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“Insurance Doesn’t Care About the Patient”: An Institutional Ethnography of the Influence of Professional Autonomy on the Provision Care for Medicaid Dental Patients with Disabilities

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ABSTRACT

In terms of unmet needs for people with disabilities (PWD), dental care is number three behind residential care and employment (Fisher, 2012). Regardless of disability, oral healthcare traverses all disability diagnoses and can be a significant factor in quality of life (Deckler, 2011; Griffin et al., 2007; Norwood & Slayton, 2013). When attempting to secure oral healthcare, people with disabilities face many challenges, including lack of access, lack of provider education on proper care of PWD, and difficulty finding a willing dental provider (Deckler, 2011; Fisher, 2012; Kennedy, 2009).

The purpose of this study was to investigate professional practices and decisions that affect provision of care for patients with disabilities. Research has clearly identified many barriers that preclude dental professionals from providing adequate care, such as lack of physical accommodations or reluctance to participate in state Medicaid programs (Deckler, 2011; Fisher, 2012; Kennedy, 2009). This study sought to understand the interoffice decision-making processes regarding participation in Medicaid, how to treat or accommodate patients with disabilities, and the extent to which market factors influenced these decisions.

Using the paradigm of institutional ethnography, this research provides insight into factors that providers considered when making decisions about patient care, and how local office decisions are connected to larger institutions and policies. A qualitative design was conducted and included open-ended interviews, observations, and textual analysis at two dental offices in the Richmond, Virginia, area.

Keywords: disabilities, dental, oral health, institutional ethnography, professional autonomy, bureaucracy

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Acronym List

ACA	Affordable Care Act
ADA	Americans with Disabilities Act
CCC+	Commonwealth Coordinated Care Plus
CVDC	Central Virginia Dental Care
CoC	Certificate of Confidentiality
CRPD	Convention on the Rights of People with Disabilities
DAC	Dental Advisory Committee
DMAS	Department of Medical Assistance Services
DSE	Disability Studies in Education
EOB	explanation of benefits
EPSTD	early periodic screening diagnosis and treatment
FAQ	frequently asked questions
FAMIS	Family Access to Medical Insurance Security
FQHC	federally qualified health centers
GA	General Assembly
GRTC	Greater Richmond Transit Company
HIPAA	Health Insurance Portability and Accountability Act
I/DD	intellectual or developmental disabilities
IDEA	Individuals with Disabilities Education Act
IED	individual education plan
LEAT	least expensive alternative treatment
MCO	Managed Care Organization
MCV	Medical College of Virginia
NEMT	nonemergency medical transportation
PPO	preferred provider organization
PWD	people with disabilities
SCHIP	state children’s health insurance programs
SHCN	special healthcare needs
SSA	Social Security Administration
UCR	usual, customary, and reasonable
VDA	Virginia Dental Association
VDAF	Virginia Dental Association Foundation
VDH	Virginia Department of Health
WIOA	Workforce Innovation Opportunity Act

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Dedication

Lovingly dedicated to my boys: Jason, Aidan, and Julian.

CHAPTER 1: Introduction and Literature Review

In this chapter, I outline the importance of oral healthcare to people with disabilities (PWD); ways in which oral health is linked to and affected by their primary diagnosis; and ways in which access to care, dental education, insurance, and accessibility affect provision of care. I also introduce the *problematic*, a key concept within institutional ethnography, at the center of this research question and how it is analyzed.

According to the 2007 United Nations Convention on the Rights of People with Disabilities (CRPD), PWD deserve the right to the highest attainable standard of health. As one of the 155 signatory nations, the United States should consider the needs and best methods of providing the highest attainable standard of health to PWD (Silvers & Francis, 2013). Providing adequate dental care to PWD is essential for achieving this goal because dental care and oral hygiene affect overall quality of life. Oral hygiene and disease are linked to ear and sinus infections, weakened immune systems, and systemic illness. Furthermore, untreated dental conditions become painful and eventually affect an individual's speech and social development (Decker, 2011; Griffin et al., 2007; Norwood & Slayton, 2013). In terms of unmet needs, dental care is number three behind residential care and employment (Fisher, 2012).

Unfortunately, oral healthcare is often secondary to other primary health concerns related to a disability and may be neglected by caregivers and healthcare providers. Advances in medicine have allowed for individuals with significant disabilities to live longer lives. In fact, it is estimated that the number of adults aged 60 or older with developmental disabilities will increase threefold over the next 20 years (Waldman et al., 2006). A decline in oral health can dramatically affect the quality of life of PWD regardless of how well their primary disability is treated. Medical care should not be limited to addressing primary disability ailments; we now understand that it is also necessary to consider continued care that affects quality of life. Poor oral health for PWD may be the result of the disability itself, medical treatment of the disability, or a combination of the two.

Poor Oral Health as a Comorbidity

Adequate oral healthcare is a concern for all individuals regardless of disability status. By studying oral health, the proposed research study is not limited to health access concerns for any particular disability diagnosis. Oral health is a concern for all patients whether their primary diagnosis is physical, intellectual, or developmental. However, disability diagnosis can vary in how it affects both oral health and oral health maintenance.

Worldwide, studies have shown that dental caries (commonly known as cavities) are the most prevalent comorbid disease and unattended health need among individuals with intellectual or developmental disabilities (I/DD) (Fisher, 2012). Often, physical or cognitive challenges contribute to inadequate self-care, such as unwillingness to brush, biting down on the toothbrush, not opening the mouth wide enough to effectively brush, reliance on caregiver for oral care, and inadequate clearance of foods from the mouth (Fisher, 2012; Norwood & Slayton, 2013).

Primary medical issues, medication, or the disability itself exacerbate some oral problems. For example, there is an inherent risk that individuals with Down’s syndrome can have decreased saliva secretion because of their tendency to mouth breathe. Decreased salvia production or xerostomia can lead to increased caries, swallowing difficulties, and chronic mouth burning (Fisher, 2012). Individuals with physical disabilities may have oral dysphagia and pocket foods and fluids in their mouth that lead to increased caries. Foods prepared for individuals with physical disabilities are often pureed, which adhere more to teeth. In addition, severe motor impairments can lead to hyperactive bite and gag reflexes that expose teeth to acidic gastric contents that further erode dental enamel (Norwood & Slayton, 2013).

Individuals with I/DD are more likely to be prescribed medication in syrup form with a higher sugar content that increases the risk of caries (Fisher, 2012). Seizure management medication can contribute to gingival overgrowth, and medications such as glycopyrrolate, trihexphenidyl, amphetamine, and datomoxetine can result in xerostomia and increased risk of caries (Norwood & Slayton, 2013).

Even when the importance of oral healthcare is acknowledged for PWD, patients can encounter barriers to care. The following section details some of the specific provision and access concerns that affect adequate oral healthcare for PWD.

Provision and Care

Class-action legislation under the Americans with Disabilities Act (ADA) has led to increased deinstitutionalization of PWD and closure of many state-run facilities. At the end of the last century, the number of institutionalized individuals had decreased 75 percent (Waldman et al., 2006). Though deinstitutionalization is positively associated with progressive social policies, it has also been correlated to a worsening of oral healthcare for PWD (Fisher, 2012; Norwood & Slayton, 2013; Waldman et al., 2009). By moving away from institutional-based care for PWD, individuals have lost access to institutional-based dental providers and must now rely on community-based providers. Even community-based residential facilities report inadequate access to dental care as a significant issue plaguing their residents. Based on a study in North Carolina, individuals with I/DD were significantly more likely than individuals without a disability to have never had their teeth cleaned or to have not had their teeth cleaned in the last 5 years (Fisher, 2012). The 2001 National Survey of Children with Special Health Care Needs estimated that 76 percent of parents reported the need for dental care in the prior 12 months, and that 13 percent of individuals did not receive the care they needed (as cited in Fisher, 2012).

Behavioral conditions can also make it difficult to seek and provide care in traditional settings. Parents or caregivers may be reluctant to take a child with a behavioral problem to the dentist, and providers may not feel comfortable providing care. Depending on cognitive impairment or high salience to stimuli, a PWD could be uncooperative during dental exams. Individuals who are uncooperative or demonstrate an oral aversion may need to be sedated for the dentist to provide an adequate exam and treatment (Norwood & Slayton, 2013).

Proper dental education and disability awareness could mitigate concerns caregivers and providers have about providing care in traditional settings. However, dental care providers do not receive the necessary training to address the special needs of this population, as I discuss next.

Dental Education

The American Dental Association has stated that dental schools are providing minimal training and clinical experience in caring for PWD. This lack of training contributes to providers' hesitancy to treat and provide services. For example, PWD may have exaggerated or unpredictable responses to anesthesia, and it is highly recommended that dentists consult with an individual's primary care physician before using local or general anesthesia in addition to consulting sedation guidelines developed collaboratively between the American Academy of Pediatrics and the American Academy of Pediatric Dentistry (Norwood & Slayton, 2013). Such increased coordination demonstrates higher client service time spent on PWD that may not be reimbursable (Decker, 2011; Kennedy, 2009; Waldman & Perlman, 2002).

On average, United States programs provide only five or fewer hours of instruction on the treatment of vulnerable populations. For example, from a sample of 640 dental graduates from 1992 to 2004, 51 percent of the respondents reported receiving no training in this area.

Graduates who did receive training indicated that previous experience of treating PWD in school had a positive effect on their willingness to provide care to PWD (Fisher, 2012).

Education and disability awareness are not the only factors that can contribute to a dental provider's decision to accept PWD patients. Potential patients' insurance can often be a deciding factor; this factor is further complicated when the patient relies on public insurance such as Medicaid or Medicare.

Private vs. Public Insurance

Whereas 80 percent of individuals without a disability have private health insurance, it is estimated that only 44 percent of individuals with significant disabilities have private insurance (Fisher, 2012). Healthcare expenditures are disproportionally large for PWD, and they are more likely to depend on public programs like Medicaid and Medicare. It is estimated that 75 percent of individuals with I/DD rely on government funding for health and dental services. Though coverage for dental services is mandatory for children covered by Medicaid, unlike adults—even those with a disability—states have wide latitude in setting payment rates for providers (Decker, 2011). Low rates have often been cited as a reason that providers choose not to participate in Medicaid, and research has found that a positive correlation exists between state Medicaid fees and the number of private providers who will treat Medicaid patients (Decker, 2011).

An evaluation of first dental visits for newly enrolled children with and without a disability who receive Medicaid indicated that they had more difficulty accessing a dental care provider than did their counterparts enrolled in State Children's Health Insurance Programs (SCHIPs) (Chi et al., 2011). Simply providing a child with Medicaid coverage does not address the issue of providing access to a willing dental care provider. A 1996 report of the Health and Human Services Inspector General estimated that only 20 percent of Medicaid-eligible children receive preventative dental care (as cited in Griffin et al., 2007).

Dental care providers cite low reimbursement rates and increased administrative requirements as reasons that make treatment of Medicaid patients exceptionally burdensome and undesirable (Decker, 2011; Kennedy, 2009). Providers also complained of slow payment and unreasonable denial of payment in addition to the low reimbursement (Kennedy, 2009). These reasons coupled with lack of education regarding care for PWD make it extremely difficult for PWD to find willing and adequate dental care. Furthermore, Medicaid typically only provides preventative dental care for children; dental care may not be provided for adults using Medicaid except when deemed medically necessary and is usually limited to extractions (Waldman & Perlman, 2002). State coverage of adult benefits varies from state to state. As of 2019, only 19 states provide extensive or comprehensive adult coverage (CHCS, 2019).

Compensation considerations contribute significantly to access as well. A secondary analysis of dental providers from 2000 to 2008 revealed that children covered by Medicaid were less likely to have been seen by a dentist in the last 6 months than children who were covered by private insurance. There was also a positive correlation between increases in state Medicaid payment and overall improvements to dental care access for children covered by Medicaid; a logit model revealed that a $10 increase in Medicaid payments was associated with a 3.92 percent increase in the chance that a child covered by Medicaid had seen a dental provider (Decker, 2011). Quality of care may also be dependent on disability diagnosis; individuals with mild learning disabilities are more likely to receive restorative dental treatments, whereas individuals with profound learning disabilities are more likely to receive dental extractions (Stanfield et al., 2003). This difference in care points to varying levels of social expectations for PWD.

Medicaid. The high utilization of Medicaid by PWD means that an analysis of the problem of access would not be complete without further investigation into what factors influence professional participation in Medicaid programs. Despite provider claims that reimbursement influences participation in Medicaid (Deckler, 2011), a series of weighted generalized least squares models reveals that the supply of dental services is relatively inelastic or does not increase proportionally to increases in rates or service demands (Scheffler et al., 1996). This insensitivity indicates that there may be additional factors (economic and noneconomic) that maintain a high marginal cost and prevent dental providers' participation in Medicaid. If increased reimbursement payments alone will not increase access, then policy makers need to identify what affects program participation satisfaction. From a professional perspective, what factors into cost-benefit decisions to apply and continue to participate in Medicaid programs?

Accessibility. Beyond a limited number of providers with adequate knowledge and compensation concerns, accessibility difficulties can also hinder access to dental care (Norwood & Slayton, 2013). Frequently missed appointments and the administrative time required for coordination of care between primary care physicians and PWD caregivers are also cited by dental providers as barriers to delivering adequate care to PWD and Medicaid recipients (Decker, 2011; Kennedy, 2009). It is likely that transportation difficulties and complex medical regimes and schedules increase the likelihood of missed appointments. Also, although the ADA requires that structural facilities be accessible, it does not address the treatment environment, including tables and equipment (Silvers & Francis, 2013). For individuals with physical limitations, access barriers may include finding a dental care provider with the necessary equipment in addition to knowledge to provide adequate care.

Title 3 of the ADA defines a private dental office as a place of public accommodation, requiring dental practitioners to serve patients with disabilities. However, dentists are not obligated to make accommodations if the disability is not discernible and if the patient does not disclose their disability. ADA requires dentists to treat a PWD as they would a person without a disability, including referrals for further treatment if necessary. Reasonable modifications must also be made to office facilities to increase access unless it can be shown that these modifications would cause an “undue burden,” and PWD are not allowed to be charged for additional auxiliary fees, such as interpreters for the deaf and hearing impaired. According to the law, a dentist is allowed to refuse treatment if the patient poses a “direct threat” to the health and safety of others (ADA, 1990).

There are legal limitations, however, to what a dentist may consider a “direct threat.” For example, the United States Department of Justice identifies a dentist who categorically refuses to treat all persons with HIV/AIDS as an example of discrimination; this exact example was upheld in the Supreme Court Case *Bragdon v. Abbott*. However, a healthcare provider is not required to treat a person who is seeking or requiring treatment outside of the provider’s area of expertise (U.S. Department of Justice, 2012). What is considered to be beyond a provider’s expertise is a gray area; it can be interpreted to mean their general discomfort or lack of knowledge working with an individual with a disability.

In fact, pediatric dentists rather than adult general dentists treat the majority of adults with disabilities (Waldman et al., 2009). This pattern is the result of limited dental education and clinical time spent on the care of PWD and mandatory dental services for children under the Early Periodic Screening Diagnosis and Treatment (EPSDT) Medicaid program. In 2005, only seven states included comprehensive adult dental care as part of their Medicaid program

(Waldman et al., 2009). However, as of 2013, there were only 5,000 practicing pediatric dentists (Norwood & Slayton, 2013). This number, not even considering distribution, is inadequate to treat the population of children and adults with disabilities. The estimate of children with special needs alone is 11.2 million in the United States (Norwood & Slayton, 2013).

Statement of the Problem

Adequate dental care is an important factor of overall health; the importance of oral health should not be overlooked in PWD in favor of narrowly treating the biological basis of the disability. Oral health not only contributes to overall physical health but also contributes to social and emotional wellbeing. However, many features of our healthcare delivery system, including lack of proper education, inadequate compensation, and meaningful access, prevent appropriate care and treatment. Most difficult though is the role of attempting to reconcile expectations of equitable access and care with individualized providers in a market-based institution. Within a market-based healthcare system, what are the incentives to provide care to a population with exceptional health expenditures? This research study seeks to use institutional ethnography as a constructive framework to understand the decision-making process of dental providers and influential institutional factors. The question is guided by the problematic, which can be described as the experiences of people at the center of the issue, in this case, dentists and dental professionals.

Identifying the Problematic

In institutional ethnography, identifying the problematic means to focus on a particular issue in someone's lived experience; it is not the research question itself but rather a starting point to begin to unravel the best approach for conducting an institutional ethnography (Campbell & Gregor, 2004). For example, in Campbell's (2000) Institutional Ethnography study on healthcare experiences of people with disabilities, she began not with a hypothesis but with recruitment of volunteers to share their experiences. The goal was to use this preliminary data to identify what would be studied in the second phase. The gathered information led her to investigate the social organization of healthcare interactions.

Starting with a specific perspective is meant to reveal the connections between people and institutions that are to be studied. These connections serve as the object of analysis as they can be stretched beyond an individual account. It is an analysis of these links that can be generalized and used to demonstrate how ruling relations direct individuals' actions. The emphasis looks beyond the existence of ruling relationships to better analyze and understand how ruling relations are performed and perpetuated (Norstedt & Breimo, 2016).

In preparation for the proposed study, two interviews were conducted with dental professionals. The conversation with these professionals suggested that dentists exercise degrees of professional autonomy in how they structure their practice and restrict potential patients. This professional autonomy is, however, limited by maintaining a viable and profitable business and by dental education. For example, it was shared that a pediatric dentist may treat a special needs child using Medicaid but likely not treat a patient who has qualified for Medicaid based on economic status. This decision was highly influenced by the fact that dental treatment for minors is mandatory through Medicaid but only "medical" treatments are reimbursed for adults (Deckler, 2011). Hence, the decision to limit Medicaid patients is greatly determined by the reimbursement structure of Medicaid that varies from state to state.

One dental professional also shared that because Medicaid may set limits on what is reimbursed, it is not uncommon for a dentist to perform a procedure that is not covered but bill for another procedure to secure some reimbursement. In Nevada, for example, Medicaid covers silver amalgam fillings only and does not cover resin composite fillings. If the affected tooth is visible, a dentist may choose to use resin composite, bill for silver, and absorb the difference in cost. Here, there is the potential for policy to limit the quality of service provided to a Medicaid patient. Furthermore, it was shared that there is no reimbursement code for cognitive care or preventative care with adult patients. Any time spent with a patient discussing oral hygiene is nonreimbursable time for the dentist. Given the specific and individual needs of a patient with a disability, this could potentially be a large amount of time the dentist forfeits that could be otherwise spent on more lucrative procedures.

In an interview with an independent dental practice owner, the dentist explained why the office declined to become a Medicaid provider. As a small business owner, he had to make decisions to ensure that his practice is solvent. Part of these decisions included which insurances to accept. In addition to Medicaid, he has chosen not to be in network with two other insurance companies who offered him lower negotiated fees than other insurances. The dentist shared his frustration that insurance does not care about a patient and that sometimes overreliance on insurance plans can be detrimental to care.

These preliminary interviews reveal the disjuncture between different versions of reality (Campbell & Gregor, 2004). Campbell (2000) analyzed the perception of care provided to PWD from their own perspective. In the case of this study, an analysis of the provider perspective reveals how larger social relations govern how care is provided and what decisions are made to maintain or disrupt the egalitarian mode of delivery that often fails to meet the specific needs of PWD. Professional autonomy allows a dentist to select patients, decide on acceptable methods of payment, and choose whether or not to be a Medicaid participant (Deckler, 2011). These decisions are often influenced by market factors and quality of care factors (Fisher, 2012). My observation that the disjuncture that dentists often experience when providing care for PWD is the conflict between *cultural competency*, *limited resources*, and *levels of care*. The professional autonomy granted to dentists gives them some leeway in whether they err more on the side of quality or profit. The question at the center of the problematic that I hope to unravel is: How does dental professional autonomy in a market-based system affect provision of care for Medicaid patients with disabilities? Specifically, how do dental providers arrive at the decision to become Medicaid providers, and what factors influence their decision to treat and the type of care to provide to patients with disabilities?

Chapter 2 will review the conceptual framework that structures this research study and demonstrate how Michel Foucault’s postmodern conception of power and knowledge, insights from Jürgen Habermas’s communicative action, the biological model versus the social model of disability, and institutional ethnography will guide the inquiry and analysis.

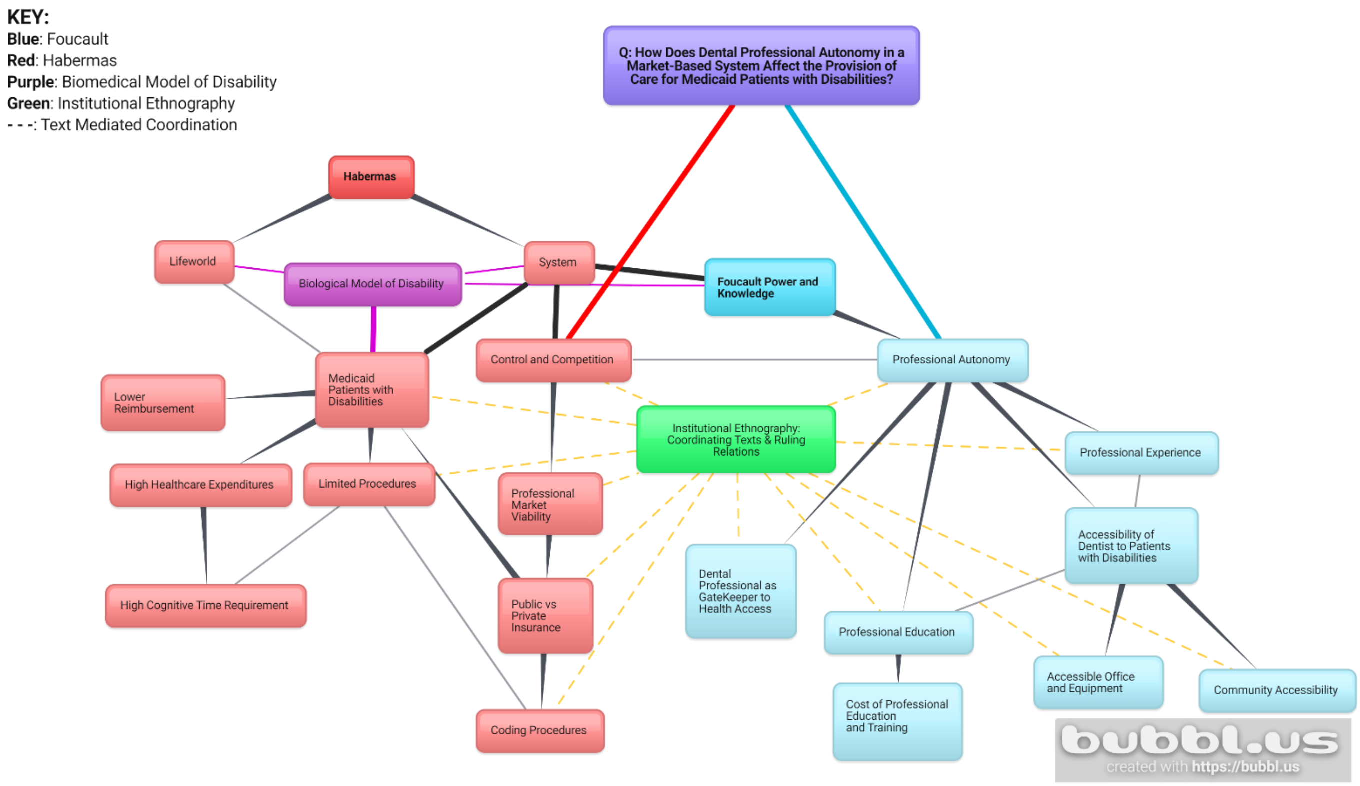
CHAPTER 2: Conceptual Framework

The conceptual framework for this research study is based on two primary theories: Foucault's conception of power and knowledge and Habermas's concept of communicative action theory. These theoretical frameworks represent simultaneously the synergistic and conflicting nature of dental professional autonomy and the market context within which they operate. For example, professional autonomy grants a dental professional a measure of market control and competition, but it does not ameliorate the fee-for-service commodification of the insurance market. Institutional ethnography, as a mode of inquiry, supplies the lens through which these theories are filtered and, in particular, reveals how everyday problems are connected to institutional policies and the ways in which daily actions reproduce institutional modes of thinking. The social construction of disability, specifically within the medical field, is outlined to reveal how disability as a concept is also affected by regimes of power and knowledge and communicative action.

Professional autonomy is conceptualized as ideas related to professional training, experience, gatekeeping, accessibility, and care of patients with disabilities (Freidson, 1989; Starr, 1982). Market control is conceptualized as ideas related to market viability, private and public insurances, Medicaid, coding, fee for procedures, and healthcare expenditures. The lens of institutional ethnography maps how local settings are connected to societal institutions when using key concepts from Foucault and critical theory to interpret data collected through observation and conversation. Figure 1 provides a visual representation of how these concepts are anticipated to connect and relate to one another in this research project.

Figure 1

1 Visual Representation of Conceptual Framework



Institutional Ethnography

For the purposes of this study, institutional ethnography is used as described by Canadian sociologist, Dorothy E. Smith, to explain the links between everyday life, organizations, and translocal administrative and governance processes. Smith (1999) defines the complex field of links as "ruling relations" and "texts" as forms of coordination. An individual's actions at the local setting are shaped by external organizational powers, and texts become the means by which those organizational powers are communicated to the individual. Within the context of this research study, emphasis is placed on understanding how local dental offices are inextricably linked to state and federal government, private insurance businesses, and other institutional organizations whose policies trickle down to affect everyday decisions of dentists and dental staff. The role of texts, and specifically the activation of texts, as described by institutional ethnography, is key to understanding how ruling relations trickle down and are perpetuated at the local level. “The notion of activation expresses the human involvement in the capacity of texts to coordinate action and get things done in specific ways” (Campbell & Gregor, 2004, p. 33). Often, ruling relations take the form of policies that are reproduced as replicable written text. The use, adherence to, and replication of texts become part of the action or work of individuals at the local level. For example, how do Medicaid policies, viewed as texts, become part of the act of providing dental services? At what point does dental care become defined by the reproducible text, and does this text contradict or redefine care from a medical perspective? As a text of replicable policies and rules, Medicaid billing directly links the local action of the dentist to state and federal guidelines. “Drawing texts into the scope of ethnographic investigation is an essential step in exploring the translocal organization of the everyday” (Smith, 2006, p. 66).

Originally, institutional ethnography was described as a combination of Karl Marx’s materialist method, Harold Garfinkel’s ethnomethodology, and feminist insights of consciousness-raising (Smith, 2006). Institutional ethnography directly addresses unequal social power relations by connecting people’s everyday experiences to institutions, bureaucracies, media, and discourse, which Smith conceptualizes as the ruling relations that constitute and maintain social networks and inequalities in power (Smith, 1987). The power of institutional ethnography is its ability to connect the micro problems and everyday lives of individuals to the macro institutions in which one works or exists by highlighting how the institution itself shapes what may be observed as personal problems. This feat is accomplished by moving away from the administrative level of observation to “[take] the standpoint of those who are being ruled”

(Campbell & Gregor, 2004, p. 15). This approach challenges the dominant ruling relations by exposing how standard concepts of knowledge and understanding often fail to account for the diverse array of experiences of the population it governs. The inattentiveness of rulers and the perpetuation of ruling relations (re)produce social injustices that institutional ethnography can help reveal.

Institutional ethnography is particularly well suited to the study of bureaucratic work settings because it "draws on local experiences in confronting and analyzing how people's lives come to be dominated and shaped by forces outside of them and their purposes" by focusing on the texts that shape that organization (Campbell & Gregor, 2004, p. 12). Organizational texts like intake forms, patient records, and billing that mediate decision making will likely reflect institutional interests over individual interests. Campbell and Gregor (2004) have demonstrated the efficacy of this methodological approach in healthcare settings; in their examples, nurses rely on texts like patient records to simultaneously translate their nursing knowledge and view their work in the terms supplied to them by their organization. For example, institutions and professionals determine via texts, such as applications and intake forms, who is eligible to receive health services, who is mentally ill, and who should receive welfare services. Texts are the tangible accountability record that makes visible the coordination of multiple institutions. In use, texts are read selectively for different purposes and, by this means, become part of the action or work performed (Smith 2006). By "mapping" these social relationships, institutional ethnography makes visible the normally invisible social organization of people's daily lives.

As described in Campbell and Gregor (2004), Roxana Ng's research on employment supports for immigrant women demonstrated how provision of services was affected by government funding. Ng's research argued that funding accountability and recordkeeping directed how services were provided, redefined success in terms mediated by state agencies, and ultimately revealed as false the assumption that a state operates in the interest of all citizens (Campbell & Gregor, 2004). Ng's research demonstrates how text-mediated decisions can redirect the focus of an agency from the lived experiences of clients to institutional categorization and funding streams. Similarly, this research seeks to evaluate how market factors and Medicaid reimbursements affect provision of care. Similar to Ng's research, institutional ethnography is an appropriate lens to investigate how funding can dictate the creation and use of texts in institutional organizations.

Campbell (2000) has used institutional ethnography to explore the healthcare experiences of PWD by mapping the social organization of the delivery of services. The goal of the study was to problematize the relationship between the services provided and the actual experience of the individual; the experiences as told by PWD illuminated the question of what is "health" and the disparities of that definition that existed between health provision and personal autonomy or experience. Campbell's (2000) study showcases how PWD "disrupt the cultural homogeneity of a population" (p. 142) and how uniform policy decisions designed for efficiency and consistency are likely to ignore rather than respond to individualized needs. The delivery of services as dictated by institutional text organize social relationships between professionals and PWD in a bureaucratic power dyad.

Dental offices can be viewed as organizations with set policies and rules that maintain economic viability and provide standards of care. Like Ng's employment agency, dental offices will consider funding and revenue streams in order to remain profitable and continue to provide care. Dental professionals are then passive gatekeepers or advocates of PWD regarding access. Furthermore, professional autonomy gives dental professionals the ability to select patients and create personal operating procedures within the confines of professional and economic constraints (Deckler, 2011). Conducting an institutional ethnography in a dental office identifies the use of texts and types of texts that coordinate professional action in the setting. For example, how do billing documents, insurance authorizations, and insurance benefits dictate provision of care? Are new patient forms used to determine patient acceptance or type of care provided? Do dental staff use documents to record patient care that then reinterpret how care is defined? In this age of technology, how are online new patient inquiries, documentation, or electronic records changing the translocal administrative processes?

Dental offices operate within a larger social and economic context, and an institutional ethnography reveals the specific dimensions of this context. Foucault's concept of power and knowledge will be key to analyzing concepts related to professional training, autonomy, and patient selection.

Power and Knowledge

The French philosopher, Michel Foucault, wrote extensively on the concept of power and its manifestations. Power in social institutions and relationships could be described as extensions of "discourses" pervasive in all aspects of society and everyday life. Foucault describes units of discourse as "…those groupings that we normally accept before any examination, those links whose validity is recognized from the outset" (Foucault, 1971/1972, p. 22). Foucault (1972) further posits that "…discourse is not the majestically unfolding manifestation of a thinking, knowing, speaking subject, but, on the contrary, a totality…" (p. 55). In his interview, Truth and Power, Foucault details how concepts of truth and knowledge are produced and maintained via discourses that are themselves not rooted in objective truth but rather socially constructed through particular practices dominated by those with power. Concepts of knowledge are thus indicative of the contextual history and the current power regime.

According to Foucault, relationships demonstrate a power dynamic: One individual dominates while the other is subordinate. Examples would include the employer-employee, teacher-student, and doctor-patient dyads. Within these dyadic relationships, the dominant individual would control the economic and ideological conditions that dictate *knowledge*. The combination of power and knowledge allow the dominant individual to inscribe their view of *truth* or *reality* onto those they influence. Mechanisms of control operate within institutions such as prisons, hospitals, schools, and asylums (Erickson & Murphy, 2003). However, relations of power must expand beyond notions of repression in order to be productive and reproductive. “What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no; it also traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network that runs through the whole social body…” (Foucault, 1976/2003, p. 307).

This conceptualization of power, knowledge, and truth removes the objective quality of truth; knowledge can now be viewed as a means of ordering and explaining the world according to the powerful. The perpetuation of a specific truth does not necessitate the objectivity of that thought rather the perpetuation of the legitimacy of the powerful, often through institutions. However, the conceptualization of power should not be limited to judicial notions of law and prohibition or power is reduced to being solely in the hands of the sovereign. To quote Foucault, “we need to cut off the king’s head” (1976/2003, p. 309). Here, notions of power and truth can be related to an institutional ethnography framework. Institutional organizations directly influence individual lives by perpetuating and reproducing ruling relations through power and knowledge. An individual willingly submits to or participates in a power dyad, just as individuals voluntarily engage in social relations per institutional ethnography.

Professional Autonomy

Foucault's conceptualization of power and knowledge is key to understanding the cultural authority of the professional. The professional is one whose expertise is legitimatized by institutions of power; he or she is an expert because the powerful say so, and we believe it. Sociologist Paul Starr describes the role the profession has in society and assesses that the profession "has been able to turn its authority into social privilege, economic power, and political influence" (1982, p. 5). Indeed, a sudden onslaught of discoveries and changes in ways of speaking and understanding is indicative of a regime change (Foucault, 1976/2003). As outlined by Starr (1982), changes in medical knowledge are linked to the professionalization of medical doctors at the expense of midwifery. To Starr, the roots of a profession's authority are based on "dependence" and "legitimacy." The subordinate submits to the "legitimate" authority of the powerful to gain access to knowledge held by them. In this fashion, the powerful are gatekeepers to those who depend on them (Freidson, 1989; Starr, 1982). Doctors are the gatekeepers to health; social workers, the gatekeepers to benefits; teachers, the gatekeepers to education. Professional legitimacy is based not on the authority of the individual but on the authority bestowed by the community of professionals who have validated their proficiency (Starr, 1982).

Oral health for PWD is predicated on access to a dental professional. To examine the role of dental professional autonomy in a market system, it is first imperative to understand the definition of a professional and the power they hold in the exercise of their professional duties. Abbot (1988) describes professions as "exclusive occupational groups applying somewhat abstract knowledge to particular cases" (p. 8). The concept of abstract knowledge is key in that it is through this abstraction to application of practical technique that a professional group controls and protects their occupation from competition (Abbott, 1998). Initially it may appear that the profession is simply linked to an occupational role, but it is the exclusivity and required training of that occupational group that are key factors in how one earned the status of professional. Furthermore, abstraction of occupational knowledge grants professionals power over occupational territory (Abbot, 1988). For example, if one were to recall a recent trip to the dentist, most likely the majority of their time was spent in the presence of a dental hygienist. Often it is the hygienist who flags potential cavities or oral health concerns, but the visit is not complete until the dentist confirms the hygienist's observations. Through abstraction, dentists hold authority over hygienists and protect their occupational territory.

The power of abstraction is what sets professionals apart from any other vocation that requires a licensure to practice, like a beautician or electrician. Based on this definition, the relationship between knowledge and control of knowledge is at the root of professional authority and autonomy.

Accessibility

In terms of accessibility to dental care of patients with disabilities, professional autonomy and personal attitudes can affect observed healthcare disparities. Unconscious biases and stereotypes of healthcare professionals regarding patients or socioeconomic factors have been shown to result in differences in care (Meade et al., 2015). This unconscious bias is important to consider because dental professionals and their staff can be considered street-level bureaucrats as described by Lipsky (2010). These street-level bureaucrats have a critical role in access to entitlements like public safety, education, and health. In fact, Lipsky (2010) argues that the influence of a street-level bureaucrat is proportional to the need of an individual. A PWD of low social economic status using Medicaid as their primary insurance would have multiple layers of gatekeepers between themselves and oral healthcare. This could include their caretaker, case manager, social worker, social security benefits advisor, and health administrator. One way in which dentists can manifest their unconscious bias is through selective insurance participation and geographic location. As previously described, transportation difficulties can affect a PWD's ability to access care in the community (Norwood & Slayton, 2013). There is also no requirement that dentists purchase potentially expensive specialized equipment needed to treat patients with disabilities and, in fact, such a requirement would impinge on their professional autonomy and control. While it would be considered discrimination to refuse care to a patient on the basis of disability, it is possible to decline care if specific treatment is incompatible with prior professional education or experience (Fisher, 2012). Professional autonomy that does not give consideration to the care of specific populations creates problems with access, and control of occupational territory means that there are no other viable options for patients. Dentists have a monopoly on oral healthcare.

Professional autonomy and occupational control grant professionals the opportunity to increase market viability. According to Starr (1982), occupational control is gained through three distinct claims to legitimacy: Knowledge and training validated by the professional community; knowledge and training based on rational, scientific grounds; and professional goals based on substantive values, primarily service rather than profit. The occupation deserves to exist because it serves a great purpose and has been vetted by rigorous scientific training. Using occupational control, the profession is able to convert authority into market control and economic power over both its services and the organizations that govern the profession (Starr, 1982). Indeed, dental schools, medical suppliers, dental business consultations, and insurance companies stand to make a profit on the professional authority of dentists. The provision and quality of care for PWD must be evaluated in this economic context.

Professional Autonomy and Economic Power

Economic power is based on a standardized professional product and producer; it limits market entrance by clearly identifying those who have a claim to the profession based on requisite knowledge gained through approved institutions. The rank of a professional can only be attained by those who hold certificates or licenses that validate both the content and source of their knowledge (Freidson, 1989; Starr, 1982). Limiting market entrance also justifies the professional ideal that places the profession above the realm of the market. The sovereignty of the consumer is replaced by the sovereignty of the professional (and the community of professionals who recognize them) (Starr, 1982).

Starr and Freidson agree that professional sovereignty is rooted in control of competition and product control (both the professional and their service). In this fashion, institutional licensing combats the two threats to professional power: Competition and control (Starr, 1982). However, Freidson (1982) points out a professional paradox that limits professional control. Professionals possess technical autonomy in the performance of their work, but the work is limited by resource allocation; they must still work within the economic constraints of the organization that employs them. This paradox not only threatens professional control but also causes tension between the profession and the institutions that control these resources.

Habermas: Colonization of Dental Healthcare

The United States healthcare system can be called a paradox of excess and deprivation. Bodenheimer and Grumbach (2012) describe it as a system in which some receive too little care and some too much, and the determinants of who receives care and who does not are largely based on who has adequate insurance coverage. Medical care and the financing of care are the economic context in which dental professionals must work, and it is a big business. The original method of paying or bartering directly for medical treatment has been replaced by payment via insurance company. The use of insurance can be viewed as a mass financing system that is supposed to ensure that medical professionals are paid and that individuals can obtain the medical care they need, regardless of their ability to afford a specific procedure. This system removed the need for a doctor to consider a patient's financial status from provision of care and was part of the process of legitimizing the accountability and authority of the professional (Stone, 1997). However, the private business context in which insurance operates means there is a push toward profitability and the managed care models of healthcare are "treated more and more like commodities" (Christiansen, 2017, p. 84). This emphasis on profitability means that insurance companies have an economic incentive in denying coverage or care and encouraging excessive medication, tests, and procedures to maximize insurance payouts; the bottom line runs counter to the access and provision of care (Christiansen, 2017). In line with critical theorists, the product of healthcare is manufactured primarily on its value and potential profitability not on its ability to satisfy human needs (Held, 1980).

In an ironic turn, the actions of the medical professionals to safeguard professional autonomy through insurance medical financing turned them into highly trained laborers. As described by Marx and Friedrich Engels (1888), "these laborers, who must sell themselves piecemeal, are a commodity, like every other article of commerce, and are consequently exposed to the vicissitudes of competition, to all the fluctuations of the market" (in Erickson & Murphy, 2001, p. 20). This study will use Habermas's concept of critical theory, specifically his theory of communicative action to evaluate how insurance, as an economic-based system, has colonized and destabilized the lifeworld or culture of dental care.

Habermas (1987) argues that society can be conceived as two distinct domains: A lifeworld and a system. A system, composed of economic and political patterns, does not function under individual autonomy, rather its main purpose is the production and circulation of goods and services. In fact, the system will often guide people to act in ways of which they are unaware, much like institutional ethnography's concept of social relation. In contrast, the lifeworld consists of the marketless areas of social life like family and culture. It is within the lifeworld that communicative action takes place and symbolic reproduction, shared social norms, morals, and understanding are created (Habermas, 1987). The lifeworld and the system operate in mutually constituent and supporting tandem with one another to hold society together (Finlayson, 2005). For example, standards of dental health and cosmetic beauty reach a consensus in the lifeworld through communicative action, and the system provides a market for advertisements and procedures.

Within the lifeworld, communicative action is constantly taking place and social norms are perpetually being (re)created or replaced. Though the system relies on these norms to operate, it can intrude or even take over the lifeworld (Finlayson, 2005). Habermas (1987) describes this development as colonization of the lifeworld. When this happens, the system takes over the social cohesion function of the lifeworld, value making is replaced by various aspects of formal rationality, and people become the means of political or economic ends that are not in their interest (Habermas, 1987). Medical financing as a system can be viewed as colonizing and reinterpreting the communicative action of healthcare. The system emphasizes the role of healthcare professionals as the economic producers of healthcare.

Medical Financing

Insurance in the United States healthcare system can be divided into public insurance programs like Medicaid and Medicare and two different types of private insurance programs: The nonprofit Blue Cross Blue Shield, which uses community ratings to determine participant premiums, and for-profit insurances, which use experience premium ratings (Bodenheimer & Grumbach, 2012). The problem with experience ratings is that the sick, elderly, and disabled are often priced out of insurance participation. Experience rating has undermined any basis of distributive justice in insurance participation (Conrad & Leiter, 2013). Public insurance was created as a means of combating the problem created by experience rating and, in 1965, Medicaid and Medicare were added as amendments to the Social Security Act (Bodenheimer & Grumbach, 2012). However, the creation of Medicaid and Medicare did not create 100 percent insurability of the United States population and did create a new problem in which the insurance companies that acted as intermediaries could increase cost and profitability. The 1970s saw a slew of overcrowded nursing homes and Medicaid mills (Conrad & Leiter, 2013). Recent trends toward a managed care model of Medicaid have been an attempt to combat rising costs, but it has also eroded physician autonomy and influenced the trend toward physicians as businessmen (Stone, 1997).

Medicaid and PWD

The use of Medicaid as a public financing option to ameliorate disparate care only creates a dual healthcare system; a public payer for the poor and a private-provider model for the rich. This system does not create a truly rights-based healthcare system (Christiansen, 2017). Medicaid eligibility is categorical. Three main groups are covered: Low-income parents and children, elderly, and PWD (Schneider et al., 2002). These three groups typically find themselves priced out of private insurance participation, either because their care is so expensive or because they cannot afford the premiums. Furthermore, the inclusion of marginalized patients through

Medicaid places a “democratizing pressure in opposition to performativity” (Campbell, 2000, p. 133). Anna Yeatman’s theory of the postmodern state demonstrates how policy legitimacy is challenged through the inclusion of previously excluded populations. “No such reduction of difference as modern liberalism effects, where all individuals come to instantiate a market-oriented possessive individual, is possible when all human beings have to be encompassed in a conception of individualized rights” (Yeatman, 2000, p. 1505). This is especially true when one considers that Medicaid is often the primary insurance of PWD. Our dominant biomedical model of disease constructs the concept of health as a body free of disease. Within this model, PWD will never exist in a body free of disease. This implies that there is something inherently wrong with PWD, something which must be fixed (Morris, 2000). Yet, these bodies exist in a market context where there is no incentive to spend the additional cost to provide more than basic care to a body that cannot be “fixed.” Cost effectiveness does not register or operationalize quality of life or human rights.

Medical Construction of Disability

Because the focus of this research inquiry is on how dental professionals provide care for PWD, it is necessary to also discuss the social construction of disability. Historically, disability has been conceptualized within a biomedical model that focuses on the medical diagnosis or disability itself (Smart, 2006). The care and services provided to PWD are based on a deficit model in which something needs to be cured, fixed, or ameliorated as close to normal as possible. This construction of disability and healthcare services for PWD can be directly linked to the conceptual framework used in this paper to describe professional autonomy and market factors in oral healthcare.

Related to Foucault’s conception of power and knowledge, the diagnosis of an individual’s disability is reliant on a physician’s medical gaze or use of a codified system of measurements to connect groups of symptoms with particular diseases (Krogh & Johnson, 2005). This medical gaze legitimizes the professional role and authority of the physician and medical profession and their ability to categorize bodies as either aberrant or normal. Once categorized, PWD are exposed to continual assessment of their disability in multiple institutions that affect their daily life; this includes education, employment, and medical treatment. Within these institutions, accommodations and treatment are dependent on a disability diagnosis, disclosure, and assessment of necessity. The medical gaze has become an administrative gaze that continues to abstract, measure, and classify the disabled body until the individual has been reduced to their disability (Krogh & Johnson, 2005). Furthermore, the high level of expertise and training required to diagnose a disability increases the presumed scientific credibility that disabilities and the difficulties experienced by PWD are solely the result of their medical ailment and not the result of social constraints (Smart, 2006).

Reliance on this medical gaze has unintentionally perpetuated social injustices for PWD. Disabilities are more likely to be viewed as solely medical concerns rather than social justice concerns. The result of this perception is that healthcare services are often limited to those medically necessary with limited consideration of quality of life. For example, Medicaid will not financially cover a wheelchair for an individual unless they are physically restricted within their home, and their guidelines specifically outline that primary use of a wheelchair is not for leisure or recreational activities (CMS, 2004). Similarly, hearing exams, hearing aids, and fittings are not covered by Medicaid in 22 states, despite evidence demonstrating its efficacious treatment and prevention of other adverse health outcomes like social isolation, falls, hospitalizations, and cognitive decline (Arnold et al., 2017). Within oral healthcare, dental treatment for adults covered by Medicaid is often limited and usually limited to tooth extraction (Waldman et al., 2009). For example, at the time of my observation in Virginia, adult services covered by Medicaid are limited to emergency services only, meaning emergency exams or extractions. Services like routine exams, preventive cleanings, restorative services, periodontal services, dentures, and oral surgery are not covered for adult Medicaid recipients (Shapiro, 2008). By limiting coverage, issues like self-esteem, employability, disease prevention, and poor quality of life can become additional stressors for a PWD reliant on Medicaid for health insurance.

Within the biomedical model, the inability to leave one's home and social isolation are not considered medically related conditions because these concerns are not bodily manifestations of a disease or disability. In contrast, a social model interprets disability as a result of a social system that bars full participation of PWD (Oliver & Barnes, 1998). Services would not be limited to the medical and would instead look at systems as opposed to the individual. For example, vocational rehabilitation has moved away from a deficit biomedical model where PWD were once assessed for employability to a capabilities social model that recognizes the value of individualized supports in maintaining employment. PWD who desire to work are provided job support services like onsite training, job restructuring, and assistive technology to be employed in community-based jobs; this is a departure from previous segregationist models that assumed that PWD were not capable of working traditional jobs (Dague, 2012; Migliore et al., 2007). This model recognizes that typical human resource systems prevent participation of PWD in the workforce. In response, other systems, like supported employment, have been created to allow for participation of PWD in the workforce. This model is reinforced by legislation like the federal Workforce Innovation Opportunity Act (WIOA) and Virginia's Employment First policy, both of which state that community-based employment should be the first option of employment for PWD (Murthy et al., 2016; Stehle, 2014).

Furthermore, legislation like WIOA reinforces educational legislation like the Individuals with Disabilities Education Act (IDEA) (2004), which mandates individualized services to students in the least restrictive environment. Gone are the days when students with disabilities were segregated from their peers in either specialty schools or hidden classrooms. In special education, proponents of a reconceptualization of the meaning of *disability* and special education practices form the basis of Disability Studies in Education (DSE) and argue the need to move from a medical deficit model to a social model that addresses the meaning of disability in a social and cultural context. Central to their argument is that disability is an idea rather than a thing and to place value or identify differences upon a person because of their disability is to make a value-based social judgement (Baglieri et al., 2011). DSE scholars recognize that the formulation of special education and early legislations was in the early days of disability studies and, therefore, the medical model is embedded in much of that legislation (Baglieri et al., 2011).

Unfortunately, most institutions continue to operate within the biomedical model. Furthermore, PWD submit to this construction of disability through their participation and reliance on institutions. A 2002 report from The Council of Canadians with Disabilities identified that the most common reason PWD went to a physician was to seek documentation of their disability to receive supports and services rather than medical treatment itself (in Krogh & Johnson, 2005). For example, in the metro Richmond area, PWD who apply for the Greater Richmond Transit Company (GRTC) para-transportation service Carevan, must submit a medical evaluation from a physician indicating that their disability prevents them from riding regular public transportation (ADAride.com). The acceptance and reliance of the biomedical model of disability has stunted acceptance of a social construction of disability.

Habermas's communicative action theory is also applicable to the way disability has been conceptualized within the medical field. This is especially noticeable when the historical context of Medicaid expansion is considered. Prior to Medicaid expansion in 1973, most PWD were reliant on segregated institutions and public charity (Master & Taniguchi, 1996). At this time, programs that pushed for the inclusion of PWD were essentially nonexistent, as care was not seen as an entitlement for PWD. At the time of Medicaid expansion, there was not a cohesive disability-rights movement but the Social Security Administration's (SSA) decision to include entitlement programs for PWD was born out of surveys from 1960, 1966, and 1972, detailing how PWD were poorer and had greater out-of-pocket expenses, higher burdens of illness, less private insurance, and more unmet needs (Master & Taniguchi, 1996). The political climate during Medicaid expansion is important because it reveals not only how disabilities were conceptualized but also the theoretical models used to address the amelioration of disparities in care.

Counsell and Agran (2012) describe how the model of Liberal Egalitarian Equity in the 1960s paved the way for programs like Head Start, Title 1, Bilingual Education Act of 1968, Education of All Handicapped Children's Act of 1975, and Special Olympics. They propose that the Liberal Egalitarian conception of distributive justice created programs to assist disadvantaged groups by giving them access to previously denied resources. However, the meritocracy ideal rooted in American culture continued to place emphasis on individual ability and effort. Once resources are equitably distributed, success or failure is entirely dependent on the individual. However, when disabilities are viewed within a deficit model, distribution of resources will not restore a disabled body to one without a disability. As previously discussed, inclusion of previously excluded populations can test and strain policy legitimacy and distributive justice

(Yeatman, 2000). This perpetuation of meritocracy ideals and a biomedical model of disability results in programs like Special Olympics, which ultimately encourage disability awareness without necessarily increasing inclusion. In fact, the personal trial of finding a knowledgeable and willing dentist to provide care for Rosemary Kennedy, the sister of Eunice Shriver, is what led to the inception of the Healthy Athletes initiative within Special Olympics (Waldman et al., 2009). Healthy Athletes offers Special Olympics athletes eye, ear, feet, and teeth exams on a voluntary basis with no charge. The dental part of the exam is called Special Smiles and comprises a dental exam, fabrication of mouth guard, oral health and nutrition education, and referrals to community dental providers (Bissar et al., 2010; Waldman et al., 2006). The Healthy Athletes program serves as an avenue to provide education and training to volunteer healthcare providers on the health needs and best practices for treating PWDs (Waldman et al., 2006). At face value, the Healthy Athletes program appears to meet a medical need of the community. However, it can also be viewed as a reinterpretation of institutionalized medical care, in which a captured audience is provided care rather than addressing how to increase community medical access and inclusion. Though an important leap forward at its inception, it can now be argued that Special Olympics may be more harmful for PWD.

In fact, Counsell and Agran (2012) argue that the segregationist model of Special Olympics perpetuates *handicapism* or the bias that someone's unequal or unjust state is warranted by their disability and that volunteer roles like "huggers" infantilize PWD. This process reveals how the medical deficit model can be expressed and perpetuated in social programs. Using communicative theory, Counsell and Agran (2012) discuss how the monetary and legal systems that sustain Special Olympics have colonized Special Olympics and prevented the organization from responding to contemporary lifeway conceptualizations of disability.

Despite the movement of disability rights toward a practice of community and social inclusion, Special Olympics continues to operate on a segregationist model.

A similar model can be applied to medical care of PWD. Like Special Olympics, Medicaid expansion occurred in response to the Civil Rights movement and operated on a distributive justice ideal. The role of Medicaid as a primary insurance for PWD is indicative of lifeway values that having a disability should not preclude one from accessing medical care. However, the restrictive nature of Medicaid coverage implies the limited societal participation expectations of PWD. The administrative and regulatory nature of Medicaid preauthorization and reimbursement support and maintain these lifeway values. Over time, the administrative policies and practices put in place to administer Medicaid care have created a self-perpetuating system that is restrictive and unyielding to changing perceptions of inclusion of PWD. As attitudes about PWD shift toward inclusion, the regulatory nature of Medicaid colonizes medical care and treatment of PWD away from emerging social models of disability as witnessed in vocational rehabilitation and special education.

The complexities of professional autonomy within a market system trickle down into patient care. As demonstrated in this literature review, care of PWD butt up against market viability in both the context of insurance profitability and professional market viability. The research methodology outlined in Chapter 3 seeks to connect the local setting of dental offices with the translocal context of state Medicaid and healthcare economics.

CHAPTER 3: Method of Approach

Research Question

How does dental professional autonomy in a market-based system affect provision of care for Medicaid patients with disabilities?

Research Design

This study employed a qualitative research methodology to investigate interoffice decisions and bureaucratic constraints that affect Medicaid program participation, access, and provision of care to patients with disabilities. A qualitative approach was chosen for this research based on the elusive nature of what factors define professional autonomy and contribute to decision making and an interest in the lived experiences of individuals working within those environments. A primary strength of qualitative methodology is its inductive approach or ability to focus on context, people, and language rather than on the numerical emphasis of quantitative analysis (Maxwell, 2005). Thus, a qualitative approach helped to elucidate the role of professional autonomy in the use and interpretation of federal, state, and office policies. This interpretation of policy became the crucial bridge between policy creation and implementation that directly affected the provision of care of PWD. If and how market factors affected decision making were more readily revealed from data collected through observation and conversation with individuals who shared their experiences in their own words, compared to what would have been gathered from statistical analysis of predetermined responses. As previously discussed, Medicaid participation is relatively inelastic to rate changes (Scheffler et al., 1996); an ethnographic qualitative analysis shed more light on economic or noneconomic factors that contributed to marginal costs or program satisfaction from a provider’s perspective. For example, the administrative difference between private insurance and Medicaid would not have revealed itself had I not been present to observe and talk to participants.

Furthermore, study participants may not be fully aware of how professional autonomy and market decisions drive and perpetuate provision of care decisions. Here, an institutional ethnography framework revealed how seemingly individual decisions are driven by institutional organizations and powers (Campbell & Gregor, 2004). I do not believe I would have arrived at the analysis and conclusions presented in Chapter 6 had I not used an institutional ethnography framework, as my analysis hinged on drawing the social relations that participants operated within but did not directly express to me. Institutional ethnography is designed as a means of understanding how people are subjected to regimes of power and how, in understanding these *ruling relations*, one can identify discrepancies between individual life experiences and administrative or categorizing systems (Smith, 2006). The social relations, ruling relations, and disjunctures I describe in Chapters 4 and 5 relied on my use of an institutional ethnography framework and lens for analysis.

Data Collection

The following sections detail unique aspects of data collection when conducting an institutional ethnography. Specifically, descriptions and explanations of my chosen standpoint and local settings are provided, as well as texts collected at first and second levels of data.

Standpoint. Rankin (2017a) discusses the need to adopt a standpoint when conducting institutional ethnography. By adopting a standpoint, I am identifying “where a group of people are positioned, within a complex regime of institutions and governance” (p. 2). From my chosen standpoint, I observed the work, tensions, and conflicts that arose for these individuals. It is this account of work that I analyzed for social construction and connections to ruling relations. It is important to stress that adopting a standpoint is not simply identifying a perspective. In fact, data collection and analysis included accounts of how other people within a regime are organized and interact with the chosen standpoint. The standpoint selected for this research study is that of dental professionals. This standpoint was selected because the heart of the study rests on understanding what policies encouraged or discouraged both Medicaid participation and provision of care for patients with disabilities. In Chapter 4, I detail how my chosen standpoint contributed to my final analysis and understanding of ruling relations that affect dental provision.

Local Setting. Because the goal was not to generalize findings to a larger population but to more deeply examine the ways that larger forces shape individual decision making, the research study is designed as a two-site ethnography and used criterion purposeful sampling to identify the appropriate sites for the research question. Inquiry into the problematic focused on dentist office staff; their actions; and the use of texts, such as new patient forms, insurance authorization requests, and billing documentation that make visible the disjunction described in Chapter 2. The research goal was to explicate experiences beyond a local setting and, because Medicaid covers two different levels of care for pediatric and adult patients, two observation sites were needed. The observation sites were a **pediatric dental provider** and an **adult general dental provider**. Both of these sites accepted Medicaid along with a variety of other insurance plans and had a high population of patients with disabilities. Observations and interviews at these locations constituted the first or entry-level data that focused on the local setting and the experiences of individuals who interacted in these settings. In addition, I interviewed one general dentist who was a **non-Medicaid provider** in order to compare and contrast the data collected at the local settings.

Accessibility and location were areas of interest based on the literature review identifying access to community-based providers as a barrier for PWD. Prior to deinstitutionalization, it was common practice for dentists to attend to patients in facilities. Now, finding and getting to dental providers willing to treat patients with disabilities can be difficult (Fisher, 2012; Norwood & Slayton, 2013; Waldman et al., 2009). Luckily, the observation sites were in geographically different locations. The **pediatric dental office** was located in a fast-growing suburban area west of the metro Richmond area. At the time of this observation, GRTC did not extend as far west as the location of this provider, and there are currently no known plans to expand. However, the location was accessible for specialized transportation, which expands past the typical bus route. The **general dental provider office** was located in an established area on the southern end of the metro Richmond area. The location of this particular office meant that it was accessible to patients who lived in the city and relied on public transportation[1] and easily accessible for residents from more affluent surrounding areas who used private transportation. However, this office would not have been easily accessible to patients who lived in the nearby county who did not have access to private transportation as the bus route does not extend into the county, and there is no county public transportation. Though I did not see the office location of the **non-Medicaid provider**, she reported that accessibility, public transportation, and proximity to other health and dental safety nets did not factor into her decision on where to set up her practice. See Figure 2 for a map of the GRTC system map.

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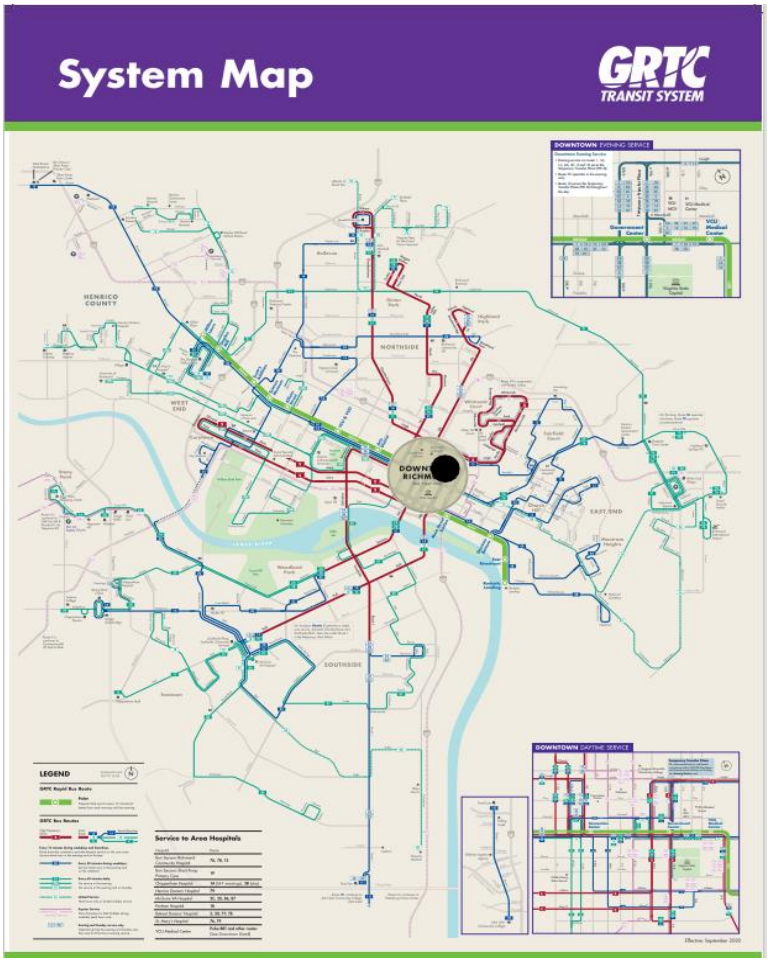
[1] I refrain from saying this location is easily accessible to city residents who rely on public transportation as the walk from the nearest bus stop is not pedestrian friendly. It lacks crosswalks across a major road and does not have sidewalks. The topography of the location could also present challenges to someone with a physical disability.

Figure 2

2 GRTC System Map



Access to the site was obtained through professional recommendations and formal requests. A brief proposal on the nature of the research and my process was developed for submission to prospective observation sites. Based on guidelines suggested in Bogdan and Biklen (2007) and in Patton (2015), the proposal addressed why the site was chosen, observation activities, any disruptions the office may experience, benefits to the observation site, and how the research findings will be reported (see Appendix A). I was exceedingly lucky in that the dental providers I contacted were eager to participate and did not have the hesitation I expected. In fact, one observation site said they wanted to know what I discovered so they could convince more dental providers to also accept Medicaid. Ultimately, one site was secured with the assistance of another researcher at VCU, and the other site was secured through professional contacts in my vocational rehabilitation work. The last non-Medicaid provider interview was secured through a personal connection.

During data collection, texts such as patient intake forms, patient forms, school notes, disclaimers, preauthorizations, and billing forms were collected for analysis. Because the goal was to identify how these texts perpetuated ruling relations, blank documents were collected. Any documents with patient information were redacted. To map social relations, data collection must expand beyond the local setting. Observations of contrasting insurance and patient interactions were essential for collecting level two data based on the institutional ethnography assumption that settings are organized and ruled in ways that are invisible to participants. Therefore, discussion of patient care was not limited to patients with disabilities using Medicaid as their primary insurance. To understand the role of Medicaid as a text, it was necessary to contrast Medicaid-based interactions with private insurance or cash-based interactions. At both observation sites, I observed and clarified differences via conversation with participants between Medicaid and private insurance patients, patients with disabilities and those without disabilities, and patients with disabilities using private insurance versus using Medicaid. Understanding this complex landscape of insurance coverage was key to understanding ruling relations and how they extend beyond the local setting.

Furthermore, data collection cannot be limited to the local setting to answer the question, “what are the connections across and beyond the boundaries of this setting and how are they enacted by actual people?” (Campbell & Gregor, 2004, p. 61). Therefore, I accessed publicly available events to further enmesh myself into the standpoint of dental providers. I attended a training entitled “Special Needs Dentistry—You Can Do It!” organized by Virginia Dental Association (VDA), Virginia Health Catalyst (then Virginia Oral Health Coalition), Virginia Department of Health (VDH), and Virginia Dental Association Foundation (VDAF) on January 26, 2019. I observed a public meeting of the Dental Advisory Committee (DAC) on May 17, 2019, where I listened to stakeholders from Department of Medical Assistance Services (DMAS), DentaQuest, VDA, and Virginia Health Catalyst provide updates and discuss Medicaid access and use in Virginia. I registered and attended sessions at the 2020 Virginia Oral Health Summit. Finally, I registered for the Adult Benefit Update webinar hosted by Virginia Health Catalyst, DMAS, and DentaQuest on February 3, 2021. Because these observations were not local settings with participants who had consented to participate in my study, I do not include any quotes from these observations unless it is information that is available for citation in webinars or presentations. These observations assisted with my final analysis by helping me draw connections between what I observed at the local setting and what information was being shared at the institutional level. Furthermore, research into Medicaid and relevant legislation provided level two data, or “the missing organizational details of how the setting works” (Campbell & Gregor, 2004, p. 60).

Observation. In institutional ethnography, data collection cannot be limited to surveys or researcher-generated questions as the hope is to understand the everyday life experience of participants. Beyond recording conversations and observations, I had to identify the way of talking that participants used to convey their expertise—for that is the template through which one demonstrates their understanding and belonging to an institution (Campbell & Gregor, 2004). Recognizing this language allowed me, as the researcher, to dig down to what is actually happening and what triggered those actions. For example, during my observations, I would stop and ask participants to explain terminology I was not familiar with. This was the case with *downgrading* or *downcoding* that I write extensively on in Chapter 4. Though the term *downcoding* has a communicative implication, it was a colloquial term with a specific definition to participants.

Based on best practices suggested in Bogdan and Biklen (2007), I gradually increased time in the field for each observation. This slow increase reduced disruption to the observation site, maintained discretion, and allowed myself to build rapport with participants. Time spent in the field did not exceed what can be noted or transcribed immediately following observation. Data continued to be collected until the problematic was made visible and I reached data saturation. For both locations, I started my observation at no more than 1 hour and extended it to 3 hours by the end of my time at each site. Between December 2018 and February 2019, I observed a total of 10 hours at the **pediatric dental office**. Between July 2019 to August 2019, I observed a total of 9 hours at the **general dental office**.

Participants. To capture a comprehensive representation of the dental offices, research participants included administrative staff as well as dentists and dental hygienists. All participants were approached in a private setting at the observation sites, where the research intent, benefits, and potential risks of participating were shared with them. All but one individual agreed to sign the informed consent form to participate in the study.

At the **pediatric dental office**, a total of nine individuals participated. They consisted of one dentist, one clinical lead, and seven administrative staff. Five of the nine participants were approached as key informants while on site. Three of these five conducted an additional interview with me. Some participants were observed in their work but their comments or actions are not included in my final analysis, so they will remain unnamed. The participants who contributed to the final analysis have been assigned the pseudonyms: **Dr. Calvin, Jessica, Gwen, Camilia,** and **Stella**. At the **general dental office**, seven individuals participated. They consisted of two doctors and five administrative staff. Five of the seven were approached as key informants on site, and three of these five conducted an additional interview with me. As this was a smaller practice than the pediatric office, all participants had either conversations or observations included in my analysis. They have been assigned the pseudonyms: **Dr. Andy, Dr. Grant, Tricia, Karlee, Danica, Alexis,** and **Katherine.** One **non-Medicaid provider** participated in an interview only for this study. This provider has been assigned the pseudonym **Dr. Karen**. Because of the small sample of my participants and the limited number of dental providers in the Richmond area that accept Medicaid, I have elected to not associate racial indicators with each participant to protect their confidentiality. I will, however, say that as an aggregate, my sample was overwhelming White. Out of the total 17 participants, only two were racial minorities.

All observations with participants took place in the natural setting, in this case, a dental office. Observations in a natural setting ensured that I was able to collect information and observe behavior within the research context. Because of the nature of the observation setting and lack of required credentials or education, I was on the observation end of the observer-participant spectrum. Though I did not participate in administrative tasks, despite offering, I was able to observe, take notes, and ask questions as participants went about their daily tasks. My observation was limited to the front desk area, and I did not observe clinical treatment. However, conversations and clinical notes about treatment were often discussed in the front office between dentists, hygienists, and administrative staff. In this manner, I was able to observe the flow of information and text through the offices. The pattern of my interaction was typically to observe from afar when participants were interacting with patients and to follow up with detailed questions when they did not have customer service duties. These detailed conversations took place with key informants on site.

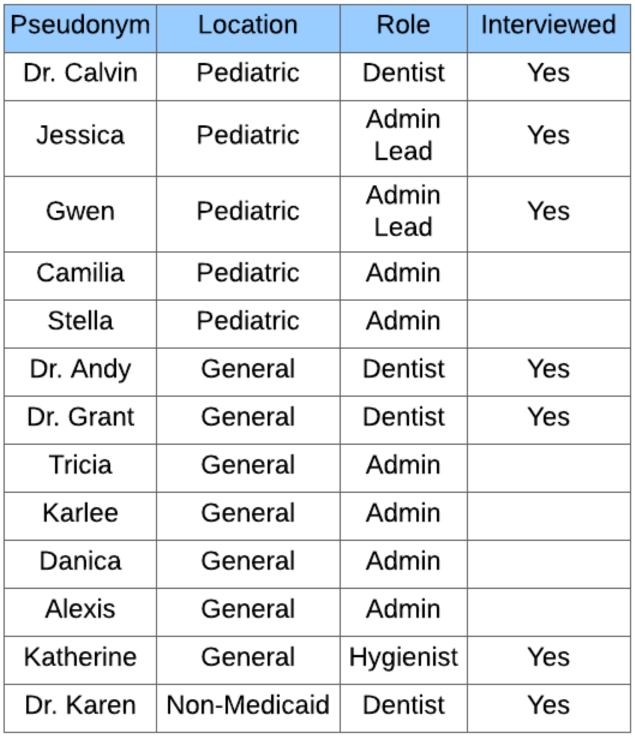
Interviews. A preliminary script was developed to approach key informants who were asked to provide insight into the social patterns and experiences that would otherwise be unavailable to me (see Appendix B). In accordance with institutional ethnography, participants at each site were interviewed primarily using an ethnographic interviewing or conversationalist approach. Key informants approached on site were engaged in conversation to explain office and administrative tasks. These information interviews were driven by what was observed on site. Emphasis was placed on understanding how one performs their work. To understand how decisions were made, justified, and recorded, it was required that I question their work and deconstruct the process. In addition, defining and avoiding jargon revealed institutional shortcuts that aided me in escaping institutional capture, a phenomenon where I as a researcher begin to be “swayed by the apparent rationalities of dominant forms of knowledge—that most often arise in a standpoint of ruling” (Rankin. 2017b, p. 2). When captured, one is less likely to understand how knowledge is generated or activated and how different forms of knowledge often interact in contradictory ways.

How language is used to interpret policy, including the written record of the interview, can be analyzed through a hermeneutic lens. The act of the interview itself creates a text that is to be interpreted (Patton, 2015). Therefore, interviews also used social constructionist interviewing and hermeneutic interviewing techniques. Social constructionist techniques acknowledge the context of each interview and my contribution to the production of knowledge, while hermeneutic techniques will clarify my interpretation of the participants' responses. To encompass all three approaches, the interviews were active so that meaning was constructed via interaction. This open active approach meant that instrumentation was informal, conversational interviews. As expected, I was able to interview participants in a way that naturally occurred during my observations. Because opportunities to discuss institutional procedures can arise serendipitously, I followed the advice of DeVault and McCoy (2006) and conceptualized interviews more as "talking to people." During these conversational interviews, I took copious notes and occasionally, with permission, audio recordings of our conversations for later transcription. I was not able to do this for all conversational interviews like when patient details were being discussed or when patients were present, such as when I sat with Tricia and observed her assist a patient.

If it was determined that a key informant was able to provide a deeper level of understanding or insight into professional autonomy, office policies, or policy implementations, they were approached to conduct a more extensive interview off site. General question topics were created for consistency between participants (see Appendix C). To maintain participant confidentiality and validity, participants were given the option to hold interviews and discussions in private or off site. All participants approached for an interview conducted it either after office hours or at a location off site. Consideration for a participant's comfort was important to minimize the chance that participants will simply repeat formal office policies or narratives beholden to office politics and power structures. Though the general question topics were followed as a guide for consistency, some participants skipped questions that were outside their purview or focused their responses on certain topics of their interest. Often, responses to a question would generate follow-up questions, or onsite observations were fleshed out in more detail during these interviews. However, data collected from key informants was analyzed with the knowledge that overreliance on these data can result in biased perspectives (Patton, 2015). With participant permission, interviews were audio recorded for later transcription. The following table of key informants provides participant pseudonym, role, location and whether or not that participant participated in a semi-structured interview.

Table 1

Key Informants



Pseudonym	Location	Role	Interviewed
Dr. Calvin	Pediatric	Dentist	Yes
Jessica	Pediatric	Admin Lead	Yes
Gwen	Pediatric	Admin Lead	Yes
Camilia	Pediatric	Admin	
Stella	Pediatric	Admin	
Dr. Andy	General	Dentist	Yes
Dr. Grant	General	Dentist	Yes
Tricia	General	Admin	
Karlee	General	Admin	
Danica	General	Admin	
Alexis	General	Admin	
Katherine	General	Hygienist	Yes
Dr. Karen	Non-Medicaid	Dentist	Yes

Ethical Review

Because this research study focused on the institutional organization of dental practices and did not require the interaction or collection of data from a vulnerable population, the research study was approved as Expedited Review according to 45 CFR 46.110 and Categories 6 and 7 (see Appendix D).

The problematic of this study focused on organizational factors that affect provision of care. Therefore, access to specific patient documents and information were not required. However, since I did observe the discussion of patient care, ethical considerations were made in the collection and reporting of data. Participants were assigned aliases to protect their anonymity, and observation sites are simply referred to as **pediatric dental office** or **general dental office**. Participant aliases were used in lieu of names during data collection to mitigate potential problems with unauthorized access to field notes, which to my knowledge, did not occur.

Any unique identifying features of either the location or participants were not reported. Because dental providers accepting Medicaid in the Richmond and surrounding areas are easily researchable online, I chose not to provide participant information beyond an alias that implies gender or gender identity. Not identifying the observational site protects patient and staff confidentiality and mitigated any potential legal risk assessment that may arise in sharing billing processes. Furthermore, I obtained a Certificate of Confidentiality (CoC) (see Appendix E) to protect the identity of my research participants. To obtain documents demonstrating insurance pre-authorization and billing practices, there were a few occasions in which I collected patients' documents. However, all patient information was redacted by office staff before I was allowed to leave the premises with it. All hardcopies of collected data or identifying documents were stored in a locked safe, to which only I had access. All interview transcripts, memos, and notes were stored on my secure VCU Google Drive.

To obtain a full picture of the observation site, observations and discussions took place not only with dentists but also with their support staff. Participant anonymity was not only an ethical responsibility but also a requirement for an accurate analysis. Anonymity between participants was also important so that participants may feel more comfortable openly discussing their opinions or frustrations. An administrative assistant will not share his or her feelings about a time they disagreed with another employee or dentist if it is possible that information could be relayed back to that individual. Therefore, the importance of confidentiality was discussed with all participants during the data collection process. However, I found that there was little disagreement between my interview participants in overall themes. Frequently, one participant would suggest I interview another participant to glean more detail into specific questions or observations. Regardless, it is still my hope that this expression increased participant confidence and that data collection was not influenced. Existing power relations in the office were taken into account, but all participant experiences were equally considered, analyzed, and used to further inquiry.

Data Analysis

The following section details how my data analysis evolved when using an institutional ethnography approach.

From Ethnography to Explication

Analysis began and continued throughout the data collection phase. Often data analysis began with blank text collected and analyzed in the field. Texts in particular are important because texts coordinate a participant's experience (Deveau, 2009). Unlike other ethnographic analyses that seek to analyze how individualized experience can be generalized, institutional ethnography analysis aims to explicate the social relations particular to a setting (Campbell & Gregor, 2004). Texts and the analysis of texts and their use shed light on their role in controlling or perpetuating ruling relations.

The analysis of interviews, conversations, observations, and texts began with an initial coding to construct how participants observed and described their work. Coding and categorization of codes followed analytic memoing, as described in Charmaz (2006) and Saldana (2016). This analytic memoing was key in helping me identify my own presumptions, focusing on what stood out to me the most prior to reviewing notes and transcripts, and recognizing the institution in which I was captured. I go further into detail about my own institutional capture in Chapter 4. Special attention was paid to in vivo codes generated by a participant's language and special terms as related to the work they perform. For example, *personal responsibility, time,* and *downcoding* were all in vivo codes generated from conversations and interviews with participants. NVivo software was used to organize field notes and index codes and to facilitate analysis. See Appendix F for my codebook exported from NVivo.

In institutional ethnography, analysis is not limited to the themes generated by people in their lived experiences; it expands from the local setting to the translocal setting to identify how institutional powers and social relations create the experiences described in the first level analysis. Indeed, I found that my analysis process using an institutional ethnography framework differed from previous qualitative studies I had conducted. Like previous studies, I used NVivo to facilitate my initial coding by indexing codes and assigning text, but my analysis process differed when I reached what would have been second cycle coding. Rather than synthesizing my codes into categories—as would have been the goal with focused, axial, or theoretical coding (Saldana, 2016)—I organized my codes around their relationships with one another. When did codes draw relationships to insurance providers, office staff, patients, or (as I was surprised to see so prominently in my data) employers? By focusing on relationships between codes, I was able to start to see the ways in which social relations were organized. As expected, analysis at the first or local level revealed higher ruling relations at the second or translocal level, and texts served as the linking clue. A primary example of this was the two-way street created by preauthorizations from insurance companies to dental providers approving treatment plans and the billing codes used by dental providers to communicate what treatment was provided to insurance companies. Both of these texts used alphanumeric codes to represent treatment services and a lexicon that is difficult for most laypeople to translate. For example, how much sense does a typical explanation of benefits (EOB) make to most people? These recorded experiences of my participants informed what additional research I conducted, such as the public observation of advocacy committees, webinars, and conferences and the reading of Medicaid member books, ADA-produced literature and legislative agendas, and state bill proposals.

The goal of this initial analysis was to identify patterns in participant experience at the local setting and connect them to larger social relations. For example, Mary Otto (2017) describes how oral healthcare has become separated from medical care, and ailments related to oral healthcare are seen as the result of poor personal hygiene or prevention as opposed to the inevitability of illness or disease. In institutional ethnography, the second level analysis would seek to understand the ways in which medical and dental education, insurances, provider networks, and patient actions create and perpetuate the concept that a patient alone is culpable for poor oral health. This linking of micro experiences to macro institutions is the unique analysis approach of institutional ethnography.

This kind of analysis uses what informants know and what they are observed doing for the analytic purpose of identifying, tracing, and describing the social relations that extend beyond the boundaries of any one informant’s experience. “An institutional ethnography must therefore include research into these elements of social organization that connect the local setting and the local experiences to sites outside the experimental setting" (Campbell & Gregor, 2004, p. 90).

As expected, secondary analysis led to further investigation of Medicaid organization at the state level, but it did not extend to the federal level as I had surmised it might. What it unexpectedly also led to was further investigation into dental insurance practice, which extended to the national level. Concept mapping was used to illustrate the connections between the local setting and organizational structure (see Chapter 4).

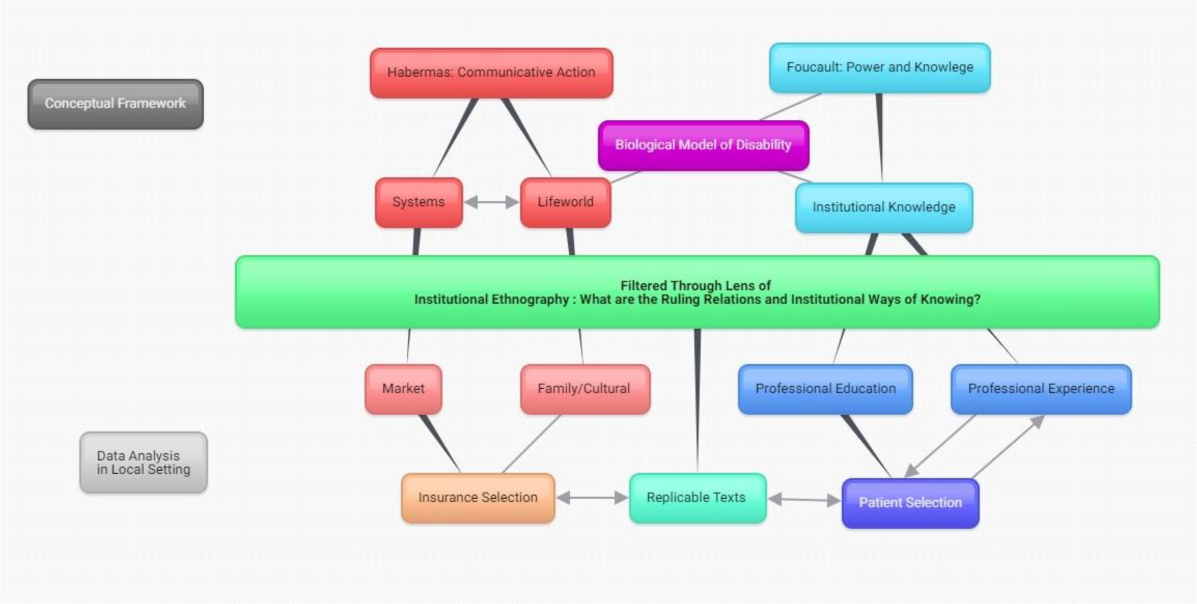
Prior to beginning my analysis, I created a list of *a priori* codes that included concepts such as treating *care as a commodity*, *pricing care*, and *identifying patients*. However, my analysis did not develop as expected and my deductive codes gave way to inductive codes. For example, I had conceptualized *care as a commodity* as times when participants discuss or reduce care to a monetary value. What inductive coding revealed was that opaque managed care plans were less likely to make providers see care as a commodity because their reimbursement varied from patient to patient depending on their agreed fee schedule with an insurance company. Rather, it was providers themselves who were commodified by patients; providers became interchangeable units within a patient's insurance network. Though *pricing care* had been conceptualized as fee negotiation and setting, my observation revealed that this was an area in which dental providers had little to no professional autonomy, and this code morphed into *economic power*. Finally, *identifying patients* had been conceptualized as provider acceptance of new patients and identifying patients with disabilities. Returning to the evolution of *care as a commodity*, it became evident during my analysis that this concept was better represented by two separate codes: *patient selection through insurance* and *provider selection through insurance*. This new conception recognized the power exchange between dental providers and patients within an agreed to social relation.

These inductive codes connected the work performed by staff to the theoretical concepts of professional autonomy and market factors. As expected, codes specific to Medicaid providers developed during the data collection and analysis process. What was unexpected was how much time I would spend combing through and analyzing data related to private insurance. Upon entering my research, I expected that I would not be able to tell the story of dental healthcare for patients with disabilities without also telling the story of Medicaid. What became evident very quickly into my observation was that I could not tell the story of Medicaid without also telling the story of private insurance.

My conceptual framework further informed my data analysis by connecting how replicable texts used by dental staff were connected to theoretical concepts like power and knowledge, Habermas's communicative action, and conceptualization of disabilities. Identifying ruling relations made it possible for me to connect institutional ways of thinking to the day-to-day experiences of dental professionals. For example, how professional knowledge of fluoride treatment was filtered through insurance as an institution to dictate treatment. Furthermore, these connections to institutional power allowed me to recognize the importance of *bureaucracy* as a theme when it came to how work was recorded and redefined by institutional powers. See Figure 3 for a visual representation of how institutional ethnography was used as a filter to analyze and connect data from the local setting to institutions within the conceptual framework.

Figure 3

3 Concept Map of Data Collection Within Conceptual Framework



Reflexivity

Because qualitative research is interpretive research, it is important for me, as the key instrument, to acknowledge pre-existing biases, personal background, and values that may influence data interpretation (Charmaz, 2006; Creswell, 2009; Maxwell 2005). Though I do not have personal experience in the dental profession, I do have preconceived notions regarding health access and quality of care as a disability advocate in vocational rehabilitation and transition research. My professional experience has exposed me to the difficulties PWD have in accessing and receiving dental care for reasons ranging from lack of transportation to inability to find a Medicaid provider, especially if the person in question is an adult. I knew this experience and the frustration and trauma of individuals I worked with would be carried with me into my research.

When engaging in data collection, I memoed my reactions to observations and contrasted it with my own professional experience. Memoing helped me identify a few aspects of my own personal experience that could have biased my analysis. First, I realized that my familiarity with PWD and a span of disabilities was rather unique. For example, it became very apparent at the dental training I attended for second level data collection that interaction with PWD happened few and far between for most of the other participants in the training. During data collection, I sought negative cases and actively pursued narratives that did not affirm my pre-existing prejudices. However, this was achieved primarily during my interviews with key informants, mostly because it had been built into my interview tool. When at the observation sites, I did not always actively pursue negative cases because I was focused more on simply understanding the work that was happening around me. After I completed all data collection and immersed myself in analysis, I also took the time to memo my thoughts on where my initial analysis was heading and how it related to my preconceived notions heading into this research. In Chapter 4, I detail how analysis from the standpoint of dental providers required an epistemological shift for me and how my inexperience in dental care was a benefit when doing this.

Validity

I employed a number of strategies to help reduce threats to validity, which included reflexive memoing, identification of preconceived notions, and collection of rich data (including negative cases). In addition to the collection of rich data, triangulation of data collection was achieved by conducting interviews, observations, and document review. However, triangulation alone is not sufficient to increase validity (Maxwell, 2005). Therefore, I conducted regular analytical memoing as a reflexive exercise throughout the data collection and analysis process. Respondent validation was also conducted regularly during data collection to confirm that researcher interpretations were not limited to confirming world-view narratives. My goal was to achieve validation naturally during the interview process by asking participants if my interpretations of responses were accurate. This style allowed for a fluid validation process that provided further opportunities for additional discussion. Often discussion of past or present legislation arose from such respondent validations. Furthermore, respondent validation was frequently used to define jargon. This was how I learned the definitions of predeterminations, preauthorizations, downcoding, recalls, and roles and responsibilities among dentists, hygienists, and assistants.

Limitations

Potential limitations of this study are that this research was conducted as a two-site ethnography. Though I did include one non-Medicaid provider as an interview participant, it is important to note that the results of my study should not be generalized to all dental providers. Other Medicaid providers may have reasons or methods of participating other than what my participants shared, and similarly, other non-Medicaid providers may have other reasons for not participating than what my participant shared. Furthermore, the context of this study is highly dependent on the legislative landscape of Virginia. Other states may have even more limiting Medicaid coverage or comprehensive coverage, and the experience of providers in those states will be very different from what is reported here.

As an ethnography, there is also the potential overreliance on key informants. Though I had multiple key informants in a variety of positions at each site, their influence in their positions could also shape the office culture, and I may have missed additional insights others could have provided. However, I will say that the experiences expressed by my key informants never conflicted in any substantial way, even across sites. In addition, there is always the risk that participants will provide socially acceptable responses, even when confidentiality is expressed.

However, responses and observations led me to address in Chapter 6 a need to include cultural competency and implicit bias training to dental professionals and their staff. Therefore, I do not believe that participants only stated socially acceptable responses to my questions.

I have already addressed the need to recognize the context of this study occurring in Richmond, Virginia. Initially, I was concerned that Medicaid participation would be influenced by proximity to Medical College of Virginia (MCV) and the dental school, as MCV's role in providing care to area individuals in need could decrease local participation. Originally, my assumption was that Medicaid practitioners in the Richmond area were unique when compared to Medicaid practitioners in other areas; perhaps they felt a calling to serve this population more strongly than others. However, I do not believe this was the case for my participants as none said it influenced their decision to participate, and one site actually frequently received patient referrals from the school. This does not, however, mean that other participants in the area do not assume that low income or patients with disabilities will be served by MCV or other local nonprofits and other federally qualified health centers (FQHC) like Daily Planet. These dental providers may feel that there are sufficient or better safety nets for Medicaid patients or patients with significant disabilities. However, I must acknowledge that accessing dental healthcare in an urban environment like Richmond may be substantially different compared to more rural areas. Therefore, the geographic context of this study is also a limiting factor.

Finally, the timing of my study places my analysis in a very specific context that may or may not be relevant into the near future. Beginning in late 2017, Virginia began to offer limited dental services to adults who are dually eligible for Medicaid and Medicare through their new Commonwealth Coordinated Care Plus (CCC+) program (DMAS, 2017). My research study took place primarily in 2018 and 2019 and what I was able to capture was a shaky and uncoordinated rollout that left many providers and patients confused about coverage and how to participate in CCC+. Though I did not find the landscape of Medicaid participation tremendously altered based on observation and interviews, there is a new change on the horizon that could have a resounding impact on Medicaid participation in Virginia: Adult comprehensive benefits (Virginia Health Catalyst, 2021).

CHAPTER 4: Social Relations and Ruling Relations

In this chapter, I will discuss how my chosen standpoint influenced my analysis and helped me avoid institutional capture. From this standpoint, I was able to map social relations of dental providers, identify the main actors and texts involved in social relations, and describe the ruling relations that dictate patient care.

Standpoint

When embarking on an institutional ethnography, the goal is to discover and reveal how individual action at a local setting is linked to coordinating activities beyond the physical location. Unlike many other qualitative methodologies, emphasis is placed on the *how* rather than the *why*. For example, how is it that people's actions are coordinated from afar and often invisibly to themselves (Rankin, 2017a)? To complete such an analysis, it was imperative that I adopt a standpoint in my research and that I stay grounded in that standpoint throughout my data collection and analysis. As discussed in my methodology, I elected the standpoint of dental professionals to understand how they were encouraged or discouraged from accepting Medicaid and how they provided care for patients with disabilities. Furthermore, by selecting dental professionals as my standpoint, I was anchoring my analysis in their work, their activities, and their interests—and ultimately prioritizing their experiences.

Choosing this standpoint was an epistemological shift for me, as I have no personal background or experience in dentistry or dental care. I do, however, have professional experience in transition and employment services for young adults with disabilities. By adopting the standpoint of dental professionals, I had to divest myself of my own preconceived notions, as I was all too aware of the dental access issues that plague PWD and especially those who rely on Medicaid. Prior to beginning my research, my interest was in discovering what constraints prevented dental providers from providing care to PWD, as my perspective was hinged on a social model of disability where the deficit lies not within the individual but in social constraints that bar full participation (Oliver & Barnes, 1998).

In my own professional training, I have been taught a social model of conceptualizing disabilities, and my professional work involves training educators and employers how to incorporate this model into their own practices. However, dental providers have not been taught to view disabilities within a social model but rather within a biomedical model, as outlined in Chapter 2. To adequately highlight the experiences of dental providers and their staff, I could not let my own attitudes eclipse the process of gathering and analyzing their empirical data. Here, the act of "talking" during repeated observations and interviews allowed me to build a rapport and empathetic bond with participants. This was crucial because, over time, I shifted from seeing lack of care as something dental providers *did* to PWD to something that was *dictated* to them by institutional forces.

Within the context of dental providers' offices, the social model of disability had little meaning because this form of knowledge is not present in its language or social relations. In fact, the institutional language I had to familiarize myself with was not only limited to dental or insurance terms but also in new ways of contextualizing disabilities. No longer were they PWD or patients with disabilities, they were special healthcare needs (SHCN)[2] patients. Unlike the social model where the person is prioritized over the disability, here the medical needs and disability are linguistically placed first to emphasize its importance. Requiring a new term for the

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[2] In Chapters 1 through 3, I refer to people with disabilities as either PWD or patients with disabilities. From this point on, I will switch to the nomenclature familiar to my participants and used in the context of their work, SHCN patients, when describing or analyzing their work.

same population is a textual example of how I had entered a new social relation with its own institutional language, ruling relations, and communicative action. By aligning with dental providers, I was shifting my epistemological understanding and acknowledging that dental providers and their staff were the experts of their own experiences and knowledge. Furthermore, a benefit of immersing myself in a novel standpoint was that it helped me avoid institutional capture as I unlearned my preconceived notions and, as I will discuss later, helped me identify how I had entered this research institutionally captured. This realization opened up an analysis that had previously been hidden from me.

Observations, conversations, and interviews allowed me to analyze what Smith (1987) describes as the "two modes of knowing" (p. 82) of standpoint informants: The knowledge gleaned from work in a physical location and the abstraction of knowledge that occurs beyond the physical or local setting. This knowledge is to be "examined for its social construction and its embedded contradictions" (Rankin, 2017a). By doing so, I was able to construct a map of the social relations of dental providers.

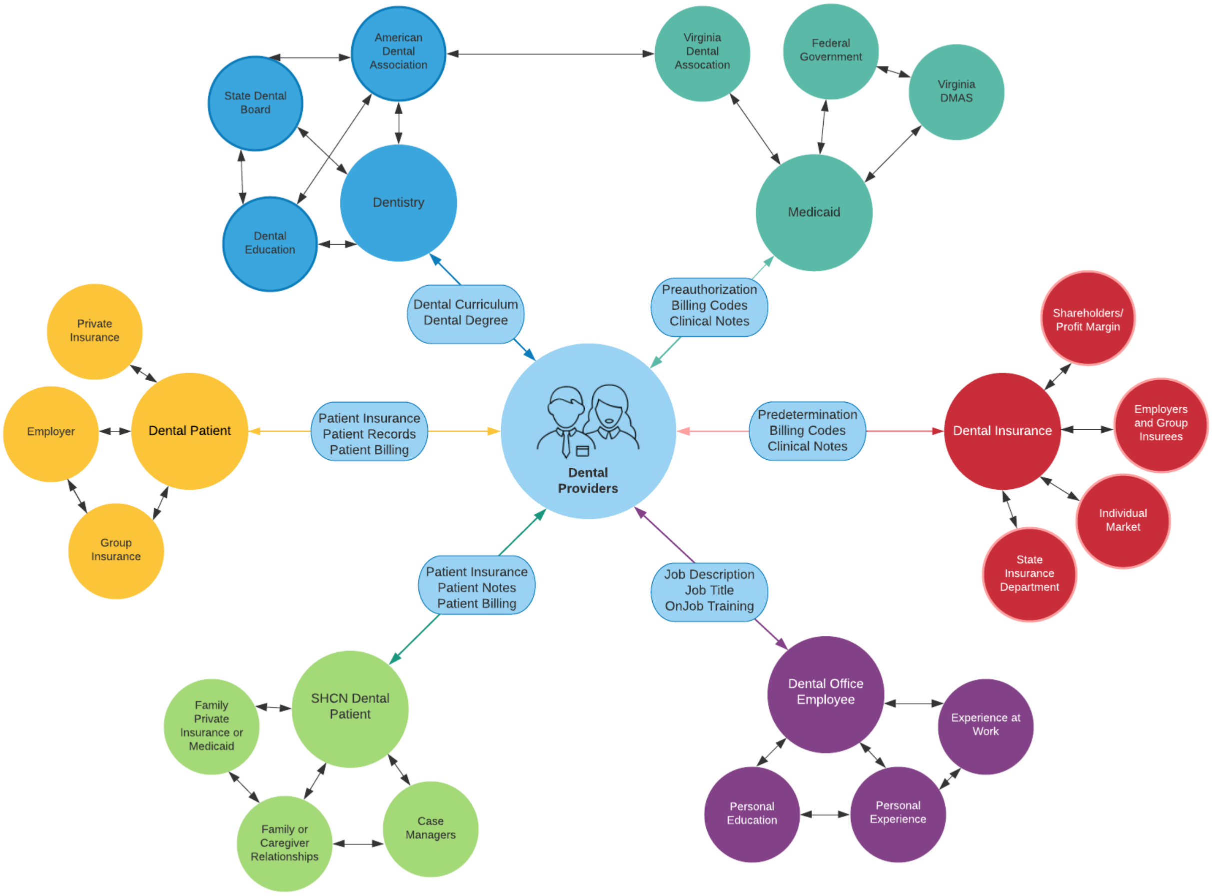
Social Relations of Dental Providers

Social relations in institutional ethnography have a very particular meaning. It is not to be confused with social relationships wherein parties interact with each other in one context. Rather, it has a deeper connotation in that it is the concerted actions of individuals that "activate a social world of things happening among people" (Rankin, 2017a, p. 3). Social relations are the actions and practices that organize people's lives into social organizations and often happen invisibly to the individuals acting them out. Campbell and Gregor (2004) give the example of a bus driver and a student passenger. The interaction of a student showing the bus driver a university bus pass is an example of an observable segment of a social relation that extends to before and after their meeting (p. 31). In this example, the social relation connects the university student to the transit employee, and it can be extended on one end to the student enrollment and accounting system, and on the other end to the transit company and its employee practices.

The goal of an institutional ethnography is to make visible the social relations that connect a local setting to the institutions that operate beyond it. This can be done because social relations are empirical and can be described ethnographically (Rankin, 2017a). Identifying these social relations is important because it is through everyday actions that people enter a social relation and their activities become coordinated into social organizations, often without their knowledge. Figure 4 provides a visual representation of the social relations of dental providers that I deduced through interviews and observation at the local setting.

Figure 4

4 Social Relations of Dental Providers



At the center of the image are dental providers, specifically the trained and licensed dentists who operate their own dental practice. Each line extending from the center is a representation of a social relation in which both parties interact voluntarily, but whose actions become coordinated purposefully. To demonstrate how the social relation extends past interactions at a dental office, the line continues past the actor to other pieces of the social relation beyond them that coordinate their action. An example analysis of a social relation depicted will explain how work at the local setting is coordinated from beyond its physical location. However, before proceeding, it is important to understand how work is coordinated from afar through the use of texts.

Role of Texts

In institutional ethnography, texts are vital to understanding how ruling relations are activated by people at the local setting (Rankin, 2017a, p. 3). It is through texts that hierarchical powers govern and replicate horizontally, and they are what bind a local setting to larger institutions beyond its physical boundaries. In Figure 4, the texts used to coordinate actions within each social relation are identified in the blue ovals. For example, a dental patient will activate the social relation by interacting with a dental provider through the use of texts such as insurance documents, patient medical records, and billing information. These texts in turn abstract the patient into an objective account of billable services, health facts, and payment information—devoid of the nuances of interpersonal communication. The interaction between the patient and dental provider transcends from the physical or experimental way of knowing to an ideological way of knowing. The ability to have two simultaneous interactions, one grounded in physical interaction and one recorded in text-mediated communication, is what allows an actor at a standpoint to have “two modes of knowing” (Smith, 1987, p. 82).

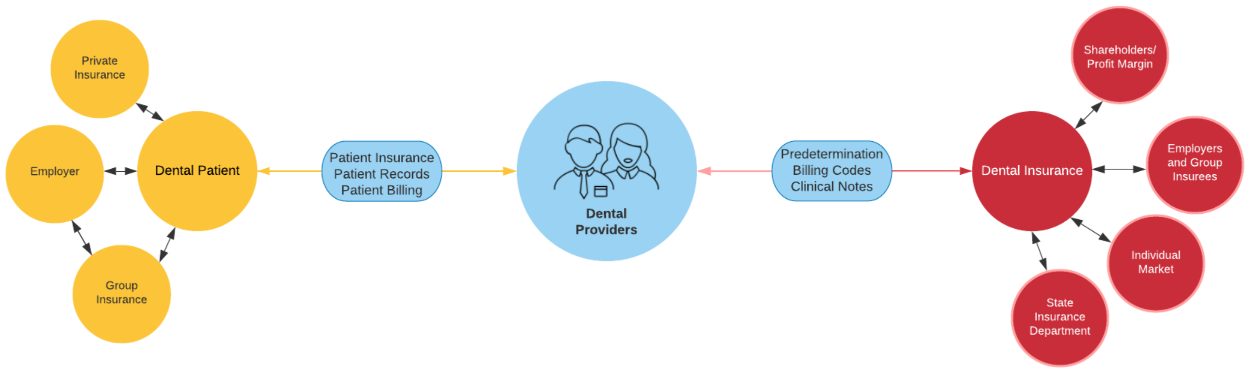
Coordination of Social Relations

For an in-depth analysis of a social relation existing at the location of dental providers, let’s use the first social relation that most people would think of for a dental office: the dental patient–dental provider relation. An everyday activity that may initiate this social relation would be a new patient calling a dental provider to inquire if they are accepting patients and if they accept a specific dental insurance. Just asking about accepted insurances activates the social relations and, though this occurs at the local setting, it begins elsewhere—perhaps where the patient works and what medical benefits their employment confers. Note that the arrows in

Figure 5 extend past the patient to their employer and insurance, and that the two are connected to one another as well.

Figure 5

5 Dental Patient–Dental Provider–Dental Insurance



When I first began data collection, one of the texts I collected from each site was blank copies of patient forms. Initially, these documents did not prompt any particular awareness of social relations or coordinated action. I was aware of how these texts abstracted a person to lists of current or past ailment, allergies, and medications, but it was not until I was updating my own personal records for my dentist that I realized how these texts extended beyond my dental visit to other nonmedical aspects of my life. I thought it interesting that my dentist needed my employer’s contact information, and a review of the documents I collected from my observation sites also showed that employer information was collected for responsible parties. Though I had assumptions, I was not sure why employer information was collected. Luckily, I was able to pose this question during my interview with Dr. Karen, as the answer proved incorrect my assumption that it was a way to track down payment. My question initially surprised Dr. Karen, and she had to think about why employer information was collected on her forms. After a moment she recalled that it…

> has to do with insurance. I think it has to do with the insurance company; it's a way for my front desk person to know when they go onto the website to figure out which insurance company they have. I think in the software, it'll record how many patients you have that come from that company so if you have a lot you can go market more to that company. That feature is built into the software I use, 'this patient works at Capital One, and here are all the other patients from Capital One.' And if it's a good insurance policy, I know I want more patients who work there.

This description of both the work of her front desk person, and her marketing plan demonstrates how this social relation actually begins with the patient's employer. By selecting a particular insurance option for their employees, the business has coordinated the patient's actions—their first step in seeking out dental care is to identify in-network providers who accept their insurance. Furthermore, the collection of employer information by Dr. Karen coordinates her future marketing efforts; her positive or negative experience with a particular insurance plan will drive her to market toward or avoid particular patients.

The social relation does not end, however, with the dental provider; it continues to extend past the local setting of the dental provider's office to other institutions activated by the textual interaction between patient and provider. Let's assume the patient chooses to move forward with a dental appointment with this provider. Once it is determined that their particular insurance is accepted, further texts are activated. The office administrator will record basic demographic information and contact information and collect an account of why this patient wants to be treated and any other pertinent health information the patient decides to share. Using the insurance and demographic information collected, the dental provider will now verify insurance coverage and request predetermination from the insurance company to provide dental care. In this example, the social relation extends to the insurance company that will now review the patient's insurance policy and remaining benefits for the year and authorize or deny care as prescribed by the dentist. Now the dentist's actions are coordinated from afar by way of activating insurance-related texts.

The social relations that run through a dental office as observed from the standpoint, are not limited to the straight pathways depicted in Figure 5. For example, some of the texts activated by the patient include Health Insurance Portability and Accountability Act (HIPAA) documents and medical release documents that are not mandated by insurance companies but rather by other institutional bodies. Dr. Karen shared that for her,

> insurance didn't influence forms at all. Forms that I have are the forms that are required by the board or guidelines like HIPAA. Only influence from insurance is on medical history and demographic forms. For those, there is a line they sign which allows us to file with insurance.

In this example, the institutional organizations that coordinate Dr. Karen's actions are the same institutions that grant her the professional legitimacy and authority to practice dentistry.

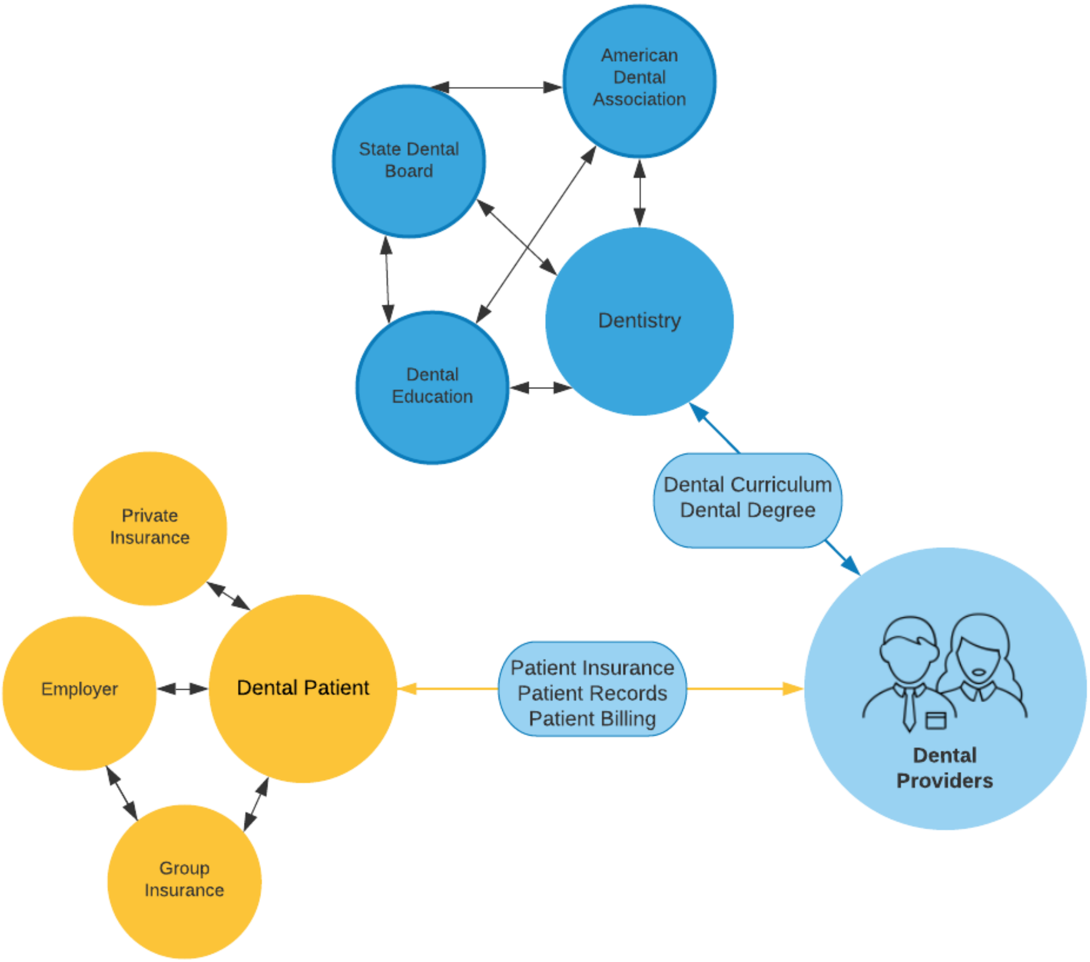
In a roundabout way, Gwen from Dr. Calvin's office also confirmed that these same institutional organizations coordinated updates to their office forms…

> based on change in people. Back when we started, parents just brought them to the office and left and didn't ask questions. Now we have to cover behinds more—yes, more litigiousness. People are a lot more picky than they used to be, have to explain more. Change of the times.

In this case, though new patient forms were geared more toward keeping liability down, the ultimate goal was still to maintain good standing as a dental provider in the eyes of licensing boards. Figure 6 depicts the social relation between dental providers and dentistry.

Figure 6

6 Dental Patient–Dental Provider–Dentistry Relation



Recognizing social relations is necessary because it is through social relations that ruling relations are transmitted. The ability of social relations to extend beyond the boundaries of a local setting makes it an appropriate conduit for relaying messages across sites, messages with the capacity to rule. Messages that convey priorities and interests that are not those of any individual at the standpoint corrupts the social relation into a ruling relation. The rest of this chapter contains an analysis of the ruling relations that systematically moves the interests at the local setting away from dental providers and patients to those that rule—the insurance companies. How this ruling relation affects and distorts the other social relations depicted in Figure 4 will be addressed in Chapters 5 and 6.

Ruling Relations

Prior to beginning my data collection, my assumption was that market factors—capitalism and profit—were a primary contributor to the lack of access to oral healthcare for patients with disabilities. Specifically, the reality is that care of patients with disabilities is expensive and often not lucrative. My preliminary research and interviews to identify the problematic, as described in Chapter 2, did not contradict this assumption. What these interviews also hinted at, but that I was not prepared to understand fully at the time, was the sheer dominance of insurance in oral healthcare. I recall being struck by a statement from one of the dentists I initially interviewed, “insurance doesn’t care about the patient.” As my data collection and analysis progressed, I went back to that quote over and over again in my head. What was implied in the statement that became abundantly clear is that, true, insurance does not care about the patient, but it does decide what kind of care a patient gets.

Insurance: Customers and Capital

Even though I had chosen the standpoint of a dental office and not the office of an insurance provider, insurance by far had the largest presence in my data. Nearly every conversation I had or observed at the dental offices, whether between employees or between employees and patients, revolved around insurance. Even though I did not observe patient treatment, what I did observe was that every dental visit began and ended at the front desk, and dental insurance was involved in nearly every interaction.

As detailed in Chapter 2, insurance was initially a solution to address the affordability of healthcare and to elevate healthcare as a profession above the market (Stone, 1997). However, the addition of a third-party payer created a dilemma. If people were no longer responsible for paying for healthcare, they were more likely to use services than someone who had to pay out of pocket, and healthcare providers could more easily raise rates without angering patients. A solution of insurance companies to address the increased cost of healthcare came with the advent of fee schedules (Bodenheimer & Grumbach, 2012). By entering into a managed care plan with dental insurances, dental providers are agreeing to provide care at a contractually reduced fee or fee schedule. This agreement removes much of the marketing and cost adjustment power from dental providers as individual office fees become irrelevant to potential patients and raising fees will not change the contractual agreement between providers and insurance carriers (Willis, 2013). Provider participation in managed care plans becomes one of the determining factors in a patient's choices of where to seek services.

By controlling the flow of potential patients, insurance companies have forced dental providers to engage and activate the social relation that organizationally links dental providers and patients to insurance companies. Dr. Karen shared her viewpoint on why dentists participate in insurance plans:

> When you start your own business, you need your own patients, can't just start with fee for service, not taking any insurance. When you work with insurance, it allows patients to look up who takes their insurance and after they review your resume and [web]page, they might call you. That is why you sign up with insurance companies...you can't compete with insurance. People work for a company and get insurance, and they will go to where

> their insurance is taken. You can have the most dedicated patients, but they will leave you if you don’t take their insurance.

Similarly, Dr. Calvin shared that when he started his practice 33 years ago, he “took anything [insurance] that people had.” Though he continues to try to be as inclusive as possible when it comes to insurance participation, he is now more selective and participates in insurance plans “as long as they are fair to both us and the patients.” As he describes it, *fair* would be a fee schedule that covers his practice’s costs, provides adequate coverage to his patients, and does not create difficulties for his administrative staff. Gwen from Dr. Calvin’s office shared that the process of becoming an approved provider under an insurance plan is a “long, long, long process” overall, but it starts with requesting a fee schedule to see what the participating fee is. Proposed fees will vary slightly between insurance plans as will the agreed percentage of coverage for specific procedures.

Typically, dental insurance fees are regionally based on established usual, customary, and reasonable (UCR) fees (Willis, 2013). Though the term *UCR* is defined as “being the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service” (Healthcare.gov, n.d.), the reality is that the reliance on insurance UCR fees creates a circular logic where dental providers starting a business will use UCR fees as the basis for their practice’s out-of-pocket fees, thereby allowing insurance companies to set the regional fees for a geographic area. Dental providers are forced to do this because asking other dentists to share their fees is potentially illegal under price fixing, and patients may receive a notification from their insurance company if a procedural fee exceeds the carrier’s UCR fee schedule (Willis, 2013). As an example of this opaqueness, Jessica at Dr. Calvin’s office shared that it was only when they joined a dental network, Central VA Dental

Care (CVDC), that they “realized the fee schedules we were getting paid on were a lot less than some of the other practices in CVDC, so we started negotiating a little bit better.”

UCR fees, as communicated from the insurance carrier to the dental provider, are a text that controls the actions of dental providers from afar, and not in their best interest. These circumstances have trapped dental providers and created such inequities between insurance carriers and dental providers that Senate bill S.350 and House of Representatives bill 1418 Competitive Health Insurance Reform Act of 2019 and 2020 seek to partially repeal the McCarran-Ferguson Act of 1945 to apply federal antitrust laws against health insurance companies. In the final months of writing my dissertation, H.R. 1418 passed and became Public Law 116-327, The Competitive Health Insurance Reform Act of 2020[3].

Contractual managed care plans and fee schedules are vital to the perpetuation of social relations and ruling relations that govern dental care. The expectation of coverage by virtue of being in-network is the means by which people are hooked into activating their dental insurance to find a dental provider. Dental providers are hooked into the “social relations of the economy and of ruling institutions” (Smith 1987, 2005, p. 40) because insurance companies control both the flow of patients and the monetary reimbursement. However, because the economic control of UCR fees is solely in the hands of insurance carriers, the economic autonomy of dental providers is significantly reduced and constrained by managed care contracts; office fees contribute little to a provider’s bottom line. For example, at Dr. Calvin’s office, sedation is a service not covered by most insurance plans, and the office fee is $273. However, there are a few plans from Anthem Insurance that cover sedation but only pay $80. Because $80 is paid from the insurance

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[3] Though Competitive Health Insurance Reform Act of 2020 is the bill that was ultimately passed, I included Competitive Health Insurance Reform Act of 2019 in my description because this was the version and bill I was made aware of during my observation.

company, Dr. Calvin's office has to write off the remaining $193 even though the contractual amount is significantly less. Furthermore, Dr. Calvin also bemoaned the fact that the costs of running a business and paying his staff rises each year, but contracted fees with insurance companies rarely change, and by very small percentages when they do. By engaging in a social relation with insurance companies, dental providers and dental care are exposed to the vicissitudes of capitalism.

> Capitalism creates a wholly new terrain of social relations external to the local terrain and the particularities of personally mediated economic and social relations. It creates an extralocal medium action constituted by a market process in which a multiplicity of anonymous buyers and sellers interrelate and by an expanding area of political activity (Smith, 1987, p. 55).

Insurance: "Not in the Business of Paying Claims"

Medical insurance was meant to address the rising unaffordability of healthcare that developed in the United States as a means of ensuring that medical professionals were paid. By design, it sought to place medical care beyond the boundaries of capitalism in that healthcare could be distributed based on need and not on ability to pay through shared risk or community rating (Bodenheimer & Grumbach, 2012). However, the creation and eventual dominance of profit-driven insurance companies has dragged care into the capitalist arena.

Initially, with community rating, all members of varying risk levels pay a premium with the expectation that they will receive care in excess of their premium should they fall ill. The premiums of the healthy individuals pay for the expenses of the sick. However, the rise of commercial insurance companies using experience rating to offer lower premiums to low-risk consumers meant that traditional insurance companies could no longer attract enough members to cover expenses. The result was that insurance companies that once used community rating adjusted to experience rating to attract low-risk, healthy consumers to offset the expenses of healthcare that was paid out for ill consumers. This is a far less distributive concept that left high-risk members with either exorbitantly expensive health insurance premiums or the inability to obtain health insurance at all (Bodenheimer & Grumbach, 2012). Though Section 1201 of the Patient Protection and Affordable Care Act (2010) (ACA) now prevents insurance companies from denying coverage to individuals with pre-existing conditions, the difficulty PWD had in accessing insurance coverage contributed to the creation of Medicaid (Bodenheimer & Grumbach, 2012). In a way, Medicaid was fulfilling the original intent of insurance, but only for those that could not afford private insurance, the chronically ill, and the most expensive members—making it an exceptionally expensive program. The divergence between private and government-funded insurance further illustrates how the social organization of patients, providers, and insurances benefit insurance carriers the most. Insurance companies are not responsible for the cost of care of SHCN patients, and their pool of relatively low-risk members maintains profitability. The social relation between dental providers, SHCN patients, and Medicaid will be further analyzed in Chapter 5, but to understand how the economic concerns of insurance act as ruling relations over dental providers, which in turn affect care for SHCN, it is necessary to continue to analyze the ways in which this ruling is mediated by texts.

Besides fee schedules, as described in the previous section, the other way insurance companies can regulate their healthcare expenditures is through the control of allowable procedures. Based on the presumed legitimacy of the managed care contract, insurance companies can dictate to dental providers what type of care they are willing to reimburse.

“All insurance companies are in the business of selling insurance—of collecting premiums—not in the business of paying claims." During my observations, nothing underscored this statement from Dr. Calvin more than the insurance practice of downcoding[4], known more formally as the least expensive alternative treatment (LEAT) clause (ADA CDBP, 2007).

Many dental insurances carry a clause that states when there are multiple treatment options for a specific condition, the plan will pay for the least expensive option. This is openly described as a *cost containment measure* by carriers with the justification that LEAT clauses maintain dental coverage affordability and are not meant to dictate treatment (ADA CDBP, 2007). However, patients willingly activate the social relation with an insurance carrier and dental provider on the expectation that most of their care will be covered and with little or no knowledge of the LEAT clause. Though the cost difference is paid by the patient should they elect the more expensive treatment, it still places the burden of education on the dental provider and could potentially sour their relationship with the patient, which is made all the more precarious by the fact that managed care plans have already commodified the dental provider in the eyes of the patient. Though dental offices may have different fees or contractual agreements for the same procedure, these differences are not obvious to an insurance member who will likely view all in-network providers similarly when it comes to price point; to a patient, dental providers are interchangeable. In fact, texts communicating fee for services are absent from the patient-provider social relation initiation process because they have been replaced by insurance benefit packages, insurance EOB, and dental billing documents. Furthermore, insurance carriers do not typically disclose their downcoding policies during the contract negotiation process, further obscuring information from the patient and provider (ADA CDBP, n.d.)

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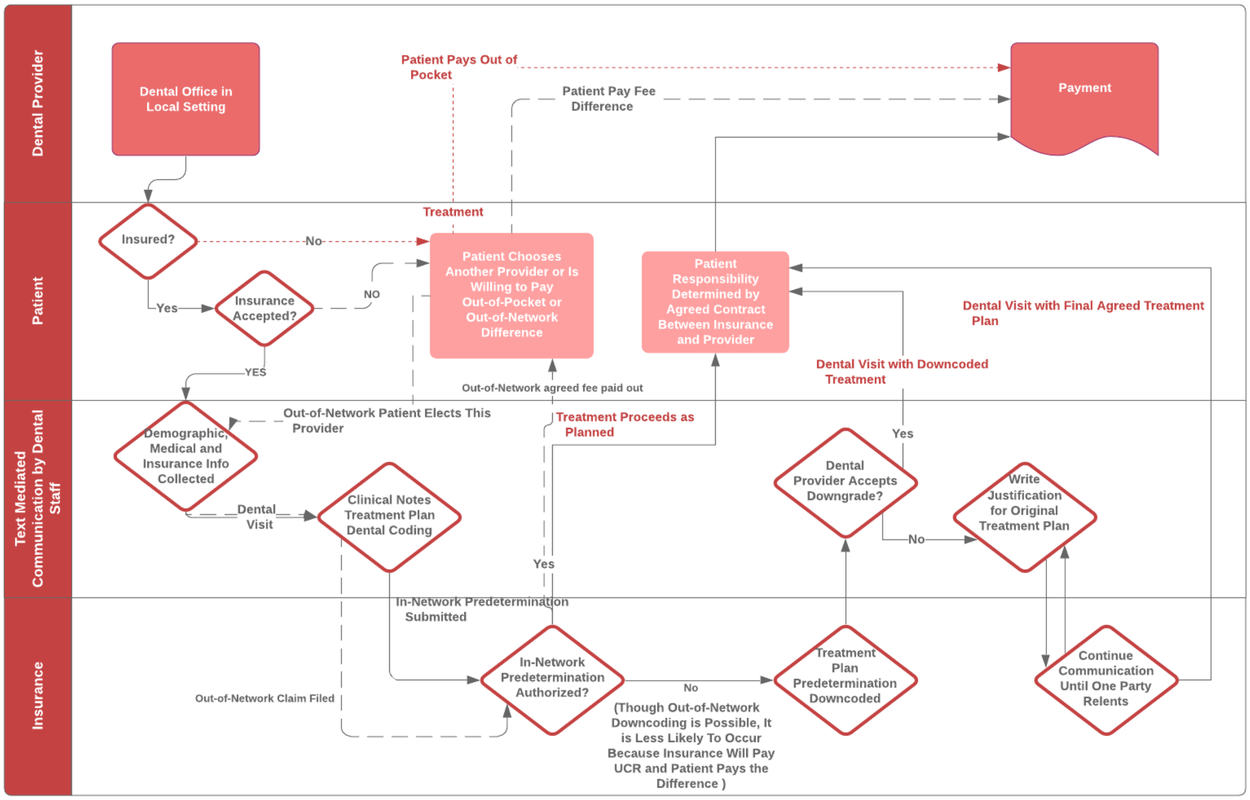
[4] For the remainder of this paper, I will use the more colloquial term *downcode* over *least expensive alternative treatment* because each dentist I observed and interviewed used the former terminology.

The most common downcodes are when composite (white) fillings are downcoded to amalgams (silver) or when crowns are downcoded to large fillings (ADA CDBP, 2007), which often may feel like an aesthetic choice to the patient. However, there were times when the dental providers I observed disagreed with the downcode on the basis of quality treatment. Sometimes these examples revolve around implants versus dentures or appropriate diagnostic x-rays. Jessica at the pediatric office described many situations where the doctors would be frustrated because they felt that the insurance decision was made in the absence of actually examining and talking to the patient and family. In these situations, downcoding places the burden on the dental provider to justify their chosen treatment plan to the patient and assert their expertise over the algorithm or insurance-employed reviewers. The dentists I observed were not alone in believing that downcoding negatively affected quality of treatment and care. The ADA has identified the practice of downcoding as intrusive and described it as a practice that denies “patients their purchased benefits and robs them of their right as informed consumers of healthcare” (The Committee on Dental Benefit Programs, 2017, p. 46).

The process of downcoding is an example of how insurance companies use texts to exert ruling relations and control the work and provider-patient interaction at the local setting. Figure 7 depicts the process of how a plan for dental treatment is transformed into textual communication and how insurance companies use that text mediated form of communication to transmit their institutional powers to the local setting. As described earlier in this chapter, texts are activated to collect insurance carrier information and basic demographics prior to an initial dental visit. After that visit, once the patient and dental provider have engaged with one another at the local setting, their interaction is transformed into texts, which begins the process of text-mediated ruling relations.

Figure 7

7 Ruling Relation: Downcoding



Institutional ethnography elucidates the ways in which knowledge and ruling are objectified when work moves from “knowing in the first hand to knowing in text-mediated ways” (Campbell & Gregor, 2004, p. 36). Predetermined organizational categories and language are used to describe a patient and situation in a context designed to facilitate coordination. In the case of oral healthcare, these predetermined categories are presented as billing codes and clinical notes (see Figure 8). Dental care is stripped and reduced to a series of billable lines, represented by a series of letters and numbers, from which insurance analysts scaffold and reconstruct an exam between patient and dental staff with help only from clinical notes. What this process allows for is the reinterpretation of a dental interaction that is bare except for silent procedural interaction. It is comparable to expecting that someone reading a scene in a scripted play would be able to imagine the sounds and smell of a theater, the art direction, the costumes, the actors' performances, and the audience engagement. Though a reader may have an image in their head, it likely deviates from the actual production.

Figure 8

8 Most Used Billing Codes

Fee Schedule **2018**

Last Revised: 7/24/2018

Exam

Diagnostic

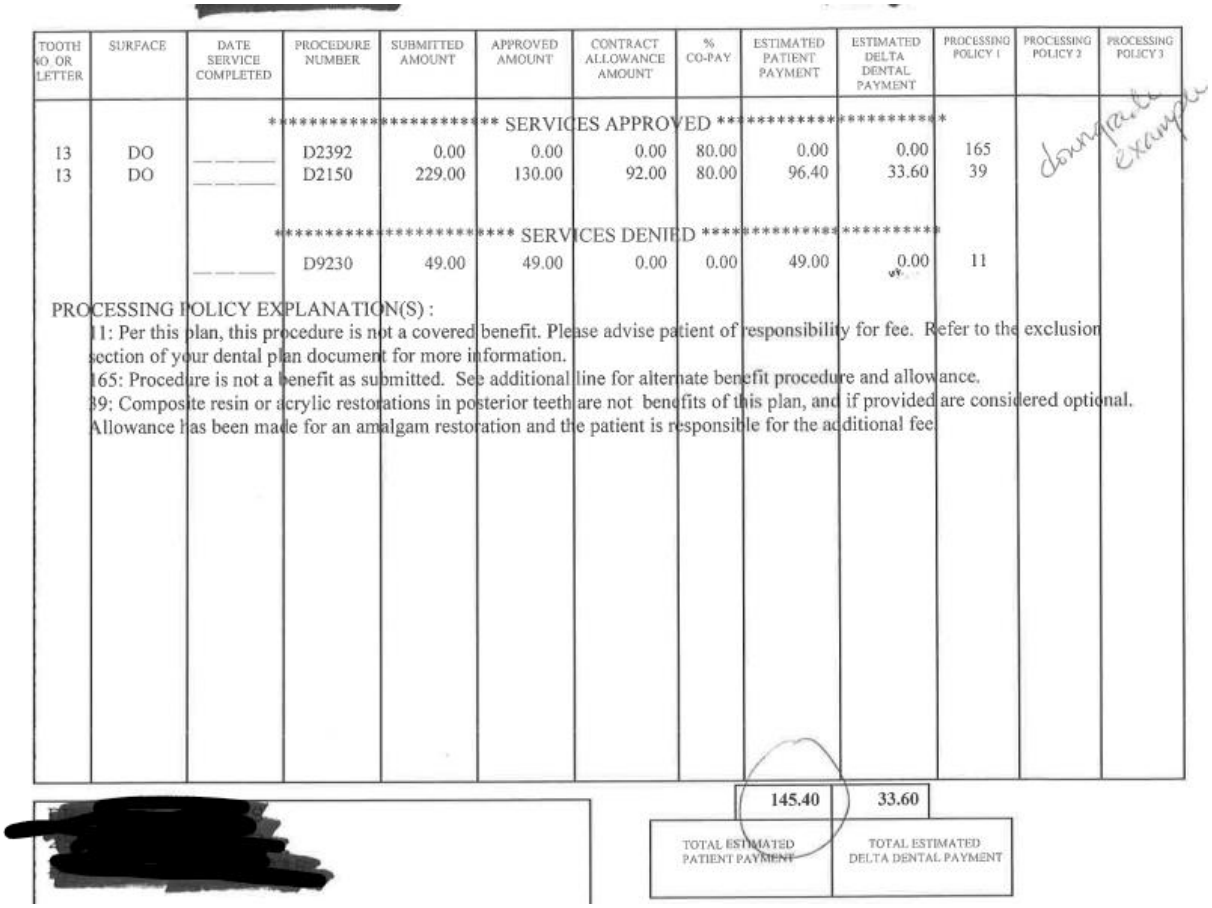
[illegible]

Code	Description	Fee
D0120	Exam	53
D0140	Emerg/Consult Exam	78
D0150	Comprehensive Exam	90
D0170	Re-Eval Exam	69
D0171	Re-Eval Post Op	0
D9310	Consultation Per-Session	184
D9440	*After Hours Office Visit*	*173*
D9110	Pallative (Emergency)	78
D1351	Sealant	57
D9920	Behavior Management	132
D0270	BW (1)	25
D0272	BWS(2)	48
D0274	BWS (4)	67
D0220	PA (1)	30
D0330	Panorex	119
D1120	Child Prophy	70
D1110	Adult Prophy	94
D1206- D1208	Fluoride/Varnish	42
D9998	Fluoride Test	31
D9630	Omni Take Home Flu	33
D4341	Scaling/Quad	267
D4355	Gross Debridement (Cavitron)	184
D2930	SSC (Stainless Steel Crown)	284
D2933	SSC w/ Facing	304
D2931	SSC Permanent	328
D2390	Strip Crown	444
D2920	Recement Crown	111
D2330	1 Surface - Anterior	163
D2331	2 Surface - Anterior	203
D2332	3 Surface - Anterior	249
D2335	4 Surface - Anterior	307
D2391	1 Surface - Posterior	178
D2392	2 Surface - Posterior	229
D2393	3 Surface - Posterior	294
D2394	4 Surface - Posterior	341
D2940	*Sedative Filling*	*122*
D3220	Pulpotomy	198
D3230/40	Pulpectomy Ant/Post	254/330
D7510	Incise & Drain	217
D3120	Indirect Pulp Cap	90
D7140	Extraction	178
D7280	Surgical Access (Unerr.Tooth)	438
D7286	Biopsy (Soft Tissue)	429
D7960	Frenectomy	513
D7971	Excision Pericoronal Ging/Arch	271
D9248	Oral Sedation	273
D9230	N2O	49
D9420	OR Doctor Fee	438
D8220	Habit Appliance (Fixed)	540
D1515	Space Maintainer (Man or Max)	489
D6985	Kiddie Partial	593
D1510	Band & Loop	349
D9940	Occlusal Guards	630
D9972	Bleaching Tray Per Arch	513
D1550	Recement Appliance	87
D7997	Remove Appliance	52
D7270	Comp Splint	526
D9941	Athletic Mouth Guard	309
D2921	Reattachment of tooth fragment	202
D9220	*GA --15mins/ IM Meds Dr.Chris*	*175*

Yet, this form of sterilized and objectified text is reviewed and analyzed by the insurance company. Without firsthand knowledge of the patient-provider interaction, a decision is made at the institutional level whether the treatment plan proposed by the dental provider is appropriate. As outlined in Figure 7, a follow-up treatment plan prescribed by the dental provider can be predetermined or authorized by an insurance carrier or it can be denied or downcoded. If the treatment is predetermined, the provider can proceed with the prescribed treatment such as restorative work like a filling. If it is denied or downcoded, the dental provider and patient can agree to the new treatment plan or original plan with increased out-of-pocket expenses for the patient. The following image, Figure 9, gives an example of a downcode and denial. The procedural code D2392 for a composite posterior filling is downcoded to an alternative treatment. Furthermore, the disparity between the office charge of $229 and the contracted amount of $130 is made all the more glaring when it becomes obvious that the patient is still responsible for 80 percent of that agreed fee and, in the end, insurance will pay only $33.60 for the filling. The denial of D9230 (nitrous oxide) is because it is not a covered benefit of the plan. Yet, it begs the question of when would nitrous oxide be covered if not for a pediatric patient as is the case here in Figure 9?

Figure 9

9 Predetermination: Downcode



[redacted]

TOOTH NO. OR LETTER	SURFACE	DATE SERVICE COMPLETED	PROCEDURE NUMBER	SUBMITTED AMOUNT	APPROVED AMOUNT	CONTRACT ALLOWANCE AMOUNT	% CO-PAY	ESTIMATED PATIENT PAYMENT	ESTIMATED DELTA DENTAL PAYMENT	PROCESSING POLICY 1	PROCESSING POLICY 2	PROCESSING POLICY 3
			********************** SERVICES APPROVED **********************									
13	DO	———	D2392	0.00	0.00	0.00	80.00	0.00	0.00	165	downgrade	example
13	DO	———	D2150	229.00	130.00	92.00	80.00	96.40	33.60	39		
			********************** SERVICES DENIED **********************									
		———	D9230	49.00	49.00	0.00	0.00	49.00	0.00	11		

PROCESSING POLICY EXPLANATION(S) :
11: Per this plan, this procedure is not a covered benefit. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.
165: Procedure is not a benefit as submitted. See additional line for alternate benefit procedure and allowance.
39: Composite resin or acrylic restorations in posterior teeth are not benefits of this plan, and if provided are considered optional. Allowance has been made for an amalgam restoration and the patient is responsible for the additional fee.

[redacted]

145.40	33.60
TOTAL ESTIMATED PATIENT PAYMENT	TOTAL ESTIMATED DELTA DENTAL PAYMENT

If the dental provider did not agree with the predetermination, I observed administrative staff add information to clinical notes and resubmit the predetermination letter or call the insurance company to argue specific points.

Using downcoding, the pathway in Figure 7 is an attempt to map out the ways in which patient care is coordinated from afar by insurance companies. Though the dental provider and patient are the ones to initiate and activate this social relation, they conduct the least amount of text mediated *work*. Rather, the majority of the *work* occurs between dental administrative staff and insurance carriers. The actual dental care provided to the patient is minimized compared to the time administrative staff prepare an objectified and textualized description of the patient and their time in order to communicate dental care to the insurance carrier in exchange for reimbursement. Figure 7 also depicts a pathway for how out-of-network patients might receive care and how the impact of text mediated communication has a lesser impact on their treatment plan. The inclusion of out-of-network patients is intended to compare and contrast how much insurance carriers can coordinate care based on activation of contracted managed care agreements. Chapters 5 and 6 will address the implications of the out-of-network pathway in more detail.

Colonization of Institutional Knowledge

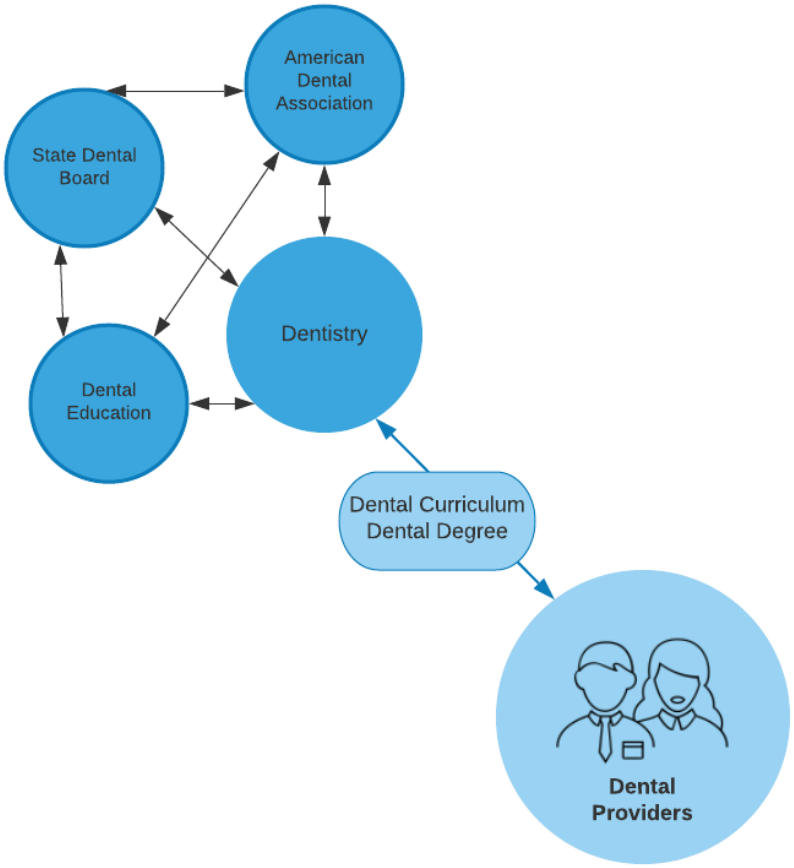
The role of texts in activating social relations and coordinating action from beyond the local setting has been demonstrated using insurance plans and medical coding. However, a deeper analysis of these social relations reveals an additional role of texts and how texts are responsible for the production and reproduction of the ideological apparatus that governs dental providers' work. Smith (1987) describes how society's image of oneself is created through "the specialized work of people in universities and schools, in television, radio and newspapers, in advertising agencies, in book publishing and other organizations forming the 'ideological apparatuses' of society" (p. 17). These ideologies form the backbone of social organization by legitimizing modes of thinking. Here, Smith's concept of text-mediated communication can be scaffolded onto Foucault's conceptualization of discourse. Foucault (1976/2003) describes *truth* as being "produced within discourses that, in themselves, are neither true nor false" (p. 307), but their power holds because they are part of a "productive network that runs through the whole social body" (p. 307). Both argue that concepts of truth are socially constructed, but whereas

Foucault describes the power dyads that govern knowledge, Smith supplies a means for knowledge translation—the replicable role of texts to communicate ideology from afar.

Dentistry, as an institution, governs dental care through the production of dental education and guidelines for the dental profession. A dentist is not legitimate or afforded any professional autonomy without demonstrating knowledge and ability through a combination of education and licensing. For example, Virginia provides two pathways to licensure through either examination or credentials (Virginia Department of Health Professions, 2020). Dental education is passed down through a power dyad to dental providers through texts in the form of textbooks, lectures, and exams. Even hands-on examinations to demonstrate skill are abstracted into exams with passing or failing marks. Dental education is part of the ideological apparatus Smith describes and the text that connects the social relation of dental providers to the practice of dentistry, dental education, and licensing, as depicted in Figure 10.

Figure 10

10 Dentistry–Dental Provider Social Relation

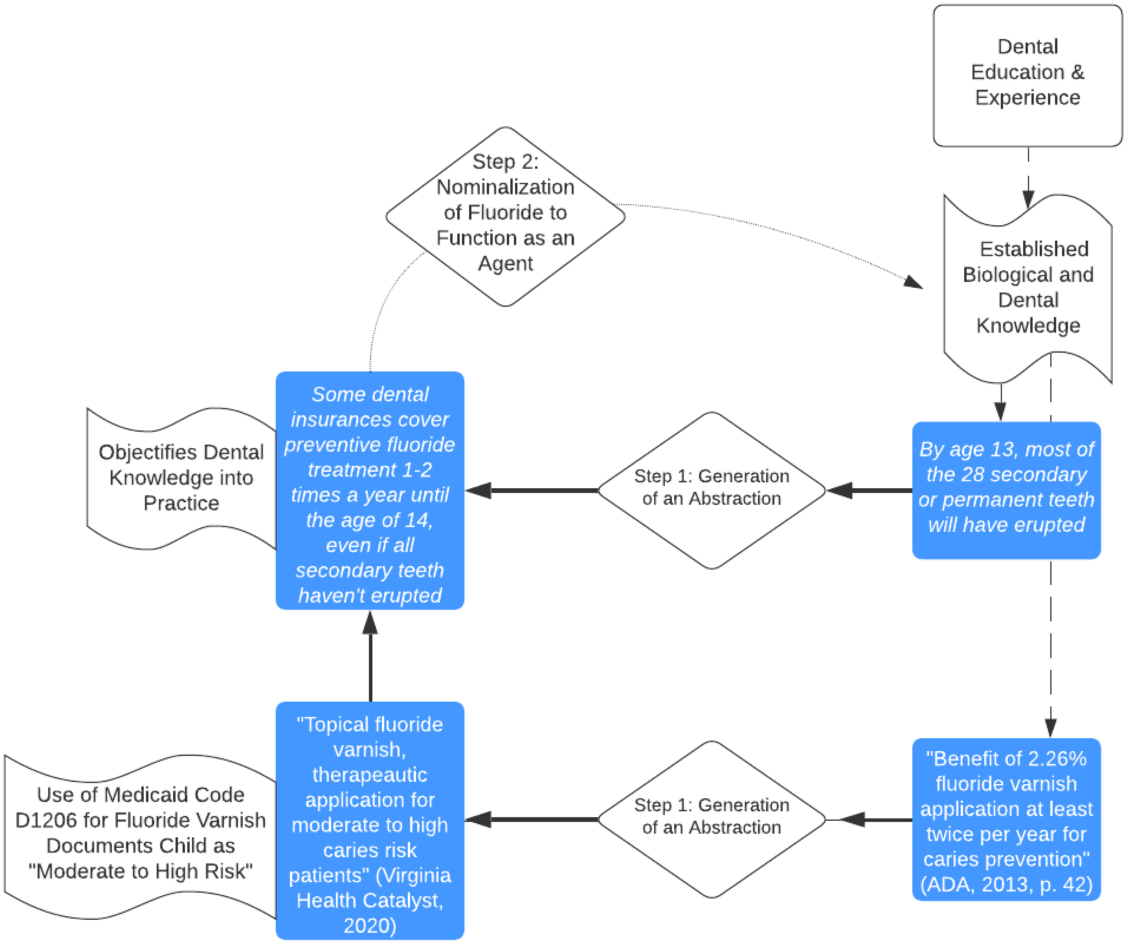


Furthermore, institutional ethnography offers a means to understand how Habermas's Communicative Action Theory functions in dentistry and dental care. Analysis of text-mediated communication makes apparent how institutional knowledge and professional autonomy based on Foucault's concept of power and knowledge are not only limited by resource allocation as hypothesized in Chapter 2 but also colonized through Habermas's communicative action theory by way of textual ideology.

Habermas describes two distinct spheres of social life—the lifeworld and system—each with their own distinct rules and institutions. Respectively, they are home of communicative and rational instrumental action. However, for the rational action of the system to be accepted by agents, it is dependent on and based on communicative action in the lifeworld (Finlayson, 2005). Colonization of the lifeworld occurs when the rational action in systems, once based on communicative action, begins to encroach and subsume the functions of the lifeworld. The result is that systems become uncoupled from the lifeworld and are no longer attached to validity claims that generate the social, marketless lifeworld (Habermas, 1987). The act of colonization can be observed in how texts become the tool to objectify and reduce institutional knowledge into instrumental reasonings. Smith's recipe for making ideology in which an abstraction is generated from an established fact and then made to be an expression of that fact (in Deveau, 2008) can be thought of as a method by which texts become the tools of colonization. For example, Figure 11 demonstrates how the system, specifically insurance, used text-mediated ideology to dictate care. The instance in Figure 11 uses the example of fluoride treatment described to me by staff at Dr. Calvin's pediatric dental office.

Figure 11

11 Text-Mediated Ideology



The ideological circle in Figure 11 starts with dental education, established institutional knowledge based in the lifeworld. Two facts from dental education: that most secondary teeth erupt by age 13 (ADADC, 2006) and that there is a benefit of a 2.26% fluoride varnish application at least twice a year to prevent caries (ADA EBD Center, 2013) are generated into an abstraction, and this knowledge takes on a new expression when reconstituted in the text of the insurance system. The universal benefit of fluoride is repurposed so that the billing code for fluoride varnish (D1206) documents patients who receive a fluoride varnish as "moderate to high caries risk patients" (Virginia Health Catalyst, 2020). In addition, the norm that all secondary teeth erupt by age 13 becomes the rule, and any individual who falls outside this rule is aberrant. When these two abstracted versions of knowledge are combined, the instrumental reasoning of the system determines that fluoride varnish treatments may only be needed once a year because not all children are moderate to high risk, and furthermore, that fluoride treatments after the age of 14 will not be covered, even if all secondary teeth have not erupted. Here, insurance texts have colonized or uncoupled institutional knowledge from the lifeworld that originally created it, and the insurance text converted that knowledge into a ruling relation. Ruling relations rely on "selecting, categorizing, and/or objectifying aspects of the social world in order to develop facts and knowledge upon which to base decisions" (Rankin, 2017a, p. 3).

Though dental providers recognize the limitations of the care they are able to provide based on an individual's insurance coverage, their hand is forced by the system that controls both monetary resources and patient expectation of coverage. Care beyond the confines of insurance coverage is preferable, but patients may balk at the idea of paying out of pocket for this care. The creation of text-mediated ideology is the key to explaining how insurance companies have come to rule over the type of care provided to patients. If you recall the example of downcoding described earlier in this chapter, you can see how the system has abstracted and nominalized institutional knowledge to dictate care as a means of minimizing expenses. To the system, which operates on profit and cost-effectiveness rather than well-being, the least expensive alternative is preferable, and by uncoupling institutional knowledge from the lifeworld, the system's preference for economic conservativeness will outweigh the moral and social consensus of the lifeworld.

Furthermore, colonization through text-mediated ideology is another way of understanding how disabilities can exist simultaneously in two vastly different conceptualizations. As introduced in Chapter 2 and discussed at the beginning of Chapter 4, disabilities have historically been conceptualized through the biomedical model. Despite societal changes and many professions, such as education and vocational rehabilitation, moving toward a social model of disability, the biomedical model persists primarily through function. Access to services couched in a social model requires medical diagnosis of a disability. This is the abstraction, classification, and measurement of bodies that Foucault (1963/1973) called the medical gaze. Use of the medical gaze to control access to services reinforces the dominance of disability over the individual and perpetuates an assumption of deficiency, meaning even services based on a social model are reliant on a diagnosis based on a biomedical model.

The existence of the social model of disability could be viewed as an example of communicative action within Habermas's lifeworld. Habermas believes actions are coordinated through language and speech, and commitments to justify actions are described as validity claims that hold both moral and rational status; in short, validity claims become the truth or rightness of the lifeworld (Finlayson, 2005). It is in the lifeworld through validity claims that knowledge is improved and transmitted, and it is to be expected that all parts of the lifeworld are open to change through gradual changes in shared meaning and understanding (Habermas, 1987). This conception of a changing lifeworld could also explain the "regime" changes that intrigued Foucault (1976/2003), the "modification in the rules of formation of statements which are accepted as scientifically true" (p. 302). If rational action in the system is reliant on communicative action in the lifeworld to be effective, then the design and basis of regimes of thought are also based on validity claims to truth and rightness. Changing validity claims in the lifeworld would require new rational actions in the system to maintain justification of actions. Why the social model of disability has yet to become the regime that governs can be explained when one realizes that the systems of power and economy, required to coordinate a modern society, colonized the lifeworld when the biomedical model was most prevalent. This allowed for the uncoupling of the lifeworld from the system and the perpetuation of patterns of instrumental reasoning that relied on concepts of deficiency that did not look toward social inclusion of PWD. Despite the adoption of the social model of disability in multiple professions, thereby demonstrating an evolving concept of disability in the lifeworld, the rational actions of the system do not adjust to this new validity claim. Hence, access to services for PWD continues to rely on medical diagnosis based on instrumental action. Rather, we witness some of the pathologies Habermas claimed resulted from the colonization of the lifeworld, such as decrease in shared meaning and increase in feelings of helplessness (Finlayson, 2005). The social model of disability will be stymied by systems that continue to function through a biomedical model, as dental healthcare does.

Everyday World as Problematic

In *The Everyday World as Problematic* (1987), Smith begins her book with the essay, *A Peculiar Eclipsing: Women's Exclusion from Man's Culture*. In this essay, she argues how the perspectives and experiences of women have been omitted from institutionalized practices that favor a male's narrative and, therefore, excludes women from a society's culture. The result is a world in which women's experiences do not conform to societal expectations, their voices lack authority, and women inhabit a culture that is not their own. However, Smith later cautions that in creating a sociology for women, one must not assume that taking the standpoint of women is equivalent to “an ideological position that represents women’s oppression as having a determinate character” (p. 106). Rather, analysis should “create the space for an absent subject, and an absent experience that is to be filled with the presence and spoken experience of actual women speaking of and in the actualities of their everyday worlds” (p. 107). Smith goes on to remind the reader that women are not the only class excluded from the ruling apparatus, so too are the working class, people of color, indigenous people, and homosexual [sic][5] men and women. Each of these groups occupies a unique standpoint, from which, different aspects of the ruling apparatus would become apparent (1987).

What drew me as a researcher to institutional ethnography was how this analysis, grounded in activism, gave voice to those caught up in the machinations of a system and drew attention to the policies of a system or institution that frequently worked counter to their intended mission. In my own personal experience, I saw how direct support service providers to PWD are bound by funding streams and how their work has to conform to institutional definitions to be considered work, an observation very similar to the research of Ng on job placement for immigrant women, as described in Campbell and Gregor (2004, pp. 114–117). I initially viewed institutional ethnography as a lens to dissect the ways in which patients with disabilities are implicitly discriminated against in oral healthcare. By equating dental providers with direct support service providers and relying on my own empirical experience, my working hypothesis was that medical coding redefined and commodified care to conform to market factors. However, my presumption was an ideological position, informed by the ruling apparatus that educated me on the social model of disability and policy analysis. I started my research institutionally

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[5] LGBTQA+ is the current appropriate terminology.

captured because I already thought in theoretical terms and had assigned my standpoint participants a determinate character, despite Smith’s warning.

Luckily, I had chosen for my research an area separate from the world that I was familiar with through work. This meant that, during my observation and data collection, I was required to learn completely new policies, administrative procedures, and, perhaps most importantly, a new lexicon. This forced a distance between myself and the data I collected. The conversations I pursued were not tainted by my presumptions. Rather, many of the questions inquiring how work was completed came from a genuine place of interest and novelty. Once I reached data saturation and was ready to embark on my analysis, the data I had to work with developed a line of analysis that deviated from the presumptions I had when I started my research. For example, one presumption I had was that SHCN patients differed significantly from other patients, partly explaining the disparities in oral healthcare. However, when one analyzes the social organization of oral healthcare and the ruling relations that coordinate care, what becomes apparent is that neither SHCN patients nor patients in general are part of the system. Like women, as posited by Smith (1987), patients are not part of the ruling class that operates the ruling apparatus; they too are subordinate, their everyday world is also problematic.

The Absent Patient

In my preliminary interviews, I identified a problematic, a conflict between market factors and care for SHCN patients, to help guide my data collection and analysis. What my analysis demonstrates is that those market factor constraints are not limited to SHCN patients. Rather, insurance companies maintain profitability by maximizing cost savings with all patients. The text-mediated ruling relations described previously reduced and objectified not only the dental procedure but also the patient. They too are flattened and reduced to a line of codes and clinical descriptors, little more than a character description in a scripted play. Because patients are absent from the ruling relation of insurance, their interactions with dental providers and staff create sticky points in the system where actions do not flow because the ruling relation never accounted for them. Within the context of institutional ethnography and ruling relations, these experiences or disjunctures become the basis for what someone knows from being and working at the local setting, but they are experiences that conflict with what one is presumed to know according to ruling relations and work coordinated from afar (Campbell & Gregor, 2004). These are the aspects of the social world that do not neatly fit into the categorizations and objectifications of ruling relations and, therefore, are not accounted for when problems at the local setting are resolved according to institutional knowledge.

For example, during my observation at the office of Dr. Andy and Dr. Grant, I witnessed Tricia spend a significant amount of time with a young female patient. The reduced, objective version of this woman based on her account at the office was that she had an outstanding balance and was responsible for both the procedure done that day and a significant amount still owed from previous procedures. However, the staff were familiar with her and once they saw the outstanding balance owed, they knew what was not immediately obvious in the text. She was one of many family members on a single insurance policy at the office, and the amount owed was from procedures conducted on other family members.

Tricia went line by line with this patient on what was owed, the date of the procedures, and identified what she owed for just herself. The remaining balance was then divided among the other family members based on their appointment dates and the individual amounts were written down on a sticky note for her to share with her family. Despite the outstanding balance, including a small amount for which she was still personally responsible, the patient was allowed to schedule a follow-up appointment for additional work. Tricia made this exception because in her experiential way of knowing, she knew the patient would be responsible for both the balance and upcoming payment based on previous payment history. In contrast, Tricia shared with me after the patient left that she would not have extended the same courtesy to some members of her family because they were still chasing payment from them. The time Tricia spent with the patient, including educating her on financing options, was undocumented work.

There is no code for institutional powers to acknowledge customer service, bill collection, personal relationship building, and problem solving. This work or experiential way of knowing is not transmitted beyond the local setting, thus maintaining the invisibility of both the patient and aspects of Tricia's responsibilities. Because the patient and her relationship with dental office staff are invisible to the system, their experience and way of knowing are problematic; institutional powers do not account for it. While it is true that dental providers cannot bill for additional time spent with an SHCN patient, it turns out that all patients are liable to cost a dental provider and their staff additional time or undocumented work.

Absent Patient; Absent Problem

When the ruling relation makes a mistake, there are often consequences that have a direct effect on patients. Jessica at Dr. Calvin's office described a situation where her experience and knowledge outranked the insurance representative, but she was still dependent on what they said, despite knowing they had made a mistake.

> I had an Aetna one that I knew was a mistake. They overpaid. I called them and told them, you overpaid. 'No. No' [they said]. [I told them,] 'I need you to confirm this.' Because this mom was getting like $600 back. 'No, it is right, we will not be asking for the money back.' A good 6 months later they called and asked for their money back... I

> did my part. I couldn't leave the $600 sitting there. I called the mother, and it was fine, she gave it back to me, but it stinks!

Despite knowing that there would be an issue and attempting to reverse it, Jessica was helpless once the decision was made by the insurance company. Jessica could not withhold money that the insurance company said was rightfully the patient's even though she knew it was an error. If the mother had argued or refused payment, Dr. Calvin's office may have had to write off $600 because of a mistake made by the insurance company that did not consider how to recoup overpayment from a patient. When the patient is absent from the formula, problems related to them are also absent from the calculation.

When Ruling Relations Collide

Though the ruling relations of insurance are activated by patients seeking in-network providers, these same patients fade into the background once the system is activated. Beyond an object onto which procedures are prescribed and performed, their experience and everyday way of knowing are not accounted for in the rational decision making of the insurance company. By selecting dental offices as my standpoint, I do not observe and capture all the ways in which the patient experience is missing from ruling relations. However, I was privy to how dental office staff interacted with patients and how those experiences were often left out or abstracted into institutional texts and forms of communication. It also brought to my attention that the patient experience in dental care started and stopped at the office doors. Occasionally I observed pieces of a patient's life beyond a dental procedure, such as the teacher who brought Karlee at Dr. Andy's and Dr. Grant's office pre-K supplies for her son. However, such patient interactions were not recorded in patient accounts, clinical notes, or insurance coding. The textual account of that patient was limited to the time she spent in the spatial confines of the dental office, devoid of any lived experience beyond the office walls. The interaction between this patient and Karlee existed only in the disjuncture, invisible to the ruling relation.

A single ruling relation in one context can create disjuncture, but when a patient enters the local setting of a dental office and brings with them other ruling relations and systems that govern their actions, multiple disjunctures are created. The SHCN patient is not more problematic because they are more invisible. They are more problematic because their world is often governed by multiple ruling relations and systems. Lipsky (2010) described how layers of bureaucracy increase as an individual’s level of need rises. SHCN patients are buried in multiple layers of abstraction, and disjunctures arise not only from differences between their experiential world and institutional knowledge but also from the collusion of different ruling relations.

Chapter 4 sought to elucidate the social relations, ruling relations, and patient context in a dental office. Chapter 5 will examine in more detail the disjunctures that arise when oral healthcare is provided to SHCN patients in a community dental provider office.

CHAPTER 5: The Disjunctures

In Chapter 5, I focus on the disjunctures I observed and discussed with dental providers and staff when it came to the provision of care for SHCN patients. In institutional ethnography, the disjuncture can be described as points of tension where institutionalized knowledge is at odds with the empirical experiences of people at the standpoint. These disjunctures are encapsulated within the problematic and are the “puzzles to be explicated” during analysis (Rankin, 2017b, p. 3). Chapter 5 seeks to analyze these disjunctures specific to SHCN patients and identify the various social relations that have a negative or mitigating effect on care.

Local Settings and Insurance Description

Because this chapter relies heavily on participant description, I am providing a review and description of the local settings observed. As described in Chapter 3, Methods of Approach, I observed, collected texts, and interviewed staff at two dental offices. The first site was Dr. Calvin’s pediatric office, which accepted Medicaid and a variety of other insurances. His office is located in a fast-growing suburban area of Richmond, Virginia. The staff observed and interviewed include Dr. Calvin, Jessica, Camilla, Stella, and Gwen. The second observation site was Dr. Andy’s and Dr. Grant’s general practice in an established suburban area geographically close to the city line of Richmond City. Their office accepts Medicaid patients, though they had decided to put a hold on new Medicaid patients when I began my observation. Their practice is out of network for all insurance providers, meaning they do not have managed care contracts or fee schedules with any insurance companies. They will collect insurance information and bill insurance for the patient on the chance a patient’s plan offers out-of-network coverage. Otherwise, all patients pay fees established by the practice. The staff observed and interviewed there include Dr. Andy, Dr. Grant, Tricia, Karlee, Danica, Alexis, and Katherine. Finally, I interviewed Dr. Karen, who started her career working for a practice that accepted Medicaid but has since gone into business for herself. Dr. Karen's office does not accept Medicaid. The interview with Dr. Karen provided additional insight and contrast to the observations and interviews conducted at the two observation sites.

The observations and experiences described by participants are the basis of the disjunctures described in this chapter. It is these disjunctures that demonstrate how dental staff experiences with SHCN patients are often complicated by the layers of bureaucracy that surround an interaction in addition to the economic factors often cited as reasons dental offices elect not to participate in Medicaid programs.

Layers of Bureaucracy

Titchkosky (2020) describes *bureaucracy* as "a collection of tasks impartially ordered through institutionally established cost/benefit rationality that provides the routines for the impersonal workings of mass consumerism" (p. 207). This definition conforms with Habermas's rationalized systems and institutional ethnography's concept of ruling relations, specifically the explanation for how bureaucracy transcends from a routine to a form of governance. From a policy perspective, this transcendence emphasizes and prioritizes the operationalized system and measures its functionality as an indicator of quality instead of asking how the routine benefits individuals in society, for whom it was designed. As discussed in Chapter 4, insurance has rationalized the patient out of the ruling relation. Experiences and interactions between patients and staff become invisible work that is not captured or calculated by the ruling relation. These experiences and invisible work are the disjunctures experienced by dental office staff. For SHCN patients, this invisible work at the disjuncture is amplified because unlike more typical patients, it may be impossible to leave behind other social or ruling relations at the dental office doors.

Chapter 4 described how social relations between dental providers and patients can extend past the patient to their employer. However, the social relation that exists between the patient and their employer is typically not relevant in a dental visit. A patient's day-to-day responsibilities are likely put on hold once they enter a dental office, where the social relation between the patient and dental provider takes priority. For an SHCN patient, it may not be so easy to divest themselves of the social relations that continue to control and direct their person. For dental office staff at the local setting, these layers of bureaucracy create dissonance and kinks that do not conform to the rationalized ruling relation, and it becomes their work to smooth out the experience so that the ruling relation can be applied to the situation.

Lipsky (2010) posits that "the poorer people are, the greater the influence street-level bureaucrats tend to have over them" (p. 6). He describes street-level bureaucrats as public service workers who interact directly with citizens and have a certain level of discretion in their work. This definition includes teachers, counselors, social workers, police officers, and anyone else who coordinates access to government programs or services. By this definition and description, SHCN are under greater influence from street-level bureaucrats and the social relations that coordinate bureaucratic action compared to their peers without special medical needs. People with disabilities are twice as likely to live in poverty compared to people without disabilities, and more than 65 percent of work-age adults with disabilities rely on at least one safety net or income support program (NCD, 2017) and the estimates for PWD using Medicaid is 75 percent (Decker, 2011).

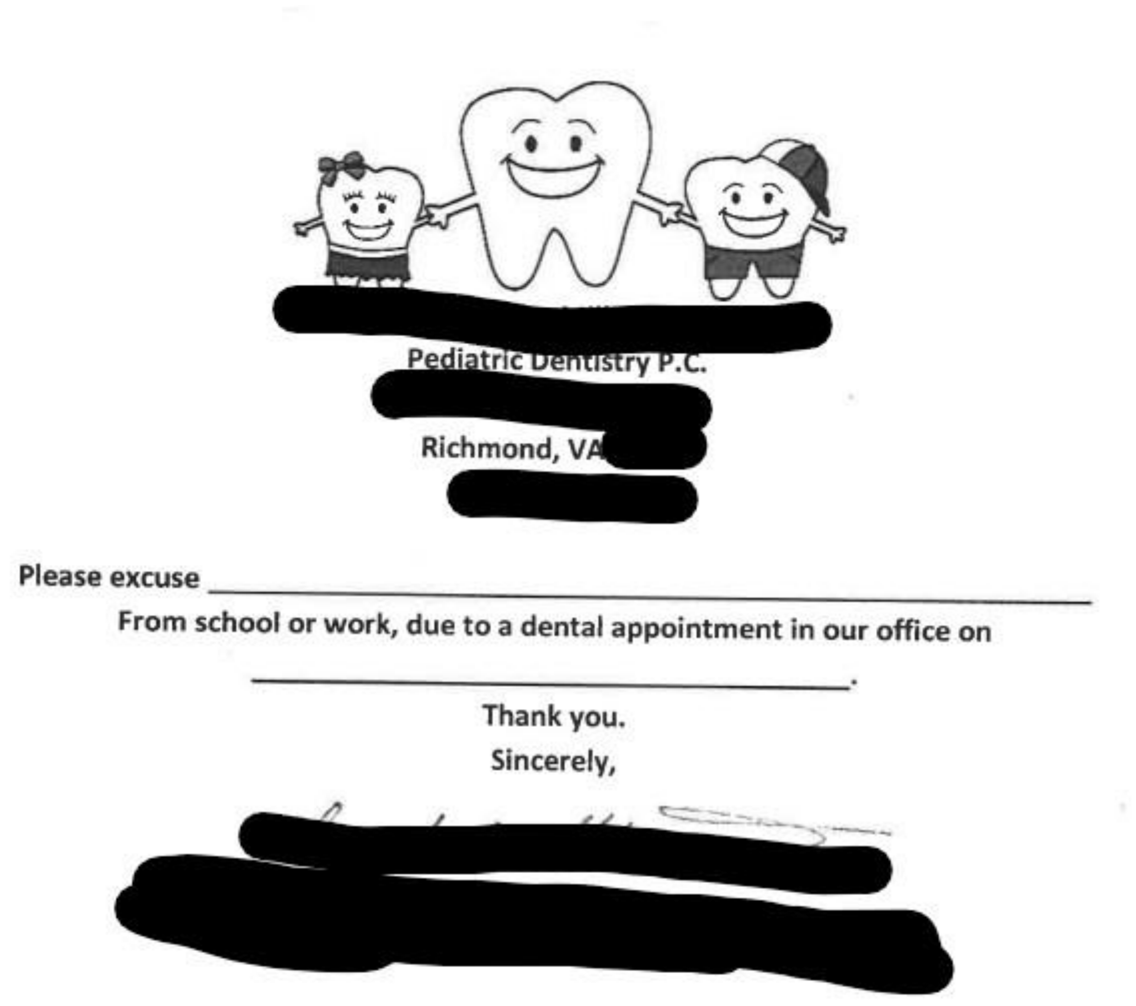
People who use Medicaid to pay for healthcare services are immediately layered in one cloak of bureaucracy by accessing this government service. Though fee-for-service Medicaid is based on a private insurance model, the ruling relation of Medicaid operates on a more personal level for the patient. The Medicaid eligibility criteria of income and disability status means that the body is consistently ruled and regulated. Since changes in life circumstances (marriage, divorce, birth, and income) can change those qualifications, these changes must be reported (DMAS, 2019); thus reflecting just one example of how SHCN patients using Medicaid are consistently layered in bureaucracy, no matter where they are. Following are examples of how SHCN patients are saddled with extra layers of bureaucracy from pediatric to adult dental care. These examples are not an exhaustive list of the bureaucracies that affect SHCN patients; what is represented are the relevant examples from observations and interviews.

Pediatric SHCN and Bureaucracy

SHCN pediatric patients are not immune to bureaucracy ruling, especially compared to their peers without SHCN. Consider a typical pediatric patient who visits Dr. Calvin's office. An appointment is made for them based on a date and time that is most convenient for their caregiver. The relative ease of making this appointment is admittedly highly dependent on the caregiver's flexibility, but that is likely the biggest impediment to scheduling. To acknowledge that the student's dental appointment takes priority over other responsibilities, the student and caregiver are offered an excused absence template for school and work, as shown in Figure 12.

Figure 12

12 School Absentee Note



[redacted]

Pediatric Dentistry P.C.

[redacted]

Richmond, VA [redacted]

[redacted]

Please excuse ______________________________

From school or work, due to a dental appointment in our office on

______________________________.

Thank you.

Sincerely,

[redacted]

[redacted]

Though these same parameters would seemingly apply to an SHCN patient, the reality is that there may be many other factors that impact scheduling. At school, the patient may receive additional services such as speech and language services, occupational therapy, and applied behavioral analysis as part of their individual education plan (IEP) under Part B of the IDEA

(2004). Caregivers may be loath to take their child out of school and lose precious time in these services. Furthermore, students with disabilities also have lower on-time graduation rates. Nationally, 65 percent of students with disabilities graduate on time compared to 83 percent of students without (Butrymowicz & Mader, 2017). The variance hints that frequent absences among other factors can affect graduation outcomes. A higher number of absences may be expected depending on the nature of an individual's disability or, at the very least, make caregivers more selective about when to pull students away from educational time. In addition to a teacher or school administration requiring an excused absence, a caregiver of an SHCN patient may also be coordinating meetings with special education teachers, collaborative teachers, occupational therapists, speech and language pathologists, and transition coordinators. Just these additional layers of bureaucracy in the school setting can complicate something as mundane as scheduling a dentist appointment.

Dr. Calvin was very aware of how school schedules could complicate recall or routine cleaning appointments. On school holidays, Dr. Calvin adjusts his typical schedule so that he only sees recalls to maximize the number of patients he sees on those days. Though appointments on school holidays or later afternoon hours were the most requested, Dr. Calvin was one of the few doctors at his practice who would adjust his schedule on days when school was closed. His choice to do so was simply to accommodate, but it was a decision that respected the fact that many caregivers were already taking those days off to provide childcare, and it eased their burden.

Transportation can also prove to be a major barrier for pediatric SHCN patients. Dr. Calvin's office is not located near any public transportation, and for students and their families with limited transportation options, this can pose a huge barrier. Dr. Calvin recounted to me that before their office moved even farther away from the bus line, one patient and her mother used to walk 2 miles on pedestrian unfriendly roads to get to their office. If this patient were to be scheduled during a school day, it would necessitate nearly a full day off from school and work for the caregiver. The time required to ride various bus lines to the closest bus stop and then walk 2 miles is a significant time burden.

Though some patients using Medicaid would be eligible for nonemergency medical transportation (NEMT)[6], the use of this service creates a layer of bureaucracy and still requires a significant time commitment to both schedule and use the service. The Virginia Medicaid NEMT Member Manual details how patients are required to schedule reservations 5 business days in advance of an appointment; urgent NEMT appointments can be made 24 hours in advance by phone only. Patients are also expected to give return times of when they will be ready to be picked up, which I would argue is a somewhat unreasonable request given my personal experiences with doctor appointments. Once the request is approved, the patient is given a trip reference number that they are responsible for even though the trip reference number does not confirm that the reservation has been assigned to a transportation company yet. Cancellations also require 24-hour notice, and failure to cancel a trip will result in a no-show documentation. The day of the appointment, the patient is expected to be ready 15 minutes prior to the scheduled pick-up time as the driver has a 30-minute window to pick up the patient, spanning from 15 minutes prior to the scheduled pick-up time to 15 minutes after the pick-up time. Finally, the member responsibilities page lists as the last item a suggestion that the patient have someone else as a backup to provide transportation and receive reimbursement in the event the transportation

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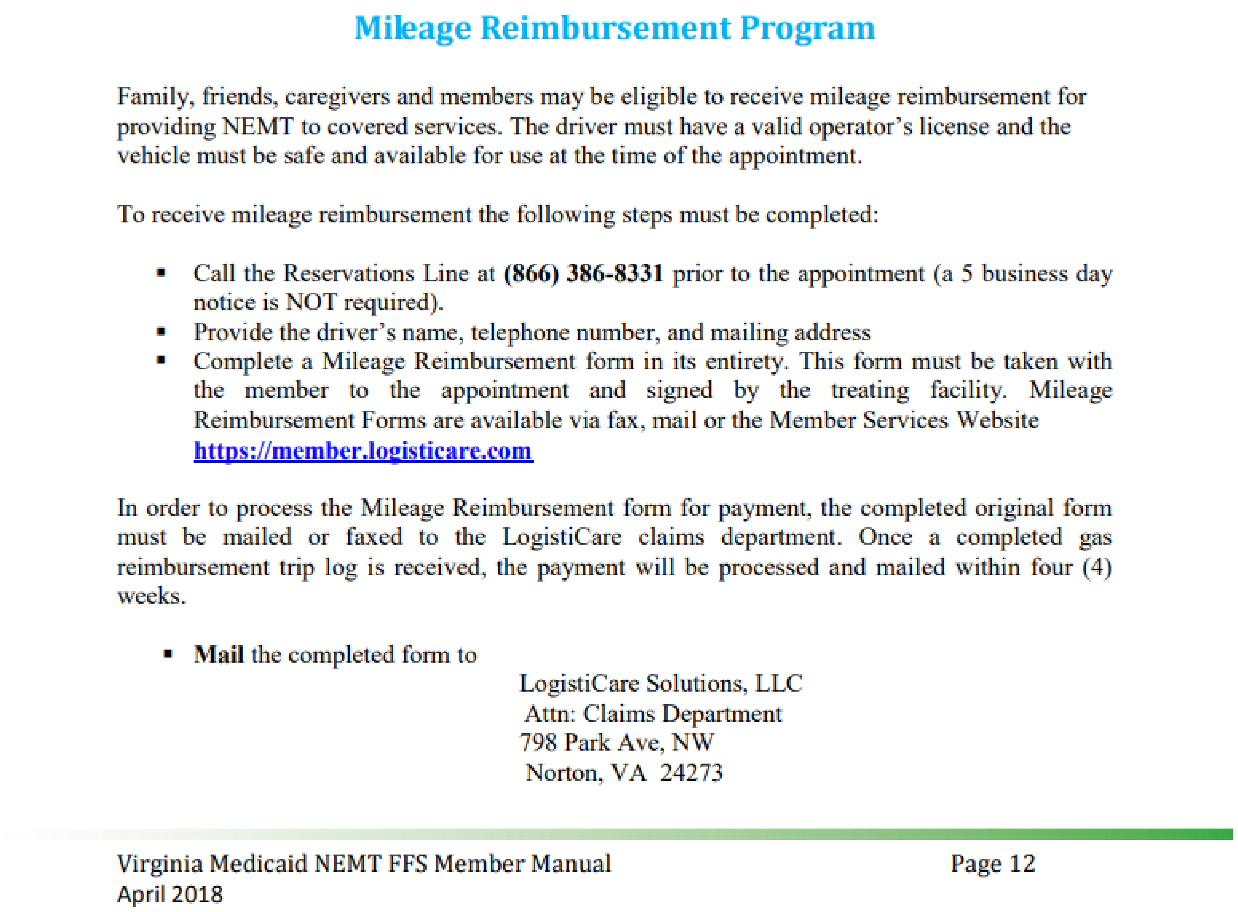
[6] In Virginia, ineligible Medicaid members are those enrolled in a Medicaid Managed Care Organization (MCO). They may still be entitled to NEMT depending on the specific MCO they are enrolled in (DMAS, 2020).

provider cancels the appointment or is delayed (Logisticare, 2018). The image in Figure 13 is from the NEMT manual and demonstrates how this option is also not without bureaucratic difficulties and time commitments.

Figure 13

13 NEMT Mileage Reimbursement Instructions



Mileage Reimbursement Program

Family, friends, caregivers and members may be eligible to receive mileage reimbursement for providing NEMT to covered services. The driver must have a valid operator's license and the vehicle must be safe and available for use at the time of the appointment.

To receive mileage reimbursement the following steps must be completed:

- Call the Reservations Line at **(866) 386-8331** prior to the appointment (a 5 business day notice is NOT required).
- Provide the driver's name, telephone number, and mailing address
- Complete a Mileage Reimbursement form in its entirety. This form must be taken with the member to the appointment and signed by the treating facility. Mileage Reimbursement Forms are available via fax, mail or the Member Services Website **https://member.logisticare.com**

In order to process the Mileage Reimbursement form for payment, the completed original form must be mailed or faxed to the LogistiCare claims department. Once a completed gas reimbursement trip log is received, the payment will be processed and mailed within four (4) weeks.

- **Mail** the completed form to

LogistiCare Solutions, LLC
Attn: Claims Department
798 Park Ave, NW
Norton, VA 24273

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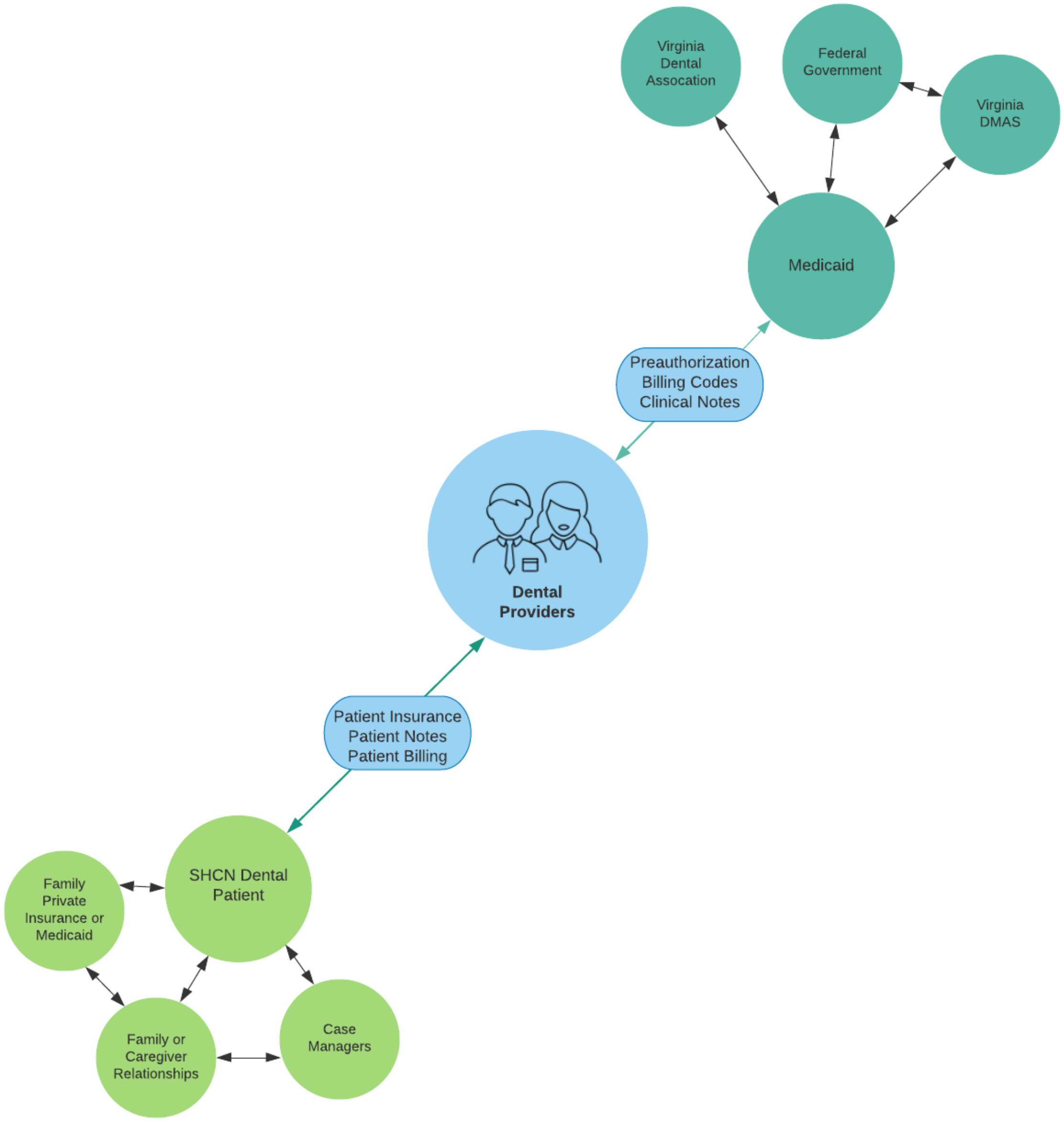
NEMT is an example of a Medicaid-based ruling relation that can have a direct effect on the SHCN patient–provider relation (as one would expect, staff at both offices complained that these services were notoriously tardy and that patients were often left waiting well after an appointment ended). The rationalized system requires that the patient demonstrate multiple layers of compliance between scheduling and riding NEMT, and should they choose reimbursement as a transportation option, they must be willing to demonstrate patience for a multiple-week turnaround to receive reimbursement (Logisticare, 2018). NEMT can only be considered free transportation if one does not value time. Unlike the ruling relation described in Chapter 4, the SHCN patient has not been rationalized out of the system, rather the SHCN patient has been rationalized into a list of compliance and eligibility requirements. Their body and the bureaucratic management of it has become part of the system.

Bureaucracy as a Mitigating Factor. NEMT demonstrates how Medicaid, as a bureaucracy, absorbs the patient into the system by rationalizing them into eligibility criteria and compliance measures. This action maintains the "idea" of the patient as part of the system and can have a mitigating effect from a care perspective. This is especially the case with pediatric preventative coverage. For example, consider the code for behavior management. When a patient requires additional time or a high level of staff support to complete a procedure, code D9920 or behavior management can be used. In the typical insurance ruling relation, this code would likely be denied according to staff at Dr. Calvin's office. In contrast, Medicaid is one of the few insurances that will reimburse D9920 when clinical notes explaining the need for behavior management are submitted. Likewise, when this code is submitted with the code for nitrous oxide to Medicaid, both nitrous oxide and behavior management will be covered for a pediatric patient (DentaQuest, 2020). This is in contrast to the lack of coverage for nitrous oxide by most plans, as described in Chapter 4.

By covering these procedures often denied by private insurances, Medicaid is acknowledging the nature and needs of the patients covered by Medicaid and maintaining their visibility in the dental–insurance relation. Figure 14 visually depicts how Medicaid as a social relation does not lose sight of the SHCN patient when reimbursing the dental office.

Figure 14

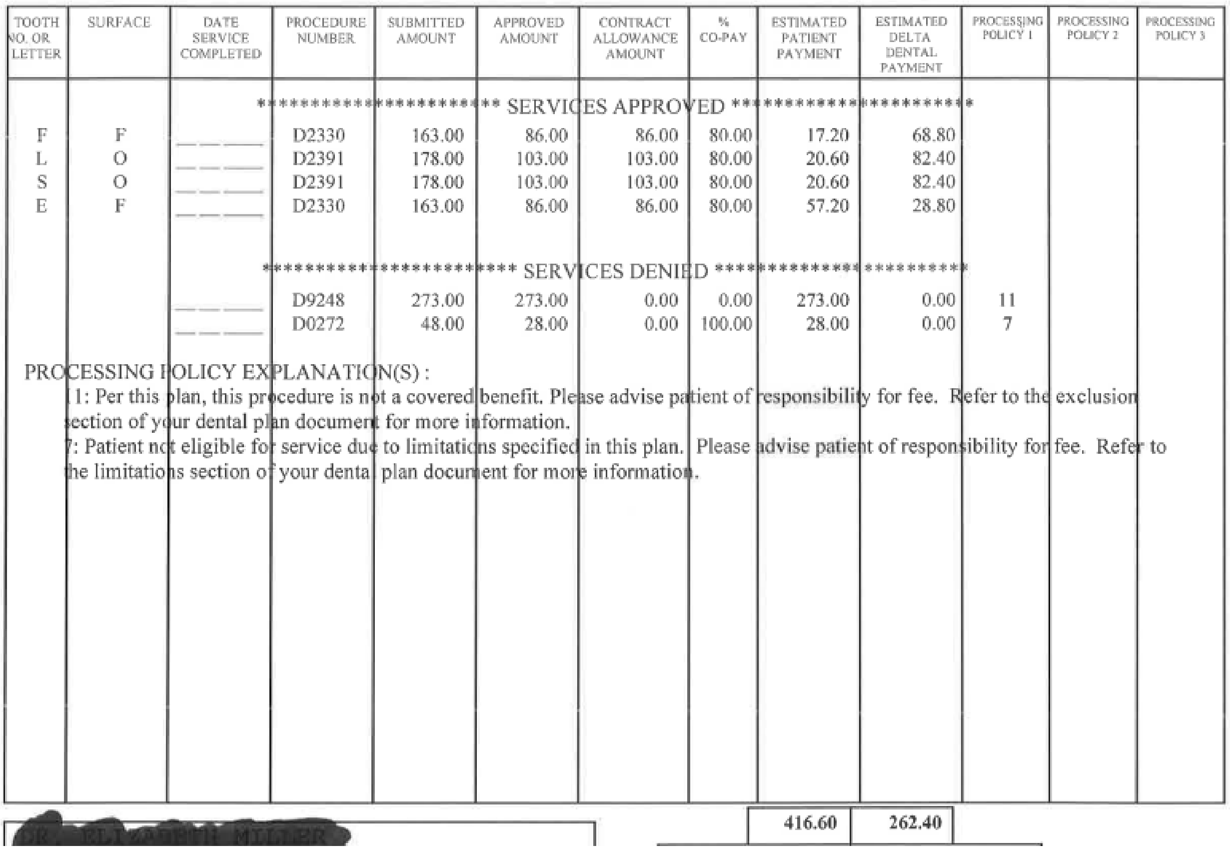
14 Medicaid–Dental Provider–Patient Social Relation



This provides a stark contrast to the typical insurance ruling relation where the patient maintains invisibility. As described in Chapter 4, the default was to defer to the patient's insurance plan without consideration of the individual patient. For example, Figure 15 shows a pediatric patient's predetermination where the code D9248 for oral sedation, required in part by the patient's young age, was denied. Because oral sedation was denied, the full cost of $273 falls to the parents despite, as Jessica describes it, "Crazy. These 3-year-olds aren't going to sit still."

Figure 15

15 Predetermination: Behavior Management Denial



TOOTH NO. OR LETTER	SURFACE	DATE SERVICE COMPLETED	PROCEDURE NUMBER	SUBMITTED AMOUNT	APPROVED AMOUNT	CONTRACT ALLOWANCE AMOUNT	% CO-PAY	ESTIMATED PATIENT PAYMENT	ESTIMATED DELTA DENTAL PAYMENT	PROCESSING POLICY 1	PROCESSING POLICY 2	PROCESSING POLICY 3
			********************** SERVICES APPROVED **********************									
F	F		D2330	163.00	86.00	86.00	80.00	17.20	68.80			
L	O		D2391	178.00	103.00	103.00	80.00	20.60	82.40			
S	O		D2391	178.00	103.00	103.00	80.00	20.60	82.40			
E	F		D2330	163.00	86.00	86.00	80.00	57.20	28.80			
			*********************** SERVICES DENIED ***********************									
			D9248	273.00	273.00	0.00	0.00	273.00	0.00	11		
			D0272	48.00	28.00	0.00	100.00	28.00	0.00	7		
								416.60	262.40			

PROCESSING POLICY EXPLANATION(S) :

11: Per this plan, this procedure is not a covered benefit. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

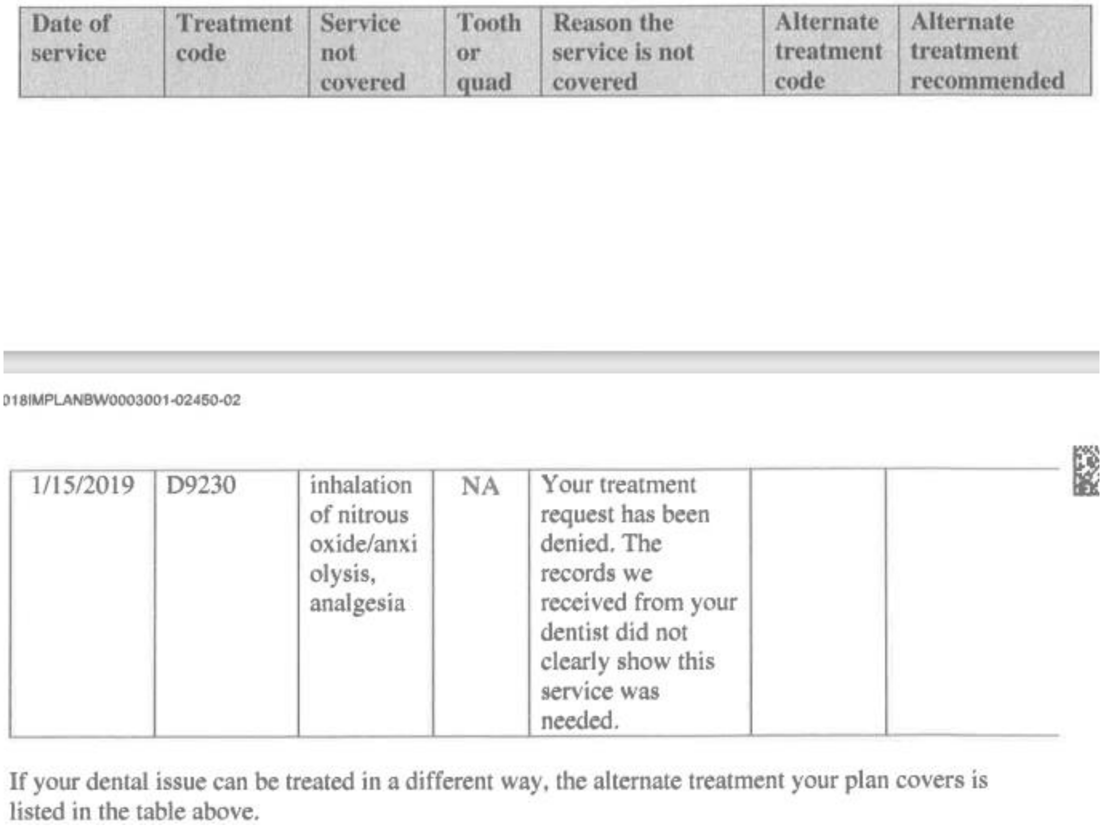
7: Patient not eligible for service due to limitations specified in this plan. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

[redacted]

Another example, depicted in Figure 16, also denies nitrous oxide treatment but places the burden on the dental provider by writing that there was no evidence given to justify its need. Even though, again, it was used in part because of the patient's young age.

Figure 16

16 Predetermination: Nitrous Oxide Denial



Date of service	Treatment code	Service not covered	Tooth or quad	Reason the service is not covered	Alternate treatment code	Alternate treatment recommended
1/15/2019	D9230	inhalation of nitrous oxide/anxiolysis, analgesia	NA	Your treatment request has been denied. The records we received from your dentist did not clearly show this service was needed.		

018IMPLANBW0003001-02450-02

If your dental issue can be treated in a different way, the alternate treatment your plan covers is listed in the table above.

Interestingly, Dr. Calvin's office would code for behavior management when it was required, even for private insurances they knew would not reimburse it. Jessica explained that though they do not receive payment for this code, it is still used to keep a record should they need to charge the parents in the future for a broken appointment because of uncooperative behavior from the patient. This action demonstrates how, unlike the ruling relation between Medicaid and SHCN patients, insurance is disconnected from the patient. The reality is that the dental office becomes not only the dental care provider but also the initial representee of the insurance company. Though they are not part of the insurance company institution, their participation in the social relation requires that they become the educators to patients on their insurance plans; they are now responsible for implementing both the office's policies and the policies of the patient's insurance. By recording and coding items they know will not be reimbursed, they are attempting to place the patient back into the social relation, if only, at the very least, to create a textualized documentation of noncompliance in their own records.

Though rationalizing the pediatric SHCN patient into the bureaucratic Medicaid system can prove to be a mitigating factor when it comes to accessing care, this is not the case with adult SHCN patients. Adult care functions under a different set of rationalized systems. Between Medicaid coverage for pediatric care and the nature of pediatric dentistry, it is more likely for an SHCN pediatric patient using Medicaid to find a community provider. A mystery shopper survey conducted in Virginia in 2018 showed that appointment rates between Virginia's Medicaid program, Smiles for Children[7], and a private insurance, Delta Dental, were similar (Yarbrough, 2019). Dr. Grant provided insight when he shared that "pediatric dentistry is a lot of volume and you can grow your practice through Medicaid, but as a general dentist, it's not really going to work."

Adult SHCN and Bureaucracy

The bureaucracy adult SHCN patients are beholden to is different from pediatric SHCN patients in one fundamental manner: namely, the assumed inability to participate competitively in society. Chapters 2 and 4 discussed how SHCN patients are subjected to the medical gaze to legitimize their disability to access social supports and services. By doing so, SHCN patients not only initiate multiple bureaucratic ruling relations, they are also engaging in a ruling relation that "measures and documents people's lack of function in relation to the possible provision of

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[7] Smiles for Children is Virginia's Medicaid and Family Access to Medical Insurance Security (FAMIS) program name, managed by DentaQuest. I have elected to use Medicaid and pediatric Medicaid throughout this study to focus on the institutional organization rather than programmatic names, that are opt to change to avoid stigma.

services oriented to assimilate or, given a failure to assimilate, legitimized exclusion" (Titchkosky, 2020, p. 201).

One of the most glaring examples of legitimized exclusion is the difference between Medicaid dental services for adult patients compared to pediatric patients. Whereas most care for pediatric patients is covered, albeit at lower reimbursement rates than private insurance plans, only the medically necessary is covered by Medicaid for adult patients (DMAS, 2019). During my observation, Virginia Medicaid had rolled out new plans under CCC+ that offered additional coverage for adult patients, but their coverage was still severely limited compared to private insurance or pediatric Medicaid (VOHC, 2018)[8]. Furthermore, dental staff reported the rollout as being extremely confusing and poorly executed. Staff at Dr. Calvin's office explained that they only learned about CCC+ when their patients started to ask if they accepted it, as they had received no information from the state about the program. This meant that participation from Dr. Calvin's office was slightly delayed as the onus was on them to educate themselves about the program. In the end, they decided to participate in all but two of the CCC+ plans for economic reasons. Staff at Dr. Andy's and Dr. Grant's office shared that they, too, learned about the program from patients but were not able to participate even though they were very interested. By being out of network, they were not eligible to participate in the program even though they accept multiple patients with Medicaid. This oversight by DMAS, the agency administering Medicaid, demonstrates further exclusionary practices that impact adult SHCN patients at out-of-network dental providers. These exclusions of services convey the message that adults with

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[8] The cited document was written by Virginia Oral Health Coalition, now renamed Virginia Health Catalyst as of August 2019 (https://vahealthcatalyst.org/introducing-virginia-health-catalyst-the-intersection-of-overall-health-and-oral-health/).

disabilities are either not in need of or deserving of preventive and comprehensive coverage.

An example of how adult SHCN patients are layered in exclusion bureaucracies is how many of them combat the limited coverage of Medicaid by continuing to be dependents of their parent's insurance. Though the ACA (2010) expanded the age to which dependents could stay on their parents' insurance to 26, dependents with disabilities can continue to be on their parent's insurance past this age. This allowance is a good thing from a pragmatic perspective, but it is also a textual and bureaucratic infantilization of SHCN patients. Rather than graduating to their own individual adult insurance plans, they maintain their dependent status—furthering the narrative that adult SHCN patients are incapable of full autonomous participation in society.

While observing at Dr. Andy's and Dr. Grant's office, staff discussed SHCN patients who were able to be on their parent's employer-sponsored insurance plan and Medicaid. In these situations, Medicaid would be the secondary insurance or payer of last resort. Though these patients usually had comprehensive coverage, they were subjected to the ruling relations of both insurance and Medicaid, which could result in additional administrative time for the staff. These complexities were especially complicated when the SHCN patient lived in a group home facility, a facility subjected to its own bureaucracy and ruling relations. Tricia shared an example where a patient's group home and poor communication resulted in confusion for the family and office staff. The group home assumed the patient had Medicaid, but the family had two additional insurances that were not reported to the office. As a result, the family had contacted the office to ask why they were receiving billing statements because they believed insurances should have covered the cost of a cleaning, which Medicaid did not. To further complicate the situation, the patient had gotten a cleaning at the local university hospital that was not disclosed to the office prior to his appointment, meaning the cleaning received at their office would be denied based on frequency by both the primary and secondary insurance because he had received two cleanings in less than 6 months. Under Medicaid's ruling relation, a cleaning is not a medical need and therefore not covered. The ruling relations of the private insurances gave no consideration to the patient and conformed only to the system. Coverage for a cleaning is determined solely on insurance plans even if it is recommended that an SHCN patient come more frequently than 6 months. Katherine, a hygienist at Dr. Andy's and Dr. Grant's office shared that patients often won't come more than every 6 months because of insurance limitations even when they are recommended for shorter intervals because "they aren't brushing their teeth as much as they should, and they may not have the help they need to brush their teeth as well as they should."

My standpoint from the dental office setting did not allow for an in-depth analysis of the ruling relations and bureaucracy within a group home setting, but it did allow for an observation of the social relation between dental staff and SHCN patients and group home counselors or administrators. Furthering the narrative of exclusion bureaucracy, the decision for an individual to live in a group home is rooted in the expectation that this individual is not able to live independently as a fully contributing member of society. This exclusion plays out when the individual is left out of or unaware of medical decisions made on their behalf. Why, if the patient had an established relationship with Dr. Grant's office, was he also taken to the university hospital for a routine cleaning? I observed how both group home staff and dental office staff elected to remove the patient from these discussions, perpetuating a system of exclusion bureaucracy. For example, I witnessed a male adult patient attend his appointment with a counselor from his group home. He seemed comfortable in the office and was excited to show the hygienist, with whom he was familiar, his t-shirt showing a graphic of a favorite cartoon character. At the conclusion of his appointment, he and his counselor left without discussing payment or insurance information. Karlee explained to me that payment information will be forwarded to the billing department at the group home because they were not able to identify the responsible party. The presumption that neither party, including the patient, could answer insurance questions was a foregone conclusion, one based on experience as these independent living skills were not expected of patients living in group homes.

The difficulty of working through the layers of bureaucracy that surround adult SHCN patients led to specific office policy decisions. Like Dr. Calvin's office, as in the earlier example provided by Jessica, an overpayment would typically be returned to the patient. However, staff learned that in multiple past occasions, these overpayments were not returned to the patient or their families. Therefore, the practice now is that Medicaid patients who reside in group homes will have a credit on their account because "they will always come back." This decision was made both on the recognition that finding a dental office that accepts adult Medicaid patients is difficult, group home staff would hopefully ensure that dental appointments are kept, and that this was the best way to protect the overpayment funds of SHCN patients.

SHCN adult patients and access. The difficulty that plagues adult SHCN patients in accessing oral healthcare is another example of exclusion bureaucracy. Though access difficulties are not a planned part of the rationalized ruling relation imposed by insurance, it is a consequence. The textual message conveyed through insurance coverage that SHCN adults deserve less oral healthcare is absorbed by community dental providers and results in few feeling a sense of obligation to treat this population. There is no moral imperative to counteract the lack of financial incentives.

Chapter 4 demonstrates how ruling relations dictated by insurance companies create an economically tenuous situation for dentists, between low UCR schedule fees and limiting approved services. In this context, it is difficult to make care of SHCN desirable when many rely on Medicaid, which has both lower reimbursement rates and fewer covered services. Even for pediatric coverage, which is much more comprehensive, Dr. Calvin expressed that Medicaid reimbursement rates for cleanings barely covered costs, and he did not make a profit off of one procedure. Beyond the low rate of reimbursement, which was her primary reason for not accepting Medicaid, Dr. Karen shared that her reasoning for not taking Medicaid patients was that she did not like feeling limited in the care she could provide.

> The problem with Medicaid is you have to do a lot of volume. It is hard to maintain a proper schedule. It's not the ideal type of environment to do good dentistry...Compared to other insurances, you get paid $90 but maybe $30 for Medicaid; so, you need more volume. Put two or three [patients] in the same amount of time for one patient so you have less time per patient...You can't do quality general work...With Medicaid there is no room for error, no room for late appointments.

When asked under what circumstances she would accept Medicaid, Dr. Karen exclaimed, “Boy!” and took a minute to respond before relating it back to her own experience working with foster kids and teens using Medicaid early in her career. Ultimately, she decided if she were working for someone else, like a nonprofit instead of running her own business, then she would be willing to work only with children using Medicaid.

> Procedures with kids are quite simple as long as you have behavior management. With adults, it's more complex, I would not be doing it. I give myself plenty of time in my practice because I don't like to be rushed. I need to have time and take my time, and I like to pamper my patients. A preference in how I do dentistry...With adults, the tooth is good and it can be saved, but Medicaid would only pay for the cheaper option. I don't

> want to take out good teeth as a dentist. Down the road, it could lead to more problems. We are more aware now of how oral healthcare affects the rest of our body. The ones who have more problems later are the ones that have a really bad bite, and that puts more pressure and problems on the teeth they have left, and they end up with more work later on. Teeth become more stable after orthodontic care; take out a tooth, things move, become less stable. We know more now.

Dr. Karen's example illustrates again how Medicaid's exclusion-based rationalization prioritizes the medicalization of disability over an individual's long-term quality of health—implying that long-term health is not consequential to SHCN patients.

Regardless of the reasoning, it is much more difficult to find an adult provider who accepts Medicaid. For children, the oral health status between Medicaid-enrolled children and non-Medicaid-enrolled children is insignificant, whereas double the percentage of Medicaid-enrolled adults compared to non-Medicaid-enrolled adults who do not plan on seeing a dentist in the next 12 months. Medicaid-enrolled adults identify lack of covered services and difficulty finding a dentist who accepts Medicaid as the two primary reasons they do not plan to visit a dentist office (Yarbrough et al., 2014). Therefore, it is no surprise that the office of Dr. Andy and Dr. Grant has a well-known reputation for being one of the few community dental offices to accept adult SHCN patients with Medicaid in their area. In fact, when I started my observation, they had just made the decision to suspend their acceptance of new Medicaid patients because they were inundated and were having difficulty scheduling all of their patients, especially the ones that required general anesthesia at a nearby hospital for care. This was not a decision they took lightly, as both Dr. Andy and Dr. Grant felt it was their responsibility to take SHCN patients and were frustrated that more dentists in the area did not accept them.

When asked about his decision to accept Medicaid, Dr. Andy said, “Medicaid doesn’t make us money. Haven’t looked at it analytically but [accepting it was] what we were going to do no matter what.” Dr. Grant expressed frustration that they were often on the receiving end of referrals from the local dentistry teaching university.

> ...places like that should be training and are instead turning [SHCN] patients away because they aren’t a good educational experience. Chicken and Egg problem. If you aren’t training, you won’t have people who can treat them. Claim they are not a good education experience because they aren’t sitting still, but that is the educational experience!

In this manner, perceptions of what makes a good educational experience were contributing to access issues. Though not fully analyzed for the purposes of this paper, a future textual analysis of what constitutes dental education could reveal how ruling relations within dentistry and education shape access to care for SHCN patients. Dr. Grant shared that their practice is approximately 90/10 SHCN Medicaid patients to Medicaid patients who are financially eligible. He does feel that some people are hesitant to take on SHCN patients and, because they cannot legally say they will not treat SHCN patients, they end up not accepting Medicaid at all, thereby limiting access for all Medicaid patients.

Considering how difficult it is for adult SHCN patients to find community dental providers, it is not surprising that many pediatric SHCN patients fail to transition to dental providers for adults. Dr. Calvin continues to provide care to quite a few adult patients and cover what expenses he can. When asked if they had a transition plan for patients aging out of pediatric care, Dr. Calvin responded, “No. What we do is we will take care of them as long as they want to be treated here. Unless it becomes a risk or requires services we can’t provide, like adult crowns and periodontal surgeries that would be better handled by general dentists who have practice with people with disabilities or hospitals who can handle medically compromised.” Not surprisingly, Dr. Calvin confirmed that it was very hard to find general practices that would accept and treat adult patients who had aged out. Similar to Dr. Andy and Dr. Grant, he described accepting Medicaid patients as a moral obligation and extended that to his adult SHCN patients. Echoing Dr. Andy and Dr. Grant, Dr. Calvin also shared that he believes he received much more clinical education on how to work with SHCN patients than dentistry students currently in school.

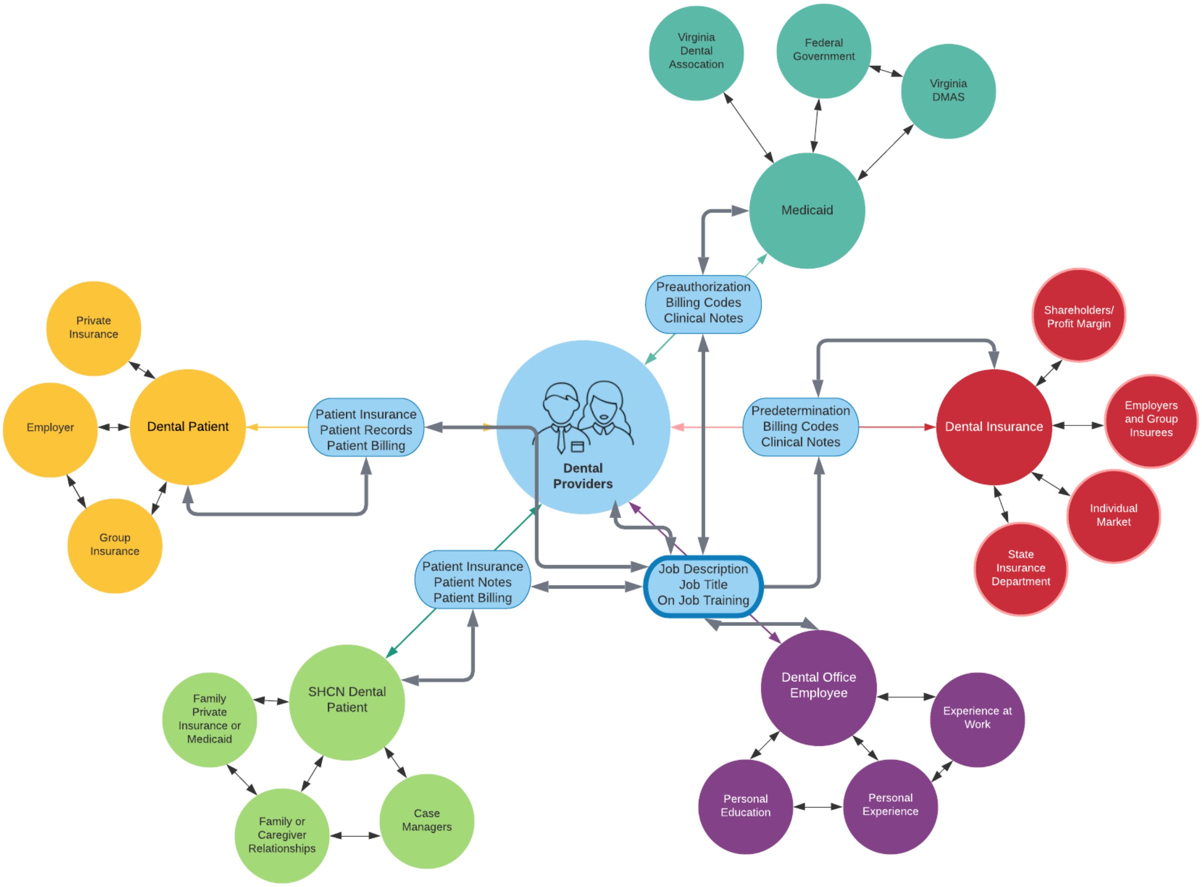
By accepting Medicaid patients, Drs. Andy, Grant, and Calvin are all fulfilling what they see as a moral obligation of their profession. Though low reimbursement was discussed candidly in their interviews with me, what I observed and felt was the most interesting aspect were the ways in which Medicaid policies mirrored or differed from private insurance and the effect those differences had on dental office staff and their work. By completing insurance paperwork and sending bills to patients, administrative office staff became the conduit through which institutional powers were transmitted via text. They flattened and objectified patients into textual accounts and reanimated predeterminations, downcodes, and bills into clinical and monetary exchanges. To patients, they are the bureaucratic representatives of dental insurance despite having no official association with either private insurance companies or Medicaid.

Dental Staff as Bureaucrats

What has been implied thus far in this chapter is that by agreeing to participate in a managed care insurance plan or Medicaid, dental practitioners are agreeing that they and their staff will become de facto bureaucrats of the program. Figure 17 depicts how the ruling relations of insurance and Medicaid are filtered through dental providers, and how it is specifically dental staff who interface with patients and insurance representatives.

Figure 17

17 Staff as Bureaucrats



Insurance information is not only collected during the initial patient interaction that activates social relations, it is also monitored and tracked by administrative staff throughout the lifespan of a patient. This work becomes a primary responsibility for administrative staff, and as insurance policies and billing become more complex, the time requirement grows. Jessica shared that when she first started at Dr. Calvin's office 24 years ago, insurance was much less complex.

> Back then, the insurance wasn't so crazy. Not as many options, and it was pretty much they brought you a card. Now no one has cards, you have to research what kind of insurance they have. But they brought you their card, and we put it in. There was no estimate or debating. They got a bill, and they paid it. Now they want to know to the penny what they are going to owe. It's a lot more complicated. The insurance part of it has really grown from what it was when we started.

The growing complexity of insurance has also meant that the administrative team has grown from two to the eight individuals I observed at the office. Jessica also detailed how some staff responsibilities were broken up based on insurance activities. Camilla at the front desk checks and verifies insurance information, Stella is in charge of surgery predeterminations, and Gwen does credentialing. It should be acknowledged that the office as a whole has grown in both number of partners and patients, so this increase in staff cannot be contributed to insurance alone.

Any observation of a dental front office will demonstrate the amount of time dedicated to monitoring insurance. I observed staff at Dr. Andy's and Dr. Grant's office verify insurance information before appointments to confirm it was still active. They shared that changes to insurance statuses happen all the time, especially at the beginning of the calendar year or policy year. Frequently patients change jobs and forget to inform staff of changes to their employer-based insurance. Sometimes patients are not aware of limitations of their insurance prior to interacting with dental staff. Alexis at Drs. Andy and Grant makes it a point to also confirm that there are no insurance waiting periods for new patients who may not be aware that they are not eligible for coverage until a certain amount of time has elapsed. Staff also described one time when an employer insurance plan dropped dental coverage, and their patients using that plan weren't even aware of the change. In that case, it became the staff's responsibility to inform the patients.

The role of staff doubling as bureaucrats is not limited to enrolling and monitoring patients' participation in insurance or Medicaid. Lipsky (2010) states, "a defining facet of the working environment of street-level bureaucrats is that they must deal with clients' personal reaction to their decision, however they cope with their implications" (p. 9). Jessica describes how even when decisions are facilitated by insurance policies, it is she who has to manage customer expectations and ire. "Even if it was the estimate insurance gave us, but when the final claim comes in, it'll be different and the parents will call us. Even though it's an insurance thing, they [parents] will call us, and we get the angry phones calls and things like that, so it's difficult."

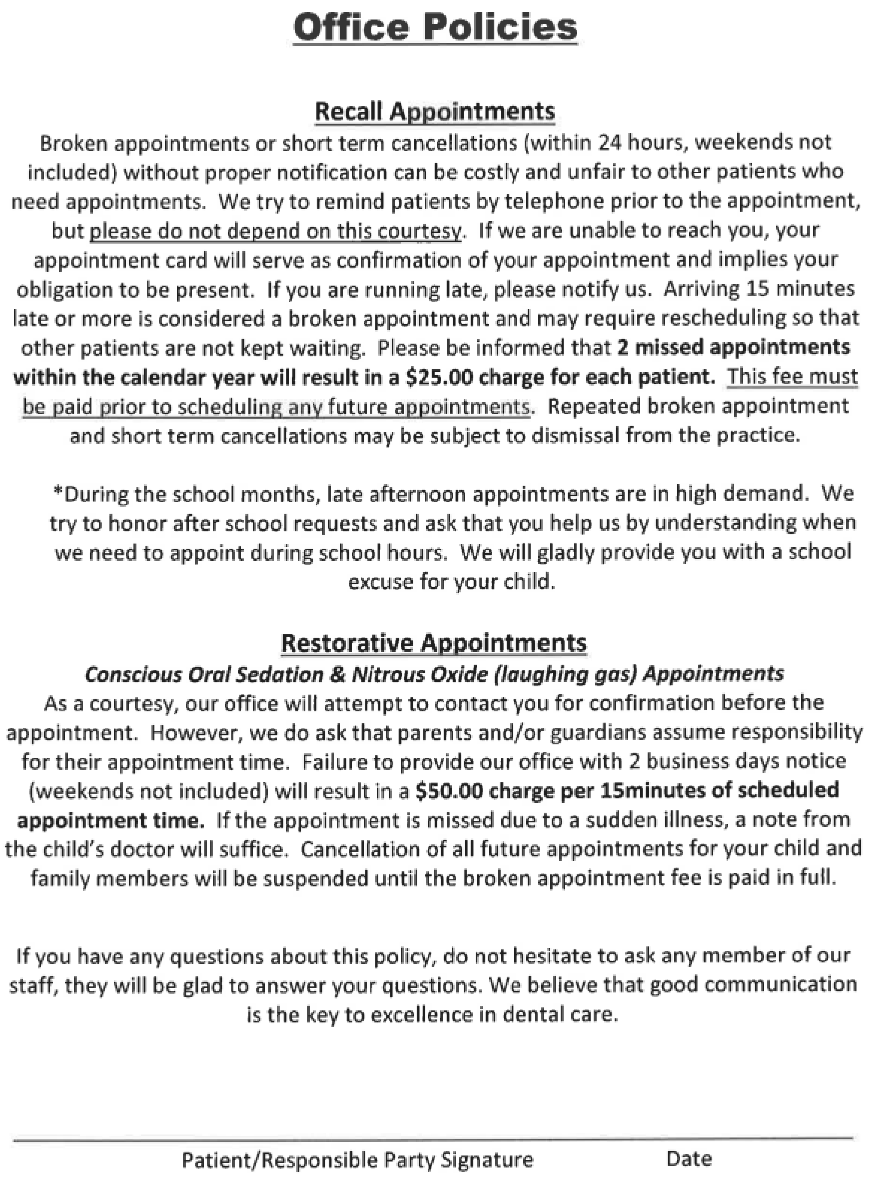
In their role as bureaucrats, dental staff are also fulfilling the responsibilities described by Lipsky (2010) to socially construct and educate the client on bureaucratic expectations. However, staff perform work for two different bureaucratic systems, a private insurance system and a public safety net system. Where the patient has been rationalized out of the private insurance system, staff responsibilities focus more on constructing the patient into textualized formats that can be conveyed to insurance administrators and on educating patients on their benefits and allowances. For Medicaid, staff become responsible for "teaching the client role" (Lipsky, p. 61) or confirming patient compliance. Operating in these two systems requires both different work and different patient interaction.

Private Bureaucracies

Chapter 4 detailed how insurance policies operate as a ruling relation dictating patient access and care. Unlike government aid programs where consumers can be described as nonvoluntary and expendable (Lipsky, 2010), insurance acceptance becomes the main driver by which patients select providers. This means that dental office staff not only become the public interface of a bureaucracy, they are also expected to provide customer service and satisfaction for the economic viability of the dental office. Various office forms include lines for signatures to acknowledge an understanding of office and patient responsibilities, as depicted in Figure 18.

Figure 18

18 Office Text: Patient Responsibility



Office Policies

Recall Appointments

Broken appointments or short term cancellations (within 24 hours, weekends not included) without proper notification can be costly and unfair to other patients who need appointments. We try to remind patients by telephone prior to the appointment, but please do not depend on this courtesy. If we are unable to reach you, your appointment card will serve as confirmation of your appointment and implies your obligation to be present. If you are running late, please notify us. Arriving 15 minutes late or more is considered a broken appointment and may require rescheduling so that other patients are not kept waiting. Please be informed that **2 missed appointments within the calendar year will result in a $25.00 charge for each patient.** This fee must be paid prior to scheduling any future appointments. Repeated broken appointment and short term cancellations may be subject to dismissal from the practice.

*During the school months, late afternoon appointments are in high demand. We try to honor after school requests and ask that you help us by understanding when we need to appoint during school hours. We will gladly provide you with a school excuse for your child.

Restorative Appointments

Conscious Oral Sedation & Nitrous Oxide (laughing gas) Appointments

As a courtesy, our office will attempt to contact you for confirmation before the appointment. However, we do ask that parents and/or guardians assume responsibility for their appointment time. Failure to provide our office with 2 business days notice (weekends not included) will result in a **$50.00 charge per 15minutes of scheduled appointment time.** If the appointment is missed due to a sudden illness, a note from the child's doctor will suffice. Cancellation of all future appointments for your child and family members will be suspended until the broken appointment fee is paid in full.

If you have any questions about this policy, do not hesitate to ask any member of our staff, they will be glad to answer your questions. We believe that good communication is the key to excellence in dental care.

Patient/Responsible Party Signature Date

These expectations include patient responsibility to know individual insurance benefits. However, it is acknowledged by dental staff that this simply does not happen. Even when discussing the benefits of being out of network for a provider, Jessica admitted that as a parent or patient, she would not go to a doctor who was out of network if it would require her to file her own insurance claim. “It’s a lot of work. If I were shopping around that [provider filing] would be a big plus. You are paying for someone to help you.”

The ruling relations of insurance and its role in patient choice are so prevalent that even the staff of Dr. Andy and Dr. Grant, who have chosen to be out of network, are still liable for patient education and plan explanations. For them, they often find themselves explaining the limitations or maximums of an insurance plan in the context of being out of network at their office. Dr. Andy feels that patients don’t understand the way insurance in dental care functions, which he feels is more akin to a benefits plan versus an insurance plan. “People believe insurance means access to care...good dental insurance means you get $1,500 maybe $2,000 coverage and a lot of money goes into propping up insurance companies who move pennies around.”

The ability for patients to move from provider to provider means their transient nature can come at an economic loss for dental providers. In addition to patient education, I observed lots of patient advocacy during disputes with insurance companies. This included my observations at Dr. Andy’s and Dr. Grant’s office despite their out-of-network status. For example, I observed Tricia speak with the patient, insurance representative, and administration at an oral surgeon’s office when a treatment plan had been denied by insurance. Tricia believed that the insurance claim had been improperly submitted at the oral surgeon’s office, causing insurance to deny it based on frequency because they had not processed the claim for extractions yet and were denying implants based on recent denture coverage. Tricia received information on how to resubmit the claim and worked with the oral surgeon’s office to start the resubmission. Tricia willingly performed all this work for the elderly patient and his wife as an act of added customer service. This work is in addition to the time spent filing claims for patients and fielding questions from patients.

A good illustration of how dental offices have to balance both patient and insurance interaction comes from another example given by staff at Dr. Andy's and Dr. Grant's office. On one particular day, I observed that the phones were ringing much more frequently than during my last observation. Danica explained that a lot of them were questions for billing statements that had just been sent out. Many of these billing statements said "90 days overdue" and for many patients this was actually the first time they were receiving a bill. This quirk arose because the bills were not processed until after insurance paid, which was after 90 days since the procedure was completed. There is no late fee for the patient because it is just the leftover balance, and they usually explain this at check out, but they still get phone calls about it each month. Here, the insurance company controls not only capital but time as a resource as well. Office staff reported that it usually requires 3 to 4 weeks for a claim to be processed, and when it does take more than 90 days it is because a claim has been denied at one point or another. This back and forth requires a lot of administrative time and gets to a point where it may no longer be worth the frustration. Underscoring my observation at Dr. Andy's and Dr. Grant's office, Dr. Calvin shared that they had recently dropped participation in some insurance plans for this exact reason.

> Some plans they would pay fairly well or they would say they would pay fairly well and [you] jump through hoops to get authorization numbers and preauthorize it. And then you would submit the claim with the authorization number, and they would deny it even though they already said that they were going to approve it. And they would play this game for 4 to 5 months before they finally paid, and we finally told them, "this really isn't worth it to us even if you pay our full fee because it takes 6 months to get the money

> and all this administrative time to do it so we are going to drop you because we were fair to you. We gave you our honest opinion on what we were going to do, we performed the work for your patient, and then you strung us along.

The time insurance companies were willing to spend disputing or denying claims was especially frustrating for staff not only because it was withholding capital, but because of its seeming hypocrisy as some insurances require a claim to be filed within 90 days or it will be automatically denied on the basis of lack of timely filing.

Not officially being part of private insurance companies can position staff to be in an awkward position in their bureaucratic role. Earlier I described the chaotic rollout of CCC+ as a new plan from Medicaid. Such situations are not limited to public bureaucracies and can be more problematic when attempting to balance customer service with rationalized ruling relations. Jessica shared an example where a woman claimed that Dr. Calvin's office was listed on a website as a location participating in discount plans. She was very upset when the office said they did not participate but decided to continue with treatment for her child as there was a discount for self-pay. Later, the office learned that they were indeed listed on the website without their knowledge because they are Anthem providers and under an umbrella group loophole, were unknowingly also participating in other Anthem programs. Jessica was since able to get the office taken off the website, but she did call the mother back to explain and apologize, "I want to make you happy. It was a mistake on the [part of the] insurance company, signing us up for something we didn't sign up for, but I want to honor this discount to you, and we will leave it on for the next time you come in."

The added level of patient education and customer service puts additional work on dental administration. For these reasons, the ease or difficulty working with different insurance companies became a large component of interviews and observations. One thing that came up frequently in my conversations with Jessica was whether or not a company's website was easy to navigate.

> The websites are very important...We like to take the main ones where we know we can get online, get their benefits, and call it a day. If you cannot, and someone is waiting on you, it can be an easy 10- to 30-minute call...any other questions or claims that have been out too long, I put aside. Thursday is my insurance day, and I dread it. Because I'm on hold or my ear starts hurting. We are at their mercy.

The flow of textual information from insurance companies to dental providers depicted in Figure 17 is evident in the example provided by Jessica. After the office has submitted a textualized objectification of the patient to insurance, they are now responsible for retrieving the insurance company's benefits available to that patient. Calling the insurance company requires relying on an insurance representative's understanding and knowledge, which Jessica shared that she frequently does not trust. Furthermore, Jessica mentioned that when she does find a good representative or point of contact at an insurance company, they don't stay there for long because of the high turnover in those positions. Rather, accessing policy benefits and information from a website is more convenient and streamlines the flow of information or ruling relation from insurance to the dental office.

In contrast, Dr. Andy explained that the office's decision to be out of network was primarily due to a desire to have less ruling relation in how they provided care. Though they are not able to escape all aspects of insurance's ruling relation as they continue to bill insurance for patients with out-of-network benefits, they are not as reliant on insurance's control of resources, both in terms of patients and insurance coverage.

> We felt like the insurance companies were coming between our relationship with our patients by disallowing things and at the clerical level. There was a financial part, too, the cost of doing business with them. We were losing money by the time we accepted their fee. When we did this [go out of network], one of the benefits was you have a filter. Now we hardly ever hear about what insurance will pay.

During my observation at Dr. Andy's and Dr. Grant's office, I learned from Tricia and Karlee that many of the office's patients had initially come for a second opinion and stayed when they learned that some of the original treatment plan they had been prescribed was heavily dictated by what their plan would or would not allow. In many cases, the treatment plan proposed by their offices required less work, and it ended up being either a similar cost or cheaper even out of network. Dr. Grant shared, "people come in for a second opinion and every little thing is charged out. When we have people, who come to our office from other places, they are surprised when we don't charge for certain things. It's because, now we don't have to."

By choosing not to participate in insurance plans, Drs. Andy and Grant were opting to focus more on customer service over rationalized bureaucracy. They could provide care without consideration of treatment benefits, and this provided them more leeway in how to provide care. Though the nature of their profession still puts them under the yoke of insurance ruling relations, their position is more tangential and indirect compared to Dr. Calvin's practice. In addition, Dr. Andy provided another reason for why they decided to go out of network. He shared a specific example of a self-pay patient who required a lot of work. The fact that this patient, who was paying cash, paid entirely different amounts from patients with insurance bothered him.

> It didn't sit well with me to have two different systems. Now everyone gets charged the same. Charging someone without insurance more than someone who has a corporate C-

> suite health insurance plan didn't seem fair. Besides, it's not insurance, it's a benefits program. Insurance is a different concept. Insurance is against loss. Better without [insurance], but we need to have something else, like Medicaid.

Dr. Andy's and Dr. Grant's decision to be out of network allows them to be more transparent in their prices and equitable to their patients. There are no differences in payment structures dependent on agreed insurance contract fee schedules. Furthermore, their decision to be out of network may have made being a Medicaid provider easier. "In a way, being out of network subsidizes but does not directly affect the setting of our fee schedule; indirectly it may." Ways to encourage increased participation in Medicaid is an area that deserves attention given its importance to the treatment of SHCN patients and patients who cannot afford private dental insurance. Though there are unique disjunctures that arise because of a dental provider's decision to participate, there are also some surprising ways in which Medicaid eases the process of being a public bureaucrat.

Public Bureaucracy

Agreeing to participate in Medicaid is not simply agreeing to participate in another managed care plan. It is agreeing to become a bureaucrat of a government subsidy program and to take on the additional responsibility of coordinating with other bureaucracies that simultaneously manage the bodies of SHCN patients. Dr. Calvin, Dr. Andy, and Dr. Grant all describe accepting Medicaid as a moral obligation. In fact, Dr. Andy and Dr. Grant bemoaned that the ADA did not emphasize it more in their code of ethics. They both recalled that their decision to participate in Medicaid stemmed from a campaign by the VDA, the "Take Five Initiative." This initiative corresponded with raising reimbursement rates and encouraged dental providers to take five Medicaid, preferably adult, patients. Dr. Andy shared that their office already had SHCN patients, so the decision to participate made sense and was best for their existing clients anyway.

Though accepting pediatric Medicaid patients is more prevalent compared to adult patients, Dr. Calvin goes a step further to state that he used Medicaid to build his business. When he first started his business, he needed to build up his clientele and actively sought out patients who were being turned away from other local safety nets. This required him to become a Medicaid provider and helped him build a reputation for treating SHCN patients and accepting Medicaid.

> We have patients that [*sic*] come from Emporia. When I started, I treated a family that [*sic*] owned a taxicab company, and for years they would bring…every day, they would bring a cab full of Medicaid kids from Emporia.

The increased coverage afforded to pediatric Medicaid patients and types of procedures makes it easier to build a pediatric practice using Medicaid. In contrast, Dr. Grant states that it would be much more difficult for general practitioners to grow their practice through Medicaid. However, he declares that "if you can make money doing it, dentists would do it." Indeed, Dr. Andy shares that during the 2008 recession when a lot of other providers were suffering, they were doing fine because they could rely on their SHCN Medicaid patients.

Providers are prohibited from billing Medicaid members for any Medicaid-covered service (Lewin Group, 2009), even if out of network. This means that unlike private insurance plans, providers like Dr. Andy and Dr. Grant cannot charge a patient for fees not covered by the managed care plan. Therefore, there is no incentive to take on Medicaid patients with low reimbursements and limited coverage. What Drs. Andy and Grant have done to make their care of SHCN patients economically viable, though, is to provide hospital-based care in addition to routine recalls or cleanings. Patients who are not able to be treated in an office or who require extensive treatment are put under general anesthesia for cleanings and extractions. Dr. Grant shares, “even with Medicaid, you could generate $1200 to $1500 in a couple of hours.” He does not, however, advocate for hospital-based treatment as a first option for a variety of reasons. If a patient only needs one extraction, that would be a reimbursement of $70 and would not be worth it for the patient or provider. Hospital treatment also precludes some procedures like a root canal and crown, which are two-step procedures and would require being put under and charged twice for a hospital fee.

Hospital-based care, however, is an excellent example of the multiple layers of bureaucracy that providers must navigate through. Many of the patients Dr. Grant treats in the hospital are covered by Medicaid and Medicare, and this frequently presents confusion to hospital administration. Though Medicaid will cover dental treatment in the hospital as a medical necessity, it is not uncommon for hospital staff to question Medicare coverage of the hospital visit, which is important because the operating room charges $60 per minute. Dr. Grant reports getting pushback from the local hospital where they take their patients because the procedure is dental and not perceived as medical. When this happens, they are able to contact the CEO of the hospital who will push through hospital approval, but this pattern “rears its head every couple of years when there is new staff.” If they require additional assistance, they are able to contact Medicaid directly, which is another way in which Medicaid differs from private insurance companies.

Dr. Grant reports that when they have needed assistance from Medicaid, they do have a point person that they can contact. This person was responsive and helpful when they needed to get hospital approval for procedures. Dr. Grant also recalls this individual at local professional meetings promoting her role and services to Medicaid providers. Jessica from Dr. Calvin's office similarly reports that they know who to call at Medicaid if they ever have an issue. Not only is this in direct contrast to private insurances, where high turnover prevents the cultivation of such a relationship, they also trust and hold their Medicaid contact in high regard. Furthermore, this relationship provides them with a sense of autonomy in their relationship with Medicaid.

Unlike private insurance companies, where participants report feeling like they are "at their mercy" or powerless to influence policies, all participants described some way in which they felt more autonomy in their relationship with Virginia Medicaid. In addition to having a direct contact at Medicaid, Dr. Andy reported going to the General Assembly (GA) to advocate the raising of Medicaid reimbursement rates. Dr. Calvin sits on an advisory committee that coordinates work between DMAS and the VDA and gives examples of how his advocacy over the past 15 years has helped to make Medicaid easier to use for providers.

> One of the first things we did was make the dental part, make it look like any commercial carrier...It used to be 15 years ago each HMO ran their own dental part, and the patients could switch once a month. So, it could be a child needed six cavities and needed to go to the operating room, and they had CareNet and now they have VA Premiere, and they didn't honor each other's preauthorizations. So, it was a nightmare, and you would go the day before surgery, [and be told] we can't do that now! So, we have gotten that straight.

Gwen gives another example of how Dr. Calvin's influence can be used with Medicaid, "Dr. [Calvin's] voice is heard. If I'm working with my specific rep, who is wonderful, if there is a push-pull situation, all I have to say is, 'Dr. [Calvin],' and it matters."

In addition to an increased sense of autonomy, participants reported that Medicaid was easier to work. When asked the difference between Medicaid and private insurance, Gwen shared that administratively there was a “lack of downcoding, more black and white. There isn’t a big difference at all, sometimes Medicaid is easier to work with.” Jessica echoed these sentiments during observations and said that Medicaid took much less administrative time compared to other insurances, “you know what they will approve and what they will not.” After observing Camilla review predeterminations, I asked if she had any for Medicaid. She responded that they don’t really have to do predeterminations for Medicaid because they know what procedures will be covered. Dr. Andy described working with Medicaid as “liberating” because he did not have to worry about insurance and could focus on care, especially for pregnant and postpartum patients. Dr. Calvin acknowledges lower payments but pointed out that “Medicaid will pay for [behavior management] that private insurance will not.”

Though the more streamlined nature of Medicaid bureaucracy is administratively beneficial for dental providers, the decision to rationalize the patient into the system creates other bureaucratic responsibilities for dental staff. For example, dental providers are not allowed to charge Medicaid patients for missed appointments (DentaQuest, 2020). Though a nominal fee can be applied to patients with private insurances to both offset the expense of a missed appointment and provide a disincentive for breaking appointments, this is not allowed with Medicaid patients. Missed appointments or *no-shows* are a significant problem for Medicaid patients. Nationwide, it is estimated that 30 percent of Medicaid patients miss appointments (McPherson, 2008), and this can have a deleterious impact on oral health for the patient. For the dental provider, missed appointments can be extremely costly, and the high rate of missed appointments among Medicaid patients is often cited as a reason to not participate as a Medicaid provider (Decker, 2011; Kennedy, 2009). Dr. Calvin spelled it out in economic terms for how detrimental no-shows were for his bottom line.

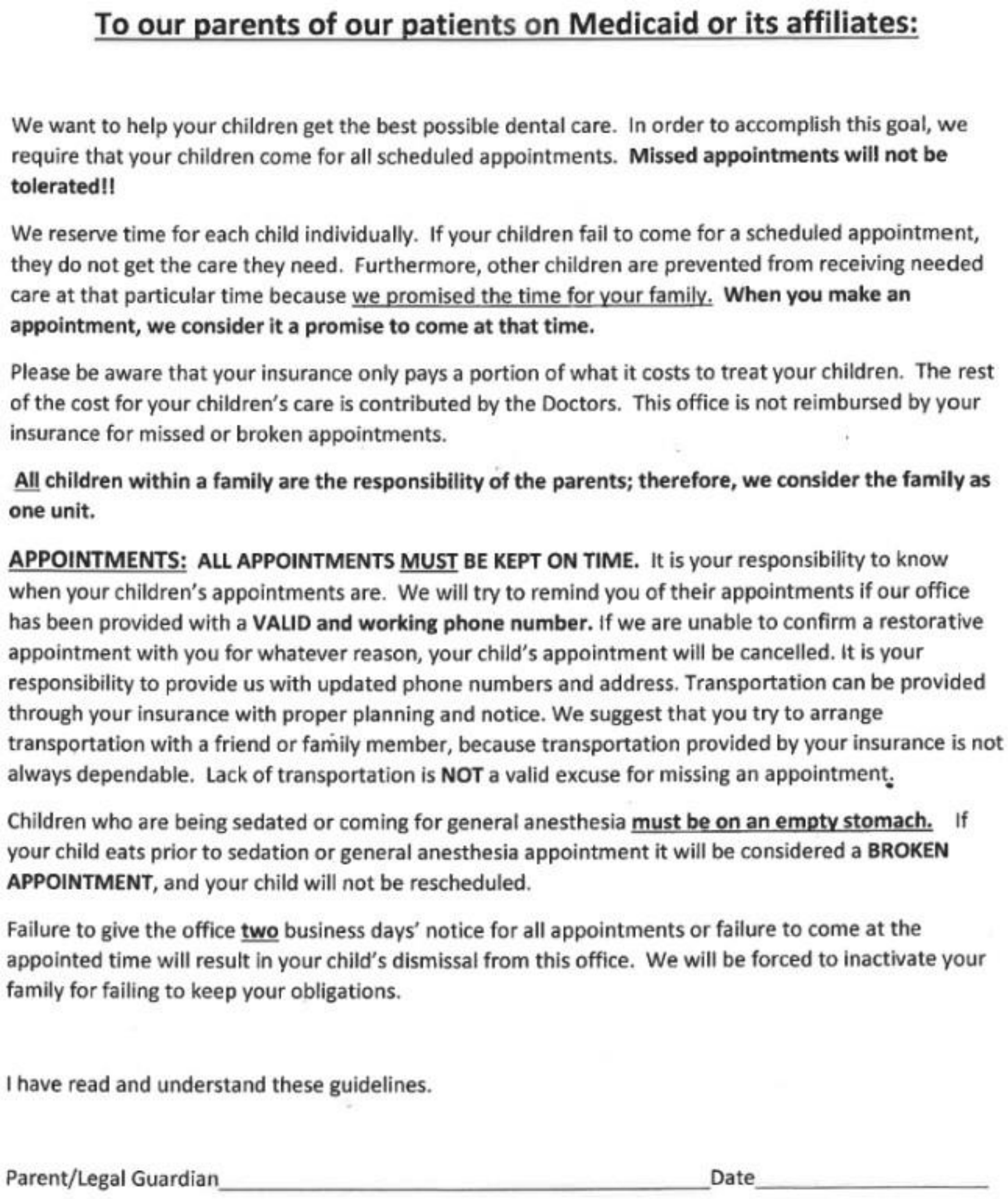
> I like to give this math example. The ADA overhead is 65 cents on the dollar. So, for a procedure that costs $100, you should have $35 in profit...Well okay, the patient doesn't come that day. It still costs you $65 because you reserved that spot for that patient. The patient comes the next time, it still costs you $65 again for that patient. You have paid out $135 to get $100 off one no-show.

To combat missed appointments, strict office policies are created to ensure compliance.

Figure 19 shows Dr. Calvin's office policy toward missed appointments for their Medicaid patients. Considering the difficulty that many patients have finding dental providers who will accept Medicaid, the threat of dismissal from the office is one of the strongest weapons available to them.

Figure 19

19 Medicaid Office Polices



To our parents of our patients on Medicaid or its affiliates:

We want to help your children get the best possible dental care. In order to accomplish this goal, we require that your children come for all scheduled appointments. **Missed appointments will not be tolerated!!**

We reserve time for each child individually. If your children fail to come for a scheduled appointment, they do not get the care they need. Furthermore, other children are prevented from receiving needed care at that particular time because we promised the time for your family. **When you make an appointment, we consider it a promise to come at that time.**

Please be aware that your insurance only pays a portion of what it costs to treat your children. The rest of the cost for your children's care is contributed by the Doctors. This office is not reimbursed by your insurance for missed or broken appointments.

All children within a family are the responsibility of the parents; therefore, we consider the family as one unit.

APPOINTMENTS: ALL APPOINTMENTS MUST BE KEPT ON TIME. It is your responsibility to know when your children's appointments are. We will try to remind you of their appointments if our office has been provided with a **VALID and working phone number.** If we are unable to confirm a restorative appointment with you for whatever reason, your child's appointment will be cancelled. It is your responsibility to provide us with updated phone numbers and address. Transportation can be provided through your insurance with proper planning and notice. We suggest that you try to arrange transportation with a friend or family member, because transportation provided by your insurance is not always dependable. Lack of transportation is **NOT** a valid excuse for missing an appointment.

Children who are being sedated or coming for general anesthesia **must be on an empty stomach.** If your child eats prior to sedation or general anesthesia appointment it will be considered a **BROKEN APPOINTMENT**, and your child will not be rescheduled.

Failure to give the office **two** business days' notice for all appointments or failure to come at the appointed time will result in your child's dismissal from this office. We will be forced to inactivate your family for failing to keep your obligations.

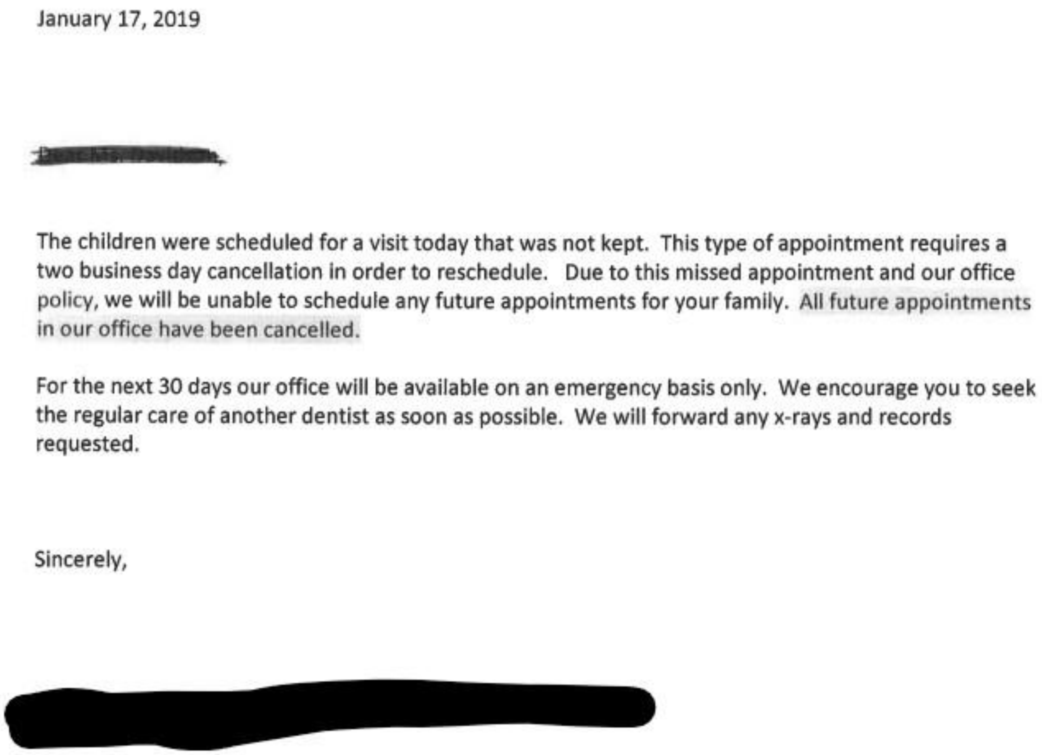
I have read and understand these guidelines.

Parent/Legal Guardian______________________________________Date__________________

Here, dental providers and their staff are using their bureaucratic role and power to control access to oral healthcare. Though they are not allowed to charge for missed appointments, they are able to flex their power and authority to maintain consumer compliance, thereby reinforcing expectations of a proper consumer. Furthermore, the preceding image and text clearly state that lack of transportation will not be considered a valid excuse to miss an appointment. The earlier analysis of NEMT demonstrates the considerable time burden required to access and use this transportation, but these outside barriers do not factor into the policies set up by dental providers to work within the confines of the rationalized system handed down to them from Medicaid. Though these are developed office policies, true to their nature as street-level bureaucrats, staff commonly demonstrate autonomy as to when to actually enforce such policies. Though the language of the office policy communicates set and objective parameters, the reality when speaking to staff was that they did consider past patient behavior and circumstances. In fact, during my observation I saw only one dismissal letter to a family that had missed a total of 16 appointments, depicted in Figure 20.

Figure 20

20 Dismissal Letter



January 17, 2019

[redacted]

The children were scheduled for a visit today that was not kept. This type of appointment requires a two business day cancellation in order to reschedule. Due to this missed appointment and our office policy, we will be unable to schedule any future appointments for your family. All future appointments in our office have been cancelled.

For the next 30 days our office will be available on an emergency basis only. We encourage you to seek the regular care of another dentist as soon as possible. We will forward any x-rays and records requested.

Sincerely,

[redacted]

Nonetheless, the role of dental staff as bureaucrats means that they are responsible for the creation and implementation of policy (Lipsky, 2010), and their role as such can be especially impactful for SHCN patients who may be limited when it comes to accessing care. Indeed, if the rationalized system of an institution is not favorable to a client, the best source of resistance may in fact be the street-level bureaucrat that engages with the client on a personal level. The disjunctures that arise from conflicts between the experiential way of knowing and the institutional ruling relation, may become the impetus for a dental provider to subvert or circumvent the rational system. Farmer (2005) proposes that bureaucrats should engage in thinking as playing, justice as seeking, and practice as art when attempting to stand against systems. By doing so, bureaucrats can “contribute to transforming those systems into ‘arrangements’” (p. 136) and begin to deconstruct textualized forms of bureaucracy. Chapter 6 will analyze the ways in which study participants have used their professional autonomy to resist ruling relations.

CHAPTER 6: Professional Autonomy as Acts of Resistance

When I first began to formulate my dissertation research, I had already decided that I did not want to investigate the experiences of PWD accessing oral healthcare. The literature review revealed what I already knew to be true: PWD had difficulty finding providers, especially if they relied on Medicaid. My decision to adopt the standpoint of dental providers was an attempt to understand which factors contribute to a provider’s decision to participate in Medicaid and thereby increase access to care for SHCN patients. The ability for a dental provider to decide whether or not to participate in Medicaid is a direct example of their professional autonomy. My initial hypothesis was that providers primarily used their professional autonomy to navigate a capitalist health market, with the unfortunate side effect being that those decisions often resulted in the exclusion of SHCN patients. What developed from my observation and analysis was a mapping of ruling relations and the ways ruling relations dictate care for all patients. What added to the burden of providing care for SHCN patients was the need to navigate multiple layers of bureaucracy in addition to insurance ruling relations. Furthermore, what was revealed in my analysis is that though it is true that participant providers did have to navigate a capitalist health market to maintain economic viability, they wielded their professional autonomy more as a weapon against insurance ruling relations. These acts of resistance actually became the means by which providers fought not only to maintain economic viability but also to provide care to their patients, including SHCN patients. This chapter concludes my analysis by demonstrating how professional autonomy becomes acts of resistance and provides suggestions for future policy implementation.

Where There Is Power, There Is Resistance

Chapters 4 and 5 use institutional ethnography to map ruling relations and demonstrate how those ruling relations are communicated from insurance companies down to the local setting by way of insurance policies, billing, and coding texts. The disjunctures described in Chapter 5 demonstrate how these ruling relations exemplify rationalized systems that have become uncoupled from the lifeworld as described by Habermas (1987), creating systems of technical rationality that conflict with experiential and ethical ways of knowing.

Habermas (1987) describes how the uncoupling of systems from the lifeworld results in autonomous organizations that rely on forms of communication removed from communicative actions central in the lifeworld. These forms of communication, such as money and power, create a social intercourse and communication that are largely disconnected from norms and values. This creation of autonomous organizations or bureaucratization is a symptom of laws replacing ethics and the rationalization or colonization of the lifeworld. Furthermore, employees in bureaucratic roles “detach themselves from lifeworld contexts and adapt themselves to formally organized domains of action” (Habermas, 1987, p. 321). This detachment can create an ethical dilemma as “ethical obligations to one’s calling give way to instrumental attitudes toward an occupational role that offers the opportunity for income and advancement” (Habermas, 1987, p. 323). Here we encounter the heart of the disjunctures experienced by dental staff and can examine how insurance ruling relations conflict with the ethical provision of care for all patients. Consider for example the Medicaid policy of disallowing charges or fees for missed appointments. As detailed in Chapter 5, no-shows are detrimental to a provider’s operating costs. This insurance ruling relation creates a rationalized system in which office policies are put in place to mitigate no-shows, and Medicaid patients who miss appointments are threatened or punished with dismissal. An office staff member who aligns strictly to office policies has every right to dismiss patients who do not adhere to office policies, and it would be in the best economical interest of the dental provider, yet their decision to do so has ethical ramifications and potentially dire consequences for the patient. Considering the difficulty in finding a provider who accepts Medicaid, especially if the patient is an adult with SHCN, a dismissal could mean the inability to access future dental healthcare.

Adams and Balfour (2009) detail how this adherence to technical rationality can lead to what they describe as administrative evil. By conforming to one's organization role and responsibility, individuals perform acts of evil without any awareness of the damages caused by their action, and they may even justify these actions through *moral inversion*. Through the lens of technical rationality, their actions are redefined to convince them that they are doing something good, and the administrative evil becomes masked. By dismissing Medicaid patients because of no-show appointments, they are saving the provider money and opening up a spot for another Medicaid patient, a patient who has been better socialized to their patient status—a more *deserving patient*.

It is often the bureaucrat who stands between technical rationality and masked administrative evil, specifically, it is their ability and discretion to make decisions and judgements that do not adhere entirely to organizational ruling relations—their street-level bureaucracy, as described by Lipsky (2010). This ad hoc power affords bureaucrats the opportunity to separate themselves from the system and reassert their individuality. Farmer (2005) advocates that "standing against" systems, applying a "deconstructive attitude," and using "hesitation" prevent practitioners from becoming cogs themselves in the bureaucratic machine (p. 135). In this manner, professional autonomy offers more than just power; it also offers resistance. From a policy perspective, these acts of resistance must be analyzed and collected as it becomes a means to combat colonization of the lifeworld and reclaim power from ruling relations.

Foucault (1976/1978) wrote “where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power” (p. 95). Because power relationships rely on institutionalized knowledge and authority, and mutually agreed to social relations, there is no single sovereign for external forces to overthrow. Instead, resistance and activism come from within. Foucault (1976/1978) describes these points of resistance as a swarm that can be found at any point in the power network, social stratification, and individual unit. Because my research is centered from the dental provider’s perspective, the points of resistance I observed were all at the local setting and acting against its ruling relation. From my observations, these acts of resistance materialized when the technical rationality of ruling relations revealed systemic inequities that harmed dental providers and their patients. Following are descriptions of such examples of resistance.

Resistance to Levels of Care

Throughout Chapters 4 and 5, examples were given to describe and explain how insurance as a ruling relation had a direct effect on provision of care. Beyond how care is provided, these ruling relations also dictate varying levels of care provided to patients. Because private and public insurances express different ruling relations at the local setting, the mechanisms in which levels of care were dictated differed depending on whether an individual relied on insurance or Medicaid. Therefore, the forms and acts of resistance I observed or had described to me also differed depending on whether or not a patient used private or public insurance.

Medicaid

The most obvious example of Medicaid dictating varying levels of care is how Medicaid coverage results in dramatically different levels of care depending on the age of the patient. Whereas preventative care is covered for pediatric patients, medically necessary or limited treatment only is provided to adult patients. Dr. Grant bemoaned how the exclusion of preventative treatments, like cleanings or scaling, but allowance of diagnostic panoramic x-rays, biopsies, and extractions (without replacement) meant that, as a practitioner, he had to wait until the patient's quality of life suffered. "If you see a tooth with a hole, but it's not infected, you just have to wait until it hurts." The limited coverage and allowances for adult patients also result in what is described as the Medicaid mill model, in which the total volume of patients seen offsets the low reimbursement values. Dr. Karen implied this was the only way to make caring for Medicaid patients economically viable when she described how she did not like to be rushed. Dr. Grant further explained that this model is incompatible with SHCN patients, too. "Seeing people in 15 minutes, that's the time it would take just to move someone from a wheelchair to your chair." However, both observed providers worked with Medicaid patients to provide care outside the confines of covered care. This meant working with patients to pay cash for care, but by performing the transaction outside of insurance reimbursements, there was flexibility in payment.

Both offices used Care Credit and provided information to patients on how to sign up if they wanted to finance treatment. Drs. Andy and Grant explained that their decision to do so was to avoid becoming the bank and assuming that financial risk. For patients, they have 1-year interest free to pay off their credit and, even though that meant the dental office was essentially paying the interest for that year, it was easier because, "If they don't pay we don't have to pay for collections. We avoid the time required and avoid damaging our reputation—trying to keep up with people—there are people who do that full time." However, partnering with Care Credit did not mean they did not offer other options to patients when necessary. During one of my observations, Tricia reviewed and explained to me a SHCN patient who had been on a monthly repayment plan. However, funds had not been recovered and payments had ceased over a year ago. If they sent the bill to collections, it would be the patient and not the caretaker whose account would be sent to collections. Instead, Tricia decided to cancel the upcoming appointment and notify the patient and their family that they would not be able to return until payments resumed. Though the technical office policy is to send anything past 90 days to collections, they elected not to in this case because it would harm the patient who was not the responsible party and would be futile because social security insurance cannot be garnished to pay past due balances. In addition, the office did not have a hard policy about when to release patients for no-shows or missed payments as they try to be as lenient as possible. Tricia even went on to express that had the family communicated with them regarding payment, they may not have canceled the upcoming appointment.

For Dr. Calvin's office, as a pediatric office, Medicaid is much more comprehensive and his staff worked with parents of SHCN patients to sign up for Medicaid to receive coverage beyond private insurance. Sometimes this meant overcoming cultural barriers and misconceptions. "A lot of the Hispanic parents are, they are worried about applying for benefits, even if they are legal[9]...but that is what the patient needs, and we can talk them into getting the benefits they need." For Medicaid SHCN patients who aged out of pediatric coverage, as previously mentioned, Dr. Calvin would retain them if they wanted to stay and continue to provide treatment for them at the cost of what Medicaid would have reimbursed. Though this

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[9] Though "legal" is not the preferred terminology for documented immigrants, I kept its use as this is a direct quote, and I believe its use here adds weight to my later section on implicit bias and cultural competencies.

still required an out-of-pocket cost to the patient, it was an option outside of covered services. However, other services that Dr. Calvin could not provide were affected by varying levels of care tied directly to age.

> We got a letter from one of the bigger ortho surgery practices this week, and they are no longer going to see Medicaid SHCN patients over the age of 18. They were only getting paid 30 percent of their costs. “We do lots of indigent care and pro bono work, but we just aren’t going to take this on.” They said something like that to justify their decision.

Also described in Chapter 5 was the example of patient dismissal. Though Dr. Calvin’s office did have a written policy and warning of dismissal for missed appointments, the fact that I only saw one dismissal letter for a family that had missed 16 appointments demonstrates that they, too, were lenient in their policy, as they knew patient dismissal had a direct effect on care.

These described acts of resistance occurred in the local setting under the professional authority of providers and their staff, and these acts did not directly subvert the ruling relation of Medicaid so much as they worked outside the confines of coverage, especially for adult patients since care for pediatric patients is comprehensive. Furthermore, I surmise that their tactics may not have required as much calculation or subversion because there were other means for them to leverage their professional authority. As described in Chapter 5, the structure of local management provided them with a direct contact at Medicaid as well as advocacy through advisory boards. Even more, staff reported that Medicaid would provide training and consultations to dental staff on how to submit claims in order to reduce denials. In fact, when asked what factors would make them change their minds about being Medicaid providers, the responses were if reimbursements were lowered significantly, if it became much harder to work with administratively, or if Medicaid adopted a capitation form of reimbursement. Low reimbursement rates have frequently been given as reasons to not participate in Medicaid and lowering those rates would make it nonviable. Removing the ease of working with Medicaid would remove one of the primary benefits of working with Medicaid described in Chapter 5. Dr. Calvin's response to capitation payments was based on the premise that capitation would be a disincentive to providing care.

> In actuality [capitation] makes more sense to provide palliative care at the beginning and then as the patients get older down the road and you've got more capitation fees, then to provide the filling and the crowns. It's a little bit dishonest, because it provides a disincentive to treat the patients, and we want to treat the child's needs now.

However, none of the participants treated my question as an imminent fear and all had to think about what would be the most damaging change to Medicaid in their eyes. This question was treated more as a thought experiment because they have seen rates go up over time; the ease of working with Medicaid is often described in direct contrast with private insurances; and individuals, like Dr. Calvin, have direct access to DMAS to advocate their position. These acts of resistance fell more in line with professional discretion to use or ignore the systems as needed. In contrast, the acts of resistance leveraged toward private insurance took on a substantially more subversive tone.

Private Insurance

For private insurance, the insurance plan textually transmitted what were allowable procedures, annual maximums, downcodes, and schedule fees, all for the goal of achieving cost-saving measures. The prioritization of cost-saving measures meant the level of care provided to individuals is highly dependent on what kind of insurance plan and managed care agreement they and their provider had with a particular insurance company. For example, during one of my first observations at the office of Drs. Andy and Grant, I observed a conversation between clinical staff and Karlee. The hygienist and Dr. Grant asked Karlee to confirm whether the patient was using the same insurance since their last appointment and to check with the insurance company if the patient had any remaining treatment amount on their plan for the year, even though their records said the patient has used all of their treatment amount. When it was determined that there was no remaining treatment amount, the clinical staff decided the best course of action was to move ahead with scheduling a cleaning next and to conduct additional procedures in a new policy year. Despite the office's out-of-network status, patients with out-of-network benefits may still rely on coverage for care that they cannot afford out of pocket. As this was the case for this particular patient, the clinical team's plan for care was entirely reliant on insurance coverage.

Tricia at the office of Drs. Andy and Grant expressed that insurance often dictates care, both from the patient perspective and provider perspective. It is not uncommon for a patient to want to have only covered procedures performed and, from her previous experience at other dental offices, doctors will also supply care based on what a patient's insurance will cover. Tricia gave the examples of annual x-rays and pointed out that patients accept the idea of annual x-rays as part of their care but wondered if it was really necessary. "What is a patient being exposed to that is unnecessary just because a doctor is trying to collect payment for a treatment?" In fact, this reasoning is partly why Drs. Andy and Grant have used their professional autonomy to make the decision to be an out-of-network office. This means that they are less beholden to insurance dictates for both coverage and levels of care. There are always patients, such as the example above, who will still take insurance coverage into consideration when it comes to agreeing with a care plan, but Drs. Andy and Grant are not held under those same ruling relation conditions. In fact, they have built a reputation and grown their business by offering treatment plans that are often less invasive. The level of care they provide is dictated by their professional training and expertise and is not influenced by insurance policies.

When insurance allowances and plans influence care decisions, the results are varying levels of care highly based on market factors rather than health factors. Here, patients with generous coverage are liable to be overtreated, and patients with less coverage are likely to be undertreated. To this point, Tricia gave an example of a patient who had been told she needed 10 fillings and extractions, but when she came for a second opinion at Drs. Andy and Grant's office, their treatment plan called for scaling, performing two extractions, and watching the wisdom teeth for potential future extractions. Dr. Andy shared, "We don't have the financial pressure of writing off [costs]. We have all seen treatment plans that we flat out disagree with...a lot of it comes from management." Katherine, a hygienist at the office of Drs. Andy and Grant, moonlights at other offices and is able to provide a direct comparison.

> We don't look at a policy detail and decide what care is needed based on insurance. I've worked at another office that is totally different. They are really, really on top of insurance and overtreat...We know that technology has improved a lot, why expose an 8-year-old to a full set of x-rays who doesn't have any extensive dental needs? We do what's needed [at Dr. Andy's and Dr. Grant's].

Returning to the idea that patient care is directed by insurance policy, Katherine discussed how patients have been habituated to expect annual x-rays, even if it is not necessary or doesn't fit with their needs.

> Special needs patients, a lot of them have strong teeth, it's more about periodontal disease. They don't need to do x-rays every year, they need more frequent cleanings, not x-rays. But they get annual x-rays because insurance is covering it. At other offices, if

> you don't get your x-rays regularly, then the doctor won't see you for your exam.

Being out of network allows Drs. Andy and Grant to not only focus on treatment without reimbursement considerations, it also allows for an honest conversation with patients about needs, wants, and affordability.

> Even if you can't afford dental implants, maybe you can do a partial denture. We like to present different choices and say here are your treatment options. For example, dental financing through Care Credit. If it's not a health risk to stage treatment over time, we can get to B over 2 to 3 years and take more time versus affording it all now. If there is no way to afford optimal treatment, then we look at alternative options. I have heard we are more willing to space things out. People have said that they [other providers] wanted them to sign this document that it all has to be done now. We believe in disease management first, and if you are missing teeth, we can restore those things over time. (Dr. Grant)

The decision of Drs. Andy and Grant to be out of network is a direct response to insurance ruling relations and an attempt to distance themselves from technical systems that direct level and type of care. In fact, some insurance policies may be viewed as a direct attempt to prevent dental providers from going out of network by making the administrative process difficult. During my observations, I observed one patient during their checkout process. Though an insurance claim was filed for them by the office, they were responsible for the full treatment costs, and they confirmed that the insurance reimbursement check would be sent to them rather than the dental office. Staff did confirm that this could be a barrier to some patients who would not be able to pay for their care upfront. Dr. Andy explained to me that this one insurance company, Delta Dental, had gotten around the Virginia law (VA code § 38.2-3407.13.) that patients were allowed to assign benefits to an out-of-network provider because this insurance company was based in another state. He goes on to state, “Our appeal to the GA is it’s the patient’s right to appeal their benefits.”

Here, there is a direct contrast to the professional advocacy available to providers when combatting insurance policies compared to Medicaid policies. Instead of advocating their position directly to the organization, dental providers are banding together through advocacy and trade organizations and relying on state legislators to pass laws that will curtail the company’s business practices. For example, Dr. Calvin described how silent preferred provider organizations (PPOs) operate to undermine the managed care plans providers believe they have agreed to.

> Say Anthem can sell part of their network to someone else, and you might not participate in Anthem, but they…let’s use Circuit City. Say Circuit City bought this insurance, which is administered by Anthem, and you take that insurance. All of a sudden you find out you are taking Anthem patients too. So, there is legislation in this year’s GA to prevent that. It’s a gotcha, you have to follow this fee schedule as opposed to the one you agreed to before...VDA is a good source for this stuff. Anthem and Delta aren’t going to fight because they said they don’t do that.

In fact, VDA’s primary legislative goal of the 2019 GA session was successful and HB 1682, limiting the sale or granting of access to third-party carriers, was passed (Virginia Dental Association, 2019).

This is not to say that state changes to Medicaid have not occurred through channeled advocacy, as The Virginia Oral Health Coalition (now Virginia Health Catalyst) was vital to Medicaid expansion in 2018 and the recent budget amendment approving adult Medicaid benefits (Budget Amendments HB 30, 2020), but this advocacy is built on a coalition of stakeholders, including dental providers, trade associations, state agencies, and nonprofit partners (Virginia Health Catalyst, N.D). In contrast, the examples provided to me during interviews were trade associations lobbying legislators to intercede on behalf of dental providers against the ruling relation in which they operate. These internal resistances coalesced into a strategic movement.

Dr. Calvin provided another example when he described how legislation was used to combat insurance companies that “were trying to do an end run on [being out of network]” by not allowing providers to charge for non-cover services if a patient had insurance. “That was them dictating treatment, and now, unless they can demonstrate a reasonable and customary fee then they can dictate it, but they can’t say that they won’t pay for this filling and you can charge a penny. They have to justify.” In terms of power, individual dental providers exhibit significantly less power with insurance companies compared to Medicaid. In fact, when I posed the question of how much negotiation power he has with insurance companies, Dr. Calvin responded, “absolutely none.”

What Drs. Andy and Grant have accomplished, being out of network, was what was described to me as an ultimate goal in one of my preliminary interviews. Being out of network means being free partially from insurance policies and systems, still having access to the economic resources of insurance companies, and all while operating in a fee-for-service market. In this manner, professional autonomy becomes a means of resistance to institutional powers by defying expected institutional practices. The social relation out-of-network providers enter into with patients is not dominated by insurance ruling relations. Though Dr. Calvin’s office continues to enter into managed care plans with insurance providers as a means of securing social relations with patients, they too made professional decisions to resist ruling relations they saw as unfair.

Dr. Calvin said he did not have any negotiating power as a single provider, but he did share that he had more clout as part of a collective of dental providers. A few years prior, Dr. Calvin’s office had been invited to join CVDC, a collective of dental providers that had originated in the Tidewater region of Virginia. Their initial reason for forming was to band together to increase their bargaining power against an insurance company. As previously described in Chapter 4, the ruling relation that exists between patient and provider often extends past the patient to their employer. This social relation was the catalyst that initiated the formation of CVDC, as many people in that area are employed by shipyards and the military. Dr. Calvin explained when the military switched insurance companies from MetLife to United Concordia for cost-saving measures, dental providers in the area suddenly got 30 percent less on their managed care agreements than they had with MetLife for the majority of their patients. The dental providers banded together to boycott participation with United Concordia until they collectively argued for a better managed care agreement. Here, dental providers used their professional autonomy strategically to avoid coercion into a social relation they found unsustainable.

The CVDC collective is an example of professionally resisting an unfair arrangement that resulted in the employer–patient social relation. Though CVDC was effective because of the scale of the resistance, sometimes small acts of resistance can be localized to a single provider’s office. Dr. Calvin expressed the importance of patient education and the role his staff had in educating and explaining dental insurance benefits to their families.

Patient will pick Plan A if it is the cheapest. But get them to talk to their HR specialist,

> and they will realize that Plan B really isn't that much more expensive and you get services out of it. So, it's actually a better deal even though it has a bigger premium. [Jessica] is very good about this. She will explain which insurance company is the better one during open enrollment. She'll look at past claim history and explain, "Yes it pays us more, but you also have less out of pocket too."

Dr. Calvin goes on to express that some dentists really like to battle with insurance companies and some tell patients they have to figure it all out on their own. He believes it is their responsibility to educate their patients and their parents. By educating patients about employer benefits, Dr. Calvin is influencing the social relation initiated by patients, the social relation in which he must operate to mitigate insurance ruling relations the best he can.

Within the typical insurance ruling relation, insurance companies control access to both patients and the economic resources on which dental providers are reliant. If dental providers were completely subservient to this ruling relation, they would participate in all insurance plans to have access to as many patients as possible—similar to what both Dr. Karen and Dr. Calvin described as necessary for providers starting out in their early career. However, eventually economic and business saliency make this subservience impractical, and providers exercise their professional autonomy by electing to not participate in some insurance policies. Such as the case of Dr. Calvin, who proudly declared that he had grown his business to the point where he had staff to deal with insurance. As a practitioner he had become successful enough that he only focused on patient care and did not have to worry himself about the day-to-day battle with insurance. This also meant that he listened to his staff and agreed to drop plans that were too onerous to work with. Dropping plans that require too much administrative time or are consistently late with payment is an act of resistance that specifically addresses another resource insurance companies tend to monopolize: Time. Refusing to participate in such managed care plans allows Dr. Calvin and his staff to regain time that was spent arguing with insurance representatives and focus instead on customer service and care. Insurance selection was not the only means by which Dr. Calvin resisted ruling relations, he also cultivated a staff trained to work within the system for his and his patients' benefit.

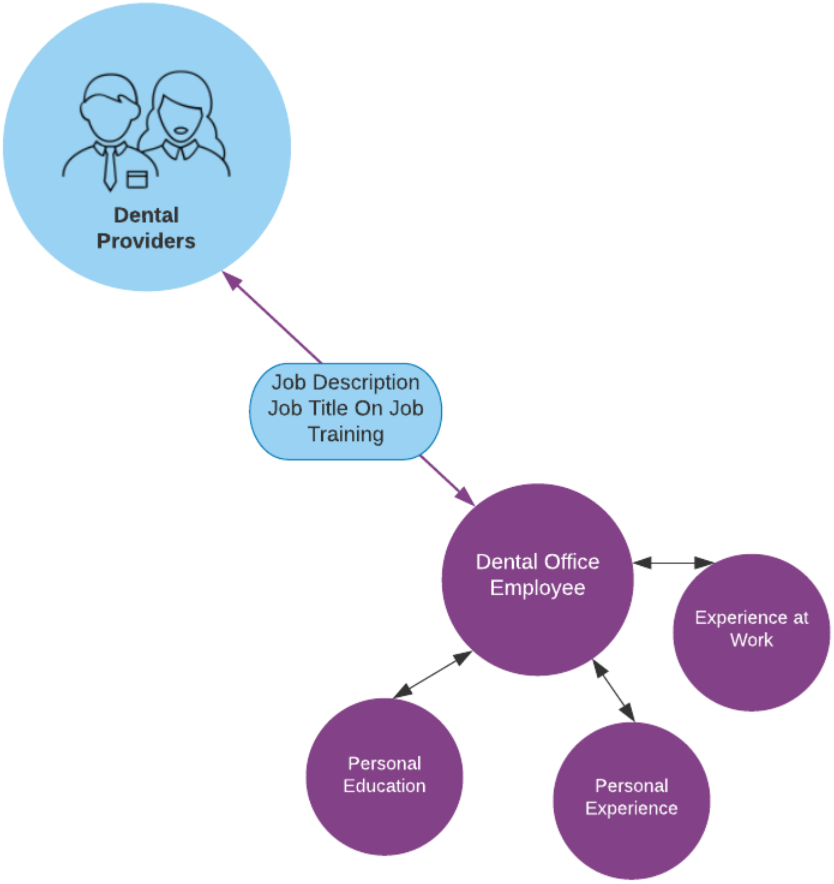
The Resistance is Administrative

Both sites I observed had an arsenal of administrative staff whose primary role was to mitigate insurance interference through textual means. They reviewed preauthorizations, claims, and policy benefits, all with the goal of abstracting the patient and preparing them to be textually documented. Though one could view this work as simply preparing the patient to be rationalized into the technical insurance system, it can also be viewed as a resistance to the system, played from within its confines. For example, Stella at Dr. Calvin's office would review clinical notes post-treatment but before claims were filed for insurance. Her role was not quality control from a clinical perspective but to make sure that clinical staff had written notes to fit institutional language so that claims could not be denied. Administrative staff accompanied patients as they traverse the dental office to prepare them to be adequately abstracted in an effort to reduce administrative battles with insurance companies. By devoting staff and resources to this task, dental providers are learning the technical language of the rational system to fight them on an equal battleground. Though claims to Medicaid also required medical codes for billing in a systematized format, the training and consultation they provided staff was meant to mitigate denials, as cost-savings was not prioritized over patient care. During my observations and interviews, staff never mentioned training offered by insurance companies on correct filing procedures. In fact, they were more likely to complain about changing codes or policies that they were not informed of until after a claim was filed. At Dr. Calvin's office, administrative team members had actually taken the time to create Microsoft Excel spreadsheets with common codes to prevent filing errors or with formulas to calculate copays based on various insurance managed care plan agreements. These artifacts were handed down and, in the case of the formula spreadsheet, that employee was no longer at the office but staff continued to use the document.

Smith (1987) points out that this invisible work of "mediating the relation of the impersonal and objectified forms of action to the concrete local and particular worlds" has been predominantly assigned to women (p. 108). This was definitely the case at both dental providers' offices I observed, in which all administrative roles were filled by women. Smith's focus on women was to point out the invisibility of women's work in a world in which work and culture had been created and dominated by men. From a feminist perspective, there is a perpetuation of this male-female power imbalance that can be extended to the power relation between dentists, a predominantly male profession, and administrative staff, a predominantly female position. Though this power relation would be an interesting aspect for a future study, I point it out here because it demonstrates the invisibility of women's work not only at the local setting but also in the resistance.

Figure 21

21 Provider–Staff Social Relation



When concepts of resistance focus on the professional autonomy of dental providers, the work and role of administrative and office staff are overlooked. Though dental office staff are often seen as an extension of the dental professional, Figure 21 shows that they are a separate body engaged in a social relation with their employer. A dental provider that has chosen to become a Medicaid provider dictates the work of his staff through this choice, and their work is to abstract patients to prepare them to receive care and receive payment for that care. As described in Chapter 5, this is largely the invisible work at the heart of the disjunctures, where “knowledge generated from ‘being there’ is abstracted into something else” (Rankin, 2017a,

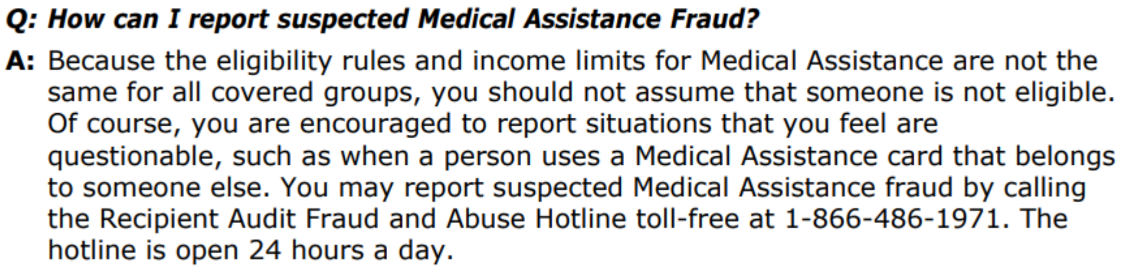
p. 3). As street-level bureaucrats, administrative staff are capable of resisting ruling relations daily. Their decision to advocate or not advocate to insurance companies can have a direct effect on the care of patients. Yet, one of the additional disjunctures I observed did not exist in the gap between patients and insurance companies, but rather between patients and empathy. Considering administrative staff's key role in resisting insurance ruling relations, their work must not only be acknowledged but also nurtured to not let implicit bias rule their bureaucratic decisions.

Implicit Bias and Medicaid

Though all staff I spoke to were committed to treating SHCN patients, it was still obvious that they held conceptions of who were deserving patients, specifically, deserving Medicaid patients. The concept of *deserving patients* is ubiquitous in our society and can be linked back to 1980s political attacks on federal welfare policies painting dependents as overdependent and abusive of aid (Whittle et al., 2017). In fact, as Figure 22 shows, one does not need to look farther than Medicaid's own frequently asked questions (FAQ) document for an example of this thought process.

Figure 22

22 Frequently Asked Question: Medicaid Fraud



Q: How can I report suspected Medical Assistance Fraud?

A: Because the eligibility rules and income limits for Medical Assistance are not the same for all covered groups, you should not assume that someone is not eligible. Of course, you are encouraged to report situations that you feel are questionable, such as when a person uses a Medical Assistance card that belongs to someone else. You may report suspected Medical Assistance fraud by calling the Recipient Audit Fraud and Abuse Hotline toll-free at 1-866-486-1971. The hotline is open 24 hours a day.

The concept of a *deserving patient* demonstrates how Medicaid's bureaucracy of exclusion also plays out for society's poor, individuals who qualify for Medicaid based on income. Like adult SHCN patients, total reliance on Medicaid presumes an inability or unwillingness to participate fully in society. Legislation like the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 used market-based work incentives to capitalize and perpetuate this attitude that recipients of government aid programs should be punished for their inability to participate in society (Whittle et al., 2017). Individuals can qualify for Medicaid under a variety of categories, including low-income families, qualified pregnant women and children, and PWD (DMAS, 2019; Schneider et al., 2002), and these eligibility criteria have created categories of deserving patients versus nondeserving patients. Children and infantilized adults with SHCN are deserving, the able-bodied poor are not.

Often comments revealing this implicit bias were made in passing and, because of the nature of these comments, quotes will not be attributed to specific participants. For example, two different participants on separate occasions mentioned how it could be frustrating that Medicaid patients had designer purses that they themselves did not have. "It can be irritating when a patient with Medicaid comes in with a Coach purse." Complaints about no-shows from administrative staff were frequently followed with statements that there was no reason to miss appointments because Medicaid paid for transportation. One participant felt that not paying was in fact what contributed to these no-shows. "They don't have to pay, so they don't want to come, they don't come." These comments bring into focus the fact that there is a cultural stigma against Medicaid and reliance on government benefits.

Often, within the context of market-based healthcare, there is an assumption that poor people lack the personal responsibility required to attain and maintain proper health. This generalized assumption blames them for not using preventive care, following drug regimens, keeping appointments, or managing their finances (Mani et al., 2013).

> Accepting Medicaid can change your business's image. Parents who come in and there are grease spots on the walls because they have been sleeping there waiting for transportation for 2 hours, with five kids in tow for one appointment. For no good reason, they could have put them on the bus but just didn't do it. We have had parents who say, "we like you guys but don't feel like it's healthy here enough for my child because you see all these Medicaid patients." Almost direct quote from a physician's wife. On occasion, we have lost patients. But we treat and provide healthcare to children. If you treat us with respect, we will treat you with respect. That won't make me change accepting Medicaid.

Another participant simply stated, "for some reason they don't take care of their teeth." These quotes demonstrate how there is a recognition of the needs of this population but also an underlining disdain. The focus on patient decisions and personal responsibility allows for the recasting of poor people with healthcare needs as financial risks that need to be managed (O'Daniel, 2018). In other words, poor people are wasteful, undeserving consumers who take Medicaid-covered healthcare for granted. By reframing access to healthcare as a personal responsibility and Medicaid recipients as financial risks, a moral inversion is created where bureaucratic systems are needed to protect resources. Adams and Balfour (2009) point out that such moral inversions are more likely to lead to administrative evil and policies of elimination when "surplus populations," those who seem undeserving, are involved (p. 113). To this point, Schweik (2009) details how individuals who occupied multiple surplus populations (Black, immigrant, disabled, and poor) contributed to the proliferation of "ugly" laws in the 19th century that sought to regulate deviant bodies with the intent of keeping them from public spaces. The racialized comments of “grease spots on the walls” and implication of unsanitary conditions from the mere presence of Medicaid patients reveals that those biases are still very much present in our society, and that the intersection of race, poverty, and disability cannot be easily dismissed.

Indeed, personal responsibility, or rather lack of personal responsibility, was implied when staff complained of no-shows and having no excuses to not use NEMT. However, these complaints did not take into account the bureaucratically demanding tasks involved with using NEMT outlined in Chapter 5 or how these requirements potentially conflicted with other aspects of a patient’s life outside of the confines of the dental office. For example, the quote above addresses parents bringing other children along during appointments as an unnecessary inconvenience. However, this need may have resulted from the family only having one vehicle available for transportation, or how the time required to attend the doctor’s appointment and wait for transportation may have meant that they were not available for after-school pickup. Perhaps, the living environment is not one in which parents feel comfortable letting their children walk home or be home unsupervised. Perhaps bringing all children along was simply easier than coordinating schedules and care. There is an expectation from many institutional organizations that clients must conform to bureaucratic standard hours of operation: 9 a.m. to 5 p.m., Monday through Friday. These expectations see failure to attend meetings or appointments as failure in personal responsibility and time management and do not recognize the cognitive load required to conform to these expectations when someone is poor. Furthermore, evidence suggests that poverty itself can impede cognitive function. Mani et al. (2013), found that decision making was reduced for low-income participants when financial concerns were triggered. They determined *attention capture* to be the primary explanatory mechanism and that the very context of being poor reduces one’s cognitive capacity. This perspective changes the narrative from personal responsibility to the ways in which policy can reduce cognitive burdens on the poor or recipients of government aid.

Turning the argument from personal responsibility provides street-level bureaucrats with the opportunity to ease the cognitive burden of their clients. Instead of requiring extensive documentation and understanding of complex policies, administrative bureaucrats can assist clients in completing forms, scheduling, and providing reminders. For dental provider offices and their staff, this means abolishing the concept of *deserving patients* and instead focusing on how to make sure all patients are supported. Lipsky (2010) notes that there is an assumption that biases are cultural and brought into the workplace by employees. Therefore, any implicit bias is rooted in the individual employee. However, Lipsky (2010) also points out that this assumption does not consider that an employee's individual experiences in the workplace shape their beliefs and that in fact the employee may be relying on stereotypes as cognitive shortcuts for deciding how to allocate limited workplace resources. In the same way dental providers influence the social relation with dental staff by choosing specific insurance participation, they can also influence the cultural competency of their staff by providing education and awareness and by reducing the circumstances in which staff rely on cognitive shortcuts or create administrative burdens that tax the cognitive load of their patients relying on Medicaid. Such efforts by dental providers should acknowledge disability, poverty, ethnicity, and race given the interrelatedness of all three categories. For example, some of the racialized comments shared may reflect the context of Richmond, Virginia. In 2015, 65 percent of the Richmond population living in poverty were Black (Moeser et al, 2017), and one of the dental offices is located in a growing suburb that is the home to major employers who have attracted a large immigrant population.

My observations underscored that awareness and education are potentially strong indicators of empathy. I observed fewer comments about personal responsibility or cultural stereotyping at Dr. Andy's and Dr. Grant's office compared to Dr. Calvin's office. I would hypothesize that it was related to one key difference as none of the participants interviewed were personally familiar with the application process for Medicaid or details about how eligibility was determined. Dr. Andy and Dr. Grant worked primarily with adult SHCN patients rather than pediatric SHCN patients, and this meant that they were more privy to the administrative burden these patients and their families endured. Reconciliation of accounts and appointment reminders were often navigated through a dizzying array of case managers, group home employees or administrators, and caretakers. Their workplace experience was more conducive to creating a culture of empathy by exposing staff to the lived realities of patients and, if anything, I observed a protective attitude toward their patients. Consider their policy to hold credits for their patients rather than return overpayments to the group home since they had no guarantee that the overpayment was in fact going to the patient. This lends credence to Lipsky's (2010) claim that workplace experiences can be the place where biases and stereotypes are formed that have the most impact on a street-level bureaucrat's treatment of clients. For example, one participant did share that, despite not knowing the process, she was aware that it was not an easy process.

> I do know that a lot of families will be ineligible because they haven't turned their paperwork back in or aren't responding to paperwork they get in mail. Something I think they don't understand it, or don't have time to answer it. I have never done the process myself. I know they have caseworkers but they are overloaded generally. I don't know, I just know there are income categories, but I am not familiar with how they determine who gets what benefits.

It would be easy to argue that someone who has applied for Medicaid but was denied failed in their responsibility to complete the application correctly or on time. If instead, it was reframed that this administrative burden overtaxed someone's cognitive load, it can engender more empathy, especially when one considers not only the burdens of poverty but also the cognitive load of having a disability or a family member with a disability. The layers of bureaucracy described in Chapter 5 are extensive for SHCN patients. Families who qualify for Medicaid on the basis of disability alone likely succumb to *attention capture* as well and would benefit from supportive dental office administrators. The participants from this study who accepted Medicaid were emphatic about continuing to accept Medicaid to offer access and care to SHCN patients. Removing the cultural stigma of Medicaid could erase the view of non-SHCN Medicaid patients as an inconvenience for current Medicaid providers and increase the number of Medicaid providers in general. For that, we may need to consider other institutional powers.

Resistance and Policy Implications

First, I must acknowledge that as a small-scale ethnography, my study is not meant to be generalized. However, I do believe I can speak to the nature of resistance and policy implications as observed with the participants of this study and extrapolate how professional autonomy may increase other providers' resistances to insurance ruling relations. The specific nature and style of other providers' resistance will likely look different from what I observed. However, all these different forms of resistance are needed to collectively make a change in the dental care landscape.

The concept of professional autonomy as resistance revealed itself as I worked on identifying the social and ruling relations that dictated oral healthcare for SHCN patients. As I worked through the data to compile themes and link these themes to social relations, the pattern of resistance started to emerge. I realized that my hypothesis for how professional autonomy is used had been turned on its head. Yes, dental providers did use their professional autonomy to select patients through insurance participation, and yes, for providers who chose not to participate in Medicaid, they were choosing not to work with many SHCN patients, especially adult SHCN patients living in poverty. Yes, this sort of patient selection was based on economic viability, thereby placing profit over care. However, the image that presented itself from my data was one where participants and their staff used their professional autonomy to work in and between social and ruling relations to provide care the way they wanted to. Even Dr. Karen, who had chosen not to participate in Medicaid, did so because she had a very specific concept of the type of care she wanted to provide. She wanted to "take her time and pamper her patients." Professional autonomy was not the weapon I had expected it to be against SHCN patients. Rather, for study participants, it was a weapon against insurance ruling relations.

Let's return to the research question: **How does dental professional autonomy in a market-based system affect provision of care for Medicaid patients with disabilities?** The answer this study provides is complicated. From the standpoint of this study, professional autonomy is *how* SHCN patients were able to access care. On the most basic level, dental providers who elect to become Medicaid providers open the door for Medicaid patients who are likely to include a high percentage of SHCN patients. What professional autonomy also allows is the ability for dental providers to train staff to better prepare them to work with SHCN patients and their families and to support administrative staff as they navigate the layers of bureaucracy that complicates the SHCN patient's access to care. The professional autonomy of administrative staff is often how SHCN patients access the level of care desired, beyond what may be dictated by ruling relations. Whereas I once saw professional autonomy as power that prevented access to care, I now also see professional autonomy as the means by which SHCN patients access care.

From a public policy perspective, we should be increasing professional autonomy in ways that encourage more providers to take up the resistance against insurance ruling relations and provide care to SHCN patients using Medicaid.

Foucault (1976/1978) expressed that the points of resistance to institutional powers can strategize and create a revolution. Because they are organized much like institutional ruling relations, connected through shared institutionalized knowledge and authority, there is no single point of resistance. This implies that no single piece of legislation or policy will be the panacea that resolves access issues for SHCN patients. Instead, we need to focus on a multitude of policies and legislations that in concert can have a positive impact on the provision of care. Furthermore, we must be looking forward rather than considering ways in which to undo our current social relations and systems of rationality, for they are the result of modernity and complexity. Habermas does not believe in abandoning the gains that have come with modernity but rather embracing and appropriating the cultural and technology systems that can bring society into a “secular humanitarian” ideal (Finlayson, 2005, p. 67).

Consider how some businesses have set themselves apart from their competitors not only in the goods and services they provide but also in the commitment they make to their employees, their local communities, and the charities they support. They use their professional autonomy in a market system to make a statement about their secular morals, and as customers, we know our participation with this business supports these endeavors, and it is our decision to engage or not engage. Chapter 4 revealed how opaque dental insurance is and how dental providers and their services have become commodities. To the patient, in-network dentists are interchangeable in terms of insurance coverage. Future policy implications should look toward how we can provide dental providers and their staff more autonomy to break free from their commodity status and reestablish their professional authority to provide care outside of what ruling relations dictate. Perhaps, if dental providers were afforded more professional autonomy, they would not make decisions based on market factors that result in limited care for SHCN patients. Following are some current policies and policy ideas that may provide more points of resistance to be strategized. This is not an exhaustive list; the policies presented here are based on my conversations, interviews, and observations. They are included as either issues discussed or legislation for which participants advocated or expressed a desire.

1. *Comprehensive Adult Medicaid Benefits*

One of the biggest barriers to access for adult Medicaid patients, and therefore adult SHCN patients, is the lack of comprehensive benefits. In Virginia, Budget Amendment SB 30 to expand Medicaid to include comprehensive adult benefits passed in 2020. Comprehensive benefits will begin July 1, 2021, and the hope is that this expansion of coverage will encourage more providers to participate in Medicaid. However, as my conversations with dental providers about CCC+ implementation revealed, provider awareness and understanding could be a huge implementation hurdle. In a webinar hosted by Virginia Health Catalyst, DMAS, and DentaQuest on February 3, 2021, it was acknowledged that they expect individuals using Medicaid to increase from 670,000 to 830,000, and this increase will create a potential access issue. Currently 2,000 or about 34 percent of dental providers in Virginia participate in Medicaid[10]. A focus of the implementation of comprehensive benefits will be to ensure that current providers are ready to accept new patients and that new dentists and specialists are recruited.

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[10] This number includes providers who only accept pediatric or pregnant patients. Provider awareness will include encouraging these providers to accept adult Medicaid patients (https://vahealthcatalyst.org/adultdentalbenefit/).

In keeping with my previous analysis that Medicaid, unlike private insurance, rationalizes the patient into the system rather than rationalizing them out, these new benefits will include coverage for three cleanings during a year as opposed to the more traditional two cleanings per year. This additional cleaning was included to acknowledge that this is a population that may be entering dental care with less maintenance and more oral healthcare needs. However, these comprehensive benefits do not address missed appointments. Providers will still not be able to charge for missed appointments (Virginia Health Catalyst, 2021). Therefore, alone, comprehensive adult benefits may not address the cultural stigma associated with Medicaid regarding *personal responsibility* and *nondeserving patients* as financial risks.

2. *Cultural Competency Training in Dental Education*[11]

The American Dental Education Association (2008) lists competencies in domains of critical thinking, professionalism, communication and interpersonal skills, health promotion, practice management and informatics, and patient care. What is missing from this list of competencies is a cultural awareness or diversity and inclusion competency. Considering that a dental provider's professional path will lead to interaction with people of all backgrounds, I believe that a cultural competency requirement would assist dental students to see and address the ways in which implicit bias can affect their role in promoting health. As outlined earlier in this chapter, implicit bias and concepts of *deserving* and *nondeserving patients* undermined even providers who felt they had a moral obligation to accept Medicaid patients. Dental providers who emphasize cultural awareness and diversity and inclusion will create a work environment that could positively shape their employees' experiences and avoid stereotyping as cognitive

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[11] The use of cultural competency here includes the concept of poverty as a cultural competency.

shortcuts as suggested by Lipsky (2010). During my analysis, I reached out to a committee member with knowledge of the local university's dental education curriculum to ask if cultural competency was addressed. She responded, "It happens a few places but not done extremely well as a topic of its own. It appears in their patient communication curriculum and dental ethics." Increasing the focus on cultural competency in dental education could work in tandem with legislation increasing Medicaid benefits to increase the number of participating providers.

3. SHCN and Dental Education

One common refrain I heard from the participants who treated SHCN patients was that they all felt they had received more clinical training on how to work with patients with disabilities during their residency compared to current students. Dr. Calvin described learning how to make molds using a tiny teaspoon for babies with cleft palates. Dr. Andy and Dr. Grant both had most of their exposure during their residency, and Dr. Grant described this method as one of the best ways to learn how to work with SHCN patients. "You just go in there and get it done, with some advice on how to position yourself. It's all pretty much hands on." Based on the 2018 issue brief from the National Council on Disability, "Neglected for Too Long: Dental Care for People with Intellectual and Developmental Disabilities," the Commission on Dental Accreditation will now require predoctoral programs to teach students how to "manage patients with intellectual and physical disabilities" (ADA, 2019). I have chosen to quote this line directly because the term *manage* does not mean *treat*. According to the ADA, managing SHCN patients can range from treatment to referral on the basis that care may be beyond the capabilities of some. Though this is an advancement from simply denying treatment on the basis of inability to provide appropriate care (which falls into professional discretion and autonomy), the new standard is a small incremental change and may not address access if dental providers are not afforded adequate hands-on opportunities to train with SHCN patients.

As it is likely that a Medicaid provider would have a high number of SHCN patients seeking treatment, this new standard of education is targeting providers who would likely not be Medicaid providers or have a small percentage of their clientele as Medicaid recipients. When considered from this perspective, this education standard does not address economic concerns a provider may have even treating SHCN patients with private insurance. Recall in Chapter 4 the description of how patients have been rationalized out of the insurance system. Private insurance companies will likely not cover behavior management like extra time or personnel to assist with SHCN patients. Therefore, the term *manage* still allows providers the ability to punt the patient down the line to another provider on the basis of capabilities, even if the main influence is economical. This new standard augments the professional autonomy of dental providers by limiting it, or providing new directives, but I do not believe it will have a significant impact unless a change to the economic landscape also happens.

4. Competitive Health Insurance Reform Act

During my observation, the repeal of the McCarran-Ferguson antitrust exemption for medical insurances had not passed yet. In fact, this law passed as I finished writing my analysis on January 13, 2021. Chapter 4 discusses extensively the power that insurance companies have in setting fee schedules, dictating regional UCRs, and limiting dental provider economic control. Under the current ruling relation, dental providers have to rely on insurance companies to set fee schedules and reimbursement rates, and dental providers submit to this relationship in order to access insurance members as potential patients. This is an opaque process to both patient consumers and dental providers. Recall that Dr. Calvin's office was not aware that their fees were set lower than competitors until they were invited into the CVDC collective. Once armed with this knowledge, they were able to advocate and negotiate for better fees. The ADA acknowledges that there will not be an immediate change from the passage of this law, but the hope is that it will “open up more opportunities for new insurance companies to enter the market and compete in offering better and more affordable coverage to consumers and better terms to doctors, hospitals, and providers” (ADA, 2021). Increasing a provider’s ability to negotiate better terms and rates could reduce the economic yoke that has pressured dental providers to make decisions for purely economic reasons, like not participating in Medicaid. Perhaps if economic restraints were loosened, more providers would choose to participate in Medicaid. Dr. Andy points out that very few dentists are at full capacity, and therefore there is an economic advantage to Medicaid when you want to grow your clientele. This coupled with more favorable fee schedules could be the incentive some dental providers need.

5. *Assignment of Benefits*

In my interview with Dr. Andy, he clarified an exchange I had witnessed in which an individual with out-of-network benefits still had to pay the full amount for services upfront with the expectation that her insurance would reimburse her directly after her claim had been filed by the office. Dr. Andy explained that though Virginia was one of the states with legislation respecting a patient’s right to assign benefits, allowing an insurance company to pay the health provider directly, this insurance company was headquartered in another state and therefore did not need to comply with Virginia’s public law. The motivation to not honor a patient’s assignment of benefits is directly related to this carrier’s belief that assignment of benefits is a “value of network participation and a method of reinforcing patient selection of dentists within the established dentists network” (ADA CDBP, 2008, p. 2). In this manner, even patients with out-of-network benefits are punished by selecting an out-of-network provider, thereby enticing members to stay in-network to persuade more dental providers into participating in managed care plans. This strong-armed approach to insurance participation may dissuade dental providers from going out of network for fear that they will lose access to potential patients, thereby taking away their professional autonomy. In addition, not allowing patients to assign benefits can have a negative effect on the patient. Forcing patients to pay upfront may be prohibitively expensive and, for patients in more rural areas with limited dental providers, not having access to an in-network provider can have a negative effect on care. Consistent legislation from state to state respecting a patient's right to assign benefits would increase patient autonomy and, thereby, provider autonomy as well. Making it easier for more dental providers to operate out-of-network releases them somewhat from the ruling relations of insurance.

6. *Geographic Access, Remote Supervision, and Teledentistry*

I have chosen to link these concepts together because I feel they are inextricably intertwined. As previously disclosed, a limitation of my study is that access to providers in urban areas is different from access to providers in rural areas. Therefore, geographic access also needs to be addressed before one can seriously tackle comprehensive access for SHCN patients. During my interview with Dr. Calvin, he was very clear that he did not believe the creation of a mid-level dental provider would solve geographic access issues. In fact, he believed it would "create more people in debt who are going to charge the same amount as you so it's not really going to help anything." His main reservation was that in training mid-level providers or dental providers who promise to practice in more rural areas, those commitments are rarely permanent as they eventually leave, as it is their professional autonomy right to do so. His comments speak to an inequitable distribution of dentists creating different problems in different areas. However, the literature and conversations with participants reveal that even in an urban area with an excess of dentists, SHCN patients simply have trouble accessing community providers. Therefore, geographic access is not limited to urban/rural dynamics. Two policy concepts that could address geographic access issues are teledentistry and remote supervision of dental hygienists.

Teledentistry and remote supervision of hygienists require a relinquishing of professional control by dental providers to let dental hygienists work to the full extent of their knowledge and abilities. Teledentistry can be used to communicate virtually with patients and remote dental teams in areas with access difficulties (ADA, 2020). This requires a trust in the abilities of the remote team to provide in-person services and documentation. Remote supervision of dental hygienists operates under a similar principle in which dental hygienists are able to provide care in the community under remote supervision of a dentist. Virginia began remote supervision as a pilot project in 2010 and expanded it in 2017 with the hope of improving access issues (Raskin, 2020). I have already addressed earlier in this chapter how the professional autonomy of administrative staff can have a significant impact on access of care. I would be remiss if I did not also address the potential gains that could come with increasing the professional autonomy of allied personnel like hygienists. A unique advantage of teledentistry and remote supervision is the ability for hygienists to meet patients where they are rather than requiring them to come to the dental office. In this manner, providing care to SHCN patients in schools, long-term care facilities, and group homes would be one way to reduce the cognitive burden of finding transportation and reduce the financial burden of no-shows. In fact, one silver lining of the global COVID-19 pandemic is that teledentistry has been given an opportunity to demonstrate how it can triage, provide care, and keep patients out of emergency rooms (Castelaz, 2020). I do have to note a personal hesitation I have about overreliance on teledentistry or remote supervision for SHCN patients, which is a fear that care for SHCN patients would revert to institution-based care as opposed to being community-based care. Therefore, as these practices grow, bureaucrats and policy administrators should take heed to recall the lifeworld communicative actions that brought them into existence, lest the system colonize it and institution-based care once again becomes the norm for SHCN patients.

Concluding Remarks and Future Research Recommendations

In my quest to understand how care is provided to SHCN patients using Medicaid, I discovered that a narrative of care for SHCN patients is impossible to tell without also giving an account of dental insurance. Using the perspective of institutional ethnography, I was able to map the social and ruling relations that dictate the dental care of SHCN patients (and all patients). This mapping elucidates the role that insurance has in abstracting patients, commodifying providers, and dictating levels of care by creating systems of technical rationality through managed care plans, downcodes, and restricting professional autonomy by controlling economic resources. The result is an abstraction of patients to the point that they are absent from the ruling relation and the technical system that provides them care. For SHCN patients, the complexities and conflicts of other bureaucracies that rule over other aspects of their lives conflict with the technical rationalities of dental insurance—thereby creating disjunctures experienced by dental staff. These layering of bureaucracies include education, transportation, and group home or independent living dynamics. SHCN patients are more problematic because the layers of bureaucracy that shroud them cannot be abstracted away as easily. However, it was surprisingly easy for dental staff to work with the bureaucracy of Medicaid.

Dr. Calvin described how dental Medicaid was designed to mirror private insurance as much as possible to reduce the administrative burden for dental staff. Ironically, it may have proven how administratively arduous private insurance actually is. Compared to private insurance, key informants of this study described over and over how much easier it was to work with Medicaid. Unlike private insurance, which has an incentive to increase profit margins, dental staff do not spend administrative time appealing downcodes or denials for Medicaid patients. They know simply what will be approved and what will not. Though reimbursements may be less compared to private insurance, there was less administrative burden and when they did have issues, they had a direct and trusted contact. However, the comprehensive coverage of pediatric Medicaid compared to the limited coverage of adult Medicaid creates two distinct systems. The results are that adult patients access care in an exclusionary bureaucracy whereas pediatric patients are able to access comprehensive care beyond what is often offered to pediatric patients using private insurance. For pediatric patients, Medicaid retains the patient as part of the technical system. However, the recent expansion of comprehensive coverage to adult patients using Medicaid could result in a drastic change to the landscape of Medicaid providers in Virginia.

My analysis in this concluding chapter revealed how study participants have and can resist insurance ruling relations by exerting their professional autonomy. The role of dental staff as bureaucrats for both private and public insurances revealed where and how the dental offices in this study primarily used their professional autonomy. Often staff used their roles to education patients about their insurance policies, guided them in making insurance decisions such as switching policies or applying for Medicaid, and educating them about financing options. In fact, it was often through administrative means that dental staff resisted ruling relations. Sometimes these resistances took the form of textual interference through billing and appeals, and sometimes they applied their street-level bureaucracy to determine when to enforce or not enforce office policies.

Though this study focused on the power dynamics and acts of resistance between dental provider offices and insurances, an area for future research consideration would be how the themes of advocacy and resistance play out for actors of varying authority levels or roles within a local setting. For example, the administrative resistance I witnessed was conducted solely by administrative staff, but they did not report any legislative advocacy related to insurance administration to me, despite being the experts of this form of resistance. Similarly, issues related to geographic access were only discussed with me by dentist, despite much of the work required for teledentistry or remote supervision falling on the shoulders of hygienists. As previously mentioned, successful implementation of either teledentistry or remote supervision would require an expansion of hygienists' professional autonomy and a surrendering of some of the occupational territory currently held by dentists. An analysis of internal power dynamics may have further implications for how to increase access to care for SHCN patients and Medicaid patients.

Just like how the story of Medicaid could not be told without also addressing private insurance, I found that Medicaid could not be limited to SHCN patients. My analysis included the implicit bias directed at *nondeserving* Medicaid patients compared to their SHCN counterparts. In order to encourage more dental providers to participate in Medicaid, the cultural stigma of poverty must be addressed. Eligibility for Medicaid requires activating and consenting to the social relation between Medicaid and a patient, and as a patient, allowing the abstraction of their body into the bureaucratic system. When these systems of bureaucracy are also based on poverty classifications, their restrictiveness on the SHCN body can create experiences for dental staff that become the basis of cultural and racial bias. For example, failure to use NEMT assumes a shortcoming and lack of personal responsibility of Medicaid patients who do not have access to private transportation, rather than a critical analysis of the administrative burden and unreliability of NEMT. When a predominant portion of Medicaid patients relying on NEMT are minorities, the cognitive short cut created is that minority patients using Medicaid lack personal responsibility.

This study focused on market factors that contribute to care for SHCN patients using Medicaid and though some of the implicit bias expressed by participants were potentially racialized, race as a theme did not emerge from the coded data. However, systemic racism in Medicaid, disability, and dental access are areas that deserve further attention and analysis. Especially, given the historical interlocking of race, poverty and resulting poor health from discriminatory policies. Considering the context of this study, Richmond, Virginia—the capitol of the Confederacy, it would be noteworthy to analyze the racial make-up of Medicaid patients, where most Medicaid patients live, and the availability or access to dental treatment along those geographic and public transportation lines. As previously mentioned, both dental offices in this study were not easily accessible by public transportation alone. Furthermore, the aforementioned relationship between race, poverty, and poor health may contribute to the disproportionality of Black children diagnosed with a disability. However, Artiles (2011) points out that these simplistic explanations do not explain disproportionate diagnoses that do not correspond with patterns of poverty in geographic areas like Chicago, Illinois. Rather, he suggests “shifting the analytic lens from individuals or groups of students to constellations of influences that force local actors’ decisions about who is able and disabled” (p.442). In short, I believe an institutional ethnography of the ruling relations that dictate disability diagnosis and Medicaid eligibility would lend additional insight into the barriers preventing SHCN patients using Medicaid from accessing care, and in particular illuminate the systemic racism inherent in these institutional systems and power relations.

Included in my concluding chapter are policy implications of new legislation and policies that may increase provider autonomy—and additional resistance against ruling relations. It should be noted, though, that my analysis of new legislation is not exhaustive and analysis of implementation beyond passage needs to be considered for these policies to take root and hold. For example, consider the potentially most impactful legislation: Comprehensive adult benefits. Without proper implementation resulting in an increase in Medicaid providers, this legislation will do little to increase access to care for adult SHCN patients. Furthermore, my analysis was conducted from the standpoint of dental providers, and by doing so I am highlighting the disjunctures of their day-to-day experiences. Any future analysis of the legislation and policies discussed in this study would benefit from a comprehensive examination from multiple lens, and include implications for patients, dental providers, insurance companies, and Medicaid.

As a final remark, I feel I must address the elephant in the room when discussing market factors and health insurance: Single payer universal healthcare. As my study sought to understand how care to SHCN patients was provided in the context of insurance profitability and professional market viability, single payer insurance was not a focus of my study. However, I will leave you with this quote; for who better to have the final word in an institutional ethnography than a participant?

> Sometimes, it's almost like we wish that everyone had the same, had this insurance [Medicaid] because then we can do what we need to do for the child and we don't have to worry about them. We know what they are going to cover. We know what they won't cover. We can make the right clinical choices without thinking something will be denied or they will want us to do an alternative treatment.

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[12] At the time of this dissertation defense, SB30 has been approved but not yet added to Virginia Code. Therefore, though approved, it is referenced here as a bill rather than a statute.

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Appendix A

Letter of Introduction to Observation Sites

Dear [identified participant]:

My name is Stephanie Lau; I am a Training Associate at Virginia Commonwealth University (VCU) Center on Transition Innovations and a Ph.D. student at VCU in Public Policy and Administration. I am interested in learning how dental providers establish office practices and policies and about the role that insurance requirements, training, and other factors have in making office decisions, particularly when treating patients with disabilities. I am interested in observing your practice to learn about how dentists provide care to patients with disabilities for my dissertation research. Your office was chosen because it was referred to me by [referral] as a location that treats patients with disabilities. By participating, you would be helping to identify how dental offices can provide quality care for patients with disabilities.

Observation will involve my visiting your office a few times, with visits never exceeding 3–4 hours, over the course of 3 months maximum. During these observations, I would like to observe interoffice interactions as well as interactions with patients with and without disabilities. For my observation to be successful, it is important that I be as unobtrusive as possible. No excessive demands will be placed on your office, and I will be respectful of your offices policies, including patient privacy. All observations will remain confidential, and any identifying information about staff, patients, or your practice will be removed. Findings from these observations will be used for my dissertation research, which will be supervised by researchers familiar with dental care and vulnerable populations. A potential benefit to your office of participating in this study includes my assistance in administrative work, if desired, during, before, or after my observation time. Thank you for your consideration; I will follow up in approximately 2 weeks to answer any questions you may have.

Sincerely,

Stephanie Lau
sjlau@vcu.edu
757-869-8232

Appendix B

Script to Key Informant

I am interested in learning how dental providers establish office practices and policies and about the role that insurance requirements, training, and other factors have in making office decisions, particularly when treating patients with disabilities. Because of my interest in how dental office practices are established, I feel that you are in a key position to offer insight and explain the process. Your knowledge would be very useful to me, as a layperson, to understand how your office decides on and implements policies and practices. I would like to schedule an interview and time to shadow you during a typical workday for no more than 3 hours. I am interested in observing your day-to-day tasks and interactions with patients with and without disabilities. In exchange for letting me observe and interview you, I would be glad to perform administrative tasks in the office to offset any time allotted to my interview or observation.

Appendix C

Interview Questions

Research Background: I am interested in learning how dental providers establish office practices and policies and about the role that insurance requirements, training, and other factors have in making office decisions, particularly when treating patients with disabilities. I have some questions that I hope will help me gain further insight, but please feel free to explain anything you think will help me gain a deeper understanding of your work and the work this dental office does with patients with and without disabilities.

Background questions:

1. How long have you been practicing [dentistry]?
2. What made you decide to get into this line of work?

I would like to learn more about your office and have some questions about staff roles.

3. Can you describe the roles and responsibilities of staff in this office?

A. *My understanding is that communication and billing insurance are the bulk of administrative time at a dental office. Because of its importance in your operations, I would like to learn more about insurance participation and how it affects your practice.*
    1. First, I would like to talk about insurance participation and how those decisions are made. What insurances does your office currently accept and how did you decide which types of insurances to accept?
    2. Can you explain the process of being an approved provider for an insurance company?
    3. What characteristics describe the insurance providers you most like to work with? What characteristics describe the insurance providers you least like to work with?
    4. What, in your experience working with insurance providers, has been easy?

What has been hard? To what do you attribute these differences?

5. In what ways do you feel that you have been able to influence negotiating fees or other insurance company policies and practices?
6. What factors were the most influential or important in your decision making to become an approved provider?
7. Do you accept out-of-network patients? Are there benefits for doing so and what are they?
8. What options are available to patients who do not have sufficient insurance coverage for treatment?
9. Have you ever not been able to serve a patient because of insurance limitations? What are some of your concerns when you have to turn a patient away?

B. *I would like to ask some questions about Medicaid and your experience with Medicaid. I am interested in what factors contribute to a dental office's decision to be or not to be a Medicaid provider.*

    1. I am interested in learning more about what motivates a dental office to become a Medicaid provider. What factors influenced your decision to become a Medicaid provider?
    2. What are some of the differences between working with Medicaid and other insurances?
    3. How, if at all, did your geographic proximity to other Medicaid providers, medical institutions, or other safety nets factor into your decision about becoming a Medicaid provider?
    4. How, if at all, did accessibility and public transportation factor into your decision about becoming a Medicaid provider?
    5. Can you think of a scenario or situation where you would decide to no longer accept Medicaid? How would that decision affect your practice?
    6. Can you please describe the process for accepting new patients?
    7. Does the new patient process differ between insurance types or insurance

companies (self-pay vs. private vs. Medicaid)?

C. *Now I would like to talk about insurance policies and the forms your office uses. I am interested in how insurance policies might shape office practices.*

   1. How, if at all, does documentation between insurance providers differ? How are they similar?
   2. When accepting new patients, what demographic information do you collect? For example, how do you collect disability diagnosis information? To what extent do insurance requirements dictate collection of this information?
   3. What is the process for creating your office documents? How have you considered insurance requirements during the creation of these forms?
   4. How have insurance requirements and documentation affected your office policies and administrative practices?

D. *I have some questions about your experience treating patients with disabilities.*

   1. What factors contribute to the decision to accept or not accept new patients with disabilities?
   2. Please describe your experience treating patients with disabilities.
      a. How have their needs differed from the needs of other patients? How are they similar?
      b. How has your experience treating patients with disabilities differed from treating other patients? How was your experience similar?
      c. Are there any insurance considerations for this population that are different from other patients?
         i. Patients with private insurance?
         ii. Patients with Medicaid?

   I would like to ask you some questions now about any training or education you received around treating patients with disabilities.

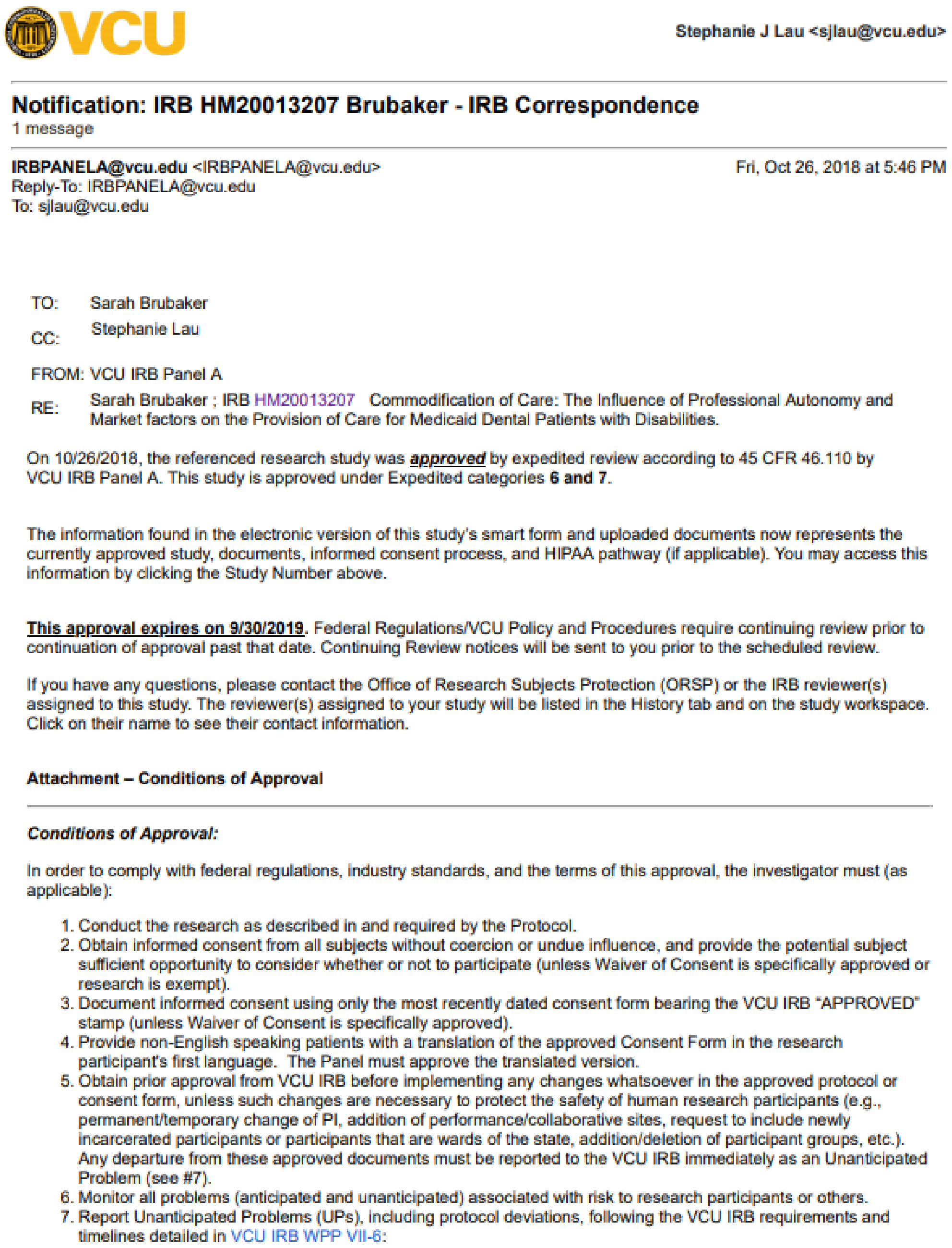
   3. Did you receive formal training on best practices for working with patients

with disabilities? Could you please describe your formal training? Are there opportunities for you to engage in informal or continuing professional development on how to work with patients with disabilities? Please describe your participation in these programs.

4. Are there any particular accommodations for patients with disabilities you are not able to provide at this office? For example, specialized equipment or care under anesthesia.

Appendix D

IRB Approval Letter



VCU **Stephanie J Lau <sjlau@vcu.edu>**

Notification: IRB HM20013207 Brubaker - IRB Correspondence
1 message

IRBPANELA@vcu.edu <IRBPANELA@vcu.edu> Fri, Oct 26, 2018 at 5:46 PM
Reply-To: IRBPANELA@vcu.edu
To: sjlau@vcu.edu

TO: Sarah Brubaker
CC: Stephanie Lau
FROM: VCU IRB Panel A
RE: Sarah Brubaker ; IRB HM20013207 Commodification of Care: The Influence of Professional Autonomy and Market factors on the Provision of Care for Medicaid Dental Patients with Disabilities.

On 10/26/2018, the referenced research study was ***approved*** by expedited review according to 45 CFR 46.110 by VCU IRB Panel A. This study is approved under Expedited categories **6 and 7**.

The information found in the electronic version of this study's smart form and uploaded documents now represents the currently approved study, documents, informed consent process, and HIPAA pathway (if applicable). You may access this information by clicking the Study Number above.

This approval expires on 9/30/2019. Federal Regulations/VCU Policy and Procedures require continuing review prior to continuation of approval past that date. Continuing Review notices will be sent to you prior to the scheduled review.

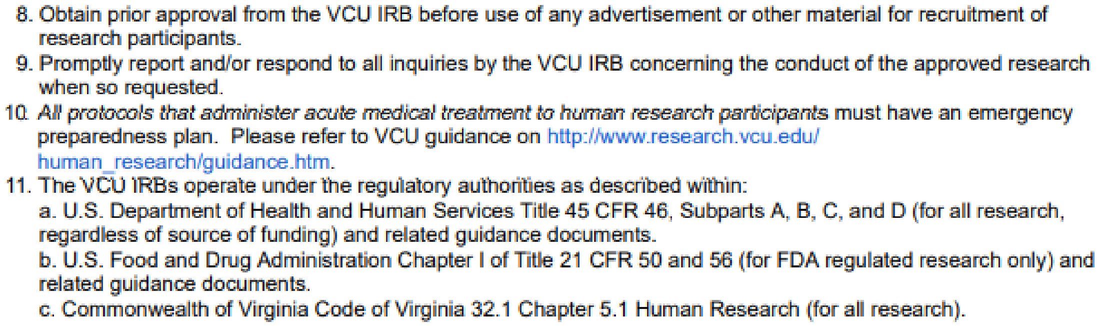
If you have any questions, please contact the Office of Research Subjects Protection (ORSP) or the IRB reviewer(s) assigned to this study. The reviewer(s) assigned to your study will be listed in the History tab and on the study workspace. Click on their name to see their contact information.

Attachment – Conditions of Approval

Conditions of Approval:

In order to comply with federal regulations, industry standards, and the terms of this approval, the investigator must (as applicable):

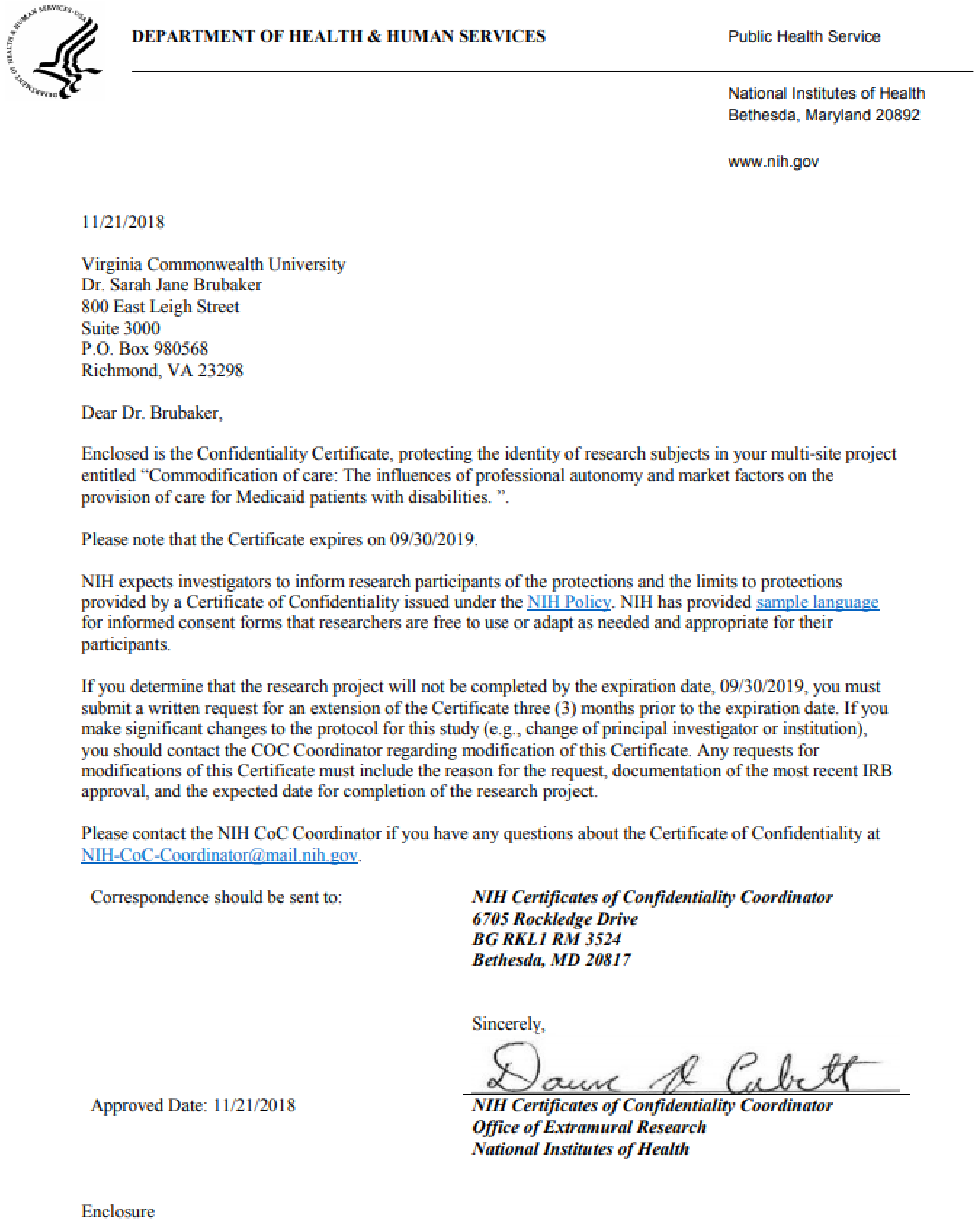
1. Conduct the research as described in and required by the Protocol.
2. Obtain informed consent from all subjects without coercion or undue influence, and provide the potential subject sufficient opportunity to consider whether or not to participate (unless Waiver of Consent is specifically approved or research is exempt).
3. Document informed consent using only the most recently dated consent form bearing the VCU IRB "APPROVED" stamp (unless Waiver of Consent is specifically approved).
4. Provide non-English speaking patients with a translation of the approved Consent Form in the research participant's first language. The Panel must approve the translated version.
5. Obtain prior approval from VCU IRB before implementing any changes whatsoever in the approved protocol or consent form, unless such changes are necessary to protect the safety of human research participants (e.g., permanent/temporary change of PI, addition of performance/collaborative sites, request to include newly incarcerated participants or participants that are wards of the state, addition/deletion of participant groups, etc.). Any departure from these approved documents must be reported to the VCU IRB immediately as an Unanticipated Problem (see #7).
6. Monitor all problems (anticipated and unanticipated) associated with risk to research participants or others.
7. Report Unanticipated Problems (UPs), including protocol deviations, following the VCU IRB requirements and timelines detailed in VCU IRB WPP VII-6:



8. Obtain prior approval from the VCU IRB before use of any advertisement or other material for recruitment of research participants.
9. Promptly report and/or respond to all inquiries by the VCU IRB concerning the conduct of the approved research when so requested.
10. *All protocols that administer acute medical treatment to human research participants* must have an emergency preparedness plan. Please refer to VCU guidance on http://www.research.vcu.edu/human_research/guidance.htm.
11. The VCU IRBs operate under the regulatory authorities as described within:
    a. U.S. Department of Health and Human Services Title 45 CFR 46, Subparts A, B, C, and D (for all research, regardless of source of funding) and related guidance documents.
    b. U.S. Food and Drug Administration Chapter I of Title 21 CFR 50 and 56 (for FDA regulated research only) and related guidance documents.
    c. Commonwealth of Virginia Code of Virginia 32.1 Chapter 5.1 Human Research (for all research).

Appendix E

Certificate of Confidentiality



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

www.nih.gov

11/21/2018

Virginia Commonwealth University
Dr. Sarah Jane Brubaker
800 East Leigh Street
Suite 3000
P.O. Box 980568
Richmond, VA 23298

Dear Dr. Brubaker,

Enclosed is the Confidentiality Certificate, protecting the identity of research subjects in your multi-site project entitled "Commodification of care: The influences of professional autonomy and market factors on the provision of care for Medicaid patients with disabilities. ".

Please note that the Certificate expires on 09/30/2019.

NIH expects investigators to inform research participants of the protections and the limits to protections provided by a Certificate of Confidentiality issued under the NIH Policy. NIH has provided sample language for informed consent forms that researchers are free to use or adapt as needed and appropriate for their participants.

If you determine that the research project will not be completed by the expiration date, 09/30/2019, you must submit a written request for an extension of the Certificate three (3) months prior to the expiration date. If you make significant changes to the protocol for this study (e.g., change of principal investigator or institution), you should contact the COC Coordinator regarding modification of this Certificate. Any requests for modifications of this Certificate must include the reason for the request, documentation of the most recent IRB approval, and the expected date for completion of the research project.

Please contact the NIH CoC Coordinator if you have any questions about the Certificate of Confidentiality at NIH-CoC-Coordinator@mail.nih.gov.

Correspondence should be sent to:

NIH Certificates of Confidentiality Coordinator
6705 Rockledge Drive
BG RKL1 RM 3524
Bethesda, MD 20817

Sincerely,

Dawn A Corbett

NIH Certificates of Confidentiality Coordinator
Office of Extramural Research
National Institutes of Health

Approved Date: 11/21/2018

Enclosure

Appendix F

Codebook

Name	Description
Bureaucracy	Administrative tasks or duties that stem from accessing dental care or dental care reimbursement, all in an effort to maintain system uniformity
Staff as Bureaucrats	Dental office staff fulfilling bureaucratic roles for insurance companies, Medicaid, and dental office
SHCN Bureaucracy	Systems requiring their own administrative tasks which are exercised on SHCN bodies; may or may not be related to accessing dental care.
Poverty Bureaucracy	Systems requiring their own administrative tasks which are exercised on able-bodied persons in poverty; may or may not be related to accessing dental care
Group Home	Experiences and disjunctures related to a patient living in a group home
Cultural Competencies	Statements or comments revealing stereotyping or implicit bias
Dentistry	Discussion of dentistry as a field, including legislative agendas
Levels of Care	Factors contribute to disparate levels of care between patients
Downcoding	Insurance act of changing prescribed dental procedures to cheaper alternatives
Access	How dentists access patients or patients access dentists
Exclusion Bureaucracy	Bureaucratic systems that result in exclusionary practices
Autonomy as Resistance	Professional autonomy is used to subvert policies and system bureaucracy
Staff Autonomy	Dental staff exercise street-level bureaucracy decisions

Name	Description
Text Resistance	Professional autonomy is exercised through textual communication
Dental Education	What dental providers were taught during their education
Employer insurance	Influence of group employer-based insurance
Patient Selection: Insurance	Participating in insurance managed care plans to access potential patients
Provider Selection: Insurance	Patient status related to in or out of network status of provider
Medicaid	Decision to participate in Virginia Medicaid program
Medicaid Bureaucracy	Medicaid related administrative tasks or duties that stem from dental care reimbursement
Life Experiences	Personal experiences that affect perception of patients
Personal Responsibility	Expectations for patient to shoulder administrative burden
Economic Power	Dental professional power or lack of power to be economically profitable
Money	Economic resource of money
Time	Economic resource of time