

# MEMO

**To:** Office of Management & Budget  
**From:** Brian J. Hartman, on behalf of the following organizations:  
Disabilities Law Program  
Developmental Disabilities Council  
Governor's Advisory Council for Exceptional Citizens  
State Council for Persons with Disabilities  
**Subject:** Division of Developmental Disabilities Services FY 16 Budget  
**Date:** November 20, 2014

Please consider this memo a summary of the oral presentation of Brian J. Hartman, Esq. on behalf of the Disabilities Law Program ("DLP"), Developmental Disabilities Council ("DDC"), Governor's Advisory Council for Exceptional Citizens ("GACEC"), and the State Council for Persons with Disabilities ("SCPD"). We are addressing one (1) component of the DDDS budget, i.e., inclusion of dental services within the proposed family support waiver.

As you know, the FY15 budget bill (§175) directs the Division to "move forward with developing and establishing a Family Support Waiver to begin in Fiscal Year 2016". The budget bill also requires OMB approval of the waiver application prior to submission to CMS. Id.

On April 29, 2014, the Department submitted its "Family Support Waiver Report" to the Legislature and OMB summarizing what services are most desired by DDDS clients and their families. The Report also outlines a dozen likely services to include in the waiver. Although dental services are included among the list of desired supports, dental services are not prominently highlighted for inclusion in the likely benefits package.<sup>1</sup> We would like to underscore the critical importance of including dental care in the benefits menu.

## Health Consequences of Lack of Dental Care

First, tooth decay and gum disease result in pronounced adverse effects on overall health. Poor oral health is linked with depressed immune systems, heart disease, exacerbation of diabetes, and cancer.<sup>2</sup> Nationally, "the average fifty-year old has lost twelve teeth and by age sixty-five over one quarter (25%) of Americans have lost all their teeth."<sup>3</sup> In Delaware, adults with disabilities are more than twice as likely to have lost all their teeth (3.3% incidence for persons without disability vs. 7.9% incidence for persons with disability).<sup>4</sup> In turn, loss of teeth results in choking and aspiration risk, a common cause of death among DDDS clients.

---

<sup>1</sup>The Report is published at <http://dhss.delaware.gov/dhss/ddds/fsw.html>. The relevant pages (3-5, 8) are included for facilitated reference. [Attachment "A"]

<sup>2</sup>See NHeLP Issue Brief and multiple Delaware News Journal articles. [Attachment "B"]

<sup>3</sup>NHeLP Issue Brief at p.2. [Attachment "B"]

<sup>4</sup>University of Delaware, "Disability and Health in Delaware" (August, 2013) at 19. [Attachment "C"]

### Lack of Alternative Sources of Affordable Dental Care

Although there are some dental clinics serving adults in Delaware, such programs cannot hope to meet demand and are characterized by waiting lists, age limits, income limits, and restrictions on services offered.<sup>5</sup>

### Advantages of Inclusion of Dental Care in Waiver

Most states include at least limited dental services in their Medicaid plans.<sup>6</sup> Legislation to add dental services to the Delaware Medicaid State Plan has been introduced on several occasions. The fiscal note on the most recent initiative (S.B. No. 56) was a daunting \$6.2 million.<sup>7</sup> An incremental approach to expanding coverage is a promising alternative. Effective January 1, 2015, one of the two Medicaid MCOs will offer an annual cleaning and dental exam annually.<sup>8</sup> This is a promising start. Adding a more robust dental benefit to the proposed DDDS family support waiver would represent another incremental step, i.e., extending coverage to less than 2,700 waiver-eligible adult DDDS clients living in the community.<sup>9</sup>

### Recommendation

In closing, we highly recommend that OMB support the inclusion of the necessary funds to offer a dental benefit in the DDDS Family Support Waiver in FY16.

Thank you for your consideration.

Attachments

E:\LEGREG\DDDBUDfy16.wpd

---

<sup>5</sup>See State of Delaware Dental Resources Guide (February, 2014) [Attachment "D"] and multiple Delaware News Journal articles compiled in Attachment "B".

<sup>6</sup>See American Dental Association list [Attachment "E"]; and J. Rini, "Low income? Dental care hard to come by" (Delaware News Journal September 1, 2014) and C. Facciolo, "Delaware sinks teeth into problem of low income dental care" (Delaware News Journal June 13, 2011) included with Attachment "B".

<sup>7</sup>The fiscal note to S.B. No. 56 is included as Attachment "F".

<sup>8</sup>See Diamond State Health Plan (DSHP) Benefit Comparison Sheet. [Attachment "G"]

<sup>9</sup>The DHSS Family Support Waiver Report (p. 3) identifies 2,700 DDDS clients (ages 3-89) living in the community earlier this year. Since children already enjoy dental coverage through the Medicaid State Plan, inclusion of dental services in the proposed waiver should only have a fiscal impact based on adult DDDS waiver participants.

**I. Where people live**

Currently, the Division of Developmental Disability Services serves approximately 3,775 individuals and their families. Of this total, approximately 980 individuals live either on their own with drop in supports, in neighborhood homes, townhouses, apartments, shared living, nursing homes or other institutions. DDDS provides supportive services to the majority of these individuals by operating a Medicaid Home and Community Based Services (HCBS) Waiver under the authority of section 1915(c) of the Social Security Act. An HCBS waiver is a cost effective alternative to placement in an institution. By operating an HCBS waiver, the State of Delaware shares the costs of the program with at least 50% of the cost borne by the federal government.

There are approximately 2,700 individuals eligible for DDDS services that are living at home with their families. The ages of the individuals range from 3 to 89. Services currently provided to these families include: a family support specialist, respite, family stipends and supported employment or day program.

**II. What families want**

At each of the forums/ meetings, family members listed the following as the services that would be supportive to their family. The list is not in rank or preference:

**A. Respite**

- Provided in a variety of settings
- Provided by well trained staff
- Provided by individuals selected by the family
- Easy to access
- Available immediately when a family crisis occurs
- Planned and unplanned
- Include opportunities for the individual with a developmental disability to have social time with their friends, i.e. weekend activities, trips; camps etc.

**B. In-Home Support/Personal Care**

- Well trained staff to provide support to individuals with challenging behavioral or medical supports in the home with the family present
- Supports to the individual with significant needs to allow parents to spend more time with siblings
- Critical need to assist the family with supports on weekends
- Supports to develop independent living skills to prepare the individual to move out of the family home to a neighborhood home or to supported living in their own apartment

- Paid support hours available for individuals living in their own home or apartment to supplement supports provided by the family

**C. Stipend payments**

- Financial support to assist the family to stay together, including assistance with housing costs, utility payment etc.
- Payments for specialized physician services not covered by insurance or Medicaid
- Payments for dental services
- Payments for goods and services, such as specialized hygiene items, nutritional supplements, specialized therapies not covered by insurance or Medicaid

**D. Home and Vehicle Modifications**

- Provide funding to modify the family home to accommodate specialized needs of the individual, including ramps, adapted bathrooms, reinforced walls and specialized windows
- Provide funding to modify the family vehicle to accommodate for a wheelchair or other specialized adaptation for behavioral supports.

**E. Assistive Technology**

- Access to the vast array of new technology now available to assist individuals to be more independent
- Technology to assist with communication

**F. Behavioral Consultation**

- Provide clinical consultation to assist the family in the development of a behavior support plan to address challenging behaviors

**G. Nursing Consultation**

- Provide nursing consultation to assist the family with addressing medical issues

**H. Waiver Design /Flexibility**

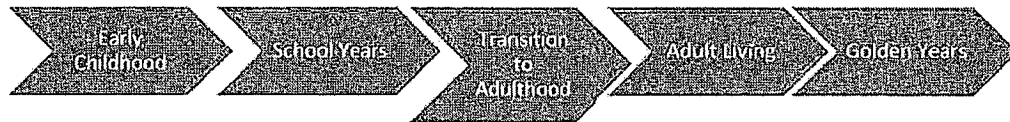
- In the forums, families asked for maximum flexibility in the design of the waiver in order to meet the varying needs of many families. Some families would like a menu of services; others would like a capped budget allowing them to design their support needs. The design of the HCBS Waiver services

can be flexible and each state can design the program to meet the needs of the waiver recipients.

#### **I. System Navigation and Information**

Listing and defining the package of services available in a Family Support waiver is only one piece of a comprehensive service system designed to support families. The essential element needed to support families is a quality case management system designed to understand and support the needs of individuals living at home and the support needs of the family.

At each of the meetings, the underlying issue of systems navigation permeated every topic. Families are not always in need of paid services but are desperate for information about resources and systems navigation. Since families are caregivers over the lifespan, the quest for information is continuous.



At each stage of the individual's life, the family plays a key and ever-changing role. As each family shared the story of their journey, the underlying thread of their story was the need for information and assistance in navigating a complex system of services, supports and cash assistance. The foundational elements in supporting individuals and their families are designed around a well-informed case management system focused on the family and a planning process designed to address the needs of the individual and the entire family. Currently DDDS provides little or no planning for families. Without the opportunity to plan for the future, many families shared their anxiety about not only day to day concerns but, overwhelmingly, what will happen to their loved one when they are no longer able to support them.

#### **III. Use of Supports Waivers across the States**

Supports waivers, under the authority of Section 1915(c) of the Social Security Act known as Home and Community Based Waivers, have been used by many states to provide self-directed services while controlling access and costs into full 24 hour services, which are typically referred to as comprehensive waivers. The current DDDS HCBS Waiver is a comprehensive waiver. To date, 24 states have an approved supports waiver (Appendix A). Supports waivers can limit a state's financial risk by including a cost cap, limiting the benefits waiver members can receive and/or limiting the target populations who can receive waiver benefits.

**A. Target Population**

Delaware could include both children and adults in the supports waiver. The benefit packages can be designed to fit age groups such as children, transition age youth, adults, seniors. There can be a smaller cap for children and services would not include employment or day habilitation support while the child was in school.

There are approximately 740 individuals with I/DD who are in day services paid for using the Medicaid State Plan Rehabilitation Option. Over time CMS has clarified what services are appropriate to be included under the State Plan Rehabilitative Services option versus an HCBS waiver. While day habilitation and prevocational service were previously approved by CMS in Delaware's Medicaid State Plan, more recent CMS guidance has indicated that these services are not appropriate under the State Plan Rehabilitation option. Using a supports waiver, Delaware could correct this by offering the same array of day services in a manner that is consistent with CMS expectations. The defined target population will include these individuals and the benefit package described below will include these day and employment services, so that they can be removed from the State Plan.

**B. Benefit/Service Package**

Delaware's Family Support Waiver can include a broad benefit/service package and let the financial cap be the control factor. Support Service Waivers must identify the services that can be utilized by any participant. The benefit/service package list can be inclusive and many states have the following list of benefits in their Supports Waiver:

- Respite
- In-home staff support
- Community inclusion
- Day services, non-work
- Pre-vocational
- Employment support
- Assistive Technology
- Home/vehicle modification
- Services and goods
- Behavior consultation
- Nursing consultation
- Family Network

Within the benefit/services included in the waiver, limits can be placed on individual services such as an annual or multi-year limit for home modification. The Delaware Family Support Waiver could consider an exceptional needs



101 E. Weaver Street  
Suite G-7  
Carrboro, NC 27510  
Ph. (919) 968-6308  
Fax (919) 968-8855  
nhelpnc@healthlaw.org

## Issue Brief

### Improving Oral Health Care: ACA Initiatives and IOM Recommendations

March 2012

Prepared by: Corey Davis<sup>1</sup>

#### Introduction

Good oral health is essential to good overall health. The largely preventable problem of poor oral health has widespread repercussions ranging from lost time at school and work to reduced quality of life and increased incidence of non-oral health problems. It is exacerbated by lack of access to quality care and disproportionately concentrated among underserved people.

In 2000, the Surgeon General released a groundbreaking examination of the state of oral health in America. While noting that progress had been made over the previous half-century, the Surgeon General concluded that a "silent epidemic" of untreated dental and oral diseases exists throughout the country. He called for a national partnership to improve the oral health care delivery system and address disparities in access to care.<sup>2</sup>

In 2011, the Institutes of Medicine (IOM) released two reports that examine the progress that has been made since the Surgeon General's report.<sup>3</sup> The IOM concludes that many oral health problems stem from poor oral health care and sets forth strategies and recommendations to improve access to care, particularly among underserved and vulnerable populations. The Patient Protection and Affordable Care Act (ACA) contains a number of provisions that target poor oral health directly, as well as a large number designed to increase access to and quality of health care in general.

This Issue Brief describes the problem of poor oral health care in America. It then discusses the solutions suggested by the 2011 Institute of Medicine reports and the provisions of the ACA intended to positively impact oral health care in America.

---

<sup>1</sup> Thanks to Colleen Healy, 2L at Duke University School of Law, for assistance with this Issue Brief.

<sup>2</sup> U.S. DEP'T OF HEALTH & HUMAN SERVS. (HHS), NAT'L INST. OF DENTAL & CRANIOFACIAL RESEARCH & NAT'L INSTS. OF HEALTH, ORAL HEALTH IN AMERICA: A REPORT OF THE SURGEON GENERAL vii (2000).

<sup>3</sup> See INST. OF MED. (IOM) & NAT'L RESEARCH COUNCIL (NRC), IMPROVING ACCESS TO ORAL HEALTH CARE FOR VULNERABLE AND UNDERSERVED POPULATIONS (2011) [hereinafter IOM & NRC, IMPROVING ACCESS]; INST. OF MED. (IOM), ADVANCING ORAL HEALTH IN AMERICA (2011) [hereinafter IOM, ADVANCING ORAL HEALTH].

#### OTHER OFFICES

1444 I Street NW, Suite 1105 • Washington, DC 20005 • (202) 289-7661 • Fax (202) 289-7724  
3701 Wilshire Boulevard, Suite 750 • Los Angeles, CA 90010 • (310) 204-6010 • Fax (213) 368-0774  
www.healthlaw.org

## Discussion

Nearly all adults have had cavities and most adults over age twenty-five have some form of periodontal disease.<sup>4</sup> Many Americans also suffer from other oral health conditions, including oral and throat cancer, oral herpes, and cleft palate.<sup>5</sup> Cavities, which strike five times more five-to-seventeen year olds than asthma, are the most common chronic illness of childhood.<sup>6</sup>

Approximately one in five children aged two to eleven have untreated tooth decay in their primary teeth.<sup>7</sup> Forty-two percent of six- to-nineteen-year-olds have had cavities in their permanent teeth, and approximately fourteen percent have untreated tooth decay.<sup>8</sup> By age seventeen, over seven percent of American children have lost at least one tooth due to decay; the average fifty-year-old has lost twelve teeth and by age sixty-five over one quarter of Americans have lost all their teeth.<sup>9</sup>

Poor oral health has severe negative repercussions on overall health, productivity and quality of life. Untreated oral health problems in children can result in attention deficits, trouble in school, and problems sleeping and eating.<sup>10</sup> Employed adults lose more than 164 million hours of work each year due to dental disease and dental visits, and in 2009 over 830,000 emergency room visits were the result of preventable dental conditions.<sup>11</sup> Poor oral health is also associated with a number of other diseases, including diabetes, stroke and respiratory disease.<sup>12</sup> In older adults, poor oral health is significantly associated with disability and reduction in mobility.<sup>13</sup>

### **Wide Disparities in Access and Outcomes**

Poor and underserved Americans are both more likely to need dental services and less likely to receive them.<sup>14</sup> According to the National Center for Health Statistics (NCHS), 4.6 million children did not obtain needed dental care in 2008 because they could not afford to see a dentist.<sup>15</sup> People who live below the federal poverty line (FPL) are less than half as likely to

<sup>4</sup> HHS, *supra* note 2, at 63, 65. This Issue Brief uses the term "cavity" to refer to clinically significant erosion of the tooth caused by infection or disease.

<sup>5</sup> HHS, *supra* note 2, at 67-72. Americans also suffer from oral health problems caused by trauma as well as agents such as smokeless tobacco. *Id.* See also IOM & NRC, IMPROVING ACCESS, *supra* note 3, at 43.

<sup>6</sup> HHS, *supra* note 2, at 63.

<sup>7</sup> Eugenio D. Beltrán-Aguilar et al., *Surveillance for Dental Caries, Dental Sealants, Tooth Retention, Edentulism, and Enamel Fluorosis—United States, 1988-1994 and 1999-2002*, 54 MORBIDITY & MORTALITY WKLY REP. at 18 tbl. 3 (2005) (reporting that 21 percent of 2- to 11-year-olds have untreated tooth decay).

<sup>8</sup> *Id.* at 20 tbl. 7; 21 tbl. 8.

<sup>9</sup> HHS, *supra* note 2, at 66.

<sup>10</sup> See Burton Edelstein et al., *Experience and Policy Implications of Children Presenting with Dental Emergencies to US Pediatric Dentistry Training Programs*, 28 PEDIATRIC DENTISTRY 431, 433 (2006); Stephanie L. Jackson, et al., *Impact of Poor Oral Health on Children's School Attendance and Performance*, 101 AMERICAN JOURNAL OF PUBLIC HEALTH 1900, 1900 (2011); The Surgeon General estimates that children with oral disease miss over 51 million hours of school each year. HHS, *supra* note 2, at 2.

<sup>11</sup> HHS, *supra* note 2, at 3; PEW CENTER ON THE STATES, A COSTLY DESTINATION: HOSPITAL CARE MEANS STATES PAY DEARLY 1 (2012).

<sup>12</sup> HHS, *supra* note 2, at 109-122. See also IOM & NRC, IMPROVING ACCESS, *supra* note 3, at 19.

<sup>13</sup> IOM & NRC, IMPROVING ACCESS, *supra* note 3, at 52.

<sup>14</sup> IOM & NRC, IMPROVING ACCESS, *supra* note 3, at 51.

<sup>15</sup> B. BLOOM ET AL., NAT'L CTR. FOR HEALTH STATS., SUMMARY HEALTH STATISTICS FOR U.S. CHILDREN: NATIONAL HEALTH INTERVIEW SURVEY, 2008, at 7 (2009).



have visited a dentist in the past year as those whose incomes are over 400 percent of the FPL.<sup>16</sup> In a recent nationwide survey, forty-one percent of Americans reported that they or someone in their household has put off dental care because of cost.<sup>17</sup>

Lack of access to care translates into poor oral health. Compared to people with incomes above the poverty line, low-income adults are more likely to have missing and decayed teeth than non-low-income people.<sup>18</sup> Severe periodontal disease is much more common among those of low socioeconomic status (SES) than those in middle or high SES groups.<sup>19</sup> Poor children experience almost twelve times more restricted-activity days as a result of dental problems than higher-income children.<sup>20</sup>

Wide disparities exist both in access to oral health care and oral health outcomes across populations.<sup>21</sup> Poor Hispanic and black children have more than twice the proportion of untreated tooth decay as poor non-Hispanic whites.<sup>22</sup> Similar racial and ethnic disparities exist among nearly all age groups and income levels.<sup>23</sup> People with disabilities and special health care needs tend to have poor oral health and problems accessing health care as well.<sup>24</sup> There are also marked disparities between rural and urban areas, and between states. For example, a 1999 study revealed that nearly half of all West Virginians over age sixty-five had lost all of their natural teeth, while the corresponding number for Hawaii was less than fourteen percent.<sup>25</sup> Disparities also exist between people of different education levels. Fewer than twenty-two percent of people who did not graduate high school had a dental visit in 2004, compared to over fifty-four percent of college graduates or children with a college graduate caregiver.<sup>26</sup>

<sup>16</sup> R. J. MANSKI & E. BROWN, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, DENTAL USE, EXPENSES, PRIVATE DENTAL COVERAGE, AND CHANGES, 1996 AND 2004, at 7 (2007) (26.5 percent vs. 57.9 percent). In 2011, the Federal Poverty Line for a family of four is \$22,350. 76 Fed. Reg. 3637 (Jan. 20, 2011).

<sup>17</sup> *New Survey: Majority of Americans Support Mid-Level Dental Provider to Expand Access to Dental Care*, W. K. KELLOGG FOUNDATION (Oct. 4, 2011), <http://www.wkcf.org/news/Articles/2011/10/New-Survey-Majority-of-Americans-Support-Mid-Level-Dental-Provider.aspx>.

<sup>18</sup> NAT'L CTR. FOR HEALTH STATS., TRENDS IN ORAL HEALTH STATUS: UNITED STATES, 1988-1994 AND 1999-2004, at 10 fig. 8 (2007). In 1996, more than forty-three percent of poor children aged five to seventeen had at least one decayed tooth. The corresponding number for children above the poverty line was just over twenty-three percent. HHS, *supra* note 2, at 63 fig. 4.2 (43.6 percent and 23.4 percent, respectively).

<sup>19</sup> HHS, *supra* note 2, at 66 fig. 4.11 (reporting that the percentage of adults aged 45-54 with at least one tooth site with 6 mm or more of periodontal attachment loss was 25.8 percent for those at 185 percent of the U.S. poverty level or below, 16.8 percent for those 185.1 percent to 350 percent of the poverty level, and 8.1 percent for those at 350.1 percent of the poverty level or higher).

<sup>20</sup> GOV'T ACCOUNTABILITY OFFICE, GAO/HEHS-00-72, DENTAL DISEASE IS A CHRONIC PROBLEM AMONG LOW-INCOME POPULATIONS 7 fig. 2 (2000). Restricted-activity days are those where children are unable to engage in normal activities, such as attending school. *Id.*

<sup>21</sup> See generally *id.* at 7 (reporting that eighty percent of untreated cavities in permanent teeth are found in roughly 25 percent of children, mostly from low-income and vulnerable groups).

<sup>22</sup> HHS, *supra* note 2, at 64 fig. 4.4.

<sup>23</sup> *Id.* at 64. These disparities are not limited to African-American and Latino Americans. For example, oral health and access to oral health services among many Native American populations are poor. See, e.g., Maxine Brings Him Back-Janis, *A Dental Hygienist Who's a Lakota Sioux Calls for New Mid-Level Dental Providers*, 30 HEALTH AFFAIRS 2013, 2014, 2015 (2011).

<sup>24</sup> See, e.g., Charlotte W. Lewis, *Dental Care and Children with Special Health Care Needs: A Population-Based Perspective*, 9 ACADEMIC PEDIATRICS 420, 423 tbl. 2 (2009) (reporting that 8.9 percent of children with special health care needs were unable to obtain needed dental care).

<sup>25</sup> Ctrs. for Disease Control & Prevention, *Total tooth loss among persons aged greater than or equal to 65 years - selected states, 1995-1997*, 48 MORBIDITY & MORTALITY WKLY. REP. 206, 207 tbl. 1 (1999).

<sup>26</sup> MANSKI & BROWN, *supra* note 16, at 8.

Poor oral health has a number of causes, including inadequate health literacy and poor oral care, lack of standardized quality measures, and poor knowledge of and attention to oral health among primary care providers.<sup>27</sup> Physicians and nurses are generally poor at recognizing and treating oral health problems, and many dentists do not have specialized training in treating older adults and other populations with special needs.<sup>28</sup> However, the proximate cause of poor oral health is often a simple lack of dental insurance coverage.<sup>29</sup> Children who lack health insurance are three times more likely to have an unmet dental need than insured children.<sup>30</sup> Since most private dental coverage is provided through the workplace and Medicare does not include dental insurance, the average person aged sixty-five or over is more than twice as likely as a person aged 45-64 not to have dental insurance.<sup>31</sup> Likewise, more than forty-one percent of people living below the poverty line have no dental insurance, compared to fewer than twenty-five percent of those earning more than 400 percent of FPL.<sup>32</sup> Fewer than half of Americans who did not graduate high school have dental insurance, compared to almost seventy-five percent of college graduates.<sup>33</sup>

Dental insurance coverage is not always sufficient to ensure access. Over forty-seven million people live in dental Health Professional Shortage Areas, which are found throughout the United States.<sup>34</sup> Even where providers exist, they may not take insurance or may take only private insurance. Although most poor children should have access to dental care through Medicaid, in practice many dentists refuse to take Medicaid patients.<sup>35</sup> In 2004, Americans with private dental insurance were nearly twice as likely as those with public dental coverage or no dental coverage to visit a dentist.<sup>36</sup>

<sup>27</sup> See generally IOM & NRC, IMPROVING ACCESS, *supra* note 3.

<sup>28</sup> *Id.* at 53-54. See also Hugh Silk et al., *Oral Health During Pregnancy*, 77 AM. FAMILY PHYSICIAN 1139, 1139 (2008) (reporting that many prenatal health providers are unaware of the importance of oral health during pregnancy).

<sup>29</sup> IOM & NRC, IMPROVING ACCESS, *supra* note 3, at 49 (reporting that children without dental insurance receive fewer dental services than insured children). Dental coverage for adults is optional in Medicaid, so states can exclude dental care from their state plans. See 42 U.S.C. § 1396d(a)(1); 42 C.F.R. § 440.100. According to the Department of Health and Human Services (HHS), almost 35 percent of Americans had no dental insurance in 2004, the latest available data. MANSKI & BROWN, *supra* note 16, at 10.

<sup>30</sup> Paul W. Newacheck et al., *The Unmet Health Needs of America's Children*, 105 PEDIATRICS 989, 993 tbl.2 (2000).

<sup>31</sup> MANSKI, *supra* note 16, at 11.

<sup>32</sup> MANSKI, *supra* note 16, at 11.

<sup>33</sup> MANSKI, *supra* note 16, at 12.

<sup>34</sup> *Designated Health Professional Shortage Areas (HPSA) statistics*, HEALTH RES. & SERVS. ADMIN. tbl. 1 (Feb. 24, 2012),

[http://ersrs.hrsa.gov/ReportServer?/HGDW\\_Reports/BCD\\_HPSA/BCD\\_HPSA\\_SCR50\\_Smry&rs:Format=HTML3.2](http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2). See generally 42 U.S.C. § 254e (defining Health Professional Shortage Area).

<sup>35</sup> GOV'T ACCOUNTABILITY OFFICE, GAO-11-96, EFFORTS UNDER WAY TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED ATTENTION NEEDED TO ADDRESS ONGOING CONCERNS 12 (2010) (reporting that in twenty-five of thirty-nine states assessed, more than half of all dentists in the state did not treat a single Medicaid patient in 2008); PEW CENTER ON THE STATES, A COSTLY DENTAL DESTINATION, *supra* note 11, at 2 (reporting that more than 16 million Medicaid-enrolled children – 56 percent – received no dental care in 2009).

<sup>36</sup> Manski, *supra* note 16, at 13 (reporting that fifty-seven percent of the population with private dental coverage had a dental visit, thirty-two percent of the population with public dental coverage had a dental visit, and twenty seven percent of the population without any dental coverage had a dental visit).

## *The Affordable Care Act and Oral Health*

The ACA aims to improve access to health care and outcomes through a number of mechanisms, including requiring most individuals to carry health insurance, prohibiting insurers from denying health insurance coverage based on pre-existing conditions, creating exchanges through which individuals and families not eligible for employer- or government-sponsored health insurance may purchase coverage, and expanding eligibility for the Medicaid program.<sup>37</sup> The ACA also contains a number of provisions targeted at improving oral health.<sup>38</sup>

Perhaps the most important of these is a requirement that most health plans cover a set of essential health benefits (EHBs) that includes pediatric oral care.<sup>39</sup> Beginning January 1, 2014, qualified health plans sold in health insurance exchanges must cover EHBs.<sup>40</sup> They must also be covered by Basic Health Plans and plans offered to most people eligible under the new Medicaid expansion.<sup>41</sup> In addition, the ACA prohibits insurers from imposing cost-sharing on some preventive oral health services, including oral health risk assessments and fluoride supplements for children whose water source does not contain fluoride.<sup>42</sup>

The ACA also requires, funds, and encourages a number of oral health prevention activities. First, it directs the Centers for Disease Control and Prevention (CDC) to establish a five-year national oral health education campaign.<sup>43</sup> This campaign is required to use science-based strategies and to target children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Native Americans.<sup>44</sup> The ACA also creates demonstration grants to study the effectiveness of research-based oral health programs, which will be used to inform the public education campaign.<sup>45</sup>

The ACA expands an existing school-based dental sealant program to each of the fifty States and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations.<sup>46</sup> It directs the CDC to enter into cooperative agreements with state, territorial, and Indian organizations to establish guidance, conduct data collection and implement science-based programs to improve oral health.<sup>47</sup> It also requires the Department of Health and Human

<sup>37</sup> See Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

<sup>38</sup> See generally CHILDREN'S DENTAL HEALTH PROJECT, SUMMARY OF ORAL HEALTH PROVISIONS IN HEALTH CARE REFORM (2010), available at <http://www.cdhp.org/system/files/Summary%20of%20Provisions-1.pdf>.

<sup>39</sup> ACA § 1302(b)(1)(J) (codified at 42 U.S.C. § 18022).

<sup>40</sup> ACA § 1301 (codified at 42 U.S.C. § 18021).

<sup>41</sup> ACA § 1331(a)(1), (e) (codified at 42 U.S.C. § 18051) (requiring states to offer Basic Health Plans that include the essential health benefits); ACA § 2001(c) (amending 42 U.S.C. § 1396u-7(b)(5)) (requiring state Medicaid programs to provide essential health benefits).

<sup>42</sup> ACA § 1001 (codified at 42 U.S.C. § 300gg-13). See *U.S.P.S.T.F. A and B Recommendations*, U.S. PREVENTIVE SERVICES TASK FORCE (August 2010),

<http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm>; HEALTH RES. & SERVS. ADMIN. BRIGHT FUTURES PROJECT & AM. ACAD. OF PEDIATRICS, RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE (2008), available at <http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf>.

<sup>43</sup> ACA § 4102(a) (codified at 42 U.S.C. § 280k). The ACA authorizes, but does not appropriate, funds for this initiative.

<sup>44</sup> *Id.*

<sup>45</sup> *Id.* (codified at 42 U.S.C. § 280k-1).

<sup>46</sup> *Id.* (codified at 42 U.S.C. § 280k-2).

<sup>47</sup> *Id.*

Services (HHS) to improve the oral health measures in a number of existing federal surveillance reports.<sup>48</sup>

The ACA authorizes HHS to make grants to, or enter into contracts with, dental schools, hospitals and nonprofits to participate in dental training programs.<sup>49</sup> This funding can be used to provide financial assistance to program participants, including dental and dental hygiene students as well as practicing dentists, and for loan repayment for faculty in dental programs.<sup>50</sup> The ACA also creates a demonstration project that will provide grants for up to fifteen demonstration programs to train or employ alternative dental health providers in underserved communities.<sup>51</sup> In addition, it provides general funding for graduate medical education and residency programs, both of which can be used by dental students.<sup>52</sup>

Finally, the ACA authorizes and requires a number of public health initiatives that should improve access to oral health care, including an \$11 billion five-year initiative that funds construction, capital improvements, and service expansions at community health centers.<sup>53</sup> The ACA also establishes a National Health Care Workforce Commission to serve as a resource to evaluate education and training to determine whether demand for health care workers is being met, identify barriers to improved coordination and encourage innovations to address identified needs.<sup>54</sup>

#### Key Affordable Care Act Oral Health Provisions

- Requires health plans to cover pediatric oral health services as Essential Health Benefits
- Creates 5-year national public health education campaign focused on oral health care prevention
- Provides grants for the study of evidence-based cavity prevention activities
- Expands school-based dental sealant programs
- Improves oral health measures in existing reports
- Provides grants for dental training programs
- Provides funds for demonstration programs for non-dentist health professionals
- Provides funds for community health centers
- Creates National Health Care Workforce Commission and identifies oral health care as a priority area

#### Institute of Medicine Reports

<sup>48</sup> *Id.* (codified at 42 U.S.C. § 280k-3).

<sup>49</sup> ACA § 5303 (codified at 42 U.S.C. § 293k-2) (authorizing HHS to make grants to, or enter into contracts with, a school of dentistry, hospital, or nonprofit entity to plan, develop, operate or participate in "an approved professional training program ... that emphasizes training for general, pediatric, or public health dentistry.").

<sup>50</sup> *Id.*

<sup>51</sup> ACA § 5304 (codified at 42 U.S.C. § 256g-1). Approved providers include community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and "any other health professional that the Secretary determines appropriate." *Id.*

<sup>52</sup> ACA § 5508 (codified at 42 U.S.C. § 239f-1).

<sup>53</sup> See ACA § 10503 (codified at 42 U.S.C. § 254b-2). \$9.5 billion of this funding will allow health centers to expand their operational capacity, and \$1.5 billion is dedicated to capital projects. *Id.*

<sup>54</sup> ACA § 5101 (codified at 42 U.S.C. § 294q). "Oral health care workforce capacity at all levels" is specifically identified as a "high priority area" for the Commission. *Id.*

In 2011, the Institute of Medicine released two reports regarding oral health in America. One addresses the overall issue, while the other focuses on improving access for vulnerable and underserved populations.<sup>55</sup> These reports go beyond previous efforts by not only cataloguing the scope of the problem but also putting forward specific recommendations for improvement.

### ***Advancing Oral Health in America***

In 2009, HHS asked the Institute of Medicine (IOM) to convene a panel to recommend actions HHS could take to improve the state of oral health in America.<sup>56</sup> In May 2011 the IOM produced *Advancing Oral Health Care in America*, a report that contains both an examination of the state of oral health care in the country as well as specific recommendations to improve it. The Report notes that, while access has improved somewhat since the Surgeon General's 2000 call to action, numerous problems persist. Access to oral health care and dental insurance remains poor. There are few standards, quality measures, or best practices in oral health, making it difficult for clinicians to improve quality of care and for individuals to make decisions about their own care. These problems are compounded by a generally low level of oral health literacy and knowledge among both the general population and non-dental clinical providers.<sup>57</sup>

The report notes that although HHS oversees or funds a number of initiatives aimed at improving oral health care, support and funding for these initiatives has been inconsistent, and clear leadership has been lacking.<sup>58</sup> The IOM finds that HHS has suffered from a lack of high-level accountability regarding oral health, and has failed to coordinate oral health initiatives among its various agencies. The Report notes that in 2010 HHS launched a cross-agency effort, termed the Oral Health Initiative, to improve oral health care nationwide, but that this effort is insufficient.<sup>59</sup>

---

<sup>55</sup> See IOM & NRC, IMPROVING ACCESS, *supra* note 3; IOM, ADVANCING ORAL HEALTH, *supra* note 3.

<sup>56</sup> IOM, ADVANCING ORAL HEALTH, *supra* note 3, at xi.

<sup>57</sup> *Id.* at 123-24. According to the report, "Many health professionals know little to nothing about oral health." *Id.* at xi.

<sup>58</sup> *Id.* at 3-4. HHS administers or provides financial support to a number of programs including the Indian Health Service and Federally Qualified Health Centers, as well as the Medicaid and Children's Health Insurance Program. *Id.*

<sup>59</sup> *Id.* at 2.

The IOM recommends a number of approaches for HHS to consider as part of or in addition to that effort. These approaches are referred to as the New Oral Health Initiative (NOHI). The NOHI is based on ten high-level organizing principles.<sup>60</sup> Seven specific recommendations are made.<sup>61</sup> The IOM concludes that, moving forward, it will be extremely important for HHS to maintain varied stakeholder involvement and strong HHS leadership.<sup>62</sup>

#### Organizing Principles for HHS and the New Oral Health Initiative

1. Establish high-level accountability
2. Emphasize disease prevention and oral health promotion
3. Improve oral health literacy and cultural competence
4. Reduce oral health disparities
5. Explore new models for payment and delivery of care
6. Enhance the role of non-dental health care professionals
7. Expand oral health research, and improve data collection
8. Promote collaboration among private and public stakeholders
9. Measure progress toward short-term and long-term goals and objectives
10. Advance the goals and objectives of *Healthy People 2020*

#### IOM Recommendations for the New Oral Health Initiative

1. Provide leader(s) of NOHI with authority and resources to successfully integrate oral health into the planning, programming, policies and research that occur across all HHS programs and agencies
2. All relevant HHS agencies should promote and monitor use of clinical-based preventive services in oral health and counseling across the life span
3. All relevant HHS agencies should undertake oral health literacy and education efforts aimed at individuals, communities, and health care professionals
4. HHS should invest in workforce innovations to improve oral health
5. The Centers for Medicare and Medicaid Services (CMS) should explore new delivery and payment models for Medicare, Medicaid and CHIP to improve access, quality, and coverage of oral health care across the life span
6. HHS should place a high priority on efforts to improve open, actionable, and timely information to advance science and improve oral health through research
7. To evaluate the NOHI, leaders should convene an annual public meeting of the agency heads to report on NOHI progress

*Improving Access to Oral Health Care for Vulnerable and Underserved Populations*

<sup>60</sup> *Id.* at 209.

<sup>61</sup> *Id.* at 210-21.

<sup>62</sup> *Id.* at 221-24.

In July 2011 the IOM, in conjunction with the National Research Council (NRC), released *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*.<sup>63</sup> In this report, an expert committee commissioned by the Health Resources and Services Administration (HRSA) found that vulnerable and underserved groups continue to face persistent, systemic barriers to accessing oral health care, which contribute to “profound and enduring” oral health disparities.<sup>64</sup>

The IOM makes recommendations in six categories: integrating oral health care into overall health care, creating optimal laws and regulations, improving dental education and training, reducing financial and administrative barriers to oral health care, promoting research, and expanding capacity.<sup>65</sup> Briefly summarized, the IOM recommends:

- *Integrating Oral Health Care into Overall Health Care:* The expert committee found that one important barrier to access is that oral health care is often viewed as a separate entity from overall health care, instead of an important component of it. With proper training, many non-dental health professionals can screen for oral health problems and deliver preventive care services. The IOM recommends that HRSA convene key stakeholders to develop a core set of competencies for non-dental health professions to be incorporated into certification, testing, and accreditation requirements.<sup>66</sup>
- *Creating Optimal Laws and Regulations:* The IOM concluded that many state-level laws and regulations—most commonly scope-of-practice regulations—act as a barrier to oral health care. The IOM recommends that state legislatures amend existing laws and regulations to permit dental health professionals to practice to the full extent of their education and training and to permit those professionals to provide care outside of the physical presence of a dentist.<sup>67</sup>
- *Improving Dental Education and Training:* The IOM noted that many dental students do not come from or receive experience working with vulnerable and minority populations. The IOM recommends that students receive clinical experience in community-based settings and with patients with complex oral health needs. It also recommends that dental education programs increase recruitment and support for students from under-represented populations, require student experiences in community-based rotations, and recruit and retain faculty with expertise in caring for vulnerable and underserved populations.<sup>68</sup>
- *Reducing Financial and Administrative Barriers:* As noted earlier in this issue brief, access-to-dental-insurance is a major determinant of access to and utilization of oral health care. The committee recommended that CMS fund and evaluate state-based demonstration projects of oral health coverage for adults. The committee also recommended that states raise Medicaid and Children’s Health Insurance Program (CHIP) reimbursement rates for oral health care, streamline providers’ administrative processes, and increase case management services for beneficiaries.<sup>69</sup>

<sup>63</sup> IOM & NRC, *IMPROVING ACCESS*, *supra* note 3.

<sup>64</sup> *Id.* at 1.

<sup>65</sup> *Id.* at 231-49.

<sup>66</sup> *Id.* at 231-33.

<sup>67</sup> *Id.* at 233-36.

<sup>68</sup> *Id.* at 236-40.

<sup>69</sup> *Id.* at 240-44.

- *Promoting Research:* The committee identified deficiencies in the collection, analysis, and use of data related to oral health. It recommends that Congress, federal agencies, and private foundations support oral health research and evaluation of new methods and technologies for the delivery of oral health care to vulnerable and underserved populations.<sup>70</sup>
- *Expanding Capacity:* The committee recommends that the federal government work with states to ensure that each state has the infrastructure necessary to perform core dental public health functions. The committee also recommends that HRSA help improve the capacity of Federally Qualified Health Centers (FQHCs) by supporting the use of a variety of oral health care professionals and enhancing financial incentives for their recruitment and retention, providing guidance to FQHCs for best practices, and assisting FQHCs in the provision of oral health care outside their physical facilities.<sup>71</sup>

## Conclusion

The United States can do much more to ensure that all individuals, particularly those most at risk, have access to quality oral health care. In 2000, the Surgeon General highlighted the scope of the problem and issued a call to action. There is evidence that oral health is improving, but at an unacceptably slow pace.<sup>72</sup> The Institute of Medicine's recent recommendations, together with the Affordable Care Act's many dental health initiatives, can help to sustain and accelerate this positive trend—but only if they are given the attention and funding necessary to put them into action.

---

<sup>70</sup> *Id.* at 244-46.

<sup>71</sup> *Id.* at 246-49.

<sup>72</sup> From the period 1971-74 through 1988-94, the average number of cavities decreased among all age groups except the elderly. HHS, *supra* note 2, at 64. See also Beltrán-Aguilar et al., *supra* note 7, at 7-8 (reporting reductions in dental caries, increased tooth retention and reduced levels of complete tooth loss among most populations in the United States).



## DENTISTRY



Letitia Rooney, 28, who has autism, has a filling put in by dentist Dr. Michael Matthias at Practice Without Pressure, a dental, medical and personal care facility that caters to people with disabilities. THE NEWS JOURNAL/JENNIFER CORBETT

## For cognitively impaired, care poses a challenge

Nonprofit  
lays  
ground-  
work for  
putting  
patients  
at ease

By KELLY BOTHUM  
The News Journal

Going to the dentist isn't likely to top the list of fun ways to spend your time. But for people with cognitive, developmental and physical disabilities, the experience can be downright frightening, from the dental tools to the unfamiliar faces to the fingers poking around their mouth.

But with a little practice, a seat in the dentist's chair doesn't have to be a scary event. That's the goal at Practice Without Pressure, a nonprofit organization in Bear that helps patients with disabilities and their families prepare for medical procedures.

Through practice sessions that introduce and explain the various equipment, procedures and participants involved in a dental visit, patients are better prepared, more cooperative and less likely to need sedation or restraints, which can be traumatic, said Karen Bashkow, senior director of programming at Practice Without Pressure.

For a time, Dan Rooney held off on regular dental care for his daughter, Letitia, because of the challenges. "It was a trying ordeal," said Rooney, whose 28-year-old daughter has autism and speaks mostly in single words. "A dentist would try to put his hand in her mouth. She would shy away. We were never able to do X-rays."

But during a recent visit to Practice With-

out Pressure, Letitia Rooney had a cavity filled, her first. Throughout the process, she remained calm, needing only verbal encouragement from the staff. "She goes through it just as good as I do," her father said.

### Participation

Now in its 10th year, Practice Without Pressure helps patients with autism, Down syndrome, cerebral palsy and other conditions overcome their apprehensions about health care visits. Although most of its focus is dental care, it also works with patients who need assistance with gynecological exams, mammography, personal care exams, blood draws and even haircuts. The nonprofit also teaches oral care and brushing techniques to group home residents.

"Our goal is if the person is able to participate in their care, then we try to get them to participate as much as possible," said Bashkow, a nurse who has a son with autism. "If you have the tools, you realize if someone practices and sees what it's all about, they can decide, 'I can do this on my own.'"

The focus on oral care is important, considering almost 40 percent of patients with disabilities in Delaware do not get routine dental exams, according to a 2010 report by the National Association of State Directors of Developmental Disabilities Services.

See DENTAL, Page B7

# Dental: Fostering self-care

Continued from Page B5

In recent years, health care providers have begun paying more attention to the link between oral health and a person's overall wellness. Studies have found connections between cardiovascular disease and periodontitis.

Inflammation in the mouth also can impair the body's ability to utilize insulin, which can affect diabetes management, said Dr. Wayne Lipschitz, associate professor of clinical dentistry for the University of Rochester Medical Center's Eastman Institute for Oral Health.

"For someone who is already medically compromised and not able to have full medical care, the risks do rise," said Lipschitz, who specializes in patients with severe developmental disabilities requiring restraints, sedation and hospitalization for dental treatment. He has a list of 300 people awaiting his care. "The more we can educate people to prevent disease, the more ability we have to use [the operating room] for severe, acute cases."

## A right to care

Three part-time dentists and two dental hygienists see about 30 patients a week at the

## LEARN MORE

Practice Without Pressure is located at 2470 Sunset Lake Road, Newark. Contact the office at 832-2800 or [www.pwppwde.com](http://www.pwppwde.com).

center off Del. 72, Bashkowsky said. Before their appointments, patients have the chance to practice with simulated instruments and pictures that give them an idea of what to expect. During visits, patients can hold up a "stop card" if they become uncomfortable.

Lipschitz said he doesn't know many dental professionals who use desensitization techniques, but they can increase patient cooperation and reduce the need for sedation, which can be expensive and time-consuming.

While most of the cost of dental care, cleaning, exams and fillings are covered by private health insurance or Medicaid for children, parents have to pay out-of-pocket for the practice sessions. Adults with disabilities don't receive dental coverage through Medicaid, so they are responsible for the cost.

The education, training, practice and other techniques used at Practice Without Pressure make it possible to serve a group of patients who



Index cards help patients understand what to expect.

might otherwise skip needed exams and cleanings, said Hope Thomas-Glavin, a Pike Creek dentist who works and volunteers with the organization. She credits founder and CEO Deb Jastrebski with helping patients to be in control of their health.

"The idea is that it's not a privilege to get treated, it's their right to get treated," Thomas-Glavin said.

She recalled a 5-year-old girl who had gone through the practice portion of the program. After the actual exam and cleaning, her smile and high-five said it all, even though the girl didn't utter a word. "There's the look - the thumbs up, the wide-open eyes," she said. "They're so excited, you can't help but be excited, too."

Contact Kelly Bothum 324-2962, [kbothum@delawareonline.com](mailto:kbothum@delawareonline.com) or on Twitter @kellybothum.

# Study: Poor oral hygiene may be HPV risk factor

By Amy Norton  
HealthDay

People whose teeth and gums are in poor condition may be more susceptible to an oral virus that can cause certain mouth and throat cancers, a new study suggests.

Researchers found that of more than 3,400 U.S. adults, those who rated their oral health as "poor" to "fair" were more likely to have an oral infection with human papillomavirus (HPV), which, in certain cases, can eventually lead to cancer.

Overall, 10 percent of people with tooth or gum disease tested positive for oral HPV. That compared with 6.5 percent of those who rated their dental health as "good" to "excellent."

The results, reported Wednesday in the journal Cancer Prevention Research, do not actually prove that diseased teeth and gums cause HPV infection.

"We don't know if poor oral health led to the HPV infection," said Christine Markham, one of the researchers on the study.

Her team tried to account for other factors that could affect dental health or the odds of hav-

## MOUTH AND THROAT CANCERS

Fewer than 12,000 cases of oropharyngeal cancer occur among Americans each year, according to the U.S. Centers for Disease Control and Prevention. But it's thought that HPV causes nearly three-quarters of them. So preventing the infection is key to preventing the cancer.

» There are two vaccines available against the most common cancer-linked strains of HPV (Gardasil and Cervarix). Experts advise vaccination for girls, boys and young adults.

» Of course, that would not be of help to most of the people in this study, the majority of whom were aged 30 or older, said Dr. Dennis Kraus, director of the Center for Head and Neck Oncology at North Shore-LIJ Cancer Institute in Lake Success, N.Y.

ing HPV — such as smoking or multiple oral sex partners. And poor oral health was still linked to a 56 percent increase in the risk of having oral HPV.

But there could be other explanations for the connection, and more research is needed, said Markham, an associate professor at the University of Texas Health Science Center in Houston.

Still, she said, there are already plenty of reasons to take care of your teeth and gums. "Good oral health care is important for your health in general," Markham said. This study just offers some more incentive, she added.

HPV, which can cause genital and anal warts, is

the most commonly transmitted sexual infection in the United States. Usually, the immune system clears the infection, but in some cases the virus persists in the body. And persistent infection with certain HPV strains can eventually lead to cancer — with cervical cancer the best known.

HPV can also invade the mouth during oral sex. Those infections usually cause no symptoms, but a lingering infection with a cancer-linked strain can lead to oropharyngeal cancer, which affects the back of the throat, base of the tongue and tonsils.

It's a rare cancer, but cases tied to HPV are on the rise in the United States. No one knows why.

# Low income? Dental care hard to come by

Jen Rini, The News Journal 2:16 p.m. EDT September 1, 2014



(Photo: WILLIAM BRETZGER/THE NEWS JOURNAL)

Middletown resident Janet Greene likes to play a bit of a waiting game when it comes to dental care.

She narrowly avoided a \$300 root canal a couple of weeks ago, but this time around, her cavities finally caught up with her.

Last Wednesday, Greene, 50 and unemployed, sat at Westside Family Healthcare's Wilmington dental clinic awaiting treatment for two cavity fillings and a chipped tooth.

She is on Medicaid, but that won't help her. In Delaware preventative dental care – routine checkups, cleanings, fillings and X-rays are not covered. Greene is not alone in her situation. There are 124,532 other Delawareans lacking that coverage.

**RELATED:** [Delawareans experience health care sticker shock \(/story/news/local/2014/03/22/delawareans-experience-health-care-sticker-shock/6745501\)](/story/news/local/2014/03/22/delawareans-experience-health-care-sticker-shock/6745501)

**RELATED:** [Delaware ranks low in breast-feeding \(/story/news/health/2014/08/11/delaware-ranks-bottom-state-breast-feeding-rates/13910569/\)](/story/news/health/2014/08/11/delaware-ranks-bottom-state-breast-feeding-rates/13910569/)

Delaware is 1 of only 4 states without Medicaid coverage for adult dental care, forcing patients to pay out of pocket for care considered to be the first line of defense against health risks, including premature births, heart disease and complications from diabetes.

State medical experts say reform is clearly needed, but it comes with a hefty price tag: More than \$6 million to implement.

For patients like Greene on fixed-income and without a monthly paycheck, scraping together \$50 for a co-pay is a struggle.

"It's a bit of a burden," she said.

Some clinics, like Westside, offer payment plans, but it's still difficult.

Nineteen-year-old Destiny Chinski, of Wilmington, watches the time tick away until she is in Greene's shoes.

Chinski is enrolled in Medicaid through a state assistance plan, Delaware Physicians Care, but dental coverage cuts off as soon as she turns 21.

Without insurance, two routine dental exams, including X-rays and teeth cleaning, can cost around \$350.

Such money can buy about 100 gallons of milk, 30 adult movie tickets or close to 350 basic paper notebooks. For some, \$350 is the sum of a paycheck or a couple months' worth of groceries.

Chinski worries about the looming cost of her dental care, so she is trying to fit in as many appointments as she can.

"It only doesn't cost me for so long," she said. "Health care in general in this state is hard to come by. There's not much they [the state] can do for every person."

Wilmington resident Norma Diaz, 32, is used to paying out of pocket for her dental care. A root canal costs her \$140; an extraction costs \$60.

Two weeks ago, she waited patiently to be seen at Westside for her final fitting and setting for partial lower dentures. The entire process to create dentures, impression, mold, fitting and setting, will cost her somewhere between \$600 to \$1,200.

Medicaid coverage for dental care would be a lifesaver, she said.

"I wouldn't have to pay out of pocket," she said, smiling at the thought.

There are no requirements under the federal Centers for Medicare and Medicaid Services to provide preventative dental coverage to adult Medicaid beneficiaries. States have the flexibility to determine how and what dental benefits are provided.

Pennsylvania's Medicaid division, for instance, offers coverage adult dental exams, cleanings and pre-approved treatments for prosthetics, extractions and crowns for as little as a 65 cent co-pay.

Most states have jumped on board to add some facets of adult dental care to Medicaid benefits, but Alabama, South Carolina, Tennessee and Delaware do not offer that coverage. However, the Centers for Medicare and Medicaid Services is in the process of approving South Carolina's preventative dental care expansion.

The cost to taxpayers has been a major obstacle to expanding the state's subsidized dental benefits, said Sen. Bethany Hall-Long, D-Middletown, chair of the state Senate Health Committee.

Hall-Long introduced two bills in the 147th Legislative session that specifically addressed that need for subsidized adult dental care in Delaware, but they failed to make it to the Senate floor.

State budget officials then estimated the expansion would cost \$6.2 million a year for about 216,000 beneficiaries.

Yes, it is expensive, but, pending re-election, Hall-Long pledges to re-introduce the bills in January when the Legislature reconvenes.

A lack of dental care is far too great of a threat to overall health, she said.

"Preventative care is so much less costly," Hall-Long said. "We have to look at how we can provide a basic, minimum standard."

In an annual survey by the Centers for Disease Control and Prevention, 70 percent of adults living in Delaware had a dental visit within the last year, said Dr. Greg McClure, dental director for the state's Bureau of Oral Health and Dental Services.

Though that is close to 700,000 people, McClure said the data does not specify whether those visits were routine or emergency.

Even though Westside recently opened a new community clinic in Dover to help better serve those on fixed incomes downstate and cut down on emergency visits, Tom Stephens, Westside's chief medical officer, said the need to expand Delaware's Medicaid is still essential.

Mouths are a breeding ground for bacteria which constantly forms sticky mineral crust on teeth, known as plaque. Untreated plaque eats away at the enamel on teeth, causing decay and gum disease.

Regular brushing and flossing can get rid of plaque, but if care is neglected, only a professional cleaning can remove it, according to the National Institute of Dental and Craniofacial Research.

MaryClare Kubasko, a dentist with Westside Family Healthcare, said the bacteria that causes gum disease can be transmitted to spouses and children. Though it might be difficult, she urges her patients with gum disease to avoid kissing their children.

"If it's left untreated, it will progress," she said.

Without routine care, a host of medical risks escalate. For instance, pregnant women with gum disease are at a higher risk of having premature births, Stephens said.

Untreated plaque can cause inflammation that stresses a woman's overall body immune response, causing early deliveries, he said.

Some studies link the bacteria in gum disease with higher chances for heart disease.

Similarly, if people with diabetes have poor oral hygiene, they are more susceptible to gum infections since their immune systems are already weakened, according to the Academy of Periodontology.

"If they have really bad dental care, it can impact their well-being. If you have dental abscesses, if you lost teeth, that impacts your feeling of self-worth. We learn more and more almost daily of the impact [dental care] has on overall health," Stephens said.

The most recent survey by the Centers for Disease Control and Prevention showed 45.2 percent of adults in Delaware had permanent teeth extracted, slightly above the national average, which sits at 44.5 percent. The extractions are the result of tooth decay, gum disease or trauma, McClure explained.

"Health care is expensive, but it's important," McClure said.

"If you have an infection because it's in the mouth, does it make it any less important? We don't think so."

Luckily, Ramos Sandoval hasn't had to go to the emergency room for a dental procedure yet.

## Low income? Dental care hard to come by

Sandoval, who works in a barber shop in Wilmington, said he wishes Medicaid subsidies would cover his dental care. On his salary, he doesn't have much room for many extra costs.

"It's really important to me, I [would treat] dental insurance like my child," he said.

Jen Rini can be reached at (302) 324-2386 or [jrini@delawareonline.com](mailto:jrini@delawareonline.com) (<mailto:%20jrini@delawareonline.com>). Follow @JenRini (<https://twitter.com/JenRini>) on Twitter.

Read or Share this story: <http://delonline.us/1u5uTkV>

### MORE STORIES



#### **Cash-short Guard's weekend drills canceled**

[\(/story/delawaredefense/2014/09/02/delaware-army-national-guard-weekend-drill-canceled-not-enough-money/14977031/\)](http://delawaredefense.com/story/delawaredefense/2014/09/02/delaware-army-national-guard-weekend-drill-canceled-not-enough-money/14977031/)

[\(/story/delawaredefense/2014/09/02/delaware-army-national-guard-weekend-drill-canceled-not-enough-money/14977031/\)](http://delawaredefense.com/story/delawaredefense/2014/09/02/delaware-army-national-guard-weekend-drill-canceled-not-enough-money/14977031/)

Sept. 3, 2014, 9:49 a.m.



#### **Gordon central topic in NCCo Council debate**

[\(/story/news/local/2014/09/02/gordon-central-topic-ncco-council-debate/15001229/\)](http://delawarenews.com/story/news/local/2014/09/02/gordon-central-topic-ncco-council-debate/15001229/)

[\(/story/news/local/2014/09/02/gordon-central-topic-ncco-council-debate/15001229/\)](http://delawarenews.com/story/news/local/2014/09/02/gordon-central-topic-ncco-council-debate/15001229/)

Sept. 3, 2014, 4:44 a.m.



#### **Arlett, Phillips face off in debate**

[\(/story/news/politics/2014/09/02/arlett-phillips-face-debate/14967957/\)](http://delawarenews.com/story/news/politics/2014/09/02/arlett-phillips-face-debate/14967957/)

[\(/story/news/politics/2014/09/02/arlett-phillips-face-debate/14967957/\)](http://delawarenews.com/story/news/politics/2014/09/02/arlett-phillips-face-debate/14967957/)

Sept. 2, 2014, 11:29 p.m.



#### **Obama vows to bring Islamic State killers to justice**

# No Medicare dental care for seniors

Letter to the Editor 6 p.m. EDT September 2, 2014



(Photo: Getty Images/Stockphoto)

In response to the article on dental care in Delaware, Medicare and supplemental insurance also do not provide for dental care for seniors. There are places to apply for care, but there are income limits. I tried Nemours Senior Health Care and its limit is under \$20,000; at DelTech Dental Center, they also have limits; I did pass it in August 2013, but I am still on a waiting list and was told it can take up to two years but you have to re-apply every year. I also found out when I called that they neglected to even put me on the list until May 2014, but this does not move me up on the list. I also tried Christiana Health Center, which works on a sliding scale but after finally after several tries, when I got through, I was told to call back in July. I did this but after waiting on hold for over 40 minutes, I hung up. I contacted Henrietta Johnson, who also offers reduced costs for dental care, and left a message on Aug. 1 and am still waiting for a return call.

I think the income limits should be adjusted or at least worked on a sliding scale. I currently have an income of under \$24,000 including Social Security and two minor retirement incomes. However, last year alone I spent over \$9,000 in medical care but that is not taken into consideration. I had previously never gone over six months for a check-up and am now over one-and-a-half years and now have to go back to DelTech to re-apply, even though I am still on their waiting list. There has to be a solution to this problem.

Elizabeth Sieracki

Bear

Read or Share this story: <http://delonline.us/1rLs0YJ>

## MORE STORIES



**The jihadi logic says they can outlast us**

[\(/story/opinion/contributors/2014/09/19/jihadi-logic-says-can-outlast-us/15896793/\)](http://delonline.us/story/opinion/contributors/2014/09/19/jihadi-logic-says-can-outlast-us/15896793/)

[\(/story/opinion/contributors/2014/09/19/jihadi-logic-says-can-outlast-us/15896793/\)](http://delonline.us/story/opinion/contributors/2014/09/19/jihadi-logic-says-can-outlast-us/15896793/)

Sept. 19, 2014, 2:47 p.m.



**Obama may have to send troops**

[\(/story/opinion/contributors/2014/09/19/obama-may-send-troops/15897095/\)](http://delonline.us/story/opinion/contributors/2014/09/19/obama-may-send-troops/15897095/)

[\(/story/opinion/contributors/2014/09/19/obama-may-send-troops/15897095/\)](http://delonline.us/story/opinion/contributors/2014/09/19/obama-may-send-troops/15897095/)

Sept. 19, 2014, 2:52 p.m.

**Where are Obama's war protesters?**

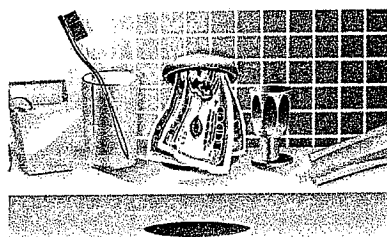

[About us](#) [Contact](#)

LISTEN LIVE

Sunday November 16, 2014

[Home](#) » [Mini Post 2](#) » Delaware sinks teeth into problem of low income dental care

## ARTICLE



## Delaware sinks teeth into problem of low income dental care

By Christine Facciolo June 13, 2011

403

0

g+1 0

Like 2

Linwood Worthington's parents always made sure he received regular dental care while he was growing up. But when he became an adult, he discovered that the dental insurance that came with his job didn't go very far. Moreover, when he became unemployed after relocating to Delaware in 2005, he learned that his Medicaid benefits excluded dental altogether. His teeth suffered. But then a friend told him about Hope Medical Clinic in Dover which offers free non-emergency treatment and consultations to low-income adults.

There, Worthington got the care he needed to maintain a healthy mouth. "I'm very grateful," said the 43-year-old Dover resident. "Now I'm smiling away."

### Lack of Dental Care for Adults on Medicaid in Delaware

States are required to cover dental for children in their Medicaid programs but coverage for adults is optional. Delaware is one of about a half dozen states that does not extend even minimal dental benefits to adult Medicaid recipients. Coverage stops at age 21. "It's a disgrace," said Dr. Thomas Conaty, past president of the Delaware State Dental Society and member of its legislative council. "And let's put the problem where it is—it's in our state."

The lack of service to this population has serious health and economic consequences. Dental caries (tooth decay), now considered an infectious disease, has reached epidemic proportions among the poor of all ages, according to a 2000 report on oral health by the U.S. Surgeon General. Poor oral health has been linked to a variety of medical conditions, including diabetes, heart disease and adverse pregnancy outcomes.

Dental disease has devastating personal consequences as well, including pain, impaired eating, speech difficulties and lost work days. Moreover, adults with visible dental caries are less likely to gain employment than those with healthy smiles, according to the Surgeon General's report.

Treating dental disease early prevents the need for more expensive services later. Indeed, when low-income individuals experience a dental emergency, they head to the hospital where care is more palliative than curative. "It costs three to four hundred bucks and it doesn't treat the problem," said Dr. Gary Colangelo, chair of the Delaware Oral Health Coalition. "When you have to have a tooth pulled, you have to have it pulled and I don't know of too many emergency room doctors that do extractions."

Low-income and Medicaid-eligible adults can access preventive care at federally qualified health centers and other clinics where dentists in private practice donate their time. Nemours offers care to persons 65 and over who meet eligibility requirements. But these efforts pale in comparison to the need they must serve. "It's a growing problem," said Dr. Thomas Mercer, dental director at the Hope Medical Clinic in Dover. "I don't think the other clinics that are doing what we're doing are able to keep up with it either. Dental disease is a rampant problem."

Dr. Carmelina D'Arro, dental director at Henrietta Johnson Medical Center in Wilmington, confirms his observations. "We have patients coming from a two-hour radius and we're seeing rampant decay," she said. "We'll have a line of patients outside the clinic on most days with emergencies."

And although these facilities provide care at a greatly reduced cost, it is often beyond the reach of the working poor whose budgets are already strained by the sour economy.

"When people have limited resources, they set priorities, and unfortunately, patients who have limited financial resources probably see their oral issues and their dental issues as low priority until they get into trouble," said Dr. Edwin Granite, chair of the



Department of Oral and Maxillofacial Surgery and Hospital Dentistry at Christiana Care Health System. Granite says Christiana Care's clinic counted over 11,000 dental visits last year.

#### Efforts to Add Dental Benefits to Adult Medicaid Coverage

Experts agree that while dental clinics provide a much-needed service, they are not the best way to treat the low-income adult population. Indeed, a 2003 report by Families USA found that states could provide the same service at a 50-70 percent discount through Medicaid.

"I think that Medicaid is really the solution we need to hammer home," said Dr. Brian McAllister, board member of the Delaware Institute for Dental Education and Research or DIDER. "Clinics are not efficient. They have a purpose but a dental office is run to be efficient. If it's not efficient, it's not profitable."

The dental community has made several attempts over the past few years to get the dental benefit extended to adult Medicaid recipients but recent efforts have fallen victim to the foundering economy.

"We've not had that history (of providing dental coverage for adults) so I think getting geared up to start with a major cost effort is what's precluded us from doing so," said Dave Michalik, chief of policy and planning for the state Division of Medicaid and Medical Assistance.

Colangelo feels legislators don't appreciate the economic value of extending benefits. "You can get long-term cost savings," he said. "That's a difficult policy for politicians to understand because they can only think until the next election and when your payoff is going to be 15-20 years down the road, they kind of glaze over."

Conaty believes it's just hard to advocate for adults. "It's easy to advocate for children because everybody wants to help the kids," he said. "But it's a much harder job to sell this for adults. We've been trying four or five years in a row to do it."



Click the image to view  
provided for Medicaid-eligible  
children

image to view  
a breakdown  
of care  
provided for  
Medicaid-  
eligible  
Delaware  
children

If and when Medicaid dental benefits get extended to adults, the dental community stands ready to accommodate the new entrants. The state has attracted many new practitioners through its mandatory one-year residency program at Christiana Care and DIDER's arrangement with Temple University's dental school to reserve a certain number of slots for Delaware residents. In addition, DIDER's loan repayment program has brought more dentists to Sussex County, lifting it from its federally underserved status.

Delaware also boasts strong provider participation and reimbursement rates. Two-thirds of the state's 400 dentists provide dental benefits to Medicaid-eligible children, receiving 80 percent of their usual fees for services. Nationally, a 2010 Government Accountability Office (GAO) report found that in 25 of 39 reporting states, fewer than half of dentists saw any Medicaid patients. And a recently released report from the Pew Center on the States finds Delaware is one of only five states nationally that reimburse at over 70 percent of the usual fee for service.

"The infrastructure is there," said McAllister.

#### Improving Utilization of Dental Services by Medicaid-Eligible Children

The lack of progress in providing adult dental benefits stands in marked contrast to the state's accomplishments with children. In addition to private practitioners, children can access care at various dental clinics throughout the state, including eight run by the Division of Public Health solely for their benefit.

"A child who has Medicaid eligibility really shouldn't have a problem getting an appointment on a regular basis," said Dr. Greg McClure, dental director for the Division of Public Health and founder of the Delaware Oral Health Coalition.

Indeed, nearly 40,000 Medicaid-eligible children accessed some type of dental service, giving the state a 41 percent utilization rate, just above the national average, according to a 2010 report from the Centers for Medicare and Medicaid. The state has also reinstated its dental sealant program, targeting schools with high percentages of low-income students.

The dental community would like to see a higher utilization rate but barriers remain.

"People on Medicaid have other concerns," said McClure. "Transportation might enter into it. A lot of people just don't put a value on dental care and that's one of the things we're trying to address through a number of initiatives."

Those initiatives include the "Tooth Troop," which engages caregivers in local community organizations and "Give Kids a Smile," an annual one-day volunteer initiative to give kids' free dental screenings.

"I think we are making progress," said McClure. "When I look at what it was ten years ago—no community clinics, relatively little Medicaid participation other than through our Division of Public Health—it's a tough thing to do, but we continue to work on it."



# Disability and Health in Delaware

Delaware Behavioral Risk Factor Surveillance System  
2010 Select Data

August 2013



Center for  
Disabilities Studies

disability and three percent (3.3%) of those without a disability lost all their teeth due to tooth decay or gum disease.

Approximately sixty percent (61.7%) of respondents with a disability have visited the dentist in the past year. Seventy-six percent (75.7%) of respondents without disabilities reported visiting the dentist within the past year.

Sixty-two percent (62.3%) of people with disabilities and seventy-six (76.4%) of people without disabilities have had their teeth cleaned in the past year.

Table 15. Dental health among adults with and without a disability			
Variable	Category	Without a Disability	With a Disability
<b>Tooth Loss</b>	None	62.5%	50.6%
How many of your permanent teeth have been removed because of tooth decay or gum disease?	1 to 5 teeth	26.0%	28.0%
	6 or more, but not all teeth	8.2%	13.5%
	All teeth	3.3%	7.9%
<b>Dentist Visit</b>	Yes	75.7%	61.7%
How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.	No	24.3%	38.3%
	Respondents who reported having visited a dentist during the preceding year were defined as Yes.		
<b>Teeth Cleaning</b>	Yes	76.4%	62.3%
How long has it been since you had your teeth cleaned by a dentist or dental hygienist?	No	23.6%	37.7%
	Respondents who reported having had their teeth cleaned during the preceding year were defined as Yes.		



# State of Delaware Dental Resource Guide



*Updated: February 2014*

ATTACHMENT "D"

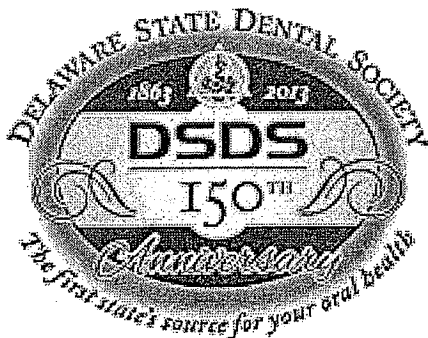
**The purpose of this guide** is to provide information about dental services available in Delaware that will help individuals and families find and access appropriate dental resources. The dental facilities and programs included in this guide participate in Medicaid and provide low-cost or special dental services (e.g., care for homeless populations). We hope you find it helpful in locating a dental provider in your area.

## **Let's get started!**

Dental services are free to Medicaid eligible children under the age of 21 and CHIP-eligible children under the age of 19! Learn about eligibility and benefit information today!



- Call: 1-800-996-9969
- To find Medicaid (up to age 21) dental providers in your area, visit: [www.InsureKidsNow.gov/state/Delaware](http://www.InsureKidsNow.gov/state/Delaware)



**Dentists who are in Private Practice:** The Delaware State Dental Society Member Locator system provides a comprehensive and searchable list of dentists by city, zip code or specialty:  
[www.DelawareStateDentalSociety.org](http://www.DelawareStateDentalSociety.org)

**Several Delaware clinics provide affordable oral health services for adults and children:** This guide contains a comprehensive list of state service centers, federally qualified health centers and other dental clinics in New Castle, Kent and Sussex counties that provide affordable care to all populations.

For more information, visit Delaware Health and Social Services online: [www.dhss.delaware.gov](http://www.dhss.delaware.gov)

# New Castle County Dental Clinics

CLINIC INFORMATION	
<p><b>Del Tech Dental Health Center</b>  333 Shipley  (Corner of Shipley and 2nd St)  Wilmington, DE 19801  (302) 571-5364  <a href="http://www.dtcc.edu/our-campuses/wilmington/dental-health-center">www.dtcc.edu/our-campuses/wilmington/dental-health-center</a></p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>• No age restrictions.</li> <li>• Accepts Medicaid (up to age 21) and other dental insurance plans.</li> <li>• Applications are taken for those who meet certain financial eligibility requirements.</li> <li>• All patients must be seen by a hygiene student before referral to dentist.</li> </ul>	<p><b>Division of Public Health  Dental Clinic  DeLaWarr State Service Center</b>  500 Rogers Road  New Castle, DE 19720  (302) 577-2973</p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>• Medicaid and CHIP-eligible children under 21.</li> <li>• Transportation is available.</li> </ul>
<p><b>Henrietta Johnson Medical Center</b>  601 New Castle Avenue  Wilmington, DE 19801  (302) 655-6187  <a href="http://www.hjmc.org/dental">www.hjmc.org/dental</a></p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>• Ages 3 and older</li> <li>• Accepts Medicaid (up to age 21) and other dental insurance plans</li> <li>• Sliding fee schedule for individuals without insurance (\$50 minimum payment)</li> <li>• Proof of identity and income required</li> </ul>	<p><b>Nemours SeniorCare</b>  1801 Rockland Rd.  Wilmington, DE 19803  1-800-292-9538  <a href="http://www.seniorcarenemours.org">www.seniorcarenemours.org</a></p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>• Ages 65 and older.</li> <li>• Required membership includes proof of age, Delaware residency and income under \$18,000 (single) / \$24,125 (married).</li> <li>• A small co-pay is required for services.</li> </ul>

## New Castle County Dental Clinics (continued)

CLINIC INFORMATION	
<p><b>Pierre Toussaint Dental Office (PTDO)</b>  830 North Spruce Street  Wilmington, DE 19801  (302) 652-8947  <a href="http://www.ministryofcaring.org/support-services">www.ministryofcaring.org/support-services</a></p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>Adults 19-65 years old.</li> <li><b>Low income:</b> Call PTDO for appointment (302) 652-8947. Initial payment of \$96.00 is required on the first visit. There are set fees for services (no sliding fee scale available).</li> <li><b>Homeless:</b> Come for appointment to Samaritan Outreach at 1410 N. Claymont St. Wilmington, DE. 19802. Client must call prior to visit to confirm verification documents to bring: (302) 594-9476. No charges for services.</li> </ul>	<p><b>Practice Without Pressure, Inc.</b>  2470 Sunset Lake Road  Newark, DE 19702  (302) 832-2800  <a href="http://www.pwpde.com">www.pwpde.com</a>  <a href="mailto:requestinfo@pwpde.com">requestinfo@pwpde.com</a></p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>Dental care for people of all ages with disabilities.</li> <li>Medicaid and most insurance for covered procedures accepted.</li> <li>Practice Training Sessions to prepare for dental services and sedation dentistry.</li> <li>Services include dental exams, x-rays, cleaning, fillings, root canals, dentures, extractions.</li> <li>Offers <i>Oral Health in the Home</i>, a toothbrush and flossing training program for individuals and their caregivers to improve care between appointments.</li> </ul>
<p><b>Westside Family Healthcare</b>  1802 West 4th Street  Wilmington DE 19805  (302) 655-5822  <a href="http://www.westsidehealth.org/services.html">www.westsidehealth.org/services.html</a></p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>Ages 3 and older.</li> <li>Medicaid accepted (up to age 21).</li> <li>Sliding fee schedule and financial aid available, charges based upon income</li> <li>Must be an existing Westside patient.</li> </ul>	<p><b>Wilmington Hospital Dental Clinic</b>  501 West 14th Street  Wilmington, DE 19801  (302) 428-4850  <a href="http://www.christianacare.org/dentistry">www.christianacare.org/dentistry</a></p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>No age restrictions.</li> <li>Medicaid accepted (up to age 21).</li> <li>\$40 fee per visit, includes routine dental services (oral examination, fillings, extractions, X-rays).</li> <li>Non-routine services priced according to a discounted fee schedule.</li> </ul>

**NEW CASTLE COUNTY PEDIATRIC DENTISTS  
ENROLLED in DELAWARE'S MEDICAID PROGRAM**

*(as of February, 2014)*

**Rosemary Clay, D.M.D** -- 533 Main Street, Wilmington, DE 19804,  
(302) 998-0500, [www.clayandclaydental.com](http://www.clayandclaydental.com)

**Dale R. Collins D.D.S & Robert M. Collins D.D.S** -- 5500 Skyline Drive, Suite 3, Wilmington, DE 19808, (302) 239-3655, [www.delawarechildrensdentist.com](http://www.delawarechildrensdentist.com)

**Lynn Collins D.D.S & Ronald E. Collins D.D.S** -- 38 Peoples Plaza, Newark, DE 19702, (302) 834-4000, [www.collinsdentaloffice.com](http://www.collinsdentaloffice.com)

**Eric R. Copes D.M.D** -- 200 Biddle Ave., Suite 201, Newark, DE 19702,  
(302) 838-1865, [www.silly-smiles.com](http://www.silly-smiles.com)

**George T. Derenzo D.D.S** -- 2000 Foulk Road, Suite 1C, Wilmington, DE 19810, (302) 475-3110 (se habla Español), [www.drgeorgederenzo.com](http://www.drgeorgederenzo.com)

**Jay J. Harris D.M.D** -- 220 Christiana Medical Center, Newark, DE 19720,  
(302) 453-9553, [www.wildsmiles4Kids.com](http://www.wildsmiles4Kids.com)

**Laurie B. Jacobs D.M.D** -- 708 Foulk Road, Wilmington, DE 19803,  
(302) 764-7714

**Rachel A. Maher D.M.D** -- 2036 Foulk Road, Suite 200, Wilmington, DE 19810,  
(302) 475-7640

**Katie Matthews D.M.D** -- 451 Hockessin Corner, Hockessin, DE 19707,  
(302) 234-2440, [www.drmatthews.com](http://www.drmatthews.com)

**Patricia Smith D.M.D** -- 38 Peoples Plaza, Newark, DE 19702, (302) 834-4000,  
[www.collinsdentaloffice.com](http://www.collinsdentaloffice.com)



## Kent County Dental Clinics

CLINIC INFORMATION	
<p><b>Delaware Hope Dental Clinic</b>  1121 Forest Avenue  Dover, DE 19904  (302) 735-7551  <a href="http://www.delawarehelpline.org/helpline/controller">www.delawarehelpline.org/helpline/controller</a></p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>• Ages 18-65 years old.</li> <li>• Provides non-emergency dental services to non-Medicaid and non-Medicare uninsured patients.</li> <li>• Offers routine dental services free of charge</li> </ul>	<p><b>Division of Public Health  Dental Clinic  Milford State Service Center</b>  Riverwalk Shopping Center  253 NE Front Street  Milford, DE 19963  (302) 424-7160</p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>• Services are free to Medicaid and CHIP-eligible children under 21.</li> <li>• Transportation is available.</li> </ul>
<p><b>Division of Public Health  Dental Clinic  Williams State Service Center</b>  805 River Road  Dover, DE 19901  (302) 857-5120</p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>• Medicaid and CHIP-eligible children under 21.</li> <li>• Transportation is available.</li> </ul>	<p><b>Nemours SeniorCare, Milford</b>  909 North DuPont Blvd  Milford, DE 19963  1-800-763-9326</p> <p><b><u>Eligibility:</u></b></p> <ul style="list-style-type: none"> <li>• Ages 65 and older.</li> <li>• Required membership includes proof of age, Delaware residency and income under \$18,000 (single) / \$24,125 (married).</li> <li>• A small co-pay is required for services.</li> </ul>
<p style="text-align: center;"><b><i>KENT COUNTY PEDIATRIC DENTISTS  ENROLLED in DELAWARE'S MEDICAID PROGRAM</i></b>  <i>(as of February, 2014)</i></p> <p>Julie Q. Nies D.D.S -- 1380 S. State Street, Dover, DE 19901, (302) 674-8000</p> <p>Richard M. Quinn D.D.S -- 1380 S. State Street, Dover, DE 19901, (302) 674-8000</p>	

## Sussex County Dental Clinics

<b>CLINIC INFORMATION</b>	
<p><b>Division of Public Health Dental Clinic Shipley State Service Center</b> 350 Virginia Avenue Seaford, DE 19973 (302) 628-2009</p> <p><u><b>Eligibility:</b></u></p> <ul style="list-style-type: none"> <li>• Medicaid and CHIP-eligible children under 21.</li> <li>• Transportation is available.</li> </ul>	<p><b>Division of Public Health Dental Clinic, Thurman Adams State Service Center</b> 546 Bedford Street Extension Georgetown, DE 19947 (302) 856-5240</p> <p><u><b>Eligibility:</b></u></p> <ul style="list-style-type: none"> <li>• Medicaid and CHIP-eligible children under 21.</li> <li>• Transportation is available.</li> </ul>
<p><b>La Red Health Center</b> 505 West Market Street, Georgetown, DE 19947 (302) 855-1233, <a href="http://www.laredhealthcenter.org">www.laredhealthcenter.org</a></p> <p><u><b>Eligibility:</b></u></p> <ul style="list-style-type: none"> <li>• No age restrictions</li> <li>• Medicaid accepted (up to age 21).</li> <li>• Sliding fee scale available, proof of income and official picture ID required.</li> </ul>	
<p style="text-align: center;"><b><i>PEDIATRIC DENTISTS in SOUTHEAST MARYLAND ENROLLED in DELAWARE'S MEDICAID PROGRAM</i></b> (as of February, 2014)</p> <p><b>Charles P. Brenner, D.D.S</b> -- 145 East Carroll Street, Suite 201, Salisbury, MD 21801, (410) 749-0133, <a href="http://www.dentistryforyoungpeople.com">www.dentistryforyoungpeople.com</a></p> <p><b>Jessica S. DiCerbo, B.S.N, D.M.D</b> -- 18947 John J. Williams Hwy, Rehoboth Beach, DE 19971, (302) 644-4460, <a href="http://www.coastalkidspedo.com">www.coastalkidspedo.com</a></p> <p><b>Gerald Krause D.D.S</b> -- 560 Riverside Drive, Suite A-205, Salisbury MD, 21801, (410) 742-1688, <a href="http://www.krausesmiles.com">www.krausesmiles.com</a></p> <p><b>Susan E. Vickers D.M.D</b> -- 6512A Deer Pointe Drive, Salisbury, MD 21804, (410) 749-0009, <a href="http://www.seasidesmilesmd.com">www.seasidesmilesmd.com</a></p> <p><b>Susan E. Vickers D.M.D</b> -- 10445 Old Ocean City Blvd, Ste 12, Berlin, MD, 21804, (410) 749-0009, <a href="http://www.seasidesmilesmd.com">www.seasidesmilesmd.com</a></p>	

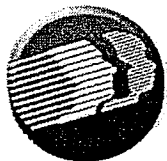
**A healthy smile should last a lifetime.** Tooth decay is the most common childhood disease in the U.S. -- nearly five times more common than asthma. Yet oral health problems can almost always be prevented.

Not only can dental disease be extremely painful, but treatment can be very costly for parents. Taking good care of your child's teeth through these simple, preventative activities can help to avoid significant problems down the road.

- Avoid sharing saliva with your baby. Don't put things in your mouth before you put them in your baby's mouth. Do not share spoons, forks or cups.
- Put only formula, milk or water in a baby bottle – no juice or sweet drinks.
- A child's first trip to the dentist should take place by their first birthday and every six months after.
- Brush twice daily with fluoride toothpaste and floss your children's teeth until they're coordinated enough to tie their shoes, usually around age six.
- Limit sugary foods and drinks, including sticky foods such as raisins and fruit roll-ups.
- Get dental sealants (a plastic coating that prevents tooth decay) by age six to protect the first permanent molars.

Dental disease can negatively impact a child's development and self-esteem. If left untreated, tooth decay can cause school absences and even affect a child's ability to learn and concentrate. **Cavities are not inevitable – you have the power to prevent dental disease!**

For more information, go to: [www.FirstSmileDelaware.org](http://www.FirstSmileDelaware.org)



***DELAWARE HEALTH AND SOCIAL SERVICES***

***Division of Public Health***

***Bureau of Oral Health and Dental Services***

HRSA # T12HP14660

Medicaid Adult Dental Benefits by State: 2011

Alabama: no coverage in 2011  
Alaska: full coverage in 2011  
Arizona: no coverage in 2011  
Arkansas: limited coverage in 2011  
California: no coverage in 2011  
Colorado: no coverage in 2011  
Connecticut: full coverage in 2011  
Delaware: no coverage in 2011  
Georgia: emergencies covered in 2011  
Idaho: full coverage in 2011  
Illinois: limited coverage in 2011  
Indiana: limited coverage in 2011  
Iowa: limited coverage in 2011  
Kansas: emergencies covered in 2011  
Kentucky: full coverage in 2011  
Louisiana: limited coverage in 2011  
Maine: limited coverage in 2011  
Maryland: emergencies covered in 2011  
Massachusetts: limited coverage in 2011  
Michigan: full coverage in 2011  
Minnesota: limited coverage in 2011  
Mississippi: emergencies covered in 2011  
Missouri: no coverage in 2011  
Montana: limited coverage in 2011  
Nebraska: limited coverage in 2011  
Nevada: emergencies covered in 2011  
New Hampshire: emergencies covered in 2011  
New Jersey: full coverage in 2011  
New Mexico: full coverage in 2011  
New York: full coverage in 2011  
North Carolina: limited coverage in 2011  
North Dakota: full coverage in 2011  
Ohio: limited coverage in 2011  
Oklahoma: emergencies covered in 2011  
Oregon: limited coverage in 2011  
Pennsylvania: full coverage in 2011  
Rhode Island: limited coverage in 2011  
South Carolina: emergencies covered in 2011  
South Dakota: full coverage in 2011  
Tennessee: emergencies covered in 2011  
Texas: no coverage in 2011  
Utah: no coverage in 2011  
Vermont: limited coverage in 2011

Virginia: no coverage in 2011  
Washington: no coverage in 2011  
West Virginia: emergencies covered in 2011  
Wisconsin: full coverage in 2011  
Wyoming: emergencies covered in 2011

### Adult dental benefits

None	No optional adult dental services covered
Emergency	Only emergency dental services covered
Limited	Covers more than just emergency dental services but not enough to be considered full coverage
Full	Covers extractions and at least preventative, diagnostic and restorative dental services

SOURCE: AMERICAN DENTAL ASSOCIATION

**147TH GENERAL ASSEMBLY****FISCAL NOTE**

BILL:	SENATE BILL NO. 56
SPONSOR:	Senator Hall-Long
DESCRIPTION:	AN ACT TO AMEND TITLE 31 OF THE DELAWARE CODE RELATING TO PREVENTATIVE AND URGENT DENTAL CARE FOR MEDICAID RECIPIENTS.

**ASSUMPTIONS:**

1. This Act is effective upon enactment and subject to appropriation.
2. This Act would expand Medicaid to provide preventative and urgent dental care to all eligible Medicaid recipients, subject to a \$1,000 annual limit (with an additional \$1,500 where authorized by the State Dental Director for emergency care). The bill also imposes a \$10.00 co-pay for each treatment visit.
3. This Act would provide dental care to approximately 216,000 recipients each month.

**Cost:**

Fiscal Year 2014:	\$6,200,000 Purchase of Services
Fiscal Year 2015:	\$6,200,000 Purchase of Services
Fiscal Year 2016:	\$6,200,000 Purchase of Services

Office of Controller General  
June 11, 2013  
KARN:KARN  
4531470005

(Amounts are shown in whole dollars)

ATTACHMENT "F"



DELAWARE HEALTH AND SOCIAL SERVICES  
Division of Medicaid & Medical Assistance

## IMPORTANT INFORMATION ABOUT YOUR HEALTH INSURANCE

### OPEN ENROLLMENT TIME IS HERE!

You are currently enrolled in one of the following health plans:

Delaware Physicians Care, Inc.

United Healthcare Community Plan

Diamond State Partners

Between November 1 and November 26, 2014, you may change your health plan for any reason. You can select from the following health plans:

Highmark BCBS Health Options Inc.

United Healthcare Community Plan

- *All Diamond State Partners clients MUST choose one of the two options. Diamond State Partners is ending December 31, 2014.*
- *All Delaware Physicians Care, Inc. clients MUST choose one of the two options. Delaware Physicians Care, Inc. is ending December 31, 2014.*
- *Please carefully read the information in this mailing to help you choose a health plan.*
- *If you would like to change your health plan, call the Health Benefits Manager (HBM) between November 1 and November 26. The HBM will help you change your health plan. Your new health plan will start on January 1, 2015.*

Call 1-800-996-9969

8 am to 6 pm Monday through Friday and 8 am to 12 pm Saturdays during November 2014

---

## INFORMACIÓN IMPORTANTE SOBRE SU SEGURO DE SALUD

### EL TIEMPO PARA MATRICULARSE HA LLEGADO!

Actualmente usted esta inscrito en uno de los siguientes seguro de salud:

Delaware Physicians Care, Inc.

United Healthcare Community Plan

Diamond State Partners

Desde el 1 de Noviembre hasta el 26 de Noviembre del 2014, usted podrá cambiar su plan de salud por cualquier razón. Usted puede seleccionar uno de los siguientes planes de salud:

Highmark BCBS Health Options Inc.

United Healthcare Community Plan

- *Todos los clientes del Diamond State Partners, Tendrán que escoger uno de las dos opciones. Diamond State Partners terminara el 31 de diciembre del 2014.*
- *Todos los clientes del Delaware Physicians Care, Inc., Tendrán que escoger uno de las dos opciones. Delaware Physicians Care, Inc. terminara el 31 de diciembre del 2014.*
- *Por favor revise la información provista en esta correspondencia para ayudarle con la selección de su plan de salud.*
- *Si usted desea cambiar su plan de salud, llame a la Gerencia de Beneficios Médicos, desde el 1 de Noviembre hasta el 26 de Noviembre. Gerencia de Beneficios Médicos le ayudara a cambiar su plan de salud. Su nuevo seguro de salud comenzara el 1 de Enero del 2015.*

Llame al 1-800-996-9969. Lunes a viernes de 8 am a 6:00 pm, y los sábados de 8 am a 12 pm durante Noviembre 2014

ATTACHMENT "G"

Diamond State Health Plan (DSHP)  
Benefit Comparison Sheet

100% Covered:	Highmark BCBS Health Options Inc.	UnitedHealthcare Community Plan
• Routine doctor office visit, check-up, sick visits	✓	✓
• Well baby, well child visits, immunizations	✓	✓
• Tests and studies, Laboratory and X-ray	✓	✓
• OB/GYN Exams Annual Pap smear	✓	✓
• Pre/post natal care. Includes: Delivery, birthing center, newborn care, and Early discharge home visits for new mothers	MOM Matters (Perinatal Care Program)	Healthy First Steps Program (Perinatal Care Program)
• Family Planning	✓	✓
• Pharmacy	✓	✓
• Routine eye exams for children covered annually and more often if medically necessary for children under 21 • Eye Glasses or contact lenses for children under 21, every 12 months	✓	✓
• Mental Health and Substance Abuse treatment *Children's outpatient visits above 30 are provided through Division of Prevention and Behavioral Health Services	Adults (18 and above): Covered Children (17 and under): *30 Outpatient visits per year	Adults (18 and above): Covered Children (17 and under): *30 Outpatient visits per year
100% Covered	Highmark BCBS Health Options Inc.	UnitedHealthcare Community Plan
• Visits to specialists	✓	✓
• Hospital: Inpatient or Outpatient care	✓	✓
• Ambulatory Service Centers	✓	✓
• Surgery: Inpatient or Outpatient	✓	✓
100% Covered when medically necessary:	Highmark BCBS Health Options Inc.	UnitedHealthcare Community Plan
• Ambulance	✓	✓
• Private duty nursing, home health care	✓	✓
• Durable Medical Equipment	✓	✓
• Physical/Speech/Occupational Therapy	✓	✓
• Skilled Nursing facility	Up to 30 days	Up to 30 days
MCO Provided Extra Services	Highmark BCBS Health Options Inc.	UnitedHealthcare Community Plan
• Disease Management programs with incentives for healthy outcomes	✓	✓
• Digital Home Scale	Provided to members with heart failure	Not Covered
• Dental for Adults	Not Covered	Age 21 and over: One cleaning (prophylaxis) and one periodic evaluation per year, one full mouth series x-ray every three years
• Vision for Adults	Age 21 and above: Eye exams once per year, Eye Glasses or contacts up to \$150 once every 2 years	Not Covered

The Delaware Medical Assistance Card covers your non-emergency transportation services and dental for children up to 21 years of age. Inpatient mental health care for children 17 yrs. and under provided through the Division of Prevention and Behavioral Health Services