VIRGINIA CARDINAL CARE SMILES NEWLY ENROLLED PROVIDER TRAINING

Cardinal Care Smiles (CCS)
2026

CardinalCare Smiles
Improving Dental Care in Virginia for Children and Adults

DentaQuest
a Sun Life company

Provider Partner Team for Virginia

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What we'll cover today

01 Virginia Partner Partner Team

02 Credentialing Application/Recredentialing Policies

03 Credentialing Links

04 Adults Over 21 Benefits

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What we'll cover today

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18 Virginia Provider Partner Team-Territories (Map)

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Credentialing & Recredentialing Policies

Initial Credentialing

The following documents are required along with one of the three applications:

- CAQH, VA Cardinal Cares Smiles Application or the DentaQuest standard application

✓Attestation Page

✓VA SFC Participation Agreement

✓VA SFC Provider Contract

✓EFT Form

✓W-9

✓DOO (Disclosure of Ownership)

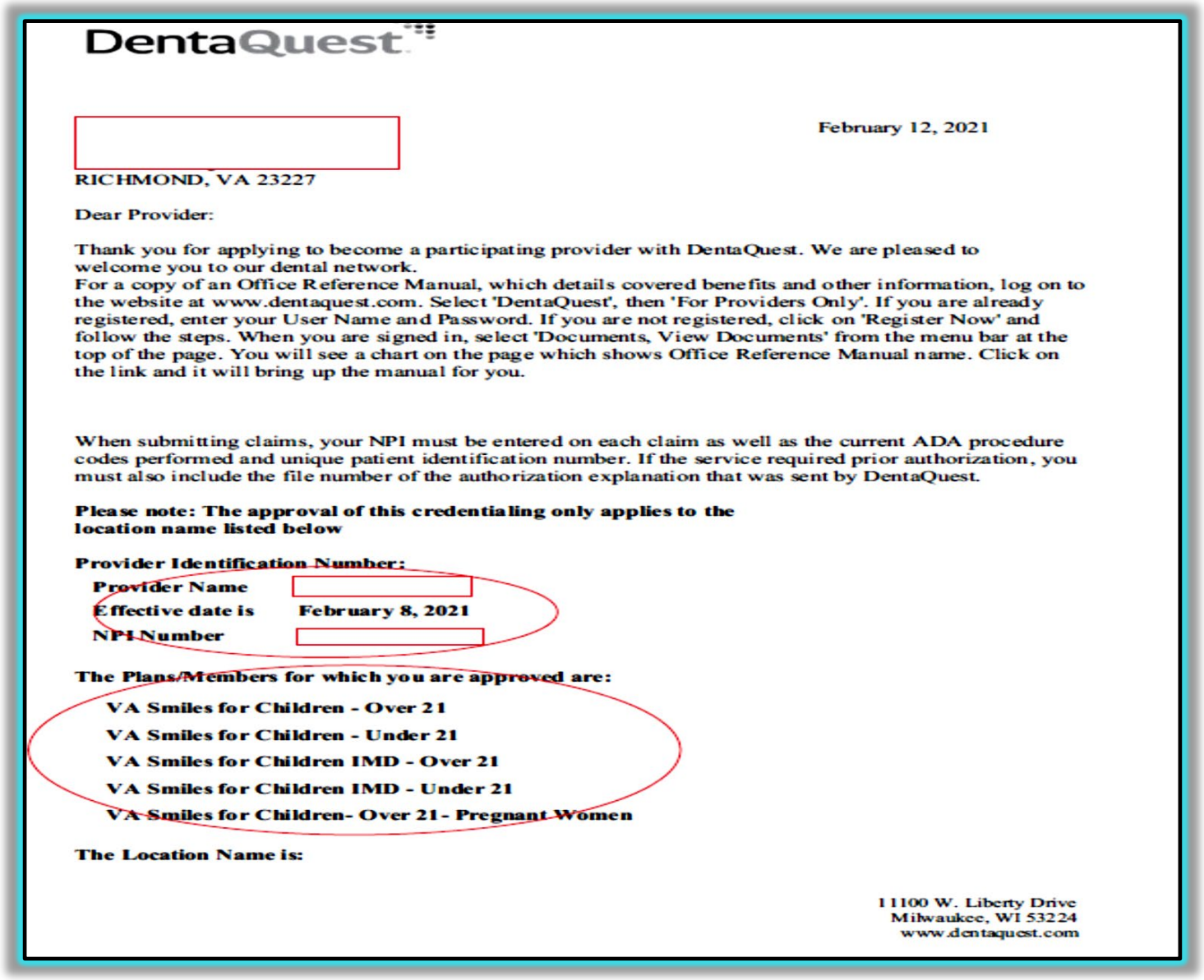
Credentialing & Recredentialing Policies-Welcome letters

The welcome letter includes:

- Service office locations
- Effective dates
- Programs/plans that were approved for the individual provider
- Business Key to set up the tax id to use the provider web portal

*Do not treat members until the receipt of your provider welcome letter via mail and/or email to the services office email on file (welcome letters for new DentaQuest providers)

Credentialing Welcome Letter-Sample



DentaQuest

February 12, 2021

RICHMOND, VA 23227

Dear Provider:

Thank you for applying to become a participating provider with DentaQuest. We are pleased to welcome you to our dental network.
For a copy of an Office Reference Manual, which details covered benefits and other information, log on to the website at www.dentaquest.com. Select 'DentaQuest', then 'For Providers Only'. If you are already registered, enter your User Name and Password. If you are not registered, click on 'Register Now' and follow the steps. When you are signed in, select 'Documents, View Documents' from the menu bar at the top of the page. You will see a chart on the page which shows Office Reference Manual name. Click on the link and it will bring up the manual for you.

When submitting claims, your NPI must be entered on each claim as well as the current ADA procedure codes performed and unique patient identification number. If the service required prior authorization, you must also include the file number of the authorization explanation that was sent by DentaQuest.

Please note: The approval of this credentialing only applies to the location name listed below

Provider Identification Number:

Provider Name

Effective date is **February 8, 2021**

NPI Number

The Plans/Members for which you are approved are:

VA Smiles for Children - Over 21

VA Smiles for Children - Under 21

VA Smiles for Children IMD - Over 21

VA Smiles for Children IMD - Under 21

VA Smiles for Children- Over 21 - Pregnant Women

The Location Name is:

11100 W. Liberty Drive
Milwaukee, WI 53224
www.dentaquest.com

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Credentialing & Recredentialing Policies-Continued

Recredentialing

Recredentialing is due every 3 years from the **initial** credentialing date of the provider with DentaQuest (not the office/clinic)

- The following documents are required for the recredentialing process:
  - An updated CAQH, DentaQuest application or Virginia Cardinal Cares Smiles (CCS) application
  - Recently dated Attestation Form
  - Current Malpractice Liability Policy
  - Disclosure of Ownership (required every 3 year by TIN)

*Email reminders are generally sent to the email address on file, 3-4 months prior to the re-cred due date

Recredentialing Letter-Sample

DentaQuest

Date

Provider Name
Address
City, St Zip

It's Time for you to be Recredentialed!

Dear «salutation_of_provideraddreProvider,

Thank you for participating in the DentaQuest Network. In accordance with the National Committee for Quality Assurance guidelines, providers are required to undergo recredentialing every three years. **This letter is to inform you that your credentials will expire on MM/DD/YYYY.**

Please submit your application within the next two weeks to ensure there is no lapse in your participation and payment of claims is not interrupted.

Complete your recredentialing application by going to the link below.

https://dentaquest.com/dentists/recredentialing/

Please include the following:

- Current copy of your **professional malpractice insurance policy** (document must include the policy number, effective date, expiration date, coverage limits and carrier name)
- Detailed disclosures for any **professional liability claim** or **license sanctions**

Please contact us at 1-800-233-1468 with any questions. Thank you again for being a part of our network. As a result of your efforts, more patients are experiencing improved oral health.

Sincerely,

Clayton Jenks
Supervisor, Provider Enrollment and Credentialing

Credentialing Links and Contact Information

- **Credentialing Customer Service** –Providers have direct access to speak with staff about the credentialing/recredentialing process or status of an application via:
  - Phone at 1-800-233-1468
  - Email at credstatusrequest@greatdentalplans.com

- Applications are sent to:
  - credenrollment@greatdentalplans.com
  - Fax: 262-241-4077 Attn: VA Cardinal Cares Smile
  - Mail: PO BOX 2906 Milwaukee, WI 53201-2906

Contacts and When to Use

Contacts:	When to use:
Credentialing Hotline: 800-233-1468	Updates on credentialing status, questions about documents
DentaQuest Provider Services: 888-912-3256	Requests for DOO forms
Fax: 844-876-3975	Fax documents for credentialing
credenrollment@greatdentalplans.com	Initial/Reapply applications
credintake@greatdentalplans.com	Recred applications, Credentialing missing information
credstatusrequest@greatdentalplans.com	Credentialing Status
Application options:	**Website:**
CAQH Application (online) - apply on the ADA website	www.ada.org
AppCentral (online) - DentaQuest's online application	https://www.dentaquest.com/en/providers

Adults Over 21- and Pregnant Women Comprehensive Dental Benefits

Coverage for adults include the following:

- Diagnostic (x-rays, exams)
- Preventive (cleanings)
- Restorative (fillings, crowns-refer to ORM for crown benefit limitations)
- Endodontics (root canals)
- Periodontics (gum related treatment)
- Prosthodontics (refer to ORM for benefit limitations)
- Oral surgery (extractions and other oral surgeries)
- Adjunctive general services (all covered services that do not fall into specific dental categories.)

Refer to the Virginia Cardinal Cares Smiles Office Reference Manual (ORM) Exhibit B and Pregnant Women Exhibit C for details of the covered benefit codes and benefit frequencies/limitations

Office Reference Manual-Prior Authorizations vs Pre-Payment Review

- Authorization Required: Indicates that either prior authorization or prepayment review is required for the specific code.
- Prior Authorization and Prepayment Review: The tables of covered services (Exhibit A, B and C) contain a column marked-"Authorization Required. A "Yes" in this column indicates that a service code listed requires either prior authorization or documentation submitted with date of service claim for pre-payment review to be considered for reimbursement. The "Documentation Required and benefit limitation" column will describe the necessary information for review, and whether it must be submitted on a prior authorization bases, or with a claim following treatment for pre-payment review. Services requiring prepayment review, require that proper documentation be submitted with the claim following treatment for the claim to be considered for reimbursement.

Office Reference Manual-Prior Authorizations vs Pre-Payment Review-Sample ORM page

Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	Periodic oral evaluation	0-20		No	One per 6 months per patient per dentist or dental group. Only one exam (D0120, D0145, or D0150) every 6 months	
D3310	Anterior root canal (excluding final restoration)	0-20	Teeth 6-11, 22-27	No	Once per lifetime.	
D7230	Removal of impacted tooth – partially bone	21 and older	Teeth 1 through 32, 51 through 82 (SN), A through T, AS through TS (SN)	Yes	Removal of asymptomatic tooth not covered.	Pre-operative radiographs and narrative of medical necessity with claim for prepayment review.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes		Study models (or OrthoCad equivalent). Panoramic or perioapical radiographs. Cephalogram and/or photos are optional. PRIOR AUTHORIZATION REQUIRED.

Prior Authorization Extension Requests

Expired Authorization Extension Request Protocols:

- General expired authorizations
  - Requests are made 30 days prior
  - Extensions may be granted for 3 months *unless SPU case*
- 5000 codes expired authorizations
  - Requests are made 30 days prior
  - Extensions may be granted for 6 months
- Orthodontic Approvals
  - Requests are made 30 days prior
  - Extensions may be granted for 1 year

Prior Authorization Extension Requests-Ellipisis

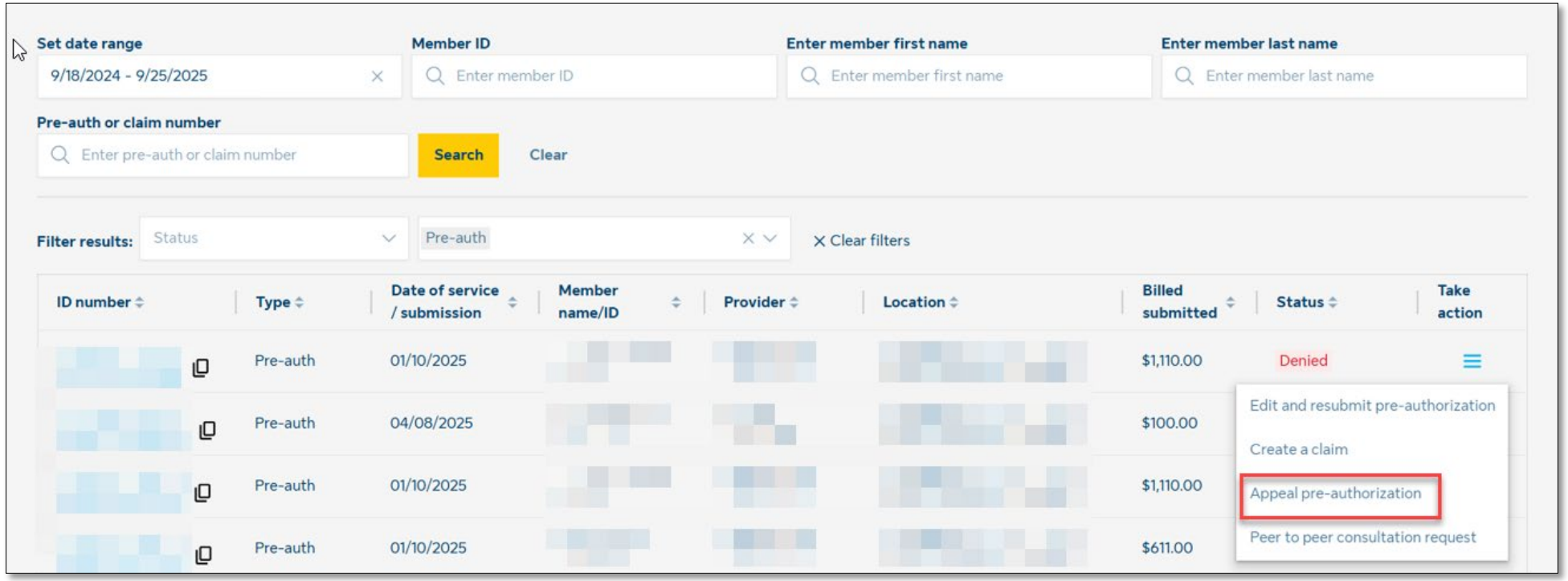
Extending or releasing a pre-authorization:

- Once a pre-auth is approved, it can be extended or released. You can request and extension from the pre-auth page or from inside the member's pre-auth.
- From the pre-auth page, click the ellipsis to the right of the status. And then click Request extension/release.

Prior Authorization Extension Requests-Member Page

Extending pre-authorization from Member page:

From the member's pre-auth page, click the ellipsis to the right of the status. And then click Request extension/release.



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Prior Authorization Extension Requests-Instructions

Extending and/or Releasing a pre-authorization:

- On the request extension/release page, follow these instructions to release or extend the pre-authorization:

1. Select the type of request (either Extension or Release).
2. Enter the supporting details.
3. Drag and drop any supporting documents or click +Add to file to add files.
4. Click Submit request.

Editing a Prior Authorization For Missing Documentation

Editing and resubmitting a pre-authorization for missing or updating SPU date of service:

You can edit and resubmit a pre-authorization at any time. Simply navigate to the pre-authorizations and claims page, click on the menu button (three lines) to the right of the status, and then select Resubmit. You can alternatively start the process by clicking the button at the top of the page from within the member's pre-auth.

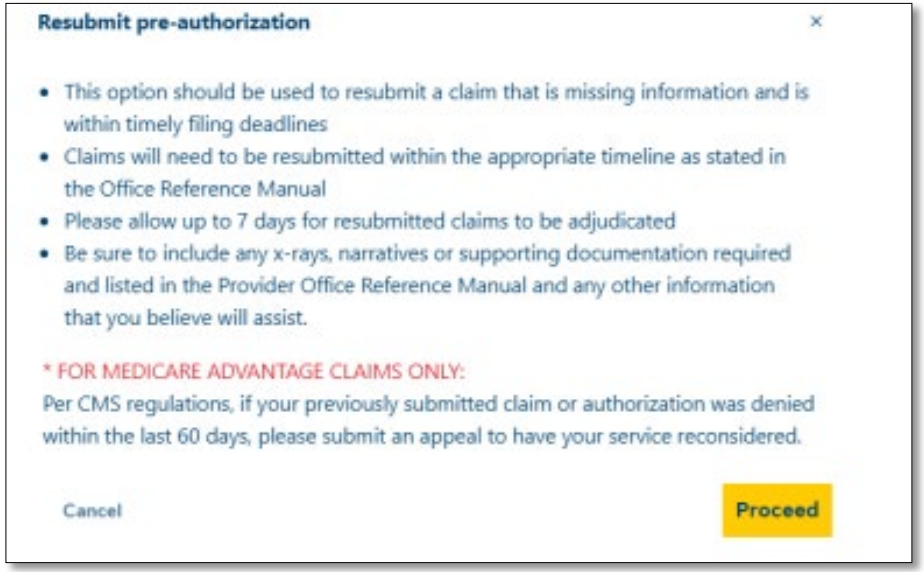
Please note, this option should be used to resubmit a pre-auth that is missing pertinent information and/or updating SPU with new DOS ONLY.

Editing a Prior Authorization For Missing Documentation- Message Displays

The Resubmit pre-authorization in message is displayed.

Click Proceed.

The pre-authorization is displayed so you can make the necessary edits and then resubmit the document.



Prior Authorization Extension or Release Requests

Extending and/or Releasing a pre-authorization:

- On the request extension/release page, follow these instructions to release or extend the pre-authorization:

1. Select the type of request (either Extension or Release).
2. Enter the supporting details.
3. Drag and drop any supporting documents or click +Add to file to add files.
4. Click Submit request.

Operating Room Cases

All operating room (OR) cases must be prior-authorized

In most cases, OR will be authorized (for procedures covered by CCS) if the following is involved:

- Patients requiring medically necessary extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV.
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures. Patients requiring medically necessary extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring medically necessary extensive dental procedures whose prior history indicates hospitalization is appropriate.

Documentation Required for Prior Authorization of OR Cases

- Prior-authorized Treatment Plan
- Narrative describing medical necessity for OR
- Fees are reimbursed in accordance with the CCS Schedule of Allowable Fees as reflected in the Provider Agreement
- Must submit D9999 for Hospital
- Must submit in the remarks field the full name of place of service and date of service-NO ABBREVIATIONS
- Box 38 must have the Hospital box checked
- MUST have the medical necessity clearly written in the remarks field. If a letter of need is submitted-then note see attachment for the need in the remarks field.

OR Cases-Do’s and Don'ts Documentation Required for Prior Authorization

- MUST INCLUDE FULL NAME OF THE FACILITY (Harper Hospital Clinic) in box 35-NO ABBREVIATIONS
  - Example-Harper Hospital Clinic
  - Not acceptable format for place of service-HHC
- Must submit in the remarks field (box 35) full date of service (MM/DD/YYYY)- for the OR case to be reviewed
  - Example-12/15/2026
  - Not Acceptable format for date of service Dec 15- must include year
- Box 38 must have the Hospital box checked
- MUST have the medical necessity clearly written in the remarks field or attach letter of need.

Office Reference Manual-Clinical Criteria Section 15.00

Section 15.00 of the ORM outlines the Clinical Criteria used for authorization and payment decisions

Documentation requests for information regarding treatment are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or description narratives.

Clinical criteria are designed as guidelines and are not intended to be all-inclusive or absolute.

When there is a special situation, additional narrative information is required.

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Provider Appointment Availability

Appointment Availability requirements are as follows per *Cardinal Care Smiles* provider contract section 2(f)

Provider agrees that under reasonable, routine circumstances, appointment times shall be the usual and customary and not to exceed:

- 24 hours for Emergency Appointments (as noted in ORM-As quickly as the situation warrants)
- 48 hours for Urgent Appointments
- 6 weeks for Routine Appointments
- Wait times shall not exceed forty-five (45) minutes

Periodontal Scaling and Root Planing-What is it?

D4341-Peridontal scaling and root planing-Four or more teeth per quadrant

D4342-Periodontal scaling and root planning-one to three teeth per quadrant

- Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces
- Indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature
- Is a definitive procedure designed for removal of the cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms
- Some soft tissue removal occurs
- Procedure may be used as definitive treatment or as part of pre-surgical procedures

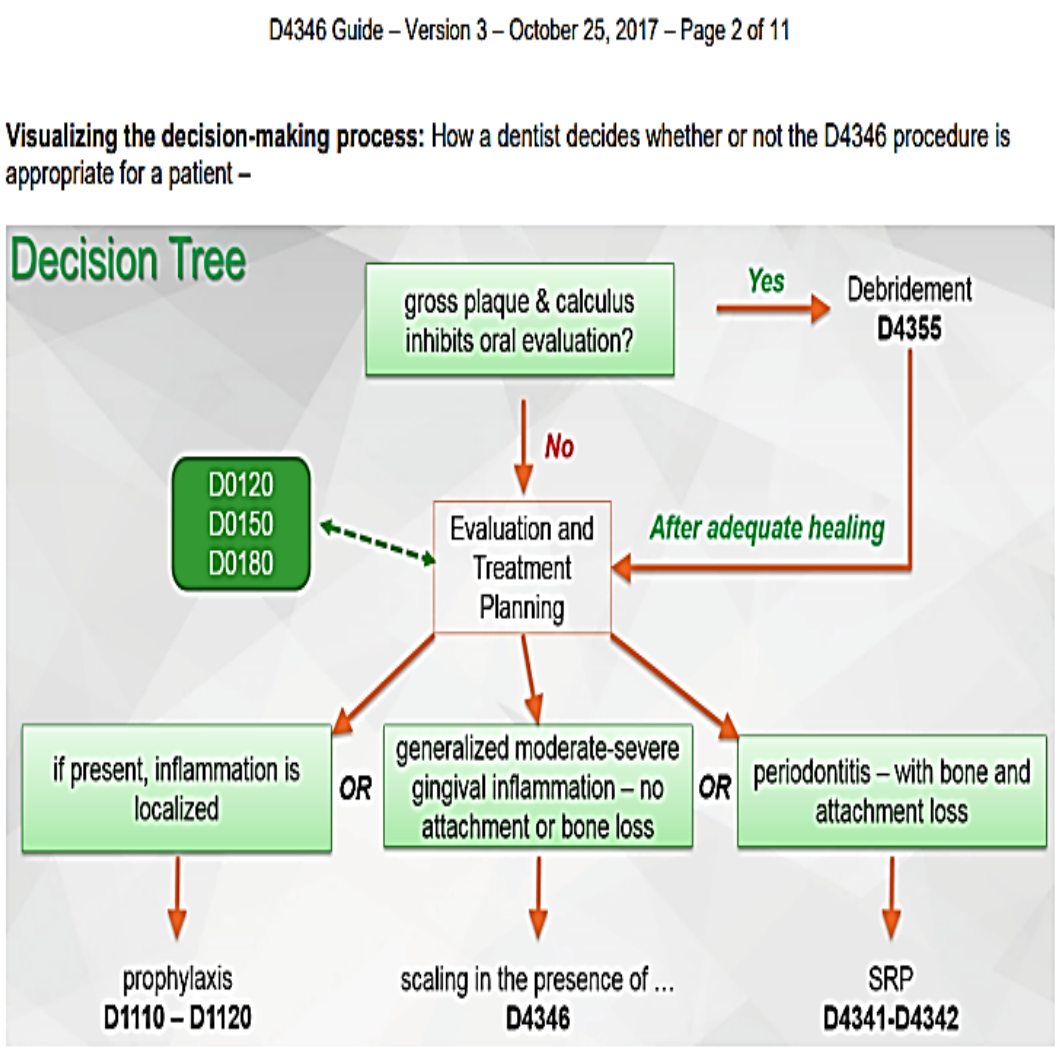
Periodontal Scaling and Root Planing-Criteria Section 15.09

- Be sure to view the ORM benefit tables by subgroup and per code to see if pre-authorization is required.

- Required Documentation:
  - Radiographs – periapicals or bitewings preferred
  - Complete periodontal charting with AAP Case Type

- Criteria:
  - Periodontal charting indicating abnormal pocket depths in multiple sites
  - Additionally, at least one of the following should be present:
    1) Radiographic evidence of root surface calculus
    2) Radiographic evidence of noticeable loss of bone support

Periodontal Scaling and Root Planing-ADA Decision Tree



- D4346 scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
- This code may be appropriate:
  - removal of plaque, calculus and stains
  - when there is generalized moderate or severe gingival inflammation in the absence of periodontitis
  - indicated for patients who have swollen or inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing

*Should not be reported in conjunction with prophy, scaling and root planing, or debridement procedures

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D4346 Education Guidelines (mouthhealthy.org)

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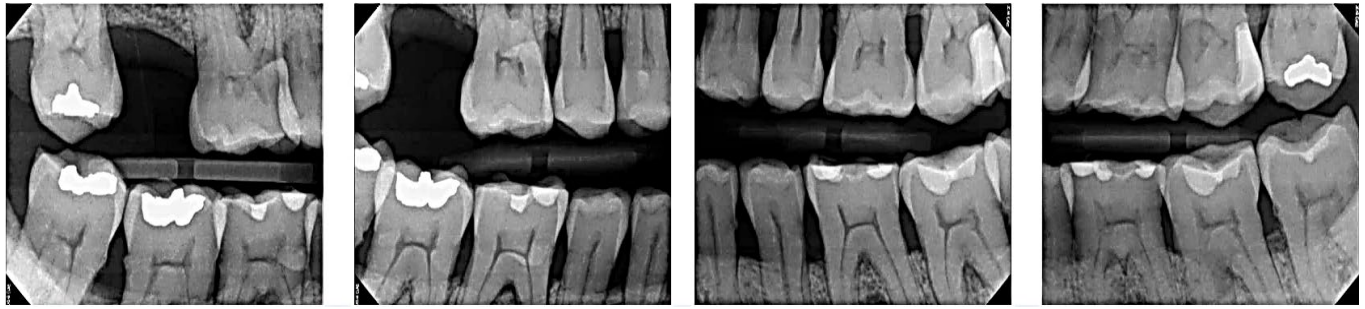
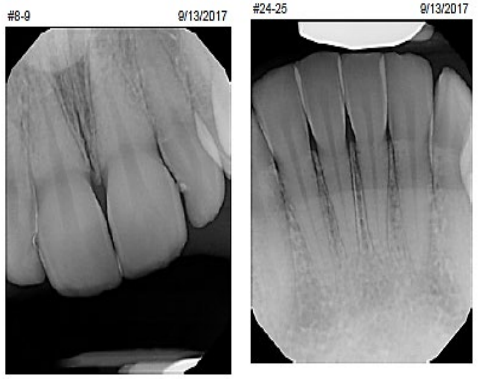
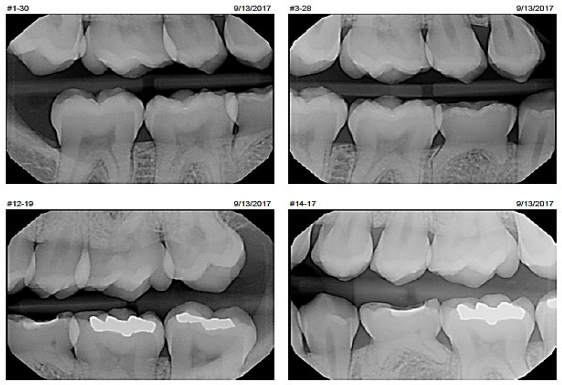
Periodontal Scaling and Root Planing-Bone Loss

Noticeable bone loss (2.5mm or more from CEJ to crest of bone)



Pocket depths without bone loss/radiographic evidence of root surface calculus is insufficient





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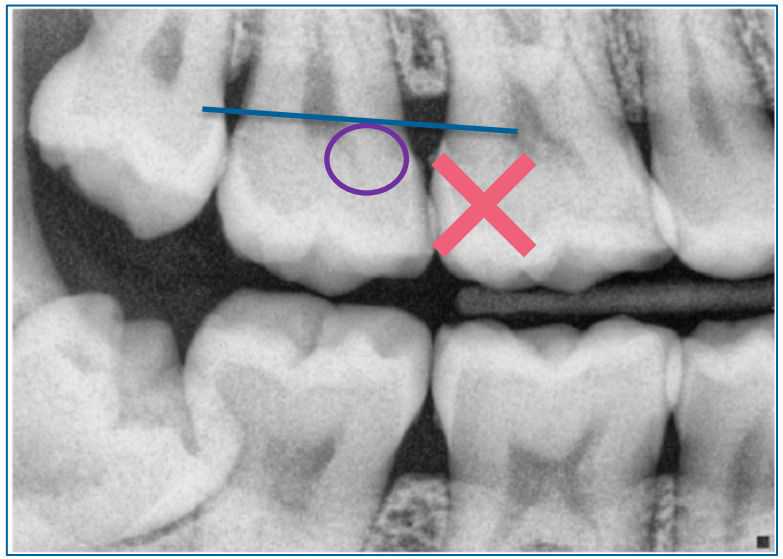
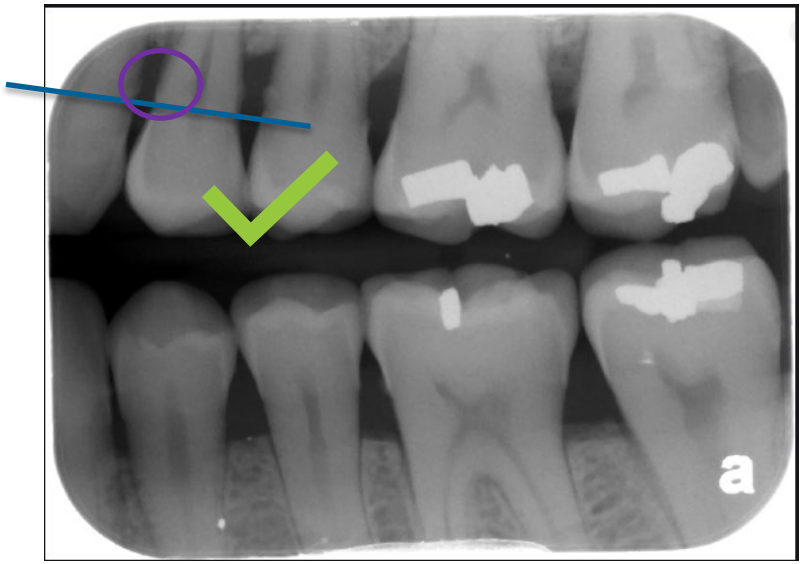
Radiographic Calculus vs Radiographic Root Surface Calculus

‘Root Surface Calculus’ is apical to the CEJ (towards the apex of the root)

Subgingival Calculus that is coronal to the CEJ is not Root Surface Calculus





Periodontal Key Points-

- D4341 requires 4 affected teeth

- 4 teeth per quadrant must have either 2.5mm of bone loss or root surface calculus

- Just because 1-2 teeth have bone loss does not mean that D4341 would be approved – D4342 would be the appropriate code (one to three affected teeth)

Appliances-Reimbursement/Bill Date

Payment for any removable/fixed prosthetics is based on date of delivery. Delivery is defined as the date the appliance was “placed” in the mouth by the billing provider. Hand delivering the prosthetics to take to the Oral Surgeon (OS) is not considered a delivery.

- Only exception is when member must see OS to have teeth removed for immediate denture placement. You must coordinate with the OS on the date the appliance was placed
- Billing for services for removable/fixed prosthetics should occur after any necessary extractions have been completed
- Example: 9/1/2026 (impression date), seat/delivery date/insertion/cementation date 9/15/2026, bill/claim date should be 9/15/2026
- Member must be eligible on the date of service (delivery date) for the service to be covered

Lab Costs: Non-Deliverable Dentures/Partials/Crowns

To receive payment for lab costs of removable/fixed prosthetics which you have not been able to deliver, you must:

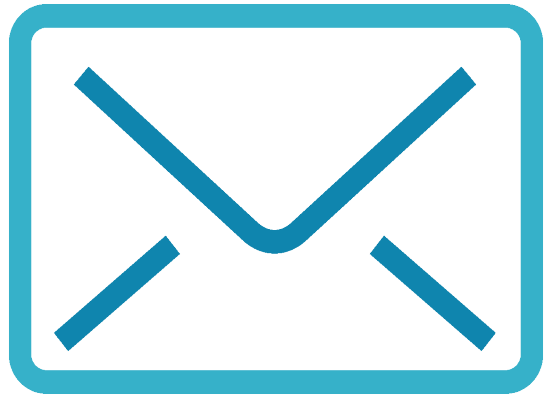
- Submit the D5999 or D2999 for the lab cost on ADA claim form or via dental claim entry on the provider web portal along with required documentation:
  - Copy of "paid" lab bill/invoice for the member
  - Copy of all the outreach attempts to get member to the office for delivery or reason unable to deliver (for example; member deceased)
  - Treatment notes and/or any documentation of what occurred and why member did not take delivery of appliance
  - The date of service was the date of the impression/prep date
  - Fee allowed is up to $100 per appliance/crown from the "paid" lab cost
  - Same timely filing guidelines apply

Professional Interpreter Services

- D9990-(Certified translation or sign-language services) – per visit (up to $65 per hour in15-minute increments) on ADA claim form
- To be reimbursed for D9990, the provider must submit the following with the claim for pre-payment review:
  - CCS Professional Interpreter Service Form documenting the services provided by and paid to an interpreter that is proficient in the specific language and that holds a Virginia business licenses allowing a fee for their service. If the interpreter is not listed on the DMAS Interpreter Resource list, the provider must attach a copy of the professional interpreter's business license with the invoice.
  - ADA claim form

Professional Interpreter Services-Continued

- To be eligible for reimbursement, services must be rendered in conjunction with an eligible CCS dental service and the claim for these services must be reflected in the DentaQuest claim system. Charges incurred for missed or broken appointments are not eligible for reimbursement
- One invoice form per member
- Invoice form and claim with D9990 must be submitted to:
  - DentaQuest-PO BOX 2906 Milwaukee, WI 53201-2906
  - Fax 262-834-3589
  - Via electronic dental claims entry and attached the form and invoice in one PDF and note in remarks/notes field box 35



Professional Interpreter Services-Requirements

- * A copy of the paid invoice/receipt to DentaQuest to include the following information:
  - Date and Time of Interpreter service (including beginning and ending time in 15-minute increments)
  - Patient Name and Medicaid ID number
  - Interpreter name, address, telephone number, language used, duration of service and interpreter's charge for the service

Professional Interpreter Services-Resources

- DMAS maintains an Interpreter Resource list located at https://www.dmas.virginia.gov/media/6267/sfc-interpreter-services-resource-list_updated.pdf
- If you do not have an interpreter resource, you may select one from the Interpreter Resource List.
- Professional Interpreter Services form available on the provider web portal under related documents
- The patient's chart must document that the patient needed and received interpreter services on a specific date. If ongoing interpreter services are required, the provider must include an annual assessment and attestation in the patient's chart confirming need. Payment for that service acknowledges DentaQuest's ability to audit the use of the service at any time.

Claim Submission Requirements for Primary Insurance EOB

All claims submitted after primary payment requires:

- Primary insurance carrier and address
- Member full name
- Date of service of EOB must match the date of service on DentaQuest submitted claim (*unless it is an ortho case where the adjustments are billed monthly/quarterly)

- Must note in remarks/note field (box 35)-**First Key word** must be one of the following:
  - EOB
  - COB
  - Primary Insurance

Example:

Claim Submission Requirements for Primary Insurance EOB-Continued

- Always include the Processing Policy/Reason for non-payment by primary insurance (usually in the footnotes section or last page of the EOB).
  - DentaQuest can't accept just a $0 payment from Primary
  - DentaQuest must see **WHY** it was not paid by primary insurance
- Full amount paid by primary insurance (codes and tooth/quad/arch **MUST** match each service line on the DentaQuest claim)
- Primary EOB information must be **CLEAR** and **LEGIBLE**
  - if the EOB is not readable DentaQuest will not be able to appropriately process the claim for payment

Broken/Cancelled Appointment Reporting Program

What is it and why is it useful?

- The broken appointment program is a tool used to educate and re-appoint members.
- The purpose is to educate members on the importance of keeping appointments and the value of maintaining good oral health.
- **Provider** reports the member broken appointment
- **DentaQuest** outreaches to member to provide education and assist with future appointments.

  - DentaQuest contacts members via phone and mail to remind them to reschedule.

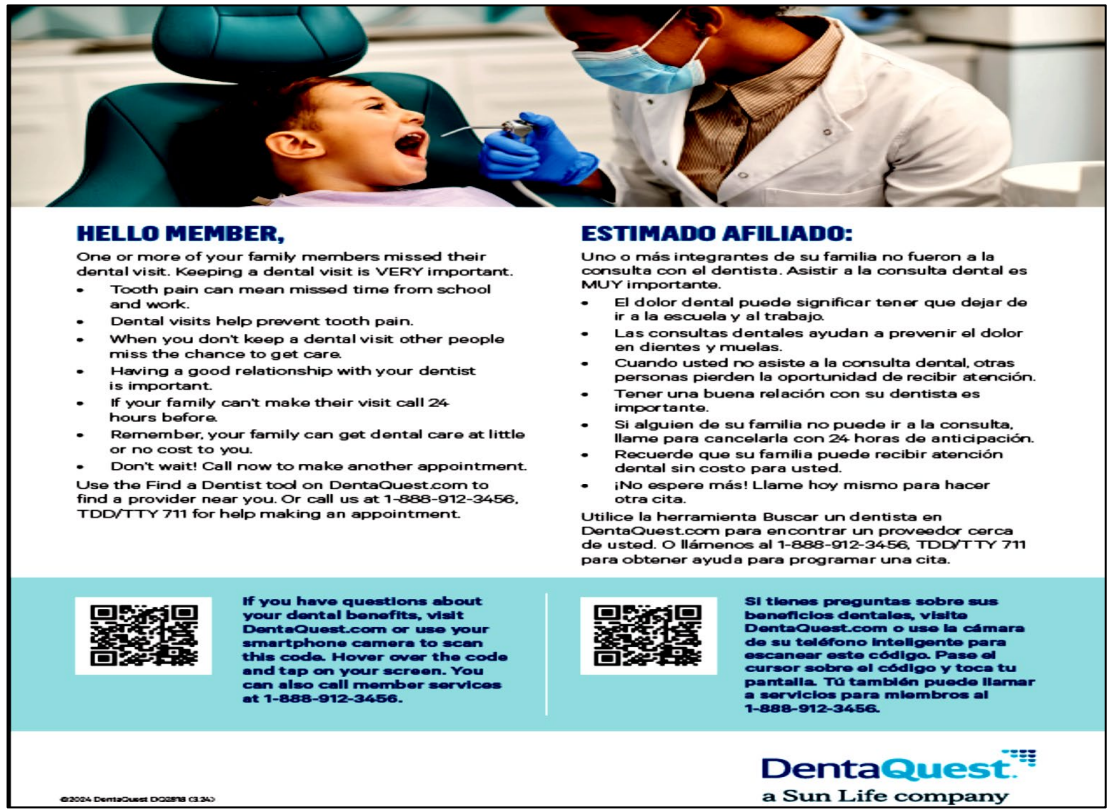
  - There is **no payment** associated with this program

Broken/Cancelled Appointment Reporting Program-continued

- Report Broken appointments to DentaQuest on an ADA claim form for recording purposes only.
- Submit a claim using one of the following codes:
  - D9986 Missed/Broken Appointment
  - D9987 Cancelled Appointment
  - Note in box 35 and identify 1st, 2nd or 3+ broken appointment
  - **No payment will be made for broken appointments**
  - Federal law prohibits charging members for BA/CA appointments and the provider contract prohibits charging members.

**It is free for the office to submit a claim for broken appointments (BA)/cancelled appointments (CA) via the provider web portal as a dental claim.

Broken/Cancelled Appointment Reporting Program-Broken Appointment Member Postcard



Records Requests for Members

Cardinal Care Smiles providers are contractually obligated to comply with any requests for medical records from DentaQuest and/or DMAS, or any external review organization approved by DMAS and/or any organization authorized by statute to investigate violations within the Medicaid, FAMIS or FAMIS Plus programs.

Requests are made for:

- Quality Assessments
- Service Utilization
- Quality Improvement
- Investigation of Member Complaints or Grievances
- Random Chart Audits

Records Requests for Members-Includes

Provider must:

- Respond timely
- Provide all requested records to include:
  - Radiographs
  - Consent forms (including member waiver)
  - Referrals
  - Treatment plan
  - Treatment Notes
  - Any/all documents relevant to the request

Corrected Claims Submissions and Void Requests

Corrected Claims Submissions:

It is preferred to “correct” a claim over “voiding” a claim

- Corrected claims are for simple corrections like incorrect code, missing fee, Wrong tooth number
- Keywords “CORRECTED CLAIM” should be the first words in the remarks/notes field (box 35) then the claim # that needs correction.
- State the correction needed (i.e., incorrect code, incorrect fee, missing pregnant, etc.) in remarks/notes section (box 35)
- Include the original claim number for the claim you are correcting/voiding (i.e., claim/ref# 2026xxxxxxxxxxxxx)
- Corrected claims can be submitted on the portal, by clearinghouse, or ADA paper claim form

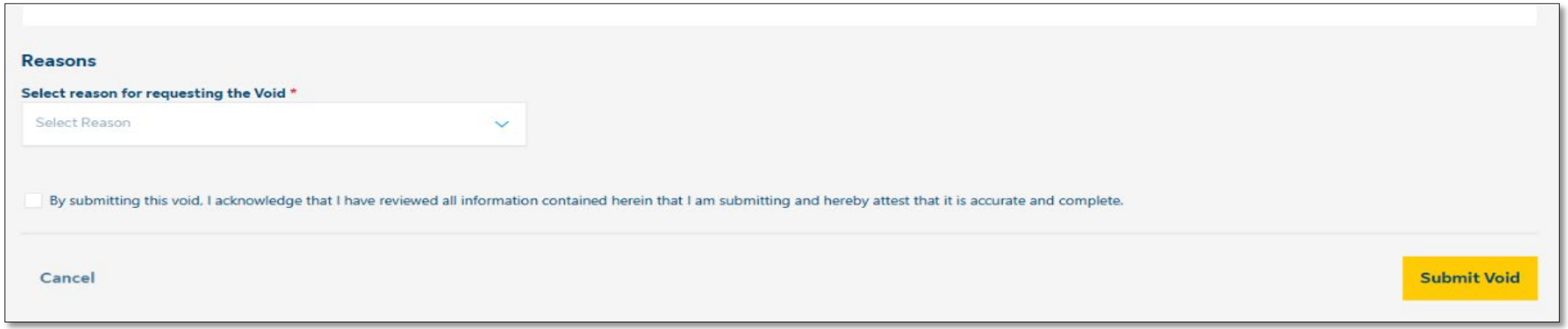
Void Requests

From the claims page, click on the ellipsis (three dots) to the right of the status, and then select VOID. You can alternatively start the process by clicking the button at the top of the page from within the member's claim. The Void Claim page is displayed.

Select the reason for the void request from the drop-down menu.

Click to highlight the attestation, and then click Submit void.

The Confirmation page is displayed.

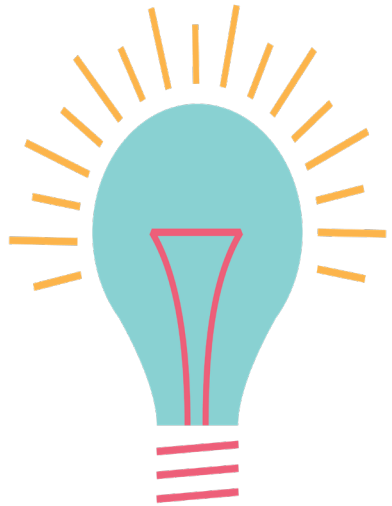


IVR System -Member Eligibility

- Ability to verify benefits and eligibility and obtain a procedure history
- Ability to have information faxed back to you
- Once member information (such as membership number or date of birth) is entered, you will be able to jump between menus without re-entering that information
- Caller dials Provider Services incoming phone number (888-912-3456)
- Caller is prompted for English vs Spanish
- Caller enters NPI
- Caller enters last 4 digits of TIN

IVR Self Service Functions-Continued

- **IVR validates caller:**
  - If provider is found – continues to enter member information
  - If provider is not found – continues to limited options



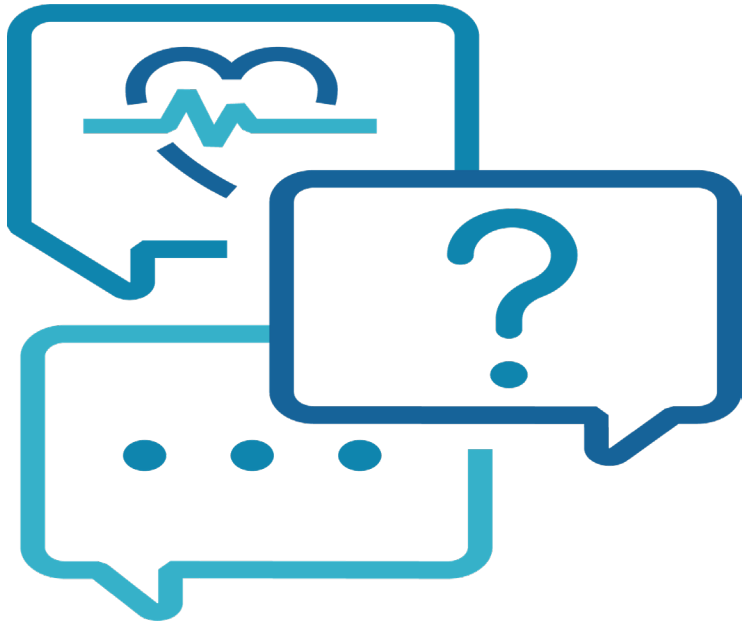
- **Caller enters member information**
  - Member ID (12-digit number only)
  - DOB
  - (First 4 characters of last name if the ID is alpha numeric)

- **IVR validates member information:**
  - If member is found – continues to main menu
  - If member is not found – prompted to re-enter information

IVR Self Service Functions-Main Menu

- **Main Menu (when both provider and member are found in system)**
  - Eligibility, Claims, Authorizations, Web Support and all other inquiries

  - Benefit Sub Menu
    - Benefit Summary
    - Benefit Detail



Provider Web Portal and Self Registration

providers.dentaquest.com/onboarding/start/

Sun Life DentaQuest

Provider portal

Sign in

Sign in to the provider portal to access member and benefits information.

Username *

CommRaeanne

Password *

Remember me

Sign in

Ready to register?

Create an account on the provider portal where you can access information about plans, claims and more.

Get started

Have questions or need help?

Explore our provider portal training materials.

Sun Life training & education

DentaQuest training & education

CardinalCare Smiles
Improving Dental Care in Virginia for Children and Adults

DentaQuest
a Sun Life company

Portal Training Tutorials-

Intro to the Provider Portal

https://youtu.be/o8L-UZdk5Mg

Registration Tutorial

you tube links for videos on registration for portal

Member and Eligibility Search Tutorial

https://www.youtube.com/watch?v=WEIiwETtIBM

Practice Management Tools Tutorial

https://www.youtube.com/watch?v=5KI-gBVzRfo

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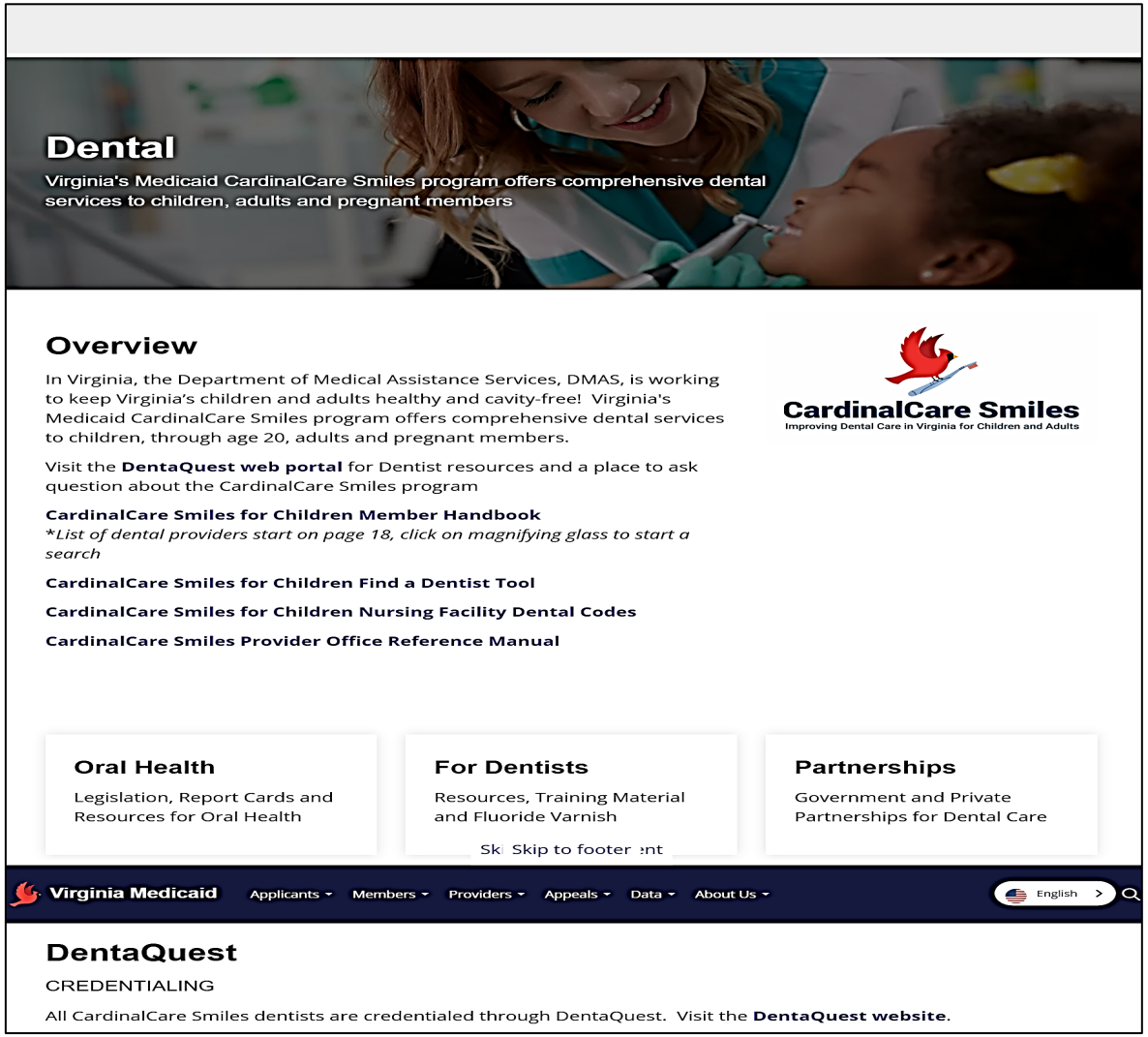
DMAS Website-Cardinal Cares Smiles Program Link

https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/



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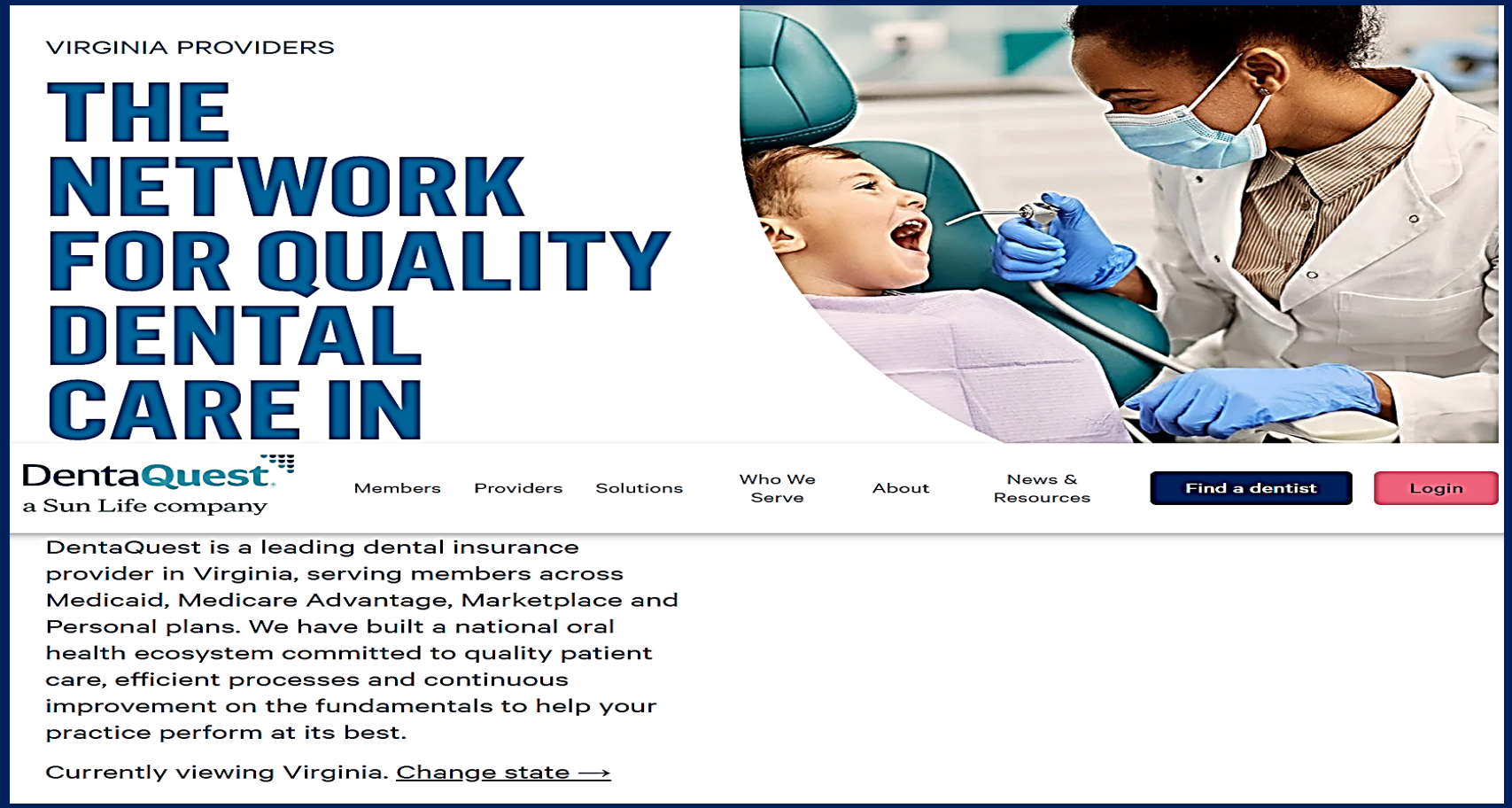
DentaQuest Website link-Virginia

https://bit.ly/3xoMjVhV



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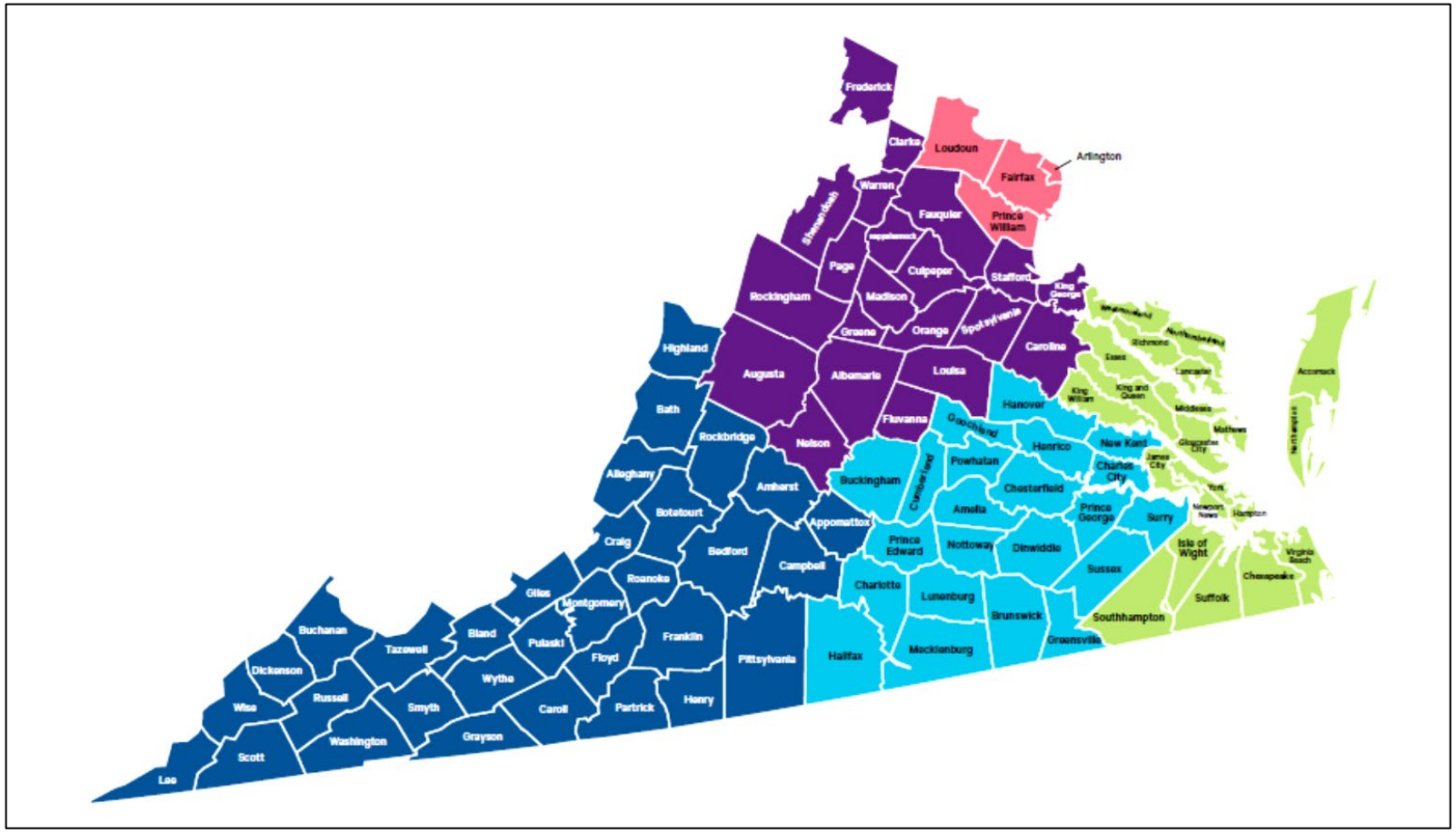
VA Provider Partners County Assignments



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Questions and Answers!

"There is no such thing as a dumb question"

"A prudent question is one-half of wisdom."

"We wish to express our gratitude for your time and consideration to join the Virginia Cardinal Cares Smiles dental Medicaid program"

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