

# CALIFORNIA HEALTH CARE ALMANAC



## Denti-Cal Facts and Figures

MAY 2010

# Introduction

Denti-Cal, Medi-Cal’s fee-for-service (FFS) dental program, was the primary public financer of dental care for more than 8 million low-income, elderly, and disabled people in California in 2007. In 2009, most of the Medi-Cal adult dental benefits were eliminated due to the state’s budget deficit. Children’s services, as required by federal law, continue to be delivered.

While nearly all Medi-Cal beneficiaries had access to Denti-Cal in 2007, most did not use the service. California’s reimbursement rates for publicly funded dental care are among the lowest in the nation, well below the fees charged by most dentists. As a result, only about one-quarter of dental practices accept Denti-Cal patients, and the difficulty of obtaining care, particularly specialty care, may have limited people’s ability to take advantage of the dental benefit. However, other social and economic factors also likely played a role.

This presentation covers the organization of Denti-Cal in 2007, how it was funded, and the demographics of the population it served. It identifies the challenges the Medi-Cal dental program faces in continuing to make dental care available to the children it now serves, and the potential consequences of leaving a large segment of the adult Medi-Cal population with no care at all, apart from emergency services.

CONTENTS

Overview..... 3

Coverage and Financing..... 5

Expenditures and Services..... 9

Providers, Reimbursement,  
and Access.....22

Children, Pregnant Women,  
and Disabled.....28

Questions .....38

Authors and Acknowledgments .....39

Methodology.....40

Glossary .....41

# Summary of Key Findings

- In 2007 the Denti-Cal program constituted less than 2 percent of the total Medi-Cal budget. It covered a variety of important oral health services for adults and children such as: diagnostic and preventive dental services (e.g., examinations, x-rays, and teeth cleanings); emergency treatment for control of pain and infection; fillings; tooth extractions; root canal treatments; prosthetic appliances (e.g., dentures); and orthodontics for qualified children.
- A number of policy changes have occurred over the past ten years to control Medi-Cal dental expenditures. The largest change in the history of Medi-Cal dental policy occurred in July 2009, when the dental benefit for most adult beneficiaries was terminated.
- Just 25 percent of Medi-Cal beneficiaries reported a dental visit in 2007. Continuity in eligibility was correlated with greater utilization; approximately four of every five dental service users had been enrolled for 12 or more continuous months.
- The reimbursement rates for Medi-Cal dental procedures are much lower than both the national Medicaid averages, as well as the fees dentists receive from commercial insurance.
- Per-person dental expenditures are highest for the senior, blind, and disabled populations; however, the dental costs for these groups are less than 2 percent of their total Medi-Cal expenditures.
- Most major medical, dental, and public health organizations recommend that children see a dentist either by age one or the time they have their first tooth, and that children see the dentist regularly. However, among children up to age two who were enrolled in Medi-Cal at any time during the year, fewer than one in ten had a preventive dental visit.
- Among pregnant women with Medi-Cal coverage, only one in seven received dental services in 2007.

# Importance of Dental Care and Oral Health

- In California, approximately 6.3 million children — or two-thirds of all children in the state — suffer needlessly from poor oral health by the time they reach the third grade.<sup>1</sup>
- Approximately 6 percent of all California adults between the ages of 21 and 65 missed work or school because of a dental problem (not including missed time for cleaning or a check-up).<sup>2</sup>
- Approximately 7 percent of California children missed school due to a dental problem in 2007, excluding time for cleaning or routine check-up.<sup>3</sup>
- In 2007 there were more than 83,000 visits to California hospital emergency departments for preventable dental conditions.<sup>4</sup>
- Seventy-three percent of California adults do not know that dental caries — the disease that causes cavities in teeth — are infectious and can be spread from person to person.<sup>5</sup>
- Californians report that the high cost of dental care is the number-one reported barrier to dental services — a barrier most common among the uninsured.<sup>6</sup>

Sources: 1. *Mommy, It Hurts to Chew: The California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children*, Dental Health Foundation, 2006.

2. California Health Interview Survey (CHIS), 2003. (More current data on missed work or school is not available from CHIS for adults.)

3. California Health Interview Survey, 2007.

4. *Emergency Department Visits for Preventable Dental Conditions in California*, California HealthCare Foundation, May 2009.

5. *Drilling Down: Access, Affordability, and Consumer Perceptions in Adult Dental Health*, Nadereh Pourat, Ph.D., UCLA Center for Health Policy Research, November 2008.

6. Ibid.

# Overview of the Denti-Cal Program

- The federal government requires state Medicaid programs to provide dental services for most children under 21.<sup>1</sup>
- Until July 2009, California also provided benefits to Medi-Cal adults primarily under a fee-for-service program, commonly known as Denti-Cal, and made dental care available for more than 8 million Medi-Cal beneficiaries of all ages enrolled at some point during the year.
- Total fee-for-service (FFS) Denti-Cal payments in 2007 were over \$584 million. Approximately 2 million beneficiaries received dental services in FFS (97 percent) and managed care plans (3 percent).
- Medi-Cal is funded by three sources: federal government (55 percent), state general fund (38 percent), and other state and local agencies (7 percent).

Although there is not a federal requirement for adults, for more than four decades California had chosen to provide dental services to both children and adults enrolled in Medi-Cal. However most benefits for most adults were terminated in July 2009.

Notes: Enrollment is based on a minimum of one month of eligibility. There were approximately 6.5 million beneficiaries enrolled in April 2007 and 6.4 million enrolled in April 2009.

Sources: DHCS Medical Care Statistics Section, 2009. HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

1. "Medicaid Dental Coverage Overview," Centers for Medicare & Medicaid Services, [www.cms.hhs.gov](http://www.cms.hhs.gov) (accessed October 2009).

# Denti-Cal Program Benefits

Until July 2009, the Denti-Cal program covered a variety of services for adults and children such as:

- Diagnostic and preventive dental services (e.g., examinations, x-rays, and teeth cleanings)
- Emergency treatment for control of pain and infection
- Fillings
- Tooth extractions
- Root canal treatments
- Prosthetic appliances (e.g., dentures)
- Orthodontics for children who qualify

## Service caps and copayments included:

- A \$1 copayment for services provided in a dental office
- A \$5 copayment for nonemergency care provided in an emergency room
- Dentists have the option to not collect some copayment amounts
- An \$1,800 per beneficiary cap (with some exemptions) on adult services in any calendar year (commenced January 1, 2006)

Note: There are a number of exemptions from the copayment policies.

Sources: California Department of Health Care Services, Beneficiary Services, [www.denti-cal.ca.gov](http://www.denti-cal.ca.gov) and *Denti-Cal Provider Manual*, [www.denti-cal.ca.gov](http://www.denti-cal.ca.gov).

Until it was scaled back in July 2009, the Denti-Cal program included a full range of dental services for both adults and children.

# Comparison of Medi-Cal and Denti-Cal, by Category, 2007

	MEDI-CAL		DENTI-CAL	
	NUMBER	PERCENT	NUMBER	PERCENT
<b>BENEFICIARIES ENROLLED</b>				
<b>Total</b>	<b>8,009,337</b>	<b>100%</b>	<b>8,009,337</b>	<b>100%</b>
Fee-for-Service	5,110,448	64%	7,698,780	96%
Managed Care	2,898,889	36%	310,557	4%
<b>BENEFICIARIES RECEIVING ONE OR MORE SERVICES</b>				
Fee-for-Service	3,839,749	75%	1,980,577	26%
<b>ANNUAL EXPENDITURES (IN BILLIONS)</b>				
Fee-for-Service	\$15.0		\$0.6	

## Denti-Cal Facts and Figures

Coverage and Financing

[<< RETURN TO CONTENTS](#)

Only about one in four beneficiaries enrolled in Medi-Cal received dental services in 2007; however three in four used medical services.

Notes: Enrollment is based on a minimum of one month of eligibility. The average enrollment per month was approximately 6.6 million beneficiaries in 2007. Managed care includes County Organized Health Systems, Commercial 2 Plan Models, Geographic Managed Care and Local Initiative (2 Plan Model). A small number of beneficiaries, less than one-tenth of 1 percent were enrolled in Primary Care Case Management and Prepaid Health Plans, which are generally not considered managed care.

Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.) DHCS Medi-Cal Base Estimates, 2007, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).

# Recent Legislation and Policy Changes

**AB 131.** \$1,800 annual cap on adult dental services per calendar year. AB 131 also contained a sunset provision that would have ended the annual cap on January 1, 2009 unless repealed or extended by statute.

APPROVED JULY 2005 (effective January 1, 2006)

**SB 377.** Provide immediate coverage of selected non-emergency dental procedures for pregnant Medi-Cal beneficiaries in 16 new aid codes in addition to four aid codes that were added in 2002.

APPROVED OCTOBER 2005 (effective October 7, 2005)

**AB 1735.** Reduce provider payments by 5 percent.

APPROVED OCTOBER 2005  
(effective for dates of service on or after January 1, 2006)

**SB 912.** Rescind the 5 percent provider payment reduction.

APPROVED FEBRUARY 2006  
(effective for dates of service on or after March 4, 2006)

**SB238.** Allow an FQHC or rural health center to count treatment by a dental hygienist as a “visit” for purposes of determining the facility’s reimbursement level.

APPROVED OCTOBER 2007 (not yet implemented)

**State Legislature Budget Cut.** Reduce provider payments by 10 percent.

IN EFFECT JULY 1, 2008 THROUGH AUGUST 18, 2008  
(The reduction is temporarily blocked due to litigation. The lawsuit alleged that the Medi-Cal reimbursement reduction would violate state and federal laws that require payments to remain adequate to ensure beneficiaries receive the same level of access to services as the general public.)

**AB1183.** Implement a provider payment reduction of 1 percent. Remove the sunset provision, making the \$1,800 annual cap permanent.

APPROVED SEPTEMBER 30, 2008  
(effective for dates of service on or after March 1, 2009)

**Federal CHIP Reauthorization Act (CHIPRA).** Includes a provision authorizing FQHCs to contract with private dentists and prohibits states from preventing an FQHC from entering into contractual relationships with private practice dental providers in the provision of FQHC services.

EFFECTIVE JANUARY 1, 2009

**Policy Change.** Increase the fee for Procedure D1203 (topical application of fluoride, prophylaxis not included) for children ages 0 to 5 from \$8.00 to \$18.00. Children age 6 and older will remain at the current amount of \$8.00. Included a provision that the policy was retroactive to March 1, 2008.

EFFECTIVE FEBRUARY 1, 2009

**ABx3 5** Eliminate selected optional benefits under the Medi-Cal program, including most adult dental services, except for necessary extractions, pregnancy-related services, and services for adults in skilled nursing or intermediate care facilities. This state law change will not affect services provided to most beneficiaries under age 21.

APPROVED STATUTES OF 2009 – 2010  
(effective July 1, 2009)

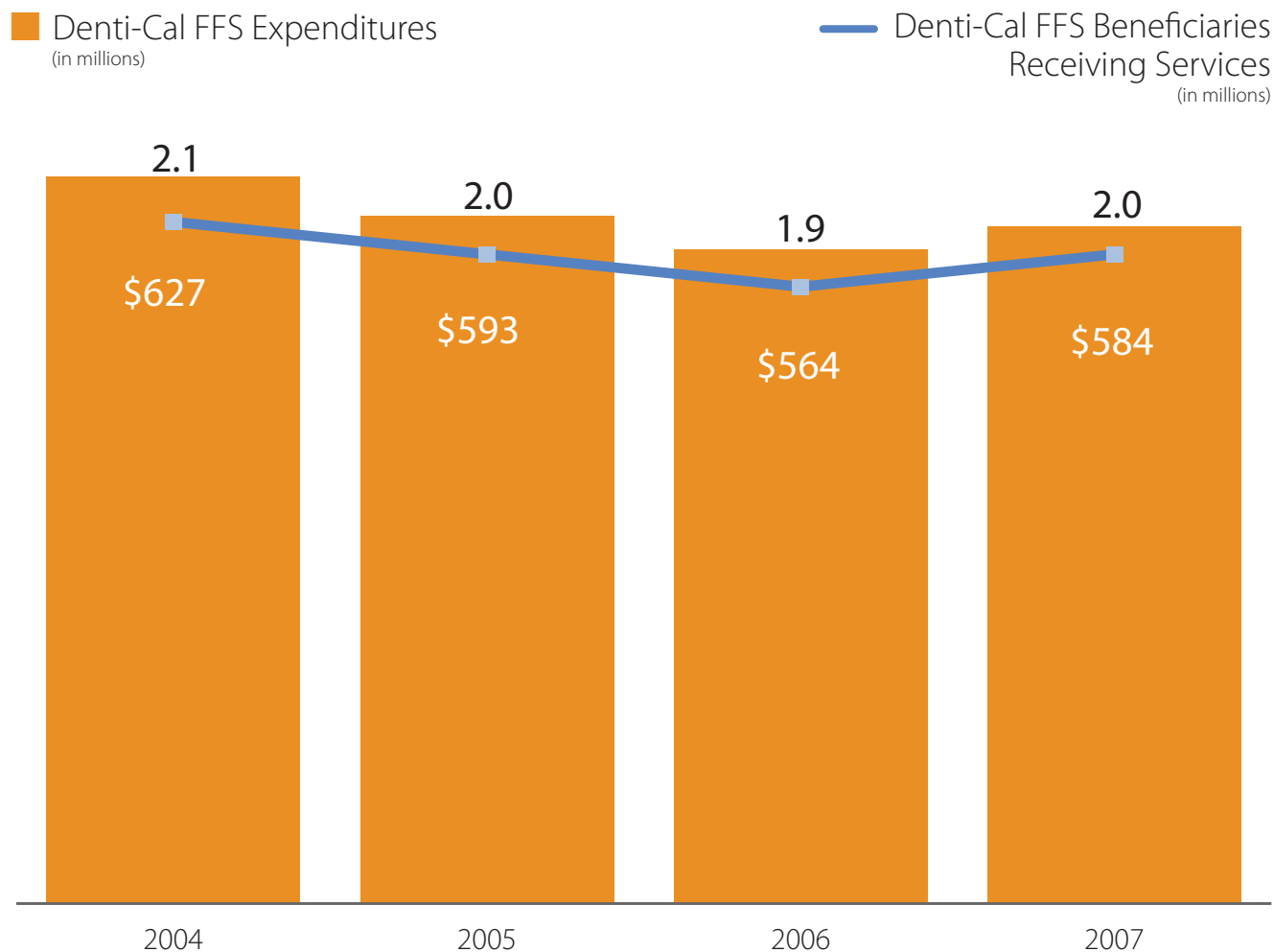
## Denti-Cal Facts and Figures

### Coverage and Financing

[<< RETURN TO CONTENTS](#)

In an effort to lower Medi-Cal dental expenditures, many policy changes have been implemented over the years. However, the elimination of adult dental benefits in July 2009 is the most significant policy change affecting Medi-Cal dental services in decades.

# Use of Denti-Cal Services, Beneficiaries and Expenditures, 2004–2007



## Denti-Cal Facts and Figures

### Expenditures and Services

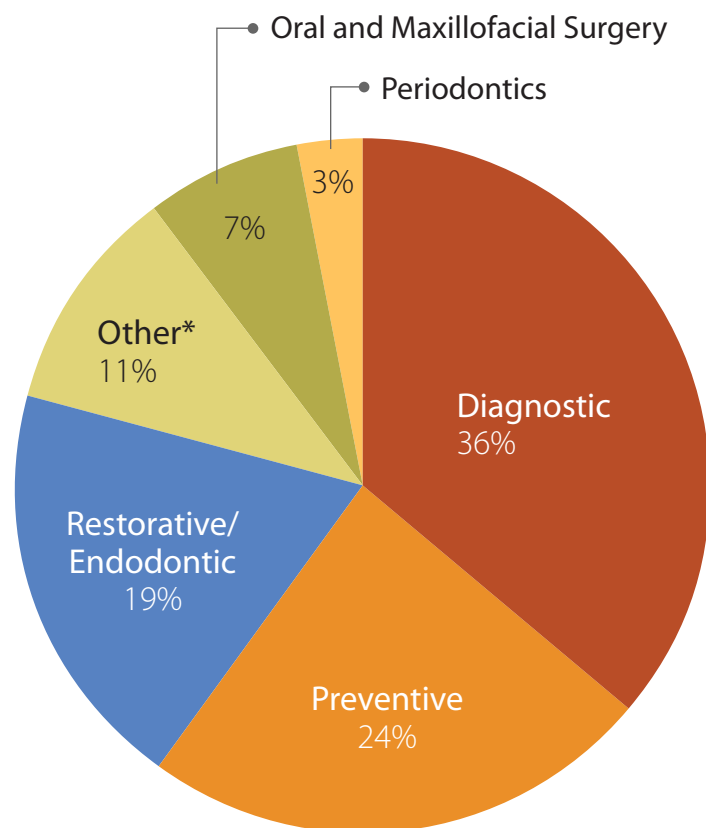
[<< RETURN TO CONTENTS](#)

The number of Medi-Cal beneficiaries receiving dental services dropped by 5 percent between 2004 and 2007. During the same period fee-for-service dental expenditures fell approximately 7 percent.

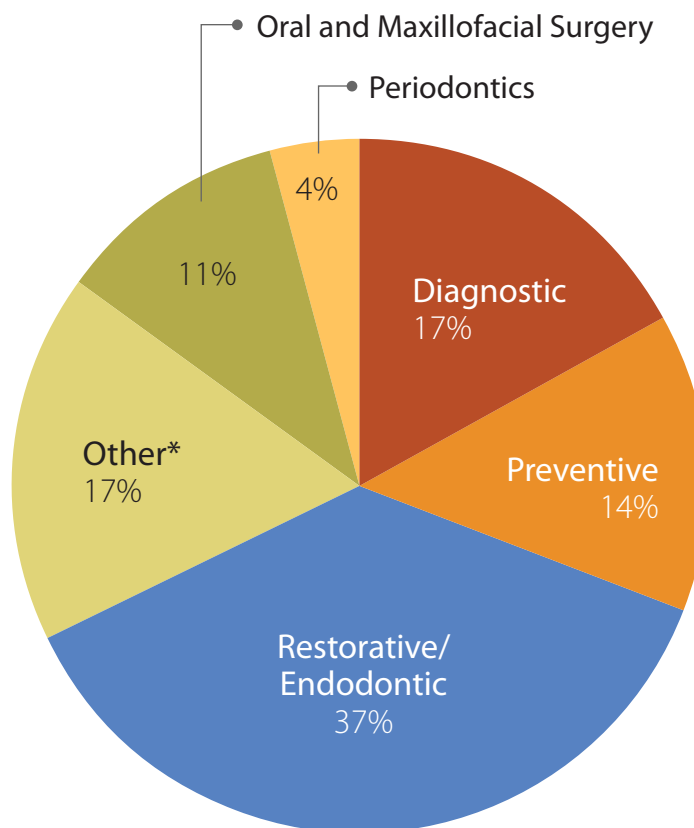
Source: HMA analysis of 2007 Medi-Cal MIS/DSS data. (Denti-Cal data includes all FFS claims paid to a dental professional.)

# Distribution of Procedures, by Beneficiary Visits and Expenditures, 2007

TOTAL FFS DENTAL VISITS  
n=7.4 million



TOTAL FFS DENTAL EXPENDITURES  
n=\$584 million



## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

While diagnostic and preventive services were the most frequently used services, restorative and endodontics accounted for the largest proportion of expenditures in 2007. Diagnostic and preventive services accounted for 60 percent of visits but just 31 percent of expenditures.

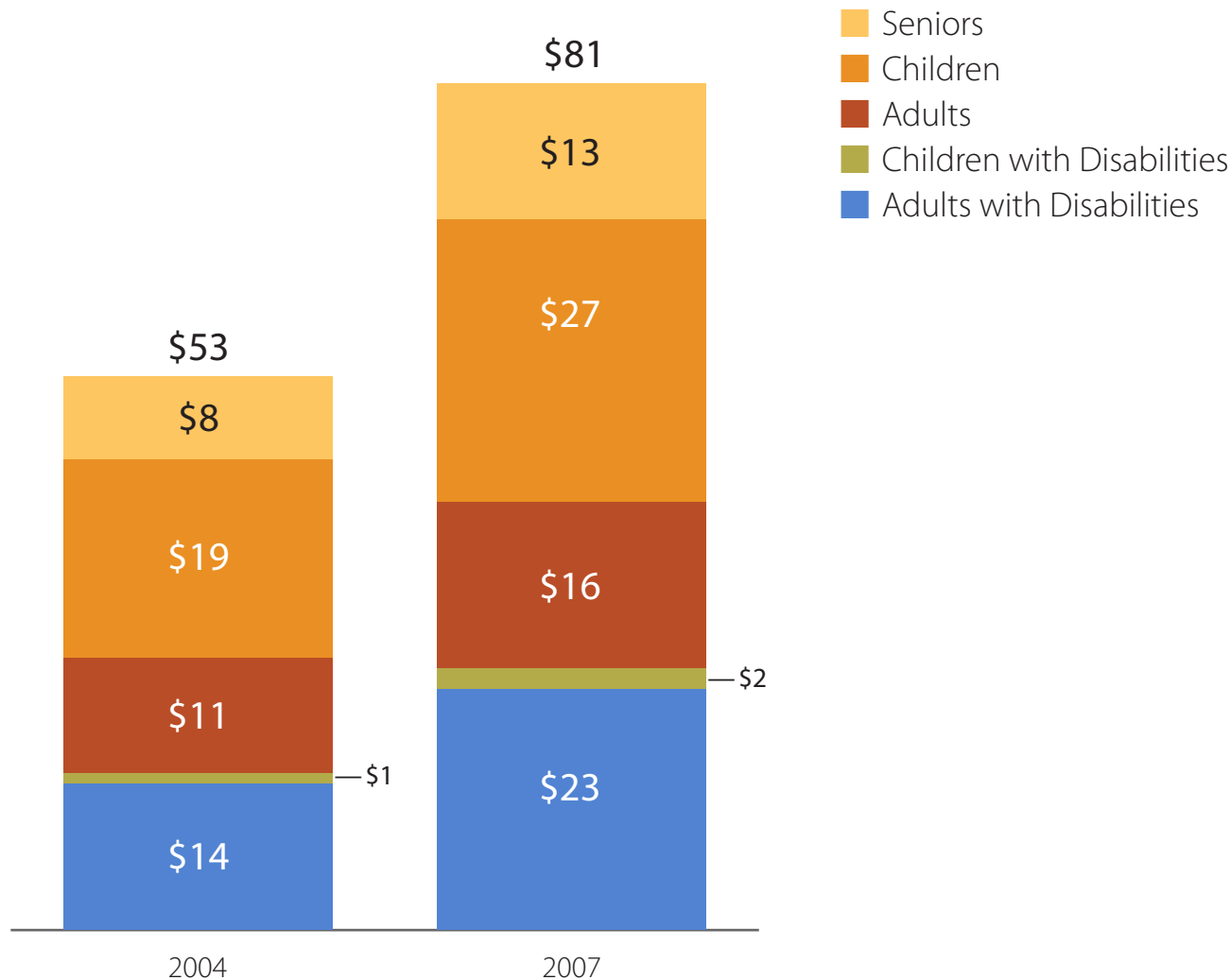
\*Other includes removable and fixed prosthodontics; maxillofacial prosthetics; implant services; orthodontics; and adjunctive general service.

Notes: Claims that did not have procedure codes (0.01 percent of all FFS claims) were not used in the analyses. A description of procedure category groups can be found in the [Glossary](#).

Sources: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

# Clinics and Denti-Cal Dollars, by Demographic, 2004 and 2007

FFS EXPENDITURES (IN MILLIONS)



Source: HMA analysis of 2007 Medi-Cal MIS/DS data. (Denti-Cal data includes all FFS claims paid to a dental professional.)

## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

Denti-Cal expenditures at Federally Qualified Health Centers (FQHCs), Rural Health Centers, and Indian Health Centers rose considerably between 2004 and 2007.

Notes: Clinics receiving cost-based reimbursements are Federally Qualified Health Centers, Rural Health Centers, and Indian Health Centers and are defined as claims with vendor code 77 and procedure code=00003. Some portion of this increase may be attributed to an accounting issue in which services rendered before 2004 were paid in arrears to clinics after 2004. Although these clinics don't provide procedure-level data, they do report encounters (visits). Medi-Cal dental expenditures for other community clinics (not receiving cost-based reimbursements) are not captured here.

# Changes in Utilization and Expenditures, by Procedure Category, 2003–2007\*

FFS EXPENDITURES (IN MILLIONS)



\*Data for 2005 by procedure category were not available in the MIS/DSS.

Notes: Claims that did not have procedure codes (0.01 percent of all FFS claims) were not used in the analyses. Prostodontics includes fixed and removable. Other includes maxillofacial prosthetics; implant services; orthodontics; and adjunctive general service.

Sources: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.) *Denti-Cal Facts and Figures*, California HealthCare Foundation, 2007.

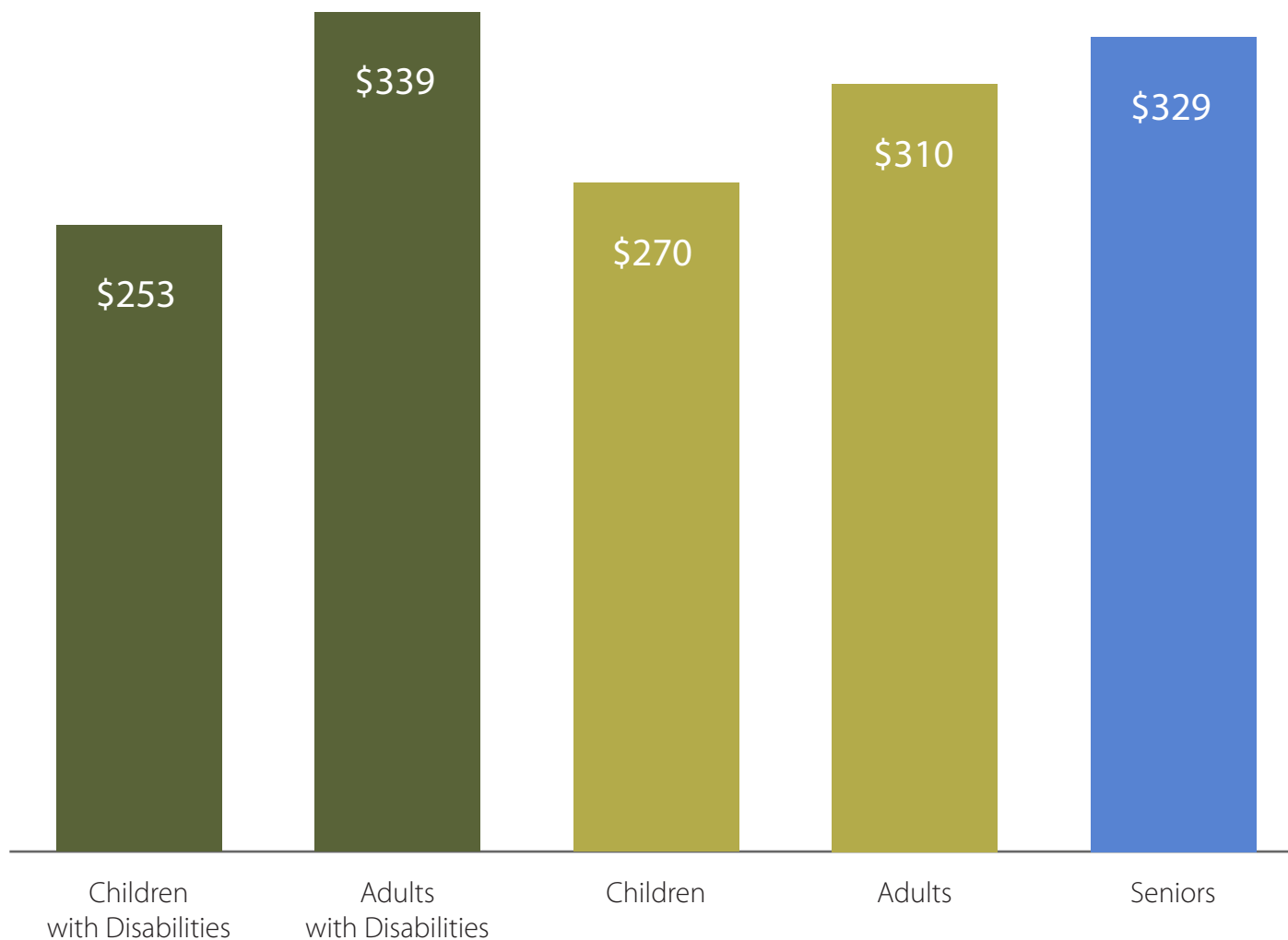
## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

Between 2003 and 2007, the greatest expenditures were for restorative and endodontic services. However, dental expenditures fell during this period for all procedure categories except preventive and diagnostic, which increased 5 percent and 7 percent respectively.

# Denti-Cal Expenditures Per Beneficiary Receiving Services, by Demographic, 2007



Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

Medi-Cal dental expenditures in 2007 varied across beneficiary types. Adults with disabilities had the highest per-beneficiary expenditures.

# Top Ten Procedures, by Highest Aggregate Payments, 2007

	CATEGORY	TOTAL FFS EXPENDITURES (IN MILLIONS)	DENTI-CAL BENEFICIARIES RECEIVING FFS SERVICES
Amalgam, two surfaces, primary or permanent	Restorative	\$31.3	336,293
Prophylaxis, topical fluoride application, ages 6 to 17	Preventive	\$26 .3	565,510
Periodontal scaling and root planing, four or more contiguous teeth	Periodontics	\$25 .3	186,314
Therapeutic pulpotomy, excluding final restoration	Endodontics	\$23 .4	128,846
Initial oral examination	Diagnostic	\$23 .3	885,676
Intraoral periapical, each additional film	Diagnostic	\$23 .1	1,400,742
Prophylaxis, adult	Preventive	\$23 .1	584,949
Prefabricated stainless steel crown, primary tooth	Restorative	\$22.7	105,719
Surgical removal of erupted tooth	Oral and Maxillofacial Surgery	\$22.4	142,145
Resin-based composite, one surface, anterior	Restorative	\$22 .0	217,602

Note: A description of Procedure Category Groups can be found in the [Glossary](#).

Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

The top ten procedures totaled \$243 million, about 42 percent of dental expenditures in 2007.

# Top Ten Procedures, by Frequency of Use, 2007

	CATEGORY	TOTAL FFS EXPENDITURES (IN MILLIONS)	DENTI-CAL BENEFICIARIES RECEIVING FFS SERVICES
Intraoral periapical, each additional film	Diagnostic	\$23.1	1,400,742
Initial oral examination	Diagnostic	\$23.3	885,676
Periodic oral evaluation	Diagnostic	\$11.9	810,043
Bitewings, two films	Diagnostic	\$8.3	730,871
Prophylaxis, adult	Preventive	\$23.1	584,949
Prophylaxis, topical fluoride application, ages 6 to 17	Preventive	\$26.3	565,510
Intraoral periapical, single, first film	Diagnostic	\$6.4	520,184
Bitewings, four films	Diagnostic	\$8.4	438,708
Amalgam, two surfaces, primary or permanent	Restorative	\$31.3	336,293
Oral/facial images, including intra and extraoral images	Diagnostic	\$2.6	324,914

Note: A description of Procedure Category Groups can be found in the [Glossary](#).

Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

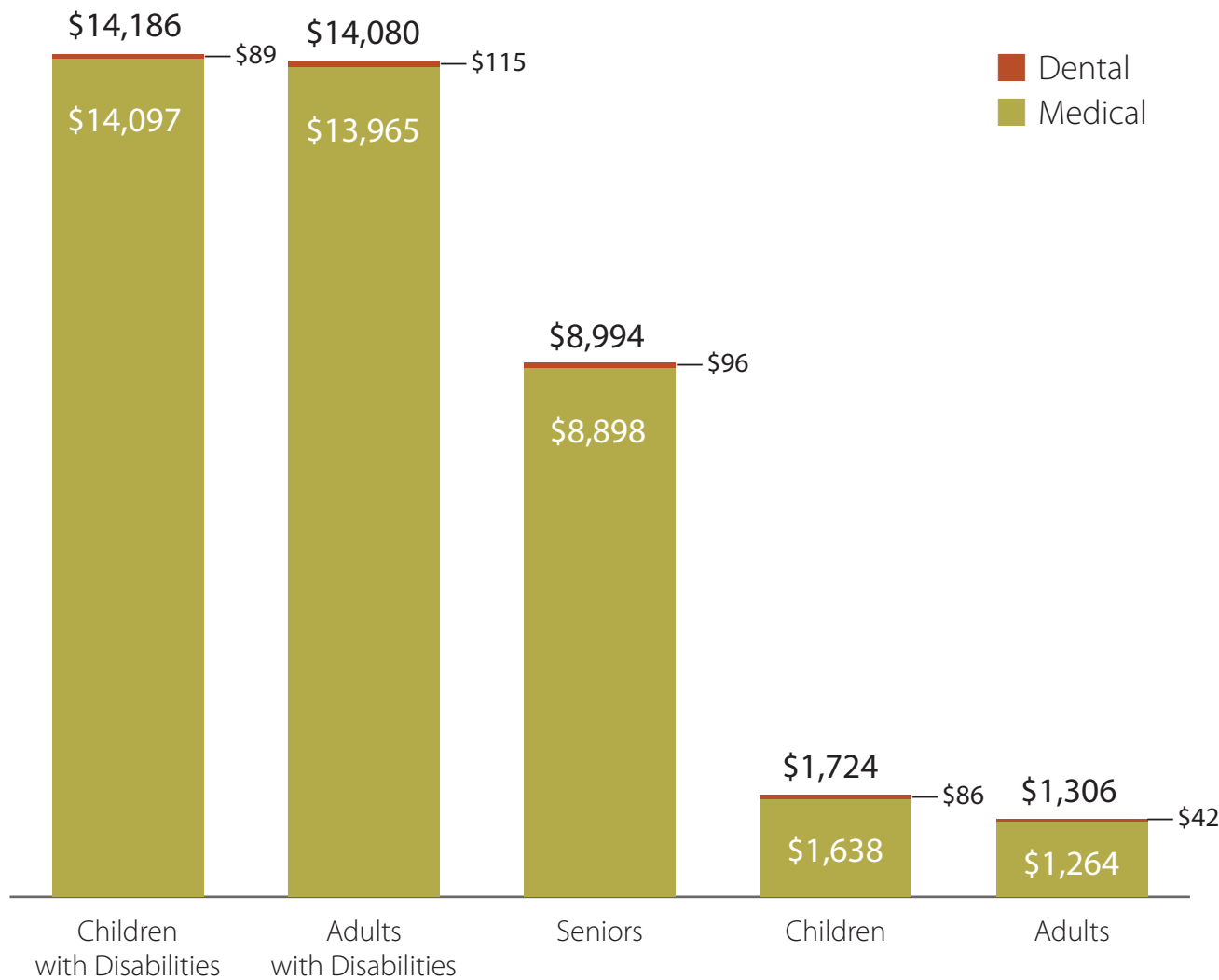
## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

More beneficiaries used diagnostic and preventive dental services than other service categories, e.g., restorative. These services totaled approximately \$165 million (28 percent) of total fee-for-service expenditures.

# FFS Medical vs. Dental Expenditures Per Beneficiary, by Demographic, 2007



Sources: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.) Ingenix Medi-Cal data, 2007.

## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

At just 1 to 5 percent of total program costs, dental payments are only a small percentage of Medi-Cal's annual spending on behalf of its beneficiaries.

# Beneficiaries and Service Use Expenditures, by Age Group (in Years), 2007

	MEDI-CAL BENEFICIARIES		DENTI-CAL SERVICE USERS			
	NUMBER	PERCENT OF TOTAL	BENEFICIARIES		FFS EXPENDITURES	
			NUMBER	PERCENT OF AGE GROUP	AMOUNT (IN MILLIONS)	PERCENT OF TOTAL
Younger than 1	275,974	3.5%	412	0.1%	\$0.03	0.0%
1	297,953	3.7%	11,784	4.0%	\$1.2	0.2%
2	257,256	3.2%	35,347	13.7%	\$7.6	1.3%
3	234,705	2.9%	61,765	26.3%	\$17.1	2.9%
4	221,253	2.8%	80,361	36.3%	\$24.6	4.2%
5	211,876	2.7%	94,104	44.4%	\$28.3	4.8%
6 to 12	1,289,974	16.1%	490,814	38.0%	\$127	21.7%
13 to 20	1,327,624	16.6%	353,435	26.6%	\$104	17.8%
21 to 64	2,909,839	36.3%	602,349	20.7%	\$192	32.9%
65 and older	982,883	12.3%	249,966	25.4%	\$82	14.1%
<b>Total (all ages)</b>	<b>8,009,337</b>	<b>100.0%</b>	<b>1,980,337</b>	<b>24.7%</b>	<b>\$584</b>	<b>100.0%</b>

## Denti-Cal Facts and Figures

Expenditures and Services

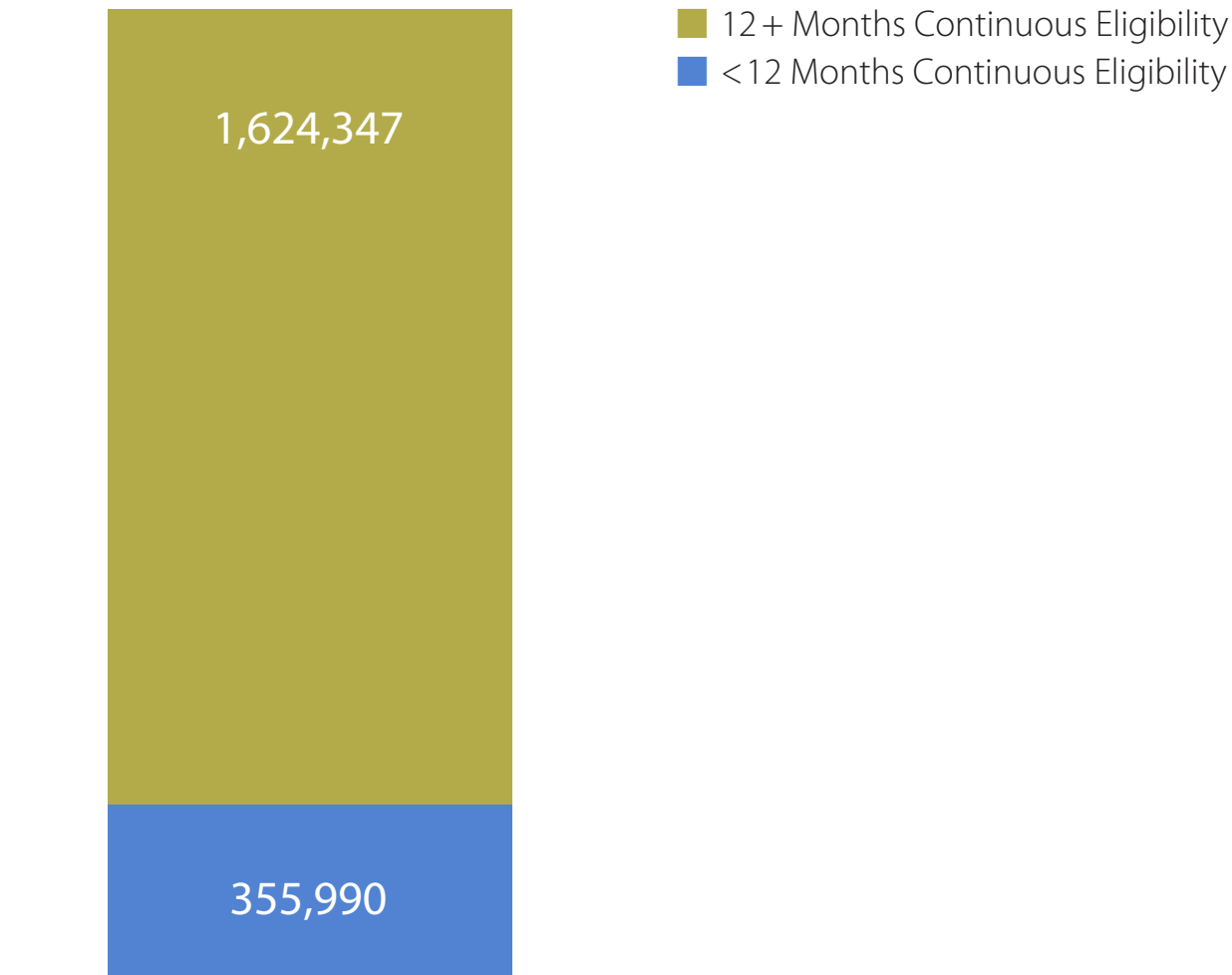
[<< RETURN TO CONTENTS](#)

The American Academy of Pediatric Dentistry recommends that children have a dental visit by their first birthday. Among children under the age of two enrolled in Medi-Cal during 2007, fewer than 1 in 25 visited a dentist.

Sources: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.) "Dental Care for your Baby," American Academy of Pediatric Dentistry, 2002–2009, [www.aapd.org](http://www.aapd.org) (accessed October 13, 2009).

# Use of Dental Services, by Length of Continuous Eligibility, 2007

TOTAL UNIQUE FEE-FOR-SERVICE DENTAL SERVICE RECIPIENTS WITH...



Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

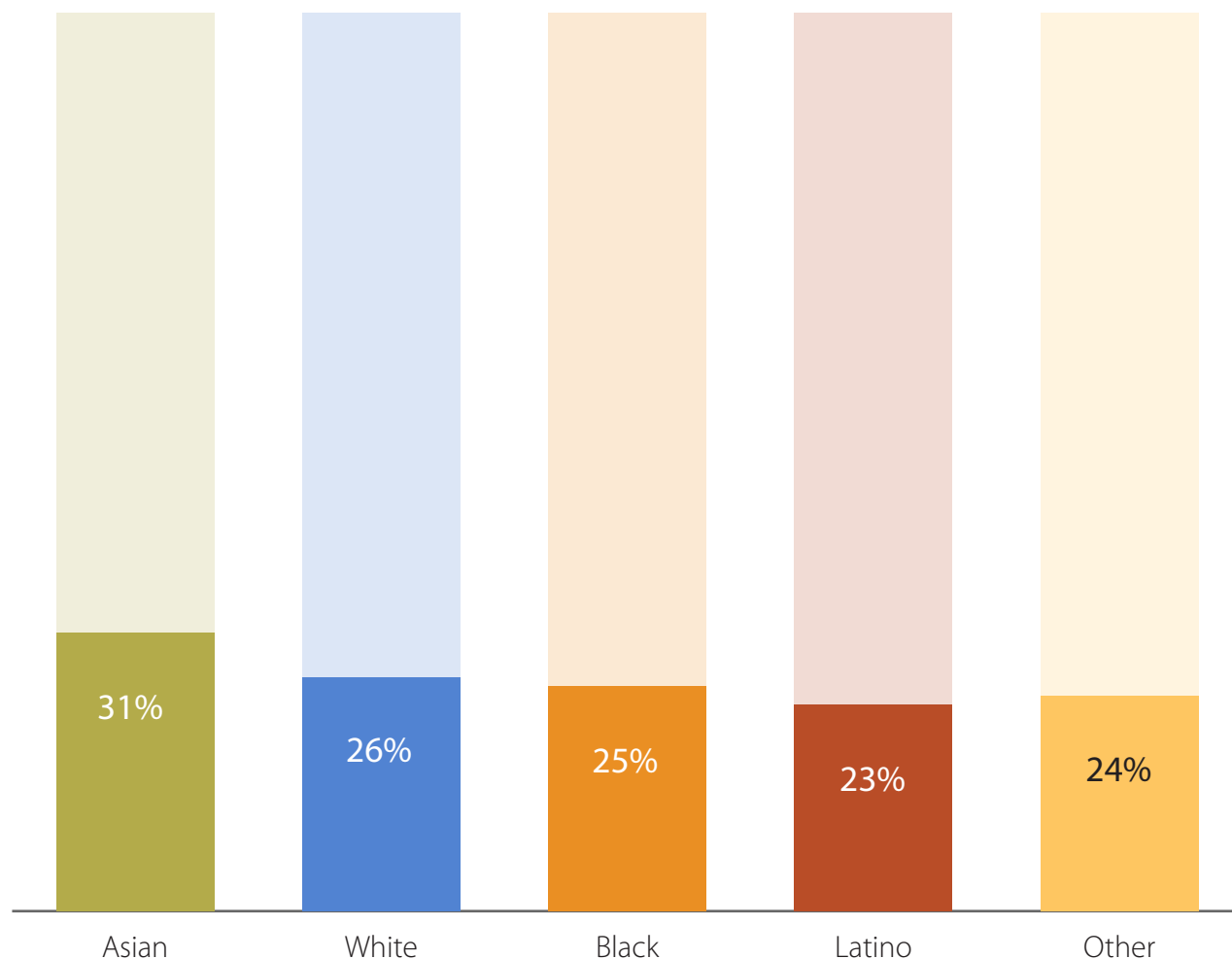
## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

People who use Medi-Cal dental services tend to be those who were continuously enrolled in the program for at least one year. In 2007, four of five dental service users had been enrolled for 12 or more months.

# Medi-Cal Beneficiaries Using Dental Services, by Ethnicity, 2007



Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

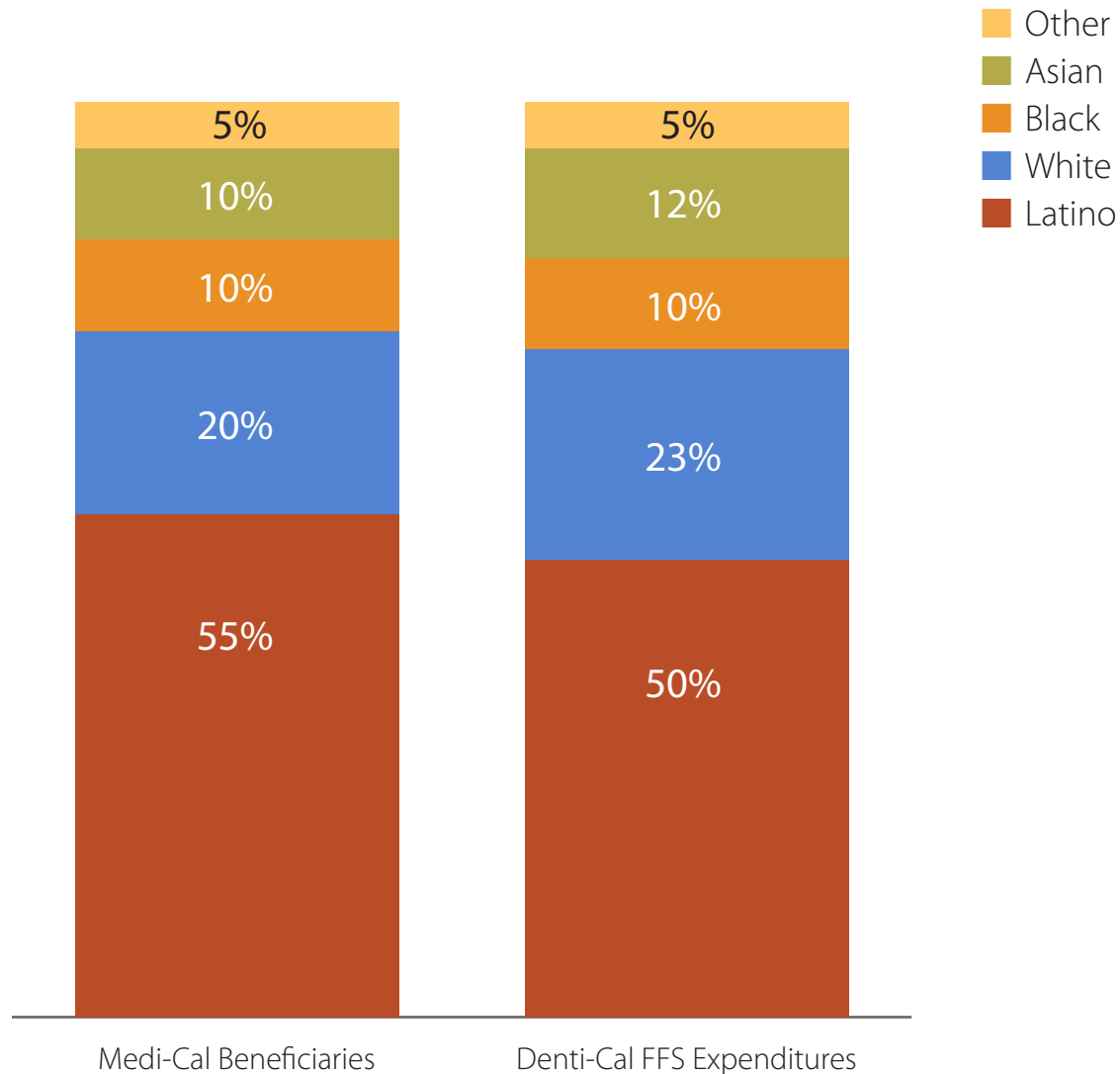
## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

Among ethnic groups, the percentage of Medi-Cal beneficiaries who used dental services in 2007 ranged from 23 percent to 31, with Asians showing the highest utilization rate.

# Beneficiaries and Expenditures, by Ethnicity, 2007



Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

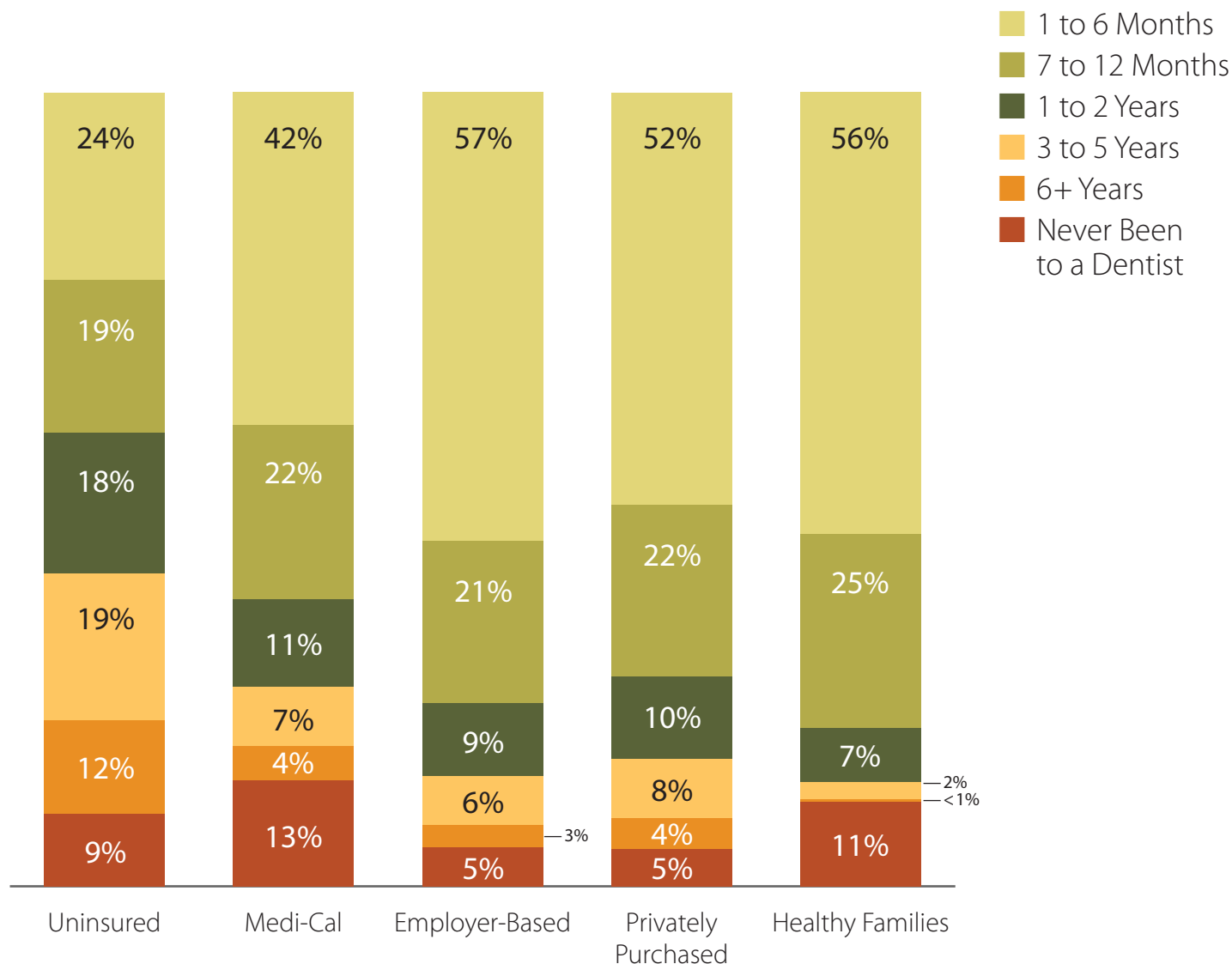
## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

The distribution of dental expenditures by ethnicity closely mirrors the composition of the population of Medi-Cal beneficiaries as a whole. Latinos, who make up 55 percent of the people enrolled in the program, account for half of all dental costs.

# Time Since Last Dental Visit, by Insurance Type, 2003



## Denti-Cal Facts and Figures

Expenditures and Services

[<< RETURN TO CONTENTS](#)

Despite having dental coverage, 13 percent of Medi-Cal beneficiaries report that they have never been to a dentist, compared to 5 percent of Californians with private or employer-based insurance.

Notes: Time since last dental visit includes information for those 2 years of age and older, as well as younger children in cases where a tooth was present. Segments may not add to 100 percent due to rounding.

Source: California Health Interview Survey, 2003.

# Barriers to Receiving Dental Services

A number of barriers may affect use of dental services by Californians in general and Medi-Cal beneficiaries in particular. They include:

- **Transportation and Work.** Many Medi-Cal beneficiaries face hurdles in getting to a dentist, such as transportation and difficulty taking time off from their jobs.<sup>1,2</sup>
- **Overall Personal Health.** Taking care of yourself is a critical component of oral health, and many people have a limited understanding of preventive oral health, such as brushing, flossing, recommended frequency of dental visits, eating a healthy diet and drinking fluoridated water.<sup>2</sup>
- **Fluoridated Water.** About 42 percent of Californians live in an area without fluoridated public water systems, the single most effective public health measure to protect against tooth decay.<sup>2,3</sup>
- **Access to a Dentist.** Only 25 percent of California dentists accept Medi-Cal patients. Medi-Cal reimbursement for dental services are some of the lowest in the country.
- **Authorization of Services.** Medi-Cal requires that dentists submit a Treatment Authorization Request (TAR) to provide certain services. Some dentists may not fully understand the process for submitting TARs, resulting in denial of service or payment.<sup>4</sup>

There are a number of barriers to dental services that can limit Medi-Cal beneficiaries' use of routine services.

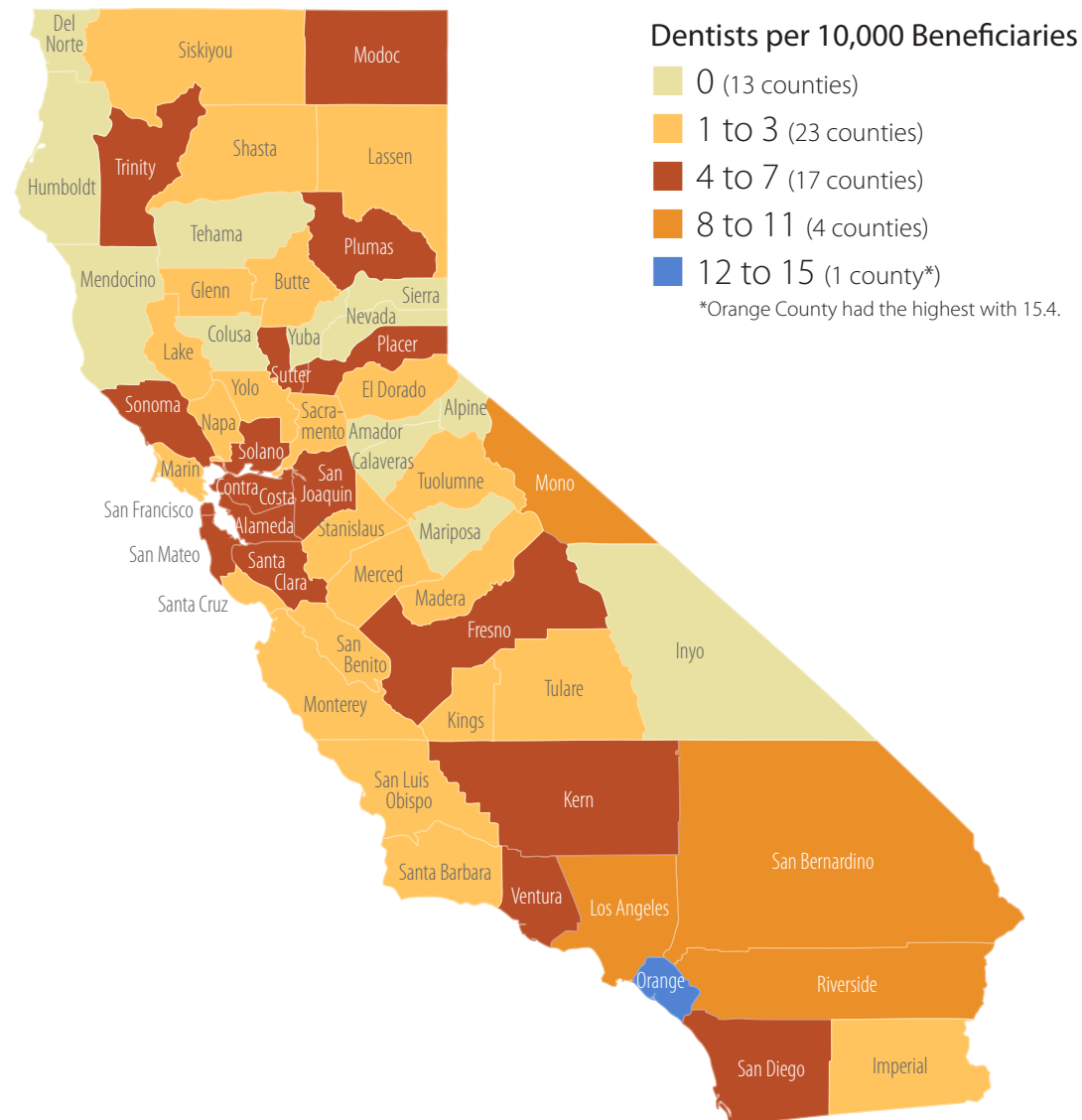
Sources: 1. California Health Interview Survey, 2007.

2. "Problems With Access to Dental Care for Medicaid-Insured Children: What Caregivers Think." Mahyar Mofidi, R. Gary Rozier, and Rebecca S. King, *American Journal of Public Health*, January 2002, Vol. 92, No. 1, pp. 53–58.

3. California Department of Public Health, special data request, 2008, [www.cdph.ca.gov](http://www.cdph.ca.gov).

4. *Denti-Cal Denied: Consumers' Experiences Accessing Dental Services in California's Medi-Cal Program*, Health Consumer Alliance, December 2002, [www.healthconsumer.org](http://www.healthconsumer.org) (accessed December 15, 2009).

# Dentists on Medi-Cal Referral List, by County, 2009



## Denti-Cal Facts and Figures

Providers, Reimbursement, and Access

[<< RETURN TO CONTENTS](#)

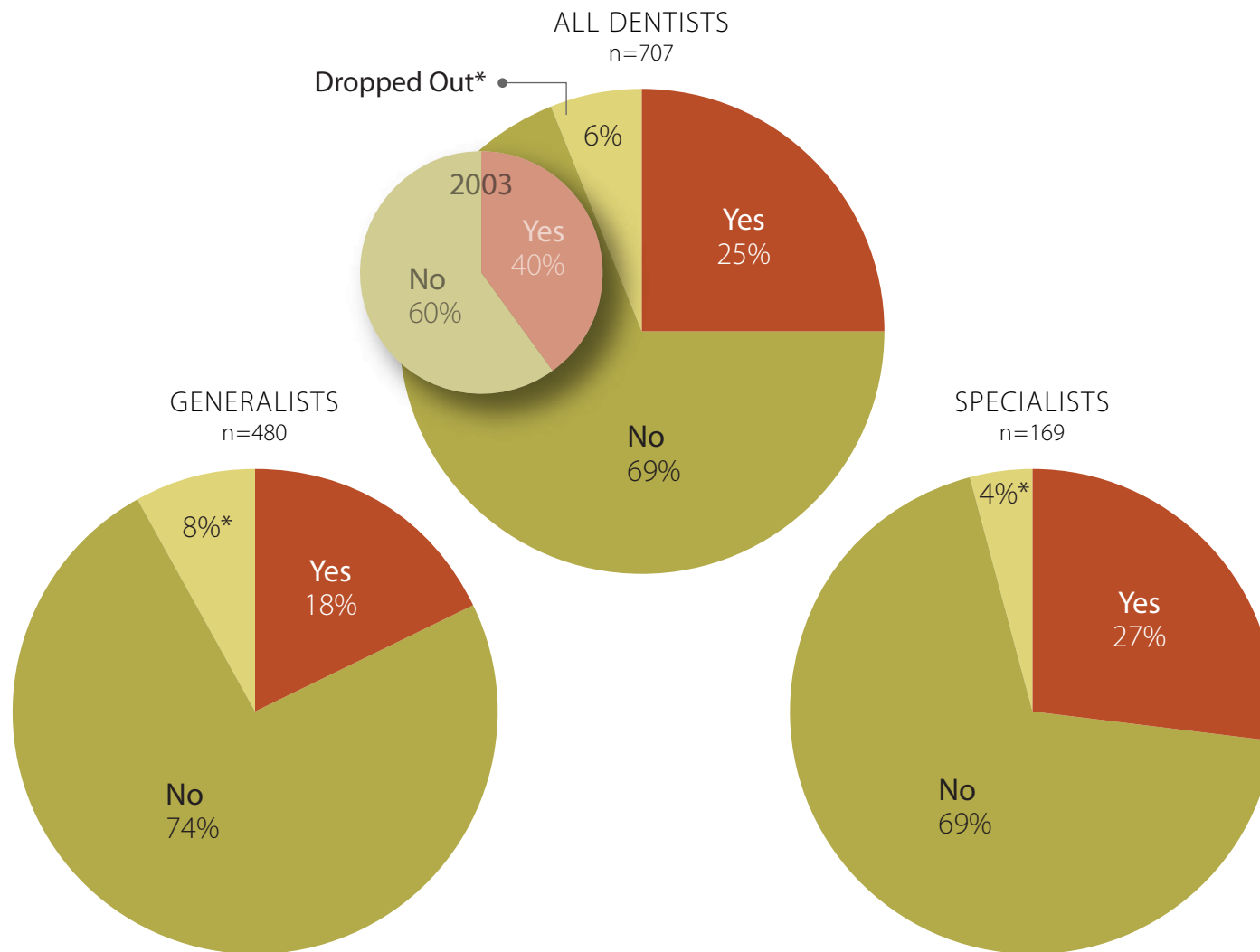
Throughout California Denti-Cal has 7.3 dentists per 10,000 Medi-Cal beneficiaries on the provider referral list. However, there is considerable variation by county. There are no dentists on the referral list for 13 Northern and Sierra Counties.

Note: There may be additional dentists accepting Medi-Cal patients who have not submitted the form required for inclusion on the Denti-Cal Web site's list of providers.

Source: California Department of Health Care Services, Denti-Cal dental referral list, [www.denti-cal.ca.gov](http://www.denti-cal.ca.gov) (accessed September 25, 2009).

# Dentist Participation in Denti-Cal, by Specialty, 2010

ARE YOU CURRENTLY A DENTI-CAL PROVIDER?



\*Stopped providing services when adult dental benefit was eliminated.

Source: California HealthCare Foundation survey of California dentists' use of technology, 2010.

## Denti-Cal Facts and Figures

Providers, Reimbursement, and Access

[<< RETURN TO CONTENTS](#)

Only one in four California dentists provides services to Denti-Cal beneficiaries, down from 40 percent in 2003. While specialists comprise only 24 percent of all dentists in the state, they are more likely than generalists to be Denti-Cal providers.

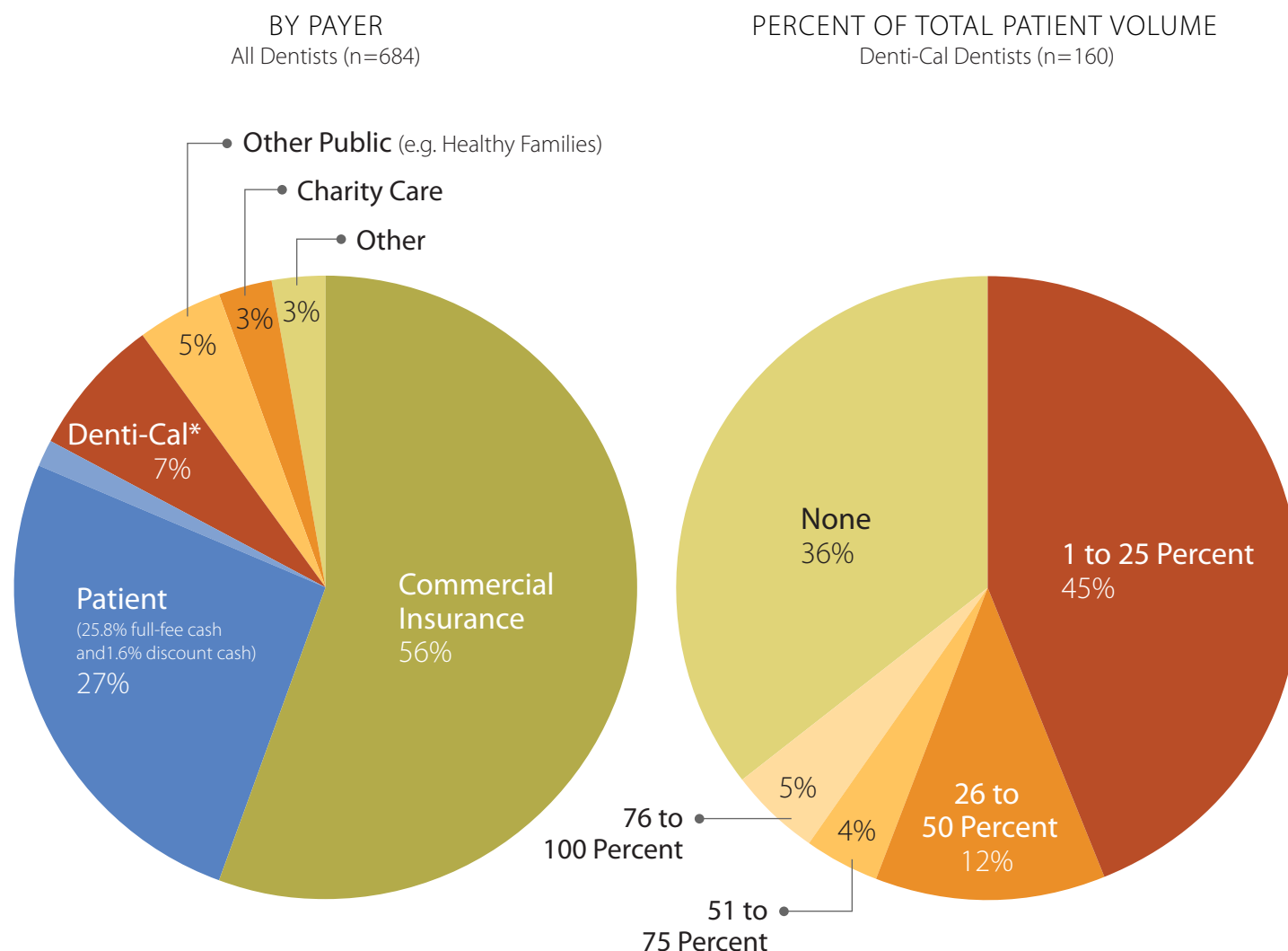
# Dentist Participation in Denti-Cal, by Payer and Percent of Total Patient Volume, 2010

## Denti-Cal Facts and Figures

Providers, Reimbursement, and Access

[<< RETURN TO CONTENTS](#)

Denti-Cal is only a small fraction of dentists' overall patient mix. Even for dentists who see Denti-Cal patients, it remains a small proportion of their volume. About a third of Denti-Cal dentists reported that they did not treat any Denti-Cal patients in the previous month.



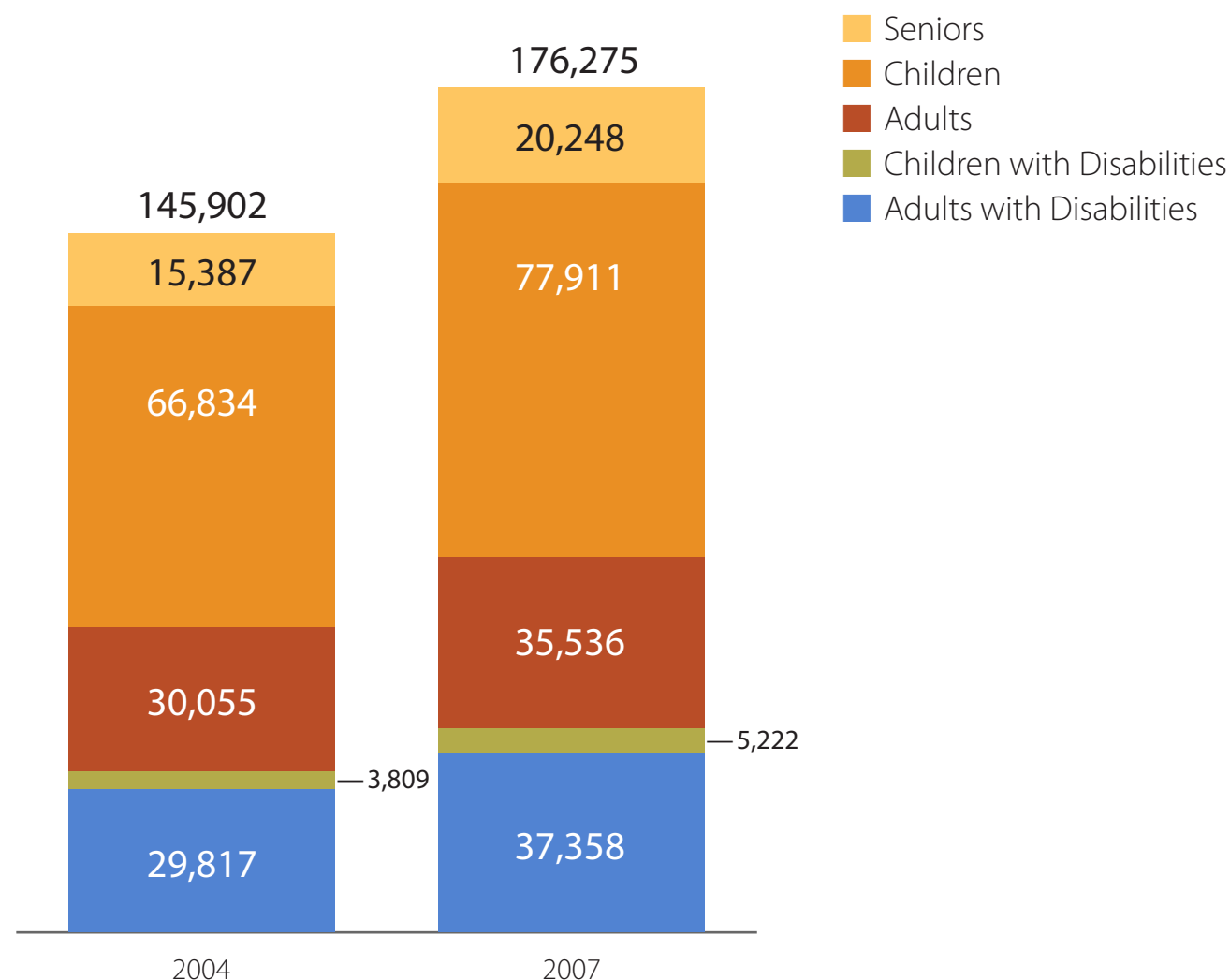
\*Includes FFS or FQHC rates.

Note: Survey question asks dentists to estimate the percentage of patient volume by payer in the last month. Segments may not add to 100 percent due to rounding.

Source: California HealthCare Foundation survey of California dentists' use of technology, 2010.

# Beneficiaries Receiving Dental Services from Clinics, by Demographic, 2004 and 2007

NUMBER OF BENEFICIARIES



Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

## Denti-Cal Facts and Figures

Providers, Reimbursement, and Access

[<< RETURN TO CONTENTS](#)

Between 2004 and 2007, Federally Qualified Health Centers and other community clinics\* played an increasingly large role in providing dental care to Medi-Cal beneficiaries. While the shift can be seen in all aid code categories, it is the elderly and disabled — Medi-Cal's most vulnerable populations — who have turned to clinics for dental services at the greatest rate.

\*Clinics receiving cost-based reimbursements are Federally Qualified Health Centers, Rural Health Centers, and Indian Health Centers and are defined as claims with vendor code 77 and procedure code 00003. Although these clinics don't provide procedure-level data, they do report encounters (visits). Denti-Cal expenditures for other community clinics (not receiving cost-based reimbursements) are not captured here.

# Medicaid Payment Rates vs. General Practice Fees, Selected Procedures, Regional and National

	2008 PAYMENT RATES <sup>1</sup>		2007 ADA GENERAL PRACTICE FEES <sup>2</sup>	
	CALIFORNIA MEDI-CAL	NATIONAL MEDICAID AVERAGE	PACIFIC REGION 75TH PERCENTILE	NATIONAL 75TH PERCENTILE
<b>DIAGNOSTIC</b>				
Periodic oral exam	\$15.00	\$22.74	\$51.00	\$44.00
Bitewings, two films	\$40.00	\$15.64	\$47.00	\$39.00
<b>PREVENTIVE</b>				
Prophylaxis (cleaning), adult	\$40.00	\$40.58	\$95.00	\$82.00
Prophylaxis (cleaning), child	\$30.00	\$31.12	\$75.00	\$60.00
<b>RESTORATIVE</b>				
Amalgam, two surfaces, permanent tooth	\$48.00	\$63.34	\$160.00	\$142.00
Extraction, erupted tooth or exposed root	\$41.00	\$53.72	\$154.00	\$144.00
Crown, porcelain fused to base metal	\$340.00	\$420.43	\$920.00	\$794.00

Notes: Denti-Cal fees for dental sealants are for those less than 21 years. Pacific Region includes California, Washington, Hawaii, Oregon, and Alaska.

Sources: 1. *Medi-Cal Physician and Dental Fees: A Comparison to Other Medicaid Programs and Medicare*, California HealthCare Foundation, 2008.

2. *2007 Survey of Dental Fees*, American Dental Association, September 2007.

## Denti-Cal Facts and Figures

Providers, Reimbursement, and Access

[<< RETURN TO CONTENTS](#)

Denti-Cal reimbursement tends to be considerably lower than national Medicaid rates and American Dental Association (ADA) general practice fees. Reimbursement for a periodic oral exam is approximately 30 percent that of the 2007 ADA 75th percentile general practice rates.

# Importance of Dental Services and Oral Health for Children in Medicaid

- In recent years, concerns have been raised about the adequacy of dental care for low-income children across the nation.
- While rare, inadequate care can result in death: Deamonte Driver, a 12-year-old boy covered by Medicaid, died as a result of an untreated infected tooth that led to a brain infection.
- Dental disease and inadequate receipt of dental care remain significant problems for children in Medicaid.
- One in three children enrolled in Medicaid had untreated tooth decay, and one in nine had untreated decay in three or more teeth.
- Children in Medicaid remain at higher risk of dental disease compared to children with private health insurance; children in Medicaid are almost twice as likely to have untreated tooth decay.
- Rates of dental disease among very young children in Medicaid — those aged 2 to 5 — worsened during the period between 1999 to 2004 when compared to earlier data from 1988 to 1994.
- Close to one in nine children (11 percent) had untreated tooth decay in three or more teeth, which can be a sign of a severe oral health problem or higher levels of unmet need.

Preventive dental care is vital for children's health. Left untreated, pain and infections caused by tooth decay may lead to problems in eating, speaking, and learning during a crucial period in their development.

Source: *Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*. Government Accountability Office, September 2008, [www.gao.gov](http://www.gao.gov).

# Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

The early and periodic screening, diagnosis, and treatment (EPSDT) program is a special process within Medi-Cal specifically for children. Under federal law, EPSDT services are provided to most Medicaid beneficiaries under age 21. EPSDT services consist of two mutually supportive, operational components: assuring the availability and accessibility of required health care resources including but not limited to dental services; and helping Medicaid beneficiaries and their parents or guardians to effectively use the resources.<sup>1</sup>

For the Denti-Cal Program, this means medically necessary dental services provided for most Denti-Cal beneficiaries who have not yet reached his or her 21st birthday are EPSDT services. Whenever a Denti-Cal provider completes an oral examination on a child, an EPSDT screening service (and diagnostic service) has occurred. Any subsequent dental treatment resulting from that examination is considered an EPSDT dental service if the dental procedure is published in the *Denti-Cal Manual of Criteria*.

EPSDT beneficiaries may require dental services that are not part of the current Denti-Cal program of benefits. Conversely, the dental service may be part of the Denti-Cal Program scope of benefits for adults but not for children, or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by the Denti-Cal Program. In these cases, such dental services are called EPSDT Supplemental Services (EPSDT-SS). Dentists are required to request prior authorization for an EPSDT Supplemental Service.<sup>2</sup>

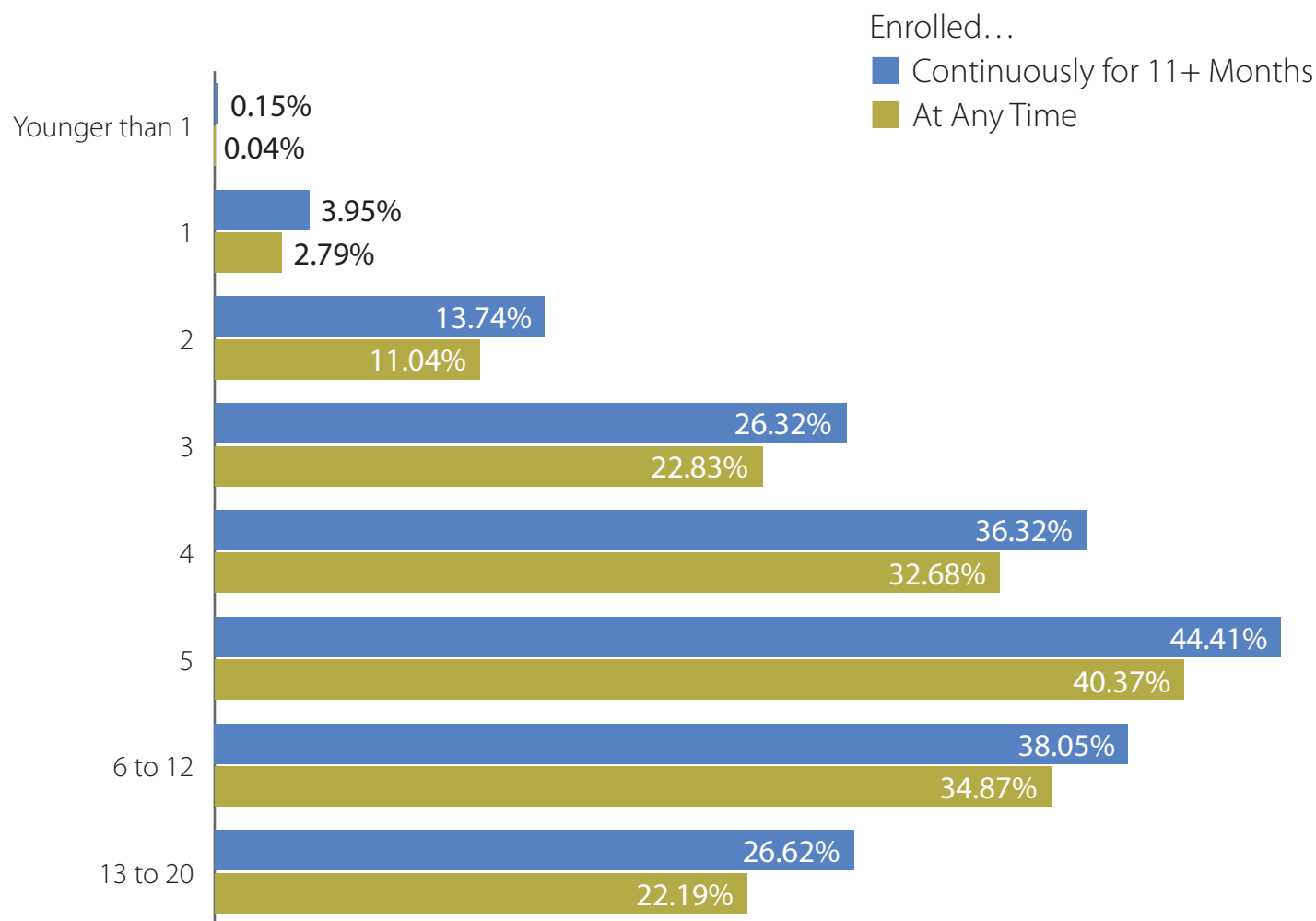
Among the top six largest U.S. states, only Florida ranks below California in the percent of children who receive EPSDT dental services.\*

Sources 1. *Guide to Children's Dental Care In Medicaid*, CMS, October 2004.

2. California Department of Health Care Services, [www.denti-cal.ca.gov](http://www.denti-cal.ca.gov) (accessed October 18, 2009).

\*EPSDT Dental Utilization Rates: Appendix E, 2008 National Dental Summary, U.S. Department of Health and Human Services Centers for Medicare and Medicaid Service, January 2009.

# Medi-Cal Children Receiving FFS Preventive Dental Service, by Age Group (in Years) and Enrollment Status, 2007



Notes: Preventive services were defined here as: sealants; prophylaxis without topical fluoride application for children under age 13; prophylaxis without topical fluoride application for children ages 13 and older; prophylaxis with topical fluoride application for children under age 6; prophylaxis with topical fluoride application for children ages 6 to 17; and space maintainers. Includes managed care and fee for service enrollees. Excludes CHDP claims. Service dates in 2007 used. Further information on these three measures can be found in the methodology section.

Source: HMA analysis of MIS/DSS 2007 data extracted by JEN Associates.

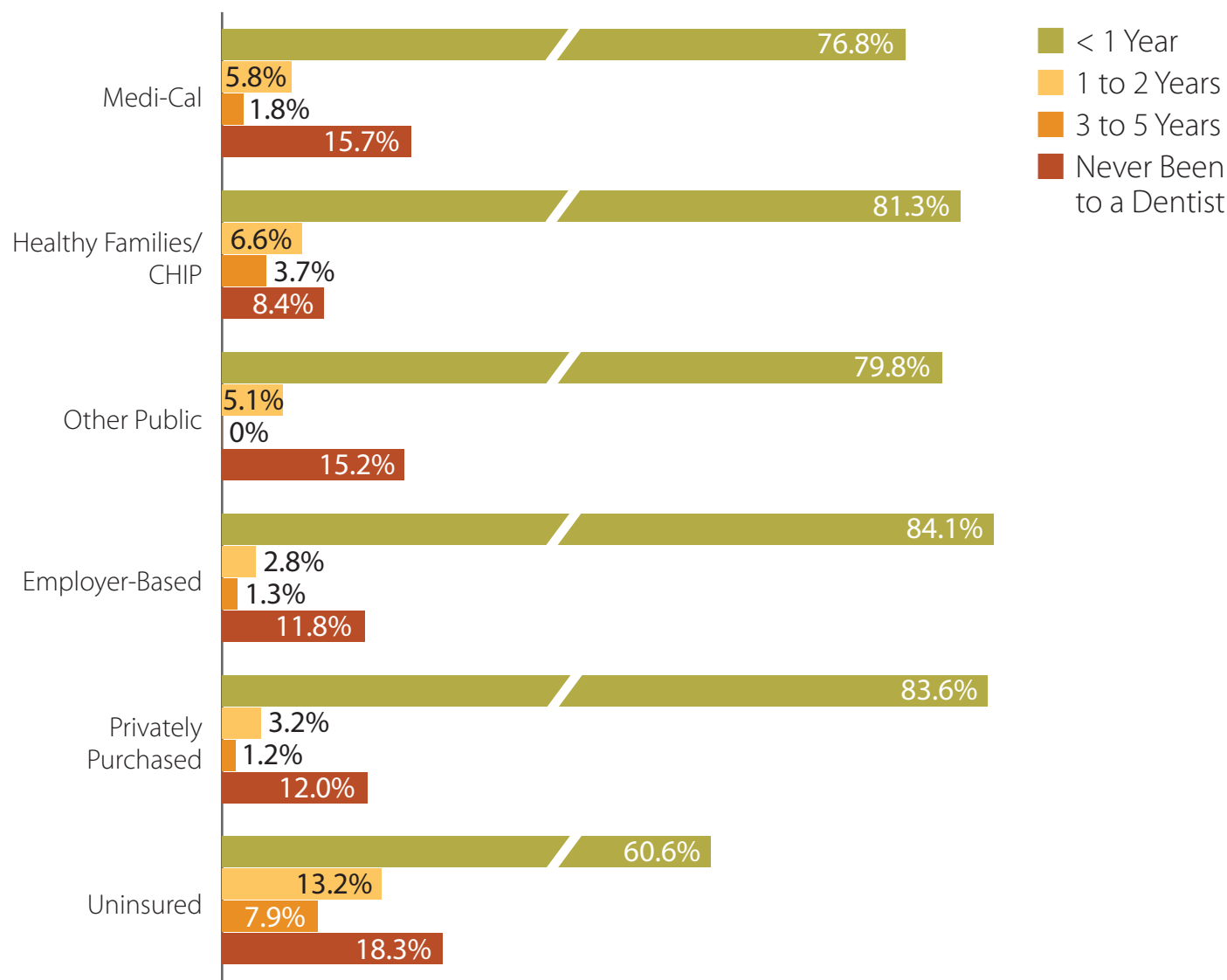
## Denti-Cal Facts and Figures

Children, Pregnant Women, and Disabled

[<< RETURN TO CONTENTS](#)

As of 2007, fewer than one in ten children under the age of 2 had received a preventive dental service. Five-year-olds were most likely to have a preventive dental service. Children who were enrolled in Medi-Cal continuously for 11 or more months were more likely to have a preventive service.

# Children's Access as Measured by Time Since Last Visit, by Insurance Type, 2007



Note: Data are for respondents older than 2 through 19, and children 1 to 2 years old who have a tooth. Comparable 2007 data for adults are not available.

Source: California Health Interview Survey, 2007.

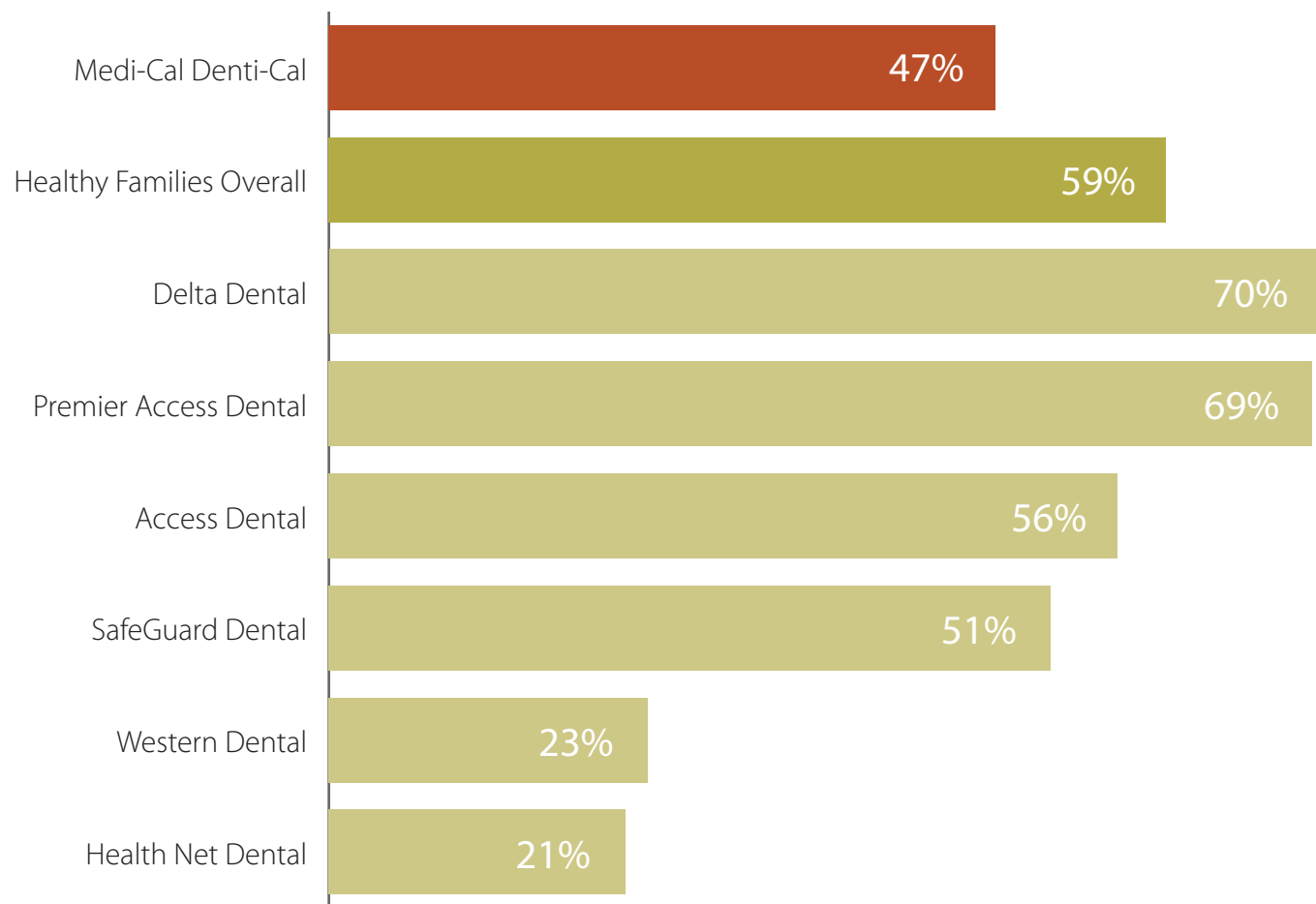
## Denti-Cal Facts and Figures

Children, Pregnant Women, and Disabled

[<< RETURN TO CONTENTS](#)

In 2007, children with Medi-Cal coverage were more likely to report that they have never visited a dentist than those with other types of insurance. Uninsured children were least likely to have seen a dentist at any point in their life.

# Children\* Receiving Dental Visit in Past 12 Months, Denti-Cal vs. Healthy Families, 2007



## Denti-Cal Facts and Figures

Children, Pregnant Women, and Disabled

[<< RETURN TO CONTENTS](#)

In 2007 children enrolled in Medi-Cal were less likely to have visited a dentist in the last 12 months than children enrolled in Healthy Families. The Healthy Families program “open” network plans, Delta Dental and Premier Access Dental, reported significantly higher rates compared to capitated dental plans.

\*Medi-Cal percentage for ages 4 to 18. Healthy Families percentages are for 2 to 18. All numbers reflect the proportion of beneficiaries enrolled continuously for 11 months or more with an annual dental visit.

Sources: *Healthy Families Program, 2007 Dental Quality Report*, June 2009, [mrmib.ca.gov](http://mrmib.ca.gov). HMA analysis of MIS/DSS 2007 data extracted by JEN Associates.

# Medicaid Reimbursement for Pediatric Dental Services, by Procedure Category, California and Five Largest States, 2008

Denti-Cal reimbursement is much lower compared to general practice fees, and is typically lower than Medicaid rates in other states.

	CA (6/1/08)	TX (9/1/08)	NY (6/1/08)	FL (6/1/08)	IL (7/1/08)	PA (9/1/08)
<b>ADJUNCTIVE GENERAL SERVICES</b>						
Conscious sedation	\$25.00	\$187.50	—	\$40.00	\$35.00	\$184.00
<b>ENDODONTICS</b>						
Therapeutic pulpotomy	\$71.00	\$87.96	\$87.00	\$50.00	\$52.70	\$75.00
Anterior endodontic therapy	\$216.00	\$355.98	\$250.00	\$148.00	\$136.40	\$275.00
Molar root canal	\$331.00	\$624.26	\$406.00	\$235.00	\$202.30	\$500.00
<b>DIAGNOSTIC</b>						
Periodic oral evaluation	\$15.00	\$29.44	\$29.00	\$15.00	\$28.00	\$20.00
Limited oral evaluation, problem-focused	\$35.00	\$19.16	\$14.00	\$8.00	\$16.20	—
Comprehensive oral exam	\$25.00	\$36.04	—	\$16.00	\$21.05	\$20.00
Intra-oral complete x-rays, including bitewings	\$40.00	\$72.08	\$58.00	\$32.00	\$30.10	\$45.00
Bitewings, two films	\$10.00	\$23.86	\$17.00	\$9.00	\$9.40	\$16.00
Panoramic x-ray film	\$25.00	\$65.08	\$40.00	\$30.00	\$22.60	\$37.00
<b>ORAL AND MAXILLOFACIAL SURGERY</b>						
Extraction, erupted tooth or exposed root	\$41.00	\$67.04	\$45.00	\$27.00	\$39.12	\$65.00

	CA (6/1/08)	TX (9/1/08)	NY (6/1/08)	FL (6/1/08)	IL (7/1/08)	PA (9/1/08)
<b>PREVENTIVE</b>						
Prophylaxis (cleaning), child	\$30.00	\$37.50	\$43.00	\$14.00	\$41.00	\$30.00
Topical fluoride application (excluding prophylaxis), child	\$8.00	\$15.00	\$14.00	\$11.00	\$26.00	\$18.00
Topical fluoride varnish	—	\$15.00	—	\$11.00	\$26.00	\$18.00
Dental sealant, per tooth	\$22.00	\$28.82	\$43.00	\$13.00	\$36.00	\$25.00
<b>RESTORATIVE</b>						
Amalgam, two surfaces, primary or permanent tooth	\$48.00	\$87.46	\$84.00	\$41.00	\$48.15	\$55.00
Resin-based composite, two surfaces, anterior tooth	\$60.00	\$105.14	\$87.00	\$39.00	\$51.90	\$60.00
Crown, porcelain fused to base metal	\$340.00	\$528.00	\$580.00	\$228.00	\$235.20	\$500.00
Prefabricated stainless steel crown, primary tooth	\$75.00	\$156.06	\$116.00	\$68.00	\$73.40	\$99.00
Prefabricated resin crown	\$45.00	\$68.75	\$116.00	\$68.00	\$56.45	\$50.00

**California Comments:** Fluoride varnish reimbursed using D1203. Note that all rates were reduced by 10 percent effective 7/1/08. A subsequent court order, which as of 9/9/08 was in the process of being implemented, requires reversal of the rate reduction retroactive to 8/18/08 (the date of the court order). The State is complying, but has appealed the order. The budget passed by the Legislature and expected to be signed by the Governor includes the 10 percent reduction. **New York Comments:** The rates listed are for the Medicaid FFS program. Rates for the Partnership Plan are proprietary and unavailable. MCOs providing services for the Partnership Plan are not restricted by FFS rates but overall expenditures must be within the range that would have been paid in the FFS program. **Illinois Comments:** The fee schedule is for children ages 0 to 18. Services rendered to EPSDT-eligible children ages 19 to 21 are reimbursed at a somewhat lower rate. **Pennsylvania Comments:** The fee schedule represents the ACCESS program FFS rates. Rates for the MCOs, which serve most Pennsylvania children, are not available.

Source: American Dental Association (ADA), *Compendium Update: A Survey of Medicaid and State Children's Health Insurance (SCHIP) Dental Programs for Children and Adults*, 2008.

# Importance of Dental Services and Oral Health for Pregnant Women

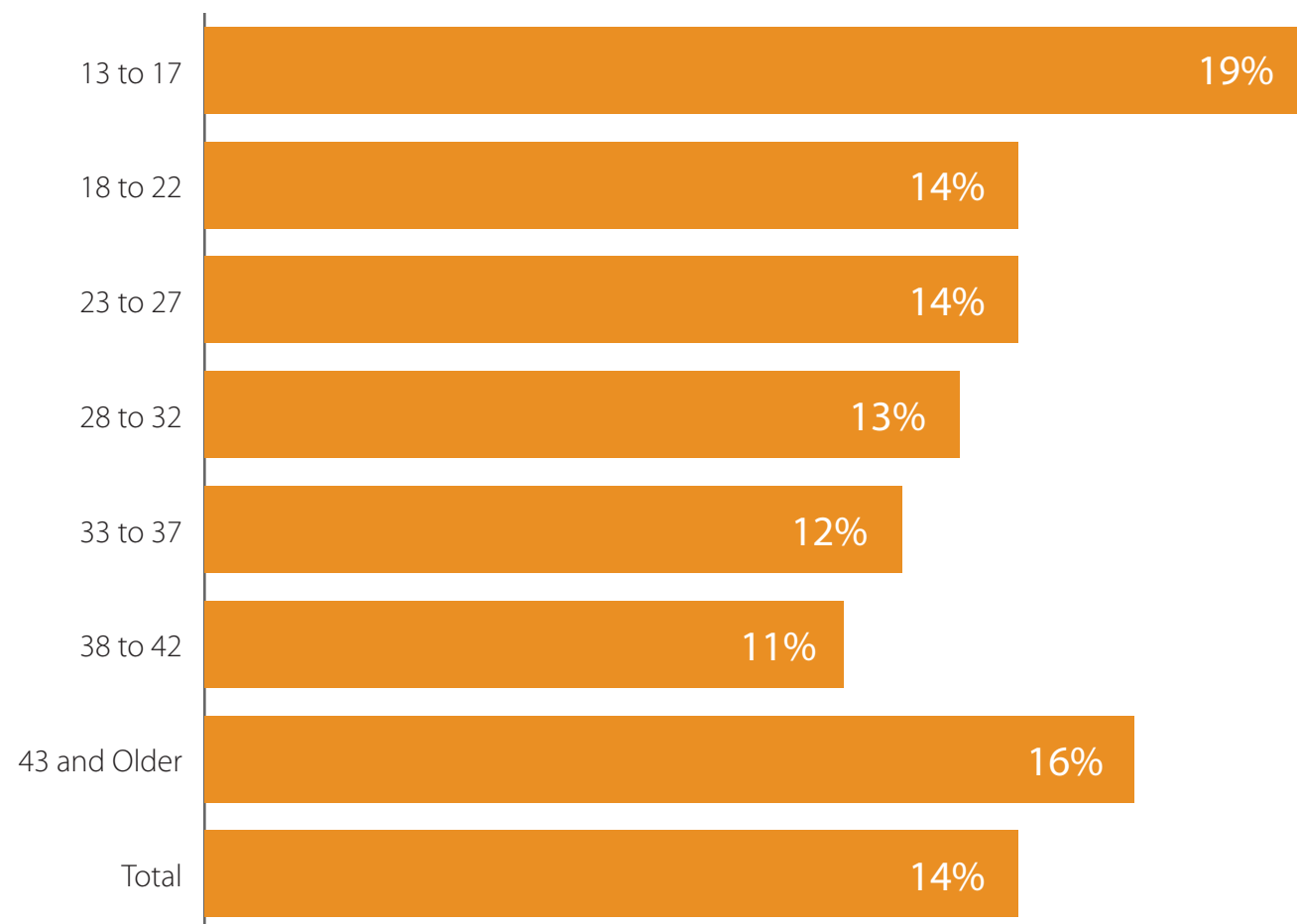
- During pregnancy, blood flow throughout the body increases by about 30 to 50 percent. Consequently, increased blood flow to a pregnant woman's gums may provide nutrition to bacteria living at the gum line, leading to gum disease. Studies suggest that 25 to 100 percent of pregnant women experience gingivitis and 10 percent may develop noncancerous growths on their gums called pyogenic granulomas, or "pregnancy tumors" caused by inflammation.<sup>1</sup>
- Improving preconception health by providing health promotion, screening, and interventions can result in improved reproductive health outcomes, with potential for reducing societal costs as well.<sup>2,3</sup>
- Research on pregnancy and outcomes is mixed. Recent studies found that routine periodontal treatment in pregnant women did not reduce the risk of pre-term deliveries.<sup>4</sup> Yet other research has shown that women with severe gum disease are at increased risk of pre-term birth, and treating a woman's periodontal disease reduced the likelihood by almost 50 percent.<sup>5</sup>
- The American Academy of Periodontology urges oral health professionals to provide preventive services as early in pregnancy as possible and to provide treatment for acute infection or sources of sepsis irrespective of the stage of pregnancy.<sup>6</sup>
- In 2007, less than one in seven pregnant Medi-Cal women had a dental visit during pregnancy.

While the evidence on the relationship between oral health and pregnancy is mixed, in 2009 the American Academy of Periodontology (AAP) continued to urge women to care for their periodontal health while pregnant, through regular tooth brushing and flossing, and routine visits to a dentist to screen for periodontal disease.

Sources: 1. Gaffield, Mary Lyn, Ph.D., M.P.H.; Brenda J. Colley, M.S. Gilbert, Ph.D.; Dolores M. Malvitz, Ph.D.; Raul Romaguera, D.M.D. "Oral Health During Pregnancy: An Analysis of Information Collected by the Pregnancy Risk Assessment Monitoring System." *The Journal of the American Dental Association*. 2001;132:1009–1016.  
2. Moos, M.K., R.C. Cefalo. "Preconceptional health promotion: a focus for obstetric care." *American Journal of Perinatology*. 1987;4:63–67.  
3. U.S. Department of Health and Human Services, Public Health Service. "Caring for our Future: The Content of Prenatal Care: A report of the Public Health Service Expert Panel on the Content of Prenatal Care," 1989.  
4. *The AAP Issues Statement on Periodontal Treatment During Pregnancy*, American Academy of Periodontology, January 30, 2009, [www.perio.org](http://www.perio.org).  
5. *Expecting Mothers Should "Brush Up" on Their Oral Hygiene Routine*, American Academy of Periodontology, November 12, 2007, [www.perio.org](http://www.perio.org).  
6. American Academy of Periodontology statement regarding periodontal management of the pregnant patient. *Journal of Periodontology*. 2004; 75(3):495.

# Dental Care During Pregnancy for Medi-Cal Beneficiaries, by Age Group (in Years), 2007

PERCENT OF MEDI-CAL PREGNANT WOMEN RECEIVING DENTAL CARE



Notes: Data are for women ages 13 to 65 who are enrolled in a Medi-Cal FFS plan who had a dental visit within six months of their first visit to a medical care provider. Dental data is based on service date. See the [Methodology](#) section for further information.

Source: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.)

## Denti-Cal Facts and Figures

Children, Pregnant Women, and Disabled

[<< RETURN TO CONTENTS](#)

Among pregnant women 18 to 22—an age group that accounts for nearly 80 percent of all pregnancies—fewer than 14 percent had a dental visit in 2007.

# Dental Care During Pregnancy for Medi-Cal Beneficiaries, by Aid Code

	MEDI-CAL PREGNANT ENROLLEES 2007	PERCENT RECEIVING DENTAL CARE 2008 (OR MOST CURRENT YEAR)
<b>NO SHARE OF COST (MEDICALLY NEEDY)</b>	<b>81%</b>	
3V Aid to Families with Dependent Children (AFDC), 1931(b) non-CalWORKS, emergency services only	43%	11%
3N AFDC, 1931(b) non-CalWORKS	15%	18%
34 AFDC, medically needy	6%	16%
30 CalWORKS, all families	5%	20%
60 Disabled, SSI/SSP, cash	3%	23%
Others	9%	20%
<b>SHARE OF COST</b>	<b>19%</b>	
37 AFDC, medically needy	5%	21%
Others	14%	23%
<b>Total</b>	<b>100%</b>	

Among pregnant women enrolled in Medi-Cal through aid code 3V, the largest proportion, fewer than one in ten received dental care during pregnancy.

Notes: Data are for women ages 13 to 65 who are enrolled in a Medi-Cal FFS plan who had a dental visit within 6 months of their first provider visit. Dental data is based on service date. See the [Methodology](#) section for further information.

Sources: Peggy, T., et al, *Dental Care Use Among Pregnant Women in the United States Reported in 1999 and 2002*, Centers for Disease Control and Prevention, Vol. 2 No.1, January 2005, [www.cdc.gov](http://www.cdc.gov). Huebner, C.E., P. Milgrom, R. Lee, and D. Conrad, *Dental Care for Pregnant Women*, Health Services Research Abstract, Metro Toronto Convention Centre Exhibit Hall Poster, July 4, 2008, [iadr.confex.com](http://iadr.confex.com).

# Dental Services and the Disabled

- Individuals with disabilities and the elderly may have physical, cognitive, or behavioral limitations that impair normal oral self-care; chronic and complex conditions that are adversely affected by oral disease; and medication regimens that reduce saliva flow (a natural defense against cavity-causing bacteria). Additionally, poor oral health may impair their ability to maintain proper nutrition.
- At \$338 per dental service user, Denti-Cal's expenditures for the disabled population are small when compared to medical payments, which averaged approximately \$14,000 per beneficiary in 2007 and account for a very large percentage of the total Medi-Cal budget.
- While California eliminated dental services for most adults in 2009, including the disabled, in 2007 some states did not offer full adult dental benefits but did preserve benefits for the disabled population in particular. For example:
  - Missouri and Oregon provided coverage in every service category for the disabled, elderly, and pregnant women, but only emergency services for all other adult enrollees.
  - Oklahoma provided coverage in every service category for disabled adults, limited coverage to pregnant women, and only emergency services to all other adult enrollees.
  - Kansas, Montana, and Texas provided coverage in every service category for the disabled and elderly, but only emergency services for all other adult enrollees.

The disabled can be particularly vulnerable to a lack of appropriate dental care.

Notes: Medi-Cal average expenditures for the disabled population of \$14 thousand per person is based on average expenditures for all disabled beneficiaries independent of whether they used services.

Sources: HMA analysis of 2007 Medi-Cal data. (Includes all FFS claims paid to a dental professional.) California HealthCare Foundation, *Medi-Cal Facts and Figures, 2009*. Mary McGinn-Shapiro, *Medicaid Coverage of Adult Dental Services*, National Academy for State Health Policy, State Health Policy Monitor, October 2008.

# Important Questions for the Denti-Cal Program

- What is the impact of the elimination of adult dental benefits on the Denti-Cal budget?
- Has the elimination of adult dental benefits disrupted children's access to dental care?
- What effect has the elimination of adult dental benefits had upon more vulnerable adults such as seniors and the disabled?
- Has the reduction in provider reimbursement rates reduced beneficiaries' access to services?
- How can performance goals and measurement be most effectively integrated in the dental contract reprocurement?
- How can dentists, specifically Medi-Cal dentists, best position themselves to earn incentives under Medicaid if they adopt and make "meaningful use" of certified electronic health records?

State budget constraints have led to significant cuts to the Medi-Cal dental program, but their impact is unknown. At the same time, a focus at the federal level on health care may offer opportunities to improve dental care for Medi-Cal beneficiaries.

Notes: The American Recovery and Reinvestment Act specifies that health care providers—including dentists—who make meaningful use of EHR technology and whose patient load includes at least 30 percent Medicaid beneficiaries are eligible for Medicaid incentive payments. Dentists who practice predominately at federally qualified health centers, and whose patient encounters are at least 30 percent "needy individuals," are similarly eligible for the Medicaid incentive payments. "Needy individuals" are Medicaid or Children's Health Insurance Program enrollees, those who are deemed needy under FQHC sliding fee scales (which are tied to federal poverty levels), and those who receive uncompensated care services from hospitals.

— California Healthline, September 28, 2009

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# Methodology

## Claims Data

The expenditure and utilization analyses for this presentation were based on the Medi-Cal paid claims data as extracted by JEN Associates. Dental data are compiled from all records on the outpatient service table with a Claim Type (CLMTYPE) equal to 5, where the value 5 specifies a dental claim. Child Health and Disability Prevention Program (CHDP) claims are also included in the dental table; however, since the CHDP program is not part of Denti-Cal, CHDP claims were omitted from the analysis. Information on clinic utilization and expenditures was based on claims with a vendor code equal to 77, indicating a clinic, and procedure code equal to 00003 indicating a dental procedure. This presentation includes some data for services through Medi-Cal dental fee for service (FFS) and managed care (MC) arrangements. However, in slides where noted, only FFS data were used and in cases where dental services and expenditures were compared, only FFS claims were used since there is mixed evidence regarding the completeness and reliability of Medi-Cal managed care data.

Dental claims with a date of service in calendar year 2007 were the focus of analysis. In instances where longitudinal data is used, calendar year 2005 was omitted due to incomplete claims for that year.

## Enrollee Demographic Data

The beneficiary data were based on Medi-Cal eligibility files as extracted by JEN Associations. Demographic data on a claim (e.g., age and ethnicity) may vary by claim; therefore all demographic data associated with an enrollee was based on information obtained from the beneficiary at the time of enrollment. The age of the recipient was based on the age of the beneficiary as of January 2007. Using aid code and age designations, beneficiaries were grouped into five categories for ease of reporting and included: seniors, blind and disabled adults, blind and disabled children, non-blind and disabled adults, and non-blind and disabled children. Unfortunately, there is no single authoritative source with a list of aged, blind, and disabled aid codes. But for the purposes of this work the authors used the following: **ABD Medically Needy Aid Codes:** 13, 14, 17, 1D, 1H, 1U, 1X, 1Y 23, 24, 27, 2D 6D, 6H, 6S, 6U, 6V, 6W, 6X, 6Y, 63, 64, 67, 8G; **ABD Public Assistance Aid Codes:** 1E, 10, 16, 18 2E, 20, 26, 28, 6A 36, 6C, 6E, 6N, 6P, 60, 66, 68; QMB=80. Aid code 60, a disabled aid code for those with Supplemental Security Income (SSI) – State Supplementary Payment (SSP) eligibility represents the largest group of the ABD population ([www.dss.cahwnet.gov](http://www.dss.cahwnet.gov)).

## Access/Utilization Measures

There are many definitions of and methods by which to measure access to care and utilization. One of the most basic is a utilization rate, i.e., the proportion of a population that uses a service in a specified time period. The numerator in this equation is typically an unduplicated count of users, i.e., an individual is only counted once regardless of the number of times that person is seen or the number of services received. The denominator, however, can be specified in several different ways, each of which tends to influence how the data are interpreted. Most of the slides used an unduplicated count of enrolled members over the course of the year. This reflected the aggregate number of people who had the benefit of dental services at any time during the period analyzed. However, it is important to note that in Medi-Cal, where over the course of a year some individuals may be eligible for a month or two while others may be eligible for the entire year, it isn't reasonable to assume that people who have been enrolled for a month have had the same opportunity to receive dental care as those who have been enrolled for a year.

## Percent of Children Receiving Preventive Services in 2007, by Age

Preventive services were defined as: sealants; prophylaxis without topical fluoride application for children under age 13; prophylaxis without topical fluoride application for children 13 and older; prophylaxis with topical fluoride application for children under age 6; prophylaxis with topical fluoride application for children ages 6 to 17; and space maintainers.

## Dental Care During Pregnancy

This analysis identified all women ages 13 and older who were enrolled in a fee-for-service dental plan in 2007 and had a vaginal delivery or C-section. Given the limitation of one calendar year of dental data, the analysis identified women who met these criteria in the first six months of 2007 and determined how many had a dental visit within six months of the first service date of their pregnancy episode. (A first service date is determined by the woman's first encounter with a health care provider.) While this approach is a good indicator of dental care for women who are pregnant, it has obvious shortcomings. First, a woman may have had a dental visit during her pregnancy, but sometime later than six months after her first service date. Second, a woman may have had a first service date late in her pregnancy and the dental visit may have actually occurred after delivery. Time constraints and data limitations precluded the use of a methodology to address these limitations. Future analyses should also take into account the end date of the episode, but one would hypothesize that good oral health for the mother is most advantageous early on and throughout the pregnancy.

# Glossary

## Amalgam

An alloy used in direct dental restorations.

## Bitewings

A dental x-ray device with a central projection on which the teeth can close, holding it in position for the radiographic examination of several upper and lower teeth simultaneously.

## Capitation Rate

A fee or payment of a uniform amount for each person in a managed care health plan.

## Composite

Tooth-colored filling material made of a plastic dental resin.

## Crowns

**Anatomical:** That portion of tooth normally covered by, and including, enamel;

**Artificial:** Restoration covering or replacing the major part, or the whole of the clinical crown, of a tooth;

**Clinical:** That portion of a tooth not covered by supporting tissues.

## Dental Procedure Categories

Below are dental procedure categories related to the charts and tables in this presentation.

Diagnostic	Includes exams, x-rays
Oral and Maxillofacial Surgery	Includes extractions
Other	Implant services, prosthetics, prosthodontics
Periodontics	Includes treatment of gums, tissue, and bone that support the teeth
Preventive	Includes prophylaxis and sealants
Restorative/Endodontic	Treatment of root and nerve of root

## Disabled Adults

Disabled people who are 21 years of age or older. Includes Medically Needy, Blind/Disabled, and Public Assisted Blind/Disabled.

## Disabled Children

Disabled people who are 0 to 20 years of age. Includes Medically Needy, Blind/Disabled, and Public Assisted Blind/Disabled.

## Endodontics

A dental specialty concerned with treatment of the root and nerve of the tooth.

## Federally Qualified Health Centers (FQHC)

A public entity or private nonprofit provider that has been approved by Medicare or Medicaid to provide primary and preventive health care services such as dental, mental health, substance abuse, hospital, and specialty care services to underserved populations.

## Denti-Cal Facts and Figures

### Appendix

[<< RETURN TO CONTENTS](#)

## Film

See radiograph.

## Gingiva

Soft tissues overlying the crowns of unerupted teeth and encircling the necks of those that have erupted.

**Subgingival Curettage:** The removal of tartar deposits or ulcerated tissues from periodontal pockets.

**Gingivitis:** Inflammation of gingival tissue without loss of connective tissue.

## Intraoral

Inside the mouth.

## Intraoral Periapical

Inside the mouth at or around the apex of a root of a tooth.

## Limited Scope

Limited scope recipients have restricted services. Beneficiaries in certain aid code categories, for example, may be restricted to emergency or pregnancy-related services.

## Maxillofacial Surgery

Surgery of, pertaining to, or affecting the jaws and the face.

## MIS/DSS

The Medi-Cal Management Information System/Decision Support System that includes Medi-Cal paid outpatient, inpatient, and pharmacy claims. It also contains eligibility and demographic data for beneficiaries and providers.

## Glossary, *continued*

### Orthodontics

A dental specialty concerned with straightening or moving misaligned teeth or jaws with braces or surgery.

### Periapical

At or around the apex of a root of a tooth.

### Periodontal

Pertaining to the supporting and surrounding tissues of the teeth.

### Periodontal Disease

Inflammatory process of the gingival tissues or periodontal membrane of the teeth, resulting in an abnormally deep gingival fissure, possibly producing periodontal pockets and loss of supporting bone.

### Periodontics

A dental specialty concerned with the treatment of gums, tissue, and bone that support the teeth.

### Prophylaxis

A scaling and polishing procedure performed to remove dental plaque, tartar, and stains.

### Prosthetic

A device, either external or implanted, that substitutes for or supplements a missing or defective part of the body.

### Prosthodontics

Replacement of missing teeth with artificial materials, such as a bridge or denture.

### Pulp

Connective tissue that contains blood vessels and nerve tissue which occupies the pulp cavity of a tooth.

### Pulpotomy

Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing; pulp amputation.

### Radiograph

An image produced by projecting radiation on photographic film. Radiographs are commonly called x-rays.

### Root

The anatomic portion of the tooth that is covered by cementum and is located in the alveolus (socket) of the jawbone.

### Root Canal

The portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

### Root Canal Therapy

The treatment of disease and injuries of the pulp and associated periradicular conditions.

### Root Planing

A procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased cementum or dentin on the root surfaces and in the pocket.

### Scaling

Removal of plaque, tartar, and stain from teeth.

### Sealants

Plastic resin placed on the biting surfaces of teeth to prevent bacteria from attacking the enamel and causing tooth decay.

### Space Maintainers

The permanent teeth may not erupt in their proper alignment, resulting in malocclusion, or crooked teeth. The main causes of malocclusion are a lack of space for the permanent teeth to erupt properly and the premature loss of the baby teeth, which usually guide the permanent teeth to their proper location. To prevent malocclusion due to premature loss of the primary teeth, space maintainers may be used to guide the teeth into proper alignment.

### Treatment Authorization Request (TAR)

A detailed report that explains why the services a beneficiary has requested are medically necessary and should be paid for by Medi-Cal.

### X-Ray

See Radiograph.