Overview of the Dental Component of the Statewide Medicaid Managed Care Program

In 2016, the Florida Legislature directed the Agency for Health Care Administration (Agency) to select dental plans. This document provides information related to the dental component of the Statewide Medicaid Managed Care (SMMC) program including:

- Where dental plans will operate
- Which dental plans will provide services
- Who must enroll in a dental plan
- When dental plans will be available and when recipients will be notified
- Who will pay for dental services (dental plans vs. health plans)
- Coordination of services between health plans and dental plans
- Continuity of care requirements.

Where will these dental plans operate?

Every dental plan will operate statewide, and provide statewide coverage. There will be no more Medicaid fee-for-service (FFS) dental services. All dental services will be provided through a dental plan.

What dental plans will provide services?

The Agency selected the following dental plans to operate statewide:

- DentaQuest
- LIBERTY
- MCNA Dental

Who is required to enroll in dental plans?

Most Medicaid recipients who are currently in the FFS and SMMC delivery systems will be required to enroll in a dental plan. The following recipients are not eligible to enroll in a dental plan:

1. Individuals eligible through emergency medical assistance for aliens
2. Presumptively eligible pregnant women
3. Individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE)
4. Individuals eligible through the family planning waiver
5. Partial dual eligible (QMB, SLMB, QI1).

Choice Counselors are available to assist recipients in selecting a plan that best meets their needs. This assistance will be provided by phone, by calling 1-877-711-3662. In-person visits may also available by request for recipients with special needs. Recipients can also enroll online at: http://www.flmedicaidmanagedcare.com.

When will dental plans be available and when will recipients be notified that they can select dental plans?

The dental plans will be available based on a phased roll out schedule as follows. Recipient letters will start mailing out approximately 45 days prior to each phase going live.

Phase	Transition Date	Recipient Letter Date	Regions	Counties
1	12/01/18	10/18/18	9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
			10	Broward
			11	Miami-Dade, Monroe
2	01/01/19	11/16/18	5	Pasco, Pinellas
			6	Hardee, Highlands, Hillsborough, Manatee, Polk
			7	Brevard, Orange, Osceola, Seminole
			8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota
3	02/01/19	12/20/18	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

Who pays for dental services?

The following table illustrates which types of dental services the dental plan covers and which the health plans cover.

Type of Dental Service(s) Provided:	**Dental Plan Covers:**	**Health Plan Covers:**
Dental Services	Covered when you see your dentist or dental hygienist	Covered when you see your doctor or nurse
Scheduled dental services in a hospital or surgery center	Covered for dental services by your dentist	Covered for doctors, nurses, hospitals, and surgery centers
Hospital visit for a dental problem	---	Covered
Prescription drugs for a dental visit or problem	---	Covered
Transportation to your dental service or appointment	---	Covered

How does coordination of services with dental plans and health plans work?

The Agency requires dental and health plans to coordinate dental services.

- 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.

- Communication Strategy: Dental plans will participate in meetings with the Agency and the health plans to foster enhanced communication, strategic planning, and collaboration in coordinating benefits.

- 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.

- Transportation Performance Improvement Project: Dental plans and health plans will be required to participate in a joint performance improvement project specific to transportation and will hold ongoing meetings to coordinate benefits.

How will the Agency ensure there will be continuity of dental care while transitioning recipients to dental plans?

The health plan will be fully responsible for continuity of care for new enrollees transitioning into dental plans.

In the event that a new enrollee is receiving a prior authorized, ongoing course of treatment with any dental provider, the dental plan is responsible for the costs of continuation of treatment without any form of authorization and regardless of provider network affiliation, for up to 90 days after the effective date of enrollment.

The dental plans will reimburse providers that do not have a contract with the dental plan ("non-participating providers") at the rate they received for dental services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30 days, unless the provider agrees to an alternative rate.