



**REPORT TO THE JOINT STANDING COMMITTEES OF THE GENERAL
ASSEMBLY ON HUMAN SERVICES**

Public Act 24-130, Section 3

Report on the Feasibility of Expanding Medicaid Diaper Coverage

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STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
REPORT ON THE FEASIBILITY OF EXPANDING MEDICAID DIAPER COVERAGE
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This report is submitted pursuant to section 3 of Public Act 24-130, which requires the Department of Social Services (DSS or “Department”) to study the feasibility of expanding Medicaid diaper coverage for children from birth to age 3 for whom diapers are medically necessary. The report, as specified in PA 24-130, includes the following: (1) federal requirements for Medicaid coverage of diapers for such children; (2) a summary of diaper coverage under Medicaid programs in other states; (3) clinical best practices; (4) programmatic and operational considerations; (5) opportunities to utilize the existing diaper coverage system for certain Medicaid recipients; (6) coverage options; and (7) fiscal impact to the state.

Federal Requirements for Medicaid Coverage of Diapers

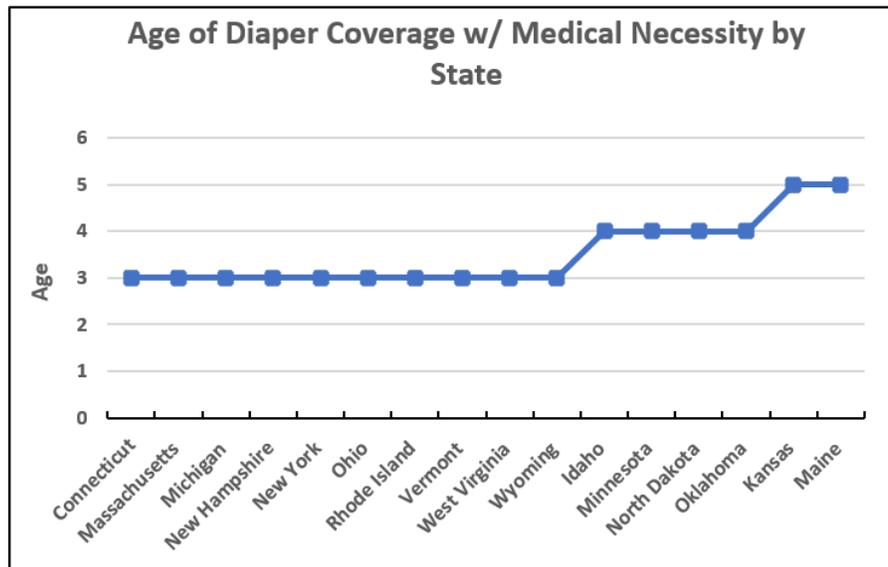
Consistent with federal and state requirements, Connecticut Medicaid provides reimbursement for diapers to any child that meets the definition of medical necessity with specific health conditions. Currently, the Department provides coverage of diapers under Medicaid for children ages 3 years and older when the diapers are medically necessary for the management of incontinence associated with a medical condition and based on the individual needs of each member. Additionally, to the extent required pursuant to federal law in section 1905(r)(5) of the Social Security Act regarding early and periodic screening, diagnostic, and treatment (EPSDT) services, the Department provides coverage of diapers under Medicaid for any child under age 21 that meets the definition of medical necessity on a case-by-case basis, considering the particular needs of the child.

Under federal regulation at 42 C.F.R. § 440.70, broad coverage of diapers for very young children does not meet the provisions for Medicaid State Plan coverage under the medical equipment, devices, and supplies benefit, under EPSDT, or any other Medicaid State Plan benefit category. The Department previously consulted with CMS about broader coverage of diapers and received confirmation that based on available guidance and existing federal approvals for other states, broader coverage of diapers than is currently covered is not a viable path under the Medicaid State Plan.

Summary of Diaper Coverage under Medicaid Programs

The chart below summarizes the Department’s research pertaining to other states’ coverage of diapers for infants 0-3 years of age through their Medicaid programs.

<u>State</u>	<u>Age of Coverage</u>
Connecticut	3
Massachusetts	3
Michigan	3
New Hampshire	3
New York	3
Ohio	3
Rhode Island	3
Vermont	3
West Virginia	3
Wyoming	3
Idaho	4
Minnesota	4
North Dakota	4
Oklahoma	4
Kansas	5
Maine	5



None of the 15 states listed above included in the Department’s research cover diapers or incontinence products for infants under 3 years of age. Additionally, six of the responding states only cover diapers/incontinence supplies for children 4 years of age and older when medically necessary. Connecticut and the remaining states provide diaper coverage for children 3 years of age and older, based on medical necessity, under Medicaid.

There are two states, Delaware and Tennessee, that recently extended coverage of diapers/incontinence supplies for infants under 3 years of age as part of very large, encompassing demonstration waivers under section 1115 of the Social Security Act. Both states used the Diaper Bank of Connecticut’s program study data to support the intervention of providing diapers as part of their 1115 demonstration waivers.

Delaware, through the “Diamond State Health Plan” 1115 demonstration waiver, provides an allowance for diapers as part of postpartum benefits. The diaper allowance, in addition to coverage for a food box and baby wipes, is part of a pilot program which focuses on health-related social needs to improve maternal and infant health and reduce disparities, in an effort to reduce food insecurity for postpartum mothers. Delaware provides up to 80 diapers and one pack of baby wipes per week (approximately 345 diapers per month) to individuals for the first 12 weeks of the postpartum period. Delaware’s demonstration is designed to address the medical needs of infants and the health-related social needs of their parents.

The Delaware demonstration program¹ goals include: (1) improving infant health, (2) reducing parental stress, and (3) preventing avoidable healthcare use. The expansive demonstration focuses on, but is not limited to, the following initiatives:

- Long-term services and supports (LTSS) to eligible individuals through Designated State Health Program (DSHP) Plus;

- Enhanced behavioral health services and supports for targeted Medicaid beneficiaries through Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), which is a voluntary program;
- High-quality, clinically appropriate substance use disorder (SUD) treatment services for short-term residents in residential and inpatient treatment settings that qualify as an institution for mental diseases (IMD);
- Adult dental services;
- Delaware’s Nursing Home Transition Program;
- Coverage of two home-delivered meals per day or one medically appropriate shelf-stable food box that does not constitute a full nutritional regimen; and
- Provision of diapers and other incontinence products to individuals with conditions that impact their bladder or bowel control, as well as up to 80 diapers and one pack of baby wipes per week to new mothers for the first 12 weeks after giving birth.

Effective August 7, 2024, Tennessee began providing diaper coverage for all children under 2 years of age who are enrolled in the Tennessee Medicaid program², TennCare, or the Tennessee Children’s Health Insurance Program (CHIP), CoverKids. Under the TennCare diaper benefit, children under 2 years of age are eligible for 100 diapers per month through the state’s Medicaid pharmacy benefit manager (PBM) network as part of a larger encompassing 1115 demonstration waiver package. Tennessee’s amendment to the demonstration waiver is designed to address the medical needs of infants and the health-related social needs (HRSN) of their families, including: (1) the expansion of eligibility for parents and caretaker relatives of dependent children; (2) the provision of a new benefit to cover a supply of diapers for infants and young children enrolled in TennCare and CoverKids; and (3) the enhancement of home and community-based services (HCBS) available to individuals with disabilities under the demonstration, with particular emphasis on employment supports. This waiver amendment is designed to assist in promoting the objectives of Tennessee Medicaid by expanding coverage and benefits available under the demonstration. Of note, Tennessee plans to use the projected federal budget savings achieved as part of the overall 1115 demonstration waiver to enable Tennessee to access federal Medicaid matching funds to provide coverage for the monthly diaper supply for children in TennCare and CoverKids. Tennessee’s unique approach to funding the coverage of diapers is not a viable option because the current structure of the 1115 demonstration waivers in Connecticut do not result in federal savings that could be redirected for this purpose.

Clinical Best Practices

DSS conducted a literature review for best practice and clinical recommendation for the treatment of diaper dermatitis. Based on this review, DSS noted several key points and reoccurring themes including:

- Diaper dermatitis (DD) is a common skin disorder seen in young infants, which is generally mild and self-limited, requiring minimal intervention.^{3,5,6,8,9,10}
- Barrier creams are used extensively to treat and prevent DD and is considered the most prevalent method for treatment of DD^{10,11}
- Up to 50% of infants experience DD and it is more frequent between 9-12 months of age^{4,6,8,9,10}
- Some infants experience more diaper rash based on their skin sensitivity⁹

- In healthcare, for children, the Braden QD Scale, is used to assess the skin of children from birth to approximately 8 years of age. The scale assesses mobility, sensory perception, friction/shear, nutrition, tissue perfusion, and skin protection.
- Presence of *C. albicans* can also cause DD ^{6,8,9,10}
- Diaper changes are not the primary and sole treatment or prevention method for avoiding skin breakdown; frequent diaper changes are instead mostly referenced in regard to soiled diapers ^{3,4}
- Treatment practices include the ABCDE approach (air, barrier, cleansing, diapering, and education), as well as pharmacological therapy, such as antibacterial, antifungal, and topical corticosteroid for more severe cases. ⁴

Other preventive methods and practices to deter DD are mentioned:

- Allowing skin to air out, applying skin creams, and monitoring diet
- Education to caregivers ^{5,8,9,10}
- Gentle cleansing of the diaper area ^{5,6,10}
- Incorporating colloid oatmeal cream application ⁹
- Super-absorbent diapers containing gelling material ^{3,5,6,8,10}
- Use of topical emollients such as zinc oxide, petrolatum, cod liver oil, and lanolin (for both prevention and treatment) ^{3,5,8,9,10}
- Insertion of a water impermeable membrane within diaper layers ⁵
- Diaper-free time (recommended between 0-15 minutes after every diaper change) ^{3,5,10}
- Prevalence of DD was reduced by egg protein consumption ⁷
- Identifying any potential underlying conditions such as a bacterial or viral infection
- Disposable diapers are not superior to cloth diapers; cloth diapers are reuseable and more cost effective than disposable diapers ⁶
- Human milk intake lessens the occurrence of diaper rash ^{6,9,10}

Programmatic and Operational Considerations

Programmatic Considerations

DSS reviewed programmatic considerations and their impact on the development, maintenance, and financing of diaper coverage. The following are high-level considerations and do not represent an exhaustive list as other implications may also arise.

The resources required to develop, implement, and maintain coverage would need to be fully assessed and considered. Based on the federal regulation and CMS guidance referenced above, adding coverage to the Medicaid State Plan (through a Medicaid State Plan amendment) is not a viable option. Accordingly, the state would need to research the possibility of coverage via other avenues, including the potential to seek a section 1115 demonstration waiver as was done by Delaware and Tennessee. Development and submission of a waiver is a labor-intensive project for which DSS would need to assess the feasibility of completing within its current resources. The development of such a waiver generally requires an extensive planning and review period in order to ensure compliance with all of the necessary requirements. Additional considerations regarding the submission of a waiver include

the ability to demonstrate federal budget neutrality for coverage, which is a requirement for any 1115 waiver submission. A particular challenge is that, as noted above, none of Connecticut's current 1115 waivers use a federal budget neutrality demonstration methodology that generates federal budget savings that could be made available to offset new federal costs, such as a potential diaper benefit. To date, DSS has required the utilization of a consultant for developing any section 1115 demonstration waiver, especially for the actuarial analysis needed to support the required federal budget neutrality demonstration, which is an additional cost in the development of coverage that would need to be included in the overall cost estimate. Another consideration includes the time and staff required to plan, develop, and facilitate discussions with CMS to attempt to obtain approval. This process would take a minimum of two years and there would be no guarantee of approval, especially considering the anticipated changes in CMS guidance and direction as a result of the new federal administration.

A key programmatic consideration would be the reimbursement rate for coverage of diapers. The current Connecticut Medicaid rate reimburses incontinence supplies for Medicaid beneficiaries ages 3 years and older who have a qualifying medical necessity determination, and ranges between \$0.48 to \$0.70 cents per brief/diaper. The reimbursement is not tied to a specific brand or supplier. In order for Medicaid durable medical equipment (DME) providers to choose to provide these services to Medicaid members, they would likely require a reconciliation between what can be purchased from suppliers based on the pre-determined Medicaid rate and ensuring a reasonable profit for their business. Based on current retail prices, it is expected that enrolled providers would stock and provide a variety of lower quality brands with supplies dependent on prevailing market costs. Furthermore, providers consistently complain that the current DSS reimbursement for incontinence supplies does not cover the costs for "brand name" or the more expensive incontinence products. Per the Diaper Bank of Connecticut's website, the diaper bank maintains unique buying power to obtain diapers and has the ability to distribute diapers through strategic networks that allow it to partner with organizations throughout the state. This creates an efficient system that allows the diaper bank to reach families in need quickly in addition to connecting them to other valuable resources. DSS would not have the same unique buying power or the ability to connect families with additional resources within the community and beyond. Additionally, DSS would have neither the ability to designate coverage for specific brands nor the ability to increase the reimbursement rate for diapers without securing additional state funding and CMS approval. This increase would directly impact the fiscal estimate as explained below. In other words, if a potential diaper benefit in Connecticut included higher rates, then that would significantly increase the fiscal estimate above the amounts listed below.

In examining other states' diaper coverage, there are additional programmatic considerations that impact other categories under the Medicaid program. For example, under Tennessee's approved section 1115 demonstration waiver, beneficiaries are also provided coverage for transportation necessary to pick up diapers at the pharmacy. DSS would need to estimate and assess the impact to the overall Medicaid budget were such provisions as transportation and baby wipes to be added. These costs have not been factored into the overall costs projected below.

DSS takes seriously our responsibility to be careful stewards of state and federal tax dollars, which fund the Medicaid program. Therefore, an important function under the Medicaid program includes ensuring program integrity and combatting fraud, waste, and abuse to ensure that Medicaid expenditures comply with federal and state requirements. DSS' Quality Assurance Division (QA), in partnership with local, state, and federal programmatic and law enforcement agencies, works to ensure that all Medicaid funds are spent in accordance with requirements. The mission of DSS QA is to ensure mechanisms are in place to proactively prevent fraudulent claims and conduct all post-payment reviews for any program abuse or waste. DSS would require assessment of any potential areas under the diaper

coverage that would be vulnerable to fraud, waste, and abuse and to develop countermeasures to prevent and mitigate impacts to the program. Any diaper expansion proposal would require at least two additional staff to properly monitor newly enrolled providers, increases in utilization and to conduct the necessary audits to ensure compliance with Department policy and combat any fraud, waste and abuse. Costs estimates including fringe would be approximately \$400,000 per year.

Another programmatic consideration is identifying ways to coordinate with the Diaper Bank of Connecticut, which not only provides access to diapers for those experiencing diaper need, but it also connects families to case management and broader social assistance programs as well as gives families access to other services (child services and parenting programs). Shifting coverage of diapers to the Medicaid program would cause individuals receiving diapers under Medicaid to lose direct access to screening and access to other agencies and resources assisting with social determinants of health (SDOH) factors. The downstream detrimental implications of such loss would need to be assessed and considered.

Operational Considerations

Development of coverage for diapers under Medicaid requires several operational considerations. In this study, DSS viewed operational considerations as the tasks or mechanisms that would be required to operate the coverage (i.e., utilization management tasks, Medicaid Management Information System (MMIS) billing and enrollment system requirements, etc.). MMIS and other system changes would require time and additional expenditures to implement.

A key operational consideration would include the development of utilization management (UM) criteria as well as policies and procedures based on the approved coverage policy. UM policies and procedures are used by DSS to ensure that specific policies and corresponding criteria are reviewed and approved for coverage accordingly. Currently, DSS works with contracted administrative services organizations (ASOs) to develop and implement UM policies and procedures. The UM policy and procedures would be directly impacted by the approved benefit coverage and depending on the level of resources required to complete the development, implementation, and especially maintenance of a UM process, the coverage of diapers will result in additional administrative costs (i.e., UM reviewers) which would need to be included in the state's budget.

Another consideration related to the coverage of diapers under the Medicaid program as opposed to the established route and funding via the Diaper Bank of Connecticut is the operational time to complete a Medicaid order. Mirroring current requirements under the medical surgical supply regulation and complying with federal Medicaid requirements, are essential requirements to providing a Medicaid recipient with a covered service, including ensuring that the beneficiary is eligible based on approved criteria (i.e., prescription requirement). This may result in a delay in receipt of the diapers while the necessary parties (licensed practitioner, medical surgical supply vendor, etc.) work to fulfill the requirements.

The identification of the need for diapers is generally a more acute need and such delays would create an administratively burdensome process. Any additional delay in DSS administrative process would most likely postpone the issuance of the prescribed diaper allowance whereas the already established Diaper Bank of Connecticut is able to fulfill the member's immediate needs in a much timelier fashion. It must be noted that while the state of Tennessee was able to obtain approval for coverage for diapers

without the need for a prescription for the diapers, Tennessee's approval is part of a larger demonstration program and while this sets precedence, it does not guarantee CMS approval for any other state, especially because there is significant CMS discretion in choosing which areas are appropriate for approval under a section 1115 demonstration waiver and there is inherent uncertainty in any new federal administration as priorities may change.

Other operational considerations include identification of a systematic method to track utilization and coverage based on the approved coverage policy. This includes researching the capabilities within the current MMIS to ensure that the system would be able to cap the number of diapers and track across approved providers to maintain systematic compliance with the coverage policy. As with any new service coverage, a review of its ability to track the costs and other resources related to such system changes will be required. Additionally, coordination of coverage would need to be developed as well as a mechanism to prevent duplicate claims for diapers in the MMIS to avoid any unintentional waste.

Opportunities to Utilize the Existing Diaper Coverage System for Certain Medicaid Recipients

DSS reviewed opportunities to utilize the existing diaper coverage systems within DSS and, on a high-level, systems outside of DSS (i.e., the Diaper Bank of Connecticut).

As previously described, current coverage for diapers under Medicaid is specific to individuals ages 3 years and older when the diapers are medically necessary in the management of incontinence associated with a medical condition. As required under EPSDT, additional coverage is available for any child under age 21 that meets the definition of medical necessity on an individual case-by-case basis. Continuation of coverage through the existing EPSDT pathway is accomplished under existing Medicaid authority and ensures that coverage aligns with the individual medical needs for the child, as evidenced through review of medical necessity. Continuation of individual consideration based on medical necessity through the EPSDT process is imperative to prevent risk of loss of federal Medicaid matching funds.

The other existing coverage system is through funds appropriated to the Diaper Bank of Connecticut. As specified on their website, the Diaper Bank of Connecticut is uniquely positioned to: (1) work with over 100 social service organizations throughout Connecticut to target and assist vulnerable families, (2) leverage their buying power to purchase diapers and distribute diapers quickly and efficiently to families in needs; and (3) connect families to broader programs and services that would not be covered under Medicaid (e.g., case management and parenting programs).

Coverage Options

Based on a review of other states' coverage and federal requirements, DSS has identified the following programmatic, operational, and fiscal implications that must be considered and addressed.

- *Continuation of diaper coverage through the EPSDT process.* This option is currently available as a pathway for children eligible under the Medicaid program and provides individual consideration based on medical necessity to ensure that coverage aligns with the medical needs of the child. While this established pathway does not require additional federal approval or state legislative authority, attempts to expand coverage beyond the parameters of this benefit

would jeopardize the state's ability to collect federal match, thus exacerbating the current and future fiscal challenges projected in Medicaid. Additionally, the EPSDT benefit is already designed to ensure that necessary health services and treatment services are available to treat, correct or reduce illnesses and conditions discovered by screening and diagnostic procedures based medical necessity on an individual case-by-case basis for Medicaid-eligible individuals under the age of 21 years.

- *Continuation of coverage through the Diaper Bank of Connecticut.* This option is an effective pathway available to needy families with children who are covered under the Medicaid program. The Diaper Bank of Connecticut has established a program that has been proven successful in tailoring the distribution of diapers based on geographical and specific population needs without the need to comply with additional Medicaid requirements. Also noteworthy, the Diaper Bank of Connecticut provides additional support with basic health needs and assists in social services support coordination.
- *Submission of an 1115 demonstration waiver.* Coverage under an 1115 demonstration waiver was approved for both Delaware and Tennessee however, diaper coverage was submitted as part of a much larger demonstration waiver program in both states and approval in those states does not guarantee approval for Connecticut, especially given pending CMS administration changes. Additionally, as described above, Tennessee's program plans to use the projected federal budget savings to cover the costs for the monthly diaper supply. A major component to the submission of a 1115 demonstration waiver includes a federal budget neutrality requirement. This requirement must be maintained throughout the duration of the 1115 demonstration waiver. CMS would not approve an 1115 demonstration waiver unless the project is expected to be budget neutral to the federal government (i.e., it cannot result in costs to the federal government that are greater than what their costs would have been absent the demonstration). The overarching goal of CMS's approach to budget neutrality is to limit federal fiscal exposure resulting from the use of section 1115 authority in Medicaid. This pathway is not currently viable because, as noted above, none of Connecticut's 1115 demonstration waivers generate offsetting federal budget savings. In addition to budget neutrality, 1115 waivers also include an audit process with which states must comply with program integrity monitoring and reporting requirements on a quarterly basis. This integrity process must ensure there is no duplication of federal funding for any aspect of the demonstration. Additionally, states must demonstrate that the state and its contractors follow standard program integrity principles and practices including retention of data, as established by CMS. Additional resources would be needed to support these processes as they are inherently different from what is required under the Medicaid State Plan.
- *Indirect inclusion of diaper coverage under a potential future alternative payment methodology.* As DSS continues to research, design and redesign Connecticut's Medicaid program, DSS could identify other potential ways to include coverage of diapers indirectly **if** there was a way to demonstrate overall cost-effectiveness for the state. Such initiatives may include various types of alternative payment models.

Fiscal Impact to the State

DSS modeled four fiscal impacts to the state as outlined in the table below.

Eligibility for the child is based on September 2024 enrollment data of children ages 0-3 years. The cost per diaper is based on the current rates found on the medical surgical supplies fee schedule effective as of April 1, 2024. Of note, the Department has received inquiries over the past several years regarding the ability to increase the reimbursement for incontinence supplies for its current Medicaid DME covered benefit. Some enrolled providers have anecdotally responded that current rates for incontinence supplies are insufficient as compared to their costs. Additionally, the current reimbursement results in acquisition of more inferior products and as such these products would not be considered “brand name” diapers, such as Pampers and Huggies. Furthermore, the federal financial participation (FFP) rate is assumed to be less than the standard 50% match for services due to the inclusion of the state-funded children who do not qualify for Medicaid due to their immigration status and are currently eligible for the same set of services as children covered under the state HUSKY A program.

Estimated Annual Medicaid Cost	Estimated Cost of Full Coverage	Option 1 (Dx Related)	Option 2 (TN Coverage)	Option 3 (DE Coverage)
Total	\$124,000,000	\$31,000,000	\$22,000,000	\$7,500,000
Federal Share	\$60,000,000	\$15,000,000	\$10,500,000	\$3,600,000
State Share	\$64,000,000	\$16,000,000	\$11,200,000	\$4,000,000

The estimated cost of full coverage column reflects the potential costs if 100% of children up to the age of 3 years old and eligible under Medicaid, were provided coverage for 250 diapers per month, consistent with the allowable number of diapers under the current DME benefit.

- Option 1 reflects utilization among children ages 0-3 with reported diagnoses of dermatitis, urinary tract infections (UTI) and/or skin conditions that would warrant provision of diapers. Reports from the Journal of the American Medical Association (JAMA) were used to obtain rates for these diagnoses among young children. The total gross expenditures for this option are estimated to be approximately \$31 million with the state share at approximately \$16 million annually.
- Option 2 estimates expenditures assuming 100 diapers per month for children up to the age of two. There is no coverage after the child’s second birthday. This mirrors the quantities covered under the approved waiver in Tennessee. Annual gross expenditures are estimated at approximately \$22 million with the state share estimated at approximately \$11 million annually.
- Option 3 estimates expenditures assuming 80 diapers are provided per week after the birth of a child and up to 12 weeks postpartum. This estimate mirrors the quantities covered under Delaware’s approved waiver. There would be no additional coverage after the 12-week postpartum period. Annual gross expenditures are estimated at approximately \$7.5 million, with the state share estimated at approximately \$4.0 million annually.

To reiterate, all the options estimated above assume current reimbursement rates as noted on the medical surgical supply fee schedule and based on enrollment data available in 2024. If there are increases to the reimbursement rates for diapers, which will likely be required for this type of diaper coverage, changes in enrollment, or changes to the available Federal Medical Assistance Percentage (FMAP), the estimates in this study will be impacted, potentially with significant increases above the figures noted above.

Furthermore, although the legislation directed DSS to study the coverage of diapers under Medicaid, DSS also administers the state's Children's Health Insurance Program (CHIP), HUSKY B, which covers children under the age of 19 when specific eligibility criteria are met. Considerations would need to be made for coverage of diapers under this program as well, as HUSKY B coverage generally mirrors the coverage under HUSKY A but federal funding under CHIP is capped. If coverage is approved for children eligible under HUSKY B, a separate fiscal estimate would need to be completed to obtain the estimated annual costs to the state, including the costs of extending coverage to state-funded children who do not qualify for HUSKY B due to their immigration status but are eligible for the same services under State HUSKY B.

Additionally, the fiscal estimate in this section is limited to the estimated expenditures for the diaper product and does not include the estimated additional expenditures of approximately \$400,000 related to quality assurance measures as previously described. It also does not include other potential costs to DSS that would result from increased administrative costs associated with, at a minimum, the ASO's utilization management requirements and MMIS updates. These costs are not included in this report and would need to be calculated separately to understand the total impact for this coverage to the overall state budget.

Should the decision be made to move forward with the development of an 1115 waiver, the costs related to contracting with an actuarial firm to assist with the preparation and maintenance of the waiver are projected at \$750,000 for the preparation and submission of the waiver and \$500,000 annually for ongoing support, with year one implementation of a waiver estimated at approximately \$1.25 million; these figures are based on consultant costs for current 1115 demonstration waivers in the state. MMIS and ASO administrative costs and any additional costs related to quality assurance measures have not been included in this report but would also need to be factored in an overall increased cost for the implementation of diaper coverage.

Conclusion

The Department has researched and reviewed the potential expansion of Medicaid benefits to include coverage of diapers to members ages newborn to 3 years. In assessing two other states' diaper programs, which were included in much larger encompassing 1115 demonstration waivers, the cost assessment would be dependent on the parameters of the actual diaper benefit.

Other factors and considerations that were examined and reviewed included programmatic and operational considerations, financial implications, time, monitoring, potential fraud, waste, and abuse, and overall goals of prevention of diaper dermatitis. In researching the treatment of DD, studies show that barrier emollients (diaper cream) are the most common and effective regimen of treatment. These creams are applied for the treatment as well as prevention.

DSS examined the impact of adding diaper coverage under Medicaid. Fiscal impacts were estimated based on full coverage of diapers for Medicaid members ages newborn to 3 years (Estimated Cost of Full Coverage), Medicaid members ages newborn to 3 years with a diagnosis of dermatitis (Option 1), impact based on the Tennessee's Medicaid coverage (Option 2), and impact based on Delaware's Medicaid coverage (Option 3). The annual gross costs related to diaper coverage range from \$7.5 to \$124 million with the state share ranging between \$4 to \$64 million annually.

Estimated Annual Medicaid Cost	Estimated Cost of Full Coverage	Option 1 (Dx Related)	Option 2 (TN Coverage)	Option 3 (DE Coverage)
Gross	\$123,664,620	\$30,953,125	\$21,689,568	\$7,468,646
Federal	\$59,715,088	\$14,946,624	\$10,473,444	\$3,606,455
State	\$63,949,532	\$16,006,501	\$11,216,124	\$3,862,191

Based on an overall review of available data, it is not feasible to cover diapers more broadly as a Connecticut Medicaid benefit, because of the increased costs related to coverage, unclear federal pathway and approval and administrative expenses necessary to implement such coverage. Furthermore, DSS is focusing its efforts to ensure all programs run by the agency are optimized for the benefit of our members and align with Connecticut’s current fiscal situation.

If funding is to be provided to expand diaper coverage, then it is recommended that the diaper coverage through the established EPSDT benefit be continued without any revisions and that the current state contribution towards the Diaper Bank of Connecticut be increased. This avoids many of the challenges that are entailed with the development of coverage options under Medicaid and the uncertainty regarding receipt of federal approval. It also recognizes that the Diaper Bank of Connecticut provides access to critical services that are unavailable under Medicaid. While there are other potential coverage options, including inclusion of diapers under a future Medicaid payment and/or reform policy and potential development of an 1115 demonstration waiver, as detailed above, these options present significant challenges (fiscal, programmatic, operational, program integrity, etc.).

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