The University of Chicago

A Dental System in Decay: An Exploration and Evaluation of Social Responsibility and Medicaid in Dentistry

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A thesis submitted for partial fulfillment of the requirements for a Bachelor of Arts degree in Public Policy Studies

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April 18, 2022

Abstract

While oral health is important to one's overall health, it often does not receive the same attention as other health services. As health inequities rise and dentistry becomes more subject to economic pressure, there is concern regarding dental students' moral education, character development, and capacity to provide care for vulnerable populations. Existing literature does not fully explore the application of social responsibility to dentistry and the relationship between social responsibility and Medicaid participation. In this paper, I examine how dentists in Illinois conceptualize social responsibility as it relates to Medicaid and the manifestation of social responsibility in dentistry. Through a series of semi-structured interviews with dentists and orthodontists in Illinois, I discover a tension between practicing social responsibility and participating in Medicaid, as this social welfare program violates the financial, legal, and ethical obligations integral to practicing social responsibility. These findings help inform the promotion of social responsibility among the next generation of dentists and the improvement of access to dental care for low-income populations. Recommendations from this study include the use of workshops and town meetings hosted by the Illinois Department of Healthcare and Family Services to address administrative burdens related to Medicaid, dental school curriculum that promotes social responsibility through service learning, and increased funding and proliferation of Federally Qualified Health Centers in Illinois.

Acknowledgements

Thank you to Kelsey Berryman for guiding me and providing feedback throughout this process.

Thank you to Mo Mitchell for sharing this journey with me and dedicating hours to strengthening my work and providing support.

Thank you to Julia Richardson and Eugen David for always encouraging me and listening to my rants about teeth.

Special thanks to Mary Otto for opening my eyes to America's oral health crisis. You inspired this endeavor.

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Introduction

In the United States, one of the wealthiest nations in the world, more than one in four adults have untreated tooth decay (CDC, 2019). In 2020, about 20% of children in the United States, aged five to eleven, had at least one untreated decayed tooth. Children of color are disproportionately affected and have higher rates of tooth decay due to systemic racial inequities (CDC, 2019). Tooth decay, though largely preventable, has not yet been conquered. Despite bipartisan recognition of America's oral health crisis, policymakers have repeatedly failed to address oral health as a core component of our healthcare system or to adopt a comprehensive oral health policy agenda centered on equity (Otto, 2017). While good oral health is an important part of an individual's overall health, it often does not receive the same focus and attention as other health services—including medical, non-oral disease prevention, and mental health.

Most attempts at oral health policy change in the United States have focused on particular populations rather than universal reform, with a lack of a unified strategy among stakeholders allowing for disparities to grow (Ticku, 2021). Americans are roughly four times more likely to lack dental insurance than medical insurance, with the greatest rates of uninsurance among racial and ethnic minorities (Burroughs et al, 2021). When oral health care is out of reach, many people are forced to rely on expensive emergency department settings for dental relief—further straining already limited hospital capacity (Ticku, 2021). The COVID-19 pandemic, which has exacerbated existing disparities in healthcare, has furthered the need to address inequities in oral health (Kalash, 2020). Massive increases in unemployment and the loss of employer-provided dental insurance caused by the pandemic demonstrates the need to strengthen the dental safety net. Without substantive policy change to address inequities in oral health care, further strain on the healthcare system and economy will result.

Persistent and consequential oral health disparities exist within the U.S. population and reducing these oral health disparities is central to the overall goal of improving population health. An important aspect of the dental safety net is Medicaid participation. Medicaid adult and child dental coverage plays a critical role in access to and use of dental care (Choi, 2011). State Medicaid programs are required to provide dental coverage for children, but not for adults. As a result, there is variation in whether states provide any dental benefits for adults and, among states that do provide such benefits, there is variation in what and who is covered (Singhal, Damiano, & Sabik, 2017). Finding dentists who treat Medicaid-enrolled children and adults is a struggle for many individuals (Modifi, Rozier, & King, 2002). Research has found that dentists are 18 times more likely to deny care to Medicaid-insured children compared to privately insured children experiencing identical symptoms (Bisgaier et al., 2011). Previous studies on dentist participation in public assistance programs have cited burdensome administrative requirements, excessive paperwork, difficulties with patients, and lack of case management to be major issues in participating (Nebeker et al., 2014).

As health inequities continue to increase and dentistry becomes more focused on the economic pressures of the marketplace, there is concern about whether appropriate attention is being given to the character development and moral education of dental students, and whether these evolving economic realities affect one's ability to respond to inequities in care and participate in social assistance programs (Ozar, 2006). The concept of social responsibility has often been considered in education, civic engagement, community service, sustainable development, and within the corporate sector and business ethics (Bhattacharya, 2017). However, reference to social responsibility in dentistry has tended to lack a clear explanation of the concept or how it is conceptualized by dentists. We know little about how dentists think

about and struggle with their social responsibilities and how these struggles relate to participation in social assistance programs, like Medicaid. The concept of social responsibility within dentistry is further complicated by the historical divide between medicine and dentistry. Unlike medicine, dentistry has increasingly become viewed as a business, as over the last decade there has been a focus on commercialization of dentist services and the rise of "corporate dentistry" (Otto, 2017). The duality of the dentist as both a healer and businessperson is perceived to be a conflict of interest (Welie, 2000). It also acts as a barrier towards practicing social responsibility, which is often related to participation in social assistance programs, as social responsibility manifests as an ethical obligation which requires hospitals and other health organizations to do something beneficial, such as delivering quality health care to everyone who is entitled to it (Brandão et al, 2013).

This paper seeks to contribute to this body of literature by answering the questions: how do dentists in Illinois conceptualize social responsibility as it relates to Medicaid, and how does social responsibility manifest itself in dentistry? Answering these questions will help inform how a more robust dental care safety net can be built to provide care for the growing number of people with Medicaid coverage in Illinois and give a more nuanced understanding of how dentists make sense of social responsibility in their profession. This knowledge could help to inform how to promote social responsibility among the next generation of dentists within an increasingly materialistic society. One might expect that there is tension between social responsibility and Medicaid participation due to the many commonly cited barriers to participation. This study will begin to answer these questions by exploring dentists' perspectives on social responsibility, Medicaid, and the relationship between the two through a series of semi-structured interviews with dentists throughout Illinois. After speaking with twelve dentists and

orthodontists, I analyze their comments by pulling out key themes, on which interviewees shared common or differing views. I find that dentists in this study have varying ideas of what constitutes being socially responsible in their profession. Three varying conceptualizations of social responsibility became evident: an obligation as individual, an obligation as a dental professional, and an obligation as a community member. I find that social responsibility in dentistry is constrained by the realities of the financial obligations required in the dental profession. Additionally, the financial pressures within the dental industry create a tension between being profitable and being an ethical provider. Dentists cite numerous barriers to Medicaid participation, including frustration towards the lack of benefits offered, and display stigmatized perspectives of Medicaid patients. Furthermore, dentists question the efficacy of the care that can be provided to Medicaid patients in private dental offices, complicating the question of how to increase access to dental care for Medicaid patients. Finally, being a Medicaid provider was felt to be in direct tension with practicing social responsibility.

The findings of this study bring up interesting questions about the role of social responsibility in increasing access to care and how to best serve the dental needs of Medicaid recipients. Improving access to dental care among low-income adults is crucial in achieving national goals to improve population health and health equity. Medicaid's growing role in covering low-income adults provides an opportunity to address the high rates of oral disease and unmet dental need among low-income adults.

Background

In 2000, former Surgeon General David Satcher issued the first-ever Report on Oral Health. The report brought attention to the oral health needs in the United States and affirmed their importance to general health and well-being. Oral disease was termed a "silent epidemic,"

highlighting the role of oral health as a gateway to general health and well-being. The report detailed widespread inequities in access, insurance coverage, and oral health status. Additionally, it raised concerns about the quality of dental care, the financial sustainability of dental education, and the lack of workforce diversity (Office of the Surgeon General, 2000). In 2003, former Surgeon General Richard H. Carmona released a *National Call to Action to Promote Oral Health*, which built upon Satcher's report and underscored the many disparities related to oral health (Office of the Surgeon General, 2003). Carmon's report charged individuals, whether as community leaders, volunteers, health-care professionals, researchers, or policy makers, to collaborate to promote oral health and reduce disparities.

Under Medicaid's Early and Periodic Screening, Diagnostic and Treatment benefit enacted in 1967, provision of dental services is a required service for Medicaid-eligible individuals under the age of 21 (Medicaid.gov, n.d.). State Medicaid programs are required to provide dental coverage for children, but not for adults. As a result, there is variation in whether states provide any dental benefits for adults and, among states that do provide such benefits, there is variation in what and who is covered. Some states cover only emergency dental services or cover only certain Medicaid enrollees (e.g., pregnant women), while other states provide more comprehensive coverage, including diagnostic and preventive treatments, to all adult enrollees (Singhal, Damiano, & Sabik, 2017). In Illinois, where this study is focused, Medicaid is an important part of overall health insurance enrollment and coverage, with Medicaid and the Children's Health Insurance Program (CHIP) covering about 20% of the state's 12.5 million residents. About 20% of those covered are eligible for Medicaid due to the state's expansion of Medicaid under the Affordable Care Act (ACA) in 2016. As of July 2021, there were 781,737 Illinois residents covered under expanded Medicaid (HFS, 2021).

Total Medicaid enrollment includes people who are eligible under the ACA's expansion of Medicaid to low-income adults, as well as people who were already in one of the traditional Medicaid groups (low-income pregnant women, children, parents of minor children, and aged, blind, or disabled residents). As of April 2021, total Medicaid enrollment in Illinois stood at about three million people (HFS, 2021). Children who qualify for Medicaid/CHIP in Illinois are covered under a program called All Kids. All Kids is Illinois's program for children who need comprehensive, affordable health insurance, regardless of immigration status or health condition. Under this program, dental coverage for children includes preventative services, diagnostic services, and most treatment services. These services include oral exams, cleanings, topical fluoride, sealants, fillings, root canals, treatment of gum disease, and extractions (HFS, 2021). Dental coverage for adults in Illinois is not as comprehensive. In 2014 adult dental benefits were restored in Illinois after being cut in 2012. Dental benefits for adults do not include any preventative or treatment services, instead only including a complete set of dentures once every five years and full mouth X-rays once every three years (HFS, 2021). As Medicaid dental benefits alone do not seem sufficient in all cases for caring for low-income populations, it is imperative to understand how social responsibility can be promoted within dentistry to address inequities in care.

Literature Review

I. Inequities in Dental Care Access

Previous studies have indicated that both Medicaid adult and child dental coverage plays an important role in access to and use of dental care. A study by Choi (2011) and one by Decker and Lipton (2015) found that providing dental coverage to adult Medicaid enrollees increases the probability that a person has a yearly dental visit by 16–22% and 13%, respectively. Child

Medicaid coverage is similarly associated with increased utilization of dental services. The number of children receiving dental care under Medicaid more than doubled from 2000 to 2010 and the percentage of children receiving dental care grew from 29.3% to 46.4% (Ku et al., 2013). Despite preventive dental services being covered for all children in Medicaid, research has found substantial variation across states in the level of access to dental services, due in part to state-level differences in Medicaid payment rates to providers and geographic variation in the supply of dentists (Fisher-Owens et al., 2016).

Although many advances have been made in oral health coverage and utilization of care, disparities in access remain. Dentist participation in state Medicaid programs is an important aspect of the dental care safety net meant to serve nearly 75 million covered adults and children yet many individuals continue to struggle to find dentists who treat Medicaid-enrolled children and adults (Modifi, Rozier, & King, 2002). A critical study conducted for the Illinois Medicaid program found that dentists were 18 times more likely to deny an appointment for a Medicaid-insured 10-year-old child experiencing dental pain from a fractured incisor compared with a privately-insured child with identical symptoms (Bisgaier et al., 2011).

Various criteria have been used to measure dentist participation in Medicaid, including provider enrollment, volume of patients, claims, and share of revenues. Each measure yields different levels and distributions of provider participation. The most meaningful way to measure dentist participation in Medicaid is still under debate as the task of assessing the percentage of dentists who participate in Medicaid in each state is complicated by numerous factors related to accessibility, accuracy, significance, and comparability of available data (Warder & Edelstein, 2017). Using newly accessible data to measure dentist participation, Vujicic, Nasseh, and Fosse (2021) found that in many states there is a significant share of enrolled providers not seeing any

Medicaid patients. They found that dentist participation in Medicaid varies not only by overall share of practicing dentists enrolled in Medicaid, but also by the distribution of the volume of Medicaid patients. Some states have a "wide but shallow" pool of Medicaid providers, meaning many dentists are enrolled in the Medicaid program but, on average, see few patients each; meanwhile, other states have a "narrow and deep" pool of providers, meaning fewer dentists are enrolled in Medicaid, but each, on average, sees a high volume of patients (Vujicic, Nasseh, & Fosse, 2021). The areas of "narrow and deep" pool of providers are of significant concern, as the high volume of patients indicate that securing appointments with providers may be difficult.

While dentist participation in Medicaid programs plays a large role in dental care access, other factors influence dental care utilization. A study involving interviews with a racially and ethnically diverse group of caregivers regarding barriers to dental care for their Medicaid-insured children found negative experiences with the dental care system discouraged many caregivers from obtaining dental services for their children. Searching for providers, arranging an appointment where choices were severely limited, and finding transportation were cited as common barriers. Additionally, caregivers who were successful in obtaining care for their children found additional barriers once in the dental care setting, including long wait times and judgmental, disrespectful, and discriminatory behavior from staff and providers because of their race and public assistance status (Modifi, Rozier, & King, 2002). Clearly removing provider barriers may not eliminate all oral health disparities but finding dental providers willing to accept public insurance is a vital step toward improving the oral health of the nation.

II. Examining the Barriers to Medicaid Participation

Previous studies on dentist participation in public assistance programs primarily relied on structured questionnaires and interviews to investigate the barriers to dentist participation. A

study among 92 California dentists identified low reimbursement rates, denial of payment, and broken appointments by patients as the three most pressing problems with the Medicaid program (Damiano et al., 1990). Burdensome administrative requirements and individuals called "difficult" patients have often been cited as factors in low participation in Medicaid (Nebeker et al., 2014; Borchgrevink, 2008). Other research has identified excessive paperwork, lack of case management to assist patients in keeping appointments, and poor oral health literacy as issues leading to the reluctance of dentists to participate in Medicaid (ADA, 2004). Building on previous research in the field, Bedos et al. (2013) conducted qualitative research whose objective was to better understand how dentists perceived and experienced treating people on social assistance in Montreal, Canada. Researchers found that most social assistance participating dentists expressed high levels of frustration and anger with the program. The sources of frustration stemmed from organizational issues, biomedical issues, and financial issues. As a consequence of the frustration with social assistance programs, dentists tended to feel discouraged and powerless, which resulted in a reluctance to treat people on social assistance at all (Bedos et al., 2013). An important limitation of this study is that it did not include any dentists that unilaterally refuse to treat people on social assistance, a practice that has been documented in the United States but not in Canada (US General Accounting Office, 2010).

Building upon previous literature, Logan et al. (2015) investigated non-reimbursement factors that influence dentists' decision on whether or not to participate in the Medicaid program in Florida. Researchers found that non-reimbursement items significantly influence the willingness of dentists to participate in the Medicaid dental program and uncovered two previously unreported barriers to participation: perceived social stigma of being a Medicaid participant and the lack of specialists who are Medicaid participants to whom patients can be

referred. Even for those enrolled as providers, the social stigma associated with providing care for Medicaid recipients was seen as a barrier. Other research indicates that diversity may also play a role in the decision to participate in Medicaid dental programs. Okunseri et al. (2008) found that racial and ethnic minority dentists were twice as likely as white dentists to accept new Medicaid patients. A study among dentists in South Florida found that African American and Hispanic dentists were more likely to participate in Medicaid than other groups of Florida dentists (Logan et al., 2014). A better understanding of dentists' Medicaid participation will help inform how a more robust dental care safety net can be built to provide care and promote oral health for the growing number of people with Medicaid coverage.

III. Theoretical Grounding: Corporate Social Responsibility (CSR)

The topic of social responsibility has been a subject of intense controversy and interest. In part, this debate is a result of the proliferation of different conceptualizations of corporate social responsibility (CSR). CSR is defined in various ways from the narrow economic perspective of increasing shareholder wealth (Friedman, 1982), to economic, legal, ethical and discretionary strands of responsibility (Carroll, 1979) to good corporate citizenship (Hemphill, 2004). The variations in definitions of CSR are rooted in fundamental assumptions of what CSR entails, from views of minimal legal and economic obligations to responsibilities to the broader society. Despite ongoing definitional disputes, in its broadest sense, CSR is about the social obligations and impacts of business in society.

Many Western theoreticians have attempted to offer theoretical, moral and ethical groundings for CSR initiatives (Dusuki, 2008). Nonetheless, these attempts have been broadly criticized for problems relating to justification, clarity, and possible inconsistency (Goodpaster, 2001). However, Carroll's four-part conceptualization has been the most durable and widely

cited in the literature (Crane & Matten, 2019) despite the presence of numerous definitions/models and CSR synonyms. Carroll's four-part definition of CSR was originally stated as follows: "Corporate social responsibility encompasses the economic, legal, ethical, and discretionary (philanthropic) expectations that society has of organizations at a given point in time" (Carroll 1979). According to the model, four kinds of social responsibilities constitute total CSR: economic ("make profit"), legal ("obey the law"), ethical ("be ethical"), and philanthropic ("be a good corporate citizen"). The model categorizes the different responsibilities hierarchically in order of decreasing importance. The most fundamental is economic responsibility: "all other business responsibilities are predicated upon the economic responsibility of the firm, because without it the others become moot considerations" (Carroll, 1979). The second level of the pyramid is the business's legal obligation to obey the law. Following is ethical responsibility defined in terms of "those activities or practices that are expected or prohibited by society members even though they are not codified into law" (Carroll, 1979). At the top of the pyramid is philanthropic responsibility, which is discretionary in nature. In summary, the pyramid describes a necessary and sufficient set of obligations that socially responsible businesses should simultaneously fulfill, taking into consideration their decreasing importance.

Importantly, the separation of domains in Carroll's model seeks to argue that businesses do not have to focus either on profits or social concerns, but instead should fulfill these obligations simultaneously (Carroll, 2016). The ordering of the four categories of responsibility strives to portray the fundamental or basic nature of these four categories to business's existence in society. The representation being portrayed, therefore, is that the total social responsibility of business entails the concurrent fulfillment of the firm's economic, legal, ethical, and

philanthropic responsibilities. However, the clear-cut separation of the domains raises the problem of integration, as it says nothing about how these responsibilities are interwoven. Practicing social responsibility becomes difficult when the satisfaction of some stakeholders' interests may be opposed to the fundamental goal of most healthcare systems and when economic responsibility is regarded as more important than ethical responsibility (Brandão et al, 2013). There is a tension between social responsibility and profit making, as traditional business ethics determines that the main goal of private corporations is to increase the profits of its shareholders. In this perspective, any use of a corporation's resources for goals other than profit making would be unethical because that use is not legitimated by shareholders (Carrol, 2016). However, in the last few decades there has been a growing social awareness that profit is a necessary condition but not a sufficient one (Brandão et al, 2013).

As Carroll's definition is one of the best known models of CSR and broadly defines the components of social responsibility, it is well suited to be applied to the healthcare field. The requirement for social responsibility in medicine is thought to be a moral commitment and duty developed over centuries within societies that advances the notion of what constitutes a profession. Medicine, having accepted the status of profession in society, and the special social, moral, and political status that follows, has also accepted a legal duty to behave altruistically, placing society's concerns before its own (Welie, 2004). The application of the concept of social responsibility to dentistry is complicated due to the duality of the dentist as both a healer and businessperson, in which dentists have both ethical and financial obligations. This duality is perceived to be a conflict of interest, as when a clinician's material well-being is linked to the quantity of treatment that is provided, it is inevitable that professional activity will be influenced by economic considerations (Welie, 2000). The commercialization of dental services and the rise

of corporate dentistry over the last few decades has contributed to the tension between social responsibility and dentistry (Otto, 2017). While most individual or small group practices are corporations in a legal sense, the term corporate dentistry has come to be colloquially understood within the dental profession as referring to multi-location, multi-doctor dental practices. The emergence of "corporate dentistry," dental clinical chains controlled by non-dental professional individuals with the motive of earning profits, has furthered the notion of dentistry as a business, as the owners or employers set profit related targets to be achieved by the employed dentists, which further leads to promotion of certain treatments with higher revenue generation rather than choosing options best suited for the patients (Otto, 2017).

Applying Carroll's model of CSR to dentistry specifically, the issue of ethical obligation becomes relevant when investigating Medicaid participation. This study will utilize Carroll's model of CSR to evaluate the ways in which participation in Medicaid is socially responsible. The ethical component of the CSR model implies that there is an ethical obligation that requires hospitals and other organizations to do something beneficial in issues such as delivering quality health care to everyone who is entitled to it. In this framework, Medicaid would appear to represent an example of dentists performing an act of social responsibility; in fact, using the CSR framework presented above, I will demonstrate how Medicaid is unable to facilitate social responsibility. I discuss the ways in which certain aspects of Medicaid participation are in tension with the components of Carroll's model of social responsibility and the implications of those tensions. Currently, only one study has addressed the application of social responsibility to dentistry. This study explored how dentists in Canada and the United States explain the concept of social responsibility and found that economic concerns greatly constrained dentists from practicing social responsibility (Dharamsi, Pratt, & MacEntee, 2008). While the concept of social

responsibility has been extended to healthcare through the lens of hospital governance and provider responsibility (Brandão et al., 2013), very little is known about the application of the concept of social responsibility to dentistry, how it manifests in dentistry, and how it is related to Medicaid participation.

Methodology

In this investigation, I conducted twelve semi-structured interviews with dentists and orthodontists in Illinois. The interviews used in this study were intended to explore the ways in which social responsibility is conceptualized by dentists in relation to Medicaid and how social responsibility manifests in dentistry. Qualitative methodologies are useful for exploring complex phenomena about which little is known (Bedos et al., 2009). Previous research on barriers to dentist participation in Medicaid have focused primarily on surveys (Damiano et al., 1990). While surveys produce useful generalized data, they fail to capture rich details of stakeholders' perspectives. Interviews can uncover perspectives that may have never been considered or addressed, which is difficult to achieve through survey research. This study uses semi-structured interviews in order to gain a richer understanding of stakeholder perspectives. These perspectives will then inform policy recommendations.

I primarily used snowball sampling to recruit participants, in addition to reaching out to organizations and individuals that appeared in my research and using my own connections to find participants. Participants were recruited by sending a written invitation by email. In the written invitation, participants were informed that the research was of minimal risk and that they had no obligation to participate. Interviews were conducted virtually and were approximately 45 minutes in length. All interviews were recorded on my computer, stored securely, and transcribed. Profiles of interviewees are provided below.

Pseudonym	**Age**	**Gender**
Dr. C	60s	Male
Dr. L	60s	Male
Dr. W	20s	Male
Dr. B	50s	Male
Dr. A	70s	Female
Dr. G	50s	Male
Dr. F	30s	Male
Dr. H	30s	Female
Dr. E	40s	Male
Dr. D	20s	Female
Dr. I	40s	Female
Dr. J	40s	Female

The key questions I asked participants were:

- What do you see as barriers to accessing dental health care?
- What are your current feelings towards Medicaid?
- Are you currently enrolled in a Medicaid program? If yes, how often do you treat Medicaid patients?
- What factors affected your decision to either participate or not participate in a Medicaid program?
- How would you define social responsibility?
- How do you think social responsibility applies to dentistry?
- In your experience, how does social responsibility manifest in dental education, practice, and policy?

A more complete list of questions can be found in Appendix A. These questions functioned to open a dialogue on feelings towards Medicaid and social responsibility; more specific follow-up questions were asked based on the participant's responses. Using the transcripts from the interviews conducted in this study, I analyzed the data through a process of

thematic analysis. An initial list of codes inspired by the research questions, relating to the main contributing factors to Medicaid participation and social responsibility in dentistry, were used and then refined throughout the coding, as recommended by Braun and Clarke (2006). Codes and their corresponding passages were examined through an iterative process, grouping them into broad themes. I then reviewed the coded data extracts for each theme to consider whether or not they formed a coherent pattern. The validity of individual themes were then considered to determine whether the themes accurately reflected the meanings evident in the data set as a whole (Braun & Clarke, 2006).

By using thematic analysis, I was able to explore the similarities and differences of perspectives of dentists who practiced in differing economic and demographic settings. A limitation to thematic analysis is that the flexibility of the design can lead to inconsistency and a lack of coherence when developing themes derived from the research data (Holloway & Todres, 2003). Importantly, given that participation in the study was voluntary, it is possible that the individuals who opted into the study may not hold the same views about social assistance programs and social responsibility in dentistry as the individuals who denied interview requests. Throughout the interview process, all questions were asked without intimating my personal views on Medicaid and the social responsibility of dentists. Additionally, all interviewees were informed that their information would remain anonymous in this study. In providing the opportunity to remain anonymous, dentists may have felt more comfortable speaking candidly about their views. All names included in the findings section are pseudonyms. An important limitation of this study is generalizability. All of the interviewees in this study practiced dentistry in Illinois, so the results cannot be generalized to other states which may have different rates of Medicaid reimbursement and different patient populations. Additionally, the majority of

interviewees in this study worked in private practices, so the experiences of Medicaid providers are not fully captured.

Findings

In this section, I discuss the major themes that have arisen out of qualitative interviews with twelve dentists and orthodontists in the greater Chicago area. This paper seeks to gain a better understanding of how dentists conceptualize social responsibility, especially in Medicaid, and the ways in which social responsibility manifests itself in dentistry. Analysis revealed interesting findings regarding dentist perspectives on Medicaid, varying conceptualizations of social responsibility, and the relationship between social responsibility and Medicaid participation. The analysis is divided by themes which stem from specific questions I asked participants and subthemes which arose from topics introduced by the participants themselves. The themes include conceptualizations of social responsibility, barriers to practicing social responsibility, barriers to Medicaid participation, tension between social responsibility and Medicaid, and providing appropriate care to Medicaid patients.

I. Conceptualizations of Social Responsibility

A major topic of discussion was the concept of social responsibility—how it is defined by dentists and how it manifests in dental practice. Throughout the interviews, three varying conceptualizations of social responsibility became evident. The varying ideas included social responsibility as a moral obligation as an individual, as a dental professional, and as a community member. Narrow definitions of social responsibility seemed to correspond with more narrow ideas of what social responsibility in dentistry constitutes, while broader definitions corresponded with a broader range of services that were seen as being socially responsible. Dr. L

defined social responsibility as, “the moral obligation to do what's right for society.” For Dr. L, being a socially responsible dentist involves charging existing customers who are experiencing “tough times or other financial hardships” lower rates or in some cases, not charging at all. However, he did not consider the need to treat patients outside of his existing clientele a professional obligation. Dr. B, a dentist in the suburbs of Chicago, felt like there was a moral obligation to practice social responsibility because of his own privilege, saying, “I feel that I have been very fortunate in my life. I've always felt that I was very fortunate, and because of that, I felt that I had an obligation to give something back.” For Dr. B, giving back to his community involved volunteering at a clinic in the suburbs of Chicago a few times a year.

Dr. C commented on the responsibility as an individual to be socially responsible, but also considers it a professional obligation. Dr. C described social responsibility as, “All about giving back at some point. I think that there is a responsibility as a professional and as an individual to give back to other individuals.” Dr. C does not accept Medicaid patients but he volunteers for the Chicago Dental Society and multiple organizations that provide care to low income communities and disadvantaged populations in his spare time. Dr. W’s view of social responsibility, the broadest of all three, believes that social responsibility involves an individual, professional, and communal obligation. Dr. W acknowledged that being socially responsible was in part a personal choice, but also felt like an obligation as a member of a community and as a dental professional.

> Social Responsibility is understanding your skill set and your past experiences and using them to serve the community to make your overall environment better for yourself and for others….I think when you're established in a community, it's important to treat the entire community. I don't feel like it's fair to select the cases you want to select, just based

> on financial reasons….As professionals, we are required to improve the overall health of our community, and that includes those who can and can't afford it.

It is important to note that Dr. W is one of the few dentists in this study who currently accepts Medicaid patients at their practice. While the majority of Dr. W's patients have traditional insurance, it is a priority of his to ensure that at least one third of his patients are Medicaid recipients. Dr. E, a dentist practicing in the suburbs of Chicago, similarly sees social responsibility as something that is required of an individual in order to be a good member of his community, but doesn't see it as something that is motivated by his profession.

> Ultimately, I don't think my profession necessarily drives me to volunteer. It's important to me to volunteer because it connects us with the community. Dentistry is very volunteer heavy overseas and there's certainly a place for that, but ultimately, I like taking care of our backyard as well.

Dr. G, on the other hand, believes that his obligation to practice social responsibility was formed during dental school and is firmly rooted in his profession.

> From the first day of dental school they made it clear that being able to attend dental school and being able to spend your life as a medical healthcare professional is a privilege. With that privilege comes responsibility to give back to the community at large, beyond just your own personal financial gains.

While some dentists like Dr. W and Dr. G believe that there is a professional obligation to be socially responsible, dentists like Dr. L believe that might be an unrealistic expectation.

> In an altruistic world, dentists would be socially responsible. In reality, we're not unlike other people that have to provide for our families, so there's a limit. In an ideal world everyone should get some kind of treatment. But realistically, who's paying for it?

The varying definitions of social responsibility have implications for the types of acts that each dentist views as being socially responsible. Based on this research, it appears that more narrow definitions of social responsibility, which are based more on individual obligation than a professional obligation, are more associated with narrow conceptions of what social responsibility constitutes; in contrast, those who see social responsibility as an obligation to their profession, like Dr. C, Dr. W, and Dr. G, may be more likely to see the importance of expanding their services beyond their existing clients. These varying conceptualizations of social responsibility reveal important truths for each of these dentists about the locus of responsibility—whether an individual dentist, the dental profession, or society as a whole is primarily responsible for the care of socioeconomically disadvantaged persons unable to access dental care. Understanding where the obligation to practice social responsibility originates and what types of acts dentists consider to be socially responsible could help to illuminate the ways in which policy and dental school curriculum could be used to not only encourage social responsibility, but to expand the ways in which social responsibility can manifest in dentistry.

II. Barriers to Practicing Social Responsibility

Dentistry as a Business

A theme consistent among many of the interviewees was the idea that social responsibility is constrained by the harsh realities of the financial aspect of dentistry. The business side of clinical practice was dominant throughout the interviews, and many spoke of the tension between a market-based health care system and an effective practice of social responsibility. Dr. W discussed the financial constraints that are placed upon dentists and how they affect the ability to treat all patients in need of care.

> As much as I want to believe that a lot of the dentists out there want to contribute to social causes or better people's oral health, more so than just looking at the costs, they also have pretty big student loans over their heads. It's hard for them to take on their social responsibility, and not worry about their own personal finances.

The tension between being a business person and a healthcare provider appears to be felt strongly during the beginning of one's career. Many dentists, like Dr. G, commented on the additional business and financial stresses that occur when a dentist first graduates dental school and how that impacts their ability to practice social responsibility.

> Younger dentists are struggling with establishing their career, the stress of extremely onerous student loans, and the stresses of transitioning from an academic environment to a commercial environment. Many younger dentists are working in corporate type environments, which have a different dynamic and additional stresses, plus a layer on top of that is the normal life cycle; they're getting married, they're having children, and establishing households at this time. It can be hard to think of anyone but yourself during this time.

Generally, there appears to be a dilemma between professional obligations and economic imperatives. As Dr. L says, "If the reimbursements are not adequate to cover your expenses, you can't lose money. It doesn't sound very nice, but it's the reality." Concerns about the economic imperatives in dentistry were also raised by Dr. C.

> It really shakes you, as far as why you went to medical or dental school, now all of a sudden, it's down to dollars and cents. I never went to dental school for purely the money, I went because I enjoyed working with my hands. I enjoyed meeting people and being around different types of people. But, you know, 30 years into my profession, all of a

> sudden, it became a money grab. The medical profession is being driven by insurance and if it was driven by dentists, there'd be a lot more social responsibility in this role.

A similar concern was echoed by Dr. H, a dentist practicing on the South Side of Chicago, as she found that the business aspects of dentistry seemed to complicate one's ability to be socially responsible.

> Anyone who goes into healthcare should have social responsibility. Dentistry is kind of hard though. For instance, you don't see your doctor advertising on Groupon. Dentistry is weird because it's always been a healthcare service, but it's always been seen more as a business.

On the other hand, Dr. E explained that while financial obligations and amount of available free time certainly constrict one's ability to donate their time or services, that doesn't mean that practicing social responsibility in dentistry is impossible.

> Early on in your career, you don't necessarily have the chance to go away to the moon and do free dentistry for two weeks, but you could easily sneak away for just an afternoon or a day and volunteer your time at a free clinic. Engaging in philanthropic activities and volunteering does not have to be an all encompassing activity, because in reality it's hard to make that work with most dentist's schedules. I wish everyone could realize that volunteering isn't supposed to be easy. It won't always be convenient for you. It will take effort, but that doesn't mean it can't be done.

While donating one's time and services may not be entirely impractical in dentistry, the tension between the economics of practice and the desire to serve the public is perceived to be a powerful force influencing the dentists in this sample, as they frequently feel made to choose between economic responsibilities and the desire to be socially responsible.

Tension between Financial Obligations and Ethics

Further, the financial obligations required within the dental profession appear to also cause tension with ethical responsibilities. While working at a private practice early in her career, Dr. H found that the incentives at her office were in tension with what she considered to be ethical dentistry.

> These private practices were pushing us to sell implants and electric brushes. They would give the staff points, which was a weird incentive process. When you work in private practice you get paid 30% of what you do, so the more you do, the more you get paid. There's a lot of room there for unethical dentistry—you know that saying, if you have a hammer, everything looks like a nail?

Similarly, Dr. C commented on how financial strain affects the treatment plan that a patient receives.

> I weekly have patients coming in saying they went to a dentist that told them they had five or six cavities that needed to be filled. [Dentists] have a tendency to over treat and find things that aren't necessarily there. It's a bad thing to say about my profession, but it's the truth. To make ends meet, instead of doing one filling that really needs to be done, somebody is in there doing three or four fillings.

The problem of overtreatment and the selling of unnecessary items or services raises questions about what actually constitutes necessary dental treatment. It appears as if a market-oriented health care system ignores professional obligations by introducing attitudes dominated by profit and favoring wealthier patients and those with dental insurance. The economic realities of working in a private dental office seem to complicate the idea of ethical responsibility in Carroll's model of Corporate Social Responsibility. To Carroll, ethical responsibilities

encompass, “behaviors and activities that are not necessarily codified into law but nevertheless are expected of business by society” (Carroll, 1979). Both Dr. H and Dr. C found that the economic incentives complicate one’s ability to practice dentistry ethically, encouraging overtreatment and the pushing of unnecessary products on patients. The costs and competition that go along with running successful private dental offices seem to have contributed to a tension between selling and caregiving. Dr. H also commented on the difficulties her husband encountered when he was trying to get dental care.

> My husband recently needed some dental work and it took him about five or six times to find an ethical, private dentist. He would go to these private practices and they would tell him that he would need a crown and a $3,000 bone graft. I knew that he didn’t need any of that stuff, but it took him so many tries to find a dentist who had a treatment plan that I actually agreed with.

However, it is important to note that the particular problem of overtreatment, or unnecessary treatment, is very poorly studied. While one might assume that dental problems have distinct solutions, there are no explicit treatment guidelines provided by the American Dental Association, as the association functions as more of a professional group rather than a regulatory agency. While most doctors will end up working for a large health care organization or a hospital with oversight, the vast majority of dentists in the U.S. open up their own practices and mostly answer to themselves. There are ethical guidelines and codes that they are supposed to follow, but there is not an agency looking over their shoulder day to day (Otto, 2017). While it may be difficult to point to what exactly overtreatment looks like in dentistry, the incentives are there for dentists to perform unnecessary procedures and for them to lean toward certain more well-reimbursed procedures and away from other less well-reimbursed ones, rather than being

led by what is in the patient's best interest. As mentioned by Dr. C, "The medical profession is being driven by insurance." More intensive procedures and services like x-rays are reimbursed at a much higher rate than cleanings (Otto, 2017). An insurance system which has higher reimbursement rates for more aggressive procedures, or a point system within a private dental office which rewards dentists for selling as many products as possible, are systems which encourage abuse, excess, and fraud, and result in unethical dentistry.

III. Barriers to Dentist Participation in Medicaid

Logistical, Financial, and Knowledge Barriers

In the discussions of dentist participation in Medicaid there was considerable overlap between perceived barriers to dentist participation. Three main barriers were discussed in regard to Medicaid participation, including logistical barriers, financial barriers, and knowledge barriers. Logistical barriers to participating in Medicaid included burdensome paperwork and poor communication between state officials and dental offices. One interviewee, Dr. C, commented on the complicated nature of Medicaid reimbursement forms and the difficulty of learning to fill out paperwork that differs greatly from traditional insurance reimbursement forms.

> The problem is, as far as Medicaid is concerned, not many dental offices are equipped to start submitting to Medicaid. We don't know how to submit to Medicaid, and it would be for me, in particular, a hard thing to start to learn how to properly handle and treat patients on Medicaid. It's the behind-the-scenes things that would be very difficult for our office to pick up.... They've got a whole different language for their treatment, and how to handle it.

The difficulty of understanding new forms of paperwork might be accentuated for dentists who have been practicing, without ever treating Medicaid patients, for a long time. Dr. C, a dentist who has been working in the field for 40 years, sees the logistical aspects of Medicaid as being difficult to overcome. Dr. C did not feel that it was necessary to hire additional staff to overcome this logistical burden but believed that there would need to be extensive training for his staff to better understand Medicaid billing. With the proper training, he could see how Medicaid patients could be incorporated into his practice but expressed that it would be difficult to find the time for his staff to be trained to understand the complexities of the system. Dr. D, a dentist practicing on the North side of Chicago, also commented on the inability of her dental office to accept Medicaid patients, saying, "You have to design your practice to go as fast as you can and see as many patients as you can. I literally could not see Medicaid patients in my practice, unless I totally changed how I work." The fast-paced nature of seeing patients, which is felt as necessary when accepting Medicaid patients, is seen as being incompatible with how many dentists currently work and prefer to run their office. Dr. W, a dentist who has been practicing for four years and accepts Medicaid patients, also identified the logistical aspects of Medicaid participation to be a significant barrier and commented on the lack of effective communication between state officials and his dental office, noting, "Even just communicating with the state is not efficient at all, because it's really hard to get hold of anyone or just get things done...the overall process is so tedious and that's why most dentists just can't do it."

However, while logistical factors were significant in constraining dentists' ability to treat Medicaid patients, the lack of proper reimbursement seemed to be of higher importance to the dentists interviewed. Interviewees commented on the effect of low reimbursement rates for both Medicaid and traditional insurance companies. Dr. W described the differences in reimbursement

rates between Medicaid and traditional insurance and commented on the slow turnaround of reimbursement.

> Medicaid compensation is never even close to what you'd get from a PPO or HMO plan or fee for service. The fee schedule is always considerably lower and even the timeframe from when the treatment gets completed to the actual payment is super long, which is not efficient. It’s sometimes almost double or triple the time of typical insurance.

Not only are dentists being paid less than what they feel is appropriate for their services, their payments are also delayed, resulting in an overall sense of frustration with the program. Dentists like Dr. F, view the low reimbursement rate as a significant factor in not accepting Medicaid patients, saying, “If I took Medicaid, then I would have to look at it as if I'm giving free service, because I know I'd be losing money on it.” Interestingly, Dr. C, who does not participate in Medicaid, sees reimbursement from private insurance to also be a significant issue. Dr. C expressed frustration with the fact that reimbursement rates have barely changed throughout his 40 years in the dental industry, even though prices for services have been rising steadily.

> When I first got out of dental school, back in the early 80s, the maximum that they would pay on a net basis was capped at $1,000 or $1,500. 40 years later, that cap is almost the same. In the last couple of years, I've seen it start to go up a little bit, but not by much. Back when I first graduated with $1,000, you could get four crowns done in one year, and it would take care of a lot of your work. Now you're lucky if you get one crown in a year for $1,000.

The frustration with the reimbursement of private insurance companies is particularly important when it comes to Medicaid participation, as Medicaid reimbursement is considerably lower than private insurance. Dentists who treat Medicaid patients, like Dr. W, acknowledged the financial

realities of treating Medicaid patients instead of solely treating patients with private insurance, saying, “You can see maybe 10 PPO patients and the equivalent of Medicaid would be 30 patients.” Considering that there is already frustration with one of the most common types of reimbursement, private insurance, there is a considerable lack of financial incentive for dentists to treat any patients that cannot pay out of pocket. Therefore, the dental needs of many vulnerable populations are likely going unmet.

These financial constraints not only affect Medicaid participation, but they also influence overall quality of care for dentists who do choose to treat Medicaid patients. When dentists are forced to take on more Medicaid patients to cover their expenses, Dr. W says, “You're not spending as much time with them and you're not understanding their needs. It's just a factory type setting where you are just taking care of the job and moving on to the next patient.” Low reimbursement rates also seem to affect the ability to hire high-quality dental practitioners and assistants in offices. Dr. E commented on the way in which reimbursement affects the hiring staff, saying, “I do wish that there wasn't such a barrier to running dental Medicaid offices, because you can't pay top shelf wages to the staff. You can't have top shelf talent, when your fee schedule is not top shelf either.” Generally, it seems that low reimbursements rates for both Medicaid and traditional insurance end up restricting a dentist’s ability to treat Medicaid patients and hire high-quality staff, which results in a sacrifice of quality of treatment.

Not at all dentists believe that raising the Medicaid reimbursement rate is a perfect solution. Dr. H noted that raising reimbursement rates can potentially lead to increased Medicaid fraud and can negatively impact patients.

> It's a fine line because if you make reimbursement rates too lucrative, then corporate chains are going to come in and really take advantage of the Medicaid population. This is

what happened in Texas because the rates were so good. There were dentists picking up kids in a van at a bus stop and just doing tons of crowns and dental treatment on them and dropping them back off hours later, without getting consent forms or telling their parents.

Clearly, the low reimbursement rates are a significant factor for many dentists when deciding to participate in Medicaid, but a substantial increase in reimbursement, without a widening of benefits offered, may cause more harm than good.

A third factor impacting dentists' ability to participate in Medicaid programs is the lack of knowledge surrounding Medicaid dental benefits. Dr. L, a dentist who has been practicing in the suburbs of Chicago for 30 years, had no knowledge of Medicaid dental benefits, including the services covered and who was eligible.

> I honestly don't know a thing about Medicaid. I don't know what they cover or what they don't cover…. I don't think I've ever had anyone in 30 years ask about it. I don't think I have ever talked to colleagues about it either.

It is worth noting that the reported logistical and knowledge barriers may be more exaggerated due to the practice location and age of the participants in this study. Many of the dentists in this study practice in affluent areas in Chicago and the surrounding suburbs, where there are typically small populations of Medicaid recipients. It's likely that dentists like Dr. L, who practice in affluent areas, have never encountered Medicaid patients and therefore have little knowledge of the program. Considering that Medicaid dental benefits were added in 1967 for Medicaid-eligible individuals under the age of 21, it is interesting that a dentist, even one working in an affluent area, would not have encountered any discussions of Medicaid dental benefits in dental school or with discussions with colleagues. This may suggest that dentists working in affluent

areas are very isolated from areas outside of their community and have little exposure to diverse patient populations.

Frustration Towards Lack of Benefits

An additional topic of interest that surfaced in interviews was dentists' overall feelings toward Medicaid dental benefits. In interviews in which interviewees were familiar with Medicaid dental benefits, there was a common theme of frustration with both the lack of services covered and overall disconnect between oral health and overall health that is signaled by the benefits. Dr. W, who frequently treats Medicaid patients and is familiar with the services offered, expressed frustration with the simplicity of covered treatments, noting, “Medicaid dental benefits are not adequate when it comes to fully treating a patient. Medicaid does provide a good number of benefits, but a lot of the time pretty important treatments aren’t covered.” Medicaid dental benefits in Illinois cover most preventative services for children but are more limited when it comes to more complex treatments. Even dentists who were less familiar with Medicaid have experienced frustration with dental policies. Dr. L, who does not treat Medicaid patients but was required to do volunteer work in dental school in 1985, remarked on a time in which he made a new set of dentures for an elderly woman in a nursing home.

> I made a denture for a 96-year-old woman, and within a month she lost it and they said she wouldn't get a new one. They said that she wouldn't be eligible for new dentures for five years. I said, ‘well she would be 101! Who knows if she's gonna make it.’ So, the poor little thing didn't get anything. I don't know what happened after that. That just sounds like a bad policy.

Notably, this policy has remained unchanged since 1985. Currently, dental benefits for adults in Illinois only include a complete set of dentures to be made once every five years and a very

limited selection of dental services (HFS, 2021). This lack of comprehensive benefits results in frustration for practitioners, as many treatments or services that are necessary for their patients cannot be completed, which creates a significant challenge. Dr. W shared his frustration with the lack of comprehensive benefits, saying, “A Medicaid patient can't be treated completely without running into any kind of financial burden, which is interesting because Medicaid is designed for those who can't afford treatment in the first place.” While a general frustration towards the lack of benefits was common, not all dentists found the benefits to be deficient. Dr. H explained, “I think the Medicaid dental benefits as they are now are okay. I’m certainly not going to complain, because I used to practice when they were worse.” As one of the few dentists in this study who actually accept Medicaid patients and is up to date on the current reimbursement rates it is significant that Dr. H does not share a similar feeling of frustration. Even for those who do not treat Medicaid patients, dentists expressed frustration with overall separation of dental benefits from typical medical benefits. Dr. F feels that states need to be required to offer dental, vision, and hearing services to all adult Medicaid enrollees, as oral health is integral to overall health.

> When you look at Medicaid at this point, you see them taking care of the body and the health of the body, but they're still not taking care of the teeth. And that's just the long-term problem that I've seen in dentistry as far as health care is concerned, that we were never included in the overall health of the human being…Health care is health care whether it's your teeth, whether it's your eyes, whether it's your feet, whether it's your heart, whether it's your lungs, that's health care.

Interestingly, Dr. H does not think that expanding the benefits to all adults and the services offered is the best solution to oral health inequities.

From a realistic policy perspective, expanding Medicaid to all adults is going to be hard because the state's bankrupt. That's a really heavy lift and nobody wants to take it, but if we can focus on particular patient populations, where expanded benefits will have the greatest impact, then I think it'll be better for the overall health of the state and the general population.

Even though Dr. H acknowledged that there is a lack of comprehensive benefits, she thinks that a targeted solution would be more effective in improving inequities in health. Overall, many dentists in the sample believed that while Medicaid dental benefits were broad in some cases, they do not cover all of the benefits that are necessary to achieve good oral health. Additionally, Medicaid dental benefits being optional for states to adopt signals to dentists that dentistry is not viewed as important to overall health as general medicine, leading to even more frustration.

Medicaid Patient Stigma

In conversations with a few interviewees, it became evident that some dentists have stigmatized perceptions of Medicaid patients, which keep them from participating in Medicaid. In a conversation with Dr. G, he commented on his uncomfortableness of having Medicaid patients in his office.

Because of the location of my office, I'm in a freestanding building in a very high-end area…. Unfortunately, the typical Medicaid patient, in terms of appearance, it almost brings tears to my eyes to say this, but I don't want my patient sitting next to that patient.

Dr. G's unwillingness to have his patients be in the same room as Medicaid patients is part of the reason he volunteers so frequently with the Chicago Dental Society. Dr. J, a dentist who accepts Medicaid patients, also commented on the perceptions other dentists have of Medicaid patients.

> I think it's hard if your office is not set up for Medicaid, because Medicaid patients have the highest no-show rate. They rely on public transportation, so if you set your office up in an affluent area, and you open your doors to Medicaid patients, they're not going to come to you. And then the dentist's say, 'oh, well, it wasn't worth the hassle, because I only saw three Medicaid patients a month and then the other two were no-shows.'

Dr. J points out here the difficult aspect of Medicaid patients being treated in private practices. Oftentimes, private dental offices are built in affluent neighborhoods so that dentists can ensure that they will have a robust patient population (Fisher-Owens et al., 2016) and transportation is often cited as a barrier to care for many Medicaid patients (Okunseri et al., 2008). This negative perception of Medicaid patients missing appointments appears to be a factor in dentists' decision to not participate in Medicaid. The social gulf between dentists and low-income patients is manifested in ways that may compound the challenges of delivering care. It can be hard for affluent individuals to understand the barriers the poor face in accessing care. Difficulties with transportation are common and workers at low-wage jobs don't always have the option of taking time off for care. Maintaining oral health and getting timely dental care, no matter how important, can be eclipsed by other urgent needs.

Not all dentists in this study presented stigmatized views of Medicaid patients. Dr. E commented on his experiences treating Medicaid patients when he first graduated from dental school and was working multiple jobs to make ends meet.

> Ultimately, treating Medicaid patients was hard work, especially because I would be working such long hours at that time, but I cherish those years. At the very end of each day I would be exhausted after seeing so many patients, but I've never worked on more appreciative, kind, and loving patients. It was wildly soul filling. It's very much not

> volunteering, because I was getting a paycheck, but it did feel similar because of the abysmal reimbursement rate.

While many dentists have positive associations with Medicaid patients, those who had negative associations mentioned that these issues were a significant factor in their decision to not participate in Medicaid.

IV. Tension between Social Responsibility and Medicaid

In the following section, I will further explore the relationship between social responsibility and Medicaid. I use Carroll's CSR framework to explore how the barriers described above result in a tension between social responsibility and participation in Medicaid that ultimately renders Medicaid an unsuitable avenue for the practice of social responsibility.

While discussing Medicaid participation, it became clear that many dentists preferred to be socially responsible in ways other than accepting Medicaid patients. Social responsibility appears to manifest itself in dentistry as volunteering, teaching at local dental colleges, and pro-bono work at private offices. Dentists discussed various types of activities that they engaged with that constituted social responsibility, including volunteering with the Chicago Dental Society and the College of Dentistry at the University of Illinois, hosting free dental care days at their practices, and providing pro-bono care or discounts to existing clients. Importantly, many dentists in the sample did not view participating in Medicaid as a feasible or practical socially responsible act. It appears that multiple aspects of participating in Medicaid violate the economic, ethical, and legal components of Carroll's model of Corporate Social Responsibility.

Economic responsibility, the foundational requirement of Carroll's model, requires business organizations to be able to sustain themselves, which is only possible by being profitable. As mentioned by many dentists, it is difficult to be a Medicaid provider and be

profitable due to the low reimbursement rate, which is compounded by the long wait time for reimbursement and added logistical difficulties. If being a Medicaid provider makes it more difficult for dentists to be profitable, then participating in Medicaid is in direct tension with practicing social responsibility. Not only does Medicaid participation violate financial responsibility, it also has the potential to violate legal responsibility. This refers to one's legal obligation to adhere to all relevant laws and regulations. Some dentists, like Dr. G, expressed concern about how low reimbursement rates can lead to illegal practices, like committing Medicaid fraud, saying, "The only way Medicaid practices can make any kind of profit is to practice fraudulently. If I were a Medicaid practitioner, and my choices were to practice fraudulently, or go out of business and file bankruptcy, I would practice fraudulently." According to Dr. G, accepting Medicaid patients can be so unprofitable that it forces dentists to practice fraudulently in order to make ends meet. This perception that Medicaid necessitates fraud is problematic, as this indicates that participating in Medicaid either violates Carroll's principle of financial responsibility, or necessitates a violation of the second level of social responsibility: legal responsibility.

Lastly, participating in Medicaid also violates the ethical responsibility component of Carroll's model, as the lack of comprehensive benefits incentivizes improper care. Society expects businesses to operate and conduct their affairs in an ethical fashion. Taking on ethical responsibilities implies that organizations will embrace those activities, norms, standards and practices that even though they are not codified into law, are expected nonetheless. Dr. F expressed frustration with Medicaid benefits in particular, commenting on how the lack of comprehensive benefits incentivizes irresponsible treatment and unethical practices.

> For a filling or a root canal, which can actually be the most important part of a service at times, the reimbursement is terrible. My supplies wouldn't even be covered with the reimbursement rate. It incentivizes less treatment and just doing exams.

As participation in Medicaid seems to be incompatible with social responsibility, many dentists look to other avenues to practice social responsibility. Multiple dentists in this study explained that they would rather give away their services for free than accept Medicaid patients.

Dr. G explained that because Medicaid participation was not something he was willing to do, he was more motivated to find other ways to give back to his community.

> My thoughts were, I do not accept Medicaid. I do not want to accept Medicaid. Yet I want to be able to help a segment of the population in society that could benefit from my talents, so that's why I spend a good percentage of my time either volunteering in a dental clinic or in the administration of volunteering, organization and practice.

Other dentists, like Dr. A, commented on her preference to give away service rather than accept Medicaid patients, saying, "For me, and for many dentists, we would just rather do pro-bono, instead of accepting Medicaid. We wouldn't be able to see as many patients, but we could provide complete care for a few patients." Even though giving away free service would mean that fewer patients overall would be able to be served, the lack of comprehensive benefits in Medicaid mean that patients cannot receive comprehensive care. Dr. B also expressed the belief that giving away free service was preferable to taking Medicaid, saying, "I'd rather just give away my orthodontics services than deal with Medicaid. If someone came in and wanted me to file Medicaid, I wouldn't even file. It's not worth it, but I would still do the service." These findings indicate that the barriers to Medicaid participation mentioned throughout the interviews are powerful enough to make these dentists believe that giving their services away completely

for free, with no expectation of any form of reimbursement, is better than engaging with oral health policy that is designed to ensure low-income populations receive proper dental care; for many of these dentists, Medicaid is actually both unable, and counter, to an expression of social responsibility.

It's important to note that this sample was restricted to only dentists in Illinois, so that the Medicaid reimbursement rate and benefits discussed would be a constant. In states where the reimbursement rate is higher, there may be less of a tension between social responsibility and Medicaid participation. Even though this sample was restricted to dentists practicing in a certain area, these discussions still have important implications for all dentists throughout the United States, as many of the barriers mentioned in this study have also been documented in previous studies (Damiano et al., 1990; Logan et al., 2015; Chalmers and Compton, 2017). As Medicaid plays a large role in both federal and state budgets and is the primary source of coverage for low-income Americans (Rudowitz, Garfield, & Hinton, 2019), the findings of these interviews are troubling. Medicaid is a program which is meant to step in where private initiatives seldom go. It is designed to serve people who are in crisis, and people who are poor, who would otherwise lack access to care. If dentists feel that giving away their services for free is more socially responsible than participating in Medicaid, then the Medicaid program is not serving the purpose it was intended for.

V. Providing Appropriate Care for Medicaid Patients

Discussions surrounding the realities of the efficacy of care that can be provided to Medicaid patients in private practice settings arose during interviews. The question of what proper care looks like for the Medicaid population and what type of facility it should come from further complicates the policies that could be implemented to address oral health inequities.

Dr. W commented on the difficulties of providing care to Medicaid patients who have coexisting health issues.

> We're sometimes the first line of healthcare professionals that see Medicaid patients. I can't tell you how many times a patient will walk through the door and I'll say, 'hey, I'm happy you're here, but I'm not the first person you have to see, you have to go to a primary care physician first.' Sometimes it's even the ER because they've neglected their health so much.

Dr. H, who works at a Federally Qualified Health Center, explained that Medicaid patients often come into her practice with co-occurring health conditions.

> Medicaid patients are medically complicated, oftentimes, with a higher burden of co-occurring, complex medical conditions. When you go to a private dental office, they might not even take your blood pressure. They're just looking at your teeth—they're not looking at your whole body.

Federally Qualified Health Centers (FQHCs) are obligated to care for patients regardless of their insurance status or ability to pay. FQHCs offer a wide range of healthcare services and are often located in low-income or underserved communities without sufficient access to primary care. Dr. H explained that providing holistic care at an FQHC to Medicaid patients was preferable to her than providing care in a private practice setting. "We treat our patients with higher quality because I have access to everything. I get concerned when patients go to some random private practice that doesn't even ask them their health history." Because in her experience Medicaid patients often have complicated medical conditions aside from purely dental issues, being able to provide care in a setting which can respond to multiple different

types of health issues ensures a higher quality of care. Dr. H believes that health centers are best suited to treat Medicaid patients.

> I don't think private practice is the best place for Medicaid patients. The answer isn't more dentists offering to take Medicaid at their private practice. The only time that could actually be helpful is in rural parts of the state, where you're the only dental practice for 50 miles. If you are located in a more affluent area, then getting more dentists to sign up for Medicaid isn't the answer.

As one of the few Medicaid providers in this study, Dr. H's belief that appropriate care cannot be given to Medicaid patients in the private practice setting is significant. She believed that the only area in which increasing the number of Medicaid providers working in private practices would be beneficial for the Medicaid population is in rural spaces. Interestingly, Dr. H believed that volunteering at the Chicago Dental Society, an organization that many of the interviewees in study were involved with, was also not the most appropriate response to treating low income patients.

> The Chicago Dental Society put a free clinic in the middle of Wheaton, Illinois. The volunteers can come to Wheaton, but most patients can't get out to Wheaton. It would be so much more impactful if you just gave that money away. It is so expensive to run a clinic like that…. But you could take those parts, take those chairs, take that equipment, and give it to health clinics in low-income areas to actually use it efficiently and effectively.

To Dr. H not only would resources be used more efficiently if they were funneled into health centers, the care that patients would receive at health centers would be of much higher quality than in private dental offices. Some dentists may argue though that by directing funds and

resources to holistic health centers, there runs the risk of less attention being paid to dental services. As mentioned previously by Dr. F, there is a disconnect between the importance of oral health to one's overall health. Dentistry, in its separate world from medicine, has long been seen as a mechanical solution to tooth decay. But tooth decay is more than a mechanical failure. Tooth decay is a symptom of a complex, progressive disease that comes with lifelong burdens and sometimes tragic consequences, particularly for the millions of Americans for whom care is out of reach. For some dentists in this study, the existence of a free dental clinic, despite the fact that it is not in a convenient location for patients, may seem like a better solution to patient needs than a health clinic, because it ensures that appropriate and adequate attention is being paid to patients' oral health needs. Consequently, addressing oral health inequities and the needs of low-income populations is complicated. Increasing the share of providers who take Medicaid in private practices appears to not fully address the needs of the Medicaid population and opening free clinics in areas that are typically hard to access with public transportation also fails to adequately reach the populations who need care the most. In order to best address the needs of low-income populations and improve overall population health, creative solutions must be implemented.

Policy Recommendations

Ensuring access to dental care to low-income populations and finding ways to encourage social responsibility in dentistry are essential to addressing oral health care inequities. The disparate impacts of the COVID-19 pandemic have brought health and health care disparities into sharper focus among the media and public; however, these disparities are not new. They have been documented for decades and reflect long-standing structural and systemic inequities. Addressing these inequities is key to improving our nation's overall health and reducing

unnecessary health care costs. Promoting an ethic of social responsibility among the next generation of dentists, ensuring the existence of multiple avenues for social responsibility in dentistry, and increasing access to care for low-income individuals is necessary to respond to growing health inequities.

A challenge in this policy area is the financial realities of the healthcare system and the Illinois state government. As mentioned by the dentists in this study, low private insurance and Medicaid reimbursement rates are a significant barrier to practicing social responsibility and participating in Medicaid. Unfortunately, increasing private insurance reimbursement rates is out of the scope of policymaking, and while increasing the Medicaid reimbursement rate is not impossible, it is unlikely. An overall increase in dental fees and broadening of the services offered would seem to have a great impact on Medicaid participation, as it would allow dentists to provide comprehensive care while balancing their economic responsibilities. In fact, the effect of increasing Medicaid reimbursement fees on dentist participation has been well documented and has been found to increase access to care to low-income populations (Nasseh, Vujicic, Yarbrough, 2014). Unfortunately, due to constrained state finances, increasing the Medicaid reimbursement in Illinois is not a realistic policy response. Additionally, some research has shown that while increased reimbursement for dental services is a key factor in increasing access to care and utilization of services for Medicaid recipients, increased reimbursement alone may not be enough to create the desired impact (Abedi, 2017). Additional policy responses, like the easing of logistical issues with the Medicaid program, are needed to adequately respond to the needs of low-income populations.

Addressing oral health inequities through policy is a complicated issue. This study does not have a single, comprehensive solution that responds to the growing population of Medicaid

recipients, the overall need for increased access to healthcare providers for low-income populations, and the tension between social responsibility and dentistry. The findings of this study demonstrate that there is frustration towards Medicaid from dentists, multiple barriers to participation in Medicaid, and programmatic realities that make Medicaid unable to facilitate social responsibility. The existence of a right to healthcare, as a positive social right, emphasizes the perspective and the need for social responsibility in healthcare. It implies that healthcare professionals contribute their resources or skills to the common good. The challenge for the healthcare sector is to continually explore ways to ensure that the welfare of individual patients remain the utmost primacy and promote health care equity via corporate socially responsible activities. The challenges for dentistry in particular is how to manage constraining and unique financial obligations to the profession with increasing access to dental care to low-income populations. The recommendations in this section are intended to improve the experience of Medicaid practitioners so that their participation can be sustained, to educate dental professionals on social responsibility and the needs of the growing Medicaid patient population, and to increase access to dental care for low-income individuals through Federally Qualified Health Centers.

I. Recommendation: Create ways to reduce administrative bureaucracy in the Medicaid

The findings in this study suggest that there is a need to address the barriers to Medicaid participation in ways that reduce the administrative bureaucracy. Participants identified logistical barriers including tedious paperwork, slow reimbursement rates, and lack of effective communication with state officials. The Illinois Department of Healthcare and Family Services should consider conducting workshops and town hall meetings with dentists and dental

administrators to both address the complicated nature of the paperwork and to document the specific needed improvements. Addressing the burdensome paperwork and educating dentists on how to submit Medicaid claims efficiently are key to improving provider's experiences with the program and sustaining participation. States that have attempted to increase dentist Medicaid participation, like Connecticut, have reported that it was not sufficient to solely focus on the administrative and financial pieces—increased reimbursement, faster claims turnaround, streamlined policies, and procedures. For them, it became clear that providers needed additional education and support to make the system function effectively and efficiently. The state of Connecticut implemented an innovative approach, involving both town halls and workshops, that engaged both the provider community and other stakeholders in policy decisions regarding system changes and conducted outreach to both providers and patients to improve performance and understanding (Abedi, 2017). While increasing the reimbursement rate may be a less realistic policy option, creating ways to ease the logistical burden of participating in Medicaid appears to be more possible. While this study is not advocating for an increase of Medicaid providers working in private practices, finding ways to improve the efficiency and experience of already registered Medicaid providers remains important.

A challenge in this area will be ensuring that these town hall meetings lead to actual change that is necessary to ease administrative bureaucracy. The Illinois Department of Healthcare and Family Services should establish a regulatory board that organizes and manages workshops and town meetings and creates benchmarks to ensure that progress is being made to address the issues presented by dentists and dental administrators. In order for this to be successful there needs to be adequate participation from both the dental community and the state government. Increasing the communication between the Illinois Department of Healthcare and

Family Services and dental offices is key to improving the logistical barriers mentioned in this study.

II. Recommendation: Promote social responsibility in dentistry through dental school service learning curriculum

The findings of this study demonstrate that while social responsibility may be constrained by financial aspects of the profession, social responsibility can still manifest in dentistry in various ways. Many of the dentists in this sample volunteered frequently at local clinics or with other non-profit organizations, hosted free dental care events for their community, or donated their services. While there were multiple different types of ways social responsibility could manifest in dentistry, participating in Medicaid was not viewed as being a socially responsible act. It is unlikely that the tension between Medicaid and social responsibility can be reconciled without drastic policy reform that addresses the financial, legal, and ethical complications created by the low reimbursement rates and lack of comprehensive benefits. While participating in Medicaid and practicing social responsibility may be incompatible, the need to promote social responsibility remains. In a profession where financial incentives encourage selling over caregiving and discourage participation in social assistance programs, promoting and encouraging social responsibility becomes even more integral to addressing oral health inequities.

A curriculum which discusses the importance of social responsibility within the dental profession, educates dental students on inequities in access to dental care, and exposes dental students to diverse patient populations is key to instilling social responsibility within the next generation of dentists. A study at Virginia Commonwealth University (VCU) School of Dentistry evaluated a service learning program's impact on senior dental students' attitude

toward community service. Researchers found that experience gained through service learning in dental school may positively impact dental students' attitudes toward community service later in their careers. Pedagogies of engagement, like service learning, empower students by providing them with an environment of authentic experiences that encourages critical thinking, problem-solving, and the application of knowledge (Coe et al., 2014). One of the key attributes of service learning is its potential to promote civic engagement and social responsibility during a student's education. If the next generation of dentists is to be socially responsive, dental education will need to demonstrate that there is no intrinsic conflict between doing well and doing good. Dental students need learning opportunities that enable them to experience the plight of vulnerable populations and better understand the social value of health as a common societal concern, regardless of its financial payout.

For this curriculum to be successful, faculty training and development must be made a priority for service learning to become an integral part of the curriculum. To increase participation in service learning by the faculty, dental institutions must support the full scope of academic work in service learning by acknowledging the importance of the interrelated areas of scholarship of discovery, integration, application, teaching, and engagement. No credible curriculum to teach social responsibility will be complete without carefully designed evaluation mechanisms. Evaluation of a social responsibility curriculum, like evaluation of all educational programs, must be a two-way process. Faculty must evaluate the dental students' progress toward fulfilling the specific educational objectives and students must evaluate the quality of the curriculum's didactics and experiences as well as faculty supervision. Additionally, time needs to be found, or created, in the curriculum for community-based service learning programs that are long enough in duration to allow meaningful learning experiences for students. To provide

students with the needed time to complete service learning requirements, dental schools need to be willing to eliminate redundancies and out-of-date subject matter throughout the curriculum. Service-learning, with thoughtful planning, implementation, and evaluation, is one much-needed way to make dental education more meaningful to a new generation of students by placing it into a larger and broader real-world context—increasing student learning, social responsibility of future dental professionals, and thereby the health of society.

III. Increase proliferation of Federally Qualified Health Centers in Illinois

For medically underserved populations, including Medicaid enrollees, Federally Qualified Health Centers (HQFCs) have become the mainstay of U.S. dental safety nets. A vast majority of the 24 million FQHC patients are disproportionately low-income, limited-English-proficient, racial/ethnic minorities, and tend to suffer from poorer health compared with the general population. The presence of dental programs in FQHCs addresses a number of barriers to access and quality dental care, including affordability, and cultural and linguistic competency, as well as enhances the opportunity to provide whole-person care (Le et al., 2017). Dentists in this study, like Dr. H, argued that the needs of low-income communities, specifically Medicaid recipients, are better served by FQHCs than private practices due precisely to their focus on holistic care. Rooted in the patient-centered care concept, the idea of colocation and coordination of medical and dental care on-site is to increase access to and utilization of dental care for low-income and underserved patients. Integration of care, for primary care, dental, and behavioral health, enhances the opportunity to provide whole-person care. Therefore, FQHCs are uniquely positioned to improve overall population health, while increasing access to oral health services in the communities experiencing the most acute access problems. By providing affordable care to low-income communities and providing other services such as transportation, translation, and

case management, health centers address barriers to access for the most vulnerable and underserved patients in the nation.

Using the 2009 Health Center Patient Survey, researchers performed multivariate logistic regressions to examine factors associated with access to dental care at health centers, unmet need, and patient experience. Researchers found that health centers play a significant role in attenuating racial and ethnic disparities while serving as critical access portals to affordable, culturally competent oral health services in underserved communities (Jones et al., 2013). These results underscore the critical role that health centers play in national efforts to improve oral health status and eliminate disparities in access to timely and appropriate dental services. According to the Health Resources & Services Administration there are currently around 53 FQHCs throughout all of Illinois (HRSA, 2022). In order to address inequities in care, both the number and funding of FQHCs should be increased in Illinois to increase access to high-quality care in low-income communities. By increasing the number of FQHCs, both access and quality of care could be improved for low-income communities.

As always, finding ways to fund large scale healthcare initiatives can be difficult. However, it is important to note the potential savings that could come from the proliferation of FQHCs. FQHCs have been found to save the healthcare system up to $24B annually through quality, innovative, whole person, community-based care (Tranby et al., 2020). Understanding the impact of funding changes for FQHCs on local care patterns is important for these types of large scale policy decisions. A study of the impact of funding for federally qualified health centers on utilization and emergency department visits in Massachusetts found that areas exposed to greater FQHC funding increases had more growth in the number of enrollees seen by FQHCs and greater reductions in ED visits for non-emergent conditions (Myong, 2020).

Emergency room visits are enormously expensive to the healthcare system as a whole and can seldom address the dental needs of patients. Dental emergencies seldom work out well for anyone: the hurting patients, the overwhelmed emergency departments, or the taxpayers. Therefore, investment in FQHCs could be a promising approach to increase access to care for underserved populations and reduce costly ED visits, especially for primary care treatable or non-emergent conditions.

Conclusion

In the world beneath our noses, oral microbes thrive and struggle and unexplainably wander. The teeth bear silent witness to our human condition. They are lost and they are found again. They say that we have traveled, we suffered, we invented, we lived. (Otto, 2017)

The oral health crisis is one that can be easily overlooked by more affluent Americans with access to private dental benefits and the resources to pay for timely care through the private practice system that provides most of America's dental care. At the same time — for roughly one third of Americans, including people with lower-incomes, people who are publicly insured, elders, minorities, people living with disabilities, those living in communities with shortages of dental providers — the immense struggle to find routine dental services is unable to be ignored. These individuals often go without care, sometimes leading to untreated disease, pain, and suffering.

By generously sharing their own opinions and experiences, people who are intimately involved in practicing dentistry explained how they make sense of social responsibility within their profession. Dentists discussed the ways in which economic pressures within the dental industry constrain one's ability to practice social responsibility. In the world of American dentistry, the boundaries between caregivers and salespeople, customers and patients, have become blurred. Importantly, these findings suggest that participating in Medicaid is not a

possible avenue for social responsibility in dentistry. Participation in Medicaid seems to violate multiple levels of Carroll's model of Corporate Social Responsibility: economically, participation in Medicaid was viewed as an infeasible and irresponsible option due to the low reimbursement rates; legally, many dentists in the study expressed concern that the low reimbursement rates necessitated Medicaid fraud; ethically, interviewees were concerned that the lack of sufficient dental benefits incentivized improper, unethical care of patients. Of course, many dental professionals in this study described the other socially responsible acts they engage in, like offering pro-bono work to those less fortunate and volunteering within their communities. Although such efforts are laudable, charity and volunteerism alone are not a sufficient substitute for a sustainable system designed to provide ongoing care. Charitable dentistry risks becoming the basic and legitimate standard of care for vulnerable populations, despite its inability to meet the sometimes dire needs of such groups, particularly as it is rarely comprehensive and tends to be episodic at best. Charitable dentistry also implies that good oral health is more of a privilege than a guaranteed right. Thus, reducing barriers to Medicaid participation and increasing low-income individuals' is crucial.

While this study does not provide one solution for inequities in access to oral health care, and there is no cure-all for the American oral health crisis, it does provide a nuanced understanding of social responsibility in the context of dentistry and suggests ways to improve access to dental care for low-income individuals in Illinois. We cannot continue to ignore the salience of oral healthcare and must work collectively to build a system of comprehensive dental care for all Americans. Only when there is consensus on the importance of dental care, and simultaneous acknowledgement of the failures of the American system to provide that care for low-income populations, can we strengthen the dental safety net.

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Appendix A: Research Questions

- What do you see as barriers to accessing dental health care?
- What are your current feelings towards Medicaid?
- Can you describe your primary practice setting?
- Are you currently enrolled in a Medicaid program? If yes, how often do you treat Medicaid patients?
    - If yes, what are the motivating factors for treating Medicaid patients?
    - If they have an infrequent answer: What factors have led to you treating Medicaid patients infrequently?
    - If no, what factors affected your decision to participate?
- What factors affect your ability to treat Medicaid patients?
- What factors affected your decision to either participate or not participate in a Medicaid program?
- How would you define social responsibility? Do you see dentists as having any type of social responsibility?
- In your experience, how does social responsibility manifest in dental education, practice, and policy?
- Do you have any policy suggestions to improve the ability to practice social responsibility?