State of Delaware, Division of Medicaid and Medical Assistance

Adult Dental Expansion

Provider Questions & Answers

Updated with new questions & answers.

Covered Services

Question #	Question	DMMA Response
1.	Will endodontic procedures be covered?	No, DMMA has determined that endodontic procedures will not be covered.
2.	Why are post-operative radiographs eligible for immediate use of the $1500 extra benefit? It's unnecessary radiation. I don't typically take radiographs on all of my post-operative restorative work. If proof of work is required, I would suggest accepting an Intraoral photo.	Post-operative radiographs are a covered service, but are not required. The provider should use their best judgement when determining radiation exposure.
3.	Will dentures be included as a benefit? What about repair of dentures?	DMMA is currently investigating the feasibility of covering dentures. New legislation with an associated appropriation to cover the cost of the new benefit would be needed to add coverage for dentures. Denture repair is a covered service.
4.	Will Medicaid cover sedation for adults?	Yes, the following codes are covered under the Adult Benefit: D9223, D9230, D9243 and D9248. All codes require a prior authorization.
5.	What is the fee schedule for non-covered services?	DMMA does not establish a fee schedule for non-covered Medicaid services.
6.	Will services be denied if the same service was provided by another provider within a certain period of time? For example, treatment for recurrent decay.	DMMA has established service limitations for certain services. A detailed list of covered services and their limitations will be posted on the DMMA website once finalized.
7.	Will fluoride be covered?	Yes, the adult dental Medicaid benefit includes fluoride varnish applied twice per year, subject to the annual $1000 limit.
8.	Will the coverage work more like commercial insurance with two cleanings a year or is it that members get the $1000 and if they use it before their second cleaning is due that year they would have no coverage?	Preventive and diagnostic services are included in the $1000 per year benefit limit. If the member has reached the benefit limit for the year, services will not be reimbursed. However, an additional $1500 in services is available through the emergency/extended benefit. This can be accessed through a prior authorization process. See response to Question #43 for a discussion on how to access the emergency/extended benefit.

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9.	When multiple teeth are extracted in a visit or when a more complex tooth extraction involves removal of bone, pain control is a concern for many oral surgeons. Would the State consider adding D9613 which would allow medication to be injected at the site of surgery for pain control following surgery?	DMMA appreciates efforts by the dental provider community to decrease the use of opioids for pain control. DMMA continues to gather data necessary to make an informed decision on the efficacy and viability of including D9613 (infiltration of sustained release therapeutic drugs (single or multiple sites) as a covered service.

Managed Care

Question #	Question	DMMA Response
10.	Will adult dental services be provided through FFS or managed care?	Adult dental services will be carved into managed care and provided and reimbursed through a member's managed care plan. Individuals who are new to Medicaid who have not yet been enrolled in managed care may access dental services. Those claims will be paid FFS.
11.	Will providers be locked into a contract with the Managed Care Organization (MCO), and if so, how easy will it be to discontinue seeing Adult Medicaid patients if a provider would like to opt out?	In order to provide services to adults under the Adult Dental Benefit, dental providers must contract with one or both of DMMA's contracted MCOs. Dental providers will be bound by the terms and conditions of their contract with the respective MCO.
12.	If I (dentist) have an existing contractual relationship with Highmark PPO am I required to enroll as a provider with Medicaid Highmark?	No, providers who have existing contractual relationships with MCOs' commercial lines of business are under no obligation to contract for the Medicaid line of business.
13.	Are providers required to enroll with one of the Medicaid MCOs?	In order to serve adults on Medicaid beyond their brief FFS period, the provider will be required to contract with DMMA's contracted Medicaid MCOs. See the Provider Contracting table on the DMMA website for provider contracting options.
14.	Will providers be listed as providers for just Adult Medicaid or will they be grouped in with other insurances managed by the MCO?	DMMA requires their contracted MCOs develop and maintain a provider directory of all participating providers. This provider directory is separate and apart from any other provider directories that an MCO may have for their commercial products.
15.	How will MCO contracting and credentialing work?	If a provider wants to provide services to adults on Medicaid beyond their brief FFS period, they will be required to contract with the member's respective MCOs and go through their provider credentialing process.

16.	How do members get assigned to an MCO?	At the time of their enrollment in Medicaid, all members who are required to enroll in managed care (either DSHP or DHSP Plus) are given the opportunity to select their MCO. DMMA's contracted Health Benefits Manager encourages (but does not require) members within the same household to select the same MCO. DSHP members who do not make an active selection are auto assigned through a process that considers the following: • Alignment of MCO enrollment with the Head of Household (HOH) or other household members if HoH is not enrolled in Medicaid, including infants with mothers. • Previous MCO enrollment. • If none of these apply members are auto-assigned. DSHP Plus members who do not make an active selection are auto assigned through a process that considers the following: • DSHP Plus LTSS clients residing in nursing facilities, DSHP Plus LTSS clients with a diagnosis of HIV/AIDS who meet hospital level of care, and DSHP Plus LTSS clients living in the community will be auto-assigned evenly among the MCOs such that there is an equal distribution in each MCO of: o DSHP Plus LTSS clients residing in nursing facilities, by nursing facility; o DSHP Plus LTSS clients with a diagnosis of HIV/AIDS who meet hospital LOC, by county; and o DSHP Plus LTSS clients who live in the community, by county. • DSHP members who are found to meet the criteria for DHSP Plus, will remain with the same MCO. Additionally, existing members have the opportunity to change their MCO during DMMA's

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		open enrollment period which takes place in October of each year.
17.	Are there adult populations who are not required to enroll in managed care?	The following populations are excluded from managed care enrollment: • Individuals residing in ICF/IIDs (i.e., Stockley Center and Mary Campbell Center). • Resident aliens who are only eligible for Medicaid to treat an Emergency Medical Condition under Section 1903(v) (2) of the Social Security Act. • Adults eligible for Delaware Medicaid who were residing outside of the State of Delaware in a nursing facility as of April 1, 2012 as long as they remain in an out-of-State facility. • Individuals who choose to participate in PACE. • Individuals receiving Medicare cost sharing only (i.e., Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, Qualifying Individuals and Qualified and Disabled Working Individuals). • Presumptively eligible pregnant women. • Individuals in the Breast and Cervical Cancer Program for Uninsured Women; Individuals in the 30 Day Acute Care Hospital Program.
18.	Can a provider be enrolled with both MCOs?	Yes.
19.	What is an ACO?	An accountable care organization (ACO) is an association of healthcare providers and insurers that share financial and medical responsibility for the patient population.
20.	Can you please describe the reporting requirements the MCOs are required to adhere to?	DMMA's contracted MCOs are contractually required to report to the State on a number of program standards such as network size, average time it takes to pay claims, call center response time, etc. Further, MCO performance and adherence to State and federal requirements are reviewed by an external quality review organization (EQRO) annually.

Children's Dental Services

Question #	Question	DMMA Response
21.	Will children's dental services continue to be carved out of managed care and paid through FFS.	Yes.
22.	How is the Public Health "Smiles" van currently being used?	The Department of Health and Social Services, Division of Public Health, Bureau of Oral Health and Dental Services operates a mobile clinic that goes to Delaware elementary schools to perform preventive dental services such as screenings, cleanings, fluoride, and sealants. Services are provided by volunteer dentists.

Provider Requirements

Question #	Question	DMMA Response
23.	Is there an issue if providers set aside a certain number of Adult Medicaid patients to be seen each day?	DMMA expects that Medicaid providers treat individuals on Medicaid as they would anyone else to whom they are providing services. 42 CFR § 438.206 requires that States and its contracted MCOs maintain and monitor a network able to meet the needs of the MCOs enrollees.
24.	How will missed visits be addressed?	Providers may not bill individuals enrolled on Medicaid for missed visits. Otherwise, DMMA expects that providers treat individuals on Medicaid as they would anyone else they serve. Since these individuals are enrolled in managed care, the MCO can help support appointment attendance through reminders and assistance with transportation.
25.	Are there "Good Samaritan" protections? So if they remove a tooth and then the client gets an oral cancer diagnosis in another area of the mouth, what is their liability? The dentist that I sat with talked about how different liability is in a clinic setting and we should explore this. This is everything around "client of record."	Individuals enrolled on Medicaid should be treated like all other patients within your practice.
26.	If a provider currently serves children are they automatically enrolled to serve adults?	For the Medicaid, FFS program, yes, unless the provider is enrolled as a pediatric dentist with its associated taxonomy. Providers who wish to serve individuals enrolled in Medicaid managed care must contract with and go through the credentialing process for each MCO.

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27.	Are dental providers required to take calls on weekends?	All individuals should be treated the same. If the provider would typically take calls and see patients on the weekend, the expectation is that there would be no discrimination. 42 CFR § 438.206 requires that MCO network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.
28.	Is there a certain number of people a dentist must serve in order to participate? Is there federal guidance around this?	No, there are no required minimums or maximums related to the number of individuals a dental provider serves. There are no federal requirements around this issue.
29.	How will frequent provider changes be addressed?	MCOs through their care coordination efforts will encourage members to only change providers as absolutely necessary.

Provider Payment/Rates/Billing

Question #	Question	DMMA Response
30.	How long will it take to receive payment?	MCOs are required per their contract with DMMA to pay 90% of all clean claims within 30 calendar days of receipt and 99% of all clean claims must be adjudicated within 90 calendar days of receipt. FFS clean claims are typically paid within seven days.
31.	Will payments be EFTs or check?	Payments from MCOs to providers are made via EFT. Payment for FFS claims are made via EFT.
32.	Will DMMA be establishing the rates for the adult dental benefit?	Yes, for at least the first year that the Adult Benefit is available DMMA will be establishing the fee schedule for adult dental services. MCOs will be required to pay the rates as prescribed by the fee schedule. At some point in the future, MCOs will be free to negotiate rates with providers.
33.	To whom will providers submit their claims?	For individuals enrolled in managed care, claims will be submitted directly to the MCOs. For individuals in FFS, claims will be submitted to DMMA.
34.	How will primary vs. secondary billing work? Will Medicaid always be secondary (like with children)? Are individuals even eligible for Medicaid if they have their own private or employer dental benefits?	If an individual has private dental insurance, it would be primary and Medicaid would be secondary. DDDS covers dental services with State funds. Individuals on Medicaid who receive DDDS services would be expected to exhaust their Medicaid benefits prior to DDDS covering any dental claims.

Question #	Question	DMMA Response
	a. How will this differ with individuals who may be eligible for DDDS to pay for some of their dental services?	
35.	Are Medicaid's rates sufficient to take on this new population?	DMMA is confident that its reimbursement rates are sufficient to ensure an adequate provider network to meet the needs of individuals.
36.	Is the $3.00 co-pay required?	Yes, the $3.00 co-pay is required per the legislation.
37.	How will the $3.00 co-pay be operationalized?	The co-pay is applied per visit, not per service. Members will pay the rendering dental provider the $3.00 co-pay per visit.

Benefit Limits and Prior Authorizations

Question #	Question	DMMA Response
38.	How is the benefit amount determined based on plan or income limit?	Senate Substitute 1 of Senate Bill 92 sets forth the dental benefit limit for all adults enrolled in Medicaid.
39.	Do preventive services count against the benefit limits?	Yes.
40.	If someone uses the entire benefit amount and they need more care, are there any other options?	Once a member exhausts the $1,000 annual benefit amount, they may access up to $1,500 in additional benefits if their clinical needs meet the extended benefit criteria. Once those monies are exhausted, there are no additional funds available through Medicaid for the remainder of the benefit year (calendar year). Members who receive services through DDDS may be eligible for additional dental coverage once their Medicaid coverage is exhausted.
41.	Can the term "Emergency/Extended" dental benefit be changed to "Supplemental" dental benefit?	No change in the language will be made as the terminology is in alignment with the legislative language.
42.	What will be the process of submitting pre-determinations? Will this go through the MCO, or DMMA?	For individuals enrolled in managed care, all pre-determinations/prior authorizations will go through the member's respective MCO. During an individual's brief FFS period their pre-determinations/prior authorizations will go through DMMA.
43.	What is the process for accessing the $1,500 extended benefit? Will this go through DMMA or through the MCOs?	To access the additional $1,500 per year dental benefit, the enrolled dental provider must submit for prior authorization to the member's MCO, a comprehensive treatment plan which anticipates the preventive, therapeutic and restorative needs

Question #	Question	DMMA Response
		for the recipient prior to rendering services, including: • Complete record of existing restorations, conditions and diagnoses. • Comprehensive periodontal assessment record. • Diagnostic full mouth series of x-rays. • Intra- and extra-oral images that support the diagnosis and treatment plan.
44.	Can you please clarify if the additional $1,500 benefit may be applied retroactively for treatment that was already performed on an immediate basis, i.e., when the need for emergency service did not allow time for a prior authorization to be submitted?	Treatment for an emergency dental condition does not require prior authorization, however sufficient evidence and documentation of the dental emergency will be required with submission of the claim.
45.	How will the adult dental benefit limits compare with the DDDS benefit limits?	The Medicaid Adult Dental Benefit offers the full range of dental services. DDDS pays for limited dental services for certain populations. The DMMA benefit limits for the most part mirror the current limits for children.
46.	Will the benefit limits for adults be the same as the benefit limits for children?	For the most part, the benefit limits for adults mirror those for children. However, some limits for adults have been adjusted for as clinically appropriate.
47.	Is the benefit year a calendar year or state fiscal year? How will partial year for 2020 be treated, will the limits be pro-rated?	The benefit year will follow the calendar year. The limits will not be pro-rated for 2020.
48.	What is the timing of the receipt of a prior authorization? How soon after submission can a provider expect to receive a determination?	MCOs are held to the following prior authorization standards: • For standard service authorization decisions, the MCO is contractually required to provide notice as expeditiously as the member's health condition requires and within 10 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days. • For cases in which a provider indicates (in making the request on the member's behalf or supporting the member's request), or the MCO determines (upon a request from the member), that the standard service authorization decision

Question #	Question	DMMA Response
		timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. • Emergency treatment does not require prior authorization, however sufficient evidence and documentation of the dental emergency will be required with submission of the claim.
49.	If an individual (usually with disabilities) is under sedation and it is determined they need to access the emergency dental benefit, how can the dentist proceed with the necessary dental work and not obtain the prior authorization? Due to risk for individual, it is better not to end sedation and schedule another appointment.	The policy allows for the access of the emergency benefit without a prior authorization in the following circumstances: "An unforeseen or sudden occurrence demanding immediate remedy or action, without which a reasonable licensed dental professional would predict a serious health risk or rapid decline in oral health." In order for the claim to be paid, "The provider would need to provide diagnostic quality pre and post-operative radiographs and images of the affected area along with a detailed narrative supporting the provider's rationale for immediate services."

Prior Services and Benefit Tracking

Question #	Question	DMMA Response
50.	Will providers be able to look at treatment history with any prior adult dental Medicaid providers?	In DMES, the portal will allow a provider to look up paid claims by procedure code or tooth number. It does not provide a list of all paid claims. The following data is available: Treatment Description, Oral Cavity Area, Procedure Code, Procedure Type, Service Date, Tooth#/Letter, Tooth Surface, and Units.

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51.	Since there is a set amount of benefits, how will providers know how much is left? Currently we can call the companies to find out. Would we call Medicaid or the MCO? Will it tell us on the EOB we receive with payment?	The amount of service used and any remaining available amount will be available via the DMMA and/or MCO provider portal.
52.	How will spending be tracked across MCOs and FFS?	DMMA and each MCO are making changes to their systems to collect information about the benefit amount that has been used during each annual period for a member. The information will be shared daily between each system. Each organization will be able to provide the YTD benefit total, remaining benefit balance, YTD emergency benefit total, and the remaining emergency benefit balance. In DMES, this data can be reported to the provider via each plan's portal, automated voice response (phone), or electronic request.

Miscellaneous

Question #	Question	DMMA Response
53.	What does the consumer outreach look like? How will individuals know this is a new benefit?	DMMA has a multi-pronged approach to outreach for this new benefit including: posting of benefit information on a webpage, MCOs providing education to their members, meeting with and working with advocacy groups to get the word out, public meetings etc.
54.	We hear there might be a delay in the start of the program?	Adult dental services for individuals enrolled on Medicaid will be available beginning October 1, 2020.
55.	Do we have a forecast for the number of dentists we will need to serve the population? Is there concern about having enough providers to meet the need?	The State is in the process of developing network adequacy standards to meet enrollee needs in accordance with 42 CFR § 438.206.
56.	Do the Public Health clinics serve adults and will they be enrolled as Medicaid providers?	No, the dental clinics operated by the Division of Public Health serve only children up to age 21. There is no plan for them to expand their scope to adults.
57.	Is there assistance for transportation for this population?	Yes, individuals may access Medicaid non-emergency transportation services for transportation to dental appointments.
58.	How many people are eligible for this new benefit?	There are approximately 121,000 adults 21 and older enrolled in Delaware Medicaid.
59.	Please provide an explanation of an FFS period.	The period of time (typically 30-60 days) after an individual is enrolled in Delaware Medicaid, but prior to their enrollment into a managed care plan. Claims for services received during this time are paid on an FFS basis.
60.	From a federal perspective, what does DMMA need to do to operationalize the adult dental benefit?	DMMA intends to submit a State Plan Amendment (SPA) to CMS in January. The SPA will include the definition of the benefit, reimbursement methodology, eligibility and service limits. DMMA will also submit an 1115 waiver amendment.
61.	Will patients that have coverage be able to pay for procedures that would not be covered by their insurance…ex. whitening, crowns, etc.?	If a member needs, or desires services that are not covered under the adult dental Medicaid benefit, they do have the option to pay out-of-pocket. However, the provider must ensure the member understands that it is not a covered benefit and must provide the individual an itemized cost estimate up front before the provision of services.

Question #	Question	DMMA Response
62.	How will providers verify insurance, will it be handled the same as the children's?	Providers can verify eligibility and enrollment by contacting the MCO provider services call center, or utilizing the MCO provider portal on their website.