CHAPTER 2

Medicaid Coverage of Dental Benefits for Adults

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Key Points

- Poor oral health is widespread among adults in the United States and especially affects those with low incomes.
  - Adults with incomes below 100 percent of the federal poverty level (FPL) are three times more likely to have untreated dental caries—commonly known as cavities—than adults with incomes above 400 percent FPL.
  - Thirty-seven percent of adults age 65 and older with incomes below 100 percent FPL had complete tooth loss compared to 16 percent of those with incomes at or above 200 percent FPL.
- Individuals with a range of chronic conditions are more susceptible to oral disease. Oral disease can also exacerbate chronic disease symptoms. Poor oral health can limit communication, social interaction, and employability.
- Medicaid programs are required to cover dental services for children and youth under age 21 but there are no minimum coverage requirements for adults. As a result, adult dental benefits vary widely across states. For example, as of February 2015:
  - 19 states provided emergency-only adult dental benefits for non-pregnant, non-disabled adults;
  - 27 states covered preventive services;
  - 26 states covered restorative services;
  - 19 states covered periodontal services;
  - 25 states covered dentures;
  - 25 states covered oral surgery;
  - 2 states covered orthodontia; and
  - 9 states placed an annual dollar limit on covered dental services.
- States change Medicaid coverage of adult dental benefits on a regular basis, cutting benefits when budgets are tight and expanding them when more funds are available.
- Initiatives to improve access to dental services include using mobile clinics and telehealth technologies, increasing the number of providers serving Medicaid enrollees, and funding demonstrations to encourage Medicaid enrollees to increase dental utilization. For example:
  - In 2014, the Health Resources and Services Administration supported 238 school-based health center oral health activities through capital grants.
  - The National Health Service Corps and some states offer student loan repayment assistance to dentists who commit to working in high-need, underserved, or rural areas.
  - Minnesota and Alaska have amended state scope-of-practice laws to allow mid-level dental practitioners to provide dental services.

CHAPTER 2: Medicaid Coverage of Dental Benefits for Adults

Federal law does not mandate any minimum requirements for adult dental coverage under Medicaid, allowing states to decide whether or not to provide such coverage. As with other optional Medicaid benefits for adults, states that cover dental services under Medicaid can define the amount, duration, and scope of the services covered. States often reduce or eliminate adult dental benefits in response to budget difficulties, and may restore benefits when the state budget outlook improves (Lee et al. 2012, Gehshan et al. 2001). In contrast, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for children under age 21 enrolled in Medicaid, and the State Children's Health Insurance Program (CHIP) require states to provide comprehensive dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions without caps or other limits that are unrelated to medical necessity (Cardwell et al. 2014, Kaiser 2012a).[1]

This chapter examines dental benefits for adults enrolled in Medicaid. We begin by examining why oral health benefits are important for all adults, and particularly those with low incomes. We describe current Medicaid dental benefits for adults, noting differences for various subpopulations, and report on recent changes in state coverage policies. We present information on the use of dental care by Medicaid enrollees as well as state and community efforts to improve access to care in underserved areas.

The Impact of Poor Oral Health

Poor oral health affects a majority of adults in the United States. Almost all (92 percent) adults age 20 to 64 have had dental caries, commonly referred to as cavities, in their permanent teeth (NIDCR 2015). Of those with dental caries, adults with incomes below 100 percent of the federal poverty level (FPL) are more than three times as likely to have untreated dental caries than adults with incomes above 400 percent FPL (Kaiser 2012b). Specifically, between 2005 and 2008, 42 percent of adults age 20 to 64 with incomes below 100 percent FPL had untreated dental caries, compared to 11 percent of those with incomes above 400 percent FPL. Additionally, among adults age 65 and older with incomes below 100 percent FPL, 37 percent were edentulous (meaning they had complete tooth loss), compared to just 16 percent of those with incomes at or above 200 percent FPL (Dye et al. 2012).

Disparities also exist within racial and ethnic groups and for older adults. Among adults age 20 to 64 with incomes below 100 percent FPL, almost 53 percent of African American adults had untreated dental caries, compared to 40 percent of non-Hispanic white adults in that income range (NCHS 2013). Additionally, 32 percent of non-Hispanic black adults age 65 and over were edentulous, compared to 22 percent of non-Hispanic white adults (Dye et al. 2012).

Individuals with a range of chronic conditions are more susceptible to oral disease, and in turn, oral disease can contribute to complications from these conditions and exacerbate their symptoms. Diseases of poor oral health include the gum disease gingivitis and the gum infection periodontitis, which may involve all of the soft tissue and bone supporting the teeth (Kaiser 2012b). People with uncontrolled diabetes are more susceptible than their non-diabetic counterparts to develop periodontal diseases,

which can, in turn, adversely affect metabolic control of diabetes (Nycz 2014, Kuo et al. 2008, Mealey 2006). Individuals with respiratory infections, such as pneumonia and exacerbated chronic obstructive pulmonary disease, are more likely than those without such infections to have poor periodontal health, gingival inflammation, and deeper pockets (deep spaces between the teeth and gum tissue that provide a place for bacteria to live) (Kuo et al. 2008, Sharma and Shamsuddin 2011). There is also evidence of a link between osteoporosis and tooth loss, although the causal relationship is unclear (Inaba and Amano 2010, Kuo et al. 2008).

Periodontal disease may also affect pregnancy outcomes. There is an emerging consensus that preventive dental care during pregnancy is desirable (Boggess et al. 2013, Albert et al. 2011, Detman et al. 2010, Offenbacher et al. 2006). Some studies show an association between maternal periodontal disease and pregnancy complications, such as preterm labor or premature rupture of membranes, both major precursors to preterm births (Offenbacher et al. 2006, USPHS 2000). Research shows a possible association between preterm birth, low birth weight, and poor oral health (Albert et al. 2011, Skelton et al. 2009).

In addition to its association with serious medical conditions, poor oral health can negatively affect individuals in other ways. Untreated dental conditions can lead to pain and tooth loss, jeopardizing employment and lowering quality of life. For example, in fiscal year 2008, 52.5 percent of U.S. Army recruits were classified as Dental Fitness Classification 3, meaning that they were non-deployable without treatment for urgent conditions that likely would cause a dental emergency within 12 months (Moss 2011). Such a classification prohibits U.S. Army recruits from serving in combat until their dental needs are addressed. Pain affects everyday activities such as speech, eating, and sleep, which may deter socialization and employment (Dubay et al. 2005, Kaiser 2012b). In addition, poor oral health can have negative cosmetic consequences affecting a person's ability to communicate and limiting social interactions (USPHS 2000).

Public and Private Coverage of Dental Services

Access to and use of dental care increases when a person has dental insurance benefits (Manski et al. 2002). Dental benefits vary widely among private and public payers, from comprehensive to emergency care only.

In 2014, 55 percent of firms in the United States offered health benefits to their employees. Health coverage may be provided as part of a broader plan that includes medical benefits or stand-alone coverage (GAO 2010). Slightly more than half (53 percent) of firms offering health benefits to their employees offer or contribute to a dental coverage benefit for their employees that is separate from any dental coverage the health plan may include. Firms with 200 or more employees are more likely to offer or contribute to a separate dental health benefit than smaller firms—88 percent and 52 percent, respectively (Claxton et al. 2014). The specific dental benefits covered vary across sponsoring employers and plans.

Adult dental services are not included in the 10 essential health benefits established in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that must be offered in health plans in the individual and small group markets, whether inside or outside of the health insurance exchanges. Consequently, adults purchasing an individual plan or purchasing a small group plan are not guaranteed dental coverage unless they enroll in a stand-alone dental plan.

Medicare provides limited dental benefits, paying only for dental services that are an integral part of either a covered procedure or a procedure done

in preparation for other covered treatment, for example:

- reconstruction of the jaw following accidental injury;
- extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw;
- oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement under certain circumstances; and
- inpatient hospital services if the severity of a dental procedure requires hospitalization in connection with the provision of services for an underlying medical condition (CMS 2013).

According to data from the 2012 Medicaid Expenditure Panel Survey (MEPS), people with low incomes are less likely to have dental coverage than those with higher incomes. Seventy-one percent of those with incomes above 200 percent FPL have some level of coverage, compared to 42 percent of those with incomes at or below 100 percent FPL. Additionally, people with low incomes who have dental coverage are more likely to have public coverage than those with higher incomes. Of adults with incomes at or below 100 percent FPL, 26 percent have public coverage, and 16 percent have private coverage. In contrast, 2 percent of people with incomes above 200 percent FPL have public coverage, while 69 percent have private coverage (Rohde 2014). As discussed later in this chapter, coverage is highly associated with use of services.

Adult Dental Benefits in Medicaid

Medicaid programs vary in the dental services they cover for adults (Table 2-1). Currently, 18 states cover emergency services only. States that cover emergency services differ in how they define those services, although most include emergency coverage of treatment for pain and infection. Thirty-three states cover services beyond emergency services, but many impose annual dollar and service limits. These limits vary widely among states. Twenty-eight states cover preventive services such as oral examinations, teeth cleanings, fluoride application, and sealant application (painting a plastic material on to the chewing surfaces of the back teeth to prevent decay).

Many of the 26 states offering restorative services place annual limits on the number of fillings or crowns an enrollee can get, the types of crowns that can be used on certain teeth, and how often root canals can be performed. Most states that cover oral surgery services include extractions, and some include jaw repair, removal of impacted teeth, or other surgical services. Most states covering denture services offer replacement dentures every 5 to 10 years, but some offer only one set of dentures per lifetime.

Many states place limits on the dental services they will cover within a certain time frame. Nine states have annual dollar limits, ranging from $500 to $2,500 a year (Table 2-2). Additionally, 31 states place limits on the frequency of service delivery. As do many commercial dental benefit providers, state Medicaid programs commonly limit examinations and cleanings to one or two per year. Connecticut and Illinois limit fillings to one per year, limit crowns to one per tooth every five years, and limit root canals to one per tooth per lifetime. North Dakota, Rhode Island, and Washington limit root canals to front teeth only. Prior authorization is also commonly required for many services, although not for emergency services. Detailed information on state coverage and limits can be found in Appendix 2A, Tables 2A-1 and 2A-2.

Some states have different Medicaid dental coverage policies for pregnant women and certain disabled adults, sometimes using Section 1115 demonstration waivers to cover dental services

TABLE 2-1. Types of Adult Dental Services Covered for Non-Pregnant, Non-Disabled Adults under Medicaid, 2015

Type of service	Number of states	Services typically included
Emergency only	18	Emergency extractions, other procedures for immediate pain relief
More extensive	33	
Preventive	28	Examinations, cleanings, and sometimes fluoride application or sealants
Restorative	26	Fillings, crowns, endodontic (root canal) therapy
Periodontal	19	Periodontal surgery, scaling, root planing (cleaning below the gum line)
Dentures	26	Full and partial dentures
Oral surgery	25	Non-emergency extractions, other oral surgical procedures
Orthodontia	2	Braces, headgear, retainers

Note: Federal Medicaid regulations define dental services as "diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including the treatment of – (1) the teeth and associated structures of the oral cavity; and (2) disease, injury, or impairment that may affect the oral or general health of the recipient." (42 CFR 440.100).

Sources: MACPAC analysis of AHCCCS 2014, Alaska DHHS 2014, Amerigroup 2014, Anthem Blue Cross and Blue Shield 2014, BadgerCare Plus and Wisconsin Medicaid 2015, BadgerCare Plus and Wisconsin Medicaid 2013, Better Health Florida 2014, California Medi-Cal Dental Program 2015, Colorado DHCPF 2014, Commonwealth of Virginia DMAS 2012, Connecticut Dental Health Partnership 2013, DentaQuest of Illinois, LLC. 2014, DentaQuest, South Carolina Healthy Connections 2014, Florida AHCA 2011, Hawaii State Med-Quest Division 2011, Holleman 2014, Idaho DHF 2015, Illinois DHFS 2014, Indiana Dental Association 2011, Indiana FSS 2014, Iowa DHS 2013, KanCare 2015, Kansas DHE 2015, 907 Ky. Admin. Regs. 1:026 (2012), Kentucky CHFS 2013, Maine Department of Health and Human Services 2014, Maryland DHMH 2015, Maryland DHMH 2007, Massachusetts EOHHS 2014, 130 Mass. Code Regs. 420 (2014), MDWise 2014, Michigan DCH 2014, Minnesota DHS 2014, Miss. Admin. Code 23-204:1 (2015), Missouri DSS 2013, MOHealthNet 2013, Montana DPHHS 2015, Montana DPHHS 2013a, Montana DPHHS 2013b, Nebraska DHHS 2008, Nevada DHHS 2010, New Hampshire Medicaid Program 2013, N.J. Admin. Code § 10:56-2.6 (2015), N.M. Admin. Code § 8.310.2.12(G) (2015), New York State Medicaid Program 2013, North Carolina DMA 2013, North Dakota DHS 2013, Ohio Department of Medicaid 2015, Okla. Admin. Code § 317:30-5-696 (2014), Or. Admin. R. 410-123 (2014), Oregon Health Plan 2012, Oregon Medicaid 2014, Peach State Health Plan 2013, Pa. Code § 55:1149.24 (2015), Pennsylvania DPW 2014a, Pennsylvania DPW 2014b, Rhode Island DHS 2010, South Carolina Healthy Connections Choices 2015, South Dakota DSS 2015, South Dakota DSS 2015, State of Louisiana BHSF 2012, State of Louisiana DHH 2015, State of Missouri 2013, Texas HHSC 2015, Utah DMHF 2014, Vermont AHS 2014, Washington AppleHealth 2014, WellCare 2014, West Virginia BMS 2015, West Virginia DHHR 2012, Wyoming Department of Health 2015, Xerox 2014. See Appendix 2A for additional details.

for these populations (Silverman 2012). The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) granted states the option of providing an enhanced benefit package to pregnant women, and approximately half of the states use this authority to provide dental benefits (Johnson and Witgert 2010). Adults with disabilities, who are more likely to have dental disease than non-disabled people, also receive Medicaid dental benefits beyond their non-disabled counterparts in some states (Waldman and Perlman 2012, McGinn-Shapiro 2008).

Adult dental benefits in Medicaid also vary in states that expanded adult Medicaid eligibility under the ACA. States that have chosen a traditional expansion, as laid out in the ACA, must create an alternative benefit plan for their Medicaid expansion population, which may be different from what the base population receives (Chazin et al. 2014, CMS 2014a). For example, North Dakota's alternative benefit plan limits dental coverage for the Medicaid expansion population to emergency-only coverage, while it provides additional dental benefits for non-expansion enrollees (CMS 2014b). States that choose to expand Medicaid using a

TABLE 2-2. Medicaid Dental Benefits for Non-Pregnant, Non-Disabled Adults by State, as of February 2015

State	Dental services covered							Limits	
	Emergency services only	Preventive services	Restorative services	Periodontal services	Dentures	Oral surgery services	Orthodontia	Annual spending limits (dollars)	Annual or lifetime limits on services
Total	18	28	26	19	26	25	2	9	31
Alabama	[1]								
Alaska		✓	✓		✓			✓ ($1,150)	
Arizona	✓								
Arkansas		✓	✓	✓	✓	✓		✓ ($500)	Yes
California		✓	✓	✓	✓	✓		✓ ($1,800)	Yes
Colorado		✓	✓	✓	✓	✓		✓ ($1,000)	Yes
Connecticut		✓	✓	✓	✓	✓			Yes
Delaware	[1]								
District of Columbia		✓	✓	✓	✓	✓	✓		Yes
Florida					✓				Yes
Georgia	✓								
Hawaii	✓								
Idaho	✓								
Illinois			✓		✓	✓			Yes
Indiana		✓							Yes
Iowa		✓	✓	✓	✓	✓			Yes
Kansas	✓								
Kentucky		✓		✓					Yes
Louisiana					✓				Yes
Maine	✓								
Maryland	✓								
Massachusetts		✓	✓		✓	✓			Yes
Michigan		✓							Yes
Minnesota		✓	✓	✓	✓	✓			Yes
Mississippi	✓							✓ ($2,500)	
Missouri	✓								
Montana	✓								
Nebraska		✓	✓	✓	✓	✓		✓ ($1,000)	Yes
Nevada					✓				Yes
New Hampshire	✓								
New Jersey		✓	✓	✓	✓	✓			Yes
New Mexico		✓	✓	✓		✓			Yes
New York		✓	✓	✓	✓	✓			Yes
North Carolina		✓	✓	✓	✓	✓			Yes
North Dakota		✓	✓	✓	✓				Yes

TABLE 2-2. (continued)

State	Dental services covered							Limits	
	Emergency services only	Preventive services	Restorative services	Periodontal services	Dentures	Oral surgery services	Orthodontia	Annual spending limits (dollars)	Annual or lifetime limits on services
Ohio		✓	✓		✓	✓			Yes
Oklahoma	✓								
Oregon		✓	✓		✓	✓	✓		Yes
Pennsylvania		✓	✓	✓	✓	✓			Yes
Rhode Island		✓	✓	✓	✓	✓			Yes
South Carolina		✓	✓			✓		✓ ($750)	Yes
South Dakota		✓	✓		✓	✓		✓ ($1,000)	
Tennessee	[2]								
Texas	✓								
Utah	✓								
Vermont		✓	✓	✓		✓		✓ ($510)	Yes
Virginia						✓			Yes
Washington		✓	✓	✓	✓	✓			Yes
West Virginia	✓								
Wisconsin		✓	✓	✓	✓	✓			Yes
Wyoming		✓	✓		✓	✓			Yes

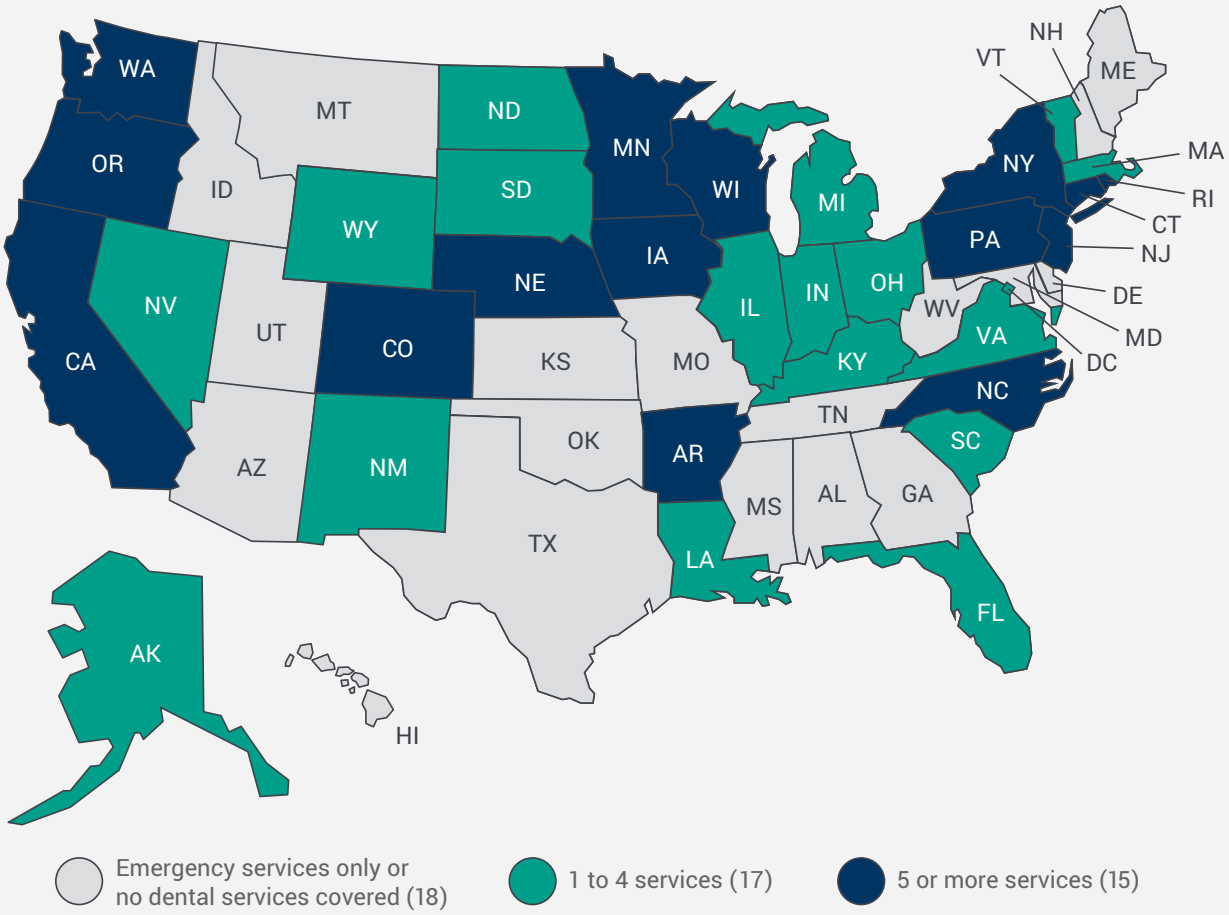
Notes:

[1] Alabama and Delaware classify themselves as offering no dental services, including no emergency services. However, emergency services related to oral health care may be covered under another benefit type. Alabama states that dental services are "any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. Such services include treatment of the teeth and the associated structures of the oral cavity, and of disease, injury, or impairment, which may affect the oral or general health of the individuals" (Alabama Medicaid 2015). Delaware states that dental services include "any services related to the dental treatment such as drugs, anesthetics, and use of operating/recovery room, etc." (DHSS 2014).

[2] Tennessee covers emergency dental treatment only when "an adult enrollee presents to a hospital emergency department with a dental problem," in which case screening and treatment of the emergency medical condition identified in the screening are covered. Tennessee does not cover services to treat the origin of the emergency medical condition and does not cover any emergency services in any setting beyond the emergency department (TennCare 2014).

Sources: MACPAC analysis of AHCCCS 2014, Alaska DHHS 2014, Amerigroup 2014, Anthem Blue Cross and Blue Shield 2014, BadgerCare Plus and Wisconsin Medicaid 2015, BadgerCare Plus and Wisconsin Medicaid 2013, Better Health Florida 2014, California Medi-Cal Dental Program 2015, Colorado DHCPF 2014, Commonwealth of Virginia DMAS 2012, Connecticut Dental Health Partnership 2013, DentaQuest of Illinois, LLC. 2014, DentaQuest, South Carolina Healthy Connections 2014, Florida AHCA 2011, Hawaii State Med-Quest Division 2011, Holleman 2014, Idaho DHF 2015, Illinois DHFS 2014, Indiana Dental Association 2011, Indiana FSS 2014, Iowa DHS 2013, KanCare 2015, Kansas DHE 2015, 907 Ky. Admin. Regs. 1:026 (2012), Kentucky CHFS 2013, Maine Department of Health and Human Services 2014, Maryland DHMH 2015, Maryland DHMH 2007, Massachusetts EOHHS 2014, 130 Mass. Code Regs. 420 (2014), MDWise 2014, Michigan DCH 2014, Minnesota DHS 2014, Miss. Admin. Code 23-204:1 (2015), Missouri DSS 2013, MOHealthNet 2013, Montana DPHHS 2015, Montana DPHHS 2013a, Montana DPHHS 2013b, Nebraska DHHS 2008, Nevada DHHS 2010, New Hampshire Medicaid Program 2013, N.J. Admin. Code § 10:56-2.6 (2015), N.M. Admin. Code § 8.310.2.12(G) (2015), New York State Medicaid Program 2013, North Carolina DMA 2013, North Dakota DHS 2013, Ohio Department of Medicaid 2015, Okla. Admin. Code § 317:30-5-696 (2014), Or. Admin. R. 410-123 (2014), Oregon Health Plan 2012, Oregon Medicaid 2014, Peach State Health Plan 2013, Pa. Code § 55:1149.24 (2015), Pennsylvania DPW 2014a, Pennsylvania DPW 2014b, Rhode Island DHS 2010, South Carolina Healthy Connections Choices 2015, South Dakota DSS 2015, South Dakota DSS 2015, State of Louisiana BHSF 2012, State of Louisiana DHH 2015, State of Missouri 2013, Texas HHSC 2015, Utah DMHF 2014, Vermont AHS 2014, Washington AppleHealth 2014, WellCare 2014, West Virginia BMS 2015, West Virginia DHHR 2012, Wyoming Department of Health 2015, Xerox 2014. See Appendix 2A for additional details.

FIGURE 2-1. Medicaid Dental Benefits for Non-Pregnant, Non-Disabled Adults, 2015



Note: Does not reflect differences in dental benefits that may be available to pregnant women, adults with disabilities, adults in the Medicaid expansion population, or those enrolled in certain Medicaid managed care organizations.

Source: MACPAC analysis of AHCCCS 2014, Alaska DHHS 2014, Amerigroup 2014, Anthem Blue Cross and Blue Shield 2014, BadgerCare Plus and Wisconsin Medicaid 2015, BadgerCare Plus and Wisconsin Medicaid 2013, Better Health Florida 2014, California Medi-Cal Dental Program 2015, Colorado DHCPF 2014, Commonwealth of Virginia DMAS 2012, Connecticut Dental Health Partnership 2013, DentaQuest of Illinois, LLC. 2014, DentaQuest, South Carolina Healthy Connections 2014, Florida AHCA 2011, Hawaii State Med-Quest Division 2011, Holleman 2014, Idaho DHF 2015, Illinois DHFS 2014, Indiana Dental Association 2011, Indiana FSS 2014, Iowa DHS 2013, KanCare 2015, Kansas DHE 2015, 907 Ky. Admin. Regs. 1:026 (2012), Kentucky CHFS 2013, Maine Department of Health and Human Services 2014, Maryland DHMH 2015, Maryland DHMH 2007, Massachusetts EOHHS 2014, 130 Mass. Code Regs. 420 (2014), MDWise 2014, Michigan DCH 2014, Minnesota DHS 2014, Miss. Admin. Code 23-204:1 (2015), Missouri DSS 2013, MOHealthNet 2013, Montana DPHHS 2015, Montana DPHHS 2013a, Montana DPHHS 2013b, Nebraska DHHS 2008, Nevada DHHS 2010, New Hampshire Medicaid Program 2013, N.J. Admin. Code § 10:56-2.6 (2015), N.M. Admin. Code § 8.310.2.12(G) (2015), New York State Medicaid Program 2013, North Carolina DMA 2013, North Dakota DHS 2013, Ohio Department of Medicaid 2015, Okla. Admin. Code § 317:30-5-696 (2014), Or. Admin. R. 410-123 (2014), Oregon Health Plan 2012, Oregon Medicaid 2014, Peach State Health Plan 2013, Pa. Code § 55:1149.24 (2015), Pennsylvania DPW 2014a, Pennsylvania DPW 2014b, Rhode Island DHS 2010, South Carolina Healthy Connections Choices 2015, South Dakota DSS 2015, South Dakota DSS 2015, State of Louisiana BHSF 2012, State of Louisiana DHH 2015, State of Missouri 2013, Texas HHSC 2015, Utah DMHF 2014, Vermont AHS 2014, Washington AppleHealth 2014, WellCare 2014, West Virginia BMS 2015, West Virginia DHHR 2012, Wyoming Department of Health 2015, Xerox 2014. See Appendix 2A for additional details.

demonstration waiver can also create different benefits for the expansion population. Indiana expanded Medicaid eligibility through a Section 1115 demonstration waiver and opted to provide additional adult dental benefits to enrollees who make monthly contributions to a health savings account (CMS 2015). Iowa also expanded through a Section 1115 demonstration waiver and opted to provide three tiers of dental benefits, allowing enrollees to gain access to additional benefits by receiving periodic examinations (CMS 2014c).

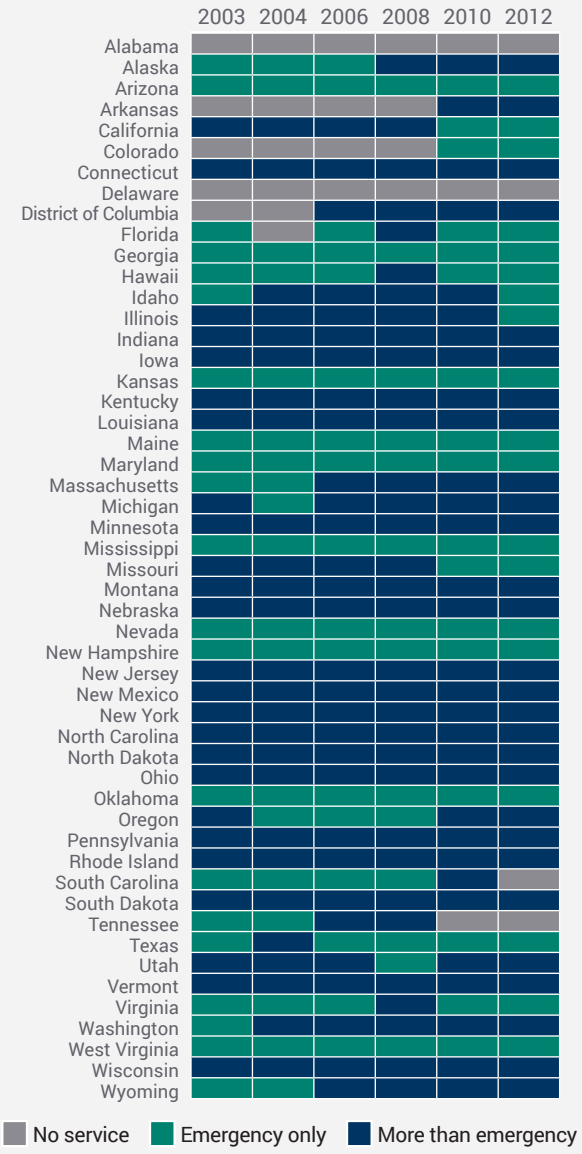
Adult dental benefits may also differ among Medicaid managed care plans. Medicaid managed care plans have the authority to apply any savings they realize through efficient management to the provision of additional benefits to enrollees, for instance, additional dental coverage for adults that goes beyond state requirements (Schneider and Garfield 2002). In Florida, Georgia, Kansas, and Maryland, for example, Medicaid programs enroll a large number of beneficiaries in managed care plans that provide adult dental benefits not available to beneficiaries enrolled in fee-for-service Medicaid (Yarbrough et al. 2014).

Changes in adult dental benefit levels under Medicaid

Because adult dental benefits under Medicaid are optional, many states make changes to benefits on a regular basis (Figure 2-2):

- Between 2003 and 2012, 20 states made at least one large-scale change in dental benefits for non-pregnant, non-disabled adult Medicaid enrollees (for example, adding an additional service to a program that was previously emergency services only), and nine of those states made two or more benefit changes within that time period.
- Between 2003 and 2012, 32 benefit changes were made among 20 states, with 10 states making more than one change—14 of these

FIGURE 2-2. Changes in Medicaid Adult Dental Benefits by State, 2003–2012



Notes: Data were analyzed through 2012, the most recent year for which data are available. The above illustration does not reflect additional dental benefits that may be available to pregnant women or adults with disabilities. Variation exists in the type of and amount of benefits among states in the category of "more than emergency services," which can include anything from one service in one category to multiple services in all service categories. Due to the scope of this category, benefit changes can occur within the category. Additionally, states create their own definitions of emergency dental services, so some states that are listed in the "no services" category may classify themselves as providing no dental benefits despite covering emergency dental services.

Source: MACPAC analysis of Kaiser Family Foundation 2014.

changes decreased dental benefits, and 18 increased dental benefits.

- Between 2003 and 2012, 12 states consistently offered no benefits or emergency services only, and 19 states consistently offered more than emergency services.
- The year 2010 marked the greatest large-scale change—five states increased benefits and six states decreased benefits.
- In 2012, no states increased benefits while three states decreased benefits.

Examples of recent changes in several states include the following:

- California eliminated coverage of non-emergency dental services for adults in Medi-Cal in 2009 (CHCF 2011). As of May 1, 2014, many adult dental benefits were restored for Medi-Cal enrollees, including preventive care, restorative care, periodontal services, and dentures (California Dental Association 2014).
- In 2011, the Idaho legislature limited Medicaid dental benefits for adults age 21 and older to emergency services only (Idaho Department of Health and Welfare 2011; H.B. 260, 61st Leg., 1st Reg. (Idaho 2011)).
- In 2012, Illinois passed legislation restricting dental services covered by Medicaid to emergency services only (S.B. 2840, 97th Leg., 1st Reg. (Ill. 2012)). Then in 2014, the legislature expanded services covered to include limited fillings, root canals, dentures, and oral surgery services (S.B. 741, 98th Leg., 1st Reg. (Ill. 2014)).
- In recent years South Carolina has covered only emergency dental services to adult Medicaid enrollees. On December 1, 2014, the state began covering cleanings, fillings, and extractions with a $750 per year maximum benefit (Holleman 2014).

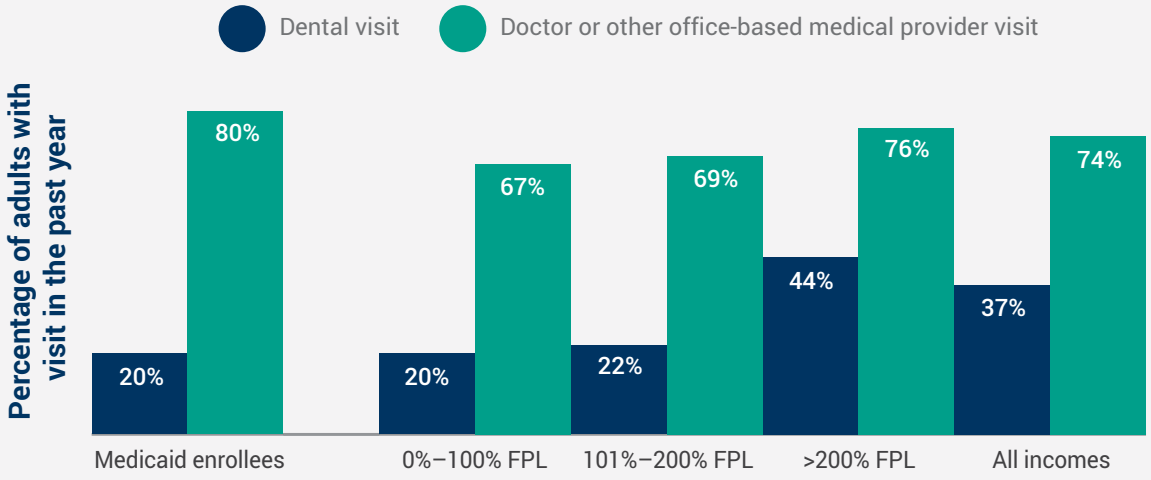
Use of Dental Services

Medicaid enrollees and individuals in other low-income populations use dental services less often than other health services. An analysis of data from the 2012 MEPS found that among adult Medicaid enrollees age 21 and older, 20 percent reported a dental visit within the past year while 80 percent reported a visit to any other type of office-based medical provider during the same time period (MACPAC 2014) (Figure 2-3).[2] Adults with a family income at or below 100 percent FPL, regardless of coverage status, reported dental visits at rates similar to rates of the adult Medicaid enrollee population, though their office-based medical provider visit rate was 13 percentage points lower than that of the adult Medicaid enrollee population.[3]

Between 2000 and 2012, the percentage of adults with a dental visit in the last 12 months decreased, with the most pronounced drop among those with lower incomes. During this time period, the share of adults age 19–64 with family incomes at or below 100 percent FPL who had a dental visit within a 12-month period decreased from 23 percent to 20 percent; for adults age 19–64 with family incomes between 101 and 200 percent FPL, the share with a dental visit during the past year decreased from 26 percent in 2000 to 21 percent in 2012 (Nasseh and Vujicic 2014).

One reason for low utilization of dental services among Medicaid enrollees who have coverage may be the inability to find a provider who participates in the program. There is a shortage of dentists available and willing to treat low-income clients, particularly those enrolled in Medicaid (Gehshan and Straw 2002). In 2008, fewer than half of dentists in 25 states treated any Medicaid patients, and most dentists who did treat Medicaid patients treated fewer than 100 Medicaid patients in a year (GAO 2010). Additionally, the high level of student debt for dental graduates has been identified as a barrier to practicing in rural and low-income communities where earning potential is lower,

FIGURE 2-3. Percentage of Adults Age 21 and Older Who Had a Dental Visit Versus Doctor or Other Office-Based Medical Provider Visit in Past Year, 2012



Notes: FPL is federal poverty level. This chart shows utilization for adults beginning at age 21 because the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires coverage of dental services for 19- and 20-year-old Medicaid enrollees. The Medicaid enrollees category includes adults regardless of income level and reflects those with at least one month of Medicaid coverage. (Estimates for enrollees with full-year coverage may differ.) Income groups include all adults regardless of coverage status.

Source: MACPAC analysis of AHRQ 2012.

creating a geographically uneven distribution of dentists (HRSA 2015).

Dentists cite several reasons for not participating in Medicaid; the most common are low Medicaid payment rates, the administrative burden, and patient issues, such as failing to keep scheduled appointments (Mofidi 2005; GAO 2000). Increasing Medicaid payment rates to a level where payments are high enough to cover overhead expenses has been found to increase provider participation, but is not a solution on its own. Rate increases must be accompanied by administrative reforms and partnerships with state dental associations and individual dentists (Borchgrevink et al. 2008). Dentists who accept Medicaid report more positive attitudes about Medicaid administration than those who do not (McKernan et al. 2015). Additionally, there is some evidence that dentists would rather donate care for low-income and Medicaid patients at a clinic than provide care at their private practices (Gehshan and Straw 2002, Mofidi 2005).

Sixty to 70 percent of dental care for low-income populations is provided in private practice settings. The remainder is provided mainly at clinics, which can be sponsored by federal, state, or local governments (including federally qualified health centers), voluntary organizations, non-profit and public hospitals, and dental schools and residency programs (Bailit and D'Adamo 2012). Some states and communities are working to increase access to dental services, particularly for underserved communities, through telehealth technologies, portable equipment that can be transported to community-based locations, and an expanded scope of practice for dental hygienists and other dental professionals (IOM 2011).

Utilization changes when benefits are cut

When a state reduces or eliminates adult dental benefits, unmet dental needs increase, and use of preventive dental services decreases (Pryor and Monopoli 2005, Wallace et al. 2011). In one study, Medicaid enrollees without dental benefits were nearly three times as likely to have unmet dental needs compared to those whose Medicaid coverage included dental benefits, and they were one-third as likely to get annual dental checkups (Wallace et al. 2011). Another study found that use of dental care among adults—poor adults in particular—decreased from 2000 to 2010, corresponding with reductions and eliminations of adult dental benefits in many state Medicaid programs (Vujicic et al. 2013).

Another consequence of benefit cuts is increased use by Medicaid beneficiaries of emergency departments for dental problems, although the magnitude of the increase varies by study. One study found that emergency department dental visits by Medicaid beneficiaries increased by 23 percent several months after California eliminated Medicaid dental benefits (CHCF 2011). A Maryland study conducted 15 years after the California study had similar results, seeing an increase of 22 percent in emergency department dental visits after Medicaid adult dental benefits were eliminated (Cohen et al. 1996). However, another Maryland study found that Medicaid spending for emergency department dental care for adults rose by only 8 percent after the state eliminated Medicaid dental benefits (Mullins et al. 2004). A national study found a small increase in the number of Medicaid adult emergency dental claims at emergency departments over a period of seven years, during which time several states reduced or eliminated Medicaid dental benefits (Lee et al. 2012). Regardless of the impact on emergency department use, when adult dental benefits in Medicaid are scaled back, community health centers have reported not having enough capacity to deal with the large numbers of new patients (Pryor and Monopoli 2005).

Some communities have created programs aimed at diverting dental patients from emergency departments to other settings. For example, a pilot program in Virginia referred patients with dental pain from the emergency department to an in-hospital dental clinic, reducing the number of dental patients with repeat visits to the emergency department by 66 percent in the first year (Chesser 2014). Another test intervention in Cincinnati, Ohio, connected an emergency department with dental providers who agreed to expedite dental appointments for Medicaid managed care members who presented at the emergency department with dental conditions. The program reported success in diverting patients from the emergency department to participating dental providers by helping patients schedule appointments from the emergency department itself during business hours or by providing contact information and assurances that patients would be seen quickly if they called the dental providers the next day if the emergency department visit was after hours (Chang 2013).

Efforts to Improve Access to Dental Services

Like other forms of health coverage, dental coverage increases access to care, and most low-income adults with dental coverage receive their coverage through Medicaid. Federal law does not mandate dental coverage for adult Medicaid beneficiaries, so despite the strong link between oral health and physical health and the significant burden of oral disease among low socioeconomic groups, state Medicaid programs vary considerably in the dental services they offer adults. Even within states, Medicaid dental benefits can vary from one year to the next, making it difficult for beneficiaries and their providers to know what services are covered. Variability in covered services can affect

continuity of care for some patients, potentially resulting in lost opportunities for prevention and early treatment.

Providers, advocates, researchers, and others have worked on multiple ways to improve access to dental health services for adult enrollees of Medicaid. Examples of innovative projects include the following:

- **Bringing dental care into the community through coordination between the Health Resources and Services Administration (HRSA) and community health centers.** HRSA administers capital development grants to support community- and school-based health center efforts to expand their capacity to provide primary and preventive health services to medically underserved populations in underserved communities (HRSA 2014). For example, in fiscal year 2014, the Bureau of Primary Healthcare at HRSA supported 238 school-based health center oral health activities through School Based Health Center Capital Grants (Makaroff 2014).
- **Funding demonstration projects to study innovative ways to improve Medicaid enrollee use of preventive dental care.** As previously stated, Iowa's current Section 1115 Medicaid expansion demonstration waiver includes three tiers of dental benefits. All waiver enrollees receive a basic level of benefits, enrollees who receive one examination per year receive enhanced dental benefits, and those who receive two examinations per year receive even more dental benefits (CMS 2014c).
- **Expanding access in dental shortage areas through the use of technology.** On January 1, 2015, California began requiring Medi-Cal, the state's Medicaid system, to pay for dental services delivered by hygienists in consultation with dentists connected through the Internet, a practice known as teledentistry. California law allows dental hygienists to perform certain procedures under remote dentist supervision, although it requires the hygienist to refer a patient to a dentist if more sophisticated procedures are needed (Hernandez 2014).
- **Expanding the number of dentists serving Medicaid enrollees through provider incentives.** Some states have worked to encourage dentists to participate in the Medicaid program by increasing reimbursement rates and simplifying administrative processes. For example, in 2008, in an effort to increase children's dental utilization, Connecticut increased its payment rates to match the 70th percentile of private insurance fees from 2005. The state also simplified administrative processes by placing all Medicaid dental services under one administrative service organization. Finally, the state initiated an outreach effort designed to increase the participation of both patients and providers in the dental program. Children's utilization rates increased from 46 percent in 2006 to almost 70 percent in 2011 (Beazoglou et al. 2013).
- **Expanding the number of dentists providing services to Medicaid enrollees through loan repayment models.** The National Health Service Corps (NHSC) provides up to $50,000 in student loan repayment to dentists and other types of health professionals in exchange for a two-year commitment to work at an approved NHSC site in a high-need, underserved area (NHSC 2015). Some states have also created their own programs. For example, since the late 1970s, Nebraska has run a loan repayment program designed to bring dentists and other health care providers to rural areas. The local-state matching program repays up to $40,000 per year for a three-year period to dentists who practice for at least three years in a dental shortage area. These dentists must also accept Medicaid patients (NORH 2011).

- **Amending state scope-of-practice laws to allow for additional members of the dental health team.** Minnesota has enacted a program to create a new type of dental professional, called a dental therapist. Dental therapists are authorized to perform a limited number of dental procedures as part of the dental team. They are required to practice in settings serving primarily low-income, uninsured, and underserved patients or in Health Professional Shortage Areas for dental care (Minnesota Department of Health 2014). Alaska, in an effort to increase the dental workforce serving tribal health consortiums, has implemented a similar, though not identical, program that allows dental health aides to perform routine dental services under the supervision of a dentist (Shoffstall-Cone and Willard 2013).

MACPAC will continue to examine issues related to adult dental benefits in Medicaid. In particular, we plan to analyze data on enrollee use of the emergency room for dental services and how such service use relates to state coverage policies. We also plan to learn more about the adequacy of the dental workforce for the Medicaid population, the sites of care for Medicaid dental services, and state initiatives to increase adult dental utilization in Medicaid.

Endnotes

[1] Originally the requirement to provide comprehensive dental services only pertained to children enrolled in Medicaid, but Congress required that states provide dental services through CHIP in the Children's Health Insurance Program Reauthorization Act of 2009 (CDHP 2012).

[2] The 2012 MEPS data does not differentiate between Medicaid enrollees who had dental benefits beyond emergency services and those who did not.

[3] The main sources of data on dental coverage and use are the MEPS and the National Health Interview Survey (NHIS). Both surveys rely on information reported by individuals, and the MEPS sample is drawn from a nationally representative subsample of families and individuals who took part in the NHIS the previous year (GAO 2008). MEPS visit data are considered more accurate than NHIS data because they are generally verified by providers and written in a journal.

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APPENDIX 2A: State Dental Benefits Policies, as of February 2015

TABLE 2A-1. Medicaid Adult Dental Benefits and Limits by State, as of February 2015

State	Adult dental services covered by state Medicaid plans and annual caps						Limits
	Preventive services	Restorative services	Periodontal services	Dentures	Oral surgery services	Orthodontia	Annual spending limit (dollars)
Total number states offering these services	28	26	19	26	25	2	9
Alabama[1]	No coverage for dental services to adults over 20 years						
Alaska	After reaching annual monetary cap, adult is responsible for any additional costs	After reaching annual monetary cap, adult is responsible for any additional costs	—	May obtain both upper and lower dentures in one year by combining current and upcoming year monetary limits	—	—	Yes ($1,150)
Arizona	Emergency services only						
Arkansas	1 exam per year; 1 cleaning per year; 1 fluoride treatment per year	Fillings and crowns covered to monetary limit (fillings will be paid beyond annual monetary limit)	Scaling and root planing	1 full or partial denture per lifetime; payments for complete or partial dentures and to lab paid beyond annual monetary limit	Simple and surgical tooth pulling will be paid beyond annual monetary limit	—	Yes ($500)
California	2 exams per year; 1 cleaning per year; 1 fluoride treatment per year	Prefabricated crowns (1 per year for primary teeth and 1 every 3 years for permanent teeth); lab processed crowns (1 every 5 years); root canals except for 3rd molar	1 scaling or root planing per quadrant every 2 years	1 full or partial denture every 5 years; 1 immediate denture per lifetime, not applied toward annual limit	Maxillofacial and complete oral surgery not applied toward annual limit	—	Yes ($1,800)
Colorado	Exams and cleanings covered to monetary limit	Fillings, crowns, and root canals covered to monetary limit	Gum treatment covered to monetary limit	Complete set of upper or lower dentures to monetary limit	Unspecified procedures covered	—	Yes ($1,000)
Connecticut	1 exam per year; 1 cleaning per year	1 filling per year; 1 crown per tooth every 5 years; 1 root canal per tooth per lifetime	Gingevectomy or gingiovoplasty covered with prior authorization	1 full or partial denture every 7 years	Extractions, impactions, and other procedures	—	—
Delaware[1]	No coverage for dental procedures for clients over twenty-one years of age in any setting						

TABLE 2A-1. (continued)

State	Adult dental services covered by state Medicaid plans and annual caps						Limits
	Preventive services	Restorative services	Periodontal services	Dentures	Oral surgery services	Orthodontia	Annual spending limit (dollars)
District of Columbia	2 exams per year; 2 cleanings per year; 2 fluoride treatments per year; 1 sealant per tooth per lifetime	1 filling per tooth, up to 5 fillings per year	1 scaling and root planing per quadrant per year	1 full or partial denture every 5 years	Emergency repair of accidental injury to jaw or related structures	1 removable or fixed appliance therapy per lifetime; 1 unspecified procedure per lifetime	—
Florida	—	—	—	1 upper and lower denture per lifetime	—	—	—
Georgia	Emergency services only						
Hawaii	Emergency services only						
Idaho	Emergency services only						
Illinois	—	1 filling per tooth; per year; 1 crown per tooth every 5 years; 1 root canal per tooth per lifetime	–	1 complete denture every 5 years; 1 immediate denture every 5 years	Surgical removal of impacted teeth, removal of tumors in emergencies	–	–
Indiana[2]	1 exam per year; 1 cleaning per year	–	–	–	–	–	–
Iowa[3]	2 exams per year; 2 cleanings per year; 4 fluoride treatments per year	1 filling per tooth every 2 years; crowns with resin window for front teeth only	Scaling, root planing, etc. with prior approval	1 full or partial denture every 5 years	Extractions, impaction, root recovery, other procedures	–	–
Kansas	Emergency services only						
Kentucky	1 cleaning per year	—	1 scaling and root planing per quadrant per year in limited circumstances	—	—	—	—
Louisiana	—	—	—	1 full or partial denture every 8 years (partial must oppose full)	—	—	—
Maine	Emergency services only						
Maryland	Emergency services only						

TABLE 2A-1. (continued)

State	Adult dental services covered by state Medicaid plans and annual caps						Limits
	Preventive services	Restorative services	Periodontal services	Dentures	Oral surgery services	Orthodontia	Annual spending limit (dollars)
Massachusetts	2 exams per year; 2 cleanings per year	Crowns (material depends upon tooth); root canals in limited circumstances	–	Only removable complete and partial dentures covered	Removal of impacted teeth; biopsies; soft-tissue surgery	–	–
Michigan[4]	2 exams per year; 2 cleanings per year	–	–	–	–	–	–
Minnesota	1 exam per year; 1 cleaning per year; 1 fluoride treatment per year	Posterior fillings; 1 root canal per tooth per lifetime	1 full mouth debridement every 5 years	1 full or partial denture per arch every 6 years	Prior authorization for removal of impacted teeth	–	–
Mississippi	Emergency services only						Yes ($2,500)
Missouri	Emergency services only						
Montana	Emergency services only						
Nebraska	1 exam per year; 1 cleaning per year; fluoride and sealants	Fillings; crowns; root canals (upper 2nd molar is not covered for root canal if 1st molar is in occlusion)	Gingivectomy or gingivoplasty; periodontal scaling, root planing; full mouth debridement	Dentures must be of a material that will last 5 years	Extractions (medical need); tooth reimplantation or stabilization	–	Yes ($1,000)
Nevada	–	–	–	With prior authorization	–	–	–
New Hampshire	Emergency services only						
New Jersey	1 exam per year; 1 cleaning per year	Fillings; crowns (excluding porcelain jackets); root canals	1 scaling and root planning per year, prior authorization required for more than one	1 full or partial denture every 7.5 years	Extractions with preauthorization (not required if tooth is impacted)	–	–
New Mexico	1 exam per year; 1 cleaning per year; 1 fluoride application per year	Fillings; 1 prefabricated stainless steel or prefabricated resin crown per tooth	Scaling and root planing; periodontal maintenance with pre-authorization	–	Simple and surgical extractions; tooth reimplantation; drainage of abscess	–	–

TABLE 2A-1. (continued)

State	Adult dental services covered by state Medicaid plans and annual caps						Limits
	Preventive services	Restorative services	Periodontal services	Dentures	Oral surgery services	Orthodontia	Annual spending limit (dollars)
New York	2 exams per year; 2 cleanings per year; 2 fluoride applications per year	Fillings; crowns (not routinely approved for molars); root canals	1 scaling and root planing per quadrant every 2 years	1 full or partial denture every 8 years	Extractions; alveoplasty; vestibuloplasty; other procedures	–	–
North Carolina	2 exams per year; 2 cleanings per year; 2 fluoride applications per year	Only resin based crowns	1 scaling and root planing per quadrant per 2 years	1 complete or immediate denture per arch every 10 years; 1 partial denture per arch every 8 years	Extractions; alveoplasty; vestibuloplasty; other procedures	–	–
North Dakota[5]	1 exam per year; 1 cleaning per year	Front crowns that have a root canal on the tooth only; root canals (front only)	Scaling and root planing; periodontal maintenance	5 year limit on replacement of immediate complete and partial dentures; missing back teeth not covered unless at least one front tooth included	–	–	–
Ohio	1 exam per year; 1 cleaning per year	Fillings; crowns; root canals upon medical necessity	–	Dentures upon medical necessity	Upon medical necessity	–	–
Oklahoma	Emergency services only						
Oregon	1 exam per year; 1 cleaning per year; fluoride	Amalgam and resin based crowns; root canals (not for molars)	–	1 set partial dentures every 10 years; 1 complete denture per lifetime	Extractions	Removable and fixed appliance therapy	–
Pennsylvania	2 exams per year; 2 cleanings per year	Root canals; crowns (with prior authorization)	Periodontal services (with prior authorization)	1 denture per lifetime	Extractions	–	–
Rhode Island	2 exams per year; 2 cleanings per year; 2 fluoride applications per year	Root canals (front teeth only); crowns (stainless steel only for back teeth)	1 scaling or root planing every 2 years	1 full or partial denture every 5 years	Upon medical necessity	–	–
South Carolina[6]	1 exam per year; 1 cleaning per year	1 amalgam and 1 resin-based filling every 3 years	–	–	Extractions; Impactions; other procedures	–	Yes ($750)

TABLE 2A-1. (continued)

State	Adult dental services covered by state Medicaid plans and annual caps						Limits
	Preventive services	Restorative services	Periodontal services	Dentures	Oral surgery services	Orthodontia	Annual spending limit (dollars)
South Dakota	Exams; cleanings; fluoride application	Fillings; crowns and root canal therapy	–	Complete and partial dentures	Extractions	–	Yes ($1,000)
Tennessee[7]	No coverage for dental procedures unless adult enrollee presents to a hospital with a dental problem						
Texas	Emergency services only						
Utah	Emergency services only						
Vermont	2 exams per year; 2 cleanings per year; 2 fluoride applications per year	Prefabricated crowns only (1 per tooth every 2 years)	Root canal therapy; 1 scaling and root planing in each quadrant per year	–	Extractions; impactions; biopsies; other procedures	–	Yes ($510)
Virginia	–	–	–	–	Upon medical necessity	–	–
Washington	1 exam per year; 1 cleaning per year; 1 fluoride application per year	1 filling per tooth every 2 years; crowns not covered; root canals for front teeth only	1 scaling or root planing per quadrant every 2 years	Partial dentures if 1 front tooth or 4 back teeth are missing per arch (but not 2nd or 3rd molar)	Extractions; biopsies; intraoral and extraoral incise; draining	–	–
West Virginia	Emergency services only						
Wisconsin	1 cleaning per year; 1 fluoride application per year	1 filling per tooth every 3 years; 1 stainless steel, or resin crown per tooth every 5 years; 1 stainless steel crown with resin window per tooth per year; (resin crowns and stainless steel crowns with resin window for front teeth only); 1 root canal per tooth per lifetime	1 scaling or root planing per quadrant every 3 years; full mouth debridement; gingivectomy and gingivoplasty; periodontal maintenance	1 full or partial denture per arch every 5 years	Extractions; alveoloplasty; other procedures	–	–
Wyoming	1 exam per year; 1 cleaning per year	Restorative services essential to restore and maintain adequate dental health	–	1 complete or immediate denture or 1 partial denture per arch per lifetime	Extractions; impactions	–	–

TABLE 2A-1. (continued)

Notes:

[1] Alabama and Delaware classify themselves as offering no dental services, including no emergency services. However, emergency services related to oral health care may be covered under another benefit type. Alabama states that dental services are "any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. Such services include treatment of the teeth and the associated structures of the oral cavity, and of disease, injury, or impairment, which may affect the oral or general health of the individuals" (Alabama Medicaid 2015). Delaware states that dental services include "any services related to the dental treatment such as drugs, anesthetics, and use of operating/recovery room, etc." (Delaware Health and Social Services 2014).

[2] Indiana: Dental benefits are available to beneficiaries in traditional Medicaid, which is available to parents making up to 22 percent of the federal poverty level. Dental benefits are also available to beneficiaries in the Healthy Indiana Plan (HIP) Plus program, which includes beneficiaries between 100 and 138 percent of the federal poverty level (who are required to make contributions to a health savings account) and beneficiaries with incomes at or below 100 percent of the federal poverty level who choose to make contributions to a health savings account. (Indiana Medicaid Website, Indiana HIP 2.0 Demonstration Approval).

[3] Iowa: Dental benefits are available to beneficiaries in traditional Medicaid. Three tiers of dental benefits are available to beneficiaries in the Iowa Wellness Plan and Iowa Marketplace Choice program, which include beneficiaries with incomes at or below 138 percent of the federal poverty level. The core benefits are basic preventive and diagnostic, emergency, and stabilization services and are available to all enrollees. The "enhanced" benefits cover restorative services, endodontic services, denture adjustments and repairs, non-surgical extractions and other oral surgery services, and designated adjunctive services. The "enhanced plus" benefits include crowns and onlays, tooth replacements, and gum surgery. To be eligible for enhanced benefits, enrollees must complete a periodic exam within 6 to 12 months of the first visit. To be eligible for enhanced plus benefits, enrollees must complete two periodic exams within 6 to 12 months of the first visit. To maintain eligibility for the enhanced or enhanced plus benefits, enrollees must continue to return for periodic exams every 6 to 12 months. (Letter from Cindy Mann to Jennifer Vermeer, 2014).

[4] Michigan: Through the state's Section 1115 Healthy Michigan waiver, the state covers two exams, cleanings, and X-rays per year. Other diagnostic, therapeutic, and restorative care (including fillings, tooth extractions, and dentures and partial dentures) are covered for conditions relating to a specific medical problem. All prosthodontics (dentures) require prior authorization. (Michigan Medicaid State Plan Attachment 3.1-C. 2014; Michigan Department of Community health 2014).

[5] North Dakota: The state created an alternative benefits plan (ABP) for its Medicaid expansion population that includes emergency-only adult dental benefits. The base Medicaid population retains additional benefits through the state plan. (North Dakota ABP State Plan Amendment).

[6] South Carolina: Beginning December 1, 2014, enrollees became eligible for cleanings, fillings, and extractions with a $750 annual limit. (The State, October 24, 2014).

[7] Tennesee covers emergency dental treatment only when "an adult enrollee presents to a hospital Emergency Department with a dental problem," in which case screening and treatment of the emergency medical condition identified in the screening are covered. Tennessee does not cover services to treat the origin of the emergency medical condition, and does not cover any emergency services in any setting beyond the emergency department. (TennCare 2014).

Sources: MACPAC analysis of AHCCCS 2014, Alaska DHHS 2014, Amerigroup 2014, Anthem Blue Cross and Blue Shield 2014, BadgerCare Plus and Wisconsin Medicaid 2015, BadgerCare Plus and Wisconsin Medicaid 2013, Better Health Florida 2014, California Medi-Cal Dental Program 2015, Colorado DHCPF 2014, Commonwealth of Virginia DMAS 2012, Connecticut Dental Health Partnership 2013, DentaQuest of Illinois, LLC. 2014, DentaQuest, South Carolina Healthy Connections 2014, Florida AHCA 2011, Hawaii State Med-Quest Division 2011, Holleman 2014, Idaho DHF 2015, Illinois DHFS 2014, Indiana Dental Association 2011, Indiana FSS 2014, Iowa DHS 2013, KanCare 2015, Kansas DHE 2015, 907 Ky. Admin. Regs. 1:026 (2012), Kentucky CHFS 2013, Maine Department of Health and Human Services 2014, Maryland DHMH 2015, Maryland DHMH 2007, Massachusetts EOHHS 2014, 130 Mass. Code Regs. 420 (2014), MDWise 2014, Michigan DCH 2014, Minnesota DHS 2014, Miss. Admin. Code 23-204:1 (2015), Missouri DSS 2013, MOHealthNet 2013, Montana DPHHS 2015, Montana DPHHS 2013a, Montana DPHHS 2013b, Nebraska DHHS 2008, Nevada DHHS 2010, New Hampshire Medicaid Program 2013, N.J. Admin. Code § 10:56-2.6 (2015), N.M. Admin. Code § 8.310.2.12(G) (2015), New York State Medicaid Program 2013, North Carolina DMA 2013, North Dakota DHS 2013, Ohio Department of Medicaid 2015, Okla. Admin. Code § 317:30-5-696 (2014), Or. Admin. R. 410-123 (2014), Oregon Health Plan 2012, Oregon Medicaid 2014, Peach State Health Plan 2013, Pa. Code § 55:1149.24 (2015), Pennsylvania DPW 2014a, Pennsylvania DPW 2014b, Rhode Island DHS 2010, South Carolina Healthy Connections Choices 2015, South Dakota DSS 2015, South Dakota DSS 2015, State of Louisiana BHSF 2012, State of Louisiana DHH 2015, State of Missouri 2013, Texas HHSC 2015, Utah DMHF 2014, Vermont AHS 2014, Washington AppleHealth 2014, WellCare 2014, West Virginia BMS 2015, West Virginia DHHR 2012, Wyoming Department of Health 2015, Xerox 2014.

TABLE 2A-2. Relevant Dental Policy Restrictions by State, as of February 2015

State	State definition of emergency services or relevant policy restrictions
Arizona	"Services furnished by dentists which are covered for members 21 years of age and older must be related to the treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction (TMJ) pain), infection, or fracture of the jaw. Covered services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma."
Georgia	The state provides emergency dental services for members age 21 and older. The state contracts with Amerigroup Community Care, Peach State Health Plan, and WellCare health plans for Medicaid services and all three provide additional dental benefits for free to beneficiaries, including oral exams, cleanings, and simple tooth removal.
Hawaii	"Individuals over 20 years of age are eligible for dental coverage limited to the treatment of dental emergencies….Adult dental benefits are restricted to a limited panel of services necessary for the control or relief of dental pain, elimination of infection of dental origin, management of trauma and/or treatment of acute injuries to teeth and supporting structures."
Idaho	"Dental benefits for adults ages 21 and older will be limited to emergency dental treatment only such as pain or infection."
Kansas	Dental services are not covered for beneficiaries under KMAP (Kansas Department of Health and Environment 2015). However, three Medicaid managed care organizations operate in Kansas, and all three offer limited dental benefits as a value-added service.
Maine	Adult dental care for adults 21 years of age or older is limited to "acute surgical care directly related to an accident where traumatic injury has occurred within three months of the accident; oral surgical and related medical procedures not involving the dentition and gingiva; extraction of teeth that are severely decayed and pose a serious threat of infection during a major surgical procedure of the cardiovascular system, the skeletal system or during radiation therapy for a malignant tumor; treatment necessary to relieve pain, eliminate infection or prevent imminent tooth loss; and other dental services, including full and partial dentures, medically necessary to correct or ameliorate an underlying medical condition, if the Department determines that the provision of those services will be cost-effective in comparison to the provision of those services will be cost-effective in comparison to the provision of other covered medical services for the treatment of that condition."
Maryland	"All of the MCOs [participating in Maryland's HealthChoice program] have chosen to offer preventive dental services for adults, a service not normally covered under Maryland Medicaid. Only those enrolled in Healthy Choice may receive these services."
Missouri	"Changes in MO HealthNet Program benefits were effective for dates of service on or after September 1, 2005. The bill eliminated certain optional MO HealthNet services for individuals age 21 and over that are eligible for MO HealthNet under one of the following categories of assistance:…MO HealthNet for Families – Adult…MO HealthNet coverage for the following programs or services has been eliminated or reduced for adults with a limited benefit package…dental services…"
Montana	"When dental services are necessary to get or keep a job, talk with your OPA Case Manager about the 'Essential for Employment' program. Emergency dental care is covered when related to emergency treatment."
New Hampshire	"Dental services for members 21 years of age and older is limited to the treatment of acute pain and acute infection. This generally means NH Medicaid covers extractions and services related to extraction to relieve pain or acute infection. For example, covered services for an adult with a complaint of acute pain may include a problem-focused examination and radiographs to the extent needed to diagnose and document the need for the extraction, as well as needed to perform the extraction itself."

State	State definition of emergency services or relevant policy restrictions
Oklahoma	"Dental coverage for adults is limited to: (i) medically necessary extractions and approved boney adjustments. Surgical tooth extraction must have medical need documented if not apparent on images of tooth. In the SoonerCare program, it is usually performed for those teeth which are damaged to such extent that no tooth is visible above the gum line, the tooth fractures, the tooth is impacted, or tooth can't be grasped with forceps; (ii) Smoking and Tobacco Use Cessation Counseling; and (iii) medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician."
Texas	"Dental Services Overview: The services provided by a dentist to preserve teeth and meet the medical need of the consumer. Allowable services include emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection; preventative procedures required to prevent the imminent loss of teeth; the treatment of injuries to teeth or supporting structure; dentures and the cost of preparation and fitting; and routine procedures necessary to maintain good oral health."
Utah	"The dental program does not cover services for Traditional and Non-Traditional Medicaid beneficiaires. Nevertheless, certain emergency dental procedures are a least costly alternative to covered services outside of the dental program and can be reimbursed."
West Virginia	"Covered dental services for adults 21 years of age and older are limited to emergent procedures to treat fractures, reduce pain, or eliminate infection. Prior authorization and service limits may apply."

Sources: MACPAC analysis of AHCCCS 2014, Amerigroup 2014, Peach State Health Plan 2013, WellCare 2014, Hawaii State Med-Quest Division 2011, Idaho DHF 2015, KanCare 2015, Maine Department of Health and Human Services 2014, Maryland DHMH 2015, State of Missouri 2013, Montana DPHHS 2015, New Hampshire Medicaid Program 2013, Okla. Admin. Code § 317:30-5-696 (2014), Texas HHSC 2015, Utah DMHF 2014, West Virginia DHHR 2012, 2015.