State of Delaware, Division of Medicaid and Medical Assistance

Adult Dental

Member Frequently Asked Questions

Question #	Question	DMMA Response
1.	Can you explain what adult individuals need to do to enroll and when?	There is no special enrollment into the dental program. Members enrolled in managed care will receive their adult dental services through their managed care plan. Individuals enrolled in fee-for-service (FFS) Medicaid will receive their adult dental services through the FFS program.
2.	Will you have a good number of providers for adults available October 1?	There is a lot of interest from the dental provider community in the Medicaid Adult Dental Benefit. However, until we actually see what provider enrollment looks like, we will not know for sure. DMMA's contracted Managed Care Organizations (MCOs) have requirements for network adequacy to demonstrate access for members. We expect to have a robust provider network very shortly into the program.
3.	How is DMMA attempting to recruit dental providers in the two lower counties of the state?	MCOs will be actively recruiting dentists to satisfy network adequacy requirements. Both DMMA and the MCOs will monitor to make sure services are available.
4.	Is the network going to be adding dental offices that provide sedated treatment for our special needs populations? Right now there are only two providers and they are both up north. There are no available providers in the Kent area.	Improving access to dental care is a goal for DMMA. MCOs are required to meet network adequacy standards. They are currently working on enrolling and credentialing providers, with the goal of providing services in a variety of locations. If access to sedation services is a problem in certain geographical areas, DMMA will work with MCOs to improve availability.
5.	Will DMMA be providing a list of Adult Dental providers? How will members know what providers are available?	Members enrolled in managed care may obtain information about their MCO's dental provider network from their respective MCO's provider directory. Members not enrolled with an MCO, who are in FFS Medicaid, may obtain a list of providers from DMMA.

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6.	What does oral surgery include? Are wisdom teeth excluded?	Wisdom tooth removal is a covered benefit under the Medicaid medical benefit, not dental. Regular tooth extractions are covered under the Adult Dental Benefit. More information about covered services can be found on the DMMA website.
7.	How many cleanings per year can an adult have?	DMMA allows for a cleaning once every six months.
8.	Is sedation covered? Is it covered only for certain procedures? Does it include IV sedation?	Yes. Sedation, including IV sedation, is covered and is not limited to any particular type of service. The use of sedation is based on medical need. Sedation services do require prior authorization.
9.	How soon can appointments be scheduled? When would it be appropriate for a member to reach out to the MCO about finding a provider and scheduling an appointment?	For members enrolled in managed care, reach out to your assigned MCO for help identifying a participating provider. For individuals in FFS Medicaid, please check with DMMA. Scheduling an appointment prior to the beginning of the benefit is up to each individual provider.
10.	Are Adult Dental services available to both community-based members as well as long-term care MCO members?	Yes. Adult Dental services are available to all adults enrolled in Medicaid.
11.	Could you please explain what is meant by the MCOs following the Medicaid fee-for-service (FFS) fee schedule for one year?	DMMA's contracted MCOs are required to provide the services and pay providers the rates prescribed by DMMA's FFS fee schedule for at least one year. During the first year that Adult Dental Benefits are available, DMMA will collect data regarding utilization and claims payment and will evaluate if changes need to be made.
12.	What happens when a child turns 21 — will they be able to continue to receive dental services?	Children who are enrolled in managed care but who are receiving dental services through Medicaid FFS will continue to receive dental services; however, the services will be provided through their Managed Care Plan rather than FFS. MCOs will work with members and their families to ensure continuity of care.
13.	Is this for Medicare participants as well?	This is a Medicaid program. Full dual-enrollees (Medicare/Medicaid) members will have access to Adult Dental Benefits. Individuals who are enrolled as Qualified Medicare Beneficiary (QMB) and Specified

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		Low income Medicare Beneficiary (SLMB) only are not eligible.
14.	Can you address how MCOs will roll this benefit out so that people are aware of it?	DMMA will work with the MCOs to develop materials for member outreach. Discussion of Adult Dental Benefits will happen as part of care coordination contacts for those individuals who receive care coordination. Additionally, information about Adult Dental Benefits will be shared during the fall open enrollment period.
15.	Could you please tell me what services the new Medicaid dental benefit will cover and when it is expected to begin (will it cover fillings?)? I see a date of October 1, 2020. Has coverage already begun for some patients?	DMMA will cover a wide variety of services under its Adult Dental Benefit including exams, cleanings and fillings. For details regarding covered services, see the DMMA website. Coverage for adults will begin on October 1, 2020.
16.	Will fluoride be covered?	Yes. The Adult Dental Medicaid Benefit includes fluoride varnish applied twice per year, subject to the annual $1,000 limit.
17.	Will adult dental services be provided through FFS or managed care?	Adult dental services will be included in managed care, provided, and reimbursed through a member's managed care plan. Individuals who are new to Medicaid and have not yet been enrolled in managed care may access dental services. Those claims will be paid FFS.
18.	Will children's dental services continue to be paid via the Medicaid FFS program?	Yes.
19.	Is the $3.00 co-pay required?	Yes. The $3.00 co-pay is required per legislation.
20.	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.
21.	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 the Division of Developmental Disabilities Services (DDDS) may be eligible for additional dental

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		coverage once their Medicaid benefit is exhausted.
22.	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 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.
23.	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 are similar to those set for children.
24.	Will the benefit limits for adults be the same as the benefit limits for children?	The adult benefit limits are similar to those set for children. However, some limits for adults have been adjusted as clinically appropriate.
25.	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.
26.	Is there assistance for transportation for this population?	Yes. Individuals may access Medicaid non-emergency transportation services for transportation to dental appointments.
27.	Please provide an explanation of a FFS period.	The FFS period is the time between an individual's enrollment in Delaware Medicaid and when they are enrolled into a managed care plan (typically 30-60 days). Claims for services received during this time are paid on an FFS basis.

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28.	Will members 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.