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Evaluation of the Missouri Dental Medicaid Program: A Final Report to The Missouri Department of Health, Bureau of Dental Health

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March 1999
EVALUATION OF THE MISSOURI MEDICAID DENTAL PROGRAM

Final Report to the Missouri Department of Health Bureau of Dental Health

March 1999

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This study was supported by the Missouri Department of Health. The results and views expressed are the independent products of university research and do not necessarily represent the view of the funding agencies.
Preface

The purpose of this project is to assist the Missouri Department of Social Services in providing improved access to dental care for Medicaid recipients, to evaluate aspects of the Medicaid dental program in Missouri, and to develop a series of policy options for improving the program. Missouri dentists were sent a questionnaire regarding utilization of dental services by Medicaid enrolled children, attitudes and participation of Missouri dentists in the Medicaid program, and factors affecting dentist participation in the program. From this data, policy options for improving the Medicaid dental program will be recommended.

This evaluation was conducted by researchers at The University of Missouri-Kansas City School of Dentistry and the University of Iowa Public Policy Center and College of Dentistry, with funding provided by the Missouri Department of Health’s Bureau of Dental Health. Information and conclusions presented in this report are the responsibility of the authors and do not represent the views of the Missouri Department of Health, the University of Missouri-Kansas City School of Dentistry or The University of Iowa.
Acknowledgments

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Special thanks to all the directors of Missouri’s Dental Managed Care Corporations for their assistance in compiling information about their programs to help with our survey instrument design.

The University of Missouri-Kansas City mailroom kept all the mail organized and flowing, while Lisa Cabra-Malone helped tremendously in tracking the incoming data. We are also grateful to Kecia Leary for her general research. Dr. Michael Kanellis from the University of Iowa Department of Pediatric Dentistry provided critical suggestions throughout the project. And finally, special thanks to our colleagues at the Public Policy Center from the University of Iowa. Without the support from those in the Public Policy Center, this project would never have gotten off the ground.
# Table of Contents

PREFACE  ................................................................................................................................. i
ACKNOWLEDGMENTS .............................................................................................................. iii
LIST OF FIGURES .................................................................................................................. vii
LIST OF TABLES ..................................................................................................................... ix
EXECUTIVE SUMMARY ......................................................................................................... xiii

CHAPTER 1: INTRODUCTION ................................................................................................... 1
CHAPTER 2: SURVEY OF MISSOURI DENTISTS ...................................................................... 8
CHAPTER 3: SURVEY OF MEDICAID ENROLLEES ................................................................. 39
CHAPTER 4: FOCUS GROUPS .................................................................................................... 49

CHAPTER 5: EVALUATION OF THE MEDICAID REIMBURSEMENT LEVELS ................................ 61

APPENDIX A. REQUEST FOR INFORMATION FROM MCO DIRECTORS ....................... A-1
APPENDIX B-1. MANAGED CARE (MC+) SURVEY ............................................................... B-1
APPENDIX B-2. DENTISTS’ COMMENTS FROM MANAGED CARE (MC+) SURVEY ............... B-2

APPENDIX C-1. FEE FOR MID-MISSOURI SURVEY .............................................................. C-1
APPENDIX C-2. DENTISTS’ COMMENTS FROM MID-MISSOURI SURVEY ......................... C-2

APPENDIX D-1. FEE-FOR-SERVICE SURVEY ..................................................................... D-1
APPENDIX D-2. DENTISTS’ COMMENTS FROM FEE-FOR-SERVICE SURVEY ................. D-2

APPENDIX E. WHAT IS THE TITLE? ...................................................................................... E-1

APPENDIX F-1. MISSOURI MEDICAID ENROLLEES SURVEY .............................................. F-1
APPENDIX F-2. COMMENTS FROM MISSOURI MEDICAID ENROLLEES SURVEY ............... F-2

APPENDIX G. WHAT IS THE TITLE? ...................................................................................... G-1

APPENDIX H. FOCUS GROUP SUMMARIES ......................................................................... H-1
LIST OF FIGURES

1-1 Missouri Counties by Medicaid Program Type ................................................................. 6
## LIST OF TABLES

Table 1-1. Managed Care Entities by Regions ..............................................................2
Table 1-2. Dental managed care entities by regions ...................................................3
Table 1-3. Enrollees by dental Medicaid region ..........................................................5
Table 1-4. Percentage of dentists by Medicaid reimbursement (1997) .........................5
Table 1-5. Plan-specific information provided by managed care directors .......................7
Table 2-1a. Demographic characteristics of dentists in the MC+ region ......................11
Table 2-2a. Missouri dentists’ participation in the MC+ program ..............................12
Table 2-3a. Participation of dentists currently contracting with an MC+ dental plan ......12
Table 2-4a. Services provided to MC+ patients .........................................................12
Table 2-5a. Primary responsibility for deciding whether to participate in MC+ ............13
Table 2-6a. Ability to refer MC+ patients for routine care .......................................13
Table 2-7a. Dentists’ perceptions of access, quality and cost-effectiveness of the MC+ program ..............................................................14
Table 2-8a. Dentists’ attitudes toward the MC+ program ...........................................15
Table 2-9a. Dentists’ attitudes toward treating low-income patients .........................18
Table 2-10a. Dentists’ perceptions of the MC+ program compared to private insurance ..19
Table 2-12a. Participating dentists’ satisfaction with the MC+ dental program ..........21
Table 2-13a. Dental program development suggestions .............................................21
Table 2-1b. Demographic information of dentists in the Mid-Missouri region .................23
Table 2-2b. Missouri dentists’ participation in the Mid-Missouri program ....................24
Table 2-3b. Participation of dentists currently contracting with the Mid-Missouri MC+ dental plan ........................................................................................................24
Table 2-4b. Services provided to Mid-Missouri MC+ patients ....................................25
Table 2-5b. Primary responsibility for deciding whether to participate in the Mid-Missouri MC+ program ..............................................................25
Table 2-6b. Ability to refer Mid-Missouri MC+ patients for routine care .....................25
Table 2-7b. Dentists’ perceptions of access, quality and cost with the Mid-Missouri MC+ program .............................................................................................................26
Table 2-8b. Percentage of dentists agreeing or disagreeing with statements about aspects of the Medicaid program .................................................................27
Table 2-9b. Dentists’ attitudes toward treating low-income patients ............................28
Table 2-10b. Dentists' perceptions of the Mid-Missouri MC+ program compared to private insurance

Table 2-12b. Participating dentists’ satisfaction with the MC+ dental program

Table 2-13b. Suggestions for program development

Table 2-1c. Demographic information of dentists in the FFS region

Table 2-2c. Missouri dentists’ participation in the Medicaid program

Table 2-3c. Participation of dentists currently accepting Medicaid FFS patients

Table 2-4c. Services provided to Medicaid patients

Table 2-5c. Primary responsibility for participation in Medicaid FFS program

Table 2-6c. Ability to refer Medicaid FFS patients for routine care

Table 2-8c. Attitudes toward the Medicaid program

Table 2-9c. Attitudes toward treating low-income patients

Table 2-10c. Dentists’ perceptions of the MC+ program compared to private insurance

Table 2-11c. Percent of dentists reporting degree of importance with certain aspects of the Medicaid program

Table 2-12c. Participating dentists’ satisfaction with the Medicaid FFS dental program

Table 2-13c. Suggestions for program development

Table 3-1. Response rates to the Medicaid recipient survey

Table 3-2. Percentage of children who have ever had a dental visit

Table 3-3. Time of last dental visit

Table 3-4. Reason for last dental visit

Table 3-5. Regular source of dental care by plan

Table 3-6. Travel time to last dental visit

Table 3-7. Reasons for never having been to the dentist

Table 3-8. Rating ability to get needed dental care

Table 3-9. Ability to find provider who sees Medicaid patients

Table 3-10. Factors that delayed or stopped children from receiving dental care

Table 3-11. Rating satisfaction, quality and respect associated with child’s dental care

Table 4-1. Waiting time for an appointment by region

Table 5-1. Dental fee comparison of average private practice fees with Medicaid fee-for-service and MC+
EXECUTIVE SUMMARY

CONCLUSIONS FROM DENTIST SURVEYS

The results from the survey of Missouri dentists point out a number of interesting issues for consideration by policymakers. Some of these issues are apparent from the answers of all dentists in each region, while others are highlighted by comparing participating and nonparticipating dentists, or comparing dentists across the three regions (Mid-MO., MC+, FFS). The Mid-MO region was surveyed separately due to its unique delivery system, which is significantly different than the rest of the MC+ areas.

Participation

Dentists’ participation in Medicaid is a critical component of access to dental care for Medicaid enrollees. Missouri dentists’ participation in the three different areas was found to be low when evaluated against Medicaid claims data and through the dentists’ self-reported level of participation.

Medicaid claims data indicated that only 29 percent of dentists had received fee-for-service reimbursement for any dental services provided to Medicaid enrollees. Many of these dentists were reimbursed for a relatively small amount of dental services. About 20 percent of all dentists were reimbursed for more than $1000, and less than ten percent were reimbursed for more than $5000 worth of services. This does not, however, include dental services for children in regions covered by the MC+ programs.

The survey with dentists also indicated that only a limited number of dentists are full participants in the Medicaid programs (i.e., that they accept new Medicaid patients into their practices). Fifteen percent of dentists in the MC+ region indicated that they were contracting to provide services, but only half of that fifteen percent reported that they were accepting new MC+ patients. In the Mid-Missouri region, only 9 dentists were contracting to provide services. This is probably due to the staff model utilized in the Columbia clinic in this area, with dentists in outlying counties seeing patients only for preventive services and emergencies. Dentists in the fee-for-service program were more likely to say they were participating, with half having a provider number (a prerequisite to accepting Medicaid patients). However, only 41 percent of these were accepting new Medicaid FFS patients, and of these, 75 percent have some criteria for who they will and will not accept (the most common criteria are: current patients who go on Medicaid; or children of current patients who go on Medicaid).
Dentists in the Mid-Missouri region were most likely to have a place where they could refer Medicaid patients they were unable to see in their own practices—75 percent, compared to 56 percent in the FFS region, and 40 percent in the MC+ region. The greater percentage in the Mid-Missouri region was most likely the result of the Mid-Missouri Dental Clinic in Columbia, which contracted to provide services to all MC+ enrolled children in that 18-county region.

**Dentists’ attitudes toward the Medicaid program and toward Medicaid patients**

Dentists were asked both about the Medicaid dental program in their region and about the treatment of low-income patients to differentiate attitudes toward programmatic issues, which the Medicaid program can change, from attitudes towards treating low-income patients, which are more difficult for the Medicaid program to influence.

In response to a series of statements about the Medicaid program, over 80 percent of all dentists agreed that it is difficult to provide comprehensive care to Medicaid patients, and that participating in Medicaid would force them to spend less time with their other patients. About three-quarters disagreed that dentists can have an impact on the Medicaid program. Participating dentists in the MC+ and FFS regions viewed these issues statistically significantly more positively than non-participating dentists, however. Forty-eight percent of all dentists were concerned about having the only practice in the area that accepts Medicaid patients, with no difference between participating and non-participating dentists.

When asked to compare Medicaid to private insurance, 100 percent of all dentists said the fees were less for Medicaid. About 75 percent said the paperwork was more complicated and that payment was slower. Over 97 percent said it was harder to find a dental specialist to accept a referral of a Medicaid patient.

Regarding patients, over 59 percent of all dentists agreed that without the Medicaid program low-income patients would not be able to get adequate dental care, while about 57 percent agreed that the oral health problems of Medicaid patients are worse than other patients in their practice. At the same time, 84 percent of all dentists did not believe dentists have an ethical obligation to treat Medicaid patients. About half agreed that low-income patients are more difficult to treat than other patients and about one-third agreed that Medicaid patients make other patients in the office feel uncomfortable.

There were significant differences between participating dentists and non-participating dentists in the MC+ and FFS regions regarding the ability of low-income patients to get dental care without Medicaid, the difficulty of treating low-income patients, and whether dentists have an ethical obligation to treat Medicaid patients.
When asked about the importance of a series of programmatic and patient problems in their office, low fees and broken appointments were listed as the two most important problems, with no differences found between participating and non-participating dentists in both the MC+ and FFS regions. Denial of payment and patient non-compliance were the next most important issues. However, participating dentists were significantly less likely to report these as important or very important compared to non-participating dentists.

**Conclusions from the enrollee survey**

The survey conducted with enrollees in the three different regions indicated differences in use of dental services and in perceived access to care by region.

Among those who had never been to a dentist, most said it was because they could not find a dentist who would see their child. This was reported significantly more often for enrollees in the FFS region. Overall about 40 percent of these people had tried to make an appointment in the last 6 months but were unable to receive one.

Almost half of enrollees in the Mid-Missouri and FFS regions rated their ability to get the dental care their child needed as fair or poor, which was significantly higher than for enrollees in the MC+ region.

The biggest factor delaying or stopping all enrollees from receiving care was that they could not find a dentist who would see Medicaid patients—but again this was significantly more likely to be reported as a problem by those in the Mid-Missouri and FFS regions (60% vs 40%). Travel distance and waiting time for an appointment were also significant problems for over half of those in the Mid-Missouri region.

Satisfaction with their child’s dental care was rated highest in the MC+ region (75% rated it good to excellent), with FFS second (64%) and Mid-Missouri third (56%). Quality of care and respect received from the office was also rated higher by enrollees in the MC+ regions.

**Fee comparison**

Medicaid fees were compared to the average fees usually charged by private practitioners (UCR fees) to estimate the appropriateness of Medicaid reimbursement levels. Medicaid fees were on average 34% of the dentists statewide UCR fees. The fees reported to be paid by one of the MC+ plans was on average 78% of dentists statewide UCR fees however this fee can be adjusted by this managed care plan depending on utilization. Thus if there are a lot of services provided in a particular time period, reimbursement can be significantly lower and thus unpredictable from the dentists’ perspective.
Numerous studies of state Medicaid programs have indicated problems with patients being able to access services (cites). One particular area of concern for Medicaid enrollees has been access to dental care. Previous studies have found that barriers to dental care for Medicaid enrollees are often related to low dentist participation in the program (cites). Factors that have been found to affect dentists’ participation in Medicaid include programmatic issues such as low reimbursement rates, perceived administrative hassles (e.g., time-consuming or different forms or coding systems, burdensome prior authorization and utilization review procedures), too few other dentists accepting new Medicaid patients in an area, as well as patient issues such as missed dental appointments and poor home dental care (cites).

This study was conducted at the request of the Missouri Department of Public Health, Bureau of Dental Health, to evaluate access to dental care for Missouri Medicaid enrollees in both the fee-for-service and managed care programs. The project was initiated after three independent needs assessments in the State of Missouri indicated that oral health problems were a significant concern. The Bootheel Oral Health Consortium, Health Outreach and Preventive Education (HOPE)-Washington County, and Consortium of Ozark County Comprehensive Health Care all identified several of the barriers listed above as the sources of problems related to accessing dental care in their geographic region. Another state report, “Missouri Healthy Kids (MHK) 2000 Final Report, September 1997” again identified the same barriers. The Missouri Dental Association identified similar issues in a survey to Missouri dentists.

The research in this study looked at issues of access and satisfaction from both the dentist’s and the enrollee’s perspective to evaluate the current status of the Missouri Medicaid dental program and to develop ways to improve the program.

**Medicaid Managed Care and the Missouri MC+ Program**

States have been introducing managed care into their Medicaid programs in an effort to reduce costs and coordinate services for their Medicaid populations. Nationally, enrollment in managed care has grown from 10% of all Medicaid enrollees (2 million) in 1991 to 40% (13 million) in 1996, the latest year for which data is available (http://www.hcfa.gov/medicaid/trends1.htm).

The Medicaid managed care program in Missouri is called the MC+ program. In the MC+ program, the Missouri Department of Social Services contracts with private managed care companies to provide medical and dental services to Missouri Medicaid enrollees. MC+ was first
implemented in September of 1995 in 4 eastern counties (St. Louis, St. Charles, Franklin, and Jefferson) and has gradually expanded to other parts of the state. Currently, 61% of the counties in the state have an MC+ option for enrollees which, as of June 30, 1997 included 43 percent of all Medicaid enrollees in Missouri (264,496 out of 614,783) (http://www.hcfa.gov/medicaid/mcsten97.htm).

Figure 1-1 contains a map showing the managed care plans available in each county and the date they began to operate. Table 1-1 lists the managed care plans by region.

Table 1-1. Managed care entities by regions

<table>
<thead>
<tr>
<th>Northwestern Plan</th>
<th>Western Plan</th>
<th>Southwestern Plan</th>
<th>Central Plan</th>
<th>Eastern Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Advantage +</td>
<td>Blue Advantage +</td>
<td>Contracts Not Yet Awarded</td>
<td>Care Partners</td>
<td>Care Partners</td>
</tr>
<tr>
<td>Community Health Plan</td>
<td>Family Health Partners</td>
<td>Missouri Care</td>
<td>Community Care Plus</td>
<td></td>
</tr>
<tr>
<td>First Guard Health Plan</td>
<td>HealthCare USA</td>
<td>HealthCare USA</td>
<td>HealthCare USA</td>
<td></td>
</tr>
<tr>
<td>HealthNet</td>
<td></td>
<td></td>
<td>Prudential</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mercy</td>
<td></td>
</tr>
</tbody>
</table>

For contracting purposes, the state is divided into 5 geographical areas. Blue Advantage Plus and Community Health Plan have contracted to provide services in the Northwest; Blue Advantage Plus, Family Health Partners, First Guard Health Plan and HealthNet in the West; Care Partners, Missouri Care and HealthCare USA in the Central; and Care Partners, Community Care Plus, HealthCare USA, Mercy and Prudential in the East. Future expansion is also being considered for the Southwestern parts of the State.

The Missouri Dental Medicaid Program

Missouri’s dental Medicaid program is currently in a transition toward managed care as well. In counties where the MC+ program is operating, the existing fee-for-service dental program for children has been replaced by the MC+ dental program (States must provide comprehensive dental care for children enrolled in Medicaid). In general, dental care for children enrolled in Medicaid in MC+ regions is provided through dental managed care entities that contract with the managed care plans who provide medical care services to MC+ enrollees in those regions. Enrollees are given the choice of which MC+ plan they would like, depending on their region. Their children must then receive their dental services from the dental plan that contracts with the
MC+ plan they selected. The dental managed care entities are in turn responsible for creating a network of dentists and providing services to participating enrollees in the region. A list of the dental managed care providers by region of the state is shown in Table 1-2.

**Table 1-2. Dental managed care entities by regions**

<table>
<thead>
<tr>
<th>Northwestern MC+ Region</th>
<th>Western MC+ Region</th>
<th>Southwestern Plan Region</th>
<th>Central MC+ Region</th>
<th>Eastern MC+ Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doral Dental</td>
<td>Doral Dental</td>
<td>Contracts Not Yet Awarded</td>
<td>Mid-Missouri Dental Center</td>
<td>Doral Dental</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Delta Dental</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Care Partners</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prudential</td>
</tr>
</tbody>
</table>

(Information collected summer, 1998)

At the time this study was conducted, the dental component of the plans in the western and northwestern regions (Community Care Plus and HealthCare USA) were administered by Doral Dental Inc. Beginning January 1, 1999, the Department of Social Services returned the Northwestern region of the state to a fee-for-service program. In the Eastern region (St. Louis area), there are two companies to whom Doral Dental provides the traditional Medicaid fee-for-service program for all services including dental services. Mercy Health Plan has their dental services administered by Delta Dental for Missouri. The other plans, Care Partners and Prudential have established their own dental networks.

There is a significant difference in the way dental services are organized in the Central MC+ region compared to the other MC+ regions. Rather than contracting with a dental managed care plan, all three MC+ health plans have contracted with a single dental provider, the Mid-Missouri Dental Center, which has agreed to provide all necessary dental care for all children enrolled in this 18-county area. The Mid-Missouri Dental Center dental operates a central clinic within the Columbia City limits (with two full time dentists and one part time specialist) and two satellite clinics in Jefferson City and Moberly. They also contract with a few dentists in the region to provide emergency care for children who are not able to travel to one of the three clinics quickly enough.

In the parts of the state without the MC+ program (the northeast, southeast, southwest and four western counties), there continues to be the traditional fee-for-service dental program.
Table 1-3 shows the distribution of Medicaid child enrollees by the three dental Medicaid geographic regions. These figures indicate that the majority of Medicaid-enrolled children are in the MC+ region, and that the Fee-For-Service region has the least number of enrollees.
Table 1-3. Enrollees by dental Medicaid region

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Enrollees</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC+</td>
<td>324,833</td>
<td>54%</td>
</tr>
<tr>
<td>Mid Missouri</td>
<td>49,498</td>
<td>8%</td>
</tr>
<tr>
<td>Fee-For-Service</td>
<td>229,311</td>
<td>38%</td>
</tr>
<tr>
<td>Total</td>
<td>603,642</td>
<td>100%</td>
</tr>
</tbody>
</table>

Dentists’ participation in the Missouri Medicaid Fee-For-Service program

Dentists’ participation in Medicaid (acceptance of Medicaid patients in their practice) is one of the most important factors affecting access to dental care for Medicaid enrollees. Looking at the amount of money a dentist is reimbursed by the Medicaid program is one way to measure participation. These records indicate both the percentage of dentists willing to see Medicaid patients and the amount of services they are providing to the population. Missouri Medicaid dental reimbursement records indicated that less than one-third of Missouri’s dentists participated in the Medicaid fee-for-service program in 1997. This includes dental care for children in the fee-for-service regions as well as all Medicaid-enrolled adults statewide. Only 29% of the dentists in Missouri received any fee for service reimbursement for dental services provided to Medicaid enrollees in 1997 (613 dentists out of 2,126 licensed dentists in the state) (Table 1-4). This does not include dental services for children in regions covered by the MC+ program. (Comparable information for dental services for children in the MC+ regions was not available at the time of this report.)

Table 1-4. Percentage of dentists by Medicaid fee-for-service reimbursement (1997)*

<table>
<thead>
<tr>
<th>Dollar Reimbursement</th>
<th>Number of Dentists</th>
<th>Percent of all dentists</th>
<th>Percent of participating dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1513</td>
<td>71%</td>
<td>6%</td>
</tr>
<tr>
<td>$1 - 100</td>
<td>34</td>
<td>1.5%</td>
<td>6%</td>
</tr>
<tr>
<td>$101 - 500</td>
<td>91</td>
<td>4%</td>
<td>15%</td>
</tr>
<tr>
<td>$501 - 1,000</td>
<td>71</td>
<td>3%</td>
<td>12%</td>
</tr>
<tr>
<td>$1,001 - 5,000</td>
<td>172</td>
<td>8%</td>
<td>28%</td>
</tr>
<tr>
<td>$5,001 – 10,000</td>
<td>80</td>
<td>4%</td>
<td>13%</td>
</tr>
<tr>
<td>$10,001 – 20,000</td>
<td>80</td>
<td>4%</td>
<td>13%</td>
</tr>
<tr>
<td>$20,001 – 30,000</td>
<td>41</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>$30,001 – 40,000</td>
<td>22</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>$40,001 – 50,000</td>
<td>5</td>
<td>&lt;1%</td>
<td>1%</td>
</tr>
<tr>
<td>$50,001 – 100,000</td>
<td>13</td>
<td>&lt;1%</td>
<td>2%</td>
</tr>
<tr>
<td>$100,001 – 218,000</td>
<td>4</td>
<td>&lt;1%</td>
<td>1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2126</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
* This does not include dental services for children in the MC+ regions.

Many of the dentists who provided $1-$1000 or $5000 worth of services may not be actively participating and providing significant access to care but may only treat an occasional Medicaid patient. About 21% of all dentists provided over $1,000 worth of services and 13% provided over $5000 worth of services in 1997.

However, these numbers may underestimate access to care for Medicaid enrollees for two reasons. First, Medicaid reimbursement is very low relative to dentists’ usual charges so the dollar amount reimbursed represents more dental care than might otherwise be expected. Second, some enrollees may be receiving services even though their dentists do not participate in Medicaid, but instead are providing service as a charity. The frequency with which this occurs is unknown however.

**Background information about the MC+ dental plans**

Prior to beginning the data collection portion of this study, it was deemed important to have an understanding of the structure of the dental managed care programs and the way they operate to provide dental services. Therefore at the beginning of the project, each of the entities providing dental care through the MC+ program in Missouri were contacted by phone and with a follow-up letter requesting the following information:

- A list of dental providers in their network and the rules for referring to specialists
- Information about how patients determine who their provider will be (e.g., are they assigned to a gatekeeper dentist or are they responsible for finding their own dentist)
- The process they use to contract and recruit dentists including whether they contract differently with dentists by region and whether they monitor participation levels of dentists
- A copy of the provider contract. In particular we were interested in expectations they might have for dentists in their network for seeing Medicaid patients and the dentists’ expectations from the plans for reimbursement levels and timeliness of payment.
- The organizational structure of the dental managed care company and the contractual arrangement with the parent MC+ plan
- The availability of encounter or claims-type data.
Specific information about each plan in relation to these questions can be found in Table 1-5.

<table>
<thead>
<tr>
<th>Table 1-5. Plan-specific information provided by managed care directors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan</strong></td>
</tr>
<tr>
<td>List of Dental Providers &amp; Rules for referrals</td>
</tr>
<tr>
<td>Selection of Provider by the Patient</td>
</tr>
<tr>
<td>Type of Dentist Recruitment into Plan</td>
</tr>
<tr>
<td>Dentists Contractual Agreement</td>
</tr>
<tr>
<td>Organizational Structure</td>
</tr>
<tr>
<td>Encounter/claims-type data</td>
</tr>
</tbody>
</table>

* Plans Include: Community Care Plus; HealthCare USA; Blue Advantage +; Family Health Partners; First Guard Health Plan; HealthNet; Community Health Plan
** Plan includes: Mercy

All entities providing dental care through the MC+ program responded to the above request.

**Summary**

Many barriers to Medicaid enrollees accessing dental care and factors affecting dentists’ participation in Medicaid have been documented. Limited studies in Missouri substantiated these findings. Missouri is moving toward a managed care model for its Medicaid program, like the majority of the other states. This is in turn causing changes in the dental Medicaid program, especially for children. There are now three primary methods of providing dental care to Medicaid enrollees in Missouri based on the region of the state in which they live: traditional fee-for-service, MC+ (managed care), and through the Mid-Missouri dental clinic program.

Examination of Missouri Medicaid reimbursement records indicate that the majority of dentists are currently not participating in the Medicaid program. Among dentists who are, most are only participating to a limited extent. The introduction of managed care, combined with the already low level of provider participation, has created concern about access to dental care for Missouri Medicaid enrollees, which is the focus of this study.
CHAPTER 2: 
METHODOLOGY: SURVEY OF MISSOURI DENTISTS

Introduction

A written survey instrument was used to evaluate Missouri dentists’ participation in and attitudes toward the Medicaid dental program in their part of the state.

Methods

All full-time, actively practicing general dentists, pediatric dentists, oral surgeons and public health dentists in Missouri (n=2,126) were selected to participate in this study. Understanding the attitudes toward participation of these practitioners was considered critical because they provide the most critical access to care for children in the Medicaid program. The sample was drawn from a list of all licensed dentists in Missouri, obtained from the Missouri Dental Board.

Three separate mail-back survey instruments were developed to evaluate the current dental Medicaid systems in the state. These instruments were based on the survey instrument used in the 1996 Study of the Iowa Dental Medicaid Program (Damiano et al.). Questions in the survey addressed the dentist’s participation in Medicaid, attitudes toward the program and toward the treatment of Medicaid patients.

The first survey was designed for dentists who practice in the MC+ regions in the Eastern, Western and Northwestern parts of the state (including the Kansas City and St. Louis areas [Appendix B]). The second survey was designed to question dentists who practice in the 18-county mid-Missouri region, where dental care is provided through the Mid-Missouri dental clinic in Columbia (Appendix C). The third survey was designed to question dentists who practice in those counties which still have a “fee-for-service” dental program (Appendix D).

As mentioned previously, prior to the development of the survey instruments, a letter was sent to all MC+ directors requesting specific information about their current plans (Appendix A-Letter 1). Information requested included: a list of the providers in their network, the method enrollees can use to select a dentist, how the plan recruits dentists into the program, a copy of the provider contract, the provider reimbursement system, the organizational relationship between the dental plan and the MC+ plan, and the availability of encounter data. This information was then used to refine the questions in the survey. Additional input about the survey instruments was provided by the Missouri Department of Health, the Missouri Department of Social Services, and the researchers on this project.
The survey process used in this study included four steps. First a pre-notification letter from Dr. McCunniff, UMKC School of Dentistry, was sent to all sampled dentists on July 19, 1998 (Appendix E-Letter 2). The first surveys and cover letters were mailed three days following the prenotification letter on July 22, 1998 (Appendix E-Letter 3). A postcard reminder was sent to all sampled dentists one week after the first survey was mailed on July 29, 1998. A follow-up survey and cover letter was mailed to all non-respondents about three weeks after the postcard on August 17, 1998 (Appendix E-Letter 4). The surveys were coded according to the county dentists practiced in to ensure each received the proper survey instrument for their region. Returned surveys were sent to DK Data Service Inc., Kansas City, MO, for data entry. Surveys were double entered and verified for accuracy.

For dentists in the MC+ and fee-for-service regions, survey results were analyzed for differences in attitudes between those dentists who participate in Medicaid and those who do not. This helped us to identify the factors that keep dentists from participating in Medicaid. Factors that were evaluated included: 1) satisfaction with the Medicaid program; 2) attitudes toward treating low-income patients; 3) perceptions of how the Medicaid program compared with private insurance on issues such as paperwork and speed of payment; and 4) perceptions of which problems with the Medicaid program affected their practices the most. A chi-square test of statistical significance was run for each of the questions of interest. The responses were considered statistically significantly different if the probability of the difference occurring by chance was less than five percent (p<0.05).

Out of the 2,126 surveys that were mailed, 30 were returned because of an undeliverable address, leaving a useable sample of 2096. A total of 1,153 surveys were returned for a response rate of 54%.
Results Section 1:

Dentists and the MC+ Program

All licensed general dentists, pediatric dentists, oral surgeons and public health dentists in the counties covered by the Missouri Medicaid MC+ program were mailed a survey about their participation in and attitudes toward the MC+ dental programs in their area. Seven hundred and fifteen out of 1452 dentists responded to the survey for a 49 percent response rate.

Description of Dentists and Their Medicaid Participation

A description of the dentists in the managed care region who responded to the survey is presented in Table 2-1a. The majority of responding dentists were solo practitioners in general practices. They had been in practice for an average of 17 years. They varied in how busy they described their practices to be. About half (52%) were either not busy enough or provided care to all requesting it without feeling overworked. The other half were either not accepting any new patients (6%), too busy to treat all new patients (13%), or were accepting all new patients but felt overworked (32%).
Table 2-1a. Demographic characteristics of dentists in the MC+ region

<table>
<thead>
<tr>
<th>Dentists Characteristic</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>585</td>
<td>85%</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>15</td>
<td>2%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>27</td>
<td>4%</td>
</tr>
<tr>
<td>Public Health</td>
<td>7</td>
<td>1%</td>
</tr>
<tr>
<td>Other Dental Specialty</td>
<td>59</td>
<td>9%</td>
</tr>
<tr>
<td>Years of Practice in current location (mean=16.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5</td>
<td>95</td>
<td>15%</td>
</tr>
<tr>
<td>6-10</td>
<td>110</td>
<td>17%</td>
</tr>
<tr>
<td>11-15</td>
<td>115</td>
<td>18%</td>
</tr>
<tr>
<td>16-20</td>
<td>113</td>
<td>17%</td>
</tr>
<tr>
<td>21-30</td>
<td>161</td>
<td>25%</td>
</tr>
<tr>
<td>31-40</td>
<td>41</td>
<td>5%</td>
</tr>
<tr>
<td>41-50</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>51-55</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Practice Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo Practitioner</td>
<td>460</td>
<td>71%</td>
</tr>
<tr>
<td>Owner of practice with associate</td>
<td>68</td>
<td>11%</td>
</tr>
<tr>
<td>Partner</td>
<td>75</td>
<td>12%</td>
</tr>
<tr>
<td>Associate/employee</td>
<td>18</td>
<td>2%</td>
</tr>
<tr>
<td>Independent contractor</td>
<td>11</td>
<td>1%</td>
</tr>
<tr>
<td>Staff dentist at public health clinic</td>
<td>18</td>
<td>2%</td>
</tr>
<tr>
<td>Busyness of practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice limited, take no new patients</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Too busy to treat all requesting appointments</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Provided care to all requesting it, but felt overworked</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>Provided care to all requesting it, but did not feel overworked</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Not busy enough, would have liked more patients</td>
<td>6%</td>
<td></td>
</tr>
</tbody>
</table>

Other indicators of Missouri dentists’ Medicaid participation are shown in Table 2-2a. Fifteen percent of dentists in the MC+ region contract to provide service to MC+ enrolled children. Close to half of those dentists have treated Medicaid patients in the past, but sixty nine percent of
them have never been asked to participate in the MC+ program. The majority (65%) of dentists said they would consider joining if fees were closer to UCR levels.

**Table 2-2a. Missouri dentists’ participation in the MC+ program**

<table>
<thead>
<tr>
<th>Level of participation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently contract to provide services to Medicaid-enrolled children in MC+ dental plan</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>For those who do not contract with an MC+ dental plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever accepted Medicaid fee-for-service patients in the past?</td>
<td>43%</td>
<td>55%</td>
</tr>
<tr>
<td>Were you ever asked to contract with an MC+ dental plan</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td>If fees were brought to a level closer to UCR, would you consider contracting with an MC+ dental plan</td>
<td>65%</td>
<td>35%</td>
</tr>
</tbody>
</table>

Dentists who are currently contracting to provide services with a MC+ dental plan were asked questions regarding their level of participation, the criteria used to determine what patients will be accepted, and the type of dental services being provided to those patients.

Table 2-3a shows that approximately half of the dentists currently participating in a MC+ dental plan are taking new MC+ patients into their practice. For those dentists who are taking new MC+ patients, the primary criteria they used for accepting new MC+ patients was setting a limit on the number of new MC+ patients per week or month (70%).

**Table 2-3a. Participation of dentists currently contracting with an MC+ dental plan**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you accepting new MC+ patients in your practice?</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Do you have any criteria for selecting new MC+ patients into your practice?</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>Criteria for patients they will accept in practice*:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A set number of new MC+ patients per week or month</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Our own patients who go on MC+</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Children of our own patients who go on MC+</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Referrals from other dentist/physicians</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Patients from our county</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

*Numbers do not equal 100 because dentists could select all that apply

Table 2-4a shows that all dentists providing services offer emergency care to Medicaid MC+ patients, and that most also provide exams/prophys, sealants, and routine restorative care. The numbers drop off sharply, however, for complex restorative care.

**Table 2-4a. Services provided to MC+ patients**
What services do you provide to MC+ patients in your practice?

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams/prophys</td>
<td>95%</td>
</tr>
<tr>
<td>Sealants</td>
<td>84%</td>
</tr>
<tr>
<td>Routine restorative care</td>
<td>95%</td>
</tr>
<tr>
<td>Complex restorative care</td>
<td>61%</td>
</tr>
<tr>
<td>Emergency care</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2-5a shows that the vast majority (81%) of dentists who were asked to participate in an MC+ dental plan were personally responsible for making the decision whether or not to participate.

**Table 2-5a. Primary responsibility for deciding whether to participate in MC+**

<table>
<thead>
<tr>
<th>Who was primarily responsible for making the decision whether your practice would contract with an MC+ plan?</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was</td>
<td>81%</td>
</tr>
<tr>
<td>The dentists in our practice as a group</td>
<td>8%</td>
</tr>
<tr>
<td>The owner of the practice</td>
<td>4%</td>
</tr>
<tr>
<td>The clinic management</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>

When dentists were asked if they had a dental practice or clinic where they could refer MC+ enrolled children that they were personally unable to treat, 57 percent responded no and 40 percent responded yes. (Table 2-6a).

**Table 2-6a. Ability to refer MC+ patients for routine care**

<table>
<thead>
<tr>
<th>Do you have a dental practice or clinic where you can refer children in the MC+ program whom you are unable to treat in your practice?</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>57%</td>
</tr>
<tr>
<td>Yes, to another private dental practice</td>
<td>23%</td>
</tr>
<tr>
<td>Yes, to a public health clinic</td>
<td>17%</td>
</tr>
<tr>
<td>I see all MC+ patients; I don’t need to refer any of them</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Dentists’ Attitudes Toward the Medicaid MC+ Program**

Dentists were presented with a series of statements about their satisfaction with the Medicaid MC+ program, the treatment of low-income Medicaid MC+ patients, a comparison of selected
issues between Medicaid MC+ and private insurance, and their perceptions of problems with the Medicaid MC+ program. For the questions about the Medicaid MC+ program and Medicaid MC+ patients, dentist responded on a scale of one to five, indicating how strongly they agreed or disagreed with each statement. They were also given a series of commonly perceived problems with Medicaid MC+ and were asked to rank the relative importance of each problem from “Not important” to Very important” in their office.

To evaluate factors that may affect dentists’ participation in the MC+ program, dentists who participate in MC+ were compared to those who do not regarding their attitudes toward the program.

**Overall rating of access, cost-effectiveness and quality of the MC+ program**

Table 2-7a shows how dentists compared the care currently provided to children in Medicaid MC+ with the dental care in the fee-for-service program before the MC+ program was initiated. The general consensus was that access to care and the cost effectiveness of providing care were about the same now as they had been before the MC+ program began. Dentists disagreed about the quality of care however. A greater percentage of fully participating dentists (89%) described the quality of care for children now as the same or better than before the MC+ program began, compared to only 75 percent of dentists who do not participate.

**Table 2-7a. Dentists' perceptions of access, quality and cost-effectiveness of the MC+ program**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you describe access to dental care for MC+ children now compared to before the MC+ program?</td>
<td>14%</td>
<td>48%</td>
<td>38%</td>
</tr>
<tr>
<td>How would you describe the quality of dental care for children enrolled in MC+ now compared to before the MC+ program?*</td>
<td>10%</td>
<td>70%</td>
<td>20%</td>
</tr>
<tr>
<td>How would you describe the cost-effectiveness of providing dental care to children enrolled in MC+ now compared to before the MC+ program</td>
<td>13%</td>
<td>51%</td>
<td>36%</td>
</tr>
</tbody>
</table>

* Statistically significant differences: $\chi^2$ p<0.05. Because of the small number of respondents in each category, statistical tests were run by combining the positive responses (much better and better) and comparing them with the combined negative responses (much worse and worse).

Table 2-8a shows the statements presented to dentists concerning their attitudes about the Medicaid MC+ program. Statistical analysis of this data found that certain aspects of the Medicaid MC+ program elicited significant differences in the responses of those dentists who are accepting new Medicaid MC+ enrolled children into their practices (full participants) with those who are not (limited participants) Limited participants may have some Medicaid MC+ patients in their practices, but are not providing access to care for new patients. Overall, full participants in the Medicaid MC+ program viewed the program significantly more positively concerning their
ability to provide comprehensive treatment; their ability to spend more time with patients; the program’s respect for their professional judgement; and, their ability to impact the Medicaid MC+ program.

Overall:

- A greater percentage (93%) of dentists not participating in MC+ feel it is more difficult to provide comprehensive treatment to MC+ patients than dentists who do participate in MC+ (72%).
- A greater percentage (86%) of dentists not participating in the MC+ feel that participating in the program would force them to spend less time with their other patients, compared to dentists who do participate with an MC+ plan (52%).
- A greater percentage (54%) of MC+ dentists believe that the MC+ program respects their professional judgment concerning patient care compared to dentists not in MC+ (24%).
- A greater percentage (48%) of MC+ dentists feel they can have an impact on the policies of the MC+ program compared to those dentists not participating with a MC+ plan (33%).

<table>
<thead>
<tr>
<th>Statement</th>
<th>MC+ Participation</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is difficult to provide comprehensive treatment to MC+ patients*</td>
<td>Full</td>
<td>6%</td>
<td>22%</td>
<td>38%</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>6%</td>
<td>36%</td>
<td>57%</td>
</tr>
<tr>
<td>Participating in the MC+ managed care program would force me to spend less time with my other patients*</td>
<td>Full</td>
<td>13%</td>
<td>36%</td>
<td>31%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>13%</td>
<td>45%</td>
<td>41%</td>
</tr>
<tr>
<td>I am concerned about having the only practice in the area that accepts MC+ patients</td>
<td>Full</td>
<td>11%</td>
<td>23%</td>
<td>23%</td>
<td>43%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>13%</td>
<td>31%</td>
<td>29%</td>
<td>27%</td>
</tr>
<tr>
<td>The MC+ program respects my professional judgment concerning patient care*</td>
<td>Full</td>
<td>10%</td>
<td>36%</td>
<td>47%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>39%</td>
<td>37%</td>
<td>20%</td>
<td>4%</td>
</tr>
<tr>
<td>Dentist can have an impact on the policies of the MC+ program*</td>
<td>Full</td>
<td>18%</td>
<td>34%</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>31%</td>
<td>36%</td>
<td>25%</td>
<td>8%</td>
</tr>
</tbody>
</table>

* Statistically significant differences: $\chi^2$ p<0.05. Because of the small number of respondents in each category, statistical tests were run by combining the positive responses (strongly agree and agree) and comparing them with the combined negative responses (strongly disagree and disagree).
Treatment of low-income patients

Dentists’ attitudes toward and perceptions of treating low-income patients may differ significantly from their attitudes and perceptions regarding the Medicaid MC+ program. A separate set of questions were asked to determine if there was any difference among participating and non-participating dentists regarding their attitudes about Medicaid patients generally.

As with the issues regarding the MC+ program, full participants viewed issues pertaining to MC+ patients significantly more positively than non-participating dentists (Table 2-9a). These issues included: importance of the program for access to dental care for low-income patients; the degree of difficulty in treating low-income patients; and whether dentists have an ethical obligation to treat Medicaid MC+ patients.

- Dentists who participate in a MC+ dental plan were significantly less likely to agree that MC+ make other patients in the office uncomfortable.
- A greater percentage (97%) of MC+ dentists feel that without the MC+ program, low-income patients would not be able to get adequate dental care compared to dentists not in MC+ (68%).
- A greater percentage (51%) of dentists not participating in MC+ feel low-income patients are more difficult to treat than others compared to dentists in MC+ (34%).
- A greater percentage (56%) of dentists in a MC+ plan feel they have an ethical obligation to treat MC+ patients compared to those dentists who are not in a MC+ plan (18%).
Table 2-9a. Dentists’ attitudes toward treating low income patients

<table>
<thead>
<tr>
<th>Statement</th>
<th>MC+ Participation</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC+ patients make other patients in the office feel uncomfortable</td>
<td>Full Full</td>
<td>32%</td>
<td>45%</td>
<td>16%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Limited Limited</td>
<td>13%</td>
<td>59%</td>
<td>20%</td>
<td>8%</td>
</tr>
<tr>
<td>Without the MC+ program, low-income patients would not be able to get adequate dental care*</td>
<td>Full Full</td>
<td>0%</td>
<td>3%</td>
<td>35%</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>Limited Limited</td>
<td>6%</td>
<td>26%</td>
<td>50%</td>
<td>18%</td>
</tr>
<tr>
<td>Oral health problems of MC+ patients are more severe than those of other patients in my practice</td>
<td>Full Full</td>
<td>3%</td>
<td>29%</td>
<td>40%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Limited Limited</td>
<td>2%</td>
<td>22%</td>
<td>51%</td>
<td>25%</td>
</tr>
<tr>
<td>Low-income patients are more difficult to treat than others*</td>
<td>Full Full</td>
<td>18%</td>
<td>48%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>Limited Limited</td>
<td>4%</td>
<td>45%</td>
<td>36%</td>
<td>15%</td>
</tr>
<tr>
<td>Dentists have an ethical obligation to treat MC+ patients*</td>
<td>Full Full</td>
<td>8%</td>
<td>36%</td>
<td>41%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Limited Limited</td>
<td>32%</td>
<td>50%</td>
<td>16%</td>
<td>1%</td>
</tr>
</tbody>
</table>

* Statistically significant differences: $\chi^2$ p<0.05. Because of the small number of respondents in each category, statistical tests were run by combining the positive responses (strongly agree and agree) and comparing them with the combined negative responses (strongly disagree and disagree).

**MC+ compared to private dental insurance**

When comparing aspects of the Medicaid MC+ program relative to private dental insurance, the consensus was that Medicaid MC+ was much more complicated, much less prompt in payment, made referring patients much more difficult, and had much lower fees (Table 2-10a). The only comparison that found a statistical difference between those dentists who participate in MC+ and those who don’t related to promptness of payment. More dentists (78%) who do not participate in MC+ feel MC+ is less prompt in terms of payment than private insurance, compared to dentists who are enrolled in MC+. 
Table 2-10a. Dentists' perceptions of the MC+ program compared to private insurance

| Statement                                                                 | MC+ Participation | Much More | More | About the same | Less | Much Less | Less | Full | Limited | 17% | 42% | 33% | 6% | 2% | 28% | 50% | 20% | 2% | 0% | 89% | 10% | 1% | 0% | 1% | 73% | 25% | 1% | 0% | 1% | 0% | 0% | 1% | 2% | 11% | 87% | 0% | 0% | 1% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 1% | 2% | 35% | 62% |

* Statistically significant differences: $\chi^2$ p<0.05. Because of the small number of respondents in each category, statistical tests were run by combining the positive responses (much more and more) and comparing them with the combined negative responses (much less and less).

Problems with participating in Medicaid MC+ Program

A combination of program and patient issues were evaluated together by asking dentists how important each of these Medicaid MC+ program and patient issues were in their practice (Table 2-11a). A significant difference was noted in four responses between fully participating dentists and limited participants.

- The majority of dentists (90%) enrolled in MC+ rate complicated paperwork as an important problem compared to dentists not enrolled (49%).

- More dentists (83%) enrolled in MC+ feel having prior approval is important compared to dentists not enrolled (71%).

- More dentists not enrolled in MC+ (88%) feel slow payments are important compared to dentists who are enrolled in MC+ (71%).

- More dentists (85%) who are not enrolled in MC+ feel patient non-compliance is important compared to dentists who are enrolled in MC+ (69%).

The relative importance of each item was evaluated by asking dentists to rank these issues as the first, second, and third most important issues in their practice. Each first response was given a score of three points, each second received two points, and each third one point. The number of
points for each issue were then added together and the total point score for each item was used to
determine the relative rank or importance of the issue compared to the other issues.

Low fees ranked the highest, followed by broken appointments and complicated paperwork.
Two of the top three issues were related to the program, while one of the top three referred to
patient issues.

This information corresponded to a question that asked dentists to indicate the three most
important changes the Medicaid program could make to increase dentists’ willingness to treat
Medicaid-enrolled children. The top three responses were: increase reimbursement levels; make
the paperwork more similar to other dental insurance; and increase the speed of payment.

Table 2-11a. Importance of problems with the MC+ program

<table>
<thead>
<tr>
<th>Problem</th>
<th>MC+ Participation</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Moderately Important</th>
<th>Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low fees</td>
<td>Full</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>17%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>19%</td>
<td>78%</td>
</tr>
<tr>
<td>Broken appointments</td>
<td>Full</td>
<td>1%</td>
<td>3%</td>
<td>6%</td>
<td>24%</td>
<td>66%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>0%</td>
<td>1%</td>
<td>4%</td>
<td>20%</td>
<td>75%</td>
</tr>
<tr>
<td>Denial of payment</td>
<td>Full</td>
<td>3%</td>
<td>4%</td>
<td>1%</td>
<td>26%</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
<td>27%</td>
<td>68%</td>
</tr>
<tr>
<td>Slow payment*</td>
<td>Full</td>
<td>8%</td>
<td>1%</td>
<td>20%</td>
<td>25%</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>2%</td>
<td>9%</td>
<td>26%</td>
<td>62%</td>
</tr>
<tr>
<td>Patient non-compliance*</td>
<td>Full</td>
<td>5%</td>
<td>10%</td>
<td>16%</td>
<td>31%</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>3%</td>
<td>11%</td>
<td>27%</td>
<td>58%</td>
</tr>
<tr>
<td>Complicated paperwork*</td>
<td>Full</td>
<td>10%</td>
<td>17%</td>
<td>24%</td>
<td>27%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>0%</td>
<td>2%</td>
<td>8%</td>
<td>28%</td>
<td>62%</td>
</tr>
<tr>
<td>Frequently changing MC+</td>
<td>Full</td>
<td>5%</td>
<td>11%</td>
<td>15%</td>
<td>28%</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>0%</td>
<td>3%</td>
<td>7%</td>
<td>31%</td>
<td>59%</td>
</tr>
<tr>
<td>Need for prior approval*</td>
<td>Full</td>
<td>8%</td>
<td>3%</td>
<td>18%</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>4%</td>
<td>12%</td>
<td>30%</td>
<td>53%</td>
</tr>
<tr>
<td>Intermittent eligibility of MC+</td>
<td>Full</td>
<td>5%</td>
<td>10%</td>
<td>9%</td>
<td>31%</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>5%</td>
<td>12%</td>
<td>31%</td>
<td>51%</td>
</tr>
<tr>
<td>Not enough other practices in the area accepting MC+ patients</td>
<td>Full</td>
<td>9%</td>
<td>5%</td>
<td>13%</td>
<td>13%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>6%</td>
<td>5%</td>
<td>11%</td>
<td>28%</td>
<td>49%</td>
</tr>
</tbody>
</table>

* Statistically significant differences: $\chi^2$ p<0.05. Because of the small number of respondents in each category,
statistical tests were run by combining the more strongly positive responses (important and very important) and
comparing them with the combined less positive responses (somewhat important and moderately important).
**Satisfaction with the Medicaid MC+ program**

Table 2-12a shows the statements presented to dentists who participate in the MC+ program concerning their satisfaction with the program. Seventy one percent of dentists report not being satisfied with the program, twenty six percent are satisfied and three percent very satisfied. The majority (69%) of dentists have seriously considered eliminating all MC+ patients from their practice.

**Table 2-12a. Participating dentists' satisfaction with the MC+ dental program**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not satisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, how satisfied are you with the MC+ dental program</td>
<td>71%</td>
<td>26%</td>
<td>3%</td>
</tr>
<tr>
<td>In the past year, how seriously have you considered eliminating all MC+ patients from your practice</td>
<td>19%</td>
<td>12%</td>
<td>69%</td>
</tr>
</tbody>
</table>

**Dentists' suggestions for restructuring the Medicaid dental program**

Dentists were asked what model they would choose if they were to develop a dental program for low-income Missouri patients. Table 2-13a shows the highest response was for the fee-for-service model with private practitioners (59%). Using public health clinics as a source of treatment was second (34%), followed by the managed care model (5%).

**Table 2-13a. Dental program development suggestions**

<table>
<thead>
<tr>
<th>If you where to develop a dental program for low-income Missourians, how would you suggest the care be delivered?</th>
<th>59%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using private practitioners and a fee-for-service program</td>
<td></td>
</tr>
<tr>
<td>Using private practitioners and a managed care program</td>
<td>5%</td>
</tr>
<tr>
<td>Using public health dental clinics</td>
<td>34%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Summary**

A large percent (85%) of practicing dentists in the dental managed care regions do not participate in the Medicaid MC+ program. The three main reasons dentists gave for not participating were low fees, broken appointments and complicated paperwork. The majority of dentists report that their practices are busy. For those dentists who are participating in the program, only about half are accepting new patients into their practice. The majority of dentists
are not satisfied with the program and have seriously considered eliminating all MC+ patients from their practice.

Results Section 2:

Dentists and the Mid-Missouri Program

Even though the Central region of Missouri is covered by the MC+ program, the three MC+ plans in the region (Care Partners, Missouri Care, and HealthCare USA) contract with a single dental program, the Mid-Missouri dental program, for all their dental services. The Mid-Missouri program operates a central clinic located in Columbia with two satellite clinics in other parts of the region. Because of the uniqueness of this program relative to the other MC+ dental plans, a survey specific to the Mid-Missouri dental program was mailed to all dentists in this 18-county area.

A total of 170 dentists were mailed a questionnaire and cover letter. One hundred and eight dentists responded to the survey for a response rate of 64 percent.

Due to the low number of dentists participating in the Mid-Missouri program, comparative analyses between those who participate and those who do not participate in the Mid-Missouri program could not be completed. Only descriptive information will be presented in this chapter.

Description of Dentists and Their Participation in the Mid-Missouri Program

A description of the dentists who responded to the survey is presented in Table 2-1b. The majority of responding dentists were solo practitioners in general practices who had been in practice at their current location for an average of 17 years. About two-thirds of them were either not taking any new patients, were turning some new patients away or were accepting all new patients but felt overworked. One-third were either not busy enough or accepted all new patients and did not feel overworked.
Other indicators of Missouri dentists’ Medicaid MC+ participation are shown in Table 2-2b. Ninety-one percent of dentists in the mid-Missouri region do not currently contract to provide service to Medicaid-enrolled children. Seventy four percent of the dentists have treated Medicaid patients in the past, but sixty seven percent of them have never been asked to
participate in the current program. The majority (61%) of dentists said they would not consider joining even if fees were closer to UCR levels.

Table 2-2b. Missouri dentists’ participation in the Mid-Missouri program

<table>
<thead>
<tr>
<th>Level of participation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently contract to provide services to Medicaid-enrolled children in Mid-Missouri MC+ dental plan</td>
<td>9%</td>
<td>91%</td>
</tr>
</tbody>
</table>

For those who do not contract with the Mid-Missouri MC+ dental plan:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever accepted Medicaid fee-for-service patients in the past?</td>
<td>74%</td>
<td>26%</td>
</tr>
<tr>
<td>Were you ever asked to contract with the Mid-Missouri MC+ dental plan</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>If fees were brought to a level closer to UCR, would you consider contracting with an MC+ Dental plan</td>
<td>39%</td>
<td>61%</td>
</tr>
</tbody>
</table>

The nine dentists who were currently contracting to provide services for Mid-Missouri MC+ were asked questions regarding their level of participation, the criteria they used to determine what patients will be accepted, and the type of dental services being provided to patients. Table 2-3b shows that twenty seven percent of the dentists currently enrolled (n=3) are taking new patients into their practice. For those dentists who are taking new patients, the primary selection criterion is accepting current patients who go on MC+. The only other criterion responded to was setting a limit on the number of new MC+ patients per week or month.

Table 2-3b. Participation of dentists currently contracting with the Mid-Missouri MC+ dental plan

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you accepting new MC+ patients in your practice?</td>
<td>27%</td>
<td>73%</td>
</tr>
<tr>
<td>Do you have any criteria for selecting new MC+ patients into your practice?</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

For those who do have criteria:

<table>
<thead>
<tr>
<th>Criteria</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A set number of new MC+ patients per week or month</td>
<td>66%</td>
</tr>
<tr>
<td>Our own patients who go on MC+</td>
<td>34%</td>
</tr>
<tr>
<td>Children of our own patients who go on MC+</td>
<td>0%</td>
</tr>
<tr>
<td>Referrals from other dentist/physicians</td>
<td>0%</td>
</tr>
<tr>
<td>Patients from our county</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table 2-4b shows that all dentists providing services offer emergency care to Medicaid MC+ patients, and that most also provide exams/prophys, sealants, and routine restorative care. The numbers drop off sharply, however, for complex restorative care.
Table 2-4b. Services provided to Mid-Missouri MC+ patients (n=9)

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams/prophys</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants</td>
<td>89%</td>
</tr>
<tr>
<td>Routine restorative care</td>
<td>78%</td>
</tr>
<tr>
<td>Complex restorative care</td>
<td>22%</td>
</tr>
<tr>
<td>Emergency care</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2-5b shows that the majority (87%) of dentists were personally responsible for making the decision whether or not to participate in the Mid-Missouri MC+ Medicaid program.

Table 2-5b. Primary responsibility for deciding whether to participate in the Mid-Missouri MC+ program

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was</td>
<td>87%</td>
</tr>
<tr>
<td>The dentists in our practice as a group</td>
<td>7%</td>
</tr>
<tr>
<td>The owner of the practice</td>
<td>5%</td>
</tr>
<tr>
<td>The clinic management</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
</tr>
</tbody>
</table>

When dentists were asked if they had a dental practice or clinic where they could refer children they were unable to treat whom were enrolled in the Mid-Missouri MC+ program, twenty five percent responded no and seventy five percent responded yes (Table 2-6b). It is important to note that twenty five percent of practicing dentists did not know about the dental center.

Table 2-6b. Ability to refer Mid-Missouri MC+ patients for routine care

<table>
<thead>
<tr>
<th>Availability</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>25%</td>
</tr>
<tr>
<td>Yes, to another private dental practice</td>
<td>12%</td>
</tr>
<tr>
<td>Yes, to a public health clinic</td>
<td>2%</td>
</tr>
<tr>
<td>Yes, to the Mid-Missouri Dental Center in Columbia</td>
<td>61%</td>
</tr>
<tr>
<td>I see all MC+ patients; I don’t need to refer any of them</td>
<td>0%</td>
</tr>
</tbody>
</table>
Dentists’ Attitudes Toward the Mid-Missouri MC+ Program

Dentists were presented with a series of statements about their satisfaction with the Mid-Missouri MC+ program, the treatment of low-income Mid-Missouri MC+ patients, a comparison of selected issues between Mid-Missouri MC+ and private insurance, and their perceptions of problems with the Mid-Missouri MC+ program. For the questions about the Mid-Missouri MC+ program and Mid-Missouri MC+ patients, dentist were asked to respond on a scale of one to five, indicating how strongly they agreed or disagreed with each statement. They were also presented with a series of commonly perceived problems with Mid-Missouri MC+ and asked to rank the relative importance of each problem from “Not important” to Very important” in their office.

Overall rating of access, cost-effectiveness and quality

Table 2-7b shows the perceptions of how current dental care for Mid-Missouri MC+ children compares to care they received before Mid-Missouri MC+ was initiated. The general perception is that access, quality of care, and cost effectiveness are about the same now as they were prior to the Mid-Missouri MC+ program being initiated.

Table 2-7b. Dentists’ perceptions of access, quality and cost with the Mid-Missouri MC+ program

<table>
<thead>
<tr>
<th>Statement</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you describe access to dental care for MC+ children now compared to before the MC+ program?</td>
<td>35%</td>
<td>37%</td>
<td>28%</td>
</tr>
<tr>
<td>How would you describe the quality of dental care for children enrolled in MC+ now compared to before the MC+ program?</td>
<td>27%</td>
<td>51%</td>
<td>22%</td>
</tr>
<tr>
<td>How would you describe the cost-effectiveness of providing dental care to children enrolled in MC+ now compared to before the MC+ program</td>
<td>17%</td>
<td>52%</td>
<td>31%</td>
</tr>
</tbody>
</table>
**Attitudes toward the Medicaid program**

Table 2-8b shows the statements presented to dentists concerning their attitudes about the Medicaid MC+ program.

Overall:

- Eighty-nine percent of dentists not participating in MC+ agree that it is more difficult to provide comprehensive treatment to Mid-Missouri MC+ enrollees.
- Ninety-percent agree that participating in the program would force them to spend less time with their other patients.
- Forty-three percent of dentists agreed that the Mid-Missouri MC+ program respects their professional opinion (about half the dentists responded ‘no opinion’ to this question).
- Forty-five percent of all responding dentists agreed that they can have an impact on the program.

**Table 2-8b. Percentage of dentists agreeing or disagreeing with statements about aspects of the Medicaid program**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is difficult to provide comprehensive treatment to MC+ patients</td>
<td>&lt;1%</td>
<td>9%</td>
<td>41%</td>
<td>49%</td>
</tr>
<tr>
<td>Participating in the MC+ managed care program would force me to spend less time with my other patients</td>
<td>3%</td>
<td>8%</td>
<td>41%</td>
<td>48%</td>
</tr>
<tr>
<td>I am concerned about having the only practice in the area that accepts MC+ patients</td>
<td>7%</td>
<td>22%</td>
<td>24%</td>
<td>47%</td>
</tr>
<tr>
<td>The MC+ program respects my professional judgment concerning patient care</td>
<td>27%</td>
<td>31%</td>
<td>33%</td>
<td>10%</td>
</tr>
<tr>
<td>Dentist can have an impact on the policies of the MC+ program</td>
<td>25%</td>
<td>30%</td>
<td>38%</td>
<td>7%</td>
</tr>
</tbody>
</table>
Attitudes toward treatment of low-income patients

Dentists’ attitudes toward and perceptions of treating low-income patients may differ significantly from their attitudes and perceptions regarding the Medicaid MC+ program. A separate set of questions sought to determine dentists’ attitudes about treating low-income Medicaid patients generally (Table 2-9b).

Overall:

- Forty-three percent of dentists agreed that MC+ patients make other patients in the office uncomfortable.
- Seventy-one percent agreed that without the MC+ program, low-income patients wouldn’t be able to receive dental care.
- Over three quarters (78%) reported that low-income patients are more difficult to treat than others patients.
- Twenty-one percent of dentists indicated that dentists have an ethical obligation to treat Medicaid patients.

Table 2-9b. Dentists’ attitudes toward treating low-income patients

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC+ patients make other patients in the office feel uncomfortable</td>
<td>12%</td>
<td>42%</td>
<td>33%</td>
<td>13%</td>
</tr>
<tr>
<td>Without the MC+ program, low-income patients would not be able to get adequate dental care</td>
<td>6%</td>
<td>23%</td>
<td>46%</td>
<td>25%</td>
</tr>
<tr>
<td>Oral health problems of MC+ patients are more severe than those of other patients in my practice</td>
<td>&lt;1%</td>
<td>20%</td>
<td>51%</td>
<td>27%</td>
</tr>
<tr>
<td>Low-income patients are more difficult to treat than others</td>
<td>6%</td>
<td>39%</td>
<td>39%</td>
<td>17%</td>
</tr>
<tr>
<td>Dentists have an ethical obligation to treat MC+ patients</td>
<td>32%</td>
<td>47%</td>
<td>16%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Dentists generally viewed the MC+ program less favorably than private dental insurance with regard to complexity of paperwork, speed of payment, fees, and ease of finding a specialist who will accept a referral (Table 2-10b).
Table 2-10b. Dentists’ perceptions of the Mid-Missouri MC+ program compared to private insurance

<table>
<thead>
<tr>
<th>Statement</th>
<th>Much Less</th>
<th>Less</th>
<th>About the same</th>
<th>More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>How complicated is MC+ paperwork compared to the paperwork for private insurers?</td>
<td>0%</td>
<td>8%</td>
<td>16%</td>
<td>56%</td>
<td>21%</td>
</tr>
<tr>
<td>How promptly does the MC+ program pay dentist compared to the speed of payment by private insurers?</td>
<td>24%</td>
<td>44%</td>
<td>28%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>How do the fees paid by MC+ compare to the fees paid by private insurers?</td>
<td>77%</td>
<td>23%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>How difficult is it to find a dental specialist who will accept an MC+ referral, as compared to the referral of a privately insured patient?</td>
<td>0%</td>
<td>2%</td>
<td>0%</td>
<td>24%</td>
<td>74%</td>
</tr>
</tbody>
</table>

Table 2-11b shows the importance that dentists place on difference problems commonly associated with Medicaid programs. More dentists rated broken appointments (95%) as either an important or very important problem than any other issue. Low fees (88%) and denial of payment (87%) were the next most common factors rated as important or very important.

Table 2-11b. Importance of problems with the Mid-Missouri MC+ program

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Moderately Important</th>
<th>Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broken appointments</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>19%</td>
<td>76%</td>
</tr>
<tr>
<td>Low fees</td>
<td>0%</td>
<td>4%</td>
<td>8%</td>
<td>18%</td>
<td>70%</td>
</tr>
<tr>
<td>Denial of payment</td>
<td>2%</td>
<td>5%</td>
<td>6%</td>
<td>20%</td>
<td>67%</td>
</tr>
<tr>
<td>Not enough other practices in the area accepting MC+ patients</td>
<td>2%</td>
<td>8%</td>
<td>12%</td>
<td>19%</td>
<td>59%</td>
</tr>
<tr>
<td>Frequently changing MC+ regulations</td>
<td>0%</td>
<td>2%</td>
<td>15%</td>
<td>25%</td>
<td>58%</td>
</tr>
<tr>
<td>Slow payment</td>
<td>4%</td>
<td>4%</td>
<td>11%</td>
<td>25%</td>
<td>56%</td>
</tr>
<tr>
<td>Patient non-compliance</td>
<td>0%</td>
<td>3%</td>
<td>14%</td>
<td>28%</td>
<td>55%</td>
</tr>
<tr>
<td>Intermittent eligibility of MC+ patients</td>
<td>3%</td>
<td>8%</td>
<td>15%</td>
<td>21%</td>
<td>54%</td>
</tr>
<tr>
<td>Complicated paperwork</td>
<td>4%</td>
<td>4%</td>
<td>9%</td>
<td>33%</td>
<td>50%</td>
</tr>
<tr>
<td>Need for prior approval</td>
<td>2%</td>
<td>7%</td>
<td>11%</td>
<td>33%</td>
<td>47%</td>
</tr>
</tbody>
</table>
Satisfaction with the Mid-Missouri MC+ program

Table 2-12b shows the statements presented to dentists concerning their satisfaction with the Mid-Missouri MC+ program. Thirty six percent of dentists reported that they were not satisfied with the program, fifty percent were satisfied, and fourteen percent very satisfied. Thirty seven percent of dentists have seriously considered eliminating all MC+ patients from their practice.

### Table 2-12b. Participating dentists’ satisfaction with the MC+ dental program

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not satisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, how satisfied are you with the MC+ dental program</td>
<td>36%</td>
<td>50%</td>
<td>14%</td>
</tr>
<tr>
<td>In the past year, how seriously have you considered eliminating all MC+ patients from your practice</td>
<td>Not seriously 36%</td>
<td>Somewhat seriously 27%</td>
<td>Very seriously 37%</td>
</tr>
</tbody>
</table>

Dentists were asked what model they would choose if they were to develop a dental program for low-income Missouri patients. Table 2-13b shows the highest response was for the fee-for-service model with private practitioners (52%). Using public health clinics as a source of treatment was second (33%), followed by the managed care model (10%).

### Table 2-13b. Suggestions for program development

<table>
<thead>
<tr>
<th>If you where to develop a dental program for low-income Missourians, how would you suggest the care be delivered?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Using private practitioners and a fee-for-service program</td>
<td>52%</td>
</tr>
<tr>
<td>Using private practitioners and a managed care program</td>
<td>10%</td>
</tr>
<tr>
<td>Using public health dental clinics</td>
<td>33%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
</tbody>
</table>

Summary

The majority (91%) of dentists in the Mid-Missouri region do not participate in the MC+ program. The main reasons given for not participating were low fees, broken appointments and complicated paperwork. A high percentage (74%) of dentists had participated in the past under the fee-for-service program, but sixty seven percent of these had never been asked to participate in the MC+ program. Sixty one percent responded that they would consider contracting with an MC+ dental plan if fees were brought closer to UCR. Twenty five percent of dentists practicing in the Mid-Missouri region were not familiar with the Dental Center in Columbia. Of those dentists who do participate in the MC+ program, the majority (64%) is satisfied/very satisfied with the program.
Results Section 3:

Dentists and the Fee-For-Service Program

A total of 504 dentists in regions of the state where there is currently no managed care plans were asked to evaluate dentists’ participation in and attitudes toward the traditional Medicaid fee-for-service (FFS) program. Three hundred and thirty dentists responded to the survey for a response rate of sixty five percent.

To determine the factors affecting the participation of Missouri dentists in the Medicaid program, dentists who accept Medicaid patients in their practices were compared with dentists who do not accept any Medicaid patients regarding 1) satisfaction with the Medicaid program; 2) attitudes toward treating low-income patients; 3) perceptions of how the Medicaid program compared with private insurance on issues such as paperwork and speed of payment; and 4) perceptions of which problems with the Medicaid program affect their practice the most.

Participating dentists in the FFS region were defined as those who were accepting new Medicaid-enrolled children into their practice. Chi-square statistical tests were used to determine the factors for which participating dentists were significantly different from non-participating dentists. The responses were considered significantly different if p<0.05.

Description of Dentists and Medicaid Participation

A description of the dentists in the Fee-For-Service (FFS) region who responded to the survey is presented in Table 2-1c. The majority of responding dentists were solo practitioners in general practices who had been in practice for an average 17 years. In general, most dentists report that they are busy in their current practice situation. Only three percent of dentists report not being busy enough and desiring to have more patients in their practice. On the other hand, only 6 percent are so busy they are not accepting any new patients.
### Table 2-1c. Demographic information of dentists in the FFS region

<table>
<thead>
<tr>
<th>Dentists’ Characteristics</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area of practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>294</td>
<td>91%</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>10</td>
<td>3%</td>
</tr>
<tr>
<td>Public Health</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Other Dental Specialty</td>
<td>11</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Years of Practice in current location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(mean=17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5</td>
<td>34</td>
<td>11%</td>
</tr>
<tr>
<td>6-10</td>
<td>51</td>
<td>16%</td>
</tr>
<tr>
<td>11-15</td>
<td>54</td>
<td>17%</td>
</tr>
<tr>
<td>16-20</td>
<td>63</td>
<td>20%</td>
</tr>
<tr>
<td>21-25</td>
<td>62</td>
<td>20%</td>
</tr>
<tr>
<td>26-30</td>
<td>29</td>
<td>9%</td>
</tr>
<tr>
<td>31-35</td>
<td>14</td>
<td>5%</td>
</tr>
<tr>
<td>36-40</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>40-55</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Practice Type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo Practitioner</td>
<td>243</td>
<td>77%</td>
</tr>
<tr>
<td>Owner of practice with associate</td>
<td>25</td>
<td>8%</td>
</tr>
<tr>
<td>Partner</td>
<td>32</td>
<td>10%</td>
</tr>
<tr>
<td>Associate/employee</td>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td>Independent contractor</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Staff dentist at public health clinic</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Busyness of practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice limited, no new patients</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td>Too busy to treat all requesting appointments</td>
<td></td>
<td>28%</td>
</tr>
<tr>
<td>Provided care to all requesting it, but felt overworked</td>
<td></td>
<td>27%</td>
</tr>
<tr>
<td>Provided care to all requesting it, but did not feel overworked</td>
<td></td>
<td>36%</td>
</tr>
<tr>
<td>Not busy enough, would have liked more patients</td>
<td></td>
<td>3%</td>
</tr>
</tbody>
</table>

Other indicators of Missouri dentists’ Medicaid participation are shown in Table 2-2c. Fifty percent of dentists in the FFS region currently have a Medicaid provider number which allows them to submit claims for services provided to Medicaid-enrolled children. Sixty three percent
of dentists have treated Medicaid patients in the past. The majority (59%) of dentists said they would consider joining if fees were closer to UCR levels.

**Table 2-2c. Missouri dentists’ participation in the Medicaid program**

<table>
<thead>
<tr>
<th>Level of participation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently have a Medicaid provider number?</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>For those who do not contract with the Medicaid dental plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever accepted Medicaid fee-for-service patients in the past?</td>
<td>63%</td>
<td>37%</td>
</tr>
<tr>
<td>If fees were brought to a level closer to UCR and other changes were made, would you consider accepting new Medicaid-enrolled children?</td>
<td>59%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Dentists who were currently contracting services for Medicaid were asked questions regarding their level of participation, the criteria they used to determine what patients to accept, and the type of dental services being provided to the patients. Table 2-3c shows that forty one percent of the dentists currently enrolled are taking new patients into their practice. Among those who are taking new patients, the primary selection criterion was accepting current patients who go on Medicaid (29%). Accepting the children of their own Medicaid patients as new patients came a close second (25%).

**Table 2-3c. Participation of dentists currently accepting Medicaid FFS patients**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you accepting new Medicaid patients in your practice?</td>
<td>41%</td>
<td>59%</td>
</tr>
<tr>
<td>Do you have any criteria for selecting new Medicaid patients into your practice?</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>Type of criteria for those with criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A set number of new Medicaid patients per week or month</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Our own patients who go on Medicaid</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Children of our own patients who go on Medicaid</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Referrals from other dentist/physicians</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Patients from our county</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

Table 2-4c shows that there are 131 dentists who said they have Medicaid-enrolled children in their practices. Ninety percent of these dentists are providing exams and cleanings. About three-quarters are providing sealants and routine restorative care, and half are providing complex restorative care. Almost all (96%) provide emergency care.
Table 2-4c. Services provided to Medicaid patients (n=131)

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams/cleanings</td>
<td>90%</td>
</tr>
<tr>
<td>Sealants</td>
<td>76%</td>
</tr>
<tr>
<td>Routine restorative care</td>
<td>73%</td>
</tr>
<tr>
<td>Complex restorative care</td>
<td>50%</td>
</tr>
<tr>
<td>Emergency care</td>
<td>96%</td>
</tr>
</tbody>
</table>

Table 2-5c shows that the majority (93%) of dentists were personally responsible for deciding whether or not to participate in the Medicaid program.

Table 2-5c. Primary responsibility for participation in Medicaid FFS program

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was</td>
<td>93%</td>
</tr>
<tr>
<td>The dentists in our practice as a group</td>
<td>3%</td>
</tr>
<tr>
<td>The owner of the practice</td>
<td>2%</td>
</tr>
<tr>
<td>The clinic management</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

When dentists were asked if there was a dental practice or clinic to which they could refer Medicaid-enrolled children they were personally unable to treat, forty four percent responded no and forty percent responded yes (Table 2-6c).

Table 2-6c. Ability to refer Medicaid FFS patients for routine care

<table>
<thead>
<tr>
<th>Ability to refer</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>44%</td>
</tr>
<tr>
<td>Yes, to another private dental practice</td>
<td>48%</td>
</tr>
<tr>
<td>Yes, to a public health clinic</td>
<td>7%</td>
</tr>
<tr>
<td>I see all Medicaid-enrolled patients; I don’t need to refer any of them</td>
<td>0%</td>
</tr>
</tbody>
</table>

Dentists’ Attitudes Toward the Medicaid Program

Dentists were presented with a series of statements about their satisfaction with the Medicaid program, the treatment of low-income Medicaid patients, a comparison of selected issues between Medicaid and private insurance, and their perceptions of problems with the Medicaid program. For the questions about the Medicaid program and Medicaid patients, dentist were
asked to respond on a scale of one to five, indicating how strongly they agreed or disagreed with each statement. They were also given a series of commonly perceived problems with Medicaid, and were asked to rank the relative importance of each problem from “Not important” to Very important” in their office.

Table 2-8c shows the statements presented to all dentists concerning their attitudes about the Medicaid program. Statistical analyses were completed to compare the results of dentists who are accepting new Medicaid-enrolled children into their practices (full participants) with those who are not (limited participants). Limited participants may have some Medicaid patients in their practices, but are not providing access to care for new patients. Significant differences were found in the responses of dentists who were taking Medicaid patients versus those who were not in the following areas:

- A greater percentage (93%) of dentists not enrolled in Medicaid feel that participating in the program would force them to spend less time with their other patients compared to dentists enrolled in Medicaid (80%).

- A greater percentage (35%) of dentists enrolled in Medicaid believe that the Medicaid program respects their professional judgment concerning patient care compared to dentists not enrolled (16%).

Full participants in the Medicaid program viewed the program significantly more positively concerning: their ability to provide comprehensive treatment; their ability to spend more time with patients; and the program’s respect for their professional judgement.

**Table 2-8c. Attitudes toward the Medicaid program**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Medicaid Participation</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is difficult to provide comprehensive treatment to MC+ patients*</td>
<td>Full</td>
<td>1%</td>
<td>9%</td>
<td>29%</td>
<td>61%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>3%</td>
<td>33%</td>
<td>63%</td>
</tr>
<tr>
<td>Participating in the MC+ managed care program would force me to spend less time with my other patients*</td>
<td>Full</td>
<td>3%</td>
<td>17%</td>
<td>36%</td>
<td>44%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>6%</td>
<td>36%</td>
<td>57%</td>
</tr>
<tr>
<td>I am concerned about having the only practice in the area that accepts MC+ patients</td>
<td>Full</td>
<td>3%</td>
<td>15%</td>
<td>22%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>9%</td>
<td>20%</td>
<td>29%</td>
<td>42%</td>
</tr>
<tr>
<td>The MC+ program respects my professional judgment concerning patient care*</td>
<td>Full</td>
<td>37%</td>
<td>28%</td>
<td>28%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>46%</td>
<td>385</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>Dentist can have an impact on the policies of the MC+ program*</td>
<td>Full</td>
<td>41%</td>
<td>30%</td>
<td>22%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>41%</td>
<td>32%</td>
<td>22%</td>
<td>6%</td>
</tr>
</tbody>
</table>
* Statistically significant differences: $\chi^2 \ p<0.05$. Because of the small number of respondents in each category, statistical tests were run by combining the positive responses (strongly agree and agree) and comparing them with the combined negative responses (strongly disagree and disagree).
Dentists’ attitudes toward low-income patients

Table 2-9c shows the statements presented to all dentists concerning their attitudes about treating low-income patients. Statistical analyses were completed to compare the results of participating dentists with those of nonparticipating dentists. Significant differences were found between the responses of dentists who were taking Medicaid patients versus those who were not in the following areas:

- A greater percentage (80%) of dentists enrolled in Medicaid feel that without the Medicaid program, low-income patients would not be able to get adequate dental care compared to dentists not enrolled (65%).

- A greater percentage (58%) of dentists enrolled in Medicaid feel they have an ethical obligation to treat Medicaid patients compared to those dentists who are not enrolled (18%).

Full participants in the Medicaid program viewed the program significantly more positively in regard to concerns about adequate dental care for low-income patients, and the ethical obligation to treat Medicaid MC+ patients.

### Table 2-9c. Attitudes toward treating low-income patients

<table>
<thead>
<tr>
<th>Statement</th>
<th>Medicaid Participation</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC+ patients make other patients in the office feel uncomfortable</td>
<td>Full</td>
<td>9%</td>
<td>32%</td>
<td>37%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>7%</td>
<td>43%</td>
<td>34%</td>
<td>16%</td>
</tr>
<tr>
<td>Without the MC+ program, low-income patients would not be able to get adequate dental care*</td>
<td>Full</td>
<td>7%</td>
<td>13%</td>
<td>44%</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>3%</td>
<td>31%</td>
<td>46%</td>
<td>20%</td>
</tr>
<tr>
<td>Oral health problems of MC+ patients are more severe than those of other patients in my practice</td>
<td>Full</td>
<td>0%</td>
<td>18%</td>
<td>49%</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>2%</td>
<td>24%</td>
<td>42%</td>
<td>32%</td>
</tr>
<tr>
<td>Low-income patients are more difficult to treat than others*</td>
<td>Full</td>
<td>6%</td>
<td>33%</td>
<td>33%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>5%</td>
<td>38%</td>
<td>38%</td>
<td>19%</td>
</tr>
<tr>
<td>Dentists have an ethical obligation to treat MC+ patients*</td>
<td>Full</td>
<td>17%</td>
<td>25%</td>
<td>44%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>35%</td>
<td>47%</td>
<td>12%</td>
<td>6%</td>
</tr>
</tbody>
</table>

* Statistically significant differences: \( \chi^2 \ p<0.05 \). Because of the small number of respondents in each category, statistical tests were run by combining the positive responses (strongly agree and agree) and comparing them with the combined negative responses (strongly disagree and disagree).

When comparing aspects of the Medicaid program relative to private dental insurance, the consensus was that Medicaid was much more complicated, much less prompt in payment, made it much more difficult to refer patients, and had much lower fees (Table 5-10). The only
comparison that found a statistical difference between those dentists who participate in Medicaid and those who don’t related to promptness of payment. More dentists (82%) who do not participate in Medicaid feel that Medicaid is less prompt in making payments than private insurance, compared to dentists who are enrolled in Medicaid (55%).

Table 2-10c. Dentists’ perceptions of the MC+ program compared to private insurance

<table>
<thead>
<tr>
<th>Statement</th>
<th>Medicaid Participation</th>
<th>Much Less</th>
<th>Less</th>
<th>About the same</th>
<th>More</th>
<th>Much More</th>
</tr>
</thead>
<tbody>
<tr>
<td>How complicated is MC+ paperwork compared to the paperwork for private insurers?</td>
<td>Full</td>
<td>0%</td>
<td>1%</td>
<td>38%</td>
<td>33%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>0%</td>
<td>2%</td>
<td>17%</td>
<td>48%</td>
<td>34%</td>
</tr>
<tr>
<td>How promptly does the MC+ program pay dentists compared to the speed of payment by private insurers?*</td>
<td>Full</td>
<td>12%</td>
<td>43%</td>
<td>42%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>34%</td>
<td>38%</td>
<td>26%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>How do the fees paid by MC+ compare to the fees paid by private insurers?</td>
<td>Full</td>
<td>97%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>94%</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>How difficult is it to find a dental specialist who will accept an MC+ referral, as compared to the referral of a privately insured patient?</td>
<td>Full</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>16%</td>
<td>81%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>0%</td>
<td>4%</td>
<td>29%</td>
<td>66%</td>
</tr>
</tbody>
</table>

* Statistically significant differences: $\chi^2$ p<0.05. Because of the small number of respondents in each category, statistical tests were run by combining the positive responses (much more and more) and comparing them with the combined negative responses (much less and less).

Problems with participating in the Medicaid Program

A combination of program and patient issues were evaluated together by asking dentists how important each of a series of Medicaid program and patient issues were in their practice (Table 2-11c). A significant difference was noted in three responses between fully participating dentists and limited participants.

- More dentists (82%) who are not enrolled in Medicaid feel having prior approval is a very important problem compared to those enrolled in Medicaid (18%).
- More dentists (64%) who are not enrolled in Medicaid feel slow payments are a very important problem compared to those enrolled in Medicaid (19%).
- More dentists (61%) who are not enrolled in Medicaid felt frequently changing Medicaid regulations were a very important problem compared to those dentists who are enrolled in Medicaid (12%).

The relative importance of each item was evaluated by asking dentists to rank the first, second and third most important issues in their practice. Each first response was given a score of three
points, the second received two points, and the third one point. The number of points for each issue were then added together and the total point score for each item was used to determine the relative rank or importance of the issue compared to the other issues. Low fees ranked the highest, followed by broken appointments and complicated paperwork. Two of the top three issues were related to the program, while one of the top three referred to patient issues.

This information corresponded to a question that asked dentists to indicate the three most important changes the Medicaid program could make to increase dentists’ willingness to treat Medicaid-enrolled children. The top three responses were: increase reimbursement levels; make the paperwork more similar to other dental insurance; and reduce the number of claims denied over small issues (e.g., minor paperwork errors).

**Table 2-11c. Percent of dentists reporting degree of importance with certain aspects of the Medicaid program**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Medicaid Participation</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Moderately Important</th>
<th>Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complicated paperwork*</td>
<td>Full</td>
<td>3%</td>
<td>9%</td>
<td>16%</td>
<td>26%</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>6%</td>
<td>9%</td>
<td>22%</td>
<td>62%</td>
</tr>
<tr>
<td>Low fees</td>
<td>Full</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>7%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>0%</td>
<td>1%</td>
<td>3%</td>
<td>12%</td>
<td>84%</td>
</tr>
<tr>
<td>Need for prior approval*</td>
<td>Full</td>
<td>13%</td>
<td>12%</td>
<td>19%</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>4%</td>
<td>4%</td>
<td>16%</td>
<td>30%</td>
<td>46%</td>
</tr>
<tr>
<td>Intermittent eligibility of MC+ patients</td>
<td>Full</td>
<td>6%</td>
<td>6%</td>
<td>19%</td>
<td>27%</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>6%</td>
<td>14%</td>
<td>30%</td>
<td>49%</td>
</tr>
<tr>
<td>Denial of payment</td>
<td>Full</td>
<td>3%</td>
<td>4%</td>
<td>17%</td>
<td>19%</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>3%</td>
<td>5%</td>
<td>23%</td>
<td>68%</td>
</tr>
<tr>
<td>Broken appointments</td>
<td>Full</td>
<td>0%</td>
<td>3%</td>
<td>1%</td>
<td>16%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>13%</td>
<td>84%</td>
</tr>
<tr>
<td>Slow payment*</td>
<td>Full</td>
<td>4%</td>
<td>12%</td>
<td>17%</td>
<td>32%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>3%</td>
<td>6%</td>
<td>10%</td>
<td>22%</td>
<td>59%</td>
</tr>
<tr>
<td>Patient non-compliance*</td>
<td>Full</td>
<td>2%</td>
<td>3%</td>
<td>7%</td>
<td>28%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>1%</td>
<td>3%</td>
<td>11%</td>
<td>20%</td>
<td>65%</td>
</tr>
<tr>
<td>Frequently changing MC+ regulations</td>
<td>Full</td>
<td>4%</td>
<td>22%</td>
<td>23%</td>
<td>22%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>Limited</td>
<td>2%</td>
<td>7%</td>
<td>11%</td>
<td>29%</td>
<td>51%</td>
</tr>
<tr>
<td>Not enough other practices in the area</td>
<td>Full</td>
<td>5%</td>
<td>4%</td>
<td>7%</td>
<td>19%</td>
<td>65%</td>
</tr>
<tr>
<td>accepting MC+ patients</td>
<td>Limited</td>
<td>4%</td>
<td>5%</td>
<td>12%</td>
<td>24%</td>
<td>55%</td>
</tr>
</tbody>
</table>

* Statistically significant differences: \( \chi^2 \ p<0.05 \). Because of the small number of respondents in each category, statistical tests were run by combining the more strongly positive responses (important and very important) and comparing them with the combined less positive responses (somewhat important and moderately important).
Satisfaction with the Medicaid program

Table 2-12c shows the satisfaction of only those dentists who are participating in the Medicaid fee-for-service program. Seventy percent of participating dentists report not being satisfied with the program, twenty seven percent are satisfied, and four percent are very satisfied. The majority (70%) of the dentists have seriously considered eliminating all Medicaid patients from their practices.

Table 2-12c. Participating dentists’ satisfaction with the Medicaid FFS dental program

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not satisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, how satisfied are you with the Medicaid dental program</td>
<td>70%</td>
<td>27%</td>
<td>4%</td>
</tr>
<tr>
<td>In the past year, how seriously have you considered eliminating all Medicaid patients from your practice</td>
<td>Not seriously</td>
<td>Somewhat seriously</td>
<td>Very seriously</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>20%</td>
<td>70%</td>
</tr>
</tbody>
</table>

Dentists were asked what model they would choose if they were to develop a dental program for low-income Missouri patients. Table 5-12 shows that the highest response was for the fee-for-service model with private practitioners (66%). Using public health clinics as a source of treatment was second (28%), followed by the managed care model (5%).

Table 2-13c. Suggestions for program development

<table>
<thead>
<tr>
<th>If you where to develop a dental program for low-income Missourians, how would you suggest the care be delivered?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Using private practitioners and a fee-for-service program</td>
<td>66%</td>
</tr>
<tr>
<td>Using private practitioners and a managed care program</td>
<td>4%</td>
</tr>
<tr>
<td>Using public health dental clinics</td>
<td>28%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
</tbody>
</table>

Summary

Fifty percent of dentists practicing in the Medicaid fee-for-service regions do not participate in the Medicaid program. The three main reasons given for not participating were low fees, broken appointments and complicated paperwork. The majority of dentists report that their practices are busy. Among dentists who are participating in the Medicaid program, only forty one percent are accepting new patients into their practice. The majority of participating dentists are not satisfied
with the program and have seriously considered eliminating all MC+ patients from their practices.
CHAPTER 3:

1998 SURVEY OF MISSOURI MEDICAID ENROLLEES

Introduction

Access to and satisfaction with dental care for children enrolled in the Missouri Medicaid program was evaluated with a survey of current Medicaid enrollees. Access and satisfaction are particularly important issues for this population because of the possible additional barriers they face in obtaining dental care. Barriers identified in other studies with Medicaid patients included dentists unwilling to accept Title XIX patients, longer waiting times for appointments, transportation problems, inability to get off work, and perceived ethnic and cultural barriers to care (CITE).

Methods

For this study, a sample of 3,000 Medicaid enrollees was initially selected from a list of all Medicaid enrollees, obtained from the Missouri Department of Social Services. One thousand enrollees were in MC+ dental plans, one thousand were in the Mid-Missouri Dental Clinic program and one thousand were in the counties with a fee-for-service dental program. Since only one questionnaire person per household was desired for the sample (to avoid similar responses from people in the same household and to reduce respondent burden), one child per household was randomly selected. This resulted in a final sample of 2,871 Medicaid-enrolled children.

The University of Iowa “1997 Survey of Iowa Medicaid Enrollees” was used as the basis for the survey instrument used in this study. The Iowa survey instrument was modified for use in this study with input from the Missouri Department of Health, the Missouri Department of Social Services, and the research team for this study. Questions in the survey addressed the child’s utilization of dental services, the site of their dental care, their access to dental care, satisfaction with dental care, and the perceived quality of the dental care they received.

The mail-only survey was conducted between August and October, 1998. A four-step survey process was used in this study. First a pre-notification letter from Dr. McCunniff, Assistant Professor, UMKC School of Dentistry, and Dr. Dean Perkins, Dental Director, Missouri Department of Health was sent to all sampled enrollees (Appendix X-Letter four). The first survey and cover letter were mailed three days following the prenotification letter (Letter five). To increase the likelihood that parents or guardians would respond specifically about the health care of a particular child, the survey was addressed ‘to the parent or guardian of…….’ And the cover of the survey had a sticker with the child’s name below the statement ‘please fill out this
questionnaire thinking about the following child’s experiences while in their current Medicaid program: (sticker placed here)’. The sticker could be peeled off before the survey was returned so that parents would have a greater feeling of confidentiality. A postcard reminder was sent to all sampled enrollees one week after the first survey was mailed. A follow-up letter and cover letter was mailed to all nonrespondents about three weeks after the postcard (Letter 6. A copy of the surveys and cover letters may be found in APPENDIX F).

To further evaluate the Medicaid dental programs, responses as to access, satisfaction and quality of care were compared for enrollees in the three types of Medicaid dental plans (fee-for-service, MC+ and Mid-Missouri program). A chi-square test of statistical significance was run for each of the questions of interest. The responses were considered statistically significantly different if the probability of the difference occurring by chance was less than five percent (p<0.05).

Results

The response rates for enrollees by plan is shown in Table 3-1. Overall, 35 percent of enrollees responded to the survey with enrollees in fee-for-service being most likely to respond and those in the Mid-Missouri region least likely to respond.

Table 3–1. Response rates to the Medicaid recipient survey

<table>
<thead>
<tr>
<th></th>
<th>Fee for service</th>
<th>MC+</th>
<th>Mid-Missouri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number in sample</td>
<td>465</td>
<td>456</td>
<td>421</td>
</tr>
<tr>
<td>Number with good addresses</td>
<td>368</td>
<td>378</td>
<td>349</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>171</td>
<td>124</td>
<td>149</td>
</tr>
<tr>
<td>Response rate</td>
<td>44%</td>
<td>33%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Access to and use of dental services

Medicaid enrollees were asked a series of questions about their past use of dental services. Overall, 78 percent of all children had been to the dentist at least once in their life, with no statistical difference by dental region (Table 3-2).
Table 3-2. Percentage of children who have ever had a dental visit

<table>
<thead>
<tr>
<th>Statement</th>
<th>Dental Plan</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your child ever visited a dentist?</td>
<td>MC+</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>78%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Almost three-quarters (73%) of all enrollees that had been to the dentist at least once had had their last visit within the previous year. Enrollees in the Mid-Missouri region (64%), however, were significantly less likely to have had a dental visit in the previous year compared to children in FFS (78%) or MC+ (79%) (Table 3-3).

Table 3-3. Time of last dental visit

<table>
<thead>
<tr>
<th>Statement</th>
<th>Provider</th>
<th>Last 6 months</th>
<th>6-12 months</th>
<th>1-2 years</th>
<th>&gt;2 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your child’s last visit to the dentist?*</td>
<td>MC+</td>
<td>49%</td>
<td>29%</td>
<td>17%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>40%</td>
<td>23%</td>
<td>25%</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>49%</td>
<td>29%</td>
<td>15%</td>
<td>8%</td>
</tr>
</tbody>
</table>

* Statistically significant differences $\chi^2$ p<0.05

Routine preventive care (check-up and/or cleaning) was the main reason for the last dental visit for almost three-quarters of the children (72%), however, this varied by plan (Table 3-4).

Table 3-4. Reason for last dental visit

<table>
<thead>
<tr>
<th>Statement</th>
<th>Provider</th>
<th>Check-up and/or cleaning</th>
<th>Emergency Care</th>
<th>Other (fillings, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the main reason for this visit?*</td>
<td>MC+</td>
<td>79%</td>
<td>7%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>70%</td>
<td>9%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>67%</td>
<td>5%</td>
<td>27%</td>
</tr>
</tbody>
</table>

* Statistically significant differences $\chi^2$ p<0.05

Preventive care was the reason for the last visit for 79% of the children in MC+ plans compared to 70 percent in Mid-Missouri and 67 percent in FFS. Those in Mid-Missouri were most likely to have sought emergency care during their last dental visit (9%) compared to seven percent in MC+ and five percent in FFS. One in five children overall (21%) went for another reason such as restorative care (fillings). Out of those whose last visit was not for an examination (check-up), 60
percent had had a check-up in the previous year with no difference by plan. For one-quarter, their last dental exam was between one and two years ago, while for 15 percent, it was more than 2 years ago.

More than four out of five of the children who had been to the dentist were reported to have a regular source of dental care (one main place where they usually went for dental care) (Table 3-5).

**Table 3-5. Regular source of dental care by plan**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Dental plan</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there one main place where you usually take your child for dental care?*</td>
<td>MC+</td>
<td>90%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>79%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>81%</td>
<td>19%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If they have one main place, where is it?*</th>
<th>Dental plan</th>
<th>Private dentist’s office</th>
<th>A public dental clinic</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MC+</td>
<td>55%</td>
<td>38%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>41%</td>
<td>47%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>67%</td>
<td>29%</td>
<td>4%</td>
</tr>
</tbody>
</table>

* Statistically significant differences $\chi^2$ p<0.05

Those in the MC+ regions were significantly more likely to report having a regular source of dental care (90%) than those in FFS (81%) and in Mid-Missouri (79%). The type of site each considered to be their regular source of care also varied by plan. Overall, just over half (55%) reported a private dentist’s office as their regular source of care, while for over a third, a public dental clinic was their main place. In the Mid-Missouri region, 47 percent reported a public clinic to be their regular source of care compared to 38 percent in MC+ regions and 29 percent in FFS. For eight percent, it was reported to be some other location.

When asked to describe the dental care-seeking behavior of their child, 58 percent reported that their child visited the dentist regularly (at least once per year), 20 percent reported that their child visited the dentist occasionally, while 22 percent of children were described as seeking care rarely or only when they had a problem.

Seventy-five percent of children who had been to the dentist were described as being in need of dental care. There were no statistically significant differences in the percentage of children reported to be in need of care or for the type of care they were believed to need by plan. Over
half of those in need believed they needed routine preventive care (check-up or cleaning). One in five were thought to need “a few fillings,” four percent needed “many fillings,” while 21 percent needed some other treatment (e.g., to have a tooth pulled).

Travel time to the dentist for the child’s last dental visit varied significantly among respondents by dental plan (Table 3-6).

**Table 3-6. Travel time to last dental visit**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Provider</th>
<th>&lt;15 minutes</th>
<th>15-30 minutes</th>
<th>30-60 minutes</th>
<th>1-2 hours</th>
<th>&gt;2 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>About how long did it take you to travel to your child’s last dental visit?</td>
<td>MC+</td>
<td>33%</td>
<td>52%</td>
<td>13%</td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>25%</td>
<td>21%</td>
<td>27%</td>
<td>21%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>30%</td>
<td>36%</td>
<td>23%</td>
<td>8%</td>
<td>3%</td>
</tr>
</tbody>
</table>

* Statistically significant differences $\chi^2$ p<0.05

About two-thirds of all children (65%) were able to get to their last dental appointment in 30 minutes or less. Eighty-five percent of those in MC+ reported a travel time of half an hour or less compared to 66 percent in FFS and 46 percent in Mid-Missouri. Travel time of over an hour was reported for more than one in four (27%) in the Mid-Missouri region compared to 11 percent in FFS and two percent in MC+.

**Access to dental care**

Although there was no statistically significant difference in the percentage of children who had been to the dentist at least once in their lives by the plan in which they were enrolled, the reason why they had never been to the dentist varied significantly by plan.

**Table 3-7. Reasons for never having been to the dentist**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Dental plan</th>
<th>Not old enough</th>
<th>Doesn’t need care yet</th>
<th>Couldn’t find a dentist who would see my child</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the main reason your child has not been to the dentist?*</td>
<td>MC+</td>
<td>12%</td>
<td>12%</td>
<td>32%</td>
<td>44%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>7%</td>
<td>13%</td>
<td>33%</td>
<td>47%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>8%</td>
<td>10%</td>
<td>48%</td>
<td>34%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Dental plan</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last six months, did you try to make an appointment for your child to see the dentist?</td>
<td>MC+</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>7%</td>
<td>13%</td>
</tr>
</tbody>
</table>
receive dental care?*  

<table>
<thead>
<tr>
<th>Fee</th>
<th>for-service</th>
<th>8%</th>
<th>10%</th>
<th>48%</th>
<th>34%</th>
</tr>
</thead>
</table>

* Statistically significant differences $\chi^2$ p<0.05

For 71 percent of children in the FFS plans, the main reason why they had never been to the dentist was that parents could not find a dentist who would see the child. This compares to 33 percent in the Mid-Missouri plan and 32 percent in the MC+ plans. For many it was not for lack of trying. Over half (56%) of those who had never been to the dentist reported that they had tried to make an appointment for their child in the last six months but were unsuccessful. Other reasons cited for why children had not yet been to the dentist: about one-third (34%) had never been for some ‘other’ reason (unspecified), while 18 percent had never been because they were either perceived to be too young (8%) or not yet in need of care (10%) by their parents.

Access to care was not only a problem for those who had never visited the dentist. When asked to rate their ability to get the dental care that their children needed, overall almost half (46%) rated it fair or poor (1 or 2 on a five point scale) (Table 3-8). About one in four (27%) rated it excellent or very good (a 4 or 5) while another quarter rated it good (3). The ability to get the care their child needed varied significantly by plan. Thirty-eight percent of those in MC+ rated their ability to get the care their child needed as excellent or very good compared to 25 percent in FFS and 21 percent in Mid-Missouri.

Table 3-8. Rating ability to get needed dental care

<table>
<thead>
<tr>
<th>Statement</th>
<th>Provider</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you rate your child’s ability to get the dental care he or she needs?</td>
<td>MC+</td>
<td>18%</td>
<td>18%</td>
<td>26%</td>
<td>16%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>33%</td>
<td>21%</td>
<td>24%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>38%</td>
<td>12%</td>
<td>26%</td>
<td>11%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Statistically significant differences $\chi^2$ p<0.05

Much of this was related to the inability to find dentists willing to provide care to children because they received Medicaid. Almost half (47%) of all children had been refused dental care because they received Medicaid. A slightly higher percentage (52%) rated their ability to get an appointment when their child needed it as fair or poor.

This again varied significantly by plan with 49 percent in the Mid-Missouri plan rating their ability to get an appointment as poor (a 1 one 5 point scale) compared to 36 percent in FFS and 17 percent of those in MC+. Thirty-four percent of those in MC+ rated their ability to get an appointment for their child as excellent or very good compared to 23 percent in FFS and 19 percent in Mid-Missouri.
Sixty percent of all respondents agreed or strongly agreed with the statement “I have had difficulty finding a health care provider who will see Medicaid patients” (Table 3-9).

Table 3-9. Ability to find provider who sees Medicaid patients

<table>
<thead>
<tr>
<th>Statement</th>
<th>Provider</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have had difficulty finding a health care provider who will see Medicaid patients.</td>
<td>MC+</td>
<td>28%</td>
<td>28%</td>
<td>20%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>10%</td>
<td>18%</td>
<td>25%</td>
<td>47%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>12%</td>
<td>21%</td>
<td>16%</td>
<td>51%</td>
</tr>
</tbody>
</table>

By plan, 72 percent in Mid-Missouri agreed or strongly agreed with the statement compared to 66 percent in FFS and 45 percent in MC+. A similar percentage of all (58%) agreed or strongly agreed that “it can be hard to get an appointment to see the dentist.” Seventy two percent of those in Mid-Missouri either agreed or strongly agreed with this statement compared to 63 percent in FFS and 42 percent in MC+.

When asked about a series of possible reasons that may have delayed or stopped them from getting care for their child, the most commonly reported problem was that they could not find a dentist who would take their child as a Medicaid patient (Table 3-10).
Table 3-10. Factors that delayed or stopped children from receiving dental care

<table>
<thead>
<tr>
<th>Statement</th>
<th>Provider</th>
<th>Did not affect</th>
<th>Caused a small delay</th>
<th>Caused a medium delay</th>
<th>Caused a long delay</th>
<th>Stopped from getting care</th>
</tr>
</thead>
<tbody>
<tr>
<td>I could not find a dentist who would take my child as a Medicaid patient</td>
<td>MC+</td>
<td>62%</td>
<td>13%</td>
<td>9%</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>38%</td>
<td>8%</td>
<td>13%</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>39%</td>
<td>10%</td>
<td>7%</td>
<td>15%</td>
<td>29%</td>
</tr>
<tr>
<td>My child did not have transportation</td>
<td>MC+</td>
<td>86%</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>71%</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>81%</td>
<td>10%</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>I could not get off work</td>
<td>MC+</td>
<td>81%</td>
<td>7%</td>
<td>6%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>77%</td>
<td>8%</td>
<td>8%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>83%</td>
<td>11%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>My child was afraid to go to the dentist</td>
<td>MC+</td>
<td>87%</td>
<td>8%</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>85%</td>
<td>8%</td>
<td>6%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>86%</td>
<td>8%</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>I had to travel too far to find a dentist who would see my child</td>
<td>MC+</td>
<td>80%</td>
<td>8%</td>
<td>5%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>48%</td>
<td>9%</td>
<td>9%</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>62%</td>
<td>9%</td>
<td>7%</td>
<td>8%</td>
<td>14%</td>
</tr>
<tr>
<td>I could not find a dental office with staff of a similar cultural or ethnic</td>
<td>MC+</td>
<td>92%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>background to my own</td>
<td>Mid-Missouri</td>
<td>92%</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>97%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>I had to wait too long to get an appointment</td>
<td>MC+</td>
<td>67%</td>
<td>10%</td>
<td>9%</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>45%</td>
<td>7%</td>
<td>16%</td>
<td>20%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>60%</td>
<td>10%</td>
<td>8%</td>
<td>16%</td>
<td>7%</td>
</tr>
<tr>
<td>My child would not cooperate for dental care.</td>
<td>MC+</td>
<td>90%</td>
<td>7%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>90%</td>
<td>5%</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>91%</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Over half indicated that this either delayed (34%) or stopped (22%) their child from receiving dental care in the previous year. Those in MC+ were least likely to be affected, with 38 percent
either delayed (28%) or stopped (10%) for this reason. More enrollees were delayed from receiving care in the Mid-Missouri plan (41% delayed, 10% stopped), however, more were stopped for this reason in the FFS plan (32% delayed, 29% stopped).

Travel distance was the second most common reason reported for stopping people from receiving dental care (13%). It also delayed one in four respondents (25%). The pattern among plan members was similar in regards to travel distance to the child’s last dental visit. People enrolled in the Mid-Missouri plan were most likely to have been delayed or stopped because they had to travel too far to find a dentist who would see their child (21% stopped, 31% delayed). For those in FFS, 14 percent were stopped and 24 percent delayed, while 3 percent were stopped and 17 percent delayed in MC+ regions.

Excessively long waiting times for an appointment was the second most common reason for delaying care (34%) and the third most common reason for stopping children from receiving care (8%). Waiting times were most significant for those in Mid-Missouri: 13 percent were stopped and 42 percent delayed for this reason. In FFS, 7 percent were stopped and 33 percent delayed, while 6 percent were stopped and 27 percent delayed in MC+ regions.

One in five (20%) had trouble because they could not get off work, again with no differences by plans. Ten percent were either delayed or stopped because their child was not cooperative when they went for dental care. Six percent were either delayed or stopped from receiving care because they could not find a dental office in which they felt comfortable due to the staff having an ethnic or cultural background similar to their own. There were no differences by plans.

Access to care could also be affected by the enrollee’s understanding (or lack of understanding) of how to receive care in the Medicaid dental program. However, from their own perspective, the vast majority of respondents did not view this as a significant problem. Eighty-one percent of all enrollees either agreed or strongly agreed with the statement “I understand how to get dental care for my child through the Medicaid program. Nine percent disagreed, while 10 percent strongly disagreed. The enrollees varied by plan regarding how strongly they agreed with this statement. Thirty-five percent of MC+ enrollees strongly agreed with this statement compared to 32 percent of those in FFS and 20 percent in Mid-Missouri.

**Satisfaction with and quality of dental care**

All enrollees were asked to rate their satisfaction with their child’s dental care and were asked questions as to how they perceived the quality of the care to be. For those who were not comfortable answering these questions, “no opinion” was given as a possible response. Overall,
satisfaction with and perceived quality of the dental care was rated similarly by enrollees. (Table 3-11).
Table 3-11. Rating satisfaction, quality and respect associated with child’s dental care

<table>
<thead>
<tr>
<th>Statement</th>
<th>Provider</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you rate your satisfaction with your child’s dental care?*</td>
<td>MC+</td>
<td>10%</td>
<td>14%</td>
<td>32%</td>
<td>16%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>20%</td>
<td>22%</td>
<td>26%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>25%</td>
<td>11%</td>
<td>26%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>How would you rate the quality of your child’s dental care?*</td>
<td>MC+</td>
<td>8%</td>
<td>10%</td>
<td>33%</td>
<td>23%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>16%</td>
<td>20%</td>
<td>30%</td>
<td>14%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>20%</td>
<td>14%</td>
<td>26%</td>
<td>19%</td>
<td>20%</td>
</tr>
<tr>
<td>How would you rate the respect you receive from the dental office?*</td>
<td>MC+</td>
<td>6%</td>
<td>15%</td>
<td>30%</td>
<td>18%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>Mid-Missouri</td>
<td>16%</td>
<td>17%</td>
<td>29%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-service</td>
<td>21%</td>
<td>13%</td>
<td>26%</td>
<td>19%</td>
<td>21%</td>
</tr>
</tbody>
</table>

* Statistically significant differences $\chi^2$ p<0.05

Thirty nine percent of enrollees rated their satisfaction with their child’s dental care as excellent (22%) or very good (17%). Thirty four percent rated their satisfaction as either fair (15%) or poor (19%). Mid-Missouri enrollees were significantly more likely to rate it fair or poor (42%) than those in FFS (36%) or MC+ (24%).

Similarly, MC+ enrollees were significantly more likely to rate the quality of their care as excellent or very good (50% vs 39% in FFS and 34% in Mid-Missouri) and were significantly less likely to rate it fair or poor (18% compared to 34 in FFS and 36% in Mid-Missouri).

Another important factor affecting both the perceived quality of the care and the satisfaction of the patient and family is whether or not they feel respect from the office. Thirty eight percent rated the respect they received as excellent or very good, while 27% rated it as fair or poor. MC+ enrollees rated the respect they received as significantly better (32% rated it excellent compared to 22% in Mid-Missouri and 21% in FFS).

The vast majority were also comfortable with the way in which they received information from the dental staff. Eighty-five percent of all enrollees agreed or strongly agreed with the statement “I get clear and understandable explanations of why certain tests and procedures are necessary.”
CHAPTER 4:
FOCUS GROUPS

Lessons from the Focus Groups

The purpose of the focus groups was, first, to delve into a number of service-delivery issues that previous research had suggested were significant, and second, to seek a deeper understanding of the wants, needs, expectations, perceptions and experiences of dental providers and consumers, who have participated in the State’s Dental Medicaid Program. Focus groups, unlike forced-choice surveys, enable respondents to speak to issues in their own voices using their own words. This allows them to:

- emphasize and describe in vivid detail those aspects of an issue which they believe are most important
- provide context and historical background
- relate anecdotes, critical incidents, and personal experiences

In all, eleven focus groups—seven consumer groups and four provider groups—were conducted for this study. Eighty-nine (89) people participated, 63 consumers and 26 providers.

The Consumer Groups

Consumer groups were held in seven different geographic and economic regions of the state: Cape Girardeau, Columbia, Kansas City, Kirksville, Maryville, St. Louis, and Springfield. Local community service and Head Start organizations helped recruit focus group members and provided meeting space for the groups, which consisted of Medicaid consumers and knowledgeable social services professionals. The groups ranged in size from five to twelve and meetings lasted from fifty to seventy-five minutes.

Focus group members were asked to address a variety of questions:

- *Have you ever experienced any problems in finding a dentist who accepts Medicaid?*
- *Have you ever had to wait a long time to get an appointment?*
- *Have transportation and travel time ever been a problem?*
- *When you or your child did see a dentist, were you treated with respect?*
- *Was the quality of care and service what you expected?*
On the whole, how good of a job is Medicaid doing in meeting your family’s dental needs?

Is there anything you would care to recommend to improve Medicaid dental care?

Are there other issues or problems with Medicaid dental care that we have not discussed? Something we overlooked?

Finding a Dentist

Finding a dentist who accepts new Medicaid patients is a problem statewide. In the large metropolitan communities of St. Louis and Kansas City, which offer a number of institutional service providers, the problem is, perhaps, somewhat more manageable (although choices remain sharply limited). In the State’s smaller metropolitan areas and rural communities, it is nearly impossible for a Medicaid consumer to find a dentist who will schedule them for a routine office visit.

In Maryville, focus group members reported that only one dentist in the five-county region is still taking new Medicaid patients. In the Kirksville area, an eight-county region, there are two dentists (one a part-timer) who accept Medicaid. In Springfield and Cape Girardeau, the situation is no better. Private practice dentists, with few exceptions, have left the program and no longer accept Medicaid patients.

The situation in Columbia was evidently much the same until two years ago when the Mid-Missouri Dental Center opened its offices in the Parkade Center specifically to serve the Medicaid population. Prior to that, private practitioners had all but dropped out of the system and there was little access to care.

Mid-Missouri is currently the only dental provider in the eight county regions that accepts new Medicaid patients, and focus group members were quick to praise it. Mid-Missouri has recently opened satellite operations in Jefferson City and Moberly.

Waiting for an Appointment

Finding a dentist who accepts Medicaid is only the first obstacle the consumer must overcome. Getting an appointment to see the dentist is also difficult, and is becoming more so each day as the number of dentists participating in the program grows smaller and smaller.

Table 4-1. Waiting time for an appointment by region
<table>
<thead>
<tr>
<th>Region</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Girardeau</td>
<td>three to four weeks</td>
<td>five months</td>
</tr>
<tr>
<td>Columbia</td>
<td>three months</td>
<td>five months</td>
</tr>
<tr>
<td>Kansas City</td>
<td>one month</td>
<td>two months</td>
</tr>
<tr>
<td>Kirksville</td>
<td>one month</td>
<td>two months</td>
</tr>
<tr>
<td>Maryville</td>
<td>one month</td>
<td>two months</td>
</tr>
<tr>
<td>St. Louis</td>
<td>two months</td>
<td>three months</td>
</tr>
<tr>
<td>Springfield</td>
<td>three months</td>
<td>six months</td>
</tr>
</tbody>
</table>

Statewide, reports of waiting times for routine office visits vary dramatically, ranging from three weeks to six months, as indicated above. Many factors seem to play a part in determining how long it will take—how busy the dentist is, whether the patient is new or returning, whether they can be flexible, can get time off from work or school, and have their own transportation.

Emergency cases—where the patient is in pain—are handled differently. Appointments can generally be made quickly, in a matter of days, if not hours.

But even these are not easy. In some parts of the state—Cape Girardeau and Springfield, for example—patients may be asked to get a physician’s referral in order to verify that they have a true emergency. In Columbia, focus group members reported that patients with abscesses or infections are instructed to see their physician for antibiotics as their first line of attack.

Referrals to the dentist for an emergency appointment are made only if the problem (and patient) persists.

**Transportation**

In the urban areas, public transportation systems, taxi services, and privately operated buses and vans make transportation a very manageable problem for most consumers.

For consumers living in rural communities, transportation often poses a serious problem. Public transportation is either limited or non-existent and there is no taxi service. For those without their own means of private transportation, friends, family members, church groups, Head Start and social welfare organizations offer potential alternatives. Arranging transportation is especially difficult, however, for those who need to see specialists—pediatric dentists, endodontists, orthodontists, oral surgeons—and who must travel long distances out-of-town to do so.
Respect

Focus group members report that once a patient finds a dentist who will accept Medicaid and gains an appointment, the experience is generally quite favorable. Most dentists, most of the time, treat Medicaid patients with respect, courtesy, compassion and care.

There were isolated reports of rudeness, dirty offices and unprofessional behavior, of abrupt manners, long waits in the waiting rooms and hurried examinations by doctors who were anxious to get them over with.

The most common complaint, when one surfaced, was that Medicaid patients were treated as “second-class citizens,” not entitled to the same level of care as other patients.

Some focus group members suggested that dentists looked at Medicaid patients as being “unreliable,” and treated them that way.

Quality of Care and Service

Focus group members, for the most part, were very satisfied with the quality of care and service they received. They reported that their dentists had been quite skillful both in diagnosing and treating their problems and in communicating with them about treatment options, outcomes and after-care.

Focus group members directed most of their complaints at Medicaid’s limited benefits and treatment options, especially its failure to cover “cosmetic” dentistry or restorative materials that are aesthetically pleasing.

They said they recognized that dentists were limited in what Medicaid would allow them to do, that it only reimbursed for a narrow range of procedures and materials. They reported that their dentists had often recommended procedures that Medicaid wouldn’t pay for, forcing them to either finance the procedures themselves or do without. Too often, they said, the costs were so prohibitive they had to do without.

As for dentists, the major concerns of focus group members were:

- the difficulty of getting to see them (“like pulling teeth,” said one)
- not spending enough time on prevention and education activities
- not doing enough to deal with patient fears
**Overall Assessment of Medicaid**

Focus group members, without exception, said that the Medicaid program was not doing a satisfactory job of meeting their family’s dental needs.

Access to care—finding a dentist and getting an appointment—was identified as the major problem. Limitations on benefits and services covered were a close second.

No one expressed any desire to terminate the program or claimed it failed to provide important services. Most members said they were thankful for what the Medicaid program offered, but that it needed to offer more.

The prevailing sentiment about the Medicaid program was that if you can get the care, it’s pretty good. But it’s not easy to get the care.

**Improvements**

Focus group members had several suggestions for improving the Medicaid program. These included:

- increase the number of providers
- expand service coverage
- improve preventive and educational services for children
- reduce the time it takes to get an appointment
- increase reimbursement rates
- give tax incentives to providers who accept Medicaid
- invest in dental hygiene
- encourage providers to communicate more effectively with patients, explain procedures, outcomes, preventive measures
- improve the emergency system
- do a better job of monitoring dentists who take Medicaid
- require all dentists to accept some minimum number of Medicaid patients
- create a state dental corps (with salaried dentists) for Medicaid patients
- create an information and referral center to assist consumers in finding dentists
- provide dental vouchers (like food stamps) to Medicaid patients
- provide dental services in the public schools or with mobile dental units
- provide transportation vouchers for dental appointments
- reduce paperwork for dentists (create a debit card payment system)
**Other Concerns**

Focus group members expressed doubts regarding the State’s ability to provide dental services as part of the newly enacted Children’s Health Insurance Program (CHIP). One member summed it up this way: “There’s not enough dentists to take care of Medicaid patients now. What’s going to happen when the new Medicaid expansion comes?”

**The Provider Groups**

Provider groups were held in Columbia, Kansas City, St. Louis and Springfield. The UMKC School of Dentistry Office of Alumni, the Missouri Department of Health, and the Missouri Dental Association and its component dental societies all assisted in identifying dentists to serve as focus group members. The groups ranged in size from five to nine and met for approximately two hours.

Focus group members were asked to address the following questions:

- Are Medicaid patients any more difficult to treat than other patients are?
- Are the oral health problems of Medicaid patients different from other patients?
- Is the reimbursement you receive for treating Medicaid patients comparable to what you receive for other patients?
- Is Medicaid’s administration of claims any different from that of commercial dental insurers?
- Does the Medicaid program enable you to offer the same quality of care to Medicaid patients that you give to your other patients?
- In your opinion, how good of a job is Medicaid doing in meeting the oral health needs of those patients who depend on it?
- Do you have any recommendations for improving the Medicaid program?
- Are there any other issues or concerns with the Medicaid program that you would like to call to our attention? Something we’ve overlooked?
Treating Medicaid Patients

Focus group members reported that Medicaid patients are more likely than other patients to break appointments, show up late, and make after-hours calls.

They said that Medicaid patients demonstrate less knowledge about oral health issues and less interest in seeking dental treatment and maintaining their oral health. They are also less likely to follow-through on after-care instructions or complete treatment plans.

Medicaid parents often serve as poor role models for their children. They do not take good care of their own teeth, or visit the dentist regularly, and they experience tooth loss. Many, it was said, would rather have a tooth pulled than restored.

Oral Health Issues

Focus group members also reported that Medicaid patients typically present more serious oral health problems than other patients—they have a higher incidence of caries (that are generally more advanced) and periodontal disease (for which Medicaid provides no treatment).

Medicaid patients are much more likely to cite pain as their reason for seeking care and less likely to show up for preventive care.

Among the pediatric patients, focus group members reported, there are more “bottle babies.”

Medicaid patients were also said to present more general health issues and to be less health-oriented in dietary and nutritional choices.

Children who receive Medicaid were said to be more likely to have behavioral health issues.

Reimbursement

In all four focus groups, the most strenuous concerns raised about the Medicaid program—and the most severe denunciations—dealt with the reimbursement problem. Medicaid’s reimbursement structure offers dentists only a fraction of their usual and customary (UCR) charges. Examples:

- In Kansas City, a focus group member reported that Medicaid reimbursement for dentures was $182; his normal charge is $725.
- In Columbia, focus group members reported that Medicaid paid about 27% of UCR for restorative cases; 43% to 48% for pediatric OR cases; and 50% to 60% for pediatric preventive cases
In Springfield, focus group members said that Medicaid was paying them about 27% to 31% of UCR.

In St. Louis, Medicaid reimbursement was estimated at 20% of UCR—$12 for a one-surface filling vs normal charges of $65; $11 for an extraction vs normal charges of $75; $80-$90 for a root canal vs normal charges of $430.

Focus group members said that the rates for many procedures do not even cover the direct costs for staff and materials, much less offer dentists compensation for their time and office overhead.

The low level of reimbursement often leads to “gamesmanship” and “incomplete treatment,” reported one member.

The major result of these reimbursement practices, focus group members agreed, is that fewer and fewer dentists are willing to participate in the Medicaid program.

**Medicaid Administration**

Focus group members said that Medicaid claims administration compared poorly with that of commercial insurers. The paperwork burden is larger and denials are more frequent.

There was anger expressed by several members at Medicaid’s failure to accept the ADA procedure codes.

Recent changes received mixed reviews. The electronic claims processing got generally high marks; members said it had simplified and expedited the filing process. The new codes for children’s services were criticized as adding unnecessary complexity, with the results being more denials and less timely payments.

Medicaid officials were described as being unhelpful and disrespectful. As one practitioner put it, “They treat dentists like children.”

**Quality of Care**

Focus group members indicated that they did not practice different standards of care for Medicaid and non-Medicaid patients.
Nonetheless, they were unanimous in their view that Medicaid inhibited their ability to offer the highest quality of care. Coverage limitations and inadequate reimbursements were cited as the primary reasons. Examples included:

- partials and dentures—one set of dentures per lifetime
- no crowns or bridges
- mandated use of inferior materials
- no periodontal care

Members said that Medicaid does a relatively good job for patients in pain, but it’s more difficult to save teeth. Dentists find themselves limited to “fix and patch” dentistry.

**Meeting Patients’ Needs**

There was unanimous agreement that the Medicaid program is performing poorly in meeting patients’ needs. Typical comments included:

- It sucks.
- It’s a sad joke.
- It’s a fraudulent entitlement.

Access to care was identified as the major weakness. Medicaid reimbursement rates are too low to attract enough practitioners to do the work that’s needed.

Despite its faults, however, members agreed that Medicaid takes care of a lot of people. It does a good job for the children who are able to access it and it provides pain control for adults.

Members expressed disappointment that Medicaid did not do more.

**Improving Medicaid**

Focus group members had a variety of suggestions for improving the Medicaid program. Voiced most strongly, however, was the need to improve reimbursement. Without this as the starting point, they argued, nothing else mattered very much.

Specific recommendations about the level of increase needed to attract participation varied. Suggestions ranged from 70% to 100% of UCR. Some suggestions also included tax incentives as a supplementary form of compensation.
Other improvements included:

- using ADA codes and universal insurance forms
- expanding service coverage and removing irrational limitations (e.g., for dentures, denture repair, endodontic restorations, periodontal problems)
- reimbursing dentists for after-hours calls, no-shows, impressions
- service requirements and loan forgiveness programs for graduates of the UMKC School of Dentistry
- service requirements (indigent care rotations) for UMKC dental and dental hygiene students
- creating a salaried public health dental corps to provide care in under-served areas
- using Medicaid dollars to subsidize voluntary efforts at free health clinics
- enabling and encouraging parents to be better role models
- providing (or paying for) interpreters for foreign patients

Summary

The focus group discussions identified a number of issues—both from the dentist’s viewpoint and the enrollee’s— that create barriers to dental care.

Consumers and providers both expressed anger and frustration with Missouri’s Dental Medicaid Program: consumers over their inability to access services; providers over reimbursement levels, treatment rules and administrative procedures.

Providers are abandoning the system in large numbers, leaving sizable portions of the state without adequate coverage for new Medicaid patients. In Maryville, focus group members reported there is only one dentist in the five-county region who is still taking new Medicaid patients. In Kirksville, in an eight-county region, there are two dentists (one of whom is part-time) who accept new Medicaid patients. In Springfield and Cape Girardeau, the situation is the same. Private practice dentists, almost without exception, are leaving the Medicaid program and will not accept new Medicaid patients. Those dentists remaining in the program feel overwhelmed.

Waiting times for routine appointments vary across the state. Three to six month waits are not uncommon in most areas. For some patients, the wait is even longer.

Emergency patients (defined as those in pain) are usually able to see a dentist within a few days. In Springfield and Cape Girardeau, consumers reported that dentists will see emergency patients only with a referral from a physician or oral surgeon. Patients are going to hospital emergency
rooms and getting their oral health conditions diagnosed by ER doctors, who refer them on to dentists agreeing to treat such patients.

Consumers reported that, when they do get an appointment, they are generally treated with respect and compassion by their dentist, and that they receive quality care. There were some isolated reports, however, of rudeness, dirty offices, and unprofessional conduct.

Consumers said that, on the whole, the Medicaid program was not meeting their family’s need for oral health care. “It’s better than nothing,” was the most frequent assessment.

Asked what they’d recommend to improve the program, consumers unanimously said “increase the number of dentists participating.” To accomplish this, they recommended increasing the fees paid to dentists or giving them tax or other financial incentives.

Other recommendations included broadening service coverage, emphasizing preventive and health promotion measures, and creating a public dental corps.

Providers reported that Medicaid patients were generally more difficult to work with than other patients. They are more likely to break an appointment, show up late, and not complete their treatment plans. Medicaid patients also present more serious health issues—more decay, more periodontal disease, more general health and behavioral health issues.

Providers complained bitterly about the level of reimbursement for Medicaid, which in many instances fails to cover even the costs of materials and supplies. Estimates of reimbursements varied by procedure and region from approximately 20 percent of usual and customary rates (UCR) to 60 percent (for pediatric preventive measures).

Providers reported that Medicaid administrative practices compared unfavorably with commercial insurance firms. They asked for less paperwork and acceptance of the ADA billing codes.

Providers complained that Medicaid treatment rules made it difficult for them to practice quality dentistry. Rules regarding partials and dentures, periodontal treatment, crowns and bridges, and restorative materials were cited as especially problematic.

Asked for an overall evaluation of how well Medicaid was meeting the needs of those who depend on it, providers responded that it was performing very poorly. Said one, “It’s a sad joke.”
The major problem was identified as “access to care.” Fewer and fewer dentists are willing to accept Medicaid patients. “How good of a job can it be doing,” asked one focus group member, “if you can’t get dentist?”
CHAPTER 5:
DENTAL SERVICE PROVIDED TO MEDICAID RECIPIENTS AND 
AN EVALUATION OF THE MEDICAID REIMBURSEMENT LEVELS

The total allowed charges for the most common dental procedures for Medicaid recipients during FY 1997 are shown in Table 5-1.

Table 5-1. Dental fee comparison of average private practice fees with Medicaid fee-for-service and MC+

<table>
<thead>
<tr>
<th>Dental Procedure</th>
<th>Procedure Code</th>
<th>UCR Rates</th>
<th>Allowable Charges</th>
<th>% of UCR</th>
<th>Allowable Charges</th>
<th>% of UCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive oral examination</td>
<td>110</td>
<td>$35.00</td>
<td>$14.50</td>
<td>41.4%</td>
<td>$26.00</td>
<td>74.3%</td>
</tr>
<tr>
<td>Periodic oral examination</td>
<td>120</td>
<td>$36.00</td>
<td>$9.75</td>
<td>27.1%</td>
<td>$21.00</td>
<td>58.3%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>150</td>
<td>$29.00</td>
<td>$19.50</td>
<td>67.2%</td>
<td>$26.00</td>
<td>89.7%</td>
</tr>
<tr>
<td>Full mouth x-rays</td>
<td>210</td>
<td>$63.00</td>
<td>$33.00</td>
<td>52.4%</td>
<td>$69.00</td>
<td>109.5%</td>
</tr>
<tr>
<td>Single periapical radiograph</td>
<td>220</td>
<td>$12.00</td>
<td>$7.75</td>
<td>64.6%</td>
<td>$9.00</td>
<td>75.0%</td>
</tr>
<tr>
<td>Each additional periapical</td>
<td>230</td>
<td>$10.00</td>
<td>$3.25</td>
<td>32.5%</td>
<td>$5.00</td>
<td>50.0%</td>
</tr>
<tr>
<td>Panoramic x-ray film</td>
<td>330</td>
<td>$55.00</td>
<td>$25.00</td>
<td>45.5%</td>
<td>$45.00</td>
<td>81.8%</td>
</tr>
<tr>
<td>Child cleaning</td>
<td>1120</td>
<td>$29.00</td>
<td>$18.50</td>
<td>63.8%</td>
<td>$28.00</td>
<td>96.6%</td>
</tr>
<tr>
<td>Topical fluoride application</td>
<td>1201</td>
<td>$27.00</td>
<td>$9.50</td>
<td>35.2%</td>
<td>$28.00</td>
<td>103.7%</td>
</tr>
<tr>
<td>Fissure sealants (per tooth)</td>
<td>1351</td>
<td>$24.00</td>
<td>$14.00</td>
<td>58.3%</td>
<td>$23.00</td>
<td>95.8%</td>
</tr>
<tr>
<td>Amalgam-one surface (primary)</td>
<td>2110</td>
<td>$55.00</td>
<td>$22.00</td>
<td>40.0%</td>
<td>$40.00</td>
<td>72.7%</td>
</tr>
<tr>
<td>Amalgam- two surfaces (primary)</td>
<td>2120</td>
<td>$72.00</td>
<td>$30.00</td>
<td>41.7%</td>
<td>$52.00</td>
<td>72.2%</td>
</tr>
<tr>
<td>Amalgam- three surfaces (primary)</td>
<td>2130</td>
<td>$89.00</td>
<td>$40.00</td>
<td>44.9%</td>
<td>$56.00</td>
<td>62.9%</td>
</tr>
<tr>
<td>Silver filling-1 surface, permanent</td>
<td>2140</td>
<td>$54.00</td>
<td>$24.00</td>
<td>44.4%</td>
<td>$41.00</td>
<td>75.9%</td>
</tr>
<tr>
<td>Silver filling-2 surface, permanent</td>
<td>2150</td>
<td>$68.00</td>
<td>$32.00</td>
<td>47.1%</td>
<td>$53.00</td>
<td>77.9%</td>
</tr>
<tr>
<td>Silver filling-3 surface, permanent</td>
<td>2160</td>
<td>$81.00</td>
<td>$42.00</td>
<td>51.9%</td>
<td>$65.00</td>
<td>80.2%</td>
</tr>
<tr>
<td>Silver filling-4 surface, permanent</td>
<td>2161</td>
<td>$107.00</td>
<td>$44.00</td>
<td>41.1%</td>
<td>$73.00</td>
<td>68.2%</td>
</tr>
<tr>
<td>One surface, anterior (Class I, V, or VI)</td>
<td>2330</td>
<td>$70.00</td>
<td>$26.00</td>
<td>37.1%</td>
<td>$51.00</td>
<td>72.9%</td>
</tr>
<tr>
<td>Two surfaces, anterior (Class III)</td>
<td>2331</td>
<td>$88.00</td>
<td>$36.00</td>
<td>40.9%</td>
<td>$65.00</td>
<td>73.9%</td>
</tr>
<tr>
<td>Three surfaces, anterior (Class III)</td>
<td>2332</td>
<td>$109.00</td>
<td>$46.00</td>
<td>42.2%</td>
<td>$77.00</td>
<td>70.6%</td>
</tr>
<tr>
<td>Four surface, anterior/incisal angle (Class IV)</td>
<td>2335</td>
<td>$135.00</td>
<td>$46.00</td>
<td>34.1%</td>
<td>$77.00</td>
<td>57.0%</td>
</tr>
<tr>
<td>Crown, chrome steel</td>
<td>2930</td>
<td>$127.00</td>
<td>$65.00</td>
<td>51.2%</td>
<td>$90.00</td>
<td>70.9%</td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>3220</td>
<td>$49.00</td>
<td>$20.00</td>
<td>40.8%</td>
<td>$55.00</td>
<td>112.2%</td>
</tr>
<tr>
<td>Root canal-anterior</td>
<td>3310</td>
<td>$300.00</td>
<td>$68.50</td>
<td>22.8%</td>
<td>$238.00</td>
<td>79.3%</td>
</tr>
<tr>
<td>Root canal-bicuspid</td>
<td>3320</td>
<td>$361.00</td>
<td>$78.50</td>
<td>21.7%</td>
<td>$289.00</td>
<td>80.1%</td>
</tr>
<tr>
<td>Root canal-molar</td>
<td>3330</td>
<td>$460.00</td>
<td>$103.50</td>
<td>22.5%</td>
<td>$383.00</td>
<td>83.3%</td>
</tr>
<tr>
<td>Extraction-single tooth, deciduous</td>
<td>7110</td>
<td>$62.00</td>
<td>$18.00</td>
<td>29.0%</td>
<td>$43.00</td>
<td>69.4%</td>
</tr>
</tbody>
</table>

Fee schedules for MC+ were obtained from the original request to all MC+ directors. The above schedule is a representative fee list from one of the MC+ companies. Medicaid provided a copy
of their fee schedule and the UCR fees were obtained from the National Dental Advisory Service Pricing Program, 1999.

Medicaid fees were compared to the average fees usually charged by private practitioners (UCR fees) to estimate the appropriateness of Medicaid reimbursement levels. Medicaid fees were on average 34% of the dentists’ statewide UCR fees. The fees reported to be paid by one of the MC+ plans was on average 78% of dentists statewide UCR fees however this fee can be adjusted by this managed care plan depending on utilization. Thus if there are a lot of services provided in a particular time period, reimbursement can be significantly lower and thus unpredictable from the dentists’ perspective.
APPENDIX A

LETTER 1-Request for Information from MCO Directors
LETTER 1-Request for Information from MCO Directors

UMKC SCHOOL OF DENTISTRY LETTERHEAD

DATE

NAME
COMPANY
ADDRESS

Dear NAME:

The University of Missouri-Kansas City, School of Dentistry and the Missouri Department of Health are conducting a research project to evaluate the access to dental care for Title XIX recipients in the state of Missouri. The goal of this project is to develop a series of policy options for improving the program.

To fully evaluate the current system, a questionnaire will be mailed to all licensed dentists in the state. To construct an accurate survey instrument, we will need information from you regarding your plan. We would like to request the following information:

1. A list of providers in your network (both general dentists and specialists) and what are the rules for referring to specialists.

2. Information about how patients determine who their provider will be (e.g. are they assigned to a gatekeeper dentist or are they responsible for finding their own dentist).

3. Information about your process for contracting with dentist (e.g. how do you recruit dentists into the program, do you have different contracts for different dentists based on county, or region, how do you monitor participation levels of dentist in the program).

4. A copy of your provider contract given to the participating dentists or a list of the understandings in the contract between your organization and the participating dentists. We are most interested in the expectations you have for dentist regarding level of acceptance of both existing and new Medicaid patients, and any other indicators of whether the dentists are providing adequate access for recipients. Included with this are what it means to be a part of your managed care organization. We are also interested in your understanding (or contractual arrangements) regarding the dentists expectations from your organizations regarding payment (amount and timeliness) or other issues.

5. Per the previous item, a description of how the dentist are reimbursed (capitation or fee for service) and the fee schedule or capitation rate agreed to with the dentists.

6. Information about the organizational structure of your dental manage care company and its contractual relationship to the parent managed care organization. Similar to the issues with
dentists, what are you expected to do as their contractee and what is your managed care organization expecting from the parent managed care organization (e.g., how are you reimbursed from the MCO, and what are you expected to provide).

7. Availability of encounter (claims-type) data and if available, what data elements are collected and how complete is the data.

This information will be used for survey design only and will be kept confidential among the researchers involved with the project. A draft of the survey will be sent to you for your review and comments prior to mailing. We appreciate your help and cooperation with this project.

Sincerely,

Michael D. McCunniff, DDS, MS
APPENDIX B-1

Managed Care (MC+) Survey
INSTRUCTIONS: In this questionnaire we will be asking about your participation in and attitudes toward the Medicaid dental program for children. In some areas of Missouri, this is known as the MC+ program. For each question, please circle or check the box next to the most appropriate response or write your response in the space provided.

For the results of this study to reflect the views of dentists in Missouri, it is important that we hear from you. However, if you come to a question you do not feel comfortable answering, feel free to skip to the next question. When you have completed the questionnaire, please fold it and return it in the enclosed postage-paid envelope.

Thank you.
• Many of the questions in this survey are about the MC+ dental program. This program replaced the regular Medicaid dental program for children on September 1, 1995 for the Eastern Region and January 1, 1997 for the West and Northwest Regions.
• Even if you are not a part of an MC+ plan, we would like to know your perceptions of the program.
• If you practice in more than one location, please answer the questions in this survey as they pertain to your primary practice location.

1. What is your area of practice?
   - 1. General Practice
   - 2. Pediatric Dentistry
   - 3. Oral Surgery
   - 4. Public Health
   - 5. OTHER DENTAL SPECIALTY

If you selected OTHER DENTAL SPECIALTY as your area of practice, please stop and send us the unfinished questionnaire in the enclosed postage-paid envelope. Otherwise please continue.

2. In what county is your primary practice located? ____________________
   county
3. How many years have you been practicing in your current location? ______ years
4. In your practice, how many dentists practice over 30 weeks/year (including yourself)?
   ______ dentists
5. How would you describe your role at your primary practice location?
   - 1. Solo practitioner
   - 2. Owner of a practice with associates
   - 3. Partner
   - 4. Associate/employee buying into the practice
   - 5. Associate/employee not buying into the practice
   - 6. Independent contractor
   - 7. Staff dentist at a public health clinic
The following questions are about your experience with the MC+ dental program.

6. Do you contract to provide services to Medicaid-enrolled children in any of the MC+ dental plans?

☐ 1. YES  ❤  6–1. With which of the following MC+ dental plans do you contract to provide services (check all that apply)?
   ☐ 1. Delta Dental
   ☐ 2. Doral
   ☐ 3. Care Partners
   ☐ 4. Prudential
   ☐ 5. HealthCare USA
   ☐ 6. Other __________________________

Please go to Question 7

☐ 2. NO  ❤

If you do not contract with an MC+ dental plan:

6–2. Have you ever accepted Medicaid fee-for-service patients in the past?

☐ 1. No
☐ 2. Yes, and I still have some adult fee-for-service Medicaid patients
☐ 3. Yes, but I stopped accepting Medicaid patients in the year 19____ before which I had been accepting Medicaid patients for ________ years

6–3. Were you ever asked to contract with an MC+ dental plan?

☐ 1. No
☐ 2. Yes  → Go to Question 6–5

6–4. If No, would you have been willing to contract with an MC+ dental plan if you had been asked?

☐ 1. No  → Go to Question 9, next page
☐ 2. Yes  → Go to Question 9, next page
☐ 3. Maybe  → Go to Question 9, next page

6–5. If MC+ fees were brought to a level closer to usual and customary, would you consider contracting with an MC+ dental plan?

☐ 1. No
☐ 2. Yes, if the fees were increased to about _____% of my usual fees
☐ 3. Yes, if the fees were increased to about _____% of my usual fees and other changes were made

7. Who was primarily responsible for making the decision whether your practice would contract with an MC+ plan (please check only one)?

☐ 1. I was  → Go to Question 9, next page
☐ 2. The dentists in the practice as a group
☐ 3. The owner of the practice
☐ 4. The clinic management
☐ 5. Other __________________________
8. What was your personal level of involvement in the decision whether to contract with an MC+ plan?
- 1. Not involved
- 2. Somewhat involved
- 3. Moderately involved
- 4. Involved
- 5. Very involved

9. Do you have a dental practice or clinic where you can refer children in the MC+ program whom you are unable to treat in your practice?
- 1. No
- 2. Yes, to another private dental practice
- 3. Yes, to a public health clinic
- 4. I see all MC+ patients; I don’t need to refer any of them

10. Please read the following statements and circle the number that indicates how strongly you agree or disagree with each statement. Even if you do not treat MC+ patients, we are interested in your perceptions of the program.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. It is difficult to provide comprehensive treatment to MC+ patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>b. Participating in the MC+ managed care program would force me to spend less time with my other patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>c. MC+ patients make other patients in the office feel uncomfortable</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>d. Without the MC+ program, low-income patients would not be able to get adequate dental care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>e. I am concerned about having the only practice in the area that accepts MC+ patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>f. The MC+ program respects my professional judgment concerning patient care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>g. Oral health problems of MC+ patients are more severe than those of other patients in my practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>h. Dentists can have an impact on the policies of the MC+ program</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>i. Low-income patients are more difficult to treat than others ..</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>j. Dentists have an ethical obligation to treat MC+ patients ..</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>
11. How would you describe access to dental care for children enrolled in MC+ now compared to before the MC+ program?

<table>
<thead>
<tr>
<th>Much better</th>
<th>Better</th>
<th>About</th>
<th>Worse</th>
<th>Much worse</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>now now</td>
<td>now</td>
<td>the same</td>
<td>now</td>
<td>now</td>
<td>opinion</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

12. How would you describe the quality of dental care for children enrolled in MC+ now compared to before the MC+ program?

<table>
<thead>
<tr>
<th>Much better</th>
<th>Better</th>
<th>About</th>
<th>Worse</th>
<th>Much worse</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>now now</td>
<td>now</td>
<td>the same</td>
<td>now</td>
<td>now</td>
<td>opinion</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

13. How would you describe the cost-effectiveness of providing dental care to children enrolled in MC+ now compared to before the MC+ program?

<table>
<thead>
<tr>
<th>Much more cost-effective</th>
<th>More cost-effective</th>
<th>About</th>
<th>Less cost-effective</th>
<th>Much less cost-effective</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>now now</td>
<td>now</td>
<td>the same</td>
<td>now</td>
<td>now</td>
<td>opinion</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

14. The following is a list of commonly reported problems with Medicaid programs. Please indicate how important you consider each problem to be with the MC+ program.

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Not important</th>
<th>Somewhat important</th>
<th>Moderately important</th>
<th>Important</th>
<th>Very important</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Complicated paperwork</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>b. Low fees</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>c. Need for prior approval</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>d. Intermittent eligibility of MC+ patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
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<tr>
<td>e. Denial of payment</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>f. Broken appointments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>g. Slow payment</td>
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<td>2</td>
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<tr>
<td>h. Patient non-compliance</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
<td>0</td>
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<tr>
<td>i. Frequently changing MC+ regulations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
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<tr>
<td>j. Not enough other practices in the area accepting MC+ patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
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</tbody>
</table>
15. Which three of the problems listed above (a–j) do you consider to be the most important for your office (with “1” indicating the most important).

16. For the next set of questions, please compare the MC+ program to private dental insurance. For each question, circle the number (1 to 5) that most closely reflects your perceptions of the program. Even if you do not treat MC+ patients, we are interested in your perceptions of the program.

a. How complicated is MC+ paperwork compared to the paperwork for private insurers?

<table>
<thead>
<tr>
<th>Much less complicated</th>
<th>Less complicated</th>
<th>About the same</th>
<th>More complicated</th>
<th>Much more complicated</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>3</td>
<td>4</td>
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</table>

b. How promptly does the MC+ program pay dentists compared to the speed of payment by private insurers?

<table>
<thead>
<tr>
<th>Much less promptly</th>
<th>Less promptly</th>
<th>About the same</th>
<th>More promptly</th>
<th>Much more promptly</th>
<th>No opinion</th>
</tr>
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</table>

c. How do the fees paid by MC+ compare to the fees paid by private insurers? MC+ pays:

<table>
<thead>
<tr>
<th>Much less</th>
<th>Less</th>
<th>About the same</th>
<th>More</th>
<th>Much more</th>
<th>No opinion</th>
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</table>

d. How easy is it to find a dental specialist who will accept an MC+ referral, as compared to the referral of a privately insured patient?

<table>
<thead>
<tr>
<th>Much easier</th>
<th>Easier</th>
<th>About the same</th>
<th>More difficult</th>
<th>Much more difficult</th>
<th>No opinion</th>
</tr>
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<td>1</td>
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</table>

17. Overall, how would you rate the ability of children enrolled in MC+ to receive dental care?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>No opinion</th>
</tr>
</thead>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>

18. Overall, how would you rate the quality of dental care for children enrolled in MC+?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>No opinion</th>
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</table>
19. What are the **three** most important changes that could be made to increase dentists’ willingness to contract with an MC+ dental plan? **Please rank your first three choices from 1 to 3.**

   ____ a. Improve communication with dentists about changes in the program
   ____ b. Decrease the need for prior approval
   ____ c. Have the MC+ program stress with enrollees the necessity to keep their appointments
   ____ d. Increase reimbursement levels
   ____ e. Increase the speed of payment
   ____ f. Inform dentists about options for broken appointment policies
   ____ g. Make the paperwork more similar to other dental insurance
   ____ h. Reduce the number of claims denied for small issues (e.g., minor paperwork errors)
   ____ i. Other: ________________________________

20. If you were to develop a dental program for low-income Missourians, how would you suggest the care be delivered?

   ❏ 1. Using private practitioners and a fee-for-service program
   ❏ 2. Using private practitioners and a managed care program
   ❏ 3. Using public health dental clinics
   ❏ 4. Other ________________________________

- **Questions 21–26 are ONLY for dentists who contract with an MC+ dental plan.**
- *If you do NOT contract with an MC+ dental plan, please Go to Question 27.*

21. From which of the following MC+ dental plans do you have patients in your practice *(check all that apply)*?

   ❏ 1. Delta Dental
   ❏ 2. Doral
   ❏ 3. Care Partners
   ❏ 4. Prudential
   ❏ 5. HealthCare USA
   ❏ 6. Other ________________________________

22. Are you accepting **new** MC+ patients in your practice?

   ❏ 1. NO ➔ Go to Question 23
   ❏ 2. YES

22–1. Do you have any criteria for selecting **new** MC+ patients into your practice?

   ❏ 1. NO, I accept all **new** MC+ patients.
   ❏ 2. YES, in our office we accept (please check all that apply):

      ❏ 1. A set number of new MC+ patients per week or month
      ❏ 2. Our own patients who go on MC+
      ❏ 3. Children of our own patients who go on MC+
      ❏ 4. Referrals from other dentists/physicians
      ❏ 5. Patients from our county
      ❏ 6. Other ________________________________

23. About what percentage of your current patients are covered by the MC+ program? ____ %
24. What services do you provide to MC+ patients in your practice? (please check all that apply)  
- 1. Exams/prophys  
- 2. Sealants  
- 3. Routine restorative care  
- 4. Complex restorative care  
- 5. Emergency care

25. Overall, how satisfied are you with the MC+ dental program?  

Not satisfied | Somewhat satisfied | Moderately satisfied | Satisfied | Very satisfied  
--- | --- | --- | --- | ---  
1 | 2 | 3 | 4 | 5

26. In the past year, how seriously have you considered eliminating all MC+ patients from your practice?  

Not seriously | Somewhat seriously | Moderately seriously | Seriously | Very seriously  
--- | --- | --- | --- | ---  
1 | 2 | 3 | 4 | 5

Questions 27–30 are related to the treatment of children in your practice.

27. What is the age of the youngest child you will see for an examination in your practice? ___ years old

28. At what age do you believe children should make their first visit to the dentist? ___ years old

29. In your practice, how often do you place sealants on children under the age of 14?  
- 1. Routinely on deciduous and permanent molars  
- 2. Routinely but only on permanent molars  
- 3. On selected children (e.g., children with high caries rates)  
- 4. I rarely or never use sealants in my practice  
- 5. Not applicable (specialist or don’t see patients under 14 years old)

30. How effective do you believe sealants are in preventing occlusal decay?  
- 1. Very effective  
- 2. Effective  
- 3. Moderately effective  
- 4. Somewhat effective  
- 5. Not effective

31. How would you best describe your practice during the past year?  
- 1. Practice limited, no new patients taken  
- 2. Too busy to treat all requesting appointments  
- 3. Provided care to all requesting it, but felt overworked  
- 4. Provided care to all requesting it, but did not feel overworked  
- 5. Not busy enough, would have liked more patients
32. Please indicate below who completed this questionnaire (check all appropriate responses).

- 1. Dentist
- 2. Hygienist/Assistant
- 3. Office staff
- 4. Other (specify) ____________________________

33. We are interested in any comments you may have about the MC+ program. _________________

__________________________________________________________________________
                                                                                   
__________________________________________________________________________
                                                                                   
__________________________________________________________________________
                                                                                   
__________________________________________________________________________
                                                                                   
                                                                                   
Thank you for completing this questionnaire.
Please return it in the enclosed postage-paid envelope.
APPENDIX B-2

Dentists' Comments from Managed Care (MC+) Survey
Dentists who have mature practices and are bringing on an associate would be good candidates to work with a new and improved Medicaid program. Junior associates will get some training.

I quit Missouri Medicaid mainly because I felt the state was denying payment due to their pressing errors. If I had employees who made that many mistakes I would fire all of them. I believe the mistakes were encourage to deny payment. It was not unusual to have to file a claim in original 4 times to get paid. The paperwork was more than the reimbursement. My worst manage care is better than Medicaid.

Best thing I ever did was to quit MCT! I can go fishing and come out money ahead. My staff is much happier. Reimbursement percentages must be increased and procedures simplified.

I do not really know the MCT. I have only participated in the old Medicaid and headstart!

I believe that the state of Missouri should eliminate the middleman in this process (Doral Dental) and increase reimbursement to dentists. Increasing access will only be accomplished by increasing reimbursement.

Medicaid programs have always been less than adequate. The fees are a joke, the bureaucrats and people you deal with are more than difficult. I’ve had paintings, drugs, other patients coats, etc., stolen by MC patients - no thanks.

I have no experience with it at all.

I don’t believe in socialism.

Myself and other dentists I have spoken with would participate if the paper work/frustration burden were removed. The fees paid are low but not the main barrier to my participation.

I would not mind treating Medicaid patients but I was frustrated dealing with problems listed on #19 of page 6.

I am currently making 10% more revenue from MCT. Doral is a good plan fair plan for children. I am overworked from the number of calls of patients seeking treatment. I am treating around 100 MCT ortho patients. Raise the amount of revenue per procedure and more doctors will accept MCT.

I terminated my contract with MC+, very poor reimbursement rate. The utilization formula/penalty is ludicrous. Medicaid went from bad to worse, count me out.

Unfortunately due to problems with low income families, i.e., no transportation, lack of responsibility, lack of follow-up, extreme no show rate, I feel that these patients cannot be treated in a private practice because we could not afford to stay in business.

I am not well informed about the current Medicare for children program. The last time I was involved in Medicare for children it was a joke! I ended up treating my Medicare children patients (foster home kids) for free rather than try to do things thru the messed up system.

Our office had been on Medicaid plan in the past, so I marked only what I had heard about it, I have no experience with it and the doctor who did has passed away.

I currently treat only a few adult Medicaid patients at my regular office who have been patients before they became eligible. My primary provision of Medicaid care is to residents of the nursing home where I am the staff dentist.
Years ago I took Medicaid patients as a favor to physicians who had special requests. As a rule I had problems with these patients keeping appointments and appreciating treatment. Since I wasn’t submitting the treatment for payment I decided to discontinue all such patients.

Since I do very little pediatric dentistry (I practice with a pedodontist), my answers may not be typical.

I know nothing about MC+ and could not answer many of the questions.

My last involvement with Missouri Medicaid was in the early 80’s. The mountain of paperwork and restrictive procedures of those who administered rules, regulations and denials, absolutely choked us out. My staff spends hours trying to comply with all the minute nonsense of form submission followed by denial was incredible!! Couple that with low fees, tougher patients and broken appointments made it very easy for us to quit!!!!

Under the old me could never get in to talk about problem in the phone. They would no answer letters.

Can’t mandate charity/kindness work despite who or what someone’s occupation is. Make process easy SIMPLE and worthwhile so all will benefit, or don’t.

In the past this program didn’t offer orthodontic treatment. Some patients told me the ortho MAX was $25.00.

I have 18 years experience treating Missouri Medicaid patients. The new managed care method of administering the program (MCT) seems to me to be yet another way of making it more difficult for dentists to get paid, more difficult to submit paperwork and more difficult to get advice or recommendations. I have been insulted by the way I was treated by the state of Missouri and I do not trust the state anymore.

I have had no contact with it, sorry.

I am so disgusted with the level of compensation that I have recently stopped seeing all Doral patients.

After seeing these patients for over 3 years I feel the best solution is having clinics in counties and having salaried dentists like PHS, this would allow better control of patients and less bureaucratic paper work. My business suffered greatly because of Medicaid and almost made me quit my profession and I’ve seen other dentist in my area quit private practice due to low income since he took MC+. These patients have the attitude we owe them, little did they realize I was working below overhead, no shows are a great problem.

I do not accept Medicaid because the dentist I bought my practice from did and reported constant delayed payment, low reimbursement, often refiling claims that were claimed to be lost up to 8 times, too much frustration, too little appreciation, compliance and responsibility from patients. Treating children is high energy work and should merit east adequate reimbursement.

I believe that Medicaid programs should be like any insurance program with unlimited choice of dentists.

I saw Medicaid patients for 30 years, but the financial loss to the practice became too great. I see no reason to belong to a program that causes continued loss to the practice.

1. Reimbursement too low. 2. Too picky on small errors. 3. Too slow payments.

I would like to see more providers. If the number of providers increase in the area less number of MCT patients. The provider have to see in another words spread the load out.

I haven’t been in it long enough to know. Please contact by boss. XXX DOS at TMC EAST for information regarding administration.
Not familiar with the program, but really not interested in belonging to it.

Low reimbursement (47% when overhead runs 65%). Broken appointments.

A better screening program for MCT recipients would help; dedicated patients who do not miss appointments when they are out of pain are more important than high fees. Trusting participating practitioners with less pre approval and prompt payment would initiate greater dentist participation.

It is a shame the children suffer, before MC+ children I our county had treatment.

I have no idea what MC+ refers to but have answered as though it means “Medicaid.” I have had adults present with “Prudential” only to learn that it was aid for dependent children. We review ID cards more carefully now. The problem is values and/or the lack thereof.

Dentists who accept Medicaid or MC+ should be allowed a deduction on their state taxes based on a UCR fee schedule and the amount written off due to contractual agreement - medicated.

Most questions difficult to answer since I do not see MCT patients.

I currently am employed at the Social Welfare Board at St. Joe and the Dept. of Corrections. The Social Welfare Office provides free service to low income residents and is state, county and federally funded. This arrangement seems to provide quality, basic dental care. Dentists assistants, and hygienists are paid a good hourly wage.

Raising reimbursement levels will increase the number of participating dentists. It will also be less stressful for the low income people. Standardizing rate of reimbursement by the different counties will help.

I have no experience in dealing with MC+, therefore feel my input is of little value.

No opinion - on MC+ program, but couldn’t be any worse than old program.

There is no pedodontist in the program in the St Louis area. The only oral surgeon in St Louis will only do Medicaid extractions with IV sedation which he charges $165 (not covered by Medicaid). Fortunately MO Medicaid has increased fees for extractions and oral gums and composite. The MC+ plans have not increased their fees. Without changes soon Medicaid dentistry will be a program with no providers to supply the necessary care. Please send me a copy of the results.

Your are welcome!

Dentistry’s obligation to treat low income people can be met in numerous ways other than MC+ type programs. I would rather give work away (and I do) than face the bureaucratic tangle in which I was involved before.

First I have heard of the program. You need much better marketing.

Do not participate in any insurance or managed programs.

I don’t feel a non dentist should determine the pay of a dentist and especially if that person is non medical in his/her background.

I am not a participant in the MCT program and don’t really know anything about it.
We are phasing out all plans including MCT which procedures increasing burden on our administration (ins. trachy, paperwork, research, appointments etc). I feel as the state and its sub-instructors do not listen to their providers or police their subscribers. I would be most interested in the states reply to the result of your survey.

I feel the Medicaid (MC) program is in great need of improvement. I believe children are not getting needed treatment do to limitations by the program.

Doral has been a thorn in our side at Gateway, they’ve refused reimbursement and are placing the lining of their pockets ahead of the care for eligible children.

Our state should never begin thinking about any plan that would mandate providers to see MCT patients. It should remain voluntary and let the market conditions drive the outcome.

Financially it is becoming harder to justify continuing in the program. We got patients from as far away as Farmington, MO and Poplar Bluff because they can find no one else who accepts Medicaid. We see so many they are crowding out cash and insurance patients. Since my practice is in the inner city I will continue to see Medicaid patients but may have to cut out denture work because lab fees continue to rise.

See #19: Tax credits as incentives. Overhead is too high to subsidize low paying programs. Same thing with managed care. I will work 1 day less per week and keep same income as if accepting lower reimbursement.

I started practice in 1981 and felt it was my duty to accept all patients. That was until I had to deal with the Medicaid bureaucracy, complicated paperwork, and ungrateful patients who only showed up when they felt like it. Even after I quit the program I continued to treat my Medicaid patients at no fee. I would charge them nothing and they still would not keep appointments. God help you in your endeavor.

State should contract W/DHMO programs. These practices are accustomed to this type of treatment, i.e., accelerated basic care.

We stopped taking Medicaid because of denial of payment after pre-approval, low fee schedule and chronic broken appointments.

You’re wasting our time with this our survey. You know the complaints you have them listed right here in this survey. Why not try a different program, dental clinics at all health depts. in rural counties, then require dental exams as we do vaccinations for school entrance requirements.

I worked 20 years in a public clinic part time in addition to my private practice. The no show rate in the clinic was huge in comparison to private practice. Preventive care was basically non-existent. I no longer treat patients who cannot afford the type of care I wish to deliver.

Over the year, a few patients have brought farther kids to me for treatment. They have this program, and believe. They asked me to sign up so treatment would be covered. We do the treatment for free. Too confusing to sign up for as few or we get. Situations may be different in low economic area. Their are dentists willing to work for little compensation. So they should handle this type of program and don’t do HMO’s either. Too controlling for me.

The reason I quit MC was the patients wanted or demanded to take them over my regular patients. I will only do work on them as a something to help people in my area. I was the only one so I quit to demanding.
Improve over the year with new MC+ plan. Better than before in most phases of dentistry.

As you can tell I don’t know much about it. I am not interested in low-fee dentistry as it will not allow us to do high-tech dentistry (expensive supplies).

You are welcome to call me at the following number XXX. I can give you an earful of deficiencies in the MC+ program. Were any MO Dds asked for the initial input? The entire program stinks!

I take care of those patients on my own without involving the state. When I checked toe programs out they were more trouble than they were worth. If I am going to give any treatment I will do it for individuals not the state.

Contact me about providing care for children - thanks.

a) We will not receive the fee inc. for Medicaid children since it doesn’t apply to MC+ programs so that was totally worthless. 99% of my children are covered by MC+.  b) We being me and the Medicaid orthodontist have become so overworked in the last 2 months that we have waiting lists, we are swamped. I easily see 30 Medicaid patients a day. I am seeing 5 counties of patients.

I don’t know much about this program but when I accepted Medicaid, it was extremely non profitable and difficult to manage.

Since I have never been a member in an MCT program, it is hard to give definite opinions. However, from what I have heard from associates in the program, I would never join. They complain of low fee, slow pay, unnecessary paperwork and ungrateful, demanding patients.

Low reimbursements keeps most practitioners away. Higher reimbursements should be a reward for excellence in care as an incentive.

I don’t understand why dentists are made to feel that they must provide high quality dental care to persons unable or unwilling to pay for it, even at a loss. I am attempting to run a business. Are Lexus dealers expected to provide new luxury cars, to people not able to afford them, at a reduced price that takes away their profit? If so, would they also be given a lot of paperwork and asked to wait months for payment?

I am not the least bit familiar with the program, but would like it explained to me.

Managed care was supposed to attract more providers into the system but actually provided fewer providers. Also, I don’t see the cost savings. These MC+ companies are doing this for profit.

No one complains on any issue if they feel they are being adequately compensated for their time. As with all health care issues, bottom line, this is fundamentally a money issue. I simply cannot afford to provide care at reduced fee structure while all other costs to provide that care remain the same or increase as the inevitably do. I provided those services for many years because I felt an obligation to do so. It just became too expensive!

One attrition of providers occurred prior to the managed care changeover, most of the providers who remained were those who only survived via massive amounts of fraud. This is a fact, and enforcement has been non-existent. Political corruption, indifference on the part of one of the worst states in the area of dental delivery, and entrenched practice patterns doomed the program. Only via staff model centers can such a program thrive properly managed staff model - no fraud.
The reimbursement depends upon the number of dentists submitting claims. Percentage of reasonable and customary fees has consistently gone down each month. Payment is horrible I accept it because it is not children’s fault they are in this position.

I am not familiar with the MCT program, how it has changed from the old Medicaid program. I might participate in a clinic donate time with no paperwork and no liability.

MC+ has not been living up to their agreement. We have not been receiving the full fee agreed upon, paperwork has been giving us headaches. Patients have been denied after they were told they would be covered. We will not be accepting new patients until these issues are resolved.

This survey was completed without up to date knowledge of MC+. All my experience was with before MC+. I do not support managed care.

Fees, paperwork difficulty.

Several areas need further consideration under the current MC+ program. Most providers do not accept MC+ due to their inconsistencies. If somehow they could incorporate fee for service, better paperwork trail along and less denials and prior authorizations, perhaps more providers would contemplate participation.

I stopped seeing Medicaid adult new patients 3 years ago. Up to January 1998 I saw new kids under Medicaid. After that, I got so many calls that I stopped seeing new pedo patients under Medicaid. If I hadn’t, 1/2 my practice would be Medicaid now. If you want to correct the problem fees should be 80% of UCR and paperwork needs to be down.

I would be interested in the survey results. I’ve never taken Medicaid children, very few dentist in this area do but there is a demand.

All publicly funded programs should provide reasonable incentives for both doctors and patients as well demand responsibility for both doctor and patient to confirm to reasonable levels of reciprocal courtesy and behavior.

I do not know it even existed.

I elected not to participate due to low levels of reimbursement. It appears that patients no shows may also be a problem. This would also affect my decision to participate.

I only opened two years ago and wouldn’t even take it then TMC EAST is so close!

Very essential for poor people and working poor. Practically all of these patients could only afford emergency care without this program. I think it is also very important for adults. An increase in fees would probably make it more accessible.

A lot of good gentleman provided services for years before the MC+ program began. Afterwards, MC+ providers were in many cases paid more than non MC+ providers. A fee hike for the old program providers would have been a good reward.

Charles Darwin described the model of survival which promotes fitness. Diluting the survival capacity of the greater society for the benefit of those less capable of promoting even their own survival, goes counter to an overall pro-survival direction. Ask me another day and I’m a generous benefactor to those in need.
I believe less reimbursement rate is the major reason why practitioners do not sign up with Medicaid.

I participated in Medicaid/dental programs early in my career. I discontinued participation when I felt that I had completed my obligation to do so. I still feel that any young dentist has an obligation to do some uncompensated public service. This possibly could be integrated with forgiveness of student-loan monies.

I would rather do things gratis than deal with you! $8.00 for can ext doesn’t even pay for the stamp to mail the claim.

As a previous Medicaid provider, I found it impossible to work with them.

Our practice stopped taking Medicaid patients in 1/97. No other changes. Since then we made more money. Why? Appointments that would have be broken by Medicaid patients were kept by paying patients. The Medicaid patients is far more likely to miss an appointment. I felt an obligation to treat the Medicaid patient. When I first started practice. I decided not to continue to treat them because they (as a group) would not keep appointments and the reimbursement was so low.

I provide low income patients dentistry, usually at no cost. I believe this is the right thing to do. I do disagree with insurance/government agencies thru Medicaid/HMO’s expecting the dentist to absorb the brunt of dental costs and misinforming patients on these programs, that we are getting additional reimbursement from them.

Need pedodontist and oral surgeons need reimbursement.

We see only limited member of MCT patients. Fee schedules and broken appointments were our biggest problems in the past. Getting approval from Dozal was a joke, it took them four months to process the paperwork.

We do preventive resin fillings w/air abrasion instead of traditional sealants. When on (AD) program we found the desire of the patients to seen dental care and to practice good oral hygiene to be very low! Patient co-payments that are significant are the only way to foster good dental habits!

I despise managed care plans that dump patients into a practice pool and require the dentist to ration treatment or lose money. If Medicaid is going to be done then fund it fully to ensure the care is provided. No ridiculous 30% of UCR.

Teach individual responsibility. Dental I2 and prevention are the most valuable assets to good dental care. The patient must be a responsible partner in good dental care, prevention, diet and good home care are all important. We routinely see a parallel of good diet, no sugars with no cavities and conversely many cavities with sugar eaters (sugared cereals-sodas).

Years ago I was interested in doing dentistry for a few families but was told if I took one person I would have to take anyone or everyone. My one opinion in caring for the under privileged is that they do not have any conception of the value at keeping and appointment or being on time.

Refer to question 10D with MC+ low income patients cannot get adequate dental care. I believe lack of participation in MC+ is a money issue as reflected in my answers above.

My answers are ambiguous because of my ignorance of the program.

I have very little information about the MC+ program and feel that my opinions concerning it are not as valid as those who are participant. Also, I am close to a retirement of practice.

Don’t know what it is.
Need more pedodontist and oral surgeons to refer to.

Only fee for service patient should have co-pay. People who receive service for nothing fail to appreciate it and have little respect for health care provider.

People need dental care and I feel under privileged persons need help. The old program (Medicaid) was ridiculous and frankly adversarial to the very professionals (dentists) who were trying to help. If this new program is not a totally different approach then I feel it is doomed.

It is imperative that the level of reimbursement increase to make is economically viable for people in private practice to accept MC+ patients. I am in public health, I have observed that there is currently a problem of limited access for care for MC+ patients (at times my schedule has been filled 5 months in the future).

I have participated in the sealant program for years. Over 50% of those responding wrote on the patient by card that they had insurance. This tells me that there are too few safeguards for fraud. People for since reason feel welfare etc is owed to them that it is a right. We need to change this make people responsible.

Use of dental codes the same as ins. companies is much easier for staff than the adult Medicaid program. Reimbursement on MC+ has been better than old Medicaid and generally quicker.

Dental care paid by the state of Missouri should be provided in a state run office/clinic or agency dedicated to providing MC care. Private care dentists cannot effectively treat “discounted” dentistry of any type (DMH, PPO or MC) and provide quality personalized care.

I would like more info its very poorly publicized.

I took my training at KC General Hospital and I believe all indigent poor should be treated by state, county or Federal free clinics. Would eliminate paper work, fraudulent claims, overworked dentists, and would better define those that are Medicaid eligible.

The fees need to be increased to a acceptable level. The state legislature is filled with idiots who think that by legislating coverage automatically means access. The new expansion will never work due to limited access (i.e.: not enough providers/fees too low).

This program and all governmental programs are doomed unless a reasonable fee schedule is considered. Just making the program is available does not mean that treatment is available.

Approval of orthodontic care acceptance unpredictable. Patients I thought should be approved were turned down and some I didn’t expect were accepted.

We are going to drop out of the MC+ program.

I am getting older and dumber every year. I used to know or think I knew all the answers. Now I don’t even understand the questions!

Must be fee-for-service (discounts) no adds (except large urban constituency) would take HMO Medicaid. Must use standard ins. forms and codes. Must accept usual electronic submission. Must have similar format for benefits like ins., type I, II, III. Must only all in services for patients who will be on for 1 year or calendar year.

Many years ago I found the program was not will managed and for me not worth while. I instead accepted patients on my own that had a limited ability to pay.
Abandon MC+, they have only been paying less than 50% of their schedule of fees. Fees should be raised to or above 80% of usual and customary. Survey data needs to be obtained for children 0-4, 5-9, and 10-15 of dentistry diagnosed and later completion percentage. How many need incisor root canals or extractions? How many primary molars need root canals or extractions before age 10?

I do not know much about it. I would not be interested in contracting into this program. I do not believe in socialized medicine.

The Medicaid program is a state program to give the state government cover. The providers are being asked to accept the responsibility and cost with the state government taking the credit. This state program should be paid for by the state and all state citizens.

I do not RX MC patients.

I do not know enough about the program to comment meaningfully. I would be willing to learn.

I suggest the patients have a universal ID card with dates of eligibility (i.e., 1/1/98-2/1/98) or a hotline to call to verify eligibility. This combined with a list of covered services. Once the dentist provides the service, a universal ADA form to be sent in and payment is less than 45 days.

It is ridiculous and inefficient to take a welfare low paying program and add the hassle and annoyance of middlemen, managed care and pre-authorization. Most dentists will not tolerate such crap. Who needs the headaches?

I have been a very active participant in Medicaid (about first 10 years of practice) until about 5 years ago: Why I stopped. 1) Very low payments (below overhead) (40-45% of fees). 2) Approval (pre-approval) then, denial or refusal to pay when claim submitted. 3) Denial if you do not dot yours I’s or cross your T’s. Note: I appreciate greatly the fact that the Missouri Medicaid program kept my practice “afloat” the first 5 years. Thank You!!!!

Hopefully the program is completely different from previous ADC programs. The three main reasons I dropped the program were: 1. Failure to pay amounts quoted for procedures as listed and payment in a timely manner. 2. Return of forms for new trivial matters. 3. At the time I dropped the program MO ADC owed me $16000+ which they said they would only be able to pay 5.0%.

Let me make this real simple for you. You do not need this survey. If you want more dentists to be involved, pay them more. If you pay them enough you’ll have dentists coming out of your ears you’ll have so many. They will want to be involved no matter how difficult you make it. If you want the system to be more efficient, copy from the business world, how do they do it. They are going to find the most cost effective while still making both sides happy. Start out paying some more and increase payments until you have enough participants.

I do not see MC+ as that much of an improvement over Medicaid. More of a lateral move than a vertical one. Too bad!

Political program to make government look good (doing something) - not very effective for dentistry.

Medicaid reimbursements have been basically forced charity. Below break even. Why not use Kansas as a model?

Would volunteer time in a clinical setting away from my office.
With low reimbursement, many dentists dropped MC+ patients, causing remaining practices to be over loaded w/net patients and leading to longer wait for appointments. Low reimbursement also compromises the quality of care MC+ patients receive. We do not have any facility specialist for pedo patients who requires comprehensive treatment. There is only one oral surgeon who charges extra for his required sedation and difficult to get appointment with.

If more dentists would participate, stress level would be lessened. The need is great to provide care but when an entire country has no care the burden is too great for the others.

Don’t really know much about it.

My experience with Medicaid in the past has been very very poor to say the least. With the kind of nonsense I was put through just to receive deeply cut fees, I would only reconsider with major changes to the program, for example taking the administration out of the hands of state/government employees.

MC+ personnel hard to reach, phone and written. Less paperwork and simplified and not complicated. No shows and last minute cancellations reduced. Over the years fees have hardly changed but my costs to treat patients have risen at a much greater rate! Treating MC+ patients is definitely an ethical obligation dentist should have but at a great sacrifice (financial) and time (broken appointments).

Patients need list of participants. Many do a great deal of calling to find enrolled offices.

Really know list of participants. Many do a great deal of calling to find enrolled offices.

Fees too low.

I do not take any MC+ or PPO or DMO programs.

Stop returning forms with requests for minor errors or questions. Do as other insurance companies do. Call the doctor and ask these questions. This will save time, paper and money. You waste far too much paper. Think of all those trees.

More doctors need to be involved in taking care of patients with MC+. You also need specialist to be on your staff such as an oral surgeon, staff treating these patients need to have input, we can tell you the ins and outs of treating patients versus someone you have that has never worked in an office before trying to dictate to something they know little about.

It costs money to the practitioner to treat these patients. They are more disruptive to the office, more demanding, and compliance is very poor. I don’t know what the MC+ program can do to change this, but without comparable fees, the effort is not worth it.

Pay fairly. Increase patients who follow thru on TX. Decrease paper work.

MC needs to inform their patients of who is participating in the program. Our phone is absolutely inundated with calls to our office asking for care under the program. It is a great inconvenience and abuse of our time. Some oral surgery practices use the Medicaid program as a tool to obtain private paying patients from their referring doctors. They tell their referring doctors they will see their Medicaid patients only if they also see their good private pay patients also. However, when the Medicaid patient calls the oral surgeon’s office needing an appointment (usually for an emergency toothache) they are told that they can not get an appointment for 2-3 months. Needless to say the Medicaid patient goes without treatment.

1) Dental IQ patients or parents i.e.: putting children to bed with bottles. 2) The litigious nature with the parents.
Great need for more specialists; oral surgeon and pedodontist.

I continue to see former Medicaid patients either on a delayed private pay or no charge basis. I feel dentists have an ethical obligation, but for an efficient system. Claims process needs to be standardized with assurance of payment and less red tape.

Worked in IL, TX and MO has the worst program so quit in MO 1998 and still enrolled in IL. Dentistry is not for everyone because they won’t change habits that are harmful, a dentist can’t do anything for a patient who will not do for himself.

I have not participated because of low fees, too much emphasis on removing teeth or making dentures.

Increase fees to provide more providers.

No idea what MCT program is.

Though I do not take MC+ program, I have often believed a managed clinic environment would be a very good option. The staff would strictly deal with one program. Mandatory staffing of dentists within the state/country should be considered. Continuity of care would be an issue.

I know very little about the MC+ program therefore I have very few opinions.

1) Program should recognize and use standard ADA codes. 2) Program should be run with patient care primary important. 3) Consider dollar for dollar reduction in Missouri taxes for dentists who provide care. 4) Factor in cost of providing quality care to reimbursement schedule.

Set program forms, payment schedule similar to Delta Dental. Fees and allowances must be equal to overhead costs!

No MC+ or Medicaid providers in our area. Anyone who signs up would have no time for their regular patients. No specialists will take them. The state just increased the number of people on Medicaid by upping the poverty levels. This is nuts! The state needs to make a commitment to reasonable feel levels and speedy payment before increasing the number of people covered. Previous Medicaid was terrible; fees below cost, slow payment, denials, many procedures not covered, phones always busy, etc.

Not familiar with program. My concerns with any of this have been: 1. failed appts. 2. Low reimbursement. 3. Patient non-compliance. I don’t want to be an emergency road service for non-dependable people.

I think that every dentist should be required to accept a certain number of Medicaid patients. The responsibility for care for the poor would be equal among dentists and the patients could more easily receive treatment. We have patients calling our office seeking care who are willing to travel great distances due to lack of participation among dentists.

Even though the dental care is free, Medicaid parents do not practice preventive dentistry for their children. They only make an appointment when they are in pain, wanting to be seen within the hour, and demand a late PM appointment because they are to lazy to get up before noon!!!!

Doral dental had no guarantee of any minimum benefits. They could only say historically this reimbursement level has been the case. I say past performance does not guarantee future outcomes. Only a fool would work for someone who promised to pay the best they could.
I have never been involved in the MC+ program because I have avoided programs that, in my estimation, cause me more headaches than I wish to deal with. I think their design invites misuses and abuse of our tax dollars.

I feel all “managed care” is really “managed cost”. It gains nothing for the patient and punishes the provider. We prefer to pick and choose our own charities. Perhaps this should be the realm of people who choose to go into public health dentistry.

Our overall experience with dental and comm health plan Blue Cross have been much more pleasant and accommodating that Missouri Medicaid before MCT began. Our concern lies in the reimbursement, which, at this point, is not usually any higher than Medicaid was. We have been the sole Medicaid provider in our 2 county area for years and have recently learned the county to the east of us no longer has dentists participating. That is a big concern to us.

PPO, HMO and MC+ expect large dollar sacrifices. Dentists have bills, overhead, families, etc, please shift the burden to the people receiving care on their insurance/employers.

The fee schedule hasn’t changed since 1975. I gave up taking new patients 12 years ago. Current Medicare reimbursement is at a loss for me and it is a ridiculous haggle to get paid.

A medical director cannot deny hospitalization for MC+ patients. If the case is reviewed and rejected by their dental consultant, then the dental consultant must provide the dental care fore the patients in his office within the guidelines of AAPD. Also the dental consultant must be an active licensed dentist in Missouri.

While the new MC+ was “recruiting” new dentists via paper/mail contacts, I called three times to ask Doral about the “sliding scale” (based on usage that calendar month?_ fee-for-service program. I left messages on those occasions for a representative to call and discuss my questions; my calls were not returned (I have an answering machine and caller ID) and subsequently, I decided not to participate.

I believe that if the fees do not significantly increase soon, and the speed of claims processing does not improve, that you will see a continued exodus of providers away from the MCT program.

I dropped out due to low fees, broken appointments, no ability to find perodontists or oral surgeons in area. Mainly emergency only patients. Since I dropped the program my practice has been grossing an extra 7,000.00 to 10,000.00 a month. Due to increase production. With these numbers it would take a lot to convince me to participate again.

I am opposed to any plan that removes CHOICE.

I used to treat Medicaid patients, I was quite upset how the “program” was managed, very slow or no pay, ver low fee. I felt treated in a shabby way by the processors, no support help with claims, processors not cooperative at all.

None, not interested.

I am not familiar with all the particulars of MC+ but I left the MO Medicaid program because of: 1) low fees, 2) broken appointments, 3) rejected claims for treatment provided, 4) many patients were combative, disruptive and destructive (waiting room).

From the foregoing it is obvious I have very little knowledge of the program, With a well-established practice I never felt a need for seeking such programs. That is why I have very little knowledge.

They should have left the old system alone.
Very satisfied with the speed in which questions are answered and phone calls are returned. It would be nice if there were an automated system where eligibility could be verified. We are on hold too long when verifying which causes patients to wait.

I would be a participant but broken appointments are my concern. I work in 3rd world countries every year the people appreciate are thankful. Here in the states the people don’t appreciate what is given to them.

I felt uncomfortable answering some questions because I don’t know enough about the program.

Make a requirement that 6 month prophy schedules must be maintained in order to remain eligible for benefits and you’ll alleviate enough emergency work to pay decent fees for the other services.

MCT would have to completely eliminate discrimination of fees for same identical service whether rendered by physician doctor dentist before I would participate. Otherwise, let the patients be treated with prescriptions by their physician for problems that require SURGERY by the dentist.

I would never participate in any government program!

No comment MC+ programs, but for Medicaid for adults I loose money because the pay for example, an extraction is 7.75 and my cost to set up is 30.00, thus my social security; which I need to live on, is diminishing every time I see adult Medicaid patients.

I took Medicaid patients when I first started our business, it just wasn’t worth the hassle, fee for service and cap patients are difficult enough without the extra problems which come with Medicaid patients.

The MO. dental association’s legal dept. through the ADA has done a contract analysis. No guarantee of payment! All questions were answered based on experiences with Gary Mandernacn (MC+) director, Lee’s Summit, Mo. They are presently violating Medicaid rules. Even Greg Vadmer Medicaid director and his committee people do not have a clue as to how to correct these contracts and access to care problems! Over 1/2 of the headstart centers in Missouri have problems trying to find (MC+) providers for the children ages 3-5 years old! Please call John Dane out at TME East hospital, he can tell you all about this MC+ program!

I could possibly be interested in this program but I know nothing about it. I quit Medicaid in the seventies because of ridiculous paperwork, not fees.

We know nothing about the MCT program. We provide services to DMO and PPO patients and feel that these programs take advantage of DDS. MCT might not do this but because of the other plans, we aren’t willing to consider the MCT plan.

I have had no experience with MC+ programs.

More specialists are needed in pedo and oral surgery specifically. There are no endodontists available at all.

I don’t know much about it. I do know if you take care of one Medicaid patient that they will spread the word and every Medicaid recipient in the area will want to have their dental work done at no cost to them. Broken appointments don’t cost them either. Not responsible.

Am phasing out Medicaid after 18 years. Is a losing proposition.

Years ago I was totally “turned off” by the program!! Now to established to start.

I have no knowledge of the program.
St Louis had/and still has a strange bunch of providers in Medicaid programs. There were many personal and unprofessional actions by those providing care. I ended up treating many patients for various reasons at the request of insurance companies.

I need to be reciprocated.

I was in the Medicaid program for 25 years. I got out in June 1995. The reasons were many but #1 was the new way it was going to be handled. 2) The Medicaid patient has changed thru the years, at least in my practice. If the didn’t like the times offered a good number of them became verbally abusive. I also had a big problem with broken appointments with them. they also reached about 40% of my time but produced only 20% of my gross. Therefore I decided to get out of the program. I would not care to get back in under any circumstances.

Don’t know anything about it, have never worked with it, but did do a little Medicaid in Chicago for a short time.

Years ago I found the program to be so frustrating that it wasn’t worth the low reimbursement levels. I provide care free of charge rather than hassle with the program because I feel dentists do have an obligation to provide a certain amount of work at little or no charge.

If a program is implemented that would provide high patient compliance, very few broken appointments, and a realistic, and a constantly updated fee schedule, myself and probably most other dentists would participate in MCT. Until this happens forget it!

I am not familiar with the new programs. I took about 18 years or so ago. I quit because fees were low (too low), one patient would show up with 5 or 6 siblings and they would trash the waiting room, I would not be paid if I put 1 proply down instead of 01 proply (or something like that) and then I would have to redo paperwork and wait 2-3 more months to get paid only a fraction of my fees. Program was ridiculous!

I don’t feel that my social responsibility is too lose money when you treat welfare patients. Reimbursement has historically not paid your overhead cost. Therefore, you either have to fraudulently bill, lose money or not accept welfare patients. This is an easy decision (not take welfare)!

I left the Medicaid program 1989 due to low fees and the high number of no-shows and cancellations.

Need to find specialists when referral is necessary; we love the MC+ patient, not the system; preferred Medicaid before it was MC+.

Under the large demand you have, I consider your service to practitioner is quite adequate and I go back to R.R. Rhoades days of pre-authorization via x-rays for every procedure. It’s very beginning. I enjoy treating those less fortunate.

Need better reimbursement to provider.

With additional money for state and Federal tax money, increasing fees to a more reasonable level should be a priority.

The doctor and staff agree that, in general, Medicaid patients are a negative presence in a practice. The management of their behavior and attitudes is not worth the while and is destructive to the morale of the staff and distrustful and disturbing to the valued fee for services patients.
I am still in MC+ and Medicaid but over the years I have come to feel personally that the government should get out of the health care business. Many of welfare recipients are not appreciative of the dental care they receive at taxpayers benefit. Broken appointments has become a serious problem at my office. Also for children we cannot treat here there are no pedodontists in North Missouri that takes Medicaid.

My practice is in an affluent upper socio-economic area. I believe no Medicaid patients are in the area!

I am interested in the MC+ program, please send me an information packet.

If you wish everyone to have the same level of care PAY FOR IT. You know private practitioners give a lot more away every year than University Research employees!
APPENDIX C-2

Dentists' Comments from Mid-Missouri Survey
For 25 years Medicaid has not listened to dentists’ complaints. I doubt they will start now!

This is the first I have heard of the MC+ program. However, I don’t see children and would not be interested in participating. Difficult to answer this questionnaire, considering what I just wrote.

GIE only takes their forms. Why not take standard insurance forms as other insurance companies do? We were looking for a way out of taking Medicaid patients because we were getting calls from a great distance. I didn’t want my husband to be the only dentist taking Medicaid patients. Also, was worried about the possibility of getting AIDS patients.

I feel this program would be best implemented through the county health dept. Staffing could be by providing a student loan forgiveness program, based on a % decrease for every year staffing the facility.

I shall send a packet of letters and records pertaining to this issue as soon as I have updated the information. Thank you for returning my call (9/10/98) and I apologize for the delay in getting this back to you.

I am too busy right now. Cannot adequately take on many more new patients without hurting quality of treatment. Prior exp. with MC patients is they never keep appts. and we lose time. Also, low fees, too much b.s. involved, reimbursements held up for little stupid reasons.

I did Medicaid about 13 to 14 years ago and don’t know anything about MC+ program. When I did Medicaid I did it to help out the children, but the parents would never bring their children until it was too late to save the tooth. Somehow, we need to educate the families to bring their children in for well patient visits at an early age.

I believe dental care should be provided in the private practice setting with adequate fee schedule and prompt payment, without the hassle that has been experienced in past years.

I am some what concerned that the quality and quantity of the dental care are not as good as they should be.

Having done extractions on one of my first patients, I contacted the Division of Welfare for instructions. I threw the thick instruction manual and the bill in the trash. The previous Director of Welfare explained the system like the following: people who wanted a system got it. Tax payers got what they wanted--no significant cost. Dentists could opt out. The manual was designed to encourage you not to take part in the system...it worked. The program is so bad that I ought to report any dentist who utilizes it to the dental board for not having adequate judgement to be permitted to continue practicing dentistry! My comment--name and administration have changed, but the program is functionally the same.

My experience with Medicaid 15 years ago has prejudiced my attitude. It was, at that time, a mindless, abusive bureaucracy. If I don’t have to endure it, I will not. If there have been improvements, I would applaud your efforts and would re-examine the program.

There should be an incentive for MC+ patients to make dental appointments.

They should feel like this is not a bawl out. However, I don’t know that you will be able to achieve this. Good luck.

I worked for Indian Health Service in the past and I believe that Public Health Dental Clinics are excellent. Child patients with special medical/behavioral needs that cannot be treated appropriately by general dentists staffing these clinics should be transferred to private practice pediatric dentists as straight Medicaid without restrictions, or use of outpatient surgery, or as a fee-for-service patients, like Head Start.

Would be willing to sign up again if fees would increase to acceptable levels. Unable to see patients and cover overhead. Refiling of paperwork a major headache. Program to help needy children is great, but being a small business we had to make money treating patients, not losing. Would rather have an empty chair than lose money treating people.
Broken appointments (75% of appointments!), very low fee structure, and young patients, in this classification, have poor oral health and are very difficult to work on!

The MC+ program needs to update this payment schedule. A lot of times, our lab expenses and other expenses are more than we are reimbursed, we end up paying out of our pocket to see a MC+ patient. We were one of the last in our area to stop accepting new MC+ patients, but we had to finally stop; we were (and still are) getting too many people wanting in. Also, the “Day Specific Eligibility” is a pain. It was easier when patients were eligible for a month at a time.

My head, ears, etc. must be buried in the ground, because I know little about the program.

I treated Medicaid people without discrimination for 12 years. Generally, they didn’t care, broke appointments, some came smelling bad, poorly dressed, ill mannered, I lost money treating them, poor compliance, and on and on. It was a source of irritation after a while and a dead end. It was “free” for them, so it had limited value.

I feel a lot of dentists are “soured” on state sponsored dental care for the poor and would not sign up again, regardless of the level of reimbursements, etc.

I believe the quality of care for our children has decreased. Myself, and many other dentists, provide Medicaid at a financial loss. HMO’s demand a total immersion into the program. My intention is not to seek new patients, but if my patients’ fortunes change, I will continue to see them. Mandatory managed care prevents me from providing care for them. My pocket thanks you, but I would rather not “throw my patients out” when they are forced on Medicaid.

Public health clinics would work best in this area.

Don’t know enough about program to judge most questions.

Would be more productive to have clinics set up to treat only MC+ patients, such as in Columbia. I worked at local health dept., but it was not cost effective and program closed. Very difficult for Randolph County patients to get to Columbia, plus long waiting list due to the large number of clients.

Payments on same level as private patients. Fee for broken appts. Less paperwork for work involved. At least monthly payments for work.

I work for the state, I only see MC+ people when they are also part of MCIDD. As a result, I am not very involved, but having been in private practice and knowing others in private practice, I took other consideration while completing this.

Too busy as it is--really I’m not looking for any new patients much less broken appts., low fees, trashy/not groomed patients in waiting room.

So happy to see it in place. The calls from Medicaid patients have significantly decreased, but for some, the need or desire to be seen sooner has caused them to schedule with me, despite having to pay more. The provider I have spoken with seems inexperienced, but very sincere and thorough; wants to do right, but voiced some frustration with “the system” and the patients.

All children should have access to dental care. Due to the circumstances surrounding the indigent population, delivery of care is difficult. There are no easy answers. I feel that if the process were limited to the patient and DDS with the patient presenting a pre-approved debit or credit card, all the paperwork, approved or not approved dentists, eligibility of patient and slow payment would be eliminated. All dentists would be eligible, patients would know their dentist and not be bounced around which might improve accountability. Make missed appointments count against eligibility.
The Kingsdaughters dental aid program here in Columbia is very successful. It combines private practice with a philanthropic organization. The patients always make their appointments, and most dentists charge a reduced fee voluntarily! I believe this is the best way to provide dental services to low income children.

I’ve provided Medicaid services for years. You will never be able to satisfactorily make recipients responsible for appointments, or being upfront about notifying the office they are on Medicaid. Today, recipients shy away from letting on their status because they feel they will be treated with less respect. They are also victims of the HMO TV promotion that has seemed to promote a new “wonderful” package of dental benefits. MC+ is Medicaid and not insurance, and provider numbers haven’t increased significantly to make access better. Until dentists are given a substantial tax break for free services provided, this continual search for the ideal plan of providing will exist.

When MC+ started in mid-Missouri, I tried to contact all 3 carriers to access opportunities. The only response was that they had contacted Dr. XXX to handle all their patients. Dr XXX offered a contract to me to see MC+ patients for 4 hours per week and I was offered $100/hour to see these patients. I thought this was a ridiculous offer, since it didn’t come close to paying my office overhead for that time. When I asked for a counter offer, I received no response. So I have been shut out from participating in the dental care of old and younger MC+ recipients, many whom I had treated in the past under old Medicaid rules. The MC+ program had denied care to many MC+ patients by the simple fact of geographical distance, 50 miles from Montgomery County. Many of these patients couldn’t make appointments at my office due to lack of transportation. How are they to get to Columbia? You may call me for any confirmation or other views on the subject of MC+ and Missouri Medicaid.

We were sick when we lost our option to care for this segment of the community.

So many of the people who want these services at reduced cost still seem to be able to buy their cigarettes and liquor and sponge off security. When they got to the store, they still pay the going rate for milk and bread, but the gov’t seems to think that is ok. If dental services are needed, then the gov’t needs to pay the going rate!

It appears that fees may be coming up--but, too little, too late. If the legislature had treated Medicaid dental programs fairly in the past, we wouldn’t have an access problem!

Too much government never works. Children need to have and be taught foundational, core values based on absolute truths. Anything less than that will fail.

10j--I believe dentists have ethical obligation to treat Medicaid population. Was much easier when fee for services instead of MC+. We are making lots of progress legislatively if only structure would have remained fee for service. I have a very negative attitude towards any type of managed care company.

I do not know very much about the program.
APPENDIX D-2

Dentists' Comments from Fee-for-Service Survey
Low fees and broken appointments are the worst problems. The ASAP program speeds up payments a lot. I have 6-7 long time patients that are paying for full services, it makes me wonder about financial need for state funded dental care.

Medicaid is necessary. Dentists would participate if fees adequate and covered procedures were clearly defined.

Current US population prosperity levels increase the number of patients willing to pay for “wanted” services. This creates a shortage of dentists available to provide “needed” services, especially for those patients from complicated or discounted sources.

In the past, there has been little interest in the dental portion of the Medicaid program, due to the small percentage of the overall budget. This sentiment was impressed by former direct. Mrs. XXX. Therefore, having not seen anything to the contrary, I would gather the same is true. Why insult us with such meaningless gestures as this worthless survey? You’d be ahead to just shut the whole thing down. Nothing is better than being wrong all the time.

Bring back the deferred compensation program for Medicaid providers.

We continue to treat patients of record who have continued routine preventive care. No new Medicaid’s. Present program is a joke. Managed position is set to enrich one group and not help needy patients! Need to raise fees to normal levels too much charity now!

It seems that approximately 50% of Medicaid feel we are obligated to accept them as new patients they sometimes have a bitter attitude. Also I see people receiving Medicaid that are taking advantage of the system. i.e.: false disability claims etc. The fraud out there is not the doctors, but people receiving Medicaid. My patients that have had hard luck that get on it appreciate what we sacrifice but the no good bums act like its coming to them, screen these people better!!!!!!

The Medicaid program needs to update the fee schedule. 10.00 for an extraction is ridiculous! Room preparation sterilization exceed this the program might be too wide (in the services covered) and not deep enough (pay fair amounts for limited number of procedures).

The fee schedule is ridiculously low it guarantees poor service and/or poor dentistry. It demonstrates how poorly we dentists have demanded a greater share of the health care dollars! The denture fee is $195.00 today the same as when I started in practice in 1965!!

I saw Medicaid patients for probably 30 years, and could get nothing done by the state about broken appointments, claims rejection, fees (I have sent lab bills showing my lab costs were higher than the amount they paid me). Could not get them to use ADA procedure codes. (Once, I had a computer program written, for $700.00, to cover the codes.) I finally got tired of fussing and quit (feeling guilty for not seeing the kids and older adults, but everyone else here quit, and I was getting all of them and couldn’t survive with your fees).

I feel many people (old and young) who are entitled to dental benefits under the program do not take advantage or don’t bother to keep appointments. A very low percentage take advantage of the benefits offered. It is very hard to help individuals who will not help themselves even if it is provided free.

Medicaid patients blaming us for DFS mistakes, covered and non covered procedures. Lack of parental responsibility, appointments, follow-ups.

My problems with Medicaid are mainly with the low reimbursement. The patient non compliance, smoking, broken appointments or no shows would be much more tolerable if the payments were higher. Our reimbursement level is so low it barely covers my staff to fill out the paperwork. My partner and I lose money so try to tell us why we should treat more Medicaid or why others should join our ranks? This system is pathetic! And the adult patients are mostly unappreciative.
I believe that the low income elderly should be given as much attention as children. We cannot continue to accept fees that are 20 yr. out of date. Fee for service is the only way to go, but fees must be increased. If the state cannot afford higher fees, then allow us to accept these fees as partial payment, and set our own fees in addition. This would provide some competition.

Fees are unfair!!!! Dentists are carrying the Missouri Medicaid program at their expense plus we pay taxes on the income!!!!! Considering not servicing the program. Thanks.

Fees are terribly low. Feel my hands are tied because of the terrible fee schedule. To provide adequate care is impossible. They deserve better.

I do not even know what Medicaid pays, but I have heard that paperwork is too much and claims are always delayed. Patients do not care and co-payments are rarely paid.

General dentists will not treat Medicaid patients until fees are near usual and customary. Even then, many will not accept them, because of broken appointments, perceptions of dirty or unruly families in waiting rooms, uncooperative patients, and other difficulties with the system. Our Medicaid appointment failure rate exceeds 33%. Higher fees = higher participation.

“A slap in the face to all dentists in the state.”

I think Medicaid is more interested in control than in providing care. My staff member who filed Medicaid had to leave my employment. I could not fill out the paperwork (too complicated - poor instructions). Properly and therefore could not train someone to do this. I continued seeing my patients for no fee. The Medicaid program took away my number because they were receiving no claims. When this happened I stopped seeing Medicaid patients entirely.

MO law requires names in prosthetic appliances but Medicaid does not pay for it and has not increased. Not fair. Broken appt. are a problem no help from Medicaid. If fees were reasonable, your problem would be solved and cheaper than not using private dentist. I have always done Medicaid many old patients go from private care when they get old or can’t work. I don’t send them away.

Make it reasonable and fair, and I will participate.

Medicaid needs to: 1) increase reimbursements, 2) go to ADA claim forms, and 3) consider making the “cutback” tax deductible. Right now, I can donate my time for a church group (true story), and do better than accepting Medicaid.

It needs help.

I have accepted Medicaid patients for 29 years because I feel I have an ethical obligation to do it. I have had to limit the number I accept in recent years. I have been on Medicaid committees for many years on the state level many of which never even called any meetings and when the did, they never listened to any of our gripes or suggestions. Only this year are they including dentists in decisions on where to increase fees that were appropriated by the legislature.

The current program is frustrating. Not fair to dentists and our tremendous overhead. This results in poor quality dentistry with 1970 fees. The real solution is state funded dental clinics for the poor and indigent; staffed by state dentist; state hygienist and state assistants. Then and only then would our legislatures in our government truly understand the costs involved to provide quality dental care.

My experience with Medicaid was that fees were insulting and paperwork a nightmare. If these problems were corrected, I would participate. However, I have no interest in a managed care program, Medicaid or otherwise.
The program is terrible and I only do it because I feel a moral obligation.

Dentistry is hard work, sometimes more so on Medicaid patients. I have difficulty scheduling private pay patients, so in order to do much Medicaid, Medicaid fees must be comparable.

The legislature has shown great apathy over the past twenty years in addressing the fee structure of Medicaid and its poor business procedures. The people and children of our state are being denied quality care while dentists are being denied minimum reimbursement to cover costs.

If the Medicaid fees were reimbursed at 75% of all UCR for the area, there would be providers lined up to participate. The current Medicaid is so complicated to use. It needs to be user friendly.

I believe the Missouri Medicaid program should be binded to treat those below 18 and over 65 years old. It is abused and a dentist is really doing charity work to accept it. It is very disappointing when your Medicaid patients have cellular phones, and your staff doesn’t, or when they can’t make appointments because they need to meet the cable guy. There has to be a better way.

Most of the patients on the program say “I’m on the card” as if they have a Visa Gold card and the dentist is going to get rich by seeing them. They don’t appreciate the hard work and sacrifice the doctors make to treat them. They have an attitude of the doctor will always be there for me, if I don’t show up it is no skin off my back, besides I’m doing him such a big favor being his patient.

Provide patients with a list of participating dentists, instead of making them phone every dentist in town.

I am in the process of phasing out all Medicaid patients. I am continuing to see only the ones on record. I will not take any new patients because of the sole reason of the low fees.

I’m not sold on it. I was brought up to work for what I want and need.

If everybody took some of the load could be spread out. Almost a 1/4 of my practice is Medicaid because only two of us accept it in the county. Another problem is care workers paint a rosy picture of how much treatment they can get but patients cannot find anyone to accept $35.00 on the dollar.

Lab fees always exceed the reimbursement from Medicaid. Therefore, since we are not suppose to charge any difference to the pt. We are actually paying the lab fees ourselves. Example: The lab may charge $20 for a dent repair, but Medicaid only pays $16.50, we not only have to pay the difference we have no payment for our time and service. That really stinks!

I don’t have the answer. I don’t believe the government does either. Good Luck!

When I started practice 26 years ago all I heard was doctors complaining about the program. Fees and broken appointments were the main complaints. Since I was a solo dentist with one employee, I did not feel I could handle the problems of Medicaid. Through all the 26 years I have not heard anything to encourage me to start.

If every dentist had to do their share, the load would be acceptable, but to open up and accept any and all Medicaid eligible persons, then we suddenly have patients coming 60-80 miles and we just get covered-up. I would be open to discuss this further or to elaborate on any of my answers. XXX.

I am in a 5 doctor practice in oral and maxillatural surgery. We have been medical providers for over 20 years we now are considering dropping the program because of reimbursement that is simply inadequate to cover our overhead patients may have to travel to the larger cities over 3 hrs away to have those service. It’s really a shame but this situation is out of our control.
It is time for the Medicaid program to increase its reimbursement to participating dentists. The reimbursement amounts have not changed for 10 years.

The program is ineffective. You can not provide proper treatment on these patients with the fee schedule, broken appointments and slow pay associated with this program.

It would be nice to have more phone operators-can rarely “get through”. It would be nice to know when last BW’s taken, last cleaning, etc. Items where there is a time limit upon payment.

I discontinued the program after trying for about a year to collect $20,000 + owed in services. I even hired a part-time employee to do the repeated paperwork. I finally said keep the money and quit the programs. I would never start again.

I participated in Medicaid for 7 years and received no compensation, although many claims were submitted. Finally a state representative checked into my situation and received a reply or don’t know what happened-no apology, will check into it, etc. I withdraw shortly thereafter.

In my opinion one of two things should be done to this program. Either pay full fees for selected treatments deemed necessary or emergency on hire dentists who wish to work for set salary and benefits as employees of the state are let them do all Medicaid related care.

Failure rate of Medicaid patients in this office was 85-90%. Much of my time was wasted on scheduled patients who never showed up. I finally had to refuse to see those who routinely missed appointments. The adult patients and parents of children treated were very often rude and verbally abusive to my staff and myself. Many of the younger children were totally unsocialized and had never been taught any oral hygiene at home; dental problems were often very severe by age 4 or 5. Reimbursement for my services was usually a small fraction of my usual fees. I will not accept Medicaid in my practice ever again.

I have treated children as a private dentist and have worked in a public health (community) clinic. Although I have not participated in a Medicaid managed care plan; I have seen private patients in the past in one and my belief it is a waste of money going to a “middle man” and that both quality and quantity of care suffer. If we are sincerely interested in care of patients, managed care is not the answer for Medicaid children.

I would love to discuss these ideas farther. I stopped taking Medicaid with the implementation of the American Disabilities Act. Aids patients are automatically given Medicaid and social agencies immediately refer to listed Medicaid providers. I have no problem with the ethics of providing care to AIDS patients but for a practitioner to be singled out as the sole source of care in a rural region would be devastating to his practice.

Fee increases are needed; Pt compliance is needed. Broken appointments were our major concern when we participated in the Medicaid program along with unacceptable low fees. A solution might possibly be to limit treatment to include children to age 16. Do not try to provide comprehensive care to adults over 16. Emergency care only extractions and routine restorative which would allow Medicaid to raise fees for other services and raise quality of care and pt’s health.

It seems like the children on Medicaid are getting better, but the broken appt. is a major problem.

Medicaid has not increased its fees since 1984. Claims are routinely rejected for trivial inconsequential errors in paperwork. I’m not surprised by the low level of participation by Missouri dentists. I do it primarily because I feel sorry for the children. They have no control in the matter.

If fees are not increased, and by a large increase, will probably drop out of the program all together. Cannot keep it up and pay overhead. Our state leaders seem to feel it is ok to increase their own income, and for us to work for nothing.
Worked with the program for years. To much of a loss in gross revenue. To many T 19’s. Would be happy to come back in the program if you had U&C don’t like to see my patients drive 45 miles.

We take calls all day from people requesting a Medicaid dentist. We turn nearly all away, except true emergencies. It does not take a genius to figure out why dentists do not take Medicaid the program virtually forces us to deliver substandard quality of care; because of that I will do little or no Medicaid dentistry.

I don’t believe in it. We don’t “owe” people dental care. People make choices, and if they choose to spend their money elsewhere and not avail themselves of the vast amounts of opportunities to better themselves, then when dental crises occur, the and their children will suffer. Many people who don’t qualify for Medicaid because they work hard make hard choices and put their children’s needs a head of their wants (drugs, alcohol, tobacco). Public health clinics providing minimal care can be safety not, but we don’t owe the vast majority of Medicaid recipients dental care.

It’s a joke with the current fee schedule.

TX limited by Medicaid procedures covered. Fees are to low so very few dentists participate.

Our Medicaid patients are less than 30% of our revenues with over 90% of total patient problems. Most of these “problems” are a direct result of non-compliance to medical care (past and present). Less than 2 years ago Medicaid patients were 50% of our total appointment with a ratio of approximately 1 of 3 not showing up for their appointment. Fees for services barely covered overhead expenses. With this in mind, you can see why we have had to limit our Medicaid patients severely!

Due mainly to low fees I see Medicaid patients for emergency services only.

Providing care to Medicaid patients was very difficult. It definitely influenced the regular patients in our practice. Fewer referrals, complaints of screaming, crying kids, bad odors, dealing with constant old wives tales, poor diets, poor oral care, low fees, pre-authorization, patients not being covered, and delayed payments were all constant problems.

I’ve talked to many dentists in my area. They said if the state raised the Medicaid fee structure to around 70% or so of their fee, then this problem patients in the “card” getting to see dentists taking the “card” would be eliminated. Therefore, the state would solve the problem and be fair to both patient and dentist. Why is the state being so confrontational with the dentist by trying.

Many problems with the Medicaid program can be resolved by making it more simple. They need to use ADT procedure numbers and universal claims forms. It is ridiculous to have their own procedures numbers. To increase access to treatment is going to require an increase in fee schedule to at least 80% if UCR statement. Its time the state of Missouri put it’s money to good use!

I am in Shell Knob Missouri. Stone and Barry County, high Medicaid if I saw Medicaid its all I would do with my overhead. I’d probably go broke. If everyone in my state would see a few it would probably take care of the problem. Good Luck!

I believe that until fee increases and patient compliance occurs there will always be a small dentists actual participate. Also, because 50% of Medicaid families physician not present, many practices feel uncomfortable having these patients in there office with self pay/insurance patients.

Fee reimbursements are ridiculous. ADA codes should be used. Too many claims returned with denied payment for various administrative reasons. Raise fees or have a Medicaid clinic with dentists on salary doing only Medicaid.
Program needs better screening in fewer recipients—better coverage for truly needy. Current fees are a joke. If you don’t think so, would you or anyone else work for 20% of their current salary and wait 5 or 6 months to get paid? I don’t think so. Everyone wants the best care, no waiting, provided by top practitioners, with best materials, for 20 cents on a dollar. It will not happen!

The reimbursement rates are pathetic. What are dentists to do when average overhead is around 60% and Medicaid reimbursement is 20%-30% payment is slow, paperwork is needlessly complicated and different than accepted ADA codes and forms. Why are dentists asked to provide services at significant losses? Physicians aren’t their overhead is considerably lower than ours. Supermarkets aren’t they get 100% of their fees when food stamps are used. I provide some charity dentistry now, but to provide Medicaid services on large scale such as generally accepting new Medicaid patients the reimbursement rates need to be reasonable. For dentistry that needs to be around 75%.

Not only do they break appointments but they bring grandma, grandpa, uncle Joe, the cats next door neighbors etc. I have treated several families for no fee and found this to be the case.

I feel that patients should have to pay a small fee for failed appointments.

The basic problem with the Medicaid program is inadequate coverage of dental pathology and inadequate reimbursement for those procedures that are covered. The most glaring example of this is Medicaid’s lack of coverage for periodontal disease—the leading cause of tooth loss. This is akin to a medical insurance policy that doesn’t cover heart disease. An example of the second problem occurred last week on Sept. 9. I extracted 6 teeth--3 surgically with osseous recontarining for which my normal fee is $396.00, an extremely low fee for what was done. My reimbursement will be $72.00--only 18% of my fee. Unfortunately, my overhead is about 70%--before I get paid.

Most important thing is to increase dds participation to share the lead. Systems must be made less cumbersome and financial penalty of participation must be relieved to attract more dentists. I and others are willing to do our share any shoulder some of the responsibility, but cannot carry whole program.

You now probably need to go to a managed care type of treatment.

We do not take Medicaid anymore. There were too many problems receiving payments and with patients keeping their appointments.

Our office has a predentist who sees most young patients. My practice is oriented to adults for reconstructive and implant dentistry. I hope a fair system can be implemented. But I would not make any changes to accept Medicaid patients.

The MCT program has not come to our area yet. I plan to stop seeing Medicaid patients when it does. I do a lot of dental rehab cases at the hospital, and understand that MCT will do this service. I have no intention of trying to do 8-20 chromesteel crowns and pupatomies on a young patients in the office setting under local anesthetic! I have no idea where these children are going to get proper dental treatment. By the way, you can use my name. I don’t mind telling anybody how I feel!

1) Horrible reimbursement! 2) The quality of the patients, overall, are poor quality patients they are uneducated, lack personal responsibility and not the type of patient I want in my practice. However I do see children because I feel sorry for these children of parents who are unwilling or unable to provide for them! 3) I know deep down, it’s never going to change! No matter what dentists, politicians, or patients say we want.

1) Many patients are not wanting care only relief of pain.
The current program is inadequate for its targeted patient population. Generally, Medicaid patients present with enormous dental needs. Chronic gum disease and rampant carries due to poor oral hygiene define logic. If you were poor and couldn’t afford comprehensive dental treatment would you not spend extra time on brushing and flossing to prevent dental disease? Patient disrespect in the form of failed appointments, body odor, etc causes many dentists to not participate.

Public health clinics would be the way to go. Medicaid was maddening from all aspects--patients were unreliable, many didn’t bathe before coming, they offended paying patients--fees were ridiculously low and payments were denied for reasons that should not have been. Just support the free clinics that are in existence. Then you would eliminate most of the paperwork jungle.

Lower social economic strata patients tend to refer others from the lower economic strata.

The good side of this system is that many children can get quality care. The down side is the level of reimbursement. It costs me 12% of my usual and customary fee to treat these kids. It would be nice to get at least a tax credit for these monies I invest in these kids. Life is interesting.

As former Medicaid providing dentist, I think if you have 100% reimbursement for fees, especially in rural areas like medical doctors receive dentists would take care of the low income patients.

I was only dentist seeing med patients on a limited basis? Other dentist and patients found out and swamped me and my office. I gave up and quit.

Most Medicaid patients don’t show up for their appointments and have no phone so you can’t get in touch with them. This messes up your whole schedule. If I took all the Medicaid patients, it would leave no room for my other insurance patients that pay the amount charged. I have counties where no dentists take Medicaid. This is why I no longer take new Medicaid patients. The fees paid by Medicaid don’t cover the time spent on the patient.

The Missouri Dental Association should be consulted about this program, and patient should be encouraged to contact their legislature about the reimbursement level. When office overhead is at least 65%, it is better to provide low income patients gratis dental work.

I have accepted Medicaid patients for the past 25 years. We now no longer accept them because the fees are now less than 25% of regular fees. I will not accept a managed care system I am willing to accept new patients if fees are set at 70% of usual and customary for our area.

My perception of the problem: A large percentage of the participants presently are a) irresponsible b) brain dead or c) slackers, or a combination of the above. They do not value the services even when they get them for free; They place little value on my time. The reimbursement rate is stupid can’t even cover my overhead at present rate; people who process the claims are frequently sloppy, yet we get payment withheld or audited for their mistakes. It is difficult to determine who is eligible at the time of service frequently we have been denied payment. I can’t think of anything about the program that makes working in it joyful or satisfying!

Medicaid program needs a complete overhaul with increased fees. Capitation should never enter the Medicaid system.

I appreciate the opportunity to address this issue. There seems to be a lack of appreciation, both from the Division of Family Services (DFS) and their recipients. Not keeping their appointments is one but there are several. It also disturbs me that with food stamps they can buy all kinds of junk food that contributes to poor dental and medical health. I believe an overall review by the dental profession and DFS will be most helpful concerning dental charges. I feel the minimum that DFS should pay would be our overhead. It disturbed me when I did except Medicaid that I had to take money out of my pocket because what DFS paid did not cover my overhead.
It’s simple economics, either raise the fees or hire a salaried dentists to staff “Medicaid Clinics” where overhead profit are not a concern. Thank you for trying to help the children in need.

Medicaid is not insurance however if it were run as an insurance program allowing offices to charge what the system does not pay, then it would drastically improve. The program should have a sliding scale, paying 100% of UCR for some and less for others, but allow the offices to collect the remainder. In question 10 is are low income and Medicaid the same?

Fees to low, paper work difficult, trying to communicate with Medicaid provider nearly impossible poor patient compliance the systems is a mess and needs new ideas, a better system and better administration. I quit seeing Medicaid patients 2 years ago thank goodness.

I’m very disappointed that the Medicaid program has been turned over to MCT. If fees had been raised, there would have been more dentist participation. Now fees have been raised some and the administrative costs of the managing firms will receive the increases, not the providers. I have stayed in the program only because of loyalty to some patients, but I don’t want to work for a managed care firm.

I have 65 - 70% overhead. How can I treat patients at less than 50% of my fees? If forced to provide treatment for these patients, I would be better off just writing the state a check and not do it!!! I would prefer the state to set up a clinic for these patients and I would donate 1 day a month of my services in their office.

My decision to stop seeing Medicaid patients was three fold. 1 Low fees would not cover fixed cost and it took forever to get paid. 2 Would not allow reimbursement for comprehensive procedures i.e.; broken appointments very low value on dental treatment. I saw a great deal of Medicaid patients for 11 years. Provided several hundred nursing bottle and pediatric patient rehabilitation both in the office and in our local hospital. Most of the time the patients never bring the children back for follow up (positive care) we frequently see them when the process was ran past again.

Paperwork excessive. Medicaid patients tend to not show up, thus taking the time of patients that do show up.

At current reimbursement and paperwork, there is no way I would return to Medicaid.

Any type of Medicaid program would not be able to allow true comprehensive care. By its very nature it must be limited to treating pain and infection and basic services. It is therefore unrewarding from a professional standpoint. Perhaps public health clinics would be a more cost effective way to serve this need.

I would consider accepting a fee for service Medicaid program, but the levels of reimbursement need to be much higher. Also, there needs to be allowances for tax of some of these children in the O. R. Too many of them are under 5 years and have extensive decay. Too much to treat with quadrant dentistry. There is an extreme need for a Medicaid accepting dentist in my area. Also, I would like to limit the number, kind of patients I accept. For example, mentally retarded adults or children under 12 years.

There are many ideas that would improve the Medicaid program. It really depends on your goals before you chose one or more new plans. Is it more participating dentists or more care to more recipients. One does not necessarily follow the other. I would enjoy discussing the different options with you at length my phone number is XXX.

Our best “show record” was when the headstart program came as a group, on the headstart bus. Also when we decided no to see general population patients and only see nursing home patients we were overwhelmed with calls for service to general population. So we had to stop all Medicaid treatment which was very unfortunate for our county and community.

Don’t see why in this age of computers, benefits can’t be customized to allow “x” dollars or coverage for Medicaid families; declining with income. As income increases at least some benefits are still allowed. In the past I have dealt with families who are simply better off to not work and take government programs. That is ridiculous.
State of Missouri can treat participating dentist as a criminal driving him out of the program. Medicaid is a donation to humanity. Medicaid penalizes the doctor for trying to help others. I do not see Medicaid due to poor treatment. I do not want to do any business with the state of Missouri.

The problem with any survey is the interlinear. We do participate I do feel an ethical and moral mission to take care of those in need. I don’t want it to become more than 25% of our practice so we do have a “short call” list except for emergencies. I react to the word managed care in a negative way. I consider Medicaid in the present form a PPO and this is the only one we do or will work with. I handle patients insurance but am not a participating dentist. I would not work with a managed care group other than a exclusivity with welfare.

Fees extremely low. We don’t know if the patient will be covered for the appointment set up 1-2 weeks ahead. They want us to buy the cord snipe mech and then pay $50.00 every time we use it in order to lose money. They have said we were overpaid!! and then withhold payment from claims sent. The codes are different etc, etc, etc. Not worth the hassle and the kids suffer.

I think we can do better in the state of Missouri in providing care under the Medicaid program. Over the past 26 years of dental practice, I have treated indigent patients for over half of those years, sometimes receiving little or no payment. Can other dentists in this state say that?

The Medicaid program needs to be monitored a lot better than it has been in the past.

Remove adults from Medicaid. See that only those needing Medicaid use program (not those that may qualify!) Make fees that will properly reward those willing to take on the increase burden of Medicaid patients i.e. paperwork, broken appts.

It would be best to treat Medicaid in clinics set up for that purpose. Their needs are different than typical fee for service patients and the two don’t mix.

There came a point where I could no longer even break even seeing Medicaid, and I refuse to go to assembly-line dentistry. Food stamps pay the grocer in full, HUD pays more than a rental is worth, MD’s seem to get a fair reimbursement, why does Medicaid except dentists to not only receive no compensation for their work, but actually pull money out of their own pockets to provide for a population segments dental care?

If the fees were changed to at least cover the overhead expenses or some other form of compensation was in place maybe more dentist would help with the large volume of patients on the program. It would not be a burden for anyone if everyone would participate in the private sector. Our office has not closed our books to all Medicaid because I feel it is a responsibility to try and help those less fortunate i.e.: The children and disabled.

I hope this helps! No one in my area accepts Medicaid except a few. It’s an ethical and business dilemma. All fees have stayed same or gone down since I started in 1977.

Low fees broken appointments, slow payments, and hassles from the paper handlers makes participation in this program both a financial drain and a real headache. Even if the patient does not foil appointments, the cost of providing care is greater than the fees allowing those wise people in Jefferson City.

Increase fees to level or even close to level of private pay patients at least raise fees to level to cover overhead expenses. Most offices range fees 50-70% overhead. Seems like Medicaid reimbursement at approximately 35%.

I would be more interested in participating if I felt all participants were equally committed state, providers, patients.

The fee structure is too low. A dentist feels he has to be almost foolish to do the procedures needed for fees which force a dentist to actually lose money. When overhead is 65% and fees are paid at 27 cents on the dollar, you lose money. The program has ignored the needs of dentists for twenty years.
Ridiculously low reimbursement rates, why should I treat these patients at a loss when I can’t see all the patients that want to pay cash?

if to become successful our legislative leaders must include dentistry important in primary health care and not look at dentistry as a non-essential service. Reimbursement must become usual customary fee amounts (at least to 90th percentile), no questions, no exceptions no denied claims this will never happen. So the ridiculous state of the program is a joke (a bad joke). Dentists resent some clerk of some company handling claims making decisions, about our work and reimbursement.

Sometimes claims are slowly processed do to government bureaucracy. Raise fees and pay them!

Imagine a dentist who treated only Medicaid patients. In order to earn a reasonable income, he would accept any Medicaid patient; provide exams, x-rays and prophys. Triple book appointments to account for failed appointments. Then, refuse treatment except for emergency extractions. Eventually, he could afford to employ a denturist.

Medicaid fees are so low patients were treated at a loss. Broken appointments would frequently sabotage a complete morning or afternoon scheduling. Administration of the Medicaid program was poorly done, i.e. slow to pay and not responsive when problems occurred.

I feel I had to quit accepting Medicaid due to over demand and very poor reimbursement. I simply couldn’t afford it. It restricted my time for people who wanted my services. They routinely broke appointments. I received calls from area ladies I never heard of. I was about the only dentist in the area for 15 years. I decided it was someone else’s turn. I wanted to treat my other patients fairly. To spend 2 hours surgically extracting a molar on a known drug addict and receive $12.00 wasn’t fair. I also had many repairs where the patients fee ran more than reimbursements.

Fees barely cover cost need to increase. Need to decrease complexity of paperwork and need fewer rules and regulations.

Very low pay less than 35% our ucr. They have their own bizarre codes-non ADA. They don’t accept ADA forms from our computer.

I have retired 7-31-98. I treated many Medicaid patients. $50,000.00 paid to me by staff each past 2 years. I did this only because my wife and I were the total office staff. Low Medicaid fees and broken appointments without reimbursement are the reasons fee for service won’t work. Pay all staff a salary in state operated clinics.

The one biggest problem with MO Medicaid besides their Medieval fee schedule is the fact that you can never, ever, talk to a living person in their central office. Their phone has been busy for 10 years.

The number one problem with Medicaid is the low reimbursement levels which, financially speaking, makes it very hard to treat additional Medicaid patients at a high level of quality.

The dental program does not have the dental Medicaid patient in mind when it decides what is best. Dentists are not going to participate in the program when fees are below overhead costs and paperwork and regulations are too extensive. The only dentists that participate are the ones that submit charges which enable them to survive.

I accept Medicaid for children only new patients up to age 12 existing patient up to age 16. Biggest problems 1 low fees. Broken appointments. I have to schedule Missouri patients like “cattle” to compensate for broken appointments the kids are great and need care otherwise I’d not put up with the hassle. Hospital care is a God-send for large cases on young kids. Do not delete hospital coverage.
Medicaid reimburses at a level less than my overhead. I dropped Medicaid because each I treated actually cost me money. When I was seeing Medicaid patients they would go thru the phone book and get non-participators. When they got to me they made appointments. Medicaid almost bankrupt me!

Some form of increased reimbursement level is needed for more participation by dentists; possibly some form of loan forgiveness for participating dentists would be considered.

This is a serious problem in our area. We get numerous calls daily requesting Medicaid treatment. When your practice is busy with insurance and self-pay patients, it is hard to justify accepting Medicaid. This leads me to believe that the only answer to increase reimbursement significantly, this would only entice those practices doing a lot of managed care programs. Maybe the increased funding would be better used to fund these public health clinics???

With the increases in pricing, we have found it helped but this office still has to double check med pat about this appointments and still we a lot time for them and they do not show up. Yet demand medication for par. Leaving other patients who want primetime appointments. Also when we call the Medicaid office and it is so bad we can’t even get someone to answer. Example. I tried for 3 days at least 10 times each day until I got there.

Why should our fees be discounted? The grocery stores do not discount food stamps. I can think of no other business or industry, except health care, that the state says this is all we are going to pay you. You cannot run a business that has a 60% overhead and accept Medicaid patients. People that are Medicaid eligible do not receive discounts on any other products or services (i.e.: gas, insurance, electricity, clothes, etc). Why should we take money out of our pockets to treat Medicaid patients?

Needs to be electronic claims as 100% of our claims to insurance are filed electronically. Past fee schedule would not ever pay our expenses. Must have higher fees or will never go back to doing Medicaid work.

I stopped seeing Missouri Medicaid patients on 12/31/97. This was due 100% to low fees my income has risen with no fee increase to my private patients. Kansas Medicaid pays me a fair fee. I see their patients on par with my private patients.

I currently see headstart kids because no one else will.

Why don’t they inform the participating dentists about the changes currently being made? When does the current Medicaid program end and the NC begin?

Fees are lousy. It’s barely break even if lucky. Paperwork, harassment by Medicaid. When fraud is perpetuated by recipient of services the patient is never pursued. Drug abuse with Medicaid patients is horrendous. The state supports drug abuse with gusto.

As a privately practicing dentist providing the highest quality of dental care possible, and utilizing the new advances in technology, I cannot afford to accept a lesser fee. The overhead of a “modern” dental practice is such that a lesser fee is the same as “going in the hole.”

I have no experience with this program and am as busy as I want to be. We are not “providers” for any pre-paid system and don’t discount our fees. No comments on Medicaid.

No dental care provider in our area accepts new Medicaid patients. People moving in and out of our area create a large block of such patients. A subsidized clinic could make a go of it in Vernon County treating only Medicaid patients.
I feel that the Medicaid program is very important, however they really need to increase the fees. The new laws that Gov. Carnahan signed (a family of 3 can make $35,000 and be approved for Medicaid if no other insurance is available will include even more families). They also need to encourage all dentists to do their fair share. Just because you have a provider number does not mean you still accept Medicaid! We feel that we are doing more than our fair share (seeing 8-10 Medicaid per day).

Poor payment. Poor paperwork.

I can’t treat Medicaid at these reimbursement levels. I lose money treating them and I am in business to not lose money!

I tried to sign up for MCT a year ago but Dorral chose no to service our area. I asked for 75% of my usual and customary fees. My overhead is 62-65% and with the increased amount of no shows you have for low income patients I figure 754% means you service these patients free of any income!

The program is out of control and I feel our governor has left a worse legacy with the new 90,000.00 plus kids adding to the Medicaid pool. I only continue to accept Medicaid because I feel sorry for the kids the payment is ludicrous, missed appointments are the norm and the patients many times capable, but unwilling to work.

Due to my student loans I do not know how much longer I can accept me patients. The state only pays me 20-30% of my fees. They consider that fair but if you don’t pay your student loans then they turn them into a collection service. They are going to have to do something like 1 credit on student loans if you accept NC. 2 Tax brake to be able to write off what is written off. The number of years I have taken me and amount of money I have written off my student loan would be paid off.

Again buerocrats cannot see the forest for the trees if you would simply increase the fee schedule where one could make a decent living. You would not have trouble with the program. Using our tax dollars to setup clinics is typical government “through money problem” but don’t get to real simple solution to problem. Increase fees.

In the fall of 1963 I had a representative of the Medicaid program from the state walk into my office, past the receptionist, into the operatory where we were treating a patient, open his briefcase and tell me where to sign and what I could charge for various procedures he did answer my question about a voluntary program. I promptly threw him from office, he has not been back!

I think most people are on Medicaid because they are too lazy to get jobs. When people get off their butts and go to work they will deserve dental treatment. We don’t treat Medicaid because they are usually dirty, smell badly, and bring 40 kids to the office. I heard one woman saying they are 3rd generation retards. Let their teeth rot.

Low fees, rejected claims for small infractions, patients not showing for appointments covers most of the problems. I think they are trying to improve, and until managed care takes over for this area, we don’t know what changes or how it’s going to be different.

Pricing not compensatory with work, i.e. $1.00 exam, $6.00 extractions. No increases in fees for 12 years. This is a disgrace.

Reimbursement levels are ridiculously low. Having to pay for a “card swiping” unit and to pay each time a user card was run through it, when I lost money on every Medicaid patient, was the last straw for me. My life got a lot easier when we got rid of Medicaid!

How can I answer experiential questions about Medicaid when I don’t take it!
I started taking Medicaid out of dental school, I felt I was making a contribution to those that needed help. After several years of the problems illuminated in this survey I would rather do services for free to needy patients, than to accommodate Medicaid. The attitude of the majority of recipients: that Medicaid is a right, is a big problem. For this, I had patients drive 60-70 miles for care, because dentists in their own county would not accept them.

I think the fees should be n/c and best answer would be publics health clinics.

There is absolutely no way adequate care can be provided for children covered with Medicaid at the present level of reimbursement. It is ridiculous.

There is a dreadful need for a system that allows dentist to treat children comprehensively and ethically with fair reimbursement. It is a total embarrassment that dentistry is reimbursed at a rate that would not even compensate the employee who has to file the stacks of paperwork involved to fill a cavity. If this system was created to actually help anyone, it wouldn’t be anything like the current system. This is a mockery, it is a front to make voters think that a system is in place that cares, it only tries to shift the blame onto the dentist who has been supplying benefits at his expense. Take time to take a look at the real system. It hasn’t changed in the 20 years I have been in practice. Get Real!

The fact you requires a survey indicates how out of touch the state is with dental health care providers. Your fees are so low that I would describe them as ridiculous insulting, and totally out of touch with reality. The state has never addressed this once and I along with the dwindling number of dentists still in the program have about had our limit. We all do our part to help the poor but there is a limit to everything. As for managed care who needs the hassle for the chump change you pay. I would quit the day that went into effect. If you can’t fund the dental program any better than you do you should simply stop this “illusion” of coverage to recipients also in reality no one will see them. The idea that you want to expand coverage to additional people when your current system is failing sounds like typical government.

Our biggest problems with the program has been low fees & broken appointments.

Resubmitting claims and claims denials were terrible when I previously accepted Medic.

I am hoping we never have a managed care program for Medicaid. I think it would be even harder to get a specialist referral. I think establishing one or two clinics to serve 10 - 15 counties is wrong. It would force low income people to drive 100 miles round trip to get their teeth cleaned. If the program can’t be made to work with local providers, the state should just forget about providing dental care.

Medicaid patients have the attitude that they are “owed” dental services and the provider never gets a “thank you” for doing usually more difficult work as a result uncooperativeness, lack of home care or taking care of dental work. As a result dental work must often be redone made more frequently than for private pay patients. In addition the Medicaid bureaucracy is adversarial toward the dentist who is making a sacrifice financially to provide the services. It make no sense!

I feel adults should be financially responsible for theirs fee. If any suggestions on Q#17 are followed in a generation we will reduced dental disease by 25% in our poor population. No body in a position to do the above has the guts to do it.

This pathetic situation has evolved over the last 20 years due to the apathy of our profession and the bureaucrats in Jefferson City. Through over efforts we were able to get the first increase in 20 years along with passed of lost for hospitalization and anesthesia for dental care for private patients. We now battle to get the increases passed through to impending met in Gulf 99 as the Medicaid patients advocate this is too little, to late. This issue will probably have to be resolved as in Texas and California.
Give us some incentive besides the so called ethical considerations. I personally would rather treat patients for free and limit the number, than being forced to lose money, and pay taxes into the Medicaid program. Give me a dollar for dollar reduction on my student loans for every dollar of Medicaid dentistry I do. My practice could stay busy 12 hrs a day seeing nothing but Medicaid patients. Why should I kill myself working tat hard for no incentive? 25% of my regular fee doesn’t even cover my overhead. Get real!!!!

I am very willing to talk with anyone about the Medicaid program. I have a son at UMKC and at KC quite often. Please feel free to call me and I will submit to an interview. XXX.

My bad experience with Medicaid goes back 9 years in dental school, when I had about 5% of my patients actually show up. Then, in private practice I saw some selective cases, quadriplegics, trauma cases. I always became frustrated with payments being denied for punctuation errors (VERY PICKY PROBLEMS!). I know kids need care, and I feel bad about that. My past experience was so frustrating that we just dropped it!

I quit Medicaid because of 1) lack of payment of submitted claims. 2) because of continual claim rejection because of t’s not crossed and I’s not dotted; and 3) because large dollar providers were paid before smaller dollar providers. I would do Medicaid if tax credits were issued for differences in Medicaid fees and my UCR fee.

With the current Medicaid fees and the time it takes to prepare a claim, the dentist cannot afford to accept Medicaid. The doctor ends up paying for the procedure out of his own pocket.

You make it too easy to be an eligible patient. They can afford tobacco and booze and movies they can pay for their dental work.

Those people receiving “free” care have much less respect than those who have to pay for it. This is what it boils down to and I think this is true of all (most) things in life. Patients would have to work to receive care in a health setting. I do...... I do feel sorry for these who are physically or mentally unable however. Solution: open state funded dental clinics which don’t have to worry so much about overhead, broken appointments.

Can not be of help with this study.

The fees need to be higher for our office to take many Medicaid patients.
APPENDIX E

LETTER 2. Pre-Notification to Dentist

LETTER 3-Dentist Survey Cover Letter

LETTER 4-Reminder Letter to Dentist
LETTER 3-Dentist Survey Cover Letter

UMKC SCHOOL OF DENTISTRY LETTERHEAD

Dr. (FNAME) (LNAME) (SUFFIX)
(ADDR1)
(ADDR2)
(CITY), (STATE)     (ZIP)

June 9, 1998

Dear Dr. (LNAME):

We are conducting a study of Missouri dentists’ participation in and attitudes toward managed care and the Medicaid (or MC+) program for the Missouri Department of Public Health. You are one of a sample of actively practicing, full-time dentists in Missouri who are being asked to participate in this study. Your experience with and perceptions of these programs are important. Even if you are not currently accepting any Medicaid (or MC+) patients, your impressions of the program are valuable.

The questionnaire should take about 10 minutes to complete. The responses you provide will be combined with the information we get from others and will never be presented on an individual basis. All the information that identifies you will be kept strictly confidential. Completion of this questionnaire does not commit you to any further participation. Records of your participation in this research will be maintained, but your name will be removed from questionnaire responses.

Please take a few minutes to complete the enclosed form. If you come to a question you do not feel comfortable answering, please skip to the next question. We appreciate your cooperation. It is important that we hear from you so that the results of this study can more accurately represent the views of Missouri dentists. Please use the enclosed self-addressed, stamped envelope to return the survey. This project does not involve any experimental procedures and does not pose any foreseeable risk to you as a participant. Additionally, completion of this questionnaire does not commit you to any further participation.

To receive a copy of the results, simply enclose a business card with your returned survey. If you have any questions, feel free to contact us toll free at 1-800-887-4477.

Sincerely,

Michael McCunniff, DDS, MS
Assistant Professor

LETTER 4-Reminder Letter to Dentist
Dear Dr. (LNAME):

**We need your help.** About a month ago, we mailed you a questionnaire as part of a study of dentists’ participation in and attitudes toward the Missouri Medicaid (MC+) dental program. This is your opportunity to share your views and suggestions with the Missouri Department of Public Health. Your experience and concerns about Medicaid (MC+) are important. We understand how busy you are with your practice, however, it is essential that policy makers in Missouri receive an accurate view of what dentists think about this program.

The questionnaire should take about *10 minutes* to complete. The responses you provide will be combined with the information we get from others and will never be presented on a individual basis. All the information that identifies you will be kept *strictly confidential*. Completion of this questionnaire does not commit you to any further participation. Records of your participation in this research will be maintained, but your name will be removed from questionnaire responses.

For the results of this study to truly represent the views of Missouri dentists, it is important that we hear from you. However, if there are any questions you do not feel comfortable completing, please skip those questions. Please take a few minutes to complete the enclosed form and return it in the enclosed self-addressed, postage-paid envelope. For a copy of the results, simply enclose a business card with your returned survey. If you have any questions, feel free to call us toll free at 1-800-887-4477.

If you have already mailed your completed questionnaire, we apologize for this inconvenience and thank you for your assistance.

Sincerely,

Michael McCunniff, DDS, MS
Assistant Professor
APPENDIX F-1

Missouri Medicaid Enrollees Survey
Please fill out this questionnaire thinking about the following child’s dental care experience with the Missouri Medicaid program:

(If you wish, you may remove the name of the child before you send back this questionnaire.)

If you have any questions or comments about this survey, please contact:

Michael McCunniff, DDS, MS, Assistant Professor
University of Missouri—Kansas City, School of Dentistry
650 E. 25th St., Kansas City, MO 64108
(800) 887-4477

INSTRUCTIONS: This questionnaire will ask about the dental care your child received or attempted to receive with the Medicaid dental program. In some parts of the state, it may be called the MC+ program. For each question, please circle or check the box next to the most appropriate response or write your response in the space provided. For the results of this study to reflect the views of Medicaid enrollees in Missouri, it is important that we hear from you. However, if you come to a question you are not comfortable answering, please skip to the next question. The information provided in this questionnaire will be kept confidential and will in no way affect your right to receive public assistance or Medicaid services. When you have completed the questionnaire, please fold and return it in the enclosed postage-paid envelope. Thank you.
MEDICAID DENTAL CARE

This survey asks about dental care for children in the Medicaid (or MC+) program. This includes dental care your child received or attempted to receive while in Medicaid.

1. Has your child ever visited a dentist?

   If not, please answer the following two questions

1–1. What is the main reason your child has not been to the dentist?
   - 1. My child is not old enough to go to the dentist
   - 2. My child doesn’t need care yet
   - 3. I couldn’t find a dentist who would see my child
   - 4. Some other reason

1–2. In the last six months, have you tried to make an appointment for your child to receive dental care?
   - 1. YES ➞ Go to question 4, page 2
   - 2. NO ➞ Go to question 9, page 4

   If yes, please answer the following three questions about your child’s last dental visit

1–3. When was your child’s last visit to the dentist?
   - 1. Within the last 6 months
   - 2. Between 6 months and one year ago
   - 3. Between one and two years ago
   - 4. More than two years ago

1–4. What was the main reason for this visit?
   - 1. Check-up and/or cleaning ➞ Go to question 1–6 below
   - 2. Emergency care
   - 3. Other (fillings, etc.)

1–5. If your child’s last visit was not for a check-up, when was your child’s last dental checkup?
   - 1. Within the last year
   - 2. Between one and two years ago
   - 3. More than two years ago

1–6. About how long did it take you to travel to your child’s last dental visit?
   - 1. 15 minutes or less
   - 2. 15 – 30 minutes
   - 3. 30 – 60 minutes
   - 4. Between 1 and 2 hours
   - 5. More than 2 hours
2. Would you describe your child as someone who (*please check only one*):
   - ☐ 1. Visits the dentist regularly (at least once per year)
   - ☐ 2. Visits the dentist occasionally
   - ☐ 3. Visits the dentist rarely or only when he or she has a problem

3. Is there one main place where you usually take your child for dental care?
   - ☐ a. NO
   - ☐ b. YES ➔ *If yes, please answer the following question*
     3–1. Where is the main place where you usually take your child for dental care?
       - ☐ 1. A private dentist’s office
       - ☐ 2. A public dental clinic
       - ☐ 3. Other (please specify)________________________

4. Do you feel that your child currently needs dental care?
   - ☐ a. NO
   - ☐ b. YES ➔ *If yes, please answer the following question*
     4–1. What type of care do you believe he or she needs (*please check all that apply*)?
       - ☐ 1. Check-up or cleaning
       - ☐ 2. A few fillings
       - ☐ 3. Many fillings
       - ☐ 4. Other (tooth pulled, etc.)________________________
5. Please check the box which shows how much, if at all, any of the following delayed or stopped your child from receiving dental care during the past year while in the Medicaid program.

<table>
<thead>
<tr>
<th></th>
<th>Did not affect my child</th>
<th>Caused a small delay</th>
<th>Caused a medium delay</th>
<th>Caused a long delay</th>
<th>Stopped my child from getting care</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I could not find a dentist who would take my child as a Medicaid patient.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. My child did not have transportation.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. I could not get off work.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. My child was afraid to go to the dentist.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. I had to travel too far to find a dentist who would see my child.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>f. I could not find a dental office with staff of a similar cultural or ethnic background to my own.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>g. I had to wait too long to get an appointment.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>h. My child would not cooperate for dental care.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

6. Please read the following statements about the dental care your child receives through your Medicaid program and circle the number which shows how strongly you agree or disagree with each statement.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I understand how to get dental care for my child through the Medicaid program.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. I have had difficulty finding a health care provider who will see Medicaid patients.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. I get clear and understandable explanations of why certain tests and procedures are necessary.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. It can be hard to get an appointment to see the dentist.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
7. Thinking about the dental care your child has received while in the Medicaid program, please tell us how you rate the following.

<table>
<thead>
<tr>
<th>How would you rate...</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Your child’s ability to get the dental care he or she needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>b. Your satisfaction with your child’s dental care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>c. The respect you receive from the dental office.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>d. The overall quality of your child’s dental care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>e. The amount of time you have to wait in the office before your child is seen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>f. Your ability to get an appointment when your child needs to be seen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

8. Has your child ever been refused dental care because he or she was on Medicaid?
   - [ ] 1. NO
   - [x] 2. YES

9. In general, how would you rate your child’s dental health?
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] 5
   - [ ] 0

10. What is your relationship to the child who received this survey?
   - [ ] 1. I am the parent of the child this survey was addressed to
   - [ ] 2. I am another person related to the child (e.g., grandparent, aunt, uncle)
     Please specify relationship ________________________________
   - [ ] 3. I am the child this survey was addressed to
   - [ ] 4. I am another person not related to the child (e.g., guardian, friend, social worker)
     Please specify ________________________________

11. What is your age now? ______

12. What is the highest grade or level of school that you have completed?
   - [ ] 1. 8th grade or less
   - [ ] 2. Some high school but did not graduate
   - [ ] 3. High school graduate or GED
   - [ ] 4. Some college
   - [ ] 5. 2-year college graduate
   - [ ] 6. 4-year college graduate
   - [ ] 7. More than 4-year college degree
13. How many months or years in a row has your child been covered by Medicaid?
   - 1. Less than 6 months
   - 2. 6 to 11 months
   - 3. 12 to 23 months
   - 4. 2-5 years
   - 5. 5 to 10 years
   - 6. More than 10 years

14. Please tell us if there is anything else you like or dislike about the Medicaid dental program.

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   __________________________________________________________

   Thank you for completing this questionnaire. Please fold the questionnaire and return it to us in the envelope provided (no stamp required).
APPENDIX F-2

Comments from Missouri Medicaid Enrollees Survey
APPENDIX G

LETTER 5-Pre-Notification to Medicaid Enrollees

LETTER 6-Instructions Sent with Survey to Medicaid Enrollees

LETTER 7-Reminder Letter to Medicaid Enrollees
 LETTER 5-Pre-Notification to Medicaid Enrollees

UMKC SCHOOL OF DENTISTRY LETTERHEAD

Date
fname lname
add1
add2
city state zip

Dear (Salut) (Lname):

At our request, the University of Missouri Kansas City (UMKC) School of Dentistry will be conducting a study about the dental care Missouri Medicaid and MC+ enrollees receive. As part of this study, you have been selected to tell us about the dental care you have received while in the Medicaid or MC+ program. You should receive a questionnaire within the next week. The purpose of this study is to learn how satisfied Medicaid enrollees are with the dental care they receive. This is your opportunity to help us serve you better.

We would appreciate if you would take the time to fill out the questionnaire. You have been chosen as part of a sample of all Medicaid and MC+ enrollees in Missouri. The accuracy of the results depends on getting answers from you and other people selected for this survey.

The responses you provide will go directly to the UMKC School of Dentistry and will be combined with the information received from others. Your individual answers will never be shown. All information that identifies you will be strictly confidential. The number on the study is used only to track who has responded to the survey so that a second survey can be mailed if necessary.

Your help is voluntary and your Medicaid or MC+ benefits will not be affected in any way, whether or not you choose to participate.

We hope you will take the opportunity to fill out this questionnaire. Your knowledge and experiences can help us provide the best dental care possible. If you have any questions, please call the UMKC School of Dentistry toll-free at 1 (800) 887 4477. Thank you in advance for your help!

Sincerely,

Michael McCunniff, DDS
Dean Perkins, DDS
LETTER 6-Instructions Sent with Survey to Medicaid Enrollees

UMKC SCHOOL OF DENTISTRY LETTERHEAD

Date
Parent or Guardian of:
FIRST~ M~ LAST~
ADDR1~
ADDR2~
CS~ Z~

Dear Parent or Guardian of TITLE~ LAST~:

We would like to invite your help with a study of the dental care children receive through the Missouri Medicaid or MC+ program. We would appreciate you taking some time today to complete this questionnaire. Your knowledge and experience are important in order to help your child and other children receive the best dental care possible.

The results of this study will be used to provide policy makers with feedback about how well your child’s current Medicaid or MC+ program is meeting his or her needs. In order for the results of this study to truly represent the views of all Medicaid enrollees, it is important that we hear from you. If you come to a question you do not feel comfortable answering, please skip to the next question.

We received your child’s name from the Department of Social Services as part of a list of Medicaid enrollees; however, your individual responses to this survey will not be shared with the Department or your child’s dentist. The responses you provide will be combined with the information we get from others. All the information that identifies your child will be kept strictly confidential. Your individual answers will never be shown. Your help is voluntary; you have no legal obligation to respond to the survey. Your child’s Medicaid benefits will not be affected in any way, regardless of your responses or whether you choose to fill out this survey.

Please consider only the child whose name appears on this letter and the child’s current Medicaid program when answering the survey questions. If the child is between the ages of 15 and 17 and you feel it is appropriate, please have the child complete the questionnaire for him or herself.

Please use the enclosed, self-addressed, postage-paid envelope to return the survey. If you have any questions, call us toll free at 1-800-887-4477. Thank you in advance for filling out this questionnaire.

Respectfully,

Michael McCunniff, DDS, MS
Assistant Professor
LETTER 7-Reminder Letter to Medicaid Enrollees

UMKC SCHOOL OF DENTISTRY LETTERHEAD

Date
Parent or Guardian of:
FIRST~ M~ LAST~
ADDR1~
CS~   Z~

Dear Parent or Guardian of TITLE~ LAST~:

We need your help! Last month, we mailed you a questionnaire about the dental care your child has received while in his/her current Medicaid or MC+ program. If your have not yet completed the questionnaire, please take some time today to complete it. If you feel this survey does not apply to your child, or if you have any questions, please call us toll-free at 1-800-887-4477.

The responses you provide will be combined with the information we get from others. Your individual answers will never be shown. All the information that identifies your child will be kept strictly confidential. We received your child’s name from the Department of Social Services as part of a list of Medicaid enrollees; however, your individual responses to this survey will not be shared with the Department or your child’s dentist. Your help is voluntary; you have no legal obligation to respond to the survey. Your child’s Medicaid benefits will not be affected in any way, regardless of your responses or whether you choose to fill out this survey.

In order for the results of this study to truly represent the views of all enrollees, it is important that we hear from you. However, if you come to a question you do not feel comfortable answering please skip to the next question.

Please consider only the child whose name appears on this letter and that child’s current Medicaid program when answering the survey questions. If the child is 15–17 years old and you feel it is appropriate, please have the child complete the questionnaire for him/herself.

Please use the enclosed, self-addressed, postage-paid envelope to return the questionnaire. Your knowledge and experience are important in order to help your child and other children receive the best dental care possible. We sincerely appreciate your assistance.

If you have already mailed your completed questionnaire, we apologize for this letter and thank you for your help.

Respectfully,
Michael McCunniff, DDS, MS
APPENDIX H

Focus Group Summaries

Consumer Focus Groups

Kansas City  
Columbia  
Kirksville  
Maryville  
Springfield  
Cape Girardeau  
St. Louis

Provider Focus Groups

Kansas City  
Columbia  
Springfield  
St. Louis
APPENDIX H-1

Focus Group Summaries

Consumer Focus Groups

Kansas City—August 18, 1998

1. Have you ever experienced any problems in finding a dentist who accepts Medicaid?

Focus group members said that it is not difficult to find a dentist who accepts Medicaid. It is accepted at Children’s Mercy, Swope Parkway and Rogers Health Center. There are also several private dentists who will accept it. Interestingly, none of the members were aware that the UMKC School of Dentistry was a Medicaid provider.

Consumers do have problems in getting the dentist of their choice. Or, maintaining the dentist of their choice when their economic circumstances deteriorate and they need Medicaid. Their private dentist may tell them that they will not accept Medicaid.

2. Have you ever had to wait a long time to get an appointment?

This is a problem. According to focus group members, it takes at least 1 to 2 months to get an appointment.

If there is an emergency, dental providers will try to fit the patient in right away, but they will only treat the emergency; they will not treat any of the patient’s other needs.

3. Has transportation or travel time ever been a problem?

Transportation has not been a problem for any of the focus group participants. They suggested that most people have private transportation and there’s public transportation, if needed. Swope Parkway Health Center, moreover, operates vans.

4. When you or your child did see dentist as a Medicaid patient, were you treated with respect?

Focus group members said they were usually treated with respect, but not always. Several complained of being treated rudely by office staff.

Participants said they sometimes feel they’re being treated differently, like second-class citizens, not entitled to the same quality of care as other people.

But, as one member put it, “no one’s ever done anything to offend me.”

5. Was the quality of care and service what you expected?

Focus group members recognize that there are limits on what the dentists can do under Medicaid. “It prevents them from giving you everything you need.”
Often, the dentist will recommend procedures that Medicaid doesn’t cover. If the patient wants to get the work done, they will have to find some other way to pay for it, which proves to be difficult (or impossible) at times.

Focus group members complained that when dentists perform a restoration or replace a tooth under Medicaid, they use inexpensive materials, which meet the need, perhaps, but are esthetically unpleasing. Medicaid does not pay for “cosmetic work.”

One member complained bitterly that she was unable to have a crown placed on an endodontically-restored tooth. “Caps for a root canal are not paid for.”

6. On the whole, how good of a job would you say Medicaid is doing in meeting your family’s dental needs?

The general sentiment of the group was, “It’s better than nothing.”

Members said, however, that a great deal of need goes unmet. Especially, in the areas education and prevention. They indicated that they would like their dentists to spend more time with them, explain procedures more fully and demonstrate effective self-care practices.

7. Is there anything you would care to recommend to improve Medicaid dental care?

Focus group members made the following suggestions:

- Expand the number of providers.
- Expand the services covered and the options the patient has.
- Strengthen education activities, especially for children.
- Expand preventive care.
- Reduce the time it takes to get an appointment.
- Improve procedures for authorizing emergency treatment — if a patient gets emergency treatment without an authorization, they have to pay for it.
- Provide better coverage for adults; emergency care is about all it pays for.

8. Are there other issues or problems with Medicaid dental care that we have not yet discussed? Something we overlooked?

N/A
1. Have you ever experienced any problems in finding a dentist who accepts Medicaid?

Until recently, it was impossible to find a dentist in Mid-Missouri who would accept new patients over the age of 21. If a patient wanted to see a dentist, they had to travel to either St. Louis or Kansas City.

Private dentists in the area quit accepting new patients a couple of years ago, about the time that Medicaid started its managed care program. Focus group members did not know whether managed care drove them out, or whether the managed care program was started in response to their leaving.

For the first couple years, the Parkade Center (Mid-Missouri Dental Care) would only serve children. It has now agreed to take adults and is planning to open a new office in Jefferson City. It is the only dental provider in the 8-county area accepting new Medicaid patients at this time.

2. Have you ever had to wait a long time to get an appointment?

Focus group members said that it was very difficult to get an appointment. Until recently, it had been nearly impossible for adults. Now that the Parkade Center will take them, however, it is possible, but it takes a long time to get an appointment.

Focus group members said it had taken them three to five months to get an appointment.

Even emergency cases are difficult. Patients are instructed to see their medical doctors for antibiotics for abscesses or infections, as their first line of attack. If there is persistent pain, and the patient is also persistent, and there are cancellations, the patient can normally be seen without too much delay.

Members said that the clinic is simply bombarded with patients, and there are not enough providers to handle the needs of everyone seeking care.

3. Has transportation or travel time ever been a problem?

In the Columbia area, transportation is a manageable problem. Most people have private transportation and the Clinic is supposed to provide it, if they do not.
If the patient needs to travel outside the area, transportation can be a serious problem. Previously, when St. Louis and Kansas City were the only alternatives for adult patients, transportation proved to be major barrier to accessing care.

4. When you or your child did see dentist as a Medicaid patient, were you treated with respect?

Focus group members expressed no complaints about the way they were treated once an appointment was established. Their satisfaction was muted, however, by the difficulty of gaining the appointment. Typical of their comments.

“They were very nice, once you get in there. But it’s like pulling teeth to get in.”

5. Was the quality of care and service what you expected?

Focus group members felt similarly about the quality of care and service. They agreed that the care they received was excellent.

Several members said that the care was especially good for children. The dentists and their assistants (including hygienists) communicate very well with the children. They explain what they’re going to do, ease fears and educate. They placed sealants on to protect against cavities.

Sometimes, unfortunately, the Center will cancel scheduled appointments in order to take advantage of the availability of an oral surgeon. According to focus group members, the surgeon will call and say he has some time and the office will try to get as many people in to see him as possible.

On the complaint side, a common lament was as follows, “You can only get in there about once a year. And then if you need another appointment, you have to wait another four months.”

6. On the whole, how good of a job would you say Medicaid is doing in meeting your family’s dental needs?

Focus group members expressed great disappointment in the operation of the program. Typical remarks:

“It’s a good plan and if you can get in to see the dentist, they do a good job.”

“They pay. And that’s better than nothing.”

“It’s good care. It’s just hard to get.”

7. Is there anything you would care to recommend to improve Medicaid dental care?
Members had several recommendations:

Expand the number of providers and service options.
Shorten the time it takes to get an appointment.
Add more prevention and education activities. “The dentists and their assistants are so busy that they don’t get to spend as much time with you as you need in the prevention and education areas.”

8. Are there other issues or problems with Medicaid dental care that we have not yet discussed? Something we overlooked?
APPENDIX H-3

Focus Group Summaries

Consumer Focus Groups

Kirksville — August 20, 1998

1. Have you ever experienced any problems in finding a dentist who accepts Medicaid?

   Focus group members said that this was extremely difficult. Only two dentists in the five-county area will take it. (And one of these only works part-time.)

   A third dentist has agreed to provide sealants to Head Start children.

   Sealants (for 2nd graders) have also been offered through the public schools.

2. Have you ever had to wait a long time to get an appointment?

   Focus group members said it usually takes one to two months to get an appointment, and it’s the same for children as adults.

   In the case of emergencies — especially bad toothaches, for example — a patient can generally get in quickly. But only the emergency is treated.

3. Has transportation or travel time ever been a problem?

   This is a problem for people living in the rural areas, who lack a reliable source of private transportation. Public alternatives are generally not available.

   Head Start will provide transportation to its students; their problems begin, however, when they graduate and are, therefore, no longer eligible for Head Start’s help.

4. When you or your child did see dentist as a Medicaid patient, were you treated with respect?

   Focus group members complained of some bad experiences. They said both the dentists and their assistants are sometimes pretty rude.

   And communication is poor. As one member put it, “I want to know what the problem is, what my options are and what all’s involved. They don’t always explain these things to you.”

   Scheduling is also a problem. Sometimes, the dentists have too many people show up at once. “Then, they have to rush through appointments or send people home.”
5. Was the quality of care and service what you expected?

Focus group members said that the quality of care they receive is good.

There were some complaints about fear, however. Focus group members said that the dentists are not doing enough to make people feel comfortable about getting the work done.

They also complained that the dentist sometimes recommends care that Medicaid won’t pay for.

6. On the whole, how good of a job would you say Medicaid is doing in meeting your family’s dental needs?

Focus group members were not satisfied with the performance of the Medicaid Program in meeting their family’s dental needs, and access was identified as the main problem. The prevailing sentiment was that if you can get the care, it’s pretty good. But it’s not easy to get the care you need.

They expressed concern that some area doctors — orthodontists, for example — would not accept Medicaid. So, as one member expressed it, “you can’t get any orthodontic care for your kids unless you’re willing to drive quite a distance to get it.”

7. Is there anything you would care to recommend to improve Medicaid dental care?

Focus group members made three recommendations.

Expand the number of dentists.
Reduce waiting times for an appointment.
Pay the dentist more so they feel better about taking Medicaid.

8. Are there other issues or problems with Medicaid dental care that we have not yet discussed? Something we overlooked?

“There’s not enough dentists to take care of Medicaid patients now. What’s going to happen when the new Medicaid expansion (the Children’s Health Insurance Program) comes?”
1. Have you ever experienced any problems in finding a dentist who accepts Medicaid?

Focus group members said that within the past three years the number of dentists providing Medicaid care had diminished.

“Up until this past week there were two. There is now only one dentist in the five-county area who is taking new Medicaid patients. And his approach is very abrupt”

There are no area dentists who provide pediatric dental care. For that, it is necessary to travel to Children’s Mercy Hospital, 100 miles away.

2. Have you ever had to wait a long time to get an appointment?

Focus group members said that it is not difficult to get in at Children’s Mercy Hospital. The average wait is 30 to 60 days.

It is very difficult to get in to see a dentist in Maryville.

3. Has transportation or travel time ever been a problem?

Focus group members said that transportation is a very serious problem.

A patient must have private transportation. Either their own or a friend’s or family members’.

Some of the churches also provide assistance.

4. When you or your child did see dentist as a Medicaid patient, were you treated with respect?

Focus group members said that there is an assumption among dentists and their and office staff that Medicaid patients are unreliable. And patients are treated that way.

Several complained that the one dentist who is still taking new patients is abrupt and hurried in his approach; as though he was eager to be through.

Members agreed that Medicaid patients are treated differently than other patients.
5. Was the quality of care and service what you expected?

For many in the group, the quality of care was less than expected. The dentist did not communicate well. They felt uninformed and poorly served.

One member complained that “the doctors like to pull teeth. And they do so without providing pain pills or antibiotics.”

One member said that if the patient was willing to travel to Liberty or Gladstone, the quality of care there was very good. She said it justified the trip.

6. On the whole, how good of a job would you say Medicaid is doing in meeting your family’s dental needs?

The consensus — not good.

Access is the problem. Patients cannot easily find a dentist who will treat them. Those who will are overworked and overburdened.

Other complaints dealt with the limitations on services. Members were concerned that Medicaid wouldn’t provide braces or cosmetic services.

7. Is there anything you would care to recommend to improve Medicaid dental care?

Focus group members had several suggestions:

Pay dentists better.

Provide tax incentives to dentists who accept Medicaid.

Increase the number of providers.

Invest in dental hygiene. At Head Start, 10% to 15% of the children enrolled have serious dental problems, which cause pain and affect their appetite, nutrition, general health and ability to learn.

Encourage dental providers to communicate more effectively with patients, explain procedures, outcomes and preventive measures.

8. Are there other issues or problems with Medicaid dental care that we have not yet discussed? Something we overlooked?

N/A
Focus Group Summaries
Consumer Focus Groups
Springfield — August 26, 1998

1. Have you ever experienced any problems in finding a dentist who accepts Medicaid?

Focus group members agreed that it is very difficult to find a dentist who will accept Medicaid in Springfield. It is particularly difficult to find a dentist for children.

Typical comments included the following:

I live in Greenfield and there is only one dentist there. He doesn’t take Medicaid so we have to drive the children 25 miles to see a dentist who will.

There’s just a couple of dentists here who will take Medicaid here, and one, who will only take them with a doctor’s referral.

When my kids went on Medicaid, it was hard to find a dentist who would see them. And when you did, you had to wait three to four months to get an appointment.

My daughter is on Medicaid. I went through hell to find a dentist who would take Medicaid, and once I found one, he was pretty much worthless. And then I had to get a doctor’s referral to get her in to see a dentist and it took months. And she still has a cavity that hasn’t been taken care of even yet.

I could have never afforded to take my child to the dentist if it wasn’t for Medicaid. But my child’s Head Start teacher had to beg the dentist to let her in or he never would have taken her otherwise.

My daughter’s four and she’s never been to the dentist. I haven’t been able to find one who’s taking new Medicaid patients.

2. Have you ever had to wait a long time to get an appointment?

Focus group members said that it took three to six months to get an appointment.

In the case of emergencies, patients may be seen sooner. According to focus group members, however, the patient must first obtain a referral from a medical doctor verifying that they have an acute need.
But even this is no guarantee. One member gave this account, “I had a friend with three children who had baby teeth and other teeth coming in at the same time. Even with a doctor’s referral, she had to cry on the phone with a dentist to get in.”

If the patient is able to get an appointment, they cannot count on getting additional appointments with that dentist, only emergency treatment.

Members indicated that area dentists were also very strict with Medicaid patients, and have been known to cancel appointments when the patients are five minutes late.

3. Has transportation or travel time ever been a problem?

Focus group members said that generally transportation was not a problem.

However, there are no orthodontists in the area who will accept Medicaid. Patients must either travel to either Joplin or Rolla and this can be problematical.

4. When you or your child did see dentist as a Medicaid patient, were you treated with respect?

Focus group members described a variety of situations. Most were treated with respect, most of the time. “I was very happy. They treated me with respect; they treated me like any other patient.”

But there were exceptions — rude dentists, rude staff, dirty offices. “I went to one office that was extremely dirty. I was told by an assistant that if I was offended by it, I could go elsewhere.”

5. Was the quality of care and service what you expected?

Focus group members said that the quality of care was generally very good.

Typical comments:

The dentist communicated well, explained what they were doing, and demonstrated how to brush and floss.

They did a good job on preventive care and education.
6. On the whole, how good of a job would you say Medicaid is doing in meeting your family’s dental needs?

   There was firm agreement among focus group members that the program was not performing adequately.

   As one member out it, “It’s not doing a good job if you can’t find a dentist.”

   A second member shared this experience that summarizes her feeling for the program. “A couple of years ago I found a dentist who would take Medicaid. A year later, he was arrested for doing meth-amphetamines. And that’s all Medicaid had to offer.”

7. Is there anything you would care to recommend to improve Medicaid dental care?

   Focus group members had several suggestions for improving Medicaid’s performance.

   Get more doctors who will take Medicaid.

   Mandate that all dentists take a certain % of persons on Medicaid.

   Raise reimbursement fees so that dentist’s receive as much for treating Medicaid patients as they do for other patients.

   The state should employ dentists just to see Medicaid patients.

   They need to improve the emergency system. “It has to be made easier for patients with emergencies to get in to a dentist. My daughter had bottle mouth and it took four months to get an appointment.”

   They should offer tax incentives to dentists who take Medicaid patients.

   They should do a better job of monitoring dentists who take Medicaid.

   There should be a central place to call to find a dentist.

8. Are there other issues or problems with Medicaid dental care that we have not yet discussed? Something we overlooked?

    N/A
APPENDIX H-6
Focus Group Summaries
Consumer Focus Groups
Cape Girardeau—August 27, 1998

1. Have you ever experienced any problems in finding a dentist who accepts Medicaid?

Finding a dentist in the Cape Girardeau area who accepts Medicaid is very difficult. Consumers spend countless hours calling around in vain looking for an appointment. One focus member said she called twelve different dentists seeking an appointment and was refused by all.

The local AFDC Office is no help. Focus group members indicated that they have called and asked for a listing of participating Medicaid dentists, but were told that none was available.

The only recourse available to the consumer is to call dentist after dentist until one agrees to see them. Oftentimes, the consumer is forced to settle for a position on a waiting list that is four to five months long.

According to focus group members, there is only one dentist in the phone book will accept Medicaid.

2. Have you ever had to wait a long time to get an appointment?

Waiting times vary from 3-4 weeks to 2-3 months to 4-5 months depending on the patient’s relationship with the dentist and his/her needs.

If the patient has an emergency, it is possible to speed things up. Those in pain can usually be seen fairly quickly. Those with an established relationship with a dentist can get right in. Those without an established relationship must go first to a physician, usually at a hospital emergency room, have their problem diagnosed and get the physician to give them a referral before a dentist will see them. At that point, the patient can be seen quickly.

For routine visits, patients without an established relationship are usually put you on a waiting list and called if there’s a cancellation. If the patient does not have a phone, they’re out of luck.

According to focus group members, it’s somewhat (but not much) easier to get in to see a pedodontist. Orthodontists are impossible.
3. Has transportation or travel time ever been a problem?

Transportation is a big problem, especially for persons living in rural areas. There is no public transportation or taxi service.

4. When you or your child did see dentist as a Medicaid patient, were you treated with respect?

Focus group members indicated that for the most part the dentists (who treat Medicaid patients) and their staffs were respectful and compassionate professionals.

Where the patients feel a lack of respect (and a stigma) is when they call for appointments and are told by office after office that the dentist doesn’t accept Medicaid. Then, they feel like second-class citizens.

5. Was the quality of care and service what you expected?

Quality of care generally got high marks from focus group members, although some patients complained of work that did not hold up (e.g., a loose filling).

Patients expressed a desire for better communication with their dentists. Some felt the doctor was hurried; some felt that the chairsides were delegated too much responsibility.

Patients also expressed unhappiness with what they felt were overly strict appointment policies. Some dentists, they indicated, would refuse to see patients who arrived late.

6. On the whole, how good of a job would you say Medicaid is doing in meeting your family’s dental needs?

The unanimous view of the focus group was that Medicaid was failing to make good on its promises. As one member put it, “I can’t do anything with my Medicaid card; it’s useless.”

7. Is there anything you would care to recommend to improve Medicaid dental care?

Focus group members offered a variety of thoughts on ways to improve the program:

- provide dental vouchers (like food stamps) to patients
- offer tax incentives to dentists who treat Medicaid patients
- require all dentists to take a certain number of Medicaid patients
- reduce Medicaid paperwork for dentists (create a debit card payment system)
provide dental services in the public schools or with mobile dental units
provide transportation vouchers for dental appointments

8. Are there other issues or problems with Medicaid dental care that we have not yet discussed? Something we overlooked?

Focus group members asked about how the state’s new child health insurance initiative would work. They expressed doubts that it would prove feasible in dentistry given the shortage of dentists, who take Medicaid patients.

They asked if the state would consider training and authorizing “dental nurses” to help meet the need.
1. Have you ever experienced any problems in finding a dentist who accepts Medicaid?

Generally, finding a dentist in St. Louis who accepts Medicaid is challenging, but by no means impossible. The city health department offers a dental clinic; there are community health centers that offer dental services; and there are private dentists, who also accept Medicaid.

The recent changes in Medicaid administration — in particular, the advent of MC+ — has made the process somewhat more difficult. Patients who had established relationships with participating dentists have found to their dismay that their dental plan does not include their dentist on its provider panel. In which case, their dentist cannot bill the plan and be reimbursed. The upshot is that many patients have either had to pay for dentistry themselves or search for a new dentist, who is in the provider panel of their plan.

The patients searching for a new dentist report that not all panel members accept new patients; some evidently have reached their limit and have quit.

2. Have you ever had to wait a long time to get an appointment?

Focus group members report that the average wait for a routine appointment is about 2 to 3 months. Follow-up visits, where work is needed, are not as difficult to schedule.

One of the major problems for the Medicaid patient is that few dentists offer evening or weekend hours. This means that the patient (or the parent of the patient) must often take off from work in order to make an appointment; and this is often not very feasible.

Emergency visits can generally be scheduled quickly. If a patient is in pain, they can usually get in to see a dentist that day.

3. Has transportation or travel time ever been a problem?

Transportation is not a problem in the St. Louis area. There is good public transportation and, for Medicaid recipients, there is free transportation.
4. When you or your child did see dentist as a Medicaid patient, were you treated with respect?

Focus group members indicate that they are generally treated with respect by participating dentists and their staffs. However, there were exceptions. One member said that she had been treated very poorly by a dentist. Most of his patients were Medicaid patients. His office was run-down and dirty. He made patients wait for long periods of time and would not let parents accompany children into the operatory.

5. Was the quality of care and service what you expected?

Focus group members expressed satisfaction with the quality of work performed by participating dentists.

There was dissatisfaction, however, with the range of services offered to them under Medicaid. One member chose to have a tooth pulled rather than restored because Medicaid would not pay for the crown.

Several members complained that co-payments were too high.

6. On the whole, how good of a job would you say Medicaid is doing in meeting your family’s dental needs?

Focus group members were generally positive about Medicaid’s role in meeting their family’s needs. MC+ covers most of the services they need; the waiting times are not to bad; and the quality of care and service is good.

7. Is there anything you would care to recommend to improve Medicaid dental care?

Getting more dentists to participate in the Medicaid program was identified as the most important thing that could be done to improve Medicaid.

Suggestions for accomplishing this included increasing reimbursement for dentists and providing tax incentives.

One member suggested that dental care be removed from MC+; the recent changes have driven some dentists from the program. It was suggested that contractual provisions be added to MC+ to stabilize provider panels.

Other recommendations included expanding the services covered by Medicaid, encouraging providers to offer evening and weekend hours, and developing a centralized information and referral service for finding dentists and making appointments.
8. Are there other issues or problems with Medicaid dental care that we have not yet discussed? Something we overlooked?

Emphasize preventative care and public education — even physicians don’t have a good idea of what children should be doing to protect their oral health.
1. Are Medicaid patients any more difficult to treat than other patients?

Medicaid patients tend to have more broken appointments than private fee-for-service patients, are more likely to show up late for appointments and more after-hours calls. This is more a reflection of the socioeconomic status of the patients than of the program itself.

This group also tends to have less knowledge about oral health care (a lower dental IQ as one member put it), to be less faithful in completing treatment instructions, and to be more demanding of the dentist’s time and patience.

Their no-show rate is considerably higher than other, better educated groups.

The exception is with elderly patients; they are more reliable and compliant; but they have more serious health problems.

Focus group members employed at community health centers reported good results from patient education programs — better attendance, compliance, etc. Unfortunately, the time required to achieve these results seemed to make the uneconomical for dentists in private practice.

2. Are the oral health problems of Medicaid patients different from other patients? More severe?

Medicaid patients tend to have more serious oral health problems than the private pay patients of focus group members. Again, socioeconomic status rather than program administration is viewed as the primary cause.

Medicaid patients present a higher incidence of periodontal disease (with attendant bone loss and tooth loss) and more advanced tooth decay.

Unfortunately, Medicaid does not offer reimbursement for most periodontal work. Focus group members unanimously agreed that this policy was ill-conceived.
3. Is the reimbursement you receive for treating Medicaid patients comparable to what you receive for other patients?

The most strenuous objections to the Medicaid program related to reimbursement levels and focus group members were prepared with examples that demonstrated the basis for their concern — dentures under Medicaid $182, under private reimbursement $725; extractions $12; repair of dentures $12.50; prophylaxis $11.25; root canal $68.

According to most of the members, the reimbursement levels paid by Medicaid for most procedures do not even cover the direct costs for staff and materials; much less offer the dentist compensation for their time or office overhead.

These levels have resulted in a virtual boycott of the program by private practice dentists. Those left participating do so out of a sense of community service; it is not a source of income for them, far from it. And as more and more dentists withdraw from the program, the remaining few feel overburdened, trapped and deeply resentful.

4. Is Medicaid’s administration of claims any different from that of commercial dental insurers?

Focus group members reported that Medicaid administration was noticeably worse than private commercial administration and that it was disrespectful of the practitioner. As one practitioner put it, “They treat dentists like children.”

The paperwork burden was described as large; denials more frequent.

Members were particularly angry about Medicaid’s refusal to use the ADA dental codes. They believe that the existing codes were modeled after medical codes and are inappropriate for dentistry.

5. Does the Medicaid program enable you to offer the same quality of care to Medicaid patients that you give to your other patients?

The group was unanimous in its view that Medicaid inhibited their ability to offer the highest quality of care. Coverage limitations and inadequate reimbursements were cited as the primary reasons. Examples included:

- partial and dentures — only one set of dentures per lifetime
- no crowns and bridges
- mandated use of inferior materials
- no periodontal care
6. In your opinion, how good of a job is Medicaid doing in meeting the oral health needs of those patients who depend on it?

The current level of reimbursement does not adequately compensate the dentist for accepting Medicaid patients. The result is that Medicaid patients have extreme difficulty in accessing care. Focus group members asked the question — How good of a job can it be doing if you can’t get a dentist?

Patients have their expectations unfulfilled. The design of the program is such that the things they need are not available.

One member summarized the situation this way, “In the real world, it’s a sad joke.”

7. Do you have any recommendations for improving the Medicaid program?

Increasing reimbursement levels — paying the dentist’s usual and customary rates — was identified as the most pressing issue by focus group members. Others included:

- Using ADA codes and universal insurance forms
- Expanding service coverage for periodontal and other problems
- Giving tax credits to participating dentists
- Reimbursing dentists for after-hours calls and no-shows

One focus group member suggested that patients need to bring lawsuit against the state demanding better access/care.

8. Are there any other issues or concerns with the Medicaid program that you would like to call to our attention? Something we’ve overlooked?

Focus group members said they did not like the current program, that it was an insult to their intelligence, and should either be improved or tossed out.

One member said he received three calls per day from patients looking for a dentist. Although, he is not accepting new patients, he is reluctant to refer them to other dentists, because the remaining few who accept them are over-burdened and resent having their names given out.

Several members were angry that they had not been reimbursed for patients whose eligibility lapsed after they had received care.

There was a complaint about the state’s 800 number — it’s never answered.

Finally, there was some concern about patient fraud — patients lending their cards to others.
APPENDIX H-8
Focus Group Summaries
Provider Focus Groups
Columbia — September 9, 1998

1. Are Medicaid patients any more difficult to treat than other patients?

Focus group members said that Medicaid patients are notorious for not showing up for appointments. At the Mid-MO Center, the no-show rate is 20%.

Compliance is also difficult. Parents are not always able to accompany their children for appointments; other caregivers — grandparents, for example — often accompany children. Self-care instructions are not always communicated well from caregiver to parent; hence, instructions are not scrupulously followed.

Parents are not always good role models for their children, when it comes to oral health care. They do not take good care of their teeth; don’t visit the dentist regularly; and experience tooth loss.

2. Are the oral health problems of Medicaid patients different from other patients? More severe?

Health issues are more serious among Medicaid patients. Among children, there is a higher incidence of cavities; they occur earlier and, when presented to the dentist, are larger.

Children also present more serious general health issues and are more likely to be on behavioral drugs.

The special needs patients have severe medical problems and are much more difficult to treat.

3. Is the reimbursement you receive for treating Medicaid patients comparable to what you receive for other patients?

Reimbursement is very low and has been for years, according to focus group members, “with little rhyme or reason.”

These levels often lead to gamesmanship by providers in an effort to generate enough revenue to cover their costs. They also lead to incomplete treatment.

Providers are paid to diagnose but not to treat. Treatment protocols that manage diagnostic work would yield better results.
Comparing Medicaid to commercial and self-pay patients:

- OR cases pay 43% to 48% of UCR
- Preventive cases, 50% to 60% of UCR
- Restorative, 27% of UCR
- Capitation rate for adults, about 50%
- Capitation rate for children, 60% to 70%

4. Is Medicaid’s administration of claims any different from that of commercial dental insurers?

Focus group members said that claims processing was improving. The electronic filing system has made the claims process much simpler and faster.

A problem that remains is that patient eligibility often terminates before their treatment plan is fully implemented, leaving important work undone or unreimbursed.

5. Does the Medicaid program enable you to offer the same quality of care to Medicaid patients that you give to your other patients?

Focus group members indicated that they did not practice different standards of care for different patients.

Nonetheless, Medicaid’s benefits are generally not as generous as the plans of other patients and the reimbursement levels are lower. So Medicaid patients may have more difficulty accessing care; they wait longer for an appointment; and are offered restorations that utilize less expensive materials and are esthetically less pleasing.

6. In your opinion, how good of a job is Medicaid doing in meeting the oral health needs of those patients who depend on it?

It “offers a fraudulent entitlement.” It cannot deliver on its promise of providing access to care. At best, it provides a source of care for people in pain.

MC+, however, has taken a big step in improving access for children in the Columbia area.

There are still major unmet needs for adults and children outside of Columbia.

7. Do you have any recommendations for improving the Medicaid program?

Focus group members felt that reimbursement improvement was a necessary, but by no means sufficient, condition for improving Medicaid. They were skeptical, however, that reimbursement levels would ever reach the point where it was
attractive financially to serve the Medicaid population. And, because Medicaid patients have more serious health issues and are generally less reliable and compliant than other patients, they believe that many dentists would remain unwilling to accept Medicaid even in the face of sizeable rate increases. Therefore, they offered the following recommendations:

- Service requirements and loan forgiveness for graduates of the UMKC School of Dentistry
- Service requirements (indigent care rotations) for dental and dental hygiene students at UMKC
- Creation of a public health dental corps — use salaried professionals in institutional settings to provide care in under-served areas
- Work creatively/flexibly with dentists to establish alternative delivery arrangements (e.g., Medicaid-subsidized free clinics)

8. Are there any other issues or concerns with the Medicaid program that you would like to call to our attention? Something we've overlooked?

One focus group member expressed concern that Medicaid’s “piece-meal treatment of the adult population” exposed participating dentists to legal and ethical risks.
1. Are Medicaid patients any more difficult to treat than other patients?

Participants said that Medicaid patients tend to be less responsible than other patients and more likely to miss an appointment (25% fail rate for Medicaid patients vs. 5%-10% for non-Medicaid).

The attitudes of Medicaid patients were also said to be different. They exhibit less interest in taking care of their teeth, seeking dental treatment, and maintaining good oral health.

Parents, they said, too often provide poor examples for their children—failing to practice good oral hygiene habits themselves, allowing their oral health to deteriorate and demonstrating little concern. Many, it was said, would rather have a problem tooth pulled than restored.

2. Are the oral health problems of Medicaid patients different from other patients? More severe?

Participants said they observed a higher incidence of periodontal disease among Medicaid patients (and also stated that Medicaid would not pay for treating it).

They also observed a higher incidence of caries and remarked that they were generally more advanced.

Medicaid patients were also said to present more general health issues and to be less health-oriented in dietary and nutritional choices.

Children on Medicaid were said to be more likely to have behavioral health issues.

3. Is the reimbursement you receive for treating Medicaid patients comparable to what you receive for other patients?

There was unanimous agreement that Medicaid fees are considerably lower than those for self-pay and commercially-insured patients. Medicaid rates were said to be 27% to 31% of their usual and customary rates (UCR).

The problem, according to participants, is that fees have not kept pace with inflation. Fees increases have been infrequent and, when instituted, much too small to make up for lost time.
Participants said that dentists were themselves to blame for this state of affairs, not having communicated adequately to state officials the seriousness of the problem. Now, the state was seeking to institute a managed care program, which they believed would actually make things worse.

4. Is Medicaid’s administration of claims any different from that of commercial dental insurers?

Participants said that recent changes in reimbursement rates for children’s services and procedural codes had not gone easily. There was much confusion and little help from state officials. Consequently, denials have been more frequent and payment less timely.

There were also complaints that Medicaid did not use the ADA codes.

5. Does the Medicaid program enable you to offer the same quality of care to Medicaid patients that you give to your other patients?

Participants said that treatment planning under Medicaid is different. Medicaid does not cover all of the services that they would recommend (in endo-, perio- or prosthodontics), nor reimburse at a level the dentist can accept for other services.

Medicaid does a relatively good job for patients in pain, but it’s more difficult to save teeth. Dentists find themselves limited to “fix and patch” dentistry.

6. In your opinion, how good of a job is Medicaid doing in meeting the oral health needs of those patients who depend on it?

Participants said that despite its many faults, Medicaid takes care of a lot of people.

It does a relatively good job for children (who can access care); yet it provides at best only pain control for adults.

In terms of access, however, Medicaid is doing a poor job. Few dentists will accept it.

Those who do receive 20 calls a day from Medicaid recipients looking for a dentist.

7. Do you have any recommendations for improving the Medicaid program?

Participants had several recommendations for improving Medicaid:

- Paving dentists at a rate of at least 70% to 80% of UCR
- Using ADA codes and standard insurance forms for claims processing
broadening service coverage and authorizing dentists to do sensible
treatment planning (e.g. permanent restorations on endodontically-
involved teeth)
providing dentists with equipment and software for electronic filing
encouraging parents to be better role models for their children

Participants expressed doubts about the wisdom of using managed care
organizations to administer the Medicaid program. The audit role, in
particular, was questioned. Participants recommended that dental review
boards, comprised of senior practitioners, serve that function.

8. Are there any other issues or concerns with the Medicaid program that you would like
to call to our attention? Something we’ve overlooked?

Participants said that the dental component of Medicaid has received an
increasingly smaller share of total Medicaid spending for the past twenty years —
dropping from about 3% in 1979 to .58% this past year.

The budget for dentistry has stayed in the range of $13 million to $16 million
since 1989.

More money needs to be allocated for dentistry.
1. Are Medicaid patients any more difficult to treat than other patients?

Participants said that they had seen a sizeable number of AIDS patients and Bosnian and Russian immigrants in their practices, all of whom are covered through the Medicaid program. The health problems of both groups are generally far more serious than those of their commercial and self-pay patients and, in the case of the Bosnians, there are difficult language barriers to overcome.

The traditional Medicaid patients also provide challenges. They tend to be somewhat less reliable in keeping appointments; so the dentists are forced to double and triple book.

2. Are the oral health problems of Medicaid patients different from other patients? More severe?

Medicaid patients have a higher incidence of periodontal disease and are more difficult to treat. They are also more likely to have multiple caries and cite pain as their reason for seeking care. They are less likely to show up for preventive care.

Among pediatric patients, there are more bottle babies.

3. Is the reimbursement you receive for treating Medicaid patients comparable to what you receive for other patients?

Participants agreed that Medicaid payment rates are very low — they estimated that it paid about 20% of their UCR. One dentist gave the following examples:

- Medicaid reimburses $12 for a one surface filling; he normally charges $65
- Medicaid pays $11 for an extraction; he charges $75
- Medicaid pays $80-$90 for a root canal; his charge is $430

The rates are so low for oral surgery, they said, that there is now only one oral surgeon in the city who still takes Medicaid patients.

For some procedures — repairing broken dentures — the dentist’s lab bill exceeds their reimbursement.

Participants felt strongly that Medicaid should give dentists the opportunity to bill patients for some of the difference between what it pays and what they
normally charge.

4. Is Medicaid’s administration of claims any different from that of commercial dental insurers?

   The recent changes in reimbursement codes for the children’s services were described as being problematical. According to participants, the codes are limiting and irrational.

   Other problems relate to eligibility. As one dentist put, it’s easy to call for verification; it’s difficult to check for recency of treatment.

   The managed care program, MC+, introduced last year, was said to be working better administratively than the older “straight Medicaid,” although the payment was a little slower.

   Overall, participants said administration was improving. Electronic filing had greatly reduced paperwork.

5. Does the Medicaid program enable you to offer the same quality of care to Medicaid patients that you give to your other patients?

   Participants agreed that treatment planning is compromised under Medicaid. “You give the best treatment you can,” was their sentiment.

   Coverage is limited and patient’s either cannot afford needed work or lack interest in paying for it. Too often, they would rather pull a tooth than save it.

   The materials used are not always the most desirable (e.g., stainless steel crowns).

6. In your opinion, how good of a job is Medicaid doing in meeting the oral health needs of those patients who depend on it?

   One dentist answered the question this way, “It sucks.” All agreed.

   The big problem is access. Reimbursement rates are too low to attract a sufficient number of practitioners to do the work that’s needed.

7. Do you have any recommendations for improving the Medicaid program?

   Increasing fees or offering some other form of compensation was said to be essential. And providing cost-of-living increases so that the value of the increase does not deteriorate over time. Other recommendations included:

      Assuring basic fairness in compensation — dental fees should increase at a pace equal to physician fees.
Increasing the services/procedures covered and removing irrational limitations (e.g., for dentures, denture repairs, endodontic restorations)
Providing (or paying for) interpreters for foreign patients.
Allowing dentists to bill for dentures when impressions are taken.

8. Are there any other issues or concerns with the Medicaid program that you would like to call to our attention? Something we’ve overlooked?

Participants expressed concern that Medicaid stigmatizes their practices. Meanwhile, patients show up late, complain and are unappreciative. Some have personal hygiene issues, too.

Participants said they want any fee increases to apply to managed care providers.

They said that tax and volume incentives should be offered to participating dentists.