ATTACHMENT I
SCOPE OF SERVICES
STATEWIDE MEDICAID MANAGED CARE DENTAL HEALTH PROGRAM
Effective Date: XXXXXX

I. Services to be Provided

A. Overview of Contract Structure

Part IV of Chapter 409, F.S. established Florida Medicaid's statewide managed care program, referred to as statewide Medicaid managed care (SMMC). Section 409.973, F.S. directed the Agency to provide Medicaid recipients with dental benefits separate from SMMC. The dental Contract consists of distinct parts as follows:

(1) **Attachment I**, Scope of Services, includes contract provisions that are unique to the particular Dental Plan.

(a) **Exhibit I-A**, Approved Expanded Benefits Coverage and Limitations

(b) **Exhibit I-B**, Medicaid Provider Identification Numbers

(c) **Exhibit I-C**, Dental Plan Rates

(d) **Exhibit I-D**, Statewide Dental Performance Targets

(e) **Exhibit I-E**, Plan-Specific Commitments

(2) **Attachment II**, Scope of Service – Core Provisions, includes contract provisions that apply to all Dental Plans unless specifically noted otherwise.

B. Authorized Regions

The Dental Plan is authorized to provide services pursuant to this Contract statewide in all eleven (11) regions for the SMMC Dental program.

C. Covered Services

The Dental Plan shall ensure the provision of covered dental services in accordance with the provisions of **Attachment II,** Scope of Service – Core Provisions.

D. Approved Expanded Benefits

The Dental Plan shall provide the following expanded benefits, in accordance with the provisions of **Attachment II,** Scope of Service – Core Provisions, and the coverage and limitations specified in **Exhibit I-A,** Approved Expanded Benefits Coverage and Limitations, of this Attachment, denoted by "X" in Table 1.

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Table 1: Approved Expanded Benefits (Adults)	
X	Diagnostic Services
X	Preventive Services
X	Restorative Services
X	Periodontics Services
X	Oral and Maxillofacial Surgery
X	Adjunctive Surgery
X	Pregnancy-Related Services
X	Diabetes (HbA1c) In-Office Testing
X	Pre-diagnostic Practice Visits for Individuals with Developmental Disabilities (Practice Acclimation)

II. Manner of Service Provision

A. Plan Qualification

The Dental Plan is approved to provide contracted services as a qualified entity under s 409.973(5), F.S., as denoted by "X" in Table 2 below.

Table 2: Plan Qualification	
	Health Maintenance Organization (HMO)
	Prepaid Limited Health Service Organization (PLHSO)

B. Plan Type

The Dental Plan is approved to provide contracted services as a **Statewide Medicaid Prepaid Dental Plan**.

III. Method of Payment

A. Total Contract Amount

The Agency shall make payment, in a total dollar amount not to exceed **$XXX,XXX,XXX.XX** to the Dental Plan in accordance with **Attachment II,** Scope of Service – Core Provisions. The Agency shall make payments through its fiscal agent using the Medicaid Provider Identification Number(s) specified in **Exhibit I-B,** Medicaid Provider Identification Numbers.

B. Capitation Rates

The capitation rate payment shall be in accordance with **Attachment II,** Scope of Service – Core Provisions. The capitation rates are contained in **Exhibit I-C,** Dental Plan Rates, of this Attachment. These rates are titled **"DENTAL PLAN RATES; NOT FOR USE UNLESS APPROVED BY CMS."**

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C. Statewide Dental Performance Targets

The Dental Plan shall meet the following performance targets contained in **Exhibit I-D**, Statewide Dental Performance Targets, Table I-D-1, Potentially Preventable Dental-Related Events, and Table I-D-2, Dental Performance Targets**,** in accordance with **Attachment II,** Scope of Service – Core Provisions; the ITN(s), including all addenda; the Vendor's response to the ITN(s), and information provided through negotiations.

IV. Special Provisions

A. Order of Precedence

(1) For all regions, the Dental Plan shall perform its contracted duties in accordance with this Contract, the ITN(s), including all addenda and the Vendor's response to the ITN(s). In the event of conflict among Contract documents, any identified inconsistency in this Contract shall be resolved by giving precedence in the following order:

a. This Contract, including all attachments;

b. The ITN(s), including all addenda; and

c. The Vendor's response to the ITN(s), including information provided through negotiations.

B. Plan-Specific Commitments

The Dental Plan shall perform the program enhancements in accordance with **Attachment II,** Scope of Service – Core Provisions. The Dental Plan's Plan-Specific Commitments are described in **Exhibit I-E**, Plan-Specific Commitments, of this Attachment.

C. Special Terms and Conditions

There are no additional special terms and conditions unique to the Vendor.

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ATTACHMENT I

EXHIBIT I-A

Approved Expanded Benefits Coverage and Limitations

Table I-A-1, Approved Expanded Benefits Coverage and Limitations						
Category	**Sub-category**	**Procedure Code Description**	**Procedure Code**	**Min Age**	**Max Age**	**Expanded Benefit Coverage (Units)**
Adult Dental Services	Diagnostic	PERIODIC ORAL EVALUATION	D0120	21	No Max	Two (2) per year
Adult Dental Services		SCREENING OF A PATIENT	D0190			
Adult Dental Services		ASSESSMENT OF A PATIENT	D0191			
Adult Dental Services		EXTRAORAL FIRST FILM	D0250			One (1) per thirty-six (36) months
Adult Dental Services		EXTRAORAL POSTERIOR RADIOGRAPH	D0251			
Adult Dental Services		DENTAL BITEWING SINGLE IMAGE	D0270			One (1) per year
Adult Dental Services		DENTAL BITEWINGS TWO IMAGES	D0272			
Adult Dental Services		BITEWINGS FOUR IMAGES	D0274			
Adult Dental Services	Preventive	DENTAL PROPHYLAXIS ADULT	D1110	21	No Max	Two (2) per year
Adult Dental Services		TOPICAL FLUORIDE VARNISH	D1206			
Adult Dental Services		TOPICAL APP FLUORID EX VRNSH	D1208			
Adult Dental Services		ORAL HYGIENE INSTRUCTION	D1330			

Table I-A-1, Approved Expanded Benefits Coverage and Limitations						
Category	**Sub-category**	**Procedure Code Description**	**Procedure Code**	**Min Age**	**Max Age**	**Expanded Benefit Coverage (Units)**
Adult Dental Services		DENTAL SEALANT PER TOOTH	D1351			One (1) per tooth per three (3) years
Adult Dental Services		INTERIM CARIES ARRESTING MEDICAMENT APPLICATION	D1354			Two (2) per tooth per six (6) months
Adult Dental Services	Restorative	AMALGAM ONE SURFACE PERMANEN	D2140	21	No Max	One (1) per [tooth + surface(s)] per three (3) years
Adult Dental Services		AMALGAM TWO SURFACES PERMANE	D2150			
Adult Dental Services		MALGAM THREE SURFACES PERMA	D2160			
Adult Dental Services		AMALGAM 4 OR > SURFACES PERM	D2161			
Adult Dental Services		RESIN ONE SURFACE-ANTERIOR	D2330			
Adult Dental Services		RESIN TWO SURFACES-ANTERIOR	D2331			
Adult Dental Services		RESIN THREE SURFACES-ANTERIO	D2332			
Adult Dental Services		RESIN 4/> SURF OR W INCIS AN	D2335			
Adult Dental Services		ANT RESIN-BASED CMPST CROWN	D2390			
Adult Dental Services		POST 1 SRFC RESINBASED CMPST	D2391			
Adult Dental Services		POST 2 SRFC RESINBASED CMPST	D2392			
Adult Dental Services		POST 3 SRFC RESINBASED CMPST	D2393			

Table I-A-1, Approved Expanded Benefits Coverage and Limitations						
Category	**Sub-category**	**Procedure Code Description**	**Procedure Code**	**Min Age**	**Max Age**	**Expanded Benefit Coverage (Units)**
Adult Dental Services		PROTECTIVE RESTORATION	D2940			One (1) per tooth per day
Adult Dental Services	Periodontics	PERIODONTAL SCALING & ROOT	D4341	21	No Max	Four (4) units every twenty-four (24) months
Adult Dental Services		PERIODONTAL SCALING 1-3TEETH	D4342			
Adult Dental Services		SCALING IN PRESC OF MODERATE OR SEVERE INFLAMATION - FULL MOUNTH AFTER ORAL EVALUATION	D4346			Two (2) per year
Adult Dental Services		FULL MOUTH DEBRIDEMENT	D4355			One (1) per year
Adult Dental Services	Oral and Maxillofacial Surgery	EXTRACTION CORONAL REMNANTS	D7111	21	No Max	One (1) per tooth per lifetime
Adult Dental Services		TOOTH REIMPLANTATION	D7270			One (1) per tooth per day
Adult Dental Services	Adjunctive General Services	TX DENTAL PAIN MINOR PROC	D9110	21	No Max	No limits, as medically necessary
Adult Dental Services		DENTAL CONSULTATION	D9310			One (1) per year
Adult Dental Services		BEHAVIOR MANAGEMENT	D9920			Three (3) per year
Pregnancy (21&+)	Diagnostic	PERIODIC ORAL EVALUATION	D0120	21	No Max	Two (2) per year
Pregnancy (21&+)		SCREENING OF A PATIENT	D0190			
Pregnancy (21&+)		ASSESSMENT OF A PATIENT	D0191			

Table I-A-1, Approved Expanded Benefits Coverage and Limitations						
Category	**Sub-category**	**Procedure Code Description**	**Procedure Code**	**Min Age**	**Max Age**	**Expanded Benefit Coverage (Units)**
Pregnancy (21&+)		EXTRAORAL FIRST FILM	D0250			One (1) per thirty-six (36) months
Pregnancy (21&+)		EXTRAORAL POSTERIOR RADIOGRAPH	D0251			One (1) per thirty-six (36) months
Pregnancy (21&+)		DENTAL BITEWING SINGLE IMAGE	D0270			One (1) per Year
Pregnancy (21&+)		DENTAL BITEWINGS TWO IMAGES	D0272			
Pregnancy (21&+)		BITEWINGS FOUR IMAGES	D0274			
Pregnancy (21&+)	Preventive	DENTAL PROPHYLAXIS ADULT	D1110	21	No Max	Two (2) per year
Pregnancy (21&+)		TOPICAL FLUORIDE VARNISH	D1206			
Pregnancy (21&+)		TOPICAL APP FLUORID EX VRNSH	D1208			
Pregnancy (21&+)		ORAL HYGIENE INSTRUCTION	D1330			
Pregnancy (21&+)	Periodontics	PERIODONTAL SCALING & ROOT	D4341	21	No Max	Four (4) units every twenty-four (24) months
Pregnancy (21&+)		PERIODONTAL SCALING 1-3TEETH	D4342			
Pregnancy (21&+)		SCALING IN PRESC OF MODERATE OR SEVERE INFLAMATION - FULL MOUNTH AFTER ORAL EVALUATION	D4346			Two (2) per year
Pregnancy (21&+)		FULL MOUTH DEBRIDEMENT	D4355			One (1) per year

Table I-A-1, Approved Expanded Benefits Coverage and Limitations						
Category	**Sub-category**	**Procedure Code Description**	**Procedure Code**	**Min Age**	**Max Age**	**Expanded Benefit Coverage (Units)**
Pregnancy (21&+)	Oral and Maxillofacial Surgery	EXTRACTION CORONAL REMNANTS	D7111	21	No Max	One (1) per tooth per lifetime
Pregnancy (21&+)		TOOTH REIMPLANTATION	D7270			One (1) per tooth per day
Pregnancy (21&+)	Adjunctive General Services	TX DENTAL PAIN MINOR PROC	D9110	21	No Max	No limits, as medically necessary
Pregnancy (21&+)		DENTAL CONSULTATION	D9310			One (1) per year
Pregnancy (21&+)		BEHAVIOR MANAGEMENT	D9920			Three (3) per year

Table I-A-1, Other Approved Expanded Benefits Coverage and Limitations						
Benefit Subcategory	**Procedure Code**	**Procedure Code Description**	**Min Age**	**Max Age**	**Expanded Benefit Coverage (Units)**	**Eligible Populations**
Diabetic Testing	D0411	HbA1c in-office point of service testing	21	No Max	One (1) per year	All Adults
Practice Acclimation for Individuals with Intellectual Disabilities	D0999	Unspecified diagnostic procedure	21	No Max	One (1) per new dental practice/provider	All Adults with Intellectual Disabilities

All expanded benefits are in excess of benefits specified in the Medicaid State Plan.

The Dental Plan may require enrollees to use an established network of providers, approved by the Agency, to obtain expanded benefits under this Contract.

Unless otherwise specified in this **Exhibit**, expanded benefits are not subject to prior authorization or co-payment charges.

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ATTACHMENT I

EXHIBIT I-B

MEDICAID PROVIDER IDENTIFICATION NUMBERS

Table I-B-1, Medicaid Provider Identification Numbers by Region	
Region	**Dental**
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	

The Agency will provide Medicaid Provider Identification Numbers to the Dental Plan subsequent to the Agency's completion of a plan-specific readiness review and prior to enrolling recipients in the Dental Plan in each region.

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ATTACHMENT I

EXHIBIT I-C

DENTAL PLAN RATES; NOT FOR USE UNLESS APPROVED BY CMS

REGIONS 1-11 – Rate Table Effective October 1, 2018 – September 30, 2019

Exhibit I-C
State of Florida Medicaid - Agency for Health Care Administration (Agency)
Statewide Medicaid Prepaid Dental Health Program (Dental Program)
SMMC Implementation to September 2019 Rate Year (Post-Implementation) Agency Capitation Rates PMPM by Rate Group / Rate Cell and Region

	Region										
Rate Group / Rate Cell[1]	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Medicaid Only/Dual Eligible 0-20	$8.82	$10.86	$9.43	$10.69	$11.96	$11.67	$9.84	$10.88	$13.16	$10.56	$10.76
Medicaid Only 21+	$8.25	$5.28	$4.60	$5.52	$7.22	$5.40	$4.01	$4.99	$4.38	$3.68	$3.95
Dual Eligible 21+	$4.10	$4.16	$3.20	$3.60	$3.59	$3.39	$2.53	$3.74	$2.87	$2.47	$2.67
Medically Needy 0-20	$8.74	$8.74	$8.74	$8.74	$8.74	$8.74	$8.74	$8.74	$8.74	$8.74	$8.74
Medically Needy 21+	$9.38	$9.38	$9.38	$9.38	$9.38	$9.38	$9.38	$9.38	$9.38	$9.38	$9.38

[1] *Medically Needy 0-20 and Medically Needy 21+ Agency capitation rates are set on a statewide basis.*

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ATTACHMENT I

EXHIBIT I-D

STATEWIDE DENTAL PERFORMANCE TARGETS

Table I-D-1, Potentially Preventable Dental-Related Events					
Potentially Preventable Dental-Related Events	**Contract Year 1 Reduction**	**Contract Year 2 Reduction**	**Contract Year 3 Reduction**	**Contract Year 4 Reduction**	**Contract Year 5 Reduction**
Potentially Preventable Dental-Related Emergency Department Visits (PPV) per 1,000 Enrollee Months					

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ATTACHMENT I

EXHIBIT I-D

STATEWIDE DENTAL PERFORMANCE TARGETS

Table I-D-2, Dental Performance Targets					
Measure	**Contract Year 1**	**Contract Year 2**	**Contract Year 3**	**Contract Year 4**	**Contract Year 5**
Annual Dental Visits (ADV) – ITN Target					
Preventive Dental Services (PDENT) - ITN Target					
Dental Treatment Services (TDENT) – ITN Target					

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ATTACHMENT I

EXHIBIT I-E

[DENTAL PLAN NAME AND DBA] PLAN-SPECIFIC COMMITMENTS

Table I-E-1, Plan-Specific Commitments					
Region	**Category**	**Sub-Category**	**Commitment (Description)**	**Important Milestones**	**Target Date(s) for Completion**

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