Medicaid adult dental reimbursement

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Medicaid is a critical source of health insurance in the United States, providing coverage to over 73 million beneficiaries.[1] While comprehensive medical coverage is a mandatory benefit available to all Medicaid recipients nationwide, dental benefits under Medicaid vary widely.

Each state's Medicaid and/or Children's Health Insurance Program (CHIP) guidelines provide mandatory comprehensive dental coverage for children but there is no nationwide minimum requirement for dental coverage for adults. Adult dental benefits under Medicaid vary by state, ranging from no coverage to comprehensive coverage of all classes of service. In addition, benefits within a state may vary by Medicaid population; subgroups such as pregnant women, disabled, or elderly Medicaid beneficiaries may receive additional dental benefits or dental benefits different from other Medicaid recipients.

As an optional benefit, Medicaid adult dental benefits are subject to change with state budgets, leading to uneven dental coverage over time (despite the cost of dental benefits being quite small relative to the cost of medical coverage). Provider availability also limits access to dental coverage for the adult Medicaid population: according to one source, only 38% of dentists nationwide accept Medicaid.[2] Medicaid enrollees may face additional barriers to accessing dental care such as transportation to appointments and differences in language. The expansion of eligibility for Medicaid in many states (37 as of January 2019[3]) thrust more adult beneficiaries into the system; in expansion states that offer adult dental benefits, an influx of newly insured beneficiaries may be seeking dental care.

This paper explores the relationships among a state's adult Medicaid dental benefit, provider reimbursement, and dental care utilization rates. Following an overview of Medicaid adult dental coverage, and the importance of oral health and provider reimbursement under Medicaid, the fee schedule data for seven states are presented. In order to provide a consistent comparison of reimbursement and utilization levels, the states selected for specific comment cover all extensive dental benefits for adults.

The goal of this paper is to shed light on the relationship between reimbursement and utilization in a dental program. Other factors in a program can also be important to utilization, such as access to dentists and beneficiary education; a discussion of these issues is beyond the scope of this paper.

[1] Medicaid. December 2018 Medicaid and CHIP Enrollment Data Highlights. Retrieved April 23, 2019, from https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[2] ADA Health Policy Institute. Dental Benefits and Medicaid. Retrieved April 23, 2019, from https://www.ada.org/en/science-research/health-policy-institute/dental-statistics/dental-benefits-and-medicaid.

[3] FamiliesUSA (November 7, 2018). A 50-State Look at Medicaid Expansion. Retrieved April 23, 2019, from https://familiesusa.org/product/50-state-look-medicaid-expansion.

The importance of oral health

Oral health is linked to general health in many ways. For example, diabetics have a three times' greater risk of periodontitis than nondiabetics,[4] women are more susceptible to gingivitis when pregnant,[5] and women lacking dental care are more likely to deliver early.[6] Claims for both diabetes and pregnancy are significant in Medicaid programs:

- Living below the poverty line can double or triple the risk of developing diabetes[7]
- Medicaid covers roughly 40% of births nationwide[8]

Other prevalent chronic conditions related to oral health include cardiovascular disease and osteoporosis.[9] Due to this relationship, increased utilization of dental benefits within the Medicaid population may result in an overall decrease in costs if savings in other health expenditures outweigh the cost of additional utilization. Additionally, the appearance of teeth can affect one's ability to gain employment, indicating that oral health has economic and social impact as well as physical.[10] Increased coverage of and access to dental care may have positive impacts on the overall health and lives of Medicaid beneficiaries.

Overview of Medicaid adult dental

COVERAGE VARIATIONS BY STATE

For children covered under state Medicaid or CHIP, dental benefits are federally required coverage nationwide. However, dental benefits for Medicaid adults are optional at each state's discretion. As of July 2018, 47 states and Washington, D.C., provide some level of dental coverage under Medicaid, with the following breakdown:

Twelve offer emergency-only coverage, limited to pain relief and infection treatment.

Sixteen states offer limited coverage, which generally includes fewer than 100 American Dental Association (ADA) procedures such as diagnostic, preventive, and restorative care and requires a per-person annual expenditure of $1,000 or less.

The remaining 19 states and Washington, D.C., provide extensive coverage, including more dental procedures and more categories of services, with per-person expenditures over $1,000.[11]

We note that the figure below is reproduced from a publicly available source as of July 2018; states' programs may have changed since that time, and different sources may categorize a particular state's coverage differently than what is shown in this map. Additionally, adult coverage can vary by population within a state because some states offer richer benefits to population subsets such as pregnant women or disabled persons.

[4] Kane, S.F. (November/December 2017). The effects of oral health on systemic health. General Dentistry. Retrieved April 23, 2019, from https://www.agd.org/docs/default-source/self-instruction-(gendent)/gendent_nd17_aafp_kane.pdf.

[5] ADA (May 2011). Oral health during pregnancy. JADA. Retrieved April 23, 2019, from https://www.ada.org/~/media/ADA/Publications/Files/for_the_dental_patient_may_2011.pdf?la=en.

[6] Frakt, A. (February 19, 2018). How dental inequality hurts Americans. New York Times. Retrieved April 23, 2019, from https://www.nytimes.com/2018/02/19/upshot/how-dental-inequality-hurts-americans.html.

[7] Diabetes in Control (November 24, 2010). Poverty a leading cause of type 2 diabetes, studies say. Retrieved April 23, 2019, from http://www.diabetesincontrol.com/poverty-a-leading-cause-of-type-2-diabetes-studies-say/.

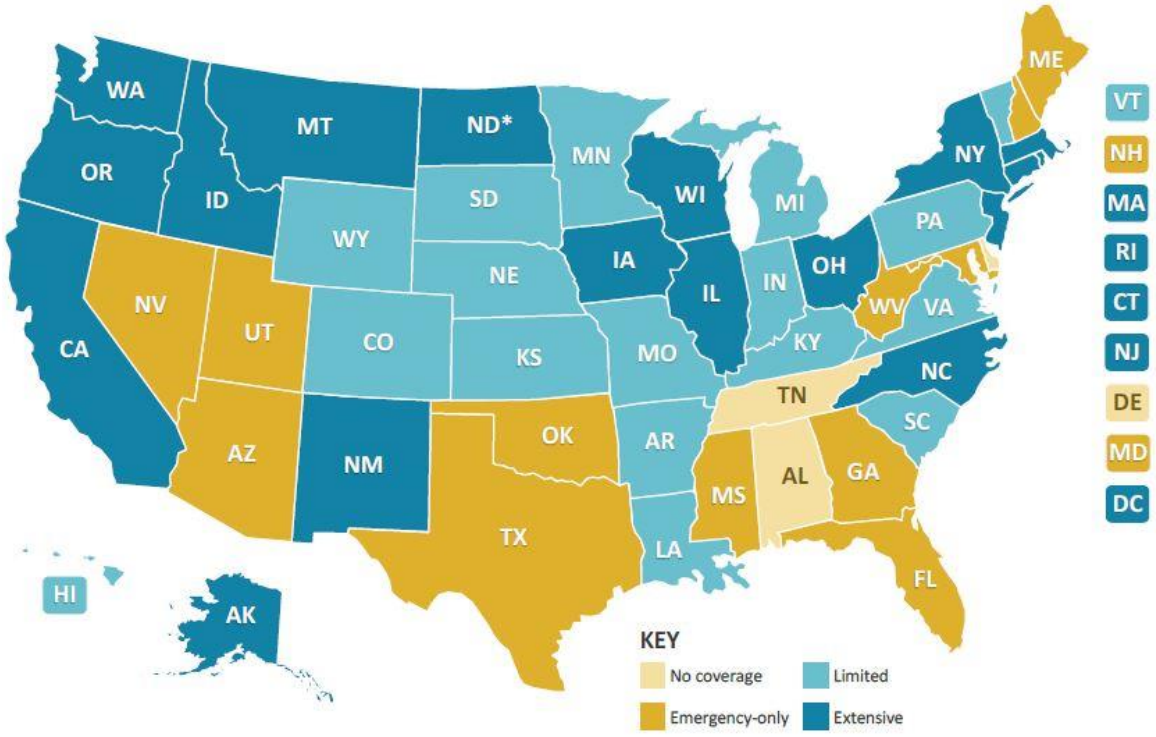
[8] Kaiser Health News. Nearly half of U.S. births are covered by Medicaid, study finds. Retrieved April 23, 2019, from https://khn.org/news/nearly-half-of-u-s-births-are-covered-by-medicaid-study-finds/.

[9] Mayo Clinic (November 1, 2018). Oral Health: A Window to Your Overall Health. Retrieved April 23, 2019, from https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475.

[10] Frakt, op cit.

[11] Medicaid Adult Dental Benefits: An Overview (July 2018). Centers for Health Care Strategies, Inc.

FIGURE 1: ADULT MEDICAID DENTAL COVERAGE BY STATE, JULY 2018



Reproduced from Medicaid Adult Dental Benefits: An Overview. Centers for Health Care Strategies, Inc. July 2018.

COVERAGE VARIATIONS BY SUBPOPULATION

Dental coverage for adult Medicaid beneficiaries may also vary within a state based on eligibility criteria. For example, in Nevada, adult dental coverage is limited to emergency care only, but pregnant women may qualify for dental cleanings and periodontal treatment.[12] Oklahoma only covers emergency dental services for most adults, but for some special populations, including the developmentally disabled, additional services such as oral exams, cleanings, x-rays, and sometimes even root canals and fillings are covered.[13] For states that expanded Medicaid eligibility under the Patient Protection and Affordable Care Act (ACA), all except North Dakota offer the same adult dental benefits to the base Medicaid population and the expansion population. North Dakota did not extend dental benefits to its expansion enrollees, while traditional Medicaid beneficiaries receive comprehensive dental coverage.

COVERAGE VARIATIONS OVER TIME

Not only does access to dental services for adult Medicaid beneficiaries differ among states and by subpopulation within a state, but it can be subject to changes over time. As one of the few non-required service categories, adult Medicaid dental benefits are often targeted for reduction or elimination when state budgets are tight. Similarly, expansion of the benefit via more covered dental procedures or coverage of additional subpopulations may occur as a state budget allows. As an example, California's adult dental benefit was cut significantly in 2009 due to state budget issues; it was then partially reinstated in May 2014 and fully restored in 2018 to include the full spectrum of dental services.[14]

[12] Oral Health Nevada. Find a Dental Provider. Retrieved April 23, 2019, from https://oralhealthnevada.com/oral-health-resources/find-a-dental-provider/.

[13] Oklahoma Health Care Authority. Dental Providers. Retrieved April 23, 2019, from http://www.okhca.org/providers.aspx?id=600.

[14] California Dental Association (November 2, 2017). New benefits for Denti-Cal adults in 2018. Retrieved April 23, 2019, from https://www.cda.org/news-events/new-benefits-for-denti-cal-adults-in-2018.

Changes in the benefit over time can lead to uneven dental care for the adult Medicaid population and may have unexpected cost consequences. In fact, California experienced a "significant and immediate" increase in emergency room visits for dental issues upon the discontinuance of the Medicaid dental benefit in 2009, with a 68% increase in the average yearly cost of dental emergency room visits. In addition, the root cause of the dental issue was less likely to be resolved in an emergency room setting as opposed to a dental office, which could provide ongoing treatment for the underlying issue rather than simply offering relief of pain and/or infection.[15]

The expansion of Medicaid by selected states in 2014 allowed a new set of adults to obtain covered dental care, in the expansion states that provide adult dental Medicaid benefits. It is estimated that up to 8.3 million adults gained access to some form of dental coverage through Medicaid expansion.[16]

THE IMPORTANCE OF REIMBURSEMENT

The number of dental providers accepting Medicaid patients varies widely by state. Issues such as low reimbursement rates as well as administrative burden and the cost of missed appointments may prevent providers from participating.[17] Reimbursement levels for Medicaid dentists average well below provider billed charge levels and are significantly lower than typical contracted reimbursement from commercial insurers. The use of federally qualified health centers (FQHCs) in a Medicaid dental program can mitigate the impact of low reimbursement, since these health centers receive an enhanced reimbursement rate. The use of FQHCs for dental services varies by state, but is increasing.[18]

Beyond the lack of dentist participation in Medicaid, overall care access can be an issue as dentists are spread unevenly across the country. As of 2017, over 62 million people live in "dental health professional shortage areas" where there are fewer practicing dentists than needed to serve the population.[19] With few dentists in some areas and fewer participating in Medicaid, beneficiaries can have a difficult time accessing a provider.

There are many additional factors at play that determine the success of a Medicaid dental program in improving access to and utilization of care; the fees paid to providers are just one component. Addressing provider shortages, transportation issues, differences in language, burdensome administrative processes for providers, and many other issues specific to the Medicaid program are all key elements of success; sufficient provider reimbursement is only one important pillar.

ANALYSIS OF STATE FEE SCHEDULES

We compiled Medicaid dental fee schedules from seven states that cover extensive dental benefits for adults and calculated the composite dental provider reimbursement rates for each state, using the distribution of services from the Milliman Dental Cost Guidelines (DCGs).[20] The states were selected from states with comprehensive adult Medicaid dental benefits (Minnesota is shown in Figure 1 as having limited adult benefits but a review of their coverage indicated a fairly rich benefit), with some consideration for geographic diversity. We then used the average commercial billed charges from the DCGs to calculate composite commercial reimbursement levels in each state. The ratio of the state fee schedule composite and the DCG composite is the Medicaid reimbursement as a percentage of commercial billed charges. We performed this calculation separately for adults and children.

[15] Singhal, A. et al. (May 2015). Eliminating Medicaid adult dental coverage in California led to increased dental emergency visits and associated costs. Health Affairs.

[16] Vujicic, M. (August 2015). Solving dentistry's 'busyness' problem. JADA. Retrieved April 23, 2019, from http://jada.ada.org/article/S0002-8177%2815%2900644-3/pdf.

[17] Medicaid Adult Dental Benefits: An Overview, op cit.

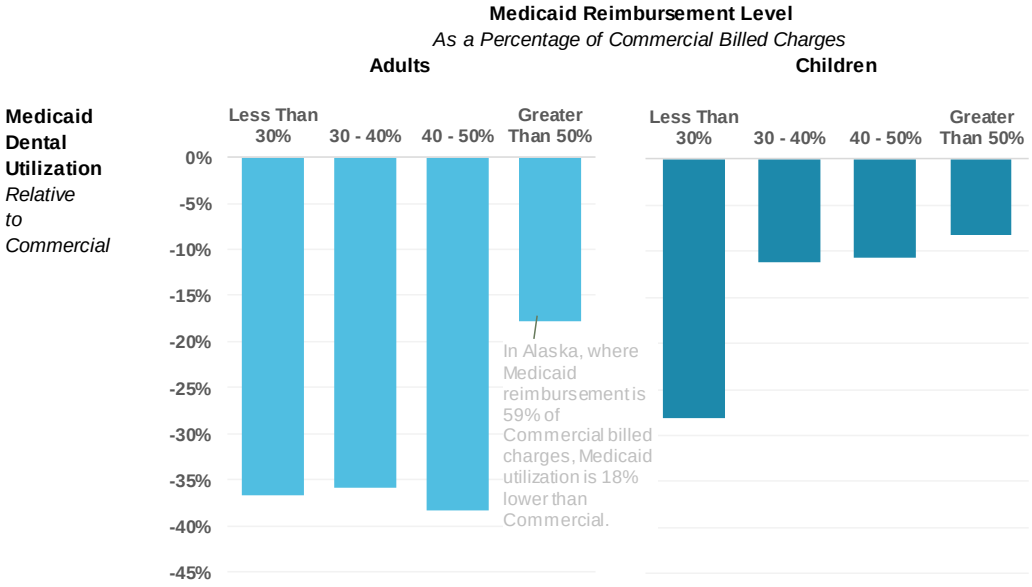
[18] Children's Dental Health Project (March 2010). Increasing Access to Dental Care Through Public Private Partnerships: Contracting Between Private Dentists and Federally Qualified Health Centers. FQHC Handbook. Retrieved May 8, 2019, from http://www.ada.org/~/media/ADA/Public%20Programs/Files/access-to-dental-care_fqhc-handbook.ashx.

[19] Kaiser Family Foundation (December 31, 2018). Dental Care Health Professional Shortage Areas (HPSAs) Retrieved April 23, 2019, from https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/.

[20] 2017 Milliman Health Cost Guidelines™ – Dental.

After calculating Medicaid reimbursement as a percentage of commercial reimbursement by state and age group, we compared the result to "utilization gaps" by state, as provided by the ADA Health Policy Institute.[21] The utilization gap is defined as the difference in utilization—i.e., the difference in the proportion of the covered population with a dental visit in a given year—between Medicaid and commercial populations. By plotting the reimbursement level on a graph with the utilization gap, as shown in Figure 2, we can see whether an empirical relationship exists between dental provider reimbursement and utilization of Medicaid dental services.

FIGURE 2: MEDICAID DENTAL UTILIZATION GAP DECREASES AS PROVIDERS ARE PAID HIGHER RATES, CLOSER TO COMMERCIAL BILLED CHARGES



Seven states included in this analysis: AK, CT, IA, MN, NC, NM, WA
Time period: 2013 utilization gap, most recent reimbursement available as of May 2018
Reimbursement levels are averages of the state Medicaid reimbursement relative to commercial billed charges

		Adults	Children
State reimbursement groupings:	**Less Than 30%**	**CT, MN, WA**	**MN**
	30 - 40%	**IA**	**IA, WA**
	40 - 50%	**NC, NM**	**NC, NM**
	Greater Than 50%	AK	AK, CT

Figure 2 suggests a correlation between Medicaid dental provider reimbursement levels relative to commercial billed charges and utilization of dental services, especially for children. In general, the higher the Medicaid fees relative to commercial billed charges, the lower the gap in utilization levels between Medicaid and commercial populations. We recognize that the fee statistics and utilization statistics are from different time periods, due to data availability. We believe that the relationship demonstrated is directionally informative, and as a next step, we could review data on a longitudinal basis.

The correlation between Medicaid dental fees relative to commercial billed charges and utilization of dental services appears stronger for children than adults. In fact, if Alaska were removed from this analysis, there would not be a clear relationship between reimbursement and utilization for adults. When comparing the adult and child graphs, you can see that Medicaid utilization levels are generally closer to those of a commercial population for children than for adults.

[21] Vujicic, Marko & Nasseh, Kamyar (December 2015). Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrows, Remains Large for Adults. ADA Health Policy Institute.

DISCUSSION AND NEXT STEPS

Our analysis indicates that reimbursement levels have a positive correlation with utilization. However, other aspects of a state Medicaid dental program influence utilization levels. We can gain some insights into state-level results by better understanding each state's Medicaid dental program. We observe the following:

- Connecticut and Washington have the largest differences between adult and child dental provider reimbursement levels relative to commercial charges (-26.5% and -7.6%, respectively). Those two states have different fee schedules for adults and children. It is notable that those two states have fairly large differentials between adult and child utilization gaps; the lower gaps for children in those states may be correlated to relatively higher reimbursement levels for children compared to adults.
- Iowa, New Mexico, and North Carolina also show significantly lower utilization gaps for children compared to adults, even though the adult and child fees are the same in each of those states. Other factors may contribute to the higher relative child utilization rates including:
  - Medicaid dental Healthcare Effectiveness Data and Information Set (HEDIS) measures are related only to children, not adults, focusing on the percentage of eligible children who received a preventive dental service and the percentage of children aged 6 to 9 at high risk for caries who receive sealants.[22] Many state-specific initiatives to improve population oral health focus on these measurable statistics and therefore focus more on child utilization.
  - Starting in 2008 North Carolina has undertaken a "Healthy North Carolina 2020" initiative, which seeks to increase the percentage of Medicaid children aged 1 to 5 who utilize dental services. According to the ADA Health Policy Institute, Medicaid pediatric dental utilization in North Carolina increased from 40% to 52% between 2005 and 2013, while commercial pediatric dental utilization moved from 56% to 65%; the gap between Medicaid and commercial utilization levels closed during that period.[23]
- Minnesota has the highest child utilization gap of the seven states we reviewed, and the gap for adults is similar. Medicaid dental reimbursement rates compared to commercial are among the lowest of the states we analyzed, and in fact were ranked 49th for Medicaid child dental reimbursement.[24] Low reimbursement levels may be affecting dentists' willingness to accept new Medicaid patients,[25] leading to low utilization. The federal government warned the state in 2017 that the program could lose funding if pediatric dental access is not improved.[26] Minnesota is one of only a handful of states that allows licensed midlevel dental providers, or dental therapists, to treat Medicaid patients, which may help improve access to care.[27]
- Alaska has the lowest utilization gaps of the seven states we reviewed, for both children and adults. In fact, for adults it has the lowest utilization gap of all states as of 2013.[28] It also has the highest Medicaid reimbursement rates relative to commercial, perhaps best illustrating the correlation between provider reimbursement and utilization. Despite having a fairly large rural population, Alaska's 2013 Medicaid utilization rate for children is 48%, on par with the national average, and its adult utilization rate is 35%. Alaska has allowed dental therapists for its Alaska Native population since 2004 which could help to explain its positive access results despite its largely rural nature.[29]

Though Figure 2 above represents a small number of states, it suggests a correlation between reimbursement and utilization. A state Medicaid dental program must be evaluated holistically to fully understand utilization drivers. Decreases in the utilization gap from commercial dental coverage may lead to better oral health of the population. As previously discussed, this could lead to overall health improvements of the Medicaid population and increased savings for the program.

[22] Centers for Medicare and Medicaid Services (February 2019). Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Retrieved April 23, 2019, from https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf.

[23] Vujicic, Marko & Nasseh, Kamyar, op cit.

[24] Minnesota Dental Association (June 11, 2018). Minnesota Dental Association seeking to put teeth in Medicaid reimbursement for state's children. Retrieved April 23, 2019, from https://www.mndental.org/news/2018/06/minnesota-dental-association-seeking-to-put-teeth-in-medicaid-reimbursement-for-states-children/.

[25] Ibid.

[26] Howatt, Glenn (May 1, 2017). Feds warn Minnesota: Improve kids' dental care in Medicaid. StarTribune. Retrieved April 23, 2019, from http://www.startribune.com/feds-warn-minnesota-improve-kids-dental-care-in-medicaid/420948643/.

[27] PEW (April 23, 2019). States Expand the Use of Dental Therapy. Retrieved May 8, 2019, from https://www.pewtrusts.org/en/research-and-analysis/articles/2016/09/28/states-expand-the-use-of-dental-therapy.

[28] Vujicic, Marko & Nasseh, Kamyar, op cit.

[29] Alaska Native Tribal Health Consortium. Alaska Dental Therapy Educational Program. Retrieved May 8, 2019, from https://anthc.org/alaska-dental-therapy-education-programs/.

Of course, seven states cannot provide conclusive insight into the relationship between reimbursement and utilization—this brief analysis only scrapes the surface of potential studies. Next steps for research could include:

- Increasing the number of states sampled.
- Conducting a longitudinal analysis of Medicaid and commercial utilization and fees over time.
- Investigating the relationship between reimbursement and class of service (i.e., preventive/diagnostic, basic, major). Particularly the reimbursement for preventive and diagnostic dental services may have more bearing on the utilization level than reimbursement for more comprehensive services.
- Gathering qualitative information about program features that may also influence utilization.

TECHNICAL NOTES

Note that the adult reimbursement as a percentage of commercial charges is higher than child reimbursement in all states except Connecticut and Washington. This is because Connecticut and Washington have distinct fee schedules for adult and child populations, and the adult fee schedule contains lower fees, whereas all other states use the same fee schedule for adults and children. The adult prophylaxis code is generally reimbursed at a higher rate than the child prophylaxis code, which drives the differences in reimbursement when the fee schedules are otherwise the same.

The distribution of Current Dental Terminology (CDT)[30] codes varies by adult and child populations. Perhaps the best examples of this are D1110 and D1120: prophylaxis for adult and child, respectively. Because adult CDT codes begin use at age 14, and adult dental benefit coverage begins at age 20 or 21 (depending on the state), adult codes are included in the child composite calculation, but child codes are not included in the adult composite calculation. Composites are calculated using child- and adult-specific utilization distributions.

DATA SOURCES AND METHODOLOGY

Commercial dental unit cost estimates for this report are based on the 2017 Milliman Dental Cost Guidelines (DCGs), a comprehensive proprietary nationwide database of commercial dental claims data. Nationwide average billed charges are adjusted to reflect costs in each state studied using the charge area factors from the DCGs, which are based on the same underlying data source.

The following steps were taken to calculate composite commercial reimbursement rates by state:

- The Milliman DCGs provide nationwide average commercial billed charges by CDT code, and average commercial utilization distribution by CDT code. We adjusted the nationwide charges to reflect each state being analyzed using DCG area factors.
- We identified the top 10 most highly utilized CDT codes from classes I and II, and the top five most highly utilized CDT codes from class III, and calculated composite reimbursement rates by class.
  - Classes of service are defined by class I (preventive/diagnostic), class II (basic), and class III (major).
  - We did not include class IV (orthodontia) because this benefit is rarely covered for Medicaid adults.
  - Note that the distribution of CDT codes selected varies by state because some of the top codes were not covered in every state.
  - The codes used in each state are shown in the tables in Figures 3 and 4.
- Using the DCG utilization distributions for children and adults, we calculated a composite commercial reimbursement rate across all three classes.

[30] Current Dental Terminology, © 2016 American Dental Association. All Rights Reserved.

State fee schedules were taken from publicly available sources online, accessed in late 2018:

Alaska:
http://manuals.medicaidalaska.com/docs/dnld/Fees_Dental_SFY2019.pdf

Connecticut:
https://www.ctdssmap.com/CTPortal/Provider/ProviderFeeScheduleDownload/tabid/54/Default.aspx

Iowa:
https://secureapp.dhs.state.ia.us/MedicaidFeeSched/X04.xml

Minnesota:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_010122

New Mexico:
http://www.hsd.state.nm.us/uploads/FileLinks/e7cfb008157f422597cccdc11d2034f0/Fee_Schedule___Dental_Codes_9.pdf

North Carolina:
https://medicaid.ncdhhs.gov/providers/fee-schedule/dental-fee-schedule

Washington:
https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

Each fee schedule was compared to the area-adjusted commercial billed charge from the DCGs. This was done only for the most frequently utilized services (according to the DCGs) in each class. Because not all frequently utilized services in the DCGs are covered in the adult Medicaid dental programs in each state, the codes included varied by state. The tables in Figures 3 and 4 show the codes used for each state. Codes that vary from the most frequent codes indicated by the DCGs are formatted in italics with blue text.

FIGURE 3: CDT CODES USED FOR CHILD CALCULATIONS BY STATE

Class	DCG Rank	Alaska	Connecticut	Iowa	Minnesota	New Mexico	North Carolina	Washington
Class I	D0120	D0120	D0120	D0120	D0120	D0120	D0120	D0120
	D1208	D1208	D1208	D1208	D1208	D1208	D1208	D1208
	D1351	D0274	D0274	D1351	D1351	D1351	D1351	D1351
	D0274	D0220	D0220	D0274	D0274	D0274	D0274	D0274
	D0220	D1206	D1206	D0220	D0220	D0220	D0220	D0220
	D1206	D0230	D0230	D1206	D1206	D1206	D1120	D1206
	D1120	D0150	D0150	D1120	D1120	D1120	D0230	D1120
	D0230	D0272	D0272	D0230	D0230	D0230	D0150	D0230
	D0150	*D0140*	*D0140*	D0150	D0150	D0150	D0272	D0150
	D0272	*D0210*	*D0210*	D0272	D0272	D0272	*D0140*	D0272
Class II	D2392	D2392	D2392	D2392	D2392	D2392	D2392	D2392
	D2391	D2391	D2391	D2391	D2391	D2391	D2391	D2391
	D7140	D7140	D7140	D7140	D7140	D7140	D7140	D7140
	D2393	D2393	D2393	D2393	D2393	D2393	D2393	D2393
	D9223	D9223	D9223	D9223	D9223	D7210	D9223	D9223
	D7210	D7210	D7210	D7210	D7210	D2330	D7210	D7210
	D2330	D2330	D2330	D2330	D2330	D2150	D2330	D2330
	D2150	D2150	D2150	D2150	D2150	D2331	D2150	D2150
	D2331	D2331	D2331	D2331	D2331	D2140	D2331	D2331
	D2140	D2140	D2140	D2140	D2140	*D2332*	D2140	D2140
Class III	D2740	D2740	D2740	D2751	D2740	D2930	D2740	D2930
	D2750	D2750	D2750	D2930	D2750	*D2920*	D2752	*D2931*
	D2752	D2752	D2752	*D2920*	D2752	*D6750*	D2751	*D2934*
	D2751	D2751	D2751	*D2791*	D2751	*D2931*	D2930	*D2933*
	D2930	*D2790*	*D2790*	*D2931*	D2930	*D6240*	*D2792*	*D2932*

FIGURE 4: CDT CODES USED FOR ADULT CALCULATIONS BY STATE

Class	DCG Rank	Alaska	Connecticut	Iowa	Minnesota	New Mexico	North Carolina	Washington
Class I	D0120	D0120	D0120	D0120	D0120	D0120	D0120	D0120
	D1110	D1110	D1110	D1110	D1110	D1110	D1110	D1110
	D0274	D0274	D0274	D0274	D0274	D0274	D0274	D0274
	D0220	D0220	D0220	D0220	D0220	D0220	D0220	D0220
	D0230	D0230	D0230	D0230	D0230	D0230	D0230	D0230
	D0150	D0150	D0150	D0150	D0150	D0150	D0150	D0150
	D0272	D0272	D0272	D0272	D0272	D0272	D0272	D0272
	D0140	D0140	D0140	D0140	D0140	D0140	D0140	D0140
	D0210	D0210	D0210	D0210	D0210	D0210	D0210	D0210
	D0330	D0330	D0330	D0330	D0330	D0330	D0330	D0330
Class II	D2392	D2392	D2392	D2392	D2392	D2392	D2392	D2392
	D2391	D2391	D2391	D2391	D2391	D2391	D2391	D2391
	D2393	D4910	D4910	D4910	D4910	D4910	D4910	D2393
	D7140	D4341	D4341	D4341	D4341	D4341	D4341	D7140
	D2330	D2393	D2393	D2393	D2393	D2393	D2393	D2330
	D2150	D7140	D7140	D7140	D7140	D7140	D7140	D2150
	D7210	D2330	D2330	D2330	D2330	D2330	D2330	D7210
	D2331	D2150	D2150	D2150	D2150	D2150	D2150	D2331
	D2140	D7210	D7210	D7210	D7210	D7210	D7210	*D2140*
	D2332	D2331	D2331	D2331	D2331	D2331	D2331	*D2332*
Class III	D2920	D2740	D2740	D2920	D2740	*D2930*	D2920	D2920
	D2751	D2750	D2750	*D2930*	D2920	*D5110*	*D5110*	D2751
	D2930	D2920	D2920	*D6750*	D2752	*D5650*	*D5650*	*D2930*
	D5214	D2752	D2752	*D6240*	D2751	*D5130*	*D6930*	*D5214*
	D5213	D2751	D2751	*D5214*	*D2930*	*D5640*	*D5640*	*D5213*

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