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May 06, 2024

Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2024-07

Applicable to the **2018-2024 SMMC contract benefits** for:
- ☐ Managed Medical Assistance (MMA) and MMA Specialty
- ☐ Long-Term Care (LTC)
- ☒ Dental

Re: Dental Provider Incentive Program (DPIP) Requirements

The Agency designed the DPIP with the goal of improving oral health in Medicaid recipients by making it easier for parents and patients to find high-quality dentists for their care and by significantly increasing the value of payments to dentists accountable to high-quality performance measures. The DPIP was implemented on October 1, 2023, for specific preventive and diagnostic dental services provided to children under the age of twenty-one (21) years. The select number of included dental services are directly linked with five (5) of the Agency's highest priority oral health quality measures. All SMMC dental plans are required to participate. The purpose of this policy transmittal is to provide requirements for the dental plan in its implementation of the DPIP.

The dental plan shall implement an incentive program wherein payment rates for eligible dental providers who meet certain qualifying criteria, as established by the Agency, are equivalent to 140% of the Florida Medicaid fee-for-service rate for the services listed in the "Payment Structure" section, provided to enrollees under the age of twenty-one (21) years. The dental plan is required to implement the Agency's DPIP model and qualifying criteria in all regions in which the dental plan is providing services.

Eligible Providers
Providers eligible to qualify for the DPIP are listed below:

(1) General Dentists – Type 35
(2) Pediatric Dentists – Type 35

Excluded Providers
Excluded providers are providers who would otherwise be included in the definition of Eligible Providers except for their specific exclusion. The following providers are excluded from the DPIP:

(1) Non-Participating Providers – Dental providers without a contractual arrangement with the plan to offer DPIP-Included Services.

(2) Federally Qualified Health Centers (FQHCs) – Services provided in an FQHC, regardless of whether or not the service is billed by the FQHC as an FQHC service or by the rendering dental provider using their own Medicaid ID.

(3) Rural Health Clinics (RHCs) – Services provided in an RHC, regardless of whether or not the service is billed by the RHC as an RHC service or by the rendering dental provider using their own Medicaid ID.

(4) County Health Departments (CHDs) – Services provided in a CHD, regardless of whether or not the service is billed by the CHD as a CHD service or by the rendering dental provider using their own Medicaid ID.

(5) Faculty Plans of Florida Dental School Faculty Physician Groups – Services provided in this faculty plan may not be included in the DPIP, regardless of whether or not the service is billed by the Dental School Faculty Physician Groups as a plan service or by the rendering dental provider using their own Medicaid ID.

Qualified Providers

A Qualified Provider is an Eligible Provider who has met all the DPIP Qualifying Criteria.

Eligible Providers must have an opportunity to earn the DPIP incentive.

The dental plan is responsible for tracking the qualified status of its providers and is required to maintain and continuously update the Provider Network Verification (PNV) files with the appropriate indicators, as defined and directed by the Agency, to identify those providers who qualify for the DPIP. Additionally, the dental plan is responsible for ensuring that the provider contracts with dentists who meet the qualifying criteria, are amended and executed with any updated qualification and payment information prior to the implementation of the DPIP.

Program Requirements

For the DPIP, any Eligible Provider who has met the following qualifications is considered a Qualified Provider and must receive the DPIP incentive payment.

To qualify for DPIP for the October 1, 2023 – September 30, 2024, contract year, a dental provider must achieve or exceed the benchmarks for each of the following metrics. Dental Quality Alliance (DQA) measures must be calculated using DQA 2023 specifications for CY 2022 services. Child Core Set measures must be calculated using the most recent technical specifications posted at: Child Core Set Reporting Resources | Medicaid.			
Metric	**Measurement Period**	**Incentive Threshold Rate**	**Metric Description**
Preventive Dental Services	10/1/2021-09/30/2022	65%	Percentage of children ages 1 to 20 who are eligible for and enrolled in the plan for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the measurement period.
Child Core Set: Oral Evaluation – Total	1/1/2022-12/31/2022	65%	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.

DQA: Caries Risk Assessment – Total	1/1/2022-12/31/2022	70%	Percentage of enrolled children under age 21 years who have caries risk documented in the reporting year.
Child Core Set: Sealant Receipt on Permanent 1st Molars – at least one	1/1/2022-12/31/2022	60%	Percentage of enrolled children who have ever received sealants on permanent first molar teeth: (1) at least one sealant
Child Core Set: Topical Fluoride for Children (Total)	1/1/2022-12/31/2022	65%	Percentage of children aged 1-21 years who received at least 2 topical fluoride applications within the reporting year.

The Agency reserves the right, in its sole discretion, to modify the DPIP qualifying criteria to establish a panel size requirement in addition to the DPIP metrics.

For a provider to qualify for DPIP for the October 1, 2024 – September 30, 2025, contract year, the provider must achieve or exceed the benchmarks for each of the above metrics, for the 10/1/2022 – 9/30/2023 and 1/1/2023 – 12/31/2023 measurement periods, as applicable for each metric. Dental Quality Alliance (DQA) measures must be calculated using DQA 2024 specifications for CY 2023 services. Child Core Set measures must be calculated using the most recent technical specifications posted at: Child Core Set Reporting Resources | Medicaid.

Payment Structure

Payment to a Qualified Provider for Included Services must be equivalent to 140% of the Florida Medicaid fee-for-service (FFS) rate that was in effect as of October 1, 2023, as calculated in the table below. Payments to Qualified Providers may be made either through a capitated arrangement or on a fee-for-service arrangement, as defined by the dental plan and outlined in the provider agreement. For the Agency-specified preventive and diagnostic dental procedure codes included in the DPIP, the following rates must be used for enhanced payments:

Procedure Code	**Description**	**FFY 2023-2024 DPIP Rate**
D1330	Oral Hygiene Instruction	$12.54
D1120	Prophylaxis - Child	$29.26
D1208	Topical application of fluoride – excluding varnish	$22.99
D1351	Sealant – Per tooth	$27.17
D1206	Topical application of fluoride varnish	$22.99
D1999	Unspecified preventive procedure, by report	$20.63

Procedure Code	Description	FFY 2023-2024 DPIP Rate
D0120	Periodic oral evaluation – established patient	$31.35
D0150	Comprehensive oral evaluation – new or established patient	$33.43
D1354	Interim caries arresting medication application. Silver Diamine Fluoride	$9.06
D0145	Oral evaluation for a patient under three years of age and counseling with a primary caregiver	$33.43

The Agency reserves the right to modify the list of preventive and diagnostic dental procedure codes for enhanced payments under the DPIP.

The dental plan is required to evaluate whether a DPIP Qualified Provider was paid equal to or greater than the DPIP fee schedule amount using the following guiding principles in its rate calculation methodology:

Step 1: The dental plan shall calculate the dentist's total compensation for included services provided to eligible enrollees for the time period (e.g., October 1, 2023 – September 30, 2024), including all of the following: fee-for-service payments, capitation payments, case management fees, incentive payments, shared savings payments (upside), and shared risk payments (upside or downside).

Step 2: The dental plan shall calculate the dentist's compensation if they were paid at the DPIP fee schedule rate for included services that were provided to an eligible enrollee, including:

- For services that the dentist was paid under a fee-for-service arrangement, reprice all FFS claims at the DPIP fee schedule amount.

- For services that the dentist was paid under a sub-capitated arrangement, reprice all encounter claims at the DPIP fee schedule amount.

Step 3: The Managed Care Plan shall compare the results of Step 1 and 2. The dentist is deemed to be paid equal to or greater than the DPIP rate if the sum of all payments under Step 1 is equal to or greater than the sum of all payments under Step 2.

Included Services

Included Services are those services for which a Qualified Provider will receive an enhanced payment under the DPIP. Included DPIP services include covered dental services rendered to recipients under twenty-one (21) years of age, utilizing the following preventive and diagnostic dental procedure codes:

Procedure Code	Description	Service Category
D1330	Oral Hygiene Instruction	Preventive
D1120	Prophylaxis - Child	Preventive
D1208	Topical application of fluoride – excluding varnish	Preventive
D1351	Sealant – Per tooth	Preventive
D1206	Topical application of fluoride varnish	Preventive
D1999	Unspecified preventive procedure, by report	Preventive
D0120	Periodic oral evaluation – established patient	Diagnostic
D0150	Comprehensive oral evaluation – new or established patient	Diagnostic
D1354	Interim caries arresting medication application. Silver Diamine Fluoride	Preventive
D0145	Oral evaluation for a patient under three years of age and counseling with a primary caregiver	Diagnostic

Plan Reporting Requirements

The dental plan must comply with the Managed Care Plan Report Guide in submitting required reports, including the report formats, templates, instructions, data specifications, submission timetables and locations, and other materials contained in the guide. The Managed Care Plan Report Guide is posted on the Agency's website. (Dental: Attachment II, Section XVI.A.1.c.). The dental plan is required to submit the following reports to provide DPIP payment data to the Agency, using the Report Guide file naming conventions:

1. Estimated Value of Enhanced Reimbursement (EVER) – The purpose of this report is to provide the Agency with information regarding the estimated value of the plan's DPIP. The report is designed to capture estimates at the individual Qualified Provider level. The EVER report template is attached to this policy transmittal. The EVER report for the October 1, 2023 – September 30, 2024, program year is due to the Agency sixty (60) days after the date of this policy transmittal or **July 5, 2024**. Subsequent submissions for each program year will be due by November 1. The report number for this report is 0198, and it should be submitted in the plan's report folder for the EVER report [SMMC_CY18-24 FTP/Plan/Reports/Estimated Value of Enhanced Reimbursement (EVER)].

2. Actual Value of Enhanced Payment (AVEP) - The purpose of this report is to provide the Agency with semi-annual reports detailing payments incurred by the dental plans' Qualified Providers, and the number of unduplicated enrollees served by Qualified Providers with enhanced payments. The AVEP report template is attached to this policy transmittal. The first AVEP report submission will be due to the Agency sixty (60) days after the date of this policy transmittal or **July 5, 2024**, for the October 1, 2023 – March 31, 2024, time period. The second AVEP report submission will be due to the Agency on

December 15, 2024, for the April 1, 2024 – September 30, 2024 period. The report number for this report is 0194, and it should be submitted in the plan's report folder for the AVEP report [SMMC_CY18-24 FTP/Plan/Reports/Actual Value of Enhanced Payment (AVEP)].

3. DPIP Metrics Report - The Agency is developing an annual report submission to evaluate the performance metrics of DPIP Qualified Providers receiving enhanced payments. As part of this annual DPIP report, the dental plan will be required to submit information for all general and pediatric dentists contracted in their network, including each dentist's panel size and the dentist's performance for each of the metrics included within the Agency DPIP model. The Bureau of Medicaid Quality will issue a new policy transmittal with additional information and a template for the DPIP metrics report.

Provider Communications

The dental plan must develop the following provider communications to ensure information about the DPIP is distributed to Identified and Qualified Providers:

(1) General Announcement Letter – This letter must inform dental providers of the initial implementation of the DPIP, notify providers that they have been identified as one of the provider types eligible to qualify for the DPIP, and include detailed information regarding how to achieve Qualified Provider status.

(2) Qualified Provider Letter – This letter must inform Qualified Providers how they have met the criteria to be considered a Qualified Provider under the DPIP.

(3) The dental plan must update and submit to the Agency the General Announcement Letter Template attached to this policy transmittal. The plan's updates to the Letter Templates must include the plan's letterhead, contact information, and plan-specific instructions for providers to monitor their progress in the DPIP. The dental plan must submit the updated General Announcement Letter Template to their Agency contract manager twenty-one (21) days after the date of this policy transmittal or **May 27, 2024**.

Should you have questions, please contact your Agency contract manager.

Sincerely,

Austin Noll
Deputy Secretary
Medicaid Policy, Quality, and Operations

AN/jp
Attachment 1: DPIP General Announcement Letter Template CY 25-26
Attachment 2: DPIP Estimated Value of Enhanced Reimbursement (EVER) Report Template
Attachment 3: DPIP Actual Value of Enhanced Payment (AVEP) Report Template