PROPOSITION 56 DIRECTED PAYMENTS FOR DENTAL SERVICES (PY3, SFY 2019-20)
Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

Standard Questions for All Payment Arrangements

In accordance with §438.6(c)(2)(i), the following questions must be completed.

DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

State Fiscal Year (SFY) 2019-20: July 1, 2019 through June 30, 2020

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018):

July 1, 2019

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years):

Program Year 1 (PY 1, SFY 2017-18) through PY 5 (SFY 2021-22), contingent on appropriation of funds by the California Legislature for this purpose

STATE DIRECTED VALUE-BASED PURCHASING:

4. In accordance with §438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. *Check all that apply; if none are checked, proceed to Question 6.*

Not applicable

☐ Quality Payments / Pay for Performance (Category 2 APM, or similar)
☐ Bundled Payments / Episode-Based Payments (Category 3 APM, or similar)
☐ Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or similar)
☐ Multi-Payer Delivery System Reform
☐ Medicaid-Specific Delivery System Reform
☐ Performance Improvement Initiative
☐ Other Value-Based Purchasing Model

5. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services (the State may also provide an attachment). If "other" was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application's payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application.

Not applicable

STATE DIRECTED FEE SCHEDULES:

6. In accordance with §438.6(c)(1)(iii), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Check all that apply; if none are checked, proceed to Question 10.*

☐ Minimum Fee Schedule
☐ Maximum Fee Schedule
☒ Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

   ☐ The State is proposing to use an approved State plan fee schedule
   ☐ The State is proposing to use a Medicare fee schedule
   ☒ The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

The State does not concur with the characterization that this payment arrangement constitutes a fee schedule. Nonetheless, the state is providing an answer to this question based on the assumption that CMS is requiring an answer for Question 8 for uniform dollar increments under part 438.6(c)(1)(iii)(B).
This arrangement will direct Medi-Cal Dental Managed Care Plans (MCPs) to pay uniform and fixed dollar amount add-on payments, and uniform percentage increase payments, for specific services (see Question 12) to eligible network providers (see Question 11) based on the utilization and delivery of services for eligible enrollees (see Question 14.b) covered under the contract.

This time-limited directed payment arrangement has been developed pursuant to the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), a ballot proposition to increase the excise tax rate on cigarettes and other tobacco products for the purpose of funding certain State expenditures, including existing health care programs administered by the Department. The Budget Act of 2019 allocated a specified portion of Proposition 56 revenue to DHCS for use as the nonfederal share of Medi-Cal expenditures in SFY 2019-20, including the directed payment arrangement for dental services described herein. As currently proposed, this includes funds to be allocated for directed payments for dental services which include restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, and visits and diagnostic services.

The specified codes (see Question 12) were viewed to complement the Dental Transformation Initiative (DTI) under the Medi-Cal 2020 Waiver which targets 5.5 million child Medi-Cal beneficiaries ages twenty (20) and under. The DTI is a 5-year program, and focuses on 3 domains: 1) preventive services, 2) caries risk assessment and management, and 3) continuity of care. This directed payment proposal is viewed to complement the DTI by primarily targeting the services (non-preventive) not already targeted by the DTI.

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

   Not applicable

   ☐ In accordance with §438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract (the State may also provide an attachment).

Dental MCPs will be directed to pay to eligible network Dental Health Professionals (see Question 11) enhanced contracted payments that are uniformly adjusted by specified amounts or percentages (see Question 12). DHCS will contractually require Dental MCPs to pay these amounts via All-Plan Letter or similar instruction.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

Class of Providers
All network Dental Health Professionals rendering the services specified in Question 12, but excluding provider types within these categories that are subject to distinct reimbursement methodologies such as: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Tribal Health Clinics (IHS/MOA), and Cost-Based Reimbursement Clinics (CBRC), unless dental services are carved out of their all-inclusive rates.

12. In accordance with §438.6(c)(2)(i)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract (the State may also provide an attachment).

Type of Procedure	# of Specific CDT codes	Uniform Dollar Amount or Percent Increase
Restorative	35 CDT codes	40.0%
Endodontic	18 CDT codes	40.0%
Prosthetic	76 CDT codes	40.0%
Oral and Maxillofacial Surgery	111 CDT codes	40.0%
Adjunctives	15 CDT codes	40.0%
	2 CDT codes	60.0%
	1 CDT Code (D9220)	$148.65
	1 CDT Code (D9221)	$110.99
Visits and Diagnostics	5 CDT codes	20.0%
	1 CDT Code (D0120)	$30.00
	1 CDT Code (D0145)	$39.00
	1 CDT Code (D0150)	$41.00
	1 CDT Code (D0350)	$3.60
	1 CDT Code (D0230)	$1.05
Preventive	1 CDT Code (D1110)	$50.00
	1 CDT Code (D1206)	$12.00
	1 CDT Code (D1208)	$9.00
Orthodontics	10 CDT codes	40.0%
Periodontics	3 CDT codes	40.0%

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State's quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State's quality strategy):

http://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf

b. Date of quality strategy (month, year):

June 2018

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives		
Goal(s)	**Objective(s)**	**Quality strategy page**
• Enhance quality, including the patient care experience, in all DHCS programs	Deliver effective, efficient, affordable care	Medi-Cal Managed Care Quality Strategy Report, Page 6

d. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

The State will direct Dental MCPs to make the enhanced contracted payments to eligible network Dental Health Professionals for the specified procedure codes/types (see Question 12). These enhanced contracted payments will be in addition to the existing contracted payments eligible network Dental Health Professionals receive from Dental MCPs, and are expected to enhance quality, including the patient care experience by ensuring that Dental Health Professionals in California receive adequate payment to deliver effective, efficient, and affordable care.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

a. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

See Attachment 1

b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

California is proposing to implement these enhanced directed payments for certain dental managed care categories of aid. Subsets of enrollees or categories of aid may be excluded from the enhanced contracted payment arrangement as necessary for actuarial or other reasons.

c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

Not applicable

d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

Not applicable

REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:

15. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

☒ In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

☒ In accordance with §438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

Additional Questions for Value-Based Payment Arrangements

In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.

APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

16. In accordance with §438.6(c)(2)(ii)(A), describe how the payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

Not applicable

QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

TABLE 17(a): Payment Arrangement Provider Performance Measures					
Provider Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward/ Developer** (if State-developed measure, list State name)	**State Baseline** (if available)	**VBP Reporting Years***	**Notes****
1					
2					
3					
4					
5					
6					
If additional rows are required, please attach.					

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.
**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

Not applicable

REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:

18. Use the checkboxes below to make the following assurances:

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

Not applicable

☐ In accordance with §438.6(c)(2)(ii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

ATTACHMENT 1

438.6(c) Proposal – Uniform Dollar or Percent Increase for Dental Services
Evaluation Plan
Program Year 3: July 1, 2019 – June 30, 2020

Evaluation Purpose

The purpose of this evaluation is to determine if the proposed Directed Payments made through the California Department of Health Care Services' (DHCS) Medi-Cal Dental Managed Care (DMC) Program to dental network providers maintain or increase the dental utilization in the following three performance measures:

- Annual Dental Visit
- Preventive Dental Services Utilization
- Dental Treatment Services Utilization

The findings from this evaluation will be used to determine if the PY 3 Dental Directed Payments to dental network providers serve to maintain or improve utilization of dental services by Medi-Cal beneficiaries.

Stakeholders

- Dental Managed Care Plans (MCPs)
- Medi-Cal Children's Health Advisory Panel
- Medi-Cal Dental Advisory Committee

Evaluation Questions

This evaluation is designed to answer the following questions:

1. Do higher payments to dental providers, via the proposed PY 3 directed payments, maintain or improve the percent of Annual Dental Visits per State Fiscal Year (SFY)?

2. Do higher payments to dental providers, via the proposed PY 3 directed payments, maintain or improve the percent of Preventive Dental Services Utilization per SFY?

3. Do higher payments to dental providers, via the proposed PY 3 directed payments, maintain or improve the percent of Dental Treatment Services Utilization per SFY?

Evaluation Design

The state will collect and assess encounter data from the DMC delivery system. All encounter data utilization measures will have a baseline determined from data submitted in SFY 2016-17 (July 1, 2016 – June 30, 2017). Each subsequent program year will be compared to the baseline and to prior measurement years to determine if any changes have occurred in the encounter data with the target of maintaining or increasing the baseline during the measurement year.

DMC Encounter Data

The Medi-Cal DMC Program contracts with six Dental MCPs in Sacramento and Los Angeles counties. The Dental MCPs are tasked with housing all encounter data as well as adjudication. The Dental MCPs submit DMC encounter data to DHCS' Post-Adjudicated Claims and Encounters System (PACES) on a weekly basis and the PACES team ultimately submits the encounter data to the Management Information System/Decision Support System (MIS/DSS). DHCS calculates the dental utilization percentages using the encounter data for the DMC delivery system.

Dental Utilization Measures

Three Months Continuous Enrollment in One Dental MCP:

The data measures beneficiaries who were enrolled in the same DMC plan for at least three continuous months during the measurement year. For purposes of this evaluation, DHCS will be looking to compare DMC performance across state fiscal years.

1. Annual Dental Visit:

   Definition: Percentage of beneficiaries enrolled in Medi-Cal for three continuous months who had at least one (1) dental visit.

   Numerator: Number of beneficiaries enrolled in Medi-Cal for three continuous months who received any dental procedure (D0100-D9999).

   Denominator: Number of beneficiaries enrolled in Medi-Cal for three continuous months.

   Target: The target is to maintain the baseline (SFY 2016-17) or demonstrate higher utilization as an indicator of improved access/utilization and/or encounter data completeness.

2. Preventive Dental Services Utilization:

   Definition: Percentage of beneficiaries enrolled in Medi-Cal for three continuous months who received any preventive dental service.

   Numerator: Number of beneficiaries enrolled in Medi-Cal for three continuous months who received any preventive dental service (D1000-D1999).

   Denominator: Number of beneficiaries enrolled in Medi-Cal for three continuous months.

   Target: The target is to maintain the baseline (SFY 2016-17) or demonstrate higher utilization as an indicator of improved access/utilization and/or encounter data completeness.

3. Dental Treatment Services Utilization:

   Definition: Percentage of beneficiaries enrolled in Medi-Cal for three continuous months who received any dental treatment service.

Numerator: Number of beneficiaries enrolled in Medi-Cal for three continuous months who received any dental treatment service (D2000-D9999).

Denominator: Number of beneficiaries enrolled in Medi-Cal for three continuous months.

Target: The target is to maintain the baseline (SFY 2016-17) or demonstrate higher utilization as an indicator of improved access/utilization and/or encounter data completeness.

Baseline and Benchmark:

Specific to PY 3 directed payments to dental providers, the first and second measurement years will be SFY 2017-18 and SFY 2018-19, and the baseline year will be SFY 2016-17. DHCS will compare the PY 3 performance to the baseline year and prior measurement years to identify any changes in utilization patterns, with the target of maintaining or increasing the baseline number of Outpatient Visits per 1000 Member Months during the measurement year, as adjusted for changes to volume of encounter data submission by Dental MCPs and providers, in response to the design of the directed payment program. DHCS will stratify the measures by Children (Age 0-20) and Adults (Age 21 and above).

Medi-Cal Dental Utilization - DMC - Baseline			
July 2016 – June 2017	**Children <21**	**Adults 21+**	**All Ages**
Three Months Continuous Eligibility*	473,740	622,675	1,096,415
Any Dental Services Users	188,888	117,960	306,848
Annual Dental Visit %	39.87%	18.94%	27.99%
Preventive Dental Services Users	161,099	46,438	207,537
Preventive Dental Services Utilization %	34.01%	7.46%	18.93%
Dental Treatment Users	92,952	69,554	162,506
Dental Treatment Utilization %	19.62%	11.17%	14.82%

*Beneficiaries who were enrolled in the same dental plan for at least three continuous months during the measurement year

**MIS/DSS as of October 2018

Data Collection Methods

All necessary data for performance measurement will be extracted from DHCS' PACES and MIS/DSS. To conduct measurement of Annual Dental Visits, Preventive Dental Services Utilization, and Dental Treatment Services Utilization, DHCS will rely on encounter data submitted by Dental MCPs. DHCS will conduct its analysis on 100% of the data received.

Timeline

All data necessary for performance measurement will be extracted after a sufficient lag period. A sufficient lag period should be no less than six months.

The performance measurements will be calculated no sooner than six months after the close of the measurement year to allow for sufficient lag period, with a report being completed within six months of the data pull.

Communication and Reporting

The results will be shared with the stakeholders listed above and a report will be shared with CMS. Annual reports will also be posted on the State's directed payment website.