DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

Adult Dental

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services (Department) / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend Title XIX Medicaid State Plan regarding Dental Services, specifically, to add adult dental services. The Department's proceedings to amend its regulations were initiated pursuant to 29 *Del. C.* § 10114 and its authority as prescribed by 31 *Del. C.* § 512.

The Department published its notice of proposed regulation changes pursuant to 29 *Del. C.* § 10115 in the January 2020 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by January 31, 2020, at which time the Department would receive information, factual evidence, and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

Effective for services provided on and after October 1, 2020 Delaware Health and Social Services/Division of Medicaid and Medical Assistance (Department/DMMA) proposes to amend Title XIX Medicaid State Plan regarding Dental Services, specifically, to add dental services for adults.

Background

Senate Substitute No. 1 for Senate Bill No. 92 was signed by the Governor of Delaware on August 6, 2019 and provides dental services for adult Medicaid Recipients. The effective date of this Act was October 1, 2020. The adult dental benefit will offer basic dental services to eligible adults 21 and over. While state Medicaid programs are required by federal rules to cover comprehensive dental services for children, coverage for adult dental services is optional. Delaware will join many of the other states that currently offer this benefit.

Providing dental care is health care, as improving oral health can impact overall physical health. According to the American Dental Association, "Evidence clearly shows that providing adult dental benefits through Medicaid has a significant impact on access to and utilization of dental care among low-income adults. Expanding dental benefits to adults also significantly reduces costly emergency department visits for dental conditions."

Statutory Authority

- 42 CFR 440.100, Dental Services
- 42 U.S.C. § 1902

Purpose

Purpose

The purpose of this proposed regulation is to add dental services for adults.

Public Notice

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205, and the *state* public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments were to have been received by 4:30 p.m. on January 31, 2020.

Centers for Medicare and Medicaid Services Review and Approval

The provisions of this state plan amendment (SPA) are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon

public comment and/or CMS feedback. The final version may be subject to significant change.

Provider Manuals and Communications Update

Also, there may be additional provider manuals that may require updates as a result of these changes. The applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals and/or Delaware Medical Assistance Portal will be updated. Manual updates, revised pages, or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding DMAP updates. DMAP updates are available on the Delaware Medical Assistance Portal website: https://medicaid.dhss.delaware.gov/provider.

Fiscal Impact Statement

The anticipated fiscal impact is below:

	Federal Fiscal Year 2021	**Federal Fiscal Year 2022**
Federal funds	**$ 8,541,792**	**$10,707,452**
General (State) funds	**$ 4,158,708**	**$5,251,558**

Summary of Comments Received with Agency Response and Explanation of Changes

The following summarized comments were received:

Comment: One commenter suggested changing the term "Emergency/Extended" dental benefit to "Supplemental" dental benefit in order to access the additional $1500 benefit.

Agency Response: No change in the language will be made as the terminology is in alignment with the legislative language.

Comment: One commenter questioned if the additional 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.

Agency Response: 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.

Comment: One commenter suggested including a denture benefit, indicating the CDE codes and fees of all covered denture procedures would mirror those of the current children's Medicaid program.

Agency Response: The adult dental benefit does cover repairs of existing dentures; however, additional denture benefits would exceed the established benefit limits.

Comment: One commenter suggested the benefit reimburses for CDT code D9613 to allow medication to be injected at the site of surgery for pain control following surgery.

Agency Response: DMMA appreciates efforts by the dental provider community to decrease the use of opioids for pain control. DMMA will review the efficacy and viability of including D9613 (infiltration of sustained release therapeutic drugs [single or multiple sites]) as a covered service.

Comment: One commenter suggested the $3 co-pay be removed from the bill.

Agency Response: Such a change would require a legislative change. Until such time as a change may be made, DMMA is moving forward with operationalizing the co-pay. However, as with all other Medicaid copays at this time, no copays will be charged during the Public Health Emergency.

Comment: One commenter indicated a preference for the use of an Administrative Services Organization (ASO) in a fee-

for-service (FFS) structure instead of Managed Care Organizations (MCO). As members are unfamiliar with MCOs, and it is imperative that the credentialing process for both DMMA and the MCOs is quick and easy.

Agency Response: DMMA recognizes that provider education and supports will be critical to the success of the implementation of a Medicaid adult dental benefit. DMMA is committed to working with MCO partners and the dental provider community to streamline the implementation and administration of the new benefit.

Comment: One commenter suggested to provide adequate dental care in a timely manner, it is crucial that the process for any needed prior authorization is simple and the response time is quick. All prior authorization requests should ideally be handled within 10-14 days for non-emergent situations and 48 hours for urgent/emergent situation. There needs to be an established appeal process to review and resolve dentist appeals. Ideally, appeals should be resolved within 30 days.

Agency Response: The current MCO contract includes the following language to address these concerns:

- 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 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.
- Resolution of an Appeal and notice to the affected parties shall not exceed 30 calendar days from the day the MCO receives the Appeal.

Comment: One commenter suggested that because there is an annual benefit limit, providers need to be able to track beneficiary spending, i.e., how much of the patient's limit is remaining. The MCOs will need to demonstrate that they are able to expand their portal to include their adult Medicaid-eligible recipients and maintain the current turn-around time on their portal (as they do with the current children's Medicaid program), there should not be a significant concern about lack of reporting when a patient transitions from FFS to a MCO. However, it is important that all providers be informed that in order for this process to work, all claims need to be submitted daily and the provider would need to check eligibility and treatment history on the day of each appointment to ensure the most accurate, up-to-date report of benefit limits.

Agency Response: DMMA and each MCO have made 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.

Comment: One commenter stated that it is important that support staff from both DMMA and the MCOs be available to answer questions and resolve any problems efficiently.

Agency Response: DMMA thanks you for your feedback. DMMA and the contracted MCOs are committed to continued effective communication as well as training and education for network providers.

Comment: One commenter suggested that a Delaware-licensed dentist should be employed by the MCOs to manage clinical aspects of the contract, such as proper provision of medically-necessary covered services and monitoring of program quality and utilization review.

Agency Response: This suggestion is currently under consideration by DMMA.

Comment: One commenter recommended the MCOs monitor patient satisfaction and dentist satisfaction annually, as well as report metrics on a quarterly basis, which would include, but would not be limited to:

- Network size
- Average time to make payment of claims
- Accuracy of paid claims
- Response time (call wait time) in dentist call center
  Response time (call wait time) in patient call center

Agency Response: MCOs are contractually required to report to the State on a number of program standards which

include, but are not limited to, those described above. Further, MCO performance and adherence to State and federal requirements are reviewed by an external quality review organization (EQRO) annually.

Comment: One commenter expressed concern that MCOs will be able to negotiate their own fee schedules. There is a concern that the fees will be reduced significantly to the point where it will not be feasible for our members to accept this program. We need to have fair reimbursement rates.

Agency Response: MCOs will follow the Medicaid fee schedule and will not bear financial risk for the costs of the adult benefit. DMMA recognizes the challenges associated with estimating the utilization that can be expected when a new benefit is implemented. However, it is DMMA's intent to eventually enter into a risk-arrangement with the MCOs for adult dental services, similar to how DMMA contracts with MCOs for other services. Once this occurs, MCOs and dental providers will have the ability to negotiate payment rates and MCOs will continue to be required to provide an adequate provider network to ensure access to dental services.

Comment: One commenter suggested providers be given at least 60-day written notification prior to any changes in fee schedule or processing policies.

Agency Response: DMMA will adhere to federal requirements regarding prior notice and public input prior to any programmatic changes.

Comment: One commenter recommended QPM reported by the MCOs for the Adult Medicaid dental program be done using the measures developed by the Dental Quality Alliance (DAA), which is specific to dentistry.

Agency Response: DMMA welcomes the dental community's input into Delaware's Medicaid Quality Strategy, including any QPMs for dental. DMMA will be updating this strategy in 2021 and will solicit public input.

Comment: One commenter raised various questions related to value-based purchasing.

Agency Response: When the Medicaid adult dental benefit is implemented, the MCOs will be required to pay the Medicaid fee schedule and dental will be excluded from the value-based purchasing strategies requirements of the MCO contracts. DMMA may address value-based purchasing with respect to dental at a future date.

Comment: One commenter asked if the $3 copay would be paid to Dental providers or Medicaid and if it is the Dental provider, is it per visit.

Agency Response: The $3.00 copay will be paid to the provider on a per visit basis.

Comment: One commenter asked if patients that have coverage be able to pay for procedures that would not be covered by their insurance…ex whitening, crowns, etc.

Agency Response: 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.

Comment: One commenter inquired if the adult dental would be like the children's Medicaid or would it be billed under United Concordia.

Agency Response: For individuals enrolled in MCOs, claims will be submitted directly to the MCOs. For individuals in FFS, claims will be submitted to DMMA.

Comment: One commenter asked if insurance verification be handled the same as the children's program.

Agency Response: Providers can verify eligibility and enrollment by contacting the MCO provider services call center or utilizing the MCO provider portal on their website.

Comment: One commenter asked if fluoride would be covered?

Agency Response: The adult dental Medicaid benefit includes fluoride varnish applied twice per year, subject to the annual $1000 limit.

Comment: One commenter asked for clarification of the $1500 emergency coverage.

Agency Response: Delaware Medicaid recipients (over the age of 21) are eligible to receive an additional $1,500 per year beyond the $1,000 annual benefit limit for dental care treatment that may be authorized on an emergency basis through a review process of the Delaware Department of Health and Social Services (DHSS). The State has chosen to define "emergency basis" as follows:

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; or, when an individual's dental care needs exceed the $1,000 per year dental benefit limit, and postponement of treatment until the next benefit year would result in tooth loss or exacerbation of an existing medical condition.

Comment: One commenter asked if patients have to have a certain MCO to be considered for the dental coverage?

Agency Response: The Adult dental benefit is not limited to any specific MCO.

Comment: One commenter asked if the coverage will work more like commercial insurance with 2 cleanings a year or will members get the $1000 and if they use it before their 2nd cleaning is due that year they would have no coverage?

Agency Response: 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.

Comment: One commenter suggested that DMMA promulgate more extensive regulations elaborating on the program.

Agency Response: DMMA will consider the need for additional policy guidance.

DMMA is pleased to provide the opportunity to receive public comments and greatly appreciates the thoughtful input given by:

- Clay and Clay Dental
- Delaware State Dental Society
- Governor's Advisory Council for Exceptional Citizens (GACEC)
- State Council for Persons with Disabilities

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the January 2020 *Register of Regulations* for Attachment 3.1-A, Page 4; Attachment 3.1-A, Page 4b Addendum; and Attachment 4.19-B, Page 19 should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend Title XIX Medicaid State Plan regarding Dental Services, specifically, to add dental services for adults, is adopted and shall be final effective February 11, 2021.

1/20/2021
Date of Signature

Molly K. Magarik, Secretary, DHSS

***Please Note: Due to the formatting requirements of Attachment 3.1-A, Page 4 of the regulation, it is being attached here as a PDF document:**
http://regulations.delaware.gov/register/february2021/final/3.1-A Page 4 Adult Dental.pdf

Attachment 3.1-A
Page 4b Addendum

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: **DELAWARE**

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Health care professionals that provide the above services at the SBWCs include: physicians, nurse practitioners, licensed clinical social workers, certified and licensed drug and alcohol counselors, certified sexual assault counselors and registered dieticians. Licensure requirements for each practitioner type are specified in the Title 24 of the Delaware Code,

Professions and Occupations and in the Delaware Administrative Code.

10. Dental Clinic Services for individuals younger than age 21 are only available as ESPDT services. ~~to children under age 21~~.

Dental services for individuals 21 and older are limited to:

- Diagnostics
- Preventive
- Restorative (Basic)
- Periodontics
- Prosthodontics Repairs
- Oral and maxillofacial Surgery

Limitations on dental services for individuals 21 and older:

- Payments for dental care treatments are subject to a $3 recipient copay
- Annual maximum Adult Dental benefit may not exceed $1,000 per year; except that an additional $1,500 may be authorized on an emergency basis

[TN No. SPA #14-001]	Approval Date **[~~June 06, 2014~~]**
[Supersedes TN No. SPA N/A]	Effective Date **[~~January 01, 2014~~]**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: **DELAWARE**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

~~Early and Periodic Screening, Diagnosis and Treatment (EPSDT)~~ Dental Services

~~Early and Periodic Screening, Diagnosis and Treatment (EPSDT)~~ Dental Services are reimbursed as follows. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both government and private providers.

Dental Services -Effective for dates of service on or after July 1, 2017, Delaware pays for dental services at the lower of:

- the provider's billed amount that represents their usual and customary charge; or
- the Delaware Medicaid maximum allowed amount per unit per covered dental procedure code according to a published fee schedule.

The Delaware Medicaid dental fee schedule will be developed based on the National Dental Advisory Service (NDAS) annual Comprehensive Fee Report. For each covered dental procedure code, Delaware's maximum allowable amount will be computed as a percentage of the NDAS published national fee. Delaware will rebase its dental fee schedule rates each time the NDAS publishes a new survey.

Preventive General Dental Services shall be paid at ~~50.00%~~ 61.00% of the NDAS 70th percentile amounts
Restorative General Dental Services shall be paid at ~~97.00%~~ 84.60% of the NDAS 70th percentile amounts
Adjunctive General Dental Services shall be paid at 72.24% of the NDAS 70th percentile amounts
Specialty Dental Services shall be paid at 68.80% of the NDAS 80th percentile amounts

Access-Based Fees for certain specialty procedure codes may be established to account for deficiencies in rates that are based on the NDAS fee schedule percentages above relating to the adequacy of access to health care services for Medicaid clients.

The maximum allowed amounts for procedure codes not included in the NDAS fee schedule or for new procedure codes established after the annual NDAS fee schedule is published will be based on the existing rates for similar existing services. If there are no similar services the maximum allowed amount is set at 80% of the estimated average charge until

a rate can be established based on the NDAS fee schedule.

The dental fee schedule is available on the Delaware Medical Assistance Portal https://medicaid.dhss.delaware.gov

TN No. SPA #	Approval Date _____
Supersedes	
TN No. SPA #17-009	Effective Date **[~~October 1, 2019~~]**