
STATEWIDE MEDICAID MANAGED CARE DENTAL PROGRAM

FREQUENTLY ASKED QUESTIONS

Table of Contents

DOCUMENT PURPOSE	1
GENERAL QUESTIONS	1
CHOICE COUNSELING/ENROLLMENT	2
COVERAGE	4
CREDENTIALING	4
PROVIDER NETWORK	4
CONTINUITY OF CARE	5

DOCUMENT PURPOSE

Dental services have previously been included in the benefit package covered under the contracts with the Managed Medical Assistance (MMA) plans operating under the Statewide Medicaid Managed Care (SMMC) program. The Florida Legislature directed the Agency to implement a separate dental component of the SMMC program. This means that dental services will no longer be covered under the MMA plans, but will be covered by standalone Medicaid dental plans.

This document is intended to provide responses to frequently asked questions related to the transition to new SMMC dental plans. Please note, this document does not take the place of the dental plan contract or Medicaid coverage policies that are promulgated in rule.

GENERAL QUESTIONS

Q: What plans are participating in the dental component of the SMMC program?

A: The three plans selected to provide Medicaid dental services statewide are:

- DentaQuest
- LIBERTY
- Managed Care of North America, Inc. (MCNA)

Q: What services are covered by SMMC dental plans?

A: For **children**, comprehensive dental care, including all medically necessary dental services, will be covered. For **adults**, all State Plan dental services will be covered, along with expanded dental benefits offered by the dental plan. All dental plans offer the same expanded benefits.

- The State Plan dental services for adults are:
 - Dental exams (limited to emergencies and dentures)
 - Dental X-rays (limited)
 - Prosthodontics (dentures)
 - Extractions
 - Sedation
 - Ambulatory Surgical Center or Hospital-based dental services provided by a dentist
- The expanded dental benefits offered by all dental plans for recipients 21 or older are:
 - Additional dental exams
 - Additional dental X-rays
 - Additional extractions
 - Dental Screenings
 - Fillings (silver and white)
 - Fluoride
 - Oral Health Instructions
 - Sealants
 - Teeth Cleanings (basic and deep)

Q: When will the new dental plans begin providing services?

SMMC Health and Dental Plan Roll-out Schedule			
	<i>Transition Date</i>	<i>Regions Included</i>	<i>Counties</i>
Phase 1	December 1, 2018	9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
		10	Broward
		11	Miami-Dade, Monroe
Phase 2	January 1, 2019	5	Pasco, Pinellas
		6	Hardee, Highlands, Hillsborough, Manatee, Polk
		7	Brevard, Orange, Osceola, Seminole
		8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota
Phase 3	February 1, 2019	1	Escambia, Okaloosa, Santa Rosa, Walton
		2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington
		3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union
		4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia

CHOICE COUNSELING/ENROLLMENT

Q: Who is required to enroll in an SMMC dental plan?

A: The majority of Medicaid eligible recipients must select a dental plan for their dental services, with limited exceptions. This means that most recipients who are receiving dental services through the fee-for-service delivery system (including Medically Needy and iBudget recipients), and those who are already enrolled in an MMA plan, will have a separate dental plan that will be responsible for their dental services.

Q: Who is excluded from enrollment in an SMMC dental plan?

A: The following individuals are excluded from enrollment in an SMMC dental plan:

- Recipients with a limited Medicaid benefit who do not currently receive any State Plan dental benefits, including the following:
 - Partial Dual eligible (QMB, SLMB, QI1) for whom the State only pays Medicare cost sharing
 - Full dual eligible enrolled in a D-SNP or FIDE-SNP
 - Presumptively eligible pregnant women
 - Individuals eligible for emergency services only due to immigration status
 - Women who are eligible only for family planning services
- Recipients in institutions or programs where the Agency pays a per diem or all-inclusive rate that includes a component for dental, which includes:
 - State mental health hospital if under the age of 65
 - Residential treatment facility

- Program of All-Inclusive Care for the Elderly enrollees
- Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455(47), F.S.

Q: How do I choose a dental plan?

A: There are several ways for Medicaid recipients to enroll in an SMMC dental plan, including online and by phone. Additionally, recipients with special needs can request a face-to-face meeting to discuss dental plan options. To enroll, recipients will need the Florida Medicaid number or Social Security Number and birth year for each person being enrolled.

Online

- Visit the SMMC Member Portal at the following link:
<https://members.flmedicaidmanagedcare.com/account/login>

Automated Phone System (open 24/7)

- Call 1-877-711-3662 with your pin
 - Follow the steps to enroll via the Automated Phone System

Call-In

- Medicaid Choice Counselors are available to help recipients enroll in a plan that best fits their needs.
- Speak with a choice counselor via phone at 1-877-711-3662 Monday – Thursday 8:00am – 8:00pm and Friday 8:00am – 7:00pm.
- TDD users ONLY call 1-866-467-4970

Q: When must I choose a dental plan, and can I change plans once a selection has been made?

A: Recipients must choose a plan by the date listed in the state-issued welcome letter that is sent to all recipients 30-45 days prior to the roll-out date for their region.

- If no plan selection is made, the recipient will be enrolled in the dental plan listed in the welcome letter.
- Recipients can change plans for 120 days after they enroll in their dental plan. This period begins on the effective date of their enrollment in the plan.

Additionally, once a year, recipients will have a chance to change plans during the Open Enrollment period.

- Open Enrollment is the 60-day period each year when recipients can change plans without state approval, and occurs yearly on the anniversary date of their first enrollment into the dental plan.

COVERAGE

Q: How will the dental plans coordinate with the health/ MMA plans to ensure enrollees receive appropriate dental care?

A: To ensure coordination between the health and dental plans, the Agency is requiring the following:

- 1) Designated Employee – Dental plans will have a designated employee to serve as a point of contact for health plans in helping to resolve operational (i.e., sharing of data/information) and care coordination /issues, and will work directly with the Agency.
- 2) Communication Strategy - Dental plans will work with the Agency and the health plans to foster enhanced communication, strategic planning, and collaboration in coordinating benefits.
- 3) Coordination of Benefits Agreement - Dental plans will enter into a coordination of benefits agreement with the health plans that includes data sharing and coordination protocols to support the provision of dental services.
- 4) New performance measures - Dental plans must contact each enrollee who went to the Emergency Department within seven days of discharge and implement strategies to ensure follow up care is obtained by the enrollee. All dental plans will participate in the Florida Health Information Exchange Encounter Notification Service in order to be promptly notified when its enrollees access the emergency department.

CREDENTIALING

Q: Please explain the 60-day credentialing requirement.

A: Dental plans are required to fully enroll/on-board all providers it chooses to contract with within 60 days. Once the dental plan receives a complete and accurate provider application, it has 60 days to complete the onboarding process. Dental plans are allowed to execute network provider agreements pending the outcome of the on-boarding process, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or at the expiration of the 60-day period.

PROVIDER NETWORK

Q: Who should I contact if I want to provide services for a dental plan?

A: Providers wishing to contract with a dental plan should contact the plan directly. Below is a table identifying the provider contacts at each dental plan:

PLAN NAME	PROVIDER RELATIONS CONTACT
DentaQuest	Vanessa Guerrero Email: Vanessa.Guerrero@dentaquest.com Phone: (305) 894-8755
LIBERTY	Betty Gilbert Email: prinqueries@libertydentalplan.com Phone: 1 (888) 352-7924 ext. 393
MCNA	Mercedes Linares

	Email: prdepartment@mcna.net Phone: 1 (855) 698-6262
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Q: How often does the Agency receive updates related to plan’s networks?

A: SMMC dental plans are required to submit a provider network file of all participating providers weekly.

Q: I have a contract with a dental plan that was subcontracted with one of the current MMA plans. If the dental plan was awarded a contract to provide services under the separate dental component SMMC program, do I need to renew my contract with the dental plan?

A: Providers should contact the dental plan to inquire about requirements related to continued contracting.

Q: Are SMMC dental plans allowed to refuse to contract with a provider?

A: Yes, dental plans are allowed to limit the providers in their networks. Dental plans must have a sufficient number of providers to provide all covered services to enrollees and to ensure that each medically necessary covered service is accessible and provided with reasonable promptness. Additionally, the dental plan’s contract with the Agency specifies the minimum number of providers each plan must use in order to effectively provide services.

CONTINUITY OF CARE

Q: If I have a previously scheduled appointment with a dental provider, do I have to cancel my appointment?

A: No. Dental providers should not cancel any appointments with current patients. SMMC dental plans must honor any ongoing course of treatment, for at least 90 days after the dental program starts in each region, if it was authorized prior to the recipient’s enrollment into the plan.

- Plans must pay non-participating providers at the rate previously received for up to 30 days.
- After 30 days, the plan may pay the provider a rate that is mutually agreed upon.

Q: Does the 90-day Continuity of Care (COC) period apply to orthodontic services?

A: Active orthodontic services will extend for the entire course of treatment with the enrollee’s current provider, as long as the enrollee continues to have Medicaid eligibility.

- The dental plan must reimburse the orthodontic provider, regardless of whether the provider is in the plan’s network.