

# Strategies to Improve Dental Benefits for the Medicaid Expansion Population

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Inadequate oral health care access can lead to advanced oral disease, compromised health status, and occasionally, even death.<sup>1</sup> Because the federal government considers dental coverage for adults to be an “optional” Medicaid benefit, it is often among the first programs to be trimmed in tight fiscal times.<sup>2</sup> Due to budget constraints, 10 states have either eliminated or substantially cut funding for adult dental services in Medicaid in the past decade.<sup>3</sup> These reductions present a significant barrier to oral health care access for low-income adults, who often cannot afford to pay out-of-pocket and have no options for oral health care other than charity dental services that are inconsistently available.

Under the Affordable Care Act (ACA), many states have opted to extend Medicaid eligibility to adults up to 138 percent of the federal poverty level (FPL). As of February 2014, 25 states and the District of Columbia have expanded Medicaid to adults below 133 percent of the federal poverty level (FPL), while 25 states are still considering expansion or have not yet chosen to expand.<sup>4</sup> States that expand eligibility must select an alternative benefit plan (ABP) that includes the 10 essential health benefit categories created by the ACA.<sup>5</sup> While dental services for adults are *not* included on this list, more than half of the states expanding Medicaid eligibility intend to include dental benefits in their ABPs.

This brief summarizes state decisions regarding the inclusion of dental benefits for the Medicaid expansion population. It details emerging strategies to ensure dental access for adults in Medicaid drawing from an environmental scan of state dental coverage decisions and interviews that the Center for Health Care Strategies (CHCS) undertook in eight states that are including dental benefits in their ABP.<sup>6</sup> CHCS held a subsequent small group consultation with dental leaders from seven Medicaid agencies – California, Colorado, Connecticut, the District of Columbia, Michigan, New Jersey, and New Mexico – to further refine the findings and inform states as they consider expanding dental benefits to newly eligible Medicaid beneficiaries. A corresponding appendix details state strategies.

## IN BRIEF

States expanding Medicaid under the Affordable Care Act can include dental coverage in their alternative benefit plan for low-income adults. Key considerations for states in deciding whether and how to offer dental benefits include the state’s perceived value of oral health, parity of benefits across populations, costs, state legislation, and administrative factors.

Through a national scan, the Center for Health Care Strategies (CHCS) found that 20 Medicaid-expansion states intend to offer at least a minimal dental benefit to newly eligible populations. Of these states, 10 will offer extensive benefits. To ensure access to care among the newly covered, these states are:

- Tailoring outreach strategies;
- Engaging oral health stakeholders;
- Exploring financial and non-financial provider incentives; and/or
- Considering opportunities to expand the dental workforce.

This brief synthesizes state decisions regarding dental benefits for the Medicaid expansion population. It can help inform other states as they determine benefit offerings for the Medicaid expansion population in 2014 and beyond.

## Medicaid Dental Policy Overview

Low-income individuals are about 50 percent less likely to have seen a dentist in the past year than those with higher incomes.<sup>7</sup> They suffer a disproportionate share of dental disease—including untreated caries and tooth loss due to decay or gum disease.<sup>8</sup> Poor oral health can contribute to elevated risks for systemic diseases; poor pregnancy outcomes; diabetes, respiratory problems, and cardiovascular disease; and declines in vital bodily functions such as eating, breathing, and speaking, as well as self-esteem.<sup>9</sup> Oral disease can also lead to lost workdays, and visible tooth decay reduces employability.<sup>10,11</sup>

While federal law requires states to provide dental benefits to children enrolled in Medicaid and/or the Children's Health Insurance Program, dental coverage for adults is optional.<sup>12</sup> Federal regulations require states that are not providing *any* dental benefits for adults to at least reimburse medical and surgical services related to an oral health problem if delivered by a medical or dental provider.<sup>13</sup> While 44 states now offer *some* dental benefit to Medicaid-enrolled adults, only 28 cover services beyond medically necessary care in emergency circumstances.<sup>14</sup> Among these 28, the services covered vary greatly—in many cases falling short of the coverage needed to maintain a healthy mouth.

Between 2000 and 2010, there was a significant reduction and/or elimination of adult dental benefits in state Medicaid programs, with a concurrent 10 percent decline in oral health care utilization among low-income adults.<sup>15</sup> Following the adult dental benefit reductions that occurred in Massachusetts in 2002, for example, the percentage of low-income adults receiving dental services dropped from 24 percent to 11 percent over three years.<sup>16</sup> Oregon's elimination of dental benefits for Oregon Health Plan Standard beneficiaries led to an increase in the use of emergency department services and ambulatory Medicaid settings for dental problems.<sup>17</sup>

In addition to benefit reductions, access to dental providers remains a major obstacle for Medicaid enrollees to get needed care. Medicaid enrollees often have difficulty finding Medicaid-contracted dental providers—only 20 percent of practicing dentists nationwide provide care to people with Medicaid.<sup>18</sup> Beneficiaries also often have difficulty using dental benefits and getting to appointments due to lack of transportation or the inability to take time off from work; have gaps in health literacy; and/or have a primary care provider who does not encourage oral health care.<sup>19</sup> As a result, low-income adults are disproportionately affected by oral health problems. These coverage and access challenges have also led to an increase in dental-related hospital visits and overall uncompensated care over the past several years<sup>20</sup>—costs that are ultimately paid for by taxpayers.

## Medicaid Expansion: An Opportunity to Extend Dental Access

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CHCS' initial scan found that a majority of states expanding Medicaid are planning to include adult dental benefits in state ABPs. Through its scan of state activities, CHCS categorized covered services as follows:

- **No coverage:** No dental services covered;
- **Emergency services:** Services provided for the relief of pain and infection under defined emergency situations;
- **Limited services:** A limited mix of services, including some diagnostic, preventive, and minor restorative procedures. Any per-person annual expenditure cap is \$1,000 or less. Includes coverage of *fewer than* 100 procedures out of the approximately 600 recognized procedures per the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature; and
- **Extensive services:** A more comprehensive mix of services, including many diagnostic, preventive, and minor and major restorative procedures. Any per-person annual expenditure cap is *at least* \$1,000. Includes coverage of *at least* 100 procedures out of the approximately 600 recognized procedures per the ADA's Code on Dental Procedures and Nomenclature.

Twenty-two Medicaid-expansion states intend to offer dental benefits to the newly eligible population. Among these 22, the following 10 will offer extensive services: California, Connecticut, Iowa, Minnesota, New Jersey, New Mexico, New York, Oregon, Washington, and the District of Columbia. Seven states – Colorado, Kentucky, Massachusetts, Michigan, Ohio, Rhode Island, and Vermont – will likely offer limited services; and five states – Hawaii, Illinois, Nevada, New Hampshire, and West Virginia – will offer emergency services only. The remaining four states (Arizona, Delaware, Maryland, and North Dakota) have decided to offer no dental coverage; of those, Maryland allows managed care organizations to voluntarily cover dental services for current and expansion beneficiaries.<sup>21</sup>

## The Big Decision: How States are Deciding on Dental Coverage

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Overall, CHCS' interviews revealed a high level of interest among Medicaid dental leaders in offering dental benefits to newly eligible adults. State decisions were influenced by a number of factors, including the perceived value of oral health for the expansion population; the desire to achieve benefit parity or equity; costs; state legislation; and administrative considerations.

**Perceived Value of Oral Health.** The majority of interviewed states that will offer adult dental benefits recognized the value of providing routine oral care to newly eligible individuals, most of whom are likely to have unmet oral health needs. Many states mentioned the link between oral care and physical health. Other states, including New Mexico, felt that dental benefits are more important to

improving health than other health-related services that would serve more limited groups within the expansion population.

**Equity.** Medicaid leaders in New Jersey and the District of Columbia emphasized the need to create benefit parity and minimize coverage gaps/differences between current Medicaid beneficiaries and the expansion population. Both states would like to ensure that all non-disabled, childless adults have access to similar services and benefits.

**Costs.** Not surprisingly, for many states, cost was the primary determining factor in both Medicaid expansion decisions and the subsequent benefits package. Most states, such as New Mexico, chose to include a dental benefit for the expansion population to reduce avoidable related costs, such as emergency-department utilization for dental needs. While many states expressed concern about including dental benefits given the gradual rise in the state share of Medicaid expansion program costs after 2016,<sup>22</sup> several intend to use existing policies – such as prior authorization requirements and limitations on scope, quantity, and duration of services – to manage costs. Some states, including New Jersey, intend to monitor the type and quantity of services used by the expansion group during the first few years to inform benefit design post-2016 when state costs increase.

**State Legislation.** In some states, recent legislative action was the impetus for including adult dental benefits in the ABP. In June 2013, California legislative leaders and the governor approved the restoration of partial funding for preventive dental care, restorative care, and dentures in the state’s Medicaid program, which had been completely eliminated in 2009. Also, in June 2013, Washington State’s legislature restored the comprehensive dental benefit that the state had cut in 2011. Both states are now able to offer dental services to the expansion population. Similarly, the Colorado General Assembly enacted legislation in May 2013 requiring a limited oral health benefit for adults in Medicaid, including those newly eligible.

**Administrative Considerations.** Medicaid expansion states face various administrative and system challenges that are further compounded by tight implementation timelines. Given the extensive technology alterations needed for the new eligibility group, a number of states, including New Jersey, are offering the expansion group a benefit package similar to existing Medicaid offerings to minimize additional system adjustments. States noted that this is less administratively burdensome—both for the state and contracted plans/providers—than creating a different benefit set.

## Strategies for Promoting Adult Coverage and Access to Oral Health Services

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States that offer adult dental benefits to the expansion population must address various challenges to facilitate enrollment and adequate access to dental care. They offered the following considerations for other state Medicaid agencies:

### 1. *Tailor outreach strategies to the targeted population.*

Tailored outreach and enrollment strategies will be crucial to ensuring that the newly eligible are informed about and enroll in their new coverage options, including adult dental benefits. Most states plan to rely heavily on their integrated eligibility systems with other state agencies such as Temporary Assistance for Needy Families, the Supplemental Nutrition Assistance Program, and other social service agencies, to identify and reach out to those who may be newly eligible. Most, if not all, expansion states, will automatically transition current beneficiaries who meet the eligibility criteria into the expansion group, greatly facilitating enrollment. Other outreach strategies tailored to enroll hard-to-reach populations, including the homeless, individuals with criminal justice involvement, and legal immigrants who have fulfilled the five-year residency requirement, may also be needed.

In many states, navigators and consumer assisters will play a critical role in enrollment efforts, helping individuals to find the appropriate coverage. These workers must be fully educated about dental coverage options—including eligibility criteria and scopes of benefits—and have access to clear talking points promoting utilization of dental coverage.

Literacy campaigns beyond the enrollment phase will be instrumental in educating beneficiaries about the importance of oral health, as well as their Medicaid dental benefits. To promote utilization and access to care, states may consider: (1) coordinating with the Centers for Medicare & Medicaid Services to develop a common set of messaging materials for adult beneficiaries that could be customized with state-specific information; (2) coordinating with other state social service programs and federal agencies to promote the value of oral health and benefit options; (3) partnering with private-sector companies to provide incentives to beneficiaries and/or providers for participation; and (4) developing public service announcements through media partnerships. A handful of state officials also suggested engaging pharmacists as distribution centers for oral health information.

Consumer incentives may be effective at promoting enrollment and subsequent utilization.<sup>23</sup> New Mexico, for

example, intends to offer incentives to consumers for fulfilling certain healthy behaviors such as completing an annual dental exam and prophylaxis.

To increase access to care, the District of Columbia intends to create dental homes and provide an insurance card listing the beneficiary's primary care physician and primary dental provider. The District already operates a dental helpline for identifying a dentist and making an appointment, and will make this tool available to newly eligible individuals.

## **2. Develop ongoing stakeholder engagement.**

States typically engage oral health and Medicaid stakeholder groups in their dental advisory boards to solicit feedback and input on policy changes. Connecticut, for example, has invested time and effort in developing relationships with key stakeholders, including consumer advocates and providers, and has included these individuals in an advisory committee that meets four times a year to provide feedback around policy changes. Similarly, in Colorado, stakeholder engagement and support were crucial in the passage of legislation authorizing dental benefits for all Medicaid beneficiaries and will continue to be as the state determines dental benefits for the newly eligible.

Minnesota's past experience in garnering stakeholder support for a new provider level to improve access to care is informative.<sup>24</sup> In May 2009, the state legislature approved the licensing of dental therapists to improve access to dental care. In advance of proposed legislation, a coalition of stakeholders was formed including lawmakers, public health dentists, educators, providers, advocates for people with disabilities and seniors, and hospital executives—spurring legislators to approve a new provider type and create a workgroup to study new workforce models that would later serve as recommendations for legislation. Without this carefully crafted group of advocates, the legislation likely would have been defeated by an opposing campaign. It should be noted that dental associations can be particularly effective partners in advocating for oral health access and coverage. In 2011, for example, the California Dental Association supported the use of mid-level providers to expand access for the underserved, leading to a legislative proposal to study mid-level providers.<sup>25</sup>

## **3. Improve oral health network adequacy through financial and non-financial incentives.**

Measuring and improving Medicaid dental provider network adequacy is an ongoing challenge for state agencies. This scan suggests that states may wish to reassess definitions of network adequacy and consider alternative factors when

assessing. For example, Connecticut determines oral health network adequacy by comparing the state's provider network to the actual capacity of the network for each city and county. The state looks at measures such as the actual capacity of each office, based upon: age of the patients providers will accept; number of practitioners in the office; the ability to see new patients; the total number of members attributed to the office; hours of operation; proximity to public transportation; linguistic accommodations; and handicap accessibility.

While fiscal challenges typically prevent states from increasing low dental reimbursement rates—a common barrier to provider participation—states can consider modifying their reimbursement structure to target key preventive dental procedures and high-risk populations. States may also consider a number of non-financial incentives for provider participation in Medicaid. Some states are streamlining requirements for oral health care providers to join the provider panels of multiple health plans. California, for example, offers a single provider credentialing process that allows providers to negotiate one rate with all contracted dental plans, eliminating the need to be credentialed by multiple plans. Other states (e.g., Connecticut and New Jersey) have attempted to ease the administrative burden on high-performing providers by allowing them to waive prior authorization submission for certain procedures. Connecticut also often allows dentists to define the quantity and types of Medicaid beneficiaries assigned to their practices, and offers opportunities for professional growth by providing performance feedback to practitioners in relation to other Medicaid-contracted providers in their area.

## **4. Expand the dental workforce.**

The ACA provides an opportunity to expand the dental workforce through the use of alternative practice and mid-level providers.<sup>26</sup> Mid-level providers, such as dental therapists and dental hygienists, can be trained and licensed to perform preventive care and other routine restorative procedures, allowing dentists to focus on more complex procedures. This workforce expansion can help to reduce dental provider shortages and expand access for low-income populations, especially those in rural areas where dentists are scarcer. A number of states, including Minnesota and Alaska, have authorized the licensure of dental therapists. An additional 15 states are considering legislation that will allow hygienist training; dental therapist licensing; and the use of telemedicine to support routine dental care.<sup>27</sup> Other states are also supporting the role of *medical* providers in preventive and routine oral health care.<sup>28</sup>

## Conclusion

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As Medicaid-expansion states consider their benefit offerings for the newly eligible, these states have a landmark opportunity to improve access to oral health care for low-income adults. Experiences of the states interviewed suggest: (1) considerations for expansion states in determining their

ABPs and (2) strategies to advance access for populations that will be newly covered for dental services by the Medicaid program in 2014. A strategic assessment and planning effort can help states to achieve the greatest clinical and fiscal value from their expanded Medicaid programs beginning next year.

**APPENDIX: SCAN OF ADULT DENTAL BENEFIT COVERAGE IN STATES PARTICIPATING IN THE MEDICAID EXPANSION**

**BENEFITS CATEGORY FOR EXPANSION POPULATION: EXTENSIVE**

Adult Dental Coverage for Mandatory/Optional Groups under State Plan: Pre-2014	Adult Dental Coverage for Newly Eligible Medicaid Population
<b>California</b>	
<p>In 2009, California eliminated most dental services for adults, except for pregnant women and those living in Skilled Nursing Facilities, licensed intermediate care facilities (ICFs), ICF-developmentally disabled, developmentally disabled habilitative, or ICF-developmentally disabled nursing facilities.</p> <ul style="list-style-type: none"> <li>▪ Pregnant women have a limited scope of services that includes periodontal services and exams.</li> <li>▪ Nursing facility residents receive a comprehensive benefit.</li> <li>▪ Service coverage is in accordance with federal law: non-exempt adult beneficiaries are eligible to receive limited dental services for the relief of pain and infection or trauma, or services that are necessary to undergo a covered medical service.</li> </ul> <p>The 2013 budget restores funding for partial restoration of dental services including preventive care, dental restorations, and full dentures.</p>	<p>Will provide the same benefit set to the expansion population in 2014.<sup>29</sup></p>
<b>Connecticut</b>	
<p>Provides comprehensive dental benefits, with limitations around scope and frequency.<sup>30</sup></p>	<p>Offering the same benefit set to its early-expansion population, and subsequently to the 2014 expansion population.</p>
<b>District of Columbia</b>	
<p>Provides comprehensive dental benefits to beneficiaries who do not live in an institution.<sup>31</sup></p>	<p>Offering the same benefit set to its early-expansion population, and subsequently to the 2014 expansion population.</p>
<b>Iowa</b>	
<p>Provides comprehensive dental benefits, with limits around frequency.<sup>32</sup></p>	<p>Will provide the same benefit set to the expansion population in 2014.</p>
<b>Minnesota</b>	
<p>Provides comprehensive dental benefits, with limits around frequency.<sup>33</sup> Also covers the following services if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:</p> <ul style="list-style-type: none"> <li>▪ Periodontics, limited to periodontal scaling and root planing once every two years;</li> <li>▪ General anesthesia; and</li> <li>▪ Full-mouth survey once every five years.</li> </ul>	<p>Offering the same benefit set to its early-expansion population, and subsequently to the 2014 expansion population.</p>
<b>New Jersey</b>	
<p>Provides comprehensive dental benefits, with limits around frequency.<sup>34</sup></p>	<p>Will provide the same benefit set to the expansion population in 2014.</p>

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<b>New Mexico</b>	
Covers dental services that are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the recipient. <sup>35</sup>	Considering offering the same benefit set to the Medicaid expansion population with copayments for certain services.
<b>New York</b>	
Covers preventive, prophylactic and other routine dental care, services and supplies, and prosthetic and orthodontic appliances required to alleviate a serious health condition, including one that affects employability. <sup>36</sup>	Will provide the same benefit set to the expansion population in 2014.
<b>Oregon</b>	
<p>Adults 21 years and older who receive Oregon Health Plan (OHP) Plus, are eligible for:</p> <ul style="list-style-type: none"> <li>▪ Basic services, including x-rays, fillings and extractions;</li> <li>▪ Exams and treatment for urgent/immediate dental needs, such as severe tooth pain or a knocked-out tooth;</li> <li>▪ Other services, such as crowns, root canals, dentures, or gum surgery; and</li> <li>▪ Emergency services.</li> </ul> <p>Individuals enrolled in OHP Standard (primarily childless adults who will become eligible for Medicaid in 2014) have coverage for immediate/urgent treatment.</p>	Will provide the OHP Plus benefit to the expansion population in 2014.
<b>Washington</b>	
<p>Covers emergency services to treat pain, infection, and trauma, or for clients awaiting a transplant, having joint replacement, or for those clients with cancer. Services are limited to exam, x-rays, and extractions.</p> <p>Comprehensive dental is provided for pregnant women, those in a skilled nursing facility, and those on a Developmentally Disabled/Home and Community Services waiver.</p> <p>The 2013-15 budget restores funding for a comprehensive dental benefit for all Medicaid-eligible adults.</p>	Will expand benefits to include comprehensive dental services for current and newly eligible enrollees beginning in 2014.
<b>BENEFITS CATEGORY FOR EXPANSION POPULATION: LIMITED</b>	
<b>Adult Dental Coverage for Mandatory/Optional Groups under State Plan: Pre-2014</b>	<b>Adult Dental Coverage for Newly Eligible Medicaid Population</b>
<b>Colorado</b>	
<p>Covers:</p> <ul style="list-style-type: none"> <li>▪ Medically necessary services limited to emergency treatment and only the most limited service(s) needed to correct the emergency oral cavity condition are allowed;</li> <li>▪ Treatment for acute pain or infection, limited to extraction of the tooth or teeth; and</li> <li>▪ Non-emergency treatment for clients with allowable concurrent medical conditions.</li> </ul>	Will provide limited dental benefits for all Medicaid-enrolled adults starting April 2014, with a cap of \$1,000 on dental services received. The specific benefits package will be determined through a forthcoming stakeholder engagement process.

**APPENDIX: SCAN OF ADULT DENTAL BENEFIT COVERAGE IN STATES PARTICIPATING IN THE MEDICAID EXPANSION**

<b>Kentucky</b>	
<p>Coverage limited to narrow state plan benefits, as well as trauma and emergency coverage. Covered services include:</p> <ul style="list-style-type: none"> <li>▪ Oral exams;</li> <li>▪ Trauma and emergency;</li> <li>▪ Emergency visits;</li> <li>▪ X-rays;</li> <li>▪ Extractions; and</li> <li>▪ Fillings.</li> </ul>	<p>Will provide the same benefit set to the expansion population in 2014.</p>
<b>Massachusetts</b>	
<p>Provides comprehensive dental benefits, with limits around frequency.<sup>37</sup></p>	<p>Newly eligible individuals, including those currently covered through Commonwealth Care and MassHealth 1115 waiver programs, will receive the same dental coverage as all other MassHealth adult beneficiaries.</p>
<b>Michigan</b>	
<p>Covers limited dental services that include:</p> <ul style="list-style-type: none"> <li>▪ Diagnostic and therapeutic services necessary to diagnose and treat conditions relating to a medical problem;</li> <li>▪ Emergency treatment such as extraction of teeth or palliative treatment for relief of pain or acute infection;</li> <li>▪ Examinations and preventive and therapeutic services as needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and</li> <li>▪ Fabrication, preparation for, adjustments to, and repair of necessary dentures.</li> </ul>	<p>Will provide the same benefit set to the expansion population in 2014.</p>
<b>Ohio</b>	
<p>Covers the following limited services:</p> <ul style="list-style-type: none"> <li>▪ Annual dental check-up and cleaning;</li> <li>▪ Fillings, x-rays, extractions, and oral surgery services (including removal of impacted teeth);</li> <li>▪ Crowns, posts and related services;</li> <li>▪ Surgical incisions;</li> <li>▪ Endodontics (including root canals);</li> <li>▪ Full and partial dentures and related services;</li> <li>▪ General anesthesia; and</li> <li>▪ Limited coverage of periodontics and such services as temporomandibular therapy (TMD/TMJ), fixed and removable appliances and maxillofacial prosthetics.</li> </ul>	<p>Will provide the same benefit set to the expansion population.</p>
<b>Rhode Island</b>	
<p>Provides comprehensive dental benefits, with limits around frequency.<sup>38</sup></p>	<p>Will provide the same benefit set to the expansion population in 2014.</p>

**APPENDIX: SCAN OF ADULT DENTAL BENEFIT COVERAGE IN STATES PARTICIPATING IN THE MEDICAID EXPANSION**

<b>Vermont</b>	
Provides comprehensive dental benefits with an annual expenditure cap of \$510. <sup>39</sup>	Will provide the same benefit set to the expansion population in 2014.
<b>BENEFITS CATEGORY FOR EXPANSION POPULATION: EMERGENCY</b>	
<b>Adult Dental Coverage for Mandatory/Optional Groups under State Plan: Pre-2014</b>	<b>Adult Dental Coverage for Newly Eligible Medicaid Population</b>
<b>Hawaii</b>	
<p>Benefits are limited to emergency dental services, which are:</p> <ul style="list-style-type: none"> <li>▪ Diagnostic services associated with a recipient’s emergent condition, chief complaint, and surgical intervention;</li> <li>▪ Oral surgery and evaluations;</li> <li>▪ Intravenous sedation; and</li> <li>▪ Radiographs and diagnostic imaging.</li> </ul>	Will provide the same benefit set to the expansion population in 2014. <sup>40</sup>
<b>Illinois</b>	
<p>Benefits are limited to emergency dental services that include:</p> <ul style="list-style-type: none"> <li>▪ Limited emergency exam;</li> <li>▪ X-rays;</li> <li>▪ Extractions and surgical removal of erupted tooth;</li> <li>▪ Sedation;</li> <li>▪ Necessary services for clearance for medical procedure such as transplant;</li> <li>▪ Extractions and dentures necessary for a diabetic to receive proper nutrition;</li> <li>▪ Extractions and dentures necessary as a result of cancer treatment; and</li> <li>▪ Necessary services for the health of a pregnant woman prior to delivery of her baby.</li> </ul>	Will provide the same benefit set to the expansion population in 2014.
<b>Nevada</b>	
<p>Covers periodontia for pregnant women, as well as the following emergency services for non-pregnant adults:</p> <ul style="list-style-type: none"> <li>▪ Emergency extractions,</li> <li>▪ Palliative care, and</li> <li>▪ Prosthetic care (dentures/partials) under certain guidelines and limitations.</li> </ul>	Will provide the same benefit set to the expansion population in 2014.
<b>New Hampshire</b>	
<p>Covered services are limited to:</p> <ul style="list-style-type: none"> <li>▪ Treatment of infected teeth;</li> <li>▪ Treatment of conditions associated with diagnosed pathology, such as tumors, cysts, etc.;</li> <li>▪ Treatment as needed prior to organ transplant or as necessitated by medical treatment such as chemotherapy or radiation;</li> <li>▪ Treatment of trauma within 24 hours of event;</li> <li>▪ Coverage for the above includes examination and radiographs as needed for diagnosis, also transportation and anesthesia as necessary to complete extractions; and</li> <li>▪ Biopsies and sometimes other oral surgeries if demonstrated to be medically necessary.</li> </ul>	State already covers individuals up to 133 percent FPL. Will provide the same benefits set to the over-21 expansion population in 2014.

**APPENDIX: SCAN OF ADULT DENTAL BENEFIT COVERAGE IN STATES PARTICIPATING IN THE MEDICAID EXPANSION**

<b>West Virginia</b>	
Limited to emergency and the following services: <ul style="list-style-type: none"> <li>▪ Removal of cysts or tumors;</li> <li>▪ Biopsies;</li> <li>▪ Treatment of fractures of the jaw bones; and</li> <li>▪ Some emergency services.</li> </ul>	Will provide the same benefit set to the expansion population.
<b>BENEFITS CATEGORY FOR EXPANSION POPULATION: NONE</b>	
<b>Adult Dental Coverage for Mandatory/Optional Groups under State Plan: Pre-2014</b>	<b>Adult Dental Coverage for Newly Eligible Medicaid Population</b>
<b>Arizona</b>	
Only covers dental services if patient needs a transplant or has a major medical issue.	Will not provide adult dental benefits to the expansion population.
<b>Delaware</b>	
Does not cover any dental services in any setting.	Will not cover any dental services in any setting for the expansion population.
<b>Maryland</b>	
Covered services are limited to trauma care and emergency treatment rendered in a hospital emergency department. However, seven of the MCOs in the state's managed care program, HealthChoice, voluntarily cover preventive dental services for members.	Will offer the same benefit set to the expansion population, with the same option for MCOs to cover dental services.
<b>North Dakota</b>	
Covers limited dental services that include: <ul style="list-style-type: none"> <li>▪ Anesthesia;</li> <li>▪ Oral exams once a year;</li> <li>▪ X-rays;</li> <li>▪ Dental prophylaxis, one prophylaxis per year;</li> <li>▪ Anterior crowns if there is a root canal on the tooth;</li> <li>▪ Anterior root canals;</li> <li>▪ Periodontal scaling;</li> <li>▪ Emergency extractions and palliative care;</li> <li>▪ Dentures once per five years (complete and partial); and</li> <li>▪ Interim prosthesis (flippers covered once every five years).</li> </ul>	Will not provide any dental benefits to the expansion population.

## About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit [www.chcs.org](http://www.chcs.org).

## Endnotes

<sup>1</sup>IOM (Institute of Medicine) and NRC (National Research Council). *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*. Washington, DC: The National Academies Press, 2011.

<sup>2</sup>V. Smith, K. Gifford, and E. Ellis et al., *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage, and Policy Trends*. Kaiser Commission on Medicaid and the Uninsured, October 2011.

<sup>3</sup>Note: States are: AZ, CA, HI, IL, MA, MI, MO, PA, UT and WA.

<sup>4</sup>Note: States that were in the process of submitting expansion waivers to CMS (such as Pennsylvania), or had recently announced their intentions to expand Medicaid (such as Utah) at the time of publication, are not counted as expansion states in this report.

<sup>5</sup>Center for Consumer Information and Insurance Oversight. *Essential Health Benefits Bulletin*. December 16, 2011. Available at: [http://ccio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf).

<sup>6</sup>Note: States are: CA, CO, CT, DC, MD, MN, NJ, and NM.

<sup>7</sup>Government Accountability Office. "Oral Health: Dental Disease is a Chronic Problem among Low-Income Populations." April 2000.

<sup>8</sup>Ibid.

<sup>9</sup>IOM and NRC, *op cit*.

<sup>10</sup>Oral Health for Adults Fact Sheet. Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. Accessed at: [http://www.cdc.gov/OralHealth/publications/factsheets/adult\\_oral\\_health/adults.htm](http://www.cdc.gov/OralHealth/publications/factsheets/adult_oral_health/adults.htm).

<sup>11</sup>Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience. Washington DC: Kaiser Commission on Medicaid and the Uninsured. September 2005.

<sup>12</sup>Use of Dental Services in Medicaid and CHIP. September 2011. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Secretaries-Report-Dental-Excerpt.pdf>.

<sup>13</sup>Centers for Medicare & Medicaid Services, Department of Health and Human Services. Public Health; Medical Assistance; Services; Final Rule.42 CFR Chapter IV 440.50. March 1991.

<sup>14</sup>"Medicaid Benefits: Dental Services." Kaiser Family Foundation (2010). Available at: <http://kff.org/medicaid/state-indicator/dental-services/>.

<sup>15</sup>Note: This decline was for the period 2002-2010. M. Vujcic, "Dental Care Utilization Declined among Low-income Adults, Increased among Low-Income Children in Most States from 2000 to 2020." American Dental Association, Health Policy Resources Center, Research Brief, February 2013. Available at: [http://www.ada.org/sections/professionalResources/pdfs/HPRC\\_Brief\\_0213\\_3.pdf](http://www.ada.org/sections/professionalResources/pdfs/HPRC_Brief_0213_3.pdf).

<sup>16</sup>Kaiser Commission on Medicaid and the Uninsured, *op cit*.

<sup>17</sup>N.T. Wallace, M.J. Carlson, D.M. Mosen, J.J. Snyder, and B.J. Wright. The Individual and Program Impacts of Eliminating Medicaid Dental Benefits in the Oregon Health Plan. *American Journal of Public Health*, 101(11), 2144-50.

<sup>18</sup>B. Sanders, Subcommittee on Primary Health and Aging. Dental Crisis in America: The Need to Expand Access. U.S. Senate Committee on Health, Education, Labor and Pensions. February 2012.

<sup>19</sup>*Oral Health and Low-Income Nonelderly Adults: A Review of Coverage and Access*. Kaiser Commission on Medicaid and the Uninsured (June 2012). Available at: <http://kff.org/private-insurance/issue-brief/oral-health-and-low-income-nonelderly-adults-a-review-of-coverage-and-access/>.

<sup>20</sup>The Pew Center on the States. A Costly Dental Destination: Hospital Care Means States Pay Dearly. February 2012.

<sup>21</sup>Note: CHCS was unable to confirm Ohio's approach to adult dental for the Medicaid expansion population.

<sup>22</sup>Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicaid Program; Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010; Final Rule. 42CFR Part 433. April 2013.

<sup>23</sup>J. Greene. *Medicaid Efforts to Incentivize Healthy Behaviors*. Center for Health Care Strategies. July 2007.

<sup>24</sup>The Pew Center on the States (September 2010). "The Minnesota Story: How Advocates Secured the First State Law of Its Kind Expanding Children's Access to Dental Care. Available at: [http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State\\_policy/060\\_10\\_DENT%20The%20Minnesota%20Story%20Brief\\_web.pdf](http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/060_10_DENT%20The%20Minnesota%20Story%20Brief_web.pdf).

<sup>25</sup>The Pew Charitable Trusts. In Search of Dental Care: Two Types of Dentist Shortages Limit Children's Access to Care. June 2013.

<sup>26</sup>Patient Protection and Affordable Care Act, Sections 5101 and 5304.

<sup>27</sup>The Pew Charitable Trusts, *op cit*.

<sup>28</sup>The Pew Center on the States, *op cit*.

<sup>29</sup>California currently classifies 169 procedures as "Federally Required Adult Dental Services" (FRADS). These procedures are currently available to all adults and will also be available to the expansion adult population as of May 2014. However, FRADS could be provided by either a dentist or physician, and include primarily emergency and some sophisticated surgical procedures, but very little restorative and no preventive procedures. As of May 2014, some adult dental benefits are being restored, and these will also be available to the adult expansion population. These include nine diagnostic procedures (some of which are also FRADS), three preventive procedures, 18 restorative procedures, two endodontic procedures, and 16 prosthodontic procedures. There is also an annual expenditure cap of \$1,800 on adult dental procedures, but many procedures are exempted from the cap.

<sup>30</sup>Connecticut currently covers: oral exams; cleanings; x-rays; fillings; extractions; partial and full dentures; root canals; crowns; and oral surgery.

<sup>31</sup>Washington, DC, currently covers: general preventive services; emergency, surgical and restorative services; denture relines and rebases, limited to two over a five-year period, unless additional services are prior- authorized; complete radiographic survey, including full, panoramic and bitewing x-rays, limited to one per year unless additional services are prior-authorized; periodontal scaling and root planing within professional guidelines; initial placement or replacement of a removal prosthesis where damage is due to circumstances beyond the beneficiary's control; and removable partial prosthesis.

<sup>32</sup>Iowa currently covers: cleaning; fillings; extractions; disease control; and surgery.

<sup>33</sup>Minnesota currently covers: comprehensive, periodic, and limited exams; bitewing, periapical, and panoramic x-rays; prophylaxis, in accordance with an appropriate individualized treatment plan; application of fluoride varnish; posterior (at the amalgam rate) and anterior fillings; endodontics, limited to root canals on the anterior and premolars only; removable prostheses; oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses; palliative

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treatment and sedative fillings for relief of pain; full-mouth debridement; house calls or extended care facility calls for on-site delivery of covered services; behavioral management when additional staff time is required and sedation is not used; and oral or iv sedation, if the service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center.

<sup>34</sup> New Jersey currently covers: diagnostic services, including oral evaluations and diagnostic imaging/laboratory (limited services include full-mouth or panoramic x-rays); preventive services, including prophylaxis (once every six months); restorative services, including fillings and crowns; endodontic services, including root canals and necessary diagnostics for treatment; periodontal services, including surgical services and non-surgical services such as root planing and scaling, debridement, and splinting; prosthodontic services, including complete and partial dentures; fixed bridges; and maxillofacial prosthetics; oral and maxillofacial surgical services; and palliative treatment for emergency treatment.

<sup>35</sup> New Mexico currently covers: emergency services; one oral examination every 12 months; radiology services; prophylaxis every 12 months (for the developmentally disabled, once every six months); fluoride treatment once every 12 months; restorative services; periodontal scaling and root planning; denture adjustments every 12 months; and oral surgery.

<sup>36</sup> New York currently covers: services required for emergency care and/or the relief of pain or acute infection; oral examination, including treatment plan, if necessary; periapical, bitewing, occlusal and extraoral radiographs, as required; oral prophylaxis, including cleaning, supra and subgingival scaling, and polishing of teeth; subgingival curettage and root planing; restoration of carious permanent and primary teeth pulpotomy for permanent or primary teeth; endodontic therapy for incisor or cuspid teeth; extraction of infected or nonrestorable teeth; repair of full or partial dentures, recementing crowns and fixed bridges, or replacing facings on bridges; and maxillofacial prosthetics, implant services, prosthodontics (fixed) oral and maxillofacial services.

<sup>37</sup> Massachusetts currently covers: diagnostic services: oral exams (twice in 12 months); radiographs; preventive services: cleanings (twice in 12 months); restorative services: fillings (limited to two surfaces of front teeth only but will later expand to cover all fillings); exodontic services: extractions, removal of erupted tooth, and removal of impacted tooth; anesthesia services; limited oral and maxillofacial surgery services; palliative treatment of dental pain or infection services; and emergency-related services.

<sup>38</sup> Rhode Island currently covers: oral exams (twice per calendar year); diagnostic imaging & x-ray services; prophylaxis (twice per calendar year); endodontic services: root canals; restorative services: amalgam; resin restorations (only allowed on anterior teeth), and crowns; periodontal services: gingivectomy and gingivoplasty if medically necessary; prosthodontic services: full and partial dentures (every five years); emergency and palliative services; extractions and oral surgery; and topical fluoride treatments for those with medical and dental conditions that significantly interrupt the flow of saliva.

<sup>39</sup> Vermont currently covers: prevention, evaluation and diagnosis, including radiographs when indicated; periodic prophylaxis (once every six months, except more frequent treatments can be authorized by the Department of Vermont Health Access); limited periodontal therapy; treatment of injuries; oral surgery for tooth removal and abscess drainage; endodontics (root canal therapy); restoration of decayed teeth; and non-surgical treatment of temporomandibular joint disorders (limited to the fabrication of an occlusal orthotic appliance, or TMJ splint).

<sup>40</sup> Hawaii's dental offering may be expanded up to a \$500 preventive dental benefit per year depending on appropriations during legislative session ending May 1, 2014.