The California Endowment

Oral Health: Successes and Opportunities for Children's Health Initiatives

Joel Diringer, J.D., MPH
Diringer and Associates
San Luis Obispo, California

February 2006

Cover California's Kids

This report was funded by The California Endowment. Cover California's Kids is a program of The California Endowment.

The views in this report are those of the authors and not The California Endowment.

Acknowledgements: The author would like acknowledge the assistance received from all of the Children's Health Initiatives, Kathy Phipps, Dr. P.H., Robert Isman, D.D.S., M.P.H., and Bobbie Wunsch, for providing data and reviewing earlier drafts of this brief, and Len Finocchio, Dr. P.H., for providing information for this report. The opinions and conclusions presented in this report are those of the author and do not necessarily represent the views of the CHIs or The California Endowment. For questions regarding this brief, please contact Joel Diringer, J.D., M.P.H., at joel@diringerassociates.com.

I. Introduction

As Children's Health Initiatives (CHIs) become operational in 18 California counties, covering more than 80,000 previously uninsured children in Healthy Kids plans, it is important to begin evaluating their impact on improving children's health. One of the most important, yet often overlooked, aspect of health is oral health. According to the United States Surgeon General, "oral health is a critical component of health and must be included in the provision of health care and the design of community programs."[1]

This issue brief addresses the issue of access to dental care for children by examining: the current state of oral health of California's children, how dental insurance improves oral health, the roles of the CHIs, access to dental care, utilization of dental services by children in the CHIs and other programs, and programs to enhance access to oral health care.

While CHIs have provided dental coverage to tens of thousands of children, they can play a larger role in improving oral health through promoting early and continuous use of dental providers, expanding coverage to those without dental coverage, and supporting programs to increase the number of providers willing to treat young low-income children. They can also partner with community organizations, such as First 5, in oral health education and prevention. Improved evaluation of utilization and plan performance will guide the CHIs to ensure access to dental care and improve the oral health of California's children.

II. Findings

What is the oral health status of California's children? Nationally, dental caries is the most common childhood disease. Among 5-17 year-olds, dental caries is more than five times as common as asthma and seven times as common as hay fever.[1] The newly released 2005 California Oral Health Needs Assessment (COHNA) screened approximately 11,000 kindergarten and 10,500 third-grade students selected from 186 schools in six regions. The assessment revealed that three out of ten (29%) California third graders had untreated decay. The COHNA also found that 71 percent of third graders had some decay experience (treated and untreated), a rate exceeded only by the state of Arkansas in the 25 states with comparable statewide screenings. Only 28 percent of California's third graders had received dental sealants, a proven cost-effective preventive measure, giving California one of the lowest rates in the nation.

There are persistent disparities in oral health among ethnic groups and income levels. The COHNA found that Latino kindergarteners were 2.4 times more likely to have had untreated decay than white children; low-income kindergarteners receiving free and reduced price lunches were 1.9 times more likely to have untreated decay than higher income children. For third graders, Latino

1 U.S. Department of Health and Human Services. *Oral health in America: A report of the Surgeon General.* Rockville, Md: DHHS, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000. http://www.surgeongeneral.gov/library/oralhealth/

children were 1.7 times more likely to have had untreated decay, and students on the school lunch program were 1.7 times more likely to have untreated decay.[2]

To overcome this epidemic of dental disease, action is required on many fronts. The United States Surgeon General issued a National Call to Action to Promote Oral Health in 2003 calling for strategies to enhance patient access to care and to improve provider participation in public health insurance programs.[3] New clinical guidelines by the American Academy of Pediatric Dentistry and the American Academy of Pediatrics advise parents and caregivers to establish a dental home for infants by 12 months of age.[4,5] Programs are also being developed to increase the participation of primary care physicians, pediatricians and other health professionals in providing oral health education and preventive care such as fluoride varnishes.

Why is dental insurance important for California's lower-income children? Dental insurance increases access to routine care and reduces the prevalence of untreated decay. Low-income children with dental insurance are 32 percent more likely than children without dental insurance to have seen a dentist in the past six months (51.9 percent of children under 300 percent of the federal poverty level (FPL) with dental insurance had been to a dentist in the past six months, compared to 35.4 percent of children without dental coverage.)[6] Kindergarteners whose parents reported not having dental coverage were 2.2 times more likely to have had untreated dental decay than those with private coverage. Uninsured third graders were 2.7 times more likely to have untreated decay.[2]

Despite its clear value, nearly one in five (18.8%) low-income California children under 300 percent FPL did not have dental coverage in 2003. In contrast, only 11.6 percent of these children lacked medical insurance. Half of California's low-income children are covered by public dental insurance: four out of ten low-income children (41.5%) had Medi-Cal coverage, and nearly one in 10 (9.2%) had coverage under Healthy Families, both of which include dental coverage.[6]

The lack of dental insurance is a greater burden on low-income children than for higher-income children. Although higher-income children lacked dental coverage at similar rates as lower-income children (17.2 percent of children over 300 percent FPL), the lack of dental insurance did not appear to impede visits as much for higher-income children. Two-thirds (67.3%) of higher-income children with dental insurance had a dental visit in the past six months, compared to 54.3 percent of those without dental insurance. In fact, the percentage of uninsured higher-income children having a recent dental visit (54.3%) exceeded the percentage of insured lower-income children with a recent visit (51.9%).[6]

2 Dental Health Foundation, "Mommy, It Hurts to Chew": The California Smile Survey - An Oral Health Assessment of California's Kindergarten and 3rd Grade Children, 2006 http://www.dentalhealthfoundation.org/topics/public/For%20web/DHF_2006_Report_tryfix1.pdf

3 U.S. Department of Health and Human Services. *National Call to Action to Promote Oral Health*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, Spring 2003. http://www.surgeongeneral.gov/topics/oralhealth/nationalcalltoaction.htm#action2

4 American Academy of Pediatric Dentistry, Clinical Guideline on Infant Oral Health Care. www.aapd.org/media/Policies_Guidelines/G_InfantOralHealthCare.pdf

5 American Academy of Pediatrics, Oral Health Risk Assessment Timing and Establishment of the Dental Home. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/5/1113

6 California Health Interview Survey (CHIS) 2003. www.chis.ucla.edu.

Do California's children have adequate access to dental care? Inadequate access to dental care for lower-income children has been a long-standing issue in California. Advocates and health providers consistently report problems for lower-income children in obtaining care. Most of these reports are based upon parent and provider experiences and anecdotal information, but few analytical studies exist to fully document the extent of the problem. There appears to be a gap between the reports of experiences of parents in obtaining dental care and that of dental plan administrators in reporting access to care. Improved indicators of access to quality care, as well as the analysis of the data, are necessary to gain a greater understanding of the reality of access to dental care.

Regardless of the debate of the extent of the problem of access, it is generally agreed that there is a lack of dental providers to serve lower-income children. There are a number of reasons for the paucity of available providers.

First, some regions of California have less dental capacity than other regions to treat the population. A recent study from the UCLA Center for Health Policy Research found that the ratio of general practice dentists per 5,000 population was highest in the Greater San Francisco Bay Area (5.0), followed by the Sacramento region (4.0), Los Angeles County (3.8), other Southern California counties (3.6) and the Central Coast region (3.5). The San Joaquin Valley region (2.3) and the Northern and Sierra counties (2.4) had the lowest dentist-to-population ratios.[7] Within regions, there are also shortages in rural and inner city areas.

Second, there are few pediatric dentists in the state and many general dentists limit the ages that their practices see and do not treat young children.

Third, a combination of low Denti-Cal (Medi-Cal) reimbursement rates and complicated billing processes have caused many private practice dentists to shun Denti-Cal.[8] While there are more than 12,000 dentists that have Denti-Cal provider numbers, many severely limit the number of Denti-Cal patients that they are willing to see. Dentists that are listed on provider panels for Healthy Families and Healthy Kids do not necessarily take new patients for those programs, or in some cases, are not even aware that they are a listed as a provider.

Existing state dental plan regulations do little to ensure access to dental care. In order for a dental plan to be approved, the Department of Managed Health Care (DMHC) requires that there be at least one provider for every 2,000 enrollees, and that services be available within reasonable proximity of the business or residence of enrollees.[9] However, this general standard for provider capacity does not account for how many plans each provider accepts, or how many enrollees of a plan that they are willing to accept.

What roles have Children's Health Initiatives played in expanding access to dental care? Children's Health Initiatives (CHIs) are local partnerships that have joined together to ensure that all children have health, dental and vision coverage. Through community outreach, CHIs attempt to maximize enrollment in existing free or low-cost public and private programs (e.g. Medi-Cal, Healthy Families, Kaiser Child Health Plan and California

7 Pourat, N., Roby, D., Wyn, R. and Marcus M. Is There a Shortage of Dental Hygienists and Assistants in California? Findings From the 2003 California Dental Survey. Los Angeles: UCLA Center for Health Policy Research. November 2005.

8 See generally Clark v. Kizer, 758 F. Supp. 572, 575-80 (ED Cal. 1990)

9 California Code of Regulations Title 28, section 1300.67.2.

Kids). As funding permits, they also provide coverage to children ineligible for the existing programs through a new insurance product, typically called Healthy Kids. As of January 2006 there were Children's Health Initiatives in 18 counties with Healthy Kids programs. Total statewide enrollment in Healthy Kids programs exceeds 80,000 low-income children.

In Fall 2005, the existing and soon-to-be-operational CHIs were asked to provide information on their dental coverage plans and their experience in providing access to oral health care. All CHIs provided basic information and a number were able to provide evaluation data on changes in access to dental care and patient satisfaction.

CHIs have taken up the call for improving oral health through the provision of dental coverage to low-income children who have previously not had access to oral health care. All counties with Healthy Kids programs provide dental benefits that are similar or identical to the benefits under the Healthy Families program. Benefits include comprehensive preventive, restorative and other major services with limited or no co-payments.

Three different commercial plans provide dental coverage for Healthy Kids programs. In all counties except Los Angeles, Riverside and San Bernardino Counties, Delta Dental of California is the chosen plan for dental services. In Los Angeles, Safeguard Dental was selected as the result of a competitive bidding process; and Riverside and San Bernardino counties selected Western Dental.

Initial reports from two counties are that parents are satisfied with the Healthy Kids dental services. In Santa Cruz County, an early Healthy Kids Member Satisfaction Survey indicated that more than 95 percent of parents indicated that they were very happy with the dental services received by their children.[10] Similar high levels of satisfaction were reported for the San Francisco Healthy Kids and Young Adults program.[11]

The Healthy Kids programs all report having sufficient providers to serve their populations, and they all meet the DMHC minimum standards many times over. Given the relatively small population that is covered by Healthy Kids in each county, it is easy to meet the DMHC standards. The Healthy Kids provider networks are the same or similar to the Healthy Families networks; some of the plans use managed care networks while others plans used preferred provider organizations (PPO) networks. One of the larger Healthy Kids programs reported that they had changed from a managed care network to a PPO network and successfully increased provider participation.

The inclusion of safety-net and community clinics in the provider networks for Healthy Kids has been challenging for some CHIs. Provider reimbursement rates are well below the Medi-Cal rates received by most community clinics, which as federally qualified health centers receive cost-based reimbursement per encounter, rather than fee-for-service procedure-based reimbursement. The dental plans have been reticent to pay higher rates to the providers for Healthy Kids fearing pressure to do so for Healthy Families and Medi-Cal, and the clinics are reluctant to accept the rates offered.

10 Personal communication from Santa Cruz County Children's Health Initiative.

11 San Francisco Health Plan, Healthy Kids and Young Adults 2005 Member Satisfaction Survey.

The Children's Health Initiatives have reported some issues with their enrollees obtaining dental care. Member surveys in two counties were conducted to determine whether enrollees had access to dental care. In San Mateo County, most children enrolled in Healthy Kids had a usual source of medical care (88.1%), but fewer (72.3%) reported a usual source of dental care. Of those participating in the San Mateo client survey, 11.4 percent reported a dental need, but were unable to receive services.[12] Similarly, results from the Santa Clara County survey showed that 9 percent of enrolled children did not see a dentist when they needed to, compared to 21 percent of those children without Healthy Kids.[16] Further research would be required in other CHIs to determine if, in fact, there are access barriers to dental care.

How are children using dental services in Healthy Kids and other public programs? Although utilization of dental services by children enrolled in Healthy Kids appears to be less than utilization experienced by all children in California or by Healthy Families children enrolled in Delta Dental, it is much higher than for children enrolled in Medi-Cal. CHIS 2003 reports that 84.5 percent of children ages 4 through 18 visited the dentist in the past year.[6*] Encounter data from Medi-Cal showed that 42.3 percent of children ages 4 through 18 statewide used dental services in 2004;[13] Delta Dental, the predominant provider for Healthy Families reported that 67.1 percent of children ages 4 through 18 statewide received services in 2004,[14] contrasting with 62 percent in 2000.[15]

Table: Utilization of dental services by children.

Age	**CHIS Statewide** (2003)	**Medi-Cal** (2004)	**Healthy Families – Delta Dental** (2004)	**Riverside** (10/04-9/05)	**San Bernardino** (10/04-9/05)	**San Francisco** (7/03-6/04)	**San Joaquin** (2004)	**San Mateo** (2/03-1/04)	**Santa Cruz** (7/04-6/05)
1-5	56.3%	29.1%	N/A	15.2%	13.5%	N/A	N/A	50.8%	N/A
4-18	84.5%	42.3%	67.1%	24.0%	33.3%	N/A	N/A	N/A	62%
Total (0-18)	75.7%	36.8%	N/A	21.4%	25.7%	63.9%	66.4%	56.0%	N/A

Note: All data, except for CHIS, are for children continuously enrolled in health plan for at least 11 of the past 12 months. CHIS asks all respondents of date of last visit. Santa Cruz County reports utilization for children ages 3-18 years, and Riverside and San Bernardino counties report data for children ages 6-15 years.

* As a household telephone survey, CHIS relies on responses from interviewees with potential recall and other biases. The encounter data from the plans is based upon provider reports and billings to dental plans and may be more accurate.

12 Evaluation of the San Mateo County Children's Health Initiative: Second Annual Report, August 2005. www.plsinfo.org/healthysmc/html/children_youth.html

13 California Dental Medicaid Management Information System Report MR-0-270, February 3, 2005.

14 Personal communication from Delta Dental of California.

15 Healthy Families Program Dental Services Report 2002. www.mrmib.ca.gov

In contrast to the statewide Medi-Cal experience, most of the CHIs have achieved much higher utilization rates. The plans have reported that there is a large "pent-up" demand for dental care, and that often parents are primarily interested in obtaining dental coverage for their children. Whereas parents had sources for obtaining medical care for their children (e.g., CHDP or local clinics), they found access to dental care to be much more restricted without insurance. Further research is required to determine why there are differing utilization rates among the programs such as Medi-Cal, Healthy Families and the various Healthy Kids plans.

Santa Cruz County reported that 62 percent of children ages 3 through 18 enrolled in Healthy Kids continuously from July 2004 to June 2005 used dental services. San Joaquin County reported that in 2004, 66.4 percent of children enrolled in Healthy Kids received dental services, and San Francisco County reported that 63.9 percent of children enrolled in Healthy Kids between July 2003 and June 2004 received dental services. In San Mateo County, 56 percent of children ages 0-18 used dental services from February 2003 to January 2004. Only Riverside and San Bernardino counties reported utilization rates that were lower than Medi-Cal. In Riverside County, only 24 percent of enrollees ages 6 to 15 years old received dental services between October 2004 and September 2005. In San Bernardino County, 33.3 percent of children ages 6 to 15 years used dental services.

Further evidence of increased utilization of dental services under Healthy Kids comes from the evaluation of the Santa Clara County Healthy Kids program, which extensively interviewed parents. The evaluation reported that without Healthy Kids, only 23 percent of children would have had a preventive dental checkup in the past six months, compared to 61 percent of those with Healthy Kids. The proportion of children who had a cavity filled or tooth pulled in the past six months tripled from 15 percent without Healthy Kids to 44 percent with Healthy Kids. The percentage of families who reported an unmet dental need dropped from 20 percent to 9 percent after enrollment in Healthy Kids, and the percentage of children with a usual source of dental care rose from 29 percent to 81 percent.[16]

What programs exist to enhance access to oral health care? Local Children's Health Initiatives reported no major initiatives to enhance access to oral health care through their Healthy Kids programs. For the most part, the CHIs only provide dental coverage to the Healthy Kids participants and have not taken on programs to increase access to dental care or to prevent dental disease. Although dental providers have participated in some of the local coalitions and assisted in plan selection and provider recruitment, the coalitions have been driven predominantly by medical providers and plans. Local health plans and county organized health systems have only limited experience in dental coverage since Medi-Cal and Healthy Families have carved out dental coverage to other plans. The dental plans are statewide organizations and have not consistently participated at the local levels to the same extent as the medical plans.

The CHIs rely on the contracted dental plans to ensure that there are sufficient providers to serve their populations and that beneficiaries can find dentists. These plans have a number of consumer services,

16 The Santa Clara County Healthy Kids Program: Impacts on Children's Medical, Dental, and Vision Care, Final Report, July 2005. hhtp://www.mathematica-mpr.com/publications/PDfs/santaclara.pdf

including multilingual call centers to assist with plan issues and finding providers, oral health education materials and newsletters.

Several of the counties have coordinated efforts with other dental access programs in their counties. Among the dental access issues in which the CHIs participated were expanding the availability of providers willing to see younger children, increasing the availability of oral sedation for more complicated cases and expanding the use of mobile dental clinics.

Los Angeles County has a program to encourage general dentists to see more younger children in their practices. LA Care has partnered with the California Dental Association Foundation (CDAF) and the California Society of Pediatric Dentistry to implement the Pediatric Oral Health Access Program. This program is designed to empower general dentists with the necessary skills to expand their practices to include children under age 5 and children with special needs (physical and developmental disabilities). At the completion of the no-cost training program, each participating dentist agrees to regularly treat young children in their practice and to provide free dental care to at least 20 underserved children. Since its inception in 2003, more than 3,300 children 0-5 years have been seen under the program, with free services valued at approximately $1 million, using Denti-Cal reimbursement rates.

II. Discussion and Recommendations

The CHIs have clearly increased access to dental coverage and care for a population that has historically not had equal access to dental care. Spending nearly $20 million or more annually for dental coverage†, they have provided comprehensive dental benefits as part of the package with medical and vision coverage to low-income children. Utilization of dental services has increased for this previously uninsured population, which should improve the oral health of children.

Further work is needed to examine utilization to determine the levels of service, the types of services, and the ages at which children are receiving services. Also, examination of the differences in utilization among the various Healthy Kids programs, and differences in utilization between the Healthy Kids programs and Denti-Cal and Healthy Families, would be useful in identifying strategies for increasing use of dental care.

There are very few Health Plan Employer Data and Information Set (HEDIS) quality and performance indicators for dental plans, and CHIs do not seem to be actively reviewing dental plan performance. The newest dental plan quality data released from the Managed Risk Medical Insurance Board (MRMIB), which covers more than 740,000 children through the Healthy Families Program dates back to 2000. And Medi-Cal, the largest source of dental coverage for low-income California children, does not regularly release its dental quality and utilization data. Evaluation plans for the local CHIs should include tracking of dental utilization and examine the types of services that children are accessing.

† This estimate is based upon 80,000 children enrolled in Healthy Kids programs paying at least $20 per member, per month for dental coverage. Actual premiums are much higher for some counties.

There are far more children without dental insurance than without medical insurance. CHIS 2003 estimates that there are approximately 400,000 children below 300 percent FPL who have medical insurance, but lack dental coverage[‡]. Many of these children might be eligible for Denti-Cal (enrolling in Medi-Cal as a secondary coverage plan), however, it would not appear that they would be eligible for Healthy Families which only provides a package that includes medical, dental and vision coverage. To meet the needs of those children who have no dental coverage, both the Healthy Kids programs and the Healthy Families program might consider offering dental coverage as a stand alone product for those children who already have medical coverage.

It must be remembered that dental treatment does not prevent caries; it only treats a preventable condition. With California's high rate of dental disease (71 percent of third graders have a history of decay), enhanced prevention efforts are required. The epidemic rate of untreated decay among younger children makes it imperative that they receive early preventive care and education. The current standard of care is that "two is too late," and CHIs need to make efforts to ensure that the youngest children establish a relationship with a dentist early and continue with regular visits.

Local CHIs and their partner First 5 Commissions can participate in the state First 5 Commission's Oral Health Education and Training Project administered by CDAF and the Dental Health Foundation. This project is designed to provide education on dental disease prevention to 30,000 dental professionals,10,000 medical professionals, and deliver intensive training to 14,000 dental professionals and over 3,500 medical professionals statewide. Coupled with programs such as the hands-on Pediatric Oral Health Access Program, the efforts can lead to increased awareness of dental disease prevention and increased supply of providers for young children.

While CHIs cannot solve all problems related to provider participation in public coverage programs, they can implement programs to increase the number of dentists that will see young children and to accept a share of lower-income patients. Partnerships with First 5 Commissions, dental societies and dental plans have met with some success throughout California. In addition, further examination of local community efforts to improve oral health, as well as state and federal initiatives, will assist CHIs in not only treating dental disease, but preventing it. Although providing insurance alone will not cure the epidemic of dental disease, CHIs can be an instrumental part in improving the oral health of all children.

[‡] Of the children under 300 percent of the federal poverty level (FPL) who are medically insured, but without dental coverage, 34 percent are under 100 percent FPL, 41 percent are between 100 percent and 199 percent FPL, and 25 percent are between 200 percent and 300 percent FPL, according to CHIS 2003. An estimated 73 percent of these children are citizens, and 27 percent are not citizens.

The California Endowment
1000 North Alameda Street
Los Angeles, CA 90012
1.800.449.4149
www.calendow.org

For more information about Cover California's Kids, please visit www.covercaliforniaskids.org

CPA/Oral Health: Successes and Opportunities for California's Children's Health Initiative
TCE 0206-2006