

Access to Oral Health Care in California

Barriers and Opportunities

by Miranda Davis, DDS, MPH, and
Elizabeth Mertz, PhD, MA
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Overview

Oral health care remains one of the most unmet health care needs for Californians. This is particularly true for those enrolled in Medi-Cal, California's Medicaid program, racial and ethnic minority populations, Tribal nation members, rural residents, and individuals with physical and developmental disabilities.^{1,2} Statewide initiatives to improve access to care and increase the number of dentists who accept Medi-Cal have not meaningfully increased access for Medi-Cal enrollees.³ This issue brief summarizes the state of access to oral health care in California and prior efforts to address this issue with limited success, with a companion [issue brief addressing the oral health workforce](#).

The Problem with Oral Health Care Access

Oral health is essential to overall health and well-being; however, millions of Californians face barriers to timely, high-quality dental care. Despite advancements in dental workforce development and policy reform, oral health disparities persist across racial, geographic, and socioeconomic lines. California boasts one of the highest dentist-to-population ratios among the contiguous United States;⁴ yet, oral health care remains one of the most unmet health

needs in the state.¹ Systemic barriers such as geographic disparities, workforce shortages, insufficient Medi-Cal provider participation, and a lack of diversity in the dental workforce continue to hinder equitable access to dental care. Over the past two decades, the state has invested millions of dollars in trying to improve access to oral health care, particularly for the Medi-Cal population. They have streamlined enrollment in the Medi-Cal program for providers and significantly increased provider payment rates, they have engaged in widespread outreach to Medi-Cal enrollees, and they have invested in community-based efforts to help Californians, particularly children, access oral health care. Despite these policy initiatives, progress has been limited.^{5,6}

Why Oral Health Matters

Oral health is integral to overall health and well-being. State, federal, and international health bodies have long recognized that dental care is among the most neglected of health care services.⁶ In 2021, the World Health Assembly approved a historic resolution that urged member states to address oral health care.⁷ This was followed by the World Health Organization adopting a global strategy and action plan for 2023-2030,⁸ and finally adopting the Bangkok Declaration: “No Health Without Oral Health.”⁹ These efforts have solidified the global health community’s commitment to the prevention and control of oral diseases as part of efforts to address non-communicable diseases and achieve universal health coverage for all.

Impact of Poor Oral Health

Poor oral health has impacts far beyond the mouth. Full economic, social, and emotional participation in society is difficult to attain and maintain in the absence of good oral health, both because diseased teeth can cause debilitating pain and infection and because of the stigma and shame of poor condition of one’s teeth.¹⁰

Morbidity and Mortality

Abundant evidence shows that comorbidities associated with dental diseases are common, underscoring the impact of dental care access on overall health.¹¹ These include diabetes, cardiovascular disease, rheumatoid arthritis, dementia, and many more. When dental diseases go unaddressed, other health problems are initiated/exacerbated, leading to additional suffering and higher overall health care costs.¹² Often, remediation for pain and infection can only be sought in emergency departments (EDs), which is very expensive and rarely treats the underlying dental condition.¹³ A nationally representative study concluded that fewer permanent teeth and untreated caries were associated with all-cause mortality and heart disease mortality, while fewer teeth were also associated with higher cancer mortality.¹⁴ The death of 12-year-old Deamonte Driver from a tooth infection highlights the tragic impact of unmet dental care needs.¹⁵

Education

A major impact on children is the loss of educational time. In 2022 in California, 351,000 children and teens were reportedly missing at least one or more days of school due to dental problems; 87% of these children missed more than one day of school, leading to a total of 869,202 school days missed in a year due to dental problems, costing school districts approximately \$60 million.¹⁶ In 2023, the California Health Interview Study (CHIS) reported that 8% of children missed one or more days of school due to oral health issues.¹⁷

Employment

The American Dental Association found that 29% of low-income adults report that poor oral health impacts their ability to interview for jobs.¹⁸ Missed work time due to dental disease is significantly associated with identifying as female, Hispanic, or having to travel 45 minutes or more to see a dental provider.¹⁰ Unmet oral health care needs may also perpetuate a cycle of poor health and less economic opportunity. Poorly appearing teeth and poor dental function can lead to decreased confidence, employability, self-reported quality of life, and reduced socioeconomic status. Lower socioeconomic status makes it difficult to access oral health

care. Improving oral health care can thus lead to improved functioning, employability, and socioeconomic status.¹⁰ Yet achieving improved oral health for Californians has been elusive for policymakers, despite recognition of the challenges and impacts of the problem.

Access to Dental Care for Californians

Access to oral health care in California is unevenly distributed, geographically and among racial or ethnic groups, amplifying inequities. California's current population is estimated at 39.5 million, with nearly 41% identifying as Hispanic/Latino. California is a majority-minority population, with no single racial or ethnic group comprising over 50% of residents.¹⁹ Disparities in oral health outcomes exist by race and ethnicity, geography, and income, among other factors.¹⁷ Almost 15 million Californians are enrolled in the Medi-Cal Dental program. Of enrolled children in 2024 aged 0-20, just half (50.0%) used dental services. Of eligible adults ages 21+, less than a quarter (24.6%) utilized dental services.²⁰ The result is the perpetuation of long-standing inequities: this lack of care disproportionately affects those who are already socioeconomically disadvantaged and compounds social determinants of health.

The California Third Grade Smile Survey (2018-2019) found that tooth decay remains a significant public health problem, especially for African American, Latinx, and socioeconomically disadvantaged children.²¹ Latinx children had the highest prevalence of tooth decay, with more than 72% having experienced some form of tooth decay compared to 40% of white children. African American children had the highest prevalence of untreated decay at 25.8%, which is almost twice the rate of white children at 13.7%. Socioeconomically disadvantaged children had almost twice the rate of tooth decay and untreated tooth decay, compared to children who were not socioeconomically disadvantaged (tooth decay 72.3% vs. 40.5%; untreated tooth decay 26% vs. 13.2%). Children from families whose parents' primary language is Spanish were more likely to have experienced tooth decay (77.9% vs. 52.2% for English language) or to have untreated decay (26.3% vs. 18.4% for English language). Preventive services remain underutilized, and disparities by race and ethnicity and socioeconomic disadvantage for tooth decay and untreated decay are profound.²¹

While Californians almost universally value oral health and know that regular dental visits keep them healthy, much of California's population does not receive regular oral health care. Twenty percent of low-income adults in California say their mouth and teeth are in poor condition, and 25% report that the condition of their teeth affects their ability to interview for a job.²² High-income adults also report significant problems due to the condition of their teeth, with 38% reporting pain and discomfort and 28% reporting embarrassment.²²

ED visits for preventable dental conditions highlight the systemic gaps in access to preventive care, particularly in rural regions.²³ When regular, preventive, and restorative dental care is unavailable, emergency rooms are the only option for relief from pain and infection. While emergency room care may temporarily address pain and infection, the underlying dental condition is rarely addressed in this setting. Research estimates there are over 50,000 ED visits in California annually for disorders of the mouth.²⁴ At an estimated average cost of \$2,437 per visit, this translates to approximately \$120 million in expenditures.¹³ The ED rates also highlight regional gaps in care. Northern rural counties in California report significantly higher rates of ED visits for preventable dental conditions compared to urban regions.²⁵ Medi-Cal is the largest payer for non-traumatic dental ED visits in California.²⁶

Barriers To Dental Care

Multiple barriers impede access to oral health care for Californians, and these barriers have been extraordinarily persistent over time.²⁷

Affordability and Insurance Coverage

The high cost of dental care remains the primary reason adults and children skip dental visits. According to the 2024 CHIS, 27% of adults skipped dental visits due to cost, while 9% reported difficulty finding a dentist. Unlike medical insurance, dental insurance is not universally mandated nor available, and co-pays for dental care, even among the insured, are very high.²⁸ For those insured by the Medi-Cal Dental program, the inability to find a dentist who will treat them at all renders the coverage meaningless, even though full adult dental benefits were restored in 2018 after being cut in 2009.²⁹ Medicare does not cover regular

dental care, and although Medicare Advantage plans often bundle dental coverage, these plans are highly variable and often restrictive.^{30,31}

California's Diverse Population and Geography

Geographic barriers to accessing oral health care are common for many Californians, particularly those who live in rural communities, are low-income, or are from minoritized communities.³² Despite California having one of the highest dentist-to-population ratios of any state in the U.S., there are 78 population-specific and 15 geographic federally designated dental health professional shortage areas (DHPSAs) as of 2023. This indicates large dental care deserts, particularly for those covered by Medi-Cal, for whom finding a provider nearby who accepts their insurance can be difficult or impossible.¹ And while California has a robust system of Federally Qualified Health Centers (FQHCs) intended to provide a safety net for these underserved communities, not all of these clinics offer dental care, and those that do are often faced with demand for care far exceeding the limited supply.^{33,34} A 2025 report noted that only 12% of clinical encounters in FQHCs were for a dental visit.³⁵

The aging workforce exacerbates these shortages, with many dentists nearing retirement. Younger dentists gravitate toward urban centers, leaving rural areas underserved. The aging dental workforce is accompanied by a rapidly growing aging population: adults over 65 are expected to double to 30% of the total population by 2026.¹⁹ Elderly and disabled persons experience additional barriers: traveling to appointments can prove prohibitive, and individuals who are homebound, living in skilled nursing facilities, or long-term care rarely have access to professional dental care.²

Vulnerable populations—including Black, Indigenous, and People of Color (BIPOC) communities; Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+) individuals; people with disabilities; and immigrants—face additional barriers, such as xenophobic policies and inadequate accommodations for disabilities.³⁶ Racial and ethnic concordance between providers and patients is low, contributing to wide disparities in access to care and health outcomes.³⁷ California is also home to over 100 federally recognized tribes; yet, tribal health systems, serving Indigenous populations, are critically understaffed and underfunded, further exacerbating oral health disparities.³⁸ In sum, the dental care

delivery system lacks the capacity, diversity, and flexibility needed to meet the oral health care needs of California's population.

Prior Efforts to Improve Access to Care in California

These issues are not new. Policymakers in the state have sought to address dental care access, primarily through programs at the California Department of Health Care Services (DHCS), which provides and regulates payment and coverage, and through the California Department of Public Health (CDPH), which oversees public health financing, infrastructure, and programming. A comprehensive assessment of these issues is beyond the scope of this brief, but recent key initiatives are worth mentioning.

Payment and Coverage Policy

While states are federally mandated to provide comprehensive dental benefits to children, providing dental benefits under Medicaid is optional for states. The primary direct investment in dental care and coverage is through the Medi-Cal Dental program (formerly Denti-Cal), which currently covers approximately 15 million Californians, or about 40% of the state's population.³⁹

Adult coverage and access. Until 2009, the Medi-Cal Dental program provided dental coverage to all enrollees, but from 2009-2014, *adult benefits* were mostly eliminated in efforts to address state budget deficits.²⁹ In 2014, the Affordable Care Act was implemented, vastly expanding the number of program enrollees, and in May of that year, adult benefits were partially reinstated. Adult coverage was fully reinstated in 2018 at the same time that Proposition 56 tobacco tax revenue was used to enhance fee-for-service rates paid by the Medi-Cal Dental program.³ Of course, the COVID-19 pandemic created massive disruptions in the program, including a freezing of coverage under the public health emergency and limits on access to care. However, even after adjusting for COVID-19, our preliminary analyses showed that these fee enhancements did not increase adult dental care utilization or significantly reduce ED use for dental concerns.⁴⁰ Notably, **seniors** (age 65+) have very little state investment in coverage unless they are dual eligible for both Medi-Cal and Medicare, as

Medicare does not cover routine dental care. The 2025-2026 California state budget eliminated Proposition 56 supplemental payments as of July 1, 2026, and eliminated full-scope dental benefits for undocumented adults.⁴¹

Children's access to care. At the urging of advocates, the California Legislature called for an audit of the Medi-Cal Dental program for children. The resulting State Auditor's report⁴² and the Little Hoover Commission report cited numerous flaws in the system, leading to enrolled children not receiving the oral health care for which they were eligible, and criticized the state for failing to ensure access to care for children.⁴³ To remediate these deficits, in 2016, the state embarked on the Dental Transformation Initiative (DTI), a 2020 Medicaid waiver program that sought to expand the Medi-Cal dental workforce and implement preliminary quality measurement aimed to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children, with mixed impact.⁴⁴ The DTI morphed into a series of ongoing performance measures under the next Medicaid waiver in 2024, California Advancing and Innovating Medi-Cal, or CalAIM.⁴⁵ CalAIM dental initiatives have included expanded payments that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home, along with reimbursements for caries risk assessments and certain preventive and treatment procedures.³ After several years of improvements, the most recent data in February 2026 continue to show declines in most measures.⁴⁵

Dental Public Health Investments

California has a long history of dental public health investments, such as water fluoridation, a Kindergarten Oral Health Assessment program for school readiness, and school screening and prevention programs.⁴⁶⁻⁴⁸ In 2014, the California Legislature authorized funding for CDPH to address the burden of oral disease statewide through the establishment of the Oral Health Program.⁴⁹ A dental director position was filled after many years of vacancy, and several initiatives revitalized dental public health investments across the state, including a comprehensive state oral health plan, a state surveillance plan, and grants to build county oral health capacity through local oral health programs.⁴⁶

In 2018, when the Office of Oral Health at CDPH released the California Oral Health Plan, the department had already identified multiple issues affecting Californians' oral health, including insufficient infrastructure to promote culturally sensitive community-based oral health programs, insufficient data to inform interventions, a range of barriers preventing access to care, a lack of implementation of evidence-based and demonstrable models of oral disease prevention and dental treatment, and a lack of consistent and effective messaging to encourage improvements in oral health.^{2,23} Since that time, the Office of Oral Health has launched a strategic plan and a series of initiatives to strengthen local dental public health infrastructure and capacity. Another new initiative is the granting of dental schools to support clinical rotations in DHPSAs.⁵⁰ The California Oral Health Technical Assistance Center is providing additional support; however, a full evaluation of these efforts has not yet been completed.⁵¹

Workforce Policy

The state has invested in multiple initiatives aimed at incentivizing meaningful participation by providers in Medi-Cal but has not achieved an expansion of the dental provider workforce serving Medi-Cal enrollees, nor has California seen a significant increase in access to dental care among the Medi-Cal population. This is not to say incremental improvements haven't been made, and a companion [issue brief on the dental workforce](#) delves into these workforce policy issues in depth.

Conclusion

Despite sustained statewide investments and policy efforts to expand access to oral health care in California, significant gaps remain. The burden of untreated disease continues to fall disproportionately on low-income communities, communities of color, rural residents, individuals with disabilities, and older adults—reinforcing broader inequities in health and economic opportunity. These disparities reflect structural limitations in a delivery system that was not designed to prevent disease early, manage it comprehensively, or ensure continuity of care across the life course.

Addressing these persistent inequities requires a reorientation of oral health policy toward prevention, workforce innovation, and integration with broader health systems. Strengthening community-based delivery models, modernizing scope-of-practice policies, investing in a diverse and geographically distributed workforce, and working toward comprehensive dental coverage are critical steps. Ultimately, improving access to dental care in California will require redesigning the system to promote equity, intervene earlier, and treat oral health as an essential component of overall health. Without structural reform, access gaps will persist; with it, California has the opportunity to build a more just and effective oral health system for all residents.

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