Inequality of Access to Surgical Specialty Health Care: Why Children With Government-Funded Insurance Have Less Access Than Those With Private Insurance in Southern California

Edward C. Wang, MD*; Meeryo C. Choe, BA*; John G. Meara, MD, DMD, FAAP‡; and Jeffrey A. Koempel, MD, FAAP*§

ABSTRACT. *Objective.* **More than 25 million children in the United States are dependent on federal and state medical insurance programs for their health care needs. In California, 3.25 million children depend on Medi-Cal for their health insurance. In Southern California alone, the figure is as high as 1.81 million. However, 9.30 million children nationally and 1.55 million in California have no health insurance. Various public policies that would increase enrollment in these programs are being discussed to address this problem. However, before their implementation, it is important to understand what impact such policies would have on the actual delivery of health care to this patient population. In California, 2 predominant health care delivery models exist for Medi-Cal: a fee-for-service (so-called regular or straight Medi-Cal) and a managed care plan. One third of the children in Medi-Cal in the state are enrolled in the fee-for-service plan with the remainder in the managed care plan, whereas in Southern California, this figure is slightly lower at 28% in the fee-for-service plan. The objective of this study was to determine the number of otolaryngologists in Southern California who would offer a new patient appointment for an evaluation for tonsillectomy for a child with commercial insurance versus government-funded (Medi-Cal) insurance through direct contact with the physician and to determine whether the surgeon would offer to perform the procedure or refer the patient to another institution and to identify the specific reason(s) for any disparity in access to health care.**

Methods. **A written questionnaire was sent via regular mail to 303 otolaryngologists in the Southern California area in 2003.**

Results. **A total of 100 fully completed questionnaires were received. Ninety-seven surgeons would offer an office appointment to a child with commercial insurance as compared with only 27 for a child with Medi-Cal. Of those 27 surgeons, 8 would then refer the child to another physician to perform the surgery, and only 19 would actually offer to perform surgery, if indicated. Reasons provided for not offering an office appointment or surgery for the child with Medi-Cal include excessive paperwork and/or administrative burdens (96%), low monetary reimbursement for the surgery (92%), and low monetary reimbursement for the office visit (87%).**

Conclusions. **There is a tremendous inequality of access to surgical specialty health care for children with government-funded insurance when compared with those with commercial insurance in Southern California. Physicians indicate that this disparity is related to excessive administrative burdens and low monetary reimbursement. The implications of our findings on public health care policies are discussed.** ***Pediatrics*** **2004; 114:e584–e590. URL: www.pediatrics.org/cgi/doi/10.1542/peds.2004-0210;** ***access to health care (health care accessibility), child health services, Medicaid, tonsillectomy, health insurance reimbursement, health insurance, medical economics.***

ABBREVIATIONS. DHS, Department of Health Services; SCHIP, State Children's Health Insurance Program; OSA, obstructive sleep apnea; TAR, treatment authorization request; LAO, Legislative Analyst's Office.

Medicaid is a government health insurance program that provides medical assistance to needy individuals and families who meet certain eligibility requirements. It was enacted on July 30, 1965, by Title XIX of the Social Security Act and is jointly funded by both federal and state governments. Each state is charged with the responsibility of administering its own program, albeit within federal guidelines. In 2002, 48.9 million individuals received health services through this program. Of this total, 24.3 million beneficiaries are children.[1] Total expenditures for the Medicaid program amounted to $258 billion for fiscal year 2002.[2]

In California, the Medicaid program, known as Medi-Cal, was created in March 1966. Total Medi-Cal spending is $28.7 billion for fiscal year 2003–2004.[3] Of the 6.50 million beneficiaries in Medi-Cal in 2003, 3.25 million were children under the age of 19. Of this number, 1.81 million children live in Southern California, which we define as Los Angeles, Ventura, San Bernardino, Riverside, and Orange Counties.[4] In 2002, fee-for-service (so-called regular or straight) Medi-Cal, Medi-Cal managed care, and other government insurance provided coverage for 30% (2.65 million) of all children with health insurance in California, with the remainder (6.08 million) being covered by private health plans.[5]

From the *Department of Otolaryngology, Keck School of Medicine, University of Southern California, Los Angeles, California; ‡Department of Plastic and Maxillofacial Surgery, Royal Children's Hospital, Melbourne, Australia; and §Department of Otolaryngology, Children's Hospital, Los Angeles, California.

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Reprint requests to (J.A.K.) Department of Surgery, Division of Otolaryngology, 4650 Sunset Blvd, MS 58, Los Angeles, CA 90027. E-mail: jkoempel@chla.usc.edu

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Health care is delivered to beneficiaries of Medi-Cal via 1 of 2 systems: a traditional fee-for-service and a managed care plan. The California Department of Health Services (DHS) administers the entire Medi-Cal program for each county in California. The traditional fee-for-service plan involves beneficiaries' finding a certified Medi-Cal physician to deliver care. A physician then submits a claim for reimbursement of services after providing care for the patient. The other system involves enrolling Medi-Cal beneficiaries into a managed care plan. DHS offers various versions of the managed care health plan in each of the different counties.[6] In California, one third of the children in Medi-Cal are enrolled in the fee-for-service plan with the remainder in the managed care plan, whereas in Southern California, this figure is slightly lower at 28% in the fee-for-service plan.[4]

Although children make up approximately half of the total enrollees in the Medicaid program, there are many more children who have no medical insurance. In 2002, there were 9.30 million uninsured children in the United States, 1.55 million of them in California. These figures account for 12% of the total population of children in the United States and for 15% of the total population of children in California.[5] The Balanced Budget Act of 1997 created Title XXI of the Social Security Act in an attempt to address this issue, which eventually led to the creation of a new children's health insurance program, known as the State Children's Health Insurance Program (SCHIP). SCHIP funds allowed each state to expand children's Medicaid coverage and/or develop new programs. In California, the enactment of SCHIP led to the expansion of Medi-Cal for children and the creation of a new health insurance program called Healthy Families, a managed care plan designed for families whose income exceeded the limits required for participation in Medi-Cal.[7]

Although these policies and programs might help to increase the number of children with medical insurance, we are concerned that a more important issue is being ignored. That is, now that they have medical insurance, who will provide health care to these children? Bindman et al[8] examined physician participation in Medi-Cal in 2001 and found that nearly half of all physicians in both medical and surgical specialties in California's urban counties were not willing to see patients with Medi-Cal insurance. An inequality in access to orthopedic surgical care was also found in a recent study of Medi-Cal patients in Los Angeles County. Skaggs et al[9] noted that timely access to orthopedic care was available to 100% of children with private insurance but to only 2% of children with Medi-Cal insurance.

We hypothesized that this same disparity in access to health care exists in other surgical subspecialties in California. Our goal in this study was to collect a larger sample size as compared with the initial study by Skaggs et al and to establish direct contact with surgeons to determine their specific reason(s) for not participating in the Medi-Cal program. We chose tonsillectomy and adenoidectomy as models for assessing access to surgical health care because these are the most commonly performed major ambulatory surgical procedures in children under the age of 15 in the United States.[10] In addition, we chose to study only the fee-for-service delivery model, regular or straight Medi-Cal, because the majority of children at our institutions have this form of health insurance. In addition, the Medi-Cal managed care plans are numerous and vary greatly in terms of the details of their contracts and the benefits that are offered. Although this data would be useful, it would have significantly increased the complexity of the study.

METHODS

The names and addresses of 404 otolaryngologists who practice in the Southern California area, which we define as Los Angeles, Ventura, Riverside, San Bernardino, and Orange Counties, were identified from the American Academy of Otolaryngology Head and Neck Surgery Membership Directory for 2001. Physicians who would not see children or perform adenotonsillectomy such as those who limit their practice to facial plastic surgery or otology were excluded. This process excluded 101 physicians, leaving 303 otolaryngologists.

An anonymous questionnaire was sent by regular mail to the office of each of the 303 otolaryngologists in early 2003 (Appendix). For those who did not respond to the first survey, a second one was sent ~6 weeks later. The questionnaire was accompanied by a cover letter explaining the nature of the study. No incentives for participation were provided.

The questionnaire presented 2 scenarios to the physician; one was modeled on obstructive symptoms as the indication for an adenotonsillectomy, whereas the other used recurrent infection. These 2 scenarios were created because the documentation required by Medi-Cal for authorization of this surgery is different for each indication. For example, a sleep study is required for a diagnosis of obstructive sleep apnea (OSA), whereas a detailed note from the referring physician documenting the date and medication given for at least 7 episodes of tonsillitis in the past year is required for recurrent infection.

We asked the surgeon whether he or she would offer an office appointment if the child had commercial insurance and likewise if the patient had regular Medi-Cal as opposed to a Medi-Cal managed care health plan. If the answer was affirmative for the child with regular Medi-Cal, then we asked whether the physician would actually offer to perform the surgery if an adenotonsillectomy were indicated or would refer the child to another otolaryngologist to perform the procedure.

Finally, if the surgeon would not offer an office appointment or surgery, then we asked for the specific reason(s). Some explanations listed were too much paperwork or administrative burdens, low monetary reimbursement for surgery or the office visit, do not perform surgery anymore, and others. Space was provided to write in additional reasons not listed or for additional commentary. The responses were collected, and results were calculated using simple percentages.

RESULTS

A total of 111 responses were received from the 2 mailings sent to the 303 physicians. Of these, only 100 were fully completed. Two incomplete surveys were not counted, and 9 blank surveys were returned but with additional comments only. These comments included retired/passed away (5), work for health maintenance organization/Kaiser (3), and do not see pediatric patients (1).

All physicians who did respond recorded identical answers for both scenarios A and B (Table 1). Ninety-seven (97%) of 100 physicians who responded would offer an office appointment if the child were insured by a preferred provider organization. Only 27 (27%) of 100 physicians who responded would offer an office appointment if the child were insured by

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TABLE 1. Data From Questionnaire, Questions 1, 2, and 2a

Questions	Scenario A: OSA			Scenario B: Recurrent Tonsillitis		
	Yes, *n* (%)	No	Total Responses	Yes, *n* (%)	No	Total Responses
1. Would you offer an office appointment to a child with PPO?	97 (97)	3	100	97 (97)	3	100
2. Would you offer an office appointment to a child with Medi-Cal?	27 (27)	73	100	27 (27)	73	100
2a. Would you offer surgery to a child with Medi-Cal?	19 (70)	8	27	19 (70)	8	27

Medi-Cal. Of the 27 physicians who would offer an appointment to those with Medi-Cal, 19 (70%) would offer to perform surgery. Eight (30%) physicians would refer the patient to another physician for surgery if the procedure were indicated. Therefore, only 19 of 100 physicians would be willing to evaluate a Medi-Cal patient in need of tonsillectomy/adenoidectomy and actually perform the operation.

The remaining 81 of 100 physicians who would not offer an office appointment or surgery for patients with Medi-cal gave an answer for question 3 to provide a specific reason(s) for not offering care (Table 2). However, some of these 81 physicians did not answer every part of question 3, a to g. Seventy-one (96%) of 74 physicians identified too much paperwork/hassle or excessive administrative burdens involved in gaining approval for the procedure as the reason for not being a Medi-Cal provider. Sixty-eight (92%) of 74 physicians stated that low monetary reimbursement from Medi-Cal for the surgical procedure was responsible for not offering treatment to a patient with Medi-Cal. Sixty-one (87%) of 70 physicians blamed low monetary reimbursement from Medi-Cal for not providing an office appointment. Thirty-three percent of surgeons stated that their practice was too busy, 12% stated that they would like to do more interesting cases than tonsillectomy/adenoidectomy, and 11% stated that they do not perform surgery anymore.

Physicians were offered the opportunity to make additional comments or provide other reasons for not offering a child with Medi-Cal an office appointment or surgery. Some examples include the following:

"The main reason for not accepting Medi-Cal patients is the [Treatment Authorization Request] TAR process. In the county of Los Angeles, the Medi-Cal field office often denies TARs on spurious grounds, eg, 1) asking for the number of infections when the indication (for surgery) is OSA and 2) asking for a sleep study when the indication is the number of infections. The amount of hassle and paperwork for the low reimbursement makes each Medi-Cal tonsil patient a management headache and an overall money loser. I would do the cases if the process were not so arduous and accept the low reimbursement if the paperwork and hassle were eliminated."

"I usually try to refer a Medi-Cal patient who really needs a surgical procedure to the most capable hands. The tragic reality is that it takes a miracle to get the patient accepted even at university, academic, or county institutions. It is very frustrating! Bottom line? If it sounds that the patient is truly surgical, I do not even get involved [in] seeing the patient to avoid the hassles of referrals. It is saddening but true. It is pathetic!"

DISCUSSION

In 2002, there were ~9.30 million children without health insurance in the United States. In California, 1.55 million children were uninsured of the total 10.27 million children.[5] Although these figures are impressive, the number of uninsured children in the United States and California has actually decreased in the past few years. During the 3-year period from 1999 to 2002, there was a decrease of 1.8 million uninsured children nationally.[11] This decline has largely been attributed to increased enrollment of children into programs such as Medicaid and SCHIP. Congress created SCHIP in the Balanced Budget Act of 1997. In California, SCHIP funding resulted in the expansion of the Medi-Cal program and the development of a new program known as Healthy Families.[7] Healthy Families is a low-cost health insurance program for children whose families earn too much money to qualify for Medi-Cal but not enough to be able to afford commercial insurance. For Healthy Families, incomes must be between 100% and 250% of the federal poverty level, depending on the age of the child.[12] For Medi-Cal eligibility, family incomes

TABLE 2. Data From Questionnaire, Question 3, a to f

Reason for Not Offering an Office Appointment or Surgery	Scenario A: OSA			Scenario B: Recurrent Tonsillitis		
	Yes, *n* (%)	No	Total*	Yes, *n* (%)	No	Total*
a. Too much paperwork/hassle	71 (96)	3	74/81	71 (96)	3	74/81
b. Low monetary reimbursement from Medi-Cal for surgery	68 (92)	6	74/81	68 (92)	6	74/81
c. Low monetary reimbursement from Medi-Cal for new office visit	61 (87)	9	70/73			
d. Practice is too busy	23 (33)	47	70/81			
e. Would like to do more interesting cases than tonsillectomy and/or adenoidectomy	8 (12)	61	69/81			
f. I do not perform surgery anymore	8 (11)	62	70/81			

* Total responses/total possible responses.

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are below those levels. In 2004, the federal poverty level for a family of 4 was $18 850 per year.[13]

The SCHIP funding for children led to an increase of 21 000 new children enrolled in Medi-Cal by March 2000 and 362 373 new children enrolled in the Healthy Families program by January 2001. Between 1998 and 2001, California allocated considerable resources to establish the Healthy Families program with a massive community outreach and education campaign. In an effort to increase enrollment, the application for the programs was shortened from 28 to 8 pages in 1999. The 2000–2001 California state budget allocated $34.2 million for outreach activities.[12]

A survey of beneficiaries showed that 80% believe that the Medi-Cal program allows access to high-quality medical services.[14] However, 31% of applicants at California's centralized processing center for government-sponsored insurance indicated that they do not want their children to be enrolled in Medi-Cal.[12] Public perception of and experiences with Medi-Cal are issues that affect enrollment and should not be ignored. In addition, 56% of those surveyed report difficulty finding doctors who will see Medi-Cal patients, and 78% believe that getting more doctors in the program is very important to increase access to health care.[14] Our findings in this study suggest that enrolling more children into government-funded health care programs such as Medi-Cal and Healthy Families is likely to worsen the already limited access to health care for this patient population.

Bindman et al[8] found that only 55% of primary care physicians, 48% of medical specialists, and 43% of surgical specialists were willing to accept new Medi-Cal patients in California's urban counties. There was a decline in participation in Medi-Cal among primary care physicians and medical specialists, although a statistically significant difference was not found.

In another study of access to health care in Los Angeles County, Skaggs et al[9] found that children with Medi-Cal insurance had significantly less access to timely orthopedic care than children with private insurance. Only 1 of 50 orthopedic offices surveyed would offer an appointment to examine a "Medi-Cal" child with a fractured arm within 7 days. All 50 offices would offer an appointment within 1 week if the same child had private insurance.

Our study found that only 27% of the otolaryngologists surveyed would offer an office appointment to children with Medi-Cal versus 97% for children with private insurance and compares more favorably with the results by Skaggs et al than the Bindman et al study. However, each of these studies provides evidence that children with Medi-Cal have limited access to health care. Our results along with those of Skaggs et al demonstrate that children with Medi-Cal have limited access to surgical specialty health care when compared with children with private health insurance and may indicate that there is a widespread pattern of poor access for children with Medi-Cal to other surgical subspecialty health care.

The orthopedic study by Skaggs et al had a sample size of only 50 physician offices. One of our objectives was to determine whether the same degree of inequity in access to surgical health care would be noted in a larger sample size. In addition, we sought direct contact with the actual surgeons through a written questionnaire sent directly to the physicians rather than through a telephone survey that involved a conversation with only office staff as in the Skaggs et al study. Rather than make an educated guess as to why physicians would not see or treat patients with Medi-Cal, we wanted to hear directly from those physicians. We believe that any decisions regarding changes in public health care policies should not be made without this information in mind. Simply increasing enrollment in public health care programs without addressing the issue of who would provide health care to this patient population would likely exacerbate the problem. On the basis of our data, the success of government-funded health insurance programs is critically dependent on adjustments that would increase the number of physicians who would provide care for these patients.

Skaggs et al[9] suggested that low Medi-Cal reimbursement rates, perceived threat of aggressive prosecution for fraud and abuse, and administrative hurdles to receiving reimbursement could be blamed for the inequality in access to health care. Our study demonstrated that the top 3 reasons for not participating in Medi-Cal include excessive paperwork/hassle (96%), low reimbursement for the surgery (92%), and low reimbursement for the office visit (87%). Our findings compare favorably with a recent study of pediatricians, which found that low payment rates, capitation, and paperwork concerns contribute to low participation of pediatricians in Medi-Cal.[15]

The Medi-Cal program requires that a TAR form be completed by the treating physician to gain authorization for reimbursement to perform certain procedures such as tonsillectomy. In addition to this form, one must submit a sleep study for patients with OSA or a letter from a primary care physician indicating the number of infections documented in the last year for patients with recurrent tonsillitis. This information is sent to a Medi-Cal field office, where it is reviewed by another physician. The reviewing physicians in the Los Angeles Medi-Cal field office are not otolaryngologists, and, in fact, most are not even surgeons, yet these physicians are given the responsibility of determining the medical necessity of surgical procedures.

The processing time for a TAR is ~6 weeks for subspecialist physicians with a decision of approved, modified, deferred, or denied.[16] We have found that these physician reviewers in the Los Angeles field office are often not up to date on many issues in our specialty, including indications for surgery. A TAR is frequently returned as "deferred" with a request for more information that can be submitted only with another TAR, which takes an additional 6 weeks to process rather than a simple telephone call.

Administrative hassle has been cited not only by our study but also by Medi-Cal itself. The Medi-Cal Policy Institute commissioned a study in 2003 to

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assess the efficiency of the TAR and claims payment processes. Comments by physicians in our study have indicated their frustration with the approval process for a TAR. Similarly, 30% of providers surveyed by the Medi-Cal Policy Institute stated a "hassle factor" when dealing with Medi-Cal, including voluminous paperwork and extensive follow-up with long delays. It was found that the average Medi-Cal TAR requires a significantly longer time to process as compared with other payers' authorizations, which are typically processed within a period of 15 minutes to 5 days.[16]

Recommendations include the creation of a new Internet-based TAR system, a so-called e-TAR, and a standardized set of criteria that would define medical necessity. This latter recommendation prevents inconsistent adjudication, which is a common complaint among Medi-Cal providers. In comparison with other surveyed payers, Medi-Cal is the only organization that does not use standardized criteria when adjudicating previous authorizations.[16] Our study showed that otolaryngologists (27 of 100) were more willing to see a child with Medi-Cal for an evaluation for tonsil surgery in the office than were willing to offer to actually perform the surgery (19 of 100). Inconsistent adjudication and hassle could explain this discrepancy because a new office visit requires no previous authorization, whereas a surgical procedure such as a tonsillectomy requires a laborious process involving the submission of several documents.

In the early 1990s, California began to transition some regular Medi-Cal beneficiaries into managed care plans to increase access to care.[17] Some also recognized that maintaining a certain number of providers would require competitive reimbursement rates for physician services. However, the recession of the early 1990s led to a rate freeze and even rate reductions for some physician services. From 1985–1986 until the 2000–2001 Budget Act, there were no general increases affecting Medi-Cal physician rates. The Medi-Cal rates are now ~60% of Medicare, the federal health insurance program for the aged (over 65) and disabled, which is a recognized standard among various payers.[18]

To help with budget problems, a 5% decrease in Medi-Cal rates was adopted by the California legislature to begin January 1, 2004. However, the California Medical Association filed a lawsuit to stop implementation of this reduction and it is currently pending. In the meantime, the courts have issued an injunction blocking the implementation of the cuts that are linked to Medi-Cal services. Subsequently, the Legislature repealed the 5% reduction from Medi-Cal–linked services effective July 1, 2004. In addition, a 10% reduction in provider rates was proposed for fiscal year 2004-2005. On the basis of our data, we believe that a decrease in reimbursement rates even as low as 5% could have a significant negative impact on the delivery of health care to the Medi-Cal population. Others have already challenged these reductions.[19]

The Medi-Cal reimbursement rate for a new patient consultation of moderate complexity (Current Procedural Terminology code 99244) was $71.05 in 2003, which was less than half of the commercial insurance rate, ranging from $143 to $195. This Medi-Cal reimbursement rate was only 42% of the Medicare rate for Southern California for the same service. The Medi-Cal reimbursement rate for the surgeon's professional fee for a tonsillectomy in a child under 12 (Current Procedural Terminology code 42825) was $168.65 in 2003. Private insurance paid approximately twice that amount, ranging from $290 to $360.

The Legislative Analyst's Office (LAO) exists to review state programs and make recommendations as to how the State of California can operate more effectively and efficiently. A 2001 LAO report determined that Medi-Cal rates were not based on a rational process or any measure of the actual costs of providing medical care. The Medi-Cal program also has not been in compliance with state and federal statutory requirements to review and adjust physician rates regularly. Federal Medicaid law mandates that "[reimbursement] rates be sufficient to enlist enough providers so that care and services are available to Medicaid participants to at least the same extent that they are available to the general population in the geographic area." The LAO's recommendations included using Medicare rates as a benchmark, increasing Medi-Cal rates to 80% of Medicare's rates, and making periodic future adjustments on the basis of an analysis of the access and quality of care provided to Medi-Cal beneficiaries.[18]

CONCLUSIONS

On the basis of the data in this study, children with Medi-Cal have limited access to surgical specialty health care when compared with patients with private insurance. Reasons for the limited access to health care include excessive administrative burdens and low reimbursement rates.

We caution efforts simply to expand enrollment in government-funded health insurance programs such as Medi-Cal without other changes to address the issue of low physician participation. Our data demonstrate that the possession of a health insurance card does not necessarily translate into access to health care, and it is very likely that increasing the number of enrollees would worsen the already limited access that these patients currently experience. Our data suggest that an increase in reimbursement rates for physician services and the elimination of administrative burdens currently in place would result in an increase in access to surgical health care for children with government-funded health insurance.

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Appendix

Questionnaire

Please circle your responses.

Scenario (A)	Scenario (B)
A parent calls your office stating that his/her child has obstructive sleep apnea symptoms. The parent would like an appointment for evaluation for tonsillectomy/adenoidectomy.	A parent calls your office stating that his/her child has recurrent tonsillitis (7 infections in the past yr.). The parent would like an appointment for evaluation for tonsillectomy.

1. Would you offer the parent an office appointment if the child were insured by commercial insurance, a local preferred provider organization (PPO) in which you participate?

Scenario (A)		Scenario (B)	
Yes	No	Yes	No

2. Would you offer the parent an office appointment if the child were insured by regular Medi-Cal (as opposed to Medi-Cal managed care health plan)?

Scenario (A)		Scenario (B)	
Yes	No	Yes	No

2a. If you answered yes to question 2: Would you perform surgery on the child if surgery were indicated (as opposed to referring the child to another institution for surgery)?

Scenario (A)		Scenario (B)	
Yes	No	Yes	No

2b. If you answered no to question 2 or 2a above: then please answer questions 3a –3g.
If you answered yes to question 2a, then you are finished. Please feel free to make comments below or on the back of this sheet. Thank you.

____

3. Which of the following reasons explains why you did not offer the child an office appointment or surgery?

a. Too much paperwork/hassle involved with Medi-Cal to obtain approval (i.e. TAR; sleep study required or documentation of recurrent infections from pediatrician, respectively).

Scenario (A)		Scenario (B)	
Yes	No	Yes	No

b. Low monetary reimbursement from Medi-Cal for professional fee for surgery (tonsillectomy/ adenoidectomy or tonsillectomy only, respectively).

Scenario (A)		Scenario (B)	
Yes	No	Yes	No

c. Low monetary reimbursement from Medi-Cal for new office patient visit.

Yes No

d. Practice is too busy.

Yes No

e. Would like to do more interesting cases than tonsillectomy and/or adenoidectomy.

Yes No

f. I do not perform surgery anymore.

Yes No

g. Other...... please explain below or use the back of this sheet.

____

Thank You.

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Inequality of Access to Surgical Specialty Health Care: Why Children With Government-Funded Insurance Have Less Access Than Those With Private Insurance in Southern California
Edward C. Wang, Meeryo C. Choe, John G. Meara and Jeffrey A. Koempel
Pediatrics 2004;114;e584
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