Community Catalyst

October 2024

Coverage and Care

Minimally-Invasive Care: Policy Opportunities to Improve Dental Care Access and Affordability

Dental Access Project

Authored by: Kasey Wilson, Senior Policy Analyst

Many people struggle to access or afford dental care for a variety of reasons, including uninsurance, cost of care, and access to providers. People of color, Tribal communities, people with disabilities, low-income communities, and other marginalized populations face the greatest barriers to dental care and also often have invasive or traumatic experiences when accessing care.

Minimally-invasive Care (MIC) refers to a variety of less complex services and procedures. It involves catching and treating oral health problems early on, rather than waiting for disease to get bad enough for someone to need more intensive care. By focusing on medical management of the underlying causes of dental problems, rather than surgical treatments, MIC can offer patients greater choice in the type of treatment they receive, address the pain and trauma that often comes along with more invasive dental care, and can easily be provided in clinical and community settings by many different health and allied care professionals, thereby expanding access to care.

A policy framework that supports the provision of MIC services by the wide variety of providers who are well-trained to offer them is critical for improving access to dental care and advancing health equity. This brief provides an overview of state-level policies advocates can push for to ensure communities have access to comprehensive dental services, as well as federal policy considerations that will support the availability of MIC.

State Policies to Advance Minimally-Invasive Care

Millions of people can't access dental care because they are uninsured or their insurance does not cover the care they need. By nature of the services being less invasive, MIC requires less specialized equipment and a less complex setup than surgical dental care. It is typically easy to offer in diverse settings, including dental offices, medical offices, federally qualified health centers (FQHCs) and other clinics, as well as community sites like schools, senior centers, and mobile clinics. However, public and private insurance arrangements vary widely in terms of their coverage of these services, limiting their availability and affordability, and leading to the predominance of invasive dental care—not necessarily because it is medically necessary, but because of how the payment and delivery system is set up. **States have a variety of options to ensure needed dental services, including MIC, are covered by public and private insurance.**

Maximize Medicaid Coverage for MIC Services

In Medicaid, dental coverage is optional for adults. Almost all states include coverage, but covered services – including MIC services – vary widely from state-to-state. For example, 29 states cover fluoride varnish application for adults, but fewer state Medicaid programs will pay for fluoride if it's administered by a medical provider. 29 states offer coverage of silver diamine fluoride (SDF) or other topical medications that can prevent or treat cavities. However, whether these medications are used for prevention or for treatment of existing decay often determines whether Medicaid will pay for them, and some states will cover the medications for one use, but not the other. Only 12 states cover dental sealants for adults and only 8 pay for less invasive approaches to treat periodontal disease with antibiotics (see table 1 for more information about coverage of specific MIC services by state).

To maximize the efficacy of MIC and ensure people can access a broad array of dental services to maintain their oral health, there are several Medicaid policy considerations advocates can encourage their states to adopt.

Coverage of Fluoride Medications

Various forms of fluoride, including fluoride varnish and sliver diamine fluoride, can be effective in preventing cavities, treating existing dental decay, and, in some cases, even reversing disease. In the 22 states where Medicaid does not pay for fluoride varnish application for adults at all, advocates can push for coverage of this important preventive measure. Because it involves painting a topical medication onto teeth, fluoride varnish application is quick, simple, and easy to provide in a variety of clinical and community settings; it is also inexpensive and can be a cost-effective approach, especially for people with a history of and/or who are at high risk for tooth decay.

23 states currently provide Medicaid coverage for fluoride varnish for adults when it is administered by a dental provider, but not when it is administered by a medical provider. Recent research shows that 67% of dentists see no pediatric Medicaid patients; while exact data are harder to find for adult Medicaid participation, provider participation also presents access to care barriers for adults covered by Medicaid. ***Advocates should encourage their state Medicaid programs to reimburse for fluoride varnish by the wide variety of providers who are trained and authorized to provide it.*** This is a simple way to expand access to care, especially in rural areas where dental providers are often much harder to access.

Similarly, SDF presents an important opportunity to prevent *and* treat dental disease before oral health problems worsen and require more invasive care. ***In the 22 states that do not cover SDF at all, advocates should push for the treatment to be included in Medicaid adult dental benefits*** for prevention and/or treatment of dental caries. Critically, 7 states (IL, IN, KS, KY, MI, SC, SD) cover SDF for the treatment of active dental decay, but do not cover application of fluoride varnish or SDF for the purposes of prevention. In these states, advocates have a key opportunity to message the importance of preventing dental disease before it develops and the availability of

inexpensive medications to do so (and in several cases, that this exact medication is authorized and used already for treatment purposes).

Expanding coverage of fluoride varnish and SDF presents particular opportunities in the 16 states that still have an annual benefit maximum for Medicaid adult dental benefits. Because these services tend to be less expensive than more invasive forms of treatment, they can help people maximize their limited benefits while cost-effectively treating existing dental problems and potentially preventing the need for more expensive, invasive care in the future.

Payment for Teledentistry

Teledentistry methods, which can range from real-time telephone and video consultations (also known as "synchronous" teledentistry) to electronic storage and transmittal of patient records and imaging ("asynchronous" teledentistry), offer people the ability to be evaluated and to get expert advice from their provider without needing to leave their home or make it to a clinic or dental office for an appointment. These methods also allow dentists to remotely supervise dental hygienists, dental therapists and other licensed oral health providers that are well-trained to offer MIC services in non-clinic and community settings. Like Medicaid adult dental benefits, teledentistry authorization varies state-by-state. Authority can be legislative and/or regulatory and in some states, the dental board holds the authority, while in other states, there is standalone legislation or regulation.

59 million people live in areas without enough dental providers; teledentistry can expand the reach of the dental delivery system by allowing mid-level providers and allied health professionals to bring care to where people are, addressing transportation and other travel barriers to accessing dental care. Because MIC services require less complex equipment and setup, they are an excellent option for community-based prevention and treatment. ***Advocates should encourage their state Medicaid program to pay for teledentistry***, which can allow people to be screened and recommended for MIC treatment (see table 2 for information about state Medicaid payment for synchronous and asynchronous teledentistry).

Advocates should also ensure that their state's legislative and regulatory environment allows dental hygienists and dental therapists to provide care under remote supervision, using asynchronous teledentistry methods to communicate with their supervising dentist, ***and that Medicaid reimburses for care provided under remote supervision***. Currently, 13 states authorize only dentists to provide teledentistry services (AL, AK, CT, DC, IL, MI, NE, NH, NY, OK, SD, VA, VT); in these states, advocates should push for broader authorization. Additionally, only 14 states allow Medicaid reimbursement for teledentistry (table 2). Authorization of asynchronous teledentistry is critical for expanding the reach of the delivery system because it allows hygienists, dental therapists, and other mid-level or allied health professionals to share relevant information with their supervising dentist without requiring real-time review or authorization for every procedure. In the 6 states that have authorized synchronous,

but not asynchronous teledentistry (AL, DC, GA, LA, OH, WI), advocates have an opportunity to improve the policy landscape to allow for broader reach of the dental delivery system.

Risk Management and Individualized Care

While standardized coverage and payment policies for MIC services are important for reducing state-by-state variation and setting a floor for comprehensive dental coverage, periodicity schedules and payment policies should reflect that some people may need MIC services provided at more frequent intervals than what the average patient receives. For example, fluoride varnish and SDF are effective for preventing and treating dental disease, but may be most effective when used more frequently for people who have existing disease and/or who are at higher risk for future disease.

While state plans will outline frequency limits that are clinically advised for the average patient, they may be at odds with clinical best practices for MIC or individualized care, in general. ***Advocates should encourage their state Medicaid programs to pay for more frequent delivery of MIC services based on clinical recommendations by providers and in accordance with Medicaid periodicity schedules.***

Improve Private Coverage of MIC Services

In April 2024, the Centers for Medicare and Medicaid Services (CMS) issued the 2025 Notice of Benefit and Payment Parameters (NBPP) final rule, which, for the first time since the ACA's passage, allowed states to add routine adult dental services to their Essential Health Benefits (EHB) benchmark plans. States now have the option of requiring private health insurance plans sold on the Marketplace to cover adult dental services and, if they do, of defining which specific services plans must include. Updating their benchmark plans, utilizing this new option to include adult dental services, and specifically outlining MIC services as part of "routine" adult dental benefits is one way states can incentivize cost-effective access to care. ***Advocates should encourage their states to update their benchmark plans and to include MIC services as part of the routine adult dental care EHB.***

Importantly, services that are defined as EHBs are prohibited from being subject to annual or lifetime limits; this marks a critical affordability protection for dental care, which presents the greatest financial barriers of any health care service and which significantly contributes to our nation's medical debt crisis. Annual and lifetime limit prohibitions are particularly important because, currently, most private dental coverage includes annual coverage limits of $1,000-$2,000. EHB status would significantly improve access to affordable dental coverage.

State benchmark plans are required to cover an array of services that are no less generous than the least generous employer plan in the state and no more generous than the most generous employer plan in the state – this is known as the typicality standard. Meeting this standard means that states have to make judicious choices about which particular services to include within the various EHB categories plans must cover. For example, states must include outpatient care as an EHB, but the specific outpatient services each state requires plans to cover varies

depending on the state's benchmark plan selections and what typical employer plans in the state cover. When states are making considerations about which dental services to include, they will need to be mindful of not surpassing the upper end of the typicality standard; incorporating cost-effective MIC services into their benchmark plans will allow for states to maximize covered oral health services, while maintaining space for other needed EHB services and abiding by the typicality standard.

Workforce Considerations

As mentioned above, a variety of provider types are well-trained to provide MIC services, including: dental hygienists; dental therapists; nurse practitioners, physician assistants, and other primary care providers; and community health workers. ***Advocates should encourage their states to authorize dental hygienists, dental therapists, and relevantly-trained medical providers to apply fluoride varnish and SDF without requiring prior authorization or exam by a dentist.***

All states authorize dental hygienists to apply fluoride varnish and, in most cases, they are authorized to do so without a dentist present. In the 7 states that do require a dentist to be present in at least some settings while the hygienist applies fluoride varnish, advocates have an opportunity to push for more appropriate supervision requirements that reflect dental hygiene training. ***Advocates should also encourage their states to authorize Community Health Workers (CHWs) to apply fluoride varnish and reimburse for their services by Medicaid & private insurance.***

Additionally, 9 states require that a dentist be in the office or examining room while a dental hygienist applies SDF, even though they are well trained to apply this medication. Maximizing dental hygiene scope to include fluoride varnish and SDF application under general supervision will allow them to expand access to important preventive care in community settings. In 2022, the American Medical Association approved a billing code for SDF application by medical providers, similarly opening the door to expand the settings where people can access needed dental care.

Federal-Level Policy Considerations

Mandatory Medicaid Adult Dental Benefits

While many states already include some MIC services as part of their Medicaid adult dental benefits, the optional nature of these benefits creates wide state-by-state variability, geographic inequities, and makes these critical services vulnerable to cuts when state budgets are strained. Peoples' access to critical health care should not be at risk in state budget fights. Doing so puts peoples' oral and overall health at risk and has the potential to drive people to less effective and more expensive sites of care, like emergency departments.

Mandating adult dental benefits in Medicaid, and ensuring a comprehensive benefit is defined to include MIC services, would improve access to care for millions of low-income Americans. Research shows that expanding adult dental coverage in Medicaid can reduce racial disparities and would save at least $273 million per year because treating oral health problems can cut down on medical costs. These potential savings are even higher when accounting for emergency department visits for preventable oral health conditions, which cost our health care system $2 billion each year.

Federal Standardization of Essential Health Benefits

While states now have an option to include routine adult dental services in their EHB benchmark plans, this option will not address the wide state-by-state variability in covered services and EHB affordability protections. Additionally, no standardized definition exists for what constitutes "routine" dental benefits; states that opt to add adult dental services to their benchmark plans will be faced with choosing which services to include, further entrenching geographic inequities. While MIC services are a great option for maximizing the dental services that can be included in benchmark plans with respect to typicality, people should have access to a wide variety of oral health services to meet their needs, including MIC, without regard to where they live. ***Adding adult dental as part of the federally-defined EHB categories that all states must cover*** could help address racial and income-based disparities and is extremely popular – 83% of voters support making dental care more affordable by including it as an EHB.

Comprehensive Medicare Dental Benefits

Despite serving as the primary source of health insurance for older adults and people with disabilities, traditional Medicare does not include a dental benefit. While many Medicare Advantage (MA) plans include coverage of at least some dental services, people with this coverage experience problems accessing care at about the same rates as those in traditional Medicare, which lacks any coverage for routine oral health services. Because they are well suited for use in community settings, MIC services provide opportunities to expand access to dental care for older adults and people with disabilities, who otherwise may face accessibility barriers to dental care in traditional clinic or office settings. As a result of these barriers, nearly two-thirds of people with disabilities have not visited a dentist in two or more years. ***Adding a comprehensive dental benefit to Medicare that includes MIC services would help ensure older adults and people with disabilities have access to community-based oral health care.***

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*Table 1: Medicaid Coverage of Select MIC Services for Adults**

	Fluoride varnish (by dental provider)	SDF prevention	SDF treatment	Fluoride varnish (by medical provider)	Dental Sealants	Antimicrobial treatment for periodontal disease
Alabama						
Alaska	x					
Arizona						
Arkansas						
California	x		x			x
Colorado	x					x
Connecticut	x		x	x		x
Delaware	x		x			
District of Columbia	x			x	x	
Florida	x					
Georgia				x		
Hawaii	x		x			
Idaho						
Illinois			x			
Indiana			x			
Iowa	x		x		x	x
Kansas			x			
Kentucky			x			x
Louisiana						
Maine	x	x	x		x	

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Maryland	x		x			
Massachusetts	x	*Can be covered based on individual considerations*	x	x	x	x
Michigan			x	x	x	
Minnesota						
Mississippi						
Missouri						x
Montana	x		x		x	
Nebraska	x	x	x	x	x	
Nevada						
New Hampshire	x		x			
New Jersey	x		x			x
New Mexico	x					
New York						
North Carolina	x	x	x	x	x	
North Dakota	x	x	x			
Ohio	x		x			
Oklahoma	x					
Oregon	x	x	x			
Pennsylvania						
Rhode Island	x					
South Carolina			x			
South Dakota			x		x	
Tennessee	x		x			
Texas						

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Utah	x		x		x	
Vermont	x					
Virginia	x	x	x		x	
Washington	x		x	x		
West Virginia			x			
Wisconsin	x		x		x	
Wyoming						

**This chart includes coverage information for the general adult population; some states have separate Medicaid payment policies for specific subgroups (e.g., pregnant/postpartum adults, people with disabilities) who may be eligible for coverage of MIC services that the broader adult population is not.*

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Table 2: Medicaid Payment for Teledentistry (Adults)

	Synchronous Teledentistry	Asynchronous Teledentistry
Alabama		
Alaska		
Arizona		
Arkansas		
California	x	
Colorado	x	
Connecticut		
Delaware		
District of Columbia	x	
Florida		
Georgia	x	x
Hawaii		
Idaho		
Illinois	x	x
Indiana		
Iowa	x	x
Kansas		
Kentucky		
Louisiana		
Maine	x	x
Maryland		
Massachusetts	*Can be covered based on individual considerations*	*Can be covered based on individual considerations*
Michigan	x	

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Minnesota		
Mississippi		
Missouri	x	x
Montana	x	x
Nebraska		
Nevada		
New Hampshire		
New Jersey	x	
New Mexico	x	
New York	x	x
North Carolina	x	x
North Dakota	x	
Ohio		
Oklahoma		
Oregon	x	x
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota	x	x
Tennessee		
Texas		
Utah	x	
Vermont		
Virginia	x	x
Washington	x	x

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West Virginia	x	
Wisconsin		
Wyoming		