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Improving Adult Access to Oral Health Care in California Medicaid: Recommendations for Advancing Oral Health from Coverage to Care

California is one of 17 states that provides comprehensive oral health care for adults in its Medicaid program. Given the state's size, its oral health benefit covers more Medicaid-eligible adults than any other state – over 7 million adult beneficiaries in total.[1]

As is the case nationwide, adults in low-income households in California experience disproportionately high rates of dental disease and are more likely to report poor oral health.[2, 3] Among low-income Californians, racial minorities face even greater disparities, with adults listing their race as black, Hispanic, or "other" being less likely to access dental care and more likely to report oral health problems.[4] The research clearly demonstrates that poor oral health is associated with numerous chronic diseases outside the scope of dental disease, including diabetes and stroke, negative pregnancy outcomes, and many mental health conditions.[5,6] Recent evidence even links poor oral health to Alzheimer's disease.[7]

In light of these troubling findings, California, a state that often leads the way in addressing public health issues, fully restored oral health benefits for low-income adults enrolled in Medicaid this past year. However, this has not always been the case: In 2008, the state eliminated adult dental coverage due to financial shortfalls stemming from the "great recession." The state partially reinstated the oral health benefit in 2014 and fully reinstated it in 2017, with coverage effective January 1, 2018.[i]

New data from California's Medicaid adult dental program, however, show that utilization rates among low-income adults remain well below the levels they reached before the benefit was cut in 2008. These rates indicate that the program is not meeting the oral health care needs of adult enrollees. Disruptions in the state's Medicaid dental benefit over the last decade seem to have interfered with utilization of services by eligible enrollees, and more action is necessary to connect enrollees with oral health care. The state must take additional steps, beyond coverage, to ensure

[i] From 2009 to 2014, California covered only emergency dental services for adults in Medicaid. In 2014, the state partially restored dental coverage to include a limited set of services. In 2018, the state fully restored coverage, which now includes initial and periodic exams, prophylaxis, fluoride, restorative services (such as amalgams, composites, and prefabricated crowns), laboratory-processed crowns, scaling and root planning (also known as "deep cleaning"), periodontal maintenance, anterior and posterior root canals, partial and full dentures, extractions, oral and maxillofacial surgery, and emergency services. More details on covered services are available in the "Denti-Cal Bulletin" at https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/Volume_33_Number_14.pdf.

Medicaid enrollees understand the dental benefit and have access to the services they need to support their oral health.

This brief examines utilization of California's Medicaid adult dental benefits, identifies barriers that prevent adults from accessing oral health care, and offers recommendations for how the state can help more low-income adults get the oral health care they need.

Utilization of Adult Dental Benefits Remains Low, Despite Improvements in Coverage

Oral health care is an optional benefit in Medicaid – states are not required to provide oral health coverage to their adult enrollees. Further, states that choose to offer this optional benefit retain complete flexibility to change the scope of or discontinue coverage at any time. As mentioned previously, while California Medicaid currently covers a robust set of dental services for adults, the state legislature has changed the scope of Medicaid adult dental benefits three times in the past decade. Utilization trends show that coverage alone is not enough to ensure that adult Medicare enrollees can access oral health care.

A study on the impact of eliminating California's Medicaid adult dental benefits found the use of dental services dropped dramatically after the state cut coverage.[8] Before the benefit cut, 35% of adults enrolled in the state's fee-for-service (FFS) Medicaid dental program[ii] used their dental benefits.[9] When services were eliminated, that number plummeted to 12% and consisted of only a small group of people whose services were exempted from the cut.[10]

When the state reinstated partial benefits in 2014, utilization rates began to improve, but at a very slow pace. Even after the state fully reinstated benefits in 2018, utilization rates have not returned to pre-elimination levels. This data indicates that changes to the Medicaid oral health benefit had – and are continuing to have – a lasting, negative effect on the rates of low-income adults who are getting oral health care in California.

Data on oral health status and care utilization indicate that despite the full reinstatement of the Medicaid dental benefit, the oral health needs of low-income adults are not being met.[11] In the year after California fully restored adult dental coverage in its Medicaid program, utilization of the benefit remained low. Utilization data shows that less than one quarter (23.3%) of eligible adults had a dental visit in 2018.[12] The percentage of adults who accessed preventive services is even lower (13.7%). In contrast, fully three-quarters of adults with incomes above $50,000 had a dental visit in the last year.[13] Unsurprisingly, the most recent oral health report from California's Department of Public Health concludes that low-income adults experience disproportionately high rates of oral disease, with even higher rates among communities of color.[14]

[ii] Over 90% of adults with Medicaid in California receive their dental benefits through fee for service. Beneficiaries in Sacramento County are enrolled in dental managed care plans. And in Los Angeles County, beneficiaries can opt in to dental managed care plans. See https://www.dhcs.ca.gov/services/Pages/DentalManagedCare.aspx to learn more.

Low-Income Adults in California Continue to Face Barriers to Accessing Oral Health Care

While California's reinstatement of the full Medicaid oral health benefit has been a critical development, the state should take additional actions to improve access to care and utilization rates. To make real strides in oral health, California must look for opportunities to help more Medicaid enrollees get the care they need.

California is often a national leader in developing, testing, and implementing effective delivery models for health coverage and care. Given the state's wise decision to reinstate comprehensive oral health coverage, it is important to better understand why low-income adults are not getting the high-quality, comprehensive oral health care they should have access to through Medicaid. Understanding the barriers they face will not only provide insight into the next steps California policymakers should take to ensure coverage is actually translated into adults getting the care they need, it will also serve as a guide for other states that are interested in expanding their oral health benefit and developing effective oral health systems.

In California, the commonly cited barriers include:

- **Disruptions in oral health coverage:** Disruptions in the Medicaid adult oral health benefit have created confusion for enrollees, strained relationships between providers and the Medicaid program, and undermined outreach and education efforts.
- **Insufficient knowledge and/or outreach about covered services:** A significant number of adults with Medicaid either don't know that their Medicaid benefit also covers oral health services or don't understand how to access these services. This is especially true for enrollees with limited English language proficiency.
- **Lack of oral health providers:** Few of California's oral health providers participate in Medicaid, making it difficult for adults with Medicaid to find a source of care in their communities.

To make real strides in oral health, California must take action to help more Medicaid enrollees get the care they need.

Recommendations to Ensure that Adults Can Get the Oral Health Care They Need

Despite the return to a robust adult dental benefit, the vast majority of eligible, low-income Californians are not obtaining oral health services. Implementation of several common sense policies would go a long way toward solving this problem. California policymakers should consider the following recommendations:

1. Maintain Comprehensive Dental Coverage
2. Expand Outreach Activities to Reach Families More Directly
3. Support and Expand the Medicaid Oral Health Care Provider Network
4. Continue to Engage Stakeholders in All Efforts to Improve the Medicaid Adult Dental Program

As part of the California Department of Health Care Services' "California Advancing and Innovating Medi-Cal (CalAIM) Initiative", California is proposing to move consolidate physical, behavioral, and oral health under managed care entities in the future. No matter what structure California ultimately uses, it will still need robust benefits and outreach and improved provider participation, as described in the recommendations below.

Recommendation 1: Maintain Comprehensive Dental Coverage

Maintaining comprehensive dental coverage in Medicaid for adults – without cuts in services -- is critical to ensuring that low-income Medicaid enrollees have appropriate access to oral health care services. Reductions or disruptions in oral health coverage can dramatically decrease care utilization, which can take decades to recover.

A closer look at the current utilization data demonstrates how important comprehensive coverage is to keeping Californians healthy. For example, deep cleanings,[iii] a service added in the coverage expansion of 2018, was the most utilized dental service in the first year of that coverage. Statewide, close to half a million deep cleanings were performed.[15] Deep cleanings treat gum infections (periodontitis) and can significantly improve both oral health and overall health.[16]

To improve access to oral health care, California should maintain – if not expand – the oral health services it currently covers for adults with Medicaid.

[iii] The covered service is formally called "root scaling and planing."

Nationwide, approximately 42% of adults over age 30 have gum infections, which research shows can worsen other health issues like heart disease, lung disease, and diabetes.[17] Studies show that treating gum infections, which includes deep cleanings, can even produce health care savings when offered as part of diabetes treatment plans.[18]

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Recommendation 2: Expand Outreach Activities to Reach Families More Directly

A robust outreach program can ensure that adults who rely on Medicaid for their health and dental coverage understand their benefits and know how to get the care they need. While California already contracts with a benefits manager to conduct outreach activities and improve benefits use, there are a number of ways that this contract and subsequent outreach activities could be improved.

The Department of Health Care Services (DHCS) currently contracts with Delta Dental, a benefits manager, to oversee beneficiary and provider outreach activities. The contract holds Delta Dental responsible for increasing benefits use each year.[19] Delta Dental's current outreach activities include:

- "Smile, California," a public communications campaign to promote oral health education and raise awareness of available benefits.
- Some direct contact with current Medicaid enrollees, including a call to encourage rescheduling of a missed appointment, and contacting families when their child is due for a dental visit.
- Informational mailers sent quarterly to new enrollees on how to contact the benefits manager.

While these activities are a good start, additional direct and regular contact strategies could more effectively connect people with care. These outreach activities could include:

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- Deployment of outreach workers, including dental hygienists, dental assistants, and community health workers, in targeted community locations and clinics to promote oral hygiene and educate people about Medicaid benefits.
- A call center run by outreach specialists who arrange members' dental appointments and transportation, if necessary. Medicaid enrollees would be encouraged to use the call center to schedule appointments with specialists rather than using provider directories.
- Automated calls to individuals who have not seen a dentist in the previous year, made during their birth month.

In addition to using better outreach services, the benefits manager should make outreach materials available in the primary languages spoken by beneficiaries. This is particularly important in California, a state in which 40% of people eligible for Medicaid reported a language other than English as their primary language.[20]

The existing Delta Dental contract requires that "Smile, California" materials be produced in English and Spanish.[21] The program has a separate plan for additional translations or adaptations for other common languages[iv] spoken by Medicaid beneficiaries. But in reality, access to translated outreach services and information is limited. Currently, a tagline on materials informs enrollees who speak a different language to call a number for language assistance services. However, numerous advocates for California's Medicaid enrollees report that many enrollees call and are unable to speak to a representative in their own language.[22]

Improving language access practices at Delta Dental's Telephone Service Center and ensuring that all vital documents are translated into all common languages in California would go a long way toward improving outreach and increase utilization.[v] This would also aid California in better aligning with federal language access requirements.

In addition to using better outreach services, the benefits manager should make outreach materials available in the primary languages spoken by beneficiaries.

[iv] The Medi-Cal Eligibility System defines a threshold language as the primary language of 3,000 beneficiaries, or 5% of the beneficiary population, whichever is lower, in an identified geographic area.

[v] In June 2019, over 25 California advocacy organizations sent a letter to DHCS, titled "Language Access Issues in DHCS' Medi-Cal Dental Division," that explores these language access problems in more depth and proposes more detailed policy solutions.

Medicaid enrollees with limited English proficiency (LEP) also face difficulties finding providers who speak their language, making the task of navigating coverage and care a significant challenge. Neither Delta Dental nor DHCS currently collects information about which languages are spoken by fee-for-service oral health providers. While managed care providers are required to report this information, only a small portion of Medicaid enrollees are covered by dental managed care plans.[23] Thus, this requirement is of limited value.

Strengthening FFS benefits manager contracts and related outreach plans and activities, and providing strong state oversight of this function, could help increase dental utilization among low-income adults, especially in potentially hard-to-reach groups. California should:

1. Upgrade member communication by employing more robust, direct-to-consumer, and community-based outreach tactics to inform members and help them use their benefits.
2. Improve Telephone Service Center practices and ensure all vital documents are translated into all common languages to help beneficiaries with limited English proficiency understand and access their coverage and care.
3. Collect information on the language spoken from all providers to help beneficiaries with limited English proficiency connect with a provider who speaks their language.
4. Revise future benefit manager Request for Proposals and contract language to incentivize more direct outreach and improved language access, and to give the state the power to hold the benefit manager accountable for results.

Recommendation 3: Support and Expand the Medicaid Oral Health Care Provider Network

Ensuring that there is an adequate supply of oral health providers who participate in Medicaid is crucial to improving adult utilization of oral health care services. Currently, California has nearly 30,000 professionally active dentists, but only 15.4% of them accept Medicaid dental.[24, 25] That means there are only about 4,500 dentists to treat over 7 million adults enrolled in Medicaid. This figure underscores the program's inadequate provider network and daunting service accessibility challenges. In contrast, more than 50% of physicians accept patients enrolled in the state's Medicaid program.[26]

Currently, California has nearly 30,000 professionally active dentists, but only 15.4% of them accept Medicaid dental. That means there are only about 4,500 dentists to treat over 7 million adults enrolled in Medicaid.

There are multiple factors[vi] that can explain the shortage of providers in Medicaid's dental network, but a principal one is reimbursement rates. While California has increased Medicaid dental reimbursement rates in recent years, they remain among the lowest in the country, and insufficient to attract providers. Moreover, this rate increase is set to expire in 2021. Current reimbursement rates in California are only about 44% of commercial rates, far behind states like North Dakota (66.5%), Alaska (63.2%), and Montana (62%), which provide the highest Medicaid FFS reimbursement rates relative to private dental insurance.[27]

Expanding the oral health workforce would also alleviate access challenges caused by low dentist participation. There are a number of ways to do this, including training new types of providers, such as dental therapists; changing scope of practice and supervision requirements to allow existing providers, like dental hygienists and registered dental hygienists in alternative practice (RDHAPs), to provide all care allowed under their license, and/or outside of a dental office; and integrating other health providers into the oral health care system. [28]

To increase the number of and improve access to oral health providers, California should:

1. Increase reimbursement rates to strengthen and ensure Medicaid's dental provider network is sufficient to provide beneficiaries with timely, conveniently located oral care. At a minimum, the state legislature should not allow the recent rate increase to expire in 2021.
2. Explore workforce expansions, such as authorizing dental therapists as a new provider type or expanding dental hygienists' and RDHAPs' scope of practice. Ensure that all dental providers can practice at the "top of their license" without overly burdensome requirements that prevent them from doing so.

While California has increased Medicaid dental reimbursement rates in recent years, they remain among the lowest in the country, and insufficient to attract providers.

[vi] Additional factors include strained relationships between the state's dentists and the program's benefits manager, as well as a provider enrollment process that is seen as burdensome and dissuades participation.

Recommendation 4: Continue to Engage Stakeholders in All Efforts to Improve the Medicaid Adult Dental Program to Best Meet Enrollees' Needs

As policymakers focus on program improvements over time, they should continuously engage with key stakeholders to understand how the Medicaid adult dental program is working and what improvements need to be made. These stakeholders include Medicaid enrollees, advocates, public health and oral health experts, dental plans, and providers.

An important way the state currently engages stakeholders on this issue are the DHCS Medi-Cal Dental Stakeholder Meetings.[29] Currently, these meetings occur every other month in Los Angeles and six times per year in Sacramento. These meetings offer a way to identify strategies on how DHCS can improve oversight of Medicaid dental to increase utilization and improve how it delivers oral health care. For advocates, these meetings offer an essential opportunity to provide feedback to DHCS about beneficiary experiences with Medicaid dental, and to gather timely updates on the program's performance -- updates that are not available elsewhere.

Ongoing stakeholder engagement allows the state to hear directly from those closest to the program about existing problems and emerging concerns, as well as the opportunity to identify, refine, and prioritize needed policy changes. At a minimum, California should:

- Continue to host stakeholder meetings on a regular basis to gather and evaluate feedback to improve the Medicaid adult dental program. Meetings should also continue to ensure that stakeholders in affected by the program receive regular program updates and performance data.

States have much to learn from California's experience in implementing a Medicaid oral health benefit for adults.

Conclusion: Improving Oral Health Care Matters for California, and Across the Nation

Affordable, accessible, high-quality oral health care services are crucial to the overall health of our nation. Making sure that low-income adults can obtain these services requires a particularly concerted effort. California is a leader in terms of offering robust oral health coverage to its adult Medicaid beneficiaries, but it falls short when it comes to educating enrollees about their benefits and helping them get high-quality care to improve oral health outcomes.

States have much to learn from California's experience in implementing a Medicaid oral health benefit for adults, especially how important it is to provide Medicaid enrollees with a stable source of comprehensive coverage. California has built a strong foundation of coverage for its most vulnerable populations -- now the state must continue the work necessary to make sure enrollees are able to get the dental care they need. Nationwide, other states can apply the lessons learned from California, both in terms of the value of offering a comprehensive oral health care benefit for adults in Medicaid, but also the importance of developing the mechanisms, systems, and supports that are necessary to ensure enrollees are actually able to access the services they need.

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Produced in partnership with Justice in Aging and the California Pan-Ethnic Health Network (CPEHN).

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