Increasing Access to Care for Denti-Cal Recipients: A New Look at Old Barriers

October 2017

Authors:
Sahiti Bhaskara, BDS, MPH
Conrado E. Bárzaga, MD

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

In April 2016, The Little Hoover Commission, an independent state oversight agency, released its report #230 "Fixing Denti-Cal". The report acknowledged Denti-Cal's reputation as broken, dysfunctional or an outright mess. The Report recommended, chiefly, **"a target of 66 percent of children with Denti-Cal coverage making annual dental visits",** which only the State of Texas, has (almost) achieved**.** Additionally, it made a few recommendations on ways to fix the system by the Department of Healthcare Services, the public, and by the same nonprofit organizations that brought complaints to the Legislature in the first place. While the recommendations in the report are valid, it fails to address a root cause of Denti-Cal's dysfunctions: years of budgetary neglect.

This brief will explore some of these remaining issues that affect access to oral health care and health outcomes of California's traditionally underserved. The intent of this brief is to provide additional context, to inform future analysis, and support formulation of potential solutions.

Dental Service Utilization in California

- Utilization of dental care services by Denti-Cal recipients in California exposes great inequities. While those with private insurance exhibit utilization rates of 67%, those with Denti-Cal average 45%.
- Utilization of dental care services in the U.S. averages 48.3%.
- Utilization of dental care services in Texas averages 64.2%.

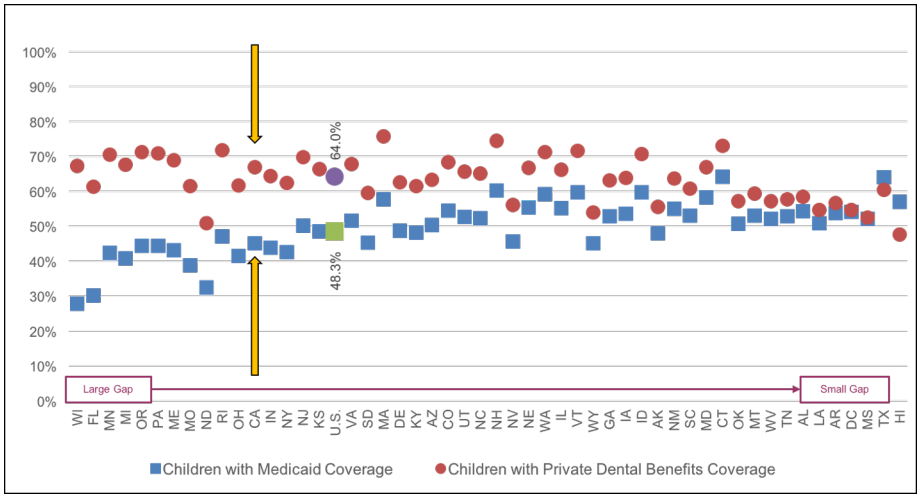

Figure 1. Dental Utilization Children with Medicaid vs. Children with Private Benefits Coverage

Denti-Cal vs. Total Medi-Cal Expenditures

- Dental expenditure amount to only 1.87% of Medi-Cal expenditures.
- While total Medi-Cal expenditures per enrollee in 2014 were $5,342, dental expenditures averaged only $100.00 (1.87%).
- Dental expenditures in the U.S. average 2.22% of the total Medicaid expenditures.
- Medicaid dental expenditures in Texas are $304.00, which amounts to 4.18% of their total Medicaid expenditures. Again, Medicaid recipients in Texas exhibit average dental utilization rates of 64.2%.

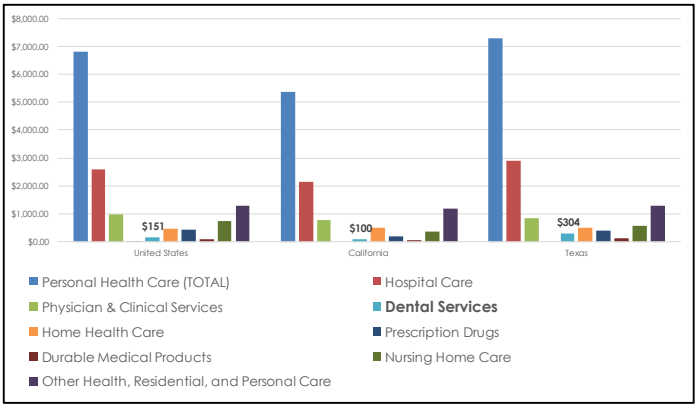

Figure 2. Dental Expenditures vs. Total Expenditures. California, Texas, and National Average

Chronically Underfunded: Denti-Cal Decline

- Denti-Cal expenditures have experienced a steady decline. Denti-Cal expenditures in 1999 were $146.00/enrollee; in 2014 they averaged only $100.00, a decline of 31%. During the same period, dental expenditures increased elsewhere.
- From 1999 to 2014 Medicaid dental expenditures in the U.S. increased from $68.00 to $151.00; in Texas, the increase was from $68.00 to $304.00.

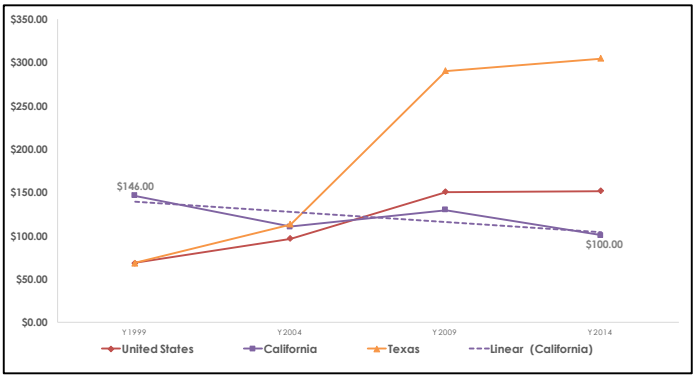

Figure 3. Dental Expenditure Trends: California's Downward Trend

Denti-Cal vs. Private Insurance Payments

- Denti-Cal pays less than 31% of what private insurers pay for similar services.

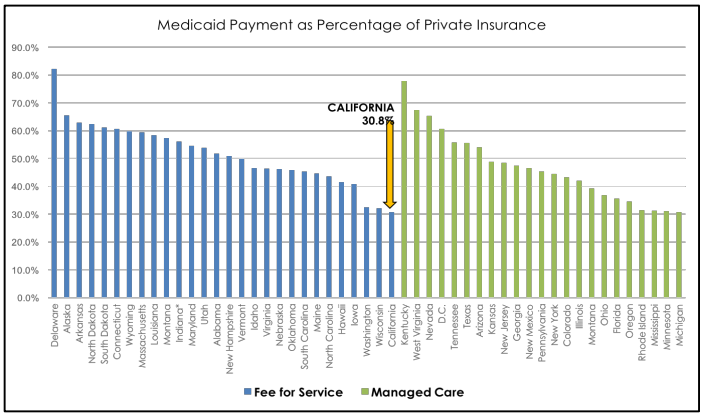

Figure 4. Dental Payments: Medicaid vs. Private Insurance

Geographic Variations of Denti-Cal Utilization

- Utilization varies widely among counties, which may indicate unequal distribution of dental care workforce and resources. Denti-Cal utilization maps resemble poverty maps.
- Coastal communities in general, have higher utilization rates. There appears to be a correlation between concentration of dental workforce resources and higher utilization rates.

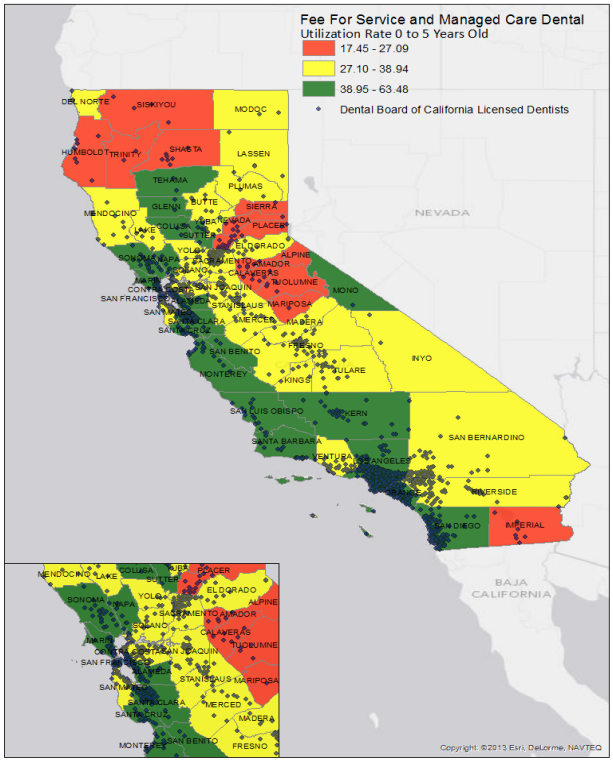

Figure 5. Dental Utilization: Geographic Variations

Conclusions

The 66% utilization rate target recommended by The Little Hoover Commission may require increasing the size of the Denti-Cal program by threefold ($300.00 vs. $100.00).

States that exhibit higher utilization rates also have higher payment rates, as percentage of those made by private insurance. The states with highest utilization rates are: 1) Texas (64%), 2) Connecticut (64%), 3) Idaho (60%), 4) New Hampshire (60%), 5) Vermont (60%), and 6) Maryland (58%). These states, on average pay 53% of what private insurance pay for similar services. Their respective reimbursement rates (as percentage of private insurance payment) are as follows: 55.5%, 60.7%, 46.5%, 51.0%, 49.9%, 54.5%.

The one-size-fits-all approach to Denti-Cal is obsolete. This approach rarely works in healthcare.

Modernization of Denti-Cal is imperative to maximize participation of dental providers, including hygienists, assistants, and other healthcare professionals.

Sound prevention and intervention measures need to be tailored to address the needs of specific groups and communities.

More efforts are needed to shift Denti-Cal expenditures from restorative care to preventive care.

Low Denti-Cal payments, compared to those by private insurance, may discourage provider participation, hindering availability of dental services for Medicaid recipients.

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.

> **"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."**
>
> **-- Dr. Martin Luther King Jr.**

Recommendations

- **Increase Denti-Cal reimbursement rates to levels that effectively reduce oral health inequities.** Denti-Cal reimbursement to providers must be at least comparable to what states with higher utilization rates exhibit; that is at least 53% of what private insurance pays for similar services.
- **Replicate efforts and learn from past successes in the primary care side of Medi-Cal**, that today, exhibits high provider participation and high levels of compliance and adherence to preventive measures (e.g. well-child visits; prenatal care).
- **Diverse health care needs and landscape of California's counties must be considered when funding and program decisions are made** – The newly created State Oral Health Plan by the California State Dental Director is a great example of this. Decentralizing Denti-Cal gives counties the power to implement strategies that place focused attention on their population's needs while evaluating successes and shortcomings closely to adapt with time. This is sure to enable equity between counties to minimize geographic disparities.
- **Promote local initiative health plans and health systems that are evidence-based and accountable.** For example, the 1992 Health System Reform 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.
- **Promote and invest in integrated care models** that increase access to care, improve quality, and reduce the cost of healthcare – help achieve the Triple Aim.
- **Increase data transparency of the Denti-Cal program** by facilitating timely access to program data to think tanks and nonprofit organizations like the Center for Oral Health, enabling unbiased, independent data analysis to inform policy-makers.

References/Sources

1. Little Hoover Commission. Report #230. Fixing Denti-Cal. April 2016. Accessed on October 15, 2017 at: http://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/230/Report230.pdf
2. Woolf SH, Husten CG, Lewin LS *et al.* The economic argument for disease prevention: distinguishing between value and savings. Partnership for Prevention & National Commission on Prevention Priorities, Feb. 2009. Accessed on June 24, 2014 at: https://www.prevent.org/data/files/initiatives/economicargumentfordiseaseprevention.pdf
3. Center for Oral Health. Issue Brief: Denti-Cal and the Wisdom Tooth(less): A Deeper Drill at a Complex Problem. September 2015.
4. Kaiser Family Foundation. State Health Facts. Total Monthly Medicaid and CHIP Enrollment. June 2015. KFF.org
5. Estimates are calculated based on CMS Data. Total Medicaid personal health care spending by state and by service, 1991-2014. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Accessed on October 20, 2017 at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData.html
6. Estimates are calculated based on CMS Data. Total Medicaid personal health care spending by state and by service, 1991-2014. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Accessed on September 21, 2015 at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html
7. Estimates are calculated based on CMS Data. Centers for Medicare & Medicaid Services. Accessed on October 19, 2017 at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads
8. National Health Expenditures 2013 Highlights. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Accessed on September 21, 2015 at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf
9. Total Medicaid personal health care spending by state and by service, 1991-2009. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Accessed on September 21, 2015 at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html
10. California HealthCare Foundation. Denti-Cal Facts and Figures. 2010. Accessed on September 1, 2015. http://www.chcf.org/
11. Gupta N, Yarbrough C, Vujicic M, Blatz A, Harrison B. Medicaid fee-for-service reimbursement rates for child and adult dental care services for all states, 2016. Health Policy Institute Research Brief. American Dental Association. April 2017. At: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0417_1.pdf.
12. The Oral Health Care System: A State-by-State Analysis. Health Policy Institute Research Brief. American Dental Association. 2017. Available at: http://www.ada.org/en/science-research/health-policy-institute/oral-health-care-system