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ISSUE BRIEF

Oral Health in California: What About Older Adults?

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Introduction

> *I am 72 years old and haven't been to the dentist in four years. It's so hard to find a dentist that is close to my house and the last time I went, they made me sign all these forms and I ended up paying all this money for them to pull my tooth out that I couldn't pay back. It's easier just to go the emergency room.*

Oral health is an essential aspect of overall health for people of all ages, but especially for older adults. Unfortunately, older adults in California experience significant challenges when attempting to access oral healthcare. Reviews of California's Medicaid coverage and delivery of dental benefits for low-income adults through the Denti-Cal program reveal serious systemic barriers to care. Nationally, California ranks thirtieth in how it addresses the oral health needs of older adults.

While some of the challenges older adults contend with overlap with those that younger populations encounter, older adults face distinct challenges that mandate distinct solutions. Yet, consideration of the oral health needs of older adults, and particularly, low-income older adults, is virtually absent from California's statewide discussions to improve oral healthcare.

This paper serves to highlight the importance of addressing the needs of older adults and the barriers to care they face. The first section of this paper summarizes the state of oral health for older adults. The second section outlines the unique barriers to oral health care that older adults face in California. The third section puts forth high-level recommendations to begin improving oral health for our aging population.

Oral Health for Low-Income Older Adults in California

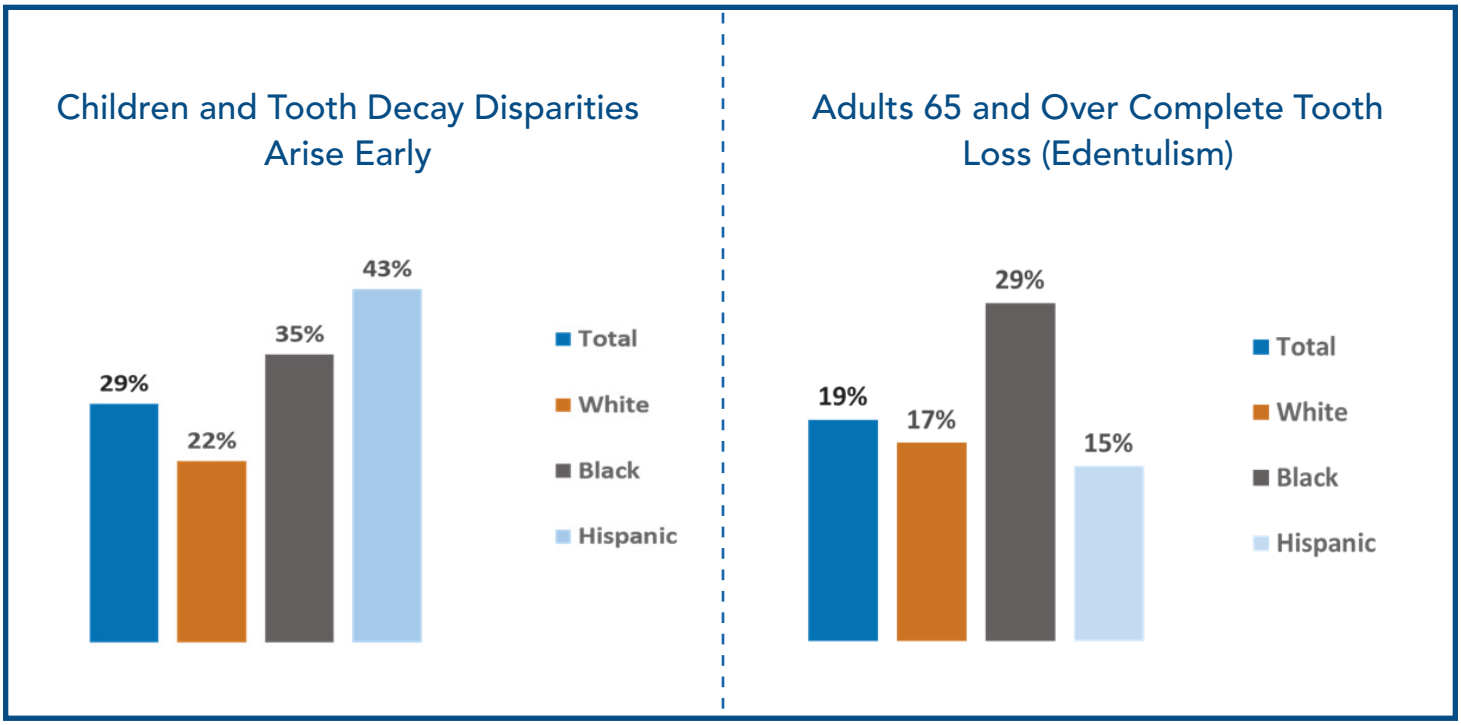
Over the last several decades, the oral health of all Americans has significantly improved. Improvements are in large part attributable to

preventative measures like fluoridated community water systems, increased use of toothpastes and rinses that contain fluoride, and early childhood access to dental services. Yet, when we dig into the data, troubling disparities based on income level, education, and race are exposed. These disparities arise early in childhood and carry forward throughout an individual's lifetime. Overall, twenty-nine percent of children have untreated dental decay, but this is much higher for black children (36%) and Hispanic children (43%), especially when compared to white children (22%). In households where the adult caretaker has less than a high school education, dental decay for children increases to 45% for black children and 52% for Hispanic children.[1]

When we turn to adults, these disparities persist: nearly 62% of black and 55% of Hispanic adults aged 20-64 have lost permanent teeth compared to just 49% of white individuals of the same age. And for black individuals 65 and over, 29% have complete tooth loss (edentulism) compared to 16% of the white individuals.[2] Similarly, 39% of older adults who have less than a high school education have complete tooth loss.[3]

Disparities in access to dental services for older adults also exist. While approximately half of all older adults 65 and older nationally have been to the dentist within the last year, this is only true for 37% of black and 38% of Hispanic older adults.[4] Worse yet, only 30% of adults 65 and over with incomes below the Federal Poverty Level had a dental visit within the last year.[5]

Disparities in oral health begin in childhood and continue into old age



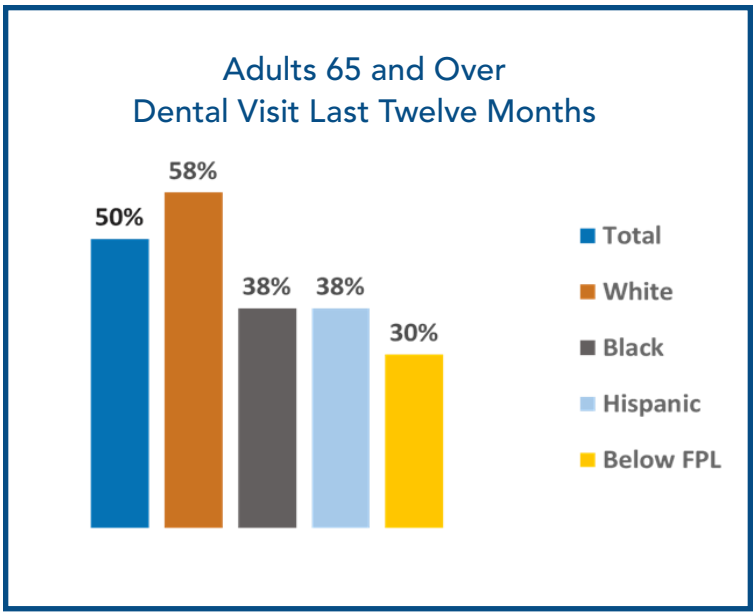
1 "Healthy People 2010: Understanding and Improving Health," U.S. Dept. of Health and Human Services (Nov. 2000), available at http://www.healthypeople.gov/2010/Document/pdf/Volume2/21Oral.pdf.

2 "Dental Caries and Tooth Loss in Adults in the United States, 2011-2012," U.S. Dept. of Health and Human Services (May 2015), available at http://www.cdc.gov/nchs/data/databriefs/db197.pdf.

3 See Footnote 1.

4 "Treatment Needs in Seniors (Age 65 and Over)," National Institute of Dental and Craniofacial Research, available at http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/TreatmentNeeds/Seniors.htm.

5 *Id.*



In California, for those individuals who have not seen a dentist within the last year, cost is the main barrier to access for individuals across all income levels. However, low-income Californians report trouble finding a dentist as a barrier to care at much higher levels (22%) than middle (6%) to high-income adults (11%).[6]

The way individuals view their oral health also differs by income level and health insurance coverage. In California, nearly one in five low-income adults report that their mouth and teeth are in poor condition.[7] Conversely, only 4% of middle-income adults and no high-income adults report that their teeth are in poor condition.[8] Expectations of oral health differ as well: where only half of high-income Californians expect that they will lose some teeth with age, three out of four low-income adults see tooth loss being inevitable as they age.[9] These are not merely perceptions: early survey data of Medi-Cal[10] residents in skilled nursing facilities found that 38% of residents have no natural teeth and 17% of these individuals have no upper or bottom dentures.[11] Of those residents with teeth, 42% have untreated decay and 14% are in need of urgent dental care due to pain or infection.[12]

The data demonstrates that barriers to good oral health care disproportionately impact low-income populations and populations of color and are compounded with age. In California, many of these individuals rely on the Denti-Cal program to meet their oral health needs.

Barriers to Oral Health for Low-Income Californians with Denti-Cal

Access to oral health care is difficult for many low-income Californians because of the challenges that low-income people with Medi-Cal experience with dental care provided through the Denti-Cal program. Denti-Cal is the program responsible for delivering dental services offered under Medi-Cal. Most individuals receiving benefits through Denti-Cal receive dental services through fee-for-service, which allows individuals to see any dental provider who is enrolled in Denti-Cal.[13] However, only one in four California dental providers provides services to Denti-Cal enrollees. In fact, there are no Denti-Cal providers available at all in five counties, and numerous other counties

6 *Id.*

7 "California's Oral Health and Well-Being," Health Policy Institute, American Dental Association (2015), available at http://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being/California-facts.

8 *Id.*

9 *Id.*

10 Medi-Cal is California's Medicaid program.

11 "Oral Health Assessment of Older Adults in California," Center for Oral Health, available at http://www.centerfororalhealth.org/images/events/2015_symposium/presentationslides/5-Anselmo.pdf.

12 *Id.*

13 There are two exceptions: Sacramento County Denti-Cal enrollees mandatorily receive dental benefits through a managed care plan. Beneficiaries in Los Angeles County have the option to receive Denti-Cal benefits through fee-for-service or through a managed care plan.

have no Denti-Cal providers who are accepting new patients.[14]

The problems with the Denti-Cal program are well documented. In December 2014, the California State Auditor released a report finding that many children enrolled in Medi-Cal face difficulties accessing dental services and that the California Department of Health Care Services was not adequately monitoring the Denti-Cal program.[15] In April 2016, the Little Hoover Commission, at the bequest of state legislators, released a robust study of the Denti-Cal program with the following main findings:[16]

- Reimbursement rates for dental services are among the lowest in the country, leading to lower provider participation.
- The Denti-Cal program has arduous, and at times, arbitrary, billing and pre-authorization requirements often costing dental providers more in staff time than the provider receives in reimbursement. It is also difficult and time-intensive to become a Denti-Cal provider; enrolling in the program can take up to three to four months compared to the one to two weeks it takes to enroll in a standard commercial insurance plan.
- Low rates lead to increased instances of fraud, which in turn, lead to increased administrative oversight and burden.
- The coverage and provision of dental services are not evidence-based. For example, dental surgery can only be completed after alternative procedures have been performed that can be life threatening.

Both the State Audit and the Little Hoover Commission report uncovered serious systemic failures of the Denti-Cal program impacting the entire population enrolled in the program. However, neither report addressed the unique issues older adults face in accessing oral health care.

California has historically focused on how Denti-Cal fails to adequately serve children, with an emphasis on the need to direct more resources towards preventative care. Of course, as noted earlier, prevention in the early years of life will promote good oral health care across the life span. Yet, the aging population today has unique oral health needs that must be made a priority in policy discussions to improve the delivery of dental services in California.

Unique Needs of Older Adults in California

Today, one out of five older adults in California live in poverty.[17] If California's older population is estimated to double from about five million to over ten million by 2050.[18] Many of these older adults will also age into poverty and will rely on public programs like Denti-Cal to meet their oral health needs. While many of these older adults will have better overall oral health than earlier generations, due to improved access to fluoride and dental services, the current systems, if left unaddressed, will continue to fail older adults.

14 "Fixing Denti-Cal," Little Hoover Commission (April 2016), available at http://www.lhc.ca.gov/studies/230/Report230.pdf.

15 "California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care," California State Auditor (Dec. 2014), available at https://www.auditor.ca.gov/pdfs/reports/2013-125.pdf.

16 See Footnote 14.

17 "A State by State Snapshot of Poverty Among Seniors" Kaiser Family Foundation (May 2013), available at http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8442-a-state-by-state-snapshot-of-poverty-among-seniors.pdf.

18 "Interim Population Projects for California and its Counties 2010-2050" State of California, Department of Finance, Sacramento, California (May 2012), available at http://www.dof.ca.gov/Forecasting/Demographics/Census_Data_Center_Network/documents/Overview_Interim_Projections_WSchwarm_5-8-2012.pdf.

California has Neglected the Oral Health Needs of Older Adults

California is currently ranked thirtieth in the nation with regard to how it addresses oral health for older adults.[19] This poor ranking is based on a number of factors: namely, California does not have a state oral health plan, much less an oral health plan that addresses the needs of older adults. California also has never completed an older adult basic screening survey (and has no plans to do so) to determine the oral health needs of older adults. And while California's Medi-Cal program does include adult coverage, it fails to cover key preventative and curative services including periodic oral evaluations, limited oral evaluations, and scaling and root planing.[20] The failure to define and determine the scope of challenges older adults face in California has seriously constrained efforts to improve the delivery of oral health services.

Aging Impacts Oral Health

Even with good preventative care and access to oral health treatment throughout life, the condition of our mouth and teeth deteriorates as we age. A lifetime of using our teeth wears away enamel, and our gums naturally begin to recede, making our teeth more susceptible to cavities and other dental conditions. Our jawbone also starts to shrink, causing tooth loss. Our ability to create saliva decreases, making it more difficult to eat and increasing the likelihood of infection. As eating becomes more difficult, we gravitate towards softer foods and supplements that are high in sugar, which in turn further worsen the condition of our teeth. This is compounded by cognitive, physical, and sensory impairments that make it difficult for older adults to regularly brush their teeth and maintain good oral hygiene.[21]

Oral Health Impacts General Health

Poor oral health has a substantial impact on the overall general health of older adults to a greater extent than for younger populations. Tooth decay and associated mouth pain make it difficult to eat, leading to weight loss and poor nutrition, which only exacerbate chronic conditions like hypertension, diabetes, and hyperlipidemia – conditions that individuals are more likely to acquire later in life.[22] Poor oral health also leads to increased infections, which early research associates with higher risk for heart and lung disease, suffering a stroke, and experiencing diabetic complications.[23] For older adults with weakened immune systems, oral infections can act as a source for ongoing infection.[24]

Poor oral health also has a significant impact on overall quality of life. Mouth pain can lead to disruption in sleep, increasing the likelihood for depression and insomnia. Nineteen percent of low-income adults reduce participation in social activities due to oral health issues, increasing the likelihood for social isolation and depression.[25] Additionally, one in four Californians feel

19 "A State of Decay, Are Older Americans Coming of Age Without Oral Healthcare?" Oral Health America and the Wisdom Tooth Project (2016), available at http://toothwisdom.org/pages/a-state-of-decay.

20 *Id.*

21 "Aging and Dental Health," American Dental Association, available at http://www.ada.org/en/member-center/oral-health-topics/aging-and-dental-health.

22 "Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants," Journal of Nutrition (February 2010), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2806885/.

23 "Oral Health in America: A Report of the Surgeon General," Dept. of Health and Human Services (2000), available at http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf.

24 *Id.*

25 See Footnote 7.

embarrassment due to oral health issues, one in five experience anxiety, and three in ten avoid smiling due to the condition of their mouth and teeth.[26]

There is a Shortage of Dentists Trained to Treat Older Adults

The Little Hoover Commission found that there are not enough providers to adequately serve enrollees in the Denti-Cal program. Both the poor administration of the Denti-Cal program and abysmal reimbursement rates are at fault. This overall shortage is more problematic for older adults, who are more likely to require providers with specialized training to effectively treat oral health issues that are complicated by other chronic health conditions.[27] For example, older adults are prescribed a large number of medications that have side effects that worsen their oral health. Older adults are also more likely to suffer from cognitive impairments like dementia or Alzheimer's disease that inhibit communication and may require the administration of anesthesia to safely perform dental procedures.

Most U.S. dental schools do offer a geriatric dentistry course, but only about 25% of schools offer a clinical course to serve older adults directly.[28] Consequently, there are few dental students who receive focused clinical experience in treating older adults. When reimbursement rates are exceedingly low and the barriers to serve as a provider in the Denti-Cal program are so high, those few dental providers with specialized training in treating older adults are unlikely to participate.

Coverage is not Comprehensive Enough to Meet the Needs of Older Adults

Many older adults, who are no longer able to work, lose dental coverage through employer-based dental plans (if they had it) and must rely on Medicare or Medi-Cal. Yet, these programs do not offer comprehensive coverage. Medicare does not cover dental cleanings, extractions, dentures, or most other dental care. Instead, Medicare provides only very restrictive coverage defined as hospital-based oral health services. Medi-Cal, which had cut dental benefits in response to state budgetary pressures, began covering dental services for adults again in May 2014, but only partially. However, root canals on back teeth, partial dentures, and treatment for gum disease remain uncovered. Medi-Cal also does not cover replacement dentures that may be needed if advancing age or health conditions cause changes in the jaw.

Dental Coverage for Older Adults is Complex

Ms. Clark was referred to a dentist by her Managed Care Organization that offered supplemental dental coverage. She assumed that her procedure would be covered because she was referred by her health plan, and the dentist was listed as a participating dentist. She presented her insurance card to the dentist staff, and was never told that the dental services she was receiving during that and subsequent visits were not covered and that she would have to pay out-of-pocket.

26 See Footnote 7.

27 "Dental Considerations for the Frail Elderly," Michael J. Helgeson, Barbara J. Smith, Mary Johnsen, Carl Ebert (2000), available at http://www.mohc.org/files/SCD%20Frail%20Elderly%209-11-02%20Helgeson%20(2).pdf.

28 "Geriatrics Education in U.S. Dental Schools: Where Do We Stand, and What Improvements Should Be Made?" Naomi Levy, D.M.D.; Ruth S. Goldblatt, D.M.D.; Susan Reisine, Ph.D (Oct. 2013), available at http://www.jdentaled.org/content/77/10/1270.full.

Older adults receive their dental coverage through a number of different programs including Medicare, Medicare Advantage, Medi-Cal, and new combined Cal MediConnect plans.

Medi-Cal Coverage

Most low-income older adults in California are either enrolled in a managed care plan for their Medi-Cal benefits or receive their Medi-Cal benefits through fee-for-service. The Medi-Cal plan and program, however, are not directly responsible for delivering the dental benefit. Instead, dental benefits are "carved out" and delivered through Denti-Cal. Most older adults receive their dental benefits through fee-for-service Denti-Cal, but some older adults are either mandatorily enrolled in or have the option to enroll in a separate managed care plan just for the dental benefit. Consequently, older adults access their dental benefits through a different process with different rules than the way they access all of their other health care benefits.

Medicare Coverage

Most older adults receive their Medicare benefits through traditional fee-for-service Medicare, with extremely limited coverage. Others are enrolled in a Medicare Advantage plan that may offer supplemental dental benefits that are not available in traditional Medicare. However, accessing the supplemental benefits is confusing and burdensome. When using the supplemental benefits, older adults must see providers who are contracted with the Medicare plan. Often these providers are not contracted with Denti-Cal, which means older adults have to see two different providers to receive their dental services. Moreover, they have to navigate two different sets of benefits with different authorization processes and coverage.

A 69 year old Cal MediConnect member needed a dental implant for a tooth she had to have pulled. She had never accessed her CMC dental benefits before so she relied on her plan and the dentist to explain her scope of coverage. While at the dentist, the office staff had the member enroll in a high-interest dental credit card and sign a financial responsibility agreement, which they said would only be necessary if her plan would not cover any of the services. The office staff gave her no reason to believe her plan would not cover all services, including the zirconium implant that the office staff encouraged her to have done (instead of a cheaper implant option). Ultimately, the zirconium implant was a non-covered benefit, and the member ended up with a $500 charge on her dental credit card. She couldn't afford the bill, which had accrued interest, and was sent to collections. She was afraid to go in for her follow-up visit on the implant in case of more charges.

Cal MediConnect Coverage

Older adults with both Medicare and Medi-Cal health insurance, living in certain counties in California, have an option of joining a health plan that combines their Medicare and their Medi-Cal benefits, called Cal MediConnect. These individuals receive the bulk of their dental benefits through Denti-Cal, and some Cal MediConnect plans, like Medicare Advantage plans, offer supplemental dental benefits. Again, older adults must access dental services through two different plans.[29]

29 For a detailed explanation and example of the complexity of accessing dental coverage in Cal MediConnect, see "Cal MediConnect Dental Benefits," available at http://justiceinaging.org/wp-content/uploads/2015/06/LA-CCI-Dental-Benefits-FINAL.pdf.

Such complexity is difficult to navigate for older adults, the advocates who serve the aging population, and dental providers. Such cumbersome processes lead many older adults to forgo services altogether or they become stuck in the confusing shuffle. Others, unfortunately, end up seeking services through a costly visit to the emergency room. Worse yet, not understanding what services are covered, many older adults unknowingly sign up for high-interest credit cards or agree to costly payment plans offered by dental providers.

Dental Services are Not Co-Located with Health Services

Low-income older adults have a number of chronic conditions that necessitate frequent trips to provider offices, but getting to those medical appointments is particularly challenging for older adults. As we age, we may lose the ability to drive or use public transportation because of physical and cognitive impairments. Co-locating dental services with health care services or community services would improve access for oral health. However, dental services are not frequently co-located with health services in California. For example, few Federally Qualified Health Centers (FQHCs) have co-located dental services with primary care.[30] Likewise, there are funding and regulatory barriers that inhibit co-locating dental services where older adults receive services, such as senior centers.

Preliminary Recommendations

The Little Hoover Commission offered eleven recommendations to address the systemic issues with Denti-Cal including, for example, streamlining billing, pre-authorization, and administrative requirements; simplifying provider enrollment; establishing an evidence-based advisory group; and expanding teledentistry and virtual dental homes. The Commission also recommended increasing preventative services for children and recruiting pediatricians to conduct preventative dental checkups during well-child visits. The following additional recommendations should also be adopted to consider the unique needs of older adults.

Improve Provider Access

Legislation should be adopted to improve the Denti-Cal program. AB 1051 has been introduced that would increase Denti-Cal funding to attract and retain more providers in the Denti-Cal program, increase funding for preventative care and management services, and increase reimbursement rates for the fifteen most common preventative treatment and oral evaluation services. AB 2207 also has been introduced to implement recommendations of the Little Hoover Commission, including expediting the Denti-Cal provider enrollment process and improving the Department of Health Care Services (DHCS) oversight of the Denti-Cal program.

Include Older Adults in a State Oral Health Plan

Last year, California appointed a State Dental Director who is currently developing an Oral Health Plan. This will undoubtedly lead to improvements in the provision of dental services, particularly for children. To ensure that the needs of older adults are heard and considered, advocates serving older adults should participate in policy discussions with both DHCS and the State Dental Director. California can look to Minnesota, a state that has emerged as a leader in addressing the oral health of older adults by including older adults in its state plan, establishing an

30 "Expanding Access to Dental Care Through California's Community Health Centers," California HealthCare Foundation (Aug. 2008), available at http://goo.gl/1yIIHG.

advisory group, and developing a basic screening survey for older adults.[31]

Expand Covered Services

Denti-Cal coverage must be expanded to include currently uncovered services necessary to maintain oral health for older adults including root canals for the back teeth, treatment of gum disease, and partial dentures. Right now, because these services are not covered, there is a perverse incentive to extract all of an older adult's teeth so that they can obtain full dentures, which are a covered benefit.

Streamline Program Administration

In efforts to streamline Denti-Cal administrative requirements, DHCS should review its regulations and administrative guidance to better coordinate dental benefits with the delivery of other health benefits. For example, DHCS could require Medi-Cal plans to coordinate Denti-Cal benefits for their enrollees. In implementing a customer-focused program for providers, DHCS could also implement a better customer-focused program for Denti-Cal enrollees that could help older adults navigate through the maze of coverage.

Incentivize Treatment of Older Adults

Under Medi-Cal 2020, California's new 1115 waiver, through the "Dental Transformation Initiative," there are several incentives to improve provider participation in Denti-Cal and provide preventative services for children.[32] Incentives, however, must also be adopted that encourage more providers to both obtain training to treat older adults and provide services to older adults. California should also consider incentive programs to encourage increased integration of oral health with the provision of primary health care.

In April 2016, the Older Americans Act was reauthorized and now permits the state and area agencies on aging to direct their funding towards disease prevention and health promotion activities and to conduct oral health screenings. California should offer guidance to the area agencies on how to best leverage their funding to take on these new allowed activities to promote oral health.

Promote Co-Location of Services

In addition to directing more beneficiaries to Federally Qualified Health Clinics (FQHCs), more is needed to increase the capacity for FQHCs to offer dental services, including providing clarity on reimbursement and incentives to increase the number of providers willing to work in community clinics. Health and Human Services recently awarded $156 million to health centers across the country. California should also consider investing additional resources in clinics offering dental to ensure increased capacity. Co-located dental services at senior centers should also be encouraged. Currently, senior centers and other non-clinics are governed by the same guidelines as clinics.[33] These regulations should be reviewed to determine if regulations should be amended to encourage co-located services in non-clinic settings.

31 See Footnote 19.

32 Dental Transformation Initiative available at http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx.

33 For example, non-clinic settings like senior centers are required to meet the same standards as a health clinic with dental services, including: installing separate AC systems in the waiting room and the clinical area; adding a bathroom in the dental clinic when restrooms are located outside of the dental clinic; adding a janitor closet; developing a policy for treating children despite not serving children; developing a drug distribution policy when drugs are not distributed.

Conclusion

While the recent and increased attention to oral healthcare in California is encouraging, California must do more to ensure improved oral health for its aging population. A state with such a large population of older adults and a high quality health care system should not rank 30th in dental care for older adults. The recommendations outlined above are broad and preliminary, based on what is known about the current state of oral health among older adults in California. It is clear that California's older adults have significant and distinct oral health needs that currently are not being addressed. The inclusion of the needs of older adults in policy discussions and proposals is a necessary first step. It is also imperative that California conduct an oral health needs survey to determine both the scale and scope of oral health issues low-income older adults face. In the absence of full knowledge of the problem, the state should still begin to implement the above recommendations to improve oral health among older adults in California sooner, rather than later.

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