Domain 1: Increase Preventive Services Utilization

Domain Goal

The goal of Domain 1 is to increase the statewide utilization of preventive services by at least ten (10) percentage points over the five (5) year Waiver 2020 period for Medi-Cal beneficiaries ages one (1) through twenty (20), as aligned with the Centers for Medicare and Medicaid Services (CMS) Oral Health Initiative.

Who can participate in this Domain?

- **Providers:** Statewide, all enrolled Medi-Cal Dental providers, in the statewide Medi-Cal Dental Fee-For-Service (FFS) delivery system including Safety Net Clinics (e.g., Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Services/Memorandum of Agreement Clinics (community health centers)), and in the Dental Managed Care (DMC) delivery system in Sacramento and Los Angeles counties, may participate in this Domain. Enrolled FFS Medi-Cal Dental providers and DMC providers are not required to take any action to participate in this Domain while SNC providers are required to complete an opt in form. The SNC opt-in form and instruction is available on the DTI webpage. All participating providers must be able to submit claims data or encounter data to the dental fiscal intermediary (DXC) using specific Current Dental Terminology (CDT) code information in order to qualify for an incentive payment.

- **Beneficiaries:** Medi-Cal beneficiaries ages one (1) through twenty (20) who are eligible for full scope Medi-Cal.

How is data collected for this Domain?

Aggregate data for this Domain is collected through Medi-Cal Dental claims data submitted by enrolled FFS Medi-Cal Dental providers, Safety Net Clinics and DMC. Statewide and county baseline data and information regarding enrolled FFS and DMC providers will also be used.

Where will this Domain be implemented?

The Domain will be implemented statewide across all counties and delivery systems. Domain 1 will apply to both the Fee-For-Service and DMC delivery systems.

What is the frequency of payment and who will the incentive be paid to?

The incentive payments are paid on a semi-annual basis to service office locations that meet or exceed a predetermined increase in preventive services to additional Medi-Cal beneficiaries. Service office locations are eligible to earn full incentive payments at 75% above the Schedule of Maximum Allowances (SMA) or partial incentive payments at 37.5% above the SMA reflecting achievement of a 1 to 1.99 percentage point increase if the benchmark is partially met. To the extent that the projected funding limit is reached for this Domain, a pro-rata share payment

amount will be determined based on remaining funds. The incentive amounts at 37.5% or 75% above the current SMA for each preventive service for children is as follows:

Table 1 Preventive Service by CDT Category Code (All current applicable procedure codes)

Procedure Code	Code Description	Frequency limitations per year	Current SMA	37.5% Above SMA	75% Above SMA
D1120	Prophylaxis	2 (once every 6 months)	$30.00	$11.25	$22.50
D1206	Topical application of fluoride varnish - child 0 to 5	2 (once every 6 months)	$18.00	$6.75	$13.50
D1206	Topical application of fluoride varnish – child 6-20	2 (once every 6 months)	$8.00	$3.00	$6.00
D1208	Topical application of fluoride - child 0-5	2 (once every 6 months)	$18.00	$6.75	$13.50
D1208	Topical application of fluoride – child 6-20	2 (once every 6 months)	$8.00	$3.00	$6.00
D1351	Sealant – per tooth	8 per year (once every 1 tooth per 36 months)	$22.00	$8.25	$16.50
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	8 per year (once every 1 tooth per 36 months)	$22.00	$8.25	$16.50
D1510	Space maintainer-fixed – unilateral	4 (once per quadrant)	$120.00	$45.00	$90.00
D1516	Space maintainer - fixed – bilateral, maxillary	Once per arch replacements are considered (for lost or non-repairable) with documentation	$200.00	$75.00	$150.00
D1517	Space maintainer - fixed – bilateral, mandibular	Once per arch replacements are considered (for lost or	$200.00	$75.00	$150.00

		non-repairable) with documentation			
D1526	Space maintainer - removable – bilateral, maxillary	Once per arch replacements are considered (for lost or non-repairable) with documentation	$230.00	$86.25	$172.50
D1527	Space maintainer - removable – bilateral, mandibular	Once per arch replacements are considered (for lost or non-repairable) with documentation	$230.00	$86.25	$172.50
D1550	Re-cementation of space maintainer	4 - per provider	$30.00	$11.25	$22.50
D1555	Removal of fixed space maintainer	4 - per provider	$30.00	$11.25	$22.50
D1575	Distal shoe space maintainer- fixed- unilateral	Once per quadrant BUT replacements are considered (for lost or non-repairable) with documentation	$120.00	$45.00	$90.00

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How will the incentive be calculated?

Incentive payments will be based on the performance of service office locations that meet or exceed the department's predetermined benchmark during the measurement period. This benchmark is calculated based on the service office location's delivery of preventive services to Medi-Cal beneficiaries' data during the baseline calendar year (CY) 2014. If a provider enters Domain 1 in a subsequent year with no 2014 data and more than a two (2) year gap in services rendered to Medi-Cal beneficiaries, they will receive a benchmark specific to their county of operation. If a provider enters Domain 1 in subsequent year with 2014 data or less than a two (2) year gap in services rendered to Medi-Cal beneficiaries, the provider will be assigned benchmarks based off their previous data.

Once the 2% benchmark is met, the service office location will be paid 75% above the current SMA for each preventive service provided to each beneficiary the eligible services are rendered to, after meeting the benchmark. If the benchmark is not met, but preventive service utilization increases by 1.00 - 1.99%, service office locations will be paid 37.5% above SMA for each preventive service provided to each beneficiary the eligible services are rendered to, after meeting the benchmark.

Example:

Provider A # of eligible services for next payment: 20 [Assume all 20 services rendered are D1510 with current Schedule of Maximum Allowance (SMA) rate of $120]

Baseline: 0

Benchmark (county) 1%: 5 @ 37.5% SMA

Benchmark (county) 2%: 10 @ 75% SMA

Provider A # of eligible services for next payment after recalculation:
30 Benchmark after recalculation (county) 1%: 3 @ 37.5% SMA
Benchmark after recalculation (county) 2%: 5 @ 75% SMA

Example 1: Full Incentive Payment Meeting or Exceeding the 2% Benchmark

Previous payment calculation methodology –

Provider A Incentive Payment = ∑ [(# of eligible procedures performed above **provider baseline** *Domain One procedure code)* x (Current SMA *Corresponding procedure code SMA* x (37.5% **or** 75%)] Provider A Incentive Payment = [(20-0) x $120(0.75)] = $2400

New payment calculation methodology -

Provider A Incentive Payment = ∑ [(# of eligible procedures performed **above provider partial benchmark** *Domain One procedure code*) x (Current SMA *Corresponding procedure code SMA* x 75%)] Provider A Incentive Payment = [(30-3) x $120(0.75)] = $3040

New Service Office Locations

In the event a new dental service office location enrolls in the Medi-Cal Dental Program, through FFS, DMC, or Safety Net Clinics, that service office location will not have an established benchmark as described above. In this instance, these locations will be subject to the State's pre- determined benchmark based on their county. The department's pre-determined number will be derived from the county's proportional expected contribution to the statewide utilization increase of existing service office locations. The new service office location's pre-determined number will be the average number of additional beneficiaries among all of the existing service office locations in the county necessary to increase the statewide goal of 2%. In the subsequent demonstration year, the department will re-evaluate the service office location and establish a benchmark using the same methodology as described above for existing service office locations.

A reassessment of this Domain and the applicable benchmarks will take place between years two and three in order to evaluate program effectiveness, increases in preventive services, adjustments for population growth or decline throughout the state, and other factors as may be appropriate.

Domain 1 Examples of Increases in Benchmark

Service Office Locations	Baseline Figures - Beneficiaries	Total Beneficiaries Necessary for Each Service Office to Achieve Benchmark Year 1 (2 Percentage Points Increase)	Total Beneficiaries Necessary for Each Service Office to Achieve Benchmark Year 2 (2 Percentage Points Increase Above Year 1)
Office 1	1000	1,020	1,040
Office 2	400	408	416
Office 3	600	612	624
Office 4	200	204	208
Office 5	800	816	832
Total	3000	3,060	3,120

Program Year (PY) 3 - 5 (2018 - 2020) Rebaselining Methodology

A provider's baseline is defined as the number of unduplicated Medi-Cal beneficiaries, ages one (1) through twenty (20), that received Domain 1 qualifying services in a specified baseline calendar year. For the first program year that a provider is eligible for Domain 1 with a baseline, their partial benchmark is a 1% increase in their baseline and their full benchmark is a 2% increase in their baseline. For each following Domain 1 eligible year, a provider's partial benchmark increases an

additional 1% from the prior eligible year and their full benchmark increases an additional 2% from their prior eligible year.

Medi-Cal Dental billing providers who were enrolled in Medi-Cal in PY 1 (2016) or prior received baselines based on their service office location data from calendar year 2014. For those providers who had no data from calendar year 2014 to establish a baseline, the provider was assigned the state's pre-determined county benchmark for the program year based on the county the service office is located in for PY1 (2016).

Medi-Cal Dental billing providers who were enrolled in Medi-Cal in PY 2 (2017) or later were assigned the state's pre-determined county benchmarks for the program year based on their service office location for the first PY that they were enrolled. The one exception to this is Safety Net Clinics (SNC) who have not yet opted into Domain 1. If the SNC chooses to opt in at a later time, they are assigned a baseline based on their data from two years prior to the program year they opted in for. For example, if an SNC opted in PY 2, the SNC data from calendar year 2015 is evaluated to determine a baseline. If no baseline can be established this way, then the SNC is assigned the county benchmark.

As a result of the recalculation, starting with PY 3 the following occurred:

1) Providers who had received a baseline in PY 1 keep their original baseline and each new PY, their benchmarks increase by an additional 1% for the partial benchmark and an additional 2% for the full benchmark from their prior eligible PY.
2) For providers who received county benchmarks:
    a. If a provider was enrolled starting at least two years prior to the current PY, then the provider will be assigned a baseline based on their data from the calendar year two years prior to the current PY. If no baseline can be established this way, then the provider will be assigned the county benchmarks for the current PY. The Department will reevaluate the provider's baseline in the next PY. For example, if the current PY is PY 3 (2018), only those providers who were enrolled in 2016 or prior with a county benchmark would be evaluated to determine if a baseline could be assigned. The 2016 data would be evaluated to determine if a service office location specific baseline and benchmark could be established.
    b. If a provider was enrolled less than two years prior to the current PY, then the provider will be assigned the county benchmark for the current PY.

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What are the Performance Metrics?

The performance metrics for analyzing the success of this Domain will be based on claims data demonstrating an increase in preventive services provided to Medi-Cal beneficiaries ages one (1) through twenty (20) who are continuously enrolled for at least ninety (90) days during the measurement periods. Additionally, claims and provider enrollment data will be analyzed to determine the number of service office locations in each county that are providing preventive dental services to Medi-Cal beneficiaries, compared to the number of service office locations in the baseline year. Finally, the number and percentage of change in Medicaid participating dentists providing preventive dental services to at least ten (10) Medicaid-enrolled children in the baseline year will be measured each year.

Although the performance metrics for analyzing success and reporting purposes to the CMS is based on the CMS-416[1] methodology using the ninety (90) day continuous eligibility parameters, incentives will be paid based on unrestricted eligibility parameters[2] for beneficiaries receiving preventive services once a service office location has met their predetermined increase. Therefore, preventive service utilization of children regardless of the number of months they are enrolled in Medi-Cal will be used to set the thresholds per service office location.

1) The first metric that will be used for monitoring Domain success is the percentage of beneficiaries who received any preventive dental service during the measurement period, which is calculated as follows:
    - Numerator: Number of unduplicated beneficiaries ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days who received any Medi-Cal covered preventive dental service in the measurement period.
    - Denominator: Number of all unduplicated children ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days during the measurement period.

2) The second metric that will be used is claims data to determine the number of service office locations in each county that are providing preventive dental services to Medi-Cal beneficiaries ages one (1) through twenty (20), compared to the number of these locations in the baseline year.

3) The third metric will track statewide the number and percentage of change of Medicaid participating dentists providing preventive dental services to at least ten (10) Medicaid-enrolled children in the baseline year, and in each subsequent measurement year.

[1] The CMS-416 is the annual federal report of Early and Periodic Screening, Diagnostic, and Treatment services provided to Medicaid children. More information can be found at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

[2] Individuals enrolled in Medi-Cal using certified eligibility regardless of share of cost, scope, or continuous months enrolled.

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The performance measures will be reported using ninety (90) day continuous eligibility.

How was the cost of Domain 1 calculated?

The costing methodology for this Domain is based upon CY 2014 data including: The total number of unrestricted Medi-Cal beneficiaries, the total current number of preventive service recipients in FFS and DMC, and the total number of services delineated in Table 1. Frequency was first established for the total number of each of the eleven (11) qualifying services and dividing the number of services by the total number of beneficiaries that received a preventive service. Table 2 illustrates the percentage of service use by the total number of unduplicated beneficiaries that received each of the preventive services.

Table 2: Percentage of Preventive Service Use in CY 2014

Preventive Service Procedure Code	Code Description	Frequency Limitations Per Year	Current Schedule of Maximum Allowances (SMA)	75% Above SMA	Unduplicated Preventive Service Users	CY14 Total Services Utilized	CY 2014 Percentage of Use out of Total Unduplicated Users
D1120	Prophylaxis	2 (once every 6 months)	$30.00	$22.50	2,226,678	3,067,985	137.78%
D1206*	Topical application of fluoride varnish - child 0 to 5, 6 to 20*	2 (once every 6 months)	$13.00	$9.75	2,226,678	458,807	20.61%
D1208*	Topical application of fluoride - child 0- 5, 6-20	2 (once every 6 months)	$13.00	$9.75	2,226,678	1,331,573	59.80%
D1351	Sealant – per tooth	8 per year (once every 1 tooth per 36 months)	$22.00	$16.50	2,226,678	1,941,727	87.20%
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	8 per year (once every 1 tooth per 36 months)	$22.00	$16.50	2,226,678	8,200	0.37%

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Preventive Service Procedure Code	Code Description	Frequency Limitations Per Year	Current Schedule of Maximum Allowances (SMA)	75% Above SMA	Unduplicated Preventive Service Users	CY14 Total Services Utilized	CY 2014 Percentage of Use out of Total Unduplicated Users
D1510	Space maintainer-fixed – unilateral	4 (once per quadrant)	$120.00	$90.00	2,226,678	70,085	3.15%
D1515	Space maintainer-fixed – bilateral	2 (once per arch)	$200.00	$150.00	2,226,678	10,493	0.47%
D1520	Space maintainer-removable – unilateral	4 (once per quadrant)	$230.00	$172.50	2,226,678	818	0.04%
D1525	Space maintainer-removable – bilateral	2 (once per arch)	$230.00	$172.50	2,226,678	321	0.01%
D1550	Re-cementation of space maintainer	4 - per provider	$30.00	$22.50	2,226,678	4,008	0.18%
D1555	Removal of fixed space maintainer	4 - per provider	$30.00	$22.50	2,226,678	7,325	0.33%

***For preventive services D1206 and D1208, the average between the SMA for children ages 1 to 5 ($18.00) and children ages 6-20 ($8.00) was used since the total services for each procedure code encompassed data for ages 1-20.**

The incentive payment metrics are based on beneficiaries using unrestricted eligibility comprised of all Medi-Cal beneficiaries' ages one (1) through twenty (20) in the eligible population regardless of their continuous eligibility status. Subsequently, a two percentage points increase

in beneficiaries' preventive services is multiplied by 75% SMA for each applicable CDT category code to arrive at the total incentive cost per category. This process is repeated for each subsequent year.

The baseline methodology for this Domain establishes the total number of beneficiaries required to increase preventive services by two percentage points each year of the demonstration, or at least 10 percentage points over a 5-year period.

To calculate estimated costs per year, the totals for each procedure code were summed for the given year to provide an estimate cost per year. Table 3 illustrates estimated incentive payments each year of the demonstration. The total cost for Domain 1 is as follows in Table 3:

Table 3: Cost Estimates for Domain 1

Year	2% Incentive	3% Incentive
CY 2016	$28,909,453	$36,428,529
CY 2017	$32,545,798	$42,203,401
CY 2018	$44,433,990	$58,282,898
CY 2019	$56,816,881	$75,060,623
CY 2020	$31,567,065	$41,813,550
Total	**$194,273,186**	**$253,789,001**