Improving Dental Care Access for Vulnerable Populations

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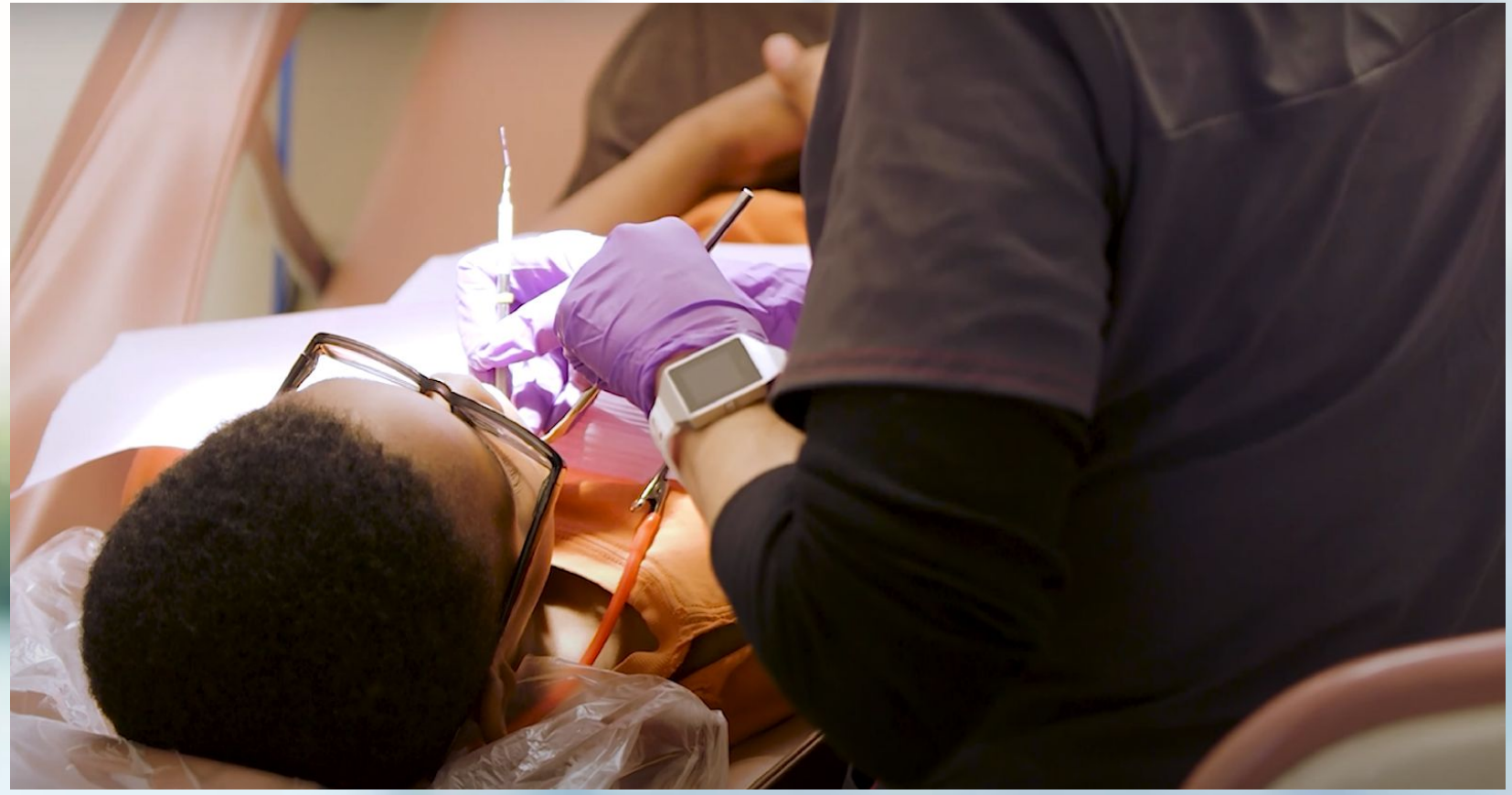
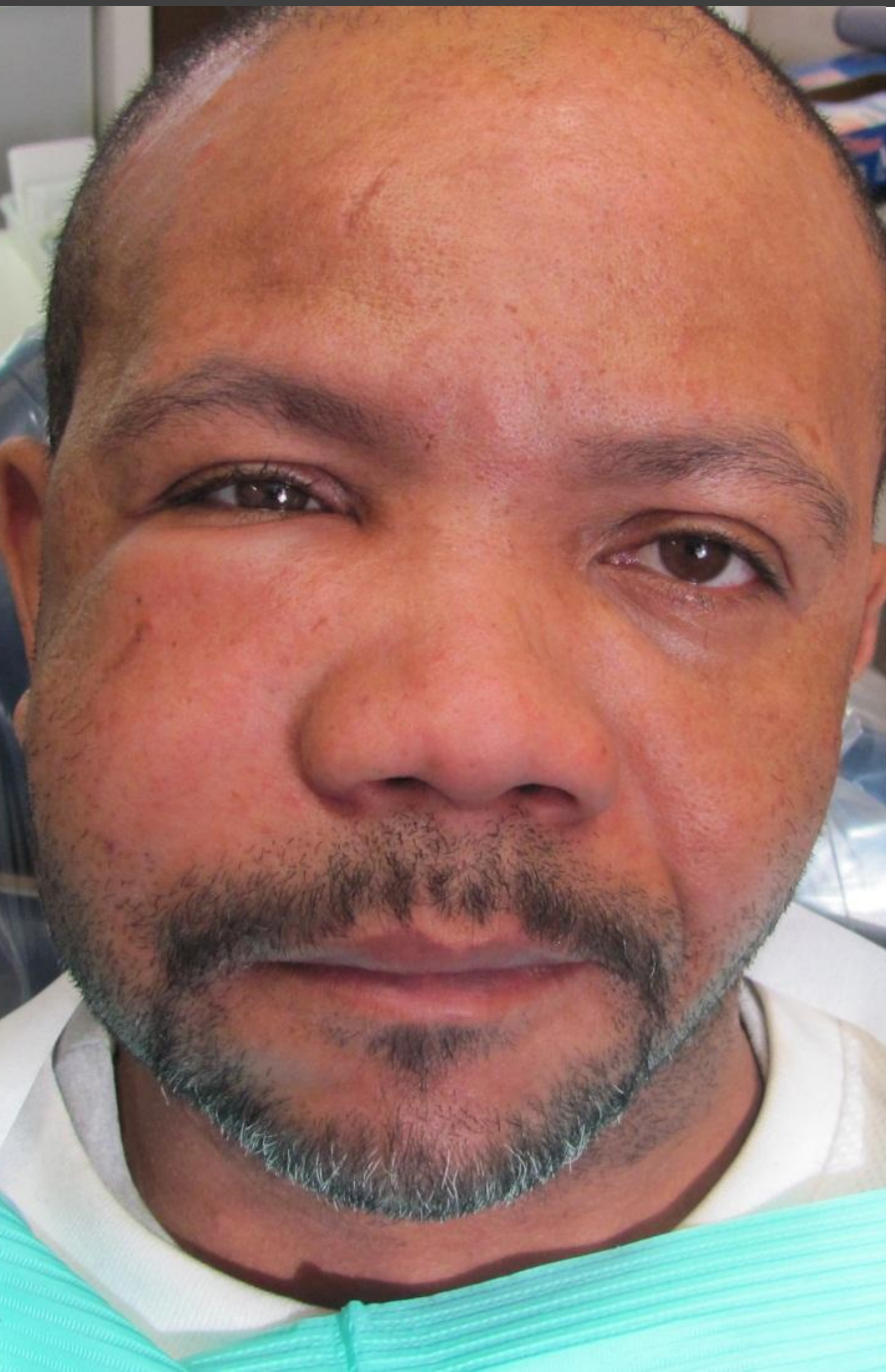
ADA American Dental Association®

Story of David





How does poor oral health occur?

- Rate of untreated dental caries is highest (44%) among adults with income below 100% FPL.
  - More than twice the rate (17%) among adults with income at or above 200% FPL.
- Cost barriers delay care
- Low-income patients who need relief from infections/pain often seek care in emergency rooms.
  - However, patients in ER often leave without treatment plan.

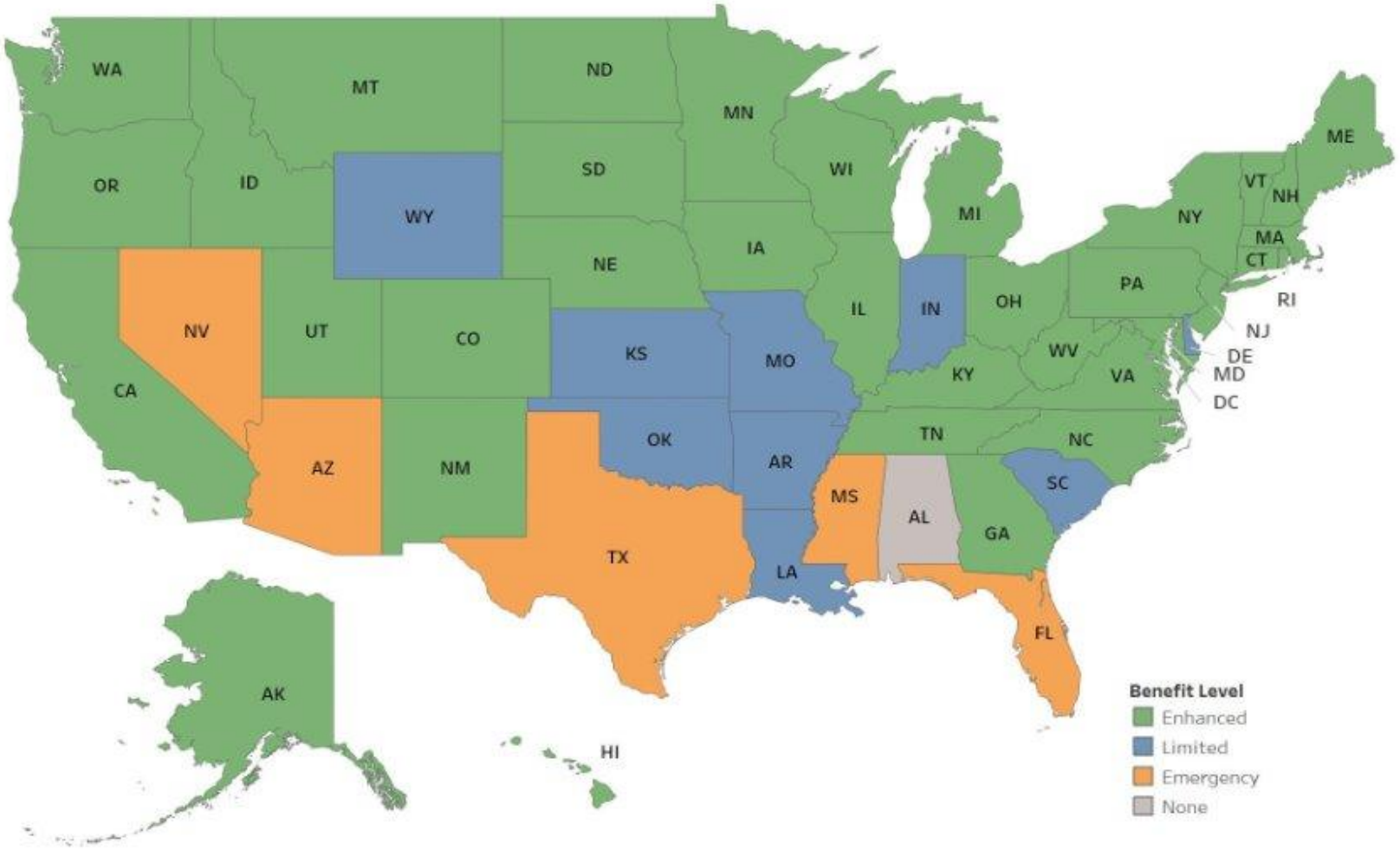
Medicaid Dental Coverage

- Low-income children [Mandatory dental coverage under Early and Periodic Screening, Diagnostic, and Treatment] (EPSDT)

- Low-income adults* (*varies by state*)
  - At or below 100% to 138% of FPL, depending on state's decision for Medicaid expansion.
  - Optional benefit for dental; sometimes limits on services

- Individuals with intellectual and developmental disabilities (IIDD)

Adult Medicaid Dental Benefit by State, 2025



Health Policy Institute analysis of data from state Medicaid websites and the CareQuest Medicaid Adult Dental Coverage Tracker

Survey of Medicaid Beneficiaries & Dentists

HPI Health Policy Institute
ADA American Dental Association®

Survey of Medicaid Beneficiaries
and
Survey of Dentist Opinions on Medicaid

Combined Results Report

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HPI Health Policy Institute
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Research Brief

Barriers to Dental Care Among Adult Medicaid Beneficiaries: A Comprehensive Analysis in Eight States

Authors: Brittany Flynn, M.A.; Rebecca Starkel Weninger, Ph.D.; Matthew Zaborowski, M.P.H., C.P.H.; Marko Vujicic, Ph.D.

The Health Policy Institute (HPI) is a thought leader and trusted source for policy knowledge on critical issues affecting the U.S. dental care system. HPI strives to generate, synthesize, and disseminate innovative research for policy makers, oral health advocates, and dental care providers.

Who We Are

HPI's interdisciplinary team of health economists, statisticians, and analysts has extensive expertise in health systems policy research. HPI staff routinely collaborates with researchers in academia and policy think tanks.

Key Messages

- *A survey of dentists and Medicaid beneficiaries in eight states indicates that underutilization of dental services among beneficiaries and low participation in Medicaid among dentists stem from several shared barriers: lack of comprehensive dental coverage for adults under Medicaid, which leads to prohibitive out-of-pocket costs, and difficulty finding a Medicaid-participating dentist.*
- *To improve dental care utilization among beneficiaries and access to care, state Medicaid programs need to enhance coverage and provide more dental care navigation tools to beneficiaries. To enhance provider participation, Medicaid programs need to increase reimbursement and ease administrative burdens. Expanding coverage will also increase provider participation.*

Introduction

Poor oral health has serious implications for one's overall health, self-esteem, and productivity. Inflammation of the oral cavity can lead to or exacerbate pregnancy complications and chronic conditions such as diabetes and heart disease.[1] Insecurity with

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Research Brief

Dentist Perceptions of Adult Medicaid Beneficiaries' Attitudes Toward Oral Health

Authors: Brittany Flynn, M.A.; Rebecca Starkel Weninger, Ph.D.; Matthew Zaborowski, M.P.H., C.P.H.; Marko Vujicic, Ph.D.

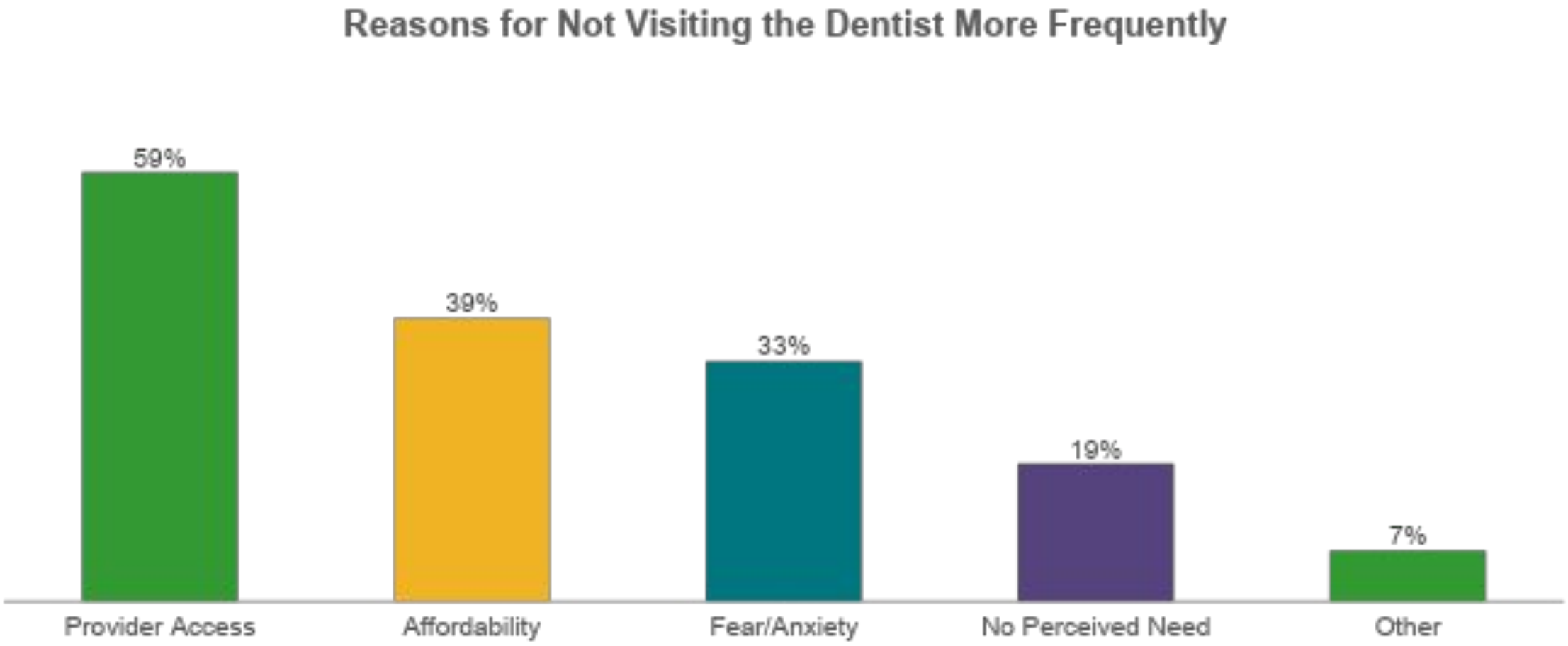
Key Messages

- *A survey of adult Medicaid beneficiaries and dentists in eight states found that two out five dentists, regardless of whether they treat Medicaid beneficiaries, agreed that Medicaid beneficiaries do not value oral health. Dentists' perceptions do not align with beneficiary attitudes; eight out of 10 beneficiaries agreed that the condition of their mouth is important to their overall health and appearance.*
- *Dentists perceive Medicaid beneficiaries as having more severe oral health problems or being more difficult to treat compared to their other patients. Gaps in oral health literacy or hesitancy to seek dental care among beneficiaries does not mean beneficiaries do not value oral health, but their oral health issues may be more severe.*
- *Understanding the challenges that adult Medicaid beneficiaries face when it comes to accessing dental care should be a guiding force in designing solutions to promote equitable access to oral health.*

Introduction

The consequences of poor oral health are well known. Dental disease impacts one's overall health,[1] productivity,[2] employability,[3] and general quality of life and costs the health care

Barriers to Dental Care



Results for adult Medicaid beneficiaries in eight states (MD, MN, NE, NH, OH, PA, RI, SD).

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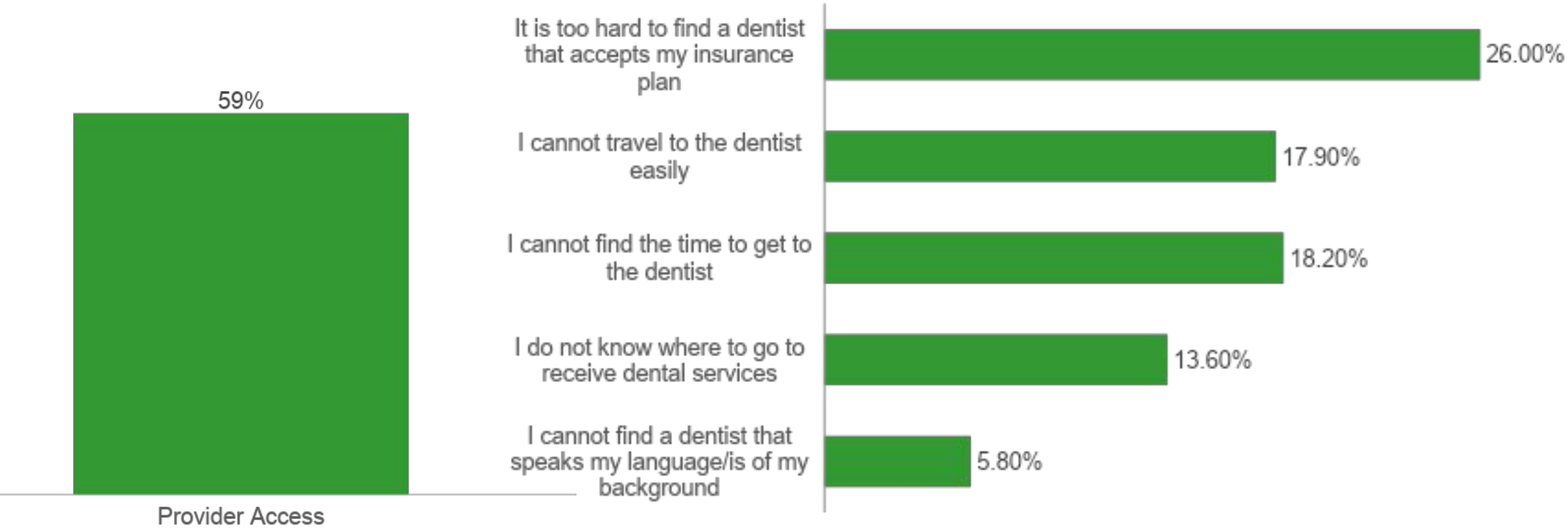

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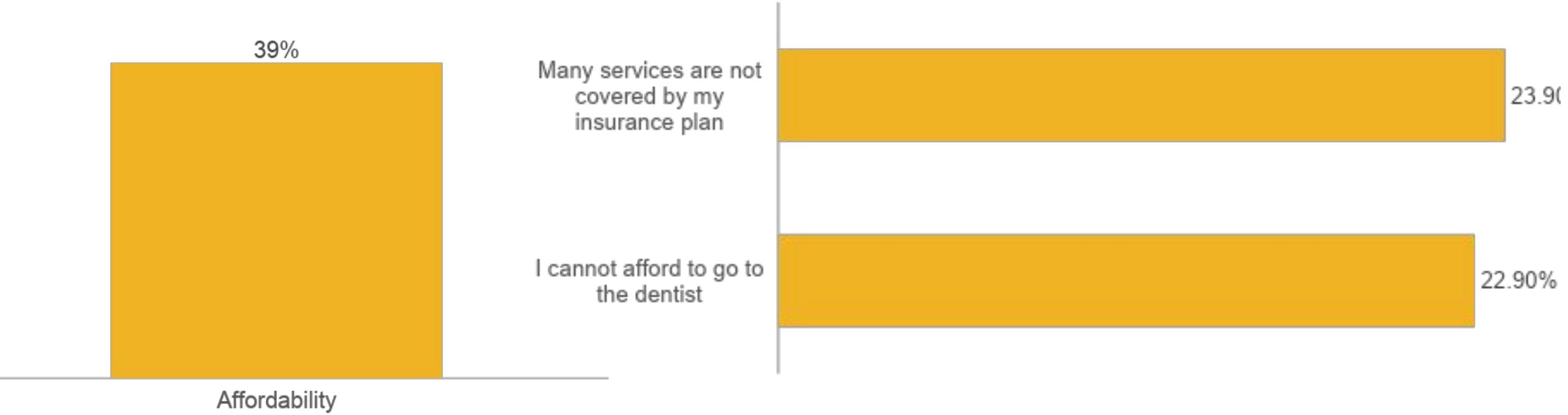

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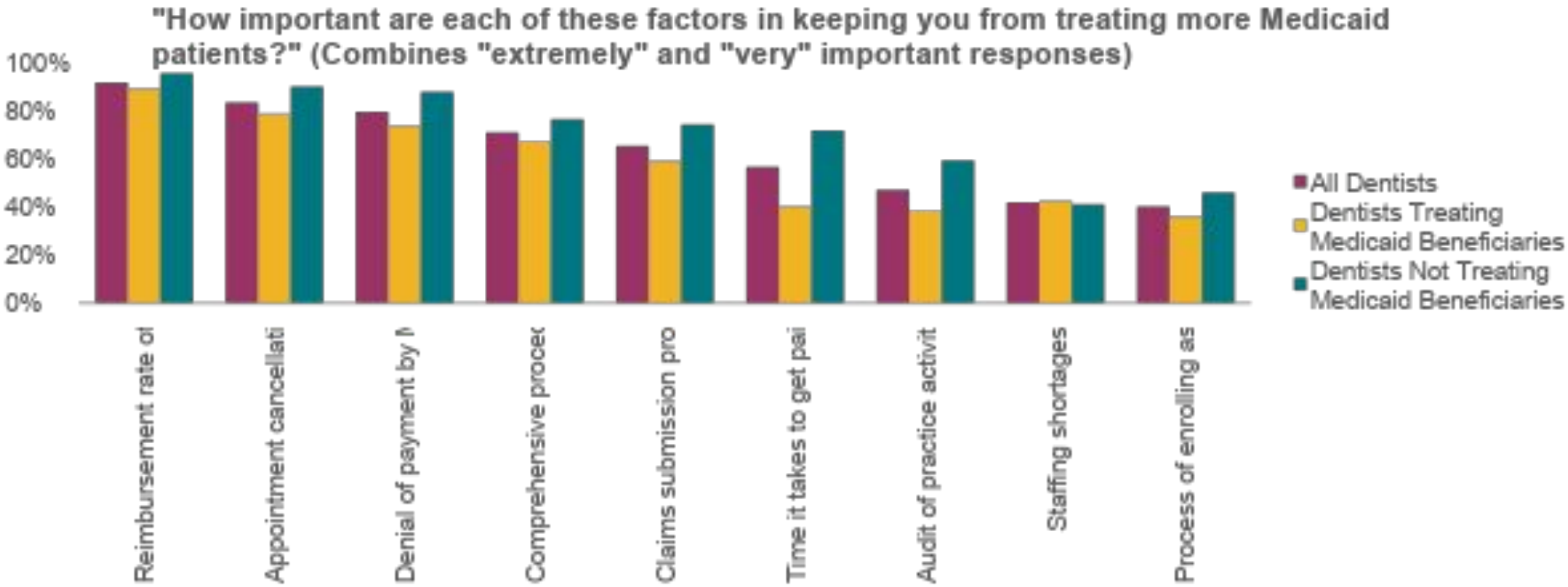
Barriers to Medicaid Participation



Results for dentists in eight states (MD, MN, NE, NH, OH, PA, RI, SD).

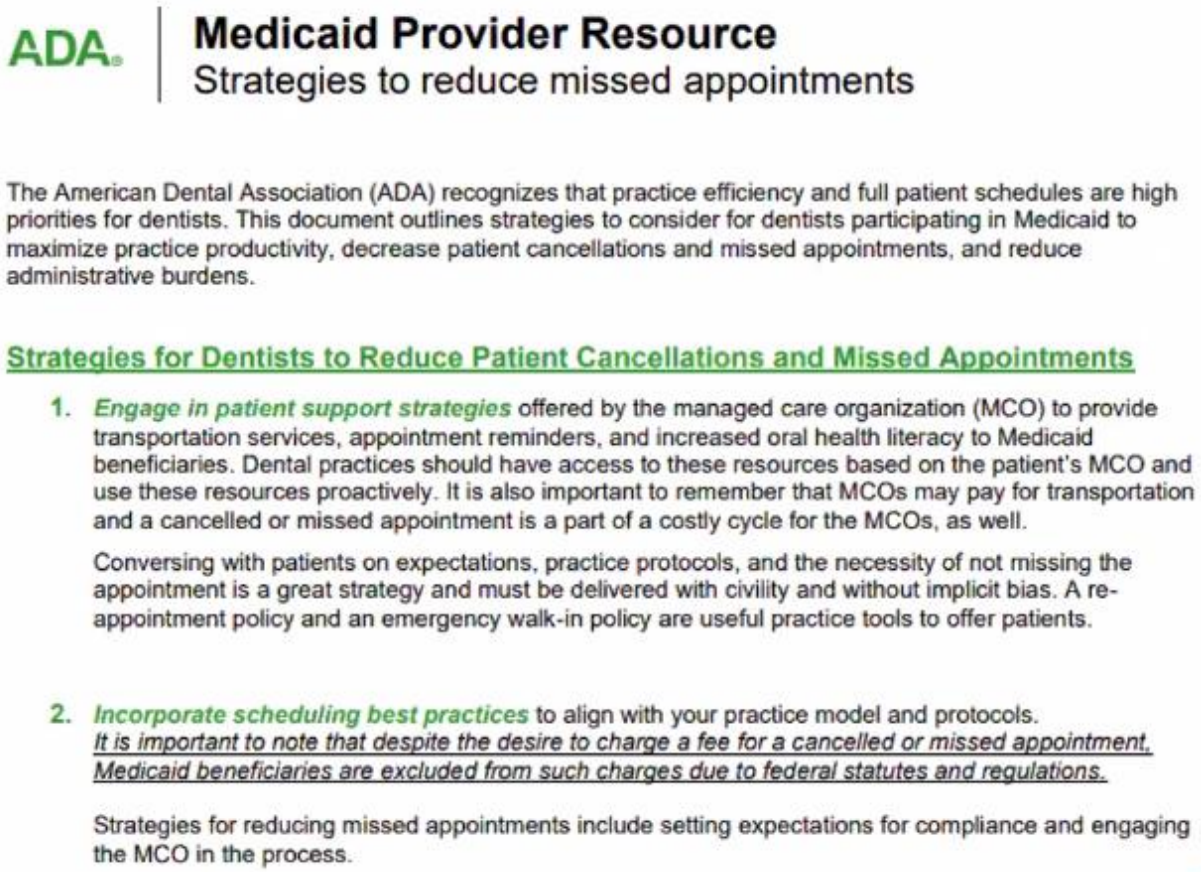
Barriers to Medicaid Participation

- Provider access is #1 challenge for beneficiaries.
  - Only 7 states are currently meeting network adequacy for dental benefits provided under Medicaid, which includes WV.
  - However, many beneficiaries who have IDD/pregnant may continue to experience issues around access.

- Besides reimbursement, many providers do not want to accept more Medicaid beneficiaries as patients due to a perception that Medicaid beneficiaries miss or “no show” to more appointments.

ADA's Medicaid Provider Resource

- Review the ADA's guidance on reducing missed appointments, including:
  - Patient support strategies
  - Scheduling best practices
  - Maximize practice staff
  - Demonstrate compassion



ADA.

Medicaid Provider Resource
Strategies to reduce missed appointments

The American Dental Association (ADA) recognizes that practice efficiency and full patient schedules are high priorities for dentists. This document outlines strategies to consider for dentists participating in Medicaid to maximize practice productivity, decrease patient cancellations and missed appointments, and reduce administrative burdens.

Strategies for Dentists to Reduce Patient Cancellations and Missed Appointments

1. ***Engage in patient support strategies*** offered by the managed care organization (MCO) to provide transportation services, appointment reminders, and increased oral health literacy to Medicaid beneficiaries. Dental practices should have access to these resources based on the patient's MCO and use these resources proactively. It is also important to remember that MCOs may pay for transportation and a cancelled or missed appointment is a part of a costly cycle for the MCOs, as well.

   Conversing with patients on expectations, practice protocols, and the necessity of not missing the appointment is a great strategy and must be delivered with civility and without implicit bias. A re-appointment policy and an emergency walk-in policy are useful practice tools to offer patients.

2. ***Incorporate scheduling best practices*** to align with your practice model and protocols.
   It is important to note that despite the desire to charge a fee for a cancelled or missed appointment, Medicaid beneficiaries are excluded from such charges due to federal statutes and regulations.

   Strategies for reducing missed appointments include setting expectations for compliance and engaging the MCO in the process.

Health Care Costs

- Emergency Department visits
- Diabetes
- Coronary Artery Disease
- Pregnancy

} *Due to lack of treatment for periodontitis*

- All costs were adjusted for inflation

- However, other costs can be explored in future research for oral health cancer detection, dental services while undergoing substance use treatment.

Increase in Healthcare Costs

Table 1: Estimated Increase in Health Care Costs Associated with Different Medical Conditions due to Removal of Adult Medicaid Dental Benefit in Each State

	ED Visits	Diabetes	Coronary Artery Disease	Pregnancy	Total Cost	5-Year Cost
Pennsylvania	$15,112,142	$61,336,383	$8,815,003	$16,450,290	$101,713,818	$508,569,089
Rhode Island	$1,363,554	$5,534,321	$795,369	$1,284,623	$8,977,866	$44,889,332
South Carolina	$1,899,498	$7,709,584	$1,107,988	$4,895,547	$15,612,617	$78,063,083
South Dakota	$527,549	$2,141,188	$307,722	$975,803	$3,952,263	$19,761,315
Tennessee	$347,904	$1,412,056	$202,935	$867,557	$2,830,451	$14,152,257
Vermont	$1,078,621	$4,377,853	$629,166	$830,220	$6,915,861	$34,579,306
Virginia	$5,552,636	$22,536,751	$3,238,885	$7,656,841	$38,985,113	$194,925,565
Washington	$8,169,040	$33,156,078	$4,765,050	$9,415,830	$55,505,997	$277,529,987
West Virginia	$1,629,456	$6,613,550	$950,471	$1,607,617	$10,801,094	$54,005,469
Wisconsin	$5,370,157	$21,796,116	$3,132,445	$7,068,172	$37,366,889	$186,834,447
Wyoming	$176,943	$718,167	$103,212	$595,311	$1,593,634	$7,968,168
United States	**$283,818,142**	**$1,151,946,428**	**$165,552,814**	**$312,651,368**	**$1,913,968,753**	**$9,569,843,764**

Notes: Costs for diabetes, coronary artery disease, and pregnancy are based off lack of periodontitis treatment with these conditions. This table only includes states that have limited or enhanced dental benefits for adults under Medicaid. Maine, Maryland, New Hampshire, Oklahoma, and Tennessee have expanded Medicaid benefits since 2021; costs for these states are underestimates. ED: emergency department.

Key Takeaways

Table 2: Estimated Impact of Removing of Adult Medicaid Dental Benefit on Number of Medicaid Beneficiaries Facing Challenges Finding Work in Each State

	Number of Beneficiaries		Number of Beneficiaries
Louisiana	33,273	Tennessee	2,492
Maine	5,332	Vermont	7,726
Maryland	26,350	Virginia	39,774
Massachusetts	80,857	Washington	58,516
Michigan	84,712	West Virginia	11,672
Minnesota	49,097	Wisconsin	38,467
Montana	10,397	Wyoming	1,267
		United States	**2,033,032**

In the U.S., 2 million adults will experience challenges finding work due to their oral health

What was California's experience?

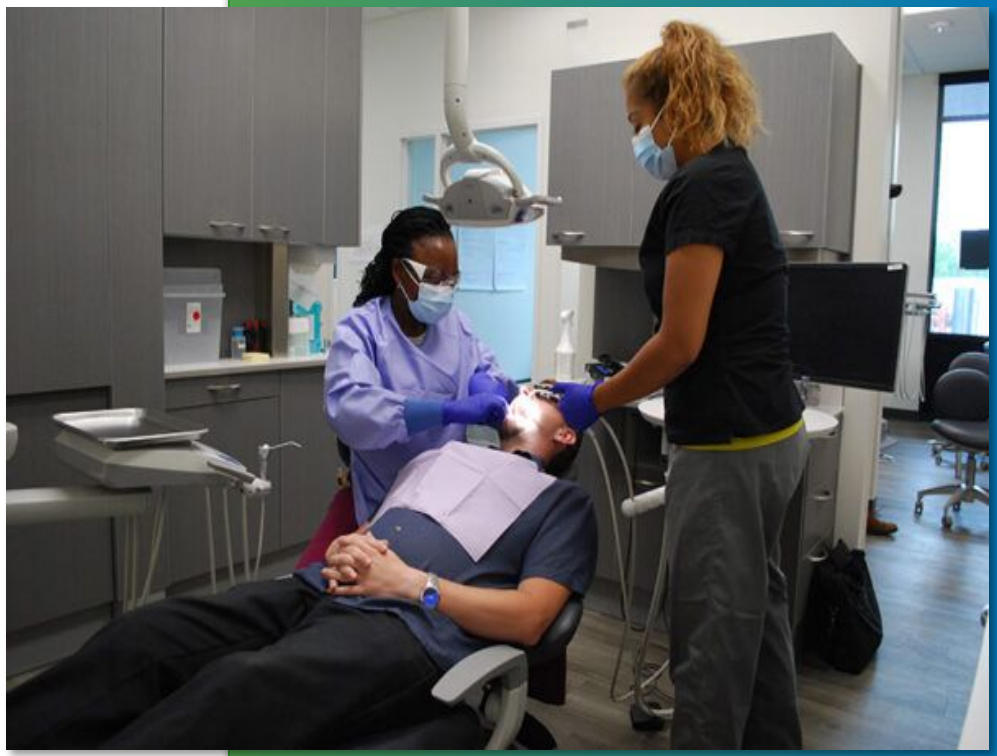
- Occurred in 2009; intention behind the dental benefit cut was to save the state money – but unintended consequences occurred.
  - Additional health effects:
    - Providers reported an increase in patients with dental abscesses.
    - An additional 1,800 ER visits per year related to non-traumatic dental injuries
  - Additional economic effects:
    - Estimated loss of nearly 4,500 jobs and over half a billion dollars in economic activity.
    - Providers felt alienated from program, continued struggle to have these providers return.

What was Oregon's experience?

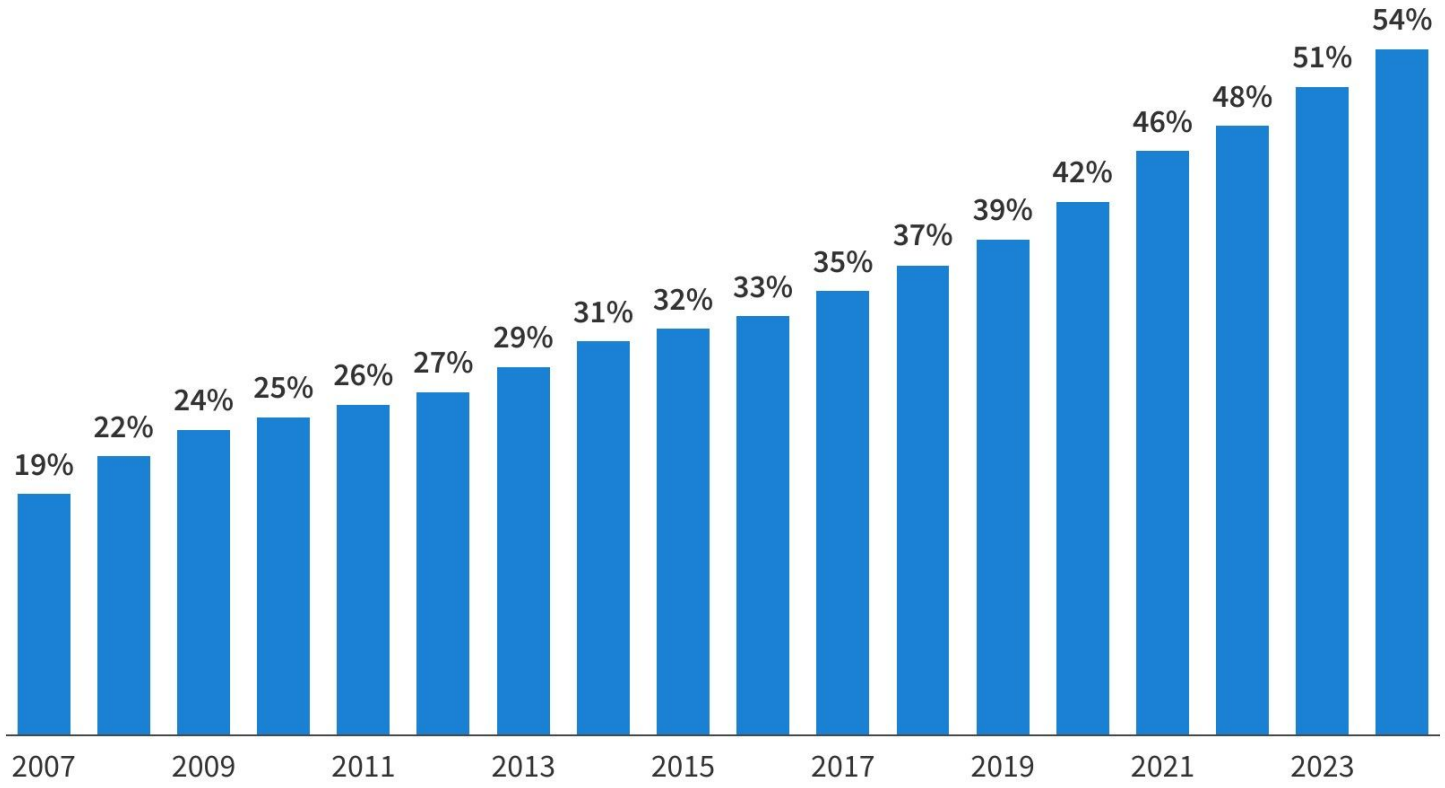
- The impact of the elimination of adult dental benefits was seen within the first 10 months
  - resulted in increased costs, negative impacts on healthcare access and utilization, and adverse health outcomes

- The number of ED visits increased from 6,600 per month in 2002 to over 9,000 per month in 2004.

- 28 percent increase in the utilization of ambulatory medical care for dental concerns and a 26 percent increase in per person expenditures – proof that low-income individuals still sought dental care.



Dental Coverage in Medicare Advantage



Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 61.2 million people are enrolled in Medicare Parts A and B in 2024.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024.

KFF

- Medicare beneficiaries earning incomes under 100 percent of the Federal Poverty Level (FPL) are nearly 70 percent more likely to enroll in Medicare Advantage than those over 400 percent of the FPL

98% of MA dental plans cover <u>some</u> dental services

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RESEARCH LETTER

Availability of Dental Benefits Within Medicare Advantage Plans by Enrollment and County

Table 1. Characteristics of Dental Benefits Offered by Medicare Advantage Plans, Quarter 4 of 2023

Characteristic	No. of plans (%) (N = 5485)	
	With benefit	Without benefit
Preventive services covered	5399 (98.4)	86 (1.6)
No co-pay or coinsurance required for preventive services	1937 (35.3)	3548 (64.7)
No prior authorization required for preventive services	4838 (88.2)	647 (11.8)
Coverage for ≥2 dental cleanings per year	5381 (98.1)	104 (1.9)
No referral required for preventive services	5325 (97.1)	160 (2.9)
Coverage of nonpreventive dental services must be offered	5288 (96.4)	197 (3.6)
Nonpreventive dental coverage must offer full range of services[a]	4016 (73.2)	1469 (26.8)
Maximum annual benefit of ≥$1500	4249 (77.4)	1236 (22.6)
Maximum mean coinsurance of 30% for nonpreventive services	3443 (62.8)	2042 (37.2)
No additional premium for preventive or nonpreventive services	3544 (64.6)	1941 (35.4)
Plans meeting all above criteria (comprehensive dental benefit[b])	460 (8.4)	5025 (91.6)

[a] Full range of services included diagnostic, restorative, endodontic, periodontic, extractions, and prosthodontic services.

[b] Comprehensive dental benefits included all services listed above.

98% of MA dental plans cover some dental services

65% of MA dental plans require cost sharing for prevention

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8% of MA dental plans have a comprehensive dental benefit

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Original Investigation

Benefit Design and Access to Dental Care Among Seniors With Medicare Advantage Dental Benefits

Kamyar Nasseh, PhD; Astha Singhal, BDS, MPH, PhD; Marko Vujicic, PhD; Lisa Simon, MD, DMD

Table 2. Association of Unmet Dental Need, Unmet Dental Need Due to Cost, and Dental Care Utilization With Medicare Advantage Dental Plan Attributes[a]

	Percentage point, mean (SE) [95% CI]		
Dependent variable	Reported unmet dental need (n=1455 observations)	Reported unmet dental need due to cost (n=1455 observations	Visited dentist in year (=1789 observations)
HMO plan	7.0 (2.0) [3.2 to 10.9][b]	4.4 (1.8) [0.9 to 7.8][c]	−2.4 (3.6) [−9.5 to 4.7]
≥2 Dental cleanings per year	0.4 (3.4) [−6.2 to 7.0]	0.1 (3.3) [−6.3 to 6.4]	−4.8 (4.7) [−14.0 to 4.3]
OOP for preventive services	3.9 (2.2) [−0.5 to 8.3][d]	2.0 (1.9) [−1.7 to 5.8]	−1.1 (3.5) [−8.0 to 5.8]
Referral required	4.0 (3.2) [−2.3 to 10.2]	4.3 (3.0) [−1.5 to 10.2]	3.4 (4.0) [−4.5 to 11.3]
Prior authorization required	4.5 (2.1) [0.3 to 8.7][c]	3.2 (1.8) [−0.4 to 6.8][d]	−2.8 (3.3) [−9.2 to 3.6]
All dental services offered	3.2 (2.8) [−2.3 to 8.7]	2.0 (2.4) [−2.7 to 6.8]	−1.2 (3.8) [−8.8 to 6.3]
OOP cost for comprehensive services			
No OOP cost	[Reference]	[Reference]	[Reference]
>0 Copayment	−4.6 (3.0) [−10.5 to 1.4]	−2.6 (2.8) [−8.0 to 2.9]	−14.6 (5.9) [−26.2 to −3.0][c]
0% <Coinsurance <50%	−2.8 (4.5) [−11.7 to 6.0]	−2.6 (3.9) [−10.3 to 5.0]	4.3 (6.6) [−8.7 to 17.3]
≥ 50% Coinsurance	−3.7 (2.9) [−9.3 to 1.9]	−0.7 (2.8) [−6.2 to 4.7]	0.7 (5.0) [−9.1 to 10.5]
Preventive only benefit	12.1 (4.5) [3.2 to 21.0][b]	7.8 (3.7) [0.6 to 15.0][c]	−3.2 (4.8) [−12.6 to 6.1]
Annual benefit maximum			
0 <Benefit maximum ≤500	[Reference]	[Reference]	[Reference]
500 <Benefit maximum ≤1500	−4.8 (4.9) [−14.4 to 4.7]	−8.5 (4.5) [−17.4 to 0.4][d]	11.1 (5.8) [−0.2 to 22.4][d]
1500 <Benefit maximum ≤2000	−4.1 (5.7) [−15.2 to 7.0]	−6.2 (5.1) [−16.2 to 3.8]	10.5 (6.9) [−3.1 to 24.2]
2000 <Benefit maximum ≤2500	−5.9 (5.5) [−16.8 to 5.0]	−5.7 (5.1) [−15.8 to 4.3]	16.2 (7.5) [1.5 to 30.9][c]
Benefit maximum >2500	−10.8 (5.5) [−21.6 to −0.0][c]	−11.7 (4.7) [−20.9 to −2.4][c]	21.6 (8.0) [6.0 to 37.3][b]
No benefit maximum	−12.4 (4.4) [−20.9 to −3.8][b]	−11.4 (4.1) [−19.5 to −3.3][b]	12.4 (5.7) [1.2 to 23.6][c]

Abbreviations: HMO, health maintenance organization; OOP, out of pocket; PPO, preferred provider organization.

[a] All probit marginal effect estimates are weighted and consider the complex survey design of the Medicare Current Beneficiary Survey. Covariates included in regression models but not reported are age, sex, race and ethnicity, rurality, respondent household income, respondent educational attainment, job status, self−reported health status, census region, dual eligibility status, log of county median household income, county percent in poverty, population density, dentists per capita and Medicare Advantage penetration.

[b] $P < .01$.

[c] $P < .05$.

[d] $P < .10$.

MA dental plans that require prior authorization, cover only preventive dental services, and have annual plan benefit maximums below $2,500 were associated with higher unmet dental needs and lower dental care use.

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≥ 50% Coinsurance	−3.7 (2.9) [−9.3 to 1.9]	−0.7 (2.8) [−6.2 to 4.7]	0.7 (5.0) [−9.1 to 10.5]
Preventive only benefit	12.1 (4.5) [3.2 to 21.0][b]	7.8 (3.7) [0.6 to 15.0][c]	−3.2 (4.8) [−12.6 to 6.1]
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0 <Benefit maximum ≤500	[Reference]	[Reference]	[Reference]
500 <Benefit maximum ≤1500	−4.8 (4.9) [−14.4 to 4.7]	−8.5 (4.5) [−17.4 to 0.4][d]	11.1 (5.8) [−0.2 to 22.4][d]
1500 <Benefit maximum ≤2000	−4.1 (5.7) [−15.2 to 7.0]	−6.2 (5.1) [−16.2 to 3.8]	10.5 (6.9) [−3.1 to 24.2]
2000 <Benefit maximum ≤2500	−5.9 (5.5) [−16.8 to 5.0]	−5.7 (5.1) [−15.8 to 4.3]	16.2 (7.5) [1.5 to 30.9][c]
Benefit maximum >2500	−10.8 (5.5) [−21.6 to −0.0][c]	−11.7 (4.7) [−20.9 to −2.4][c]	21.6 (8.0) [6.0 to 37.3][b]
No benefit maximum	−12.4 (4.4) [−20.9 to −3.8][b]	−11.4 (4.1) [−19.5 to −3.3][b]	12.4 (5.7) [1.2 to 23.6][c]

Abbreviations: HMO, health maintenance organization; OOP, out of pocket; PPO, preferred provider organization.

[a] All probit marginal effect estimates are weighted and consider the complex survey design of the Medicare Current Beneficiary Survey. Covariates included in regression models but not reported are age, sex, race and ethnicity, rurality, respondent household income, respondent educational attainment, job status, self−reported health status, census region, dual eligibility status, log of county median household income, county percent in poverty, population density, dentists per capita and Medicare Advantage penetration.

[b] $P < .01$.

[c] $P < .05$.

[d] $P < .10$.

Dental Coverage in Medicare Advantage

- Most MA plans have some dental coverage. But it is often ‘CINO’ (coverage-in-name-only).
- Lots of evidence suggesting little impact of MA dental coverage (vs traditional Medicare) on dental care utilization and oral health outcomes.
- As Congress debates MA’s use of prior authorization/delayed payment, consideration should be made for supplemental benefits reform.

What's Going Wrong?

- **Lack of transparency:** Plan limits and exclusions often are not clear at sign-up
- **Choice overload:** Too many plans with inability to identify meaningful differences
- **Insufficient benefits:** Does not often address serious oral health needs
- **Annual changes:** Plans can cut or change dental supplemental benefits, but beneficiaries feel stuck with their MA plan to stay within their current medical provider network
- **Administrative burden:** Beneficiaries may not fully understand their benefits as supplemental benefits vary greatly, and dental offices often have to spend a significant amount of administrative time to research a beneficiary's benefit

What Can We Do Moving Forward?

- **Pass legislation that requires up-front transparency about supplemental dental benefits,** and include a structured summary of the plan's specific dental coverage, clearly listing key features such as covered services limitations or exclusions, waiting periods, annual maximums, cost-sharing, predetermination or prior authorization requirements, and out-of-network policies
- **Require Medicare Advantage plans to automate administrative transactions** for dental services similarly to medical services, so dental offices can quickly and accurately confirm a patient's dental benefit and cut down on delays and paperwork that often impede care

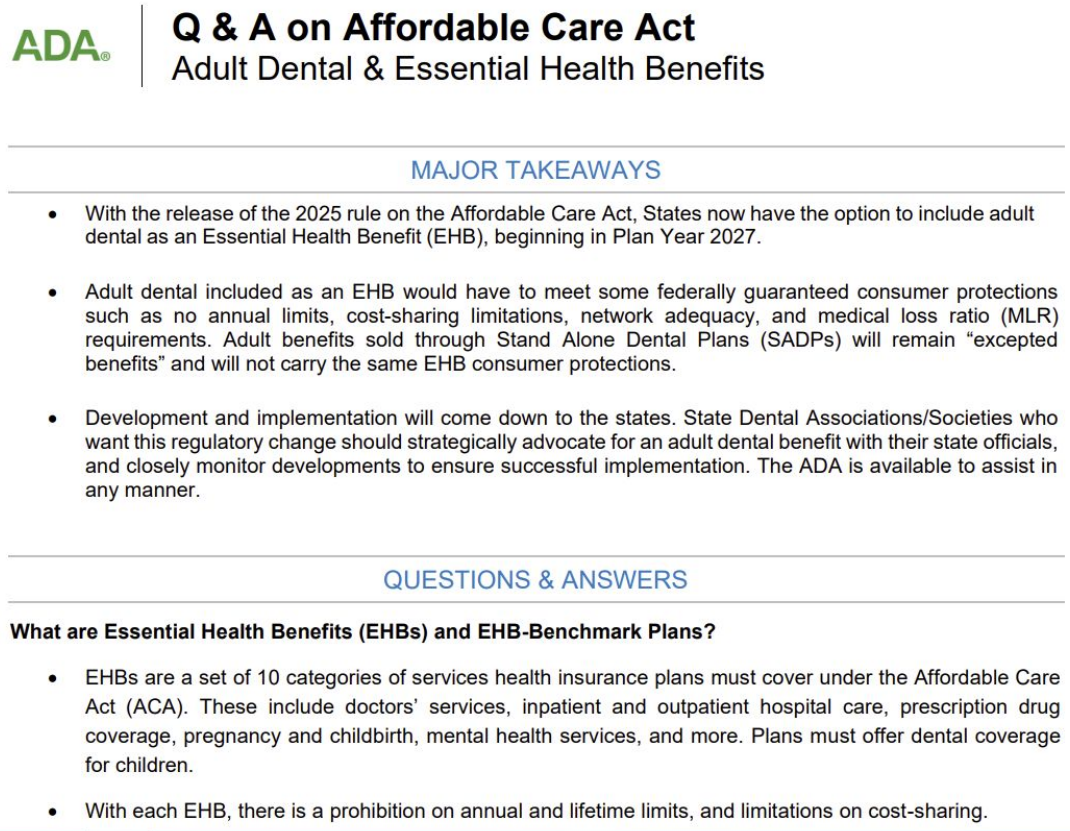
Essential Health Benefits (EHB) Overview

The 10 Essential Health Benefits under the ACA

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity, and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Pediatric services, **including pediatric oral** and vision **care**

New 2025 Adult Dental Benefit EHB Rules

- 96% of individuals who utilize the dental marketplace are at or below 400% of the FPL.
- Removes the prohibition on adult dental as an Essential Health Benefit (EHB).
- Each state will still have to act in order to include this as part of their EHB-Benchmark plan.
- Visit www.ada.org/EHB to learn more about this new regulation.



ADA®

Q & A on Affordable Care Act

Adult Dental & Essential Health Benefits

MAJOR TAKEAWAYS

- With the release of the 2025 rule on the Affordable Care Act, States now have the option to include adult dental as an Essential Health Benefit (EHB), beginning in Plan Year 2027.
- Adult dental included as an EHB would have to meet some federally guaranteed consumer protections such as no annual limits, cost-sharing limitations, network adequacy, and medical loss ratio (MLR) requirements. Adult benefits sold through Stand Alone Dental Plans (SADPs) will remain "excepted benefits" and will not carry the same EHB consumer protections.
- Development and implementation will come down to the states. State Dental Associations/Societies who want this regulatory change should strategically advocate for an adult dental benefit with their state officials, and closely monitor developments to ensure successful implementation. The ADA is available to assist in any manner.

QUESTIONS & ANSWERS

What are Essential Health Benefits (EHBs) and EHB-Benchmark Plans?

- EHBs are a set of 10 categories of services health insurance plans must cover under the Affordable Care Act (ACA). These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Plans must offer dental coverage for children.
- With each EHB, there is a prohibition on annual and lifetime limits, and limitations on cost-sharing.

For further information or more details

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