Improving Denti-Cal Provider Reimbursement Impacts Access to Dental Care for California's Children

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About COH:
The Center for Oral Health (COH), founded in 1985, is a non-profit organization dedicated to promoting public oral health, with a focus on children and vulnerable populations. COH collaborates with national, state, and local partners to develop innovative community-based strategies for improving oral health outcomes. COH has offices in Northern and Southern California.

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Poor oral health among low-income children is gaining more attention as a significant healthcare problem. Tooth decay remains the most common chronic illness among school age children in the United States.[1] Though children's oral health is a primary part of their overall health, California ranked 41st out of 50 in a recent national ranking of children's well being. Currently, California is home to 9.3 million children, approximately 13% of the total child population in the United States.[2] And almost half of California's children now live in low-income families.[3] With limited access to basic health care services, too many lower-income children suffer needlessly from untreated tooth decay. One of the key barriers to dental services stems from the low reimbursement rates of Denti-Cal, California's Medicaid for dental services. As a result, a shortage of expendable income combined with a shrinking Denti-Cal provider network threatens to negatively affect the oral health of an increasing number of California children.

Because oral health is a fundamental component of children's overall health, poor dental health negatively impacts all areas of children's development. For example, children who lack health coverage generally perform worse in school.[4] California students miss an estimated 874,000 days of school each year due to dental problems, costing schools over $29 million each year.[5] In addition, children who reported having recent tooth pain were 4 times more likely to have a low grade point average.[6]

By kindergarten, over 50% of children in California have already experienced dental decay and 28% have untreated decay.[7] In fact in 2011, children on Denti-Cal had 26,614 emergency room visits for dental problems.[8] While the American Academy of Pediatric Dentistry recommends that children have a dental visit by the time their 1st tooth appears and no later than their 1st birthday,[9] 37% of 2-and 3-year-olds in California have never been to the dentist.[10] These rates are even lower for California's poorest young children, as only 1 in 3 children ages birth-to-3 enrolled in Denti-Cal have seen a dentist.[11]

To date, approximately 3.6 million children are enrolled in Denti-Cal and nearly half of all California children are expected to be enrolled by early 2014.[12] Currently, there is a shortage of providers, with only 1 in 4 California dentists providing services to Denti-Cal beneficiaries. Many of these dentists see a low volume of children on Denti-Cal.[13]

Dentists cite low reimbursement rates as the number one reason for not accepting Denti-Cal patients.[11] In addition, 22 California counties have no pediatric dentists who accept Denti-Cal.[14]

Each year, a new group of dentists begin their practices in California, many of whom are extremely willing to treat the underserved patient populations; however, high debt and poor Denti-Cal rate reimbursements prohibit these willing providers from doing so. Simply put, providers cannot afford to provide treatment if their reimbursement is less than the cost of providing care. By increasing funding for Denti-Cal provider reimbursement the dental provider network will expand and children will be able to regularly access more available dental care.

The Medi-Cal system is foundational to the state's implementation of federal health care reform, which expands coverage for children, youth, and families. This influx of large numbers of children into Denti-Cal has highlighted concerns around continuity of care and the adequacy of the program's dentist and specialist networks.[15] The 2013-14 state budget includes a 10% reimbursement rate reduction to most Medi-Cal providers. The only pediatric service affected by the cut is dentistry, despite the fact that California already ranks among the lowest nationally in reimbursing dental providers in Medicaid.[16] In 2013, during the state-mandated transition of children from Healthy Families to Medi-Cal, the Department of Health Care Services worked to recruit more dental providers to accept Medi-Cal payments in order to ensure that children have access to oral health care. However, the Medi-Cal payment rate cuts will likely reduce the number of providers available and harm children's access to care.

The Affordable Care Act mandates that California provide every child with affordable and comprehensive health insurance coverage, including children's dental coverage for basic preventive services. Quality dental insurance coverage not only allows children to regularly access care, but it makes fiscal sense. Children accounted for 40% of Medi-Cal enrollment in 2010,[17] but only 18% of its expenditures.[18] While providing children with comprehensive health coverage through Medi-Cal is relatively inexpensive,[19] the potential savings are quite significant. For example, each preventable child hospitalization costs the state an estimated $7,000.[20] Providing financial incentives for pediatricians to explain the importance of routine dental care to parents will help increase the utilization of cost-effective, preventive dental services for children.

Each year approximately 500,000 infants are born in California.[21] Many of these children will have coverage with Denti-Cal, but will not be able to find a provider. We call on California legislators to prioritize the increase in funding of Denti-Cal to ensure adequate provider networks and timely access to services so children can actually get the care these programs are intended to deliver. Rate increases are necessary – although not sufficient on their own – to improve access to dental care. In addition, easing administrative processes and involving individual dentists as active partners in program improvement are also critical.

Now is the time to act to make a positive impact in children's lives and improve access to dental care.

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The views expressed in this brief do not necessarily reflect the views of Center for Oral Health. This brief is a work in progress and/or is produced in parallel with other briefs contributing to other work or formal publications by Center for Oral Health. Comments are welcome; please direct them to Dr. Conrado Bárzaga at cbarzaga@tc4oh.org

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