

Emerging Approaches in Oral Health Care: Considerations for Minimally Invasive Care in Medicaid

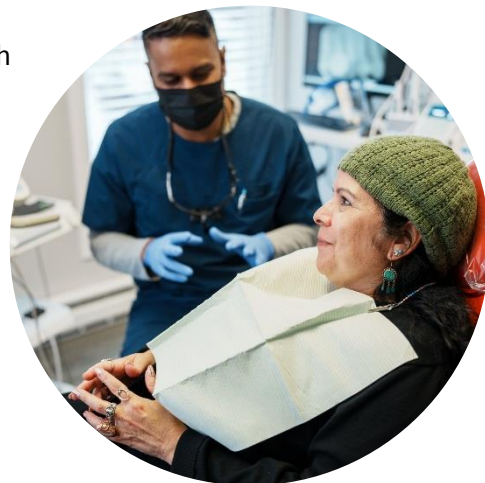
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TAKEAWAYS

- Minimally invasive care (MIC) is an approach in dentistry that prioritizes dental caries (tooth decay) risk assessment and prevention, early dental caries detection and restoration, and the preservation of tooth structure in dental caries treatment.
- By supporting and prioritizing MIC, state Medicaid agencies can help: (1) increase access to oral health care in non-traditional settings; (2) advance health equity; (3) expand the oral health care workforce; and (4) integrate oral health care services into physical health care.
- This brief also describes opportunities for state Medicaid programs to support the availability of MIC through payment strategies that encourage the uptake of these services.

Medicaid plays an important role in meeting the health care needs of more than 92 million people across the United States.¹ While coverage of oral health care services varies significantly across state Medicaid programs, there are myriad opportunities for state officials to pursue innovative models of care to improve health outcomes and experience for children and adults enrolled in Medicaid. Minimally invasive care (MIC) is one strategy states can use to increase access to oral health care, including opportunities to expand the oral health care workforce, advance health equity, and integrate oral health into overall health care.²

MIC uses preventive care and restorative services to address tooth decay and is an approach to deliver high quality oral health care to people without invasive surgical interventions.³ Many oral health care providers, including those who serve Medicaid members, are incorporating MIC into patient care and are exploring how to expand its use in their practices.⁴



While MIC is not new, there is no uniform definition of what these services include, and many providers are unfamiliar with this approach. With support from CareQuest Institute for Oral Health, the Center for Health Care Strategies (CHCS) spoke with national and state-level Medicaid oral health stakeholders (see [Acknowledgements](#), page 15) to:

- Learn where and how providers are delivering MIC;
- Gauge familiarity with this approach among Medicaid stakeholders, including state agencies, plans, and providers;
- Identify how MIC could be better incorporated in Medicaid programs; and
- Highlight challenges and opportunities for its widespread adoption.

This brief describes opportunities for state Medicaid programs to promote and expand access to MIC. It begins with a high-level summary of MIC services, then explores considerations and recommendations for Medicaid to advance the use of MIC, including: (1) expanding access to nontraditional settings; (2) advancing equity; (3) supporting the oral health care workforce; (4) promoting opportunities for clinical integration; and (5) identifying payment strategies.

What is Minimally Invasive Oral Health Care?

MIC is an approach in dentistry that prioritizes dental caries (tooth decay) risk assessment and prevention, early dental caries detection, and the preservation of tooth structure in dental caries treatment.⁵ MIC is also less invasive when compared to traditional “drill, fill, and extraction” dentistry methods and can thus induce less anxiety among patients. A wide range of dental professionals can provide MIC including dental hygienists, dental therapists, dental assistants and in certain cases, even those in the physical health space, including primary care providers and nurses, thereby expanding the oral health care workforce.⁶

Sometimes interchangeably referred to as minimally invasive dentistry, MIC encompasses a range of treatments including diagnostic solutions, fluorides, antimicrobials, regeneratives, and therapeutic fillings and sealants that are applied directly on teeth.⁷ Some examples of MIC include:

- **Silver diamine fluoride (SDF):** A water-based liquid applied to teeth to kill germs that can cause dental caries and prevent new cavities. It is commonly used for children and primary care providers can also provide this treatment.⁸

- **SMART (Silver Modified Atraumatic Restorative Technique) filling:** A dental filling that uses a combination of SDF and glass ionomer to restore decayed or damaged teeth. It is a painless alternative to drilling and filling.⁹
- **Fluoride varnish (FV):** Highly concentrated fluoride is applied to teeth to prevent tooth decay. It is used on children from the time they have their first tooth and can be applied every three months to prevent cavities.¹⁰
- **Povidone-iodine:** A water-based liquid applied to teeth to prevent tooth decay.¹¹
- **Guided enamel regeneration:** A method used to treat initial signs of tooth decay. When applied to the affected area of the tooth, this intervention promotes regeneration of tooth enamel.¹²
- **Interim therapeutic restoration (ITR):** A treatment that involves the removal of caries with a hand or rotary instrument followed by application of a material such as glass ionomer that is adhesive and restorative in nature.¹³

Interviewed providers noted that MIC is still a developing approach to care and while there is not a standard definition of treatments that are characterized as MIC, more common treatments include SDF, SMART fillings, and fluoride varnish. Researchers continue to develop new treatments. In the future, providers can expect to continue to expand upon the care they provide and increase their ability to employ more conservative strategies to protect and rebuild tooth structure.

An Introduction to Silver Diamine Fluoride

While SDF is relatively new in the U.S., it has been used extensively outside of the country to control caries. It contains 25 percent silver, eight percent ammonia, five percent fluoride, and 62 percent water.¹⁴ SDF takes only a moment to apply and halts tooth decay without the need for local anesthetic and can postpone or completely avoid the need for traditional surgical caries treatment.¹⁵ Unlike traditional fillings, SDF can remineralize treated teeth, potentially kill bacteria, and prevent future caries. Recent trials reveal that SDF application twice per year is most effective to reduce caries.



Medicaid Avenues to Support Minimally Invasive Oral Health Care

Following are five key considerations to shape the approaches that states can take to advance MIC in Medicaid, including: (1) expanding access to nontraditional settings (e.g., schools, nursing homes, and other community settings); (2) advancing health equity; (3) supporting a redefined oral health care workforce; (4) promoting opportunities for clinical integration; and (5) identifying oral health payment strategies.

1. Expanding Access to Alternative Settings

Some areas, particularly rural or regions that have been historically underserved, may have limited or no access to dental care providers or dental facilities that accept Medicaid. This can result in long wait times, limited choices for patients, lack of treatment, and a need to travel long distances to reach a dentist's office, leading to unaddressed care needs and worsened health outcomes. State Medicaid programs focused on increasing access to services may look to MIC to strategically expand oral health care offerings where they are needed most.

Enabling diverse provider types to offer oral health care services in alternative settings can make it more convenient for individuals to receive care, particularly for people in rural communities or regions that have been historically underserved, individuals with disabilities, older adults, or people without reliable transportation. Many MIC services, due to their nature, are delivered by a wide variety of providers, including dentists, dental hygienists, dental therapists, nurses, and physicians, among other providers. MIC services can be delivered in nontraditional settings, such as schools, nursing homes, primary care offices, and other community settings.

By providing oral health care services in a wide array of settings, state Medicaid programs can more easily reach members who are at a higher risk of dental problems due to lack of access. Making MIC available can increase access to a specific set of oral health care services to support the prevention and early intervention of disease and reduce the potential for progression to more complicated and costly treatments. Medicaid members who are unable to access routine oral health care services are also more likely to end up seeking care in an emergency setting.¹⁶ Emergency departments are not equipped to adequately address and treat individual's oral health care needs. **Furthermore, visits to the emergency department for oral health care are three times more expensive than dental visits, resulting in an annual expenditure of \$1.6 billion nationally, with Medicaid covering one-third of these expenses.**¹⁷

Increasing access to care in diverse settings offers more appropriate and comprehensive care for patients in a cost-effective manner that decreases Medicaid program costs. Two alternative settings are schools and nursing homes, as described below.

FACILITATING ACCESS TO SCHOOL-BASED CARE

Good oral health in school-aged children is essential to supporting their overall health and development. Children between five and 19 years from households with lower incomes are twice as likely to have caries compared to their peers from households with higher-income.¹⁸ Children with dental caries are three times more likely to miss school and perform poorly academically due to dental pain when compared to those without caries.¹⁹ School-based programs can prioritize populations, including Medicaid-enrolled children, that are at higher risk for developing dental caries and less likely to see a dentist.

School-based oral health initiatives prove cost-effective by offering a combination of services during a single visit, including oral health screenings, oral health education, referrals, toothpaste and fluoride supplies, and other preventive care necessary to maintain children’s oral health needs. MIC services, including the application of sealants, fluoride varnish, and SDF, are often included as a part of this strategy. Services are provided via mobile van or portable or stationary equipment within a school by dentists, dental hygienists, and other advanced practice providers.

SPOTLIGHT Oregon School-Based MIC Model

The dental practice model in Oregon allows expanded practice dental hygienists with an expanded practice permit to deliver care to specific populations that have been historically underserved without the supervision of a dentist.²⁰

Oregon Health Authority allows dental hygienists to make clinical decisions in a school-setting regarding what sealants are most appropriate for their patients. CHCS spoke with Ashley Danielson, an Oregon-based expanded practice dental hygienist who delivers MIC within school-based programs. She educates her patients on healthy habits, conducts assessments, and facilitates on site treatment. Consent for services, which include permission to provide a suite for MIC (e.g., SDF, FV, povidone iodine, etc.) is gathered during registration. Based on an assessment, the hygienist decides which treatments are to be provided. Following the services, a report card is produced detailing the appointment. She additionally offers assistance coordinating an outside dental appointment if the family is in need of assistance. For Medicaid programs looking to bolster the types and availability of services available in school settings, MIC may be a good fit.



REACHING NURSING HOME SETTINGS

Older adults are at increased risk for caries primarily because of an increased exposure of root surfaces that occur with aging and the increased use of medications that induce dry mouth; 50 percent of people over 75 years old have at least one tooth with caries.²¹ Although nursing homes have limited capacity to deliver oral health care services, the U.S. Code of Federal Regulations mandates nursing home facilities adhere to the following requirements: (1) conduct oral health assessments upon admission and periodically thereafter; (2) fulfill residents' routine and emergency dental service needs through external resources; (3) assist residents in arranging dental appointments, coordinating transportation, and applying for dental service reimbursement when requested; and (4) refer residents with lost or damaged dentures within three days.²²

Medicaid is the primary payer for nursing home care and covers six in ten residents.²³ Given this, state Medicaid programs may consider if, and how, coverage and facilitation of MIC may impact cost and oral health outcomes for Medicaid-enrolled nursing home residents. SDF may be useful in older adults for caries management with limited mobility and the ability to seek care outside of their care setting.

SPOTLIGHT MIC in Nursing Home Settings: Sound Dental Care

Sound Dental Care provides dental services in more than 268 long-term care facilities — including nursing homes, adult family homes, and memory care homes — throughout Washington State using a mobile/portable dental practice.^{24,25} By bringing care to where it is needed, the Sound Dental Care model eliminates the challenges of coordinating outside transportation for dental appointments. They also employ a team of dental hygienists to work at the top of their practice scope to provide more affordable care. For more specialized services, they also utilize dentists and denturists also is a part of their program. Sound Dental Care focuses on areas and communities that have been historically economically or socially marginalized. Of the 5,700 patients enrolled in their program, about 70 percent are covered by Medicaid. By using MIC in their practice, such as SDF and SMART fillings, Sound Dental Care is able to reduce the need for costly, higher-risk treatment plans for nursing home residents.



2. Advancing Health Equity

Oral health care disparities in the U.S. are tied to factors such as race and ethnicity, disability status, geographic location, income, and insurance status, among others.²⁶ In fact, 93 percent of people living in poverty report unmet dental needs.²⁷ Black and Latino children and adults are more likely to have untreated caries, and Black and Latino children are less likely to receive sealants.²⁸ Medicaid's size and diversity of enrollees gives the program significant power to address systemic inequities in oral health care access, diminish longstanding disparities, and promote equity in oral health care. When considering the application of MIC, state Medicaid programs should consider potential application of MIC to empower patient choice and decision-making and meet the needs of historically marginalized populations, including communities of color and those with disabilities.

ADDRESSING BIAS

Repeated discriminatory experiences in health care settings lead to mistrust and fear among people from historically marginalized communities and less utilization of routine dental care.²⁹ Black communities are more likely to receive recommendations for invasive treatments, including tooth extractions, which may be attributed to provider-based racial bias.³⁰ MIC may be an alternative, less invasive choice when it may appear that no other option exists. If education on MIC is available, and the option is available to patients, Black patients can reclaim having choices and clinical decision-making power in the type of care they receive.³¹

Additionally, improving access to providers that represent the communities being served is critical for trust building and increasing access to oral health care services. Dental therapists, for instance, are more likely than other types of dental providers to speak the language of and be a part of the culture of the communities they serve and provide culturally competent care.³² They are also well-equipped to provide MIC, as discussed further on in this brief.

SPOTLIGHT Dental Therapy’s Critical Role in Alaska Native/ American Indian Communities



In the U.S., the dental therapy movement began in Alaska in 2004 when a group of Alaska Native students trained to become dental health aide therapists (i.e., dental therapists).³³ In the following years, the Alaska Native Tribal Health Consortium established the Dental Health Aide Program to train dental therapists, primary dental health aides, expanded function dental health aides, and dental health aide hygienists — all with varying scopes of practice, training, and education requirements.³⁴ This program includes training that equips students to perform minimally invasive approaches, including SDF, atraumatic restorative technique, and ITR, among other approaches.³⁵

This customized workforce enabled the Alaska Native community to restructure a longstanding system that previously relied on infrequent visits from dentists outside of the community and beyond Alaska.³⁶ Due to these circumstances, visiting providers primarily concentrated on restorative and surgical requirements, with little time for preventive treatment.³⁷ Dental therapy has since spread beyond Alaska to reach American Indian communities. There are 13 states with authorization in place for dental therapists to practice in at least some settings.³⁸

American Indian/Alaska Native (AI/AN) communities face a significant burden of adverse oral health outcomes due to the impacts of systemic racism. The rate of early childhood caries in AI/AN communities is three times greater than that of white children and adults who identify as AI/AN are twice as likely than the overall U.S. population to have untreated caries.³⁹ AI/AN communities experience lower utilization of preventive care and elevated rates of extractions and treatment under general anesthesia, and dental therapists are associated with increased preventive care and fewer extractions.⁴⁰ Tribal-led dental therapy aims to address these long-standing disparities and trauma in a culturally competent manner. This community-based dental therapy workforce, deeply rooted in their culture and language, has transformed oral health care in many AI/AN communities from a service limited to a small number of external providers into a self-sustained endeavor.

TAILORING CARE TO IMPROVE EXPERIENCES FOR INDIVIDUALS WITH DISABILITIES

When compared to people without a disability, individuals with disabilities are less likely to visit the dentist, more likely to be denied care due to discrimination, and visit the emergency department three times more often for dental care.⁴¹ These inequities, among others, lead to barriers accessing care and worsened oral health outcomes. Individuals with disabilities have oral health care needs that vary depending on the nature and severity of their conditions. Their care requires special consideration, and for many, having access to MIC is valuable. For example, individuals with a disability require

sedation more than the general population.⁴² This may be due to overstimulation, uncontrollable motor functions, and anxiety, among other reasons.⁴³ Medicaid coverage for anesthesia is contingent on “medically necessary” for the procedure.⁴⁴ When a traditional filling is not feasible or requires sedation, MIC is a less intensive and often less risky but effective alternative for individuals with disabilities. The American Academy of Pediatric Dentistry acknowledges that some MIC treatments, including SDF, FV, and ITR, among others, are especially useful for individuals with special health care needs, including those with physical, developmental, and/or intellectual disabilities.⁴⁵

Dental anxiety and fear are also a significant barrier to care for some individuals that cannot be overlooked. Individuals with disabilities are twice as likely as those without disabilities to experience high dental anxiety which may prevent or delay utilization of oral health care services.⁴⁶ MIC is an approach that may be more palatable to those with dental fear, as it does offers patients a more comfortable experience by reducing the need for needles, drills, and other invasive instruments.

3. Supporting an Expanded Oral Health Workforce

The U.S. is experiencing shortages of dental professionals; only 32 percent of the nation’s dental provider needs are met.⁴⁷ Many dentists choose to establish practices in prosperous areas, leaving rural and lower-income areas lacking providers.⁴⁸ Children and adults enrolled in Medicaid are further limited to providers who accept Medicaid, which exacerbates access challenges for this population, since only about 38 percent of licensed dentists in the U.S. accept Medicaid.⁴⁹ Training and employing a diverse range of oral health care professionals who can perform MIC, such as dental hygienists and dental therapists, allows for the distribution of this type of care across various settings. Medicaid programs can expand their oral health care provider network by supporting a diverse workforce and reduce the burden placed on dentists.

Scope of practice laws outline the types of services health care professionals can provide and because these laws differ across states, the mobility of the oral health care workforce is limited.⁵⁰ State Medicaid programs should consider how best to optimize different provider capabilities to enable opportunities for non-dentists, including dental therapists, dental hygienists, nurses, and physicians, and more, to deliver MIC.

Over the past decade, the use of dental therapists has been emerging across the U.S. as a promising strategy to: (1) increase access to care in dental shortage areas; and (2) expand who can provide quality care to patients, including MIC.⁵¹ Dental therapists serve as advanced practice providers, akin to physician assistants in the medical field. Dental therapists deliver preventive and standard restorative services, including cavity fillings, temporary crown placement, and the extraction of severely diseased or loose

teeth, among other treatments, and are well positioned to deliver MIC as a part of their scope of practice.⁵² Dentists can oversee dental therapists remotely, providing a high degree of flexibility for using their services, whether it be in the dental practice to extend operational hours or in community-based locations. Dental therapists frequently practice within their local communities, enabling them to build strong patient trust, thus enhancing overall patient experience and outcomes.

States are also beginning to take notice and authorize dental therapy practice statewide, with several states, including Minnesota, Vermont, and Maine, among others, covering dental therapists as authorized Medicaid providers.⁵³ Covering dental therapists as a provider type and reimbursing dental therapist services, including MIC, under Medicaid is a cost-effective and workforce-expanding opportunity for states looking to increase and mobilize MIC efforts in their Medicaid oral health care workforce.⁵⁴

SPOTLIGHT Oregon's Dental Pilot Project

For states interested in exploring new provider types and MIC services not currently covered by Medicaid, pilot projects may be a practical way to build evidence before rolling out a fully developed program. In Oregon, Senate Bill 738 allows the Oregon Health Authority to initiate dental pilot projects focused on addressing health inequalities and establishing fairer systems for delivering oral health care. Pilot projects experiment with creative approaches to enhance oral health practices, workforce, and accessibility.⁵⁵ Pilot projects offer opportunities to: (1) equip current dental providers with new skills; (2) explore categories of dental providers (e.g., dental therapists); (3) expedite the training of existing dental providers; and/or (4) introduce new oral health care roles to health care professionals without prior training. Examples of pilot projects that support MIC and/or provider types able to deliver MIC include:



- **Dental Therapist Project: Dental Hygiene Model** - Sponsored by Willamette Dental Group, this pilot, which began in May 2020 and will conclude in January 2025, is exploring opportunities to introduce a dental therapist model in Oregon.⁵⁶ The pilot will assess whether the inclusion of a dental therapist within the existing dental team enhances dental care accessibility. The first phase of the project will enroll and educate dental hygienists to become dental therapists. The second phase will employ these new dental therapists under the supervision of a dentist. The project will evaluate how dental therapists impact efficiency, cost, quality, access, patient safety, and satisfaction.

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- **Oregon Tribes Dental Health Aide Therapist Pilot Project** - Sponsored by the Northwest Portland Area Indian Health Board (NPAIHB), this pilot sought to create a new category of dental professionals in Oregon and train individuals using the successful Alaska Dental Health Aide Therapist (DHAT) model.⁵⁷ Select tribal communities in Oregon sent students to Alaska to participate in their DHAT training, which includes training in MIC approaches. Simultaneously, tribal health directors and leaders collaborated with NPAIHB to establish regulatory frameworks, train dentists to serve as DHAT supervisors, and conduct community education and outreach to introduce the new provider type. DHAT trainees completed a preceptorship with experienced DHAT dentists. The pilot, which ended in May 2023, is awaiting evaluation results to determine whether to expand to additional sites and trainees.
- **Training Dental Hygienists to Place ITR** - Sponsored by Oregon Health & Science University School of Dentistry, this pilot, which ended in 2021, sought to demonstrate that trained expanded practice dental hygienists can effectively provide interim therapeutic restorations in community settings after a teledentistry diagnosis from a supervising dentist.⁵⁸ Pilot findings led to Oregon Senate Bill 1550, allowing expanded practice dental hygienists to administer ITR. A collaborative agreement between a dentist and an expanded practice dental hygienist is necessary to support the extended scope of practice related to interim therapeutic restorations.

SPOTLIGHT Teaching Nurses to Offer Oral Health Care in Montana

Smiles Across Montana is a nonprofit organization dedicated to addressing oral health care disparities in Montana. The organization partners with Montana State University's Mark and Robyn Jones College of Nursing to offer dental experience for students encouraging them to connect oral health with physical health. Students are taught how to use intra-oral cameras to examine patients' mouths, make referrals, provide FV and SDF, and participate in teledentistry.⁵⁹ Under direct supervision, nursing students are able to experience hands on application of this learning through Smiles Across Montana's mobile dental program working in community centers, nursing facilities, schools, Head Start locations, and mobile vehicles on Native Lands and areas with low access to care.



4. Promoting Opportunities for Clinical Integration

Integrating oral health care services with primary care allows for a more holistic approach to health care. It ensures that both oral and general health needs are addressed in a coordinated and comprehensive manner. Many oral health issues can be identified and treated or referred to a dentist during routine primary care visits. This can help prevent the progression of dental problems, ultimately reducing the need for more expensive and invasive treatments. State Medicaid programs can support the facilitation of clinical integration by reimbursing for oral health care services, including MIC, in primary care offices.

Clinically integrated MIC can benefit both adults and children, particularly in states with no or a limited adult dental benefit. For instance, in a state with no adult dental benefit, allowing for SDF reimbursement for trained physicians may be the only way a Medicaid-enrolled adult can access caries treatment. For children under the age of five who are more likely to visit their pediatrician than dentist, medical providers have a special opportunity to promote oral health prevention by including oral health risk assessments, brush-on MIC (e.g., FV and SDF), and facilitating referrals to dental homes as a component of primary care appointments.⁶³ Research indicates that medically-integrated preventive oral health care services can lessen racial/ethnic, geographic, and disability-related disparities for children.^{64,65,66}

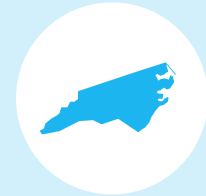
Many Medicaid programs reimburse for certain MIC treatments performed by medical providers. For instance, All state Medicaid programs reimburse primary care physicians for applying fluoride varnish to young children.⁶⁷ Additionally, the American Medical Association introduced a code for physicians bill for SDF application in July 2023.⁶⁸ States adding SDF coverage would benefit from exploring authorizing medical providers to expand their reach. For instance, in Minnesota, physicians, physician assistants, nurse practitioners, and community-based health care professionals under direct supervision of a dentist or

MIC Can Address Pandemic-Related Access Gaps

During the COVID-19 pandemic, dental facilities were advised to postpone elective procedures and focus only on emergency-only services.⁶⁰ At the time, dental teams faced a high risk of contracting COVID-19 from patients due to the possibility of transmission by respiratory droplets and the use of aerosol-generating dental handpieces.⁶¹ Some dental services are less aerosolized than others, and being able to easily mobilize these treatments during a pandemic can ensure that individuals experiencing tooth decay have an option for care. Conversations with Washington Medicaid revealed that the program observed an increase in SDF applications during the COVID-19 pandemic. Medicaid programs may benefit from exploring if and how MIC services fit into pandemic strategies.⁶²

physician are all eligible for reimbursement of SDF.⁶⁹ Given the shortage of primary care physicians and heavy workload, reimbursing for MIC alone will not be enough — states can support training opportunities for physicians and their staff to encourage adoption, as shown below.

SPOTLIGHT North Carolina’s Into the Mouths of Babes Program



Some states have dedicated programs to enroll and support medical providers to offer oral health care services. For example, North Carolina’s Into the Mouths of Babes (IMB) program trains medical providers to administer preventive oral health care services to young children covered by NC Medicaid.⁷⁰ These services can be offered every 60 days, up to six visits total, from the time a child’s teeth start erupting until they reach three and a half years of age. Services include: (1) oral health assessment and risk evaluation; (2) counseling for parents/caregivers; (3) application of fluoride varnish; and (4) connecting children to a dental home. Program objectives include averting and diminishing tooth decay in early childhood and increasing the number of high-risk children referred to a dental home. Medical providers are reimbursed through Medicaid for these services. NC Medicaid requires a live one-hour training session for medical professionals and staff who are interested in providing IMB services.

North Carolina has had significant success with IMB. A study of the program found that children receiving four or more IMB visits before age three showed a 17.7 percent reduction in tooth decay.⁷¹ A 2016 study ranked North Carolina third nationally in providing oral preventive care from a medical or dental provider for Medicaid-insured children ages zero to five.⁷² IMB has contributed to declines in tooth decay rates statewide since 2004, reducing decay disparities between Medicaid-enrolled children and the general population.⁷³

5. Identifying Oral Health Medicaid Payment Strategies

Medicaid payment for MIC services varies across states. In fee-for-service, which is the predominant payment method for dental services, state-by-state variation may also include the following limitations:

- **Coverage.** Not all states cover MIC services, and some states only cover certain services. Coverage for services may be limited to pediatric or adult populations.
- **Rates.** The rates for MIC service may not adequately cover providers’ time and the associated administrative costs. As a result, providers may forego MIC in favor of a traditional service. One state that CHCS spoke with, for example, reimburses dentists \$4 per tooth for applying SDF.

- **Service limits and time periods.** For example, state policy may limit the number of teeth to which SDF may be applied per visit, as well as the number of times SDF may be used over a period of time.

Payment policies can be used to advance MIC in several ways:

- **Provide adequate reimbursement rates.** Evaluate rates for MIC services, such as applying SDF, to ensure that the costs that providers incur, including administrative costs, are fully covered for those providers that are delivering MIC. Robust reimbursement rates for MIC services may also encourage providers who are new to MIC to incorporate these services into their practices.
- **Offer incentives.** A Medicaid health plan in Louisiana, for example, makes an additional payment above the Medicaid rate to providers who apply fluoride varnish to members six months to five years of age. Federally qualified health centers are also eligible for this incentive.⁷⁴
- **Ensure coverage by capitated rates.** For states with managed dental programs, rates should include MIC services. For example, rates for California’s dental managed care plans were designed to increase the use of preventive services and cover the application of SDF.⁷⁵
- **Pay advanced practice providers.** Advanced practice providers, including expanded practice dental hygienists, dental therapists, and nurse practitioners among others, are on the forefront of delivering MIC and should be paid for delivering that care.

Conclusion

MIC is an effective way to provide greater access to high quality oral health care for Medicaid members. It offers a patient-friendly approach for preventing tooth decay and efficiently addressing dental issues. This brief identifies several ways for Medicaid to support MIC services. This includes opportunities to: (1) increase access to oral health care in nontraditional settings; (2) advance health equity; (3) expand oral health care teams beyond dentists to administer important preventive and restorative oral health care services; (4) promote opportunities for clinical integration; and (5) use payment strategies that encourage the uptake of these services. The information and state examples highlighted in this brief can inform Medicaid stakeholders seeking to explore new ways to meet the oral health needs of their communities.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

ENDNOTES

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