ACCESS TO DENTAL CARE
FOR MEDI-CAL RECIPIENTS

by

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California Policy Seminar
Research Report
1990
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Published by
California Policy Seminar
University of California
1990
The California Policy Seminar, which funded this study, is a joint program of the University of California and state government to link systemwide University resources with state policy concerns. The Seminar sponsors research, conferences, seminars, and publications pertaining to public policy issues in California.

This analysis was supported by the Seminar's Technical Assistance Program. The views and opinions expressed in this report are those of the authors and do not necessarily represent the California Policy Seminar or the Regents of the University of California.
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ACKNOWLEDGMENTS

The authors would like to thank the following people for their valuable assistance in the completion of this study; Julie Damiano, Leslie Hanson, Thaddeus Juarez, Jae Hwan Kim, Amy Koepsell, Pelayo J. Pelayo, Jr., Mary Scheetz, Daniel Shugars, Vera Snyder, and Mel Widowski.

The authors would also like to thank the Special Committee on Medi-Cal Oversight of the California Legislature, the California Policy Seminar and the Robert Wood Johnson Foundation for their support and assistance in this project.

This study was approved by the Human Subjects Protection Committee of the University of California, Los Angeles.
EXECUTIVE SUMMARY

Access to dental services is important for the emergency treatment of pain and infection, the detection and diagnosis of oral diseases, the restoration of oral health, and the provision of preventive services. Regular check-ups, cleanings, sealants, and fluoride treatments can prevent the majority of oral health problems. These preventive treatments make it possible for young people today to grow up with fewer serious oral health problems.

However, access to dental services may not be available for many Medi-Cal eligible children and adults. Access to dental services for the poor is particularly important in California where only 17 percent of the residents live in areas with optimally fluoridated drinking water. In 1985, the Special Committee on Medi-Cal Oversight of the California Legislature heard testimony indicating that access to dental services for Medi-Cal recipients was inadequate due to declining participation by dentists in Medi-Cal. However, the degree of dentists' participation in Medi-Cal was unknown.

The four primary objectives of this study were to:
1. Determine the accessibility of dental services for Medi-Cal recipients.
2. Determine how Medi-Cal dental fee schedules compare with fee schedules for private dental practitioners.
3. Evaluate the perceptions of dentists toward Medi-Cal patients and toward the Medi-Cal program.
4. Evaluate the Medi-Cal dental referral program's ability to increase access to care.

Access to Medi-Cal dental services was measured in two ways. The first method was to determine the number of dentists who would accept new Medi-Cal patients. Dentists' participation was determined when research assistants called dentists as proxy Medi-Cal patients for a check-up appointment. The second measure of access was the amount of time these proxy Medi-Cal patients had to wait for a check-up appointment compared with a patient with private dental insurance. To prevent any financial loss, appointments made by the proxy Medi-Cal patients were canceled within two working days of the time of the call.

The fees paid by Medi-Cal were reviewed by comparing Medi-Cal reimbursement with fee schedules obtained from general practitioners, pediatric dentists, and a health maintenance organization (HMO). The dentists' perceptions of Medi-Cal patients and of the Medi-Cal program were determined by using telephone interviews with a systematically subsampled group of the dentists who did and did not accept new proxy Medi-Cal patients.

The Medi-Cal dental referral program, which matches patients with dentists who accept new Medi-Cal patients, provides a toll-free phone number established by the Medi-Cal program to allow patients to call and receive the name of a dentist in their area who accepts new Medi-Cal patients. Proxy Medi-Cal patients were used to determine the availability of providers in all the counties in the state, how up to date the information provided by the referral program was, and how successful the program was in placing Medi-Cal patients.
MAJOR FINDINGS

1. Access to dental services for Medi-Cal recipients is very limited.
   a. Only an estimated 16 percent of all general practice and pediatric dentists in California accept children as new Medi-Cal patients, and only 15 percent of all general practice dentists accept adults as new Medi-Cal patients. Both rural and urban areas have low provider participation, and many rural Medi-Cal patients have to travel a considerable distance because some rural counties do not have a single dentist who will accept them.
   b. Access to Medi-Cal dental services was further limited by the fact that Medi-Cal patients had to wait almost 40 percent longer, on average, for their first appointments than patients with private insurance. The longer a patient has to wait prior to an appointment, the greater the likelihood that the appointment will be missed.
   c. Access to care is also limited by dentists’ criteria regarding the type of Medi-Cal patients they will accept. Four out of 10 dentists interviewed qualified their acceptance of new Medi-Cal patients to only certain types, such as those with emergency or denture needs.
   d. The low number of providers participating in the Medi-Cal dental program has reduced access to dental care for children through the Child Health and Disability Prevention (CHDP) Program. All Medi-Cal eligible children over the age of three and non-Medi-Cal eligible children under age 19 from families with incomes up to twice the poverty level are required to be referred annually to a dentist. Many local CHDP programs are having difficulty identifying dentists in their area who will accept eligible children for referral.

2. Medi-Cal fee schedules are considerably lower than those for private practitioners.
   Medi-Cal fees were compared with fee schedules from general practitioners, pediatric dentists, and an HMO in California. On average, Medi-Cal pays less than half the fees established by the general practitioners and the HMO. In addition, Medi-Cal fees were estimated to pay only about two-thirds of the dentists’ overhead costs. Thus, many dentists lose money when they provide services to Medi-Cal dental patients.

3. Dentist had several concerns about Medi-Cal patients and about the Medi-Cal program.
   a. Although fewer than one in six dentists accepted new Medi-Cal patients, the majority of dentists interviewed indicated that they felt Medi-Cal was important for poor patients’ access to dental care and that they would not be able to receive dental services without the Medi-Cal program.
   b. Many dentists believe that the Medi-Cal program does not allow them to provide comprehensive care. They cite the lack of reimbursement for a second cleaning or for the use of sealants, a clear plastic coating placed on the biting surface of children’s back molars. The plastic fills in the deep grooves, protecting the teeth from cavities, which can begin in the grooves where it is difficult to clean.
   c. Low reimbursable fees were the most important problem reported by 98 percent of the dentists surveyed, with little difference between dentists who accepted new proxy Medi-Cal patients and those who did not.
   d. Dentists perceive the Medi-Cal dental program as administratively complex. A combination of problems such as denial of payment, complicated paperwork, and the need
to obtain prior approval for many routine services was seen as very important in determining dentists' participation in the program. Although Medi-Cal has made some effort recently to make the program less complicated, such as eliminating the need to receive prior authorization before treating children for routine procedures, the perception among the dentists surveyed was that Medi-Cal was still a complicated program.

4. The Medi-Cal dental referral program was found to have limited success in increasing access to care.

This referral program was effective in identifying dentists accepting new Medi-Cal patients in only 30 of the state's 58 counties. In the other 28 counties, proxy patients were unable to receive an appointment as a new Medi-Cal patient through the referral program. The low number of providers currently participating in the program, even in the 30 counties, also limits the success of the program. There are only 1,800 dentists in the referral network to serve all the new requests from the approximately 3 million Medi-Cal eligibles in California; if the level of knowledge among Medi-Cal recipients of the existence of the referral program was increased, these proportionately few dentists in the referral program could be overwhelmed with requests, and they might leave the program.

Conclusion: Access to dental care for Medi-Cal recipients fails to meet minimum federal standards for both participation of dentists and the level of fees paid in Medi-Cal.

The findings of this study indicate that with approximately 16 percent of the dentists in California accepting new Medi-Cal patients, the program is well below the minimum federal regulations for provider participation. The Medi-Cal fee schedules, estimated at less than half of the usual and customary fees in California, are also below federal standards. The low fees are not consistent with the prevailing community fee structures and discourage providers from participating in the program, thus reducing access to dental services.

Federal regulations indicate that at least two-thirds of the providers in a state should be participating in the Medi-Cal program. The regulations were strengthened in the federal Omnibus Budget Reconciliation Act of 1989, which states that fees should be set to encourage enough dentists to participate so that Medi-Cal recipients have the same access to dental services as persons with private insurance coverage in their same geographic area.

RECOMMENDATIONS

To approach the federal standards for access to care, the Medi-Cal dental program will need to attract a significant number of new dentists to the program.

Based on information from interviews with both dentists who do and do not participate in Medi-Cal, the authors offer the following recommendations for the Medi-Cal dental program:

1. Significantly increase reimbursable fees to a level above overhead costs.

   Most dentists realize that Medi-Cal will not be able to pay their usual fees. However, if the program is going to attract a significant number of new dentists who can provide quality care, a substantial fee increase is needed. If the fee increase is not large enough, it will simply add to the incomes of currently participating dentists and not attract new ones. An overall average increase of at least 50 percent would place Medi-Cal dental fees at a level that approximates overhead costs.
This fee increase could be implemented so that preventive and basic restorative services were increased 100 percent, with smaller increases for the more expensive procedures such as root canals, dentures, and crowns (caps). This would provide dentists with a small profit for those procedures most often provided Medi-Cal recipients, while overall costs to the Medi-Cal program for the more expensive procedures would remain about the same. It would also encourage dentists to perform primarily preventive, basic restorative, and emergency procedures for Medi-Cal patients.

Future fee increases could be tied to the consumer price index so that dentists deciding whether to participate in Medi-Cal could be assured that current fee increases will continue to be adequate in the future.

2. Simplify administrative procedures.
Making Medi-Cal dental claim forms similar to other insurance forms (instead of the present use of a unique coding system) would ease the paperwork burden, especially for solo practitioners with small office staffs — the majority of dentists in California.

As is the case with most private dental insurance programs, Medi-Cal could also eliminate the requirement that X-rays or written explanations be submitted for routine procedures, such as fillings, on adult patients. (Medi-Cal has removed this requirement for children.) The presubmission of X-rays for routine procedures increases the cost of service and does little to prevent fraud or to increase quality care. Many of the dentists interviewed complained that they were denied payment because of poor-quality X-rays — not because the film was not diagnostic. In order to be reimbursed, they had to take more X-rays, thus exposing patients to additional radiation.

3. Add dental sealants and a second cleaning to the services covered by Medi-Cal.
The Medi-Cal dental program has one of the most complete benefit packages for dental services of any Medicaid dental program in the country. However, there are two common preventive services that are lacking, which, if added, would increase the oral health of Medi-Cal recipients. The first is the use of dental sealants, and the other is the addition of a second cleaning per year, which would benefit many Medi-Cal patients whose periodontal (gums) health status may be poor. The addition of these two services would be a relatively low-cost way to improve care and thus decrease the perception among some dentists that Medi-Cal does not allow comprehensive care.

4. Keep dentists up to date about the Medi-Cal dental program.
Most of the dentists interviewed who were not participating in the program had accepted Medi-Cal patients in the past. Some left because of the growth of their practice, but many more stopped accepting new patients because of the problems outlined here, such as low fees and complex paperwork.

In addition, over half of the dentists interviewed were unaware of changes in the program, such as a fee increase just two months prior to the interview. Medi-Cal will need to make an effort, possibly with the help of local dental societies, to keep dentists up to date on the current status of the program and to increase trust among those who stopped accepting Medi-Cal patients.

5. Educate patients about the benefits and responsibilities of the program.
In response to dentists' concerns about broken appointments and patients who are unaware of their benefits, Medi-Cal could provide recipients with information about the dental program at the time they receive their benefits. This information could include the toll-free phone number for the Medi-Cal referral service and could explain the importance of arriving on time for appointments.

With increased provider participation, the CHDP Program could provide low-income families with information about the dental service available for their children, along with a better chance of finding a dentist for their treatment.

6. Increase access to and accuracy of the Medi-Cal dental referral program.

The survey of the referral program indicated that the program may help match some Medi-Cal patients with dentists, but it is limited in its ability to improve access because so few dentists are accepting new Medi-Cal patients.

If other changes in the Medi-Cal program encouraged a significant number of new providers to begin accepting new patients, the program could have a positive impact on the access to dental services for Medi-Cal patients. It is also important that the referral program regularly update its list of participating dentists to increase the accuracy of the names provided.

The ideal way to increase access to dental services for low-income patients in California would be for every dentist in the state to accept a small number of Medi-Cal patients in their practice. It could be argued that if the state made significant improvements in the Medi-Cal program, enabling dentists to provide dental care to low-income residents while making a small profit, dentists in California might be motivated to view new program participation as worthwhile, as well as a moral and ethical obligation.
INTRODUCTION

Importance of Access to Dental Services

Access to dental services is important for the emergency treatment of pain and infection, the detection and diagnosis of oral diseases, the restoration of oral health and the provision of preventive services. Most dental problems are not self-limiting. Without adequate access to dental services, these problems will become more serious and more expensive the longer dental treatment is delayed. Teeth that could have been treated with a filling, if detected early could require a root canal or even the loss of the tooth. While not as common as in the past, abscessed teeth due to large cavities or severe gum disease can produce very serious swelling and infections. Prompt treatment of these severe infections is essential.

Dental examinations result in the early detection of many diseases, including AIDS. Kaposi’s sarcoma and “hairy leukoplakia,” two of the first clinical signs of the AIDS virus in many patients, can be detected early during a routine oral exam. Regular check-ups, cleanings, sealants, and fluoride treatments can prevent the majority of oral health problems today. These preventive measures make it possible for young people today to grow up with fewer serious oral health problems.

Access to dental services may not be available for many Medi-Cal eligible children and adults. In 1985, the Special Committee on Medi-Cal Oversight of the California legislature heard testimony indicating that Medi-Cal patients may not have adequate access to dental services.(1) Access to dental services for the poor may be particularly important in California where only 17 percent of residents have drinking water with optimal levels of fluoride, either occurring naturally or with treatment.

Medi-Cal makes dental services affordable to the Medi-Cal population. But to be considered accessible, dental services must be available to Medi-Cal recipients near their homes, patients must not have to wait excessively to obtain appointments or at the dentist’s office, transportation must be readily available, and patients must be treated with respect by the dentist and office staff so that the patients’ experiences with their care is satisfactory. (2)

Medicaid Can Improve Access to Health Services

There is evidence from a variety of sources that nationally Medicaid is responsible for a significant increase in the use of health services by the poor. Historical evidence comparing the use of services by the poor and the nonpoor shows significant improvement in access to medical care since Medicaid began in 1965.(3) A recently published study demonstrates that Medicaid coverage increases the use of physician services by low-income children.(4) However, poor school-aged children as a group are less likely to receive timely preventive care regardless of Medicaid coverage than children in families with incomes above the poverty line.(5) Access to preventive services, such as physical exams, eye exams, and dental
exams for poor children, is improved by Medicaid coverage. Children covered by Medicaid are more likely to use preventive services than children with no insurance coverage.

While family income is a major determinant of whether children receive a dental exam, children from low-income families are 40 percent less likely to have had a dental exam prior to age five than children from families with incomes over the poverty level. Among poor children, Medicaid has been shown to improve access and increase the use of preventive dental services.(5)

Low Provider Participation Can Limit Success of Medicaid

Although Medicaid has improved access to care for the poor, recent evidence suggests that, at least for some Medicaid populations and for some types of services, Medicaid access is compromised by low provider participation.(6,7,8) In California, declining numbers of dentists accepting new Medi-Cal patients is reducing the access to dental services for Medi-Cal recipients.

Objectives

This study was conducted at the request of the Special Committee on Medi-Cal Oversight to evaluate access for Medi-Cal dental patients. This study had four primary objectives:

1. Determine the access to dental services for Medi-Cal recipients
2. Determine how Medi-Cal fee schedules compare with fee schedules for private practitioners
3. Evaluate perceptions of dentists toward the Medi-Cal program and Medi-Cal patients
4. Evaluate the Medi-Cal dental referral program.

Access to Medi-Cal dental services was measured in two ways. The first method was to determine the number of dentists who would accept new Medi-Cal patients for an initial examination appointment (a check-up). The second measure of access was the amount of time Medi-Cal patients had to wait for an appointment compared with a patient with dental insurance.

The dentists' perceptions of the Medi-Cal program and Medi-Cal patients were determined using telephone interviews with a systematically subsampled group of the dentists who did and did not accept new proxy Medi-Cal patients. The fees paid by Medi-Cal were reviewed by comparing Medi-Cal reimbursement with fee schedules obtained from several sources, including general practitioners, in California.

The Medi-Cal dental referral program, a toll-free phone number established by the Medi-Cal program to allow Medi-Cal patients to call and receive the name of a dentist in their area who accepts new Medi-Cal patients, was also reviewed. Proxy Medi-Cal patients were used to determine the accuracy of the information provided by the referral program and the program's success in placing Medi-Cal patients.
RESEARCH METHODOLOGY

1. Use of proxy patients to determine dentists’ acceptance of new Medi-Cal patients

Access to dental care was measured as the number and percentage of dentists accepting new Medi-Cal patients for a check-up. A stratified, systematic sample of 611 dentists geographically distributed throughout California was used for the survey. To determine the number of dentists accepting new Medi-Cal dental patients, trained research assistants, acting as proxy Medi-Cal patients, called the dentists in our sample. The research assistants requested an appointment for a check-up both for themselves and for their seven-year-old daughter, from the person who answered the phone in the dental practice. Proxy Medi-Cal patients were used to most closely resemble the situation a Medi-Cal patient would encounter when seeking an appointment.

Access to dental care was also assessed by determining the amount of time Medi-Cal patients had to wait for an appointment. Dentists who accepted a proxy Medi-Cal patient were contacted again by a proxy patient with private dental insurance requesting a check-up. The average waiting time for the Medi-Cal patients was compared with the average waiting time for the privately insured patients as the second measure of access to care.

To prevent any financial loss to the dentists in this survey, appointments made by the research assistants were canceled within two working days of the original call. The research methods used in this project were reviewed and approved by the UCLA Human Subjects Protection Committee. All of the information regarding the responses of individual practices is strictly confidential.

Sample Determination

A list of all of the dentists in California was obtained from the State Department of Consumer Affairs. Dentists in California were stratified into two groups: urban dentists and rural dentists, using the federal government designations of Metropolitan Statistical Area (MSA) for urban locations and non-MSA for rural areas. A systematic sample of 1,002 dentists was selected following the stratification to ensure that the sample contained a statewide geographic distribution of dentists.

After the data was collected, the results were weighted to more accurately represent the population of all general practice and pediatric dentists in California. The weighting was conducted due to the oversampling of rural dentists. Rural dentists were sampled in a greater percentage than they represent among dentists in California to more accurately determine the access to Medi-Cal dental services in the rural counties. The systematic sampling technique selected 70 percent of all the rural dentists in California.
Dentists were removed from the sample of 1,002 if they were not in practice or if they were specialists other than pediatric dentists. Only general dentists and pediatric dentists were surveyed in order to determine access to primary care providers. The number of active general practice and pediatric dentists was determined by calling directory assistance operators for each of the 1,002 dentists selected for the study. If there was no listing for the dentist at the address provided by the Department of Consumer Affairs, the directory assistance operator was called again at a later date. If this second call did not produce a phone number for the dentist, the dentist was classified as no longer actively practicing in California. This estimate may be conservative due to practitioners who have moved within the state and have not notified the State Board of Dental Licensure.

Table 1 shows the distribution of dentists in urban and rural areas of California. Of the 20,778 licensed dentists in California, slightly more than 1,000 were initially selected by MSA and non-MSA strata, and 611 remained in the sample after nonpracticing and nonprimary care providers were eliminated.

Table 1. Sample Selection for the Proxy Patient Calls

<table>
<thead>
<tr>
<th></th>
<th>Number of dentists in California</th>
<th>Number of dentists Selected</th>
<th>Number of dentists Surveyed *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>20,072</td>
<td>514</td>
<td>288</td>
</tr>
<tr>
<td>Rural</td>
<td>706</td>
<td>488</td>
<td>323</td>
</tr>
<tr>
<td>Total</td>
<td>20,778</td>
<td>1,002</td>
<td>611</td>
</tr>
</tbody>
</table>

* The number surveyed = the number of dentists selected minus the number of nonpracticing and nonprimary care dentists.

Research Assistants Used as Proxy Medi-Cal Patients

To determine the number of dentists accepting new Medi-Cal dental patients, trained research assistants, acting as proxy Medi-Cal patients, called the dentists in our sample. The proxy patient calls were standardized by using two female research assistants for all appointment requests. The callers were trained by conducting pilot calls prior to beginning the research calls and by using a standardized script for all calls. (See Appendix C, Survey Form for Proxy Patient Calls.) The calls were completed within a six-week period in the fall of 1989.

The research assistants requested an appointment for a check-up for themselves and for their seven-year-old daughter from the person who answered the phone in the dental practice. Proxy Medi-Cal patients were used in this study to most closely resemble the situation a Medi-Cal patient would encounter when seeking an appointment. The request for a check-up was used to evaluate the ability of Medi-Cal patients to receive comprehensive care. The age of seven was chosen for the proxy child patient to differentiate between dentists who do not see very young children and dentists who do not accept Medi-Cal.

Receptionists in half of the practices were asked if the dentist was accepting new patients prior to requesting an appointment. The dentists may have refused to provide the proxy Medi-Cal with an appointment because they were not accepting any new patients. It was determined that only two out of 300 practices were not accepting any new patients.
Therefore "closed practices" were eliminated as a reason proxy Medi-Cal patients were refused appointments.

Access to dental care was also assessed by determining the amount of time Medi-Cal patients had to wait for an appointment compared to patients with private insurance. Dentists who accepted a proxy Medi-Cal patient for an appointment were contacted again within two weeks, by a research assistant calling as a proxy patient with dental insurance. The waiting time for the proxy Medi-Cal patients were compared with the proxy insurance patients to determine whether patients with Medi-Cal had to wait longer for their appointments than patients with private insurance, which could also limit their access to care.

2. Interviews with Dentists

The perceptions of dentists toward the Medi-Cal program were determined using a telephone interview. The interview included questions about the respondent's attitudes toward the Medi-Cal program and Medi-Cal patients, their current participation level, problems with the Medi-Cal program and suggestions for improvement.

Sample Determination

To determine the attitudes of practicing dentists toward the Medi-Cal program, a stratified, systematic, subsample of 100 dentists, from the original sample of 611 dentists, were selected to be interviewed by telephone.

A stratified systematic sampling method was used to select the 100 dentists to be interviewed. Twenty-five of the 100 dentists selected were urban dentists who accepted proxy Medi-Cal patients in the first part of this study, 25 were urban dentists who did not accept proxy Medi-Cal patients, 25 were rural dentists who accepted proxy Medi-Cal patients, and 25 were rural dentists who did not accept proxy Medi-Cal patients.

Four of the practices were eliminated because the dentists had retired or were in the process of retiring in the two months time since the proxy patient calls were made to their office. This left a usable sample of 96 dentists to be interviewed. Ninety-two of the dentists participated in the interview for a 96 percent participation rate. The distribution of the dentists interviewed is shown in Table 2.

Table 2. Sample Selection for Dentists' Interviews

<table>
<thead>
<tr>
<th></th>
<th>Accepted New Proxy Medi-Cal Patients</th>
<th>Did Not Accept New Proxy Medi-Cal Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>Rural</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Total (n=92)</td>
<td>43</td>
<td>49</td>
</tr>
</tbody>
</table>

The dentists were asked questions regarding their attitudes and knowledge of the Medi-Cal program and Medi-Cal patients. (See Appendix D, Survey Form for Dentist Interviews.) The importance of commonly reported problems with the program was recorded as well as their comments and suggestions for improving the program. Each interview lasted approximately five minutes. The interviews were conducted by two dentists in the Robert
Wood Johnson Dental Health Services Research Scholars Program at the UCLA School of Dentistry.

The interview included questions about the dentists and their practice, the dentists' attitudes toward the Medi-Cal program and Medi-Cal patients and their knowledge of the program. Respondents also were asked about their participation in the Medi-Cal program, perceived problems and their suggestions for improvement. For dentists not accepting new Medi-Cal patients, the questions were designed to determine which factors discouraged them from participating in the program.

3. Fee Comparison

To assess the validity of the dentists' perceptions that the Medi-Cal dental program's fees are substantially lower than the fees of private practitioners, several sources of fee schedules were collected for comparison. Fee schedules were received from four urban and four rural general practices in California, a California-wide HMO, the average of 58 fee schedules from pediatric dentists throughout California collected by the California Society of Pediatric Dentists, a published fee schedule in the journal Dental Management, and a fee schedule based on insurance claims data weighted for the Los Angeles/Long Beach area which is sold by an independent company. (See Appendix A, List of Fee Schedules Collected for Use in Fee Comparison.) An estimate of the average overhead cost for practitioners was made, using data from the American Dental Association Annual Survey of Dental Practice, to determine if Medi-Cal fees met the operating costs of dentists in California.

It is difficult to get accurate information about dental fee schedules. Insurance company fee schedules are closely guarded because of the way "usual and customary" fee schedules are determined. The process of determining the fees insurance companies will reimburse a dentist usually begins with the dentist submitting their fee schedules to the insurance company. The company then compares this dentist's fee schedule with their model fee schedule for the dentist's geographic area. If the fees are below the insurance company's model schedule, all of the fees will be approved. If the insurance company determines fees for certain procedures are too high, the dentist will only be paid a percentage of the fees requested for that procedure. If the insurance company's fee schedules were public, dentists could establish their fees at the maximum level allowed by the insurance company, rather than determining their fees individually.

Fee schedules were received from eight general practitioners in California, four in rural areas and four in urban areas. To check the validity of using the average of these fee schedules to represent general practice fees in California, several other fee schedules were also obtained. One fee schedule is for a California-wide HMO, whose fees would be expected to be slightly lower than general practice fees. Another is the average of 58 fee schedules collected from pediatric dentists in California by the California Society of Pediatric Dentists, whose fees would be expected to be slightly higher than general practice fees. Another was from a private company that computes weighted fee schedules for various regions of the country based on insurance company claims data. This private fee schedule is for the Los Angeles/Long Beach area. Another fee schedule was published in the February 1990 Dental Management journal for the Pacific states region.

The fee schedule for the HMO was slightly lower than the average fees for the eight general practice fee schedules, as expected. The pediatric dentists fee schedules were slightly higher than the general practice fee schedules. The private company's fee schedule
was very similar to the fees of the eight general practitioners. The fee schedule published in Dental Management for the Pacific states was slightly higher. (A complete list of each fee schedule can be found in Appendix A.) This comparison validated the use of the eight general practice fee schedules as an estimate of general practice fees in California.

Fees used in the comparison are fees for the most commonly provided Medi-Cal procedures. Estimates for the general practice fees were intentionally figured conservatively because of the inherent weakness of the data used to estimate general practice fees. The estimate of "general practice" fees were an average of the eight general practice fee schedules from California and the private fee schedule for the Los Angeles/Long Beach area. The published fee schedule for the Pacific states was not included in the calculation of general practice fees to keep the estimate conservative since this published schedule was higher than the other fee schedules. The fees for crowns (caps) were also not used in the average. General practice fees for a crown can be about $450 where as Medi-Cal will pay about $150. Eliminating crowns from the comparison also decreased the estimate of general practice fees in comparison to the Medi-Cal fees.

An estimate of the average overhead costs of dentists was made to determine how Medi-Cal fees compare to the dentist's cost to provide the services. The average overhead cost was estimated by subtracting the average net income of solo practicing dentists from their gross income. Data was obtained from the 1989 Survey of Dental Practice from the American Dental Association.(9)

Median gross income (independent general practitioner) = $225,000
Median net income (independent general practitioner) = $70,000
Estimated overhead 69 percent

To be more conservative in the comparison with Medi-Cal fees, an overhead level of 65 percent was used in the charts in the text of the report. The estimate of 65 percent overhead costs was validated in conversations with practicing dentists in California as approximating their overhead costs.

4. Evaluation of the Medi-Cal Dental Referral Network

A new Medi-Cal dental referral program was instituted by the Medi-Cal program in the fall of 1989. A toll-free number was established to assist patients in finding a dentist in their area who accepts new Medi-Cal patients.

The purpose of this portion of the study was to assess the ability of the Medi-Cal dental referral program, which began in the fall of 1989, to increase access to care. The referral program permits Medi-Cal recipients to call a toll-free number to receive the name of a dentist in their area who accepts new Medi-Cal patients. To investigate whether the referral program is successfully matching Medi-Cal patients with dentists in their area, a trained research assistant called the Medi-Cal referral program as a proxy Medi-Cal patient. The proxy patient contacted the Medi-Cal referral phone number 58 times, requesting information about a dentist from each of the counties in California.

The dentists, whose names were provided by the referral program as accepting new Medi-Cal patients, were then called by the research assistants as proxy Medi-Cal patients requesting an appointment for a check-up for themselves and for their seven year-old
daughter. The calls to the dentists whose names were provided by the referral program were made using the same protocol as the proxy patient calls in the first part of this study.

Information regarding the accuracy and effectiveness of the referral program was obtained as well as the length of time patients had to wait for an appointment from dentists accepting Medi-Cal patients.
FINDINGS

Findings from Proxy Patient Calls

1. Few Dentists Accept New Medi-Cal Patients.
   The proxy patient survey of 611 dentists' offices indicated that 16 percent of general practice and pediatric dentists in California accept children as new Medi-Cal patients. Sampling information indicated that about 60 percent (13,000) of the 21,000 licensed dentists in California are active general practice and pediatric dentists. With a 4 percent margin of error, this corresponds to 2,100 (± 500) general practice and pediatric dentists in California, who accept children as new Medi-Cal patients.

   Fifteen percent of active general practice and pediatric dentists in California accept adults as new Medi-Cal patients. This corresponds to about 2,000 (± 500) general practice and pediatric dentists in California who accept adults as new Medi-Cal patients.

Figure 1. Percentage of General Practice and Pediatric Dentists Accepting New Medi-Cal Patients in California

(weighted estimates)

Based on the survey of 611 dentists' offices in California, it is estimated that 16 percent of the approximately 12,000 active general practice and pediatric dentists in urban areas of California were found to accept children as new Medi-Cal patients. This corresponds to about 2,000 (± 500) urban general practice and pediatric dentists statewide.

Thirteen percent of the approximately 500 active general practice and pediatric dentists in rural areas of California accept children as new Medi-Cal patients. With a 4 percent margin of error, this corresponds to 65 (± 20) active rural general practice and pediatric dentists statewide.

Figure 2. Percentage of General Practice and Pediatric Dentists Accepting Children as New Medi-Cal Patients by Urban and Rural Practices
3. Adults’ Access to Medi-Cal Dental Services Is Also Limited in Urban and Rural Areas.

Based on the survey of 611 dentists’ offices in California, it is estimated that 16 percent of the approximately 11,800 active general practitioners in urban areas of California were found to accept adults as new Medi-Cal patients. This corresponds to about 1,900 (± 470) urban general practitioners statewide.

Thirteen percent of the approximately 460 active general practice and pediatric dentists in rural areas of California accept adults as new Medi-Cal patients. With a 4 percent margin of error, this corresponds to 60 (± 18) active rural general practitioners statewide.

Figure 3. Percentage of Active General Practitioners Accepting Adults as New Medi-Cal Patients by Urban and Rural Practices

The information gathered in these studies indicates that access to dental services is inadequate to meet the needs of Medi-Cal patients. Federal regulations for access to Medi-Cal providers were described in the 1966 Handbook of Public Assistance Administration:

Participating practitioners include sufficient members of each profession, and a proportionate number of practitioners qualified for specialty practice within professions, so that the items of medical care and services included in the plan are available to eligible persons at least to the extent they are available to the general population. At a minimum, the participation ratio determined separately for each profession, and for specialties within a profession, should be approximately two-thirds of such practitioners in the state.(10)

The federal standards also state that "Eligible persons are not forced to travel outside their communities to receive medical care and services of the types available to others within their communities."(10)

The standard of adequate access to care for Medicaid persons was reinforced by report language in the federal Omnibus Reconciliation Act of 1989:

The Committee expects that the Secretary, in determining whether services are available to Medicaid beneficiaries at least to the extent they are available to the general population, will compare the access of beneficiaries to the access of other individuals in the same geographic area with private or public insurance coverage.(11)

With approximately 16 percent of general practice and pediatric dentists in California accepting new Medi-Cal dental patients, the Medi-Cal program is currently not meeting the minimum federal standard of two-thirds of the dentists in a state participating in the program. The program does not meet the stricter standard that Medi-Cal patients should have the same access to providers and waiting time for an appointment as others with private insurance in their area.

5. Low Participation by Dentists in Medi-Cal Reduces Access for Children Through the CHDP Program.

The low number of providers participating in the Medi-Cal dental program has reduced access to dental care for children under the Child Health and Disability Prevention (CHDP) Program. All Medi-Cal eligible children over the age of three and non-Medi-Cal eligible children under age 19 from families with incomes below 200 percent of the poverty level are required to be referred annually to a dentist. Many local CHDP programs are having difficulty identifying dentists in their area who will accept eligible children for referral.(12)

The Child Health and Disability Prevention Program is the California program established to implement the federal Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. The EPSDT regulations are mandated by the federal government to insure that low-income children are provided with necessary preventive health measures.

The EPSDT regulations require that an annual referral to a dentist for dental services be offered to each eligible Medi-Cal recipient three years of age or older. The eligibility categories were expanded by California Assembly bill AB 75 to include children under age
19 from families below 200 percent of the poverty level. A review of the adequacy of referrals provided by county CHDP programs is outside the scope of this study. However, with only 16 percent of dentists in California accepting new Medi-Cal eligible children, it is likely that local CHDP programs would have few choices, or in some cases no choices regarding dentists to refer their clients for care. This could prove to be an important factor limiting the access to dental care for low-income children in California.

6. Rural Counties Have Few Dentists Accepting New Medi-Cal Patients.
   Access to Medi-Cal dental services is particularly limited for rural residents of California. In many areas, it is necessary to travel long distances to find a dentist who will accept a new Medi-Cal patient.
   Rural counties were oversampled in this study to estimate more accurately the access to Medi-Cal services for rural residents. The oversampling allowed 70 percent of the 706 rural dentists to be selected for this study. Problems were reported in the urban areas as well, although the sampling technique employed in the proxy patient study does not allow for information to be reported for individual urban counties, only for urban counties as a group, because only a small percentage of dentists were sampled from individual urban counties.
   In 13 of the state’s 23 rural counties, no dentists surveyed would accept new Medi-Cal patients. In five other rural counties, there were three or fewer dentists who would accept new Medi-Cal patients. For example, one dentist reported that a seven-year old girl with a "golf ball sized swelling" in her jaw due to an infected tooth arrived as a mid-week emergency patient. Her mother had called 14 dentists and none of them would accept her daughter as a new Medi-Cal patient. The mother had driven 90 miles to see him. The dentist reported that it is not uncommon for a Medi-Cal patient to drive 100-115 miles, bypassing 70 nonparticipating dentists on the way to see him.
   Dentists in other areas reported similar problems with access for patients. One dentist reported that there was only one dentist out of 65-70 in the Eureka area of 85,000 people who will see Medi-Cal patients. Another dentist said that there were no dentists in a 75-mile radius of the city of Truckee that will accept Medi-Cal patients. Only one dentist in the Sierra Foothills area accepts Medi-Cal patients. This dentist said the burden of being the only Medi-Cal provider in the area could drive him from the program.
   Comments from respondents to the interview survey of dentists identified serious access problems in urban counties. For example, in Santa Barbara, a dentist reported that only 3 out of 150 dentists accept new Medi-Cal patients.

7. Waiting Time for an Appointment Was Almost 40 Percent Longer for Medi-Cal Dental Patients.
   Proxy Medi-Cal patients were found to have a significantly longer waiting period prior to their first appointment than proxy patients with private dental insurance. The average waiting period for proxy Medi-Cal patients (7.5 days) was 39 percent longer than the average waiting period for proxy patients with private insurance (5.4 days) (see Figure 4). Twenty-five percent (25%) of Medi-Cal patients had to wait over 10 days, with a maximum waiting time of 37 days for their first appointment. Only 11 percent of the patients with private dental insurance had to wait over 10 days for an appointment, with a maximum wait of 25 days.
The average difference of two days may not be large by itself, but it is important that 25 percent of the Medi-Cal patients were not able to receive an appointment within 10 days. The longer the waiting period, the greater the likelihood that an appointment will be canceled or missed entirely. This is probably true for all patients, not just for Medi-Cal patients. The longer initial wait may indicate that some Medi-Cal patients will have to wait a long time before every appointment, making it difficult to follow through with comprehensive care. Each barrier to the access of dental services increases the likelihood that the oral health of Medi-Cal patients will be adversely affected.

Findings from Dentists' Interviews and Review of Fees

The following information was gathered through telephone interviews with 92 dentists geographically distributed throughout California. (See Appendix D, Survey Form for Dentist Interviews.) The dentists interviewed by phone were a subsample of the dentists who were called by the research assistants as proxy Medi-Cal patients in the first part of this study. Fee schedules for dental procedures were also collected from a variety of sources to determine the appropriateness of the fees paid by Medi-Cal in comparison with these other fees. (See Appendix A, List of Fee Schedules Collected for Use in Fee Comparison.) For the purpose of this study, "participating" dentists represent dentists who accepted a proxy Medi-Cal patient in the first part of this study, whereas "nonparticipating" dentists did not accept a proxy Medi-Cal patient in the first part of this study. A "nonparticipating" dentist may actually be treating some Medi-Cal patients but they are not accepting new Medi-Cal patients.

1. Low Fees Were the Most Important Problem Cited with the Medi-Cal Dental Program.

The most important problem with the Medi-Cal program according to both "participating" and "nonparticipating" dentists was that the fees were too low to meet their costs of providing the service. Ninety-eight percent of the dentists believed that low fees were an important problem with the Medi-Cal program (see Figure 5).
- 84 percent of the dentists interviewed stated that low fees were a very important problem.
- 14 percent said they were a moderately important problem.
- 2 percent said they were not important.

The near consensus of "participating" and "nonparticipating" dentists indicates that without increasing fees, it will be very difficult to encourage new dentists to participate in the program, while dentists who currently participate may stop accepting new Medi-Cal patients. These attitudes were confirmed in the comments of the dentists. Respondents were also asked which single problem they considered most important.
- 51 percent of the dentists said that low fees were the most important problem with the program.

Figure 5. Low Fees: Is It an Important Problem?

It is evident from the responses and comments of the dentists interviewed that a significant fee increase is needed to attract new dentists and retain current providers. The comments of many dentists indicated that they understood that Medi-Cal would not be able to pay their usual and customary fees. However, fees had reached the point where they felt they were losing money by accepting a Medi-Cal patient.

Three dentists mentioned that it cost them more to pay for their hygienist's salary than the $17.50 they received from Medi-Cal for cleaning a Medi-Cal recipient's teeth. Another dentist noted that new infection control procedures, such as masks, gloves, and toxic waste disposal, were increasing his costs well beyond what Medi-Cal reimbursements would cover.

2. Medi-Cal Reimburses Less Than Half of HMO and General Practice Fees.
Fee schedules were obtained from several sources to evaluate dentists' perception that the fees paid by Medi-Cal are too low to meet their costs. Fee schedules from four urban and four rural general practices in California, a statewide Health Maintenance Organization (HMO), a published list of fees for Pacific states, and a fee schedule for the Los
Angeles/Long Beach area based on weighted insurance claim data were used for comparison (see Figure 6).

The fees for the most commonly provided Medi-Cal services were averaged and compared with the average fees for a statewide HMO. Dentists’ overhead costs were estimated at 65 percent using American Dental Association income data. Medi-Cal fees averaged less than half of the California-wide HMO fees, well below the estimated overhead costs.

**Figure 6. Medi-Cal Pays About 49 Percent of HMO Dental Fees**

![Chart showing Medi-Cal and HMO fees with Medi-Cal at 49% and HMO at 100%]

To compare Medi-Cal fees with fees for general practice, the eight rural and urban general practice fee schedules were averaged with the private insurance fee schedule for the Los Angeles/Long Beach area. The fee schedules published in the journal *Dental Management* were not used when computing the general practice fees because they appeared to be significantly higher than the other general practice fees. The calculations of the general practice fees were made as conservative estimates. These fees are not meant to be used as an exact representation of general practice fees in California but rather as a range of comparison standards with Medi-Cal fees. General practice fees will differ significantly throughout the state, while there is only one fee schedule for Medi-Cal making this comparison more problematic. (All the fee schedules are provided in Appendix A.)

Medi-Cal fees averaged about 43 percent of the estimated general practice fee schedules. This estimate is slightly higher than the estimate (see Figure 7).

This fee comparison supports the claims of practitioners that Medi-Cal fees do not pay the dentists’ cost to provide the services. This disparity also indicates that in order to attract new providers into the system, the fees probably will need to be raised above the overhead costs to provide the services. This would indicate a fee increase on the order of 50 percent is needed. Any fee increase should be substantial enough to attract new providers and not simply to increase reimbursements to dentists currently participating in the program.

The fee increase should not be uniform across all procedures, but should be done to ensure access to emergency services, while encouraging comprehensive care and preventive
services. Fees for dentures, root canals and crowns (caps), for example, do not have to be increased as much as for exams, cleanings, emergency treatment and routine fillings.

Figure 7. Medi-Cal Pays About 43 Percent of Private Practice Dental Fees

3. Fee Comparison for a Cleaning, an Extraction and a Filling.
To demonstrate how the Medi-Cal fees compare with private charges for individual services, three of the most common dental procedures were evaluated individually. The three procedures were a cleaning with fluoride for a child, a single tooth extraction, a two surface silver filling for a child.

For the comparison of individual services, the fee schedules from the Medi-Cal program, a California-wide HMO, the average fees for the California general practitioners and the average fees from 58 pediatric dentists throughout California.

For a cleaning and fluoride for a child, the fee for the HMO and the average general practice charges and the average fees of the pediatric dentists were all $46. The fee paid by Medi-Cal was $19. 41 percent of the general practice fees. The Medi-Cal fee was only about two-thirds of the estimated overhead costs for this service (see Figure 8).

Figure 8. Cleaning and Fluoride for Children Ages Six Through 17
The Medi-Cal fee of $16 for a tooth extraction was just over a third of the HMO fee of $42, 31 percent of the estimated general practice fee of $52 and 28 percent of the average fees of the pediatric dentists. Medi-Cal paid only about two-thirds of the estimated overhead cost for the dentist to extract a tooth (see Figure 9).

Figure 9. Tooth Extraction (first tooth)

![Graph showing fees for different types of dental procedures]

The HMO and estimated general practice fees for a silver amalgam filling in a child were similar while the average fee for the pediatric dentists was higher. Medi-Cal fees of $19 paid about 40 percent of HMO and general practice fees for the filling, while only covering 30 percent of the charges of the pediatric dentists. Medi-Cal fees were again about two-thirds of the estimated overhead cost to provide the procedure for the HMO and general practitioners while less than half of the costs of the pediatric dentists (see Figure 10).

Figure 10. Two Surface Fillings for Children

![Graph showing fees for different types of dental procedures]

Low reimbursement rates paid by Medi-Cal for dental procedures figure as the single most important reason for low provider participation. The fee structure established by the
Medi-Cal dental program is low the minimum federal standards. The federal regulations in Supplement D state:

Fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan to the extent these are available to the general population.(13)

The federal regulations also state:

In order to secure a high quality of medical and remedial care and services, it will be necessary for states to establish realistic schedules of compensation for services, which should be commensurate with "reasonable cost" or "reasonable charge" and not inconsistent with prevailing community payments, such as those under title XVIII or Blue Shield plans.(14)

The finding that Medi-Cal fees do not meet the overhead costs of the dentists indicates that Medi-Cal fees will need to be increased to attract new providers and prevent current dentists from leaving the program. The low provider participation produces two serious problems: inadequate access to dental care and quality of care that may be compromised.

When the Medicaid program was enacted in 1965, its goal was to increase the access to health services for the poor. Rather than develop a two-tier health care system, Medicaid was supposed to encourage private practitioners to accept low-income patients into their practice, with payment for the care coming from a combination of state and federal money.

Mainstreaming low-income patients into existing private practices would serve three purposes. First, geographic access problems would be reduced since many more providers would be included in the network to treat low-income patients. Second, the burden on providers would be reduced by spreading the impact of the low-income patients to many practitioners. Third — as a result of one and two — the quality of care for poor patients should improve since Medicaid patients would be more likely to receive the same quality care as other patients in a practice.

If fees were increased to a level where dentists could at least pay their expenses for providing a service and some of the administrative problems were eased, the prospect of a Medicaid program which distributes the care for low-income patients among many providers could be brighter, but it would probably take time for this to occur.

5. Access to Dental Care Is Further Limited by the Criteria That Dentists Establish.

Among the respondents who said they accept new Medi-Cal patients, more than four out of 10 had established criteria for the type of Medi-Cal patient they would accept. This could significantly reduce the number of dentists actually accepting new Medi-Cal patients, ultimately reducing access.

The reported criteria used for acceptance of Medi-Cal patients included denture patients, patients residing in the county, family members of patients that they had treated in the past, compliant patients, referrals from regular patients, emergencies, handicapped patients, and children and retired patients, and those who accept a certain number of Medi-Cal patients/month.
6. Most Dentists Believe Poor Patients Would Not Be Able to Receive Dental Care Without Medi-Cal.

It is important to understand the perceptions of practitioners toward the Medi-Cal program when considering changes to attract new dentists. The dentists' perceptions of the Medi-Cal program and Medi-Cal patients were examined with a series of statements read to the dentists. The dentists' perceptions of the Medi-Cal program's importance in providing poor patients with access to dental services were determined. Two-thirds of the respondents disagreed with the statement that low-income patients would be able to receive dental care without the Medi-Cal program (see Figure 11).

- 23 percent of dentists agreed that low-income patients would be able to get dental care without the Medi-Cal program.
- 11 percent had no opinion.
- 66 percent disagreed, believing that low-income patients would not be able to receive dental care without the Medi-Cal program.

There was no statistically significant difference in the responses of "participating" dentists who accepted proxy Medi-Cal dental patients and "nonparticipating" dentists who did not accept proxy Medi-Cal patients. Thus, respondents who participate in Medi-Cal as well as those who do not, indicated that they believe Medi-Cal plays an important role in providing access to dental care for low-income people in California.

Figure 11. Low-Income Patients Would Be Able to Get Dental Care Without the Medi-Cal Program?

![Graph showing the percentage of dentists surveyed (disagree, no opinion, agree) for whether low-income patients would be able to get dental care without Medi-Cal.]

7. Most Dentists Surveyed Perceive the Medi-Cal Program to Be Administratively Complex.

Administrative problems were the second most important problem cited with the Medi-Cal dental program. By a four-to-one margin, dentists disagreed with the statement that the Medi-Cal program has been getting less complicated in the last few years (see Figure 12).

- 16 percent believed the Medi-Cal dental program was getting less complicated.
- 23 percent had no opinion.
- 60 percent believed it was not getting less complicated.

There was no statistically significant difference between "participating" and "nonparticipating" dentists regarding how they felt about this issue.
Figure 12. The Medi-Cal Program Has Been Getting Less Complicated in the Last Few Years?

Although the Medi-Cal dental program has made some effort recently to make the program less complicated, such as eliminating the need for prior authorization for routine care of children, the perception among the respondents was that Medi-Cal was still a complicated program. This is an important perception when considering ways to attract new providers into the program.

The single most important administrative problem reported by the respondents was the denial of payment. More than 90 percent of the dentists interviewed reported that denial of payment is an important problem with the Medi-Cal program (see Figure 13).

- 73 percent of the dentists interviewed said denial of payment was a very important problem.
- 20 percent said it was moderately important.
- 7 percent said denial of payment was not important.

Figure 13. Denial of Payment: Is It an Important Problem?

The second most important administrative problem reported by respondents was the need for prior approval of treatment decisions, which four out of five dentists considered an important problem (see Figure 14).

- 42 percent considered prior approval a very important problem.
- 40 percent said it was moderately important.
- 18 percent said it was not important.
Figure 14. Need for Prior Approval: Is It an Important Problem?

Only 40 percent of the dentists perceived the need for prior approval to be very important whereas 73 percent considered denial of payment to be a very important problem. Dentists may be used to having to preauthorize their treatment decisions with private insurance. Their negative responses to the need to preauthorize treatment may be directed at prior authorization for all insurance plans and not just Medi-Cal in particular.

Some problems with denial of payment were detailed in the dentists' comments. One practitioner stated that he had been preauthorized by Medi-Cal to place a post and a crown (cap) on a tooth. After completing the procedure, Medi-Cal reversed their decision and denied payment, so the dentist paid for the crown himself. This same dentist had a case retroactively denied after he had been paid for the procedure. Medi-Cal deducted money from the reimbursement for another patient's treatment. Another dentist said he was denied payment for treatment on a pregnant patient because he did not take any X-rays to verify the treatment, despite the fact that the verification X-rays would have exposed the pregnant patient to additional radiation, which is clinically contraindicated.

Two questions were asked regarding the paperwork for the Medi-Cal program. In the first question, dentists were asked how Medi-Cal paperwork compares to the paperwork for private insurance. By more than a three-to-one margin, dentists disagreed with the statement: Medi-Cal paperwork is less confusing than paperwork for private insurance (see Figure 15).

Figure 15. Denti-Cal Paperwork Is Less Confusing Than Paperwork for Private Insurance?
• 68 percent disagreed, believing that the Medi-Cal paperwork is not less confusing than paperwork for private insurance.
• 10 percent had no opinion.
• 22 percent believed that Medi-Cal paperwork was less confusing than paperwork for private insurance.

There was no statistically significant difference between the responses of "participating" and "nonparticipating" dentists concerning Medi-Cal paperwork.

A second question was asked about the paperwork required by Medi-Cal. Four out of five dentists considered the complexity of the paperwork required by Medi-Cal to be an important problem (see Figure 16).
• 42 percent said complicated paperwork was a very important problem.
• 38 percent said it was moderately important.
• 20 percent said it was not important.

While 80 percent considered complicated paperwork a problem, it was considered a less important problem than denial of payment and about equal to the need for prior approval by the respondents. However, since over half of the dentists considered it a problem, it contributes to the overall perception that the program is bureaucratically cumbersome.

Figure 16. Complicated Paperwork: Is It an Important Problem?

8. Speed of Medi-Cal Payment Is Not Perceived to Differ from Private Dental Insurance.
The timeliness of payment to the dentists by Medi-Cal does not appear to be a significant problem with the Medi-Cal program. Seven out of 10 dentists said that the speed of payment by Medi-Cal was an important problem. However, speed of payment was ranked least important among problems with the Medi-Cal program (see Figure 17).

Figure 17. Slow Payment: Is It an Important Problem?
• 28 percent said slow payment was a very important problem.
• 35 percent said it was moderately important.
• 37 percent said it was not important.

Another indicator that the speed of payment by Medi-Cal is not a serious problem is that seven out of 10 "participating" dentists believed that Medi-Cal paid them as fast or faster than for private insurance.
• 16 percent said that speed of payment in Medi-Cal was faster than for private dental insurance.
• 51 percent said that it was the same as for private insurance.
• 30 percent said it was slower.

This suggests that there is a bigger problem with the perception of Medi-Cal payment being slow than with the actual speed of payment. This is especially true among "nonparticipating dentists," suggesting a lack of experience with the program.


The respondents' perceived ability to provide comprehensive care to Medi-Cal patients was evaluated further when the dentists were asked if they perceived the number of services covered by Medi-Cal to be a problem (see Figure 18).
• 52 percent of respondents considered the number of services covered a very important problem.
• 32 percent said it was moderately important.
• 16 percent said it was not an important problem.

Both "participating" and "nonparticipating" dentists believed the number of services covered by Medi-Cal could be limiting when treating Medi-Cal patients. This may be a difficult perception to address because California already has one of the most generous benefit packages for Medicaid patients in the country. The respondents' frustrations were softened in comments from some of the dentists who said they understood that there had to be limitations placed on the program.

Figure 18. Not Enough Services Covered: Is It an Important Problem?

10. Dentists Are Divided over Adequacy of Coverage for Preventive Services.

Dentists were also asked about Medi-Cal's coverage of preventive services. Slightly more than four in ten dentists believed preventive services were not covered appropriately by Medi-Cal, while just under four in 10 perceived current services adequate (see Figure 19).
• 38 percent thought preventive services were covered appropriately.
46 percent said they were not covered appropriately. 
15 percent had no opinion.

Specific recommendations for improvement were requested from the dentists who believed current Medi-Cal preventive services were inadequate. Over half of the "participating" dentists recommended that two cleanings per year be included due to the need for periodontal care of many Medi-Cal patients. The inclusion of preventive sealants was also recommended for Medi-Cal.

Figure 19. Preventive Services: Are They Covered Appropriately?

The differences in the attitudes of respondents was characterized by two of their comments. One dentist said she would not see Medi-Cal patients because she was not able to provide the kind of procedures, and thus the quality of care, that she felt the patients deserved. Another dentist differed radically, saying that the program should provide only emergency treatment and dentures.

11. Dental Health Is Perceived to Be Worse for Medi-Cal Patients, Yet Dentists Feel Medi-Cal Does Not Allow Comprehensive Care.

To determine whether practitioners believed Medi-Cal recipients have more need for dental care, the dentists were asked to respond to the statement, the dental health problems of Medi-Cal patients are the same as other patients (see Figure 20).

Figure 20. The Dental Health Problems of Medi-Cal Patients Are the Same as Other Patients
• 42 percent agreed, believing that the oral health status of Medi-Cal patients is the same as the general population.

• 58 percent of the dentists disagreed, believing that the oral health of Medi-Cal patients is worse than other patients ("disagreed" is interpreted to mean a worse dental health problem, since it is unlikely that a dentist would indicate that Medi-Cal patients have better oral health than the general population.)

More than half of the respondents believe that Medi-Cal patients have worse oral health than other patients. Among dentists accepting new Medi-Cal patients, 69 percent believed that the oral health of Medi-Cal patients is worse. Although this difference was not statistically significant, "participating" dentists should have a more accurate impression of the oral health status of Medi-Cal patients.

Despite the majority view, that the oral health status of Medi-Cal patients is worse, there is overwhelming sentiment among the dentists interviewed that Medi-Cal does not allow the comprehensive treatment of patients.

By a 15 to 1 margin, respondents agreed with the statement, the Medi-Cal program does not permit the comprehensive treatment of patients (see Figure 21).

Figure 21. The Medi-Cal Program Does Not Permit the Comprehensive Treatment of Patients

- 92 percent agreed, believing that the Medi-Cal program does not allow the comprehensive treatment of patients.

- 1 percent had no opinion.

- 6 percent disagreed, believing that Medi-Cal did permit the comprehensive treatment of patients.

There was no significant difference in the response of "participating" versus "nonparticipating" dentists.

12. Medi-Cal Patients Are Not Perceived to Make Other Patients Feel Uncomfortable.

It has been hypothesized that practitioners are wary of providing care to Medi-Cal patients because they believe private patients would not want to be in a practice with Medi-Cal patients. By more than a two-to-one margin, respondents disagreed with the statement, Medi-Cal patients make other patients feel uncomfortable in the office (see Figure 22).

- 24 percent of the dentists interviewed agreed that Medi-Cal patients make other patients feel uncomfortable.
• 15 percent had no opinion.
• 59 percent disagreed, indicating that Medi-Cal patients do not make other patients feel uncomfortable.

Unexpectedly, "nonparticipating" dentists were significantly more likely to feel that Medi-Cal patients do not make other patients feel uncomfortable (p < 0.01). One possible explanation is that the "nonparticipating" dentists were conscious of the fact that they do not accept Medi-Cal patients during this interview. Therefore, they might be more inclined to give the socially expected response that Medi-Cal patients do not make others feel uncomfortable. Another possibility is that "participating" dentists would be more knowledgeable about the effect Medi-Cal patients have on other patients. There is not enough information to support or reject either explanation.

Figure 22. Medi-Cal Patients Make Private Patients Feel Uncomfortable in the Office

13. Broken Appointments Are Considered an Important Problem.
Medi-Cal patients, in general, are perceived to miss their appointments more often than other patients. Almost 90 percent of the respondents reported that they believed broken appointments were an important problem with treating Medi-Cal patients (see Figure 23).
• 59 percent said broken appointments are a very important problem.
• 29 percent said it was moderately important.
• 12 percent said it was not an important problem.

Broken appointments ranked as the third most important problem behind low fees and denial of payment when all of the problems were ranked by the dentists.

Figure 23. Broken Appointments: Are They an Important Problem?

To gauge the knowledge of dentists about the Medi-Cal dental program, dentists were asked whether they were aware of a 5 percent increase in fees, which began about two months prior to the interviews. Less than four in 10 respondents knew that there had been a fee increase (see Figure 24).

Figure 24. The Medi-Cal Program Has Not Had a Fee Increase in over a Year

Almost two-thirds of the respondents therefore were unaware that Medi-Cal had increased its fees in the last year. "Participating" dentists were significantly more knowledgeable about the fee increase than "nonparticipating" dentists, as would be expected (p < 0.01). However, 46 percent of the "participating" dentists also did not know about the fee increase.

The method used to communicate the increase in fees to the dentists apparently was not very successful. It is possible that the small size of the fee increase was related to the knowledge of the respondents. Dentists might have been more aware if a larger increase in fees had occurred. However, the lack of knowledge of the program change indicates a potential problem when recruiting new dentists to accept Medi-Cal patients. Good communication with practitioners will be important to educate the dentists about changes made to improve the Medi-Cal program and elicit their support in the future.

15. Most of the "Nonparticipating" Dentists Had Accepted Medi-Cal Patients in the Past Before Leaving the Program.

Understanding the relationship "nonparticipating" dentists have had with the Medi-Cal program in the past is important when developing a strategy for encouraging dentists to begin accepting new Medi-Cal patients. More than eight out of 10 of the "nonparticipating" dentists interviewed in this study had accepted Medi-Cal patients at some time in the past. Of these, almost two-thirds participated in Medi-Cal from six to 20 years prior to leaving the program.

The length of participation of these dentists prior to leaving the program suggests some commitment to Medi-Cal patients and the Medi-Cal program.

Two possible reasons for dentists leaving the Medi-Cal program are the growth of their practice or problems they encountered with the Medi-Cal program. When asked if the growth of their practice influenced their decision to discontinue accepting Medi-Cal, just over half said that it was important in their decision to leave the program.
24 percent of the dentists said the growth of their practice was very important in their decision to discontinue accepting new Medi-Cal patients.
29 percent said it was moderately important.
47 percent said it was not important in their decision to discontinue accepting new Medi-Cal.
Half of the dentists stopped accepting Medi-Cal for reasons completely unrelated to the growth of their practice, such as the lower fees or administrative complexities. The comments received in the interview also indicated that some of the dentists currently participating in Medi-Cal may leave soon if changes are not made in the program. Understanding the perceived problems with the Medi-Cal program becomes important for the attraction and retention of providers.

The load of Medi-Cal patients among dentists accepting new Medi-Cal patients was evaluated. Two-thirds of "participating" dentists have less than 25 percent Medi-Cal patients in their practice whereas a fourth of the practices have over 40 percent Medi-Cal patients (see Figure 25).

Figure 25. Percentage of Medi-Cal Patients per Practice

- 37 percent of the "participating" dentists said that between 1 percent and 15 percent of their patients were Medi-Cal patients.
- 25 percent said that between 16 percent and 25 percent of their patients were Medi-Cal.
- 14 percent said between 26 percent and 40 percent of their patients were Medi-Cal.
- 16 percent said between 41 percent and 55 percent of their patients were Medi-Cal.
- 8 percent said that over 56 percent of their patients were Medi-Cal.
The practices of the "participating" dentists had from 1 percent to 80 percent Medi-Cal patients with a median of 20 percent Medi-Cal patients.
The concentration of Medi-Cal patients within a relatively small number of practices is important for two reasons. First, dentists apparently are losing money on many Medi-Cal procedures. Combined with increasing operating costs due to infection control efforts such as masks and gloves, having a very large percentage of Medi-Cal patients in their practice may make it difficult for dentists to provide adequate quality of care due to insufficient resources received per patient. This question needs further investigation however.
Second, the goal of mainstreaming Medi-Cal patients among a broad cross-section of the
dentists in the state is not being met. The concentration of Medi-Cal patients will always
be a problem because of the concentration of low-income people in certain neighborhoods.
However, the concentration of Medi-Cal patients with a few dentists could be eased with
more providers accepting new Medi-Cal patients. This was indicated in the interviews by
two dentists in rural counties with large Medi-Cal practices (over 50% of their patients
were on Medi-Cal). These dentists reported that they were continuing to accept new
Medi-Cal patients only out of obligation to their patients since there were no other dentists
in the neighboring counties who would accept new Medi-Cal patients. However it was a
severe financial drain on their practices and they were not sure how long they could
continue accepting new Medi-Cal patients.

Findings from the Medi-Cal Dental Referral Program

In the fall of 1989, the Medi-Cal program began offering a service to match Medi-Cal
recipients with dentists accepting new Medi-Cal patients. Letters were sent out to dentists
in California who were eligible to treat Medi-Cal patients, asking if they would like their
name placed in this referral network. About 1,800 dentists, out of a total of about 21,000
dentists statewide, agreed to have their names placed in the referral network. A toll-free
phone number was established for Medi-Cal patients to receive the name of a dentist in
their area who accepts new Medi-Cal patients.

The purpose of this portion of the study was to assess the accuracy and effectiveness of
the Medi-Cal dental referral program. A trained research assistant called the referral
program as a proxy patient from each of the 58 counties in California and requested the
name of a dentist in that area who accepts Medi-Cal.

The dentists whose names were provided by the referral program as accepting new
Medi-Cal patients were called by the proxy Medi-Cal patient to request an appointment.
The calls to the dentists provided by the referral program were made using the same
protocol as the proxy patient calls in the first part of this study.

1. The Medi-Cal Referral Program Does Not Consistently Solve the Access Problem for
   Dental Patients.

The referral network provided the names of dentists in only 36 of the 58 counties in
California. Twenty-two counties had no dentist participating in the referral program. For
the larger counties, two or three names were provided for a total of 65 dentists in the
survey. Proxy Medi-Cal patients were appropriately given appointments in 30 of the 58
counties with the information provided by the referral program. In the other six counties,
the names or phone numbers of the dentists provided by the referral program were
inaccurate or the dentist would not accept the proxy patient.

- Proxy patients were appropriately given appointments with dentists in 30 counties using
  the referral program.
- 22 counties had no dentist listed with the referral program as accepting new Medi-Cal
  patients.
- A total of 28 counties did not have a dentist who accepted a new Medi-Cal patient
  after the calls were completed. This included counties with no referral listings, dentists
who were listed but would not accept the proxy patient, and dentists who were unreachable at the phone number provided by the referral service.

Overall, one-quarter of the information provided by the referral program was inaccurate. Eleven of the 65 dentists were not accepting new Medi-Cal patients, while five of the phone numbers were incorrect.

* A total of 25 percent of the information provided was inaccurate (16 out of the 65 dentists).

2. Referred Patients Had to Wait Significantly Longer Than Proxy Medi-Cal or Proxy Insurance Patients for Their Appointments.

Access for the patients who did receive appointments through the referral program was limited in two ways. First, the average waiting time for an appointment was significantly longer than the average waiting time for either the Medi-Cal or insurance proxy patients in the first part of the study (see Figure 26).

Figure 26. Average Waiting Time for a Check-Up (including referral patients)

![Graph showing average waiting time for check-up by type of patient](image)

Additionally, six of the dentists who did accept a proxy Medi-Cal patient requested a $1 sitting fee (co-payment) for each visit. One of the offices specified that there was no co-payment for the proxy child patient. This one dollar co-payment is allowed by the Medi-Cal regulations but was not required by any of the practices that accepted a proxy Medi-Cal patient in the first part of the study, conducted about four months prior to the calls for the referral program.

It is not known whether this $1 co-payment will actually limit the access to care for Medi-Cal dental patients, but it does raise an additional financial barrier for this low-income population.

The referral network could function as an adjunct for Medi-Cal patients who need assistance locating a dentist in their area. However, the low participation by dentists limits the current success of the referral program. It is also not known how well informed Medi-Cal recipients are about the referral network.

The future success of the referral program hinges on attracting new Medi-Cal dental providers. There are approximately 1,800 dentists who have agreed to be placed on the Medi-Cal dental referral list to serve the approximately 3 million Medi-Cal beneficiaries in
California. It might be argued that given the current low provider participation in the referral program, once the referral programs' existence is well publicized, dentists may begin to leave the network as they become saturated with as many Medi-Cal patients as they are willing to accept. One of the dentists in the study of the referral program indicated that he had received all of the Medi-Cal patients that he would accept for the month, and denied an appointment to the proxy patient.
POLICY IMPLICATIONS AND RECOMMENDATIONS

Access to Medi-Cal dental services is primarily limited by the low participation rates of dentists. The Medi-Cal program could implement several changes which would help change the reliability of the Medi-Cal program and thus improve dentists' perception of the program. This could attract new providers into the program and encourage current participants to continue accepting new Medi-Cal patients.

1. Significantly Increase Medi-Cal Fees to a Level Above Overhead Costs.

The most significant problem with the Medi-Cal dental program is the low fees. The fee comparison indicates that, in many cases, Medi-Cal fees do not pay the dentists' cost to provide the services. This disparity also suggests that in order to attract new providers into the system, the fees will need to be raised above the overhead costs to provide the services. Any fee increase should be substantial enough to attract new providers and not simply to increase reimbursements to dentists currently participating in the program.

An increase on the order of 50 percent would be minimally needed to increase fees above the overhead costs of the dentists. The fee increase should not be uniform across all procedures however, but should be structured to ensure access to emergency services, while encouraging comprehensive care and preventive services. This fee increase could be implemented so that preventive and basic restorative services would be increased 100 percent with small or no increases for root canals, dentures and crowns (caps). This would provide dentists with a small profit for those routine and emergency procedures most often provided to Medi-Cal recipients while overall costs to the Medi-Cal program for the more expensive procedures would remain about the same. It would also encourage dentists to primarily perform preventive and basic restorative and emergency procedures for Medi-Cal patients.

2. Add Dental Sealants and a Second Cleaning to the Services Covered by Medi-Cal.

The Medi-Cal dental program has one of the most complete benefit packages for dental services of any Medicaid dental program in the country. However, there are two common preventive services that are lacking which would increase the oral health of Medi-Cal recipients. The first is the introduction of dental sealants. Sealants are a clear plastic coating that is placed on the biting surface of children's back molars. The plastic fills in the deep grooves on the teeth, protecting it from cavities which can begin in the grooves where it is difficult to clean. This is a relatively quick and painless procedure which greatly reduces the number of cavities which begin on the biting surface of the teeth.

There is some concern that sealants may be abused by the dentists since it a difficult procedure to verify. If the guidelines are written so that sealants may be applied for
children between the ages of six and 14 on permanent first and second molars, the ability to abuse this procedure is reduced while many children who could benefit from this procedure would be able to receive them. The ages of six and 14 were chosen since this is the time when most first and second permanent molars erupt into the mouth.

The addition of a second cleaning per year would benefit many Medi-Cal patients whose periodontal health status (gums) may be decreased. The addition of this service might also be a relatively low cost way to decrease the perception among some dentists that Medi-Cal does not allow comprehensive care. Many dentists interviewed cited a second cleaning as an important service that they believed was lacking for their patients.


Dentists’ concerns about denial of payment, complicated paperwork, and prior approval of treatment could be improved with a few changes in the procedures of the program. First, Medi-Cal could eliminate the requirement that X-rays or a written explanation accompany routine procedures, such as fillings. This would put Medi-Cal more in line with other private insurance plans, such as Delta Dental of California, which do not have these requirements. The presubmission of X-rays increases the cost to provide the service and does little to prevent fraud. Many denials are a result of poor quality X-rays rather than the fact that the film is not diagnostic. This unnecessarily exposes the patient to additional radiation exposure if the dentist is to be reimbursed for the service, without adding to the quality of the care provided to the patient. This requirement evoked many complaints from dentists during the interviews.

Second, Medi-Cal could use a standard billing form, such as the American Dental Association’s generic insurance billing form. This would decrease the number of forms and procedure codes that each office needs to be familiar with for billing purposes. Simpler billing procedures are particularly important for dentists because, unlike physicians, most dentists in California are solo practitioners and have less clerical assistance.

If quality assurance is a major concern, a periodic office-based quality review could be implemented for Medi-Cal participating dentists, similar to the review by the Department of Corporations, under the Knox-Keene Act for prepaid plans in California. This review could be conducted on a once every three year basis for example. There were indications from dentists in the interview that some dentists are familiar with an office-based quality assurance review. However, it may stop some other dentists from accepting Medi-Cal patients because they view the office review as an excessive intrusion compared with the small reimbursement they receive from Medi-Cal.

4. Increase Access to and Accuracy of the Medi-Cal Dental Referral Program.

The survey of the Medi-Cal patient referral program indicated that the program may help match some Medi-Cal patients with dentists, but it is limited in its ability to improve access to dental care. There are so few dentists accepting new Medi-Cal patients that if this referral program were widely advertised, many dentists might leave the referral program. This is already occurring to some degree, as determined in the survey.

If other changes in the Medi-Cal program encouraged a significant number of new providers to begin accepting new Medi-Cal patients, the referral program could have a positive impact on the access to dental services for Medi-Cal patients. The phone number of the referral program could be distributed to people along with the patient education material at the time they receive their Medi-Cal benefits.
5. Educate Dentists About the Medi-Cal Program.

The 96 percent response rate in the interview survey and the comments of the dentists indicate that there is considerable interest in the Medi-Cal program among practicing dentists. However, there also appears to be considerable history that needs to be taken into account. Many of the practitioners feel that they are essentially performing charity work by seeing Medi-Cal patients and then, because of bureaucratic problems, become penalized for providing the care. While this is probably not entirely accurate, perception is more important than reality when considering how to encourage more dentists to participate.

Fees alone probably will not increase participation to an acceptable level. Many dentists expressed frustration that they are viewed by Medi-Cal as cheats who are always "out to get the system." The dentists appeared to believe that there are some practitioners who are abusing the system and some safeguards have to be in place. However, the current restrictions are broad and appear to have a negative impact on the majority of dentists who participate.

The Medi-Cal program could improve its relationship with dentists, with the help of the local dental societies, by educating dentists about future improvements in the program such as increased fees and simplified claims procedures. The survey indicated that most dentists are not aware of the changes that are occurring in the program, such as the 5 percent increase in fees last year. The problem of being inadequately informed about the program is more severe among nonparticipating dentists for obvious reasons, but it is also significant among currently participating dentists as well. For example, speed of payment was not a problem for "participating" providers, according to our survey. However, many nonparticipating dentists still considered this a problem with the program, possibly from their past experience.

6. Educate Patients About the Benefits and Responsibilities of the Program.

An educational program designed to inform patients about the Medi-Cal program would help patients and dentists in several ways. First, patients could be informed about the dental benefits for which they are eligible. The resources for the CHDP program could be increased to improve their ability to achieve their mandate of educating parents about the Medi-Cal program and the services available for their children. Second, the phone number for the Medi-Cal referral program could be provided to Medi-Cal recipients to assist them in locating a dentist in their area who accepts new Medi-Cal patients. Third, patients could be told about their responsibility for keeping their appointments, which might help ease the problem of broken appointments and would demonstrate to dentists who have left the program that Medi-Cal is making an effort to improve.

The ideal way to increase access to dental services for low-income patients in California would be for every dentist in the state to accept a small number of Medi-Cal patients in their practice. It could be argued that if the state made positive changes in the Medi-Cal program, enabling dentists in California to provide the care and not lose money, dentists in California would have a moral and ethical obligation to participate in the program.
APPENDICES
Appendix A. List of Fee Schedules Used for Comparison with Medi-Cal Fees (dollars)

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1. Fee schedule from the February 1990 journal *Dental Management* for the Pacific Coast states.
2. Fee schedule from a California-wide health management organization.
3. Fee schedules for 58 pediatric dentists in California collected by the California Society of Pediatric Dentists.
4. Fee schedule from a private company, derived from insurance claims data and weighted to represent the Los Angeles and Long Beach areas.
5. The average of the eight fee schedules collected from individual dentists in California, which are listed in urban 1-4 and rural 1-4.
6. Rural 1-4: Fee schedules received from four general practitioners in rural locations throughout California.
7. Urban 1-4: Fee schedules collected from four general practitioners in urban locations throughout California.
Appendix B. Sampling and Results of Proxy Patient Calls by Rural Counties

<table>
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<tr>
<th>County</th>
<th>No. of Dentists in County</th>
<th>No. of Dentists Selected in Sample</th>
<th>No. Accepting New Medi-Cal Adults</th>
<th>No. Accepting New Medi-Cal Children</th>
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</table>

Total 706 507 38 42
Appendix C. Survey Form for Proxy Patient Calls
(data coded on a separate form)

OFFICE SURVEY SCRIPT

Interviewer:

1. Hello, I would like to get an appointment for a check-up. Are you accepting new patients?
   No:.............End Interview
   Yes:...........Continue

2. Do you accept Medi-Cal?
   No:.............Go to Q.3
   Yes:...........Continue

3. Do you accept Medi-Cal for children? I have a seven-year-old daughter who needs a check-up.
   No:.............Go to Q.4
   Yes:...........Continue

   A. When can she/we get an appointment?
   B. Thank you very much, I/we will see you then.

4. Do you know anyone around here who does take Medi-Cal?
   A. Thank you very much.
Appendix D. Survey Form for Dentist Interviews

DENTI-CAL PROVIDER SURVEY-FALL 1989/WINTER 1990

INTERVIEWER ID#_______  COUNTY _______  URB/RURAL_____

DENTIST ID#_____________  PHONE # (____)________________

DENTIST NAME _______________________________________

DENTIST ADDRESS____________________________________

________________________________________________________________________

<table>
<thead>
<tr>
<th>DATE</th>
<th>DAY</th>
<th>TIME</th>
<th>RESULTS</th>
<th>COMMENT</th>
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<td>2.</td>
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<tr>
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<tr>
<td>8.</td>
<td>PM</td>
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</table>

RESULT
UNABLE TO SPK TO DNTST......01  REFUSED.........................05
LINE BUSY..........................02  COMPLETED.......................06
ANSWERSERV./REC.MES..............03  LANGUAGE BARRIER............07
CALL BACK ARRANGED..............04  NO ANSWER.....................08
Hello, Dr. __________, my name is ______________ from the UCLA School of Dentistry. I would like to ask you some questions about the Denti-Cal program. After we've finished with the questions I would like to hear any other recommendations you might have for the program.

I would like to start by asking you some questions about your practice.

1. ARE YOU IN GENERAL PRACTICE?

   GENERAL PRACTICE...........SKIP TO Q.2........1
   SPECIALTY PRACTICE...........2

1A. WHAT IS YOUR SPECIALTY?

   PEDODONTIST.............(terminate)...........01
   ORAL SURGERY...........(terminate)...........02
   PERIODONTIST...........(terminate)...........03
   PROSTHODONTIST...........(terminate)...........04
   ENDODONTIST...........(terminate)...........05
   ORTHODONTIST...........(terminate)...........06
   ORAL PATH.................(terminate)...........07
   PUBLIC HEALTH...........(terminate)...........08
   OTHER (specify).............(terminate)...........09

   IF SPECIALTY IS OTHER THAN PEDODONTIST, PLEASE END THE INTERVIEW.

2. HOW MANY YEARS HAVE YOU BEEN PRACTICING IN YOUR CURRENT GEOGRAPHIC AREA.

   ________________________ years

3. WHAT YEAR DID YOU GRADUATE FROM DENTAL SCHOOL

   19______ Compute later years since graduation _________
4. INCLUDING YOURSELF, HOW MANY DENTISTS ARE IN YOUR PRACTICE?

SELF ONLY.........GO TO Q.6...............1
OTHERS......................2

SPECIFY NUMBER__________

5. HOW MANY ARE PRACTICING OVER 30 HOURS/WEek?

Next I am going to read some statements about the Denti-Cal program. Please tell me whether you strongly agree, agree, disagree, or strongly disagree to the following statements.

THE FIRST STATEMENT IS:

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<th>6. Denti-Cal paperwork is less confusing than paperwork for private insurance.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>No Opinion</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>2</td>
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<td>4</td>
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</tr>
</tbody>
</table>

| 7. The Denti-Cal program does not permit the comprehensive treatment of patients. | | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| 8. The dental health problems of Denti-Cal patients are the same as other patients. | | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| 9. Denti-Cal patients make private patients feel uncomfortable in the office. | | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| 10. The Denti-Cal program has been getting less complicated in the last few years. | | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| 11. Low income patients would be able to get dental care without the Denti-Cal program. | | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

| 12. The Denti-Cal program has not had a fee increase in over a year. | | | | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
Now I would like to ask you a few questions about how your practice deals with the Denti-Cal program.

13. ARE YOU CURRENTLY TREATING ANY DENTI-CAL PATIENTS?

   YES .............................................. 1
   NO ........... SKIP TO Q29 ........... 2

14. ARE YOU CURRENTLY ACCEPTING NEW DENTI-CAL PATIENTS?

   YES ............................................. 1
   NO ............................................. SKIP TO Q30 .......... 2
   CHILDREN ONLY ...... SKIP TO Q30 ........ 3
   DENTURES ONLY ...... SKIP TO Q30 ........ 4
   CHILDREN AND DENTURES ONLY
       SKIP TO Q30 ............................. 5

15. SOME DENTISTS WE HAVE FOUND ARE LIMITING THE NUMBER
    OF DENTI-CAL PATIENTS IN THEIR PRACTICE BY SEEING
    ONLY DENTI-CAL CHILDREN OR ONLY EMERGENCIES. DO
    YOU HAVE ANY CRITERIA FOR SELECTING DENTI-CAL
    PATIENTS?

   YES ............................................. 1
   NO-ACCEPT ALL NEW PTS..... SKIP, TO Q.16 .... 2

   (PROBE)

   15A. WHAT ARE THE CRITERIA

   .............................................................

   .............................................................

   .............................................................

16. ABOUT WHAT PERCENT OF YOUR PATIENTS ARE DENTI-CAL
    PATIENTS?

   .................................................... %
17. AFTER YOU SUBMIT A CLAIM TO DENTI-CAL, WOULD YOU SAY YOU ARE BEING PAID: MORE PROMPTLY, ABOUT THE SAME, OR SLOWER THAN FOR PRIVATE INSURANCE?

MORE PROMPTLY .................. 1
ABOUT THE SAME .................. 2
SLOWER ................................ 3
NO OPINION ........................... 4

In the next section, I am going to read a list of commonly reported problems with the Denti-Cal program. Please tell me how important these problems are for your office. Please respond by saying they are VERY IMPORTANT, MODERATELY IMPORTANT, OR NOT IMPORTANT problems for your office.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Very Important</th>
<th>Moderately Important</th>
<th>Not Important</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Complicated Paperwork</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. Low fees</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Need for prior approval</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. Denial of payment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. Broken appointments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. Slow payment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. Not enough services covered</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

25. WHICH IS THE MOST IMPORTANT PROBLEM FOR YOUR OFFICE? (READ LIST)
26. DO YOU FEEL THAT PREVENTIVE SERVICES ARE APPROPRIATELY COVERED BY DENTI-CAL?

YES ........SKIP TO Q28........1
NO........................................2

27. WHAT CHANGES DO YOU SUGGEST?

__________________________________________

__________________________________________

__________________________________________

__________________________________________

28. DO YOU HAVE ANY OTHER COMMENTS ABOUT THE DENTI-CAL PROGRAM?

__________________________________________

__________________________________________

__________________________________________

__________________________________________

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.
**FOR DENTISTS NOT ACCEPTING DENTI-CAL PATIENTS**

29. HAVE YOU EVER TREATED DENTI-CAL PATIENTS IN THE PAST?

   YES ...........................................1
   NO......SKIP TO Q. 32...........2

30. IN WHAT YEAR DID YOU DISCONTINUE ACCEPTING NEW DENTI-CAL PATIENTS?

   ----------------------------------------

31. HOW LONG DID YOU PARTICIPATE?

   ____________________ Years

32. HOW IMPORTANT A FACTOR WAS THE GROWTH OF YOUR PRACTICE IN YOUR DECISION TO DISCONTINUE SEEING DENTI-CAL PATIENTS: VERY IMPORTANT, MODERATELY IMPORTANT OR NOT IMPORTANT.

   VERY IMPORTANT..........................1
   MODERATELY IMPORTANT..................2
   NOT IMPORTANT...........................3
   NO OPINION...............................4

In the next section, I am going to read a list of commonly reported problems with the Denti-Cal program. Please tell me how important these problems were in your decision not to participate in the Denti-Cal program. Were they very important, moderately important or not important to you in your decision not to participate.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Very Important</th>
<th>Moderately Important</th>
<th>Not Important</th>
<th>No opinion</th>
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<tbody>
<tr>
<td>33. Complicated Paperwork</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>34. Low fees</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>35. Need for prior approval</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>36. Denial of payment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
40. WHICH OF THESE WAS THE MOST IMPORTANT IN YOUR DECISION NOT TO PARTICIPATE. (READ LIST)

<table>
<thead>
<tr>
<th></th>
<th>Very Important</th>
<th>Moderately Important</th>
<th>Not Important</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Broken appointments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>38. Slow payment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>39. Not enough services covered</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

41. DO YOU FEEL THAT PREVENTIVE SERVICES ARE APPROPRIATELY COVERED BY DENTI-CAL?

YES ............SKIP TO Q43...........1
NO........................................2

42. WHAT CHANGES DO YOU SUGGEST?

43. IF DENTI-CAL FEES WERE BROUGHT UP TO A LEVEL THAT WAS CLOSE TO USUAL AND CUSTOMARY FEES, WOULD YOU PARTICIPATE IN THE PROGRAM?

YES ....................................1
NO........................................2
44. DO YOU HAVE ANY OTHER COMMENTS ABOUT THE DENTAL PROGRAM?


THANK YOU VERY MUCH FOR PARTICIPATING!
44. DO YOU HAVE ANY OTHER COMMENTS ABOUT THE DENTI-CAL PROGRAM?

THANK YOU VERY MUCH FOR PARTICIPATING!
REFERENCES

1. Special Committee on Medi-Cal Oversight, Hearing on Access to and Use of Dental Services for Medi-Cal Children, November 13, 1985, San Francisco.


A Dental Crisis for the Poor

The decline of Medi-Cal's dentistry program and curbed local funding reduce access to quality, low-cost care. Ignorance about preventing decay is a part of the problem.

By SEBASTIAN ROTELLA
TOKES STAFF WRITER

For months, Dora Puentes' face was swollen, her mouth bleeding and infected. Finally, the 42-year-old went to the dentist—for only the second time in her life.

At a clinic in West Los Angeles, the mother of five conceded to an alarmed dentist that her teeth were literally crumbling. Pieces broke off when she ate.

"I knew there was something wrong," Puentes said, "but we didn't have any money for the dentist. I just tried to ignore the pain."

While dramatic improvements over the last two decades have given most Americans the best dental health ever, poor people such as Puentes have not shared in the gains. The upper class and middle class have begun to take good teeth for granted, the poor are finding it more difficult to get low-cost, quality dental care.

Easily preventable disease and decay remain pervasive among low-income adults and their children—largely the result of continued immigration from poor countries to the United States, widespread ignorance about routine preventive care and a public health crisis in California and throughout the country.

"There are segments of the population where disease patterns are rampant. They resemble earlier decades of the century," said Dr. James Freed of the UCLA School of Dentistry.

Dr. David Puckas, who found widespread decay in screenings of low-income students at two Los Angeles elementary schools recently, said: "By the time they are 30 or 40, these kids will need dentures. Many recent immigrants, like our grandparents from Europe, will lose their teeth."

The consequences of bad teeth go well beyond the cosmetic. In extreme cases, untreated cavities and gum disease cause infections that can travel through the bloodstream to organs, including the heart and brain. Neglected abscesses lead to swollen faces, persistent and debilitating pain and tooth loss. Puentes faces root canal treatments and the extraction of as many as four teeth.

There are other penalties in a society that prizes physical beauty. Children do not want to smile. Adults' chances for employment are jeopardized.

"In another country, having very bad teeth may not be an issue in getting hired," said Diane Chamberlin of the Valley Community Clinic in North Hollywood. "In this country, it's an issue. It's one of the things that keeps people where they are. It keeps people in poverty."

In California, the crisis in low-cost dental care has arisen partly

Please see DENTAL, A22