through fixed facilities or mobile clinics. By not ensuring the performance of contract provisions aimed at increasing beneficiary utilization and provider participation in underserved areas, Health Care Services increases the risk that dental disease and tooth decay will affect children in those areas.

Further, Health Care Services' current data collection efforts lack the specificity required to fully meet federal and state reporting requirements. For example, federal law requires Health Care Services to report annually the number of children receiving specific types of dental services, but Health Care Services does not collect all of the data in sufficient detail to report accurately the number of children who have received these dental services. In addition, recently enacted state law requires Health Care Services to report on dental health access, dental care availability, and the effectiveness of preventive care and treatment. We believe that one critical measure of access and availability is each county's provider-to-beneficiary ratio. Health Care Services does not currently track this type of information; thus it cannot effectively measure either children's access to or the availability of dental services in each county, nor can it accurately predict whether sufficient numbers of providers are available to meet the increasing needs of the program. In addition, because of limitations in the data related to dental providers that Health Care Services collects, it cannot accurately calculate this ratio by county. Finally, Health Care Services and its fiscal intermediaries authorized reimbursements of more than $70,000 for dental services purportedly provided to deceased beneficiaries because it had not updated its beneficiary eligibility system with death information.

Recommendations

To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015:

- Establish criteria for assessing beneficiary utilization of dental services.
- Establish criteria for assessing provider participation in the program.
- Develop procedures to identify periodically any counties or other geographic areas where beneficiary utilization and provider participation fail to meet applicable criteria.
- Immediately take actions to resolve any declining trends identified during its monitoring efforts.

To ensure that the influx of beneficiaries resulting from recent changes to federal and state law is able to access Medi-Cal's dental services, Health Care Services should do the following:

- Continuously monitor beneficiary utilization, the number of beneficiaries having difficulty accessing appointments with providers, and the number of providers enrolling in and leaving the program.
- Immediately take actions to resolve any declining trends identified during its monitoring efforts.

To make certain that Medi-Cal beneficiaries have reasonable access to dental services, Health Care Services should immediately resume performing its annual reimbursement rate reviews, as state law requires.

To ensure that child beneficiaries' access to Medi-Cal dental services is comparable to the general population's access to service in the same geographic areas, Health Care Services should immediately adhere to its monitoring plan and compare its results measuring the percentage of child beneficiaries who had at least one dental visit in the past 12 months with the results from the three surveys conducted by other entities, as its state plan requires.

To improve utilization rates and provider participation under the fee-for-service delivery system, Health Care Services should immediately take these actions to make certain that Delta Dental performs the following contract-required outreach activities:

- Direct Delta Dental to submit annually a plan that describes how it will remedy the dental access problems in underserved areas within California.

- Direct Delta Dental to contract with one or more entities to provide additional dental services in either fixed facilities or mobile entities in underserved areas, as its contract requires.

To meet the requirements of the new state law, Health Care Services should establish the provider-to-beneficiary ratio in each county as one of the performance measures designed to evaluate access and availability of dental services and require that the provider field in its data systems is populated in all circumstances.

To ensure that it reports an accurate number of children who received specific types of dental services, Health Care Services should continue working on a solution to capture the details necessary to identify specific dental services rendered.

To make certain that Health Care Services and its fiscal intermediaries reimburse providers for services rendered to eligible beneficiaries only, Health Care Services should do the following:

- Obtain the U.S. Social Security Administration's Death Master File and update its beneficiary eligibility system with death information monthly.

- Coordinate with the appropriate fiscal intermediaries to recover any inappropriate payments made for services purportedly rendered to deceased beneficiaries.

Agency Comments

Health Care Services agrees with all but one of our recommendations. Regarding the recommendation that it establish the provider-to-beneficiary ratio statewide and by county as performance measures, Health Care Services states that it does not agree because these measures are not part of the reporting required by state law.

Introduction

Background

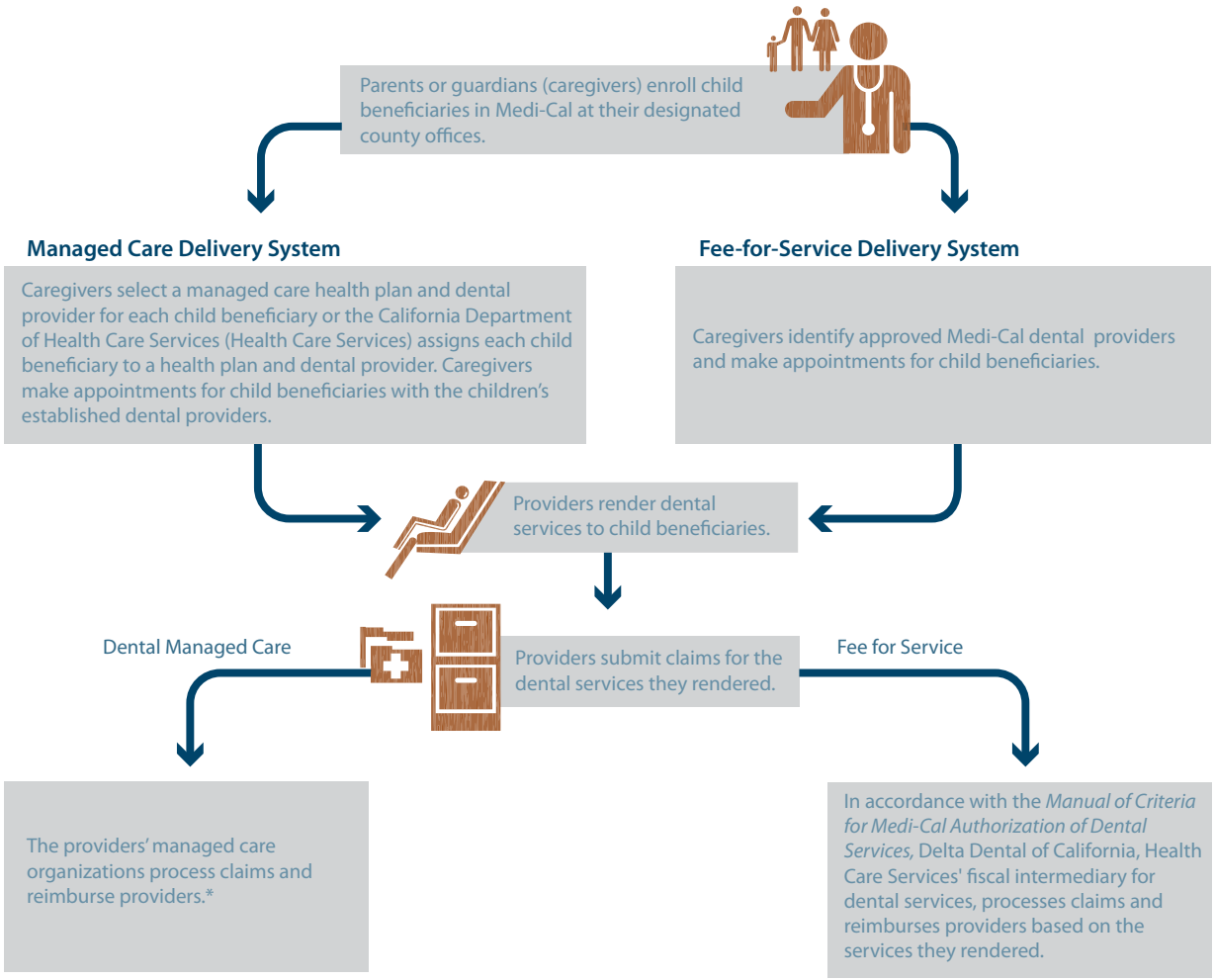
The federal Medicaid program provides funds to states to pay for the medical treatment of the needy. The State of California participates in the federal Medicaid program through its California Medical Assistance Program, known as Medi-Cal, which provides health care services to the aged, disabled, and indigent. The California Department of Health Care Services (Health Care Services) is the single state agency responsible for administering Medi-Cal. Federal regulations mandate that California's state plan—essentially, a contract between the State and the federal government describing how it will administer its Medicaid program—meets the requirements for providing early and periodic screening, diagnostic, and treatment (EPSDT) services for beneficiaries under the age of 21 years. EPSDT services include dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age and dental care, at as early an age as necessary, to relieve pain and infections, restore teeth, and maintain dental health. Health Care Services covers dental services through its Medi-Cal Dental Program (program). In addition to the EPSDT dental services, the program covers emergency and essential diagnostic and restorative dental services for all Medi-Cal beneficiaries, except for orthodontic care, fixed bridgework, and partial dentures that are not necessary for the balance of a complete artificial denture.[3] However, the program generally does not cover certain services, such as periodontal treatment, for beneficiaries who are 21 years or older. The Joint Legislative Audit Committee (audit committee) specifically directed the California State Auditor (state auditor) to audit the program's mandate to provide dental services to beneficiaries under the age of 21, whom we refer to as child beneficiaries.

Child beneficiaries can receive services under the program through two delivery models: fee-for-service and managed care. Providers that wish to render dental services to Medi-Cal beneficiaries must submit an application to Health Care Services to enroll in the program. Health Care Services' *Medi-Cal Dental Program Provider Handbook* (handbook) defines *providers* as individual dentists, certain registered dental hygienists, dental groups, dental schools, or dental clinics. Under the fee-for-service model, state regulations require that each provider receive the maximum reimbursement rate for dental services established by Health Care Services. However, if the provider's billed amount is less than the maximum, the provider receives the lesser amount.

[3] Effective May 1, 2014, state law restored certain dental benefits—such as dentures and crowns—to Medi-Cal beneficiaries who are 21 years old or older.

Health Care Services contracts with Delta Dental of California (Delta Dental) to perform fiscal intermediary services, such as adjudicating provider claims, and to underwrite the program's fee-for-service delivery system.[4] Figure 1 presents an overview of how child beneficiaries receive dental services via Medi-Cal.

Figure 1
Process Used by Child Beneficiaries Who Access Dental Services Under Medi-Cal



Sources: Federal law, state law and regulations, and Health Care Services' contracts with fiscal intermediaries and managed care organizations; the *Medi-Cal Dental Program Provider Handbook;* and documentation from Health Care Services' Web site.

Note: Child beneficiaries can receive dental services from centers and clinics that include federally qualified health centers, rural health clinics, and Indian Health Service clinics. Xerox State Healthcare LLC, Health Care Services' fiscal intermediary for medical services, or the beneficiaries' managed care plans (if applicable), processes claims and reimburses the centers and clinics generally on a per-visit basis.

* Health Care Services pays each managed care organization a capitated rate based on the number of beneficiaries enrolled in the plan.

[4] Delta Dental underwrites the program's fee-for-service delivery system by paying providers' claims and by billing Health Care Services weekly for cost reimbursements.

Since 1994, as part of the geographic managed care program, state regulations have required Health Care Services to provide dental services in geographic areas designated by Health Care Services; care is provided through dental-only prepaid health plans licensed in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) by the California Department of Managed Health Care. One of the Legislature's purposes for implementing the Knox-Keene Act was to ensure that patients receive available and accessible medical services that provide for continuity of care. For example, Health Care Services contracts with three prepaid health plans to provide Medi-Cal dental services in the counties of Los Angeles and Sacramento. Health Care Services pays the prepaid health plans a fixed amount per month for each Medi-Cal beneficiary regardless of the number or type of services they deliver.

Medi-Cal beneficiaries residing in Los Angeles County can access dental care through either the prepaid health plans or the fee-for-service delivery system, while Medi-Cal beneficiaries residing in Sacramento County are—with the exception of specific populations—mandatorily enrolled in prepaid health plans for dental care. If Sacramento County beneficiaries are unable to secure services through their prepaid health plan in accordance with the applicable contractual time frames and the Knox-Keene Act, they can qualify for the beneficiary dental exception, which allows them to move into the fee-for-service delivery system. In 2013, about 143,000 child beneficiaries received services under the dental managed care plans operating in the counties of Los Angeles and Sacramento.

Finally, under Medi-Cal, child beneficiaries may also obtain dental services from federally qualified health centers, rural health clinics, and Indian Health Service clinics (centers and clinics).[5] These centers and clinics generally provide dental services to medically underserved locations or populations. Medi-Cal allows these centers and clinics to bill for dental services. Federal law requires states to reimburse the centers and clinics for performing Medicaid services based on an annually adjusted rate. Specifically, the State calculates the centers' and clinics' payment for services on a per-visit basis in an amount equal to 100 percent of their average costs for furnishing the dental services in the previous year, after adjusting for factors such as changes in the scope of services they are furnishing in the current year. However, Medi-Cal reimburses Indian Health Service programs at 100 percent of the amounts expended for the services they render to Medi-Cal beneficiaries.

[5] Federal law defines federally qualified health centers as entities that provide primary health services, such as dental care, to a population that is medically underserved. In addition, federal law defines a rural health clinic as a clinic located in a rural area that has been designated as having a shortage of personal health services or primary medical care. Finally, federal law designates Indian Health Service programs as the health service program for Indians administered by the Indian Health Service within the U.S. Department of Health and Human Services. The program also serves non-Indians.

Health Care Services' data indicate that about 550 centers and clinics provided Medi-Cal dental services in 2013. These centers and clinics were located in 50 of California's 58 counties and range from one in the counties of Lake, Nevada, Plumas, San Benito, Siskiyou, and Sutter to 90 in Los Angeles County. There were none in the counties of Alpine, Amador, Imperial, Inyo, Modoc, San Luis Obispo, Sierra, and Trinity. Medi-Cal authorized payments to the centers and clinics for more than $127 million in 2012. This represented payments for more than 772,000 dental visits, an average of $164 per visit, which is much higher when compared to payments to Medi-Cal dental providers. For example, Health Care Services' 2012 data indicate that the average reimbursement per procedure for the Medi-Cal dental providers was $20. Each visit can include either one or multiple procedures.

Healthy Families Program

The federal government's State Children's Health Insurance Program (CHIP) provides health insurance for medical, vision, and dental services to children in families with incomes too high to qualify for Medicaid but too low to afford private coverage. Like Medicaid, CHIP is administered by each state but is jointly funded by the federal government and states. Every state administers its own CHIP program with broad guidance from the U.S. Department of Health and Human Services (HHS). States have the option to run a separate CHIP program or a combined Medicaid and CHIP program.

Until November 1, 2013, California operated separate Medicaid and CHIP programs. The Managed Risk Medical Insurance Board (board) was responsible for the administration of the Healthy Families Program, California's CHIP program. Through managed care plans, the Healthy Families Program offered dental services to enrolled children. Families enrolled in this program paid a monthly premium determined by family size, family income, and the plan chosen. Enrolled families also paid copayments for certain dental procedures, such as a root canal. In 2012, about 7,200 providers rendered dental services to nearly 1.1 million children from birth to age 18 years in the Healthy Families Program.

The State now runs a combined Medicaid and CHIP program. State law required that children enrolled in the Healthy Families Program transition to Medi-Cal beginning January 1, 2013.[6] Medi-Cal covers these children under a new coverage group known as the Optional Targeted Low-Income Children's Program. According to the Health Care Services' transition report submitted to the Legislature in July 2014, more than 750,000 former Healthy Families Program

[6] State law exempted from this transition any infants linked to the Access for Infants and Mothers program whose families had incomes above 250 percent of the federal poverty level.

enrollees were receiving comprehensive health, dental, mental health, and substance use disorder services under Medi-Cal's new coverage group. Further, more than 470,000 additional children enrolled in Medi-Cal under its new coverage group. Thus, roughly 1.2 million children were enrolled in Medi-Cal as a result of the transition and changes to its income eligibility requirements. The 2014–15 Governor's Budget did not provide funding for the board effective July 1, 2014, and thus, in effect, eliminated it.

Scope and Methodology

The audit committee directed the state auditor to audit the Medi-Cal Dental Program to understand how it is fulfilling its mandate to ensure that children enrolled in the program receive the dental care for which they are eligible. Table 1 lists the audit committee's objectives and the methods we used to address those objectives.

Table 1
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	• Reviewed relevant state and federal laws and regulations, as well as other relevant information applicable to the administration by the California Department of Health Care Services (Health Care Services) of the Medi-Cal Dental Program (program), and the administration of the Healthy Families Program by the Managed Risk Medical Insurance Board (board). • Interviewed key Health Care Services and board staff. • Examined studies, reports, reviews, journal articles, issue briefs, compendiums, presentations, and papers (collectively, studies) regarding the provision of dental services under the federal Medicaid program. • Because our audit focused on state-level activities, we did not examine local governments' role in either program. Also, although our audit work included examining Health Care Services' activities and data for the program's fee-for-service and managed care delivery systems, most of the results described in our report pertain to the fee-for-service delivery system. The California Department of Managed Health Care oversees managed health care plans and their provision of dental services. Further, Health Care Services uses the managed care delivery system in only two of California's 58 counties. In 2013 only 6.1 percent of the Medi-Cal child beneficiaries received dental services from a managed care dental provider.
2	Compare the utilization rates of specialty, preventative, and treatment services for children enrolled in the Healthy Families Program and the program over the past three years, to the extent the data are available.	• Analyzed beneficiary utilization data for the past three years for both programs to identify trends, and interviewed Health Care Services and board staff for their perspective. • Although Health Care Services' periodicity schedule recommends seeing a dentist every six months (or twice per year), we assessed whether child beneficiaries in both programs received dental care at least once per year. Our approach is consistent with the approaches described in studies issued by the federal Centers for Medicare and Medicaid Services (CMS) and others. • To calculate a utilization rate, we included in the numerator any child beneficiary who received a paid dental service through either program during a calendar year and included in the denominator any child beneficiary who was enrolled in either program at any point during a calendar year. Although some studies we examined included only those beneficiaries who were continuously enrolled in a program for a certain length of time (for example, 90 consecutive days of continuous enrollment during the year), we did not use a similar approach because we did not want to exclude children from our analysis unnecessarily. • Health Care Services' *Medi-Cal Dental Program Provider Handbook* separates dental procedures into different categories, including *diagnostic, preventive,* and other categories such as *restoration, endodontics,* and *periodontics*. For purposes of our analysis, we considered dental procedures not categorized as either *diagnostic* or *preventive* to be *treatment*. Our approach is consistent with the approach used by CMS.

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	AUDIT OBJECTIVE	METHOD
	a. Assess reasons for any significant differences in utilization rates between the two programs.	• Analyzed the beneficiary utilization rates of both programs, stratified by service type (for example, diagnostic, preventive, and treatment procedures). • Interviewed Health Care Services and board staff to determine the reasons for any significant differences between the two programs' utilization rates. • We did not compare utilization rates between the two programs at the county level because the data we received for the Healthy Families Program did not consistently contain the beneficiaries' residential addresses for the years 2009 to 2013.
	b. Determine the reasons for any changes in the dental service access or utilization rates for children formerly enrolled in the Healthy Families Program that are now enrolled in the program.	• Reviewed and analyzed beneficiary utilization data from Health Care Services and the board. • Because of the likelihood of incomplete data, we did not calculate changes in utilization rates for children formerly enrolled in the Healthy Families Program who were subsequently enrolled in the program. The scope of our audit ends at December 31, 2013, and the State was still transitioning children from the Healthy Families Program to the program until November 2013. Also, dental providers may submit a claim within six calendar months after the end of the month in which the service was performed for full payment, and as late as 12 months after the end of the month in which the service was performed for 50 percent payment.
3	Review and determine the effectiveness of Health Care Services' efforts over the past three years to improve the beneficiaries' utilization of child dental care in the program.	• Examined documents to identify Health Care Services' efforts to improve beneficiary utilization rates and to evaluate its progress in implementing these efforts. • Compared California's utilization rates to national and other states' utilization rates. • Interviewed Health Care Services' key staff.
4	Assess Health Care Services' efforts over the past five years to increase the participation of dental providers in the program.	• Examined documents to identify Health Care Services' efforts to increase provider participation and to evaluate its progress in implementing these efforts. • Interviewed Health Care Services' key staff. • Despite concerns we discuss in Chapter 1—and in the absence of any formal criteria established by Health Care Services—we used a ratio of one dental provider per 2,000 beneficiaries, or 1:2,000, as an indicator of geographic areas in which an insufficient number of dental service providers may exist.
	a. Review trends in the number of participating dental providers, to the extent data are available.	• Reviewed and analyzed Health Care Service's provider participation data for the past five years. • Calculated a statewide provider participation ratio for each of the past five years and determined whether the result exceeded 1:2,000. • Estimated the increase in the number of program beneficiaries using dental services based on recent changes in law.
	b. Assess the effectiveness of Health Care Services' outreach efforts to dental providers.	• Examined documents to identify Health Care Services' outreach efforts to dental providers and to determine whether those efforts were successful. • Reviewed studies to identify methods other states used to successfully increase provider participation. • Interviewed Health Care Services' key staff.
5	Determine the effect of reimbursement rates over the past three years on participation of dental providers in the Healthy Families Program and in the program.	• Reviewed the *Medi-Cal Dental Program Provider Handbook*, which identifies in its Schedule of Maximum Allowances the covered dental services and the fee-for-service maximum reimbursement rates. • Reviewed studies for how reimbursement rates could affect provider participation. • Because prepaid health plans determine how they pay their dental providers (Health Care Services and the board pay the prepaid health plans a fixed amount per month for each Medi-Cal beneficiary), we did not obtain reimbursement rates that the program's prepaid health plans in Los Angeles and Sacramento counties used to pay their providers, nor did we obtain reimbursement rates that the Healthy Families Program's prepaid health plans used to pay their providers. Therefore, we did not include these rates as part of our analysis.
	a. Review trends in dental provider reimbursement rates under both programs, to the extent data are available.	• Identified reimbursement rates for the program's fee-for-service delivery model since 1994 and compared trends in the reimbursement rates to the number of providers from 2011 through 2013. • Identified and reviewed court cases relevant to the program's fee-for-service reimbursement rates. • Compared the fee-for-service reimbursement rates for the 10 dental procedures most frequently authorized for payment under the program to national and regional average rates charged by private dentists for the same 10 procedures and to the Medicaid program's fee-for-service rates for three other states.

	AUDIT OBJECTIVE	METHOD
	b. Compare and assess reasons for any significant differences in dental provider participation in both programs.	Compared the program's provider participation ratio to the ratio for the Healthy Families Program. Because the statewide ratios for both programs fell below 1:2,000, we performed no additional analysis.
6	Determine, for the most recent year that information is available, the availability of dental providers participating in the program for both general and specialist dental services throughout the State.	Analyzed Health Care Services' 2013 provider participation data. We present a summary of these data in Appendix A.
	a. Determine areas where the greatest gaps exist between patient need and dental provider availability.	Analyzed Health Care Services' 2013 provider participation data for each county. We present a summary of these data in Appendix A.
	b. Assess Health Care Services' efforts to improve dental provider availability in areas where such gaps exist.	• Examined documents to identify Health Care Services' efforts to improve provider availability and evaluated its progress in implementing these efforts. • Interviewed Health Care Services' and its fiscal intermediary's key staff. • Assessed efforts by Health Care Services' fiscal intermediary to implement contract provisions related to provider outreach.
7	Determine whether Health Care Services has appropriate data collection methods to track beneficiary utilization and dental provider participation rates.	Reviewed relevant federal and state laws and regulations to assess the types of data Health Care Services is required to collect and report.
	a. Evaluate the effectiveness of Health Care Services' current data collection methods.	• Interviewed staff at Health Care Services to gain an understanding of its current data collection methods. • Reviewed Health Care Services' draft report for the program in response to requirements set forth by Chapter 3, Statutes of 2011 (Assembly Bill 97).
	b. Assess Health Care Services' plans to modify data collection methods in response to changes in state and federal laws.	Interviewed staff at Health Care Services to gain an understanding of its methods for tracking and responding to changes in state and federal laws. According to Health Care Services, it tracks changes through its regular correspondence and conference calls with CMS and by reviewing and tracking informational bulletins and clarifications on laws related to the provision of dental service.
8	To the extent possible, identify factors that may contribute to the program's provider rates being lower than comparable programs administered in other states.	• Compared California's utilization and reimbursement rates to those of the states of Connecticut, Texas, and Washington. We selected these three states primarily because they had high utilization rates compared to those of other states. • Interviewed key staff from the three states to identify factors contributing to their relatively high reimbursement rates and the factors they believed contributed to those higher rates.
9	Review and assess any other issues that are significant to the program.	We did not identify any other significant issues.

Sources: California State Auditor's analysis of the Joint Legislative Audit Committee's audit request number 2013-125, planning documents, and analysis of information and documentation identified in the column titled *Method*.

Assessment of Data Reliability

In performing this audit, we obtained electronic data files extracted from the information systems listed in Table 2. The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support findings, conclusions, or recommendations. Table 2 describes the analyses we conducted using data from these information systems, our methodology for testing them, and the limitations we identified in the data. Although we recognize that these limitations may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

Table 2
Methods Used to Assess Data Reliability

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
California Department of Health Care Services (Health Care Services) Fiscal Intermediary Access to Medi-Cal Eligibility system (FAME) Eligibility data for calendar years 2009 through 2013	To identify the number, age, and county of residence for children enrolled in the Medi-Cal Dental Program.	We performed data-set verification procedures and found no errors. We also performed electronic testing of key data elements and found no issues in the fields used for this analysis. We did not perform accuracy or completeness testing because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.
Health Care Services California Dental Medicaid Management Information System (CD-MMIS) Data for dental service providers	To identify the number of dentists accepting new patients as of December 28, 2013.	We performed data-set verification procedures and found no errors. We also performed electronic testing of key data elements and found no errors in the fields used for this analysis. We did not perform accuracy or completeness testing because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
Health Care Services California Medicaid Management Information System (CA-MMIS) and CD-MMIS Data for paid or denied dental claims	To identify the number and type of dental services performed, and the amounts authorized for payment for these services from January 2009 through December 2013. To identify the counties in which providers performed dental services in 2013.	We performed data-set verification procedures and found no errors. We also performed electronic testing of key data elements and found no issues in the fields used for this analysis. We did not perform accuracy or completeness testing because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.
	To identify the number of dentists rendering Medi-Cal dental services from January 2009 through December 2013.	We performed data-set verification procedures and found no errors. We also performed electronic testing of key data elements and found no issues in the fields used for this analysis. However, we were not able to determine the unique number of providers because Health Care Services does not require that providers who rendered certain types of dental services be identified in the system. In fact, when we performed our analysis, we excluded nearly 18 percent of the more than 111 million dental services because we were unable to uniquely identify the providers of these services in the data. Thus, we may be undercounting the number of providers who rendered dental services. We did not perform accuracy or completeness testing because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Not sufficiently reliable for the purposes of this audit. Although we identified limitations in the data that may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations
U.S. Social Security Administration (Social Security) Death Master File Death records reported to Social Security as of March 2014	To determine the death dates recorded for Social Security numbers associated with Medi-Cal Dental Program beneficiaries.	We performed data-set verification procedures and electronic testing of key data elements and did not identify any significant issues. Social Security does not guarantee the accuracy of the Death Master File; however, we did not perform accuracy and completeness testing of its data because the source documents that support these data are maintained by the U.S. government, and our access statute does not compel the U.S. government to provide us with records.	Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.
MAXIMUS, Inc. Healthy Families Enrollment Database (MAXe2) Enrollment records for the Healthy Families Program from 2009 through 2013	To identify the number and ages of children enrolled in the Healthy Families Program for each year from 2009 through 2013	We performed data-set verification procedures and found no errors. We also performed electronic testing of key data elements and found no issues in the fields used for this analysis. We did not perform accuracy or completeness testing because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

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INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
Premier Access Insurance Company and Access Dental Plan MCARE database Delta Dental of California (Delta Dental) MetaVance database Health Net, Inc. HSP database Western Dental Services, Inc. Dansoft ERP database Data for dental services rendered from 2009 through 2013	To identify the number of children receiving Healthy Families Program services and the types of services performed from January 2009 through December 2013. To uniquely identify the dentists providing dental services to Healthy Families Program beneficiaries.	For each of these databases, we performed data-set verification procedures and found no errors. We also performed electronic testing of key data elements and found no issues in the fields used for this analysis. However, the data did not include the rendering providers' National Provider Identifier number for all dental services, so we excluded these services from our analysis. Specifically, we excluded from the listed systems between zero percent to 2 percent of the total services. We did not perform accuracy or completeness testing because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.
Delta Dental DB2 database SafeGuard Health Plans, Inc. (SafeGuard) NOVA database Data for dental services rendered from 2009 through 2013	To identify the number of children receiving Healthy Families Program services and the types of services performed from January 2009 through December 2013.	For both of these databases, we performed data-set verification procedures and found no errors. We also performed electronic testing of key data elements and found no issues in the fields used for this analysis. We did not perform accuracy or completeness testing because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.
	To uniquely identify the dentists providing dental services to Healthy Families Program beneficiaries.	For both of these databases, we performed data-set verification procedures and found no errors. We also performed electronic testing of key data elements and found that the data did not include the rendering providers' National Provider Identifier number for all dental services, so we excluded these services from our analysis. Specifically, we excluded nearly 25 percent of the more than 2.3 million services rendered through SafeGuard and all of the nearly 37,000 services recorded in Delta Dental's DB2 database. As a result, we may be undercounting the number of providers who rendered dental services because we were unable to uniquely identify in the data the provider of these services. We did not perform accuracy or completeness testing because testing the number and variety of data systems used in this audit would be cost-prohibitive.	Not sufficiently reliable for the purposes of this audit. Although we identified limitations in the data that may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

Sources: California State Auditor's analysis of various documents, interviews, and data obtained from the entities listed in this table.

Chapter 1

SOME CHILDREN ENROLLED IN MEDI-CAL MAY FACE DIFFICULTIES ACCESSING DENTAL SERVICES

Chapter Summary

Children's use of free dental services available through the California Medical Assistance Program (Medi-Cal) is low. California's utilization rates for children's dental services, or the proportion of children enrolled in Medi-Cal who had at least one dental procedure performed during a year, increased statewide by 1.2 percentage points from 2011 to 2012 and by 1 percentage point from 2012 to 2013; however, these utilization rates were still low compared to those of other states. According to the Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health and Human Services (HHS), dental disease and tooth decay are almost entirely preventable through a combination of an early and regular use of preventive dental services, a healthy diet, and good oral health practices. A CMS report indicates that California's utilization rate of 43.9 percent was the 12th worst among states that submitted data to CMS in federal fiscal year 2013.

The studies we reviewed concerning utilization rates for children who are beneficiaries of Medicaid programs cite low provider participation among the factors contributing to low utilization rates. In California, the number of active providers statewide appears sufficient to provide services to child beneficiaries.[7] An active provider is one who rendered at least one dental procedure to at least one Medi-Cal child beneficiary during the year. However, data from the California Department of Health Care Services (Health Care Services), which administers Medi-Cal, show that some counties may not have enough active providers to meet the dental needs of child beneficiaries. For example, according to Health Care Services data, five counties, containing roughly 2,000 child beneficiaries who received at least one dental procedure in 2013 did not have any active providers in 2013. Because of data limitations, we were unable to identify the providers rendering dental services to these 2,000 child beneficiaries. Moreover, Health Care Services' data show that in 2013 11 counties had no dental providers willing to accept new Medi-Cal patients and that 16 counties had provider-to-beneficiary ratios above 1:2,000, indicating there may be an insufficient number of dental providers willing to accept new Medi-Cal patients.

[7] Individuals under age 21 enrolled in the Medi-Cal program are *child beneficiaries*.

According to several studies, including those published by CMS, The Children's Partnership, the National Academy for State Health Policy, and the Urban Institute, dentists cite three main reasons for not participating in the Medicaid program: cumbersome administrative paperwork related to enrolling as a provider, seeking prior authorization for certain procedures, and obtaining reimbursement for rendering services; poor beneficiary behavior, such as frequently missing appointments; and low reimbursement rates. Health Care Services has taken some action to address these concerns, such as issuing guidance to providers on how to minimize missed appointments. However, its reimbursement rates for dental services are low. The fee-for-service reimbursement rates in 2012 for the 10 dental procedures most frequently authorized for payment under the Medi-Cal Dental Program (program) averaged $21.60, which was only 35 percent of the national average of $61.96. Health Care Services has not increased reimbursement rates since fiscal year 2000–01.

Recent changes to Medi-Cal make us question whether there will be enough dental providers available to meet the needs of children not previously receiving services and of adults who can now receive additional covered services.

Finally, while the statewide active provider-to-beneficiary ratio of 1:807 in 2013 appears sufficient to provide reasonable access to dental services for child beneficiaries, recent changes to Medi-Cal make us question whether there will be enough dental providers available to meet the needs of children not previously receiving services and of adults who can now receive additional covered services. For example, federal and state law expanded Medi-Cal's eligibility income limits and restored some dental services for adults. We estimate that these changes in federal and state law could increase the number of individuals using Medi-Cal's dental services from 2.7 million to up to 6.4 million.

Children's Use of Medi-Cal's Dental Services Is Low

The utilization rate for Medi-Cal dental services by child beneficiaries is low relative to national averages and to the rates of other states. According to state law, the Legislature intends, whenever feasible, that the health care needs, including dental services, of enrolled families and individuals who rely on public assistance be met under Medi-Cal. Federal law requires those states that provide the early and periodic screening, diagnostic, and treatment (EPSDT) benefit to children in their Medicaid programs to report data to CMS annually. CMS uses its *Form 416: Annual Early and Periodic Screening, Diagnostic, and Treatment Participation Report* (CMS-416) to collect basic information from the states such as the number of children receiving dental services.

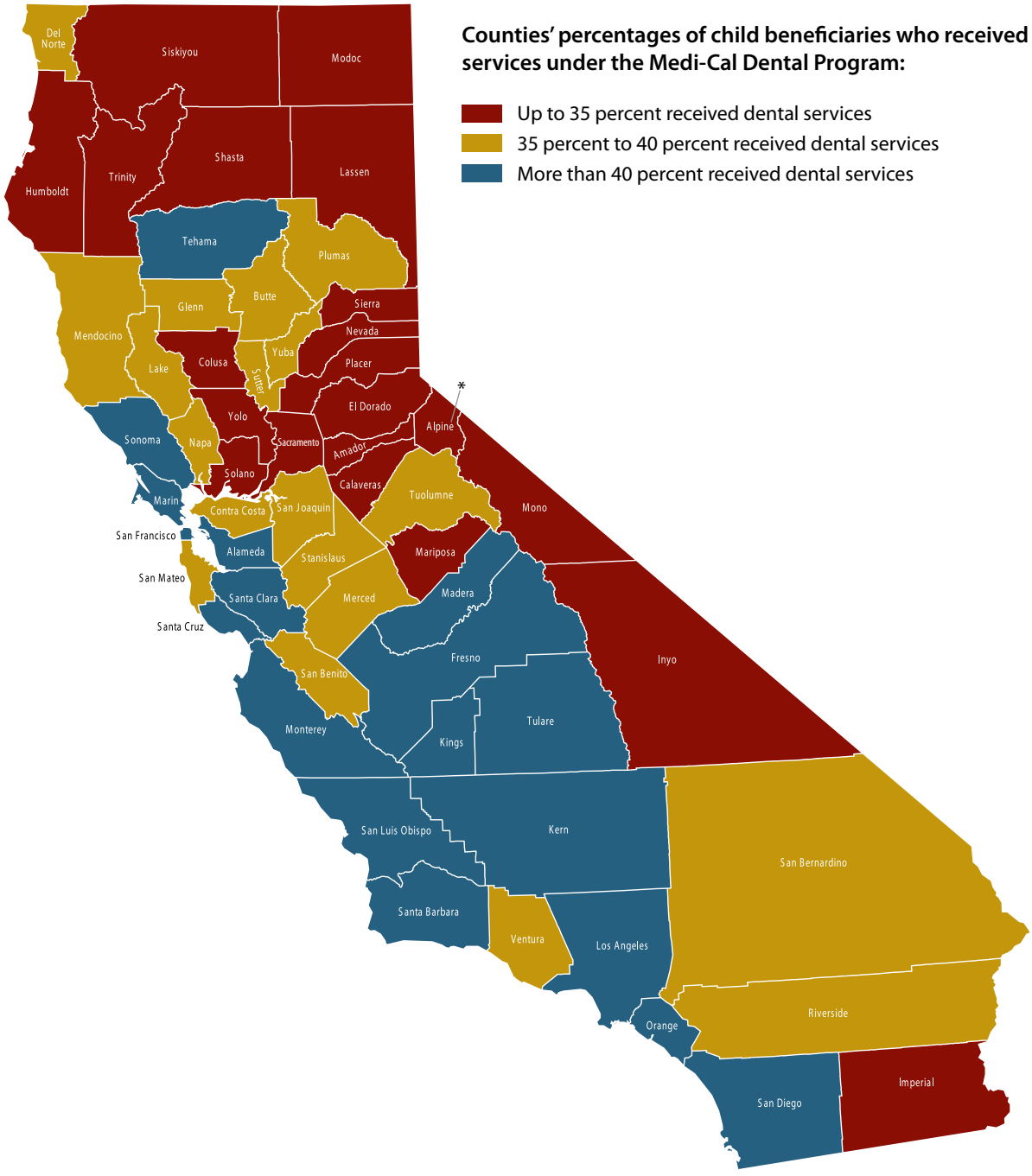
Our analysis of data from CMS-416 for federal fiscal year 2013 (October 1, 2012 through September 30, 2013) shows that California had the 12th worst utilization rate for Medicaid children receiving dental services among 49 states and the District of Columbia (data from Missouri was unavailable). According to the CMS-416 data, only 43.9 percent of California's child beneficiaries received dental services in federal fiscal year 2013 while the national average for the 49 states and the District of Columbia was 47.6 percent. Utilization rates for the individual states ranged from a low of 23.7 percent in Ohio to a high of 63.4 percent in Texas.

The HHS 2013 *Annual Report on the Quality of Care for Children in Medicaid and CHIP* states that tooth decay is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services. Tooth decay can cause significant pain and loss of school days and lead to infections and even death. Our analysis of Health Care Services' data yielded results similar to those we derived from the CMS-416 data for 2013. The program's statewide utilization rates for child beneficiaries for 2011, 2012, and 2013 were 39.2 percent, 40.4 percent, and 41.4 percent, respectively.[8] The California statewide utilization rate for child beneficiaries increased each year by 1.2 percentage points and 1 percentage point, respectively. However, the utilization rates for 26 of California's 58 counties decreased from 2011 to 2013. In 2013, the utilization rates ranged from a low of 6.4 percent in Alpine County to a high of 53.4 percent in Monterey County. As Figure 2 on the following page indicates, California's lowest utilization rates for child beneficiaries tended to be in rural counties.[9]

[8] The 2.5 percentage point difference between the 2013 utilization rates can be attributed to CMS's use of figures for child beneficiaries who had been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 days in the federal fiscal year and our use of figures for child beneficiaries who were enrolled in the program at any point during a calendar year. In addition, the difference can be attributed to CMS's use of figures from federal fiscal year 2013 and our use of figures from calendar year 2013.

[9] Health Care Services' Primary, Rural, and Indian Health Division considers the following 14 counties to be urban: Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Ventura. This division considers the remaining 44 counties to be rural.

Figure 2
The Medi-Cal Dental Program's 2013 Utilization Rates by County for Child Beneficiaries



Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services, including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

Note: *Child beneficiaries* are Medi-Cal enrollees under age 21. The service utilization rates are calculated by dividing the number of child beneficiaries who received at least one dental service during the year by the number of child beneficiaries eligible for Medi-Cal dental services for at least one month during the year.

* The Dental Board of California's Web site shows no licensed dentists located in Alpine County.

As Table 3 shows, utilization rates for child beneficiaries under the Medi-Cal fee-for-service delivery system were highest in the State's 14 urban counties, which contained 67 percent of California's child beneficiary population in 2013, including nearly 30 percent in Los Angeles County alone. Utilization rates for managed care in Los Angeles County were low compared to the fee-for-service delivery system. The low rates may be because in Los Angeles County, Medi-Cal beneficiaries also have the option to obtain dental services through the fee-for-service delivery system. Further, utilization rates for federally qualified health centers, rural health clinics, and Indian Health Service clinics (centers and clinics) were highest in California's 44 rural counties. In both urban and rural counties, the fee-for-service delivery system utilization rates were significantly higher than utilization rates at centers and clinics. Tables A.1 through A.4 in Appendix A display additional information and analyses related to child beneficiaries' utilization rates for dental services.

Table 3
Differences Between the Medi-Cal Dental Program's Utilization Rates for Child Beneficiaries in Urban and Rural Counties From 2011 Through 2013

	UTILIZATION RATES		
	2011	2012	2013
Utilization Rates in the Fee-for-Service Delivery System*			
Rural counties†	31.5%	31.8%	33.4%
Urban counties†	33.6	33.8	34.2
Utilization Rates in the Managed Care Delivery System‡			
Los Angeles County	3.3	3.9	5.6
Sacramento County	20.6	27.2	22.8
Utilization Rates in Centers and Clinics*			
Rural counties†	7.7	8.3	8.0
Urban counties†	4.0	4.7	4.9

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services (Health Care Services), including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

* The service utilization rates are calculated by dividing the number of child beneficiaries who received at least one dental service during the year by the number of child beneficiaries eligible for Medi-Cal dental services for at least one month during the year. The centers and clinics include federally qualified health centers, rural health clinics, and Indian Health Service clinics.

† Health Care Services' Primary, Rural, and Indian Health Division (division) considers the following 14 counties to be urban: Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Ventura. The division considers the remaining 44 counties to be rural.

‡ Because Health Care Services uses a managed care delivery system in Los Angeles and Sacramento counties, we used the number of child beneficiaries eligible for Medi-Cal dental services for at least one month during the year in these counties as the denominator to calculate utilization rates.

The studies, reports, reviews, articles, issue briefs, and papers (collectively, studies) we reviewed concerning utilization rates for Medicaid child beneficiaries cite several reasons for low rates. For example, an issue brief titled *In Search of Dental Care: Two Types of Dentist Shortages Limit Children's Access to Care* published by The PEW Charitable Trusts in June 2013 cites an uneven distribution of dentists nationwide and a relatively small number of dentists who participate in Medicaid among the reasons why tens of millions of children lack access to dental care each year. We discuss the number of providers participating in the program (provider participation) in more depth in the next section.

Many Counties Lack Active Providers or Providers Who Are Willing to Accept New Patients

As noted earlier, studies indicate that the lack of providers rendering dental services can contribute to low utilization rates for Medicaid child beneficiaries. For example, according to the issue brief and action plan titled *Fix Medi-Cal Dental Coverage: Half of California Kids Depend on It* (issue brief), which was published by The Children's Partnership in January 2013, the primary reason that children enrolled in Medi-Cal are not getting needed dental care is that too few dentists practice where they live.

Health Care Services has not formally established criteria to measure the adequacy of the beneficiaries' access to dental services under the program's fee-for-service model.

Health Care Services has not formally established criteria to measure the adequacy of the beneficiaries' access to dental services under the program's fee-for-service model. According to the acting division chief of its Medi-Cal Dental Services Division (acting division chief), Health Care Services used a ratio of one provider for every 2,000 beneficiaries to monitor the adequacy of the fee-for-service delivery system during the Healthy Families Program transition. State regulations require health care service plans or specialized health care service plans to use this same ratio to demonstrate that they can render a comprehensive range of services that are readily available and accessible to all enrollees throughout the geographic regions in their service area. Specifically, the state regulations require that all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider and that providers exist in such numbers and distribution so that all enrollees experience a ratio of at least one primary care provider (on a full time equivalent basis) to each 2,000 enrollees.

However, in its issue brief, The Children's Partnership questioned the appropriateness of Health Care Services' use of the 1:2,000 provider to-beneficiary ratio to measure provider adequacy. Specifically, The Children's Partnership stated that the ratio should factor in all of the providers' patients, including those who have private insurance or are private payers. The Children's Partnership

also stated that the ratio should account for the number of patients a provider treats and the number of available providers who treat certain subpopulations of children who have especially limited access to care, such as young children and children with special health care needs. Also according to the American Dental Association (ADA), a simple dentist-to-patient ratio cannot take into account the differing economic environments from region to region, state to state, and urban to rural. Therefore, the ADA does not recommend a dentist-to-patient ratio.

In response to The Children's Partnership's concerns, the acting division chief acknowledged that the ratio is not meant to work for a fee-for-service delivery system because beneficiaries are free to choose any provider and thus, assessing the individual capacity of that provider is difficult because the provider does not know in advance how many beneficiaries he or she will treat. However, he stated that Health Care Services used the ratio because it is a recognized Knox-Keene standard.[10] Further, Health Care Services continually assesses provider participation within the program and is currently exploring a more appropriate method of network evaluation in light of the characteristics of a fee-for-service delivery system. Specifically, the acting division chief stated that Health Care Services needs to formally establish quality and access criteria to assess the adequacy of the child beneficiaries' access to dental services under the program's fee-for-service model. Although Health Care Services planed to establish such criteria by November 30, 2014, it did not meet this deadline. In addition, Health Care Services did not indicate that it would establish criteria for assessing provider participation under the fee-for-service model.

We acknowledge the concern that the 1:2,000 provider-to-beneficiary ratio does not consider several factors and consequently does not necessarily tell the whole story of network adequacy in a given area. Nonetheless, in the absence of any formal criteria established by Health Care Services, we used the 1:2,000 provider-to-beneficiary ratio to identify geographic areas in which an insufficient number of dental service providers may exist. Our analysis found that the number of active providers in the program statewide appears sufficient to provide reasonable access for child beneficiaries.[11]

Our analysis found that the number of active providers in the program statewide appears sufficient to provide reasonable access for child beneficiaries.

[10] State regulations require that Health Care Services' dental-only prepaid health plans be licensed in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). State regulations implementing the Knox-Keene Act provide that each enrollee must have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider and that providers exist in such numbers and distribution so that all enrollees experience a ratio of at least one primary care provider to each 2,000 enrollees.

[11] As discussed in this report's Scope and Methodology section, Health Care Services does not require that the provider who rendered certain types of dental services be identified in two of Health Care Services' data systems. Thus, because of this data limitation, we were not always able to identify the provider who rendered each service. As a result, our analysis of the numbers of dental providers and child beneficiaries may understate the number of providers who rendered dental services.

Table 4 presents the number of active dental providers in the program statewide that rendered services to child beneficiaries and indicates that the provider-to-beneficiary ratio did not exceed the ratio of 1:2,000 for the five years from 2009 through 2013. For purposes of our analysis, we define *active providers* as those rendering at least one dental procedure to at least one Medi-Cal child beneficiary during the year.

Table 4
Ratios of Active Providers to Child Beneficiaries in the Medi-Cal Dental Program From 2009 Through 2013

	2009	2010	2011	2012	2013
Medi-Cal dental child beneficiaries*	4,531,566	4,695,281	4,833,214	4,825,161	5,549,929†
Active providers in the Medi-Cal Dental Program‡	6,473	6,950	7,016	7,048	6,874§
Provider-to-beneficiary ratio	1:700	1:676	1:689	1:685	1:807

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services (Health Care Services), including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

Note: As discussed in the Scope and Methodology, because of a data limitation, we may be undercounting the number of providers who rendered dental services.

* Child beneficiaries are Medi-Cal enrollees under age 21.

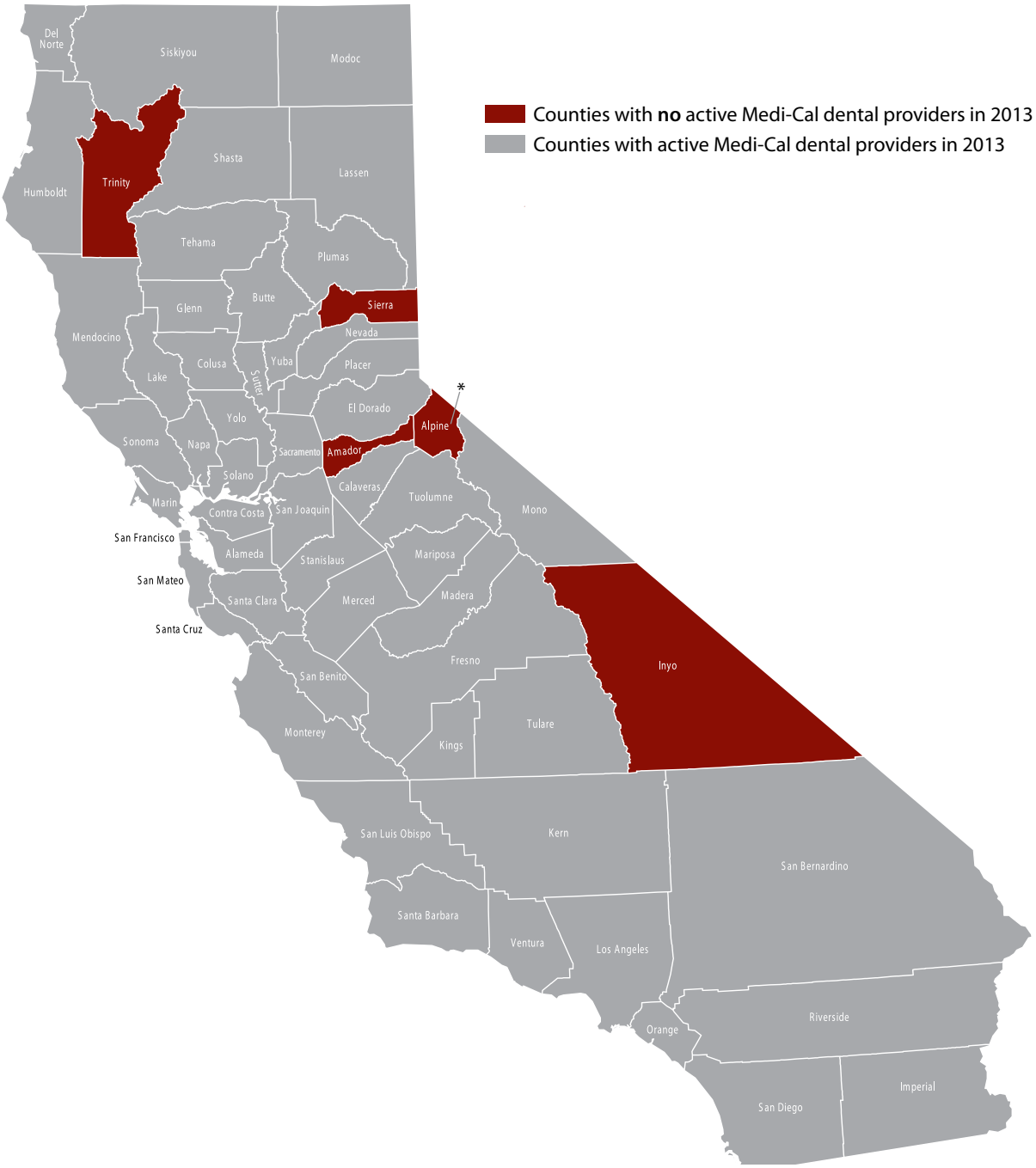
† According to the acting division chief of the Medi-Cal Dental Services Division, the 15 percent increase in child beneficiaries from 2012 to 2013 was likely due to the Healthy Families Program transition.

‡ An *active provider* is an individual dentist, registered dental hygienist in an alternative practice, dental group, dental school, or dental clinic enrolled in the Medi-Cal program to provide health care, dental services, or both to Medi-Cal beneficiaries. To be counted as an active dental provider, the provider must have rendered at least one dental procedure to a child beneficiary in the Medi-Cal Dental Program. The count includes fee-for-service providers, managed care providers, and providers associated with centers and clinics. We counted each provider only once per year for any dental procedure they rendered.

§ The data indicate that there was a 2.5 percent decrease in providers from 2012 to 2013. Health Care Services expressed concerns with our calculation of active providers and stated that enrolled providers rendering services actually increased during that period. However, Health Care Services did not provide documentation to support its statement.

However, Health Care Services' data showed that some counties may not have enough active providers to meet the dental needs of child beneficiaries in that geographic area. Because of our concerns with Health Care Services' data, we were unable to formulate definitive conclusions on the sufficiency of dental access in these counties. Nonetheless, we calculated the number of dental providers in each county based on whether they were active providers or whether, according to Health Care Services, they were willing to accept new Medi-Cal child beneficiaries. When we calculated the number of active providers for 2013 for each of the State's 58 counties, Health Care Services' data showed that five counties, containing roughly 2,000 child beneficiaries who received at least one dental procedure, may not have any active providers. Figure 3 identifies these counties. Because of data limitations, we were unable to identify the providers rendering dental services to these 2,000 child beneficiaries.

Figure 3
California Counties That Lacked Dental Providers for Child Beneficiaries in the Medi-Cal Dental Program in 2013



Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services, including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

Note: *Child beneficiaries* are Medi-Cal enrollees under age 21. To be counted as an active dental provider, the provider must have rendered at least one dental procedure to a child beneficiary in the Medi-Cal Dental Program in 2013. As discussed in the Scope and Methodology, because of a data limitation, we may be undercounting the number of providers who rendered dental services.

* The Dental Board of California's Web site shows no licensed dentists located in Alpine County.

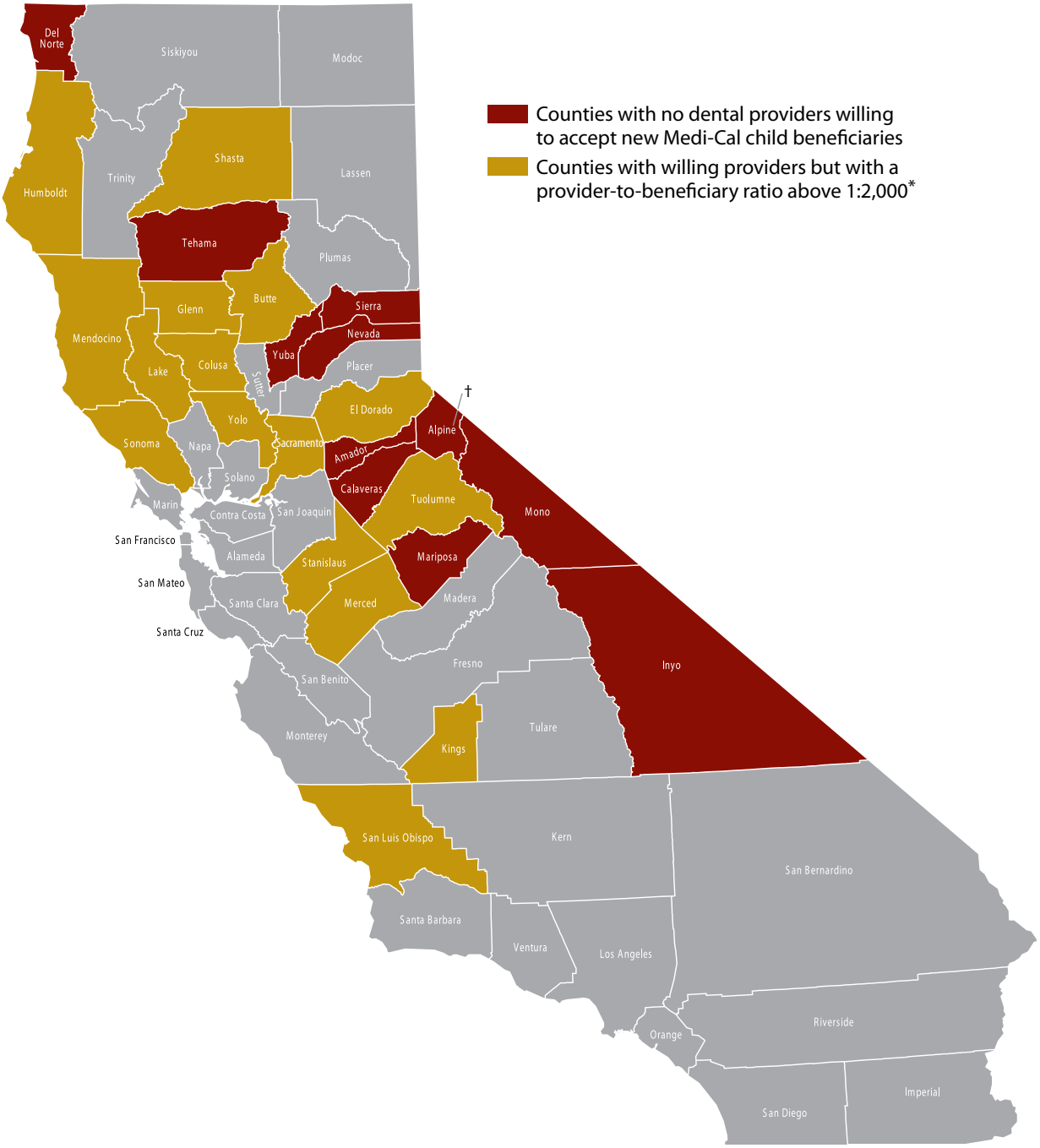
Nearly 468,000 child beneficiaries enrolled in Medi-Cal and residing in 27 counties did not receive any dental services in 2013.

Finally, Health Care Services' data indicated that 27 counties identified in Figure 4 did not have any or may not have enough dental offices or providers willing to accept new Medi-Cal child beneficiaries as of December 28, 2013. Nearly 468,000 child beneficiaries enrolled in Medi-Cal and residing in these 27 counties did not receive any dental services in 2013. The data show that 11 counties did not have any dental offices or providers willing to accept new Medi-Cal child beneficiaries, while the other 16 counties had provider-to-beneficiary ratios above 1:2,000. Our calculation of the provider-to-beneficiary ratios for the 16 counties includes applying a 65 percent utilization rate to the number of child beneficiaries who did not receive a dental procedure in 2013 because all of these child beneficiaries are not likely to seek services in the future. Tables A.5 and A.6 in Appendix A provide additional information about the number of child beneficiaries and providers in each county.

As mentioned previously, several studies cite dentists as reporting three main reasons for not participating in the Medicaid program: cumbersome administrative paperwork related to enrolling as a provider, to seeking prior authorization for certain procedures, and to obtaining reimbursement for rendering services; poor beneficiary behavior, such as frequent missed appointments; and low reimbursement rates.

Those studies indicate that dentists generally believe the Medicaid enrollment procedures are lengthy, complex, and burdensome. According to the March 2008 study *The Effects of Medicaid Reimbursement Rates on Access to Dental Care* from the National Academy for State Health Policy, California dentists noted that the Medi-Cal provider enrollment forms are paper-based, lengthy, and not specific to dentists and that the forms require supplemental information that may be confusing to dentists. State law requires each prospective provider for any type of Medi-Cal service to enroll in Medi-Cal by submitting to Health Care Services for its review and approval a complete application form that is signed under penalty of perjury or that is notarized, a disclosure statement, a provider agreement, and all applicable attachments. These forms and attachments are about 22 pages. Health Care Services also requires each prospective rendering provider of dental services to complete the *Medi-Cal Rendering Provider Application/Disclosure Statement/ Agreement for Physician/Allied/Dental Providers* form. The form is five pages, of which two pages are instructions. Although the prospective rendering providers must submit supplemental information with the form, the type of information Health Care Services requests of them appears to be unambiguous. For example, the requested supplemental information includes copies of the prospective provider's driver's license, professional license certificate, and proof of professional liability insurance.

Figure 4
California Counties That Lacked Providers or Lacked Sufficient Providers Willing to Accept New Medi-Cal Dental Child Beneficiaries in 2013



Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services, including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

* Because all child beneficiaries not having dental procedures in 2013 are not likely to seek services in the future, we applied a 65 percent utilization rate to estimate the number of child beneficiaries who could seek services from providers willing to accept new patients. The 65 percent utilization rate is based on data reported to the U.S. Department of Health and Human Services by 49 states and the District of Columbia for federal fiscal year 2013.

† The Dental Board of California's Web site shows no licensed dentists located in Alpine County.

However, Health Care Services has not established an electronic process for submitting the applicable forms and any attachments. In August 2014, the California State Auditor issued *California Department of Health Care Services: Its Failure to Properly Administer the Drug Medi-Cal Treatment Program Created Opportunities for Fraud*, report 2013-119. In that report, the chief of Health Care Services' Provider Enrollment Division (enrollment division) stated that the enrollment division was implementing a system that would automate its provider enrollment process and that it would be fully implemented by spring 2015. Further, the system would include efficiencies that should significantly reduce the time it takes to process applications. In that report, we recommended that Health Care Services continue its implementation of an automated provider enrollment system. Thus, Health Care Services has taken some actions and is working toward other actions that should address the concerns the California dentists noted in the 2008 study.

Also according to those studies, dentists generally believe that the Medicaid prior authorization requirements are cumbersome and that they create barriers to participation in the program's fee-for-service delivery system. State law establishes utilization controls for services rendered under Medi-Cal. One utilization control is the prior authorization of a specified procedure based upon a determination of medical necessity by a Health Care Services' consultant. State regulations require prior authorization through the submission and approval of a treatment authorization request (TAR). Health Care Services' *Medi-Cal Dental Program Provider Handbook* (handbook) generally excludes from prior authorization the diagnostic and preventive treatment codes as well as more than half of the billable codes for dental treatment procedures. For example, preventive dental prophylaxis and fluoride treatment procedures do not require prior authorization unless the frequency exceeds the stated limitations of once in a six-month period for beneficiaries under age 21 and once annually for beneficiaries ages 21 and older. Health Care Services' 2012 data indicate that it paid roughly $458 million to Medi-Cal dental providers for services rendered to child beneficiaries and only $40.9 million, or roughly 9 percent, of the services required those providers to submit TARs. Thus, although the prior authorization process may be cumbersome, it does not appear to be creating a barrier for providers to render dental services to child beneficiaries.

Health Care Services' 2012 data indicate that it paid roughly $458 million to Medi-Cal dental providers for services rendered to child beneficiaries and only $40.9 million, or roughly 9 percent, of the services required those providers to submit treatment authorization requests.

Further, the studies stated that dentists generally believe the Medicaid billing and payment requirements create additional barriers to participating in the program. For example, state law requires Medi-Cal dental providers to submit pretreatment radiographs or photographs with posttreatment claims to establish

the medical necessity for dental restorations when four or more dental fillings have been completed on a beneficiary in any 12-month period. The purpose of this requirement is to reduce fraudulent claims for unnecessary fillings. According to Health Care Services' handbook, 96, or 26 percent, of Medi-Cal's 369 codes for covered dental procedures require providers to submit radiographs or photographs for reimbursement. Health Care Services' 2012 data indicated that Medi-Cal dental providers were reimbursed for 312 procedure codes under the fee-for-service delivery system, of which 24.4 percent required radiographs or photographs as a condition of reimbursement.

According to the acting division chief, Health Care Services has taken steps to reduce administrative barriers. Health Care Services gave us five "dental operating instruction letters" that it identified as reducing administrative barriers. Health Care Services issues these instruction letters to its fiscal intermediary—Delta Dental of California (Delta Dental)—to modify processes. However, these five instruction letters do not appear to reduce materially the administrative barriers for providers. For instance, Health Care Services issued two instruction letters in September 2014. One instruction letter directed Delta Dental to make changes to the dental database to eliminate its review of photographs when none of the associated procedures on the provider's claim require Delta Dental's review to establish the medical necessity of the procedures. The acting division chief explained that this change benefits providers because it results in a reduction of the delays in Health Care Services' review, claims adjudication, and payment processes. In fact, he stated that this change eliminates at least seven days in payment delays. The acting division chief did not provide us with documentation to support his assertion that this change shortens the payment process by seven days. Further, this change does not improve the process for providers because they must still submit the photographs with their claims.

The five "dental operating instruction letters" that Health Care Services identified as reducing administrative barriers do not appear to reduce materially the administrative barriers for providers.

Another instruction letter directed Delta Dental to discontinue contacting the original provider when it receives multiple TARs from different providers for the same beneficiary within 60 days. Instead, Delta Dental is to deny the duplicate TARs. The acting division chief also stated that this change benefits providers because it reduces delays in Health Care Services' review, claims adjudication, and payment processes. However, even though this modification benefits Delta Dental, it does not appear to benefit the providers. The remaining three instruction letters primarily focused on allowing providers to submit their referral forms to Health Care Services without signatures and by e-mail and fax instead of by mail only; on eliminating the requirement for providers to include their names and permit numbers on the anesthesia records for certain dental procedures codes; and on establishing procedures

for providers to request enrollment in the program as a preferred provisional provider if they meet the requirements set forth in state law. State law requires Health Care Services to notify applicants or providers who request consideration as preferred providers within 60 days of submitting their application whether they have met the applicable requirements. The preferred provisional provider enrollment procedures have been in effect since December 27, 2012. However, according to the quality management director of Delta Dental's State Government Programs, as of October 31, 2014, Delta Dental had not enrolled any providers using this enrollment process.

As of October 31, 2014, Delta Dental had not enrolled any providers using the preferred provisional provider enrollment process.

Finally, the studies generally state that dental providers believe that poor behavior by beneficiaries, such as frequently missing appointments, creates barriers to providers' participation in the program. In its 2013 strategy guide *Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children & Adolescents*, CMS cited poor patient compliance as a barrier to participation as reported by providers. Specifically, missed patient appointments are a reason providers often cite for not wanting to accept Medicaid patients because providers cannot charge for those missed appointments. In its February 2014 bulletin for program providers, Health Care Services presented best practices for providers to address no-show rates, such as using e-mail and automated system reminders and delivering appointment reminders in English and Spanish. According to *Influence of Caregivers and Children's Entry Into the Dental Care System*, an April 2014 study published by the American Academy of Pediatrics, improving access to dental services for young children is a goal best achieved by engaging caregivers and families in a culturally, linguistically, and literacy-appropriate manner. However, as we discuss more fully in Chapter 2, Health Care Services can do more to educate and assist the caregivers and families of Medi-Cal's child beneficiaries in accessing dental services.

California's Reimbursement Rates for the Medi-Cal Dental Program Are Low

California's dental reimbursement rates are lower than national and regional averages and lower than the reimbursement rates of other states. Studies published by CMS, the National Academy for State Health Policy, and the National Bureau of Economic Research identify low reimbursement rates as a barrier to securing provider participation and thus children's access to dental care and children's subsequent utilization rates.

Based on the ADA's 2011 *Survey of Dental Fees*, California's reimbursement rates for the 10 fee-for-service procedures most frequently authorized for payment under the program in 2012 averaged $21.60, or 35 percent of the national average of $61.96. These reimbursement rates were just 31 percent of the average reimbursement of $70.32 for the same 10 procedures for the five states that fall into the Pacific Division of the U.S. Census Bureau—Alaska, California, Hawaii, Oregon, and Washington. Similarly, our comparison of California's fee-for-service reimbursement rates for these 10 procedures with the fee-for-service rates of Connecticut, Texas, and Washington showed that California's average reimbursement rates were lower. We selected these three states primarily because they were among the top five states with high percentages of Medicaid-enrolled children in their programs receiving dental care according to The PEW Charitable Trusts' June 2013 issue brief titled *In Search of Dental Care: Two Types of Dentist Shortages Limit Children's Access to Care*. In other words, these states had high utilization rates. Table 5 on the following page presents our comparison of the 10 fee-for-service dental procedures most frequently authorized for payment in 2012 for child beneficiaries under the program with the national and regional averages and with the averages for the three other states.

Medicaid officials from three states believed their reimbursement rates were one of the factors leading to the states' higher utilization rates.

Medicaid officials from those three states believed their reimbursement rates were one of the factors leading to the states' higher utilization rates. The dental program manager from Connecticut stated that its high rates were driven by competitive reimbursement rates and the lessening of the administrative burden on providers related to claims processing and prior authorization. The dental program manager also stated that the reimbursement rates had last been updated in 2008 in accordance with a 2008 class action settlement. Specifically, in the settlement agreement, Connecticut agreed to reimburse participating providers directly for rendering covered dental services to children enrolled in Medicaid at levels that are at least equal to the fee schedule specified in the agreement for patients under the age of 21. These fees represented an increase in dental reimbursement rates.

In addition, the strategic decision support director (director) of Texas' Health and Human Services Commission stated that Texas increased its reimbursement rates for selected commonly used dental procedures in 2008 as a result of a lawsuit. A corrective action order from a federal court directed the state to increase its reimbursement rates for dental providers in the 2008–09 biennium to 50 percent above the state fiscal year 2006–07 reimbursement rate levels. The director also stated that the data suggest the increase in the reimbursement rates was a primary driver in increasing Texas' dental utilization rates.

Table 5

Comparison of Reimbursement Rates in the Fee-for-Service Delivery Systems of the Medi-Cal Dental Program and Other States' Medicaid Programs

		GENERAL PRACTITIONERS' REIMBURSEMENTS (2011)		STATE MEDICAID PROGRAMS' REIMBURSEMENTS					
DENTAL PROCEDURE CODE*	NAME OF DENTAL PROCEDURE*	NATIONAL AVERAGE†	PACIFIC DIVISION OF THE U.S. CENSUS BUREAU AVERAGE†	CALIFORNIA'S MAXIMUM ALLOWANCE (IN EFFECT UNTIL SEPTEMBER 5, 2013)‡	CALIFORNIA'S MAXIMUM ALLOWANCE, INCLUDING PROVIDER PAYMENT REDUCTIONS (EFFECTIVE SEPTEMBER 5, 2013)	TEXAS (IN EFFECT UNTIL FEBRUARY 29, 2012)§	CONNECTICUT (EFFECTIVE APRIL 1, 2008)	WASHINGTON-THROUGH AGE 5 (IN EFFECT SINCE 2007)‖	WASHINGTON (IN EFFECT SINCE 2007)
D0120	Periodic oral evaluation–established patient	$44.10	$52.03	$15.00	$13.50	$28.85	$35.00	$29.46	$21.73
D0150	Periodic oral evaluation–new or established patient	70.39	79.16	25.00	22.50	35.32	65.00	40.38	33.64
D0230	Intraoral–periapical each additional film	19.84	20.42	3.00	2.70	11.51	17.00	NA	2.37
D0272	Bitewings–two films	39.33	47.23	10.00	9.00	23.38	32.00	NA	10.29
D0350	Oral/facial photographic images	42.20	42.80	6.00	5.40	18.38	none	NA	45.00
D1120	Prophylaxis–child	61.14	75.53	30.00	27.00	36.75	46.00	NA	22.98
D1203/D1208#	Topical application of fluoride**	31.70	36.07	**	**	14.70	29.00	23.41	13.25
D1351	Sealant per tooth	46.67	55.80	22.00	19.80	28.24	40.00	NA	21.98
D2140	Amalgam–one surface, primary or permanent	117.65	132.30	39.00	35.10	64.41	95.00	63.61	49.97
D2150	Amalgam–two surfaces, primary or permanent	146.61	161.82	48.00	43.20	85.71	114.00	69.97	61.97
	Average reimbursement rate for services rendered to all child beneficiaries through age 20†	**$61.96**	**$70.32**	**NA**	**NA**	**$34.73**	**$52.56**	**NA**	**$28.32**
	Average reimbursement rate for services rendered to child beneficiaries from birth to age 5	**NA**	**NA**	**$21.60**	**$19.44**	**NA**	**NA**	**$45.37**	**NA**
	Average reimbursement rate for services rendered to child beneficiaries age 6 through 20	**NA**	**NA**	**$20.60**	**$18.54**	**NA**	**NA**	**NA**	**NA**

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services (Health Care Services), including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system; Health Care Services' *Medi-Cal Dental Program Provider Handbook*, dated March 2014; the State of Texas Medicaid Dental Fee Schedule, dated September 4, 2011; the State of Connecticut Dental Fee Schedule, dated January 1, 2014; the State of Washington Health Care Authority Dental Program Fee Schedule, dated January 1, 2014; and the American Dental Association's (ADA) 2011 *Survey of Dental Fees*.

NA = Not applicable.

* This table shows the 10 dental procedures most frequently authorized for payment in 2012 under the Medi-Cal Dental Program (program). These 10 procedures constituted 77 percent of all services rendered under the program. The dental procedure codes are published by the ADA.

† The average dental procedure fees for the National and Pacific Division of the U.S. Census Bureau are from the ADA's *2011 Survey of Dental Fees*. The data used here were reported by general practitioners and represent the actual fee amount most often charged to patients. The Pacific Division includes Alaska, California, Hawaii, Oregon, and Washington.

‡ Effective September 5, 2013, Health Care Services implemented the 10 percent provider payment reduction for dental services in accordance with Chapter 3, Statutes of 2011 (Assembly Bill 97). These reductions applied to most dental service providers.

§ Effective March 1, 2012, the State of Texas changed its dental service delivery model for Medicaid-eligible children under the age of 21 from a fee-for-service model to a managed care model.

‖ The Access to Baby and Child Dentistry (ABCD) program increases access to dental services for Medicaid-eligible clients ages 5 and younger. For example, dentists who are certified through the continuing education program at the University of Washington School of Pediatric Dentistry or who graduate after 2006 from the University of Washington School of Dentistry are eligible for ABCD program-enhanced reimbursement rates.

Effective January 1, 2013, the ADA replaced codes D1203 and D1204, topical application of fluoride for children and adults, respectively, with code D1208 because the procedures are essentially the same.

** California has two reimbursement rates for the topical application of fluoride. The rate is $18 for children from birth to age 5 and $8 for children ages 6 through 20. We present separate average rates for the 10 procedures based on these age categories.

Finally, the dental program administrator from Washington stated that its Access to Baby and Child Dentistry program (ABCD program) is a primary driver in its high utilization rates. Washington established the ABCD program to increase access to dental services for Medicaid-eligible child beneficiaries through age 5. The ABCD program provides enhanced reimbursement rates to dentists who possess a certificate in pediatric dentistry or who graduated after 2006 from the University of Washington's School of Dentistry. The ABCD program also provides enhanced reimbursement rates to primary care medical providers who receive training and a certificate from the Washington Dental Service Foundation. These providers also render such services as periodic oral evaluations and the topical application of fluoride to the children in the program.

California has not increased its reimbursement rates for Medi-Cal fee-for-service dental services since fiscal year 2000–01.

California has not increased its reimbursement rates for Medi-Cal fee-for-service dental services since fiscal year 2000–01. We asked Health Care Services to provide us with documentation to demonstrate its consideration of increasing the reimbursement rates since fiscal year 2000–01. However, Health Care Services has elected to keep confidential any analyses it may have performed related to this issue, as permitted by state law. Nevertheless, because of difficult economic times, in 2011 California's governor and Legislature passed Chapter 3, Statutes of 2011 (Assembly Bill 97), to require Health Care Services to reduce by 10 percent its payments for many Medi-Cal fee-for-service benefits, including dental services. This statute in effect reduces reimbursement rates. In October 2011, HHS approved California's state plan amendment to reduce certain reimbursements, including dental services, by 10 percent. According to the associate regional administrator of HHS's Division of Medicaid and Children's Health Operations, the state plan amendment complied with all applicable federal requirements.

The reduction in payments was to become effective on or after June 1, 2011. However, several parties, including the California Dental Association, challenged the reductions in court, claiming that Health Care Services' reductions did not comply with federal law because the rates did not ensure that payments to providers were consistent with the providers' efficiency, economy, and quality of care; in addition, they claimed that the rates were not sufficient to enlist enough providers so that care and services were available to the Medi-Cal population to the same extent that such care and services were available to the general population in the same geographic areas. Although the plaintiffs won in a district court, the U.S. Court of Appeals for the Ninth Circuit (court) overturned the decision in May 2013. The court did not decide whether California's specific reimbursement rates were reasonable; rather, it concluded that HHS's review and approval of Health Care Services' state plan amendment implementing the reimbursement

reduction was reasonable. Health Care Services implemented the 10 percent reduction effective September 5, 2013. However, several plaintiffs, including the California Dental Association, appealed the court's decision to the U.S. Supreme Court. The U.S Supreme Court refused to hear the appeal of the court's decision in January 2014, and the reductions remained in effect.[12]

Recent Changes in Law May Affect Children's Access to Dental Services

We question whether enough Medi-Cal dental providers will be available to meet the needs of children not previously receiving services and the needs of adults who are now eligible to receive additional covered services.

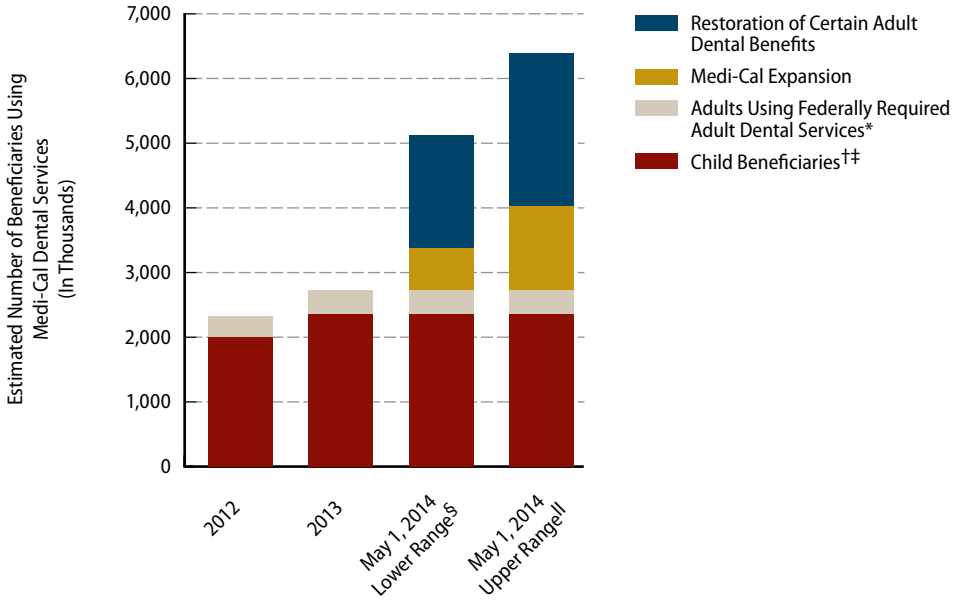
Although the 2013 provider-to-beneficiary ratio of 1:807 statewide appears sufficient to provide reasonable access to dental services from active providers for child beneficiaries, recent changes to Medi-Cal make us question whether enough Medi-Cal dental providers will be available to meet the needs of children not previously receiving services and the needs of adults who are now eligible to receive additional covered services. Specifically, state law required that children enrolled in the Healthy Families Program transition to Medi-Cal beginning in January 2013.[13] (We describe the Healthy Families Program in the Introduction to this report.) In addition, beginning January 1, 2014, federal and state law expanded Medi-Cal by allowing certain individuals under the age of 65 and whose income does not exceed 133 percent of the federal poverty level that is applicable to their family size to receive medical assistance such as dental services. For example, the 2014 annual federal poverty level for a family of four residing in all states except Alaska and Hawaii is $23,850 and 133 percent of this amount is $31,721. Until April 2014, state law generally excluded adult dental services from coverage under Medi-Cal unless they were medical or surgical services performed by a doctor of dental medicine or dental surgery who could be either a physician or a dentist or unless the services were performed as an emergency procedure. Effective May 1, 2014, state law allows specified medically necessary dental services for individuals 21 years of age or older, including examinations, prophylaxis, fluoride treatments, crowns, root canal therapy, and full dentures. These services are subject to utilization controls.

[12] According to a 2013 dental operating instruction letter that it issued, Health Care Services exempted from the 10 percent payment reduction certain pediatric surgery centers with at least 95 percent of their Medicaid patient bases consisting of beneficiaries under the age of 21. Health Care Services indicated that it did not want to adversely affect access to care because the nature of the treatments these centers offer—such as restorative, endodontic, and adjunctive procedures as well as oral and maxillofacial surgery—are limited by office participation on the referral list.

[13] State law exempted from this transition infants linked to the Access for Infants and Mothers program whose families had incomes above 250 percent of the federal poverty level.

Figure 5 presents our estimate of the effect these recent changes to federal and state laws could have on the program. Our analysis included both Health Care Services' estimate that between one and two million individuals will benefit from the Medi-Cal expansion and Health Care Services' reported number of adults who were able to obtain certain covered dental benefits as of January 2013. We estimate that the number of individuals using covered dental services could increase from 2.7 million adult and child beneficiaries to between 5.1 million and 6.4 million adult and child beneficiaries.

Figure 5
Recent Changes in Federal and State Laws Could Significantly Increase the Number of Medi-Cal Dental Program Beneficiaries Using Dental Services



Sources: California State Auditor's analyses of data from the California Department of Health Care Services (Health Care Service), including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system; as well as information presented on Health Care Services' Web site titled *Medi-Cal Expansion: Covering More Californians* and *Population Distribution by Age/Gender, January 2013*, Report Date: January 2014.

* This portion of the column represents the number of adult beneficiaries who received medical or surgical services under the Medi-Cal Dental Program (program) that were performed by doctors of dental medicine or dental surgery, who were either physicians or dentists, or that were performed as an emergency procedure.

† The number of child beneficiaries who received services under the program.

‡ Health Care Services' July 2014 report *Healthy Families Program Transition to Medi-Cal Monitoring Report and Summary* states that between January 2013 and November 2013, 751,293 children transitioned from the Healthy Families Program to the Medi-Cal program. Thus, Health Care Services' data for 2013 should include these children.

§ The lower range includes Health Care Services' estimate of 1 million beneficiaries for the Medi-Cal Expansion and nearly 2.7 million beneficiaries for adults who are now able to obtain certain dental benefits. The nearly 2.7 million beneficiaries exclude beneficiaries ages 65 and older because they could include individuals living in skilled nursing facilities, who were allowed dental benefits before 2009 and who would not be affected by the restoration. After applying a 65 percent utilization rate to the nearly 3.7 million beneficiaries, we estimate that 2.4 million adult beneficiaries could use services. We selected the 65 percent rate because, as indicated earlier in the chapter, it is at a high end of the range of utilization rates based on data reported to the U.S. Department of Health and Human Services by 49 states and the District of Columbia for federal fiscal year 2013.

ǁ The upper range includes Health Care Services' estimate of 2 million beneficiaries for the Medi-Cal Expansion and roughly 3.6 million beneficiaries for adults who are now able to obtain certain dental benefits. The 3.6 million beneficiaries include beneficiaries ages 65 and older. After applying a 65 percent utilization rate to the more than 5.6 million beneficiaries, we estimate that as many as 3.7 million adult beneficiaries could use services. (See previous note for the reason we chose the 65 percent rate.)

Figure 5 includes an additional 2.4 million beneficiaries in the lower range and 3.7 million in the upper range who we estimate may use dental services. According to the chief of the Medi-Cal Dental Services Division's provider and beneficiary services section, Health Care Services is monitoring the additional beneficiaries' access to care via the fee-for-service delivery system. However, Health Care Services has elected to keep confidential the details related to its monitoring activities, as permitted by state law. Health Care Services' data, as of December 28, 2013, indicate that 2,886 service offices and providers were willing to accept new patients. Because a limited number of providers are willing to accept Medi-Cal beneficiaries, Health Care Services should continue its monitoring efforts to ensure that any child beneficiaries and any additional adult beneficiaries who now can receive covered dental services because of the recent changes to federal and state laws can access dental care.

Recommendations

To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015:

- Establish criteria for assessing beneficiary utilization of dental services.
- Establish criteria for assessing provider participation in the program.
- Develop procedures for identifying periodically counties or other geographic areas in which the utilization rate for child beneficiaries and the participation rate for providers fail to meet applicable criteria.
- Immediately take action to resolve any declining trends identified during its monitoring efforts.

To help increase the number of providers participating in the program's fee-for-service delivery system, Health Care Services should improve its identification and implementation of changes that minimize or simplify administrative processes for providers. These changes should include revising its processes pertaining to dental procedures that require radiographs or photographs.

To ensure that the influx of beneficiaries resulting from recent changes to federal and state law is able to access Medi-Cal's dental services, Health Care Services should take these steps:

- Continuously monitor beneficiary utilization, the number of beneficiaries having difficulty accessing appointments with providers, and the number of providers enrolling in and leaving the program.

- Immediately take action to resolve any declining trends identified during its monitoring efforts.

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Chapter 2

THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES HAS FAILED TO MONITOR THE MEDI-CAL DENTAL PROGRAM ADEQUATELY

Chapter Summary

The California Department of Health Care Services (Health Care Services) has not always conducted activities, such as performing rate reviews and enforcing key contract provisions, to ensure that child beneficiaries have access to dental services under the California Medical Assistance Program (Medi-Cal).[14] For instance, Health Care Services has not complied with state law to assess the adequacy of reimbursement rates for these services, which the Medi-Cal Dental Program (program) provides. State law requires Health Care Services' director to review reimbursement rates annually but Health Care Services has performed only two annual reviews since fiscal year 2000–01. If Health Care Services does not perform annual reimbursement rate reviews, it remains unaware of the impact that reimbursement rates may have on its ability to ensure that California has sufficient providers for Medi-Cal child beneficiaries to have reasonable access to dental services.

Health Care Services also did not comply with its plan for monitoring child beneficiary access to services. In its monitoring plan approved by the Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health and Human Services (HHS), Health Care Services stated that it would compare the results from one of its dental utilization metrics with dental results from three surveys conducted by other entities. However, a draft copy of Health Care Services' monitoring report did not disclose the results of these comparisons. According to the chief of the provider and beneficiary services section within the Medi-Cal Dental Services Division (division), the division did not include the comparisons because it thought another division was responsible for full compliance with the monitoring plan. However, he stated that the division would revise the report to include the comparisons listed in the monitoring plan. Because Health Care Services did not compare the Medi-Cal child beneficiaries' utilization data to the results of the three surveys, it lacks information critical for determining whether California's utilization rates for child beneficiaries (utilization rates) are low.

[14] Individuals from birth through age 20 enrolled in Medi-Cal are *child beneficiaries*.

In addition, Health Care Services' actions for improving beneficiary utilization and provider participation have been ineffective. Our analysis of beneficiary utilization rates and provider-to-beneficiary ratios indicates that Health Care Services' actions have not resulted in meaningful improvements. For example, as presented in Chapter 1, beneficiary utilization rates statewide increased by only 1.2 percentage points from 2011 to 2012 and by 1 percentage point from 2012 to 2013. Health Care Services also is not enforcing key contract provisions related to improving beneficiary utilization rates and provider participation. Health Care Services contracts with Delta Dental of California (Delta Dental) to help administer the program. According to the contract, Delta Dental is responsible for performing several beneficiary and provider outreach activities among other things. However, Delta Dental did not perform some of these outreach activities, including contracting with entities to provide additional dental services through fixed facilities or mobile clinics in underserved areas. By not performing activities aimed at increasing beneficiary utilization and provider participation in underserved areas, Health Care Services increases the risk of dental disease and tooth decay for children in those geographic areas.

Health Care Services also does not collect sufficient data to fully comply with federal and state reporting requirements, and it has not updated its system for monitoring beneficiary eligibility. Federal law requires Health Care Services to report annually the number of children receiving specific types of dental services. Further, recently enacted state law requires Health Care Services to report a performance measure on access to dental care. However, because of data limitations, Health Care Services cannot provide the information required. Finally, Health Care Services and its fiscal intermediaries authorized payments of more than $70,000 for dental services purportedly provided to deceased beneficiaries because it had not updated with death information its beneficiary eligibility system.

Health Care Services and its fiscal intermediaries authorized payments of more than $70,000 for dental services purportedly provided to deceased beneficiaries.

Health Care Services Has Not Complied With State Law Directing It to Assess the Adequacy of Dental Reimbursement Rates

Health Care Services has not complied with state law that requires it to conduct annual reimbursement rate reviews. According to state law, the director must perform annual reviews of the reimbursement levels for dental services under Medi-Cal, and the director must revise periodically the rates of reimbursement to dentists. The purpose of that review is to ensure Medi-Cal beneficiaries have reasonable access to dental services. As Chapter 1 mentions, California has not increased its reimbursement rates

for dental services since fiscal year 2000–01. In fact, Health Care Services implemented a 10 percent state-mandated payment reduction in 2013 for most dental providers.

Health Care Services has only performed two annual reviews in conformance with state law since fiscal year 2000–01 and did not perform any between 2001 and 2011.

Health Care Services has only performed two annual reviews of the reimbursement levels for dental services in conformance with state law since fiscal year 2000–01. Health Care Services performed the first annual review during the period we examined in December 2011. Health Care Services stated that Medi-Cal pays an average of 31.5 percent of the statewide average for commercial usual, customary, and reasonable rates (UCR rates), which the report defined as provider fees established for noninsured clients. The American Dental Association does not define UCR rates, but it does define *the usual fee* as the fee an individual dentist most frequently charges for a specific dental procedure independent of any contractual agreement. Health Care Services concluded that the utilization rate among child beneficiaries was increasing but that there was a slight decrease in the number of active providers rendering dental services to child beneficiaries who were continuously enrolled in Medi-Cal. However, Health Care Services did not comment on the adequacy of the reimbursement levels for dental services or connect those facts to its reimbursement rates.

Health Care Services completed another annual review of the reimbursement levels for dental services in February 2013, which reported that Medi-Cal pays an average of 31.3 percent of the statewide average for commercial UCR rates. Health Care Services concluded that the Medi-Cal dental reimbursement rates were adequate to provide access to care for Medi-Cal beneficiaries based on the fact that utilization rates for child beneficiaries increased and the number of children receiving services increased as did the number of services provided.

Health Care Services did not perform similar annual reviews between 2001 and 2011, and it has not finalized a plan to conduct annual reviews in the future. According to the acting division chief, Health Care Services did not perform annual reimbursement rate reviews before 2011 because of the State's fiscal climate and its own workload, and it prepared the reviews in 2011 and 2013 only at the request of its legal counsel. The acting division chief also stated that Health Care Services did not notify the Legislature that it would not comply with state law that requires the annual reviews of the reimbursement levels for dental services. In fact, he said that until 2011 he was not aware of the requirement to perform the annual reviews. Further, the acting division chief stated that Health Care Services has had some internal discussions about the rate review and will be working toward developing a plan to incorporate this task into its workload. Health Care Services did not provide us with an estimate as to when it will resume performing the annual

reviews of the reimbursement levels for dental services; thus, we are concerned that it may not implement its plan in a timely fashion. If Health Care Services does not perform annual reimbursement rate reviews, it remains unaware of the impact that reimbursement rates may have on its ability to ensure that Medi-Cal's child beneficiaries have reasonable access to dental services. Therefore, it cannot reasonably justify requesting changes to the reimbursement rates for dental services from the Legislature.

Health Care Services Has Not Complied With Its Plan for Monitoring Medi-Cal Child Beneficiaries' Access to Dental Services

As part of the state plan amendment to reduce certain reimbursements by 10 percent, Health Care Services also submitted its monitoring plan titled *Monitoring Access to Medi-Cal Covered Healthcare Services*. Health Care Services told HHS that it would monitor predetermined metrics quarterly or annually to ensure that beneficiary access is comparable to services available to the general population in the same geographic areas. The monitoring plan states that Health Care Services intended to use three metrics to monitor the program:

- The difference in the number of child beneficiaries from the previous quarter to the current quarter as a percentage of total beneficiaries from the previous quarter.
- The number of child beneficiaries divided by the number of active dental providers, with the results stratified by factors such as the county in which the child beneficiaries reside.
- The number of child beneficiaries who each had at least one dental visit in the past 12 months divided by the total number of child beneficiaries.

For the first two metrics, Health Care Services would report on its comparison of program trends quarterly and yearly, respectively. In addition, Health Care Services would report yearly on its comparison of the results from its third metric with the results related to dental services from the California Health Interview Survey conducted by the University of California, Los Angeles, in collaboration with Health Care Services and the California Department of Public Health and with the results related to dental services of HHS's National Health Interview Survey and Medical Expenditure Panel Survey. Figure 6 presents the purpose and relevant questions from these surveys about dental services.

Figure 6
The California Department of Health Care Services Uses Results from Certain Surveys to Monitor the Results of the Medi-Cal Dental Program

California Health Interview Survey (CHIS)

Purpose	Conducted by the University of California, Los Angeles Center for Health Policy Research in collaboration with the California Departments of Health Care Services and Public Health, the CHIS aims to provide a detailed picture of the health and health care needs of California's large and diverse population.
Questions	The 2011–2012 CHIS included the following two questions about dental care for adults, children (ages 11 and under), and teens (ages 12 to 17): (1) When was your last dental visit? and, (2) If applicable, what was the main reason you have not visited a dentist?

National Health Interview Survey (NHIS)

Purpose	Conducted by the federal Centers for Disease Control and Prevention, the main objective of the NHIS is to monitor the health of the U.S. civilian noninstitutionalized population through collecting and analyzing data on a broad range of health topics. Examples of persons excluded from the sample include those who live in long-term facilities, who are on active duty with the Armed Forces, who are incarcerated in the prison system, and who are U.S. nationals living in foreign countires.
Questions	The 2013 NHIS included the following two questions about dental care for children (ages 17 and under): (1) During the past 12 months was there any time that you needed dental care but did not get it because you could not afford it? and (2) About how long has it been since you last saw a dentist?

Medical Expenditure Panel Survey (MEPS)

Purpose	The MEPS, which began in 1996, is a set of large-scale surveys of families and individuals, their medical providers, and employers across the U.S. that are conducted by the federal Agency for Healthcare Research and Quality. The MEPS collects data on specific health services and how they are paid for as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers.
Questions	The 2012 MEPS included the following two questions about dental care for children ages 2 through 17: (1) What type of dental care provider did you see during this visit? and (2) What did you have done during this visit?

Sources: *Monitoring Access to Medi-Cal Covered Healthcare Services,* Attachment 4.19 F to California's Medicaid State Plan, as well as information from the Web sites of the University of California, Los Angeles; the federal Centers for Disease Control and Prevention; and the federal Agency for Healthcare Research and Quality.

CMS approved Health Care Services' monitoring plan in October 2011. However, Health Care Services still had not issued its first monitoring report as of October 2014. According to the chief of the Research and Analytic Studies Division (research division), Health Care Services does not have a specific release date for its monitoring report. We evaluated a draft copy of the dental portion of the report, which does not compare the results from its third

metric, measuring the percentage of Medi-Cal's child beneficiaries who had at least one dental visit in the past 12 months, with the results from the three surveys (listed in Figure 6), as the monitoring plan requires. According to the division's chief of the provider and beneficiary services section, the division did not include the comparison because it thought the research division was responsible for full compliance with the monitoring plan, including any comparisons with surveys. However, he stated that the division would revise the current draft of the report to include the comparisons explained in the monitoring plan. Health Care Services acknowledges in its plan that the benefit of seeing a dentist annually includes an increased likelihood of children's receiving preventive dental services and early diagnoses and treatment of dental problems. The purpose of the third metric was to allow Health Care Services to monitor the child beneficiaries' annual contact with their dentists. Because Health Care Services has not compared the child beneficiaries' utilization data to the results of the three surveys, it lacks information critical for determining whether utilization rates are low.

Because Health Care Services has not compared the child beneficiaries' utilization data to the results of the three surveys, it lacks information critical for determining whether utilization rates are low.

Health Care Services' Actions Related to Improving Beneficiary Utilization and Provider Participation Have Been Ineffective, and Health Care Services Has Not Enforced Some Key Contract Provisions

Health Care Services has identified activities that it and Delta Dental are required to take to increase beneficiary utilization and provider participation in the program. Health Care Services contracts with Delta Dental to perform fiscal intermediary services, such as adjudicating provider claims and underwriting the program's fee-for-service delivery system. Our analysis of beneficiaries' utilization rates and provider-to-beneficiary ratios indicates that these activities have not resulted in meaningful improvements. For example, as Chapter 1 explains, beneficiary utilization rates increased statewide by only 1.2 percentage points from 2011 to 2012 and by 1 percentage point from 2012 to 2013. In addition, Health Care Services' data indicate that participation of active providers decreased from 2012 to 2013.

CMS established national oral health goals and announced them in April 2010 at the National Oral Health Conference. One of CMS's goals is to increase by 10 percentage points over a five-year period the rate of children ages 1 through 20 who are enrolled in Medicaid and who receive any preventive dental service. CMS asked each state to develop a specific oral health action plan to support this goal. Health Care Services developed an action plan in October 2013 describing the activities that it already had underway or that it was planning to implement to achieve this goal in federal fiscal year 2015. Health Care Services contracted with Delta Dental

to fulfill its responsibility for many of its beneficiary outreach and provider recruitment activities. However, in some instances these two entities were unable to produce measureable outcomes for the activities, or they did not demonstrate to us that these activities occurred. According to Health Care Services' acting division chief, given the current status of its strategies and utilization rates, it is unrealistic to expect an increase of 10 percentage points in child beneficiaries' utilization rates by September 2015.

According to Health Care Services' acting division chief, it is unrealistic to expect an increase of 10 percentage points in child beneficiaries' utilization rates by September 2015.

Health Care Services identified its Oral Health Action Plan (action plan) as a step that it and Delta Dental would take to increase beneficiary utilization and provider participation. According to the plan, Delta Dental's outreach unit is to conduct many of the activities described in the action plan—activities that are largely requirements of Health Care Services' contract with Delta Dental. The two entities entered into a contract for nearly $7.8 billion on December 9, 2004, with a term of November 1, 2004, through September 30, 2010. The contract term also included four optional one-year extensions. For no additional cost, Health Care Services extended the contract term through September 30, 2013, by exercising those extensions on March 26, 2010; April 30, 2010; and August 2, 2010. The acting division chief stated that these three extensions were signed in close proximity because Health Care Services did not realize it had to process a contract amendment to ratify the extensions. In addition, on November 29, 2012, Health Care Services extended this contract for an additional year ending on September 30, 2014, at no additional cost. Our legal counsel advises us that Health Care Services' contract amendments were appropriate. Finally, on June 11, 2013, the Department of General Services, which state law generally requires to approve contract amendments, authorized Health Care Services to extend this contract an additional two years ending on September 30, 2016. Health Care Services increased the maximum amount payable under the contract to $8.6 billion. According to the acting division chief, Health Care Services is currently working on a new fiscal intermediary contract for the program's fee-for-service delivery system.

Health Care Services' contract requires Delta Dental to develop a provider services manual (manual). According to the manual, Delta Dental's outreach unit is to focus on giving beneficiaries access to quality dental care within their geographical location and emphasizing underserved counties. In addition, the outreach unit's efforts are to focus on increasing the number of dentists in the program, increasing the number of beneficiaries treated, and maintaining the level of provider participation. The manual outlines a number of activities that the outreach unit should undertake. For instance, to increase beneficiary utilization rates, the outreach unit

is to contact federal, state, and county organizations or agencies—such as Rural Health Services, Child Health and Disability Prevention, and Women, Infants and Children—to notify them of the program's beneficiary services.

The outreach unit also is to notify organizations of the program's toll-free telephone line to help beneficiaries find dentists. When beneficiaries call the toll-free telephone line to request assistance in accessing dental providers, service representatives are to provide beneficiaries with names, addresses, phone numbers, and specialties of providers in their areas who accept new dental patients enrolled in Medi-Cal. In January 2013, Health Care Services and Delta Dental implemented a new referral process aimed at increasing the number of successfully scheduled dental appointments for beneficiaries. Upon receiving a request to find a dentist, service representatives are to call providers listed in the referral database, verify that the provider is still accepting new patients and can perform the necessary services that the beneficiary requires, and then use three-way calling to include the beneficiary on the call with the provider to schedule an appointment.

The manual also identifies the steps that the outreach unit should take to increase provider participation in underserved counties. These steps include increasing provider awareness about the program and communicating with providers, provider organizations, and clinics. For example, the outreach unit might periodically contact providers to ascertain their feelings or concerns about the program and to offer assistance. Further, the manual states that the outreach unit should contact newly licensed dentists and encourage them to enroll in the program. In its action plan, Health Care Services acknowledges that the impact of these activities has not been well documented or at least that they have not been well known or felt in the dental community. Health Care Services stated that it planned to review Delta Dental's outreach activities and develop measureable objectives for the outreach unit that better reflect the activities that it believes are most likely to improve access to dental services. Health Care Services also stated that it would develop an interactive performance measurement dashboard by November 2013; this dashboard would allow staff to access dental data on beneficiary eligibility, utilization rates, and expenditures so that staff could identify issues that require improvement and outreach activities to specific populations. Although Health Care Services has created the interactive performance measurement dashboard, as of December 2014 Health Care Services is still working on developing measureable objectives, and it plans to implement the objectives in early 2015.

Although Health Care Services has created the interactive performance measurement dashboard, it is still working on developing measurable objectives and plans to implement the objectives in early 2015.

In addition, the contract directs Delta Dental to undertake the tasks that we present in Figure 7 on the following page to remedy the dental access problem in underserved areas within the State and in California's border communities near the Oregon, Nevada, and Arizona state lines. Our review of five of the eight provisions in Health Care Services' contract found that Delta Dental did not implement three of them. In May 2014, the director of customer service of Delta Dental's State Government Programs stated that the following contract provisions were waived for Delta Dental by Health Care Services: (1) submitting a plan to Health Care Services for its review and approval to remedy the dental access problem in underserved areas within California and the border communities, (2) contracting with one or more entities to provide additional dental services in fixed facilities or through the use of portable dental equipment in the underserved areas, and (3) initiating a process in which beneficiaries in underserved areas receive direct contact to ensure that they are aware of their Medi-Cal dental benefits and that each beneficiary has access to a dental provider within a reasonable distance. Nevertheless, Health Care Services stated that it did not waive these provisions.

Our review of five of the eight provisions in Health Care Services' contract found that Delta Dental did not implement three of them.

Health Care Services' contract with Delta Dental states that should either party desire a change or amendment to the terms of the contract, the changes and amendments must be proposed in writing to the other party, and the other party must respond in writing as to its acceptance or rejection of the proposed changes and amendments. In addition, the contract requires the agreed-upon changes to be made through the State's official contract amendment process and formally approved by the State. Further, the contract states that "no covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract shall be waived except by written agreement of the parties or by explicit language found in the contract." However, the director of customer service was unable to provide us with a written agreement for the waiver of these contract provisions. Moreover, the contract amendments we referred to previously do not mention the waiver of these contract provisions.

In October 2014, Health Care Services gave us documents to support its belief that Delta Dental has complied with these three contract provisions. Nevertheless, we remain convinced that Delta Dental did not implement them. For instance, to demonstrate Delta Dental's compliance with the contract provision that it submit a plan to Health Care Services for review and approval to remedy dental access problems in underserved areas within the State and in the border communities near California's state lines, Health Care Services gave us a document labeled *Provider Services Plan*. Health Care Services stated that Delta Dental submitted this plan as part of its technical proposal for the contract in 2004. This plan describes provider

Figure 7
Delta Dental of California's Contract Provisions for Provider Outreach

The contract between the Department of Health Care Services (Health Care Services) and Delta Dental of California (Delta Dental) requires Delta Dental–the contractor—to do the following:

1. Submit a plan to Health Care Services for review and approval to remedy the dental access problems in underserved areas within California and in the border communities. Areas to be targeted for outreach activities will include any area with a low utilization rate—defined by the federal courts as 41.17 percent or less—or areas that appear to be in danger of low or decreased utilization.
2. Contract with one or more entities to provide additional dental services in either fixed facilities (such as existing dental offices or clinics) or through the use of portable dental equipment (such as mobile clinics) in the underserved areas.
3. Initiate a process whereby beneficiaries in the underserved areas are contacted directly to ensure they are aware of their Medi-Cal dental benefits and that they have access to a Medi-Cal dental provider within a reasonable distance.
4. Ensure that new Medi-Cal dental providers are established in the underserved areas.
5. Include with the plan (described above) an evaluation of the accessibility to Medi-Cal dental care providers throughout the State, including which Medi-Cal dental providers (by provider number) serve which cities, counties, and geographic areas of the State; whether dentists provide general dentistry or specialties, by type of specialty; whether they are currently accepting new Medi-Cal patients; and current addresses/telephone numbers of their locations of practice. This information shall be continuously updated on an on-line system as changes occur to previously gathered and recorded information received by the contractor. The on-line system shall be made available to approved contractor staff as well as Health Care Services.
6. Conduct a semi annual survey of Medi-Cal dental providers in a form and manner previously approved by Health Care Services. This survey should query providers regarding the points addressed in the paragraph above. Survey results and recommendations shall be submitted to the contracting officer within 45 state workdays.
7. Based on the survey results, the contractor shall develop and maintain a referral system for beneficiaries. This referral system shall provide beneficiaries with three provider names, addresses, phone numbers and specialties of dental providers who are in their geographical location, and who are currently accepting new Medi-Cal patients. In areas where more than one provider fits these specifications, the system shall refer beneficiaries to all such providers, or to at least three (3) such providers, on a rotational basis to ensure each enrolled provider receives an equal share of the referrals. Referrals shall be in a manner that ensures that neither the contractor nor Health Care Services is perceived as recommending a particular provider or assuming responsibility for the quality of care rendered by any provider.
8. Develop and recommend methods to assist beneficiaries' ability to access Medi-Cal dental providers in identified underserved areas.

Source: Contract number 04-35745 between Health Care Services and Delta Dental.

outreach activities Delta Dental anticipated taking such as promoting the program at dental forums, conventions, and other appropriate venues; strengthening its liaisons with counties, social service agencies, and school districts; and regularly surveying program providers to update its dental database. However, other than stating that it would work with dental schools to place graduates in underserved areas, this plan does not specifically describe how Delta Dental planned to remedy the dental access problems in underserved areas within California and the border communities. For example, the plan does not state how Delta Dental intended to identify the underserved areas and measure the effectiveness of its actions. In addition, we fail to understand how Health Care Services believes this 10-year old plan is sufficient to address the conditions outlined in its more recent action plan. In fact, Health Care Services stated in its action plan that the impacts of Delta Dental's outreach has not been well documented or at least not well known or felt in the dental community and that it planned to review Delta Dental's outreach activities and develop measureable objectives for the outreach unit that better reflect the activities that it believes are most likely to improve access to dental services.

We fail to understand how Health Care Services believes that a 10-year old Provider Services Plan is sufficient to address the conditions outlined in its more recent action plan.

The director of customer service at Delta Dental stated that it has taken steps to ensure that Medi-Cal dental providers are established in underserved areas. For example, its outreach unit has conducted biannual campaigns for new dental provider outreach in an effort to acquire applications from newly licensed dentists, and it has reached out to dental schools to speak with graduating dental students about working in rural communities. However, Delta Dental was unable to provide us with any statistical reports that summarize the results of its outreach activities and how its efforts have increased the number of dental providers established in underserved areas. The acting division chief stated that Health Care Services has evaluated program data to identify geographic areas with few or no dental providers and has given this information to Delta Dental to request targeted provider outreach. He also stated that Health Care Services has absorbed the responsibility for identifying underserved areas as part of its Healthy Families Program transition to Medi-Cal and its implementation of the 10 percent provider payment reduction. However, Health Care Services has elected to keep confidential the details related to its monitoring activities, as permitted by state law.

We also fail to understand Health Care Services' assertion that Delta Dental complied with the contract provision that requires Delta Dental to contract with one or more entities to provide additional dental services in either fixed facilities or mobile clinics in underserved areas. In October 2014, Health Care Services acknowledged that Delta Dental did not contract directly with fixed

facilities or mobile clinics to provide dental services in underserved areas. In fact, according to its director of dental policy, as of September 24, 2014, Delta Dental was reviewing a draft contract for it to begin contracting directly with these entities. Although Health Care Services stated that Delta Dental had instead participated in many outreach activities to facilitate and promote these entities' provision of services in underserved areas, these activities do not fulfill the contract provision.

We disagree with Health Care Services' assertion that Delta Dental met the contract provision requiring Delta Dental to initiate a process to contact beneficiaries directly in underserved areas.

Finally, we disagree with Health Care Services' assertion that Delta Dental met the contract provision requiring Delta Dental to initiate a process to contact beneficiaries directly in underserved areas to ensure they are aware of Medi-Cal's dental benefits and that each has access to a Medi-Cal dental provider within a reasonable distance. Health Care Services stated that Delta Dental employees attend health fairs and other functions to meet face to face with beneficiaries; that Delta Dental distributes benefits information at teen mother programs, food banks' parenting programs, and other community events at which beneficiaries are likely to congregate; and that Delta Dental distributes information to organizations such as Head Start so the organizations can share it with beneficiaries. Under this process, Delta Dental has abrogated its responsibility to initiate a process and instead generally relies on the counties and other organizations that sponsor the health fairs and other functions. In addition, Delta Dental in essence places the burden on the beneficiaries to attend these events to get the information they need. Our view of this provision is that Delta Dental bears the burden of identifying beneficiaries in underserved counties who do not use Medi-Cal's dental services and of informing them directly about the benefits that Medi-Cal affords them. Health Care Services' acting division chief acknowledged that the beneficiary outreach and education activities were not developed robustly and that Health Care Services planned to reengineer this area in the near future. He also stated that although Health Care Services is looking into contacting beneficiaries directly to inform them of their benefits, it has not yet done so because Delta Dental has limited access to beneficiary address information.

Health Care Services stated that Delta Dental fully complied with these three contract provisions. Specifically, Health Care Services stated that it interprets the applicable deliverables and performance standards as well as the contractual requirements to refer to the criteria identified in its financial management manual (financial manual) and the monthly invoices it requires Delta Dental to submit. The contract required Delta Dental to submit the financial manual three months after the effective date of the contract, which was in December 2004. Health Care Services initially reviewed and approved the financial manual in 2005 and has reviewed and approved subsequent changes made to it in 2006. The financial

manual requires Delta Dental to demonstrate that it has met the contract deliverables for the categories shown in Figure 8 on the following page before receiving payment. However, the financial manual does not require Delta Dental to demonstrate that it has met other applicable contract deliverables found in the scope of work section of the contract for the provider services subsystem, such as the provider outreach we present in Figure 7. Health Care Services acknowledges that the financial manual's criteria do not address each category of the contract's scope of work section for the provider services subsystem.

Health Care Services' interpretation is inconsistent with the general terms and conditions of the contract. These terms and conditions state that the contract will be governed by and shall be interpreted in accordance with the laws of the State of California. Our legal counsel advises that Health Care Services' interpretation results in the financial manual's overriding the terms of the contract, and this situation, in effect, creates a contract amendment. Although Health Care Services should have sought General Services' approval of the contract amendment in accordance with California's Public Contract Code, Section 10335, it did not do so. This same section of the law states that contract amendments have no effect unless and until General Services approves them.

The contract specifically states that Health Care Services will pay for provider services when all applicable deliverables have been met as defined in the contract. Further, the contract states that the contractor's failure to meet the requirements for a given month will constitute failure to provide the deliverable, and the contractor will not be entitled to payment for that month. The contract states that such a denial of payment will occur unless Health Care Services determines that Delta Dental was in substantial compliance with specific contract requirements. Health Care Services does not believe the State should attempt to recover any funds from Delta Dental for its failure to demonstrate that it met the requirements for delivering all applicable provider services defined in the contract. Health Care Services stated that in the future it will ensure that the financial manual and invoices are consistent with the contract language, commit to developing tangible measurements to better evaluate Delta Dental's performance of all functions, and implement contract amendments via the appropriate channels, including state contracting procedures. By not ensuring the performance of contract provisions aimed at increasing beneficiary utilization and provider participation in underserved areas, Health Care Services increases the risk that children in these areas will suffer needlessly from dental disease and tooth decay.

Health Care Services does not believe the State should attempt to recover any funds from Delta Dental for its failure to demonstrate that it met the requirements for delivering all applicable provider services defined in the contract.

Figure 8
The Financial Management Manual's Requirements for Delta Dental of California's Contract Deliverables

Provider enrollment responsibilities for Delta Dental of California (Delta Dental) include the following:

- Ensuring that prospective Medi-Cal dental providers receive sufficient information to understand program requirements to enable accurate processing of enrollment applicants and agreements, billing intermediary registration requirements, and certification. This responsibility shall include the review and processing of prospective dental providers' application agreement packages.
- When processing enrollment application agreement packages, ensuring that prospective providers meet certain requirements in accordance with state regulations and as directed by the California Department of Health Care Services (Health Care Services), such as the provider's having an active, unrestricted license to practice dentistry.

Delta Dental's provider master file responsibilities include the following:

- Making certain that the California Dental Medicaid Management Information System (CD-MMIS) meets the federal requirements for systems performance review. The purpose of this review is to ensure that it is operating effectively and efficiently and to ensure that the claims processing and information retrieval system meets the minimum operational performance standards on an ongoing basis. Performance standards establish levels of achievement that the CD-MMIS must sustain in terms of accuracy, timeliness, and cost.

Delta Dental's billing intermediaries and Electronic Data Interchange responsibilities include the following:

- Approving, processing, developing, and maintaining a tracking system of registration forms from billing intermediaries and of notification forms for providers who wish to register or have notified Delta Dental of billing intermediary participation. State law requires companies who bill the Medi-Cal program on behalf of providers, to register with Health Care Services and include their registration number on all claims they submit.
- Ensuring that all billing intermediaries register with it and that the registration number is on the claims the intermediaries submit for payment.
- Processing provider requests to discontinue or modify existing Electronic Data Interchange and billing intermediary arrangements.

Delta Dental's provider publications and forms responsibilities include the following:

- Producing and providing publications on paper, electronic media, or both to providers, billing agents, government, and private entities using Health Care Services' approved criteria. After Health Care Services' review and approval, Delta Dental is to print and disseminate the Delta Provider Manual, including replacement pages, priority bulletins, and general bulletins to providers regarding Medi-Cal related policies, procedures, statutes, and regulations.

Delta Dental's provider support services are to inlude the following:

- Receiving and responding to provider inquiries via telephone, correspondence, or on-site visits; contacting newly-enrolled dental providers after they have been enrolled for three months to ensure they understand Medi-Cal dental program requirements, the Medi-Cal dental billing process, and the availability of specialized training for their office staff; answering all correspondence and appeals regarding Medi-Cal dental policy, procedures, regulations, and statutes; and coordinating and conducting training seminars for providers regarding program policies, law, regulations, and claim issues.

Sources: Delta Dental's Financial Management Manual for the Medi-Cal Dental Program and contract number 04-35745 between Delta Dental and Health Care Services.

Because Delta Dental did not submit a plan to Health Care Services that specifically describes how it plans to remedy the dental access problems in underserved areas within California and the border communities, it cannot demonstrate that it performed an evaluation of the accessibility to Medi-Cal dental providers throughout the State. Delta Dental stated that it fulfilled the latter half of contract provision number 5 in Figure 7 on page 48 that requires it to update continuously an online system as changes occur to information that Health Care Services has previously gathered and recorded from Medi-Cal dental providers. Specifically, the director of customer service stated that this requirement pertains to the referral database it maintains for the State, which includes all of the listed requirements in the contract provision. He also stated that Health Care Services has access to a report generated from the database that contains this information. Our review found that the reports contained the listed requirements in the contract provision.

Finally, although not shown among the eight contract provisions listed in Figure 7, the contract requires Delta Dental to develop a dental outreach and education program for Medi-Cal beneficiaries in accordance with state law. This program is to cover recommended frequencies for regular and preventive dental care, how to obtain Med-Cal dental care, how to avoid inappropriate care or fraudulent providers, and how to obtain assistance in getting care or resolving problems with care. The contract also requires Delta Dental to deliver the plan for the outreach and education program to Health Care Services for its review and approval by the end of each calendar year. State law requires that the dental outreach and education program particularly target underserved populations and parents of young and adolescent children. Neither the director of customer service nor Heath Care Services' acting division chief was able to provide us with copies of the annual plans for the dental outreach and education program. Instead, the director of customer service and Heath Care Services' acting division chief described materials—such as brochures, charts, and flyers that contain dental information—that were distributed to Medi-Cal beneficiaries. Without reviewing and approving Delta Dental's outreach and education plans annually, Health Care Services may not know whether Delta Dental is using effective methods for communicating with and educating beneficiaries or whether it has a well-developed strategy to do so.

Neither the director of customer service nor Health Care Services' acting division chief was able to provide us with copies of the annual plans for the dental outreach and education program.

Health Care Services Has Not Fully Complied With Federal and New State Reporting Requirements

Health Care Services' current data collection efforts lack the specificity required to fully meet federal and state reporting requirements. Federal law requires states to report on the

Because of data limitations, Health Care Services cannot report on dental health access and availability and the effectiveness of preventive care and treatment.

number of children receiving specific types of dental services. Further, recently enacted state law also requires Health Care Services to report on dental health access and availability and the effectiveness of preventive care and treatment. However, because of data limitations, Health Care Services cannot provide the information required.

Health Care Services does not collect all of the data in sufficient detail to report accurately, as a federal report requires, the number of children who received specific types of dental services. More specifically, federal law requires that states receiving funds for the early and periodic screening, diagnostic, and treatment (EPSDT) benefit to children in their Medicaid programs report performance data annually to CMS about the dental care provided to these beneficiaries as indicated on its *Form 416: Annual Early Periodic Screening, Diagnostic, and Treatment Participation Report* (CMS-416). The CMS-416 requires Health Care Services to identify the number of children receiving specified types of dental services, including preventive and diagnostic services. Health Care Services tracks these data by classifying the dental procedures using standardized codes, and it then uses these codes when compiling the data to populate the CMS-416. However, according to a section chief in the division, because of a system limitation, the division has not used these codes to classify the dental services that federally qualified health centers, rural health clinics, and Indian Health Service clinics (centers and clinics) provided. Instead, the dental services provided by centers and clinics are assigned a single generic code—03—that does not provide the detail necessary to identify the specific dental services rendered by providers. Consequently, Health Care Services currently does not report in the CMS-416 the number of children who receive specific types of dental services from the centers and clinics. The dental services rendered by these centers and clinics represented just over 3 percent of the total amount paid under EPSDT between 2009 through 2013. Although the section chief indicated that Health Care Services is working on a solution to capture these codes for the centers and clinics, he was unable to provide a date by which Health Care Services expects to correct this issue.

In addition, because of limitations in the data related to dental providers that Health Care Services collects, we had to qualify the ratios we developed when we analyzed the number of providers rendering dental services to children in the program. Specifically, as indicated in this report's Scope and Methodology section, we were asked to determine the availability of dental providers participating in the program throughout the State and to determine areas where the greatest gaps exist between patient need and the availability of dental providers. Using data included in Health Care Services' systems, we developed and analyzed the provider-to-beneficiary

ratios and compared these ratios to a ratio that Health Care Services indicated it often uses as a measure of the adequacy of beneficiaries' access to dental services under the program. However, as we acknowledge in the Scope and Methodology section and in Chapter 1, we were unable to calculate these ratios with precision because the data we obtained from Health Care Services' systems did not allow us to do so. We found that although Health Care Services' systems contain fields that indicate the provider who actively rendered services to child beneficiaries, the field was not always populated. As a result, in Chapter 1's discussion of these ratios, we qualify our analysis by indicating that our count of dental providers rendering dental services to children may be understated because of data limitations in certain circumstances that prevented us from identifying the providers who rendered the services. According to Health Care Services, its electronic business rules do not require the provider field to be populated in all circumstances. For example, the rules do not require that this field be populated for certain dental services, such as an X-ray or fluoride treatment.

However, a recent amendment to state law, effective June 2014, requires Health Care Services to establish a list of performance measures to ensure that the program meets quality and access criteria. State law also requires that these performance measures be designed to evaluate utilization, access, availability, and effectiveness of preventive care and treatment. Finally, Health Care Services is required to post these performance measures on its Web site annually beginning October 1, 2014. We believe that one critical measure of access and availability is each county's provider-to-beneficiary ratio for this program and that Health Care Services should include these ratios as one of the performance measures it establishes and reports. However, for Health Care Services to calculate these ratios accurately, it will need to ensure that in the future the provider fields in its data systems are populated. Although Health Care Services did include on its Web site by October 3, 2014, the performance measures related to service utilization and the effectiveness of preventive care and treatment, it did not include measures related to access and availability. According to the acting division chief, Health Care Services believes that most of these performance measures relate to access in varying degrees. However, our review of these measures indicates that they are more directly related to utilization and that they do not fully address access and availability. As a result, we believe that until Health Care Services begins tracking for all of its dental services the providers that render services to child beneficiaries, it cannot effectively measure children's access to and the availability of dental services, nor can it accurately predict whether sufficient numbers of providers are available to meet the increasing needs of the program in each county.

We believe that one critical measure of access and availability is each county's provider-to-beneficiary ratio for this program.

Finally, when we initially attempted to calculate each county's provider-to-beneficiary ratio using Health Care Services' available data, we identified multiple data anomalies. Health Care Services investigated these anomalies and determined that it had incorrectly transferred provider information from its mainframe computer to its data warehouse—the system, according to Health Care Services, that it uses to produce performance measures included in various reports. Ultimately, because of the errors in its data warehouse, Health Care Services had to provide us with data from a different source to enable us to calculate the data presented in Chapter 1's Figure 3 and in Appendix A's Table A.5. Although Health Care Services' October 2014 report, discussed earlier, did not rely on this provider information, we believe it should begin using the information to calculate the ratio of providers to beneficiaries by county. For that process to occur before its next annual report, Health Care Services needs to correct the errors in its data warehouse to ensure that its performance measures are accurate.

We believe Health Care Services should begin using the information to calculate the ratio of providers to beneficiaries by county.

Health Care Services Authorized Reimbursements for Services Providers Purportedly Rendered to Deceased Beneficiaries

Health Care Services and its fiscal intermediaries inappropriately authorized reimbursements to providers for services rendered to child beneficiaries using Social Security numbers belonging to deceased individuals. Specifically, using the Death Master File of the U.S. Social Security Administration (Social Security), we determined that Health Care Services and its fiscal intermediaries authorized reimbursements to providers for services rendered to 153 beneficiaries who, according to Social Security records, were deceased at the time the services purportedly occurred. Our analysis of Health Care Services' dental procedures data indicates that these reimbursements totaled more than $70,000 for dental procedures that were purportedly provided to deceased beneficiaries between 2009 and 2013. We identified a similar concern in our earlier report titled *California Department of Health Care Services: Its Failure to Properly Administer the Drug Medi-Cal Treatment Program Created Opportunities for Fraud*, Report 2013-119, issued in August 2014. Specifically, we reported that Health Care Services and the California Department of Alcohol and Drug Programs authorized payments totaling more than $10,300 for 323 services purportedly provided to 19 deceased beneficiaries under the Drug Medi-Cal Treatment Program. The fact that we found this problem in a second Medi-Cal program supports a conclusion we made in the August 2014 report that this issue "could have even greater implications related to Health Care Services' other Medi-Cal programs that also rely on this system's data."

Federal law requires that Health Care Services authorize reimbursements to providers only for services rendered to eligible beneficiaries; thus, reimbursements for services purportedly rendered to deceased beneficiaries are not allowable. Health Care Services indicated that it relies on information it receives from California Vital Statistics and Social Security to update its beneficiary eligibility system with available death records. According to Health Care Services, it uses this system to verify the eligibility of beneficiaries before reimbursing providers for services they rendered to those beneficiaries. However, we found instances indicating that Health Care Services had not updated the beneficiary eligibility system with death information. For example, our analysis found that Health Care Services and its fiscal intermediaries authorized reimbursements for a total of $3,569 for services purportedly rendered to a beneficiary between February 2009 and April 2011. However, Health Care Services' data were not updated to reflect that this beneficiary had died in March 2004.

After researching 15 of these 153 beneficiaries' Social Security numbers, Health Care Services indicated that these Social Security numbers had been entered incorrectly into its beneficiary eligibility system. However, the fact remains that although Health Care Services believes it is obtaining sufficient death information from sources other than Social Security's Death Master File, these other sources are not sufficient. In fact, until we brought this issue to its attention, Health Care Services was not aware that it had authorized payments for services purportedly rendered to deceased beneficiaries. Until it develops robust procedures for using available death information to update promptly all records in its beneficiary eligibility system, Health Care Services and others that use the system risk reimbursing providers for services they did not render. Again, as we indicated in our earlier report, this issue has implications that extend beyond the dental program because Health Care Services as well as others use the beneficiary eligibility system to verify beneficiary eligibility for all Medi-Cal programs.

Recommendations

To ensure that Medi-Cal's child beneficiaries have reasonable access to dental services, Health Care Services should immediately resume performing its annual reimbursement rate reviews, as state law requires.

To make certain that access to dental services for child beneficiaries is comparable to the access available to the general population in the same geographic areas, Health Care Services should immediately adhere to its monitoring plan. Health Care Services should also compare its results for measuring the percentage of

child beneficiaries who had at least one dental visit in the past 12 months with the results from the three surveys conducted by other entities, as its state plan requires.

To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions:

- Direct Delta Dental to submit annually a plan that describes how it will remedy the dental access problems in the State's underserved areas and in California's border communities.
- Direct Delta Dental to contract with one or more entities to provide additional dental services in either fixed facilities or mobile clinics in underserved areas, as its contract requires.
- Increase Delta Dental's access to beneficiary address information and require it to contact beneficiaries residing in underserved areas directly to make them aware of the program's benefits.
- Review Delta Dental's outreach activities and implement measurable objectives for its outreach unit.
- Require Delta Dental to develop a dental outreach and education program and to submit an annual plan by the end of each calendar year.

To ensure that the State pays only for deliverables performed by Delta Dental under the terms of its contract, Health Care Services should immediately take these steps:

- Ensure that the financial manual and invoices are consistent with contract language.
- Develop and implement tangible measurements to evaluate Delta Dental's performance of all functions under the contract.

To comply with state contracting laws that protect the State's interests, Health Care services should implement future contract amendments via appropriate channels, including state contracting procedures.

To ensure that it reports in the CMS-416 an accurate number of child beneficiaries who received specific types of dental services from the centers and clinics, Health Care Services should continue working on a solution to capture the details necessary to identify the specific dental services rendered.

To make certain that it meets the requirements of the new state law and that its performance measures are accurate, Health Care Services should do the following:

- Establish the provider-to-beneficiary ratio statewide and by county as performance measures designed to evaluate access and availability of dental services and include this measure in its October 2015 report to the Legislature.

- Require that the provider field in its data systems be populated in all circumstances.

- Correct the erroneous data currently in its data warehouse and fix its process for transferring data from its mainframe to its data warehouse.

To ensure that Health Care Services and its fiscal intermediaries reimburse providers only for services rendered to eligible beneficiaries, Health Care Services should do the following:

- Obtain Social Security's Death Master File and update monthly its beneficiary eligibility system with death information.

- Coordinate with the appropriate fiscal intermediaries to recover inappropriate payments made for services purportedly rendered to deceased beneficiaries, if necessary.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

ELAINE M. HOWLE, CPA
State Auditor

Date: December 11, 2014

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

Appendix A

DATA RESULTS FOR THE MEDI-CAL DENTAL PROGRAM

The following tables summarize additional or more detailed results of our review of data related to the beneficiary utilization rates and provider-to-beneficiary ratios for the Medi-Cal Dental Program (program), which we discuss in Chapter 1.

Table A.1 summarizes beneficiary utilization rates across California for program services of the California Department of Health Care Services (Health Care Services) for 2011 through 2013. In 2013 Alpine County had the lowest utilization rate at 6.4 percent, and Monterey County had the highest utilization rate at 53.4 percent.

Table A.1
Service Utilization Rates by County for Child Beneficiaries in the Medi-Cal Dental Program

Dental Services for Child Beneficiaries From Fee-for-Service and Managed Care Delivery Models, and From Centers and Clinics

	UTILIZATION RATES				UTILIZATION RATES		
COUNTY	2011	2012	2013	COUNTY	2011	2012	2013
Alameda	38.7%	39.2%	41.5%	Orange	45.8%	46.9%	48.1%
Alpine	14.1	6.0	6.4	Placer	31.9	31.1	28.1
Amador	28.8	28.7	28.6	Plumas	41.3	40.4	35.2
Butte	37.2	36.4	35.8	Riverside	37.6	38.1	40.6
Calaveras	30.9	31.4	26.9	Sacramento	23.9	30.2	25.8
Colusa	34.7	38.4	34.8	San Benito	37.2	39.1	39.6
Contra Costa	34.5	35.3	37.9	San Bernardino	37.9	38.0	40.3
Del Norte	39.3	39.3	35.1	San Diego	40.3	40.7	42.7
El Dorado	31.5	33.1	29.2	San Francisco	43.5	43.8	45.0
Fresno	39.0	39.8	41.3	San Joaquin	34.5	35.1	36.3
Glenn	43.1	44.6	40.9	San Luis Obispo	40.0	44.6	43.4
Humboldt	29.6	29.7	27.0	San Mateo	37.3	39.1	40.6
Imperial	35.8	35.7	33.6	Santa Barbara	39.9	42.4	44.9
Inyo	35.3	31.4	27.8	Santa Clara	42.2	44.4	47.3
Kern	42.1	42.6	44.0	Santa Cruz	47.3	49.1	47.1
Kings	35.6	37.5	41.5	Shasta	32.6	33.1	30.2
Lake	37.0	37.2	37.6	Sierra	29.4	27.0	27.4
Lassen	39.5	36.9	33.1	Siskiyou	30.1	27.2	25.2
Los Angeles	40.8	42.3	42.8	Solano	30.2	31.5	33.8
Madera	39.3	41.4	43.6	Sonoma	37.6	39.8	41.4
Marin	49.7	53.7	52.3	Stanislaus	33.2	33.7	35.2
Mariposa	34.0	32.8	32.0	Sutter	37.2	39.8	38.5
Mendocino	39.8	39.9	39.3	Tehama	41.3	44.1	41.9

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Dental Services for Child Beneficiaries From Fee-for-Service and Managed Care Delivery Models, and From Centers and Clinics

COUNTY	UTILIZATION RATES 2011	2012	2013	COUNTY	UTILIZATION RATES 2011	2012	2013
Merced	36.4	37.4	38.9	Trinity	27.3	29.8	25.5
Modoc	39.6	34.8	32.4	Tulare	38.1	39.5	42.3
Mono	35.5	40.3	34.8	Tuolumne	37.9	40.1	36.5
Monterey	46.6	48.6	53.4	Ventura	37.4	37.6	36.6
Napa	39.5	41.9	40.8	Yolo	35.1	34.5	33.9
Nevada	36.1	34.1	27.6	Yuba	35.8	36.0	36.1
				Statewide utilization rates	**39.2%**	**40.4%**	**41.4%**

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services, including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

Note: Child beneficiaries are Medi-Cal enrollees under age 21. The utilization rates are calculated by dividing the number of child beneficiaries who received at least one dental service during the year by the number of child beneficiaries eligible for Medi-Cal dental services for at least one month during the year.

Table A.2 summarizes fee-for-service utilization rates by county for 2011 through 2013. In 2013 fee-for-service utilization rates ranged from 1.2 percent in Mono County to 45.9 percent in Orange County.

Table A.2
Service Utilization Rates by County for Child Beneficiaries in the Medi-Cal Dental Program

Fee-for-Service Dental Services for Child Beneficiaries

COUNTY	UTILIZATION RATES 2011	2012	2013	COUNTY	UTILIZATION RATES 2011	2012	2013
Alameda	28.1%	27.1%	29.0%	Orange	44.8%	45.4%	45.9%
Alpine	8.9	0.8	4.8	Placer	26.8	26.6	24.4
Amador	16.1	18.0	17.5	Plumas	7.8	6.9	6.1
Butte	19.5	17.8	18.1	Riverside	35.7	35.8	38.3
Calaveras	19.4	20.3	17.4	Sacramento	3.4	3.2	3.1
Colusa	14.2	16.6	18.7	San Benito	25.2	26.3	25.0
Contra Costa	25.1	25.5	28.9	San Bernardino	37.4	37.3	39.7
Del Norte	3.7	4.1	3.1	San Diego	31.3	31.1	33.3
El Dorado	25.9	26.4	22.2	San Francisco	31.3	31.0	33.2
Fresno	35.6	36.1	37.2	San Joaquin	33.7	34.2	35.5
Glenn	8.8	9.8	9.6	San Luis Obispo	29.3	30.9	30.2
Humboldt	4.3	3.7	3.4	San Mateo	31.7	32.1	34.0
Imperial	28.1	27.3	25.5	Santa Barbara	28.9	29.8	32.0
Inyo	3.2	3.4	2.7	Santa Clara	37.6	37.8	40.0
Kern	38.6	39.1	40.8	Santa Cruz	27.7	28.3	28.0

Fee-for-Service Dental Services for Child Beneficiaries

COUNTY	UTILIZATION RATES 2011	2012	2013	COUNTY	UTILIZATION RATES 2011	2012	2013
Kings	25.5	25.5	27.9	Shasta	16.5	16.1	13.7
Lake	8.1	7.7	9.3	Sierra	12.7	8.1	3.9
Lassen	16.8	15.0	14.0	Siskiyou	12.7	11.2	10.3
Los Angeles	36.9	37.4	36.1	Solano	23.5	23.2	23.4
Madera	28.6	30.0	32.7	Sonoma	26.1	25.6	26.0
Marin	9.3	8.0	7.8	Stanislaus	29.7	30.0	31.9
Mariposa	16.8	17.2	18.1	Sutter	30.2	32.2	32.9
Mendocino	6.7	6.8	6.7	Tehama	9.3	7.2	6.4
Merced	28.7	29.7	31.5	Trinity	7.6	8.4	11.4
Modoc	6.4	5.7	6.9	Tulare	30.7	31.3	33.6
Mono	1.4	2.0	1.2	Tuolumne	12.3	15.5	16.0
Monterey	38.5	39.4	45.3	Ventura	33.0	33.2	32.1
Napa	19.2	22.4	23.1	Yolo	22.8	24.3	23.7
Nevada	9.3	7.5	5.3	Yuba	19.0	20.0	21.7
				Statewide utilization rates	**33.1%**	**33.4%**	**34.0%**

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services, including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

Note: Child beneficiaries are Medi-Cal enrollees under age 21. The utilization rates are calculated by dividing the number of child beneficiaries who received at least one dental service during the year by the number of child beneficiaries eligible for Medi-Cal dental services for at least one month during the year.

Table A.3 summarizes by county the utilization rates of federally qualified health centers, rural health clinics, and Indian Health Service clinics (centers and clinics) for 2011 through 2013. Services rendered by centers and clinics are more common in rural areas than urban areas. Health Care Services was unable to tell us why the utilization rate in Marin County was so much higher than in other urban counties.

Table A.3
Service Utilization Rates by County for Child Beneficiaries in the Medi-Cal Dental Program Centers and Clinics

Dental Services From Centers and Clinics for Child Beneficiaries

COUNTY*	UTILIZATION RATES 2011	2012	2013	COUNTY*	UTILIZATION RATES 2011	2012	2013
Alameda	12.1%	13.8%	14.2%	Orange	2.1%	3.2%	3.6%
Alpine	7.4	5.3	2.4	Placer	5.5	4.8	3.8
Amador	14.8	12.4	12.9	Plumas	37.3	37.6	33.1

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Dental Services From Centers and Clinics for Child Beneficiaries

COUNTY*	UTILIZATION RATES 2011	2012	2013	COUNTY*	UTILIZATION RATES 2011	2012	2013
Butte	20.6	20.8	20.2	Riverside	2.5	3.0	3.0
Calaveras	13.9	13.1	10.9	Sacramento	0.5	0.6	0.6
Colusa	24.7	26.5	18.9	San Benito	15.7	15.1	17.7
Contra Costa	10.6	11.0	10.4	San Bernardino	0.7	0.8	0.8
Del Norte	37.6	37.6	33.7	San Diego	11.1	12.0	11.4
El Dorado	6.9	8.3	8.6	San Francisco	13.6	14.1	12.8
Fresno	4.2	4.8	5.1	San Joaquin	1.1	1.2	1.0
Glenn	36.5	38.4	34.3	San Luis Obispo	13.9	19.7	17.1
Humboldt	27.3	27.8	25.1	San Mateo	6.4	7.9	7.4
Imperial	9.4	9.9	9.5	Santa Barbara	13.4	16.1	15.3
Inyo	32.9	28.8	25.8	Santa Clara	5.6	8.2	9.6
Kern	4.4	4.5	4.2	Santa Cruz	23.6	23.9	21.3
Kings	12.8	15.5	16.7	Shasta	18.6	19.2	18.3
Lake	32.1	32.6	32.0	Sierra	19.6	21.6	24.2
Lassen	28.5	27.8	23.9	Siskiyou	19.7	17.8	16.7
Los Angeles	1.2	1.5	1.7	Solano	7.9	9.5	12.2
Madera	13.4	14.3	13.8	Sonoma	13.8	17.2	17.9
Marin	43.5	48.1	46.8	Stanislaus	4.4	4.3	4.0
Mariposa	21.3	19.8	17.3	Sutter	8.4	9.1	7.1
Mendocino	36.9	36.9	36.4	Tehama	35.0	39.3	37.9
Merced	9.6	9.5	9.4	Trinity	22.0	24.6	15.9
Modoc	35.1	30.8	28.0	Tulare	9.4	10.8	11.2
Mono	34.4	38.9	33.9	Tuolumne	29.7	28.5	23.5
Monterey	10.2	10.9	9.6	Ventura	5.4	5.3	5.4
Napa	23.7	22.6	19.8	Yolo	15.8	12.0	12.1
Nevada	28.4	28.4	23.7	Yuba	18.9	18.7	16.7
				Statewide utilization rates	**5.3%**	**5.9%**	**5.9%**

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services (Health Care Services), including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

Note: Child beneficiaries are Medi-Cal enrollees under age 21. The utilization rates are calculated by dividing the number of child beneficiaries who received at least one dental service during the year by the number of child beneficiaries eligible for Medi-Cal dental services for at least one month during the year.

* Health Care Services' Primary, Rural, and Indian Health Division (division) considers the following 14 counties to be urban: Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Ventura. The division considers the remaining 44 counties to be rural.

Table A.4 summarizes fee-for-service utilization rates by service type for 2011 through 2013. For all years, utilization rates for diagnostic and preventive services were higher than utilization rates for treatment services. Further, the closeness of the utilization rates for diagnostic and preventive services to the overall utilization rates indicates that most child beneficiaries receiving services are obtaining diagnostic and preventive services.

Table A.4
Service Utilization Rates for Child Beneficiaries in the Medi-Cal Dental Program Who Received Diagnostic, Preventive, and Treatment Services

	FEE-FOR-SERVICE DELIVERY SYSTEM		
	UTILIZATION RATES		
SERVICE TYPE	2011	2012	2013
Diagnostic	32.3%	32.5%	33.2%
Preventive	30.4	30.6	31.5
Treatment	18.6	18.2	17.6
Totals*	**33.1%**	**33.4%**	**34.0%**

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services, including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

Note: Child beneficiaries are Medi-Cal enrollees under age 21. The utilization rates are calculated by dividing the number of child beneficiaries who received at least one dental service during the year by the number of child beneficiaries eligible for Medi-Cal dental services for at least one month during the year.

* *Totals* represents the statewide utilization rate for all types of dental services. Because some child beneficiaries received more than one type of dental service, the statewide utilization rate is less than the sum of the individual service utilization rates.

Table A.5 summarizes data related to provider-to-beneficiary ratios for active providers. In 2013 Health Care Services' data show that five counties had no active providers.

Table A.5
Provider-to-Beneficiary Ratios for 2013 by County for Active Providers in the Medi-Cal Dental Program

COUNTY	NUMBER OF CHILD BENEFICIARIES*	NUMBER OF ACTIVE DENTAL PROVIDERS†	RATIO OF PROVIDERS TO BENEFICIARIES‡
Alameda	65,203	264	1:247
Alpine§	8	0	no providers
Amador	852	0	no providers
Butte	10,958	46	1: 238
Calaveras	1,199	4	1: 300

COUNTY	NUMBER OF CHILD BENEFICIARIES *	NUMBER OF ACTIVE DENTAL PROVIDERS†	RATIO OF PROVIDERS TO BENEFICIARIES‡
Orange	179,871	968	1:186
Placer	6,738	45	1:150
Plumas	687	1	1:687
Riverside	150,698	608	1:248
Sacramento	58,164	263	1:221

continued on next page . . .

COUNTY	NUMBER OF CHILD BENEFICIARIES*	NUMBER OF ACTIVE DENTAL PROVIDERS†	RATIO OF PROVIDERS TO BENEFICIARIES‡
Colusa	1,648	4	1: 412
Contra Costa	36,754	134	1: 274
Del Norte	1,688	6	1: 281
El Dorado	3,989	20	1: 199
Fresno	91,969	225	1: 409
Glenn	2,399	11	1: 218
Humboldt	4,838	19	1: 255
Imperial	13,535	29	1: 467
Inyo	671	0	no providers
Kern	82,314	191	1: 431
Kings	11,585	37	1: 313
Lake	4,087	5	1: 817
Lassen	1,047	4	1: 262
Los Angeles	696,872	3,064	1: 227
Madera	14,828	39	1: 380
Marin	7,463	33	1: 226
Mariposa	568	2	1: 284
Mendocino	6,144	9	1: 683
Merced	24,653	81	1: 304
Modoc	383	1	1: 383
Mono	487	2	1: 244
Monterey	44,762	57	1: 785
Napa	5,610	22	1: 255
Nevada	2,439	5	1: 488
San Benito	3,445	6	1:574
San Bernardino	162,344	665	1:244
San Diego	157,209	480	1:328
San Francisco	26,678	145	1:184
San Joaquin	48,609	164	1:296
San Luis Obispo	11,024	18	1:612
San Mateo	22,090	82	1:269
Santa Barbara	28,838	74	1:390
Santa Clara	81,601	405	1:201
Santa Cruz	15,268	44	1:347
Shasta	7,743	33	1:235
Sierra	78	0	no providers
Siskiyou	1,632	5	1:326
Solano	16,239	85	1:191
Sonoma	21,071	60	1:351
Stanislaus	35,240	105	1:336
Sutter	6,684	43	1:155
Tehama	5,004	10	1:500
Trinity	415	0	no providers
Tulare	52,184	142	1:367
Tuolumne	1,968	9	1:219
Ventura	37,551	162	1:232
Yolo	7,835	32	1:245
Yuba	4,978	6	1:830

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services, including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

Note: As discussed in the Scope and Methodology, because of a data limitation, we may be undercounting the number of active providers who rendered dental services.

* Child beneficiaries are Medi-Cal enrollees under age 21 who received at least one dental procedure in 2013.

† To be counted as an active dental provider, the provider must have rendered at least one dental procedure to a Medi-Cal Dental child beneficiary through one of the Medi-Cal Dental Program's delivery models—fee-for-service or managed care—and the provider must have been registered as a general practitioner. This number also includes active dental providers affiliated with federally qualified health centers, rural health centers, and Indian Health Service clinics. We counted those providers rendering dental services to child beneficiaries in multiple counties once for each county in which they provided services.

‡ On Table A.6 we present the ratio of providers to beneficiaries for those child beneficiaries who did not have a dental procedure.

§ The Dental Board of California's Web site shows no licensed dentists located in Alpine County.

Table A.6 summarizes data related to the provider-to-beneficiary ratio for generalist dental providers willing to accept new patients. Health Care Services' data show that in 2013 11 counties had no dental providers willing to accept new Medi-Cal patients and that 16 counties had provider-to-beneficiary ratios above 1:2,000, indicating there may be an insufficient number of dental providers willing to accept new Medi-Cal patients.

Table A.6
Provider-to-Beneficiary Ratios by County for Dental Service Offices and Providers Willing to Accept New Medi-Cal Patients as of December 28, 2013, for the Medi-Cal Dental Program

COUNTY	NUMBER OF CHILD BENEFICIARIES*†	NUMBER OF GENERALIST DENTAL SERVICE OFFICES AND PROVIDERS WILLING TO ACCEPT NEW MEDI-CAL PATIENTS	RATIO OF PROVIDERS TO BENEFICIARIES‡
Alameda	59,840	59	1:1,014
Alpine§	76	0	no providers
Amador	1,380	0	no providers
Butte	12,776	6	1:2,129
Calaveras	2,123	0	no providers
Colusa	2,005	1	1:2,005
Contra Costa	39,210	21	1:1,867
Del Norte	2,033	0	no providers
El Dorado	6,282	3	1:2,094
Fresno	85,112	80	1:1,064
Glenn	2,249	1	1:2,249
Humboldt	8,503	1	1:8,503
Imperial	17,400	12	1:1,450
Inyo	1,130	0	no providers
Kern	68,010	53	1:1,283
Kings	10,624	4	1:2,656
Lake	4,410	1	1:4,410
Lassen	1,377	1	1:1,377
Los Angeles	605,728	1,222	1:496
Madera	12,483	9	1:1,387
Marin	4,420	5	1:884
Mariposa	786	0	no providers
Mendocino	6,159	1	1:6,159
Merced	25,188	8	1:3,148
Modoc	519	2	1:259
Mono	593	0	no providers
Monterey	25,370	19	1:1,335
Napa	5,301	3	1:1,767
Nevada	4,163	0	no providers
Orange	126,138	385	1:328
Placer	11,204	7	1:1,601
Plumas	824	1	1:824
Riverside	143,387	193	1:743
Sacramento	108,558	42	1:2,585
San Benito	3,414	3	1:1,138
San Bernardino	156,363	217	1:721
San Diego	137,014	166	1:825
San Francisco	21,197	35	1:606
San Joaquin	55,531	29	1:1,915
San Luis Obispo	9,359	4	1:2,340
San Mateo	21,003	20	1:1,050
Santa Barbara	23,035	15	1:1,536
Santa Clara	59,044	105	1:562
Santa Cruz	11,171	11	1:1,016
Shasta	11,629	3	1:3,876
Sierra	135	0	no providers
Siskiyou	3,152	2	1:1,576
Solano	20,641	13	1:1,588
Sonoma	19,396	9	1:2,155
Stanislaus	42,177	15	1:2,812
Sutter	6,945	6	1:1,158
Tehama	4,514	0	no providers
Trinity	787	1	1:787
Tulare	46,369	29	1:1,599
Tuolumne	2,225	1	1:2,225
Ventura	42,271	58	1:729
Yolo	9,946	4	1:2,487
Yuba	5,725	0	no providers

Sources: California State Auditor's analyses of data from systems administered by the California Department of Health Care Services, including the California Dental Medicaid Management Information System, the California Medicaid Management Information System, and the Fiscal Intermediary Access to Medi-Cal Eligibility system.

* These child beneficiaries—who are Medi-Cal enrollees under age 21—did not have dental procedures in 2013.

† Because all child beneficiaries not having a dental procedure in 2013 are not likely to seek services in the future, we applied a 65 percent utilization rate to estimate the number of child beneficiaries who could seek services from providers willing to accept new patients. The 65 percent utilization rate is based on data reported to the U.S. Department of Health and Human Services by 49 states and the District of Columbia for federal fiscal year 2013.

‡ On Table A.5 we present the ratio of providers to beneficiaries for those child beneficiaries who received at least one dental procedure.

§ The Dental Board of California's Web site shows no licensed dentists located in Alpine County.

The ratio of providers to beneficiaries for this county is higher than 1:2,000.

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Appendix B

DATA RESULTS FOR THE HEALTHY FAMILIES DENTAL PROGRAM

The following tables summarize our review of data related to the beneficiary utilization rates and provider-to-beneficiary ratios of California's Healthy Families Program.

Table B.1 shows that utilization rates for the Healthy Families Program dropped in 2013. According to the former deputy director for eligibility (former deputy director) at the Managed Risk Medical Insurance Board (board), the 45 percent decrease in the utilization rates between 2012 and 2013 was because the Healthy Families Program ceased the enrollment of new beneficiaries and transitioned existing beneficiaries to the California Medical Assistance Program, or Medi-Cal. Further, the similarity of the utilization rates for diagnostic and preventive services to the overall total utilization rates indicates that most child beneficiaries receiving services are obtaining diagnostic and preventive services.

Table B.1
Service Utilization Rates for Child Beneficiaries in the Healthy Families Program Who Received Diagnostic, Preventive, and Treatment Services

	UTILIZATION RATES		
SERVICE TYPE	2011	2012	2013
Diagnostic	37.9%	40.9%	20.8%
Preventive	35.2	38.2	19.4
Treatment	21.9	23.4	11.1
Totals*	**40.7%**	**43.1%**	**23.8%**

Sources: California State Auditor's analysis of data obtained from Delta Dental of California's MetaVance and DB2 databases; Health Net, Inc.'s HSP database; MAXIMUS, Inc.'s Healthy Families Enrollment Database (MAXe2); Premier Access Insurance Company and Access Dental Plan's MCARE database; SafeGuard Health Plans, Inc.'s NOVA database; and Western Dental Services, Inc.'s Dansoft ERP database.

Note: Child beneficiaries were Healthy Families Program enrollees under age 19. The service utilization rates are calculated by dividing the number of child beneficiaries who received at least one dental service during the year by the number of child beneficiaries eligible for this program's dental services for at least one month during the year.

* Totals represents the statewide utilization rate for all types of dental services. Because some child beneficiaries received more than one type of dental service, the statewide utilization rate is less than the sum of the individual service utilization rates.

Table B.2 on the following page indicates that from 2009 to 2013, the number of Healthy Families Program dental providers decreased overall by 189. However, the number of dental providers in this program increased in 2011 and 2012 before dropping

below the 2009 and 2010 levels. According to the former deputy director, the 21 percent increase in providers between 2010 and 2011 occurred because of new performance requirements the board added to its contracts with the health plans in an effort to increase utilization of dental services. To meet these requirements, the plans added more providers to increase access to services. Further, according to the former deputy director, the 22 percent decrease in providers between 2012 and 2013 occurred because the Healthy Families Program ceased the enrollment of new beneficiaries and transitioned existing beneficiaries to the Medi-Cal program.

Table B.2
Ratios of Active Providers to Child Beneficiaries in the Healthy Families Program From 2009 Through 2013

	2009	2010	2011	2012	2013
Child beneficiaries receiving dental services under the Healthy Families Program*	1,124,777	1,102,669	1,099,858	1,081,857	663,418
Active dental providers in the Healthy Families Program†	5,809	5,904	7,175	7,222	5,620
Provider-to-beneficiary ratio	1:194	1:187	1:153	1:150	1:118

Sources: California State Auditor's analysis of data obtained from Delta Dental of California's MetaVance and DB2 databases; Health Net, Inc.'s HSP database; MAXIMUS, Inc.'s Healthy Families Enrollment Database (MAXe2); Premier Access Insurance Company and Access Dental Plan's MCARE database; SafeGuard Health Plans, Inc.'s NOVA database; and Western Dental Services, Inc.'s Dansoft ERP database.

Note: As discussed in the Scope and Methodology, because of a data limitation, we may be undercounting the number of providers who rendered dental services.

* Child beneficiaries were Healthy Families Program enrollees under age 19.

† To be counted as an active dental provider, the provider must have rendered at least one dental procedure to a Healthy Families Program child beneficiary.

TOBY DOUGLAS
Director

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

EDMUND G. BROWN JR.
Governor

Ms. Elaine M. Howle*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby provides response to the draft findings of the California State Auditor's (CSA) report entitled, *Department of Health Care Services: Weakness in Its Medi-Cal Dental Program Limited Children's Access to Dental Care.*

DHCS agrees with all but one of the findings and has prepared corrective action plans ① to implement the recommendations made by the CSA. DHCS appreciates the work performed by the CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Sarah Hollister, Audit Coordinator, at (916) 650-0298.

Sincerely,

Toby Douglas,
Director

Enclosure

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Department of Health Care Services Response to the The California State Auditor's Report entitled, "California Department of Health Care Services: Weakness in its Medi-Cal Dental Program Limit Children's Access to Dental Care

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Chapter 1 (pg. 19): Some Medi-Cal Children May Face Difficulties Accessing Dental Services ②

A. To ensure that child beneficiaries throughout California can reasonably access dental services under the Medi-Cal program and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015:

1. **Establish criteria for assessing beneficiary utilization**.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS will develop criteria for assessing beneficiary utilization and will consult with the stakeholder community. DHCS will develop benchmarks for this measurement on an annual basis and will publicly report this measurement in accordance with Departmental reporting policies along with the other legislatively required performance measures. Further, DHCS will develop processes to help track utlization by county and will identify mitigation strategies when benchmarks are not met.

Implementation Date: May 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

2. **Establish criteria for assessing provider participation.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS will develop criteria for assessing provider participation and will consult with the stakeholder community. DHCS will develop benchmarks for this measurement in accordance with Departmental reporting policies on an annual basis and will publicly report this measurement. DHCS will develop processes to track provider participation to assess capacity by region and will identify mitigation strategies when geographic problem areas are identified.

Implementation Date: May 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

3. **Establish procedures for periodically identifying counties or other geographic areas where child beneficiary utilization and provider participation fail to meet applicable criteria.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS will use the criteria developed in recommendations 1 and 2 to establish procedures to perform annual assessments of beneficiary utilization and provider participation capacity by geographic region. This will allow DHCS to identify underperforming areas and to develop mitigation strategies.

Implementation Date: May 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

4. **Immediately implement actions to resolve any declining trends identified during its monitoring efforts**.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees to take the necessary steps to resolve any declining trends that are within its purview to implement. DHCS recognizes that some solutions may require additional resources and funding and will take the necessary steps to seek approval within the Administration in order to implement identified mitigation strategies.

Implementation Date: N/A
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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B. To help increase the number of providers participating in the Medi-Cal Dental Program fee-for-service delivery system, Health Care Services should improve its identification and implementation of changes that minimize or simplify administrative processes for providers. These changes should include revising its processes pertaining to dental procedures that require radiographs or photographs.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees with the recommendation to evaluate and simplify administrative processes to encourage provider participation while consulting with the stakeholder community. DHCS is committed to re-evaluating all program criteria and utilization management tools. DHCS has a responsibility to develop, implement, and monitor program policies and procedures and to ensure medical necessity criteria is met for covered benefits which, in totality, are designed to protect and ensure the health and well-being of Medi-Cal beneficiaries.

Implementation Date: July 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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C. To ensure that the influx of beneficiaries resulting from recent changes to federal and state law are able to access Medi-Cal dental services, Health Care Services should:

1. Continuously monitor beneficiary utilization, the number of beneficiaries having difficulty accessing appointments with providers, and the number of providers enrolling in and leaving the Medi-Cal program.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS will use the criteria developed in recommendations 1 and 2 of Section A to establish procedures to perform periodic assessments of beneficiary utilization, the number of beneficiairies reporting difficulty accessing dental appointments, and provider enrollment trends by geographic region. This will allow DHCS the ability to identify underperforming areas and to develop mitigation strategies to address identified issues.

Implementation Date: July 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

2. Immediately implement actions to resolve any declining trends identified during its monitoring efforts.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.

If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees to take the necessary steps to resolve any declining trends that are within its purview to implement. DHCS recognizes that some solutions may require additional resources and funding and will take the necessary steps to seek approval within the Administration in order to implement identified mitigation strategies.

Implementation Date: July 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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② **Chapter 2 (pg. 40): The California Department of Health Care Services Has Failed to Adequately Monitor the Medi-Cal Dental Program**

D. To ensure that Medi-Cal child beneficiaries have reasonable access to dental services, Health Care Services should immediately resume performing its annual reimbursement rate reviews as state law requires.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees and is currently working on a timeline to perform its annual rate review. DHCS also recognizes that the findings of the rate review and implementation of any such changes will be subject to approval within the Administration, the Legislature, and with the federal Centers for Medicare and Medicaid Services for purposes of receiving federal reimbursement while ensuring the proper and efficient administration of the program.

Implementation Date: July 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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E. To ensure that child beneficiary access is comparable to services available to the general population in the same geographic areas, Health Care Services should immediately adhere to its monitoring plan and compare its results for measuring the percentage of child beneficiaries who had at least one dental visit in the past 12 months with the results from the three surveys conducted by other entities, as its state plan requires.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is

required.

DHCS is in agreement and is already working towards implementation of this recommendation.

Implementation Date: February 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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F. To improve beneficiary utilization rates and provider participation under the fee-for-service delivery system, Health Care Services should immediately take the following actions:

1. **Direct Delta Dental to annually submit a plan that describes how it will remedy the dental access problems in underserved areas within California and the border communities.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees and is already working with Delta Dental who will develop and submit to DHCS an annual plan that shall address access problems in underserved areas within California and the border communities.

Implementation Date: July 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

2. **Direct Delta Dental to contract with one or more entities to provide additional dental services in either fixed facilities or mobile entities in underserved areas, as its contract requires.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees and is already working with Delta Dental on the needed steps they will take to contract with mobile entities to provide access in underserved areas pursuant to contract requirements.

Implementation Date: July 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

3. **Increase Delta Dental's access to beneficiary address information and require it to directly contact beneficiaries residing in underserved areas to make them aware of the program's benefits.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees and is already working with Delta Dental to provide them with beneficiary address information so that they can contact beneficiaries directly who reside in underserved areas to inform them about program services.

Implementation Date: July 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

4. **Review Delta Dental's outreach activities and implement measurable objectives for its outreach unit.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees and will be working with Delta Dental on this recommendation and will review their outreach plan to ensure it contains measurable objectives for its outreach unit.

Implementation Date: July 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental ServicesDivision

5. **Require Delta Dental to develop a dental outreach and education program and submit an annual plan by the end of each calendar year.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees and will require Delta Dental to develop and submit to DHCS annually a dental outreach and education program that includes measurable objectives.

Implementation Date: June 1, 2015

Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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G. To ensure that the State only pays for deliverables performed by Delta Dental under the terms of its contract, Health Care Services should immediately:

1. **Ensure that its financial manual and invoices are consistent with contract language.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS will take the necessary steps as required by the Delta Dental contract to align the financial manual and invoices with contract language.

Implementation Date: May 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

2. **Develop and implement tangible measurements to evaluate Delta Dental's performance of all functions under the contract.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS will take the necessary steps required to work with Delta Dental to identify tangible measurements to evaluate Delta's performance with respect to all functions under the contract.

Implementation Date: May 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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H. To comply with state contracting laws that protect the State's interest, Health Care services should implement future contract amendments via appropriate channels, including state contracting procedures.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS concurs and will take appropriate steps to ensure that all future contract amendments follow the appropriate contracting procedures.

Implementation Date: January 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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I. To ensure that it reports an accurate number of children that received specific types of dental services from the centers and clinics in the CMS-416, Health Care Services should continue working on a solution to capture the detail necessary to identify the specific dental service rendered.

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees and is already working toward this goal. DHCS is working across all applicable divisions within the department to ensure that all required information for the CMS-416 is being reported by DHCS.

Implementation Date: July 1, 2016
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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J. To ensure that it meets the requirements of the new state law and that its performance measures are accurate, Health Care Services should do the following:

1. **Establish the provider-to-beneficiary ratio statewide and by county as performance measures designed to evaluate access and availability of dental services and include this measure in its October 2015 report to the Legislature.**

① **Response:** ☐ DHCS Agrees ☒ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

① DHCS does not agree with the recommendation to include provider-to-beneficiary ratio in the October 2015 report to the Legislature as this requirement is not part of the required reporting in Welfare and Institution Code 14132.915. However, DHCS is committed to establishing and monitoring provider to beneficiary ratios as part of its ongoing monitoring efforts to ensure that beneficiaries are able to access care.

Implementation Date: N/A

Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

2. **Require that the provider field in its data systems be populated in all circumstances.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees with this recommendation; however, DHCS must evaluate the necessary system changes required to implement this requirement and the implications of such a requirement in light of the current procurement effort that is underway. There will be a need to freeze all future system changes at some point in time. Based on other programmatic priorities DHCS must weigh this effort against, it may be decided that this requirement is better accomplished through the procurement process.

Implementation Date: N/A
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

3. **Correct the erroneous data currently in its data warehouse and its process for transferring data from its mainframe to its data warehouse.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees with this recommendation and is already in the process of remedying this anomaly. When this issue has been resolved, it will also fix existing data back to the inception of this problem.

Implementation Date: March 1, 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

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K. To ensure that Health Care Services and its fiscal intermediaries only reimburse providers for services rendered to eligible beneficiaries, Health Care Services should do the following:

1. **Obtain the U. S. Social Security Administration's Death Master File and update its beneficiary eligibility system with death information monthly.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.

If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS intends to increase the frequency of updates to the Medi-Cal Eligibility Data System (MEDS) with the SSA Death Master File from quarterly to monthly. The request to increase the frequency to monthly was already in progress and will most likely require an amendment to the existing DHCS/SSA information sharing agreement. The implementation date takes into account the development and testing needed to complete this request.

Implementation Date: No later than April 30, 2016
Contact Name: Manuel Urbina
Title: Chief, Program Integrity Unit, Medi-Cal Eligibility Division

2. **Coordinate with the appropriate fiscal intermediaries to recover inappropriate payments made for services purportedly rendered to deceased beneficiaries, if appropriate.**

Response: ☒ DHCS Agrees ☐ DHCS Disagrees with the recommendation.
If you agree, describe the corrective action taken or planned below.
If you disagree, indicate the specific reason(s) for the non-concurrence and a statement of any alternative corrective action taken or planned below. An estimated date of completion is required.

DHCS agrees and will implement procedures to collect for inappropriate payment to providers.

Implementation Date: May 2015
Contact Name: Jon Chin
Title: Acting Division Chief, Medi-Cal Dental Services Division

DHCS Concerns Regarding CSA Audit Report

In the Department of Health Care Services' (DHCS) review of the California State Auditor's (CSA) Audit Report, there are several areas of concern that have arisen regarding the content and methodologies utilized. DHCS feels due to the nature of the concerning areas, it is important that these factual and content-based concerns be presented. The following are the some of the areas that the Department feels inappropriately represent information:

- In several areas of the report, CSA compares California's Medi-Cal Dental Program to that of Texas. This comparison is not appropriate as Texas' Medicaid program has been widely suspected to have suffered from rampant fraud due to program integrity issues. Therefore, Texas' high utilization is to be expected and is not an accurate representation of what a Medicaid program with strong program integrity should be modeling. Thus, the utilization of Texas' data inappropriately skews the data. ③
- Additionally, more appropriate state Medicaid programs based on comparable state eligible sizes and program integrity should have been selected as comparisons to California's Medicaid program. If this more suitable methodology would have been employed, the data clearly shows that California is on par with states of a similar eligible population size. Below are the data to support DHCS' above statements. ④
    - Based on the CMS-416 Report for federal fiscal year (FFY) 2013, the following are the utilization numbers for states in the top ten percentile based on eligible population size, with the exception of Texas for the aforementioned reasons:

Table 1: Utilization for States in the Top Ten Eligibles Percentile

State	Users	Eligibles	Utilization*
California	2,242,896	5,113,405	43.9%
New York	930,563	2,263,808	41.1%
Florida	666,077	2,110,488	31.6%
Illinois	885,468	1,624,037	54.5%

**Utilization was calculated by dividing the number of users receiving any dental or oral health services (section 12g in the CMS-416 Report) by the number of eligible beneficiaries eligible for EPSDT for 90 continuous days of enrollment (section 1b in the CMS-416 Report) for the applicable state. Data is drawn from the CMS-416 for FFY 2013, which was updated by CMS on October 22, 2014.*

Although DHCS largely agrees with the overall recommendations made by CSA in the Audit Report, DHCS believes these aforementioned concerns should be noted as the report does not appropriately represent the facts and programmatic health of the California Medi-Cal Dental Program. ⑤

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on the response to our audit by the California Department of Health Care Services (Health Care Services). The numbers below correspond to the numbers we have placed in the margin of Health Care Services' response.

We believe Health Care Services should reconsider its decision to not implement our recommendation. Although Section 14132.915 of the Welfare and Institutions Code does not specifically mention provider-to-beneficiary ratio as a performance measure to report annually, it does require Health Care Services to establish a list of performance measures to ensure that the program meets quality and access criteria and that this list include, but not be limited to [emphasis added], certain specific performance measures. In addition, state law requires that these performance measures be designed to evaluate utilization, access, availability, and effectiveness of preventive care and treatment and that Health Care Services post these performance measures on its Web site annually. (1)

As we point out on page 55 of our report, we believe one critical measure of access and availability is each county's provider-to-beneficiary ratio for this program. Although Health Care Services included on its Web site performance measures related to service utilization and effectiveness of preventive care and treatment, it did not include measures related to access and availability. As a result, until Health Care Services establishes the provider-to-beneficiary ratio as a performance measure, it cannot accurately predict whether sufficient numbers of providers are available to meet the increasing needs of the program in each county.

During the publication process for the audit report, page numbers shifted. Therefore, the page numbers cited by Health Care Services in its response do not correspond to the page numbers in our final report. (2)

Contrary to Health Care Services' statement that comparing California's Medi-Cal Dental Program to the equivalent Texas program is not appropriate because of suspected fraud, we believe it would be inappropriate to exclude Texas from our analysis based simply on allegations. Although the fraud allegations have been mentioned in the media and the Office of the Inspector General within the U.S. Department of Health and Human Services (3)

issued a report in August 2014 related to the allegations, Health Care Services provided no evidence that the allegations had been adjudicated or that the effect of any proven fraud on Texas' utilization rate had been calculated. Furthermore, data from the Centers for Medicare and Medicaid Services do not indicate that Texas was an outlier. Although Texas had the highest utilization rate among the reporting states, the second highest utilization rate—62.7 percent from Connecticut—was less than one percentage point lower than Texas' utilization rate and 8 other states had utilization rates that exceeded 55 percent. Therefore, Health Care Services' assertion that the inclusion of Texas' data inappropriately skews the data is without merit.

④ We strongly disagree that the methodology we used was not suitable. To the contrary, Health Care Services' efforts to have the State Auditor present a narrower perspective by comparing California's utilization rates to only certain other states can be interpreted as self-serving. In particular, if readers were to rely only on data for the four states Health Care Services mentions in its response, California's utilization rates would appear to be the second highest. However, as we mention on page 19 of our report, California had the 12th worst utilization rate for Medicaid children receiving dental services among 49 states and the District of Columbia. In the absence of criteria established by Health Care Services for assessing the usage of Medi-Cal dental services by child beneficiaries, we compared California's utilization rates to others' rates to provide readers an unbiased perspective of where California stands relative to the 49 states that provided data. Based in part on this comparison, we point out on page 18, "The utilization rate for Medi-Cal dental services by child beneficiaries is low relative to national averages and to the rates of other states."

⑤ Health Care Services is wrong when it states that our "report does not appropriately represent the facts and programmatic health of the California Medi-Cal Dental Program." We stand by our recommendations, and by the facts and conclusions presented in our report to support those recommendations. The California State Auditor's Office is established in state law as the State's independent auditor. Furthermore, state law requires the California State Auditor to conduct its audits in conformity with Government Auditing Standards issued by the Comptroller General of the United States. These standards provide a framework for performing high-quality audit work with competence, integrity, objectivity, and independence to provide accountability and to help improve government operations and services. They also provide the foundation for government auditors to lead by example in the areas of independence, transparency, accountability, and quality through the audit process. As we state on page 60 of our report, "We conducted this audit… according to generally accepted government auditing standards."

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 12

Legislative and Regulatory Subcommittee Report: The DHCC may take action on any items listed on the Legislative and Regulatory Subcommittee agenda and the recommendations provided by the subcommittee.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 13

Licensing and Examination Subcommittee Report: The DHCC may take action on any items listed on the Licensing and Examination Subcommittee agenda and the recommendations provided by the subcommittee.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 14

Enforcement Subcommittee Report:

The DHCC may take action on any items listed on the Enforcement Subcommittee agenda and the recommendations provided by the subcommittee.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 15

Education Subcommittee Report:

The DHCC may take action on any items listed on the Education Subcommittee agenda and the recommendations provided by the subcommittee.

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 16

CLOSED SESSION:
The DHCC may meet in Closed Session to deliberate on disciplinary matters pursuant to Government Code §11126 (c)(3)

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 17

Future Agenda Items

Sunday, May 3, 2015

Dental Hygiene Committee of California

Full Committee

Agenda Item 18

Adjournment