DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

FINAL

ORDER

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Dental Services

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend existing rules in the Title XIX Medicaid State Plan regarding Medicaid dental benefits for eligible recipients. Dental services are available only to clients under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the January 2012 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by January 31, 2012 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed provides notice to the public that the Division of Medicaid and Medical Assistance (DMMA) intends to amend the Title XIX Medicaid State Plan regarding Medicaid dental benefits for eligible recipients. Dental services are available only to clients under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Statutory Authority

- 42 CFR §447.205, *Public notice of changes in Statewide methods and standards for setting payment rates;*
- 42 CFR §441 Subpart B, *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) of Individuals under Age 21*; and,
- 42 CFR §440.100, *Dental services*.

Background

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

Summary of Proposal

The Division of Medicaid and Medical Assistance (DMMA), pursuant to the requirement of 42 CFR §447.205, gives notice to the following action relating to Medicaid reimbursement for dental services for eligible recipients under age 21 years.

With approval of the Centers for Medicare and Medicaid Services (CMS) by a submitted state plan amendment, effective for services provided on or after April 1, 2012, DMMA modifies reimbursement for dental services provided under the EPSDT program.

The provisions of this state plan amendment are subject to approval by the CMS.

Fiscal Impact Statement

The proposed revision imposes no increase in cost on the General Fund.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY

The Governor's Advisory Council for Exceptional Citizens (GACEC), the State Council for Persons with Disabilities (SCPD), and Peninsula Dental, L.L.C. and Bear-Glasgow Dental, L.L.C. offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each

comment and responds as follows.

GACEC and SCPD

As background, the Division's current standard reimburses dentists for most treatment at 85% of billed charges. There are a few problems with this approach. First, CMS disfavors such payment methodology which is not based on a uniform fee schedule. Second, inequities arise when DMMA pays different amounts to providers for the same service. Third, DMMA is interested in cost containment which is better secured through use of a fee schedule than a percentage of dentists' typical billing.

The new reimbursement standard would be the lower of: 1) the provider's billed amount that represents their usual and customary charge; or 2) the Delaware maximum allowed amount based on a fee schedule. DMMA worked with representatives of the Dental Society to arrive at an approach to the fee schedule which is based on a National Dental Advisory Service (NDAS) survey. DMMA plans to use the latest survey results (not yet released) to create the final schedule which will be effective in April, 2012.

GACEC and SCPD have the following observations.

First, the current "85% of charges" approach is actually more generous than the State VCAP dental reimbursement rate of "80% of U&C charges" adopted in November, 2011. [15 DE Reg. 176 (August 1, 2011) (proposed); 15 DE Reg. 678 (November 1, 2011) (final)].

Agency Response: Actually, the current reimbursement rate for dentists is 80% of charges. The agency reduced the fee from 85% to 80% as of April 1, 2009. DMMA apologizes for the agency-error; simply, a typo.

Second, use of a uniform fee schedule is ostensibly a preferable approach to dental services than use of an individual provider's usual and customary billing. The Councils previously endorsed a similar approach to renal services in which DMMA historically had a similar "85% of charges" standard. DMMA changed its approach and adopted a cap of "100% of the Medicare rate" for uniformity. See 13 DE Reg. 375 (September 1, 2009) (proposed); and 13 DE Reg. 658 (November 1, 2009) (final). DMMA's rationale for that change was as follows:

> Currently, DMMA pays providers based on their U&C charges for each procedure and different providers can charge different rates for the same service. The purpose of this methodology is to promote predictability of payments, equity and consistency of those payments among providers while maintaining access to quality care.
>
> **13 DE Reg. 375, 376 (September 1, 2009)**

Third, based on a comparison of actual Medicaid dental expenditures versus expenditures that would have resulted from use of the 2011 NDAS survey results, the overall differences are not dramatic. The biggest reduction would be in the context of orthodontic care. In some cases (e.g. diagnostic and restorative services), the reimbursement rate would actually be somewhat higher.

Agency Response: The fees in the draft dental fee schedule were based on the 2010 NDAS survey. The most current 2011 NDAS survey upon which the dental fees will be constructed will result in a total comprehensive orthodontic service being paid at $6,592.00 vs. the current total of $5530.00. The new fee schedule will be posted once it is finalized.

Fourth, the prospect for the State not revising the rates on an annual basis is obviated by the inclusion of the following sentence in the standards: "Delaware will rebase its dental fee schedule rates each time the NDAS publishes a new survey."

Fifth, the regulation does authorize DMMA to adjust the maximum allowable amount if "not appropriate for the service provided". It would be preferable for DMMA to clarify that this could result in enhanced reimbursement for services rendered to particularly "involved" individuals. For example, providers such as Practice Without Pressure may need to conduct some acclimation sessions with individuals with severe disabilities which might not be fairly compensated through a standard fee schedule.

Agency Response: Practice Without Pressure is enrolled and paid like any other dental provider. Acclimation is part of a continuum of behavior management approaches which are considered part of the service being provided.

Sixth, the Councils recommend that DMMA "track" the number of Medicaid dental providers to determine if the number of such providers decreases given the implementation of this initiative. The Division should establish a current baseline number and monitor this number in the outlying years subsequent to implementation of the new reimbursement standards.

Agency Response: There are 296 confirmed providers. The DMMA thanks the Councils for their recommendation to track the number of participating dentists following implementation of the dental fee schedule and will adopt the recommendation to assure that access to care is not unduly diminished.

GACEC and SCPD **endorse** the proposed regulation subject to the clarification request consistent with the fifth observation and the recommendation in the sixth observation.

Agency Response: DMMA thanks the Councils for their endorsement.

Peninsula Dental and Bear-Glasgow Dental

With offices in both Sussex and New Castle Counties, our 8 doctors and staff of nearly 50 make up one of the largest Medicaid providers in the State. Both of our practices provide general dental services to families and have a strong focus on special needs dentistry, including children.

The comments/suggestions are numbered for reference, and include a descriptive synopsis of our thoughts. We would welcome the opportunity to discuss further should you find it constructive to the process.

1. **Extend the public comment period.**

Even if the implementation date is not to be moved, we do not feel that adequate time has been allowed to collect public comment on the proposal. The public notice has likely been published in the normal, required fashion. However, it includes erroneous direction to view the proposed fees on the DMAP (DMMA) website. The fees have not been made available. We have spent weeks either on the phone or by e-mail, trying to get a copy to evaluate. In addition, the link to use for public comments is broken. These problems with the official notice have likely caused confusion and discouraged public input.

We are aware that the Delaware State Dental Society was provided with a copy of the proposed fees, and that based on their suggestions, some modifications may have been made to the formulas proposed. While the DSDS is certainly a major stakeholder in this proposal, and we agree that it was wise to consult with the group, it does not represent every dentist accepting Delaware Medicaid. It also does nothing for the families of children who may be affected by services offered or access to care. Without seeing the fees or being able to understand how they compare to what their doctor's reimbursement is currently, the general public cannot determine if this change affects them positively, negatively, or not at all.

Agency Response: You are correct that the normal process for public comment has been followed in this process. In our work with the State Dental Society, it was our request and understanding that they would share the information about the proposed change in rate methodology with the members of the Society. The draft fees, which were shared with the DSD and which should have been forwarded to the members, were examples of how the fee schedule would work under the new methodology. We ultimately did not publish the draft fees on the DMMA website since they were not the true final version. Once the final rates are completed they will be made available on the DMMA website. In the meantime, we have provided you with a copy of the draft rates in order to understand the rate methodology.

2. **Hold a public hearing.**

While it may not be required by the regulations, holding a public hearing would serve to help educate the public about the ramifications of the proposed fee changes. Additional public input should be sought via a hearing before the proposed change is implemented.

We are aware that the Delaware State Dental Society was provided with a copy of the proposed fees, and that based on their suggestions, some modifications may have been made to the formulas proposed. While the DSDS is certainly a major stakeholder in this proposal, and we agree that it was wise to consult with the group, it does not represent every dentist accepting Delaware Medicaid. It also does nothing for the families of children who may be affected by services offered or access to care. Without seeing the fees or being able to understand how they compare to what their doctor's reimbursement is currently, the general public cannot determine if this change affects them positively, negatively, or not at all.

Agency Response: The public notice does serve to advise the public and providers and any other interested parties about changes occurring in the Medicaid Program, and does so in a way that is available to everyone. As part of the process to develop the new dental rate methodology, DMMA worked directly with a subgroup of the DSD. That subgroup reported back to the DSD to keep the Executive Committee and members apprised of the progress on the fee schedule. We believe the workgroup process and the release of the public notice adequately provides for informing the public about the proposed change in reimbursement methodology.

3. **Do not adopt the proposed formula for reimbursement for dental services.**

Imposing a fee schedule whereby every single procedure has a maximum allowable charge is contrary to the current regulation which recognizes, in part *"…the consideration that 65- 70% of the usual and customary rate is nationally known to account for the dental provider's actual costs"* and "*…an allowance… to permit a reasonable and fair profit and as an incentive for providers to participate in the Medicaid Program…*". Even non-profit providers must be able to cover their overhead in order to operate.

By capping every procedure at some predetermined, artificially lower rate, providers are unable to make up for procedures on which they break even or even lose money to treat patients.

A fee schedule with reimbursements that are too low is one factor contributing the failure of Medicaid programs in

surrounding states. This is nothing to emulate, regardless of whether CMS may approve of it. Delaware enjoys almost 65 % participation by its dentists in the State Medicaid program for children, in part because it recognizes the need for adequate revenue for providers.

In some cases the proposed fees will create "winners" who may be able to raise fees to offset other losses. This will quickly eliminate any cost savings to the program. In many cases, the proposed fees will create "losers" whose practices provide much needed services that they can no longer sustain financially. Non-profits like LaRed or the other clinics who provide mostly basic services may stand to lose money to treat most or all of their patients. Practices like ours, with a focus on office based dental sedation, may be unable to continue to offer these much needed services below cost. Paradoxically, in an effort to save money or meet CMS guidelines, the proposed reimbursement formula stands to actually cost the State more when care is transferred to hospitals, and emergency room visits increase for those patients who go without treatment until it is too late.

Agency Response: The rate methodology established for the Medicaid and CHIP dental benefit is based on annual surveys by the National Dental Advisory Services (NDAS) – an organization which many dental offices use to assist with the setting of their own rates. This particular survey was chosen by the members of the DSD's dental workgroup as being more comprehensive and more closely reflecting the rates currently charged by dentists in the Delaware region. The ADA annual survey of rates was determined not to be representative of Delaware rates. By using the NDAS survey and calculating the DMMA dental rates, we believe we will continue to provide for a rate that will both cover a dental office's costs and allow for a fair mark-up. Access to care is always a concern within Medicaid and CHIP, and while we do not believe that the final rates will result in an unacceptable loss of access or will result in a spike of referrals to hospital emergency rooms, we will be monitoring closely the impact.

4. Amend the proposed reimbursement formula to include other options – a hybrid option.

One method employed by private insurance is to contract with providers including a fee schedule of maximum allowable charges, similar to what is proposed here. However, only certain fees in each category of procedures are included. Insurers recognize that most of their expense falls under frequently performed, routine procedures. By limiting their exposure on these fees, but allowing providers to make up revenue on other necessary procedures, a win-win situation is created for providers, patients, and the insurance company. This well established market practice could benefit DMAP.

Another option available to the private insurance market is to modify their contracts with individual providers, further customizing their fee allowances, modifying the need for pre-authorizations, etc. This could be a powerful tool to reduce overall Medicaid expense, while simultaneously increasing access to care for different services in different parts of the state. There is ample precedent for these types of contracts in the way that DHSS agencies contract for services already. By extending this flexibility to the DMAP, providers would have even more incentive to participate in the program. After an initial review and modification of the boilerplate contract language, fees would be allowed to fluctuate up and down, taking inflation into account, as delineated in the current proposal. The individual provider modifications would carry forward, unchanged, from fiscal year to year unless the provider were to request changes prior to contract renewal. We feel that CMS would likely endorse a plan encompassing these well established procedures from the private sector. I hope that the comments provided here will be given serious consideration before, and perhaps in conjunction with, any implementation of the proposed regulations. We here at Peninsula Dental and Bear-Glasgow Dental have been proud to partner with the Delaware Children's Medicaid Program in its mission to improve public health while efficiently using State resources.

5. ***Agency Response:*** DMMA felt the pursuit of a hybrid option would add an unnecessary level of complexity to the proposed rate methodology. DMMA reached this decision after consulting the DSD dental work group who strongly advocated that a rate methodology based on NDAS would be well received by the majority of the dental community. It was agreed by all, the reimbursement methodology introduced needed to be a simplistic model to facilitate an easy transition from a percentage of billed charges to a maximum allowable rate schedule.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the January 2012 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Title XIX Medicaid State Plan regarding the reimbursement methodology for EPSDT Dental Services is adopted and shall be final effective March 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #12-05
REVISION:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: **DELAWARE**
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

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

~~1. Screening services - fee-for-service.~~

~~2. Treatment services - fee-for-service.~~

~~3. Dental Treatment - reimburse 85% of billed charges for routine dental services.~~

~~4. Specialized Dental Services - reimburse (a) a percentage of charges for non-orthodontic related services and (b) a flat fee-for-service for orthodontic related services.~~

~~a. Percentage of Charges for non-orthodontic services -The State pays 85% of billed charges for medically necessary non-orthodontic dental care, determined by: 1) the consideration that 65-70% of the usual & customary rate is nationally known to account for the dental provider's actual costs; and, 2) an allowance of an additional mark-up to permit a reasonable and fair profit and as incentive for providers to participate in the Medicaid Program in order to create adequate access to dental care.~~

~~b. Flat Fee-for-Service for orthodontic services - The State identifies three primary orthodontic related services that encompass orthodontic reimbursement: 1) Pre-orthodontic treatment visit; 2) Comprehensive orthodontic treatment of the adolescent dentition; and, 3) Periodic orthodontic treatment visit. Rates for each orthodontic service are determined by adopting the 75th percentile of orthodontic rates paid by the Division of Public Health Special Dental Program, which, compare favorably to commercial coverage and encourage provider participation and adequate access to orthodontic care. Care provided outside of these three services will be reimbursed at a percentage of charges. Medicaid reimbursement for these three orthodontic services will be the lower of the submitted charges or the established Medicaid rate.~~

Dental Services – Effective for dates of service on or after April 1, 2012, Delaware pays for dental services at the lower of:

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

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

General Dental Services shall be paid at 84% of the NDAS 70th percentile amounts Specialty Dental Services shall be paid at 80% of the NDAS 80th percentile amounts.

The Delaware Medicaid Dental Fee Schedule is effective April 1 through March 31 of each year.

The State reserves the right to adjust the fee schedule in order to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems such as HCPCS and CPT and CDT;
3. Establish an initial maximum allowable amount for a new procedure code based on information that was not available when the fee schedule was established for the current year;
4. Adjust the maximum allowable amount when the State determines that the current amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The dental fee schedule is available on the Delaware Medicaid Assistance Program (DMAP) website at: http://www.dmap.state.de.us/downloads.html