CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: April 22, 2025

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: All Plan Letter (APL) 25-001*(Revised)*: Disaster Assistance to Evacuated Members and Dental Offices

PURPOSE:

The purpose of this Dental All Plan Letter (APL) is for the Department of Health Care Services (DHCS) to direct Medi-Cal Dental Managed Care (DMC) Plans on temporary state and federal flexibilities due to the California State of Emergency and federal Public Health Emergency (PHE) from the southern California wildfires.
With the expiration of the southern California wildfires PHE on April 6, 2025, DMC plans must begin transitioning away from PHE-related flexibilities and return to standard operational policies as outlined in applicable state and federal guidance. This APL outlines the temporary guidance applied during the PHE period and provides clarification on the expiration of those flexibilities. Updated guidance will continue to be provided as needed, and revised text is reflected in italics.

BACKGROUND:

On January 7, 2025, the Governor of the State of California, in accordance with the authority contained in the State Constitution and statutes of the State of California, issued Executive Order (EO) N-2-25[1] and declared a State of Emergency for Los Angeles (19) and Ventura (56) Counties due to the Palisades Fire. Additional EO's have been issued, including as of February 4, 2025,[2] due to additional flexibilities and multiple fires including Eaton, Hurst, Lidia, Sunset, Woodley, and Hughes Fires.

On January 10, 2025, pursuant to section 1135(b) of the Social Security Act, the U.S. Department of Health and Human Services (HHS) Secretary declared a Public Health Emergency (PHE) to address the health impacts of the ongoing wildfires in California[3]. During a PHE, the Centers for Medicare and Medicaid Services (CMS) may approve the use of section 1135 authority to help ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in CMS programs.

As provided in 42 U.S.C. § 247d(a)[4], PHEs (valid for 90 days) expire if not renewed for another 90 days. HHS has permitted the 90 days to lapse for the southern California

[1] 1.8.2025-LA-Fires-EO-N-2-25.pdf
[2] EO-N-17-25.pdf
[3] https://aspr.hhs.gov/legal/PHE/Pages/CA-Wildfires-Jan2025.aspx
[4] 42 U.S.C. § 247d - U.S. Code Title 42. The Public Health and Welfare § 247d

wildfires PHE, as the HHS Secretary has not commenced any renewal. Accordingly, the southern California wildfires PHE has thus ended, effective April 6, 2025.

POLICY:

Note: The following policy guidance was applicable during the effective period of the LA Fires PHE, which expired on April 6, 2025. Plans must begin phasing out temporary flexibilities and resume adherence to standard program requirements.

Removable dental appliances are fabricated by professionals and may be removed and inserted by the member, and include orthodontic retainers, space maintainers, partial and full dentures, and temporomandibular joint appliances.

DMC Plans shall exercise flexibility when evaluating claims submitted by Medi-Cal dental providers regarding prior authorization and frequency limitations for removable dental appliances for members who are residents of impacted counties. DMC Plans shall manually process, override denials, and accept claims from Medi-Cal dental providers without requiring prior authorization and shall not reject claims due to frequency limitations. DMC Plans shall accept in the Comments field on the claim: "Patient appliance(s) must be replaced due to State of Emergency."

DMC Plans shall also accept claims for exams and radiographs connected to the removable appliances. The negative impact of the fire alone shall meet the criteria of medical necessity. Damaged appliances shall be screened for repair. DMC Plans shall accept late claims from impacted Medi-Cal dental providers. DMC Plans shall accept in the Comments field on the claim: "Late claim submission due to State of Emergency." Other criteria outlined in the Medi-Cal Dental Manual of Criteria[5] will still apply. Payment for removable appliances that have been fabricated by a lab but cannot be delivered to the member shall follow the requirements in the Medi-Cal Dental Provider Handbook[6].

Claims for processing by this expedited method shall be effective from January 7, 2025 until the declared PHE ends, including any extensions. DMC Plans shall approve claims with a date of service thirty (30) calendar days prior to the corresponding effective date when the removable appliance(s) was delivered to the member but because of the loss of dental office records, the service had not yet been billed. Medi-Cal dental providers shall submit the same documentation about loss in the State of Emergency for the fire as stated above for late billing.

Additionally, deadlines for providers to submit and for DHCS to review a cost report, change in scope of service request, or reconciliation request are each extended 90 days beyond the date on which such would otherwise be due for providers impacted by this emergency in Los Angeles or Ventura counties.

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[5] https://dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_05_MOC_SMA.pdf Medi-Cal Dental Provider Handbook, Section 5, Manual of Criteria and Schedule of Maximum Allowances

[6] https://dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/PHB_section_02_program_overview.pdf Medi-Cal Dental Provider Handbook, Section 2, Billing and Payment Policies, Time Limitations for Billing, page 2-19.

Section 1135 Waiver Approvals

The approved modifications and waivers under Section 1135 will remain in effect with a retroactive effective date of January 7, 2025, until the declared PHE ends, including any extensions. After the PHE concludes, delayed evaluations and assessments must be completed within 90 days, while annual reviews and reassessments must be finalized within 12 months of their original due dates. To the extent applicable, the following waivers and modifications also apply to Children's Health Insurance Program (CHIP).

Provider Enrollment

With respect to providers not already enrolled with another State Medicaid Agency (SMA) or Medicare, pursuant to section 1135(b)(1) and (b)(2) of the Act, CMS waives the following screening requirements so the state may provisionally and temporarily enroll the providers for the duration of the PHE:

- Criminal background checks
- Licensing requirements
- Site visits

CMS is granting this waiver authority to allow the state to temporarily enroll providers who are not currently enrolled with another SMA or Medicare, so long as the state meets the following minimum requirements:

1. Must collect minimum data requirements in order to file and process claims, including, but not limited to NPI.
2. Must collect Social Security Number, Employer Identification Number, and/or Taxpayer Identification Number (SSN/EIN/TIN), as applicable, in order to perform the following screening requirements:
    a. OIG exclusion list
    b. State licensure – provider must be licensed, and legally authorized to practice or deliver the services for which they file claims, in at least one state/territory
3. The state must also:
    a. Issue no new temporary provisional enrollments after the date that the PHE is lifted,
    b. Cease payment to providers who are temporarily enrolled within six months from the termination of the PHE, including any extensions, unless a provider has submitted an application that meets all requirements for Medicaid participation and that application was subsequently reviewed and approved by the state before the end of the six-month period after the termination of the PHE, including any extensions, and
    c. Allow a retroactive effective date for provisional temporary enrollments that is no earlier than January 7, 2025.

Pause Revalidation Deadlines
Pursuant to section 1135(b)(1)(B) of the Act, CMS is approving to temporarily pause revalidation for providers located in the state or are otherwise directly impacted by the emergency.

If the state pauses revalidation for providers with revalidation due dates that fall during the PHE, the state would recalculate the provider's revalidation due date by adding six months plus the length of the PHE to the provider's original revalidation due date. For instance, if the provider's revalidation due date was April 1, 2021, and the PHE lasted 12 months, the provider's new revalidation due date would be October 1, 2022 (April 1, 2021, + six months + 12 months).

Allow out-of-state provider reimbursement
CMS 1135 waiver is temporarily allowing provider enrollment screenings performed by other SMAs and by Medicare for the duration of the PHE for Out-of-state providers, as long as the requirements are met in the waiver.

DHCS currently has the authority to rely upon provider enrollment screenings performed by other SMAs and by Medicare.[7] As a result, DHCS is authorized to provisionally and temporarily enroll providers who are enrolled with another SMA or Medicare for the duration of the PHE.

As described in section 1.5.1.B.2.c of the MPEC, Medi-Cal may reimburse otherwise payable claims from out-of-state providers not enrolled with DHCS if the following criteria are met:

1. The item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state/territory practice location– i.e., located outside the geographical boundaries of the reimbursing state/territory's Medicaid plan,
2. The National Provider Identifier (NPI) of the furnishing provider is represented on the claim,
3. The furnishing provider is enrolled and in an "approved" status in Medicare or in another state/territory's Medicaid plan,
4. The claim represents services furnished, and
5. The claim represents either:
    a. A single instance of care furnished over a 180-day period, or
    b. Multiple instances of care furnished to a single participant, over a 180-day period.

For claims for services provided to Medicaid participants enrolled with DHCS, CMS waives the fifth criterion listed above under section 1135(b)(1) of the Act. Therefore, for the duration of the PHE, DHCS may reimburse out-of-state providers for multiple instances of care to multiple participants, so long as the other criteria listed above are met.

[7] This guidance can be found in section 1.5.3.B. of the Medicaid Provider Enrollment Compendium (MPEC) https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf

Modify Timelines to Resolve Appeals
Currently, standard appeals must be resolved within 30 calendar days, expedited appeals within 72 hours, and written acknowledgement of an appeal must be provided within five calendar days of receipt. This modification under 42 CFR § 438.408(f)(1) allows shortened timeline for DMC plans to resolve appeals to as little as one day during the PHE. Additionally, if a DMC plan does not meet the required timing or notice standards, the appeal can be automatically deemed denied, allowing the member to move directly to a state fair hearing.

Modify State Fair Hearings Timelines
Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify timeframes in 42 CFR § 438.408(f)(2) for DMC Plan members to exercise their appeal rights. Currently members have 120 calendar days from the date of the DMC plan's notice of resolution to request a state fair hearing. For DMC members whose 120-day deadline to request a state fair hearing falls within the PHE period, CMS allows states to provide an additional 120 days to make this request. This means that DMC members now have a total of 240 days from the date of their DMC plan's notice of resolution to request a state fair hearing.

Modify Continuation of Benefits Timelines
The current policy requires members to request continuation of benefits within 10 calendar days of receiving the notice of an adverse benefit determination for benefits to be continued during the appeal or State Fair Hearing process. The modification under Section 1135(b)(5) of the Act extends this timeframe, allowing members to request continuation of benefits between 11 and 30 days after receiving notice if the managed care plan has not yet made a decision on the appeal or State Fair Hearing is pending.

Modify Authorization Decision Timelines
Currently, DMC plans must make standard service authorization decisions within 14 days. This adjustment extends the timeframe to up to 180 days (two 90-day extensions) during a PHE. It ensures DMC plans continue authorizing and paying for services during the extension, protecting enrollees from disruptions. DMC plans cannot seek reimbursement for these services, aside from cost sharing, even if the decision is adverse. This flexibility allows DMC plans to gather necessary information while maintaining uninterrupted care for enrollees.

Adverse Benefit Appeals Filing Timeline
The current policy allows members 60 days to file an appeal of an adverse benefit determination. The temporary modification extends this to 120 days, providing more time to file an internal appeal with the DMC plan. During this period, the DMC plans must continue to authorize and pay for services and cannot seek reimbursement, aside from applicable cost-sharing, even if the decision is adverse. This ensures continued access to services and additional time for the appeals process without affecting the member's right to a state fair hearing.

REQUIREMENTS:

Note: Policies and procedures (P&Ps) that were temporarily modified in response to the LA Fires PHE must be reviewed and revised as needed to reflect the expiration of the PHE and the return to standard operations.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in a DMC plan's contractually required P&Ps, the plan must submit its updated P&Ps with and without Track Changes to DHCS' Medi-Cal Dental Services Division (MDSD) at dmcdeliverables@dhcs.ca.gov within 90 days of the release of this APL.

If a DMC plan determines that no P&P changes are necessary, the DMC plan must submit an email confirmation to dmcdeliverables@dhcs.ca.gov within 10 days of the release of this APL, stating that the DMC plan's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

DMC plans are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each DMC Plan to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact the Medi-Cal Dental Services Division, at dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by:

Dana Durham
Chief, Medi-Cal Dental Services Division
Department of Health Care Services