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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

FILED
12/20/2018 5:24 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

DMAP 111-2018

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: The "Incentive" for Oral Health Prevention Fee-for-Service Program

EFFECTIVE DATE: 01/01/2019 THROUGH 06/29/2019

AGENCY APPROVED DATE: 12/20/2018

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NEED FOR THE RULE(S):

The adoption of OAR 410-123-1245 implements and provides FFS dental Medicaid guidance regarding The "Incentive" for Oral Health Prevention Fee-for-Service Program. With this implementation, this program marks the first effort in the provision of value-based FFS dental services.

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to public interest, to the interest of OHP clients, the Division, and providers. The Division needs to adopt this rule promptly so that dental providers understand the criteria and parameters of the incentive program

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

State Plan Amendment (SPA) #: 18-0006, SPA analyst (HSD)

ADOPT: 410-123-1245

RULE TITLE: The "Incentive" for Oral Health Prevention Fee-for-Service Program

RULE SUMMARY: The adoption of OAR 410-123-1245 implements and provides FFS dental Medicaid guidance The "Incentive" for Oral Health Prevention Fee-for-Service Program. With this implementation, this program marks the first effort in the provision of value based FFS dental services. This rule needs to be adopted promptly so that dental providers understand the criteria and parameters of the incentive program.

RULE TEXT:

(1) Beginning January 1, 2019, qualifying fee-for-service dental and Indian/Tribal/Urban (I/T/U) providers are eligible to participate in the performance supplemental Medicaid payments program through The "Incentive" for Oral Health Prevention Fee-for-Service Program. Supplemental payments are achieved through the provision of preventive services to new Medicaid dental clients.

(2) "Qualifying Dental Provider" means a dentist, I/T/U health clinic, or dentist working for an I/T/U health clinic, currently or newly enrolled as a Medicaid provider in an individual office, facility, institution, corporate entity, or other

organization that supplies health services or items, also termed a rendering provider; or who bills, obligates, and receives reimbursement on behalf of the rendering provider of services, also termed a billing provider (BP).
(3) "New Medicaid Dental Client" means any adult or child client enrolled in the Medicaid program and has not received dental services through Medicaid resources in the prior two years.
(4) New and existing qualifying dental providers shall be eligible for performance supplemental payments.
(5) Access Tier 1: Qualifying dental billing providers accepting a minimum of five new Medicaid clients, and who render at least one preventive service to those clients, between January 1, 2019, and June 30, 2020, shall receive a supplemental payment of $200 for the one preventive dental service rendered to each of the five clients for a total of $1,000 as an enhanced payment.
(6) Access Tier 2: Qualifying dental billing providers accepting an additional 20 new Medicaid clients, for a total of 25 new clients, and who render at least one preventive service to those clients, between January 1, 2019, through June 30, 2020, shall receive a supplemental payment of $50 for the one preventive dental benefit rendered to each of the additional twenty new clients for a total of an additional $1000.
(7) Dental billing providers qualifying for the supplemental performance payment in Access Tiers 1 and 2 shall be identified through an internal Authority reporting process. No supplemental reporting is required by the provider. The Authority claims data captures new clients by Medicaid ID with the dates of service for preventive services after January 1, 2019.
(8) Quality Tier 3: Qualifying dental billing provider locations defined and meeting a set benchmark of preventive service utilization for the practice, specified in (8)(a), are eligible for a supplemental payment of $1,000:
(a) The Authority shall set the Tier 3 benchmarks as follows:
(A) For existing providers, all preventive services claims shall be pulled for CY 2017. The benchmark claims data count is the average number of claims per month for CY 2017;
(B) For new providers, the baseline is set at the first month of preventive service utilization;
(C) If the calculated baseline for existing or new providers is less than three, the baseline is set to three.
(b) Tier 3 calculations:
(A) All preventive service claims shall be pulled for the reporting month;
(B) All billing providers with a 10 percent increase in preventive service claims in the reporting month compared to the benchmark claims data count shall qualify for a supplemental incentive payment. The provider location may qualify for more than one supplemental payment for Tier 3.
(9) Supplemental Payment Dispersal: An internal Authority report identifying those providers who qualify for the Tier 3 supplemental payment is run after the first Monday of the month, three months after the end of the month in which services occurred. This delay accounts for the lag in claims reporting time. Incentive payments are issued within 30 days of the report out. (For example, for January services, the report is run after the first Monday in May, and payments shall be issued by early June.) Payments are made to billing providers, as identified by Medicaid ID.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065