Title

Shaking Up the Dental Safety-net: Elimination of Optional Adult Dental Medicaid Benefits in California

Journal

Journal of Health Care for the Poor and Underserved, 25(1)

ISSN

1049-2089

Authors

Wides, Cynthia
Alam, Sonia Rab
Mertz, Elizabeth

Publication Date

2014-02-01

DOI

10.1353/hpu.2014.0072

Peer reviewed

Published in final edited form as:
J Health Care Poor Underserved. 2014 February ; 25(1 0): 151–164. doi:10.1353/hpu.2014.0072.

Shaking Up the Dental Safety-net: Elimination of Optional Adult Dental Medicaid Benefits in California

Cynthia Wides MS., MA [research analyst],
Center for the Health Professions and the Department of Preventive and Restorative Dental Sciences, University of California at San Francisco (UCSF)

Sonia Rab Alam MS., MPH [graduate student researcher], and
Center for the Health Professions, and the Department of Social and Behavioral Sciences, UCSF

DR. Elizabeth Mertz, PhD, MA [assistant professor]
Department of Preventive and Restorative Dental Sciences, the Department of Social and Behavioral Sciences, and the Center for the Health Professions, UCSF

Abstract

In July 2009, California eliminated funding for most adult non-emergency Medicaid dental benefits (Denti-Cal). This paper presents the findings from a qualitative assessment of the impacts of the Denti-Cal cuts on California's oral health safety-net. Interviews were conducted with dental safety-net providers throughout the state, including public health departments, community health centers, dental schools, Native American health clinics, and private providers, and were coded thematically using Atlas.ti. Safety-net providers reported decreased utilization by Denti-Cal-eligible adults, who now primarily seek emergency dental services, and reported shifting to focus on pediatric and privately-insured patients. Significant changes were reported in safety-net clinic finances, operations, and ability to refer. The impact of the Denti-Cal cuts has been distributed unevenly across the safety-net, with private providers and County Health Departments bearing the highest burden.

Keywords

Medicaid; dental clinics; vulnerable populations; oral health; dental public health; access to care

Medicaid provides insurance coverage for medical and dental care to low-income children and adults, and vulnerable populations, including eligible aged, blind, or disabled individuals. Federally Required Adult Dental Services (FRADS)[1] including emergency procedures to address dental trauma and the management of pain and infection related to dental disease are mandated, however, all other dental benefits for adults are optional.

For more than 40 years Medicaid-enrolled Californians of any age were eligible for basic diagnostic, preventive, restorative and emergency dental procedures provided by

Please address correspondence to Elizabeth Mertz, 3333 California St, Ste 410, San Francisco, CA 94118; (415) 502-7934; Elizabeth.Mertz@ucsf.edu.

participating dentists through the fee-for-service Medicaid dental program, Denti-Cal. In 2007, Denti-Cal provided comprehensive oral health care to more than eight million people.[2]

In July 2009, Denti-Cal coverage for all non-emergency procedures was eliminated for adults, with the exception of pregnant women and residents of skilled nursing care facilities.[1] The Denti-Cal cuts were part of a package of trigger cuts in the February 2009 State Budget, which took effect when California did not receive at least $10 billion from the American Recovery and Reinvestment Act of 2009.[3] This change effectively prevented as many as three million adults from receiving comprehensive dental care.[4] Completion of pre-approved treatment plans begun prior to July 1, 2009 were allowed through December 2009 as were dental services precedent to a covered medical service.

A group of federally qualified health centers (FQHCs) sued the State of California for the right to continue to provide adult dental services, resulting in a temporary stay on the cuts for a short time in 2009. However ultimately the lawsuit was decided in favor of the State of California, and the policy change held. In January 2012, dental benefits were restored *via* an interagency agreement with the Department of Developmental Services (DDS) for an estimated 200,000 adults with developmental disabilities who are associated with regional care facilities.[5,6]

Background

Dental insurance coverage is associated with increased utilization of dental care among vulnerable populations, and cuts to public insurance have a negative impact on access to care.[7–9] Despite this evidence, states in fiscal deficit have a long history of reducing optional Medicaid benefits through adjustments in eligibility requirements or in providers' reimbursement rates, or, in some cases, eliminating entire programs. In 2010, six states (Alaska, Connecticut, the District of Columbia, Idaho, South Carolina, and South Dakota) provided comprehensive adults dental benefits, 42 states provided limited benefits or emergency only services for adults, and three states (Alabama, Delaware, and Tennessee) provided no benefits.[10] Among states offering optional adult dental Medicaid benefits, a wide variation exists in the services covered and in dental provider participation in the program. Therefore, having a dental benefit does not necessarily result in access to dental care.[11]

The outcomes of eliminating optional Medicaid dental benefits have been studied in Oregon, Maryland, and Massachusetts. In Oregon, researchers found that the elimination of dental benefits in 2003 resulted in significant increases in unmet dental care needs among adults. [8] In addition, adults increased their visits to medical settings, such as physician's offices and emergency departments, for treatment of dental problems.

In Maryland, researchers found increases in dental-related emergency room visits after the elimination of optional adult Medicaid dental benefits.[12,13] Similarly, a Pew Center On the States study found that lack of access to preventive care accounts for a significant portion of dental-related visits to hospitals and emergency rooms.[14]

In 2002, Massachusetts eliminated almost all non-emergency dental services for adult Medicaid beneficiaries. An evaluation of the impacts of these cuts found that adults' utilization of dental services decreased and children's utilization increased.[15] Since Medicaid adults no longer had a payer source for dental services, adults who formerly saw a private provider instead sought care at lower cost care delivery sites such as community clinics and dental schools. The resulting shift in care-seeking behavior led to private providers struggling financially due to decreased patient volume, while community clinics and dental schools, both of which have greater flexibility in their revenue streams, were overwhelmed by the increase in patient volume. Private providers took various approaches to dealing with the changes including raising fees, reducing staff, and shifting focus from Medicaid adults to children and privately insured patients.[15]

In California, the impact of the Denti-Cal cuts has not been studied fully. One study projected significant impacts in terms of the expected pain and suffering of Californians who would lose coverage as well as in fiscal consequences throughout the California's economy.[4] In 2011, the impact of the Denti-Cal cuts was analyzed quantitatively using eight consecutive quarters of dental claims data for continuously enrolled Medicaid beneficiaries from July 1, 2008 through June 30, 2010.[16] Expenditures on adult dental care services dropped from $76 million in the first quarter to $14 million in the last period, while expenditures on children's dental services increased from $92 million to $113 million and the number of children using services increased by 12%. In addition, the number of rendering providers (individual service providers) dropped from 10,500 in fiscal year (FY) 2008-2009 to 9,500 in FY 2009–2010, while the number of billing providers (generally, employers of rendering providers) decreased from 6,200 to 5,600.

Based on the well-established impact of dental insurance on utilization, prior studies of other states' elimination of dental benefits, and the preliminary evidence of financial and utilization data from California, we hypothesized that we would find significant impacts across the dental safety-net and at all levels of safety-net organizations—patient utilization, financing, operations, and workforce. This paper presents the findings of a qualitative assessment of the impacts of the Denti-Cal cuts on the oral health safety-net in California, and discusses the implications of these findings for California's Medicaid expansion plans under the Patient Protection and Affordable Care Act (ACA).

Methods

Study participants

Study participant selection was designed to gain the perspectives of a cross section of the dental safety-net, including various provider types, locations, and sizes. Three private practice dentists were interviewed whose Denti-Cal patient population was, respectively, 50%, 75%, and 100% of their total patient base. These practices included one rural and two urban locations in Central and Southern California.

Two County Public Health Departments were selected—one in Northern California and one in Southern California. One of these is a county with rural and urban populations, and the other is primarily urban. Data on county dental health programs from the California

Department of Public Health, Office of Oral Health do not report how many counties across the State provided dental services for adults prior to 2009. In our own research, we were only able to identify eight of 58 counties in 2011 that provided preventive and restorative dental services for adults and children. Based on the 2011 data, researchers interviewed one county that only offers referral services to dental care services for children and one county that provides comprehensive services for adults and children.

Three dental schools across the state were selected, one of which is a public university. Because dental schools have multiple types of clinics, researchers conducted interviews with representatives from one specialty clinic, two adult clinics, and one pediatric clinic, as well as with dental school administrators. Procedures in all of the clinics are performed by dental students with supervision by dental school faculty. Faculty practices were not included in this study.

Three federally qualified health centers (FQHCs) and two Indian Health Clinics (IHC) were interviewed, with clinic locations throughout California. Two of the FQHCs serve rural populations, and one serves an urban populations. The IHCs were located in one urban and one rural location. One of the FQHCs is a single, stand-alone dental clinic, and the other FQHCs and IHC are multi-site clinics co-located with medical service provision. In California, FQHCs and IHCs receive reimbursement for dental services on a Prospective Payment System (PPS), wherein payment is at a fixed rate per patient encounter rather than based on a fee-for-service system.

One large Dental Health Maintenance Organization (DHMO), which serves as both a provider and a plan, with multiple sites across the state of California was included in our study. Prior to the Denti-Cal cuts, this organization was one of the largest Denti-Cal providers in the State.

Interviews

Fourteen semi-structured interviews were conducted with 21 safety-net providers (comprising senior dentists and administrative staff) between November 2011 and April 2012. (Table 1) Ten interviews were conducted by telephone and four interviews were conducted in person. More than one site representative participated in most of the interviews. To be eligible to participate, at least one interviewee at each site must have been working continuously at his/her site from prior to the cuts in July 2009.

The semi-structured interview guide was approved by the UCSF (IRB) Committee on Human Research and included approximately 30 open-ended questions. The interview guide included the following domains pre-identified in our background research as possible areas of impact:

1. patient utilization of services,
2. revenue and revenue sources,
3. patient and employee-related policies and clinic operations, and

4. participants' perceptions of the Denti-Cal program and the current funding environment.

Prior to the interview, participants were asked to complete an administrative survey including questions on dental services provided, clinic size, patient demographics, numbers and types of employees, and operations. These preliminary data helped the researchers frame the interview questions and provide context for the analysis.

All interviews were conducted in English, lasted between 60 and 90 minutes, were audio-recorded, and were transcribed for clarity by a professional transcription service. The transcriptions were analyzed using ATLAS.ti® soft ware package.[17] Two members of the research team separately, but not independently, coded the interview transcripts with respect to the domains of central concern. Using both open and axial coding, researchers identified concepts and categories as they emerged in the interviews in order to identify patterns across interviews. As themes emerged, the researchers met to discuss and agree upon the codes and themes and to theorize the relationships among codes.

Results

The dental safety-net in California is a loosely organized delivery system, largely dependent on the federal and state Medicaid funding streams. The impacts of the elimination of optional adult dental benefits from Denti-Cal on California's dental safety-net were immediate, far-reaching, and exacerbated by the very economic recession that spurred the policy change. The primary negative impact reported was to Denti-Cal beneficiaries, whose coverage became limited to emergency services, such as tooth extractions. In response, this population drastically decreased its utilization of dental services, causing significant turmoil and restructuring across all sectors of the safety-net. This study details these changes.

Impact on utilization

All safety-net providers felt that Denti-Cal-eligible adults decreased utilization of care, experienced a loss in their usual sources of care, and reported that the safety-net is no longer able to provide comprehensive dental services to these individuals.

> [The cuts] have definitely had impact. We see a lot of people coming in, and we're doing a lot more extractions. A lot of restorable teeth not being restored, and a lot of people coming in pain, where before they would come in more preventatively. It's pretty sad.
>
> —FQHC Dental Director

Providers reported that their Denti-Cal adult patients are suffering under a growing tide of delayed dental care. These patients cannot afford the costs of a basic evaluation or treatment plan, much less restorative care. Denti-Cal-eligible adults were reported to be waiting longer to seek care, seeking primarily emergency dental care, and presenting with more extensive disease.

> I think we've had to make ourselves more available for emergencies. We're seeing more of those and more serious consequences. We had a patient who passed away

> about three months ago from a dental abscess. We're seeing many more hospitalizations this year. I think I've had to hospitalize about 10 patients in 2011, which is normally one or two a year.
>
> —FQHC Dental Director

In addition to a decrease in the frequency and types of utilization by Denti-Cal-eligible adults, study participants reported shift s in the sites at which patients are receiving care. Private providers with large Medicaid practices provide emergency care to their adult patients and continue to provide care to their pediatric patients. Public Health Departments and the DHMO continue to provide care to pediatric patients, but reported referring their adult Denti-Cal patients to dental schools and to FQHCs for services no longer reimbursable under Denti-Cal. Federally qualified health centers and county health departments reported referring their pediatric patients to dental schools for specialty care when such care is unavailable through their own resources. Dental schools reported that adult Denti-Cal patients seek urgent care with greater frequency, and the pediatric clinic reported an influx of pediatric patients. All of the providers reported greater difficulty in finding specialty care for pediatric and adult Denti-Cal patients.

Both urban and rural parts of the state with large underserved populations saw deepening unemployment throughout the recessionary period. In January of 2008, 76% of California's 58 counties had unemployment rates at or below 10%.[18] However, by December 2010 41% of counties' unemployment rates were between 15-28%. Safety-net practices in these areas saw an increase in Denti-Cal beneficiaries needing care concurrent with a decrease in available funding sources to pay for this care. One administrator expressed deep concern for the effect of the Denti-Cal cuts on this population and on the system as a whole.

> One of the many intents of Denti-Cal as I knew it in the past was to enable an adult who maybe wasn't working, had limitations, couldn't even go on a job interview, to furnish them with not only emergency care, but provide them with some type of prosthetic treatment that allowed them to get back on their feet, back into the workforce and moving again on their own. With the changes [to Denti-Cal], obviously that's pretty darn hard to do when you can treat the pain, but generally not a whole lot else.
>
> —DHMO Administrator

Differential impacts and responses across the dental safety-net

The impacts of the elimination of optional adult dental benefits and the concurrent economic downturn have been distributed unevenly throughout the safety-net. In the following section, the impacts and responses are detailed by sector.

Private practice providers—Private dental providers with large Medicaid practices found themselves nearly without an adult patient base. These practices reported declines between 50–97% in Denti-Cal adult patients as a result of the cuts. The rural providers and one of the urban private providers reported an inability to diversify their patient payer mix. The rural practice provider reported that after the cuts, non-pregnant adults constituted only 1% to 2% of his practice, which represented a significant decrease in his patient population.

> Because the adult benefit has been cut, most of my [dental] chairs are now empty. I just care for the kids. You know, there's no major work. The office is actually not making any income right now, not enough to survive.
>
> —Private Denti-Cal Provider

For these private providers, the income from increases in pediatric and emergency dental services was insufficient to offset the losses from adult patients, resulting in cuts to hours, pay, and staff. Even after implementing strategies to increase pediatric and insured patients, each provider expressed concern that he would not be able to remain solvent.

> I just passed on a cut to my dear employees. For 2012 they're all taking a dollar an hour less money than they used to. I think Denti-Cal does have a lot to do with it … I mean the numbers [of patients] just dropped down in the basement.
>
> —Private Denti-Cal Provider

Two of the three private providers in our study reported that they are considering closing their Denti-Cal practices, and the third told researchers that he could not even consider the future beyond the day-to-day. The overwhelming sense among private providers was that policymakers had put them at risk of losing their livelihoods, with no regard for the patient, the community, or the providers themselves.

County public health departments—County health departments that provide direct care are governmental entities expressly charged with serving indigent county residents and therefore do not have the option of diversifying their patient payer mix. These providers reported severe reductions in funding due both to the Denti-Cal cuts and to dwindling local and state tax revenues during the recession.

In response, the county health departments interviewed reported shifting their focus to children and pregnant women, who are still covered under Denti-Cal, and limiting adult dental services to those adults whose care is funded by categorical grants, such as those for patients with HIV or with specific types of cancer. One county reported that only emergency services are available to non-pregnant adult patients, as children and pregnant women receive priority for dental services. Despite the increased demand for low-cost or no-cost dental care reported by this county, the county has reduced appointment availability due to an inability to generate adequate dental clinic revenue to hire enough dentists to fully staff their clinics. As a result, all of this county's clinics have been cut from five to four days of service per week, and the dentists must work at multiple clinic sites across the county to ensure access to the local population.

> [One clinic just] says “days vary” because right now I'm short of one dentist at one site. At that clinic there is no full-time dentist. So I rotate my staff, half-day here, half-day there, one day here. So it's a four-unit [dental chair] clinic. We are under-utilizing it. You have overheads. Those don't go away. You pay the electricity bill. All those overheads stand, but the clinic is sitting empty. The patients are not being seen because we are not staffed because we don't have enough funding. It all is a cycle. If we could generate more, if we could get better revenue from Denti-Cal, we could do more. We could hire more. We could run to capacity.

—County Public Health Department

Both counties reported relying heavily on volunteers to provide education and out-reach to increase utilization by children and pregnant women, who still have a payer-source under Denti-Cal. The counties also reported increasing their networking and coordination with local dental societies, dental professional groups, and other volunteers in order to increase access to dental care.

> Volunteers actually run three clinics in town, and they have [opened] a fourth one. They've become more and more swamped. They're no longer taking new patients.
>
> —County Public Health Department

Dental school clinics—While all dental schools we interviewed reported financial belt-tightening as their Denti-Cal-eligible adults lost benefits, the public dental school reported additional financial stress due to significant cuts in educational funding from the state. Both public and private dental schools reported successfully implementing strategies to replace revenue from Denti-Cal patients with revenue from self-pay or private-pay patients. Because the dental schools interviewed are not-for-profit and have dual missions of teaching and care delivery, the schools have tried, with mixed success, to continue to provide services to the Denti-Cal population. Their access to more diversified funding streams, including private donors, grants, and student tuition, allowed them to adapt more readily to the Denti-Cal policy change.

The dental schools' adult clinics reported that Denti-Cal adults began seeking emergency care and extractions after the cuts in place of the more extensive preventive and restorative care that they formerly received. Schools reported reallocating resources to increase the provision of urgent care and training their pre-doctoral students in simple extractions, which previously were performed in oral surgery. As well, the Denti-Cal population tends to be more medically complex than the population with private insurance. Schools reported a decline in the Denti-Cal population seeking care, which has resulted in fewer training opportunities for more complex, comprehensive treatments.

> We just saw more people coming in because of their urgent need. And dealing with them was quite difficult in a sense because of their frustration over losing the benefits and their frustration of not being able to get the work done that they needed to have done. They were emotionally angry. They could've gotten a bridge or a crown with Denti-Cal, but now they can't afford it. So they're going to have to do an extraction, and now they'll have this gaping hole in their teeth, in their smile. That's just crushing to a person, to a human being.
>
> —Dental School Administrator

The pediatric clinic in the public dental school reported being overwhelmed with referrals of pediatric Denti-Cal patients from private dental providers with small Medicaid practices who had stopped participating in Denti-Cal. They had to create a new process of referrals to manage all the incoming new patients. Additionally, they reported an inability to find specialty dental providers who were willing to treat Denti-Cal-eligible children. Even within the dental school itself, the number of these patients accepted for specialty treatment was cut

dramatically. The interviewee speculated that pressure to generate revenue within the school required a focus on privately insured patients, as Denti-Cal reimbursement rates are much lower than those of private insurers.

> [The cuts have] really caused problems with kids who need endodontics [root canals] because our program here quit taking Denti-Cal. It's very hard to find an endodontist who will [take such patients], and it's very expensive. For oral surgery we've had to really find places that are—we have an oral surgery clinic here, but it's not always easy for patients to come back here if they're far. It's not as easy to find oral surgeries out in more rural places, farther up north for example. [Our oral surgery] will only take referrals for impacted wisdom teeth and stuff like actual surgical cases. We used to have oral surgery at … another dental center. But one of the doctors left, so they have none there. Now extractions for ortho[dontics] we're having to send [outside of our school].
>
> —Dental School Pediatric Clinic Coordinator

Dental school administrators reported that the pipeline of new dentists entering the safety-net may be diminishing as opportunities for private Denti-Cal practice and clinical dental public health positions are shrinking.

Federally qualified health centers (FQHC) and Indian Health Centers (IHCs)— Federally qualified health centers and IHCs reported that adult Denti-Cal patients are primarily seeking extractions and other emergency services. In addition to Denti-Cal-eligible adult patients, these clinics reported that more uninsured adults are seeking dental care at FQHCs; however, these clinics have had to focus on children's services, which maintained coverage under Denti-Cal. These clinics report that the majority of their patient population now consists of children, whereas prior to the Denti-Cal cuts adults made up the larger share of patients. In addition, most of these clinics reported expanding or adding new mobile dental care services to treat pediatric patients at schools and Women, Infants, and Children (WIC) Centers.

> When the Denti-Cal cuts first happened, I think we were very quick and nimble on our feet, like a featherweight boxer, in terms of figuring out how to make changes and how to do it quickly. So we had already had all of our dentists within a year or two of that go through some additional pediatric dental training. And we did initially have this goal where half of the patients would be children. At the same time, we then added on pretty quickly some additional FTE of pediatric dentist time.
>
> —Indian Health Clinic Dental Director

All of the FQHCs and IHCs reported that they have expanded in physical space, numbers of dental staff (most oft en pediatric providers), and numbers of operatories. These expansions have been financed through federal grants, private grants, capital campaigns, and, in some cases, by cross-subsidizing with funds from the provision of medical services.

Dental health maintenance organization (DHMO)—The dental health maintenance organization (DHMO), being a for-profit company with locations throughout the state, was

able to re-focus its business plan and strategy in order to maintain profitability. The DHMO reported that due to declines in utilization by adult Denti-Cal beneficiaries, the organization did have to cut pay and staffing at the outset of the cuts. Ultimately, they opted to move away from relying on Denti-Cal as a payer source by expanding into frontier regions in California with populations covered by managed care or PPO insurance plans.

> [The strategy] of basically not ignoring the Denti-Cal opportunities, but looking forward to working with other opportunities that are in the market that would tie to a business model that would be successful, as well as looking to other dental entities to support remote areas [that] have a managed care or PPO population that's not adequately being served.
>
> —DHMO Administrator

In addition, the DHMO invested in technological upgrades to improve efficiency. The DHMO also noted that their organization had benefitted more broadly from the recession in so far as they have been able to pull from a larger pool of talented, professional dental clinicians and staff in search of employment due to the economic downturn. However, in order for their business model to be sustainable, the DHMO has moved away from serving the most vulnerable adult populations in California and is the only safety-net provider in our study to report a decline in their volume of Denti-Cal pediatric patients.

> A lot of the office personnel were kind of devastated [by the cuts], not because it directly affected them or their paycheck, but because of their inability to provide services to people they knew had problems. When you've got a patient who was planning on getting a denture so he can get back in the workforce, and then you get something in the mail saying, “Sorry, no more benefits,” there's not a whole lot you can do for the patient. So sometimes we will try to—I don't want to say it's a literal sliding fee schedule, but the office would always make their best efforts to somehow accommodate the patient. But we can't provide a $1,000 service for $25.
>
> —DHMO Assistant Dental Director

Discussion

The elimination of optional adult Denti-Cal benefits in California has had a negative impact on beneficiaries, leaving most poor adults in the state with virtually no access to comprehensive dental care. The state has experienced a drastic shift in the utilization patterns of the Denti-Cal population as these individuals seek low-cost or free care, or wait for their dental problems to progress to emergency status so they can have a covered extraction. This is undoubtedly leading to unnecessary pain and suffering among these individuals, who previously had access to comprehensive prevention and care. Given the impact of the loss of teeth, particularly anterior teeth, on employability, the policy may be inflicting long-term economic harm on already disadvantaged individuals, potentially prolonging their reliance on state and federal assistance.[19]

The fact that these beneficiaries of adult Denti-Cal are delaying care makes it likely that the policy has shift ed the burden for dealing with oral disease to other health care providers in

California. Like other places across the country where dental benefits have been cut,[14,20] California has seen an increase in demand for dental care in emergency departments.[21]

The policy change penalized those safety-net providers with the least flexibility in responding to the cuts—including private practice dentists and county health departments, who have had to cut hours, staff, and pay. Additionally, dental laboratories and dental materials suppliers have likely experienced a decline in demand due to the Denti-Cal cuts. Federally qualified health centers have increased dental service delivery since rule changes stemming from the 2002 Health Center Growth Initiative have mandated that new FQHCs include dental care as part of primary care.[22] Unfortunately, while both FQHCs and IHCs report expanding capacity and hiring more providers, specifically pediatric providers, under the new policy they are able to provide only emergency care to their adult Denti-Cal patients.

This reorganization of care provision to poor adults may have long-lasting impacts on the safety-net workforce. Even providers whose economic well-being has not been threatened by the cuts expressed dismay at their inability to provide the level of care that they believe all patients deserve. The effect has been severely demoralizing to safety-net providers who have dedicated their careers to caring for low-income populations, and many private Denti-Cal providers have simply opted out of the safety-net system altogether. Dental students who experience difficulty finding patients during their training may develop negative perceptions about participating in Denti-Cal, while job opportunities within the safety net may be dwindling.

The safety-net providers who have navigated this policy change successfully, similar to what is reported in other states, have done so largely by shifting their practice to care for children, pregnant women, and where possible, to insured and self-pay patients.[15] This may be increasing competition with dentists in the private market who have seen a downturn in their own practices due the recession, which blurs the lines around the safety-net. In sum, there is currently no sustainable delivery system in place to provide basic or comprehensive dental care to poor adults, a stark contrast within an era of health care reform focused on expanded coverage and prevention. However, this situation may evolve given policy changes coming in 2014 and beyond.

In May 2013, in response to increased state revenues, dental advocates pushed for a reinstatement of optional adult Denti-Cal benefits.[23] A partial reinstatement was ultimately granted; however, a 10% provider rate cut is also being implemented.[24, 25] Approximately 3 million adults will regain access to dental benefits through the reinstatement of optional adult Denti-Cal, and almost 1 million more adults are estimated to gain these benefits under the ACA Medicaid expansion in California.[4,26] In addition, due to the ACA mandate that all children have access to dental coverage, almost 5 million children will be insured through public programs in California in 2014.[27] While this is may be good news for those dependent on dental safety-net for care, it raises serious concerns about the safety-net's ability to handle the huge influx of patients expected under these changes.

This qualitative study complements prior quantitative examinations of both the budget savings and utilization declines from the Denti-Cal policy change by providing an in-depth look at what the cuts meant for the day-to-day operations, the overall structure, and the patient experience of the dental safety-net in California. It also raises new questions about yet-to-be-quantified effects of the policy change. The impetus for the cuts to the program was to save the state money; however, the long-term financial impacts in cost shift ing to medical services, economic loss to the dental sector, and the ripple effect to supporting industry, as well as personal financial loss to individuals unable to find work or unable to work due to pain and suffering has yet to be calculated. Also unclear is the impact of this contraction of the dental safety-net on patient access and provider capacity in the face of the expansion of Medicaid under the ACA in California concurrent with a reinstatement of optional adult dental benefits.

Study limitations

While consistent narratives emerged from safety-net providers in a variety of settings across California, this small qualitative study does not speak to the experience of all safety-net dental care providers in the state. In addition, because interviews were conducted almost two years after the initial cuts took effect, all of our participants have survived economically; the voices of others who may have been unsuccessful are not included here. Additionally, the cuts to Denti-Cal are embedded in the larger landscape of the recession and our results can only evaluate the Denti-Cal cuts within this context.

Conclusions

The elimination of optional adult dental benefits from the Denti-Cal program in California resulted in a decrease in utilization by this adult population who now seek care primarily for emergency services and extractions. The cuts to the Denti-Cal program have made obtaining preventive and restorative dental care financially impossible for many adults who receive Denti-Cal benefits, leaving this population largely excluded from comprehensive dental care.

Within the dental safety-net, FQHCs, IHCs, dental schools, and the DHMO have been more resilient than other providers in surviving the cuts due to greater flexibility in their patient payer-type and funding streams. Private providers with large Denti-Cal practices and county health departments have reported the greatest negative impact from the cuts. Safety-net providers report that the cuts are causing irreparable harm to their patients and that there is currently no sustainable system of dental care to replace the loss. This has resulted in frustration, disillusionment, and demoralization among a pool of practitioners long committed to the state's underserved population.

Safety-net providers in California successfully advocated for a restoration of some optional adult dental benefits starting in May 2014 under Denti-Cal. This will follow on the heels of a large expansion of the Medicaid program under the ACA, raising concerns about the safety net's current capacity to address the potential influx of new dental patients.

Acknowledgments

This study was funded by the Pacific Center for Special Care (Grant Number T12HP14666 from the Health Resources and Services Administration and Contract #10-10153 from the California Department of Public Health) and National Institute of Dental and Craniofacial Research Award # P30DE020752. Thanks to Catherine Dower, Stuart Gansky and Judith Barker for their thoughtful assistance in reviewing and editing this paper.

Notes

1. California Medi-Cal Dental Program. Elimination of most adult dental services. Vol. 25. Sacramento, CA: California Medi-Cal Dental Program; 2009.
2. Simonson-Maiuro, L. California health care almanac: Denti-Cal facts and figures. Oakland, CA: California HealthCare Foundation; 2010.
3. State of California Governor's Office. 2009 Budget act. Sacramento, CA: State of California Governor's Office; 2009.
4. Hughes, D.; Diringer, J. Adult dental Medi-Cal cuts: costs and consequences. Sacramanto, CA: University of California; 2009.
5. California Medi-Cal Dental Program. Optional Adult Dental Services for Department of Developmental Services (DDS) regional center consumers restored. Vol. 27. Sacramento, CA: California Medi-Cal Dental Program; 2009.
6. Chin, J.; Elizabeth, R. Denti-Cal benefits for developmental disabilities. San Francisco, CA: Californian Department of Health; 2013.
7. Pourat, N. Coverage matters: the role of insurance in access to dental care in California. Oakland, CA: California HealthCare Foundation; 2009.
8. Wallace NT, Carlson MJ, Mosen DM, et al. The individual and program impacts of eliminating medicaid dental benefits in the Oregon health plan. Am J Public Health. 2011 Nov; 101(11):2144–50. http://dx.doi.org/10.2105/AJPH.2010.300031. [PubMed: 21680938]
9. Choi MK. The impact of Medicaid insurance coverage on dental service use. J Health Econ. 2011 Sep; 30(5):1020–31. http://dx.doi.org/10.1016/j.jhealeco.2011.08.002. [PubMed: 21885138]
10. Kaiser Family Foundation. Medicaid benefits: online database. Thousand Oaks, CA: Kaiser Family Foundation; 2010.
11. Coughlin TA, Long SK, Shen YC. Assessing access to care under Medicaid: evidence for the nation and thirteen states. Health Aff (Millwood). 2005 Jul-Aug;24(4):1073–83. http://dx.doi.org/10.1377/hlthaff.24.4.1073. [PubMed: 16012148]
12. Cohen LA, Manski RJ, Hooper FJ. Does the elimination of Medicaid reimbursement affect the frequency of emergency department dental visits? J Am Dent Assoc. 1996 May; 127(5):605–9. [PubMed: 8642140]
13. Cohen LA, Manski RJ, Magder LS, et al. Dental visits to hospital emergency departments by adults receiving Medicaid: assessing their use. J Am Dent Assoc. 2002 Jun; 133(6):715–24. [PubMed: 12083647]
14. The Pew Center. A costly dental destination: hospital care means states pay dearly. Washington, DC: The Pew Center; 2012.
15. Pryor, C.; Monopli, M. Eliminating adult dental coverage in Medicaid: an analysis of the Massachusetts experience. Washington DC: Kaiser Commission on Medicaid and the Unisured; 2005.
16. Maiuro, L. Health Management Associates. Eliminating adult dental benefits in MediCal: an analysis of impact. Oakland, CA: California HealthCare Foundation; 2011.
17. Muhr, T. User's manual for ATLAS (ti 5.0). Berlin, Germany: ALAS.ti Scientific Software Development GmbH; 2004.
18. Merced Sun-Star. Interactive map: unemployment in California. Merced, CA: Merced Sun-Star; 2012.
19. Hyde S, Satariano WA, Weintraub JA. Welfare dental intervention improves employment and quality of life. J Dent Res. 2006 Jan; 85(1):79–84. http://dx.doi.org/10.1177/154405910608500114. [PubMed: 16373686]

20. Goszkowski, R. Most dental ER patients are young, uninsured, rural. San Francisco, CA: 2012. drbicuspid.com

21. Joseph, D. Filling demand for dental care. San Francisco, CA: San Francisco Chronicle; Feb 1. 2013

22. Ruddy, G. Health Centers' role in addressing the oral health needs of the medically underserved. Washington, DC: National association of Community Health Centers Inc; 2007.

23. Domino, D. California Governor says no to adult dental Medi-Cal benefits. San Francisco, CA: 2013. drbicuspid.com

24. Caifornia Medi-Cal Dental Program. Restoration of some adult dental services in 2014. Vol. 29. Sacramento, CA: Caifornia Medi-Cal Dental Program; 2013.

25. California Medi-Cal Dental Program. Implementation of AB 97 reductions. Vol. 29. Sacramento, CA: Caifornia Medi-Cal Dental Program; 2013.

26. California HealthCare Foundation. Health reform in translation: infographic: what will happen to California's 5.6 million uninsured under health reform in 2015. Oakland, CA: California HealthCare Foundation; 2013.

27. Kattlove, J. Fiz Medi-Cal Dental Coverage: half of California kids depend on it. Santa Monica, CA: Children's Partnership; 2013.

Table 1

Distribution of Interviews by Site

Interview Site	Telephone Interview	In-person Interview	Total Interviews	Total in California (with dental services)
Private Denti-Cal Provider	3	0	3	27,000[a]
County Public Health Department	1	1	2	8[b]
Dental School	2	1	3	6[c]
Federally Qualifed Health Center (FQHC)	2	1	3	92[d]
Indian Health Centers	1	1	2	35[e]
Dental Health Maintenance Organization (DHMO)[f]	1	0	1	20[g]
Total Interviews	10	4	14	

[a] Not all of these dentists participate in Medicaid, and fewer than 10,000 billed Denti-Cal for any services in 2010.

[b] California State Oral Health Programs identifed 31 counties with any dental program. Researchers identifed 8 remaining in 2012 with preventive and restorative services.

[c] Only 5 dental schools existed in 2009.

[d] Provided by the California Primary Care Association (CPCA) for 2012 in email personal communication. We did not interview any community clinics without FQHC status.

[e] Provided by the Indian Health Service for 2012 in email personal communication

[f] Both a plan and provider with multiple sites across the state of California.

[g] California Department of Managed Care (http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx)