State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: May 16, 2018

TO: ALL DENTAL MANAGED CARE PLANS

SUBJECT: **APL 18-010: PROPOSITION 56 DIRECTED PAYMENT EXPENDITURES FOR DENTAL SERVICES FOR STATE FISCAL YEAR 2017-18**

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide information to Dental Managed Care (DMC) plans on directed payment requirements for certain dental services funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) for State Fiscal Year (SFY) 2017-18.[1]

BACKGROUND:
Proposition 56 increases the excise tax rate on cigarettes and tobacco products and allocates the resulting revenue, in part, to increase funding for existing health care programs administered by the Department of Health Care Services (DHCS). Assembly Bill (AB) 120 (Chapter 22, Statutes of 2017) [2] added Item 4260-101-3305 to Section (§) 2.00 of the Budget Act of 2017 to appropriate Proposition 56 funds for SFY 2017-18, including a portion to be used for directed payments for dental services in dental managed care according to the DHCS developed payment methodology outlined below.

On February 21, 2018, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) pursuant to Title 42 Code of Federal Regulations (CFR) § 438.6(c)(2) [3] for this directed payment arrangement for SFY 2017-18. The requirements of this APL may be revised should changes be necessary to secure further CMS approvals applicable to this directed payment arrangement.

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[1] Proposition 56 text is available at: https://oag.ca.gov/sites/all/files/agweb/pdfs/tobacco/text-prop56.pdf
[2] AB 120 is available at: AB 120 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB120
[3] Title 42, Code of Federal Regulations section 438.6 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=52461dc6125be929877dd802df7504c2&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_16

POLICY:
Proposition 56 appropriated funds will result in directed payments by DMC plans to providers for certain dental services. Consistent with Title 42 CFR § 438.6(c)[4], DMC plans, and their delegated entities and subcontractors (as applicable), are required to make directed payments for qualifying services (as defined below) Current Dental Terminology (CDT) codes, which can be found on the DHCS Medi-Cal Dental website.[5] The amount of the directed payments vary by CDT code. The directed payments must be in addition to other payments that eligible network providers (as defined below) normally receive from DMC plans. The projected value of the directed payments will be accounted for in the DMC plans' actuarially certified risk-based capitation rates.

Eligible network providers are "network providers" (as defined in the DMC contract and Title 42 CFR § 438.2[6]) who are qualified to provide and bill for the CDT codes. DMC plans are responsible for ensuring qualifying services reported using the specified CDT codes are appropriate for the services being provided and reported to DHCS in encounter data pursuant DMC Contract, Exhibit A, Attachment 4 (Management Information System).

No later than June 30, 2018, and on a quarterly basis (no later than the last day of each calendar quarter) thereafter, DMC plans must begin reporting data on all directed payments made pursuant to this APL, either directly by the DMC plan or by the DMC plan's delegated entities and subcontractors at the DMC plan's direction, to DHCS. At a minimum, the data must include the Health Care Plan code, CDT code, service month, payor (i.e. DMC, or delegated entity, or subcontractor), and the provider National Provider Identifier. DHCS may require additional data as deemed necessary, and all reports must be submitted in a consumable file format (i.e. Excel or Comma Separated Values). Data must be submitted to the DMC deliverables inbox.

DMC plans must continue to submit encounter data for the specified CDT codes as required by DHCS; however, there are no new encounter data submission requirements associated with Proposition 56 directed payments.

DMC plans must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment of a Proposition 56 directed payments, as is already required in the DMC contract for other payments.

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[4] Ibid
[5] Current Dental Terminology (CDT) codes for Proposition 56 Supplemental Payments can be found at: http://www.dhcs.ca.gov/services/Documents/MDSD/Prop56Dental%20CodesforSupplementalPaymentsv2.pdf
[6] Title 42 CFR Section 438.2 can be found at: https://www.ecfr.gov/cgi-bin/text-idx?SID=52461dc6125be929877dd802df7504c2&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_12

DMC plans must have a process in place to communicate with providers about the payment process and must be approved by DHCS. The communication, at a minimum must include: how payments will be processed, how to request amounts owed, how to file a provider grievance, and how to determine who the payor will be.

DMC plans are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs. These requirements must be communicated by each DMC plan to all delegated entities and subcontractors.

If you have any questions regarding the information in this letter, please send an email to dmcdeliverables@dhcs.ca.gov.

Sincerely,

Originally signed by:

Alani Jackson, Division Chief
Medi-Cal Dental Services Division
Department of Health Care Services

Enclosure