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CALIFORNIA'S MASTER PLAN FOR AGING

Oral Health Recommendations

California has committed to developing a Master Plan for Aging in order to meet the needs of older adults today and for generations to come. The state has outlined four broad goals that the plan should accomplish: Every Californian should be able to 1) continue living in our communities and have the help we need to do so; 2) live in and be engaged in age-friendly communities; 3) maintain our health and well-being as we age; and 4) have economic security and be able to live in safe environments throughout our lives.

Advocates and service providers have broadly supported the state's efforts to develop the Master Plan, developing principles and priorities to guide the planning process. This issue brief focuses on the specific topic of oral health.

The Master Plan offers an opportunity to improve the oral health of older adults in California. Oral health is of critical importance to overall health. Unfortunately, the attention to the oral health needs of older adults has been inadequate. As a consequence, older adults have significant unmet oral health needs impacting their overall health and emotional and social well-being. For example, 50 percent of older adults living in nursing facilities and 33 percent in the community have untreated tooth decay.[1] We also know that poor oral health disproportionately impacts older adults of color, individuals with disabilities, and those residing in institutional settings and rural areas. Nationally, for example, 31 percent of Black older adults have complete tooth loss compared to 15 percent of white older adults.[2]

Untreated oral health needs complicate chronic conditions like diabetes and heart disease, increase the likelihood of infection, and have significant impact on emotional and overall well-being. Below we outline seven recommendations to equitably improve oral health outcomes for older adults and people with disabilities.

1. COLLECT ORAL HEALTH DATA ON OLDER CALIFORNIANS AND PEOPLE WITH DISABILITIES

California must collect oral health data by age, disability, race, primary language, sexual orientation and gender identity, and setting. Today, there is a nearly complete absence of data on the oral health status of older adults and people with disabilities, their treatment needs, insurance coverage, and utilization of

1 Center for Oral Health, "A Healthy Smile Never Gets Old: A California Report on the Oral Health of Older Adults," Nov. 2018, available at centerfororalhealth.org/wp-content/uploads/2018/11/Oral-Health-of-Older-Adults.pdf.

2 Centers for Disease Control and Prevention, "Oral Health Surveillance Report 2019, Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999-2004 to 2011 to 2016" (2019) (herein after "Oral Health Surveillance Report"), available at cdc.gov/oralhealth/pdfs_and_other_files/Oral-Health-Surveillance-Report-2019-h.pdf.

services.[3] This makes it particularly difficult to assess the extent of the need, develop solutions, and target resources. This is especially true for measuring disparities. Available California and national data demonstrate significant racial disparities in oral health outcomes, but California data is not disaggregated for older adults and is outdated. Data based on disability and by residential setting (e.g. home, residential congregate setting, rural, urban) is non-existent.

In addition to demographic data, California must also collect and report data on the availability of oral health services in communities of color, the number of providers that are trained to treat older adults and people with disabilities with complex care needs, and providers available by residential setting (e.g. residential care facilities like nursing homes; and rural/urban). For example, in Los Angeles County, there are significant regions that have a high density of low-income individuals and no or insufficient dental services.[4] Such data is critical to establishing baselines, targeting resources, addressing disparities, and developing solutions to meet the oral health needs of older adults and people with disabilities.

2. INCLUDE OLDER ADULTS IN ORAL HEALTH STATEWIDE PLAN AND LOCAL ORAL HEALTH PLANS

California has developed a statewide oral health plan, but the plan contains few objectives aimed specifically at improving oral health outcomes for older adults.[5] With funding from Proposition 56, counties have also developed local oral health plans under the leadership of the statewide Office of Oral Health. Unfortunately, most of these local plans also omit older adults or include few objectives to improve their oral health.

The Office of Oral Health must develop objectives specific to older adults to implement statewide and to guide local oral health planning. At minimum, such planning objectives should include increasing the number of providers trained and able to provide care to individuals with complex and chronic health care conditions, and better integrating oral health into medical care. These objectives also must specifically address oral health disparities based on race, disability, and residential setting.

3. ENHANCE DELIVERY MODELS TO BETTER REACH OLDER ADULTS AND PEOPLE WITH DISABILITIES

California must develop delivery models for oral health services that can better connect older adults and people with disabilities to oral health services in their homes and communities, much like efforts to connect children to oral health services in school-based settings and through other mobile clinics. These models would emphasize prevention and early intervention, lower the cost of treatment services, and reduce the costs and consequences of oral health neglect. Such delivery models would, for example, include the expansion of teledentistry, the virtual dental home, and co-location of oral health services with medical services. To ensure such models do not perpetuate existing racial and other disparities, investments must be made to ensure their availability to individuals with limited English proficiency.

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3 California Department of Public Health, "Status of Oral Health in California: Oral Disease Burden and Prevention 2017," available at cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/Status%20of%20Oral%20Health%20in%20California_FINAL_04.20.2017_ADA.pdf.

4 Cabezas, Martita, DDS, MPH, County of Los Angeles Public Health, "Identifying Dental Deserts in the Los Angeles Safety Net Using GIS Maps," (2016), available at nationaloralhealthconference.com/docs/presentations/2016/04-19/Maritza%20Cabezas-Dental%20Deserts%20of%20the%20Los%20Angeles%20County%20Safety-Net%20Dental%20Clinics%20Using%20GIS%20Maps.pdf.

5 California Department of Public Health, "California Oral Health Plan, 2018-2028," Jan. 2018, available at cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/FINAL%20REDESIGNED%20COHP-Oral-Health-Plan-ADA.pdf.

4. COMMIT TO CONTINUED MEDI-CAL DENTAL COVERAGE

California must commit to continued Medi-Cal dental coverage with a sufficient provider network to ensure access. Federal rules do not require states to include dental coverage for adult Medicaid recipients. Consequently, California has eliminated adult dental coverage in the past during times of budget shortfalls, and proposed such cuts in the 2020-21 budget. While coverage was maintained in the final 2020-21 budget, cuts to provider rates are set to take effect next July. Such cuts are shortsighted. Cutting oral health coverage increases other costs to Medi-Cal, such as increased emergency room use for oral health problems and costs associated with chronic conditions. Such cuts also disproportionately impact communities of color. Of those who lose coverage, 73% are from communities of color: 48% are Latinx, 8% are Black, and 15% are Asian American/Pacific Islander American.[6]

In light of COVID-19, many older adults and people with disabilities have deferred or postponed needed dental care, so access to oral health coverage is needed more now than ever. California, therefore, must make adult Medicaid dental coverage a permanent benefit and reimburse providers at rates that ensure network adequacy. We cannot return to coverage that forced older adults to have their viable teeth extracted in order to obtain dentures.

5. DEVELOP STATEWIDE MEDI-CAL DENTAL ADVISORY BOARD

California should create an evidence-based advisory group for the Medi-Cal dental program to guide decisions and make sure they are based on the best evidence and science and not merely on cost.[7] This advisory board would be responsible for establishing, for example, Medi-Cal utilization targets for older adults and people with disabilities. The most recent Medi-Cal dental utilization data indicates that fewer than 1 in 4 older adults had an annual dental visit in 2018, and just over 1 in 10 accessed a preventive service.[8] The Department of Health Care Services has established statewide Medi-Cal utilization targets for children. Unfortunately, no such utilization targets are in place for older adults and people with disabilities and none to address disparities based on race, disability, and residential setting.

The advisory board would also be responsible for ensuring that Medi-Cal dental coverage is evidence-based and that care models are designed to adequately provide services to older adults and people with disabilities with complicated health, physical, and social conditions. For example, individuals with complex care needs often require additional time for oral health services to be rendered compared to individuals with less complex care. Today, the Medi-Cal dental system is a "one-size-fits-all" program that fails to account for these differences in care needs. Consequently, providers are less willing to serve older adults and people with disabilities. Having a Medi-Cal Dental Advisory Board would serve to improve access to oral health for all Medi-Cal enrollees.

6. ENFORCE MEDI-CAL MANAGED CARE PLANS RESPONSIBILITIES TO CONNECT MEMBERS TO ORAL HEALTH CARE

In 2016, the California Legislature passed AB 2207 that puts in place a number of measures to improve the Medi-Cal dental program and oral health outcomes. Specifically, the law requires Medi-Cal managed care

6 Families USA analysis of American Community Survey (ACS) data for 2018. IPUMS USA, Minnesota Population Center, University of Minnesota, usa.ipums.org/usa.

7 Little Hoover Commission, "Fixing Denti-Cal," April 2016, available at lhc.ca.gov/sites/lhc.ca.gov/files/Reports/230/Report230.pdf.

8 Department of Health Care Services, Adult Dental Utilization CY 2017 and CY 2018, available at dhcs.ca.gov/services/Pages/DentalReports.aspx.

plans to connect their members to oral health care; provide a dental screening for every enrolled member as part of the initial health assessment; refer members who have oral health needs to a Medi-Cal dental provider; and identify health plan liaisons to establish relationships with dental providers to assist referrals from dental providers to the health plans for health plan covered services. Despite this law, the Department of Health Care Services (DHCS) has issued no guidance to health plans on these requirements and not enforced these requirements. AB 2207 should be put in place immediately and enforced by DHCS with the requirement that managed care plans report on the number of screenings conducted and referrals made measured by race, disability, and residential setting.

7. SUPPORT FEDERAL MEDICARE COVERAGE

Today, traditional Medicare does not include dental coverage. As a result, nearly 37 million older Americans have no dental coverage. Efforts are underway to expand Medicare to include coverage for routine and preventive oral health care. A Medicare oral health benefit would provide coverage to all 6.2 million Medicare enrollees in California, including the 1.4 million Medicare beneficiaries dually enrolled in Medi-Cal. California should, therefore, support efforts to expand this federal coverage.

CONCLUSION

Expanding access to oral health for low-income older Californians will improve oral health outcomes, combat systemic health inequities, and is key to improving their overall health. By collecting robust data to assess the need, expanding availability of coverage, enhancing delivery models, continuing to provide dental coverage through Medi-Cal, developing a statewide advisory board, enforcing Medi-Cal managed care plan requirements, and supporting the expansion of oral health coverage nationwide through Medicare, California can meet the core goals of the Master Plan for Aging. All Californians should be able to live in the community with the help we need to do so, live in and be engaged in age-friendly communities, maintain our health and well-being as we age, and have economic security and be able to live in safe environments throughout our lives.