Denti-Cal and the Wisdom Tooth(less): A Deeper Drill at a Complex Problem

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About COH:
The Center for Oral Health was founded in 1985 as The Dental Health Foundation with the goal to serve the State Public Health Department in its quest for stronger policies and deeper understanding of the complex issues that affect access to dental care and to achieving optimum health outcomes.

The Center for Oral Health has been the leading non-profit organization in California raising awareness about oral health. It has trained thousands of healthcare professionals regardless of their dental sciences background and established demonstrations projects that improved access to care for millions of underserved children through innovation, research, education, and advocacy.

The views expressed in this brief do not necessarily reflect the views of the Center for Oral Health. This brief is a work in progress and/or is produced in parallel with other briefs contributing to other work or formal publications by Center for Oral Health. Comments are welcome; please direct them to Dr. Conrado E. Bárzaga at cbarzaga@tc4oh.org

Introduction

Despite considerable progress in oral health care achieved over the last 30 years, oral diseases remain highly prevalent. Tooth decay is one of the most preventable common chronic diseases of childhood. Tooth decay can cause significant pain, loss of school days, productivity loss due to missed work days by adults affected by oral diseases, and by parents and guardians of children affected by tooth decay. Due to difficult access to regular dental care many Denti-Cal beneficiaries seek treatment to their oral infections at hospital emergency room, where only palliative measures can be offered and no real dental care is available. If left untreated, oral infections can even lead to death. While most Californians enrolled in Medicaid have coverage for dental care, ensuring access to these services remains a significant challenge.

Additionally, rising costs of health care pose a formidable challenge for policymakers. Health care in the U.S. already accounts for 16% ($ 2.54 trillion) of the Gross Domestic Product (GDP, ~$ 15.9 trillion in 2014) and the cost of health care is projected to increase to 25% by 2025. For many years, policymakers, politicians, and professionals have advanced the *economic* argument that prevention saves money[1], but in California, most of the Medicaid dental expenditures are used to pay for restorative treatment.

In California, policy-makers, consumer advocates, and oral health experts continue to explore how to improve the Medicaid dental care system (Denti-Cal) with many unanswered questions. This brief will expose some of the complex issues that affect oral health outcomes, including provider participation in the Denti-Cal program, geographical distribution of dental care workforce, access to care for Denti-Cal beneficiaries, and the types of services they receive. The intent of this brief is to provide additional context, to inform future analysis, and support formulation of potential solutions.

California Healthcare Landscape

- **High dependency on Medi-Cal:** 1/3 of the State Population depends on Medicaid for health care coverage.
- California is home to over 38 million people, making it the most populous state in the U.S. Of the 38 million people, 12.6 million (nearly 33%) depend on Medi-Cal to pay for their health care needs. [2]
- Medi-Cal represents **only 15.5%** of total general fund spending. [3]

Denti-Cal vs. Medi-Cal Expenditures

- Denti-Cal expenditures **average approximately 1.2%** of Medi-Cal expenditures. [4]
- In the mid 1990s Denti-Cal averaged 2.7% of Medi-Cal expenditures. [4]

Denti-Cal Expenditures vs. Total Expenditures in Dental Care

- Total dental care expenditures in the State of California are estimated at nearly **$18 Billion**.[5]
- **Private insurance** accounted for **47 percent** of dental spending; **out-of-pocket** spending accounted for **42 percent** of all dental spending in 2013.[6]
- In 2009 Denti-Cal expenditures totaled **$915 million**[7], representing **less than 5% of total dental expenditures.**

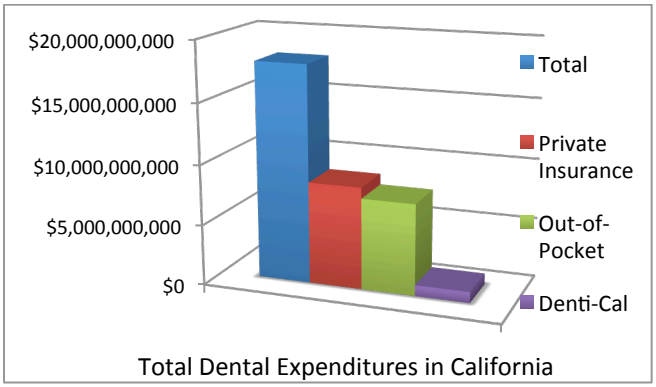

Figure 1. Denti-Cal Expenditures vs. Total Expenditures in Dental Care

Denti-Cal Coverage ≠ Access to Care

- The latest data accessed by The Center for Oral Health (FY 2013-14) exhibits slight improvements in utilization of dental care services for the 0-18 years old population.
- Most utilization, however, happens in age groups in which dental decay and other oral pathologies may already be onset.
- Utilization varies widely among age groups. **Among 0-3 year** old beneficiaries utilization rate is **very low**.
- Utilization varies widely among counties, which may indicate unequal distribution of dental care workforce and resources.
- State average for Denti-Cal fee-for-service (FFS) utilization ranges from 27% in the 0-3 y.o. population to 52% among children between the ages of 6 and 18.
- Among counties with higher poverty rate and lower *dentist:population* ratio like **Imperial County**, benefit utilization ranges from 15 to 33% for the same population groups.

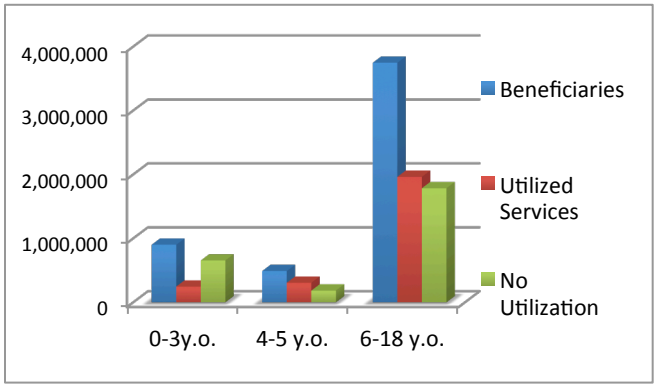

Figure 2. Denti-Cal Fee-for-Service Utilization FY 2013-14

How Denti-Cal dollars are used.

- Over 90% of Denti-Cal payments are made through a fee-for-service schedule. [8]
- Denti-Cal fee-for-service expenditures by dental procedure shows that **most of the dollars are used to pay for restorative care**. [8]
- **Less than 15%** of Denti-Cal expenditures are used **in preventive care** procedures.

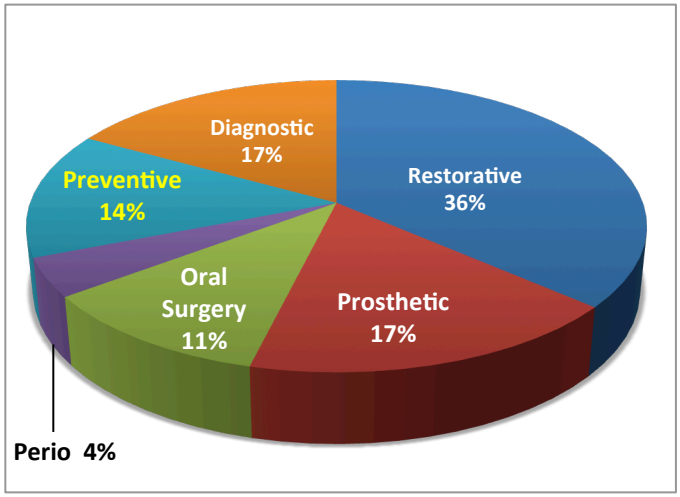

Figure 3. Denti-Cal FFS Expenditures by category.

Conclusions

When 33% of the population depends on an allocation that represents only 5% of the expenditures it becomes morally imperative to solve a problem that disproportionally affects a significant percentage of the State population.

Years of neglect and budget cuts to a necessary program have affected our ability to make immediate and easy corrections.

Although dental disease is preventable, little effort is being made to shift expenditures from restorative care to prevention.

Only 1/10 of each cent of Medi-Cal funds is spent to prevent dental disease. Most of the scarce dollars allocated to the Denti-Cal program are used in restorative care that could be avoided by effective preventive care.

The small magnitude of the Denti-Cal program compared to private insurance and out-of-pocket payments may be a bigger deterrent of provider participation than low reimbursement or payment rates of the program.

Keeping the Denti-Cal understaffed worsens the administrative burden of the program, another point of discontent among providers.

The complexities and magnitude of the challenges faced by Denti-Cal require political courage and profound understanding of the interrelation of public policy decisions and the ultimate fulfillment of societal needs.

Recommendations

- Understand that access to oral health care is complex and multidimensional.
- Understand that different age groups have different oral health care needs.
- Understand that different geographical regions have different oral health care needs and assets.
- Take time to envision long-term solutions.
- Engage a variety of constituents in the pursuit of long-term solutions to the Denti-Cal dysfunctions.
- Learn from past successes in the primary care side of Medi-Cal, which today exhibit high provider participation and high levels of compliance and adherence to preventive measures (e.g well-child visits; prenatal care)
- Decentralize Denti-Cal. Enable equity among counties by giving county or regional entities local control.
- As inspiration, look at the 1992 Health System Reform that resulted in the creation of local initiative health plans, such as L.A.Care Health Plan, the Inland Empire Health Plan (IEHP), and similar agencies in Contra Costa, Alameda, San Francisco, and other regions. It also resulted in the creation of successful County organized health systems, such as CalOptima in Orange County and Central California Alliance for Health in Santa Cruz, Monterey and Merced counties.
- Increase the size of the Denti-Cal program in relation to the overall Medi-Cal expenditures to at least the levels of the 1990s (2.7% of total Medicaid expenditures).
- Innovate. Learn from Accountable Care Organization models organized to improve health outcomes.
- Promote and invest in integrative care models that increase access to care, improve quality, and reduce the cost of healthcare.
- Invest in a more robust Denti-Cal program staff within the California Department of Healthcare Services.
- Improve the transparency of the Denti-Cal program by facilitating timely access to program data to nonprofit organizations that, like the Center for Oral Health, provide unbiased, independent data analysis to inform policy-makers through briefs like this one.

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