Delaware Health and Social Services

Division of Medicaid & Medical Assistance

2016 Access Monitoring Review Plan

September 28, 2016

The Mission of the Division of Medicaid and Medical Assistance is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner.

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1. OVERVIEW

On November 2, 2015, the Centers for Medicare and Medicaid Services (CMS) issued the final rule entitled: ***Methods for Assuring Access to Covered Medicaid Services (CMS-2328-FC).*** The final rule requires state Medicaid programs to develop access monitoring review plans (AMRPs) that include an analysis of access to Medicaid covered services under the state's fee-for-service (FFS) delivery methodology consistent with section 1902(a)(30)(A) of the Social Security Act. The rule requires states to review certain categories of services every three years and additional services should the state reduce (or restructure) provider payment rates.

CMS requires AMRPs to:

- Address the availability of care, providers and how health care needs are met;
- Review access to Primary Care, Physician Specialists, Behavior Health, Pre/Post-Natal Care, and Home Health services;
- Document changes in utilization;
- Compare Medicaid rates and other health care payers; and
- Be developed with recipient, provider, and stakeholder feedback.

The Delaware Division of Medicaid and Medical Assistance (DMMA), within the Department of Health and Social Services (DHSS), administers Delaware's Medicaid program and other public medical assistance program. The mission of DMMA is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner.

In accordance with 42 CFR 447.203, DMMA developed Delaware Medicaid's AMRP to assess FFS Medicaid recipients' access to the specified Medicaid services and determine whether reimbursement rates are sufficient to enlist enough providers so that care and services are available as required by the Social Security Act. DMMA's AMRP analyzes and evaluates access to care for services covered through the Medicaid State Plan and reimbursed on a FFS basis.

This AMRP provides information about the extent to which FFS Medicaid recipients' needs are met, the accessibility of Medicaid-enrolled providers, changes in utilization of covered services, and comparisons of Delaware Medicaid FFS reimbursement rates to payment available from other sources. Through this report, Delaware addresses access to care by assessing the availability of providers, FFS reimbursement rates, and the utilization of services.

DMMA developed the AMRP from April through July 2016 and posted it for public comment in the Delaware Register from August 1, 2016 through August 30, 2016.

1.1 Background

Delaware is a small, but densely populated state with approximately 946,000 residents, with the majority residing in Delaware's most populous county, New Castle. Delaware's other two counties, Kent

and Sussex, have areas that are more rural. Delaware is bordered to the south and west by Maryland, to the northeast by New Jersey, and to the north by Pennsylvania. As a result, Delaware residents often access health care in neighboring states and Delaware Medicaid covers treatment provided by numerous enrolled out-of-state providers.

1.1.1 Medicaid Managed Care and Fee-For-Service Population

The Delaware Medicaid program currently provides health care coverage to approximately 227,377 Delaware residents. Since 1996, the majority of Delaware Medicaid recipients have been served under a managed care service delivery arrangement through the Diamond State Health Plan. In 2012, DMMA moved additional Medicaid recipients and programs to a managed care arrangement, including individuals dually eligible for Medicaid and Medicare, individuals receiving nursing facility care, and individuals receiving home and community-based services in lieu of nursing facility care. At that time, additional Medicaid services, such as nursing facility, and home and community-based services became the responsibility of the Medicaid managed care organizations (MCOs).

Currently, the following Medicaid populations remain under the Medicaid FFS delivery methodology:

- 1**,085** individuals receiving services under the Developmental Disabilities Home and Community Based Waiver Program administered by the Division of Developmental Disabilities Services (DDDS)
- **118** Medicaid recipients residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Delaware has a small, state operated ICF/IDD, The Stockley Center, and one privately operated ICF/IDD, The Mary Campbell Center.
- **46** women receiving Medicaid under the Breast and Cervical Cancer Program. This program serves previously uninsured women who are identified through the Centers for Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need for treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer.

DMMA provides the following Medicaid services under a FFS payment delivery arrangement for all Medicaid recipients, including those served by the Medicaid MCOs:

- Dental services for **96,333** Medicaid children under the age of 21
- Extended behavioral health services for all Medicaid populations to the extent that they are provided via the FFS delivery system.

1.1.2 Delaware's Health Professional Shortage Areas

A federally designated Health Professional Shortage Area (HPSA) is a geographic area, population group, or health care facility that the federal government designates as having a shortage of health professionals. The federal Office of Shortage Designation has established three categories of HPSAs:

primary care, dental, and mental health professionals. HPSAs are designated using several criteria, including population-to-clinician ratios. This ratio is usually 3,500:1 for primary care, 5,000:1 for dental care, and 30,000:1 for mental health care. When there are 3,500 or more people per primary care physician, an area is eligible to be designated as a primary care HPSA. When there are 5,000 or more people per dentist, an area is eligible to be designated as a dental HPSA. When there are 30,000 or more people per psychiatrist, an area is eligible to be designated as a mental health HPSA.

Since 2007, The Delaware Division of Public Health (DPH) within DHSS has contracted with the University of Delaware's Center for Applied Demography and Survey Research (UD CADSR) to perform health professional shortage area designations. UD CADSR establishes HPSA designations, Medically Underserved Area/Population (MUA/P) designations and Governor's Exceptional MUP Designations. The federal government defines the methodology by which HPSAs and MUA/Ps are designated. For areas that do not meet HPSA or MUA/P criteria, Exceptional MUP Designations are permitted if "unusual local conditions which are a barrier to access to or the availability of personal health services" exist and are documented.

For its HPSA analysis, UD CADSR conducts a survey of physicians, dentists, and mental health professionals every three to four years. Before issuing the surveys, it reviews their contents with key stakeholders across the state, and revises them as needed based on stakeholders' input. UD CADSR judges the appropriateness of accessing health care services by the ratio of providers to patients in a given geographic location, wait times for new and existing patients, languages spoken, and other factors. UD CADSR uses survey data to estimate the number of active health professionals and their geographic distribution. The following maps show Delaware's HPSA, MUA and MUP areas.

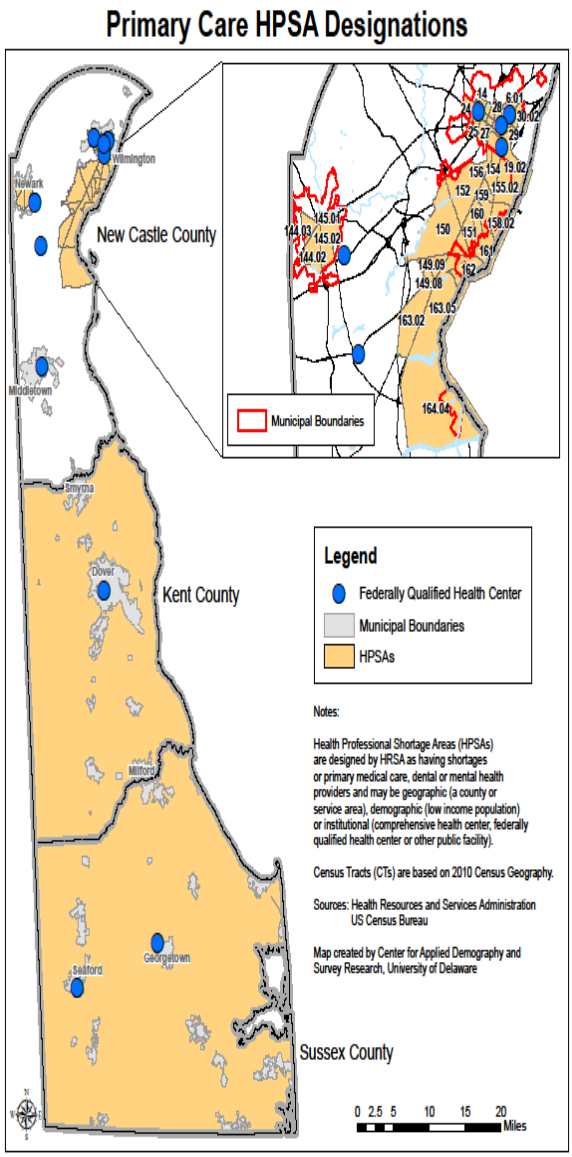


Figure 1: Primary Care Health Professional Shortage Area Designations in Delaware, 2015

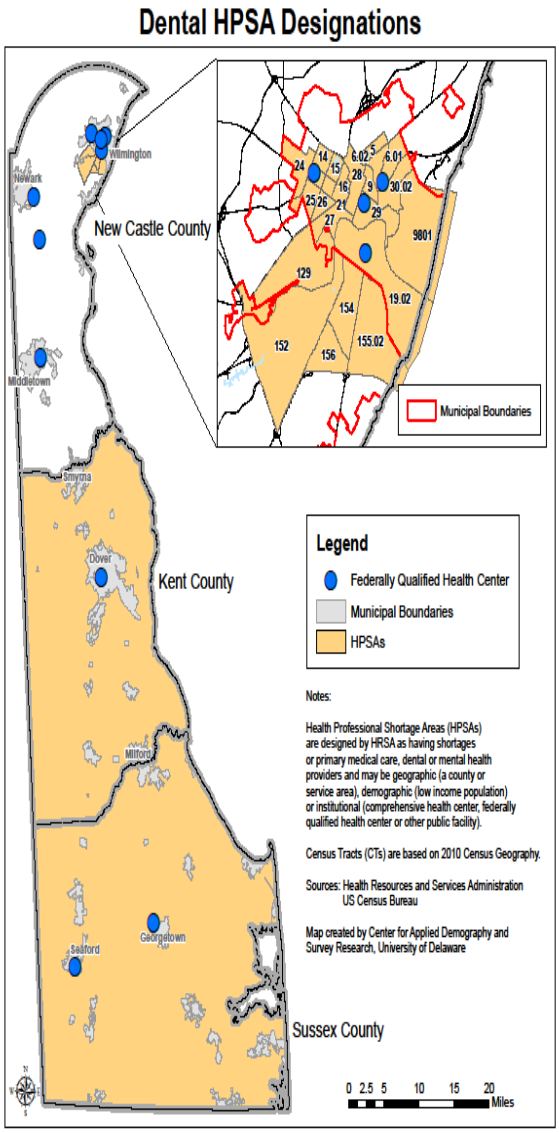


Figure 2: Dental Health Professional Shortage Area Designations in Delaware, 2015

Source: State of Delaware, Office of Primary Care and Rural Health

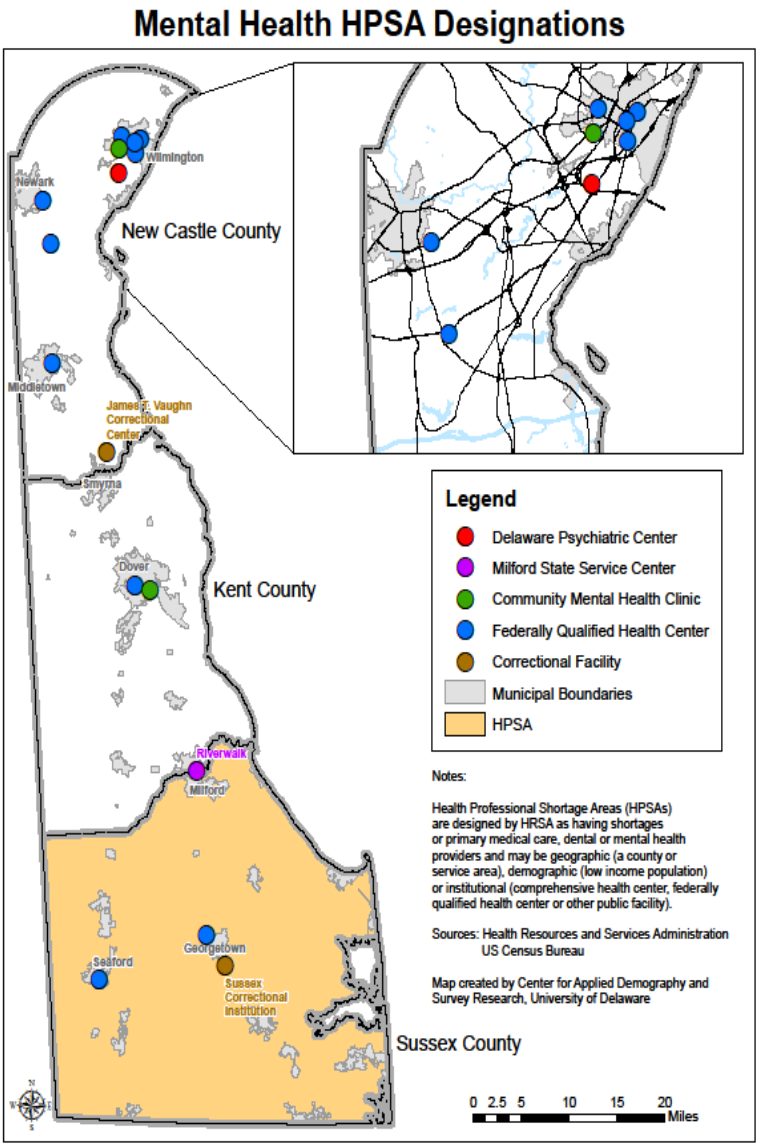


Figure 3: Mental Health Professional Shortage Area Designations in Delaware, 2015

Source: State of Delaware, Office of Primary Care and Rural Health

1.1.3 Provider Recruitment and Retention Programs

Delaware has a number of programs designed to increase the availability and accessibility of health care professionals within the State.

State Loan Repayment Program (SLRP) – The SLRP aims to increase the availability and accessibility of primary care, dental, and mental health services. The SLRP is a comprehensive statewide effort jointly administered by the Delaware Health Care Commission (DHCC), the Delaware Higher Education Office, and DPH. Recently, the Division of Substance Abuse and Mental Health (DSAMH) was added as a key

partner as part of a broader mental health focus. Under SLRP, the Delaware Higher Education Commission is authorized to make awards to primary care clinicians for repayment of outstanding government and commercial loans incurred during undergraduate or graduate education, in exchange for practicing a minimum of two years in a federally designated HPSA.

Conrad State 30/J1 Visa Waiver Program – This program aims to improve access to primary care and needed specialty care for Delawareans. It places international medical graduates who have completed their medical education in the United States in underserved areas of the State. Normally, upon completion of their education, these international medical graduates are required to return to their country of nationality for at least two years before returning to the United States. However, under the Conrad State 30/J-1 Visa Waiver Program, this home residency requirement can be waived for up to 30 J-1 physicians annually. In exchange, the J-1 physicians must agree to practice medicine full time at a Delaware pre-approved sponsoring site for at least three years. These practice sites must be located in federally designated HPSAs or a MUA, with the exception of 10 positions that can be placed in areas of need that are not in federally designated HPSAs.

National Health Service Corps (NHSC) – This program offers financial and other support to primary care providers and sites in underserved communities. The NHSC Program offers the following incentives to health care professionals agreeing to practice in a federally designated HPSA:

- **NHSC Loan Repayment Program**: $50,000 (up to the outstanding balance of qualifying student loans if less than $50,000) provided tax free, to primary care medical clinicians in exchange for two years of service at an approved site in a designated HPSA.

- **NHSC Scholar Program**: Tuition, required fees, and other education costs (including books, clinical supplies, laboratory expenses, instruments, uniforms and travel for one clinical rotation) provided tax free, for up to four years. Recipients also receive a monthly living stipend, which is taxable. NHSC scholars are committed to completing a primary care residency (family medicine, general pediatrics, general internal medicine, or obstetrics/gynecology), becoming licensed, and serving one year for each year of support (minimum of two years of service) at an approved site in a high-need HPSA upon graduation.

National Rural Recruitment and Retention Network (3RNet) – DPH supports health professional recruitment efforts of Delaware's medical community through membership in the 3RNet. Through this membership, community health centers, hospitals, private practices, and community-based organizations have the opportunity to post job vacancies that can be easily accessed by candidates seeking employment. This is a free service, providing national exposure for practice sites' recruitment efforts. Along with job postings, practice sites may include information about their practices' characteristics and other information.

1.1.4 Telehealth

Delaware Medicaid has reimbursed health care providers for telehealth services since 2012 as an important access improvement tool. Telehealth assists in addressing health care access issues, whether

from shortfalls in critical health care specialties or in underserved geographic locations, as it enables remote patient monitoring. In 2015, DHSS created the position of Director of Telehealth Planning and Development within the DHSS Secretary's Office to help fully integrate telehealth into Delaware's health care system. The Mid-Atlantic Telehealth Resources Center and the Delaware Telehealth Coalition support Delaware's telehealth efforts. The Coalition and more than 85 stakeholders developed a Delaware Telehealth Strategic Action Plan to advance telehealth through advocacy and favorable public policies and legislation.

1.1.5 Delaware's Oral Health Initiative

DMMA developed and submitted an Oral Health Action Plan for the CMS Oral Health Initiative. The objectives of the Oral Health Action Plan include the following:

- Improve state Medicaid dental program performance through policy changes
- Maximize dental provider participation in Medicaid
- Partner with oral health stakeholders
- Increase the rate of children ages 1-20 enrolled in Medicaid or CHIP who receive any preventive dental service by 10 percentage points over a 5-year period
- Increase the rate of children ages 6-9 enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over a 5-year period

2. METHODOLOGY

DMMA's AMRP covers the following categories of services provided via the FFS delivery system to the Medicaid populations identified in the following table. DMMA did not analyze pre- and post-natal obstetric services as no Medicaid FFS recipient utilized these services within the past three years.

Table 1: AMRP Categories of Services and Medicaid Population

Categories of Service	Medicaid Population
Primary care services including those provided by a physician, Federally Qualified Health Center (FQHC), and clinic	➢ DD HCBS Waiver program recipients ➢ ICF/IDD residents ➢ Breast and Cervical Cancer program recipients
Physician specialist services (i.e., cardiology, urology, and radiology)	➢ DD HCBS Waiver program recipients ➢ ICF/IDD residents ➢ Breast and Cervical Cancer program recipients
Home health services	➢ DD HCBS Waiver program recipients ➢ ICF/IDD residents ➢ Breast and Cervical Cancer program recipients
Behavioral health services including mental health and substance use disorder	➢ All Medicaid populations to the extent that behavioral health services are provided via the FFS delivery system
Dental services	➢ All Medicaid children under the age of 21 to the extent that dental services are provided via the FFS delivery system

DMMA's methodologies used in developing the AMRP are described in the following sections.

2.1 Recipients access to care

Given Delaware Medicaid's small FFS population and services, DMMA reviewed Delaware's support services for FFS Medicaid recipients and developed a three-year trend in utilization of services in each of the following service categories: primary care, dental, physician specialist, behavioral health, and home health services.

2.2 Provider Participation in FFS

DMMA reviewed the support provided to FFS providers. In addition, DMMA analyzed provider enrollment data for three-years, for all provider taxonomies that fall under the AMRP's categories of services. DMMA analyzed the enrollment data to identify changes in enrollment of providers in

Delaware Medicaid. DMMA also analyzed Medicaid recipients' utilization of these services over a three-year period.

2.3 Rate Analysis

To conduct the rate comparisons, DMMA queried the top 10 procedure codes by claim volume for the following categories of service: primary care, physician specialists, behavioral health, and home health. DMMA then compared the Delaware Medicaid rate for these procedure codes to the Medicaid rates in the neighboring states of Maryland, New Jersey, and Pennsylvania, and to the Medicare rates for these procedure codes.

For our dental services reimbursement rate analysis, DMMA utilized the October 2014 Research Brief produced by the Health Policy Institute (HPI). HPI is a source for policy knowledge on critical issues affecting the U.S. dental care system. HPI generates, synthesizes, and disseminates research for policy makers, oral health advocates, and dental care providers. In October 2014, HPI released a research brief titled ***A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services.*** The entire brief can be found at ***http://www.aapd.org/assets/1/7/PolicyCenter-TenYearAnalysisOct2014.pdf.***

For its analysis, HPI acquired pediatric Medicaid FFS reimbursement rate data for 2003 from previously published research and 2013 reimbursement rate data from state Medicaid program webpages for all states and DC. HPI constructed an index that measures FFS reimbursement rates in Medicaid relative to commercial dental insurance charges. HPI based its index for pediatric dental care services on fourteen common procedures. Within its index, HPI weighted the reimbursement rate for each procedure by its share of total billings in the aggregated 2010-12 FAIR Health database.

3. OVERVIEW OF FINDINGS

3.1 Recipients' Access to Health Care Services

DHSS has a comprehensive support system that assists Medicaid recipients with any access concerns that may arise. These support systems are described in detail in the following sections.

3.1.1 DHSS Divisions Supporting Medicaid Recipients

- **DHSS Division of Medicaid and Medical Assistance (DMMA)**
  - DMMA eligibility staff determines Medicaid applicants' eligibility for the DD HCBS Waiver program, ICF/IDD services, and Breast and Cervical Cancer program. They assist these program recipients and DD Waiver case managers with access to care issues.
  - DMMA's Health Benefit Manager (HBM) Call Center assists Medicaid recipients select and enroll in a Medicaid Managed Care Organization (MCO). When the HBM receives calls from Medicaid FFS recipients or from MCO recipients concerning access to medical care covered by FFS (for example, dental services), the HBM connects the caller to the DSS Customer Relations Call Center or to DMMA management for additional assistance.
- **DHSS Division of Developmental Disabilities Services (DDDS)** administers the DD HCBS Waiver program and provides DDDS case managers who assist DD HCBS Waiver recipients access needed medical services. In addition, DDDS administers Delaware's state operated ICF/IDD, The Stockley Center, and assures that its residents receive all needed medical services.
- **DHSS Division of Substance Abuse and Mental Health (DSAMH)** works directly with mental health providers and adults receiving extended behavioral health services to assure they receive timely and quality services.
- **DHSS Division of Social Services (DSS)** operates a Customer Relations Unit (CRU) staffed by experienced Senior Social Workers/Case Managers. The CRU staff has access to Delaware's integrated eligibility system and MMIS and assists Medicaid recipients with Medicaid eligibility, access to care, and billing issues.

3.1.2 Delaware 2-1-1 Helpline

Delaware 2-1-1 is part of a national 2-1-1 system covering 90% of the United States population. Delaware 2-1-1 provides one central resource for access to health and human service organizations. It operates statewide Monday through Friday from 8 AM–9 PM and is staffed by trained information and referral specialists. It assists callers access local organizations and agencies and provides guidance regarding health insurance, dental plans, counseling and preventative health care.

3.1.3 DHSS Advisory Councils

The Department has numerous Department councils that provide a venue to hear from the community in various settings. These Councils serve in an advisory capacity to the Director of their affiliated

Division. They consider matters related to the Division's services and any other matters that may be referred to the Council by the Governor or DHSS. They include, but are not limited to the following:

- The DMMA Medical Care Advisory Committee
- The Governor's Advisory Council on Substance Abuse and Mental Health
- The DDDS Governor's Developmental Disabilities Advisory Council
- The DSS Social Services Advisory Committee

3.1.4 Recipient Service Utilization Analysis

DMMA analyzed statewide utilization and expenditure data for calendar years 2013 through 2015 for primary care, physician specialist, behavioral health and home health services to identify any decreases in utilization that could indicate a potential access problem. Medicaid claims were grouped by provider type based on the taxonomy of the billing provider.

DMMA utilized the data it provides to CMS on an annual for dental services, which is based on federal fiscal year (FFY).

Table 2: Service Utilization (Primary Care, Physician Specialist, Behavioral Health, Home Health)

Provider Type	CY 2013		CY 2014		CY 2015	
	Expenditures	Recipients	Expenditures	Recipients	Expenditures	Recipients
Primary Care	$ 957,207	1,100	$ 934,695	1,115	$ 994,522	1,173
Physician Specialists	$ 41,638	527	$ 51,240	600	$ 51,976	591
Behavioral Health	$ 219,811	1,756	$ 245,083	1,702	$ 110,737	1,391
Home Health	$ 0	0	$ 298,955	4	$ 462,303	4

Table 3: Dental Service Utilization

	FFY 2012	FFY 2013	FFY 2014
Number of Medicaid children receiving dental services	53,429	49,326	55,828

3.2 FFS Provider Network Analysis

3.2.1 DMMA Provider Support Services

DMMA provides a number of supports to providers to assist in the provider enrollment process, resolve provider billing issues, and identify and address access to care issues.

- Delaware Medical Assistance internet-based **Provider Portal** offers providers automated assistance with the following processes:
    - Provider Enrollment and Disclosures
    - Electronic Claims Submission and Attachments
    - View and Submit Prior Authorization
    - Make Inquiries
    - Check Member Eligibility

  DMMA's new MMIS, the Delaware Medicaid Enterprise System (DMES), will feature a new provider healthcare portal. The new portal will meet federal MITA certification requirements and will streamline the enrollment, claims submission, prior authorization, and eligibility inquiries processes for providers.
- DMMA Provider Services staffs a **Provider Call Center** Monday - Friday, 8:00 a.m. to 5:00 p.m. to answer providers' questions and assist them with any issues. Provider services also issues quarterly Provider Bulletins and e-mail notifications that inform providers of changes in policies and procedures, and provide enrollment and billing tips to providers.
- DMMA holds quarterly **Provider Association meetings** to share information and maintain open lines of communication with providers. Provider Associations and individual providers that participate in these meetings include, but are not limited to the Delaware Hospital Association, Delaware Healthcare Facilities Association, the Medical Society of Delaware, Delaware State Dental Society, Medicaid managed care organizations, FQHCs, Nemours Children Health System, home health providers, hospitals, and behavioral health providers.
- DMMA's efforts to increase dental provider enrollment and satisfaction include the following:
    - Corresponds with providers via e-mail, phone calls, outreach letters and office visits
    - Surveys dental providers on a regular basis to identify problem areas
    - Works with DMMA Provider Services and dental providers directly to respond to dental providers regarding claims, payments, prior authorization process, and enrollment
    - Clarifies and develops guidance for providers regarding policy, billing, prior authorizations, reporting and quality
    - Collaborates with the Oral Health Coalition to set goals for Delaware
    - Works with Delaware Dental Society to address concerns
    - Tracks the use of oral health services by children in Medicaid and CHIP in order to identify gaps in services and develop intervention plans
    - Reviews State Medicaid dental reimbursement methodology and rates to identify any barriers to provider participation

- Conducts on-site outreach to non-Medicaid practices to explain benefits and garner interest in the Medicaid program and enrollment

3.2.2 Delaware Medicaid Provider Enrollment Statistics

DMMA receives provider enrollment statistics weekly, enabling DMMA to quickly identify and address any problems with the provider enrollment process. Provider enrollment statistics are provided below for three years – calendar year 2013, 2014 and 2015. These statistics show the following:

- A 29% increase in provider enrollments received from 2013 to 2015
- A 7% increase in provider enrollments added from 2013 to 2015
- A 16% decrease in provider enrollments rejected over the three year period
- A decrease in the average number of days for a provider to enroll in the Delaware Medicaid program from 33.98 days in 2013 to 18.26 days in 2015

Table 4: Provider Enrollment Statistics

Enrollment Status	CY 2013	CY 2014	CY 2015	Percentage Change
Enrollments Received	3,606	4,048	4,632	+ 29%
Returned to Provider for Missing information	1,577	1,893	1,981	+ 26%
Enrollments Added	1,762	1,834	1,890	+ 7%
Enrollments Rejected	201	228	169	- 16%
Average (days) to Enroll	33.98	12.22	18.26	- 46%

The following tables show the number of active providers in each of the AMRP categories of services for the past three calendar years. The provider count is by taxonomy and unique National Provider Identifier (NPI). While DMMA eliminated provider groups in order to provide an unduplicated count of providers, some providers may be counted more than once if they have multiple NPIs.

The first table is broken down between in-state and out-of-state providers. It should be noted that many out-of-state providers have been enrolled in Delaware Medicaid for the benefit of one specific Delaware Medicaid recipient. As a result, the number of enrolled out-of-state providers is not representative of the number of out-of-state providers available to serve all Delaware Medicaid FFS recipients. The second table shows the percentage increase in the number of in-state provider enrollments in each category.

Table 5: Number of Enrolled Providers by Category

CY 2015			
Provider Type	**In State**	**Out of State**	**Summary**
Primary Care	6,431	15,876	22,307
Dental	420	109	529
Physician Specialist	1,238	727	1,965
Behavioral Health	1,733	593	2,326
Home Health	286	118	404
Total	**10,108**	**17,423**	**27,531**
CY 2014			
Provider Type	**In State**	**Out of State**	**Summary**
Primary Care	6,326	16,283	22,609
Dental	410	104	514
Physician Specialist	1,205	744	1,949
Behavioral Health	1,806	608	2,414
Home Health	283	121	404
Total	**10,030**	**17,860**	**27,890**
CY 2013			
Provider Type	**In State**	**Out of State**	**Summary**
Primary Care	5,954	13,168	19,122
Dental	404	96	500
Physician Specialist	1,124	503	1,627
Behavioral Health	1,439	457	1,896
Home Health	239	81	320
Total	**9,160**	**14,305**	**23,465**

Table 6: Percentage Change in the Number of Enrolled In-State Providers by Category

Provider Type	**CY 2013 In-State**	**CY 2014 In-State**	**CY 2015 In-State**	**3-Year Percentage**
Primary Care	5,954	6,326	6,431	+ 8%
Dental	404	410	420	+ 4%
Physician Specialists	1,124	1,205	1,238	+ 10%
Behavioral Health	1,439	1,806	1,733	+ 20%
Home Health	239	283	286	+ 20%

3.3 Medicaid Reimbursement Rate Analysis

3.3.1 Comparison of Reimbursement Rates

As shown in the following table, Delaware Medicaid reimbursement rates for the top ten procedure codes are approximately 69% of the Medicare national rates. The Delaware Medicaid rates are consistently higher than the NJ Medicaid rates, similar to the Pennsylvania Medicaid rates and roughly 70% of the Maryland Medicaid rates.

Table 7: Delaware Medicaid Provider Reimbursement Rate Comparison

Procedure Code	Procedure Code Description	Medicare National Rates [1, 2, 3]	DE Medicaid	NJ Medicaid	PA Medicaid	MD Medicaid [4, 5]
99213	Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient	$ 51.56	$ 34.44	$ 23.50	$ 35.00	$ 49.86
99214	Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient	$ 79.13	$ 53.26	$ 23.50	$ 54.42	$ 76.48
S9124	Nursing Care, in the Home by Licensed Practical Nurse, per Hour	N/A	$ 46.14	$ 23.50	$ 40.00	Not Avail.
99232	Subsequent Hospital Care, per Day, for the Evaluation and Management of a Patient	$ 72.68	$ 49.36	$ 23.50	$ 17.00	$ 70.22
99285	Emergency Department Visit for the Evaluation and Management of a Patient	$ 175.44	$ 134.94	$ 32.30	$ 50.00	$ 168.77
S9123	Nursing Care in the Home by a Registered Nurse, per Hour	N/A	$ 51.50	$ 50.00	$ 40.00	Not Avail.
99233	Subsequent Hospital Care, per Day, for the Evaluation and Management of a Patient	$ 104.91	$ 71.02	$ 23.50	$ 17.00	$ 101.39
11721	Debridement of Nail(s) by any Method(s), 6 or more	$ 25.42	$ 25.42	$ 21.00	$ 20.00	$ 21.42
99212	Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient	$ 25.42	$ 17.04	$ 23.50	$ 26.00	$ 24.60

99203	Office or Other Outpatient Visit for the Evaluation and Management of a New Patient	$ 77.70	$ 50.42	$ 32.30	$ 54.25	$ 75.37

Notes:

1. The Medicare rates shown are at the national level; that is, they do not have a Medicare Administrative Contractor (MAC) locality adjustment applied to them.
2. In any instances where the Medicare rate for a service performed in a facility differed from the rate for administering that same service in a non-facility setting, the rate shown is the facility rate
3. Per the CMS website, the current Physician Fee Schedule does not price home health HCPCS codes
4. In any instances where the Maryland rate for a service performed in a facility differed from the rate for administering that same service in a non-facility setting, the rate shown is the facility rate
5. The Maryland rates for home health are currently under revision, per **https://mmcp.dhmh.maryland.gov/pages/provider-information.aspx**

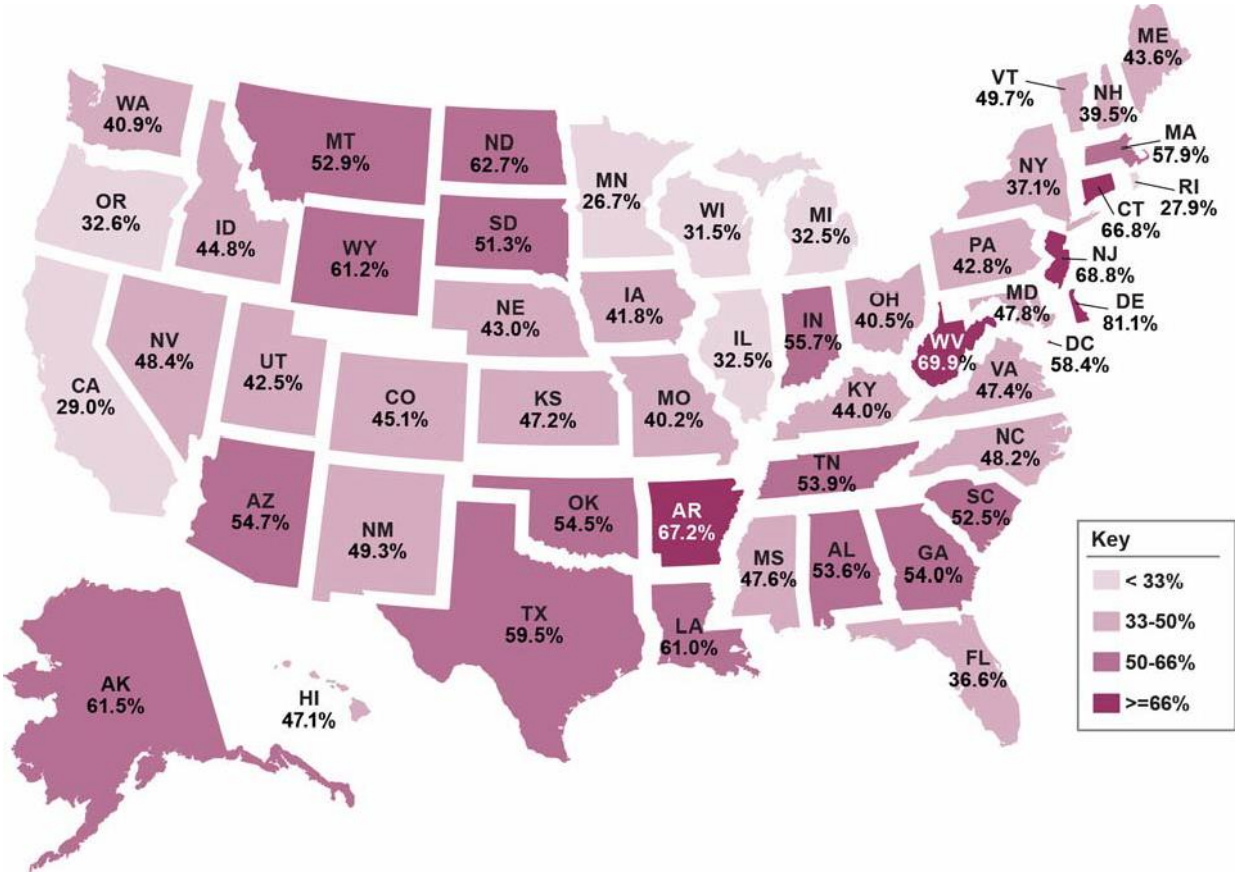
Table 8: Other Reimbursement Rates Shown as a Percentage of Delaware Medicaid Rates

Procedure Code	Medicare National Rates	NJ Medicaid	PA Medicaid	MD Medicaid
99213	150%	68%	102%	145%
99214	149%	44%	102%	144%
S9124	N/A	51%	102%	Not Avail.
99232	147%	48%	34%	142%
99285	130%	24%	37%	124%
S9123	N/A	97%	78%	Not Avail.
99233	148%	33%	24%	143%
11721	100%	83%	79%	84%
99212	149%	138%	153%	144%
99203	154%	64%	108%	149%

DMMA Dental Rates Comparison

DMMA's current reimbursement methodology for dental services has been in place since April 1, 2012. In its analysis of dental rates, HPI found wide variation in Medicaid reimbursement rates for pediatric dental care services. In 2013, state Medicaid reimbursement was, on average, 48.8% of commercial insurance charges for pediatric dental services. HPI also found that Delaware Medicaid had the highest state Medicaid dental reimbursement rate at 81.1% of commercial insurance charges**.** West Virginia Medicaid had the second highest reimbursement rates at 69.9%, with New Jersey Medicaid and Connecticut Medicaid following at 68.8% and 66.8% respectively.

Figure 4: **Pediatric Dental Medicaid FFS Reimbursement as a Percentage of Commercial Dental Insurance Charges in 2013**



Source: HPI Research Brief: ***A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services***, released October 2014. HPI collected Medicaid FFS reimbursement data 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.

4. ONGOING ACCESS MONITORING

As required by 42 CFR 447.203, DMMA will submit to the Centers for Medicare and Medicaid Services (CMS) an updated version of the Access Monitoring Review Plan every three years. Should DMMA seek to reduce or restructure any FFS provider rates, DMMA will prepare an updated version of the Plan that includes an analysis of the effect of the change in payment rates on access. DMMA will submit the updated plan to CMS with any State Plan Amendment request involving FFS provider payment rate changes.

5. CONCLUSION

Ensuring access to care is a priority of the Delaware Medicaid program. The Access Monitoring Review Plan provides specific data and analysis of access levels and rate comparisons for the specified services, which demonstrate that DMMA has adequate capacity to serve Delaware's FFS Medicaid recipients. The Plan demonstrates DMMA's compliance with 1902(a)(30)(A) of the Social Security Act, which requires that state payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that services under the State Plan are available to recipients at least to the extent that those services are available to the general population.

DMMA will continue to review and refine its Access Monitoring Review Plan to assure that the report provides meaningful information and value to policy discussions and to the administration of the Delaware Medicaid Program.