

# Adult Utilization of Medicaid Dental Benefits in California: Impact of Policy Changes 2014-2019

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## Research objectives

Adult dental coverage in Medicaid was eliminated in California in 2009, but was reinstated in 2014 followed by several other policy initiatives designed to improve dental care access (see below). Our study utilizes dental claims data to evaluate the impact of two policies effective January 2018 (full reinstatement of adult dental benefits and supplemental payments for specific dental procedures, circled in green below) on improvements in capacity and access to care for the adult Medicaid population in California.

Timeline	Description of policy/initiative
Jul 2009	Elimination of adult dental benefits
Jan 2014	ACA expanded Medicaid eligibility
May 2014	Partial adult benefits (AB 82)
Dec 2014	State Auditor's report
Jul 2015	10% rate increase
Jan 2016	DTI initiated* (focus on children)
Apr 2016	Little Hoover Commission report
Jul 2016	HRSA OHSE grants
Jul 2017	Prop 56 suppl. payments for procedures
Jan 2018	Full adult benefits (SB 97)
Jul 2018	Prop 56 suppl. payments expanded
Sep 2018	Letter from Little Hoover Commission
May 2019	FY18-19 loan repayment awards
Sep 2019	HRSA OHI grants
May 2020	FY19-20 loan repayment awards
Jun 2021	FY20-21 loan repayment awards

\* Impact on service would vary by demonstration pilot sites, which also vary by domains and counties

ACA = Affordable Care Act; DTI = Dental Transformation Initiative; HRSA = Health Resources and Services Administration; OHSE = oral health service expansion; suppl. = supplemental; repay. = repayment; OHI = oral health infrastructure

## Research funder

West Health Policy Center

## Study design

Data from come from Medicaid enrollment and claims files, provider state license and national provider identifier (NPI) data, as well as county-level neighborhood data from the American Community Survey (ACS).

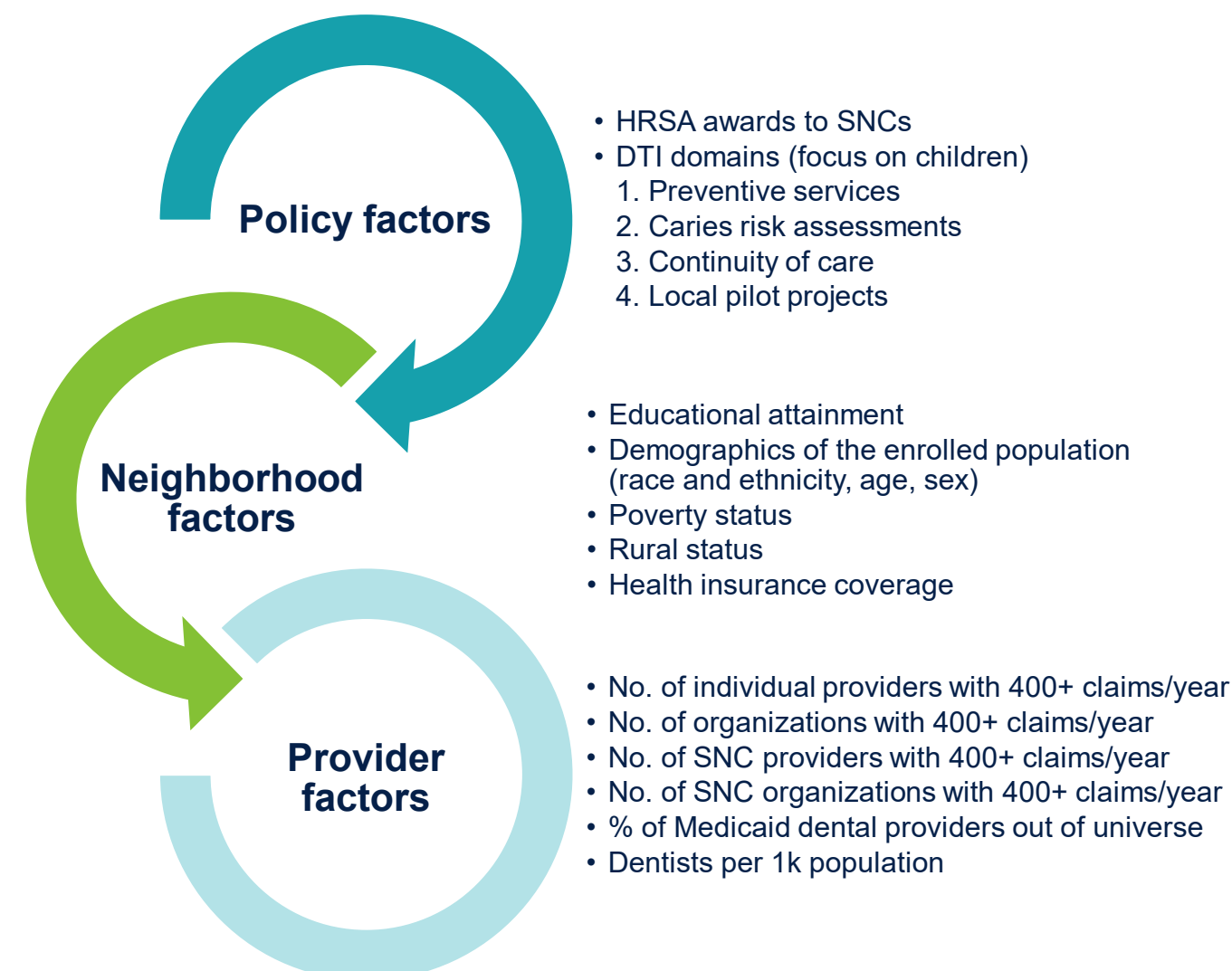
### Population studied

Adults ages 21+ with Medicaid dental insurance in California from 2014-2019.

### Statistical methods

Autoregressive moving average models adjusted for autocorrelation of the months (i.e., unit of time is month) and seasonality by specifying the correlation matrix (first order or nth-order autocorrelation), tested with random intercepts, random slopes, and both in the interrupted time series were used to model monthly adult utilization by county. Utilization was calculated as an aggregate monthly measure of Medicaid enrollees with dental claims in each month.

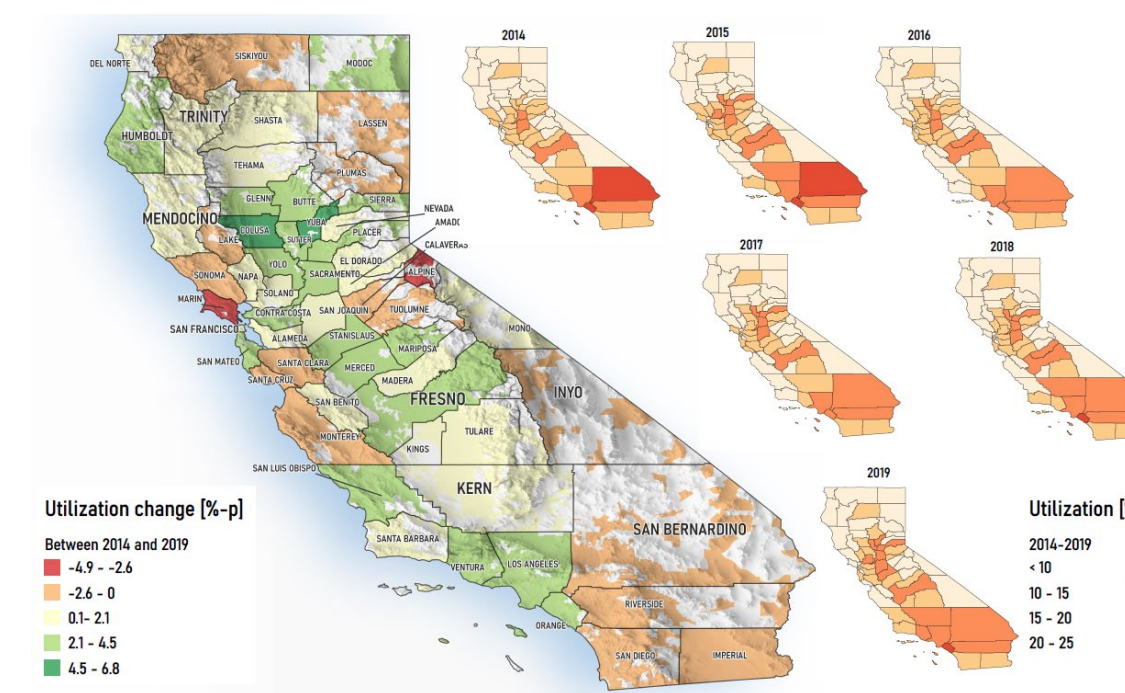
Separate models were created by setting of care: safety net clinics (SNCs) vs. all other dental settings. Models were adjusted to include time markers for other policies implemented in the timeframe, provider factors, and county characteristics (see below).



## Principal findings

There was a **very modest increase** in monthly utilization in both settings of care following the two policies (full reinstatement of benefits, supplemental payments to providers), but the **impact levels off over time** and the trend in monthly utilization afterward is insignificant.

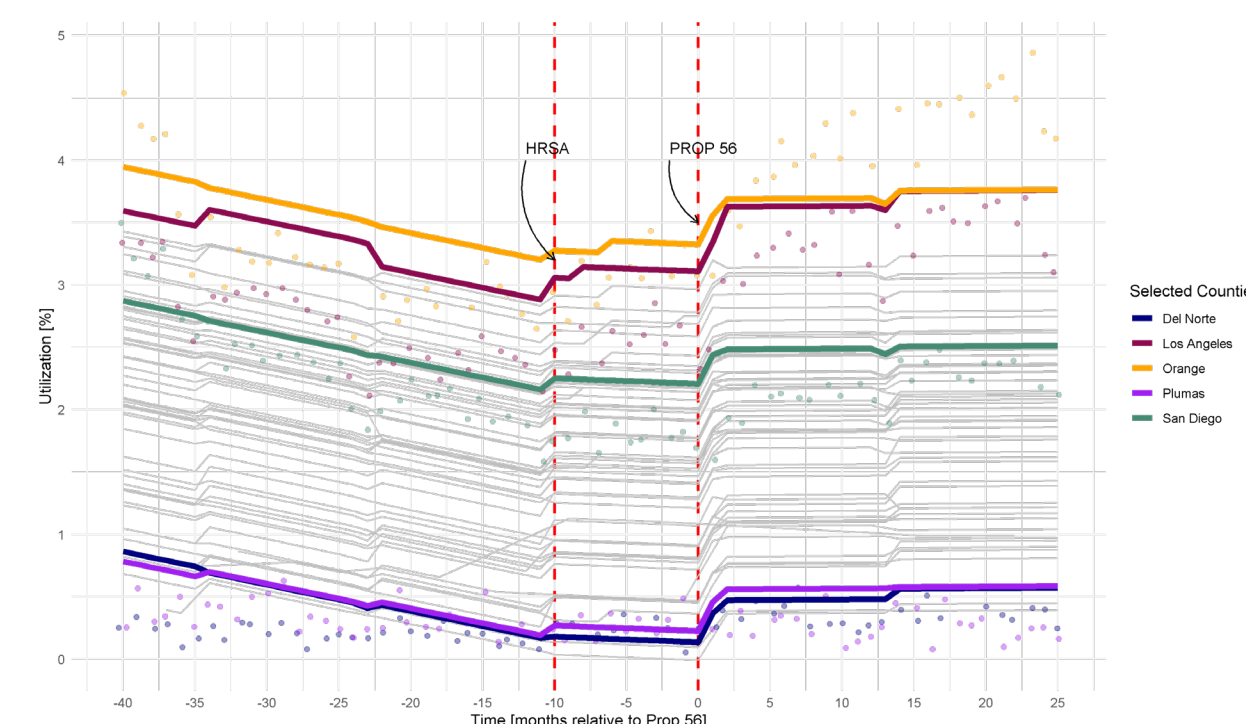
### Setting: private practices and other non-SNCs



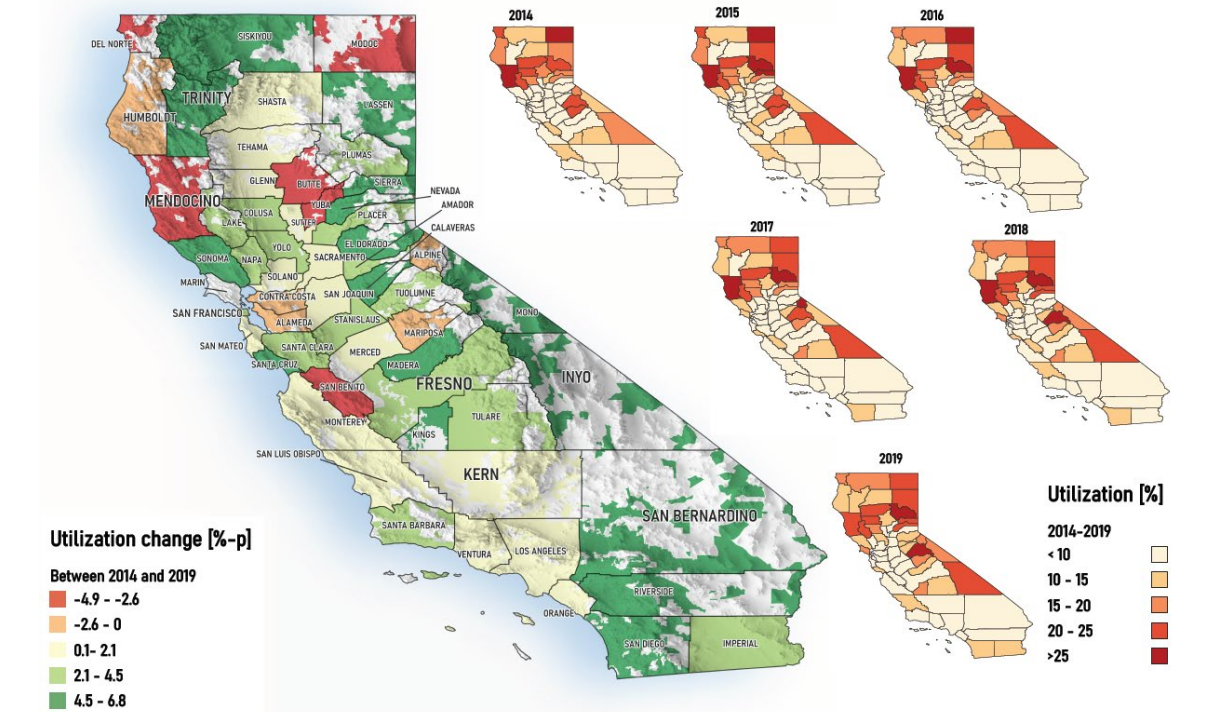
### Model predicting non-SNC utilization by county

**Positive predictors:** number of individual providers with 400+ claims in a year and the share of providers in the county actively participating in Medicaid.

**Negative predictors:** other policy initiatives focused on children and the safety net, the number of safety net providers in the county with 400+ visits in a year, rurality, and the share of Hispanic county enrollees.



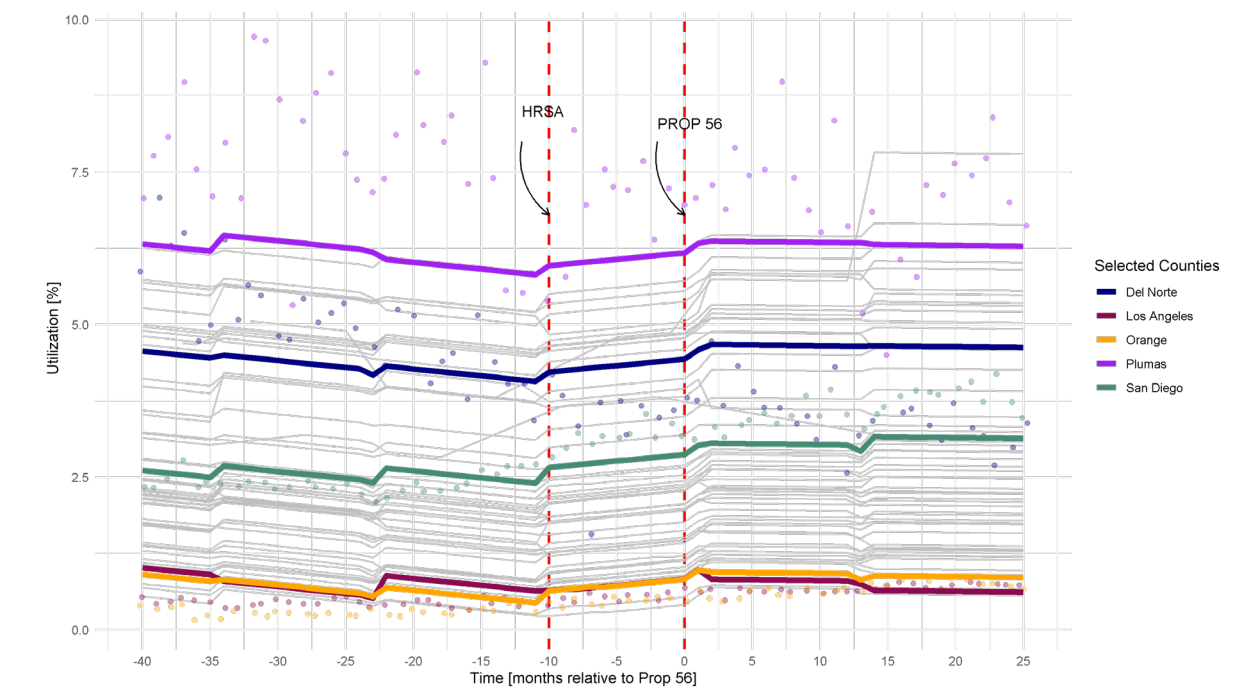
### Setting: SNCs



### Model predicting SNC utilization by county

**Positive predictors:** rurality, dentists per capita, and the number of safety net providers with 400+ visits in a year.

**Negative predictors:** the share of the county with health insurance, the county median age, and other policies focused on children's access to dental care



## Conclusions

Access to dental care after the reinstatement of benefits for adults in California remains abysmal, with on average 15.5% annual utilization. Since 2014, access has improved marginally; however, the return on investment for recent statewide policy measures is minimal.

The reinstatement of adult dental benefits has been hailed as an essential oral health policy development; however, the **capacity** of the dental care system to provide for Medicaid-enrolled adults **severely limits access to dental care.**