DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: August 8, 2017

Consistent with Council requests, I am providing analyses of seven (7) regulatory initiatives appearing in the August, 2017 issue of the Register of Regulations. Given time constraints, the analyses should be considered preliminary and non-exhaustive.

1. DOE Final DIAA H.S. Interscholastic Athletics Reg. [21 DE Reg. 147 (8/1/17)]

The SCPD and GACEC commented on the proposed version of this regulation in April, 2017. A copy of the April 20, 2017 GACEC letter (which includes one comment not reflected in the SCPD letter) is attached for facilitated reference.

The DOE has now adopted a final regulation.

First, the Councils questioned the justification for a categorical 90-day ban on a student who transfers more than once in two years from playing any sport for 90 days. No change was made.

Second, the Councils questioned the justification for a ban on a student transferring to a "choice" school participating in sports even if the student never participated in sports at the former school. No change was made since the ban is based on a statute.

Third, the GACEC recommended retention of the term "athletics" in §2.4.7. The DOE suggests that it agreed but the text was not changed:

> (3) The Department retained the word "athletics" in Section 2.4.7 to avoid any implication that the DIAA is regulating non-athletic activities. The Department originally struck the word "athletics" and added "contests or competitions" to align this section with Title 14 of the Delaware Code Ch. 4 §410 and to clarify that students can participate in practices in the sports that are regulated by the DIAA;...

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DELAWARE'S PROTECTION AND ADVOCACY SYSTEM FOR PERSONS WITH DISABILITIES

It's unclear if the lack of an amendment in the text is in error. As of August 2, the text of the regulation in the Administrative Code is the 2016 version. The GACECs could consider soliciting clarification from the DIAA.

Fourth, the Councils observed that the waiver section did not account for students with IEPs which include sports. No change was made.

Fifth, the Councils recommended that the regulation address participation of students with disabilities in unified sports. The DOE effected no change at this time but implied that it may consider a change in the future:

> The Department appreciates the suggestion to clarify students with disabilities' participation in unified sports. The DIAA Board has not discussed any changes to date regarding students with disabilities who participate in unified sports.

At 148.

Since the regulation is final, no further action appears warranted apart from discretionary GACEC consultation with the DIAA consistent with the "Third" paragraph above.

2. DMMA Medicaid Dental Fee Schedule Reg. [21 DE Reg. 124 (8/1/17)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to amend the Medicaid State Plan to reduce the reimbursement rate for child dental care. The Division recites that the current rate is "81.1% of commercial insurance charges". At 125. The Division proposes a 14% reduction in the rate, i.e., to approximately 69.75%.

I have the following observations.

First, there is ostensibly ample justification for the proposed rate reduction. DMMA notes that the 81.1% rate is the highest in the Nation based on a 2014 Health Policy Institute Policy Brief. A copy of the 2014 Brief is attached for facilitated reference. The Health Policy Institute published a more recent Brief in April, 2017. A copy of the 2017 Brief is also attached. It corroborates that the Delaware Medicaid reimbursement rate is an "outlier" and exceeds that of all other states. See pp. 5-6.

Second, since the Medicaid reimbursement rate is based on a percentage of local commercial /insurance rates, the local commercial/insurance rates in Delaware are material in assessing the Medicaid rate. Delaware's commercial/private insurance child dental services rates rank 15th in the Nation. Id at p. 7. As a result, the new 69.75% rate would result in a higher reimbursement than application of the same rate in a state with a low commercial/insurance rate.

Third, as DMMA observes, the 14% rate reduction was incorporated into the State FY18 budget. At p. 125. Therefore, as a practical matter, it would be difficult to prompt reconsideration of the proposed Medicaid Plan amendment.

Fourth, it is instructive to assess the likely effect of the lower rate on access to services. Consistent with the attached access statistics for Delaware, New Jersey, Pennsylvania, and Maryland, the lower reimbursement rates in our sister states have not had any negative effect on access to dentists accepting Medicaid.

Fifth, DMMA projects a cost savings of $2.6 million in state funds and $4.1 million in federal funds in FY18. Therefore, while the State may save $2.6 million, the value of this savings is undercut by the loss of $4.1 million in federal dollars to the Delaware economy.

Sixth, the 2017 Brief (pp. 1-2) offers the following statistics:

A. Fifty-four percent (54%) of Medicaid-enrolled adults live in states that provide adult dental benefits in their Medicaid program.

B. Medicaid FFS reimbursement, on average, is 49.4 percent of fees charged by dentists for children and 37.2 percent for adults.

Thus, while Delaware is at the forefront in supporting child dental services, it is a laggard in supporting adult dental services. Since the average Medicaid reimbursement rates for adults nationwide (37.2%) is much lower than the rates for children (49.4%), it would be propitious if DMMA would assess prospects for devoting cost savings for children's dental services to adult coverage. The attached fiscal note on 2016 legislation (S.B. No. 142) to offer adult dental coverage was approximately $7.3 million on an annualized basis. DMMA could assess the following financial options:

1) the effect of capping dental care assistance to an eligible recipient at $500 instead of the $1,000 contemplated by S.B. No. 142;

2) the effect of incorporating lower adult reimbursement rates into the fiscal note to reflect national norms; and

3) the effect of initially limiting the adult dental benefit to subpopulations (e.g. DDDS Lifespan Waiver enrollees).

The above options, alone or in combination, could facilitate adoption of an adult Medicaid benefit and potentially "draw down" millions of dollars in federal matching funds.

The Councils may wish to share the above observations with DMMA with a courtesy copy to Lt. Governor Hall-Long and the DDDS Director.

3. DMMA Prop. DPAP Elimination Reg. [21 DE Reg. 127 (8/1/17)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to amend the regulations establishing the Delaware Prescription Drug Payment Assistance Program (DPAP). The DPAP has historically been paid from the Delaware Health Fund (p. 128). The rationale (p. 128) is as follows:

> The most recent internal Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) report indicates that all but two members have prescription coverage through Medicare Part D. The program is being eliminated due to a reduction in usage, along with an overall reduction in expenditures by DMMA.

I have the following observations.

First, the above justification is not very illuminating since most DPAP enrollees have had Medicare-D coverage in past years as well. DMMA notes (p. 128) that most costs for low-income Medicare-D beneficiaries are covered by Medicare -D:

> Individuals with Medicare (the majority of DPAP clients) would select a Part D Prescription Plan and apply for Extra Help (Low-Income Subsidy) through the Social Security Administration. The Low-Income Subsidy, or LIS, which is paid by the Centers for Medicare & Medicaid Services, would provide financial assistance (at levels of 100%, 75%, 50%, and 25%) for monthly Part D premiums, annual deductibles, and prescription coverage through the Part D coverage gap to low-income individuals. Medicare Part D would be primary to the Delaware Prescription Assistance Program.

However, it would be informative to disclose what costs the DPAP covered which Medicare-D and the Low-Income Subsidy do not cover. For example, it is troubling to note that the FY17 Delaware Health Fund Advisory Committee approved $2.5 million for this program which was included in the FY17 budget.[1] See attachments. In contrast, the FY18 budget (excerpt attached) omits any DPAP funding and the DHSS website (excerpt attached) indicates the program has already been eliminated. A reasonable person might ask what the $2.5 million covered in FY17 that will not be covered in FY18.

Second, consistent with the attached excerpt from the Delaware Code, the enabling legislation for the DPAP has been repealed. Therefore, as a practical matter, the current regulation merely implements the repeal of the enabling law. However, if the Councils would like more information on the effect of the repeal, they could request the last few annual reports on the DPAP prepared in fulfillment of Title 16 Del.C. §3006B.

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[1]I could not locate the FY18 Delaware Health Fund Advisory Committee recommendations to determine if it supported elimination of the DPAP. DHSS includes the FY11-17 Delaware Health Fund Advisory Committee final recommendations on its website but omits the FY18 recommendations. See http://www.dhss.delaware.gov/dhss/healthfund/

In sum, the Councils could consider the following approach: 1) acknowledge the legislative repeal of the DPAP enabling law justifies the regulation; 2) express concern that the ramifications of the elimination of the program (which had a $2.5 million appropriation in FY17) are not clear; and 3) request (via FOIA or otherwise) a copy of the last three annual reports prepared pursuant to the recently-repealed 16 Del.C. §3006B.

4. DFS Prop. Family & Lg. Family Child Care Homes Reg. [21 DE Reg. 134 (8/1/17)]

The DFS Office of Child Care Licensing proposes to amend its regulations covering family and large family child care homes. The most significant revision is a requirement that covered settings have "a trained staff member who has successfully received a valid Administration of Medication certificate from OCCL ... present at the home at all times." The following rationale (p. 134) is provided:

> Currently, child care regulations require applicants or providers to have administration of medication certification only if they choose to give medications in their licensed child care home. By amending these regulations, the needs of children requiring medication (with parent/guardian permission) while in child care will be met, consistent with the principles of the Americans with Disabilities Act.

The DFS regulations, along with the Nurse Practice Act [24 Del.C. §1921(a)(10)], authorize child care workers to administer prescription and nonprescription medications if they have successfully completed a state-approved medication training program.

By requiring the presence of a staff member qualified to administer medications at all times, the regulation should facilitate appropriate access to medications by minors in child care settings. I did not identify any concerns with the proposed amendments. Providers may object to this initiative. The Councils may wish to consider a strong endorsement and alert other agencies (e.g. Autism Delaware; UCP; NAMI-DE; Arc of Delaware; NeMours) of the opportunity to comment.

5. DFS Prop. Early Care, Education & School-Age Center Reg. [21 DE Reg. 133 (8/1/17)]

The DFS Office of Child Care Licensing proposes to amend its regulations covering early care, education, and school-age centers. The most significant revision is a requirement that covered settings have "a trained staff member who has successfully received a valid Administration of Medication certificate from OCCL ... present at the center at all times." The following rationale (p. 134) is provided:

> Currently, Section 60.1 does not require an individual with a valid Administration of Medication certificate to be on site during all hours of operation. By amending these regulations, the needs of children requiring medication (with parent/guardian permission) while in child care will be met, consistent with the principals (sic "principles") of the Americans with Disabilities Act.

The DFS regulations, along with the Nurse Practice Act [24 Del.C. §1921(a)(10)], authorize child care workers to administer prescription and nonprescription medications if they have successfully completed a state-approved medication training program.

By requiring the presence of a staff member qualified to administer medications at all times, the regulation should facilitate appropriate access to medications by minors in child care settings. I did not identify any concerns with the proposed amendments. Providers may object to this initiative. The Councils may wish to consider a strong endorsement and alert other agencies (e.g. Autism Delaware; UCP; NAMI-DE; Arc of Delaware; NeMours) of the opportunity to comment.

6. DMMA Notice: DSHP Amendments [21 DE Reg. 156 (8/1/17)]

The Division of Medicaid & Medical Assistance is soliciting comments on two (2) proposed amendments to the Diamond State Health Plan (DSHP) Waiver. The DSHP is the general Medicaid program initiated in 1996 which covers most of Delaware's Medicaid participants. It is implemented through managed care organizations (MCOs). The relevant DMMA documents are difficult to locate on the Web and are attached for facilitated reference. I highlighted some important references.

I. DDDS Lifespan Waiver Interaction with DSHP

The first proposed amendment is to allow non-residential enrollees in the DDDS Lifespan Waiver to obtain State Plan benefits through the DSHP MCO-based system.

As background, the DDDS Waiver population has historically been "carved out" from the DSHP. DDDS Waiver enrollees were limited to those receiving Residential Habilitation. Effective July 1, 2017, the DDDS Waiver was rebranded the Lifespan Waiver and eligibility was expanded to include non-residential DDDS clients.

Under the DMMA proposal, the residential DDDS Waiver enrollees would continue to receive both Waiver and State Plan services through a "fee for service" model. Non-residential DDDS Waiver enrollees would receive Waiver services through a "fee for service" model but State Plan services through the DSHP MCO system. The cited rationale for the divergent approaches is as follows: a) continuity of MCO-managed services; and b) transition to eventual conversion of all DDDS Waiver enrollees to the DSHP MCO system:

> ...Delaware seeks CMS approval to amend the current 1115 DSHP Waiver to enable the individuals that do not live in a provider-managed residential setting to remain enrolled in the DSHP Waiver to continue to receive their acute care benefits from their MCO. If Delaware does not make this amendment, the lives of these individuals will be needlessly disrupted.

DMMA Proposed Amendment, Section I.

If Delaware does not amend the 1115 waiver, new enrollees in the DDDS Lifespan 1915(c) waiver who have previously been enrolled in the 1115 waiver will be forced to dis-enroll from the Managed Care Organization. This amendment is needed to avoid unnecessarily disrupting the lives of prospective DDDS Lifespan waiver enrollees who live with their family. These individuals have established relationships with the Managed Care Organizations and their network of providers to whom they have become accustomed.

21 DE Reg. 156, 157 (8/1/17).

Individuals who are enrolled in the 1915(c) Lifespan Waiver and are receiving Residential Habilitation will continue to be carved out of the 1115 DSHP Waiver and will receive their acute care benefits via fee for service. It is our plan to eventually include this population among the individuals who receive their State Plan benefits from an MCO but we were not able to perform the necessary up front work to do this concurrent with the amendment to the DDDS Lifespan Waiver.

DMMA Proposed Amendment, Section II.

As a result, <u>non-residential</u> DDDS Waiver enrollees will receive all State Plan services through the DSHP MCOs while receiving the following medically necessary DDDS Waiver supports through the DDDS Waiver:

- Day Habilitation
- Personal Care
- Prevocational Services
- Respite
- Supported Employment
- Community Transition
- Home or Vehicle Accessibility Adaptations
- Specialized Medical Equipment & Supplies not otherwise covered by • Medicaid
- Supported Living

DMMA Proposed Amendment, Section I.

I have the following observations.

A. First, the proposition that non-residential DDDS Waiver enrollees would prefer to receive State Plan services through the DSHP MCO network strains credibility. Consider the following:

1. The bifurcation invites conflicts between the DDDS Waiver case managers (Community Navigators) and MCO case managers. Having multiple service managers/coordinators will be confusing to participants and is not cost-effective. The DDDS Waiver services and State Plan services are interrelated, interdependent, and sometimes overlapping For example, nursing consultation and personal care are ostensibly covered services under both the DDDS Waiver and DSHP Waiver. For another example, the efficacy of home modifications under the DDDS Waiver may be affected by the availability of home health and private duty nursing services subject to DSHP MCO approval/disapproval.

2. The DDDS Waiver envisions a single "service plan" which includes both DDDS Waiver and State Plan services:

> Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in Appendix D. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency.

DDDS Waiver Application at 5 [emphasis supplied][copy attached]

Bifurcating the administration and provision of DDDS Waiver and State Plan services between DDDS-contracted Navigators and MCO case managers will predictably lead to confusing and non-integrated service plans to the detriment of participants.

3. MCOs operate under a capitated model in which profits are enhanced by providing fewer services. Positing that DDDS Waiver enrollees would prefer to have their health care regulated by agencies with an inherent profit motivation may not be plausible.

4. DMMA may be incorrectly assuming that all affected DDDS Waiver enrollees will be adults:

> The purpose of the 1915(c) Lifespan Waiver amendment is to increase the waiver enrollment to include individuals with intellectual and developmental disabilities, autism, and/or Prader-Willi Syndrome who have left school but do not require a residential support as of the time of enrollment.

DMMA Proposed Amendment, Section I.

> Delaware has added 1122 unduplicated recipients to the DDDS waiver enrollment cap for WYE 4, the first year of the Lifespan amendment to allow enrollment of all individuals graduating from school that year and those who have already graduated and continue to living (sic "live") with their family.

DMMA Proposed Amendment, Section II.

The DDDS Waiver has historically included minors and the revised DDDS Waiver effective July 1, 2017 has a minimum age of 14. See attached excerpt.

Consistent with the attached articles, one of Delaware's two DSHP MCOs refuses to cover services at Delaware's only pediatric hospital specializing in minors with disabilities. Therefore, it would facilitate access to NeMours and the duPont Hospital for Children if the non-residential DDDS Waiver enrollees were under a fee-for-service model rather than the DSHP model in which access may be barred.

5. The DDDS Waiver is designed to allow a seamless transition between non-residential and residential services and vice versa. Under the proposed model, DDDS Waiver enrollees transitioning between residential and non-residential services could potentially transfer on multiple occasions between DSHP managed care and a fee-for-service model. This will be confusing and problematic to implement.

B. Second, DMMA may wish to clarify that individuals with brain injury are included in the proposal.

Section I of the Proposed Amendment specifically mentions individuals with brain injury:

> The Division of Developmental Disabilities Services (DDDS) Home and Community Based Services Lifespan Waiver provides services and supports as an alternative to institutional placement for individuals with intellectual developmental disabilities (IDD) (including brain injury), autism spectrum disorder or Pracer-Willi Syndrome.

In contrast, Section II of the Proposed Amendment omits the reference to brain injury by defining the eligibility group as follows:

> Individuals with IDD, autism, and/or Prader-Willi Syndrome enrolled in the 1915 (c) DDDS Lifespan Waiver who are not receiving Residential Habilitation.

The Councils may wish to consider sharing reservations with DMMA concerning this initiative. A courtesy copy of any Council commentary could be shared with Autism Delaware, the Arc of Delaware, UCP, BIAD, the DDDS Director, and the Advisory Council to the Division of Developmental Disabilities Services.

II. Medicaid Coverage of Former Out-of-State Foster Care Youth

The second proposed State Plan amendment is to authorize Medicaid coverage until age 26 of former foster care youth from other states.

As background, the SCPD and GACEC endorsed a DMMA proposed regulation in March, 2017 extending Medicaid coverage to 18-26 year olds who aged out of the foster care system in another state. A copy of the March 20, 2017 SCPD letter is attached for facilitated reference. The current proposed DMMA State Plan amendment simply implements the final regulation approved in May. See 20 DE Reg. 908 (May, 2017).

The description of the State Plan amendment is as follows:

> Delaware currently provides coverage to former foster care youth under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care in Delaware when they turned 18 or "aged out" of foster care. Delaware also currently provides coverage to individuals with income up to 133 percent of FPL under the new adult group identified in the ACA. The purpose of this amendment is to provide coverage on a state-wide basis to former foster care youth who currently reside in Delaware and were in foster care and enrolled in Medicaid at age 18 or when they "aged out" of the system in a different state.

21 DE Reg. 156, 157 (8/1/17)

Consistent with the attached summary of the proposed State Plan amendment, Delaware Medicaid currently covers approximately 150 former foster care youth who "aged out" of the Delaware foster care system. DMMA anticipates that the coverage for former foster care youth from out-of-state will "likely result in very few new clients, and therefore won't have a significant fiscal impact." See 20 DE Reg. at 696 (May 1, 2017).

Since the Councils previously endorsed this initiative, they may wish to consider issuing conforming commentary on the implementing State Plan amendment.

7. DMMA Notice: MHPAEA Compliance [21 DE Reg. 158 (8/1/17)]

The Division of Medicaid & Medical Assistance (DMMA) is soliciting comments on its plan/approach to determining compliance of the Delaware Medicaid and CHIP programs with federal parity law, i.e., the Mental Health Parity and Addiction Equity Act (MHPAEA). CMS issued final regulations in 2016 [81 Fed Reg. 18390 (March 30, 2016)] and Delaware is required to comply with the regulations no later than October 2, 2017. See 21 DE Reg. 158, 159 (8/1/17). A CMS summary of the MHPAEA is attached. DMMA clarified in an August 3 email to the DLP that it is soliciting comments on the process used to determine whether Delaware is compliant with the federal regulation, not whether Delaware is actually compliant.

Relevant documents are available through the DMMA website - http://dhss.delaware.gov/dhss/dmma/info_stats.html . The most important document, "MHPEA Report for Public Comment" [hereinafter "Report"], is attached for facilitated reference. The 9-page Report offers background on the methodology used to develop Delaware's assessment of compliance with the MHPAEA.

I have the following observations.

First, the Report is the product of a 9-month review which was ostensibly limited to State agencies and MCOs with zero private provider and consumer input:

> This draft report reflects over nine months of work by the State and its MCOs to conduct a review of the State's Medicaid/CHIP delivery system to assess compliance with the final Medicaid/CHIP parity rule. This process started in the fall of 2016 with the establishment of a cross-agency workgroup tasked with conducting the parity analysis. The workgroup included representatives from state agencies involved in the administration of the State's Medicaid/CHIP program, including:
>
> • The Division of Medicaid and Medical Assistance (DMMA)
> • The Division of Substance Abuse and Mental Health (DSAMH)
> • The Department of Services for Children, Youth and Their Families (DSCYF)
> • The Division of Developmental Disabilities Services (DDDS)

Report, p. 1.

Although the CMS regulation does not require involvement of other stakeholders, it does "encourage" states to do so as preferred practice:

> Although we are not requiring states to work with stakeholders and other public interests to determine the best way to comply with these rules, we believe that states will need to discuss options with stakeholders in their current delivery systems to be able to ascertain the best delivery system for any additional benefits that may be required. We also encourage states to have discussions with stakeholders other than their providers and plans to ensure they achieve compliance in the best way for their beneficiaries.

81 Fed Reg. at 18415.

The validity and reliability of the approach adopted in the Report may be viewed as suspect without the benefit of consumer input.

Second, the definitions of mental health and substance abuse disorders subject to application of the parity law merits review. DHSS generally adopts conditions listed in ICD-10-CM, Chapter 5 "Mental, Behavioral, and Neurodevelopmental Disorders" with several exceptions. At p. 4. For example, DHSS is excluding dementia as well as psychosis and mood disorders attributable to physiological conditions:

> Delaware excluded subchapter 1 from the definition of MH/SUD because these mental disorders are due to known physiological conditions (e.g. dementias, delirium, psychosis, and mood disorders due to known physiological conditions) and all except one require that the physiological condition be coded first, indicating that the physiological (rather than the MH) condition is the focus of services.

Report, at p. 4.

This approach is troubling. Excluding mental health disorders because of a correlation with physiological etiology is the polar opposite of the approach adopted in Delaware's State parity law. The Delaware parity law requires a biological basis for a mental health condition as a prerequisite of application of the parity law:

> "Serious mental illness" means any of the following biologically based mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo affective disorder, and delusional disorder.

See H.B. No. 41 enacted May 30, 2017.

The focus of the federal parity law was not on the catalysts and causes of a mental illness. Rather, the intent of the federal law is best promoted through adoption of a liberal approach to definitions of mental health and substance abuse disorders.

Third, DHSS is excluding not only mental disorders due to physiological conditions but neurological conditions as well:

> Delaware excluded subchapters 8 and 9 from the definition of MH/SUD because these chapters identify neurodevelopmental disorders are opposed to mental or behavioral disorders.

Report, at p. 4. If the DHSS approach results in exclusion of brain injuries, it is an unfortunate result which will have a disproportionate effect on veterans who suffered service-connected brain trauma.

Fourth, the DHSS description of its ICD-10 coding approach implies that secondary codes may be ignored or overlooked when assessing application of parity law. See above reference, "all except one require that the physiological condition be coded first, indicating that the physiological (rather than the MH) condition is the focus of services." There may be occasions when a treatment modality addresses both mental and physical impairments. For example, prescribing a medication to alleviate headache or pain for a patient with depression could be justified under both mental and physical bases. Alternatively, someone with autism (ostensibly unqualified for protection under the intellectual or pervasive developmental disorder exclusion) may have a secondary mental health diagnosis (e.g. intermittent explosive disorder; depression). A treatment may be prescribed to address a mental health condition which should trigger application of the parity law. Cf. inclusion of "behavioral health treatment", "pharmacy care", and "psychiatric care" in the definition of "treatment of autism spectrum disorders" in the autism parity law [Title 18 Del.C. §§3366(e) and 3370A(e)].

Fifth, the Report ignores overlapping State laws which promote parity. See 18 Del.C. §§3366 and 3570A and 18 Del.C. §§3343 and 3578. The latter statutes specifically incorporate some standards from the federal parity law [18 Del.C. §§3343(b)(1)a.2 and 3578(b)(1)a.2]. If there are State law provisions which reinforce or overlap with the federal parity law, they should preferably be included in the Report.

Sixth, the DHSS approach to "quantitative treatment limitations" should be reconsidered. The description is as follows:

> Quantitative Treatment Limitations
>
> Delaware does not apply any quantitative treatment limitations to MH/SUD benefits that cannot be exceeded based on medical necessity. Thus, these limitations were analyzed as NQTLs (non-quantitative treatment limitations) (see Section VIII).

Report, at p. 6.

The problem with this approach is that it ignores presumptive limits. For example, if an MCO employed presumptive limits for 90% of mental health drugs and only 10% of physical health drugs, the parity standards are not met. Alternatively, if an MCO adopted a formulary which discouraged a significantly higher percentage of mental health drugs, parity standards would not be met. Requiring prescribers to overcome additional "hurdles" to prescribe a quantity of mental health drugs versus physical health drugs is discriminatory. Simply allowing an appeal based on medical necessity does not remove the discrimination inherent in the adoption of differential "presumptive" or formulary limits.

The Councils may wish to consider sharing reservations concerning the Report with DHSS. A courtesy copy of comments could be shared with the DPBHS, DDDS, DSAMH, Autism Delaware, NAMI-DE, the Mental Health Association, BIAD, and veterans organizations.

Attachments
E:legis/2017/bils817
F:pub/bjh/legis/2017p&l/817bils

STATE OF DELAWARE

GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS
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April 20, 2017

Tina Shockley
Education Associate – Policy Advisor
Department of Education
401 Federal Street, Suite 2
Dover, DE 19901

RE: 20 DE Reg. 762/14 DE Admin. Code 1009 [DOE Proposed DIAA High School Interscholastic Athletics Regulation (April 1, 2017)]

Dear Ms. Shockley:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Department of Education (DOE) proposal to amend several regulations covering student participation in high school sports in consultation and cooperation with the Delaware Interscholastic Athletic Association (DIAA). Council would like to share the following observations.

1. Section 2.4.4.1.4.2 disallows a student who participated in athletics and then transfers more than one time in his first two years of eligibility from playing any sport for 90 days. While barring the student from playing the same sport is intuitive, barring the student from playing a new sport is not. If one assumes that athletic activity is advantageous to the wellbeing of a student, it is excessive to disallow a student from engaging in all athletic activities unrelated to sports played at the former school.

2. Section 2.4.7 disallows a student transferring to a "choice" school in grades 10-12 from participating in any sport offered at the former school even if the student did not participate in any sports at the former school. The justification for this ban is difficult to understand if one assumes that athletic activity is advantageous to the wellbeing of a student. If a student played no sports at the prior school, it makes little sense to ban the student from playing in any sport offered by the prior school for a full school year. Students should not be penalized for opting to attend a "choice" school as allowed by law.

3. Also in section 2.4.7, the DIAA strikes the word "athletics". To obviate any implication that the DIAA is regulating non-athletic activities in the standards, the DIAA should preferably retain the word "athletics".

4. Section 2.7.3. authorizes the DIAA to grant hardship waivers based on the cap on years of participation. Council has two concerns with this section. First, the U.S. DOE Office for Civil Rights publicizes many advantages to participation in athletics for students with disabilities. See attached January 25, 2013 OCR guidance at 1. The IDEA encourages schools to include extracurricular activities (including athletics) in IEPs. See 34 C.F.R. §300:320(a)(4) and 14 DE Admin Code 925.20.1.4.2. The

IEP team would therefore be a primary decision-maker in the context of participation in athletics. This concept is omitted from the regulation. By analogy, each district typically has a transportation director who determines eligibility for a school bus and assignment to a bus stop. Since transportation is a special education related service, the IEP team (generally in consultation with the transportation director) determines how transportation will be provided for special education students. In the event of disagreement, the IEP team decision prevails. The same concept applies to participation in IEP-listed athletics. The IEP team is the primary decision-maker concerning participation in IEP-listed athletics. Second, imposing a "burden of proof" on a student with an IEP to justify participation in athletics is a foreign concept in special education. The IEP team would deliberate and make a decision typically by consensus. There is no "burden of proof" in the IEP context.

5. The DIAA is involved in the unified sports program. Cf. House Bill No. 175 from 148th General Assembly for description and attached articles. The regulation does not address how participation by students with disabilities is affected by participation in unified sports. For example, if a student with a disability plays in one unified sports scrimmage, does that count for one year of the participation cap under §2.7? The DIAA could consider inserting an exception for students with disabilities participation in unified sports from counting towards the participation cap in §2.7.

Thank you for the opportunity to share our observations with you. Please contact me or Wendy Strauss at the GACEC office if you have any questions on our comments.

Sincerely,

Dafne A. Carnright

Dafne A. Carnright
Chairperson

DAC:kpc

CC: The Honorable Susan Bunting, Secretary of Education
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Research Brief

A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services

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Key Messages

- *In 2013, the average Medicaid fee-for-service reimbursement rate was 48.8 percent of commercial dental insurance charges for pediatric dental care services.*
- *In 2014, the average Medicaid fee-for-service reimbursement rate was 40.7 percent of commercial dental insurance charges for adult dental care services in states that provide at least limited adult dental benefits in their Medicaid program.*
- *From 2003 to 2013, for pediatric dental care services, Medicaid fee-for-service reimbursement relative to commercial dental insurance charges fell in 39 states and rose in seven states and the District of Columbia.*
- *The available evidence strongly suggests that increasing Medicaid reimbursement rates for dental care services, in conjunction with other reforms, increases provider participation and access to dental care for Medicaid enrollees.*

Introduction

Recent years have brought significant changes in dental care use patterns for low-income Americans. In 47 out of 50 states plus the District of Columbia (DC), dental care utilization among Medicaid-enrolled children increased during the past decade.[1,2] In contrast, dental care use among low-income adults has declined steadily.[3] As a result, the gap in dental care utilization between low-income and high-income children has narrowed,[4] while it has widened for adults.[5]

Low-income children and adults are subject to different dental safety nets. Medicaid and the Children's Health Insurance Program (CHIP) must provide dental benefits for children, but states have the option of providing dental benefits for adults in Medicaid.[6] In fact, increased

enrollment in Medicaid and CHIP led to a decline in the percentage of U.S. children without any form of dental benefits.[7] The increase in the dental care utilization rate among Medicaid-enrolled children during a time of significant enrollment expansion – one out of three U.S. children were in Medicaid or CHIP by 2011[8] – has been a truly remarkable achievement.

A key issue for Medicaid is having a sufficient number of providers willing to participate. Research has shown that a variety of reasons, including a high rate of cancelled appointments among Medicaid enrollees, low reimbursement rates, low compliance with recommended treatment and cumbersome administrative procedures, limit the number of dentists that accept Medicaid. For a good overview of factors contributing to the low use of dental services by low-income individuals, see a report published in 2000 by the U.S Government Accountability Office (GAO).[9] In terms of reimbursement rates, recent research has documented a modest, but statistically significant positive relationship between Medicaid fee-for-service (FFS) reimbursement rates and dental care utilization among publicly insured children[10,11] as well as dentist participation in Medicaid.[12,13]

In this research brief, we analyze the most up-to-date information on Medicaid FFS reimbursement rates for dental care services. We measure Medicaid FFS reimbursement relative to typical commercial dental insurance charges. We analyze changes in pediatric Medicaid FFS reimbursement between 2003 and 2013. For pediatric dental care services, we present data for all states and DC. For adult dental care services, we focus only on states that provide dental benefits beyond emergency care to their adult Medicaid population. We discuss the policy implications of our findings, particularly in light of Medicaid enrollment expansion under the Affordable Care Act (ACA).

Data & Methods

We acquired pediatric Medicaid FFS reimbursement rate data for 2003 from previously published research.[14] The Health Policy Institute collected 2013 reimbursement rate data from state Medicaid program webpages. Reimbursement rate data for pediatric dental care services were collected for all states and DC. Data for adult dental care services were collected, where available, from states that provided either extensive (AK, CA, CO, CT, IA, IL, MA, NC, ND, NM, NY, OH, OR, RI, WA and WI) or limited (AR, DC, IN, KY, KS, MI, MN, MT, NJ, PA, SD, VT, VA and WY) adult Medicaid dental benefits as of August 2014.[15,16,17,18,19] Two states, Louisiana and Nebraska, offer limited adult Medicaid dental benefits, but have insufficient FFS data on their webpages and are excluded from the analysis. Medicaid programs in Kansas and Maryland do not officially cover services beyond emergency care. The majority of Medicaid beneficiaries in these states are enrolled in managed care programs which provide limited adult dental benefits.[20,21]

Many state Medicaid programs contract with a "managed care" provider and do not pay dentists directly through FFS. For example, New Jersey is a state that contracts the majority of their pediatric Medicaid enrollees to dental managed care providers. Managed care reimbursement data are not available publicly in any state, to our knowledge, and were not included in our analysis. In other words, we focused solely on Medicaid FFS reimbursement rates understanding that in many states this is not how most dental care is reimbursed. We attempted to identify the states that enroll the majority of their Medicaid beneficiaries in dental managed care programs based on an email survey and interviews with Medicaid dental program directors carried out between September 2, 2014 and September 9, 2014. In instances where we did not receive a conclusive response from program

directors (AL, DE, FL, HI, IA, LA,OH, TN and VT), we reviewed state Medicaid websites and the Centers for Medicare and Medicaid Services website to try to ascertain how states managed Medicaid dental services.[22,23,24,25,26,27,28,29,30] In instances where we did not receive a response and could not find information on the management of Medicaid dental services on a state's website (KS, KY, ME, MS, OK, PA, SC, UT and WV), we referenced previous analysis of managed care in Medicaid from 2010 data.[31] We could find no other source of information to classify states according to their intensity of managed care in Medicaid.

In fiscal year 2010, approximately 62 percent of full-benefit Medicaid-enrolled children were in a comprehensive managed care program.[32] However, we cannot definitively state how many of these managed care enrolled children received dental benefits via managed care. Further, these data are from fiscal year 2010, and many states have made changes to their Medicaid delivery models since then.

The lack of availability of reimbursement data within managed care systems presented a significant limitation to our analysis. While state Medicaid programs post FFS schedules on their websites, Medicaid managed care providers may be subject to completely different reimbursement schedules.

We obtained commercial dental insurance reimbursement charges for each state and DC for 2003 and 2013 from the FAIR Health Dental Benchmark Module.[33] The most recent data contained within the FAIR Health database cover 125 million individuals with commercial dental insurance,[34] which captures approximately 80 percent[35] of the total commercial dental insurance market. The FAIR Health database provides charge data for dental procedures, billed using the American Dental Association (ADA) CDT® codes. The benchmarks are based on the non-discounted reimbursement rates charged by providers before network discounts are applied. Since our Medicaid FFS data for adult dental care services were from 2014, we inflated the 2013 FAIR Health reimbursement rates to 2014 levels using the all-items Consumer Price Index in order to match data years.[36]

We constructed an index that measures FFS reimbursement rates in Medicaid relative to commercial dental insurance charges. We feel this is a useful measure as it takes into account Medicaid reimbursement relative to "market" conditions. Nationwide, 97.6 percent of dentists report accepting some form of commercial dental insurance and, on average, such payments account for 53.9 percent of gross billings.[37] Commercial dental insurance is a significant source of dental care financing in the United States, accounting for 48 percent of dental care expenditure in 2012.[38]

The index for pediatric dental care services is based on fourteen common procedures: periodic oral exam (D0120), comprehensive oral exam (D0150), complete x-rays (D0210), bitewing x-rays with two radiographic images (D0272), panoramic x-rays (D0330), child prophylaxis (D1120), application of topical fluoride (D1203/D1208), application of dental sealants (D1351), permanent tooth amalgam (D2150), anterior tooth resin (D2331), prefabricated steel crown (D2930), therapeutic pulpotomy (D3220), root canal (D3310), and extractions (D7140). This same basket of procedures was used to construct a Medicaid reimbursement index in previous research.[39]

The index for adult dental care services is based on ten common procedures: periodic oral exam (D0120), comprehensive oral exam (D0150), complete x-rays (D0210), bitewing x-rays with four radiographic images (D0274), panoramic x-rays (D0330), adult prophylaxis (D1110), permanent tooth amalgam (D2150), anterior tooth resin (D2331), root canal (D3310) and extractions (D7140).

Within our index, the reimbursement rate for each procedure was weighted by its share of total billings in the aggregated 2010-12 FAIR Health database.[40] In other words, both the Medicaid FFS reimbursement index and the commercial dental insurance charges index were constructed using a common weighting scheme that is based on commercial dental insurance billings patterns. We divided the Medicaid FFS reimbursement index by the commercial dental insurance charges index to calculate our main outcome of interest: Medicaid reimbursement relative to commercial dental insurance charges. We did this separately for pediatric and adult dental care services.

To test the sensitivity of our analysis, we also created indices where the reimbursement rate for a procedure is weighted by its share of total number of procedures in the aggregated 2010-12 FAIR Health database. Our results did not change substantively.

We calculated the percentage change in Medicaid-to-commercial-dental-insurance fees from 2003 to 2013 for pediatric dental services.

We also calculated Medicaid-to-commercial-dental-insurance fees in 2014 for adult dental services. The list of procedures and their corresponding weights in the pediatric and adult dental fee indices are shown in Tables 1 and 2.

There are several limitations to our analysis. First, as noted, our Medicaid reimbursement rates are based on FFS schedules. In some states, these are less relevant since most care is delivered through managed care arrangements. Second, our reimbursement indices are based on a limited set of procedures. While, ideally, all procedures would be included, this is not feasible given the data availability on Medicaid webpages and our interest in comparability across states. Moreover, our sensitivity analysis shows that alternative weighting schemes do not alter our conclusions significantly. Third, our weighting scheme is based on care patterns within the commercially-insured population. There are differences in the relevant importance of various procedures between the Medicaid and commercially-insured population.[41,42] Due to data constraints – mainly that we do not have access to claims-level data from Medicaid programs – we feel our approach is the best possible. Fourth, there may be some inconsistency in how dentists submit charge data in commercial claims which could lead to measurement error. FAIR Health's dental module provides fee data based on "the non-discounted fees charged by providers before network discounts are applied." However, based on anecdotal information, we feel that providers often submit the fees they expect to be paid rather than their true, non-discounted fees. We have no basis to evaluate this empirically and simply raise this as a potential limitation.

An alternative data source for market fees would be HPI's annual fee survey that collects full, undiscounted fees from a national sample of dentists. We did not use these data because they are not available at the state level.[43]

Results

As shown in Figure 1, there is wide variation in Medicaid reimbursement rates for pediatric dental care services. In the United States in 2013, Medicaid reimbursement was, on average, 48.8 percent of commercial insurance charges for pediatric dental services. Minnesota (26.7 percent), Rhode Island (27.9 percent), California (29.0 percent), Wisconsin (31.5 percent), Michigan (32.5 percent), Illinois (32.5 percent) and Oregon (32.6 percent) have the lowest Medicaid reimbursement rates. Delaware (81.1 percent), West Virginia (69.9 percent), New Jersey (68.8 percent) and Connecticut (66.8 percent) have the highest. As noted in the Data & Methods section, it is important to note that New Jersey, for example, has a high concentration of managed care and the Medicaid FFS reimbursement rate does not capture average

payment rates to dental providers. As a result, the New Jersey calculation needs to be interpreted extremely carefully.

Figure 2 and Table 3 also show the percentage change in Medicaid-to-commercial-dental-insurance fees for pediatric dental care services from 2003 to 2013. Connecticut, Louisiana and Texas had the largest increase in Medicaid FFS reimbursement relative to commercial dental insurance charges for pediatric dental services. For example, in Connecticut, pediatric dental Medicaid FFS reimbursement increased from 38.7 percent of commercial dental insurance charges in 2003 to 66.8 percent in 2013. Conversely, Minnesota, Tennessee, Wisconsin, New York and Iowa had the largest decline in the Medicaid-to-commercial-dental-insurance fee ratio for pediatric dental services between 2003 and 2013.

Between 2003 and 2013, 39 states experienced a decline in the Medicaid-to-commercial-dental-insurance fee ratio for pediatric dental services. Only seven states and DC experienced an increase. This means that Medicaid FFS reimbursement has not kept up with "market" rates in most states.

In 2014, there is also wide variation in Medicaid FFS reimbursement for adult dental care services (see Figure 3). Illinois (13.8 percent), New Jersey (17.8 percent) and Michigan (20.3 percent) have the lowest Medicaid FFS reimbursement rates compared to commercial dental insurance charges. Arkansas (60.5 percent), North Dakota (60.2 percent) and Alaska (58.4 percent) have the highest Medicaid FFS reimbursement rates relative to commercial dental insurance charges. In the sample of states we focused on – those that have at least a limited adult dental benefit in Medicaid – Medicaid FFS reimbursement averaged 40.7 percent of commercial dental insurance charges for adult dental care services.

Indices using weights based on the total count of procedures do not produce substantively different results. This alternative analysis is available on request.

Table 1: List of Procedures and Corresponding Weights for Pediatric Dental Services

CDT Procedure Code	Weight
D0120: Periodic Oral Exam	32.1%
D1120: Child Prophylaxis	10.5%
D0150: Comprehensive Oral Exam	8.9%
D0210: Complete X-Rays	7.4%
D7140: Extraction	7.0%
D0330: Panoramic X-rays	6.5%
D2150: Permanent Tooth Amalgam	5.5%
D1203/D1208: Application of Topical Fluoride	4.5%
D2331: Anterior Tooth Resin	4.5%
D0272: Bitewing X-rays with 2 Radiographic	4.4%
D3310: Root Canal	3.8%
D1351: Application of Dental Sealants	3.0%
D2930: Prefabricated Steel Crown	1.1%
D3220: Therapeutic Pulpotomy	0.6%

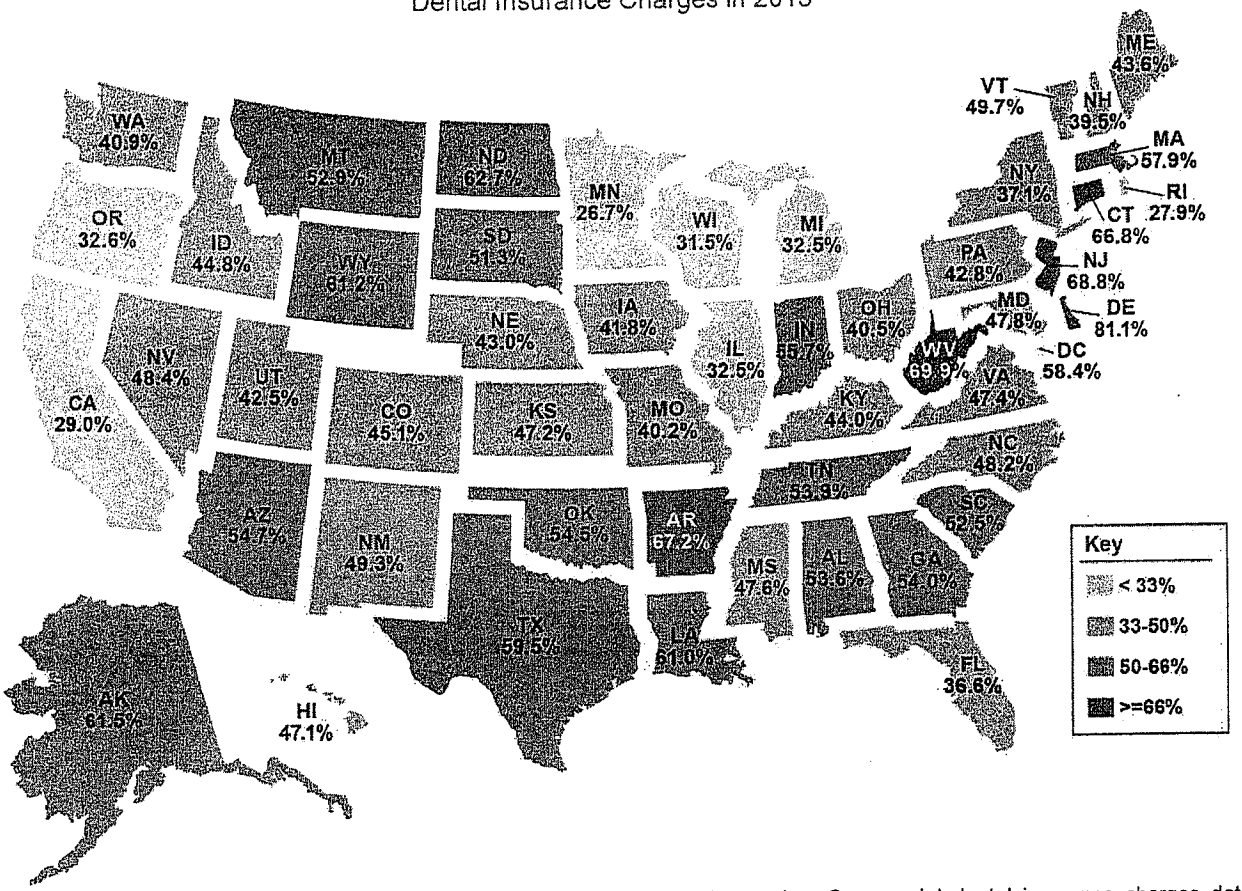
Source: FAIR Health Dental Module. **Notes:** Weights based on data from 2010-2012.

Table 2: List of Procedures and Corresponding Weights for Adult Dental Services

CDT Procedure Code	Weight
D1110: Adult Prophylaxis	37.8%
D0120: Periodic Oral Exam	21.8%
D0274: Bitewing X-rays with 4 Radiographic	10.7%
D0150: Comprehensive Oral Exam	6.0%
D0210: Complete X-Rays	5.0%
D7140: Extraction	4.8%
D0330: Panoramic X-rays	4.4%
D2150: Permanent Tooth Amalgam	3.7%
D2331: Anterior Tooth Resin	3.0%
D3310: Root Canal	2.6%

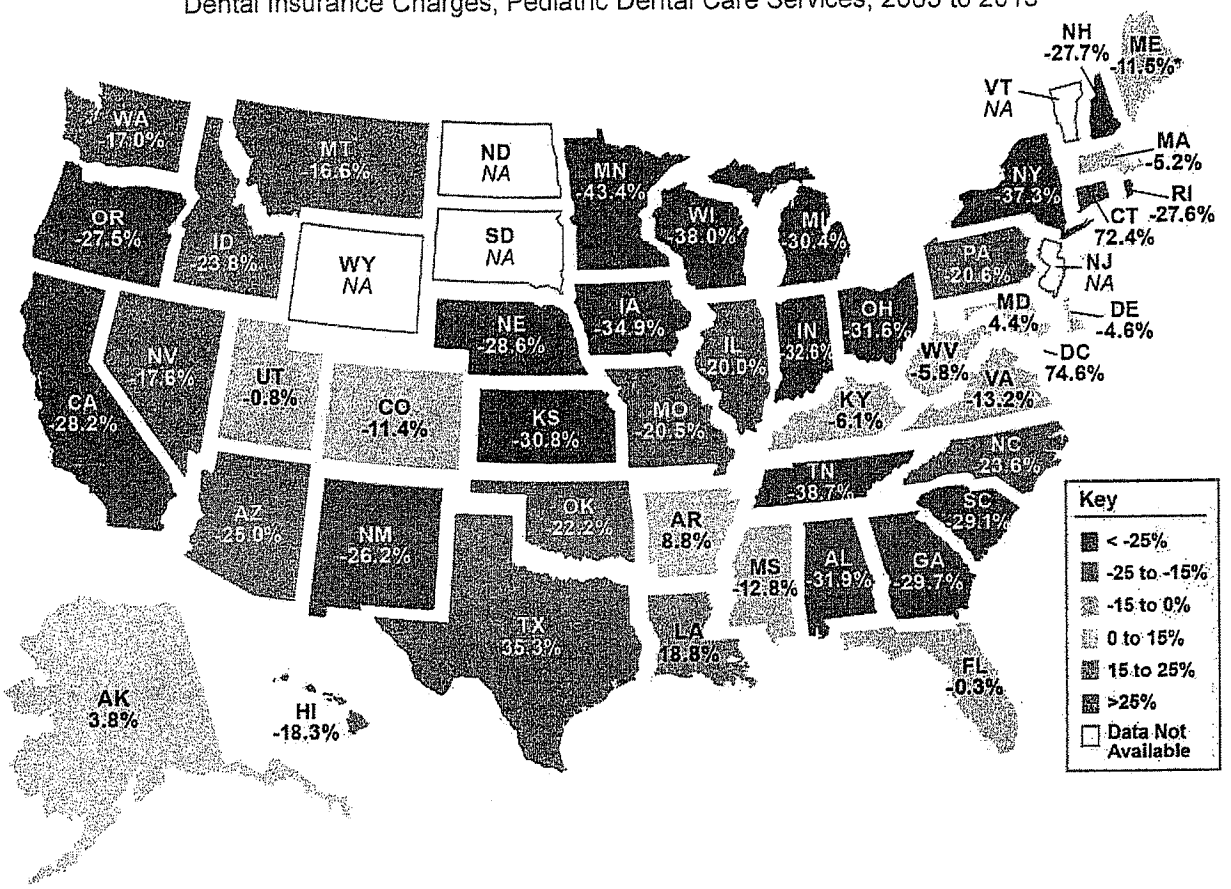
Source: FAIR Health Dental Module. **Notes:** Weights based on data from 2010-2012.

Figure 1: Pediatric Dental Medicaid Fee-for-Service Reimbursement as a Percentage of Commercial Dental Insurance Charges in 2013



Source: Medicaid FFS reimbursement data collected from state Medicaid agencies. Commercial dental insurance charges data collected from FAIR Health. **Notes:** The following states contract the majority of their Medicaid enrollees to managed care programs for dental services: DC, FL, GA, ID, KY, LA, MI, MN, NJ, NM, NV, NY, OH, OR, RI, TN, TX, VT and WV. The relative fee rates shown in this figure for these states, therefore, may not be representative of typical dentist reimbursement in Medicaid.

Figure 2: Percentage Change in the Ratio of Medicaid Fee-for-Service Reimbursement to Commercial Dental Insurance Charges, Pediatric Dental Care Services, 2003 to 2013



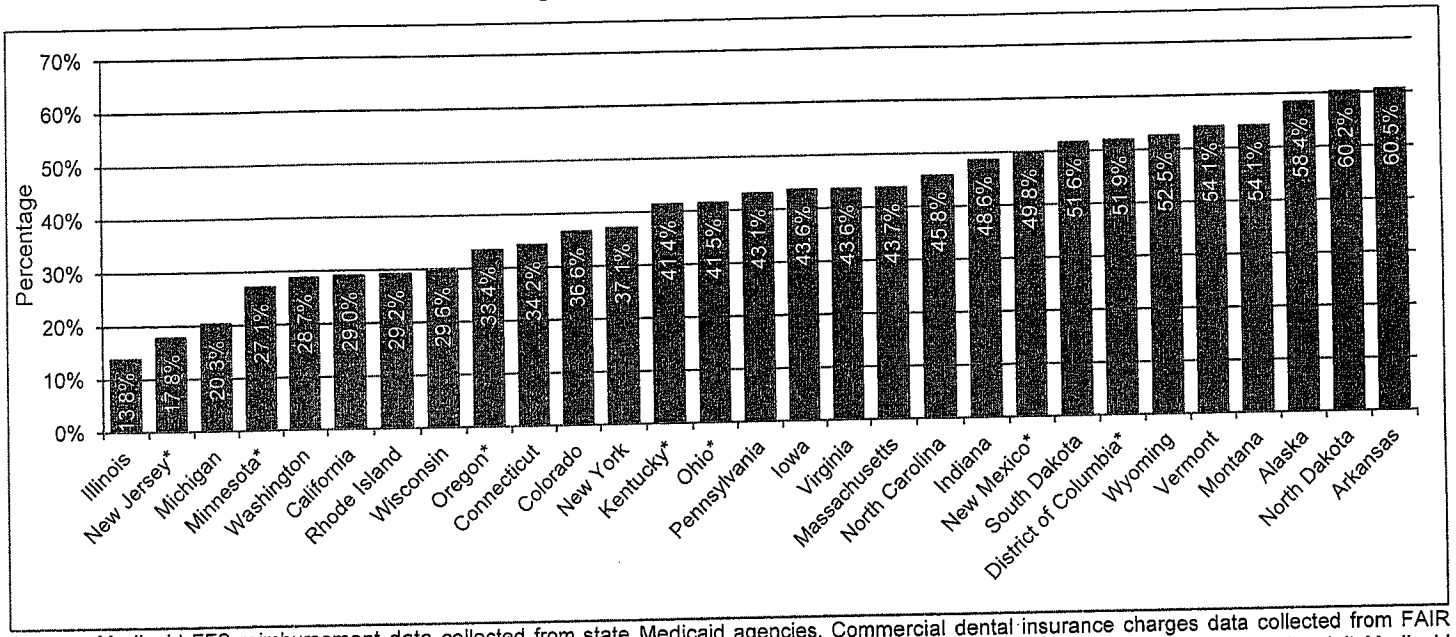
Source: Medicaid FFS reimbursement data collected from state Medicaid agencies. Commercial dental insurance charges data collected from FAIR Health. **Notes:** 2003 Medicaid FFS data for pediatric services were not available for Maine, North Dakota, South Dakota, Vermont and Wyoming. For Maine, the percentage change in the relative Medicaid FFS to commercial insurance charges rate for pediatric dental services was calculated from 2004 through 2013. The following states contract the majority of their Medicaid enrollees to managed care programs for dental services: DC, FL, GA, ID, KY, LA, MI, MN, NJ, NM, NV, NY, OH, OR, RI, TN, TX, VT and WV. For these states, the percentage change from 2003 through 2013 in relative reimbursement rates shown in this figure may not be representative of changes in typical dentist reimbursement in Medicaid.

Table 3: Medicaid Fee-for-Service Reimbursement as a Percentage of Commercial Dental Insurance Charges, Pediatric Dental Care Services, 2003 and 2013

State	2003	2013	% change
Alabama	78.7%	53.6%	-31.9%
Alaska	59.2%	61.5%	3.8%
Arizona	72.9%	54.7%	-25.0%
Arkansas	61.8%	67.2%	8.8%
California	40.4%	29.0%	-28.2%
Colorado	50.9%	45.1%	-11.4%
Connecticut	38.7%	66.8%	72.4%
Delaware	85.0%	81.1%	-4.6%
District of Columbia**	33.4%	58.4%	74.6%
Florida**	36.7%	36.6%	-0.3%
Georgia**	76.8%	54.0%	-29.7%
Hawaii	57.6%	47.1%	-18.3%
Idaho**	58.8%	44.8%	-23.8%
Illinois	40.6%	32.5%	-20.0%
Indiana	82.6%	55.7%	-32.6%
Iowa	64.1%	41.8%	-34.9%
Kansas	68.2%	47.2%	-30.8%
Kentucky**	46.8%	44.0%	-6.1%
Louisiana**	51.3%	61.0%	18.8%
Maine*	NA	43.6%	-11.5%*
Maryland	45.7%	47.8%	4.4%
Massachusetts	61.1%	57.9%	-5.2%
Michigan**	46.8%	32.5%	-30.4%
Minnesota**	47.3%	26.7%	-43.4%
Mississippi	54.6%	47.6%	-12.8%
Missouri	50.5%	40.2%	-20.5%
Montana	63.4%	52.9%	-16.6%
Nebraska	60.2%	43.0%	-28.6%
Nevada**	58.7%	48.4%	-17.6%
New Hampshire	54.7%	39.5%	-27.7%
New Jersey**	NA	68.8%	NA
New Mexico**	66.8%	49.3%	-26.2%
New York**	59.1%	37.1%	-37.3%
North Carolina	63.1%	48.2%	-23.6%
North Dakota	NA	62.7%	NA
Ohio**	59.2%	40.5%	-31.6%
Oklahoma	70.1%	54.5%	-22.2%
Oregon**	44.9%	32.6%	-27.5%
Pennsylvania	53.9%	42.8%	-20.6%
Rhode Island**	38.6%	27.9%	-27.6%
South Carolina	74.1%	52.5%	-29.1%
South Dakota	NA	51.3%	NA
Tennessee**	88.0%	53.9%	-38.7%
Texas**	44.0%	59.5%	35.3%
Utah	42.8%	42.5%	-0.8%
Vermont**	NA	49.7%	NA
Virginia	54.6%	47.4%	-13.2%
Washington	49.3%	40.9%	-17.0%
West Virginia**	74.2%	69.9%	-5.8%
Wisconsin	50.8%	31.5%	-38.0%
Wyoming	NA	61.2%	NA

Source: Medicaid FFS reimbursement data collected from state Medicaid agencies. Commercial dental insurance charges data collected from FAIR Health. **Notes:** 2003 Medicaid FFS data for pediatric dental care services were not available for ME, ND, SD, VT and WY. *For Maine, the percentage change in the ratio of Medicaid FFS to commercial dental insurance charges for pediatric dental care services was calculated from 2004 through 2013. **These states enroll the majority of their Medicaid beneficiaries in managed care programs for dental services; for these states, the data shown in this table may not be representative of typical dentist reimbursement in Medicaid.

Figure 3: Medicaid Fee-for-Service Reimbursement as a Percentage of Commercial Dental Insurance Charges, Adult Dental Care Services, 2014



Source: Medicaid FFS reimbursement data collected from state Medicaid agencies. Commercial dental insurance charges data collected from FAIR Health. **Notes:** 2013 commercial charges inflated to 2014 dollars using the all-items CPI. *These states enroll the majority of their adult Medicaid beneficiaries in managed care programs for dental services; for these states, the data in this figure may not be representative of typical dentist reimbursement in Medicaid.

Discussion

In most states included in our analysis, Medicaid FFS reimbursement rates have decreased in recent years when measured relative to "market" rates. For pediatric dental care services, 39 states experienced a decline in Medicaid-to-commercial-dental-insurance fees compared to seven states and DC that experienced an increase.

Low Medicaid FFS reimbursement is one of many important factors influencing the success of Medicaid programs. Research has shown that Medicaid FFS reimbursement increases, in conjunction with other reforms, have a significant positive effect on provider participation and access to dental care. For example, Connecticut, Maryland and Texas significantly reformed their Medicaid programs in recent years and this led to increased dental care use for Medicaid-eligible children.[44]

The Medicaid program in Connecticut increased dental reimbursement rates to the 70th percentile of commercial dental insurance rates in mid-2008 and implemented a case management program to reduce appointment cancellations. This led to a significant increase in provider participation, access to dental care, and dental care use among Medicaid-enrolled children.[45]

Maryland's Medicaid program increased dental care reimbursement, carved Medicaid dental services out of managed care,[46] increased the Medicaid dental provider network, improved customer services for providers and patients, streamlined credentialing, and created a missed appointment tracker.[47] Over the past decade Maryland has seen one of the largest increases in dental care use among Medicaid-enrolled children of any state.[48,49]

The Texas Medicaid program increased dental reimbursement by more than 50 percent in September 2007,[50] implemented loan forgiveness programs for dentists who agreed to practice in underserved areas and allocated more funds to dental clinics in underserved communities.[51] By 2010, dental care use among Medicaid-enrolled children in Texas had increased so much that it actually exceeded the rate among children with commercial dental insurance.[52]

The experience of Maryland, Texas and Connecticut illustrate the impact of "enabling conditions" – reimbursement closer to market rates, patient and provider outreach, streamlined administrative procedures, patient navigators, enhanced incentives in underserved areas – on provider participation and, ultimately, access to dental care.

In addition to state-specific evidence of the impact of Medicaid reforms, analysis at the national level also confirms the important role enhanced provider reimbursement plays in increasing provider participation and dental care use[53,54]. Unfortunately, far less research is available to quantify the impact of other types of program innovations such as the introduction of patient navigators, community dental health coordinators, enhanced program integrity measures, and streamlined administrative procedures. This is an important area for future research.

Looking forward, over eight million adults[55] and more than three million children[56] could gain dental benefits through Medicaid expansion under the ACA, significantly increasing demand for dental care among the Medicaid population. At the same time, there is strong evidence of significant unused capacity within the dental care delivery system,[57] which could potentially be leveraged to deliver care to this growing Medicaid population. In fact, new research demonstrates that significant increases in dental care delivery to low-income adults can be achieved with the existing dental workforce.[58] However, for the unused capacity in the dental care delivery system to be harnessed effectively, certain "enabling conditions" are needed, one of which, is reasonable financial incentives to providers.

It is important to highlight that low Medicaid reimbursement has been recognized as a critical issue not just in dentistry but in primary care more broadly. In fact, one key provision of the ACA mandated increases in Medicaid reimbursement rates to primary care physicians. Specifically, states were mandated to increase Medicaid reimbursement rates for key primary care services to Medicare levels, resulting in a 73 percent average increase in Medicaid reimbursement rates in 2013.[59] Dental care services were exempt from this provision of the Affordable Care Act.

The evidence strongly suggests that moving Medicaid FFS reimbursement rates for dental care services closer to commercial dental insurance levels, in conjunction with other reforms, increases provider participation and access to dental care for Medicaid enrollees. To reverse the growing gap in dental care utilization between low-income and high-income adults[60] policy makers can look to the success stories and 'promising practices' of states such as Maryland, Texas, and Connecticut in considering reforms to their Medicaid program.

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$$Price\ Index = \frac{\sum_{i=1}^{P} weight_i * Fee_i}{\sum_{i=1}^{P} weight_i}$$

where "P" is the number of dental procedures in the basket of services that make up the reimbursement index. Fee_i is the measured dollar reimbursement rate for procedure *i*. Separate commercial and Medicaid reimbursement indices are calculated in this brief.

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HPI Health Policy Institute
ADA American Dental Association

Research Brief

Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016

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Key Messages

- *Wisconsin, Washington and California had the lowest Medicaid reimbursement rates for both adult and child dental care services among states that provide dental services via fee-for-service.*
- *There is considerable variation across states in Medicaid fee-for-service reimbursement rates.*

Introduction

Low-income children and adults are subject to different dental safety nets. States are required to provide dental benefits to children, who are covered by Medicaid and the Children's Health Insurance Program (CHIP), but providing adult dental benefits is optional.[1] Increased enrollment in Medicaid and CHIP led to a historic low of 11 percent of children lacking dental benefits in 2014, the most recent year data are available.[2] There has also been a steady increase in dental care utilization among children enrolled in Medicaid and CHIP over the past fifteen years.[3] Low-income adults have not experienced similar gains. In 2014, the latest year for which we have data since Medicaid expansion under the Affordable Care Act, 54 percent of Medicaid-enrolled adults lived in states that provide adult dental benefits in their Medicaid programs.[2] However, 35.2 percent of adults in the U.S. do not have any form of dental coverage.[2]

A key issue for Medicaid is having a sufficient number of providers willing to participate. Research shows that a variety of factors limit the number of dentists that accept Medicaid, including high rates of cancelled appointments among Medicaid enrollees, low

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reimbursement rates, low compliance with recommended treatment, and cumbersome administrative procedures.[4] In terms of reimbursement rates, numerous studies illustrate a statistically significant positive relationship between Medicaid reimbursement rates and dental care utilization among publicly insured children[5-7] as well as dentist participation in Medicaid.[6,8]

In this research brief, we analyze Medicaid reimbursement rates for dental care services in all states and the District of Columbia for 2016.

Results

Table 1 describes Medicaid fee-for-service (FFS) reimbursement relative to fees charged by dentists and private dental insurance reimbursement. Medicaid FFS reimbursement, on average, is 49.4 percent of fees charged by dentists for children and 37.2 percent for adults. Medicaid FFS reimbursement, on average, is 61.8 percent of private dental insurance reimbursement for children and 46.1 percent for adults. Private dental insurance reimbursement is, on average, 80.5 percent of fees charged by dentists for children and 78.6 percent for adults.

Figure 1 illustrates Medicaid FFS reimbursement as a percentage of fees charged by dentists for child dental services. Delaware (82.3 percent), Alaska (65.6 percent), Arkansas (63.0 percent), North Dakota (62.4 percent), and South Dakota (61.1 percent) have the highest Medicaid FFS reimbursement rates relative to fees charged by dentists while California (30.8 percent), Wisconsin (32.1 percent), Washington (32.5 percent), Iowa (40.8 percent), and Hawaii (41.6 percent) have the lowest.

Figure 2 illustrates Medicaid FFS reimbursement as a percentage of private dental insurance reimbursement for child dental services. Delaware (98.4 percent), Maryland (79.3 percent), Utah (75.3 percent), Arkansas (75.2 percent), and Massachusetts (74.1 percent) have the highest Medicaid FFS reimbursement rates relative to private dental insurance reimbursement rates while Wisconsin (36.4 percent), California (38.7 percent), Washington (40.4 percent), Maine (49.8 percent), and Iowa (49.8 percent) have the lowest.

Figure 3 illustrates private dental insurance reimbursement as a percentage of fees charged by dentists for child dental services. Alaska (93.0 percent), Wyoming (92.7 percent), South Dakota (92.4 percent), Oregon (92.4 percent), and North Dakota (91.8 percent) have the highest rates relative to fees charged by dentists while New York (55.5 percent), Maryland (68.8 percent), Pennsylvania (70.0 percent), Utah (71.5 percent), and Kentucky (72.7 percent) have the lowest.

Figure 4 illustrates Medicaid FFS reimbursement as a percentage of fees charged by dentists for adult dental services in states with extensive adult dental benefits within their Medicaid programs. Alaska (59.4 percent), North Dakota (59.0 percent), Montana (56.9 percent), North Carolina (43.7 percent), and Iowa (40.4 percent) have the highest Medicaid FFS reimbursement rates relative to fees charged by dentists while Rhode Island (25.5 percent), Washington (25.8 percent), Wisconsin (27.1 percent), Connecticut (27.3 percent), and California (34.3 percent) have the lowest.

Figure 5 illustrates Medicaid FFS reimbursement as a percentage of private dental insurance reimbursement for adult dental services in states with extensive adult dental benefits within their Medicaid programs. North Dakota (66.5 percent), Alaska (63.2 percent), Montana (62.0 percent), North Carolina (52.9 percent), and Massachusetts (49.4 percent) have the highest Medicaid FFS reimbursement rates relative to private dental insurance reimbursement rates while Wisconsin

(31.4 percent), Washington (32.4 percent), Rhode Island (33.7 percent), Connecticut (34.2 percent), and California (43.8 percent) have the lowest.

Figure 6 replicates Figure 3, but for adult dental services. Wyoming (94.3 percent), Alaska (94.0 percent), Montana (91.7 percent), South Dakota (91.4 percent), and North Dakota (88.7 percent) have the highest private dental insurance reimbursement rates relative to fees charged by dentists while New York (51.4 percent), Maryland (66.0 percent), Pennsylvania (67.2 percent), District of Columbia (67.7 percent), and Utah (70.1 percent) have the lowest.

Discussion

In our view, we have the most up-to-date, comprehensive, and scientifically sound analysis of Medicaid FFS reimbursement for dental care services in the United States. As noted in our methods section, our analysis has several important shortcomings, which all stem from data limitations. Most notably, for states with managed care programs for Medicaid dental care services, there is no publicly available source of data for reimbursement rates. The managed care "data void" continues to be a limiting factor for researchers, and we continue to urge state policymakers to push for data transparency.

While our analysis in this research brief is descriptive, there are some important conclusions that can be drawn. First, the lowest Medicaid FFS reimbursement for both adult and child dental care services tend to be found in the same states: Wisconsin, Washington and California. Second, there is considerable variation across states in Medicaid FFS reimbursement rates. Third, there is considerable variation across states in the private dental insurance "discount" rate.

Medicaid reimbursement rates, in part, determine the success of Medicaid programs. Research has shown that adjusting Medicaid payment rates closer to "market" levels in conjunction with other reforms has a significantly positive effect on access to dental care.[7] For example, the Medicaid program in Connecticut increased dental reimbursement rates to the 70th percentile of private dental insurance rates in mid-2008 and implemented a case management program to reduce appointment cancellations. This led to a considerable increase in provider participation, access to dental care, and dental care use among Medicaid-enrolled children.[8] Maryland's Medicaid program increased dental care reimbursement, carved Medicaid dental services out of managed care,[9] increased the Medicaid dental provider network, improved customer services for providers and patients, streamlined credentialing, and created a missed appointment tracker over the past decade.[10] During this time, Maryland has seen one of the largest increases in dental care use among Medicaid-enrolled children of any state.[11,12] The Texas Medicaid program increased dental reimbursement by more than 50 percent in September 2007, implemented loan forgiveness programs for dentists who agreed to practice in underserved areas, and allocated more funds to dental clinics in underserved communities.[13] By 2010, dental care use among Medicaid-enrolled children in Texas had increased so much that it actually exceeded the rate among children with commercial dental insurance.[14] The experiences of Connecticut, Maryland and Texas illustrate the impact of "enabling conditions" — reimbursement closer to market rates, patient and provider outreach, streamlined administrative procedures, patient navigators, enhanced incentives in underserved areas — on provider participation and, ultimately, access to dental care.

The Health Policy Institute is pursuing additional research based on the data summarized in this research brief. We aim to answer questions about the impact of Medicaid FFS reimbursement rates on

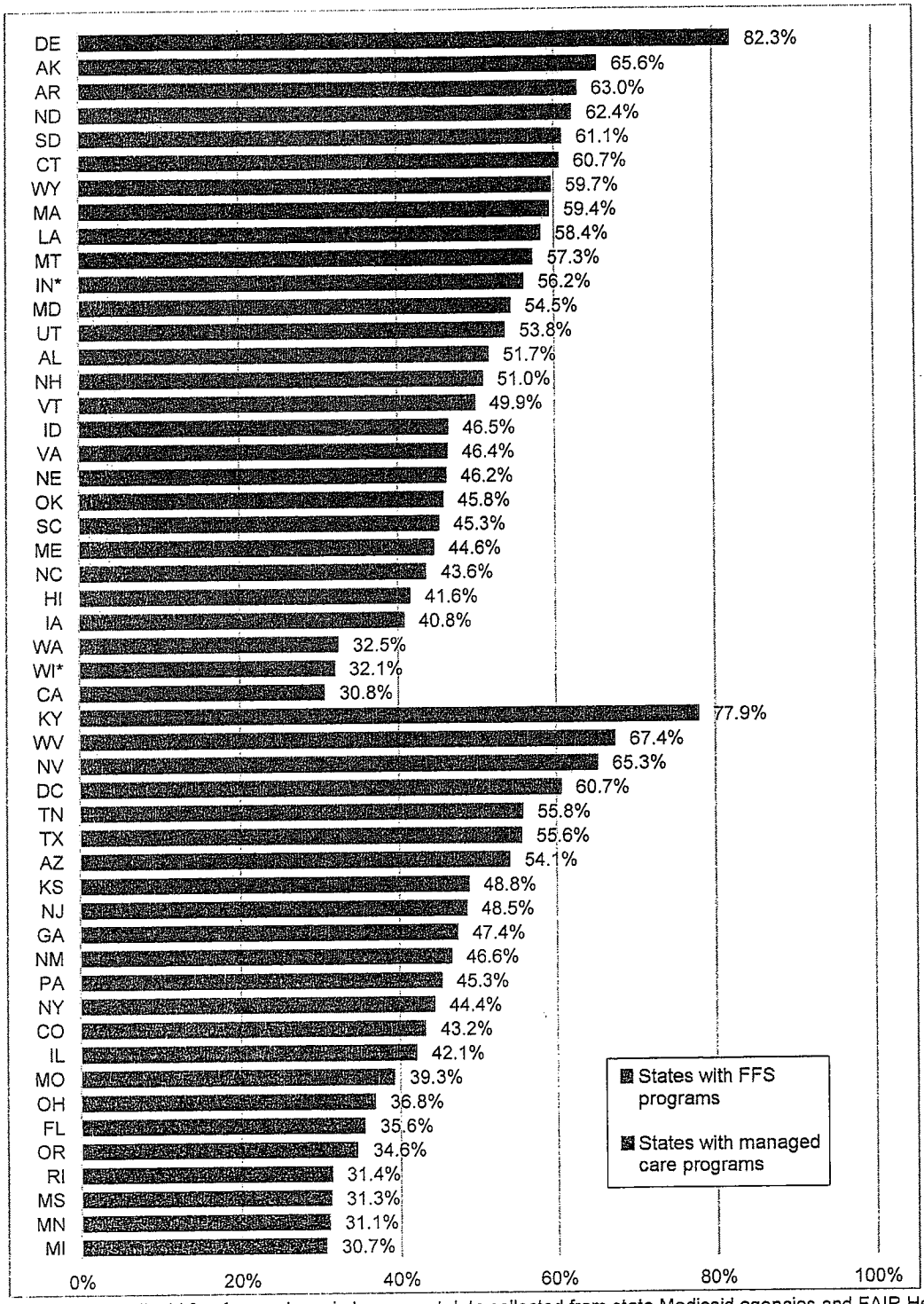
dentist participation and dental care use among Medicaid enrollees. We will also compare Medicaid reimbursement rates provided to dentists to those provided to physicians.

Table 1: Summary of Reimbursement Rates, 2016

	Medicaid fee-for-service reimbursement relative to fees charged by dentists	Medicaid fee-for-service reimbursement relative to private dental insurance reimbursement	Private dental insurance reimbursement relative to fees charged by dentists
Child dental services	49.4%	61.8%	80.5%
Adult dental services	37.2%	46.1%	78.6%

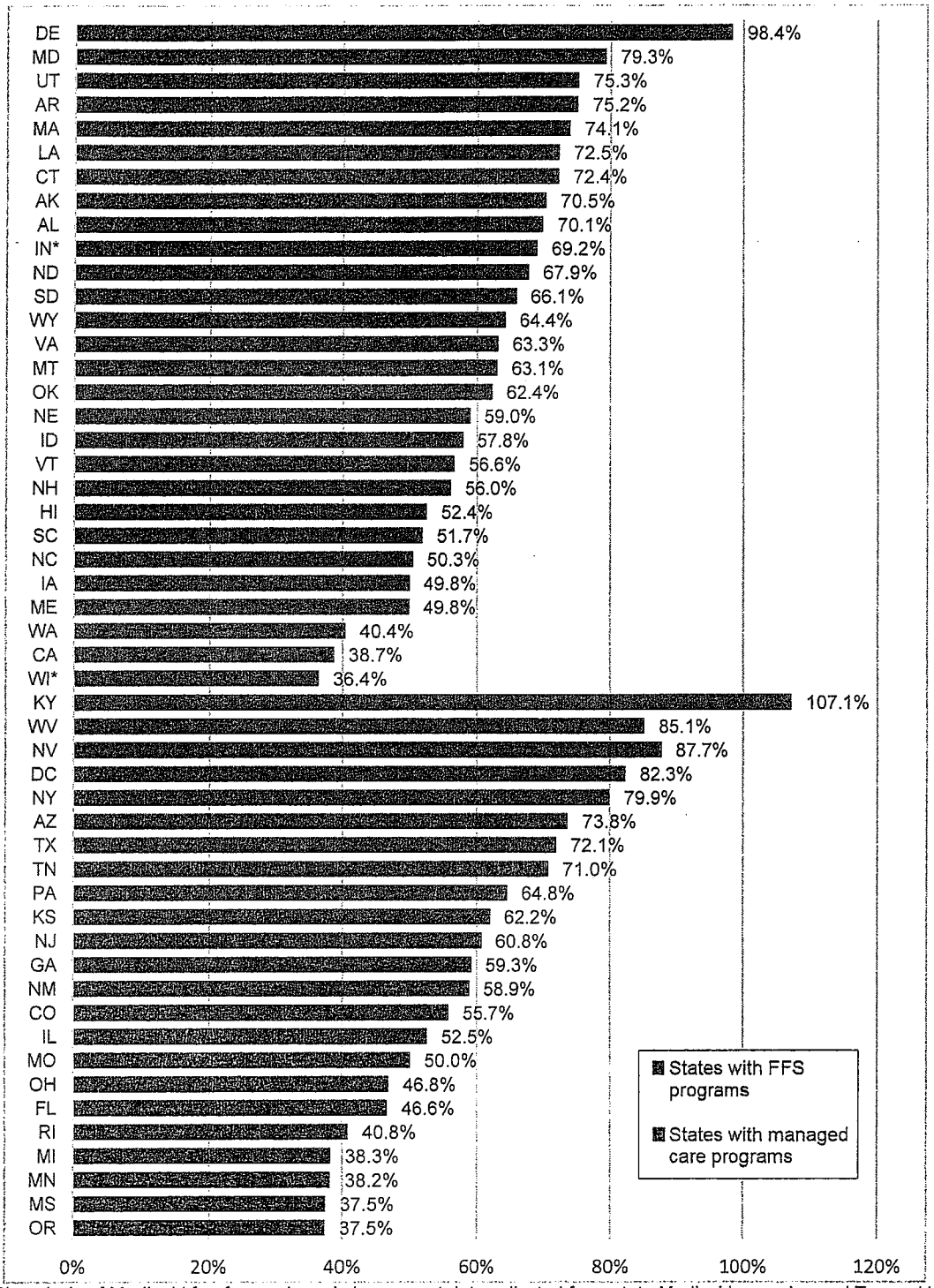
Source: HPI analysis of Medicaid fee-for-service reimbursement data collected from state Medicaid agencies, FAIR Health, and Truven Health MarketScan® Research Database. **Note**: For child dental services, this table provides the average across 50 states and Washington, D.C. For adult dental services, this table provides the average across 16 states with an extensive Medicaid adult dental benefit for the Medicaid FFS reimbursement relative to fees charged by dentists and Medicaid FFS reimbursement relative to private dental insurance reimbursement. For adult dental services, this tables provides the average across 50 states and Washington, D.C. for the private dental insurance reimbursement relative to fees charged by dentists.

Figure 1: Medicaid Fee-For-Service Reimbursement as a Percentage of Fees Charged by Dentists, Child Dental Services, 2016



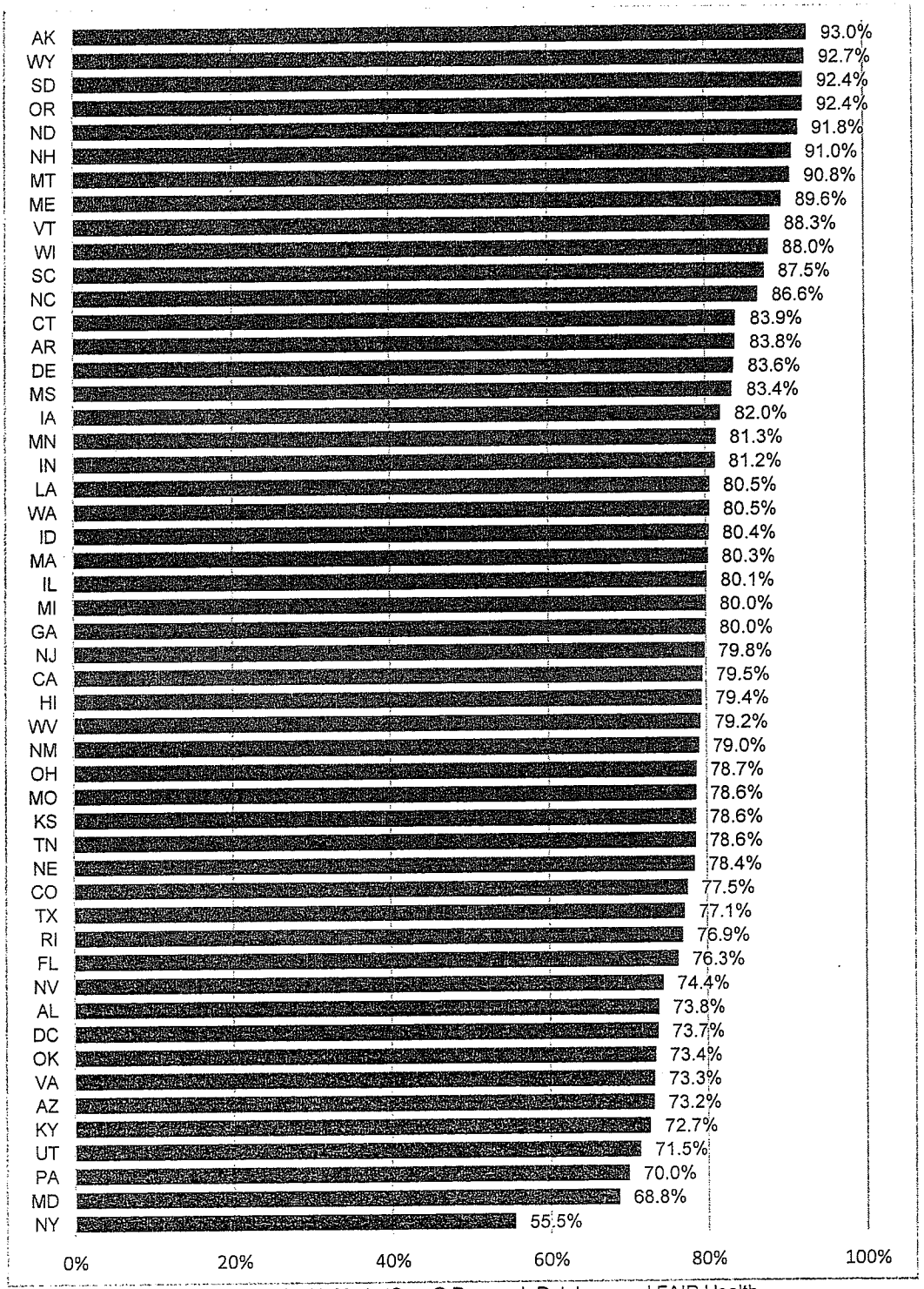
Source: HPI analysis of Medicaid fee-for-service reimbursement data collected from state Medicaid agencies and FAIR Health. FFS versus managed care designation primarily based on analysis by the Kaiser Commission on Medicaid and the Uninsured. Note: Some states enroll only certain segments of Medicaid enrollees in managed care programs, or provide certain services through managed care programs. These states are denoted by *.

Figure 2: Medicaid Fee-For-Service Reimbursement as a Percentage of Private Dental Insurance Reimbursement, Child Dental Services, 2016



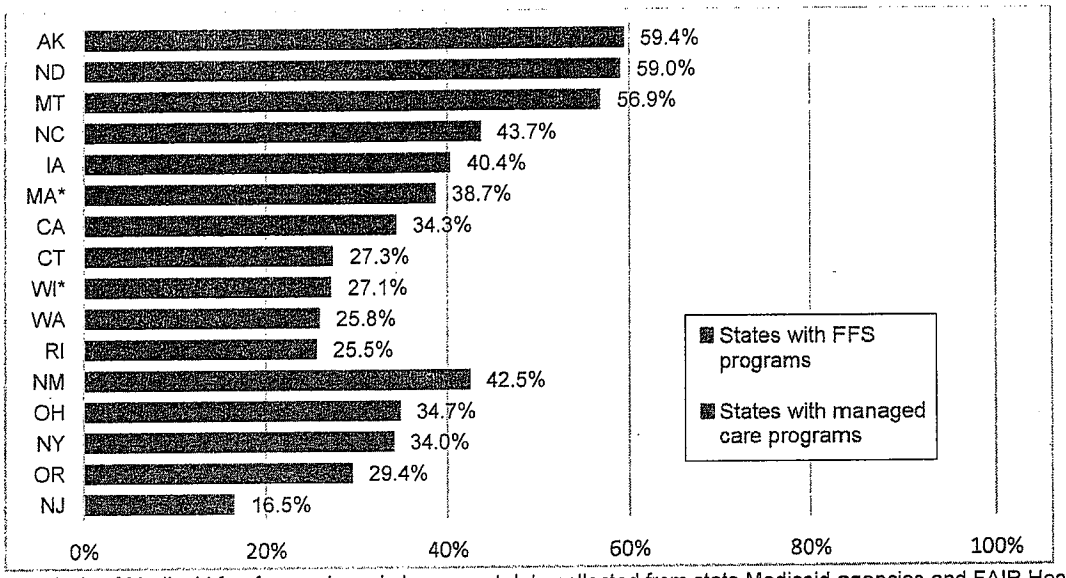
Source: HPI analysis of Medicaid fee-for-service reimbursement data collected from state Medicaid agencies and Truven Health MarketScan® Research Database. FFS versus managed care designation primarily based on analysis by the Kaiser Commission on Medicaid and the Uninsured. **Note:** Some states enroll only certain segments of Medicaid enrollees in managed care programs, or provide only certain services through managed care programs. These states are denoted by *.

Figure 3: Private Dental Insurance Reimbursement as a Percentage of Fees Charged by Dentists, Child Dental Services, 2016



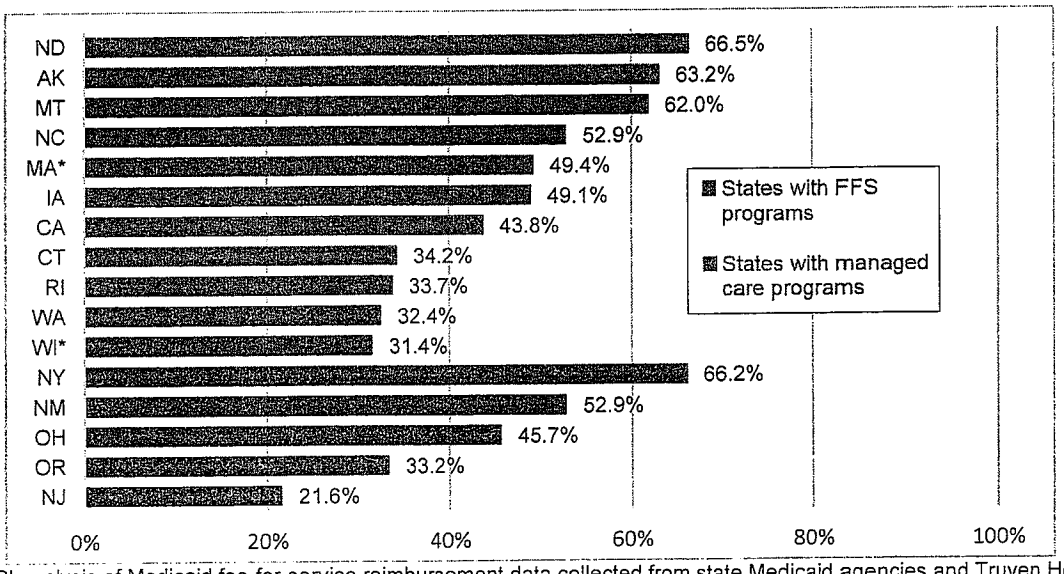
Source: HPI analysis of Truven Health MarketScan® Research Database and FAIR Health.

Figure 4: Medicaid Fee-For-Service Reimbursement as a Percentage of Fees Charged by Dentists, Adult Dental Services, 2016



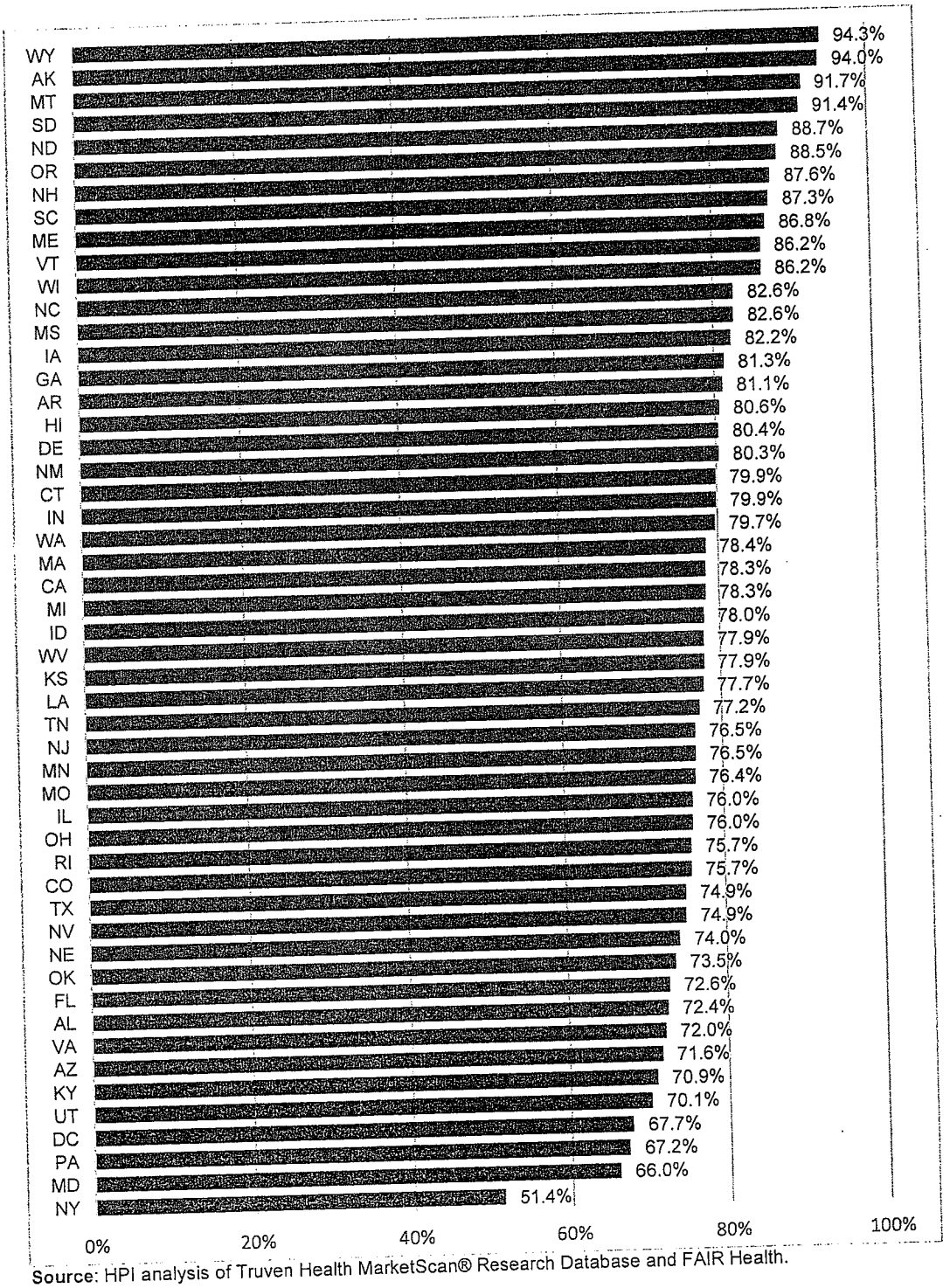
Source: HPI analysis of Medicaid fee-for-service reimbursement data collected from state Medicaid agencies and FAIR Health. FFS versus managed care designation primarily based on analysis by the Kaiser Commission on Medicaid and the Uninsured. **Note**: Some states enroll only certain segments of Medicaid enrollees in managed care programs, or provide only certain services through managed care programs. These states are denoted by *.

Figure 5: Medicaid Fee-For-Service Reimbursement as a Percentage of Private Dental Insurance Reimbursement, Adult Dental Services, 2016



Source: HPI analysis of Medicaid fee-for-service reimbursement data collected from state Medicaid agencies and Truven Health MarketScan® Research Database. FFS versus managed care designation primarily based on analysis by the Kaiser Commission on Medicaid and the Uninsured. **Note**: Some states enroll only certain segments of Medicaid enrollees in managed care programs, or provide only certain services through managed care programs. These states are denoted by *.

Figure 6: Private Dental Insurance Reimbursement as a Percentage of Fees Charged by Dentists, Adult Dental Services, 2016



Source: HPI analysis of Truven Health MarketScan® Research Database and FAIR Health.

Table 2: List of Procedures and Corresponding Weights for Child Dental Services

CDT Procedure Code	Weight
D0120 - Periodic oral evaluation - established patient	25.614%
D1120 - Prophylaxis - child	25.125%
D1110 - Prophylaxis - adult	14.113%
D1208 - Topical application of fluoride – excluding varnish	9.010%
D1351 - Sealant - per tooth	7.280%
D0272 - Bitewings - two radiographic images	6.340%
D0274 - Bitewings - four radiographic images	5.561%
D1206 - Topical application of fluoride varnish	3.234%
D0220 - Intraoral - periapical first radiographic image	2.218%
D0230 - Intraoral - periapical each additional radiographic image	1.505%

Source: HPI analysis of Truven Health MarketScan® Research Database.

Table 3: List of Procedures and Corresponding Weights for Adult Dental Services

CDT Procedure Code	Weight
D1110 - Prophylaxis - adult	36.856%
D0120 - Periodic oral evaluation – established patient	20.065%
D0274 - Bitewings – four radiographic images	9.751%
D2392 - Resin-based composite – two surfaces, posterior	8.469%
D4910 - Periodontal maintenance	6.347%
D2391 - Resin-based composite – one surface, posterior	6.108%
D0140 - Limited oral evaluation – problem focused	3.777%
D0150 - Comprehensive oral evaluation – new or established patient	3.578%
D0220 - Intraoral - periapical first radiographic image	3.535%
D0230 - Intraoral – periapical each additional radiographic image	1.515%

Source: HPI analysis of Truven Health MarketScan® Research Database.

Data & Methods

We collected 2016 Medicaid fee-for-service (FFS) reimbursement rate data from state Medicaid program webpages on March 18 and 20, 2017. For some of the states that had updated their reimbursement rates for 2017, we used 2017 reimbursement rate data. Data for child dental care services were collected for all 50 states and D.C. Data for adult dental care services were collected for states that provided extensive dental benefits to Medicaid-enrolled adults in 2016 (AK, CA, CT, IA, MA, MT,NJ, NM, NY, NC, ND, OH, OR, RI, WA, WI).[15]

Many state Medicaid programs contract with a managed care provider and do not pay dental care providers via the publicly available FFS schedule. To our knowledge, managed care reimbursement rate data are not publicly available in any state and we were not able to include such data in our analysis. We focused solely on Medicaid FFS reimbursement rates, understanding that in many states, this is not how most dental care is reimbursed. According to the Kaiser Commission on Medicaid and the Uninsured, Medicaid programs in 23 states contracted with managed care organizations for children's dental care services (AZ, CO, DC, FL, GA, IL, KS, KY, MI, MN, MS, MO, NV, NJ, NM, NY, OH, OR, PA, RI, TN, TX, WV) and in 15 states for adult dental care services (AZ, CO, DC, FL, IL, KY, MN, MS, MO, NJ, NM, NY, OH, OR, PA) in 2015.[16] In some cases, however, certain dental care services are covered under a managed care program while others are covered under FFS. Two states have such arrangement for dental services for children (IN, WI) and four states have such arrangement for dental services for adults (IN, MA, MI, WI).[16] The lack of transparent, publicly available data on reimbursement rates within managed care programs presented a significant limitation to our analysis. While Medicaid FFS reimbursement rates are intended to be a benchmark or guide for managed care organizations, it is unclear whether this happens in practice. As a result, we distinguish FFS states and managed care states in our analysis.

We obtained private dental insurance reimbursement rate data for each state and D.C. for 2015 from the Truven Health MarketScan® Research Databases (Truven). Truven contains medical and dental claims and enrollment data from beneficiaries of large employer medical and dental plans across the United States, including claims from a variety of FFS, preferred provider organization (PPO), and capitated dental plans. Truven includes the amount paid to the dentist for various procedures as well as the amount paid out of pocket by the beneficiary. In other words, it includes total payments to dentists. In 2015, there were 8.8 million people with private dental insurance included in Truven. Based on the latest data from the Medical Expenditure Panel Survey (MEPS),[17] we estimate that Truven captures about 5.4 percent of the private dental insurance market in the United States. Because our Medicaid reimbursement rate data are for 2016, we inflated the Truven reimbursement rate data to 2016 levels using the all-items Consumer Price Index.[18]

We obtained data on fees charged by dentists for each state and D.C. for 2015 from the FAIR Health Dental Benchmark Module (FAIR Health).[19] FAIR Health provides data on the non-discounted amount charged by dentists for various procedures before network discounts are applied. In 2015, there were 54.7 million people with private dental insurance included in FAIR Health.[19] Based on the latest MEPS data,[17] we estimate that FAIR Health captures about 33.5 percent of the private dental insurance market in the United States. We also inflated the 2015 FAIR Health charges

data to 2016 levels using the all-items Consumer Price Index.[18]

We constructed two measures of Medicaid FFS reimbursement: (1) Medicaid FFS reimbursement rates relative to the fees charged by dentists, and (2) Medicaid FFS reimbursement rates relative to reimbursement rates through private dental insurance. These measures express Medicaid FFS reimbursement relative to "market" rates. We also constructed a measure of private dental insurance reimbursement relative to the fees charged by dentists. Nationwide, 97.6 percent of dentists report accepting some form of private dental insurance and, on average, such payments account for 41.5 percent of gross billings in dental offices.[20] Private dental insurance is a significant source of dental care financing in the U.S., accounting for 47 percent of total dental care expenditures in 2015.[21]

The analysis for child dental care services is based on the top ten most common procedures among children with private dental insurance as identified in previous research (see Table 2).[22] These ten procedures accounted for 40.3 percent of the total of billings and 74.2 percent of the total number of procedures among children with private dental insurance in 2015 within the Truven data set. We consider children ages 0 to 18.

The analysis for adult dental care services is based on the top ten most common procedures among adults with private dental insurance as identified in previous research (see Table 3).[23] These ten procedures accounted for 39.2 percent of the total billings and 73.7 percent of the total number of procedures among adults with private dental insurance in 2015 within the Truven data set. We consider adults ages 19 to 64.

We computed the weighted average of the reimbursement rates for the ten most common procedures to create an index. The weights for each of the ten procedures were calculated as the share of total billings represented by each procedure. The weights were calculated separately for child dental care services and adult dental care services. The weights are summarized in Tables 2 and 3. The Medicaid FFS reimbursement rate index, the fees charged by dentists index, and the private dental insurance reimbursement rate index were constructed using this common weighting scheme.

We divided the Medicaid FFS reimbursement index by the fees charged by dentist index to calculate our first outcome of interest: Medicaid reimbursement relative to fees charged by dentists. We divided the Medicaid FFS reimbursement index by the private dental insurance reimbursement index to calculate our second outcome of interest: Medicaid reimbursement relative to private dental insurance reimbursement. We also calculated private dental insurance reimbursement relative to fees charged by dentists to estimate the average "discount" rate off of dentist charges. We did this separately for child and adult dental care services.

It is important to note that previous research shows no substantial differences in results if the indices were created by weighting reimbursement rates and charges by their share of the total number of procedures performed versus total billings.[24]

There are several limitations to our analysis. First, as noted, our Medicaid reimbursement rates are based on FFS schedules. In some states, these are less relevant because most care is delivered through managed care arrangements. To account for this, we present managed care states separately from FFS states, according to the best publicly available information.

Second, our reimbursement indices are based on a limited set of procedures. While ideally all procedures would be included, this is not feasible given our interest

in comparability across states. Because our procedure lists capture three quarters of the total volume of dental procedures, we feel we struck an appropriate balance between comprehensiveness and feasibility.

Third, our weighting scheme is based on the mix of dental care services for adults and children with private dental insurance. There are likely differences in the relevant importance of various procedures between the Medicaid and privately insured populations.[25,26] Unfortunately, we do not have access to Medicaid claims data in order to assess these differences. However, several Medicaid colleagues and researchers have indicated the procedure mix within Medicaid and privately insured populations will be comparable, particularly for children. Moreover, our list of the top ten most common procedures is quite comparable to published research focusing on Medicaid populations.[27-29] Again, we feel we struck an appropriate balance between feasibility and complexity in our analysis.

Fourth, we were not able to distinguish PPO, HMO, and other types of plans within our private dental insurance reimbursement rate data. It is likely that reimbursement rates to dentists differ systematically across these types of private dental insurance plans. We have no way of assessing this with the Truven data, and we assume simply that the mix of PPO, HMO, and other types of plans are representative of the market. According to the National Association of Dental Plans, in 2015, PPO plans accounted for 82 percent of the private dental insurance market and HMO plans accounted for 7 percent.[30]

Fifth, there may be some inconsistency in how dentists submit charges data on private dental insurance claims, which could lead to measurement error. FAIR Health's dental module provides fee data based on "the non-discounted fees charged by providers before network discounts are applied." In theory, this should be true, non-discounted fees. However, based on provider feedback, providers often submit the fees they expect to be paid rather than their true, non-discounted fees. We have no basis to evaluate this empirically and simply raise this as a potential limitation. An alternative data source for market fees would be HPI's annual fee survey that collects full, undiscounted fees from a national sample of dentists. [31] We did not use these data because they are not available at the state level.

Disclaimer

Research for this article is based upon the data compiled and maintained by FAIR Health, Inc. and Truven Health Analytics™. HPI is solely responsible for the research and conclusions reflected in this article. FAIR Health, Inc. and Truven Health Analytics™ are not responsible for the conduct of the research or for any of the opinions expressed in this article.

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Health Policy Institute

ADA American Dental Association®

Geographic Access to Dental Care: Delaware

98% OF PUBLICLY INSURED CHILDREN LIVE WITHIN 15 MINUTES of a Medicaid dentist

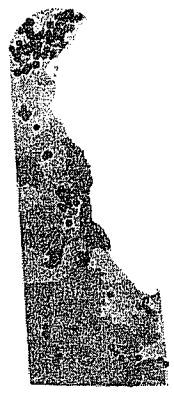
87% of publicly insured children live in areas where there is at least one Medicaid dentist per 2,000 publicly insured children within a 15-minute travel time.

76% of the population live in areas where there is at least one dentist per 5,000 population within a 15-minute travel time.

DISTRIBUTION OF POPULATION ACCORDING TO POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

Publicly Insured Children per Medicaid Dentist		Population per Dentist	
<500	55%	<2,500	41%
500–2,000	32%	2,500–5,000	35%
>2,000	11%	>5,000	23%
No Medicaid dentist within 15-minute travel time	2%	No dentist within 15-minute travel time	1%

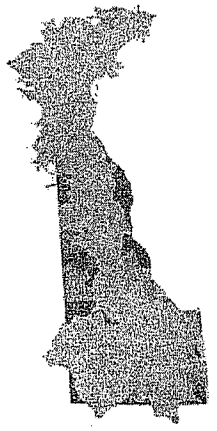
DENTAL OFFICE LOCATIONS AND PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE



- OFFICE DOES NOT PARTICIPATE IN MEDICAID
- OFFICE PARTICIPATES IN MEDICAID

PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0–10%
- 10.1–20%
- 20.1–30%
- 30.1–40%
- 40.1–50%
- 50.1–60%
- >60%

GEOGRAPHIC COVERAGE OF MEDICAID DENTISTS



- 15-MINUTE TRAVEL TIME TO MEDICAID OFFICE

PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0–10%
- 10.1–20%
- 20.1–30%
- 30.1–40%
- 40.1–50%
- 50.1–60%
- >60%

PUBLICLY INSURED CHILDREN PER MEDICAID DENTIST WITHIN A 15-MINUTE TRAVEL TIME

- NO MEDICAID OFFICE
- <500:1
- 500:1–2,000:1
- >2,000:1

POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

- NO DENTAL OFFICE
- <2,500:1
- 2,500:1–5,000:1
- >5,000:1

Sources: Based on ADA Health Policy Institute analysis of the 2015 ADA office database and 2011–2015 American Community Survey. For full methodology, see Nasseh K, Eisenberg Y, Vujicic M. **Geographic access to dental care varies in Missouri and Wisconsin.** *J Public Health Dent.* 2017 Jan 11. Notes: In this infographic, a Medicaid dentist is a dentist who is an enrolled provider in Medicaid or the Children's Health Insurance Program. Percentages in table might not add up to 100% due to rounding. For analyses based on alternative travel time or population-to-provider thresholds, contact hpi@ada.org.

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Health Policy Institute

ADA American Dental Association®

Geographic Access to Dental Care: New Jersey

99% OF PUBLICLY INSURED CHILDREN LIVE WITHIN 15 MINUTES of a Medicaid dentist

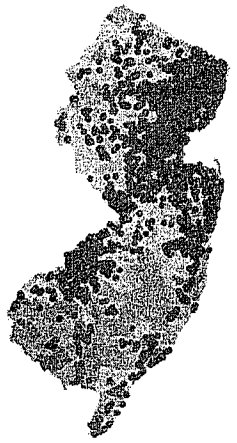
97% of publicly insured children live in areas where there is at least one Medicaid dentist per 2,000 publicly insured children within a 15-minute travel time.

97% of the population live in areas where there is at least one dentist per 5,000 population within a 15-minute travel time.

DISTRIBUTION OF POPULATION ACCORDING TO POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

Publicly Insured Children per Medicaid Dentist		Population per Dentist	
<500	69%	<2,500	82%
500–2,000	28%	2,500–5,000	15%
>2,000	2%	>5,000	3%
No Medicaid dentist within 15-minute travel time	1%	No dentist within 15-minute travel time	0%

DENTAL OFFICE LOCATIONS AND PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE



- OFFICE DOES NOT PARTICIPATE IN MEDICAID
- OFFICE PARTICIPATES IN MEDICAID

PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0–10%
- 10.1–20%
- 20.1–30%
- 30.1–40%
- 40.1–50%
- 50.1–60%
- >60%

GEOGRAPHIC COVERAGE OF MEDICAID DENTISTS

- 15-MINUTE TRAVEL TIME TO MEDICAID OFFICE

PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0–10%
- 10.1–20%
- 20.1–30%
- 30.1–40%
- 40.1–50%
- 50.1–60%
- >60%

PUBLICLY INSURED CHILDREN PER MEDICAID DENTIST WITHIN A 15-MINUTE TRAVEL TIME

- NO MEDICAID OFFICE
- <500:1
- 500:1–2,000:1
- >2,000:1

POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

- NO DENTAL OFFICE
- <2,500:1
- 2,500:1–5,000:1
- >5,000:1

Sources: Based on ADA Health Policy Institute analysis of the 2015 ADA office database and 2011–2015 American Community Survey. For full methodology, see Nasseh K, Eisenberg Y, Vujicic M. **Geographic access to dental care varies in Missouri and Wisconsin.** *J Public Health Dent.* 2017 Jan 11. **Notes:** In this infographic, a Medicaid dentist is a dentist who is an enrolled provider in Medicaid or the Children's Health Insurance Program. Percentages in table might not add up to 100% due to rounding. For analyses based on alternative travel time or population-to-provider thresholds, contact hpi@ada.org.

For more information, visit **ADA.org/HPI** or contact the Health Policy Institute at **hpi@ada.org.**

Health Policy Institute

ADA American Dental Association®

Geographic Access to Dental Care: **Maryland**

97% OF PUBLICLY INSURED CHILDREN LIVE WITHIN 15 MINUTES of a Medicaid dentist

96% of publicly insured children live in areas where there is at least one Medicaid dentist per 2,000 publicly insured children within a 15-minute travel time.

93% of the population live in areas where there is at least one dentist per 5,000 population within a 15-minute travel time.

DISTRIBUTION OF POPULATION ACCORDING TO POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

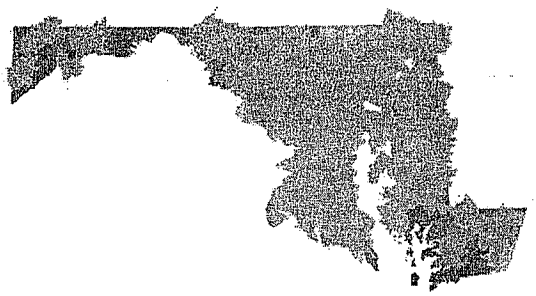
Publicly Insured Children per Medicaid Dentist		Population per Dentist	
<500	72%	<2,500	71%
500-2,000	24%	2,500-5,000	22%
>2,000	2%	>5,000	7%
No Medicaid dentist within 15-minute travel time	3%	No dentist within 15-minute travel time	1%

DENTAL OFFICE LOCATIONS AND PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE

- OFFICE DOES NOT PARTICIPATE IN MEDICAID
- OFFICE PARTICIPATES IN MEDICAID

PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0-10%
- 10.1-20%
- 20.1-30%
- 30.1-40%
- 40.1-50%
- 50.1-60%
- >60%

GEOGRAPHIC COVERAGE OF MEDICAID DENTISTS



- 15-MINUTE TRAVEL TIME TO MEDICAID OFFICE

PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0-10%
- 10.1-20%
- 20.1-30%
- 30.1-40%
- 40.1-50%
- 50.1-60%
- >60%

PUBLICLY INSURED CHILDREN PER MEDICAID DENTIST WITHIN A 15-MINUTE TRAVEL TIME

- NO MEDICAID OFFICE
- <500:1
- 500:1-2,000:1
- >2,000:1

POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

- NO DENTAL OFFICE
- <2,500:1
- 2,500:1-5,000:1
- >5,000:1

Sources: Based on ADA Health Policy Institute analysis of the 2015 ADA office database and 2011-2015 American Community Survey. For full methodology, see Nasseh K, Eisenberg Y, Vujicic M. **Geographic access to dental care varies in Missouri and Wisconsin.** *J Public Health Dent.* 2017 Jan 11. **Notes:** In this infographic, a Medicaid dentist is a dentist who is an enrolled provider in Medicaid or the Children's Health Insurance Program. Percentages in table might not add up to 100% due to rounding. For analyses based on alternative travel time or population-to-provider thresholds, contact hpi@ada.org.

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HPI Health Policy Institute

ADA American Dental Association®

Geographic Access to Dental Care: **Pennsylvania**

97% OF PUBLICLY INSURED CHILDREN LIVE WITHIN 15 MINUTES of a Medicaid dentist

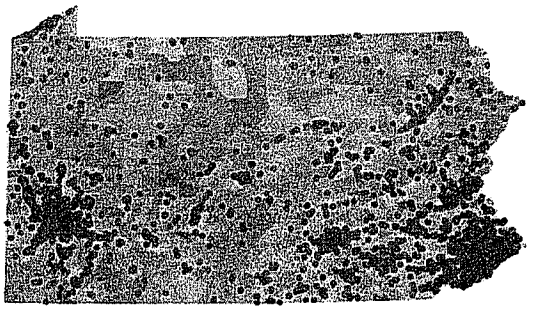
96% of publicly insured children live in areas where there is at least one Medicaid dentist per 2,000 publicly insured children within a 15-minute travel time.

89% of the population live in areas where there is at least one dentist per 5,000 population within a 15-minute travel time.

DISTRIBUTION OF POPULATION ACCORDING TO POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

Publicly Insured Children per Medicaid Dentist		Population per Dentist	
<500	91%	<2,500	67%
500–2,000	5%	2,500–5,000	22%
>2,000	1%	>5,000	10%
No Medicaid dentist within 15-minute travel time	3%	No dentist within 15-minute travel time	2%

DENTAL OFFICE LOCATIONS AND PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE



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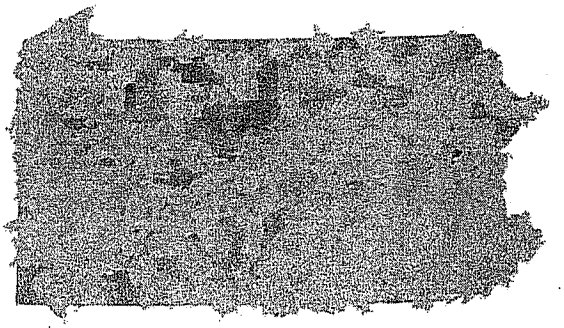
- OFFICE PARTICIPATES IN MEDICAID

PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0–10%
- 10.1–20%
- 20.1–30%
- 30.1–40%
- 40.1–50%
- 50.1–60%
- >60%

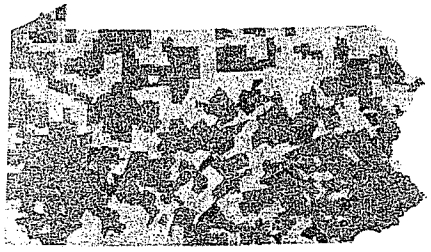
GEOGRAPHIC COVERAGE OF MEDICAID DENTISTS



- 15-MINUTE TRAVEL TIME TO MEDICAID OFFICE

PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0–10%
- 10.1–20%
- 20.1–30%
- 30.1–40%
- 40.1–50%
- 50.1–60%
- >60%

PUBLICLY INSURED CHILDREN PER MEDICAID DENTIST WITHIN A 15-MINUTE TRAVEL TIME



- NO MEDICAID OFFICE
- <500:1
- 500:1–2,000:1
- >2,000:1

POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

- NO DENTAL OFFICE
- <2,500:1
- 2,500:1–5,000:1
- >5,000:1

Sources: Based on ADA Health Policy Institute analysis of the 2015 ADA office database and 2011–2015 American Community Survey. For full methodology, see Nasseh K, Eisenberg Y, Vujicic M. Geographic access to dental care varies in Missouri and Wisconsin. *J Public Health Dent.* 2017 Jan 11. Notes: In this infographic, a Medicaid dentist is a dentist who is an enrolled provider in Medicaid or the Children's Health Insurance Program. Percentages in table might not add up to 100% due to rounding. For analyses based on alternative travel time or population-to-provider thresholds, contact hpi@ada.org.

For more information, visit **ADA.org/HPI** or contact the Health Policy Institute at **hpi@ada.org.**

148TH GENERAL ASSEMBLY

FISCAL NOTE

BILL:	SENATE BILL NO. 142
SPONSOR:	Senator Hall-Long
DESCRIPTION:	AN ACT TO AMEND TITLE 31 OF THE DELAWARE CODE RELATING TO PREVENTATIVE AND URGENT DENTAL CARE FOR MEDICAID RECIPIENTS.

ASSUMPTIONS:

1. This Act shall become effective upon appropriation by the General Assembly of funds sufficient to accomplish the purpose of the Act.

2. The Act expands Delaware's Public Assistance Code to provide preventative and urgent dental care to all Medicaid recipients. Payments for preventative and urgent dental care treatments shall be subject to a $10.00 recipient co-pay and the total amount of dental care assistance provided to an eligible recipient shall not exceed $1,000.00 per year, except that an additional $1,500.00 may be authorized for an emergency basis for urgent dental care treatments through a review process.

3. This Act would provide preventative and urgent dental care to approximately 116,918 eligible recipients.

4. The estimated total cost of the Act for Fiscal Year 2015 is $14,780,551 for both Federal and State share combined. The state share estimated at the State Fiscal Year 2016 FMAP is projected at $4,311,622. This project is a result of the following assumptions:

    a. Projections are based on experience with recipients between the age of 19 and 21 currently covered and assumes that older recipients will be more expansive;

    b. Projections include an assumption that a certain percentage of recipients will exceed the $1,000 a year spending cap; and

    c. Projections include a rate adjustment from CY 2012 to SFY 2016.

5. The estimated total cost for this Act for Fiscal Year 2016 and Fiscal Year 2017 assume an FMAP of 50%.

Cost:

Fiscal Year 2015:	$4,331,622
Fiscal Year 2016:	$7,390,276
Fiscal Year 2017:	$7,390,276

(Amounts are shown in whole dollars)

Office of Controller General
June 23, 2015
KARN:KARN
4531480002