

# Access to Dental Care

## DEFINITION

*Access to dental care* is the percentage of children under age 21 who were enrolled in RIte Care, RIte Share or Medicaid fee-for-service on September 30 who had received dental services at any point during the previous federal fiscal year.

## SIGNIFICANCE

Dental caries (tooth decay) is the most common disease among children five to 17 years old.<sup>1</sup> Children with untreated dental problems are more likely to have problems chewing and swallowing, speech problems and poor school performance due to difficulty concentrating and absenteeism.<sup>2</sup>

Insurance is a strong predictor of access to health and dental care. Nearly one in four (24%) uninsured children in the U.S. has unmet dental needs, compared with 6% of those with Medicaid and 4% of those with private health insurance.<sup>3</sup> National estimates indicate that the number of children without dental insurance is 2.6 times greater than the number without medical insurance.<sup>4</sup> The percentage of Rhode Island children with dental insurance increased in the 1990s through the early 2000s (from 62% in 1990 to 76% in 2004, the most recent year for which data are available).<sup>5,6</sup>

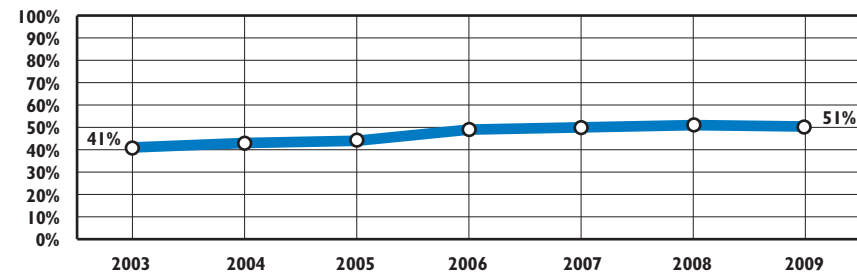
Children living in poverty are more likely to have severe and untreated tooth

decay than higher-income children. Medicaid-eligible children are twice as likely to have dental disease as higher-income children, although children with Medicaid coverage have better access to dental care than those without insurance. For children in low-income families, the efficacy and continuity of public dental insurance is a critical factor in access to dental care. In the U.S., children who have continuous enrollment in public health insurance programs have greater access to dental and medical care than children who have no insurance or are covered for only part of the year.<sup>7,8,9</sup> Children who are uninsured for only part of the year are nearly six times as likely to have an unmet dental need as children who are insured for a year or more.<sup>10</sup>

Minority children have the highest rates of tooth decay and untreated dental problems. One in five (19%) Hispanic children in the U.S. has gone for more than two years without a dental visit, compared with 15% of non-Hispanic Black and 14% of non-Hispanic White children.<sup>11,12</sup>

Children with special health care needs may have problems finding and accessing providers who are trained and equipped to address their special dental, medical and mobility needs.<sup>13</sup> A dental home can provide comprehensive, continuously accessible, coordinated and family-centered oral health care.<sup>14,15</sup>

**Children Enrolled in Medical Assistance\* Programs Who Received Any Dental Service, Rhode Island, Federal Fiscal Years 2003-2009**



Source: Rhode Island Department of Human Services, Federal Fiscal Years 2003-2009. \*Medical Assistance includes RIte Care, RIte Share or Medicaid fee-for-service.

◆ Half (51%) of the children who were enrolled in RIte Care, RIte Share or Medicaid fee-for-service on September 30, 2009 received a dental service during Federal Fiscal Year 2009.<sup>16</sup> The Centers for Medicare and Medicaid Services (CMS) reports that Rhode Island ranked 6th best in the U.S. for the percentage of children under age 21 enrolled in Medicaid who received dental services in Federal Fiscal Year 2008.<sup>17</sup>

◆ The increase in access to dental care for low-income children has been attributed to the RIte Smiles program, Rhode Island's dental benefits management program for young children (who were born on or after May 1, 2000).<sup>18,19</sup> As of December 31, 2009, there were 45,684 Rhode Island children receiving dental benefits through the RIte Smiles program. At the end of 2009, there were 276 dental providers participating in the RIte Smiles program, up from 90 when it began in September 2006. All children receiving Medical Assistance who were born before May 1, 2000 continue to receive dental benefits under the fee-for-service system.<sup>20</sup>

◆ The federal Medicaid program mandates that states provide comprehensive dental services, including diagnostic and preventive services, treatment services, emergency services, and medically necessary orthodontic services to eligible children up to age 21.<sup>21</sup>

◆ Dental insurance is not available to many working families in Rhode Island. In 2007, half (50%) of Rhode Island employers reported offering dental insurance to their full-time employees, and 9% offered it to their part-time employees (compared to 79% and 10% who offer health insurance, respectively).<sup>22</sup>

## Oral Health Services for Young Children

- ◆ Nearly one-half of children in the U.S. do not receive dental care in accordance with the American Academy of Pediatric Dentistry's recommendations of two visits per year beginning at age one. The youngest children are the least likely to receive dental care.<sup>23</sup>
- ◆ There are too few dentists in the U.S. trained to treat very young children, and too few who treat children with special health care needs or those who have public insurance.<sup>24</sup>
- ◆ Despite significant improvements in oral health in the U.S., the number of very young children with dental caries (cavities) in their primary teeth has increased. Between 1988 and 1994, 24% of children ages two to five had caries, compared with 28% between 1999 and 2004, an increase of 17%. Between 1999 and 2004, more than half (51%) of children ages six to 11 had dental caries, essentially the same as between 1988 and 1994 (50%).<sup>25</sup>

## Medicaid Reimbursement Rates

- ◆ In 2006, reimbursement rates were raised for Rhode Island dental providers participating in the RIte Smiles program. As a result of RIte Smiles, the number of dentists accepting qualifying children with Medical Assistance has increased from 27 in 2006 (before RIte Smiles) to 90 (at the launch of RIte Smiles) in September 2006 to 276 in 2009.<sup>26</sup>
- ◆ General dentists and specialists providing oral health services to Medicaid-enrolled children who do not qualify for RIte Smiles continue to be reimbursed at Medicaid fee-for-service reimbursement rates.<sup>27</sup> Fewer than 1% of dentists in Rhode Island report that the Medicaid reimbursement rate is equal to or greater than their standard rate. Rhode Island's fee-for-service Medicaid reimbursement rates for key dental services for children have not been increased since 1992 and continue to be the lowest in New England and to lag behind much of the nation.<sup>28,29</sup>
- ◆ Dentists cite low reimbursement rates that fail to cover the cost of services and administrative difficulties as the two main reasons for limiting or not serving Medicaid patients. State efforts to attract more dentists to Medicaid by paying higher fees and streamlining administrative requirements have resulted in increased access.<sup>30</sup>

## Consequences of Untreated Dental Disease

- ◆ Between 2006 and 2008, an average of 881 children under age 21 were treated for a primary dental-related condition in Rhode Island emergency departments each year. Half (49%) of these children had public insurance (Medicaid/RIte Care) and 26% had private/commercial health or dental insurance. Nearly one-quarter (23%) were self-pay patients, which could mean that their health or dental insurance did not cover the cost of the emergency department visit or that they were uninsured. The number of children treated for a dental condition at emergency departments increased from 813 in 2006 to 875 in 2007 and 956 in 2008.<sup>31</sup>
- ◆ Between 2006 and 2008 in Rhode Island, an average of 56 children under age 19 were hospitalized each year with a diagnosis that included an oral health condition, and an average of 13 children were hospitalized each year with an oral health condition as the primary reason for the hospitalization.<sup>32</sup>

## State Policy Solutions for Children's Oral Health

- ◆ Ensuring that children have good oral health and access to care can be achieved through a combination of policy solutions that cost relatively little and have large returns on investment. States can improve children's oral health when they implement school-based sealant programs in schools with many high-risk children, fluoridate their community water supplies, and ensure access to care for Medicaid-eligible children. Innovative workforce models can be used to expand the number of dental and medical providers that are able to offer oral health services when dentists are unavailable.<sup>33</sup>

### References

- <sup>1</sup> U.S. Department of Health and Human Services. (2000). *Oral health in America: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.
- <sup>2</sup> U.S. Department of Health and Human Services. (2000). *Tracking Healthy People 2010*. Washington, DC: U.S. Government Printing Office.

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- <sup>4</sup> Lewis, C., Mouradian, W., Slayton, R. & Williams, A. (2007). Dental insurance and its impact on preventive dental care visits for U.S. children. *Journal of the American Dental Association*, 138(3), 369-380.

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