TESTIMONY TO THE LITTLE HOOVER COMMISSION
JENNY KATTLOVE, SENIOR DIRECTOR OF PROGRAMS

The Children's Partnership

BACKGROUND

Thank you for the opportunity to present to the Little Hoover Commission on ways to help ensure children enrolled in Medi-Cal get the dental care they need and have improved oral health. The Children's Partnership (TCP) is a national nonprofit, nonpartisan child advocacy organization with offices in California and Washington, DC. We work to ensure that all children—especially those at risk of being left behind—have the resources and the opportunities they need to grow up healthy and to lead productive lives. Improving the oral health of California's underserved children is a top priority for TCP.

With more than half of children enrolled in Medi-Cal and dental disease being the number one chronic health problem among children in the state, we have an imperative to make sure Medi-Cal's dental program is operating to its full potential to meet the diverse needs of California's children.

In our view, the recent audit report of Medi-Cal's dental program is one of the singular most important reports completed in recent years and merits continued, serious attention by the Legislature and Administration. It drew attention to what advocates and community providers have known for a long time; children enrolled in Medi-Cal are not receiving the dental care they need.

We are pleased that the Little Hoover Commission was tasked with studying Medi-Cal's dental program and developing recommendations for the Legislature and Governor for how Denti-Cal can better serve the children and adults who depend on it. We have the opportunity and momentum to address the long-standing problem of inadequate access to dental care for children enrolled in Medi-Cal, and we look forward to the Little Hoover Commission's report to inform all of our efforts.

The audit report and the efforts of the Little Hoover Commission, along with the fact that we now have a state Dental Director to lead statewide efforts to improve the oral health of California's residents, provide the impetus and tools to finally make real change and put California on the path to ensuring its children have the optimal oral health care they need to stay healthy and succeed in school and life.

THE NEED

As the audit report found, more than half of children enrolled in Medi-Cal did not have a dental visit in 2013. In addition, less than one-quarter of young children (0-3) had a dental visit in 2013, despite the recommendation by the American Academy of Pediatric Dentistry

that children visit the dentist at the time the first tooth appears (and no later than the age of 1) and have a dental check-up every six months thereafter. As a result, 71 percent of children experience tooth decay by the time they reach the third grade.[1]

Children are simply not receiving the care they need when they need it and where they need it. The audit found that nearly half—twenty-seven—of California's counties had either no dental providers willing to accept new Medi-Cal patients or had an insufficient number of dental providers willing to accept new Medi-Cal patients.

The shortage of dental providers who take Medi-Cal can only be expected to get worse. Enrollment in Medi-Cal has grown by more than 4 million individuals (a 36 percent increase) between 2009 and 2014.[2] With the Healthy Families to Medi-Cal transition, nearly 800,000 children joined the Medi-Cal program. Millions of adults have joined the program as a result of the Affordable Care Act's Medicaid expansion. And with the recent budget action to expand Medi-Cal to all income-eligible children, regardless of documentation status, hundreds of thousands more children will enroll soon after May 2016, when that budget action becomes effective. Finally, with the recent restoration of adult dental benefits in Medi-Cal, the strain on the Denti-Cal system is clear.

This is fantastic progress for California. Every child and adult should have health and dental coverage. Yet, the recent rate review, done as recommended by the state auditor, showed a 12.6 percent decrease in rendering providers and a 14.5 percent decrease in billing providers since 2008.[3] In other words, the State not only have many millions more children and adults to serve, it also have far fewer dental providers to provide those services. And if the State does not address the current and future crisis in Medi-Cal's dental program, California's advances in providing health coverage will be in vain, and it is money wasted.

THE CONSEQUENCES OF POOR ORAL HEALTH AMONG CHILDREN

The consequence of this neglect is that children suffer. Poor dental health can disrupt normal childhood development and seriously damage overall health.[4] In rare but tragic cases, untreated tooth decay can lead to death, as it did for 12-year-old Deamonte Driver of Maryland, who died in 2007 from a brain infection, due to untreated dental disease.[5] In addition, decay in primary teeth is a significant predictor of decay in permanent teeth, meaning many children with poor dental health grow up to be adults with poor dental health.[6]

Dental disease also impacts children's ability to learn and succeed in school. Children with poor oral health are nearly three times more likely than their counterparts to miss school as a result of dental pain. Nationally, children between ages 5 and 17 years miss nearly 2 million school days every year due to dental health problems.[7] In 2007, more than half a million of California's school-aged children missed at least one school day due to a dental

problem—a total of 874,000 missed school days. This translates to a statewide average loss of nearly $30 million in attendance-based school district funding.[8] Finally, a 2012 study of the relationship between poor oral health and academic achievement in disadvantaged children in the Los Angeles Unified School District found that students who had a toothache in the last six months were four times more likely to have a Grade Point Average (GPA) that was lower than the median.[9]

When their children experience pain, fevers, and infections as a result of poor oral health, families with limited access to dental care often have little choice but to take their children to the emergency room for care. In 2007, there were over 83,000 emergency room visits for preventable dental problems, at a cost of $55 million.[10] This rate of emergency room visits for preventable dental problems is a 12 percent increase from 2005. Close to half of California's counties had higher emergency room visit rates for dental conditions than for asthma and diabetes.[11]

Untreated decay not only impacts children's health, but emergency room and hospital-provided care for preventable dental problems are a poor use of taxpayers' and families' dollars. Hospital-provided dental care, including emergency room care, ranges from $172 to $5,044 per encounter, compared to $60 for a comprehensive dental exam.[12]

RECOMMENDATIONS

The evidence is clear. The promise of dental care that comes with Medi-Cal coverage is not being kept. As a result, fewer children grow up to realize their full potential. We have a moral imperative to address this gap in dental care for millions of California's children.

At a minimum, the Legislature should hold the Department of Health Care Services accountable for developing an accurate measure of dental provider network adequacy in the Denti-Cal program, as recommended in the audit report. Until we understand precisely where the gaps are, we will not be able to adequately address this crisis in children's dental care access.

Such an assessment should include the number of available providers who treat certain subpopulations of children who traditionally go without needed care, particularly very young children and children with special health care needs. The Department should also track racial disparities related to Medi-Cal-enrolled children getting care. In addition, an assessment of access should look at smaller regions within counties, knowing that county-based data do not always tell the whole story. Further, as we acknowledge that dental care can be delivered in a number of places by different types of providers, a system for identifying the services children receive in community settings—such as at schools, Head Start sites, mobile vans, and WIC sites—should be developed, and the results should be included into an assessment, so that we have the full picture of children's access to care

and remaining gaps. These elements are in addition to the factors the Department are already considering, such as the number of current and new Medi-Cal enrolled patients a provider treats and the time it takes families to get an appointment and receive care.

Once these gaps are identified accurately, the State should work closely with stakeholders to identify and implement tangible solutions to address them. Additionally, state agencies, including the Department of Health Care Services and the Department of Public Health should collaborate with advocates to identify innovative solutions to provide needed dental care to children. Outlined below are a few areas to explore and adopt.

BRING CARE TO WHERE CHILDREN ARE

First, we are pleased to see the enactment of AB 1174 in 2014, and we hope to see enactment of AB 648 in the near future. These bills will help ensure the successful Virtual Dental Home (VDH) program will be spread across the state to bring dental care to children in community settings where they go nearly every day (such as schools and Head Start sites). By bringing dental care to patients, the VDH addresses barriers families face in accessing the traditional office-based dental care delivery system. The VDH utilizes specially-trained dental hygienists and assistants who examine patients in community settings—such as schools, Head Start sites, and nursing homes. They then send that information electronically to the supervising dentist at a clinic or dental office. The dentist uses that information to create a dental treatment plan for the hygienist or assistant to carry out. The hygienists and assistants refer patients to dental offices for procedures that require the skills of a dentist.

The VDH has been rigorously evaluated under a Health Workforce Pilot Project under the supervision of the Office of Statewide Health Planning and Development and has proven to be a safe way to bring high quality dental care to children and others who may otherwise go without needed care. We look forward to working with the State to integrate the VDH into California's dental delivery system as a critical way to achieve our goals of making sure all children and adults have optimum oral health.

INVEST IN PREVENTIVE CARE FOR YOUNG CHILDREN

The Department and Legislature must also invest in making sure younger children receive the dental care recommended. The dental care needs of young children deserve particular attention. Early preventive dental care results in better oral health as well as overall health and well-being over a lifespan. However, because dentists are often reluctant to see very young children, young children enrolled in Medi-Cal receive dental services at disproportionately low rates. For example, TCP conducted an informal secret shopper survey in 2013 and found that, while the majority of Medi-Cal dentists we called said they

were taking new Medi-Cal patients, they either would not see a three-year-old child or had several caveats for seeing the three-year-old.[13]

Further, anecdotal evidence suggests that, even when younger children get care, they are not getting appropriate care for their age. Pediatric dentistry encompasses disciplines, techniques, and skills required to meet the unique needs of young children, including behavior guidance and sedation.[14] The American Academy of Pediatrics recommends that dentists who treat children be skilled to meet the unique needs of children, based on their developmental level.[15]

We are pleased the Department of Health Care Services has begun to look at this population through outreach efforts, but if there are not enough of the right providers to serve this population, outreach efforts will not work. What good is it to tell parents to take their young children for dental check-ups, if there are no dentists who will see them? Further, critical to improving outcomes for this population is making sure they are receiving community-based preventive care, family education, and care coordination. The State should invest in what will truly make a difference for this population. This could include raising reimbursement rates for providers who see this population or raising rates for particular services that impact this population, such as preventive services.

One example is the Access to Baby and Child Dentistry program (ABCD) in Washington State. The goal of the ABCD program is to ensure Washington's youngest children enrolled in Medicaid have access to dental care that promotes good, lifelong oral health habits and helps them avoid cavities, pain, and high-cost dental interventions later in life. The program works at the local level with community partners—including dental champions—to connect young children to dental providers and to provide case management to address barriers families face in getting needed care for their children. Families and children receive culturally-competent education and care. Dentists receive continuing education in early pediatric dental techniques and are certified by University of Washington Pediatric Dentistry staff or by the local ABCD Dental Champion. And the State pays enhanced dental fees to ABCD-certified dentists for selected procedures, including oral evaluation, family oral health education, fluoride varnish application, and certain restorative procedures. The State also provides support to dental offices on training in billing and other issues.

In the nearly two decades ABCD has been improving access to dental care for families, the number of young Medicaid children in Washington receiving dental care has more than tripled. Further, Washington's 2010 Smile Survey shows that the rate of untreated decay among low-income preschoolers was cut in half over the last five years, from 26 percent in 2005 to 13 percent in 2010. Finally, the program has demonstrated cost savings by providing early preventive care; prevention efforts save nearly $525 per child over five years in projected treatment costs.[16]

MAKE THE MOST OF OUR WORKFORCE

We can no longer assume that the dentist is the only provider that can address children's dental care needs. It takes a team to provide the comprehensive oral health education, care management, and treatment to families need. For example, dental hygienists and assistants—as part of a larger team that includes a dentist at the head of the team—are increasingly playing a role in bring dental care to where children are, such as through the VDH. As mentioned this model should be supported and replicated.

However, more can be done. For example, community health workers provide health education, coordination, and other basic health services to their community. As trusted members of their communities, they can play a vital role in educating families about the importance of good oral health, how to achieve good oral health, and connect families to services. However, there currently is no sustainable source of funding for these workers. Yet, they play a vital role in providing preventive services, saving money for the state and other payers in the long run.

For example, the My Smile Buddy program in New York City uses community health workers without previous dental training to engage poor, minority, low-literacy parents of young children in order to assess a child's risk for early dental disease, provide pediatric oral health education, and help them set oral health goals, based on their specific needs. The community health workers are equipped with an iPad to support individualized plan development and implementation work. Initial studies of the project have demonstrated positive results.[17]

Home visitors can also play a critical role in getting families off to a good start when it comes to oral health. Home visiting programs—funded by federal and/or state dollars—support at-risk pregnant women, parents, and children from birth to kindergarten in connecting to resources and honing the skills they need to raise children who are physically, socially, and emotionally healthy and ready to learn. Several programs across the nation have integrated oral health education into their home visiting program to introduce families to dental disease prevention, engage families in good oral health habits at home, and connect families to oral health services. California should explore how to adopt and support best practices for integrating oral health into home visiting programs.

One program is the Child Health Investment Partnership (CHIP) of Roanoke Valley, Virginia: a home visiting program that promotes children's health and family self-sufficiency. CHIP's Begin With A Grin program provides preventive dental services in the home (oral health anticipatory guidance and fluoride varnish) for children from 0 to 6 years old. The home visiting model introduces children and their families to dental prevention and has been shown to improve dental health literacy, establish dental homes, and increase the application of fluoride varnish.[18]

Finally, California should work with communities to assess additional ways oral health education and prevention services can be incorporated into community-based health programs, such as using school health personnel, Head Start staff, and others who touch the lives of children and their families and who are trusted by families.

NEXT STEPS

We are pleased to see that the Legislature and the Brown Administration are taking steps toward filling the dental care gap for children. With more than half of California's children enrolled in Medi-Cal, it is time to explore real solutions to this appalling gap. However, it is critical that the State engage stakeholders in a meaningful way in developing and implementing strategies to address the dental care needs of these children. We often have direct contact with families or contact with community providers who see families on a day-to-day basis. We know what it takes to build a system that truly addresses the barriers our families face in getting needed care. We hope to partner with the State to explore, shape, and implement solutions. And the Legislature should continue to identify and support cost-effective and sustainable system-wide solutions to improving the oral health of California's most vulnerable children.

TCP looks forward to working with the Little Hoover Commission, the Administration, and the Legislature to identify real solutions to ensure that Medi-Cal's children—more than half of all of California's children—get the oral health care they need.

---

[1] Dental Health Foundation, Mommy, *It Hurts to Chew: The California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children* (Oakland, CA: Dental Health Foundation, 2006): 12.
[2] California HealthCare Foundation, "ACA 411: Tracking Health Reform in California," accessed August 31, 2015, http://www.chcf.org/aca-411?_cldee=amthdHRsb3ZlQGNoaWxkcmVuc3BhcnRuZXJzaGlwLm9yZw%3d%3d.
[3] California Department of Health Care Services, *Medi-Cal Dental Services Rate Review*, (Sacramento, CA: California Department of Health Care Services, 2015): 8, http://www.dhcs.ca.gov/Documents/2015_Dental-Services-Rate-Review.pdf.
[4] Katrina Holt and Karen Kraft, *Oral Health and Learning: When Children's Health Suffers, So Does Their Ability to Learn*, 2nd ed. (Washington, DC: National Maternal and Child Oral Health Resource Center, Georgetown University, 2003): 1-2, http://www.mchoralhealth.org/pdfs/learningfactsheet.pdf.
[5] Hazel J. Harper, "A Community Steps Up and Speaks Out: The Deamonte Driver Dental Project," in Maintaining Momentum Through Continuity of Care: Finding Dental Homes for America's Children, Symposium Proceedings (Chicago, IL: American Dental Association, 2009): 28, http://www.ada.org/sections/newsAndEvents/pdfs/2009_symposium_proceedings_full.pdf.
[6] Yihong Li and W.J. Wang, "Predicting Caries in Permanent Teeth From Caries in Primary Teeth: An Eight-Year Cohort Study," Journal of Dental Research 81(8) (2002): 561.
7 Hedy N. Chang and Rochelle Davis, "Mapping the Early Attendance Gap: Charting a Course for School Success" (September 2015): 10.
[8] Nadereh Pourat and Gina Nicholson, *Unaffordable Dental Care is Linked to Frequent School Absences* (Los Angeles, CA: UCLA Center for Health Policy Research, 2009): 1-6.
[9] Hazem Seirawan, et al., "The Impact of Oral Health on the Academic Performance of Disadvantaged Children," *American Journal of Public Health* 102(9) (2012): 1729-34.
[10] California HealthCare Foundation, *Snapshot: Emergency Department Visits for Preventable Dental Conditions in California* (Oakland, CA: California HealthCare Foundation, 2009): 2, 26, 28.
[11] California HealthCare Foundation, *Addendum to Emergency Department Visits for Preventable* Dental Conditions: Data by County and Age Group (Oakland, CA: California HealthCare Foundation, 2009): 1-13.
[12] California HealthCare Foundation, *Snapshot: Emergency Department Visits for Preventable Dental Conditions in California* (Oakland, CA: California HealthCare Foundation, 2009), 16.

[13] The Children's Partnership, "Finding Dental Care in California: A Snapshot of Using the State's Website to Find a Medi-Cal Dentist for Children," (July 2013), http://childrenspartnership.org/storage/documents/Publications/Finding_Dental_Care_July_22-1.pdf.
[14] American Academy of Pediatric Dentistry, *Reference Manual* 36(6) (2015): 2-3.
[15] Ibid.
[16] "Results," Access to Baby Child Dentistry, accessed August 31, 2015, http://abcd-dental.org/results.
[17] Courtney H. Chinn, et al., "An Interpersonal Collaborative Approach in the Development of a Caries Risk Assessment mobile tablet application: My Smile Buddy," *Journal of Health Care for the Poor and Underserved* 24(3): 1010–1020, www.chwnetwork.org/_templates/80/my_smile_buddy.pdf.
[18] Tegwyn Brickhouse, et al., "The impact of home visiting program on children's utilization of dental services," *Pediatrics* 132(2) (2013).