STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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October 21, 2011

Ms. Susan K. Haberstroh
Education Associate
Department of Education
401 Federal Street, Suite 2
Dover, DE 19901

RE: 15 DE Reg. 432 [DOE Proposed Student Physical Exam & Screening Regulation]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to amend its regulation covering student physical examinations and screening. The proposed regulation was published as 15 DE Reg. 432 in the October 1, 2011 issue of the Register of Regulations. The principal change is to require a second physical examination for high school students. In a nutshell, students would be required to have the first physical exam within 2 years prior to entry in school. Beginning with the 2012-13 school year, students would have to submit the results of a second physical exam conducted within 2 years when entering 9th grade. DOE and DIAA physical evaluation forms are deemed acceptable and districts have the discretion to accept other forms which include certain minimum components. SCPD has the following observations.

First, substitute "health examination" or "medical examination" for "physical examination" throughout the regulation since the evaluations should preferably include mental health diagnoses (e.g. ADHD; depression). Moreover, § 2.1.3 requires the report to include medical diagnoses and prescribed medications and treatments. Obviously, schools would benefit from prescription information not only for "physical" conditions (e.g. an inhaler for asthma) but also "mental" conditions (e.g. Ritalin for ADHD or Prozac for depression).

Second, the DOE may wish to consider whether dental health examinations should be required with some provision in place to ensure the availability of examinations for low-income students who are not enrolled in Medicaid, CHIP, or private insurance. Recent studies have highlighted the importance of dental health on overall health and a Surgeon General's report in 2000 noted that tooth decay is the most common chronic disease for

children. See attachment. This has motivated the Legislature and DHSS to include dental coverage for children in the Medicaid and CHIP programs. See attached excerpt from DMMA Dental Provider Specific Policy Manual.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations and recommendations on the proposed regulation.

Sincerely,

Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

cc: The Honorable Lillian Lowery
Dr. Teri Quinn Gray
Ms. Mary Ann Mieczkowski
Ms. Paula Fontello, Esq.
Ms. Terry Hickey, Esq.
Mr. John Hindman, Esq.
Mr. Charlie Michels
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Developmental Disabilities Council
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ment and then closely defined the "substantially limiting" circumstances in which an individual had a disability by indicating that the person must have a permanent or long-term disability that "prevents or severely restricts the individuals from doing activities that are of central importance to most people's daily lives."

As a result, legal interpretation of the ADA succeeded in eliminating the intent of Congress to provide the broadest range of protection to individuals with disabilities, thereby setting the groundwork for the advent of the ADAAA.

ADAAA

The ADAAA begins the process of re-establishing greater protection for a wider range of individuals with disabilities under the ADA by supporting a broad interpretation of the definition of a disability. Among other provisions, the new law directs the Equal Employment Opportunity Commission (EEOC) to revise the portion of its regulations that define the term "substantially limits" to the less stringent "significantly restricts" instead. The ADAAA then expands the definition of "major life activities" by providing a detailed list of activities, as well as a list of major body functions that can be used to determine whether an individual has a disability.

Second, the ADAAA eliminates the requirement for individuals to demonstrate that they are "regarded as" having a disability that substantially limits a major life activity. Instead, individuals can show that they are regarded as having a disability by demonstrating that they have been adversely subjected to a prohibited action under the ADA, due to a real or perceived physical or mental disability. One limitation is that the ADAAA does not require covered ADA entities to provide reasonable accommodations and modifications to those who qualify for ADA coverage only because they are "regarded as" having a disability.

Third, the ADAAA does not consider mitigating measures to address a disability (e.g., mobility devices, medication, medical supplies, low-vision devices other than ordinary eye glasses and contact lenses, and prosthetic limbs and devices) in determining whether an individual has a disability. This provision grants ADA protection to individuals – who were previously denied coverage under the ADA – with physical disabilities that could be treated with medication (e.g., cerebral palsy, epilepsy and cancer) or assistive devices (e.g., hearing aides, oxygen therapy equipment and cochlear implants).

Fourth, the new law reinforces the current exemption for academic institutions (including postsecondary education institutions) from making reasonable ADA modifications to their policies, practices or procedures that fundamentally change the nature of their programs or services.

The ADAAA becomes effective Jan. 1, 2009.

GAO Report on Dental Disease in Medicaid-Enrolled Children

In 2000, the U.S. surgeon general issued the report *"Oral Health in America: a Report of the Surgeon General,"* noting that tooth decay was the most common chronic disease for children. Tooth decay, it stated, was almost entirely preventable, and preventive dental care significantly improved health outcomes and was cost-effective. Recognizing the importance of good oral health, the surgeon general's Healthy People 2010 report included an oral health objective: to increase the proportion of low-income children and youth (under the age of 19) who receive any preventive dental service in the past year from 25 percent in 1996 to 66 percent in 2010.

Medicaid provides health coverage for 20.1 million children in the United States ages 2 through 18. Through its Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, it provides for children under the age of 21, dental screening, diagnostic (such as X-rays) and preventive services and treatment for all eligible Medicaid beneficiaries. Unfortunately, many of these children experience dental disease and never obtain needed treatment.

To determine the extent of this problem, the Government Accountability Office (GAO) reviewed a number of national studies on oral health access and published in September 2008 a report entitled *"Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay."* Data from the National Health and Nutrition Examination Survey (NHANES) for 1999 through 2004 found that one-third of Medicaid-enrolled children ages 2 through 18 suffered from untreated tooth decay. Additionally, the survey found that one in nine of these children had untreated tooth decay in three or more teeth. Based upon the estimates of the NHANES survey, the GAO projected for the 2005 enrollment levels that 6.5 million Medicaid-enrolled children experienced untreated tooth decay, and 2.2 million had untreated tooth decay in three or more teeth. The proportion of children in Medicaid with untreated tooth decay, 33 percent, was similar to that of uninsured children, 35 percent, but almost double that of children with private insurance, only 17 percent. Similarly, Medicaid-enrolled

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children were more than twice as likely as privately insured children to have untreated tooth decay in three or more teeth.

Information gathered through the Medical Expenditure Panel Survey (MEPS) for 2004 and 2005 indicated that approximately two out of three children in Medicaid ages 2 through 18 did not receive dental care in the previous year and that one in eight had never seen a dentist. Based upon this data and again using the 2005 enrollment levels, the GAO projected that about 12.6 million children in Medicaid had not seen a dentist in the previous year. Additionally, the MEPS survey found that four percent of Medicaid-enrolled children were unable to access needed dental care; of these children, approximately 15 percent had difficulty accessing dental care because the provider refused to accept their insurance plan.

The GAO did find that Medicaid-enrolled children were more likely to have received dental care than uninsured children; 37 percent of children in Medicaid received care while only 26 percent of uninsured children did. However, the Medicaid rate was much lower than the rate of privately insured children who received care, which was 55 percent. All of these figures were well below the Healthy People 2010 target of 66 percent for low-income children under the age of 19.

Finally, the GAO compared past data with more recent survey data and found that the rate of dental disease in Medicaid-enrolled children did not decrease, though the receipt of care modestly improved. A review of NHANES data from 1988 through 1994 with results from 1999 through 2004 indicated that untreated tooth decay rates were largely unchanged, increasing slightly from 31 percent in the earlier years to 33 percent for the period of 1999 through 2004. Moreover, the proportion of children in Medicaid with tooth decay actually increased from 56 percent in the earlier period to 62 percent in the more recent years.

On the positive side, the GAO reported that in comparing MEPS data for 1996-1997 to data for 2004-2005, there was an increase from 31 percent to 37 percent of Medicaid-enrolled children between 2 and 18 who received dental care. Also, according to NHANES data, the percentage of children ages 6 through 18 in Medicaid receiving at least one dental sealant increased from 10 percent for the years 1988-2004 to 28 percent for the years 1999-2004.

The information from the NHANES and MEPS survey, the GAO concluded, raises serious concerns about the oral health of children in Medicaid. While access to dental care increased somewhat, the rates of access were far below national health goals for all populations of children. Furthermore, the prevalence of dental disease in low-income children did not decrease, leaving the need greater than ever for appropriate oral health care.

Medicaid Early and Periodic Screening, Diagnosis and Treatment FAQs

These questions and answers are excerpted from the Medicaid Early and Periodic Screening Diagnosis and Treatment Fact Sheet recently posted on the NHeLP website.

Introduction

The Early and Periodic Screening, Diagnostic and Treatment service, EPSDT, is a comprehensive set of benefits available to children and youth under 21 who are enrolled in Medicaid. Some commonly asked questions about the program are:

- Why EPSDT?
- How does EPSDT address screening?
- How does EPSDT address treatment services?
- How can I measure EPSDT performance and hold programs accountable?

Why EPSDT?

Low socioeconomic status carries with it numerous byproducts: poor nutrition, fewer educational opportunities, greater exposure to environmental hazards and inadequate housing, to name just a few. All of these disadvantages increase the likelihood that a poor child will be in poor health. Recent research by Edward L. Schor and others confirms that children living in poverty, particularly children of color, are more likely than other children to suffer from ill health, including vision, hearing and speech problems, dental problems, elevated lead blood levels, behavioral problems, anemia, asthma and pneumonia. Dr. Schor also points to the growing body of evidence establishing that lifelong patterns of health and well-being are established during childhood. (Health Affairs, March-April 2007.)

Early detection of health conditions, comprehensive treatment and health education are needed. Added to the

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EXCERPT:
DMMA POLICY MANUAL

Dental Provider Specific Policy Manual

1.0 Overview

1.1 General Criteria

1.1.1 Dental services are covered by the Delaware Medical Assistance Program (DMAP) for children eligible for Medicaid (through age 20 years) and for children eligible for the Delaware Healthy Children Program (DHCP) (through age 18 years).

1.1.2 An enrolled dental provider may treat any Medicaid-eligible or DHCP-eligible child and will be paid directly by the DMAP.

1.1.3 Managed care organizations (MCOs) are responsible for covering the removal of bony impacted wisdom teeth for their members.

1.1.4 The DMAP dental program does impose certain limitations and prior authorization requirements for some services. Refer to Section 8.0 Appendix A for CDT Code Coverage Guidelines.

1.1.4.1 Exceptions to the DMAP CDT Code limitations may occur when accompanied by documentation of medical necessity.

1.1.4.2 This documentation will be evaluated by the DMAP Dental Consultant.

2.0 Eligibility

2.1 Criteria

2.1.1 Children through age 20 years who are currently covered by Medicaid and children through age 18 years covered by the DHCP are eligible to receive medically necessary dental services.

2.1.2 The DMAP will continue orthodontic payment for individuals who lose DMAP eligibility, so long as the individual remains a resident of the State of Delaware.

2.1.3 Non-qualified non-citizens are covered for life threatening emergency services and labor and delivery care only. On a case-by-case basis, emergency dental services for a non-qualified alien child through age 20 will be considered for payment when a true documented dental emergency has been substantiated by review by the DMAP Dental Consultant. Only the initial triage services necessary to treat the emergency condition (pain, infection, bleeding) are covered. Follow-up care is not considered to be emergency in nature. Refer to DMAP General Policy Manual Section 1.24.2, Emergency and Labor/Delivery Services Only, found at http://www.dmap.state.de.us/downloads/manuals/General.Policy.Manual.pdf.

3.0 Services

3.1 Dental Services

3.1.1 The DMAP covers medically necessary dental services in appropriate care settings for the relief of pain and infections, restoration of teeth, and maintenance of oral health.

3.1.1.1 Covered dental services may be limited by age range, maximum number of units allowable per day, prior authorization requirements, or other report requirements. For a detailed list of covered services, refer to Section 8.0 Appendix A, which includes a listing of all CDT codes with their coverage status and any restrictions or limitations.

3.1.2 Prior authorization requests for restorative, endodontic, periodontic, prosthodontic, or prosthetic services must include diagnostic quality radiographs and a comprehensive treatment plan for the patient. Faxed and/or photocopies of radiographs will not be accepted.
3.1.2.1 Dental prior authorization forms are found in Section 8.0 Appendix C, and are also available at http://www.dmap.state.de.us/downloads/forms.html.

3.2 Orthodontic Services
3.2.1 DMAP does not require prior authorization for the **initial diagnostic visit** for orthodontics treatment. DMAP will reimburse providers for the initial diagnostic visit irrespective of its decision to approve or deny the request for comprehensive or interceptive orthodontic treatment for the individual.

3.2.2 All other orthodontic care must receive prior approval by the DMAP. Providers should not begin comprehensive or interceptive orthodontic treatment prior to receiving approval from DMAP. DMAP will not pay claims for comprehensive or interceptive orthodontic care that did not receive prior authorization.

Requests for prior authorization of orthodontic treatment should be mailed to:
Dental Administrator
P.O. Box 906
New Castle, DE 19720

3.2.3 The DMAP defines **interceptive orthodontics** only as the placement of appliances for the correction of an isolated crossbite.

3.2.3.1 Providers must submit the Prior Authorization Request for Interceptive Orthodontics (found at Section 8.0 Appendix C, and also found at http://www.dmap.state.de.us/downloads/forms/interceptortho.pdf).

3.2.4 **Comprehensive orthodontics** is a covered dental service for Medicaid-eligible and DHCP-eligible individuals who have been diagnosed with a "handicapping" or "crippling" malocclusion.

3.2.4.1 The DMAP only considers individuals who have reached the stage of adolescent dentition for orthodontic services. Providers should not submit cases in primary or transitional dentition for consideration for orthodontic coverage.

3.2.4.2 Each prior authorization request for comprehensive orthodontics must include the Delaware Special Dental Orthodontic Evaluation Form (Appendix B), treatment plan, diagnostic quality radiographs, and models. Providers may also include pictures of the individual, although this is not required. The DMAP will review requests for orthodontic coverage in the order in which they are received.

3.2.4.2.1 The orthodontist must evaluate the individual chairside using the evaluation form.

3.2.4.2.2 In general, the individual must reach a score of 26 on the evaluation form to be considered as having a handicapping malocclusion. However, the individual may still qualify for coverage if he or she meets one of the five identified exceptions.