DENTAL DIRECTED PAYMENT GUIDANCE

The Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR § 438.6(c) govern how states may direct plan expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts. For Contract Year 2025 (CY25),[1] the Oregon Health Authority (OHA) has implemented three dental directed payments (DDPs) for coordinated care organizations (CCOs) that further the goals and priorities of the Agency, as follows:

The DDPs apply to the CY25 Medicaid, Non-Medicaid,[2] and OHP Bridge-Basic Health Program Contracts, with some differences as noted in this document. This document provides guidance on policy, operational, and rate-setting considerations for each of the DDPs.

In the CY25 Medicaid Contract, which is the primary CCO contract, these payments are referred to as “Qualified Directed Payments (QDPs) within CCO Payment Rates” and covered in Exh. C, Sec. 1, Para. d, Sub.Para. (2).

The bundled DDPs in Section 1 below apply the same across all three CY25 contracts. The bundled DDP requirements in the Medicaid Contract are incorporated by reference in both of the other contracts in Exh. C, Sec. 1, Para. d, Sub.Para. (1), Sub-Sub.Para. (e).

[1] The CCO Contract Year is the same as the calendar year.
[2] The Non-Medicaid Contract covers most services for most Members eligible for the Oregon Health Plan (OHP) through the Healthier Oregon Program (HOP) and all dental services for OHP Members eligible for the COFA Dental Program and the Veteran Dental Program.

The New Provider and Existing Provider Directed Payments in Sections 2 and 3 apply to the CY25 Medicaid Contract for payment purposes. However, OHA will use utilization data for Members served under all three contracts to calculate the number of services provided in CY25.

Capitalized terms not defined in this document have the meanings assigned to them in the CCO contracts. Unless the term "Member" is qualified by reference to a specific CCO contract, it means an individual enrolled with a CCO under any of its three contracts.

GENERAL INFORMATION

- The time period for provided services to count toward incentives is January 1, 2025, through December 31, 2025.
- Earned incentive bonuses will be paid in 2026.
- New Provider Directed Payment and Existing Provider Directed Payment incentive bonuses are earned by providing services to all OHP enrolled members, including those enrolled in the Healthier Oregon Program (HOP), Basic Health Program (BHP), COFA Dental Program, and Veterans Dental Program.
- Billing providers can earn incentives—from qualifying services provided—particularly when the services are provided by more than one OHP enrolled rendering provider.
- For FQHCs, the organization can earn incentives using the FQHC's Oregon Medicaid ID particularly when services are provided by OHP-enrolled rendering providers to Members at differing locations. Clinics may decide how to distribute the incentive bonuses distributed to billing providers when they are earned by more than one rendering provider.
- To be eligible for DDPs, the provider must have an Oregon Medicaid ID number and have a contract with each specific CCO[3] whose Members are served by the provider. (A single case agreement is not a provider contract and does not satisfy this requirement.) The provider types whose services can count towards Bundled services are listed in the Appendix of the DDP Guidance document.
- Only paid claims count towards the incentive bonuses.

1. BUNDLED ADD-ON DIRECTED PAYMENTS

Effective January 1, 2025, OHA will require payments for two types of dental bundles. The bundle of services can be either:

i) Pediatric Bundle, or

ii) Minimally Invasive Bundle.

(Refer to Exh. C, Sec. 1, Para. d, Sub.-Para. (2), Sub-Sub.Para. (e) in the Medicaid Contract.)

[3] A CCO may Subcontract with a third party(ies) that is responsible for contracting with dental providers to serve the CCO's Members. In most cases, this third party is a Dental Care Organization (DCO). For purposes of the DDPs, having a provider contract with the third party, including a DCO, is the same as having a contract with the CCO.

Upon completion of either bundle for a unique Member, the billing Provider will be eligible for a bonus payment. Bonus payments to dental providers must be issued at least once a year by the CCO or its Subcontractor.

Dental providers who complete a pediatric preventative bundle will receive an add-on payment of $30 per bundle. Dental providers who complete a minimally invasive bundle will receive an add-on payment of $50 per bundle. Bonuses are only provided for one set of bundled services performed per Member per contract year. *(Note: Based on CMS regulation for CHIP coverage, the CCOs are not legally required by the Medicaid contract to make the bundled add-on directed payment for HOP members. Bundle services are covered through the non-Medicaid contract)*

The required services within each of the two bundle options are described below.

i) Pediatric Bundle (Ages 0-15)

The Pediatric Bundle consist of three types of services: dental cleaning, fluoride treatment, and sealant treatment. All three services must be completed within six months. This bundle is for Members age 15 and younger, and who clinically qualify for all three services. Each service and allowable Current Dental Terminology (CDT) codes are as follows:

- *Cleaning*: D1110, D1120, D4341, D4342, D4346, or D4910
- *Fluoride*: D1206, D1208, or D1355
- *Sealant*: D1351 or application of caries arresting medicament (SDF) D1354

ii) Minimally Invasive Bundle (Age 16 and older)

The Minimally Invasive Bundle consist of a dental cleaning and at least two additional services from the list below. All services must be completed within six months. Each service and allowable CDT codes are as follows:

Cleaning: D1110, D1120, D4341, D4342, D4346, or D4910.

Additional services: (must provide two, only one per category counts towards incentive)

- *Fluoride:* D1206 or D1208
- *Protective Restoration:* D2940
- *Counseling:* (Immunization) D1301, (Nutritional) D1310, (Tobacco) D1320, or (High-Risk Substance Use) D1321
- *Vaccine Administration:* Covid-19 and HPV
- *Caries Arresting and Caries Preventive Medicaments:* D1354 or D1355

WHAT SHOULD YOU DO?

Providers:

- Provide services that meet the bundle requirements within six months of the first cleaning for a Member within CY25. The services must be completed within the calendar year.
- Bill using the appropriate and eligible CDT codes.

CCOs:

- Develop a reporting process that identifies the bundled services and determine when the requirements are met.
- Calculate earned bonuses and provide them to the billing providers on a regular basis.
- Report to OHA the bonuses earned and paid, per Exhibit L financial reporting.

2. NEW PROVIDER DIRECTED PAYMENTS

Effective January 1, 2025, OHA will implement a directed payment arrangement that provides bonuses to New Providers. To be eligible, Providers must have a taxonomy ID listed in Appendix A. (Refer to Exh. C, Sec. 1, Para. d, Sub.-Para. (2), Sub-Sub.Para. (f) in the Medicaid Contract.) The provider as must achieve a Caries risk assessment for all ages during evaluation visits (as defined by Dental Quality Alliance (DQA)) performance of at least 53%.

A “New Provider” is defined as a dental provider who did not have an Oregon Medicaid Provider identification (ID) in CY23 or CY24, or who billed for 25 or fewer unique Members in each of those years. Incentives are earned based on the number of unique members served. The three tiers of bonuses for New Providers are as follows:

Number of services/claims for Members in CY25	Bonus amount to be earned
100 - 349	$3,500
350 - 699	$8,000
700 or more	$15,000

WHAT SHOULD YOU DO?

Providers:

- Take steps to contract with one or more CCOs (or a delegated Subcontractor of a CCO).
- Schedule and provide services to members in CY25 to meet the service/claim thresholds.
- Make sure to document caries risk assessment using CDT codes D0601, D0602, or D0603 during your evaluation visits (D0150, D0120. D0180)

CCOs:

- Submit Encounter Data to OHA based on the timeframes in the contracts. OHA will determine which Providers have met the thresholds to qualify for the bonus.

- Retain estimated CY25 capitation payments for the New Provider DDP to be paid out in CY26. Bonus payments will be calculated and paid out in CY26.

3. EXISTING PROVIDER DIRECTED PAYMENTS

Effective January 1, 2025, OHA will implement a directed payment for Existing Dental Providers who retain and/or increase the number of Members served.

"Existing Providers" is defined as those with a taxonomy code listed in Appendix A who do not meet the New Provider definition in Section 2. Existing Providers are eligible for two bonuses: (i) retention of Members and (ii) increased unique Members served. The provider as must achieve a Caries risk assessment for all ages during evaluation visits (as defined by Dental Quality Alliance (DQA)) performance of at least 53% to qualify for either bonus.

Retention Bonus: "Retention" is defined as the percentage of unique prior year Members (CY24) who receive services in the following year (CY25) performed by the same Provider. Retention bonuses are built to encourage Providers to maintain current capacity first and then to increase access to achieve additional bonuses as specified in the next section. Bonuses for retention are tiered depending on the number of unique Members served in the prior year. The maximum bonuses are as follows:

Number of unique Members served in CY24 and again in CY25	Maximum bonus amount to be earned
26 - 50	$2,000
51 - 100	$4,000
101 - 250	$8,000
251 - 500	$16,000
500 or more	$25,000

Bonus achievement schedule based on retained Members served in CY25 as compared to CY24:

- **0%**: If the retention percentage is under 50%, the Existing Provider will receive 0% of the bonus listed above.
- **50%**: If the retention percentage is at least 50% but less than 65%, the Existing Provider will receive 50% of the maximum bonus listed above.
- **75%**: If the retention percentage is at least 65% but less than 80%, the Existing Provider will receive 75% of the maximum bonus listed above.

- **100%**: If retention is 80% or higher, the Existing Provider will receive 100% of the maximum bonus listed above.

Increased Unique Member Bonus: The increased unique Member bonus is based on the number of unique Members in the current calendar year compared to the prior calendar year. Existing Providers who serve at least one more unique Member in the current year than in the prior year will receive a bonus of $4,000. For example, if a provider saw 200 unique Members in 2024 and saw 201 unique Members in 2025, the provider would be eligible for a $8,000 retention bonus and a $4,000 unique Member bonus for a total of $12,000. For every additional increase of 50 unique Members served in the current year over the prior year, the Existing Provider will receive a bonus of $2,000 up to a maximum of 400 additional unique Members (max of $20,000 for increased unique Member bonus).

WHAT SHOULD YOU DO?

Providers:

- Contact and schedule services in CY25 for members seen in CY24. Provide services to Members.
- Make sure to document caries risk assessment using CDT codes D0601, D0602, or D0603 during your evaluation visits (D0150, D0120)

CCOs:

- Submit Encounter Data to OHA based on the timeframes in the contracts. OHA will determine which Providers meet the thresholds that qualify for the bonus.
- Retain estimated CY25 capitation payments for the Existing Provider DDP to be paid out in CY26. Bonus payments will be calculated and paid out in 2026.

4. DETERMINATION OF BONUSES

As noted in Section 1, the pediatric and minimally invasive bundles must be determined by the CCO or their Subcontractor on at least an annual basis. Payments must be made by the CCO to the billing Provider for all of the bundles based on the most recent reporting. Providers are eligible for the bonuses listed under Section 1 for services provided to any Member.

For the DDPs in Sections 2 and 3, OHA will calculate the bonuses using Encounter Data already required to be submitted by CCOs under all three contracts. Bonuses are calculated based on services provided to Members under all three contracts and to individuals whose services are by paid by OHA under the Fee for Service (FFS) program. Payments will be directed from CCOs under the Medicaid Contract.

The measurement period for the purposes of the CY25 directed payment will be January 1, 2025, to December 31, 2025. The prior year shall be January 1, 2024, to December 31, 2024.

Calculations for each directed payment shall be made at least once a year, on a calendar year basis with the first calculation made in 2026 using full CY25 claims.

OHA will perform the calculations for the directed payments in Sections 2 and 3, including determining whether a Provider has met the requirements for a directed payment. CCO Encounter Data and OHA FFS claims data in MMIS will be used to calculate each Provider's achievements.

The amount each CCO owes to Providers for the New Provider and Existing Provider directed payments will be determined by OHA in mid-2026. For Providers who serve multiple CCOs, the bonus payment will be proportionally allocated to each CCO based on the number of member months each Member was enrolled in that CCO, even if dental services were not performed in that month. For example, if a Provider had a utilizing Member who qualified for a bonus and was eligible for six months in CCO 1 and six months in CCO 2, 50% of that bonus will be paid by CCO 1 and 50% by CCO 2.

While the expectation is that the initial full CY25 claims submission by the CCOs will be sufficient for OHA to determine the New Provider and Existing Provider earned bonuses, there may be a situation where additional runout data would have increased the earned bonuses. OHA will determine a process and timeframe for when a recalculation of the bonuses will be performed using additional data. Any changes in bonuses earned by Providers will be sent to the CCOs. The CCOs are responsible for accruing and paying the bonuses and for any additional bonuses from the CY25 funding. No additional capitation payments will be made by OHA to cover these higher costs.

This following section outlines frequently asked questions (FAQ) related to the new DDPs going into effect January 1, 2025.

PROVIDERS INCLUDED

1. **What is the intent of various provider types being eligible for the DDPs?**

   The DDPs are intended to improve access to oral health services for Members enrolled in a CCO. The list of provider types in Appendix A of this guidance document is intended to cover the variety of providers who would be meeting the members' needs.

2. **Which provider types are eligible for the Bundles, New Providers, and Existing Providers payments?**

   The provider types eligible to earn DDP incentives are all dental provider types, and are listed in Appendix A.

3. **Are specialty providers excluded from the Retention Bonus since they typically see patients episodically, not on an ongoing basis?**

   No. The directed payments are designed to increase access and provide needed services to all dental providers. Access to specialists for higher acuity conditions is a Member need, and the directed payments are intended to increase access to these Providers.

4. **How can I find out if a provider is contracted with a CCO and has an Oregon Medicaid ID number?**

   Contact OHP Provider Enrollment by calling 800-336-6016, option 6 or by emailing Provider.Enrollment@odhsoha.oregon.gov

WHICH POPULATIONS WILL HAVE THE DIRECTED PAYMENTS

5. **Does the member need to be enrolled for the entire 12 months of the calendar year without any gaps of enrollment to be included in the DDP program?**

   No, the member only needs to be enrolled at the time of the service.

6. **Which populations are included in the Bundled Add-On Directed Payments?**

   Bundles completed for Members covered under any of the three CCO contracts will earn a bonus. This includes all OHP enrolled members, those enrolled in Healthier Oregon (HO), Basic Health Program (BHP), COFA Dental, and Veterans Dental. Providers will not receive a bundle payment for FFS patients.

   Utilization data for members served under any of the three CCO contracts as well as for FFS individuals whose services are paid by OHA will be used to calculate the size of New Provider and Existing Provider incentives.

TECHNICAL QUESTIONS

7. **If the qualifying bundled services are all provided by different rendering providers operating under the same entity, and that entity holds a contract with the DCO, would the services count toward a bundled incentive payment?**

   Yes.

8. **When a Member under the age of 16 does not need sealants, therefore not qualifying for the Pediatric Bundle, what alternative services are considered appropriate?**

If a member is not clinically recommended for sealants or SDF caries arresting medicament, regular reimbursement will be provided for services provided and would go towards the New Provider and Existing Provider incentive payments.

9. **For the Bundled incentives, what is the timeline and order for services to be provided?**

   Services must be provided within six months from when the first service is provided. It is possible that all three services are provided on the same day. The cleaning is not required to be the first service.

10. **What happens if a Member is age 15 when receiving a listed service for the Bundled Add-On incentive, and then turns age 16 during the six month period?**

    The provider can claim the minimally invasive bundle.

11. **How does OHA define 'retention' for a patient for the Existing Provider Incentive?**

    "Retained members" are those who the billing provider received at least one paid encounter for during CY24, and at least one paid encounter for during CY25.

12. **What types of services must be rendered to Members to qualify for the *Retention Bonus* and *Unique Member Bonus?* For example, will telehealth or educational consulting be eligible?**

    Any dental service with a CDT code included in the FFS Covered Dental Code list will be eligible.

13. **Will denied claims or line items count towards bonuses?**

    No. Only approved dental claims on the FFS Covered Dental Codes list will be included.

14. **How will it be determined which Provider receives directed payment for services delivered to Members who receive bundled services multiple times a year?**

    Only the first bundle provided to a Member will be deemed eligible for the bonus.

PAYMENT OF BONUSES

15. **Who will calculate the bonus payments for New Providers and Existing Providers?**

    OHA will determine and create a list of providers who are considered Existing Providers. The final list of New Providers will be determined during the bonus calculation period as New Providers can sign up during the year and become eligible for the payments.

16. **How will providers working for multiple Medicaid serving organizations be handled related to incentives?**

    The CCOs that pay the incentive bonuses to the billing providers—for the services provided to their CCO members. Billing providers contracted with more than one CCO has the opportunity to receive incentive bonuses from each of the CCOs.

17. **How are services that are provided by multiple rendering providers captured by organizations or billing providers recorded for reporting?**

    CCOs are responsible for tracking provided services and reporting to OHA.

18. **Will OHA provide a template for CCO usage for collecting the various reporting details or should CCOs develop their own templates?**

    OHA is not planning to provide a template and believes it can use the existing MMIS data to collect all the information needed for determining the new and existing provider bonuses

19. **How do CCOs handle distribution of incentives earned by providers who are contracted with more than one DCO?**

    OHA will instruct the CCOs what they owe the providers and for which services. CCOs will need to work out the details of how to get that money to their providers or Subcontractors.

20. **What happens if a rendering provider that has contributed to earned bonuses leaves prior to the end of CY25?**

    Paid encounters received by a billing organization by a rendering provider who then leaves an organization will still count toward earned incentives for the organization.

21. **Will DDP Incentive bonuses replace any other bonuses/payment plans that are currently in place?**

    No this is a new program which does not replace any existing programs

22. **Will the bonus incentives earned be included in the capitation payments?**

    The money to pay the incentives is included in the capitation rate OHA pays to the CCOs

23. **How will the payments be calculated for Providers working at multiple locations or CCOs? How will the payments be dispersed?**

    OHA will calculate which Providers have earned New Provider or Existing Provider bonuses based on claims data spanning OHA (FFS membership and CCO membership) across all

three CY25 contracts. Calculations will be made after March 2026 for the CY25 directed payments.

Pediatric Bundles and Minimally Invasive Bundles will be calculated by CCOs for their membership and should be provided on a regular basis at least annually. Providers have six months to complete the bundles, but achievement is limited to the calendar year. If a Provider did a Member's cleaning in October, then the bundle must be completed by December.

Estimated DDP costs are already built into the CY25 CCO capitation rates. These amounts should be accrued and either held by the CCO or passed to the Subcontractors that pay the dental providers and practices. The amount due to each rendering dental provider will be provided by OHA using the incurred CY25 claims and will be allocated by CCO based on the utilizing membership. These payments should be made to the specific provider at the provider's location of record.

24. FQHC organizations have the same Medicaid ID across all sites. How will incentives account for this?

CCO-contracted billing provider can earn incentive bonuses by meeting the criteria of each of the three incentive options (Existing Provider, New Provider, Bundles Services), whether the CCO's members are served at the same site each time or at differing sites.

25. Individual providers are assigned a National Provider Identifier (Type 1 NPI) whereas Type 2 NPIs are assigned to organizational providers. How will the incentive account for this?

Type 2 NPIs are allowable, when contracted with a CCO.

26. Please confirm that payment is going to be made to a Provider's "Pay To" organization. For example, if the dentist is an employee of a Federally Qualified Health Center (FQHC), it is the FQHC that will receive the payment and not the actual provider.

For the Bundles, services provided will be calculated at the billing Provider level, and the billing provider will receive the payment.

For New Provider and Existing Provider bonuses, the bonus will be calculated for the rendering provider and sent to the billing provider.

27. Is the intention to require Members to be seen by the same practitioner at each appointment or could visits within a common practice be aggregated to achieve the measurements?

Bundles can be aggregated within a common practice. New Provider and Existing Providers are based on services for unique Members by the rendering Provider.

28. **Are dental Subcontractors required to allocate or pass through a percentage of the funds to different types of Providers?**

    All earned bonuses must be paid to the provider. Even if CCOs choose to shift the risk of the directed payments to their dental Subcontractors or other Subcontractors, the earned bonuses must be paid to the provider.

29. **Is the tiered Retention Bonus for Existing Providers calculated per retained Member or per tier?**

    The maximum bonus is based on the tiers — number of unique Members seen in the prior year — with the percentage of maximum bonus earned based on the percentage of Members retained.

30. **Will the Directed Payment language appear in all three CCO contracts (Medicaid, Non-Medicaid [HOP], and BHP)? How can health plans use the funding to reward services provided to nonMedicaid members?**

    For the Non-Medicaid and OHP Bridge-Basic Health Program Contracts, Directed Payments will be made by the CCOs for completed bundles under the separate requirements of the BHP and Non-Medicaid Contracts. *However, based on CMS regulation, CCOs are not required to make the bundled add-on directed payment for HOP members when covered by the Medicaid contract.*

    For the New Provider and Existing Provider directed payments, Members covered under the Non-Medicaid and OHP Bridge-Basic Health Program Contracts will contribute to the Retention Bonus or New Provider thresholds but will be paid via the amounts accrued in the Medicaid Contracts' CCO capitation rates.

APPENDIX A – Taxonomy of Providers that qualify for the directed Payments

- 125K00000X for Advanced Practice Dental Therapist
- 122300000X for Dentist
- 1223D0004X for Dentist Anesthesiologist
- 1223G0001X for Dental General Practice
- 124Q00000X for Dental Hygienist
- 1223D0001X for Dental Public Health
- 125J00000X for Dental Therapist

- 122400000X for Denturist
- 1223E0200X for Endodontics
- 1223P0106X for Oral and Maxillofacial Pathology
- 1223X0008X for Oral and Maxillofacial Radiology
- 1223S0112X for Oral and Maxillofacial Surgery
- 125Q00000X for Oral Medicinist
- 1223X2210X for Orofacial Pain
- 1223X0400X for Orthodontics and Dentofacial Orthopedics
- 1223P0221X for Pediatric Dentistry
- 1223P0300X for Periodontics
- 1223P0700X for Prosthodontics