



The Department of Health Care Services Medi-Cal Dental Services Rate Review

July 2016

Submitted by the
California Department of Health Care Services
In Fulfillment of the Requirements of
Welfare & Institutions Code §14079

Table of Contents

Introduction.....	2
Scope of Rate Review	2
Methodology	3
Background.....	3
Medi-Cal Dental Reimbursements Rates Compared to Other Medicaid Programs	5
Geographical Comparison of Medi-Cal Reimbursement Rates to Commercial Rates.....	5
FFS Medi-Cal Beneficiary Population Characteristics	5
Provider Network	6
Ongoing Program Improvement.....	7
Appendix 1 – CDT Procedure Code Description	8
Appendix 2- SFY 2013-2014, Percentage of 25 Most Utilized Denti-Cal Procedures Reimbursement Rate Comparison	9
Appendix 3- SFY 2014-2015, Percentage of 25 Most Utilized Denti-Cal Procedures Reimbursement Rates Compared to Others.....	10
Appendix 4 – SFY 2013-2014, Average Percentage Denti-Cal Pays of Regional Commercial Rates.....	11
Appendix 5 – SFY 2014-2015, Average Percentage Denti-Cal Pays of Regional Commercial Rates.....	12
Appendix 6 – 2015 Total Population.....	13
Appendix 7– California Geographic Rating Areas	14
Appendix 8 – Total Children’s Enrollment in the Medi-Cal Program	15
Appendix 9 – Total Adult Enrollment in the Medi-Cal Program.....	16
Appendix 10 – Dental Provider Enrollment & Referral List Numbers	17

Introduction

The Department of Health Care Services (DHCS), pursuant to Welfare & Institutions (W&I) Code §14079, must annually review reimbursement levels for Medi-Cal Dental Services (Denti-Cal), specifically:

“The director annually shall review the reimbursement levels for physician and dental services under Medi-Cal, and shall revise periodically the rates of reimbursement to physicians and dentists to ensure the reasonable access of Medi-Cal beneficiaries to physician and dental services. This annual review, as it relates to rates for physician services, shall take into account at least the following factors:

- (a) Annual cost increases for physicians as reflected by the Consumer Price Index.*
- (b) Physician reimbursement levels of Medicare, Blue Shield, and other third-party payors.*
- (c) Prevailing customary physician charges within the state and in various geographical areas.*
- (d) Procedures reflected by the current Relative Value Studies (RVS).*
- (e) Characteristics of the current population of Medi-Cal beneficiaries and the medical services needed.”*

To undertake this analysis, DHCS compares reimbursement rates of the top 25 most utilized Denti-Cal Fee-For-Service (FFS) procedures, with other comparable states' Medicaid Programs, in addition to the commercial rates from five different geographic regions around the nation.

Overall Findings

DHCS compared California's Medi-Cal dental reimbursements rates against other Medicaid programs from states of comparable size, with a comparable Medicaid population. While the overall average of DHCS' rates for the 25 most utilized FFS procedure codes may be lower, depending on the procedure, the applicable DHCS reimbursement rate was either higher or lower. In State Fiscal Year (SFY) 2013-14, Denti-Cal paid an overall average between 65.5 and 129.2 percent of New York, Illinois, Florida, and Texas' Medicaid Program's dental fee schedule. In SFY 2014-15, Denti-Cal paid an overall average between 64.8 and 105.8 percent of New York, Illinois, Florida, and Texas' Medicaid Program's dental fee schedule. Review findings also identified a decrease in providers that render and bill for dental services from Calendar Year (CY) 2008-2015.

Scope of Rate Review

While W&I Code §14079 requires DHCS to review Medi-Cal reimbursement levels for dental services, and to periodically revise such rates to ensure “reasonable access” for Medi-Cal beneficiaries, it is important to note that several significant developments have occurred in the field of rates and access in the twenty-four years since the statute was last amended.

Most significantly, the courts have recognized that a reimbursement rate's relationship to access is an exceedingly complicated and multi-faceted analysis. In *Managed Pharmacy Care v. Sebelius*¹, for example, the Ninth Circuit noted that discretion should be afforded to the federal government's review of DHCS rates, in large part, relying on a comprehensive eighty-two page access monitoring plan, which identified twenty-three different measures that DHCS would study on a recurring basis to ensure the State Plan Amendment (SPA) that changed FFS reimbursement rates for a number of Medi-Cal provider categories did not negatively affect beneficiary access. These measures addressed the three key categories of factors the federal Medicaid and CHIP Payment and Access Commission (MACPAC) identified as affecting access: beneficiary data, provider availability data, and service utilization data.

¹ *Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1249 (9th Cir. 2013)

Consistent with this federal regulatory approach, last year, the United States Supreme Court confirmed that this complex analysis, which applies to rate setting, means that Medicaid rate challenges do not allow a private right of action – by Medi-Cal providers or beneficiaries – or claim upon which legal relief can be granted.² Given these recent legal actions, DHCS must reiterate that a reimbursement rate and its relationship to beneficiary access is neither a strict nor linear concept. Instead, as the federal regulator, the Centers for Medicare and Medicaid Services (CMS), has found, there are a multitude of factors that must be considered and addressed when ensuring appropriate access to covered services.

Further, CMS recently amended 42 Code of Federal Regulations (CFR) Part 447, which requires states' to document access to care and service payment rates, effective January 4, 2016. These amendments expand the Federal access reporting requirements and consequently necessitate the restructuring of DHCS' Medi-Cal FFS access monitoring report. DHCS' current annual and quarterly FFS access monitoring reports will be updated in a version structured to meet the new federal requirements. Such updated requirements include: dental provider participation measured by the number of dentists that administered a service trended by time, geographic region, and service setting (if applicable); utilization trended by age group, aid category, geographic region, and service setting (if applicable); reimbursement rate comparison analysis of Medicaid FFS payment rates for dental services to those from Medicare and other payers; and, feedback by dental providers and beneficiaries.

Methodology

Denti-Cal is provided through two delivery systems: Dental Managed Care (DMC) and Denti-Cal FFS. DMC ensures the provision of medically necessary dental services through DMC plan enrolled providers, and it is a delivery model in two counties within the State – Los Angeles County and Sacramento County. DMC plans receive a monthly per member, per month capitation rate. The capitation rates are actuarially sound based upon data from Denti-Cal FFS and are reviewed and approved by CMS.

Denti-Cal FFS delivers services through enrolled FFS providers by DHCS' current Dental Fiscal Intermediary (FI), Delta Dental. FFS providers are paid according to a Schedule of Maximum Allowances (SMA), which denotes the maximum dollar amount payable for each dental benefit of Denti-Cal. The SMA is defined in the FFS Manual of Criteria (MOC), in accordance with W&I Code §14105.05. Throughout this review, these payments may also be referenced as reimbursement and/or payment rates. Adjustments to the MOC are established through DHCS' adoption of regulations as specified in the Title 22, California Code of Regulations (CCR), §51501. These payment rates are periodically modified, and in the last 25 years, several adjustments of the payment rates have occurred.

This rate review evaluates the SMA in relation to other comparable states' Medicaid reimbursement rates, in addition to commercial reimbursement rates. In order for providers to bill Denti-Cal, providers use Current Dental Terminology (CDT) codes, which are developed by the American Dental Association (ADA) as the standard coding system to document and communicate accurate information about dental treatment procedures and services. Throughout this document "CDT codes" will be used synonymously with "procedure codes."

This review examines the most recent data available, covering SFY 2013-2014 and 2014-2015. The most recent SFY were chosen to review the current rates of reimbursement to dental professionals and evaluate the reasonable access of services for Medi-Cal beneficiaries, which

² See *Armstrong v. Exceptional Child Center*, 135 S.Ct. 1378 (March 31, 2015).

includes previously transitioned populations into Medi-Cal.

Background

Denti-Cal offers a range of dental services to eligible beneficiaries. The array of services includes: diagnostic, preventive, restorative, and endodontic services; periodontics; removable and fixed prosthodontics; maxillofacial prosthetics; implant services; oral and maxillofacial surgery; and orthodontic and adjunctive services. The appropriateness of many of these dental benefits depends on a beneficiary's eligibility, medical conditions, and age. Eligible children currently receive full scope benefits while eligible adults receive a modified benefit package, which includes preventive, diagnostic, restorative, prosthetic, and other medically necessary services. Full scope services for adults were eliminated on July 1, 2009. However, a modified adult dental benefit was restored in May 2014, administered via the California State Plan, SPA CA 13-018, and the Alternative Benefit Plan, SPA CA 14-018. Subsequent to May 2014, the Medi-Cal Dental program has expanded comprehensive services in the Denti-Cal MOC for pregnant beneficiaries, effective October 1, 2014.

Over the years, Denti-Cal FFS rates have fluctuated, sometimes significantly, by way of actions taken by both the courts and the Legislature. Some of the most notable examples are:

- In response to a federal court lawsuit from the 1990's, *Clark v. Kizer/Coye*, Denti-Cal FFS rates were increased by 40-55 percent of average billing rates in 1991, and later increased to 80 percent of average billing rates by an additional court order in 1992;
- In 2000, pursuant to state budget action, Medi-Cal implemented a rate increase of 6.8 percent for dental services and added two regular cleanings and two dental exams to the scope of covered benefits for all beneficiaries (May 2000 Estimate; November 2000 Estimate);
- Directives pursuant to Assembly Bill (AB) 1762 (Chapter 230, Statutes of 2003), effective January 1, 2004, reduced all Denti-Cal FFS rates by five percent³;
- On July 1, 2008, pursuant to ABX 3 5, DHCS implemented a ten percent provider payment reduction, which continued until August 18, 2008, at which time the federal district court issued an injunction to halt the application of the payment reduction to certain providers, including dentists;
 - On September 9, 2008, DHCS ceased applying the ten percent provider payment reduction to Denti-Cal providers, retroactive to the date of the injunction.⁴
- On August 1, 2013, pursuant to AB 97 (Chapter 3, Statutes of 2011), DHCS announced implementation of a ten percent provider payment reduction, beginning October 1, 2013. The reduction was retroactive for services performed on or after June 1, 2011⁵;
- Since November 5, 2013, pursuant to the Budget Act of 2013, the ten percent provider payment reduction has been modified to be prospective only for dental service providers, thereby eliminating the need for retroactive payment recoupment;
- Effective December 1, 2013, DHCS exempted dental pediatric surgery centers from the provider payment reduction imposed by AB 97;
- Beginning May 1, 2014, DHCS implemented a soft cap for non-exempt, medically necessary services on or after May 1, 2014 that may exceed the \$1,800 threshold;

³ California Medi-Cal Dental. Denti-Cal Bulletin. November 2003.

Retrieved from http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume19_33.pdf

⁴ California Medi-Cal Dental. Denti-Cal Bulletin. October 2008.

Retrieved from http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_24_Number_38.pdf

⁵ California Medi-Cal Dental. Denti-Cal Bulletin. August 2013.

Retrieved from http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_29_Number_15.pdf

- Effective July 1, 2015, DHCS received federal approval from CMS and state approval via Senate Bill 75 (Chapter 18, Statutes of 2015), to exempt dental services and applicable ancillary services from the provider payment reduction imposed by AB 97.

Medi-Cal Dental Reimbursements Rates Compared to Other Medicaid Programs DHCS

compared the reimbursement rates of Denti-Cal FFS' 25 most utilized procedure codes [Appendix 1 CDT Procedure Code Description](#) to the same 25 procedure codes from other comparable states' Medicaid dental fee schedules. These 25 procedures made up approximately 89 percent of billed procedures in FY 2013-14 and FY 2014-15.

California's SMA for Denti-Cal FFS in FY 2013-14 paid an average of 129.2, 86.1, 75.4, and 65.5 percent of Illinois⁶, Florida⁷, New York⁸, and Texas' Medicaid Program's dental fee schedules, respectively⁹. California's SMA for Denti-Cal FFS in FY 2014-15, paid an average of 105.8, 94.2, 76.9, and 64.8 percent of Illinois, Florida, New York, and Texas' Medicaid Program's dental fee schedule, respectively. Please find the comparisons located in [Appendix 2 FY 2013-14](#) and [Appendix 3 FY 2014-15](#), respectively.

Geographical Comparison of Medi-Cal Reimbursement Rates to Commercial Rates

Prevailing customary dental charges within California were compared to Denti-Cal FFS rates using the ADA's 2013 Survey of Dental Fees for General Practitioners¹⁰. DHCS compared the average payment rate of the same 25 most utilized procedure codes with five different geographical regions as represented in [Appendix 4](#) and [Appendix 5](#). The Pacific Division, which includes the State of California, was selected to represent the prevailing customary dental charges within California and the Pacific Region.

FFS Medi-Cal Beneficiary Population Characteristics

In 2015, the Medi-Cal Dental Program reimbursed dental providers approximately \$1.3 billion for approximately 64 million claims across all aid code groups, accounting for nearly 14 million beneficiaries. This total is a combined sum of DMC and FFS providers. The distribution of services and reimbursement between the adult and child populations of both DMC and FFS is displayed in [Appendix 6](#). For both the adult and child populations, the majority of beneficiary claims fall under FFS, and combined make up approximately 92 percent of the total beneficiary population.

Additionally, the child and adult FFS population account for approximately 97 percent of the 2015 total claims. DHCS stratified beneficiary enrollment by children (ages 0-20) and adults (ages 21+) and examined the results over the last seven SFYs. In addition, data was compared by region using California Geographic Rating Areas established by CMS. While CMS split Los Angeles into two regions based on zip codes, DHCS is unable to do so at this time. A list of the regions and the county(s) included within each region can be located in [Appendix 7](#).

⁶ Illinois Medicaid Dental Fee Schedule. May 2015.
Retrieved from <https://www2.illinois.gov/hfs/SiteCollectionDocuments/DentalFeeSchedule050115.pdf>

⁷ Florida Medicaid Dental Fee Schedule. January 2013.
Retrieved from <http://www.med-quest.us/pdfs/provider%20memos/medicaid%20fee%20schedule.pdf>

⁸ New York Medicaid Dental Fee Schedule.
Retrieved from <https://www.emedny.org/ProviderManuals/Dental/index.aspx>

⁹ Texas Medicaid Dental Fee Schedule. April 2015.
Retrieved from <http://public.tmhpc.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx>

¹⁰ 2013 Survey of Dental Fees.
Retrieved from <http://success.ada.org/en/practice/operations/financial-management/2013-survey-of-dental-fees>

Beneficiary enrollment numbers include the number of unduplicated beneficiaries, who had full scope benefits, no share of cost, and three months or more of continuous eligibility in the measurement year.

Children (Ages 0-20) Data illustrates statewide enrollment for children has increased since FY 2008-09, particularly between FY 2011-12 and FY 2012-13, during the Healthy Families Program (HFP) transition to Medi-Cal¹¹ of 2013. Unduplicated numbers of enrolled children with full scope benefits, no share of cost, and at least three months of continuous eligibility during the measurement year for FY 2008-09 through FY 2013-14, is detailed in [Appendix 8](#). In FY 2008-09, 3,687,103 children were eligible, compared to 5,382,054 in FY 2014-15, demonstrating a 45.97 percent increase in unduplicated numbers of enrolled eligible children since FY 2008-09.

Adults (21+) Data illustrates statewide enrollment for adults has increased steadily since FY 2008-09. Between FY 2012-13 and FY 2014-15, the number of enrolled adults more than doubled statewide, due in large part to the Affordable Care Act (ACA). Beginning January 2014, Medi-Cal expanded to cover low-income, childless adults. Since the ACA expansion, Medi-Cal's total beneficiary population increased from 7.6 million FY 2012-13, to approximately 10 million in FY 2013-2014 and continued to grow to nearly 12 million beneficiaries in FY 2014-2015.

The number of unduplicated adults enrolled with full scope benefits, no share of cost, and at least three months of continuous eligibility during the measurement year for FY 2008-09 through FY 2014-15, is detailed in [Appendix 9](#). There were 2,935,862 eligible adults in FY 2008-2009, compared to 6,536,679 in FY 2014-15, demonstrating over a 120 percent increase of unduplicated enrolled eligible adults since FY 2008-2009. Between FY 2013-14 and FY 2014-15 there has been nearly a 25 percent increase from 5,196,011 eligible adults to 6,536,679.

Provider Network

Rendering providers are defined as those who perform the dental services, and billing providers are defined here as the provider's office location where the dental service was provided. The number of both provider types enrolled in the Denti-Cal FFS network with at least one paid claim for measurement year CY 2015 was 8,001 and 5,676 for rendering and billing providers, respectively. [Appendix 10](#) illustrates the numbers of both provider types from measurement year CY 2008 through CY 2015. In addition, the line graph in Appendix 10 shows the number of billing providers on the referral list (i.e., the list of providers who are willing to accept additional beneficiaries for services) for the aforementioned years. Data shows a 16.0 percent decrease in rendering providers and 15.9 percent decrease in billing providers since 2008. Additionally, since 2008, the number of providers on the referral list has decreased by 28.2 percent; however, the number of providers in each of the three noted categories increased between CY 2012 and CY 2014.

Ongoing Program Improvement

Below are several of the actions DHCS has made in its ongoing effort to continuously improve utilization for beneficiaries, including efforts to expand the network of dental providers:

- Continued monitoring of beneficiary utilization for children and adults, specifically identifying children/adults who have not seen a dentist in the last fiscal year;

¹¹ HFP Transition to Medi-Cal pursuant to AB 1494 (Chapter 28, Statutes of 2012), as amended by AB 1468 (Chapter 438, Statutes of 2012)

- Developed and implemented targeted and focused beneficiary and provider outreach plans with the FI;
- Sought and obtained federal and state approvals to enroll and directly compensate allied dental professionals, including registered dental hygienists;
- Directed the FI to contract with additional providers, such as mobile vans, in areas where there are comparatively fewer numbers of providers; and,
- Established a new data category to capture the number of beneficiaries reporting difficulty in accessing dental appointments.
 - Effective September 2013, DHCS started to monitor provider enrollment and disenrollment information to help assess access to care.
- Sought and obtained federal and state approvals to allow asynchronous transmission (store and forward) teledentistry to be approved as a modality for the provision of dental services. On July 1, 2015, enrolled Denti-Cal providers were allowed to begin submitting claims for qualified services.
- Sought and obtained federal and state approval to implement the dental service exemption of the AB 97 provider payment reduction effective July 1, 2015.
- Received federal approval from the Centers for Medicare and Medicaid Services on December 30, 2015, for California's 1115 Waiver Renewal known as [Medi-Cal 2020](#). A component of the Medi-Cal 2020 waiver is the [Dental Transformation Initiative \(DTI\)](#) funded at \$750 million over the next five years with the goals to increase the use of preventive dental services for children by at least ten percent, prevent and treat more early childhood caries to reduce the necessity of more invasive and costly procedures, increase dental continuity of care for children, and fund up to a total of fifteen local dental pilots aimed at one or more of the three aforementioned goals.

Appendix 1 – Denti-Cal’s 25 Most Utilized CDT Procedure Code Description¹²

Procedure Code	CDT Procedure Code Description
D0120	Periodic oral evaluation – established patient
D0150	Comprehensive oral evaluation – new or established patient
D0210	Intraoral – complete series (including bitewings)
D0220	Intraoral – periapical first film
D0230	Intraoral – periapical each additional film
D0272	Bitewings – two films
D0274	Bitewings – four films
D0350	Oral/facial photographic images
D1110	Prophylaxis – adult
D1120	Prophylaxis - child
D1206	Topical fluoride varnish, therapeutic application for moderate to high caries risk patients
D1208	Topical application of fluoride
D1351	Sealant – per tooth
D2140	Amalgam – one surface, primary or permanent
D2150	Amalgam – two surfaces, primary or permanent
D2160	Amalgam – three surfaces, primary or permanent
D2330	Resin-based composite – one surface, anterior
D2391	Resin-based composite – one surface, posterior
D2392	Resin-based composite – two surfaces, posterior
D2930	Prefabricated stainless steel crown – primary tooth
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to dentinocemental junction and application of medicament
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal or erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9410	House/extended care facility call
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed

[Return to Medi-Cal Dental Reimbursements Compared to Other Medicaid Programs](#)

¹² DHCS intentionally included 26 CDT codes to account for the variance between SFY 2013-2014 and 2014-2015.

**Appendix 2 – SFY 2013-2014, Percentage of 25 Most Utilized Denti-Cal Procedures
Reimbursement Rates in Relation to Other Comparable Medicaid Programs**

Procedure Code ¹	Denti-Cal SMA	New York		Illinois		Florida		Texas	
		Reimbursement Rates and % Denti-Cal Pays		Reimbursement Rates and % Denti-Cal Pays		Reimbursement Rates and % Denti-Cal Pays		Reimbursement Rates and % Denti-Cal Pays	
D0120	\$ 15.00	\$ 25.00	60.0%	\$ 28.00	53.6%	\$ 29.12	51.5%	\$ 28.85	52.0%
D0150	\$ 25.00	\$ 30.00	83.3%	\$ 17.52	142.7%	\$ 29.12	85.9%	\$ 35.32	70.8%
D0210	\$ 40.00	\$ 50.00	80.0%	\$ 25.06	159.6%	\$ 58.24	68.7%	\$ 70.64	56.6%
D0220	\$ 10.00	\$ 8.00	125.0%	\$ 4.66	214.6%	\$ 10.92	91.6%	\$ 12.56	79.6%
D0230	\$ 3.00	\$ 5.00	60.0%	\$ 3.16	94.9%	\$ 6.76	44.4%	\$ 11.51	26.1%
D0272	\$ 10.00	\$ 14.00	71.4%	\$ 7.83	127.7%	\$ 18.93	52.8%	\$ 23.38	42.8%
D0274	\$ 18.00	\$ 24.00	75.0%	\$ 14.07	127.9%	\$ 25.48	70.6%	\$ 34.61	52.0%
D0350	\$ 6.00	\$ 12.00	50.0%	N/A	N/A	\$ 26.00	23.1%	\$ 18.38	32.6%
D1110	\$ 40.00	\$ 45.00	88.9%	\$ 21.15	189.1%	\$ 36.40	109.9%	\$ 54.88	72.9%
D1120	\$ 30.00	\$ 43.00	69.8%	\$ 41.00	73.2%	\$ 26.00	115.4%	\$ 36.75	81.6%
D1206	\$ 11.00	\$ 30.00	36.7%	\$ 26.00	42.3%	\$ 4.16	264.4%	\$ 14.70	74.8%
D1351	\$ 22.00	\$ 35.00	62.9%	\$ 36.00	61.1%	\$ 24.32	90.5%	\$ 28.24	77.9%
D2140	\$ 39.00	\$ 50.00	78.0%	\$ 25.68	151.9%	N/A	N/A	\$ 64.41	60.5%
D2150	\$ 48.00	\$ 67.00	71.6%	\$ 40.08	119.8%	N/A	N/A	\$ 85.71	56.0%
D2160	\$ 57.00	\$ 82.00	69.5%	\$ 48.33	117.9%	N/A	N/A	\$ 109.19	52.2%
D2330	\$ 55.00	\$ 50.00	110.0%	\$ 28.80	191.0%	N/A	N/A	\$ 77.75	70.7%
D2391	\$ 39.00	\$ 50.00	78.0%	\$ 25.68	151.9%	N/A	N/A	\$ 82.40	47.3%
D2392	\$ 48.00	\$ 67.00	71.6%	\$ 40.08	119.8%	N/A	N/A	\$ 108.00	44.4%
D2930	\$ 75.00	\$ 116.00	64.7%	\$ 61.11	122.7%	\$ 74.36	100.9%	\$ 152.94	49.0%
D3220	\$ 71.00	\$ 87.00	81.6%	\$ 43.87	161.8%	\$ 67.60	105.0%	\$ 86.20	82.4%
D7140	\$ 41.00	\$ 50.00	82.0%	\$ 32.57	125.9%	N/A	N/A	\$ 65.70	62.4%
D7210	\$ 85.00	\$ 85.00	100.0%	\$ 47.79	177.9%	\$ 145.60	58.4%	\$ 100.75	84.4%
D9230	\$ 25.00	N/A	N/A	\$ 21.65	115.5%	\$ 55.99	44.7%	\$ 27.81	89.9%
D9410	\$ 20.00	\$ 50.00	40.0%	N/A	N/A	N/A	N/A	\$ 24.50	81.6%
D9430	\$ 20.00	\$ 20.00	100.0%	N/A	N/A	N/A	N/A	\$ 14.70	136.1%
Average % Denti-Cal Pays of Other States' Medicaid Rates		75.4%		129.2%		86.1%		65.5%	

N/A = No rate available for procedure code and/or procedure code is not a covered service by that state's Medicaid Program.

¹ See Appendix 1 for description of procedure codes.

[Return to Medi-Cal Dental Reimbursements Rates Compared to Other Medicaid Programs](#)

**Appendix 3 – SFY 2014-2015, Percentage of 25 Most Utilized Denti-Cal Procedures
Reimbursement Rates in Relation to Other Comparable Medicaid Programs**

Procedure Code	Denti-Cal SMA	New York		Illinois		Florida		Texas	
		Reimbursement Rates and % Denti-Cal Pays		Reimbursement Rates and % Denti-Cal Pays		Reimbursement Rates and % Denti-Cal Pays		Reimbursement Rates and % Denti-Cal Pays	
D0120	\$ 15.00	\$ 25.00	60.0%	\$ 28.00	53.6%	\$ 22.29	67.3%	\$ 28.85	52.0%
D0150	\$ 25.00	\$ 30.00	83.3%	\$ 21.05	118.8%	\$ 23.78	105.1%	\$ 35.32	70.8%
D0210	\$ 40.00	\$ 50.00	80.0%	\$ 30.10	132.9%	\$ 47.56	84.1%	\$ 70.64	56.6%
D0220	\$ 10.00	\$ 8.00	125.0%	\$ 5.60	178.6%	\$ 5.95	168.1%	\$ 12.56	79.6%
D0230	\$ 3.00	\$ 5.00	60.0%	\$ 3.80	78.9%	\$ 4.46	67.3%	\$ 11.51	26.1%
D0272	\$ 10.00	\$ 14.00	71.4%	\$ 9.40	106.4%	\$ 13.38	74.7%	\$ 23.38	42.8%
D0274	\$ 18.00	\$ 24.00	75.0%	\$ 16.90	106.5%	\$ 16.35	110.1%	\$ 34.61	52.0%
D0350	\$ 6.00	\$ 12.00	50.0%	N/A	N/A	\$ 10.40	57.7%	\$ 18.38	32.6%
D1110	\$ 40.00	\$ 45.00	88.9%	N/A	N/A	\$ 26.75	149.5%	\$ 54.88	72.9%
D1120*	\$ 30.00	\$ 43.00	69.8%	\$ 33.20	90.4%	\$ 20.81	144.2%	\$ 36.75	81.6%
D1206*	\$ 11.00	\$ 30.00	36.7%	\$ 20.43	53.8%	\$ 16.35	67.3%	\$ 14.70	74.8%
D1208*	\$ 10.67	\$ 14.00	76.2%	\$ 20.43	52.2%	\$ 16.35	65.3%	N/A	N/A
D1351	\$ 22.00	\$ 35.00	62.9%	\$ 36.00	61.1%	\$ 19.32	113.9%	\$ 28.24	77.9%
D2140	\$ 39.00	\$ 50.00	78.0%	\$ 30.85	126.4%	\$ 46.08	84.6%	\$ 64.41	60.5%
D2150	\$ 48.00	\$ 67.00	71.6%	\$ 48.15	99.7%	\$ 60.94	78.8%	\$ 85.71	56.0%
D2160	\$ 57.00	\$ 82.00	69.5%	\$ 58.05	98.2%	\$ 75.80	75.2%	\$ 109.19	52.2%
D2330	\$ 55.00	\$ 50.00	110.0%	\$ 34.60	159.0%	\$ 50.53	108.8%	\$ 77.75	70.7%
D2391	\$ 39.00	\$ 50.00	78.0%	\$ 30.85	126.4%	\$ 46.08	84.6%	\$ 82.40	47.3%
D2392	\$ 48.00	\$ 67.00	71.6%	\$ 48.15	99.7%	\$ 60.94	78.8%	\$ 108.00	44.4%
D2930	\$ 75.00	\$ 116.00	64.7%	\$ 73.40	102.2%	\$ 101.07	74.2%	\$ 152.94	49.0%
D3220	\$ 71.00	\$ 87.00	81.6%	\$ 52.70	134.7%	\$ 74.32	95.5%	\$ 86.20	82.4%
D7140	\$ 41.00	\$ 50.00	82.0%	\$ 39.12	104.8%	\$ 40.13	102.2%	\$ 65.70	62.4%
D7210	\$ 85.00	\$ 85.00	100.0%	\$ 57.40	148.1%	\$ 59.45	143.0%	\$ 100.75	84.4%
D9230	\$ 25.00	N/A	N/A	\$ 26.00	96.2%	\$ 41.62	60.1%	\$ 27.81	89.9%
D9430	\$ 20.00	\$ 20.00	100.0%	N/A	N/A	N/A	N/A	\$ 14.70	136.1%
Average % Denti-Cal Pays of Other States' Medicaid Rates		76.9%		105.8%		94.2%		64.8%	

N/A = No rate available for procedure code and/or procedure code is not a covered service by that state's Medicaid Program.

*D1208 - Schedule of Maximum Allowances average. Denti-Cal SMA dependent on beneficiary age (\$6 - adult; \$8 - child age 6 through 20; \$18 - child age 0 through 5). Illinois SMA dependent on beneficiary age (\$26 - child age 0 through 18; \$14.85 - child age 19 through 20).

*D1120 - Schedule of Maximum Allowances average. Illinois SMA dependent on beneficiary age (\$41 - child age 0 through 18; \$25.40 - child age 19 through 20).

*D1206 - Schedule of Maximum Allowances average. Illinois SMA dependent on beneficiary age (\$26 - child age 0 through 18; \$14.85 - child age 19 through 20).

¹ See Appendix 1 for description of procedure codes.

*Add caveat about timing.

[Return to Medi-Cal Dental Reimbursements Rates Compared to Other Medicaid Programs](#)

Appendix 4 – SFY 2013-2014, Average Percentage Denti-Cal Pays of Regional Commercial Rates

Procedure Code ¹	Denti-Cal SMA	National Average	Pacific Division (CA)	Middle Atlantic (NY)	East North Central (IL)	South Atlantic (FL)	West South Central (TX)
D0120	\$ 15.00	\$ 45.61	\$ 53.37	\$ 46.44	\$ 43.99	\$ 43.44	\$ 41.16
D0150	\$ 25.00	\$ 72.92	\$ 79.51	\$ 72.03	\$ 73.38	\$ 72.98	\$ 65.86
D0210	\$ 40.00	\$123.70	\$134.73	\$123.13	\$122.56	\$121.32	\$111.10
D0220	\$ 10.00	\$ 26.59	\$ 32.40	\$ 24.60	\$ 25.85	\$ 26.15	\$ 23.21
D0230	\$ 3.00	\$ 21.29	\$ 22.16	\$ 19.82	\$ 21.11	\$ 21.95	\$ 19.24
D0272	\$ 10.00	\$ 42.00	\$ 49.11	\$ 41.50	\$ 40.31	\$ 41.15	\$ 37.09
D0274	\$ 18.00	\$ 59.67	\$ 68.32	\$ 60.86	\$ 57.61	\$ 58.48	\$ 52.70
D0350	\$ 6.00	\$ 42.66	\$ 41.53	\$ 47.10	\$ 48.45	\$ 35.77	\$ 42.53
D1110	\$ 40.00	\$ 85.38	\$101.81	\$ 86.97	\$ 79.37	\$ 83.32	\$ 76.38
D1120	\$ 30.00	\$ 63.08	\$ 76.50	\$ 62.70	\$ 58.99	\$ 61.92	\$ 56.48
D1206	\$ 11.00	\$ 35.86	\$ 39.99	\$ 37.18	\$ 35.26	\$ 35.10	\$ 30.56
D1351	\$ 22.00	\$ 49.31	\$ 56.19	\$ 50.08	\$ 47.28	\$ 48.17	\$ 45.56
D2140	\$ 39.00	\$125.29	\$144.11	\$122.52	\$118.93	\$126.59	\$116.38
D2150	\$ 48.00	\$155.11	\$173.87	\$152.37	\$147.42	\$157.78	\$145.61
D2160	\$ 57.00	\$186.24	\$207.14	\$185.72	\$176.13	\$188.94	\$177.38
D2330	\$ 55.00	\$148.77	\$174.55	\$145.66	\$140.45	\$148.56	\$142.02
D2391	\$ 39.00	\$162.97	\$190.47	\$162.69	\$155.83	\$161.75	\$152.56
D2392	\$ 48.00	\$208.81	\$240.98	\$205.70	\$199.84	\$205.84	\$195.80
D2930	\$ 75.00	\$249.10	\$255.19	\$252.77	\$251.61	\$269.92	\$227.65
D3220	\$ 71.00	\$168.75	\$172.21	\$171.35	\$174.02	\$172.35	\$156.11
D7140	\$ 41.00	\$156.39	\$173.20	\$168.87	\$150.18	\$156.99	\$142.92
D7210	\$ 85.00	\$253.35	\$268.65	\$270.78	\$250.78	\$251.18	\$233.84
D9230	\$ 25.00	\$ 52.77	\$ 50.81	\$ 58.10	\$ 48.78	\$ 61.81	\$ 48.51
D9410	\$ 20.00	\$172.88	\$174.21	N/A	\$183.24	\$194.06	N/A
D9430	\$ 20.00	\$ 57.07	\$ 74.92	\$ 49.04	\$ 55.89	\$ 46.24	\$ 56.46
Average % Denti-Cal Pays of Regional Rates		26.7%	28.3%	32.4%	32.7%	31.9%	35.5%

N/A = No rate available for procedure code and/or procedure code is not a covered service by that state's Medicaid Program.

¹ See Appendix 1 for description of procedure codes.

[Return to Geographical Comparison of Medi-Cal Reimbursement Rates to Commercial Rates](#)

Appendix 5 – SFY 2014-2015, Average Percentage Denti-Cal Pays of Regional Commercial Rates

Procedure Code ¹	Denti-Cal SMA	National Average	Pacific Division (CA)	Middle Atlantic (NY)	East North Central (IL)	South Atlantic (FL)	West South Central (TX)
D0120	\$ 15.00	\$ 45.61	\$ 53.37	\$ 46.44	\$ 43.99	\$ 43.44	\$ 41.16
D0150	\$ 25.00	\$ 72.92	\$ 79.51	\$ 72.03	\$ 73.38	\$ 72.98	\$ 65.86
D0210	\$ 40.00	\$123.70	\$134.73	\$123.13	\$122.56	\$121.32	\$111.10
D0220	\$ 10.00	\$ 26.59	\$ 32.40	\$ 24.60	\$ 25.85	\$ 26.15	\$ 23.21
D0230	\$ 3.00	\$ 21.29	\$ 22.16	\$ 19.82	\$ 21.11	\$ 21.95	\$ 19.24
D0272	\$ 10.00	\$ 42.00	\$ 49.11	\$ 41.50	\$ 40.31	\$ 41.15	\$ 37.09
D0274	\$ 18.00	\$ 59.67	\$ 68.32	\$ 60.86	\$ 57.61	\$ 58.48	\$ 52.70
D0350	\$ 6.00	\$ 42.66	\$ 41.53	\$ 47.10	\$ 48.45	\$ 35.77	\$ 42.53
D1110	\$ 40.00	\$ 85.38	\$101.81	\$ 86.97	\$ 79.37	\$ 83.32	\$ 76.38
D1120	\$ 30.00	\$ 63.08	\$ 76.50	\$ 62.70	\$ 58.99	\$ 61.92	\$ 56.48
D1206	\$ 11.00	\$ 35.86	\$ 39.99	\$ 37.18	\$ 35.26	\$ 35.10	\$ 30.56
D1208*	\$ 10.67	\$ 33.71	\$ 37.97	\$ 34.25	\$ 33.78	\$ 33.34	\$ 28.53
D1351	\$ 22.00	\$ 49.31	\$ 56.19	\$ 50.08	\$ 47.28	\$ 48.17	\$ 45.56
D2140	\$ 39.00	\$125.29	\$144.11	\$122.52	\$118.93	\$126.59	\$116.38
D2150	\$ 48.00	\$155.11	\$173.87	\$152.37	\$147.42	\$157.78	\$145.61
D2160	\$ 57.00	\$186.24	\$207.14	\$185.72	\$176.13	\$188.94	\$177.38
D2330	\$ 55.00	\$148.77	\$174.55	\$145.66	\$140.45	\$148.56	\$142.02
D2391	\$ 39.00	\$162.97	\$190.47	\$162.69	\$155.83	\$161.75	\$152.56
D2392	\$ 48.00	\$208.81	\$240.98	\$205.70	\$199.84	\$205.84	\$195.80
D2930	\$ 75.00	\$249.10	\$255.19	\$252.77	\$251.61	\$269.92	\$227.65
D3220	\$ 71.00	\$168.75	\$172.21	\$171.35	\$174.02	\$172.35	\$156.11
D7140	\$ 41.00	\$156.39	\$173.20	\$168.87	\$150.18	\$156.99	\$142.92
D7210	\$ 85.00	\$253.35	\$268.65	\$270.78	\$250.78	\$251.18	\$233.84
D9230	\$ 25.00	\$ 52.77	\$ 50.81	\$ 58.10	\$ 48.78	\$ 61.81	\$ 48.51
D9430	\$ 20.00	\$ 57.07	\$ 74.92	\$ 49.04	\$ 55.89	\$ 46.24	\$ 56.46
Average % Denti-Cal Pays of Regional Rates		32.5%	29.0%	32.4%	33.5%	32.8%	35.6%

*D1208 - Schedule of Maximum Allowances average. Denti-Cal SMA dependent on beneficiary age (\$6 - adult; \$8 - child age 6 through 20; \$18 - child age 0 through 5).

¹ See Appendix 1 for description of procedure codes.

[Return to Geographical Comparison of Medi-Cal Reimbursement Rates to Commercial Rates](#)

Appendix 6 – 2015 Total Population

Calendar Year 2015	Adult Population		Child Population	
	DMC	FFS	DMC	FFS
Total Reimbursement	\$6,216,708	\$559,855,483	\$14,953,986	\$739,977,160
Total Count of Beneficiaries (eligibles)	600,824	7,116,088	555,752	5,713,333
Total Claim Count	529,599	16,551,291	1,288,312	46,036,270

[Return to FFS Medi-Cal Beneficiary Population Characteristics](#)

Appendix 7 – California Geographic Rating Areas

Alameda: Alameda

Central Coast: Monterey, San Benito, Santa Cruz

Central Valley: Mariposa, Merced, San Joaquin, Stanislaus, Tulare

Contra Costa: Contra Costa

Greater Fresno: Fresno, Kings, Madera

Greater Sacramento: El Dorado, Placer, Sacramento, Yolo

Inland Desert: Imperial, Inyo, Mono

Inland Empire: Riverside, San Bernardino

Kern: Kern

Los Angeles: Los Angeles

North Bay: Marin, Napa, Solano, Sonoma

Northern: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba

Orange: Orange

San Diego: San Diego

San Francisco: San Francisco

San Mateo: San Mateo

Santa Clara: Santa Clara

South Coast: San Luis Obispo, Santa Barbara, Ventura

[Return to FFS Medi-Cal Beneficiary Population Characteristics](#)

Appendix 8 – Total Children’s Enrollment in the Medi-Cal Program

Region	Beneficiary Enrollment - Ages 0-20						
	Ages 0-20 ¹						
	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Alameda	118,442	122,371	126,858	129,420	150,633	162,032	168,739
Central Coast	74,921	80,302	85,574	87,128	111,473	124,546	128,091
Central Valley	311,291	327,393	340,052	347,638	387,747	426,356	448,134
Contra Costa	68,564	73,723	76,969	79,234	93,275	106,260	116,409
Greater Fresno	222,473	230,815	238,449	242,388	266,815	284,315	296,753
Greater Sacramento	111,836	110,741	113,411	114,157	123,634	148,541	131,443
Inland Desert	32,329	33,961	35,404	35,608	37,204	42,665	23,046
Inland Empire	503,702	540,642	571,202	585,299	704,344	784,853	839,706
Kern	139,587	148,079	151,427	153,863	171,612	187,202	197,941
Los Angeles	1,099,694	1,121,600	1,130,322	1,131,880	1,204,692	1,335,214	1,407,859
North Bay	82,302	88,571	93,800	95,514	111,319	133,317	143,650
Northern	148,213	154,446	161,355	161,453	166,504	198,920	208,909
Orange	226,067	243,508	256,911	263,979	334,139	383,655	401,563
San Diego	223,796	226,000	240,039	245,069	301,721	340,913	361,012
San Francisco	42,817	44,448	46,390	47,462	56,716	60,645	61,260
San Mateo	34,177	36,677	37,978	39,672	47,907	57,420	60,948
Santa Clara	120,325	127,752	131,695	131,711	163,441	176,420	178,708
South Coast	126,567	134,717	140,244	142,667	160,725	196,976	207,883
Statewide Total	3,687,103	3,845,746	3,978,080	4,034,142	4,593,901	5,150,250	5,382,054
¹ Age Group 0-20 is equivalent to Ages <=20							

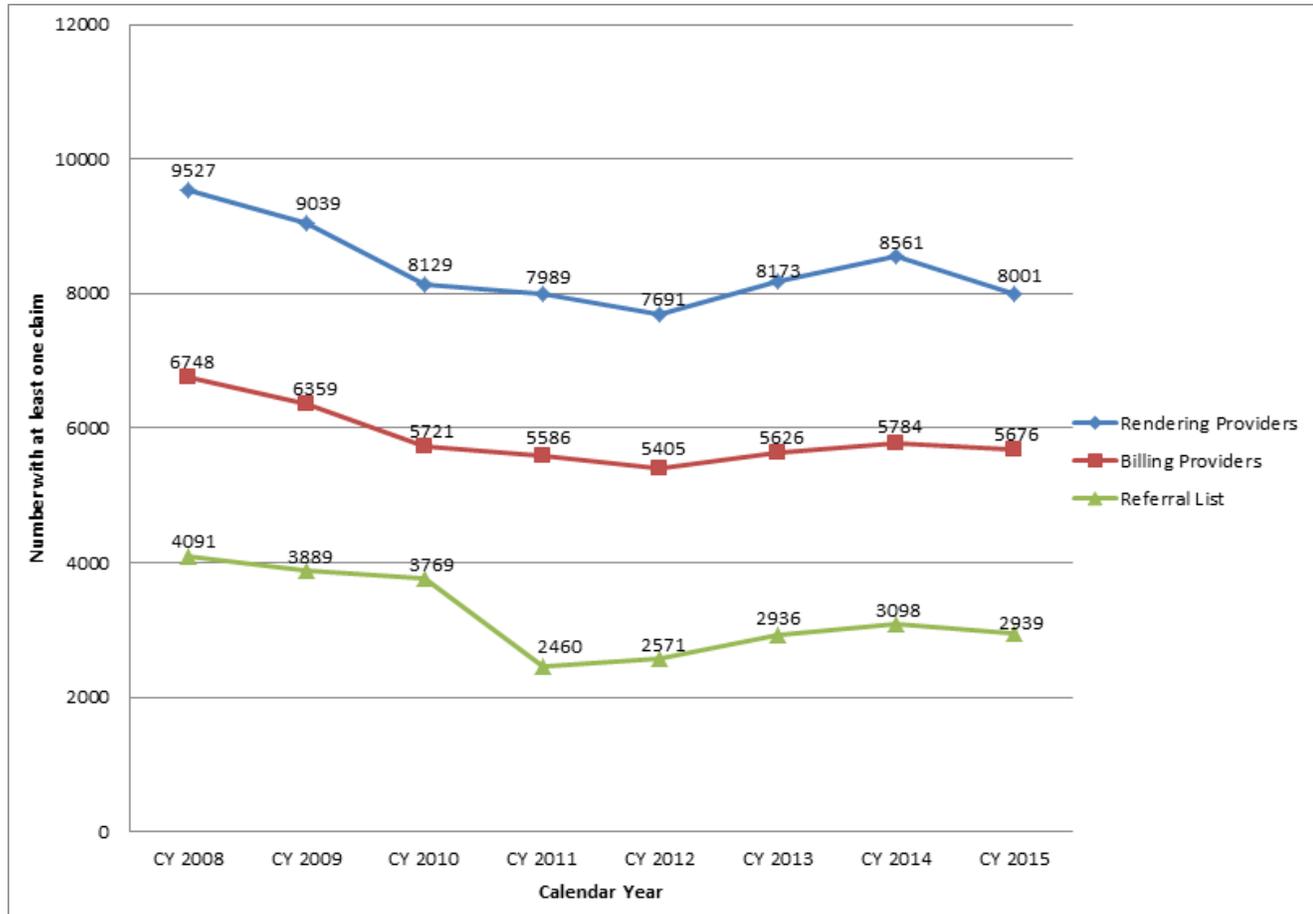
[Return to FFS Medi-Cal Beneficiary Population Characteristics](#)

Appendix 9 – Total Adult Enrollment in the Medi-Cal Program

Region	Beneficiary Enrollment - Ages 21+						
	Ages 21+						
	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Alameda	121,575	126,172	131,053	134,487	136,066	216,301	265,169
Central Coast	49,333	51,888	54,039	55,138	56,030	85,285	113,508
Central Valley	217,277	227,306	237,301	244,368	249,252	352,781	451,156
Contra Costa	59,550	63,004	66,279	69,462	70,854	113,671	148,808
Greater Fresno	145,006	150,552	155,044	159,379	161,471	226,640	288,447
Greater Sacramento	133,417	135,737	139,114	140,786	140,000	231,268	242,807
Inland Desert	31,781	32,731	34,127	34,547	34,997	45,098	41,106
Inland Empire	313,249	333,265	355,983	372,211	381,022	614,673	818,797
Kern	88,166	92,987	93,680	96,088	96,912	137,495	179,053
Los Angeles	887,565	903,279	925,108	938,976	940,537	1,564,748	1,912,295
North Bay	73,182	77,314	80,376	82,524	84,195	135,784	175,834
Northern	153,523	159,152	167,108	168,149	167,393	243,588	304,487
Orange	160,547	170,797	180,852	188,260	193,662	338,597	442,664
San Diego	179,212	184,555	195,179	200,098	203,167	337,185	453,531
San Francisco	86,849	88,463	90,698	92,125	92,244	142,844	170,106
San Mateo	32,174	33,676	34,545	36,113	36,808	64,060	80,102
Santa Clara	115,260	119,550	122,737	123,096	125,159	193,370	244,514
South Coast	88,196	91,850	93,570	94,923	95,410	152,623	204,295
Statewide Total	2,935,862	3,042,278	3,156,793	3,230,730	3,265,179	5,196,011	6,536,679

[Return to FFS Medi-Cal Beneficiary Population Characteristics](#)

Appendix 10 – Dental Provider Enrollment & Referral List Numbers



[Return to Provider Network](#)