

## Testimony of Jared I. Fine, DDS, MPH for the

### Little Hoover Commission Hearing on the Denti-Cal Program - November 19, 2015

I am very encouraged that the Little Hoover Commission is evaluating the quality and availability of Denti-Cal-provided oral health care for the millions of California beneficiaries it is intended to serve. More specifically, in this second hearing, I am pleased to contribute to your exploration of potential improvements to broaden the supply of participating dentists and available care. Perhaps most importantly, I hope to contribute to your understanding of ways that targeted investment using successfully demonstrated models can reap both short and long term improvements in the oral health of California's most vulnerable.

As the Dental Health Administrator of the Alameda County Public Health Department for nearly 40 years, I was confronted by the day in and day out experience of attempting to address the epidemic level of dental disease in our young children and their families - from, the toddlers who waited months for treatment under general anesthesia in the operating room because they were too young to be able tolerate treatment for extensive dental decay in an office setting, to tooth-decay-ravaged kindergarteners too embarrassed to smile; to elementary school students who were mysteriously disruptive only to be relieved when their dental conditions were discovered and the source of unrelenting dental pain treated.. In fact, the Alameda County's Oral Health Needs Assessment of public school students, 2005 revealed that by kindergarten 30% of **all** students had untreated decay. It also documented that **students from low-income families had nearly twice the level of untreated dental decay and only half the benefit of preventive dental sealants** as compared to their counterparts from more affluent families. In each case this is far below the USPHS Healthy People Objectives for the nation. Similar findings have been documented in each of the California's own statewide oral health needs assessments of kindergarten and 3<sup>rd</sup> grade school children in both 1993-94 (California Oral Health Needs Assessment of Children 1993-94) and 2005 (California Oral Health Needs Assessment 2005).

When we initiated a dental program at the Alameda County-operated Women, Infants and Children (WIC) Nutrition Supplementation Program sites, which serves virtually the same population as that eligible for Medi-Cal, we found that as early as 9 and 15 months of age, 20% of the infants and toddlers had already developed clinical evidence of the dental infection (white spot lesions) or frank decay on their “baby” teeth; and by age 5, that proportion had risen to 70% having experienced tooth decay. This is particularly disconcerting since we know that dental decay while, epidemic, is with appropriate early preventive and health promoting practices, nearly 100% preventable.

The California Audit Report (December 2014) of the Denti-Cal Program revealed that in FY 2012-2013 fewer than 47% of beneficiaries under 21 had received the benefit of dental services to which they were entitled. The California HealthCare Foundation (CHCF, 2004) report *Denti-Cal Facts & Figures*, showed that the percentage of 0-5-year-old Medi-Cal children who saw a dentist at least once in the preceding year was only 9% for 1 year olds, only 30% for all those ages 2-5 years. Many reasons have been cited to explain why access to dental care for young Medi-Cal beneficiaries so low. For example:

- Parents are unaware their children have dental coverage or have difficulty locating care. The 2003 California Health Interview Survey (CHIS) found that 30% of parents whose children were enrolled in Medi-Cal didn't know they were eligible for dental benefits. When a family enrolls in Medi-Cal, the information they receive does not always make it clear that dental coverage is included. Parents who do know that they have coverage often find that they cannot locate an accessible dental office willing to provide care.
- Parents often lack information about the value of early care. Too often the public is uninformed about the important role of deciduous teeth believing that they will fall anyway and be replaced by permanent teeth. Too often this is reinforced by the mere fact that dental offices suggest the child be appointed when they are “older”.
- Providers are not adequately trained to care for young children. Many dentists receive minimal or no experience caring for young children as part of their dental school education. Consequently, they are uncomfortable working with these children.
- Providers prefer older children or adults in their practices. Most general dentists are more comfortable treating older children and adults in their practice. They may believe that young children will be disruptive to other patients and there is little incentive to do so.

- Low fees. Denti-Cal fees are far below market rates—so low that many dentists refuse to accept the coverage.

In 2013 there were more than 5.5 million children and youth (0 to 21) enrolled in the Medi-Cal dental program and utilization rates were below 47%. With the expansion of enrollment in Medi-Cal through both the Affordable Care Act, as well as coverage for 8 million adults, the program is challenged to respond to the needs of over 13 million Californians – with no concomitant increase in the capacity of dental providers to serve this astronomical growth. These facts compel us to recognize that doing business as usual is simply no longer an option and that innovative approaches are in order. If there were ever a time to consider going upstream to invest more heavily in preventing the disease before it begins, to find ways to encourage more providers to participate and reduce the downstream effects of the disease and needless preventable suffering, as well as to reduce more costly treatment costs, now is that time.

My primary purpose in this testimony is in sharing a California success story of the Alameda County Healthy Kids, Healthy Teeth program and the opportunities it reveals to accomplish just those goals.

### **Alameda County's Healthy Kids, Healthy Teeth Program**

**Background:** As borne out by the tooth decay prevalence just summarized, dental decay or dental caries in infants and toddlers, also known as Early Childhood Caries (ECC), can, in the absence of education to health-promoting dietary choices and preventive dental practices and interventions, develop as early as 6-10 months of age, when the deciduous or baby teeth first erupt into the child's mouth. As a result, over the past 15 years, a broad consensus had emerged in the dental, pediatric and public health community that a child's first dental visit should occur by age 1. This allows dental problems to be detected before they become more difficult and costly to treat. This policy is currently recommended by the American Academy of Pediatrics, American Dental Association, American Academy of Pediatric Dentistry, American Association of Public Health Dentistry, as well as the California's own Child Health and Disability Prevention Program.

Recognizing that access to dental care for young children was a nationwide problem, the Centers for Medicare & Medicaid Services (CMS) issued a Request for Proposals in 2000 for programs to address “innovative management of dental decay for young children enrolled in Medicaid/SCHIP.” The California Department of Health Services responded by submitting a proposal that created the Healthy Kids, Healthy Teeth program (HKHT), which was funded as a national demonstration project to be conducted in Alameda County, awarded by the Center for Medicaid and Medicare Services (CMS) (with subsequent funding from the Health Resources and Services Administration [HRSA]). The program was designed to address the early onset of dental caries, the progressive nature of the dental caries infection, if untreated, leading to the need for more extensive and costly care, and the fact that access to dental care and utilization rates for children were abysmally low. The program was in part inspired by the success of the State of Washington Access to Baby and Child Dentistry (ABCD) Program, although modifications were made to maximize program success the potential despite significant differences in California.

Goals: HKHT, administered by the Medi-Cal Dental Services Branch, in partnership with the Alameda County Health Care Services Agency and the UCSF School of Dentistry, was aimed at:

- 1) Increasing access to dental care to dental care for Medi-Cal-eligible children ages 0-5 in Alameda County,
- 2) increasing the use of preventive dental care services for Medi-Cal-eligible children ages 0-5 in Alameda County and,
- 3) reducing or controlling the cost of dental care among 0-5-year-old Medi-Cal children in Alameda County.

Objectives and Methods: The program was designed to accomplish these goals by:

1) **Conducting aggressive outreach to recruit families of 0-5-year-old children enrolled in Medi-Cal.** Program staff developed and distributed promotional materials and made direct contact for presentations to agencies, programs and organizations that presented the opportunity to educate and engage Medi-Cal eligible and/or enrolled families including, for example, Head Start and Early Head Start, state and private pre-schools, WIC,

individual pediatric medical practitioners, Medi-Cal enrollment assisters, staff of community clinics, early childhood education programs, childcare centers, programs targeted to high risk families such as Comprehensive Perinatal Services (CPSP), community based organizations.

**2) Orienting enrollees on office expectations and responsibilities, helping to resolve barriers to care, and providing case management services, including linking families with participating providers.** Community health outreach workers (CHOWs) who mirrored the language and culture of the target population engaged with families in person or by telephone and provided education including, for example, the value of primary teeth, the importance of dental care and expectations regarding getting care and of the dental patient. CHOWs assisted families in overcoming barriers of language, transportation and geography to enhance successful access to and utilization of care with a participating dentist.

**3) Recruiting, training and certifying dental providers on child management, caries risk assessment, family education, and use of preventive agents.** Medi-Cal dental providers were recruited both by direct mail and through the newsletters and presentations to the 3 local dental societies. As part of the recruitment effort, dentists and their office staffs were invited to participate in a special one-day continuing education training, provided by UCSF and University of Washington dental school faculty (the faculty that conducted the dentist training in the ABCD program in Washington State). Instruction included child management, caries risk assessment, family education, use of preventive agents, for example, including fluoride varnish and fluoride releasing materials. Instruction also included emergencies, billing and claims processing. Special emphasis was placed on claiming for Family Oral Health Education (FOHE) a 5-part anticipatory guidance preventive educational service, that was funded and administered locally by Alameda County and introduced to complement the Medi-Cal-covered dental benefits.

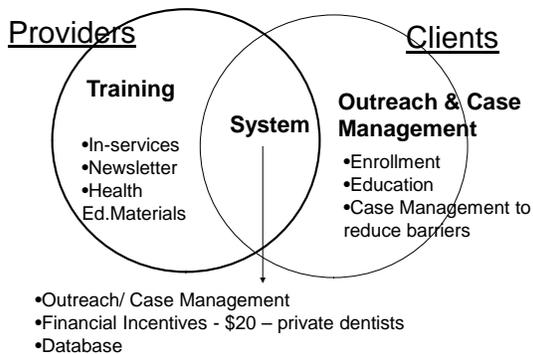
**4) Assisting families to access these dental services from certified dental providers.**

Community health outreach workers had principle responsibility for educating and engaging families via the aforementioned agencies and programs. Cultural sensitivity, language capability and problem solving were integral to assuring that clients were

successful in getting to and utilizing the services of dental offices to which they had been referred. Case management and patient navigation was facilitated by the development a data base that was developed to document basic demographic information of clients enrolled in the program, and to track and manage referrals provided.

**5) Offering a modest financial incentive to dental providers certified by the project who care for project enrollees.** Unlike in Washington, where the ABCD program certified dentists through continuing education training and reimbursed those dentists an augmented fee for selected services, the budget crises in California prohibited such an approach. Instead, Alameda County committed as part of the federal application to fund the fee that certified dentists would be paid for the anticipatory guidance preventive and educational counseling service not covered by the Medi-Cal dental program. Family Oral Health Education (FOHE) is a valued enhancement to existing reimbursable services and includes: (1) risk assessment, (2) “lift the lip” caregiver training to look for evidence of early infection in the mouth of the young child, (3) teeth cleaning training for caregivers, (4) dietary counseling, and (5) fluoride supplements. Those dentists who completed the course and committed to accept referrals were offered a contract explicitly describing the elements of the family oral health education (FOHE). FOHE is a billable service (\$20 per instance) when provided in conjunction with a topical fluoride varnish application (reimbursed by Medi-Cal), no more than 2 times per year within 12-month period. The same billing document used by the Denti-Cal program was employed and a billing code was created for the service and it was administratively processed and paid by Alameda County.

HKHT System Figure 1.



In essence the program was designed as a “system” (Figure 1). to facilitate and sustain an increase in both provider willingness to care for young children and increase the number of clients who would successfully avail themselves of their dental services by removing the barriers experienced by both dentists as well as clients.

**Results:** Data from the HKHT program show it has been quite successful at increasing children’s early access to dental care. During the period of the grant project (2003-2006) utilization of Medi-Cal dental services (Figure 2.) for those 0-5 year olds enrolled in the Healthy Kids, Healthy Teeth Program was 70% as compared with 28% utilization of services by their 0-5 year old counterparts in Alameda County not enrolled in HKHT. These findings were derived from claims paid data that matched the Medi-Cal number with the services provided.

Figure2.

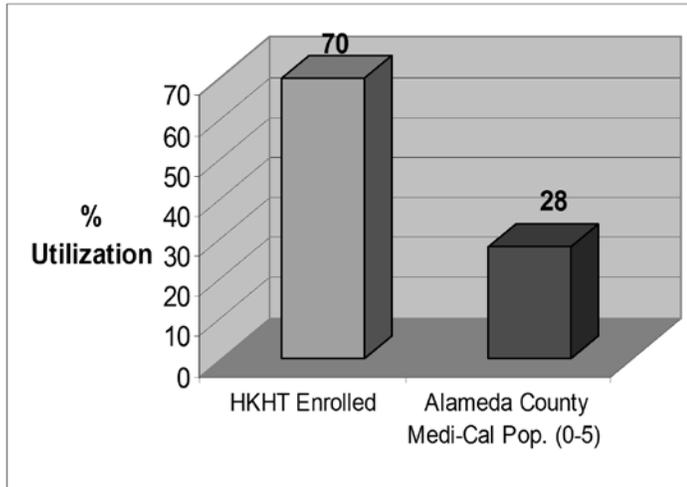
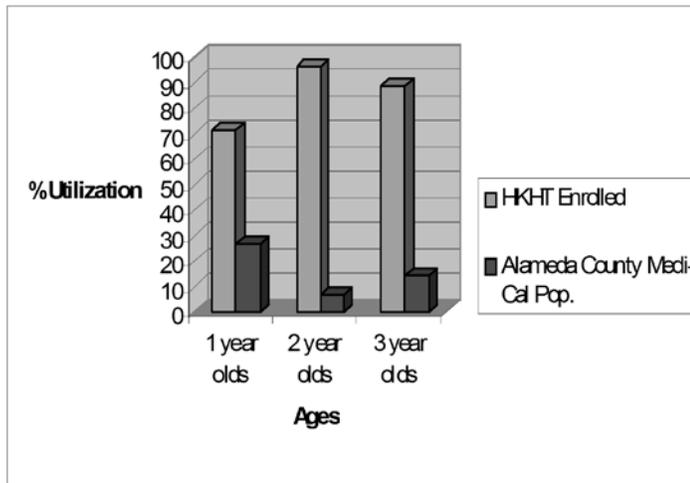


Figure3.



Utilization of services by age at entry into the program (Figure 3.) showed dramatic increases in utilization of services especially at ages 1, 2 and 3 for those enrolled in HKHT as compared to their Medi-Cal Alameda County counterparts not enrolled in HKHT. By February 2006, there were 2,428 0-5-year-olds enrolled in Healthy Kids, Healthy Teeth. The number of participating dentists varied from 12 to 15 over the period of the grant. One goal of the grant was to determine reduction in cost. The UCSF evaluator who analyzed the program found that HKHT participants with earlier ages at first visits treated by private practitioners had lower total visit costs when summarizing the cost of care for their first four visits for care. This finding is consistent with findings of a study of North Carolina's Medicaid program, which found that for 0-5-year-old

children continuously enrolled in Medicaid for five years, if their first preventive dental visit occurred before age 1, cumulative costs over five years were 40% lower than if their first preventive visit occurred later than age 1. More extensive and long term results have been published regarding the very successful ABCD program in Washington which has dramatically increased access to care for children ages 0-5 years.

### **Lessons Learned**

*Client support:* Locally-employed community health outreach workers who reflect the population they serve are critical to engaging, educating, empowering and supporting families in navigating their way to being successful dental care consumers. A database, to which that local program staff and administrators have access to track case management and care coordination, enables program monitoring, operations, evaluation and reporting. In addition, incentives, educational materials and support calls facilitate the success with families. A combination of general fund support, matched with Federal Financial Participation Medicaid administrative funding through the CHDP and MCH program in Alameda County, has continued to assure the sustainability of those staff beyond the original grant support.

*Provider support to increase pediatric dental workforce:* Targeted continuing education training as described to certify dentists and enable their comfort, confidence and skill in care for young children is essential. Developing, nurturing and sustaining the network requires periodic program updates, expectation setting, “warm line” for professional and administrative problem solving and developing a partnership with local program staff who interact with their clients and the dental office staff. The HKHT project initially enrolled dentists from within the existing pool of Med-Cal dental care, however, that provider pool has eroded. In order to attract new dental providers to Medi-Cal and to sustain current providers to serve this population of young at risk children, the State would be well served to follow the successful example of ABCD and enhance rates for certain key services that emphasize prevention and basic treatment for the very young children which will both expand access and which set the stage for a lifetime of good oral health.

### **Additional Thoughts and Conclusion**

The evidence is indisputable. California is seriously challenged to improve access to care for its most at-risk populations and determine how best to maximize its resources to do so. Fortunately, dental disease and the needless suffering it causes, is preventable when relatively low-cost interventions are employed and if initiated at an early age. Targeted programmatic improvements that emphasize education and engagement of families of young children, training for dentists and targeted financial incentives, as demonstrated in both the Healthy Kids, Healthy Teeth Program and in Washington's ABCD Program, show promise in expanding access to care and should be given serious consideration.

I can envision a similar program for pregnant women using the same model. Research has shown that women who have untreated dental disease are more likely to pass the decay-causing infection to their infants. Targeted programmatic efforts should be considered as they have been suggested above for very young children. Fifty to sixty percent of California's newborns are WIC eligible. In 2008, Alameda County began to integrate preventatively-oriented "dental days" at WIC and has expanded to 4 sites serving 1000 children annually. In essence, FOHE and fluoride varnish has been brought to the WIC population, augmented by CHOWs onsite who refer for care by age 1 to HKHT providers. Pregnant women who participate in WIC programs could be served in a similar manner.

Use of federal financial participation (FFP) administrative matching funds for local programmatic infrastructure to aid enrollment in Medi-Cal, and to assure access to Medi-Cal dental services are only being accessed by a very few counties. Recognizing the critical role of local infrastructure and the limitation of resources, I strongly encourage the Commission to include the critical role of local infrastructure and the maximal use of federal matching funds (FFP) to sustain it.

Thank you for the opportunity to provide testimony. I am encouraged by your efforts to improve a system that requires significant improvement. I believe this is a watershed moment when California's resources can be intelligently invested and repurposed to assure the oral health oral health of its youngest and most vulnerable populations.