Community Catalyst

Advancing Equitable Workforce Opportunities Post Medicaid Adult Dental Benefit Expansion

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Introduction

Oral health is critical to overall health, impacting people's physical, mental, social, and emotional well-being. Beyond the immediate effects on someone's ability to eat, speak, and attend work or school, oral health is linked to other health issues such as cardiovascular disease, diabetes, and respiratory infections. Despite the importance of oral health, millions of people in the U.S. lack access to dental care. 68.5 million adults do not have dental insurance, and even among those who are insured, access barriers and disparities remain. Many people, particularly those in marginalized communities, face additional barriers to accessing dental services, including struggling to find a provider, especially one who accepts their insurance. While expanding dental coverage can significantly impact people's access to care, a sufficient, well-distributed, and representative workforce is also needed to ensure coverage can be used.

This paper describes oral health workforce issues in the U.S., particularly regarding widespread improvements to Medicaid adult dental benefits in states nationwide. As states increase Medicaid coverage for dental care, whether by authorizing payment for additional services, increasing or removing annual benefit caps, or expanding access to additional population groups, a robust and well-distributed oral health workforce will be necessary to meet increased community needs and demand. Widespread oral health workforce improvements – including increasing the number of oral health providers, improving their distribution in currently underserved communities, and maximizing the impact of existing providers by ensuring they can work at the top of their scope – are necessary across the country. This need is not exclusive to states that have added or expanded Medicaid dental benefits; however, there are specific considerations in states that have recently expanded benefits, and that context is the focus of this paper.

Limitations of the Current Oral Health Workforce

The current oral health workforce is insufficient to meet community needs, with over 58 million people living in areas without enough dental providers. The problem is only getting worse, with nearly 10% of dental hygienists and assistants having left the workforce since 2020, and approximately one-third expected to retire within the next five years. People of color, those living in rural areas, and those with low incomes are among the most likely to experience the effects of provider shortages. Improving the oral health workforce is pivotal to promoting better oral health outcomes and addressing issues related to the accessibility and affordability of dental care.

Between 2020 and 2023, the U.S. witnessed some of the most significant expansions of Medicaid adult dental benefits. States have taken various approaches to enhance these

benefits, including expanding the range of services covered, increasing per-member spending, and introducing benefits for the first time. As a result, millions more low-income people now have access to dental coverage. Now, many states are confronting a long-term reality that, **while having access to insurance can greatly impact people's ability to get the care they need, without an adequate workforce, care can be just as inaccessible.** Even with Medicaid coverage, many people struggle to find a dentist who will accept their insurance, is accepting new patients, and/or has appointments available within a reasonable amount of time. Recent research shows that about two-thirds of dentists see no patients with Medicaid, with white dentists being the least likely to serve those with Medicaid coverage.

Additionally, the demographic makeup of the oral health workforce does not reflect the diversity of the U.S. population. Approximately 70% of dentists and 80% of dental hygienists are white, and Black, Hispanic, and American Indian/Alaska Native communities are significantly underrepresented in the oral health workforce. Despite efforts to increase diversity, dental school enrollment and graduation rates for these groups have shown minimal progress. Data indicates that the number of dental school applicants from historically underrepresented racial and ethnic groups increases by merely 2% annually, with graduation rates increasing by 4%. These small changes, on their own, are not sufficient to meet the needs of an increasingly diverse US population.

The underrepresentation of people of color and Tribal members in the dental field is not just a matter of equity but also impacts the quality and accessibility of care. Minority dental professionals are more likely to serve in or near communities of color and to treat patients of color, who often face barriers to accessing care. Racial concordance—where providers and patients share the same racial or ethnic background—has been shown to foster better communication, stronger patient-provider relationships, and better acceptance of health care. This concordance is critical for enhancing trust and understanding between patients and providers, leading to improved health outcomes. While the solution is not for patients to only see providers of their same race or ethnic background, a more diverse workforce provides the opportunity for someone to find a provider they have more in common with if they choose to. The racial and ethnic diversity of the current oral health workforce must grow in order to meet the need for accessible and culturally respectful dental care, especially in light of coverage expansions, which increase demand for care.

Economic Benefits of Expanding the Oral Health Workforce

In addition to access to care barriers and ongoing inequities, the limits of the current oral health workforce also place economic burdens on individuals, families, and communities. Dental care presents the most significant financial burden of any health care service; this is especially true for low-income working-age adults, those who are uninsured, and those with Medicaid coverage. Without the ability to afford regular dental care, job opportunities and earning potential can suffer because of societal assumptions about appearance and because the pain of untreated dental issues can result in missed work or

reduced productivity. Poor oral health associated with lacking access to care can also have adverse effects on family financial outcomes.

Additionally, when people lack dental coverage, they often have no choice but to wait until oral health problems become so severe that they seek care in an emergency department (ED). ED visits alone cost an estimated $2.1 billion annually; nearly 79 percent of these visits could be addressed in a dental office. Increasing access to timely preventive care and treatment could foster savings of up to $1.7 billion annually.

Expanding the oral health workforce can help ensure people can access timely preventive care, avoiding the need for more invasive and expensive care down the road, which can often lead to debt. **An accessible oral health workforce has the potential to improve communities far beyond their oral health.**

Designing and Implementing Solutions Should Start with Communities

Because multiple factors contribute to health and reduce inequities, the first step in designing or implementing any potential solutions should be to spend time with BIPOC, Tribal, immigrant, low-wealth, rural, disabled, and other marginalized communities to learn what would work best from their perspectives.

Oral health advocates consistently find that people in their community care about their oral health, understand its importance, and when asked about their health care needs, report it as one of the top concerns. Communities, especially marginalized communities, should be at the forefront of selecting, designing, and implementing solutions that best meet their specific needs.

To fully understand and address the factors that influence equitable access to dental care, advocates and Medicaid programs should engage directly with people who rely on these programs. States can implement strategies like Medicaid patient advisory boards. They can also partner directly with community-based organizations to garner input from people who face the most significant barriers to care. Such mechanisms are critical to ensuring that policy solutions to improve access to dental care center the needs of patients.

Windows of Opportunity and Policy Recommendations

For decades, there have been various attempts to increase the number of dental providers who serve people with Medicaid, such as increasing Medicaid reimbursement rates, streamlining Medicaid administrative processes to be more provider-friendly, cultural competency training, and outreach or education for people with Medicaid coverage to inform them of their benefits or aid them in signing up for them. While no single policy can address this multifaceted problem, many of these attempts have been inadequate and antiquated, producing little actual impact.

There is a unique window of opportunity to modernize our oral health workforce to better meet the needs of all people, and particularly to ensure that people with Medicaid can practically access the dental benefits their coverage offers them on paper. There are a range of strategies – both innovative and those with a track record of success – being explored around the country that hold promise for right-sizing the oral health workforce to improve access to care. These strategies go beyond the four walls of a dentist's office – they bring care directly into communities closer to where people live, work, and play.

Authorize Dental Therapists

Dental therapists are licensed providers who work under the supervision of a dentist to provide care like fillings and exams and provide care in community settings, such as mobile clinics, schools, or long-term care facilities. Initially brought to the U.S. by Alaska Native leaders seeking to address provider shortages in their community, dental therapists are now spread across the country and are authorized to practice in at least some settings in 14 states. Given that dental therapists receive specialized training that allows them to practice beyond traditional clinic settings, such as schools, senior centers, and mobile clinics, they serve as invaluable channels for extending the reach of quality oral healthcare cost-effectively while simultaneously engaging in community outreach and education.

> Dental therapy creates good-paying jobs in these communities while improving the community's oral health. Hiring dental therapists can be a cost-effective way for nonprofit and private practice dentists to grow their clinics, stimulating economic growth in local communities. Dental therapy has the potential to bend the cost curve long-term by getting more people access to routine and preventive care, which can prevent the need for more expensive and invasive care later on, and getting more people access to a regular provider to keep people out of the ED, which is a costly site of care.

The dental therapy model was intentionally designed to train providers who represent the language and culture of the communities they serve, improving trust and addressing structural barriers to care. Additionally, dental therapy training is more financially

accessible and is built around the needs of low-income, nontraditional, or first-generation college students.

Expanding the Scope of Practice

Dental Hygienists, Dental Assistants, and Expanded Function Dental Assistants (EFDAs)

Many states have increased the capacity of other members of the dental team to make care more accessible and cost-effective. Evidence shows that by utilizing the full capabilities of these professionals, we can optimize the efficiency of the oral health workforce and improve access to essential dental services. Dental hygienists, with their expertise in preventive and periodontal care and patient education, can play a significant role in delivering routine dental services, such as cleanings, sealants, and fluoride treatments, which in particular can allow more children to avoid tooth decay and more seniors to keep their natural teeth. Policies that expand Direct Access, meaning the ability of a dental hygienist to initiate treatment without the presence of a dentist, can allow hygienists to provide all of the services they are already trained to provide, and potentially do so in community settings, which can improve the availability of care in underserved communities. Similarly, EFDAs, trained to perform certain advanced tasks under the supervision of a dentist, can alleviate workload burden by handling procedures like placing fillings and sealants and applying fluoride varnish. Allowing all providers to work at the top of their scope increases the efficiency and effectiveness of the entire dental team.

Dental hygienists, dental assistants, and EFDAs can serve as vital resources in mobile dental clinics, school-based health centers, and community health centers, bringing essential dental care directly to those who need it most. By strategically deploying these professionals where they are most needed, we can address disparities in access to oral health care and improve overall population oral health outcomes.

Accessible education, competitive salaries, opportunities for professional development, and a supportive work environment are crucial factors in attracting and retaining qualified personnel. Additionally, policies should be in place to provide these professionals with the necessary resources and training to excel in their roles, ultimately contributing to better patient outcomes and satisfaction.

Medical and Non-Oral Health Providers

Because oral health is health, dental providers are not the only clinicians who should be able to offer oral health services. Oral health screening and prevention in primary care settings presents opportunities to halt dental disease early and prevent future disease as well as forestalling the need for more invasive care. Policymakers can allow pediatricians, nurses, and other primary care providers to offer basic services, like conducting oral health assessments and applying fluoride varnish and silver-diamine fluoride In addition, co-locating dental and medical services and sharing dental and medical records are other policy options to better integrate oral and medical care. Importantly, patients express a

willingness and desire to access dental care in non-dental settings, with about one-third of people wanting to see co-location of dental and medical care.

Community Health Workers

Community Health Workers (CHWs) are community-based public health workers who offer health education, social support, and advocacy and serve as a link between community members and health care and social services. In certain states, CHWs can also be trained to apply fluoride varnish, further increasing accessibility to necessary preventive services. Like dental therapists, most CHWs come from the communities they serve and, therefore, have a strong understanding of the cultural and language needs of the community. CHWs also include culturally-specific health workers like Tribal Community Health Representatives and Promotores. In some states, CHWs provide information and resources to educate their communities on oral health and coordinate access to preventive dental care, resulting in lowered treatment costs, reduced emergency department visits, and an increased number of low-income adults receiving dental care.

As more states expand their Medicaid adult dental benefits, CHWs can play a critical role in providing education and resources in communities about newly added benefits and connecting people to providers to have their care needs met. Particularly in states that are considering or implementing other workforce advancements in light of adult dental benefit improvements, CHWs can be a valuable resource to ensure that people know what dental services they're covered for, where they can go to use those benefits, and connect patients and providers in culturally grounded ways. These states may also consider incorporating oral health curricula into CHW training so these community providers are well-equipped to respond to the changing oral health coverage and workforce landscape. Some states add oral health modules to regular CHW training programs, either by using standardized curricula, like Smiles for Life, or by creating their own programs. Recently, Kansas developed a program to incorporate oral health information into each of the existing modules CHWs are already trained on to encourage integrated education about oral and overall health.

> Investing in CHWs can be part of the holistic oral health workforce a state needs to meet demand when adult dental benefits are expanded; as with all other health and allied professions, doing so will require dedicated resources. Currently, 15 states have Medicaid reimbursement arrangements for CHW services. Other states utilize Medicaid 1115 waivers or encourage (or, in some cases, require) managed care organizations (MCOs) to incorporate CHW services. While grant funding and other financial mechanisms are also used in various states, Medicaid reimbursement is an important part of the financing structure for supporting CHW services and improving health equity.

Teledentistry

Teledentistry is part of a broader digital health transformation that is expanding the reach of our current dental workforce, lowering costs, and leading to better outcomes. Such technology allows people to receive consultations, evaluations, and advice from their providers via telephone or video. This helps address transportation barriers and can facilitate care for older adults or people with disabilities. Advocates can push their state Medicaid programs to authorize coverage of coverage of teledentistry and to permanently expand teledentistry policies that were authorized to facilitate care during COVID-19 shutdowns. Teledentistry also allows dental therapists, hygienists, assistants, and EFDAs to work in community settings while being supervised by their supervising dentist. Critically, dental therapists have been leading innovators in using teledentistry to improve access to care.

Additional State Funding for Oral Health Workforce Programs

Authorizing additional providers and expanding the scope of practice for existing providers often requires financial support. To maximize the sustainability of Medicaid adult dental benefit improvements and the oral health workforce, in general, several federal opportunities exist to shore up state programs. The Health Resources and Services Administration (HRSA) provides Grants to States to Support Oral Health Workforce Activities. These funds are available to states to foster innovative programs that boost the oral health workforce in areas without enough dental providers, including to support the development of dental therapy programs.

The Public Health Service Act also authorizes funding for Oral Health Training Programs (Title VII) to support dental education and training. These funds can be used to offer financial assistance to students while they are in school and to support student loan repayment programs for practicing providers. Given that the current dentist workforce is insufficient to meet community needs, and projections about the future dentist workforce will still leave many people without access to providers, ensuring that the full range of oral health providers, including dental therapists, have access to scholarship and loan repayment programs is critical. HRSA's Advisory Committee on Training in Primary Care Medicine and Dentistry has recommended that dental therapy programs be explicitly included in Title VII Oral Health Training Programs, that Congress increase funding for the program, generally and authorize specific funds to be used to support dental therapy training programs, and that dental therapist be made eligible for scholarship and loan repayment through the National Health Service Corps.

These financial supports will be critical for ensuring enough providers are available to meet increased community need post-Medicaid adult dental benefit expansions. They are especially important for bolstering the oral health workforce in areas that currently lack enough dental providers and for ensuring the oral health workforce reflects the communities it serves.

Equity, Inclusion, and Systems Change

Addressing systemic inequities in dentistry requires concerted efforts to dismantle systemic barriers and promote equity and inclusion within the profession. This includes policies to increase the racial diversity of dental professions and also policies to address workplace conditions that help recruit and retain a diverse pool of dental providers along racial, ethnic, and gender lines. Some examples are:

- Implementing targeted recruitment and retention strategies to diversify the dental workforce
- Expanding access and affordability to educational opportunities and mentorship programs for prospective students from underserved communities
- Fostering inclusive and accessible learning environments
- Addressing implicit bias and discrimination at all levels of the dental education and workforce pipeline
- Increasing diversity among faculty and leadership in dental schools and professional organizations
- Expanding loan forgiveness and repayment assistance programs for dental professionals serving in underserved areas
- Prioritizing pay equity, including implementing transparent salary policies, conducting regular pay equity audits, and addressing any disparities in hiring, promotion, and retention practices

Conclusion

While access to insurance and the expansion of Medicaid benefits can impact people's ability to get the care they need, traditional approaches to improving oral health are inadequate, antiquated, and have failed to meet community need. If the oral health workforce is not effectively designed to meet the demand, access barriers and worsening oral health will only be perpetuated. We must act now to solidify long-term coverage and workforce solutions, or we will find ourselves in the same predicament for years to come.